CALIFORNIA CONFERENCE OF LOCAL HEALTH OFFICERS

POLICY PAPERS RELATED TO

HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION

ADOPTED AUGUST 6, 1987
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In recognition of the responsibility of Local Health Officers to lead their communities in response to the AIDS epidemic in California, the California Conference of Local health Officers has begun the development of a series of policy papers related to AIDS and HIV infection. Each of these papers, by Local Health Officers, addresses a different aspect of the response strategy for local health departments. The first document, "The Prevention and Management of HIV Infection in California," outlines the scope of responsibility of the Local Health Officer; the second document, "Case Management of AIDS Patients," presents a strong argument for the use of case management principles in the provision of care to individuals infected with HIV; the third document, "Epidemiologic Study/Mapping at the Local Level," describes the basic epidemiologic activities that local health departments should undertake in the face of the epidemic; and the fourth paper, "California Local Health Jurisdictions and the Management of Recalcitrant Patients with AIDS or AIDS Related Conditions," discusses interventions a Local Health Officer should consider when presented with a recalcitrant patient with AIDS or ARC.

Additional papers dealing with confidentiality, community education, and contact follow-up are now being drafted and will be released by the end of 1987.
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THE PREVENTION AND MANAGEMENT OF HIV INFECTION
IN CALIFORNIA

A Guide for Local Health Officers

November 5, 1986

The Purpose for This Guide

This paper is designed to assist Local Health Officers as they assume leadership in the organization of services related to HIV infection and undertake the development of local HIV response plans. This guide defines the scope of responsibility of the Local Health Officer and suggests public health management principles which the Health Officer may consider in carrying out these responsibilities.
THE PREVENTION AND MANAGEMENT OF HIV INFECTION IN CALIFORNIA

A Guide for Local Health Officers

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I. INTRODUCTION AND SUMMARY OF THE PRESENT SITUATION

In the six years following the report of a disease which was noted to compromise the immune response system in five gay men in three hospitals in Los Angeles and was to be named Acquired Immunodeficiency Syndrome (AIDS), infection with Human Immunodeficiency Virus (HIV) has become a major epidemic. By June, 1986, 5188 cases of AIDS (Centers for Disease Control Classification: Group IV; subgroup C, category C-1; subgroup D; and subgroup E HIV infection) had been reported in California. In addition to these cases it is estimated that there are at least an equal number of cases of AIDS Related Conditions (ARC) (Group III and Group IV; subgroups A, B and C, category C-2) and an unknown number of individuals infected with the HIV virus but who have lesser or no clinical manifestations.

Since the recognition of the disease, the scientific response has been dramatic. The etiologic agent, a lentivirus, has been identified and characterized; epidemiologic models for the transmission of infection have been developed; and studies have been started to attempt to identify therapeutic agents which interrupt viral replication and thus modify the course of the disease. Despite these impressive accomplishments we are still years away from the development of a possible immunizing agent; no antiviral agent has been identified to cure infection with the HIV; and treatment of clinical manifestations of HIV infection is only palliative.

We are faced with a true public health emergency. Without an immunizing agent and without any useful antibiotic we must rely on classic public health principles to contain this epidemic. These measures have proven to be successful in the absence of vaccines and antibiotics and we anticipate that they will continue to serve us well in the control of HIV infection.

This paper addresses issues facing Local Health Officers as they develop programs for the public health containment and for the management of HIV infection, ARC, and AIDS. As Local Health Officers our strategies include: (1) preventing infection of uninfected individuals, (2) preventing transmission of the virus by infected individuals, (3) using case management principles to assure complete care for individuals with clinical manifestations of the disease, and (4) developing care systems which assure the provision of care and other services for all aspects of HIV infection.
Although at this time 95% of individuals diagnosed as having AIDS are in high risk groups (gay and bisexual men, IV drug abusers, recipients of blood products, sexual contacts of individuals at risk, and children of infected mothers), any valid public health response must be directed toward the entire community. Recent epidemiologic studies suggest that the infection rate may be increasing in individuals not included in high risk groups. As we watch closely for indications of an increased incidence in the heterosexual population, it becomes evident that the control of the epidemic will only be accomplished through the close cooperation and support of all segments of the community. Control strategies must include preventive measures, particularly education, directed toward the entire population.

The control of HIV infection must be based on sound scientific principles. Just as the development of a vaccine and effective therapeutic agents is dependent on stringent scientific logic and method, the public health response to the epidemic must be founded on meticulous epidemiologic procedures and the promulgation of clear factual information about HIV infection.

One of the more difficult problems in getting effective collaboration and support of all segments of the population is the difficult and persistent tension that has been shown over the years between a scientific versus a moralistic approach. As stated in No Magic Bullet, by Allen M. Brandt, "the persistent tension between a rational scientific program and a behavioral moralistic approach continues to characterize current efforts to deal with venereal disease as it has throughout the 20th Century."

Public Health Officers have the challenge of convincing the public that the scientific approach has already produced much information on the epidemiology of the disease, while clinical description and discovery is simultaneously taking place. The scientific process may involve research into high risk practices which may be considered by many to be socially deviant behavior, both in sexual activities and drug use, thus creating a tension between the high risk group members and the greater population. All of this points out the need to be particularly adept at emphasizing the scientific versus the moralistic approach to control measures.

II. THE PUBLIC HEALTH MANAGEMENT OF HIV INFECTION

As stated in the introduction, this paper is designed to assist Local Health Officers as they assume leadership in the organization of services related to HIV infection and undertake the development of local HIV response plans. The California Conference of Local Health Officers, in
defining the scope of responsibility of the Local Health Officer suggests public health management principles which the Health Officer may consider in carrying out these responsibilities.

Public Health management of this epidemic should be based on principles which apply to communicable diseases in general and specifically to the prevention of HIV spread. Public health management addresses all aspects of transmission of the virus while awaiting the development of a specific treatment to enable infected individuals to become noninfectious.

A. Confidentiality

The Local Health Officer defends the confidentiality of patient information related to HIV infection. In order to carry out an effective HIV control program the Local Health Officer must preserve and protect the confidentiality of medical and epidemiologic records. It is only through a demonstrated guarantee of confidentiality that the Local Health Officer can elicit the necessary support of high risk groups in disease control activities. Health Officers will work to:

- Make information about HIV antibody status available to the medical team treating the patient while protecting the confidentiality of this information.
- Encourage confidential antibody testing as opposed to anonymous testing to make antibody status more available to the medical and epidemiologic team.
- Encourage the State to fund HIV antibody testing outside of anonymous testing sites.

B. The Local HIV (AIDS) Response Plan

The Local Health Officer leads the effort to develop an HIV (AIDS) Response Plan. This plan contains an assessment of the current infection and disease situation, projections of the increase of infection in the community, and a description of what the local agency's and other community bodies is and will be in response to the current and projected impact of HIV infection. The plan should be presented to the governing body of the jurisdiction and where appropriate be reviewed by local advisory committees (if they exist), local providers, and representatives of high risk groups.

C. Policy Development at the Local Level

The Local Health Officer should work with schools,
criminal justice systems, other governmental agencies, and local industry to develop policies which relate to HIV infection. The Health Officer assumes an active role in approaching institutions in the community to be certain that the policies which they develop related to employment, school attendance, detention, return to work, food handling, emergency transport, client and employee education, and cardiopulmonary resuscitation are consistent with scientific information and the HIV infection control activities of the local health jurisdiction.

D. Education Plan

The Local Health Officer is responsible for the development of an Education Plan for the general public and for special groups based on the needs of the community. The most effective measure available at this time to prevent the transmission of HIV is education. Programs designed to prevent the transmission of HIV must be, in fact, educational programs. Preventive educational programs should be developed which stress limiting the number of sexual partners, low risk sexual activity, and which discourage intravenous drug use. As part of the county or city's response to the HIV epidemic the Local Health Officer must establish a coordinated plan for addressing the educational needs of the community. This will be a multi-faceted document which includes provisions for the general public, professional providers of services, and individuals from high risk groups. The Health Officer will assure that the general public is provided with factual scientific information which will serve to develop public confidence, control anxiety and channel community activities toward support of AIDS patients and the reduction of high risk activities. In developing the Education Plan for the jurisdiction the Health Officer should be aware of the following principles:

- The Health Officer should become a leader in the development of educational programs.

- Educational materials must be scientifically based, targeted to specific groups, culturally appropriate, and internally coherent and consistent.

- For the purpose of primary prevention, culturally and linguistically acceptable educational materials about the transmission of HIV, low risk sexual activity, and the risks of IV drug use must be made available as appropriate to the designated target group.

- Multiple educational activities need to be coordinated through the local health department.
and must be consistent with the objectives of the HIV control program.

- Special educational programs are needed for adolescent and school age youth, correctional institutions, industry, military personnel, professional groups, defined high risk groups, and non-risk groups that may perceive themselves to be at risk. The Health Officer works with these groups to make continuing education about HIV an integral part of the on-going activities of the organization.

- Health care professional and other employer groups at low risk for exposure may be especially made aware of the available educational information to alleviate their undue anxiety.

- Locations where high risk behavior may occur in spite of other control efforts should offer educational materials and posting which encourage individuals to prevent HIV transmission.

- In addition to current antibody screening of the blood supply, individuals from groups at high risk for HIV infection should continue to be actively encouraged to defer themselves from the pool of potential donors.

- Health Officers should recognize the interrelatedness of chemical dependency, binge behavior and compulsive high risk sexual behavior.

E. Scientific Information Source

The Local Health Officer is responsible for the creation of a source of sound scientific information related to HIV infection within the county or city health department. By establishing a repository of current information about HIV the Local Health Officer is able to use this information as the basis for the development of the local HIV response plan, to evaluate the effectiveness of public health interventions, to supply the public with scientific information about HIV infection, and to establish credibility as an authoritative source of information. In order to maintain a current body of HIV information at the local level Local Health Officer should consider:

- The establishment of close ties with universities and other institutions engaged in HIV related research.

- The development of access to current HIV
information through electronic systems such as MINET and CAIN.

- The organization of information to assure staff easy access.

- The development of systems to make information available to professional, other organizations, and to the general public.

F. Special Epidemiologic Studies and Disease Investigations

The Local Health Officer is responsible for conducting special epidemiologic studies and disease investigations to obtain the information needed to prevent the transmission of HIV. These activities include active case surveillance, serologic studies, contact investigation, and disease investigation. These special studies and investigations have as their purpose the identification of individuals and groups who are most in need of education and information about the prevention of HIV transmission. Individuals who are determined to be at increased risk of infection based on epidemiologic information should be educated about how to prevent transmission of the HIV. Confidential (or anonymous) testing should also be encouraged at that time. Individuals meriting special attention are women who may transmit the virus to their unborn children and adolescents who are beginning to experiment with intravenous drug use and sexual practices which may lead to transmission of the virus. The Health Officer may use epidemiologic investigations to try to identify a locus of infection.

In order to develop preventive educational strategies the Health Officer can establish an information system which allows for the determination of trends and unique features of the infection in the community. This system would use existing reporting regulations, collect demographic information from anonymous testing sites, apply relevant data from similar populations already studied, and encourage special studies of high risk groups.

In conducting epidemiologic investigations and special studies the Health Officer should:

- Ensure that participants in the investigation are aware of the importance of their participation, understand the reasons for the investigation, and are willing voluntary participants.

- Prioritize contact follow-up to those situations in which a reasonably effective public health measure is available to protect the susceptibles at risk.
Recognize that the principal value of contact follow-up is to educate at-risk individuals about how to prevent acquisition and transmission of the virus and/or to encourage them to ascertain their infection status.

Recognize current legal restraints, and assist local blood banks in the notification and follow-up of individuals found to be HIV antibody positive on screening.

Encourage blood banks to develop programs which accomplish the notification and followup of recipients of blood of donors later found to have HIV antibodies. This should include notification of contacts of the recipients who may be at risk, i.e., those who have had sexual or needle contact.

Ensure that reporting procedures are responsive to legal mandates and local circumstances.

G. Research Studies

The Local Health Officer participates in the planning and implementation of research studies related to HIV infection. These research studies have as their purpose the estimation of the future course of the epidemic in the community, the estimation of future service needs, and additional contributions to the general body of scientific knowledge related to HIV infection. In carrying out these research studies the Health Officer should keep the following in mind:

The definition of the scope of infection in the community is based on individual medical information, but should be reported and discussed only in demographic groupings.

Blood testing to determine the prevalence or incidence of infection in the community must be done with the subject's (or guardians) knowledge and consent. Blind procedures may be used to the extent allowed by law.

All special and ongoing studies related to determining the prevalence of HIV infection in the community require human subjects protection review.

Special study of high risk individuals should clearly spell out how information obtained from the study will be used and only assure that the confidentiality of study participants is protected.
The investigator must certify that participants in any investigation are aware of the importance of participation, understand the study, and are willing voluntary participants.

With appropriate precautions based on demographic and risk group differences, it is possible to make use of some national data and data from other areas.

Whenever possible special studies should be done on a state-wide or regional basis.

Results of statewide, regional, and local studies should be shared with local health departments in a timely manner.

H. The Legal Authority of the Local Health Officer Related to the Control of HIV Infection

Existing law provides the Health Officer with the necessary legal power to control communicable disease. This power is assigned to the Health Officer by our society with the expectation that it will only be exercised after the Health Officer has carefully evaluated the status of the individual involved and has exercised sound medical and epidemiologic judgment.

If a Health Officer determines that all other available means of education and control have failed and can demonstrate that the behavior of an individual with a communicable disease endangers the health of the community, the Health Officer may issue a legal order to appear for examination. The Health Officer must recognize that given the current prevalence of the disease, the difficulty in demonstrating the presence of the causative virus, and the difficulty in documenting repeated high risk behavior, such an action has to be carefully considered and only undertaken in exceptional circumstances.

In the event it becomes necessary to consider the use of isolation powers, it is essential that the procedure allow due process for the individual who is isolated. In order to be effective the extent of isolation must take into account the mode of transmission of the disease.

Infected individuals must be protected from indiscriminate isolation for fear of transmission of the disease.

The public must be protected against infection from infectious individuals who knowingly are engaging in behaviors which are known to transmit HIV.
I. Environmental Factors Conducive to the Transmission of HIV

The Health Officer should encourage cities to adopt and enforce business permit/license and building code regulations to preclude unsafe sexual encounters in establishments which have traditionally been associated with such activities (for example, bath houses, adult book stores, some bars and public rest rooms). Behavior of individuals is often influenced by environmental factors. Those environmental factors which promote or encourage high risk behavior should be modified by educational approaches or by regulation, the changed environment thereby altering behavior and preventing transmission of the disease. Such establishments which contribute to high risk behaviors can also be regulated to limit their premises to their primary purposes such as fitness activities, social interaction, selling books, or the provision of toilet facilities.

- Monitoring of establishments for sexual activity is not productive. A more effective way to prevent HIV transmission in environments where unsafe sexual activities occur is through modification in the physical structure of the establishment and through education programs aimed at clients.

J. Comprehensive Services for Individuals with HIV Related Diseases

The Local Health Officer should assist in developing a comprehensive health care system for HIV related diseases which is tailored to the specific needs of the health jurisdiction. A comprehensive system for the care of HIV infection has the following components or levels: screening, outpatient services, inpatient hospital services, extended care services, intermediate care services, home health and hospice services, emotional and practical support for daily living, emergency and long term housing, in-hospital emotional support and advocacy, outpatient mental health support, HIV education, services for HIV and substance abuse problems, health and social service advocacy, and legal services.

Families and friends of HIV infection patients play an essential role in the provision of care. They require training and support which continues through the period of illness and after the death of the patient. Appropriately designed services will help to assure positive feedback of family members and assure their continued involvement as volunteers. A committed group of volunteers is one of the most effective techniques for providing supportive services that has been shown.
In developing the system the Health Officer recognizes the role of the private provider as an essential part of the system and assures that the provider is kept informed of the HIV care system, and has access to all its components for his/her patients.

The following public health management principles should apply to the comprehensive service delivery systems:

- Treatment for individuals with HIV related conditions (including extended and intermediate care) must be provided near the patient's residence to assure continued contact with friends and relatives.

- Local communities need to share information and resources with neighboring health jurisdictions.

- Care systems must assure efficient use of resources, continuity of care and patient advocacy.

- Case management techniques should be utilized to assure continuity of care and patient advocacy.

- Treatment and other services must be provided in an environment which is sympathetic to the patient and free from judgment regarding lifestyle preference.

- Special services such as adult day care for HIV disease patients should be developed based on local need.

K. Coordination of HIV Related Services

The Local Health Officer is central to the coordination of HIV related services within the health jurisdiction. Through the development of a local HIV response plan, the involvement of professional and community advisory groups, and active participation in all aspects of the development of HIV related programs, the Local Health Officer is critical to the coordination of services. All funding of HIV related programs in the health jurisdiction by the State, federal, and philanthropic agencies should be coordinated through the local health department. The Health Officer not only coordinates services but also assures that policies developed by agencies and health providers in the community are consistent with other local efforts and the local plan. In coordinating services the Local Health Officer:

- Creates local advisory committee(s) to provide advice from the community, local providers, and
representatives of high risk groups on how to provide HIV related services.

- Establishes formal and informal relationships with the State Department of Health Services and the Centers for Disease Control to be certain that programs funded by these offices are coordinated through the local health department.

- Contracts services when appropriate with agencies/facilities sensitive to the specific needs of at risk groups.

III. MULTI-COUNTY PLANNING FOR THE PROVISION OF HIV RELATED SERVICES

Many aspects of HIV infection control and the treatment of HIV related disease may be best addressed on a regional basis. Local Health Officers must work together to identify services and activities which may be provided on a centralized basis and those which are better provided in a decentralized system. Examples of activities which would be best provided on a multi-county basis are the use of the media to educate the general public about HIV infection, the creation of regional volunteer support organizations, participation in regionalized experimental treatment programs, and the development of curricula related to HIV infection for public and private schools. A goal of a multi-county system should be to assure that individuals with HIV related disease receive a high quality of care close to their residence regardless of county residence. Epidemiologic activities should be performed on the county level with close collaboration between other departments. Rather than attempt to house patients in need of long term nursing care in a centralized location, the strategy of Local Health Officers should be to develop the capacity and incentives for nursing homes throughout the region to provide care for HIV patients along with their existing case load. Regulatory barriers to the placement of patients with HIV related diseases in intermediate and long term care facilities should be modified to remove this barrier to the care of HIV patients close to home.

IV. PARTICIPATION IN THE DEVELOPMENT OF LEGISLATION RELATED TO HIV

The California Conference of Local Health Officers will actively participate in the development of legislation which will assist Local Health Officers in the public health management of HIV infection.

Laws and regulations related to the control of HIV infection must:
o Be based on sound scientific information about the virus and its epidemiology.

o Protect the rights of all individuals including those who may be at risk for infection.

o Clearly demonstrate that the public health will be protected by the subject action.

o Recognize that the Local Health Officer currently has the authority and expertise to determine what steps must be taken in the local community to prevent the transmission of the virus.

V. THE FUNDING OF SERVICES RELATED TO HIV

Funding for the control and treatment of HIV infection and related diseases must be provided by all levels of government. Local government must participate in, but cannot sustain the kinds of programs required in the face of the growing epidemic. Funding is necessary for research, education, and for the care of individuals with HIV related diseases. Treatment funds must be available for the whole spectrum of diseases associated with the infection—not just for the patient with classic AIDS. In addition to the need for increased funding it must be recognized that these funds need to be devoted to outpatient, in home, long term care, and hospice services which have traditionally been underfunded for all disease processes. Local Health Officers recognize that the primary strategy available for the prevention of infection is education. This has not been recognized by state and federal funding sources who continue to fund the research which will lead to the development of an effective vaccine and useful therapeutic agents but which ignores the equally pressing need to educate the public and all individuals at risk about how to prevent infection.

VI. REFERENCES


CASE MANAGEMENT OF AIDS PATIENTS

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I. RATIONALE

The AIDS epidemic will have an extraordinary impact on national health care expenditures in the coming years. A Rand Corporation report estimates that the cost of treating AIDS patients between 1986 and 1991 may exceed $37 billion, including $10 billion that will be paid out of Medicaid. The Public Health Service has projected that some 174,000 AIDS patients will be alive at some time during 1991. The cost of providing health care for these individuals has been estimated to range from eight billion to sixteen billion dollars. The majority (80%) of these expenditures will occur outside of San Francisco and New York City. Nonetheless, San Francisco anticipates that AIDS cases will use 9.5% of available hospital beds in 1991, a level nearly five times the current rate of use. Given the magnitude of the impact of the AIDS epidemic on the Nation's health care system and health care finances, it is incumbent upon all public health officials and health care providers to develop and implement the most humane, effective, and cost conscious systems for providing health care to persons with AIDS. Resources, both human and financial, cannot keep pace with this epidemic. All resources must be fully coordinated for maximum coverage of the population needs.

Case management is a model used in other clinical settings such as mental health, geriatric and social service programs. It allows for not only cost effective care but also more humane care based on individual assessments of the patient's needs. The individual AIDS patient will depend upon a variety of community resources during his illness. Haphazard and unplanned use of these resources is not only ineffective but inhumane. Each patient deserves the dignity of having an advocate for his needs in a system which, by definition, will involve interfacing with many different types of providers and different agencies. The case manager can most appropriately fulfill this role. The goal of case management is appropriate care at the appropriate time in the appropriate setting with a focus on normalizing life with the disease.

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II. NEEDS STATEMENT

There is no typical AIDS patient. This statement will be particularly true in coming years as the epidemic spreads into population groups previously relatively unaffected. San Francisco has developed highly regarded community-based systems for the provision of humane and economic care to AIDS patients. The San Francisco experience has been primarily with the gay population, however, and its success can be partially attributed to an extraordinary support system and network of organizations in the gay community devoted to the effort, not a specifically designed case management system. There has not been a designated case manager for a specific AIDS patient who follows the patient through the different community services. Instead, each community agency in San Francisco has case managers who assist patients. In contrast, Los Angeles has one agency primarily responsible for case management (AIDS project of LA). As the epidemic spreads into other groups, such as IV drug users, comparable types of support systems and community organizations will not likely be readily available. New and innovative approaches to case managed care will have to be developed. Pediatric AIDS cases are expected to increase almost tenfold to approximately 3,000 cumulative cases by the end of 1991. The pediatric population also presents special management problems such as drug-addicted mothers, lack of foster care and families with no resources.

There is, at the present time, a dearth of long-term beds available to AIDS patients. This is partly a financial issue and partly an educational issue. Both issues need to be addressed aggressively to create the availability of long-term care beds for AIDS patients. Such extraordinary efforts as the reactivation of the public health hospital in San Francisco to serve as a long-term care facility for AIDS patients also need to be explored.

Case management should also address the special needs of people of color who have AIDS or ARC. We must develop service networks which are accessible and relevant to people of color both culturally and linguistically and recognize the different cultural reactions to the epidemic.

III. STRATEGIES

The spectrum of care required for AIDS patients reflects the spectrum of HIV-related symptoms in the affected population. Asymptomatic HIV-positive individuals may require only appropriate counseling and psychological support. ARC patients will require ongoing monitoring and treatment of symptoms, as well as psychological support. Active AIDS cases will require medical intervention ranging from monitoring and support during quiescent phases of the illness to aggressive, intensive
intervention for secondary infections and administration of chemotherapy. Until now, without effective treatments, it has been assumed that most patients will be dead within two years after diagnosis. With the advent of AZT and the expectation that there will be more drugs which delay the course of the disease, we must begin to consider AIDS as a chronic disease. This means different strategies and long term planning for the care of patients infected with HIV. As patients live longer with fewer life-threatening crises, they will require more and different types of care. In addition, there is the spectre of a large number of patients with only the neurological manifestations of HIV disease. As the predictions of many cases of chronic dementia are borne out, there will be a significant impact on mental health facilities as well as skilled nursing facilities. In the terminal stages of the disease, appropriate hospice care should be made available to those desiring it.

This wide spectrum of disease manifestations will occur in patients receiving care in a wide spectrum of health care systems. Much care is currently being rendered in the private sector for insured individuals. The role of the public sector will increase as the epidemic spreads into uninsured populations. Public institutions and systems will then be impacted even more heavily than at the present time. Part of this distribution of care will depend upon the availability of Medi-Cal and Medicare coverage for AIDS patients and the willingness of the private medical community to accept these patients. (ARC should be included as presumptive disability for Medi-Cal eligibility or there will be further disproportionate impact on the public system and local financial resources in the form of expenses for Medically Indigent Adults).

A variety of case management systems can be developed in public settings, private settings, and combinations of the two. It is important for public health leadership in each county to assure that appropriate case managed systems are available to all AIDS patients. Case management systems should consist of the following elements:

A. An identified Case Manager. The case management role may be performed by a variety of types of providers, including public health nurses, social workers, family practitioners, psychologists, and other health care professionals. The case manager must understand the disease, the community and the continuum of care. The role is primarily one of patient advocacy and coordination of available services to meet the individual needs of the AIDS patient. This requires not only being aware of all of the community resources available to provide services for the AIDS patient, but also having the time, capability and interest to access and coordinate those services. Ideally the case manager will provide a continuity of care for the
patient from the early recognition to the terminal stages of the illness. Thus the case manager will interface with the patient in a variety of settings dependent upon the particular stage of illness of the disease.

The case manager is responsible for the overall management, integration and continuity of the care provided to a person infected with HIV. One vehicle for accomplishing this is an Interdisciplinary Team Approach with the case manager heading the team and responsible for the implementation of its decisions.

The case manager: (1) performs an initial medical and social history on each patient; (2) develops a written individualized care plan for each patient and enters it into the case management record; (3) implements and coordinates all aspects of the plan; (4) explains to the patient the care plan recommendations, including special instructions, transportation and housing arrangements; (5) receives advice and input from the patient on the plan and any subsequent changes and modifies the plan based on this input; (6) assists the patient in fulfilling the plan's recommendations (i.e. referrals, tests, special appointments, etc); (7) maintains ongoing contact with all providers of care, especially the physician and home care providers and modifies the plan based on this input; (8) modifies the plan as problems are ameliorated or resolved or as new problems arise; (9) assures compliance with all the recommendations in the plan with results and progress recorded in the case management record; (10) assures the completion and accuracy of the documentation in the case management record; (11) uses all available methods to assure continuity of care including cooperative care conferences, special case presentations, etc.; (12) evaluates the care plan and the specific services by assessing the patient's health and the appropriateness of the intervention that is being evaluated.

In his patient advocacy role, the case manager (1) maintains communication and close contact with the patient throughout his care; (2) advocates for the needs of the patient with inpatient and outpatient medical services as well as all service providers affecting the patient; (3) keeps track of patient attendance and appointments, identifying the reason for missing appointments, etc.; (4) assists the patient in problem solving, making herself/himself available to the patient; (5) assures that the patient's own decision-making abilities are utilized to the maximum.

B. Primary Care Physician. In some systems there will be a large enough volume of AIDS patients to warrant
specialized AIDS clinics. In other systems, the majority of outpatient care will be delivered in primary care settings, hopefully by physicians who are not only familiar with AIDS treatment issues, but are also able to access specialty consultation and an AIDS resource support team as needed.

C. Specialty Consultation. Much of the expertise in treating AIDS patients to date has been concentrated in a few large public hospital settings. Methods for spreading that expertise out to other public and private providers in the community must be developed. This could be done through continuing education as well as consultation networks. Consultation with Tuberculosis Specialists and Control Programs is needed with regard to the interaction of tuberculosis morbidity with HIV infection.

D. Public Health Nurses. Public Health Nurses, Visiting Nursing or Home Health Nurses will be the primary providers of in-home care. They will be providing services ranging from routine follow-up visits to coordination of full-scale, in-home care provided by home health aides or attendants, occupational therapists, physical therapists and volunteers. There will also be a need for home IV infusion programs with personnel trained to support this program.

E. Social Workers. AIDS patients will require a great deal of social worker support for issues including housing and living arrangements, food, health insurance and welfare issues, and counseling.

F. Psychologists. Psychologists and other mental health professionals can provide specialized types of counseling necessary for AIDS patients. These will be much the same issues confronting other types of terminally ill patients, but with obvious AIDS-related issues. There is also going to be a need for less traditional kinds of mental health therapy including trained peer counselors (volunteers) and support groups for various needs (i.e., AIDS patients, family, friends, lovers, persons who are HIV antibody positive patients and worried well). Patients with chronic dementia and other organic mental disorders will need appropriate psychiatric treatment.

G. Legal Services. AIDS patients may face a variety of legal problems such as discrimination in housing and employment. Legal services may be required to assure that legislated protections are available for individual patients. There will also be a need to deal with the legal issues of terminal illness. Patients with dementia will need conservatorship and guardianship services.
H. **Financial/Insurance Counselors.** Advice and counseling are necessary to maximize the insurance, disability and other benefits to which the patient is entitled.

I. **Volunteers (Hospice Programs and AIDS Support Programs).** Volunteers who have been trained to deal with AIDS issues as well as terminal illness issues are essential to the success of any case management. There will never be enough professional employed personnel available to meet the needs of the anticipated number of AIDS patients. The success of case management systems to date has been largely due to the participation of volunteers from community organizations. It is essential to continue to tap this source of support. Volunteers can be coordinated through AIDS task forces or hospice programs, recognizing that the cross-training of individuals from both organizations is essential. Volunteers should be trained in dealing with AIDS and in dealing with terminal illness and psychological aspects of death and dying. Ideally, community-based and publicly-sponsored hospice programs and AIDS task forces can work together to maximally benefit the AIDS patient. These efforts must also be integrated with those of Home Health Agencies and all other support services. Those counties, such as Contra Costa, with all three programs (Hospice, AIDS support programs and Home Health Agency) available under the authority of one department are in a unique position to coordinate services appropriately. Other counties may wish to consider developing their own inhouse Home Health Agencies as demand increases.

Such a public case management system can form the focal point for coordination with community service organizations, as well as interfacing with private providers. This system requires special training, excellent communication and good will.

It is also important to involve the AIDS patients themselves, not only in their own self care, but also in participation and support programs for other AIDS patients. The San Francisco experience has proven the value of utilizing the support of AIDS patients for each other.

J. **Acute Care Hospitals.** Inpatient care for the AIDS patient will occur in a variety of inpatient settings ranging from the small community hospital to the large tertiary county or university hospital. With an appropriate volume of patients, specialized AIDS wards can be established with the advantages inherent in having a staff committed to the program and well versed in AIDS issues. Nevertheless, appropriate and humane care can be delivered on the wards of any general hospital with the appropriate staff training.
and support. This training and support must also be made available to hospitals in smaller communities. A case management system should follow the patient into the acute care setting to guarantee coordination with outpatient services.

K. Long Term Care. Perhaps the most difficult issue facing those responsible for providing care for AIDS patients is the profound lack of long term care facilities. This is already a crisis situation in many counties. The case management system should deal with this issue as well by advocating for the availability of long term care facilities and placing patients appropriately.

Alternatives to long term care can also be sought. San Francisco again provides a model for community-based living arrangements. Non-institutional care seems to be the most significant aspect of cost reduction. It also may be the most psychologically healthy for the patient. There is however, the harrowing projection of neurologically impaired AIDS patients requiring the care provided in skilled nursing facilities.

There is no single model for a case management system which will apply to all settings and counties. The list of the above elements may differ from setting to setting. Important, however, is the concept and principle of a system to assure coordinated care and access to all available community resources for all AIDS patients. We recommend this as the guiding principle for the delivery of health care to AIDS patients.

A number of reimbursement issues will have to be faced in developing case management systems. Many third party payors including Medi-Cal and Medicare do not always pay appropriately for in-home care, and specifically for hospice care. We must advocate for the inclusion of these services in benefit packages and adequate reimbursement for their provision. Moreover, most third party payors do not reimburse for the specific case management service that we have been describing. We must encourage appropriate recognition and reimbursement of this role in the health care system. Without appropriate funding, any case management system will remain a paper plan.

IV. EVALUATION

It is obvious that provision of health care in a coordinated fashion maximizing community resources is a laudable goal for the provision of humane and effective care. It is also assumed that care delivered in such a fashion will be more economical. This assumption stems partly from the San Francisco experience where inpatient
lengths of stay and total costs have been significantly less than that for AIDS patients treated in other systems. It remains to be proven whether Case Management Systems can accomplish similar savings in other settings with different groups of patients. We therefore recommend that efforts to promote Case Management Systems be accompanied by requirements for evaluation and monitoring of those systems to document their efficacy in terms of outcome and economic savings. A data base must be developed to obtain demographic data, medical parameters, and identifiable outcome data (length of stay, quality of life, etc.). Only then can we begin to make informed decisions with regard to where to spend the scarce health care dollars to combat this devastating disease.
CCLHO PAPERS ON HIV INFECTION CONTROL:
EPIDEMIOLOGIC STUDY/MAPPING AT THE LOCAL LEVEL

Presented By:
Robert J. Melton, M.D.
Health Officer, Monterey County

I. BACKGROUND

The study of epidemics in a community involves the attempt to describe the segment of the population that is ill, identify those who may be at risk of future illness or infection and define the mechanism of spread of the disease in question. In the case of a widespread epidemic such as AIDS, it is necessary to create a system of epidemiologic surveillance extending from the local community to the State and National level. Surveillance is the systematic collection of data on cases of disease in the population and on deaths due to the disease. The goals of surveillance at the local level are then twofold: to contribute to the nationwide system, and to identify any significant way in which the local community differs from the national or regional pattern.

II. RATIONALE

The information gathered through epidemiologic surveillance is used for three broad purposes: first, to plan strategies and interventions to interrupt the spread of the epidemic; second, to determine the kinds and quantities of health services that will be required to assist those who are ill; third, to monitor and evaluate the effectiveness or success of prevention efforts that are established as the epidemic progresses.

At the present time, with little prospect for a vaccine to prevent spread of the Human Immunodeficiency Virus (HIV) or of a drug to treat the illness (AIDS), the principal strategy for intervention is education for behavior change. Thus, the information gathered from surveillance is used, for example, to focus educational messages for a particular community and to select target groups for the messages. Other important uses of the information are to increase community awareness of the epidemic and to provide objective and scientific information about its impact to the public and to policy makers.
III. HIV SURVEILLANCE: EXISTING DATA SOURCES

Surveillance of a communicable disease usually begins with counting of cases of the most severe illness or deaths due to the illness. The syndrome called "AIDS" was in fact created as a surveillance definition for epidemiologic reporting purposes. We have subsequently learned that there is an entire spectrum of illness associated with the causative agent of AIDS, i.e., Human Immunodeficiency Virus. Thus, we have established a system of surveillance that is currently being modified, and which will continue to expand. The development and improvement of laboratory markers of HIV (antigen, virus, antibody) or the effects of HIV (T-cell subsets) allow for this expansion.

A. Surveillance of Advanced Disease: AIDS Case Reporting

Definitions: AIDS is a reportable condition under California law, and physicians must report cases through local health departments to the State. The Centers for Disease Control's original definition has been revised, and local health jurisdictions must play a role in informing physicians of this. (See Appendix I for the revised definition of August 14, 1987)

Tasks: To ensure completeness and accuracy of reporting, local health departments must have established good working relationships with hospitals and practicing physicians. Special effort may be required to ensure that physicians understand the definition of AIDS and the somewhat more complex reporting procedures. This may require both initial and ongoing orientation of the medical community through hospital staff presentations, newsletters to physicians and/or individual contacts with their nursing and clerical staff. It is especially important to work with hospital infection control nurses in setting up reporting systems. In larger communities, it may be helpful to work with "sentinel physicians," that is, those who see significant numbers of AIDS patients and who are willing to make special efforts to ensure complete and accurate case reporting.

Data collection/analysis: Each local jurisdiction should retain copies of case reports and tabulate local data weekly or monthly or as often as needed. Although larger jurisdictions may have automated systems to do this, a simple monthly manual tabulation of data on the case report form is remarkably useful. Sample formats are shown in Appendix II, III and IV. Each jurisdiction will want to compare its distribution of risk factors with state, regional and national data, and to look for unusual patterns of age, gender, ethnicity, behavioral risk factors or residence. Mapping of cases by census tract or city of residence may be useful in areas with large case
loads, both for assessing needs for health services and for targeting educational efforts. An example of such mapping is given in Appendix III-d.

Data dissemination: It is essential to provide summaries of these data both to those involved in reporting (physicians and hospitals) and to the community at large. This may be done on a monthly, quarterly or annual basis, depending on the size of the community or amount of new data, but it is essential to provide feedback to those who are doing individual case reports, and to let the community at large know what is being learned about aspects of the epidemic unique to a particular area. Some communities have found that this may be a time consuming task because many reporters are not familiar with the process of interpreting numerical data; it is especially important to have trained staff available to answer questions and to assist in distinguishing between significant and spurious trends.

B. Data on HIV Infection

It is now well established that there may be a long and variable latency period between the time of exposure to HIV and the onset of AIDS as a clinical syndrome. During this time the individual is described as HIV infected, and the presence of infection can usually be detected by the presence of HIV antibody.

There is no mandatory reporting or surveillance method contemplated for HIV infection in California, for reasons discussed elsewhere in this series of papers. Nevertheless, there are several potential sources of data on HIV infection in special populations, and these are of great importance even in the small community.

Alternative Test Site data: The Alternative Test Site System offers an opportunity to assess HIV positivity in a self-selected segment of the population who have perceived themselves to have had high risk of exposure. During this anonymous testing, data are collected on age, zip code of residence and risk behaviors. Even when the numbers of tests being conducted are small, it is worthwhile to describe the positivity rates for the various subsets of the community, and to compare this to regional or national data. A manual tabulation of data can be done in a format such as Appendix II-a and -c, and these data can be compared to findings reported in California Morbidity, the State AIDS Program, or the MMWR.

Blood bank data:

Local jurisdictions should make every effort to obtain
statistical summaries from blood banks serving them. These data provide information on individuals specifically screened to have no identified risk of exposure to HIV infection. If prevalence increases in such low-risk individuals, every effort should be made to investigate such cases. Currently, blood banks report a range of 0.02 - 0.05% seropositivity.

Confidential testing data:

These data represent individuals who have had high risk exposure and whose health care providers have agreed to test or have advised testing; there are also special studies funded by the State which specifically target at-risk populations. Although such data have not been available in the past, with the recent upsurge in interest in confidential testing, an effort should be made to obtain summary data, and to organize and present data on positives by risk behavior.

Data from military installations:

Those communities having significant military populations or recruitment centers should attempt to gather data that are available from local or regional military authorities. Case counts, antibody testing data and other special studies may have direct relevance for the military families living in the community as well as for the civilian population.

C. Mortality Data

Death certificates and reports from hospitals and physicians can provide the basis for linking AIDS case reports with subsequent mortality. It is essential to use a combination of these methods as any one may not be reliable. Follow-up data on mortality is reported to the State and Federal government and should be included in data summaries provided to practitioners and the community. In larger communities, it may be worthwhile to monitor the interval between initial case reporting and death, both to evaluate changes in stage of diagnosis and reporting of the disease and to evaluate length of survival following diagnosis and treatment.

D. Special Issues in Reporting

The issue of confidentiality has been discussed elsewhere, but has never been more important than in the AIDS epidemic. The most likely source of error in the data related to AIDS surveillance is underreporting, and this in turn is most likely to be due to fears about breach of confidentiality. While local health departments have been successful in preserving privacy and confidentiality of communicable
disease reports for many years, it is essential for each jurisdiction to thoroughly review its procedures for receiving, processing, reporting and storing records related to the AIDS epidemic. Provisions of California Health and Safety Code (Appendix V) should be made familiar to all clinic and clerical staff, and staff should keep abreast of all changes in the law related to confidentiality. The local health department also is viewed as the source of this information for the practicing medical community, and may be required to regularly provide information on this topic to hospital staffs, medical societies and other groups. Finally, a continual effort should be made to assess the completeness and reliability of all the data being collected relating to AIDS, whether through independent studies, through comparison with regional trends or through periodic evaluation of samples of data. In cases where gaps or weaknesses in data are detected, surveillance systems may need to be changed or refined.

VI. OTHER DATA SOURCES

A. Other Sexually Transmitted Disease

Reporting of other communicable diseases which may be viewed as surrogate markers of high risk behaviors including sexually transmitted diseases and Hepatitis B may provide useful information on the progress of the AIDS epidemic, to the extent that they provide indicators of the level of risk-taking behavior in particular segments of the community. Such data can be organized in terms of trends in disease rates (e.g. gonorrhea or syphilis) in age or sex-specific groups (e.g., women, single men) over the decade that includes the appearance of the AIDS epidemic. Similarly, the trends relating to Hepatitis B in IV-drug related cases may provide an indicator of change or lack of change in practices related to IV drug use. Since these data are already available in most local communities, they can be organized and analyzed with relatively little additional effort. Provision of this information back to the community at large may play a significant role in supporting or modifying the prevention strategies that are underway.

B. Contact Notification as a Data Source

Findings of contact notification studies may provide examples of heterosexual transmission or may provide local evidence of how uncommon such transmission is. It may also be applied to homosexual and IV drug populations in areas where the majority of individuals are not infected.
Contact investigation may be particularly useful in prevention of transmission of HIV in settings where the exposed individuals are not likely to perceive themselves as at any risk of HIV exposure. For example, follow-up of sexual partners of transfusion-associated AIDS cases or female sexual partners of closeted bisexual men will usually reveal that the persons had no reason to believe they had been exposed to HIV. On the other hand, follow-up of sexual contacts to exclusively homosexual men will yield only other homosexual men, the large portion of whom are already aware of their potential risk of exposure.

C. Basic Demographic Data - Denominators

In order to develop rates related to some aspects of AIDS, it is necessary to use denominators, and much of these data are available through local planning and economic development agencies. However, for most communities, accurate data on key variables such as the extent of IV drug use or sexual orientation are not available, and it is not likely to be worthwhile trying to develop estimates.

D. Comparisons with National or Regional Data

Local intervention plans should be developed with specific reference to similarities and differences between local data and state/regional/national data. In smaller communities where little local data are available, some caution should be exercised in interpolating from national data for purposes of planning local programs. A better approach would be to seek data from one or several similar small communities, selected for comparable demographic and socio-economic factors.

E. Special Targeted Studies

For many communities, it may be possible to conduct special studies of selected populations at points in time. These may include seroprevalence studies (e.g. prevalence of HIV positivity in STD clinic populations, jail populations, prostitutes, IV drug users) in order to periodically monitor spread of HIV infections in these communities. In conducting such studies in California, it is currently necessary to obtain written consent of the subjects, and it is desirable to conduct the studies under the auspices of a scientific institution that has a human subjects' review process.

Problems with such studies include but are not limited to: 1) Difficulty in recruitment secondary to fears surrounding breaches in confidentiality and access to medical records, 2) In jail/prison populations,
knowledge of antibody status by other inmates has provoked death threats, and knowledge by correctional staff may lead to discrimination or abuse. 3) Knowledge by the local health department of antibody status in prostitutes poses some ethical and potential legal issues, 4) Self-selection bias.

Blind seroprevalence studies have been recommended to identify populations with increased levels of HIV infection at a point in time, and may be useful for this purpose where a sufficient number of serum specimens is available to determine level of infection. Such populations may then be targeted for voluntary, confidential testing. However, this type of study is not appropriate on an ongoing basis, and it poses ethical problems because the anonymity inherent in the method prevents notification of any positives identified. Any such study should thus be carefully reviewed by a human subjects' review committee prior to implementation.

In larger communities it may be possible to conduct studies on the extent of risk-taking behavior. These are analogous to the KAP studies, (Knowledge, Attitude and Practice) that have been used extensively in the family planning field over the past 30 years. These studies may be used to evaluate both the effectiveness of current educational and prevention strategies and to develop new approaches.

Regional studies may be practical in situations where one county alone cannot mount the resource for "research" on special populations. This may become possible and useful where several counties share common special populations, and where national and statewide data are not applicable. An example of such a study might be one on knowledge, attitudes and practices among single male, seasonal agricultural workers in the central valley, who commonly employ the services of prostitutes. There is also significant IV drug use in this population, but it almost certainly involves different patterns and practices from those studied on the Eastern seaboard in Eastern cities and in West Coast inner cities. Findings from such a study should be shared with rural counties throughout California.

V. STUDIES ON HEALTH CARE: NEEDS, COSTS AND ORGANIZATION

Studies of implications of the AIDS epidemic for health care will vary greatly according to the size of a community, and according to the time frame that is attempted. While many of the costs for such care will ultimately be borne by the State and Federal governments, and thus large-scale and long-term projections are already
being conducted at these levels, the local policy makers will want to be aware of workload and organizational implications at the community level. California's Medical system currently provides one source of data for these purposes.

The most important variable, expected case load, is also one of the most difficult to project on a small scale. Case load modeling studies on the national and regional levels demonstrate the pitfalls in making estimates of the epidemic curve more than a few years into the future. In fact, models used by different agencies and jurisdictions are currently producing dramatically different projections of caseload in the future. In choosing any one model or method, the local jurisdiction should be aware that others exist and may produce different results. Nonetheless, the local community needs to estimate numbers of new cases for the purpose of health service planning for three to five years in advance.

In addition, an attempt should be made to determine where patients are receiving outpatient, inpatient, extended or hospice care services, and how these services are being financed. Home health services, laboratory services, counseling and family support may also be part of such an inventory. In those communities that establish case management systems for assisting patients with AIDS, some very valuable information will become available on all aspects of medical and support needs of the patient, and this can also be used in planning and providing such care.
1987 REVISION OF CASE DEFINITION FOR AIDS FOR SURVEILLANCE PURPOSES

For national reporting, a case of AIDS is defined as an illness characterized by one or more of the following "indicator" diseases, depending on the status of laboratory evidence of HIV infection, as shown below.

I. Without Laboratory Evidence Regarding HIV Infection

If laboratory tests for HIV were not performed or gave inconclusive results (See Appendix I) and the patient had no other cause of immunodeficiency listed in Section I.A below, then any disease listed in Section I.B indicates AIDS if it was diagnosed by a definitive method (See Appendix II).

A. Causes of immunodeficiency that disqualify diseases as indicators of AIDS in the absence of laboratory evidence for HIV infection

1. high-dose or long-term systemic corticosteroid therapy or other immunosuppressive/cytotoxic therapy ≤3 months before the onset of the indicator disease
2. any of the following diseases diagnosed ≤3 months after diagnosis of the indicator disease: Hodgkin’s disease, non-Hodgkin’s lymphoma (other than primary brain lymphoma), lymphocytic leukemia, multiple myeloma, any other cancer of lymphoreticular or histiocytic tissue, or angioimmunoblastic lymphadenopathy
3. a genetic (congenital) immunodeficiency syndrome or an acquired immunodeficiency syndrome atypical of HIV infection, such as one involving hypogammaglobulinemia

B. Indicator diseases diagnosed definitively (See Appendix II)

1. candidiasis of the esophagus, trachea, bronchi, or lungs
2. cryptococcosis, extrapulmonary
3. cryptosporidiosis with diarrhea persisting >1 month
4. cytomegalovirus disease of an organ other than liver, spleen, or lymph nodes in a patient >1 month of age
5. herpes simplex virus infection causing a mucocutaneous ulcer that persists longer than 1 month; or bronchitis, pneumonitis, or esophagitis for any duration affecting a patient >1 month of age
6. Kaposi’s sarcoma affecting a patient < 60 years of age
7. lymphoma of the brain (primary) affecting a patient < 60 years of age
8. lymphoid interstitial pneumonia and/or pulmonary lymphoid hyperplasia (LIP/PLH complex) affecting a child <13 years of age
9. Mycobacterium avium complex or M. kansasii disease, disseminated (at a site other than or in addition to lungs, skin, or cervical or hilar lymph nodes)
10. Pneumocystis carinii pneumonia
11. progressive multifocal leukoencephalopathy
12. toxoplasmosis of the brain affecting a patient >1 month of age

II. With Laboratory Evidence for HIV Infection

Regardless of the presence of other causes of immunodeficiency (I.A), in the presence of laboratory evidence for HIV infection (See Appendix I), any disease listed above (I.B) or below (II.A or II.B) indicates a diagnosis of AIDS.

A. Indicator diseases diagnosed definitively (See Appendix II)

1. bacterial infections, multiple or recurrent (any combination of at least two within a 2-year period), of the following types affecting a child < 13 years of age:
   - septicemia, pneumonia, meningitis, bone or joint infection, or abscess of an internal organ or body cavity (excluding otitis media or superficial skin or mucosal abscesses), caused by Haemophilus, Streptococcus (including pneumococcus), or other pyogenic bacteria
2. coccidioidomycosis, disseminated (at a site other than or in addition to lungs or cervical or hilar lymph nodes)
3. HIV encephalopathy (also called "HIV dementia," "AIDS dementia," or "subacute encephalitis due to HIV") (See Appendix II for description)
4. histoplasmosis, disseminated (at a site other than or in addition to lungs or cervical or hilar lymph nodes)
5. isosporiasis with diarrhea persisting >1 month
6. Kaposi’s sarcoma at any age
7. lymphoma of the brain (primary) at any age
8. other non-Hodgkin’s lymphoma of B-cell or unknown immunologic phenotype and the following histologic types:
   a. small noncleaved lymphoma (either Burkitt or non-Burkitt type) (See Appendix IV for equivalent terms and numeric codes used in the International Classification of Diseases, Ninth Revision, Clinical Modification)
   b. immunoblastic sarcoma (equivalent to any of the following, although not necessarily all in combination: immunoblastic lymphoma, large-cell lymphoma, diffuse histiocytic lymphoma, diffuse undifferentiated lymphoma, or high-grade lymphoma) (See Appendix IV for equivalent terms and numeric codes used in the International Classification of Diseases, Ninth Revision, Clinical Modification)

Note: Lymphomas are not included here if they are of T-cell immunologic phenotype or their histologic type is not described or is described as "lymphocytic," "lymphoblastic," "small cleaved," or "plasmacytoid lymphocytic"

9. any mycobacterial disease caused by mycobacteria other than M. tuberculosis, disseminated (at a site other than or in addition to lungs, skin, or cervical or hilar lymph nodes)
10. disease caused by M. tuberculosis, extrapulmonary (involving at least one site outside the lungs, regardless of whether there is concurrent pulmonary involvement)
11. Salmonella (nontyphoid) septicemia, recurrent
12. HIV wasting syndrome (emaciation, "slim disease") (See Appendix II for description)

B. Indicator diseases diagnosed presumptively (by a method other than those in Appendix II)

Note: Given the seriousness of diseases indicative of AIDS, it is generally important to diagnose them definitively, especially when therapy that would be used may have serious side effects or when definitive diagnosis is needed
for eligibility for antiretroviral therapy. Nonetheless, in some situations, a patient's condition will not permit the performance of definitive tests. In other situations, accepted clinical practice may be to diagnose presumptively based on the presence of characteristic clinical and laboratory abnormalities. Guidelines for presumptive diagnoses are suggested in Appendix III.

1. candidiasis of the esophagus
2. cytomegalovirus retinitis with loss of vision
3. Kaposi's sarcoma
4. lymphoid interstitial pneumonia and/or pulmonary lymphoid hyperplasia (LIP/PLH complex) affecting a child <13 years of age
5. mycobacterial disease (acid-fast bacilli with species not identified by culture), disseminated (involving at least one site other than or in addition to lungs, skin, or cervical or hilar lymph nodes)
6. *Pneumocystis carinii* pneumonia
7. toxoplasmosis of the brain affecting a patient >1 month of age

III. With Laboratory Evidence Against HIV Infection

With laboratory test results negative for HIV infection (See Appendix I), a diagnosis of AIDS for surveillance purposes is ruled out unless:

A. all the other causes of immunodeficiency listed above in Section I.A are excluded; AND
B. the patient has had either:
   1. *Pneumocystis carinii* pneumonia diagnosed by a definitive method (See Appendix II); OR
   2. a. any of the other diseases indicative of AIDS listed above in Section I.B diagnosed by a definitive method (See Appendix II); AND
   b. a T-helper inducer (CD4) lymphocyte count <400/mm³.

COMMENTARY

The surveillance of severe disease associated with HIV infection remains an essential, though not the only, indicator of the course of the HIV epidemic. The number of AIDS cases and the relative distribution of cases by demographic, geographic, and behavioral risk variables are the oldest indices of the epidemic, which began in 1981 and for which data are available retrospectively back to 1978. The original surveillance case definition, based on then-available knowledge, provided useful epidemiologic data on severe HIV disease (1). To ensure a reasonable predictive value for underlying immunodeficiency caused by what was then an unknown agent, the indicators of AIDS in the old case definition were restricted to particular opportunistic diseases diagnosed by reliable methods in patients without specific known causes of immunodeficiency. After HIV was discovered to be the cause of AIDS, however, and highly sensitive and specific HIV-antibody tests became available, the spectrum of manifestations of HIV infection became better defined, and classification systems for HIV infection were developed (2-5). It became apparent that some progressive, seriously disabling, and even fatal conditions (e.g., encephalopathy, wasting syndrome) affecting a substantial number of HIV-infected patients were not subject to epidemiologic surveillance, as they were not included in the AIDS case definition. For reporting purposes, the revision adds to the definition most of those severe non-infectious, non-cancerous HIV-associated conditions that are categorized in the CDC clinical classification systems for HIV infection among adults and children (4,5).

Another limitation of the old definition was that AIDS-indicative diseases are diagnosed presumptively (i.e., without confirmation by methods required by the old definition) in 10%-15% of patients diagnosed with such diseases; thus, an appreciable proportion of AIDS cases were missed for reporting purposes (6,7). This proportion may be increasing, which would compromise the old case definition's usefulness as a tool for monitoring trends. The revised case definition permits the reporting of these clinically diagnosed cases as long as there is laboratory evidence of HIV infection. The effectiveness of the revision will depend on how extensively HIV-antibody tests are used. Approximately one third of AIDS patients in the United States have been from New York City and San Francisco, where, since 1985, <7% have been reported with HIV-antibody test results, compared with >60% in other areas. The impact of the revision on the reported numbers of AIDS cases will also depend on the proportion of AIDS patients in whom indicator diseases are diagnosed presumptively rather than definitively. The use of presumptive diagnostic criteria varies geographically, being more common in certain rural areas and in urban areas with many indigent AIDS patients.

To avoid confusion about what should be reported to health departments, the term "AIDS" should refer only to conditions meeting the surveillance definition. This definition is intended only to provide consistent statistical data for public health purposes. Clinicians will not rely on this definition alone to diagnose serious disease caused by HIV infection in individual patients because there may be additional information that would lead to a more accurate diagnosis. For example, patients who are not reportable under the definition because they have either a negative HIV-antibody test or, in the presence of HIV antibody, an opportunistic disease not listed in the definition as an indicator of AIDS nonetheless may be diagnosed as having serious HIV disease on consideration of other clinical or laboratory characteristics of HIV infection or a history of exposure to HIV.

Conversely, the AIDS surveillance definition may rarely misclassify other patients as having serious HIV disease if they have no HIV-antibody test but have an AIDS-indicative disease with a background incidence unrelated to HIV infection, such as cryptococcal meningitis.

The diagnostic criteria accepted by the AIDS surveillance case definition should not be interpreted as the standard of good medical practice. Presumptive diagnoses are accepted in the definition because not to count them would be to ignore substantial morbidity resulting from HIV infection. Likewise, the definition accepts a reactive screening test for HIV antibody without confirmation by a supplemental test because a repeatedly reactive screening test result, in combination with an indicator disease, is highly indicative of true HIV disease. For national surveillance purposes, the tiny proportion of possibly false-positive screening tests in persons with AIDS-indicative diseases is of little consequence. For the individual patient, however, a correct diagnosis is critically important. The use of supplemental tests is, therefore, strongly endorsed. An increase in the diagnostic use of HIV-antibody tests could improve both the quality of medical care and the function of the new case definition, as well as assist in providing counselling to prevent transmission of HIV.
FIGURE I. Flow diagram for revised CDC case definition of AIDS, September 1, 1987

Laboratory evidence of HIV infection (Appendix I)

Unknown or Inconclusive

Positive

Has any disease in Sections I.B or II.A been definitively diagnosed (Appendix II)?

YES

AIDS Case

NO

Not a Case

Negative

Are there other causes of immunodeficiency (Section I.A)?

YES

Not a Case

NO

Has any disease in Section II.B been presumptively diagnosed (Appendix III)?

YES

Has Pneumocystis carinii pneumonia been definitively diagnosed (Appendix II)?

YES

AIDS Case

NO

Not a Case

NO

Has any other disease in Section I.B been definitively diagnosed (Appendix II)?

YES

Is the T-helper lymphocyte count <400/mm³?

YES

AIDS Case

NO

Not a Case

NO

Not a Case

NO

Not a Case

REFERENCES

5. CDC. Classification system for human immunodeficiency virus (HIV) infection in children under 13 years of age. MMWR 1987;36:225-30,235.
COUNTY OF ORANGE
AIDS MONITORING STATISTICS

3/27/87

HIV CASE REGISTRY
As of 3/25/87:

396 AIDS cases of whom 237 have died
202 ARC cases of whom 7 have died
29 have gone on to AIDS
506 ARF cases of whom 13 have died
26 have gone on to AIDS
8 have gone on to ARC
1 ruled out
105 HIV + only of whom 6 have died
1 has gone on to AIDS
3 have gone on to ARF

ALTERNATIVE TEST SITE
As of 1/31/87:

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<tr>
<td>Tests done</td>
<td>5,244 (685+) 13.1%</td>
<td>523 (41+) 7.8%</td>
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<td>2,101 (532+) 25.3%</td>
<td>117 (23+) 19.7%</td>
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<td>Bisexual</td>
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<td>60 (9+) 15.0%</td>
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<td>65 (9+) 13.8%</td>
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<td>16 (2+) 12.5%</td>
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<td>750 (12+) 1.6%</td>
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<tr>
<td>Hemophiliac</td>
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<td>0 (0+) 0.0%</td>
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<td>531 (8+) 1.5%</td>
<td>64 (0+) 0.0%</td>
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JAIL TESTING PROGRAM
As of 3/24/87:

1300 tests
32 positives (2.5%)
of which 3 are convertors from negative to positive

RED CROSS BLOOD SCREENING
As of 2/28/87:

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>3/85</td>
<td>7/86</td>
<td>110,000 units</td>
<td>41 positive</td>
<td>37.3+/100,000 units</td>
</tr>
<tr>
<td>8/86</td>
<td>12/86</td>
<td>40,000 units</td>
<td>6 positive</td>
<td>15.0+/100,000 units</td>
</tr>
<tr>
<td>1/87</td>
<td>2/87</td>
<td>19,500 units</td>
<td>2 positive</td>
<td>10.5+/100,000 units</td>
</tr>
</tbody>
</table>
COUNTY OF ORANGE HIV CASE REGISTRY
CASES THROUGH 3/18/87 BY DIAGNOSIS

NUMBER

AIDS  ARC  ARF  HIV+

391  200  502  102

HCA/POS
3/87
ALTERNATIVE TEST SITE SUMMARY STATISTICS
PERSONS TESTED THROUGH 12/31/86
HIV ANTIBODY TESTING TOTALS BY QUARTER

ALTERNATIVE TEST SITE SUMMARY STATISTICS
PERSONS TESTED THROUGH 1/31/87
TEST RESULTS BY MAJOR RISK GROUP

---

-36-
COUNTY OF ORANGE - AIDS MONITORING STATISTICS

JAIL TESTING PROGRAM

TEST RESULTS THRU 3/24/87

RED CROSS BLOOD SCREENING
HIV POSITIVITY RATE PER 100,000 UNITS

HCA/PDS
3/87
### PRIMARY DISEASE

<table>
<thead>
<tr>
<th>Disease</th>
<th>Cases</th>
<th>Percent of Total</th>
<th>Deaths</th>
<th>Percent Dead</th>
</tr>
</thead>
<tbody>
<tr>
<td>KS without PCP</td>
<td>641</td>
<td>22%</td>
<td>357</td>
<td>56%</td>
</tr>
<tr>
<td>PCP without KS</td>
<td>1531</td>
<td>54%</td>
<td>957</td>
<td>60%</td>
</tr>
<tr>
<td>Both KS and PCP</td>
<td>253</td>
<td>9%</td>
<td>167</td>
<td>66%</td>
</tr>
<tr>
<td>OI without KS or PCP</td>
<td>480</td>
<td>16%</td>
<td>326</td>
<td>68%</td>
</tr>
<tr>
<td>Total</td>
<td>2965</td>
<td>100%</td>
<td>1807</td>
<td>61%</td>
</tr>
</tbody>
</table>

*KS = Kaposi's sarcoma  
PCP = Pneumocystis carinii pneumonia  
OI = Other opportunistic infections

### AGE

<table>
<thead>
<tr>
<th>Age</th>
<th>Cases</th>
<th>Percent of Total</th>
<th>RACE/ETHNICITY</th>
<th>Cases</th>
<th>Percent of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 5</td>
<td>16</td>
<td>1%</td>
<td>White</td>
<td>2082</td>
<td>70%</td>
</tr>
<tr>
<td>05 - 12</td>
<td>0</td>
<td>0%</td>
<td>Black</td>
<td>411</td>
<td>14%</td>
</tr>
<tr>
<td>13 - 19</td>
<td>6</td>
<td>0%</td>
<td>Hispanic</td>
<td>435</td>
<td>15%</td>
</tr>
<tr>
<td>20 - 29</td>
<td>534</td>
<td>18%</td>
<td>Asian</td>
<td>31</td>
<td>1%</td>
</tr>
<tr>
<td>30 - 39</td>
<td>1344</td>
<td>45%</td>
<td>Other/Unknown</td>
<td>6</td>
<td>0%</td>
</tr>
<tr>
<td>40 - 49</td>
<td>710</td>
<td>24%</td>
<td>Total</td>
<td>2965</td>
<td>100%</td>
</tr>
<tr>
<td>Over 49</td>
<td>355</td>
<td>12%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unknown</td>
<td>0</td>
<td>0%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2965</strong></td>
<td><strong>100%</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### HISTORY OF INTRAVENOUS DRUG USE (adult cases)

<table>
<thead>
<tr>
<th>SEXUAL ORIENTATION</th>
<th>Yes</th>
<th>No</th>
<th>Unk</th>
<th>Total</th>
<th>Percent IV Drug Users</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male-homosexual</td>
<td>199</td>
<td>1356</td>
<td>761</td>
<td>2316</td>
<td>9%</td>
</tr>
<tr>
<td>Male-bisexual</td>
<td>45</td>
<td>224</td>
<td>104</td>
<td>373</td>
<td>12%</td>
</tr>
<tr>
<td>Male-heterosexual</td>
<td>56</td>
<td>105</td>
<td>16</td>
<td>177</td>
<td>32%</td>
</tr>
<tr>
<td>Male-orientation unk</td>
<td>4</td>
<td>5</td>
<td>5</td>
<td>14</td>
<td>29%</td>
</tr>
<tr>
<td>Female-heterosexual</td>
<td>13</td>
<td>49</td>
<td>7</td>
<td>69</td>
<td>19%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>317</strong></td>
<td><strong>1739</strong></td>
<td><strong>893</strong></td>
<td><strong>2949</strong></td>
<td><strong>11%</strong></td>
</tr>
</tbody>
</table>
PATIENT CHARACTERISTICS**

<table>
<thead>
<tr>
<th></th>
<th>MALES</th>
<th>% OF CASES</th>
<th>FEMALES</th>
<th>% OF CASES</th>
<th>TOTAL</th>
<th>% OF TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADULT/ADOLESCENT:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Homosexual or Bisexual</td>
<td>2700</td>
<td>0.4%</td>
<td>0</td>
<td>0%</td>
<td>2700</td>
<td>92%</td>
</tr>
<tr>
<td>Intravenous Drug User</td>
<td>61</td>
<td>0.2%</td>
<td>13</td>
<td>10%</td>
<td>74</td>
<td>3%</td>
</tr>
<tr>
<td>Hemophilia/Coag Disorder</td>
<td>16</td>
<td>1%</td>
<td>3</td>
<td>4%</td>
<td>19</td>
<td>1%</td>
</tr>
<tr>
<td>Heterosexual Contact**</td>
<td>8</td>
<td>0%</td>
<td>17</td>
<td>25%</td>
<td>25</td>
<td>1%</td>
</tr>
<tr>
<td>Transfusion</td>
<td>37</td>
<td>1%</td>
<td>20</td>
<td>23%</td>
<td>57</td>
<td>2%</td>
</tr>
<tr>
<td>None Apparent/Unknown</td>
<td>58</td>
<td>2%</td>
<td>18</td>
<td>23%</td>
<td>74</td>
<td>3%</td>
</tr>
<tr>
<td>Total</td>
<td>2830</td>
<td>100%</td>
<td>69</td>
<td>100%</td>
<td>2949</td>
<td>100%</td>
</tr>
<tr>
<td>PEDIATRIC:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hemophilia/Coag Disorder</td>
<td>0</td>
<td>0%</td>
<td>0</td>
<td>0%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Parent at Risk</td>
<td>3</td>
<td>27%</td>
<td>5</td>
<td>100%</td>
<td>8</td>
<td>50%</td>
</tr>
<tr>
<td>Transfusion</td>
<td>8</td>
<td>73%</td>
<td>0</td>
<td>0%</td>
<td>8</td>
<td>50%</td>
</tr>
<tr>
<td>None Apparent/Unknown</td>
<td>0</td>
<td>0%</td>
<td>0</td>
<td>0%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Total</td>
<td>11</td>
<td>100%</td>
<td>5</td>
<td>100%</td>
<td>16</td>
<td>100%</td>
</tr>
</tbody>
</table>

**Ordered hierarchically; cases with multiple characteristics are tabulated only in group listed first.

***With a person with AIDS or at risk for AIDS.

AIDS CASE-FATALITY BY HALF-YEAR OF DIAGNOSIS

<table>
<thead>
<tr>
<th>Diagnosis date</th>
<th>Number of cases</th>
<th>Number of deaths</th>
<th>Case-fatality rate</th>
<th>Cumulative case-fatality rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior to 1981</td>
<td>3</td>
<td>2</td>
<td>67%</td>
<td>67%</td>
</tr>
<tr>
<td>1981 Jan - June</td>
<td>8</td>
<td>8</td>
<td>100%</td>
<td>91%</td>
</tr>
<tr>
<td>July - Dec</td>
<td>12</td>
<td>8</td>
<td>67%</td>
<td>78%</td>
</tr>
<tr>
<td>1982 Jan - June</td>
<td>18</td>
<td>15</td>
<td>83%</td>
<td>80%</td>
</tr>
<tr>
<td>July - Dec</td>
<td>55</td>
<td>49</td>
<td>89%</td>
<td>85%</td>
</tr>
<tr>
<td>1983 Jan - June</td>
<td>109</td>
<td>94</td>
<td>86%</td>
<td>86%</td>
</tr>
<tr>
<td>July - Dec</td>
<td>146</td>
<td>121</td>
<td>83%</td>
<td>85%</td>
</tr>
<tr>
<td>1984 Jan - June</td>
<td>186</td>
<td>160</td>
<td>86%</td>
<td>85%</td>
</tr>
<tr>
<td>July - Dec</td>
<td>253</td>
<td>195</td>
<td>77%</td>
<td>83%</td>
</tr>
<tr>
<td>1985 Jan - June</td>
<td>382</td>
<td>298</td>
<td>78%</td>
<td>81%</td>
</tr>
<tr>
<td>July - Dec</td>
<td>451</td>
<td>299</td>
<td>66%</td>
<td>77%</td>
</tr>
<tr>
<td>1986 Jan - June</td>
<td>589</td>
<td>322</td>
<td>55%</td>
<td>71%</td>
</tr>
<tr>
<td>July - Dec</td>
<td>549</td>
<td>199</td>
<td>36%</td>
<td>61%</td>
</tr>
<tr>
<td>1987 Jan - Mar</td>
<td>204</td>
<td>37</td>
<td>18%</td>
<td>61%</td>
</tr>
</tbody>
</table>

TOTAL                        | 2965           | 1807             | 61%                |
# Epidemiologic Profile of AIDS Cases in Los Angeles County

<table>
<thead>
<tr>
<th>Patient Characteristic</th>
<th>Number of cases</th>
<th>Mean Age</th>
<th>Sex</th>
<th>Race</th>
<th>Primary Disease</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>M</td>
<td>F</td>
<td>KS Both PEP OI</td>
</tr>
<tr>
<td>Homosexual or Bisexual</td>
<td>2700</td>
<td>37</td>
<td>100</td>
<td>0</td>
<td>23 9 52 15</td>
</tr>
<tr>
<td>Intravenous Drug User</td>
<td>74</td>
<td>34</td>
<td>82</td>
<td>18</td>
<td>7   3 62 28</td>
</tr>
<tr>
<td>Hemophiliacs</td>
<td>19</td>
<td>38</td>
<td>84</td>
<td>16</td>
<td>0   5 68 26</td>
</tr>
<tr>
<td>Transfusion: Adult</td>
<td>57</td>
<td>56</td>
<td>65</td>
<td>35</td>
<td>3   2 72 23</td>
</tr>
<tr>
<td>Pediatric: Adult</td>
<td>8</td>
<td>38 mo</td>
<td>100</td>
<td>0</td>
<td>0   0 50 50</td>
</tr>
<tr>
<td>Heterosexual Contact</td>
<td>25</td>
<td>36</td>
<td>32</td>
<td>68</td>
<td>0   0 76 24</td>
</tr>
<tr>
<td>Pediatric: Parent at Risk</td>
<td>8</td>
<td>19 mo</td>
<td>38</td>
<td>63</td>
<td>0   0 38 62</td>
</tr>
<tr>
<td>Other/Unknown</td>
<td>74</td>
<td>41</td>
<td>78</td>
<td>22</td>
<td>7   0 70 23</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>2965</td>
<td>38 *</td>
<td>98</td>
<td>2</td>
<td>22 9 54 16</td>
</tr>
</tbody>
</table>

*Adult cases only.
REPORTED AIDS CASES BY HEALTH DISTRICT OF RESIDENCE

LOS ANGELES COUNTY

MARCH 31, 1987

* Excludes 95 cases with unknown residence.
### MONTEREY COUNTY AIDS STATISTICS - Period Ending: August 14, 1987


Total AIDS Cases: 50
Total AIDS Deaths: 32

### AIDS CASES AND DEATHS BY YEAR REPORTED TO THE HEALTH DEPT. (1981 - AUG 1987)

<table>
<thead>
<tr>
<th>YEAR</th>
<th>CASES</th>
<th>DEATHS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1981</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>1982</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>1983</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>1984</td>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td>1985</td>
<td>10</td>
<td>1</td>
</tr>
<tr>
<td>1986</td>
<td>12</td>
<td>1</td>
</tr>
<tr>
<td>1987</td>
<td>14</td>
<td>2</td>
</tr>
</tbody>
</table>

### Table 1.1 AIDS CASES BY RISK CHARACTERISTIC

<table>
<thead>
<tr>
<th>Risk Characteristic</th>
<th>Cases (1980-86)</th>
<th>Cases (Jan-Aug 1987)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homosexual</td>
<td>11 (32)</td>
<td>10 (63)</td>
</tr>
<tr>
<td>Bisexual</td>
<td>11 (32)</td>
<td>3 (19)</td>
</tr>
<tr>
<td>I.V. Drug User</td>
<td>6 (18)</td>
<td>1 (6)</td>
</tr>
<tr>
<td>Homo/BI IVDU</td>
<td>2 (6)</td>
<td>0</td>
</tr>
<tr>
<td>Hemophilic</td>
<td>2 (6)</td>
<td>0</td>
</tr>
<tr>
<td>Blood Recipient</td>
<td>2 (6)</td>
<td>1 (6)</td>
</tr>
<tr>
<td>Heterosexual</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>34 (100)</td>
<td>16 (100)</td>
</tr>
</tbody>
</table>

### Table 1.2 AIDS CASES BY RACE/ETHNIC GROUP

<table>
<thead>
<tr>
<th>Race/Ethnic Group</th>
<th>Cases (1980-86)</th>
<th>Cases (Jan-Aug 1987)</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>21 (62)</td>
<td>13 (81)</td>
</tr>
<tr>
<td>Black</td>
<td>6 (18)</td>
<td>0</td>
</tr>
<tr>
<td>Hispanic</td>
<td>7 (21)</td>
<td>3 (19)</td>
</tr>
<tr>
<td>Asian P.I.</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>34 (100)</td>
<td>16 (100)</td>
</tr>
</tbody>
</table>

### Table 1.3 AIDS CASES BY AGE GROUP

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Cases (1980-86)</th>
<th>Cases (Jan-Aug 1987)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 13</td>
<td>2 (6)</td>
<td>0</td>
</tr>
<tr>
<td>13-19</td>
<td>0 (0)</td>
<td>0</td>
</tr>
<tr>
<td>20-29</td>
<td>7 (21)</td>
<td>3 (19)</td>
</tr>
<tr>
<td>30-39</td>
<td>10 (29)</td>
<td>9 (56)</td>
</tr>
<tr>
<td>40-49</td>
<td>11 (32)</td>
<td>1 (6)</td>
</tr>
<tr>
<td>Over 50</td>
<td>4 (12)</td>
<td>3 (19)</td>
</tr>
<tr>
<td>Total</td>
<td>34 (100)</td>
<td>16 (100)</td>
</tr>
</tbody>
</table>

### Table 1.4 AIDS CASES BY SEX

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>33 (97)</td>
<td>15 (94)</td>
</tr>
<tr>
<td>Female</td>
<td>1 (3)</td>
<td>1 (6)</td>
</tr>
<tr>
<td>Total</td>
<td>34 (100)</td>
<td>16 (100)</td>
</tr>
</tbody>
</table>
## MONTEREY COUNTY HIV ANTIBODY TEST STATISTICS - Period Ending: July 1987

### Table 1  MONTEREY COUNTY HEALTH DEPARTMENT: ALTERNATIVE TEST SITE RESULTS

<table>
<thead>
<tr>
<th></th>
<th>Aug - Dec 1985</th>
<th>Jan - Dec 1986</th>
<th>Jan - June 1987</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No. Tested</td>
<td>Positive No.</td>
<td>Tested No. (%)</td>
</tr>
<tr>
<td>Homosexual</td>
<td>57</td>
<td>12 (21.1)</td>
<td></td>
</tr>
<tr>
<td>I.V. Drug User</td>
<td>9</td>
<td>0 (0)</td>
<td></td>
</tr>
<tr>
<td>Bisexual</td>
<td>33</td>
<td>6 (18.2)</td>
<td></td>
</tr>
<tr>
<td>Blood Recipient</td>
<td>7</td>
<td>1 (14.3)</td>
<td></td>
</tr>
<tr>
<td>Heterosexual</td>
<td>21</td>
<td>1 (4.8)</td>
<td></td>
</tr>
<tr>
<td>Partner at Risk</td>
<td>15</td>
<td>0 (0)</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>6</td>
<td>0 (0)</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>148</strong></td>
<td><strong>20 (13.51)</strong></td>
<td></td>
</tr>
</tbody>
</table>

|                  | No. Tested     | Positive No.   | Tested No. (%)  | No. Tested     | Positive No.   | Tested No. (%)  | No. Tested     | Positive No.   | Tested No. (%)  |
| Homosexual       | 0              | 0 (0)          |                 | 0              | 0 (0)          |                 | 0              | 0 (0)          |                 |
| I.V. Drug User   | 5              | 1 (20.0)       |                 | 9              | 1 (11.1)       |                 | 33             | 0 (0)          |                 |
| Bisexual         | 0              | 0 (0)          |                 | 0              | 0 (0)          |                 | 0              | 0 (0)          |                 |
| Blood Recipient  | 9              | 1 (11.1)       |                 | 13             | 0 (0)          |                 | 55             | 0 (0)          |                 |
| Heterosexual     | 4              | 0 (0)          |                 | 19             | 0 (0)          |                 | 145            | 0 (0)          |                 |
| Partner at Risk  | 17             | 0 (0)          |                 | 38             | 1 (2.6)        |                 | 101            | 0 (0)          |                 |
| Other            | 5              | 0 (0)          |                 | 9              | 0 (0)          |                 | 36             | 0 (0)          |                 |
| **Total**        | **40**         | **2 (5.0)**    |                 | **88**         | **2 (2.3)**    |                 | **370**        | **0 (0)**      |                 |

**Male & Female Total: 188 (11.7%), 391 (14.6%), 796 (2.9%)**

### Table 2  PRIVATE PHYSICIANS' PATIENTS - TEST RESULTS, BY LABORATORY

<table>
<thead>
<tr>
<th></th>
<th>Monterey County Health Department</th>
<th>Community Hospital of the Monterey Peninsula</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Jan - Dec 1986</td>
<td>Jan - July 1987</td>
</tr>
<tr>
<td>No. Tested</td>
<td>Positive No.</td>
<td>Tested No. (%)</td>
</tr>
<tr>
<td>108</td>
<td>17 (15.7)</td>
<td></td>
</tr>
<tr>
<td>212</td>
<td>7 (3.3)</td>
<td></td>
</tr>
</tbody>
</table>

### Table 3  SPECIAL TESTING PROGRAMS

<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>No. Tested</td>
<td>Positive No.</td>
<td>Tested No. (%)</td>
<td>Positive No.</td>
<td>Tested No. (%)</td>
</tr>
<tr>
<td>262</td>
<td>4 (1.5)</td>
<td></td>
<td>14,893</td>
<td>25 (0.168)</td>
</tr>
</tbody>
</table>

**Total Force 14,893, 25 (0.168%), 11,581, 10 (0.086%)**

### Table 4  COMMUNITY HOSPITAL OF THE MONTEREY PENINSULA (CHOMP): BLOOD CENTER

#### Blood Donor Test Results

<table>
<thead>
<tr>
<th></th>
<th>Jun - Dec 1985</th>
<th>Jan - Dec 1986</th>
<th>Jan - June 1987</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. Tested</td>
<td>Positive No.</td>
<td>Tested No. (%)</td>
<td>Positive No.</td>
</tr>
<tr>
<td>2,195</td>
<td>0 (0)</td>
<td></td>
<td>5,033</td>
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#### Transfusion Recipient Test Results

<table>
<thead>
<tr>
<th></th>
<th>March - June 1987</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. Tested</td>
<td>Positive No. (%)</td>
</tr>
<tr>
<td>676</td>
<td>4 (0.4)</td>
</tr>
</tbody>
</table>

* Program completed. (Transfusion recipients did not necessarily get their blood from CHOMP.)
On March 2, 1985 the U.S. Food and Drug Administration licensed for use an enzyme-linked immunosorbent assay (ELISA) for the detection of antibodies to the human T-cell lymphotropic virus III (HTLV III), the probable causative agent of the acquired immune deficiency syndrome (AIDS). Primary use of the ELISA HTLV III antibody test to date has been to screen blood donors to minimize the risk of HTLV III infection by blood transfusion. In California, blood bank screening of donors for HTLV III antibody is mandated by law (June 3, 1985) as is the soon to be initiated alternative test site program for persons in AIDS risk groups who want free and immediate HTLV III antibody tests. Licensed clinical laboratories, utilized by physicians throughout the State, may also provide HTLV III antibody testing services.

The newly enacted laws created by Assembly Bills 403 and 488 (California Morbidity #13 April 5, 1985) require confidentiality of HTLV III antibody test results and protect the privacy of individuals who are the subjects of such tests. The Department of Health Services has summarized it's interpretation of these requirements as follows:

1) Physicians who want to test patients for HTLV III antibody must obtain specific consent from the patient in the form of a written statement signed by the patient affirming that consent was obtained. For donors tested for antibody at blood banks, this requirement is met when donors sign the mandated written statement confirming that they have been notified in writing of the conditions of donation as set forth in section 1603.Xa(1-6) of the Health and Safety Code (e.g., donors confirmed to be positive for HTLV III antibody to be placed on a confidential statewide Deferred Donor Register without mention of the reason for being included on the register). The requirement of written consent does not apply to tests performed at alternative sites where a coded system will be used that does not link individual identity with tests requests or results.

2) Physicians who wish to disclose HTLV III antibody test results obtained in a patient under their care and treatment to a third party must obtain written authorization from that patient for each separate disclosure of the results and specify to whom the disclosure will be made. "Disclosed" as used in the law means to disclose, release, transfer, disseminate or otherwise communicate all or any part of any record orally, in writing, or by electronic means to any person or entity. The new law further provides that no person can be compelled to identify or provide identifying characteristics which would identify any individual who is the subject of a blood test to detect antibodies to HTLV III in any proceeding (including civil, criminal, administrative, or legislative proceedings) unless written authorization has been given by the test subject for that purpose.

Persons who negligently or willfully disclose results of HTLV III antibody tests to any third party in a way which identifies or provides identifying characteristics of the person to whom the test results apply (except pursuant to a written authorization or in accordance with any reporting requirement for a diagnosed case of AIDS or reports required by blood banks and plasma centers in accordance with AB 488) are subject to various civil or criminal penalties as specified in section 199.21 of the Health and Safety Code.

The Infectious Disease Section has been asked if clinical laboratories must also obtain separate prior written consent from a test subject before performing the HTLV III antibody test. We have interpreted the law to require that only the person (physician) who ordered the HTLV III antibody test needs to obtain the written consent. The laboratory would appear to be only acting as the agent of the physician who ordered the test. This interpretation is based upon discussions with legislative staff who drafted AB 403. The laboratory, however, has responsibility (as with all other tests) for maintaining the confidentiality of test result records.

While all laboratory test results are considered sensitive and confidential, several procedures have been suggested to minimize the possibility of any break in confidentiality.

1) Blood specimens and laboratory forms can be submitted to the laboratory in coded form so that identifying information about the test subject is not available to the specimen or laboratory report with the identity of the test subject.

2) A separate laboratory form may be used for submitting or reporting the results of HTLV III antibody tests to facilitate management of these sensitive data.

3) When the written consent for performing the antibody test is obtained, consideration should be given to including on the consent form information as to how the test results and identifying data might be handled. For example, will the specimen and laboratory slip be coded? If not coded, what classifications of medical personnel (or others) might see the report of test results as a matter of routine record processing? Will the test results form be a part of the patient's hospital or office chart, etc.?

All health care providers should be aware of the provisions of AB 403 and 488 and take appropriate measures to safeguard the confidentiality of HTLV III antibody test requests and results.

The Department has provided this general summary of these selected new statutory requirements to facilitate prompt and consistent conformity with the requirements. Individual hospitals, physicians, laboratories, etc., are encouraged to consult their attorneys regarding how to best comply with the law based upon their particular concerns and circumstances.
I. INTRODUCTION

The California Conference of Local Health Officers (CCLHO) recognizes that almost all persons who have Acquired Immunoodeficiency Syndrome (AIDS) or AIDS Related Conditions (ARC) will assume responsibility for the prevention of Human Immunodeficiency Virus (HIV) transmission. It has been demonstrated that once informed of HIV infection and educated about how to prevent infection, people with AIDS and ARC will modify their behavior so as to prevent transmission to others.

These guidelines are prepared to assist the Local Health Officer when he/she is confronted with that rare individual with AIDS or ARC who knows he/she is infected with HIV virus, knows how transmission is accomplished and continues to knowingly and willfully engage in high risk activities which are likely to expose others. The guidelines describe a variety of interventions that the Local Health Officer should consider when he/she attempts to change the dangerous and reckless behavior of such a recalcitrant person with AIDS or ARC.

It is important to state at the onset that these guidelines do not consider those persons infected by HIV in whom the infection has not progressed to the stage of symptomatic illness (AIDS or ARC). The reasons for this exclusion are twofold. First, only a small number of HIV infected individuals are aware of their infected status (as indicated by a confirmed reactive test for antibody toward HIV); and second, HIV infection is not a reportable condition under California law. In fact, reporting the result of the HIV antibody test to a person not expressly authorized by the subject of the test to receive such information is prohibited by California law (Health & Safety Code, sec. 199.21 et seq).

Currently, and until research produces effective treatment and/or immunizing agents, we must depend upon community
and individual education to reduce the spread of HIV infection. Educational efforts to reduce the spread of HIV by encouraging reduction of behaviors with a high risk of transmitting HIV is underway in most communities. These efforts are working. Local Health Officers must be particularly careful that any action taken in regard to the recalcitrant patient not interfere with these highly productive activities or be perceived as a barrier to persons with AIDS or ARC who seek care.

II. PUBLIC HEALTH CONCERN

Persons with AIDS/ARC who have the potential for transmitting AIDS/ARC should be educated about how to prevent the spread of HIV infection to others. These educational efforts must be individualized to fit the person's specific personal habits and can be reinforced by support groups and other interventions, including professional counseling. As long as persons understand how to and agree to prevent the spread of infection, the Local Health Officer need take no further actions. The responsibility of the Local Health Officer to intervene in any case of AIDS/ARC is present only when there is a valid threat to the public health. Action is only appropriate in those cases in which the individual with AIDS/ARC knows he/she is infected, knows how transmission is accomplished and continues to knowingly and willfully engage in high risk activities which are likely to expose others.

III. DEFINITION OF TERMS

Acquired Immunodeficiency Syndrome (AIDS): Relates to a clinical condition which is part of the spectrum of disease caused by the Human Immunodeficiency Virus (HIV) as defined by the Centers for Disease Control (CDC).

AIDS Related Condition (ARC): Refers to a number of different CDC classifications which are part of the spectrum of disease of the HIV infection. These include Group III and those parts of Group IV which do not meet the strict CDC definition of AIDS.

Recalcitrant Patient: A person with AIDS or ARC who knowingly and willfully engages in high risk behavior after being informed of the risk to the public of such behavior.

Quarantine: Title 17 of the California Administrative Code 2520 states: "Quarantine is defined as the limitation of movement of persons or animals that have been exposed to a communicable disease for a period of time equal to the longest usual incubation period of the disease, in such manner as to prevent effective contact with those not so exposed. If the disease is one
requiring quarantine of the contacts in addition to isolation of the case, the local health officer shall determine the contacts who are subject to quarantine, specify the place to which they shall be quarantined, and issue instructions accordingly. He shall insure that provisions are made for the medical observation of such contacts as frequently as necessary during the quarantine period." (underlining added)

Isolation: Title 17 of the California Administrative Code 2515 states: "Isolation is defined as separation of infected persons from other persons, for the period of communicability in such places and under such conditions as will prevent the transmission of the infectious agent."

Modified Isolation: If the disease does not require strict isolation from all contact with other persons, the local Health Officer shall issue appropriate instructions of modified isolation, prescribing the isolation technique to be followed. 17 Cal. Adm. Code 2518.

Order for Examination: This is a legal order for a person to appear at a designated site for a medical examination and an evaluation of medical records excluding information regarding HIV status. 17 Cal. Adm. Code 2512.

IV. INTERVENTIONS

Most individuals will willingly comply with reasonable requests to modify their behavior so that they reduce the likelihood of infecting others. Presented below are a number of interventions possible in helping individuals to reduce risk behavior. In considering interventions the Health Officer should attempt to determine the underlying reasons for the behaviors which endanger the public health.

A. Community Education: All persons must be made aware of AIDS, the transmission of the HIV, and risk reduction behaviors. All persons need to be encouraged to practice risk reduction routinely. Community education remains the most important tool in stopping the epidemic.

B. Individual Education: Persons infected with HIV, as demonstrated by a diagnosis of AIDS or ARC, must be intensively educated about risk reduction. Specific risk activities must be discussed, so that the individual understands what he/she must do in order to prevent infecting others. Equally important is education about what activities do not pose a risk of infection to others.

C. Intensive Counseling/Peer Pressure: Persons who know of their infection and how it is spread and yet
continue at-risk behaviors without informing others of their infection should receive intensive education/counseling in order to ensure that they truly understand their disease and the potential risk of infecting others. If the individual is involved in a group such as a support group and he/she is willing to discuss his/her infection and activities, the group can be a useful tool in encouraging risk reduction.

D. Rehabilitation: Prostitutes and others who gain financially through at-risk activities may require counseling or employment opportunities outside of prostitution in order to assist them in their efforts to reduce at-risk behaviors. Condoms must be readily available for all persons willing to use them.

E. Drug Treatment Programs: Persons who are at risk of infecting others through the sharing of needles during intravenous drug use should be referred to treatment resources for their drug use. The availability of an adequate number of methadone treatment slots for persons with AIDS/ARC should be assured by state and local treatment programs. The availability of these programs may assist in modifying the behavior of an IV drug user with AIDS/ARC. However, since opiate use constitutes only a portion of all intravenous drug use, methadone treatment services alone will not provide all necessary drug abuse interventions.

All of the above interventions necessary to encourage risk reduction behavior should be available in every local jurisdiction. Consultation from experts in the field of risk behavior change are available at the local and state level, and can be utilized to describe the best approach to intervention in a particular case.

IV. FAILURE OF INTERVENTIONS

Unfortunately, there are likely to be a few individuals for whom all interventions fail, and who continue to knowingly and willfully engage in risk behaviors which may infect others. These individuals are termed "recalcitrant." Their recalcitrance is not established due to the presence of AIDS/ARC, but due to the fact that they knowingly and willfully continue to behave in a way which puts others at risk of infection. These recalcitrant individuals present a threat to the public health. The Surgeon General, the Institute of Medicine, National Academy of Sciences, and others agree that, while they oppose isolation or quarantine of persons with AIDS/ARC, compulsory measures may need to be used in the rare case of the recalcitrant patient.

Several Local Health Officers have had cases of recalcitrant individuals referred to them for possible
legal action under current state law. Local jurisdictions have been able to intervene in such a manner as to not involve current law in order to gain compliance from the person referred. The referrals have come from the criminal justice system, from the community, and from medical practitioners. Successful compliance has been accomplished voluntarily. Legal action was not required because education and community support services succeeded. The response by Local Health Officers to referrals for possible legal action should attempt to achieve voluntary compliance and must follow current disease control statutes, provide for confidentiality, and assure due process of law for potentially affected individuals.

V. CONSIDERATIONS

In responding to a request to invoke current statutes in the case of an alleged recalcitrant individual with AIDS/ARC, the Health Officer must consider a number of different issues.

A. Facts of the Case: There is a potential for abuse of any system, and the Health Officer must be aware that there is prejudice against some groups with higher prevalence rates of HIV infection and disease and against persons with AIDS/ARC. The Health Officer must determine that the facts of the case warrant his/her involvement beyond interventions mentioned above, and that the individual is truly recalcitrant. If a request for action comes from the criminal justice system, it is hoped that it will have already established the facts which will permit the Health Officer to determine whether legal intervention is warranted. The facts must establish that the individual does indeed have AIDS/ARC, is behaving in a manner which threatens the public health and that the interventions mentioned previously have been tried without success. If the referral comes from a source which has not established the facts, the Local Health Officer must obtain the information to establish these facts.

B. Behavior, Not Disease: It should be repeatedly stressed that any possible legal action on the part of the Local Health Officer should be as a result of specific recalcitrant behavior(s), and not as a result of the presence of disease. Existing CDC recommendations, if followed, adequately protect the health of the public. It would be only if those recommendations are knowingly and willfully violated that the Local Health Officer might consider legal action. Any legal action which may be considered must be in terms of changes in behavior.

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C. Reason for Exercising Authority: The Health Officer must have a clear idea of the intended outcome of any legal action which may be considered. He or she must document that all other possible interventions have failed, and be able to explain why legal action is necessary in the individual case. If the intended action is to add legal authority to a prescribed program of risk reduction, that should be stated. An additional consideration is how far the Health Officer will pursue a legal course. If the first step fails, will step two be taken, etc.

D. Due Process of Law: Requests being made to local jurisdictions are for the application of current laws to alleged recalcitrant persons with AIDS/ARC. Although these laws do not contain specific provisions for due process of law in their application, such provisions are constitutionally required. We strongly urge every Health Officer to add due process of law to his/her jurisdiction's policies and procedures. The California Conference of Local Health Officers (CCLHO) requests that the Department of Health Services establish statewide guidelines for due process of law. Some counties have established a due process policy which can serve as a model.

E. Frequent Review: Any possible legal action taken must be frequently reviewed by the Health Officer. Any legal action taken would be the result of the specified behavior(s) of individuals, and would be specific to the behavior rather than to the disease. Once an individual changes his or her behavior so that he or she no longer presents a threat to the health of the public, all legal action should be dropped.

F. Consultation: Consultation from experts in the field of behavior evaluation should be sought to try to identify any interventions short of legal action which may be helpful in dealing with a recalcitrant individual. Additionally, consultation from Health Officers in counties more experienced with AIDS/ARC should be sought. Those counties have dealt with requests to act in cases of alleged recalcitrant individuals and can provide valuable consultation in dealing with a request. The Health Officer is encouraged to form an advisory panel of local experts to review any request. Such review must assure confidentiality of information about all individuals involved. Panel members should not be provided with identifying information about the person involved.

G. Negative Program Impact: A very serious consideration is the negative effect that any legal action against a recalcitrant individual with AIDS/ARC may have. The concern is that any move to invoke current laws (regardless of justification) would frighten all
persons with AIDS/ARC and that non-recalcitrant persons would not seek needed medical attention, fearing legal action. If infected individuals avoid care and counseling from public health services and private physicians, the loss of opportunity for education about prevention may contribute to the spread of infection in the community. This is a serious concern, and must be carefully weighed prior to the time any possible legal action is taken. Discussions of this issue should occur between the Health Officer and community leaders, especially the gay/bisexual community and the drug abuse prevention community. These discussions should be held prior to any specific request.

H. Resource Exhaustion: A related concern is that of resource exhaustion. Some persons believe that local jurisdictions would exhaust valuable resources in situations involving the invocation of current laws against any individual, and that those same resources would be better put toward community and individual education, and other nonlegal interventions. This is a consideration in deciding how to respond to a request for evaluation of a particular case. However, it must be recognized that requests for action may come from outside the health agency (rather than from within) and therefore some response must be made. In most cases the request does not justify any involvement of the legal authority of the Health Officer; either the facts show the individual in question to not be knowingly and willfully behaving in a manner which endangers the public health, or nonlegal interventions enable the individual to change his/her behavior. However, the Local Health Officer must consider how he/she will respond in the case of a person who is truly recalcitrant, and for whom no nonlegal interventions seem to work. Each jurisdiction must decide how to proceed if all nonlegal efforts fail and an individual remains recalcitrant. Planning for this possibility, including discussions of the issues within the community, will save time and resources if action is required.

I. The state of knowledge of individuals exposed to HIV: Most HIV transmission is by mutually consenting behavior. Therefore, the responsibility for the prevention of HIV infection is shared between infected persons and their uninfected partners, either sexual or needle sharing. The Health Officer must consider this factor in evaluating to what extent the individual who may be recalcitrant is exposing others without their knowledge. The Health Officer must continually assess the level of knowledge related to the transmission of HIV in the community and be
certain that all individuals are aware of the risks of infection and understand how to reduce or eliminate these risks.

J. Is it Worth It? Ultimately, the Health Officer must determine what, if any action should be taken. After all nonlegal interventions have been tried, consultation has been obtained, and if a recalcitrant individual continues to act so as to present a threat to the public health, the Health Officer may find it necessary to consider legal action. Such action should be taken only after careful consideration of issues presented above. (To move to invoke current law to reduce the public health threat caused by the actions of one or a very few individuals will do no overall good if other aspects of the local jurisdiction's AIDS programs suffer disproportionately. The effect of such an action may do more overall harm than good.)

K. Mental Competence: It must be recognized that some persons with AIDS/ARC engaging in activities which might infect others might be mentally incompetent to understand the danger their activities pose to others. In cases in which there is a question of a person's competence to control his/her behavior, psychiatric examination is an appropriate part of the examination of the individual. The psychiatric examination and its outcome are adjuncts to, not a replacement for interventions and legal actions related to the control of communicable disease. The responsibility for disease control is that of the Local Health Officer. There are a few individuals who are so gravely disabled that they are conserved, or otherwise become the responsibility of the local mental health agency. Even in these cases, the Local Health Officer must retain responsibility for directing steps and establishing procedures to reduce behavior which might spread HIV infection.

L. Judicial Remedy: The possible legal actions discussed below constitute application of current state law. Judicial remedy may be sought by individuals at any point in the process. Once any official action is taken on the part of the Local Health Officer, affected individuals may seek injunctions or other activities through the judicial system. The Health Officer should be certain that the individual is adequately informed of these options.

VI. POSSIBLE LEGAL ACTION RELATING TO THE RECALCITRANT INDIVIDUAL

Legal action taken by the Local Health Officer to alter an individual's at-risk behavior must be considered only
after the above mentioned interventions have been offered or tried, and the recalcitrant individual continues to behave in such a manner as to pose a threat to the public health. Legal action should not apply to individuals engaging in consensual acts in which the other individual(s) are aware of risk. All persons should be advised to refrain from activities which may put them at risk of acquiring infection with HIV, and therefore be able to make choices about their own activities.

Actions which are authorized by current state law for consideration by the local health jurisdiction include Order for Examination, Order of Modified Isolation, Order of Strict Isolation, and Quarantine. Of these possibilities, quarantine is totally inappropriate: it pertains to the limitation of movement of a person exposed to a communicable disease, not to the behavior of a person known to be capable of infecting others. We do not recommend that the Local Health Officer issue an Order of Strict Isolation. Any order restricting the movement of an individual with AIDS/ARC should be issued by the judicial system and not through administrative law. The Health Officer may consider two possible actions—the Order for Examination and the Order of Modified Isolation.

A. Order for Examination: The purpose of the Order for Examination is to establish facts in a case referred to the Local Health Officer for action to invoke current laws. The first step in the consideration of any action must be to establish the facts. Most referrals for local jurisdiction legal action are not justified from the standpoint of protecting the public health. The Order for Examination may be necessary to evaluate a referral in rare cases. Such an order should be issued only if there is clear, factual evidence which demonstrates a compelling need to examine a particular individual. Simply put, the Order for Examination orders a person to appear for examination. Its use would provide for an opportunity to interview an alleged recalcitrant individual in order to assess the individual's infection status, his/her knowledge and understanding of risk behaviors, how to reduce risk, and his/her willingness to voluntarily comply with risk reduction activities. During the interview, the individual should be informed of options available to the Health Officer should the individual be unwilling to comply in reducing the risk of infecting others. The hoped for outcome of the interview will be that the individual increases his/her knowledge of how to prevent the possible transmission of infection and agrees to engage in the discussed risk reduction program. If that is the case, further legal actions are not necessary. If the individual does not agree to behave in such a manner as to no longer present a threat to the public health by knowingly and willfully acting so
that he/she might infect others, further action should be discussed with the local County Counsel or District Attorney.

B. Order of Modified Isolation: The purpose of this action in the case of a recalcitrant person with AIDS/ARC would be to specifically and legally define desired activities, or to prohibit undesired activities. This Order should concern definition or limitation of activities, and not of movement. A Modified Order of Isolation might prescribe regular attendance at counseling sessions, participation in education, and/or compliance with a treatment regimen. It will not be possible to monitor compliance with orders to refrain from high risk sexual and intravenous drug use behaviors; therefore, the emphasis in the Order of Modified Isolation is placed on affirmative interventions such as active participation in activities which will lead to changes in behavior. If the Order is violated, the individual is guilty of a misdemeanor under current law, and the District Attorney may take action against the individual.

C. The Judicial System: If, with the failure of the above two measures, the Local Health Officer finds it necessary to consider restriction of movement of the AIDS/ARC patient, he/she should request that his/her local district attorney charge the recalcitrant person with AIDS/ARC with (1) refusal to comply with a modified isolation order (section 3351, Health and Safety Code) or (2) a violation of section 3353 of the Health and Safety Code. This section states that "any person afflicted with any contagious, infectious, or communicable disease who willfully exposes himself, and any person who willfully exposes another person afflicted with such disease, is guilty of a misdemeanor." This Section appears to make it a misdemeanor to willfully expose an individual to a communicable disease. Action on either of these charges will assure that the individual's situation is considered in the judicial system rather than in the administrative law system, thereby assuring the individual of due process of law in any further actions.
VII. REFERENCES:

1. Surgeon General's Report on AIDS

