Oregon Health Authority

HIV and Advanced HIV Infection Investigative Guidelines

November 2023

1. DISEASE REPORTING

1.1 Purpose of Reporting and Surveillance

1. To identify new cases of HIV infection and advanced HIV infection (also known as AIDS).
2. To accurately monitor HIV in Oregon.
3. To describe persons with HIV infection, also referred to affected persons throughout this document.
4. To plan and evaluate treatment and prevention programs.
5. To identify affected persons in need of care and treatment and direct them to available resources and supports.
6. To advise affected persons regarding prevention of HIV transmission to others.
7. To identify localized clusters of new infection and prevent further transmission of disease.
8. To insure that persons who have been exposed (e.g., sexual contacts, others exposed to blood or body fluids, injection drug use partners) and unaware of their exposure are counseled about measures to prevent infection.

1.2 Laboratory and Physician Reporting Requirements

1. Licensed laboratories must report to the Local Public Health Authority (LPHA) within one working day results of all tests indicative of and specific for HIV infection (e.g., detectable levels of HIV ribonucleic acid [RNA], positive tests for p24 antigen, positive enzyme linked antibody (EIA) tests for HIV with an FDA-approved antibody immunoassay that differentiates HIV-1 antibodies from HIV-2 antibodies, (OAR 333-018-0015). Upon agreement between the LPHA and the Oregon State Public Division (HST) (OAR 333-018-0005), reports may be made directly to HST (OAR 333-018-0005). In addition, licensed laboratories must report results of all CD4 + T-lymphocyte counts and viral RNA tests (“viral loads”) regardless of result within seven days. Laboratory reports may be made directly to the Oregon State Public Health HIV/STD/TB (HST) Program (OAR 333-018-0015).
2. Physicians and other health care providers must report a case or suspected case of HIV within one working day to the Local Public Health Authority (LPHA) (OAR 333-018-0015). Upon agreement between the Local Public Health Authority and the Oregon State Public Health Division, HIV/STD/TB Section (OAR 333-018-0005), reports may be made directly to HST (OAR 333-018-0005).

1.3 Local Public Health Authority Reporting and Follow-up Responsibilities

LPHA must report all confirmed cases of HIV infection to HST no later than the end of the business week of the initial report by the laboratory, physician or other health care provider. (OAR 333-018-0020).

2. THE DISEASE AND ITS EPDEMIOLOGY

2.1 Etiologic Agent

Human immunodeficiency virus-1 (HIV-1), a retrovirus, is the cause of almost all HIV-related disease in the U.S. and is found throughout the world. HIV-2 is a closely related virus, causing similar illness. To date, most HIV-2 infections have been documented in people living in West Africa and or their contacts; only a handful have been reported in the U.S and none have been reported in Oregon.

2.2 Description of Illness

Untreated illness due to HIV infection is biphasic. The initial phase, which may go unnoticed, occurs shortly after infection. This acute syndrome resolves spontaneously, and the infection becomes latent for several years. Eventually, if untreated, a progressive immune dysfunction develops, associated with depletion of CD4+T-lymphocytes, which predisposes the affected individual to opportunistic infections, tumors, and other conditions.

1. **Acute Infection**
   Shortly after exposure, many affected persons experience a flu-like illness that may resemble mononucleosis. Onset is typically abrupt. Common symptoms of acute infection include fever or sweats, myalgias or arthralgias, malaise and lethargy, lymphadenopathy, sore throat, anorexia, nausea and vomiting, headaches, photophobia, rash, and diarrhea. Symptoms usually resolve over two to three weeks.

2. **Subsequent Illness**
   Most people with HIV infection remain asymptomatic for years after resolution of acute symptoms. During this latent period infection can only be determined by antibody, viral load, or other laboratory testing. If untreated, most HIV-affected individuals eventually manifest myriad signs and symptoms that reflect progressive immune deficiency and herald the onset of advanced HIV infection such as persistent generalized lymphadenopathy, neurological disorders, opportunistic infections (OIs), and malignancies. However, treatment with antiretroviral medications (ART) can delay or reverse the progression of immune deficiency. Many of the more common manifestations of advanced

immunosuppression associated with HIV-infection are listed in the AIDS case definition.

2.3 Reservoirs

Humans with HIV infection only.

2.4 Sources and Routes Transmission

HIV transmission occurs when blood, blood products, semen, vaginal fluids or breast milk from an affected, and untreated person enters the bloodstream of another person via injection or across breaks or small abrasions of the skin or mucous membranes (e.g., the eye, mouth, vagina or rectum). Virtually all transmission occurs through sexual (sex with an untreated affected person), parenteral (injection with contaminated equipment or injection of contaminated blood or blood products), or vertical (passage of HIV from a pregnant person to the baby during pregnancy or breast feeding) routes. While HIV may also be found in cerebrospinal fluid, tears, amniotic fluid, urine and bronchoalveolar fluid of affected persons, transmission via exposure to these fluids has not been documented. HIV is not transmitted by casual contact (e.g., shaking hands, sharing dishes, closed-mouth kissing).
It should be noted that when an affected person is on HIV ART and achieves and maintains viral suppression, they cannot transmit HIV to others through oral, anal or vaginal sex. And vertical transmission or transmission via breastfeeding is significantly less likely to occur when on HIV ART and the virus is undetectable.

2.5 Incubation Period

When present, symptoms of acute HIV (see 2.2-1) occur 6 days–6 weeks (rarely, up to 6 months) after infection. HIV antibodies usually develop within a few weeks of exposure. While uncommon, HIV antibodies can develop as much as 6 months later. The interval between infection and antibody development is referred to as the “window period.” Without treatment, about 50% of HIV-affected persons develop advanced HIV infection (AIDS) within 10 years of infection; advanced HIV infection is rare within 3 years of initial infection.

2.6 Period of Communicability

Untreated HIV affected persons with elevated viral loads (>1500 copies/mL) can transmit HIV to sexual partners. However, when an affected person is on HIV ART and achieves and maintains viral suppression, they cannot transmit HIV to others through oral, anal or vaginal sex. Vertical HIV transmission and transmission via breastfeeding is significantly less likely to occur while on arti-retroviral therapy and the virus is undetectable (<1% risk). There is not yet enough research on injection drug related transmission while virally suppression or with an undetectable viral load, but relative infectivity is believed to be reduced.

2.7 Treatment

Specific treatment of HIV infection is complex and beyond the scope of these guidelines. (Treatment guidelines can be found at https://clinicalinfo.hiv.gov/en/guidelines.) Locally, health care providers can obtain

treatment advice from the AIDS Education and Training Center by dialing, 971-200-5266 or online: https://www.oraetc.org/what-we-do.

As per Section 2.6, consistent and effective HIV treatment eliminates or significantly reduces the risk of transmission and viral replication. All patients with HIV should be referred for treatment and care rapidly since consistent ART use and viral suppression can eliminate HIV transmission through sex. ART in pregnancy and during labor reduces the risk of vertical transmission of HIV at birth from mother to infant to less than 1%. Elective cesarean delivery may further reduce vertical transmission in cases where plasma levels of HIV RNA are not sufficiently suppressed (<1000 copies ml) prior to the onset of labor. The risk of HIV transmission while breastfeeding is less than 1% (but not zero) for people with HIV on antiretroviral therapy (ART) with sustained undetectable viral load through pregnancy and postpartum.

Antiretroviral drugs in current use include nucleoside and non-nucleoside reverse transcriptase inhibitors, protease inhibitors, integrase inhibitors, CCR5 binding inhibitors, fusion inhibitors, and capsid inhibitors. Additional medications can prevent opportunistic infections (OIs) such as disseminated Mycobacterium avium complex and Pneumocystis pneumonia in the presence of advanced immune deficiency.

3 CASE DEFINITIONS, DIAGNOSIS, AND LABORATORY SERVICES

In Oregon, newly diagnosed cases of HIV infection, regardless of severity must be reported to local or state public health authorities (ORS 433.004 and OAR 333-018-0000, 333-018-0010, 333-018-0005, 333-018-0015, 333-018-0030, 333-019-031).

Centers for Disease Control and Prevention testing guidance can be found here:

https://www.cdc.gov/hiv/guidelines/testing.html

https://www.cdc.gov/hiv/guidelines/recommendations/technical-update-for-hiv.html (NAT updates May 2023).

Definition of HIV Infection

Persons aged ≥18 months

3.1 Confirmed Case

Once case investigation is complete, the OHA HIV Data and Analysis Program staff will update case “Status” in Orpheus as Confirmed.

3.2 Under Investigation Case

The initial HIV serologic test and the other or “supplemental” HIV antibody test that is used to verify the result of the initial test may be of any type approved by the federal Food and Drug Administration for screening or diagnosis of HIV infection, but they must not be identical (FDA website: https://www.fda.gov/vaccines-blood-biologics/hiv-1). The type of HIV antibody test that verifies the initial test may be one

formerly used only as an initial or preliminary test (e.g., as a conventional enzyme immunoassay [EIA], rapid immunoassay [IA], chemiluminescent assay, HIV-1/2 type-differentiating immunoassay, or it may be one traditionally used as a supplemental test for confirmation (e.g., Western blot [WB], immunofluorescence assay [IFA]). For the purpose of HIV infection surveillance, the CLSI algorithms that conclude with a "presumptive positive" are to be considered equivalent to those that conclude with a definitive positive and will be investigated pending confirmation testing.

OR

Positive conclusion of a multi-test HIV antibody algorithm from which only the final result was reported (including a single positive test result from a "supplemental" test indicative of HIV (e.g., HIV-1/2 type-differentiating immunoassay, immunofluorescence assay).

OR

Positive result or report of a detectable quantity (i.e., within the established limits of the laboratory test) from any of the following HIV virologic (i.e., non-antibody) tests:
Qualitative HIV nucleic acid (DNA or RNA) test (NAT) (e.g., polymerase chain reaction [PCR]),
Quantitative HIV NAT (viral load assay),
HIV isolation (viral culture).

Case "Status" in Orpheus will remain as Under Investigation until OHA HIV Data and Analysis Program staff deem the case investigation complete.

3.3 Suspect Cases

Unconfirmed positive antibody test such as a single rapid or laboratory-based antigen/antibody test without evidence of confirmation.

OR

A note written by a physician or other qualified medical-care provider that does not meet the laboratory criteria described above but states that the patient has HIV infection.

OR

Evidence of testing by licensed health care provider for any of the following: HIV nucleic acid (DNA or RNA) detection (a.k.a. "viral load"); HIV p24 antigen test; HIV isolation (viral culture); CD4+T-lymphocyte count or percentage of total lymphocytes; antiretroviral resistance testing.

Follow up investigation is incomplete.

Definition of HIV Infection

Persons aged <18 months

3.4 Confirmed Cases

Positive results on two separate specimens (not including cord blood) from one or more of the following HIV virologic (non-antibody) tests:

- HIV nucleic acid (DNA or RNA) detection,
- HIV p24 antigen test, including neutralization assay, for a child aged >1 month,
- HIV isolation (viral culture),
- HIV genotype nucleotide sequence.

Follow up investigation is complete.

3.5 Suspect/Under Investigation Cases

Positive results on only one specimen (not including cord blood) from any of following HIV virologic tests:

- HIV nucleic acid (DNA or RNA) detection,
- HIV p24 antigen test, including neutralization assay, for a child aged >1 month,
- HIV isolation (viral culture),
- HIV genotype nucleotide sequence.
-

AND

No subsequent negative results on HIV virologic or HIV antibody tests.

OR

A note written by a physician or other qualified medical-care provider that does not meet the laboratory criteria described above but states that the patient has HIV infection.

Follow up investigation is incomplete.

3.6 Staging the Infection

The CDC distinguishes HIV stages of infection for surveillance from stages defined for clinical management. For more information, go to https://www.cdc.giv/mmwr/preview/mmwrhtml/rr6303a1.htm?s_cid=rr6303a1_e.

3.7 Services Available at Oregon State Public Health Laboratory (OSPHL)

OSPHL uses serum tests which detect HIV-1 p24 antigen, HIV-1 & HIV-2 antibodies. Specimens reactive by Chemiluminescent microparticle immunoassay (CMIA) will

automatically be reflexed to an HIV differentiation test. When results from these two assays are discordant, specimens are forwarded to a reference lab for an HIV Nucleic Acid Test (NAT) to confirm HIV status. OSPHL does not offer rapid antibody testing. Rapid testing can be obtained from on-line self-collected testing sites (e.g., Take Me Home, Get Tested), from some LPHAs and private health care providers.

HIV antibody testing processed by OSPHL is available to clients of an LPHA, and to others by special arrangement with OSPHL and the HIV Prevention Program.* For HIV antibody testing, 5-7 ml of blood in a 13x100 Vacutainer® tube is required. Contact the virology section at OSPHL (503-229-5882) or the state HIV Program (971-673-0153 or email at prevention.info@odhsoha.oregon.gov) with questions about HIV testing.

3.8 Other Laboratory Methods (Not Available at OSPHL)

HIV RNA detection (a.k.a. “viral load”), HIV p24 antigen test, HIV isolation (viral culture), and testing for resistance to antiretroviral drugs are not available at OSPHL. These tests can be obtained from various private clinical labs. However, OSPHL will send discordant test results to a partnering reference lab for HIV NAT testing.

Rapid and self-collected lab-based testing can be obtained through a variety of websites (e.g., Take Me Home, Let’s Get Checked, I Want the Kit, etc.), some LPHAs, private laboratories and health care providers.

4 CASE INVESTIGATION

Oregon’s HIV/STD/TB Section is committed to promoting and achieving health and racial equity in all its work and share the Oregon Public Health Division’s (PHD) definition of health equity: the absence of unfair, avoidable, or remediable difference in health among social groups. Considerations include providing culturally responsive and respectful services which are trauma informed, and mindful of stigma, cultural norms and are linguistically accommodating. These principles guide our work and are foundational elements of our case investigation efforts.

4.1 Primary Investigation by Local Public Health Authority

New Suspect and Under Investigation HIV cases may be identified by the LPHA through a direct report from a physician or from a laboratory report of a confirmed positive (both HIV-1 p24 antigen, HIV-1 & HIV-2 antibodies and HIV-1/2 type-differentiating immunoassay reactive/positive), HIV antibody test, or a detectable HIV viral load (more than 200 copies of the human immunodeficiency virus (HIV) per milliliter) in an individual whose case has not previously been reported. Cases may also be reported to the LPHA by HST as a result of direct reporting by laboratories or

Until February 2012, a person could not be tested for HIV in Oregon unless he or she provided informed consent in a strict medico-legal sense. With the passage of SB 1507 in February 2012, a person upon whom HIV testing is being conducted must be notified of the intent to test for HIV and given an opportunity to decline testing. Notification may be conducted verbally or in writing and may be contained in a general medical consent for treatment.

physicians or as a result of required laboratory reporting directly to HST of all tests indicative of HIV, including HIV screening tests, viral loads and CD4+ T-lymphocyte and CD4+ T-lymphocyte percent tests.

1. Under Investigation Case

For case investigations not referred to LPHAs by HST HIV Data and Analysis staff, verify that the affected person has not been previously reported by contacting HST's HIV Data and Analysis Program. If the affected person has previously been reported, no additional investigation is required. If there is suspicion the affected person is not engaged in regular HIV medical care, an attempt to contact the affected person and/or the health care provider should occur to offer care linkage, treatment or referrals as needed. A list of case management specialists who can assist with referrals to care in every county can be found at the following website: http://public.health.oregon.gov/DiseasesConditions/HIVSTDViralHepatitis/HIVCareTreatment/Pages/cmcontacts.aspx or see Attachment A – Case Management and Other Services.

2. Completing the Case Report

(in Orpheus or by paper copy for persons not previously reported.)

Contact the facility or health care provider/s where the HIV diagnosis was made or medical treatment was rendered. Paper case report forms can be faxed securely and completed by the provider or completed by the local health department via an interview with the provider or designated staff. (See Appendix 1 for a printable case report form and instructions.) A supplemental case report form should be completed for each new facility or provider from which data are obtained. Information from the completed paper report must be entered into Orpheus. When completing the case report via telephone, information can be directly entered into Orpheus without completing a paper case report form. After the case report information has been entered into Orpheus, the paper form can be destroyed. Supplemental case reports, collected from additional providers or facilities or from affected person themselves, need only record clinical, social, Race, Ethnicity, Language and Disability (REALD) or Sexual Orientation and Gender Identity (SOGI) information not collected on the initial report and any information that contradicts information collected or reported on an earlier report.

Additionally, one local health authority may receive a laboratory report for someone who is ultimately determined to live in another county. This occurs when residence information is not reported to the clinical laboratory and by default, the laboratory lists the patient county of residence as the county from where the ordering provider is located. If contact is made with a medical provider or facility, only to learn that the affected person doesn't reside in your

jurisdiction, every effort should be made to collect the information necessary to complete the case report. This action saves time and creates efficiencies for all parties involved. After updating case report information in Orpheus, update the person's residence on the "HIV Case Entry" layout and send a courtesy note to the health department staff in the affected person's local jurisdiction as well as the OHA HIV Data and Analysis staff advising them of the new HIV case.

Note: for some providers, diagnosing someone with HIV is a rare event and they may not be aware of the AIDS Drug Assistance Program (ADAP, known as CAREAssist in Oregon). Many persons with HIV could be eligible for ADAP, which can help with premium, co-pays and deductibles for care associated with an HIV diagnosis. Also, for uninsured persons newly diagnosed with HIV, CAREAssist's Bridge Program provides eligible persons who need medical coverage for prescription medications related to their HIV care may be eligible for up to a **30-day supply**. This program can also assist with a limited number of medical services to confirm HIV diagnosis and determine appropriate HIV treatment regimens. Payments for specialty care referrals are not available at this time, although exceptions will be considered with prior authorization. Enrollment into CAREAssist or the Bridge Program will not impact immigration status or employment: careassist@oha.oregon.gov.

3. Interviewing the Patient

a. Advise the physician or other health care provider that someone from public health will likely contact the HIV affected person (or parent or guardian if the patient is aged <13 years) to collect information and verify the case report data, including REALD, SOGI, and exposure categories, to offer support and assistance with partner notification and referral to available health, medical and social services (e.g., case management and harm reduction services). When possible, service referral should be performed with a 'warm handoff' to ensure continuity of care and patient comfort. In some instances, the newly reported case might represent a prevalent case, not previously reported to public health. The affected person may be aware of their HIV status but not be receiving HIV medical care. When this circumstance arises, advise the provider that the person is being investigated as our records indicate they are not currently in HIV medical care and/or not virally suppressed.
b. Newly diagnosed HIV affected persons should be interviewed to (1) identify sex and partners who use substances, or others who could benefit from testing and counseling to reduce their risk of infection or transmission, and (2) assure they have been referred for medical care, treatment and social services. Early and sustained medical intervention is a key HIV prevention strategy and prolongs survival for people with HIV and reduces community transmission.

c. Interview the affected person following the Patient Interview Form and Instructions (Attachment B), then enter the information in the appropriate areas of the "HIV Case Entry" screen as well as in the "Risk," "Clinical" and "Treatment" tabs of the Orpheus case report. If the person provides information that contradicts information collected from health care provider/s, overwrite the provider response with the affected person response and make a note of the change in the "Notes" tab in Orpheus. In situations where the affected person is aged <13 years, speak with the parent or legal guardian first. Exercise professional judgment about the need to interview the child separately or in the presence of the parent or guardian.

d. During the case interview, ask the affected person to identify any partners or other individuals who may benefit from testing (contacts) and work with them to develop a plan for notification and testing of their contacts. A contact form can be completed for each named contact (Attachment B). Individuals to consider as contacts include any sex partners within the previous 12 months, or people with whom the person has shared injection drug use equipment. Ideally, notification of contacts should be done by the LPHA. If the affected person prefers to notify contacts themself, the LPHA should arrange a follow-up call with the affected person to verify that those contacts have been notified. Sometimes hybrid approaches are successful such as making plans with the affected person to co-notify. For example, the affected person tells the partner to expect a call from the local health department to offer services and information. Motivational interview techniques, including role playing with the affected person in how to inform partners, encourage testing, and increase comfort for this conversation is suggested. Record the date of the interview and the names and other identifying information in the "Contact" tab in Orpheus. Any additional information, such as medical referrals, etc., can be entered in a note in the "Notes" tab.

LPHA's may not have available staff who are specifically trained to interview persons newly diagnosed with HIV to identify sexual and drug use partners or other people in social networks who would benefit from HIV testing. Oregon Health Authority's, HIV and STD Program (HST) staff are available for consultation about how to conduct HIV interviews and follow-up. In some situations, the health care provider may want to inform the patient they will be contacted by the LPHA. Generally, as a matter of professional courtesy, LPHAs should not contact the patient prior to having a discussion with the health care provider or their proxy. In addition, the affected person might not have been notified of their result yet so receiving this information from the LPHA before being notified by the health provider can be upsetting for all parties. On rare occasion, a medical provider may believe direct contact by a public health representative would be detrimental to the health or well-being of the affected person or their contacts. Such instances should be noted in the "Notes" section in Orpheus and discussed with OHA

HIV Data and Analysis staff (971-673-0153). There may be situations where a LPHA staff is not able to make contact with the health care provider to discuss the patient and confirm they have been informed of their test results. In these instances, LPHA staff should use their best judgement in initiating contact with the patient directly.

If you used a paper case report form rather than completing the case report in Orpheus, send the completed case report form to HST HIV Data and Analysis Program by secure fax (971-673-0179) or by secure file transfer protocol or other secure transmission methods: contact the HIV Data and Analysis Program at 971-673-0183. The paper case report form can also be added as an attachment in the "Docs" tab on the case in Orpheus.

4. **Suspect Case**

   Contact the patient's provider(s) and/or reporting laboratory to determine whether laboratory confirmation of HIV infection has been collected (refer to Section 4.1 for confirmatory testing information). Advise the health care provider that laboratory testing history suggests the patient may have a case of HIV infection. If laboratory evidence of HIV infection is verified, partner elicitation and service referral follow up can begin. If laboratory confirmation of infection cannot be verified, the patient may benefit from a referral to follow up testing and if negative, PrEP services.

5 CONTROLLING FURTHER SPREAD

5.1 Patient/Household Education

If the affected person is not receiving HIV related medical or supportive services, refer them to a medical provider or case management resources. HIV case managers are available throughout Oregon. Link to HIV case management by county can be found here: https://www.oregon.gov/oha/ph/DiseasesConditions/HIVSTDViralHepatitis/HIVCareTreatment/Pages/cmcontacts.aspx

Case managers can provide support and access to a variety of HIV related services including medical care, health insurance, prescription drugs, dental care, mental health and substance use treatment, harm reduction services, treatment adherence counseling, housing, transportation, food and utility assistance, and a host of other services.

See Attachment A – Case Management and Other Resources for information about who to contact for case management services in your jurisdiction.

5.2 Partner Notification

It is standard practice for LPHAs to offer assistance with partner notification and referrals. If the affected person desires help with partner notification, LPHAs should offer HIV and STD testing and counseling, as well as a referral to PrEP for any partners who test HIV negative.

Affected persons are also encouraged to notify their partners if they feel comfortable doing so. One resource to do so anonymously is *tellyourpartner.org*.

5.3 Unusual Transmission

Unusual situation such as transfusion, transplant, or hemophilia-associated disease; persons with occupational exposure or persons with no identified risks should be discussed with HST HIV Data and Analysis Program Coordinator (971-673-0183).

5.4 Isolation

Not applicable unless otherwise indicated for specific infections that occur in people living with HIV.

5.5 Occupational Restrictions

None. The Americans with Disabilities Act prohibits workplace discrimination against HIV affected individuals.

5.6 Restrictions on Household Contacts

None

5.7 Contacts

Affected persons and their sex or partners who use substances should be counseled about the ways that HIV can be transmitted including through sex, sharing of drug injection equipment, from pregnant woman to fetus or newborn infant, and by transfusion or transplant of blood or tissue.

1. Information should be shared about the importance of ART and viral suppression in the prevention of HIV infection.
2. Information should be shared about the importance of routine STI screening.
3. Information should be shared about PrEP services.
4. Information should be shared about doxyPEP.

Persons with HIV should not share needles or other drug supplies.

Additionally, community-based harm reduction programs can provide safe supplies, peer support, and ongoing trauma responsive services: https://www.oregon.gov/oha/ph/preventionwellness/substanceuse/pages/harm-reduction.aspx.

Until on ART and virally suppressed, persons with HIV should not engage in unprotected oral, vaginal or anal sex. A new, intact, latex condom is recommended for each act of oral, vaginal, or anal sex between the affected person and a partner until viral suppression is achieved. Once an affected person is on HIV ART and achieves viral suppression, HIV cannot be transmitted through sex. Vertical HIV transmission and transmission while breastfeeding is significantly less likely to occur while on arti-retroviral therapy and undetectable (<1% risk). However, there is not yet enough research on injection drug related transmission while virally suppression or with an undetectable viral load, but it is believed to be reduced.

Patients and their sexual or needle sharing partners should not donate blood, plasma, organs for transplantation, tissues, cells, semen for artificial insemination, or breast milk for human milk banks.

Universal precautions should be observed for all patients in health care settings and by household contacts who may come into contact with blood or body fluids of the patient. (Universal Precautions for Prevention of Transmission of HIV and Other Bloodborne Infections. Centers for Disease Control and Prevention. 1996. (Available at https://www.cdc.gov/niosh/topics/bbp/).These include:

1. Use of gloves, gowns, masks, and other protective barriers to prevent skin and mucous membrane exposure during contact with any patient's blood or body fluids.

2. Precautions to prevent injuries caused by needles, scalpels, and other sharp instruments or devices during procedures; when cleaning used instruments; during disposal of used needles; and when handling sharp instruments after procedures. To prevent needlestick injuries, needles should not be recapped by hand, purposely bent or broken by hand, removed from disposable syringes, or otherwise manipulated by hand. After they are used, disposable syringes and needles, scalpel blades, and other sharp items should be placed in puncture-resistant containers for disposal. The puncture-resistant containers should be

located as close as practical to the use area. All reusable needles should be placed in a puncture-resistant container for transport to the reprocessing area.

5.8 Environmental Measures

Surfaces or items contaminated with blood, body fluids or excretions or secretions visibly contaminated with blood should be cleaned with bleach solution.

6 SPECIAL SITUATIONS

6.1 Person has been a Blood or other Tissue Donor

If an affected person has donated blood, plasma, sperm, tissue or other body organs since 1978, obtain details of all donations, including date(s), type(s), and site(s) of donation. Verify the recipient agency (e.g., the Red Cross) has been informed.

6.2 Person has been Convicted of a Sex Crime

1. All data requests from law enforcement and the justice system are to be reported to the HST HIV Surveillance Coordinator. These requests will be triaged to the HST Section Manager who will forward requests to state legal counsel and/or the OHA Public Records and Internal Litigation Process Coordinator who is responsible for communications with the requestor.
2. HST will obtain information on circumstances of exposure from court records and prosecuting district attorney and, based on information obtained, assess whether HIV transmission was possible.
3. If the situation involves children under the age of 18 years at the likely time of exposure, consult with HST Section Manager regarding the need to report the situation to the Children's Services Division. Consult with state legal counsel before notifying victims. If the situation involves child molestation, Children's Services Division will need to be involved.

6.3 Person has Un-notified Sex Partners or Other Contacts

As noted above (5.2), all persons newly diagnosed with HIV should be offered a partner services interview. Optimally, a plan should be developed with the affected person for notification and testing of all sex, partners who use substances, and others who could benefit for HIV testing with counseling to reduce further HIV transmission and link those who test positive to care and treatment. STD testing (including for syphilis, gonorrhea and chlamydia at all exposed sites) and hepatitis B (hepatitis B surface antigen, hepatitis B core antibody, hepatitis B surface antibody) and hepatitis C (antibody testing with reflex to HCV RNA) testing is also highly recommended. Partner notification to exposed contacts will be done with the full knowledge and collaboration of the affected person.

Affected persons are also encouraged to notify their partners if they feel comfortable doing so. One resource to do so anonymously is *tellyourpartner.org*.

Partners who test positive for HIV and/or an STD should be linked to care, referred for treatment, and interviewed about partners.

Other than the responsibility to investigate and control communicable disease according to "procedures outlined in the Authority's Investigative Guidelines" (OAR 333-019-0000), Oregon law does not explicitly require notification to partners of people with HIV who may have been exposed to HIV through sex, drug use, or other means and who might benefit from testing and counseling services. However, in some instances the Local Public Health Administrator or Oregon Health Authority may notify partners/contacts without the consent or knowledge of the affected person. Oregon law (ORS 433.008) permits the Oregon Health Authority and Local Public Health Administrators to release information obtained during an investigation of a reportable disease to a person who may have been exposed to a communicable disease. The law permits the Authority or the Local Public Health Administrator to release individually identifiable information *if there is clear and convincing evidence that the release of information is necessary to avoid immediate danger to other individuals or to the public*. An example of a circumstance where the Local Public Health Administrator might judge notification is critical irrespective of having consent of the affected person would be a situation where a sexual contact is pregnant and their HIV status is unknown or last known to be HIV-negative. In such circumstances a plan for notification should be established with the Local Health Officer and/or the HST Medical Director. Before proceeding LPHAs should ensure that the affected person has received counseling about HIV infection, that confirmatory testing has been done, that the affected person has received appropriate referrals for medical evaluation and follow-up, and that all reasonable efforts to support, encourage or persuade the patient to notify partner(s) themself have failed.

6.4 Health Care Workers

All health care providers who routinely participate in procedures that pose a significant risk of bleeding into a patient are encouraged to voluntarily test for HIV. Health care workers with HIV who are engaging in such procedures, are encouraged to work with their employer or the HST Medical Director to review their professional practices, to minimize risk of transmission to patients.

6.5 HIV co-infection with chlamydia, gonorrhea, syphilis, or viral hepatitis

Sexually transmitted co-infections increase the infectiousness of HIV. HIV, syphilis, gonorrhea, and chlamydia affect similar patient groups and co-infection is common. All patients presenting with syphilis, gonorrhea and/or chlamydia should be offered HIV testing. Additionally, all persons living with HIV should be regularly screened for syphilis, gonorrhea, chlamydia and hepatitis B and C.

Appropriate hepatitis B testing includes hepatitis B surface antigen, hepatitis B core antibody, hepatitis B surface antibody. Appropriate hepatitis C testing includes

hepatitis C antibody testing with **reflex** to HCV RNA testing to determine whether the infection is active, cleared, or cured.

It is recommended to offer HIV/STI and viral hepatitis screening/testing as routine practice and/or based on a thorough sexual and assessment of substance use. If positive for STIs, the affected person should be referred to, and offered, treatment for bacterial sexually transmitted infections. Persons newly diagnosed with HIV should be quickly referred and treated with ART. Those testing positive for viral hepatitis should be referred for hepatitis treatment as appropriate.

If an HIV affected person is diagnosed with gonorrhea or syphilis, the LPHA should offer HIV and STI partner notification, doxyPEP, and referral to prevention and care services regardless of whether or not this was offered at the time of the HIV case report. Notification of potential exposure to gonorrhea and/or syphilis should be accompanied by notification of exposure to HIV.

6.6 Person is Involved in a Cluster of Interest

The HIV Data & Analysis Program regularly collects, analyzes, and interprets HIV data and information. In the event an HIV cluster or outbreak is identified, the HIV Data and Analysis and Prevention teams will review and discuss any needed action, which includes meeting with local health authority leadership and program staff to present information and conduct response planning.

LPHAs have primary authority over local cluster and outbreak response and, unless they choose to yield responsibility to OHA, will be tasked with responding to, coordinating and managing cluster/outbreak activities. HST staff will work closely with the LPHA Health Officer(s) and Response Lead(s) to provide data, guidance, and support to the response. Outbreaks involving multiple jurisdictions may be coordinated and lead by HST and OHA.

LPHA(s) will be responsible for identifying and enlisting the assistance of local stakeholders, organizations, and community groups to aid in a culturally specific and appropriate response. Most LPHAs have established relationships with their local CBOs, harm reduction, syringe services programs, HIV care providers and other local resources. As requested, OHA staff are available to assist LPHAs as needs are identified.

Investigation for all tests believed to be indicative of unreported, newly diagnosed HIV infection are referred for follow up to LPHA staff of the patient's county of residence. The LPHA is responsible for:

1. Contact the provider of record to collect case report information to be entered into Orpheus,
2. Contact with the patient to offer medical and service referral,
3. Elicitation of sex and needle sharing partners or persons exposed through other means,
4. Entering partner service information into Orpheus,
5. Rapidly linking newly diagnosed persons to care,
6. Increased testing and outreach efforts until there is a decrease/stabilization in new diagnoses,
7. Follow up with affected persons not in care or not virally suppressed.

Suggested intervention activities include:

1. Linkage to care for affected persons
2. Elicitation of sex and needle sharing partners
3. Testing and interviewing sex and needle sharing partners
4. Re-interviewing/interviewing affected persons using an enhanced interview tool
5. Providing rapid home HIV test kits to affected persons to share with people in the social, sexual and drug-using networks
6. Offering online ordering of home HIV test kits through takemehome.org
7. Offering incentives to facilitate access to testing and treatment
8. Referring HIV negative sex and needle sharing partners to PrEP
9. Referring those with a recent HIV exposure (within 72 hours) to PEP
10. Referring those with co-occurring STI or partners found to STI to doxyPEP
11. Coordinating and providing pop up community testing events
12. Working with outreach programs, case managers and affected community members or people (aka Peers) to assist with recruitment for HIV testing and prevention services
13. Increasing distribution of needles and other supplies at syringe exchange or harm reduction sites
14. Increasing outreach or field work to find partners and/or inform community
15. Other activities as needed.

Attachment A – Case Management and Other Resources

PORTLAND METRO AREA

Case management services are provided by multiple agencies in the Portland Metro Area, depending on where the client lives and/or receives medical care.

Counties	Agency	Phone/Website
Clackamas, Columbia Multnomah, Washington or Yamhill	Cascade AIDS Project (CARELink Program) - For persons not linked to medical care	503-223-5907 www.capnw.org
	Kaiser Permanente Immune Deficiency Clinic	503-249-5536 (option 1 & 2 for intake) www.kp.org
	Multnomah County HIV Health Services Center	503-988-5020 www.multco.us
	OHSU Partnership Project - Legacy Emanuel, Good Samaritan, Providence St. Vincent, Providence Portland, Neighborhood Health Clinic, and Veteran's Affairs (VA)	503-230-1202 www.ohsu.edu/partnership
Clark County (Washington)	Cascade AIDS Project, Southwest Washington	360-986-3500 www.capnw.org

COUNTIES OUTSIDE THE METROPOLITAN AREA

Counties	Agency/Website	Contact	Phone
Clatsop, Coos, Curry, Douglas Jackson, Josephine, Klamath Lake, Lane, Lincoln, Linn/Benton, Marion, Polk, Tillamook	HIV Alliance www.hivalliance.org	Ask for intake coordinator	541-342-5088 1-866-470-3419
Baker, Gilliam, Grant Harney, Malheur, Morrow Sherman, Umatilla, Union Wallowa, Wasco, Wheeler	EOCIL www.eocil.org	Kelly Rumsey kelly@eocil.org	Pendleton: 541-276-1037/1-877-711-1037 Ontario: 541-889-3119/1-844-489-3119
Crook, Deschutes, Jefferson	Deschutes County Health Department	Susan McCreedy susanmc@deschutes.org	541-322-7402
Hood River	Hood River County Health Department	Patricia Elliot trish.elliott@co.hood-river.or.us	541-386-1115

Other statewide resources

- Oregon HIV/STD Hotline is a partnership with 211 info to provide information and referral for HIV, STDs and general sexual health. English: 800-777-2437; Spanish: 800-344-7432. Interpreter services can be arranged. Alternate number is 503-222-5555. Available M-F 8-5:30pm. CAREAssist (Oregon's AIDS Drugs Assistance Program) helps people living with HIV pay for medical care expenses, insurance, medical visits and prescription medications. (971-673-0144, careassist@oha.oregon.gov).
- Oregon Lines for Life provides 24/7 crisis intervention and referral for thoughts of suicide or a mental health crisis. Call or text 988. The 988 suicide and crisis LifeLine connects callers to trained crisis counselors in their area who can provide support and resources.
- The Oregon Alcohol and Drug Helpline provides education, support and referrals for A&D treatment and counseling at 1-800-923-4357. Text Recovery Now to 839863 (available M-F from 2-6pm PST)
- Lines for Life Military Helpline at 1-888-457-4838
- Senior Loneliness Line at 1-800-282-7035
- Free Treatment and Recovery Services: https://app.powerbigov.us/view?r=eyJrIjoiMmM2MjI3MTktMWMyMi00NzA2LWE4MDctNTA5ZmExYmRhNGM1IiwidCI6IjY1OGU2M2U4LThkMzktNDk5Yy04ZjQ4LTEzYWRjOTQ1MmY0YyJ9.

Attachment B – Patient Interview Form and Instructions

In Development