Notice: As of 11:59 PM on March 11, 2022, Oregon is lifting the indoor mask mandate and pausing quarantine and contact tracing for the general population, including K-12 and childcare settings. The mask mandate for health care settings remains in effect, as does the need to quarantine and contact trace in high-risk congregate settings. This decision comes on the tail of the Omicron surge, when Oregon Health and Science University modeling data suggest that at least 86% of the population of Oregon currently have vaccine-induced or infection-induced immunity to COVID-19. The transmissibility of the Omicron variant has limited the effectiveness of contact tracing outside of specific settings.

Moving forward, the Centers for Disease Control and Prevention and Oregon Health Authority are pivoting to focusing on individual decision making with regard to prevention behaviors based on COVID-19 Community Levels.

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1. DISEASE REPORTING

1.1 Purpose of Reporting and Surveillance
To monitor the burden of COVID-19 in Oregon, inform efforts to reduce transmission to others, promote health equity and better understand the epidemiology of this emerging disease.

1.2 Laboratory and Physician Reporting Requirements
Healthcare providers and laboratories, including entities who have a CLIA waiver, are required to report test results indicative of and specific for COVID-19 to the local public health authority (LPHA) within 24 hours. Non-CLIA waiver testing entities are required to report negative results of COVID-19 testing within one local public health working day. As of January 28, 2022, under Oregon law, CLIA-waived facilities are not required to report negative COVID-19 antigen test results.

Healthcare providers are additionally required to report within 1 working day:
- All hospitalizations, defined in §10, among persons with COVID-19, whether or not the case was previously reported
- All deaths, defined in §10, among persons with COVID-19, whether or not the case was previously reported
- All cases of Multiorgan Inflammatory Syndrome in Children (MIS-C) (§3.7)

Reporting may be done through an “Online Morbidity Report,” which can be found at
1.3 Local Public Health Authority Responsibilities

1. Educate and consult with local providers and facilities to promote compliance with outbreak reporting, quarantine, isolation, and infection-control procedures.
2. Encourage symptomatic persons and known high-risk close contacts of confirmed and presumptive cases of COVID-19 to be tested and follow isolation recommendations.
3. Investigate cases and outbreaks of COVID-19 associated with high-consequence settings as defined in §10.
4. Report all confirmed and presumptive cases not already transmitted electronically (e.g., cases identified through outbreak investigation or other passive means) by entering them into Opera with disease “Coronavirus” and subtype “COVID-19.”
5. Consult with the OHA COVID-19 Response and Recovery Unit (CRRU) as needed about patient isolation and protection of contacts, including healthcare personnel, and about strategies for public health response, testing, and contact investigation.
6. Make available education for confirmed and presumptive cases on best practices to prevent disease spread, including self-isolating to limit additional close contacts, informing their close contacts about monitoring for symptoms, testing and seeking care when appropriate.
7. If auto-processing by OHA not already adopted, process ELRs of positive and indeterminate COVID-19 test results.
8. If auto-processing by OHA not already adopted, process electronic case reports (eCRs) in Opera. Make sure to manually update test results, hospitalization status, and death status.
9. Review suspect cases created from REDCap surveys to determine case status. Update case status accordingly.

1.4 State Public Health Division Responsibilities

1. Update LPHAs on changes to criteria for investigation (e.g., through HAN, multijurisdictional conference calls, etc.).
2. Relay to LPHAs information on suspect, presumptive, and confirmed cases and close contacts received from Oregon Department of Corrections, CDC, and other jurisdictions.
3. Assist LPHAs in processing eCRs and REDcap surveys in Opera, including creating cases and approving testing for patients who meet testing criteria, adding hospitalization status, and recording deaths.
5. Assist LPHAs in processing ELRs of COVID-19 test results.
6. Develop and maintain information systems for case and contact surveillance and to ensure adequacy of response activities.
7. Manage notifications from the CDC Division of Global Migration and Quarantine (DGMQ).
8. Advise LPHA, Tribal, and private-sector health professionals concerning:
   - Isolation of cases and symptomatic persons;
   - Quarantine of asymptomatic close contacts;
   - Protection of healthcare personnel;
   - Diagnostic evaluation;
- Required reporting and surveillance activities;
  10. Arrange consultation with infectious disease specialists and CDC as needed.
  11. Report confirmed and presumptive COVID-19 cases and deaths to CDC.
  12. Update REDCap survey, importing, and matching process as needed.

2. THE DISEASE AND ITS EPIDEMIOLOGY

2.1 Etiologic Agent
Coronaviruses are enveloped, single-stranded RNA viruses. With the notable exceptions of
SARS-CoV and MERS-CoV, most human coronaviruses typically cause mild upper respiratory
illness. The coronavirus causing COVID-19 was first identified in Wuhan, China in December
2019 among patients with severe respiratory illness and pneumonia and has spread around
the globe through person-to-person transmission. Genetic sequencing of isolates
demonstrates that the COVID-19 virus is a betacoronavirus with roughly 80% genome identity
with SARS-CoV and 50% with MERS-CoV. The virus that causes COVID-19 has been named
“SARS-CoV-2.” Variants with demonstrated or suspected characteristics of public health
importance such as increased transmissibility, severity, vaccine resistance or diagnostic or
therapeutic escape have been labeled ‘variants of concern’ or ‘variants of interest’,
respectively.

2.2 Description of Illness
Symptoms are non-specific and may include fever (defined throughout as a temperature of
≥100.4°F or 38.0°C) or chills, sore throat, cough, shortness of breath or dyspnea, myalgias,
fatigue, loss of smell (anosmia) or taste (ageusia), headache, congestion or runny nose,
nausea/vomiting and diarrhea. A significant proportion of cases are asymptomatic.
Pneumonia typically presents with patchy, multilobar infiltrates on chest X-ray. Reported
complications have included but are not limited to acute respiratory distress syndrome,
cardiac events, and death.

COVID-19-associated multisystem inflammatory syndrome in children (MIS-C) is defined by
fever, multisystem involvement (cardiac, renal, respiratory, hematologic, gastrointestinal,
dermatologic or neurologic), laboratory evidence of inflammation and recent COVID-19
infection.

COVID-19 associated multisystem inflammatory syndrome in adults (MIS-A) is defined by
fever, multisystem involvement which must include severe cardiac illness or rash and
conjunctivitis, laboratory evidence of inflammation and recent COVID-19 infection.

2.3 Reservoirs
Members of the coronavirus family are common in many different species of animals, including
camels, cattle, cats, and bats. Rarely, animal coronaviruses can infect people and then spread
from person to person, as occurred with MERS-CoV and SARS-CoV. The frequency with
which the COVID-19 virus is transmitted from its original animal reservoir(s) to humans is
unknown, but such events are probably rare. The prevalence of animal infection with SARS-
CoV-2 is an area of active research.

2.4 Sources and Routes of Transmission
This virus probably originated from an animal source and was followed by rapid person-to-
person spread. Person-to-person transmission occurs primarily from respiratory droplets and
aerosols produced when an infected person coughs, sneezes, **breathes or speaks**. It is possible that a person can get COVID-19 by touching a surface or object that has the virus on it and then touching their own mouth, nose, or eyes, but this is not a major route of transmission. Studies (including preliminary studies of SARS-CoV-2) suggest that coronaviruses may persist on surfaces for up to several days. **Virus** is detectable in the urine and feces of infected persons, and replication-competent virus has been demonstrated. While no concrete evidence exists for the fecal-oral spread of SARS-CoV-2, one study has demonstrated probable evidence of fecal-aerosol transmission of SARS-CoV-2. Transmission from blood or other body fluids has not been identified.

2.5 Incubation Period
Typically 4–6 (range, 2–14) days.

2.6 Period of Communicability
In announcing the change to a 5-day isolation period, CDC has cited evidence that “the majority of SARS-CoV-2 transmission occurs early in the course of illness, generally in the 1-2 days prior to onset of symptoms and the 2-3 days after.” Various studies pre-dating the emergence of the Omicron variant indicated an infectious period ranging from 3-9 days after symptom onset. Patients with more severe illness—i.e., hospitalized or severely immunocompromised (see §10 for definition)—have shed replication-competent virus for longer periods of time (e.g., up to 20 days after symptom onset).

2.7 Treatment, Prevention, and Limitation of Spread
*Note: FDA’s list of authorized treatments and preventives has changed continually. For the current list, see [www.fda.gov/emergency-preparedness-and-response/mcm-legal-regulatory-and-policy-framework/emergency-use-authorization#coviddrugs](http://www.fda.gov/emergency-preparedness-and-response/mcm-legal-regulatory-and-policy-framework/emergency-use-authorization#coviddrugs).*

2.7.1 Vaccines against COVID-19: primary series
1. Pfizer-BioNTech (BNT162b2, Comirnaty®): approved for persons aged ≥16 years; emergency use authorization (EUA) for persons aged 5–15 years.
   The primary series is 2 doses, administered ≥3 weeks\(^1\) apart. The dose for persons ≥12 years is 0.3 mL (30 µg mRNA). The formulation for children 5–11 years of age is different, and the dose is 0.2 mL (10 µg mRNA). An additional dose is authorized at ≥28 days after the second dose for moderately or severely immunocompromised persons ≥12 years of age.
2. Moderna (mRNA-1273, Spikevax®): approved for persons aged ≥18 years.
   The primary series is 2 doses, 0.5 mL (100 µg mRNA) each, administered ≥4 weeks\(^1\) apart. An additional 0.5-mL dose is authorized at ≥28 days after the 2\(^{nd}\) dose for moderately or severely immunocompromised persons ≥18 years of age.
3. Janssen (Ad.26.COV2.S): EUA for persons aged ≥18 years. **Note: mRNA vaccines are now preferred to this Janssen adenovirus vector vaccine.**
   The primary series is a single dose, 0.5 mL (5×10\(^{10}\) virus particles). A dose of mRNA vaccine is recommended at ≥28 days after the primary series dose for moderately or severely immunocompromised persons.

A booster dose of any of the 3 authorized or approved vaccines is recommended at ≥5

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\(^1\) An 8-week interval may be optimal for some people ages 12 years and older, especially for males ages 12 to 39 years. A shorter interval (3 weeks for Pfizer-BioNTech; 4 weeks for Moderna) between the first and second doses remains the recommended interval for: people who are moderately or severely immunocompromised; adults ages 65 years and older; and others who need rapid protection due to increased concern about community transmission or risk of severe disease.
months after a primary mRNA series (or ≥ 3 months after the additional dose, if given) or ≥2 months after a primary Janssen dose, with Pfizer or Moderna vaccines preferred as boosters in most situations.

- persons 12–17 years of age may receive a Pfizer booster, only
- persons ≥18 years of age may receive any of the 3 authorized or approved vaccines

Each of the vaccines is contraindicated in patients who have had a severe allergic reaction (e.g., anaphylaxis) to a previous dose of that vaccine or to any of its components. The Janssen vaccine is additionally contraindicated in patients with a history of thrombosis with thrombocytopenia syndrome (TTS) following a previous dose of the Janssen vaccine or to any other adenovirus-vectored COVID-19 vaccine (e.g., AstraZeneca’s COVID-19 vaccine, which is not authorized or approved in the United States). In most situations, the Pfizer-BioNTech and Moderna vaccines are preferred over the Janssen vaccine for primary and booster vaccination due to the risk of serious adverse events.

Table 1.

<table>
<thead>
<tr>
<th>Vaccination Status</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to Date</td>
<td>For individuals ≥18 years of age: Boosted² or Completed the primary series³ of Pfizer or Moderna within the last 5 months or Completed the primary series³ of J&amp;J within the last 2 months</td>
</tr>
<tr>
<td></td>
<td>For individuals 5–17 years of age⁴: Completed the primary series³ of COVID-19 vaccines</td>
</tr>
<tr>
<td>Not Up to Date</td>
<td>Unvaccinated or Has not completed the primary series³ of any COVID-19 vaccine or For individuals ≥18 years of age: Completed the primary series³ of Pfizer or Moderna over 5 months ago and is not boosted or Completed the primary series³ of J&amp;J over 2 months ago and is not boosted</td>
</tr>
</tbody>
</table>

Note: Individuals ≥18 years of age who were vaccinated outside the United States and have received two doses of AstraZeneca, Covishield, BIBP/Sinopharm, Sinovac, Bharat Biotech (COVAXIN), or Novovax/Covovax COVID-19 vaccines in the previous 5 months are considered up to date. If the second dose was administered >5 months ago, the individual is eligible for an mRNA booster dose and must receive one to be considered up to date.

2.7.2 Prophylactic monoclonal antibodies

1. Bamlanivimab/etesevimab: as of January 24, 2022, no longer authorized for post-exposure prophylaxis against COVID-19, as it is not effective against the Omicron variant.

2. Tixagevimab co-packaged with cilgavimab (Evusheld®): administered as two separate, consecutive intramuscular injections (one injection per monoclonal antibody, given in

² An individual is considered boosted immediately after receipt of their booster dose.
³ Completion of the primary series assumes that the individual received all recommended doses, appropriately spaced according to the ACIP recommendation, and that at least 14 days have elapsed since the last dose was administered.
⁴ Children aged 12-17 years are eligible and should be encouraged to receive a booster dose of the Pfizer vaccine 5 months after completing their primary series; however, they are still exempt from quarantine if they have completed their primary series at the time of their exposure.
immediate succession), for pre-exposure prophylaxis of COVID-19 in certain persons ≥12 years of age and weighing at least 40 kilograms (about 88 pounds). The product is authorized only for individuals who
a. are not currently infected with the SARS-CoV-2 virus and
b. have not recently been exposed to an individual infected with SARS-CoV-2 and
c. have either
   i. moderately to severely compromised immune systems due to a medical condition or due to taking immunosuppressive medications or treatments and who therefore may not mount an adequate immune response to COVID-19 vaccination (see the fact sheet for health care providers); or
   ii. a history of severe adverse reactions to a COVID-19 vaccine or a component of those vaccines, such that vaccination with an available COVID-19 vaccine is not recommended.

2.7.3 Treatments
Note: On January 24, 2022, FDA announced that Bamlanivimab/etesevimab and Casirivimab/imdevimab are no longer authorized for use as they are not effective against the Omicron variant.
1. Remdesivir (Veklury®):
   a. FDA-approved for persons ≥12 years of age and weighing at least 40 kilograms (about 88 pounds) for the treatment of COVID-19, whether or not they are hospitalized.
   b. Authorized for treatment of suspected or laboratory-confirmed COVID-19 in pediatric patients weighing 3.5 kg to <40 kg; or pediatric patients <12 years of age weighing ≥3.5 kg whether or not they are hospitalized.
2. Baricitinib: Authorized for treatment, in combination with remdesivir, of suspected or laboratory-confirmed COVID-19 in hospitalized patients ≥2 years of age requiring supplemental oxygen, invasive mechanical ventilation, or extracorporeal membrane oxygenation (ECMO).
3. Sotrovimab: Authorized for treatment of mild-to-moderate COVID-19 in patients ≥12 years of age and weighing ≥40 kilograms (about 88 pounds), with positive results of direct SARS-CoV-2 viral testing and who do not require oxygen therapy or hospitalization due to COVID-19 but who are at high risk for progression to severe COVID-19.
4. Tocilizumab (Actemra®): Authorized for the treatment of COVID-19 in hospitalized persons ≥2 years of age who are receiving systemic corticosteroids and require supplemental oxygen, non-invasive or invasive mechanical ventilation, or extracorporeal membrane oxygenation (ECMO).
5. Nirmatrelvir/ritonavir (Paxlovid®, copackaged for oral use); authorized for the treatment of mild-to-moderate COVID-19 in patients ≥12 years of age and weighing ≥40 kilograms (about 88 pounds), with positive results of direct SARS-CoV-2 testing, who are at high risk for progression to severe COVID-19. Paxlovid® is available by prescription only and should be initiated as soon as possible after diagnosis of COVID-19 and within five days of symptom onset.
6. Molnupiravir: authorized for the treatment of mild-to-moderate COVID-19 in patients ≥18 years of age with positive results of direct SARS-CoV-2 viral testing, and who do not require hospitalization due to COVID-19 but who are at high risk for progression to severe COVID-19, and for whom alternative COVID-19 treatment options authorized by the FDA are not accessible or clinically appropriate. Molnupiravir is available by prescription only and should be initiated as soon as possible after diagnosis of COVID-19 and within five days of symptom onset. Molnupiravir is not authorized for use in patients younger than 18 years of age because molnupiravir may affect bone and cartilage growth.
7. Convalescent plasma with high titers of anti-SARS-CoV-2 antibodies: authorized for
treatment of COVID-19 in both outpatients and inpatients with immunosuppressive disease or who are receiving immunosuppressive treatment.

### 3.0 CASE AND CLINICAL DEFINITIONS

#### 3.1 Close Contact

A close contact is a person with an epidemiologic exposure to a person with confirmed or presumptive COVID-19. The exposure may be close contact with a confirmed or presumptive case—being within 6 feet of a COVID-19 case for ≥15 minutes\(^5\)—or contact with their infectious secretions or clinical specimens.

Notes:
- This definition only applies to persons who have close contact with a confirmed or presumptive case. Persons who have an epidemiologic exposure to a close contact do not meet this definition.
- Outdoor settings can generally be considered low risk exposure settings that may not warrant quarantine, particularly when individuals are unlikely to have been within 6 feet of a confirmed case for 15 or more minutes. LPHAs should consider individual scenarios to determine whether an outdoor exposure warrants quarantine. Circumstances that increase the risk of outdoor exposures include:
  - Low vaccination rate in the community or among those participating in the activity where the exposure occurred
  - High community case rates
  - Type of exposure (e.g., repeated exposures, exposure during physical exertion, close proximity)
  - Duration of exposure (prolonged)
- See §8.6.2 for considerations to the close contact definition in the K–12 setting.

#### 3.2 Suspect Case

A suspect case is a person with:
- New onset of symptoms consistent with COVID-19, including fever or chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, or diarrhea
- AND
- No more likely alternative diagnosis
  - Note: This includes people who had close contact with a presumptive\(^6\) case and have an acute illness featuring at least two of the following: shortness of breath, cough, fever, new loss of smell or taste, radiographic evidence of viral pneumonia.

OR
- A test result that, in combination with their symptoms, does not meet the definition of a confirmed or presumptive case, including:

\(^5\) This time is cumulative over a 24-hour period and does not have to be consecutive.

\(^6\) If a contact of a presumptive case has symptoms consistent with COVID-19 but neither the contact nor the case has tested positive, the contact remains a suspect case.
- An indeterminate reverse transcriptase polymerase chain reaction (RT-PCR), other nucleic acid amplification test (NAAT), or antigen result;
- A close contact who is getting tested

OR

- Self-identifies as having COVID-19 and completes the REDCap case investigation survey

These criteria are for epidemiologic classification and are not meant to direct clinician testing or clinical care.

Individuals who initially are classified as Suspect may ultimately be re-classified to Confirmed or Presumptive pending additional laboratory testing, new or worsening symptoms, or previously unknown epidemiologic linkage. LPHAs should update the case status for close contacts whose test results are pending once those results are reported to public health. See §4.5 for further guidance on managing individuals whose initial test results were obtained from an at-home test kit.

### 3.3 Confirmed Case

A confirmed case is someone who tests positive using a laboratory-based FDA Emergency Use Authorized (EUA) diagnostic test. Any positive result from a laboratory-based RT-PCR, other NAAT, or antigen platform developed under an FDA EUA, even if conducted as asymptomatic screening, is considered a positive result. A follow-up test which is negative does not negate the initial positive test.

If a laboratory report has not been received, but a confirmatory laboratory result has been reported verbally by a healthcare provider or by an electronic case report (eCR) that clearly identifies a confirmatory laboratory result, the case will be considered confirmed.

Note: If the eCR does not clearly identify a confirmatory laboratory result, consider the person a suspect case with a pending test.

If a person is diagnosed with MIS-C (see §3.6), create a confirmed Coronavirus case in addition to their MIS-C case. If their only diagnostic test was serology, consider them a confirmed case, but do not initiate contact tracing; offer testing to household members.

### 3.4 Presumptive Case

A presumptive case is a person without a positive laboratory-based COVID-19 RT-PCR, NAAT, or antigen test result, with:

- An acute illness featuring at least two of the following: shortness of breath, cough, fever, new loss of smell or taste, radiographic evidence of viral pneumonia;
  - AND
- No more likely alternative diagnosis;
  - AND

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7 e.g., a polymerase chain reaction (PCR) test.
8 Even with a negative test, a person with an identified epi-link, compatible symptoms, and no more likely diagnosis is still considered a presumptive case.
9 Fever can be objective (≥100.4°F) or subjective.
Within the 14 days before illness onset:
  o Had close contact with a confirmed case
  OR
  o Lived in the same household or congregate setting as a confirmed case
  OR
  o Is identified as having been exposed in an outbreak
  OR

  • A COVID-19-specific ICD-10 code listed as a primary or contributing cause of death on a death certificate.
  OR

  • A person with a positive test result from an at-home test kit

If a presumptive case tests positive for COVID-19 by a laboratory-based RT-PCR, NAAT, or antigen test, update the case’s status to confirmed. If a presumptive case tests negative for COVID-19 by an RT-PCR, NAAT, or antigen test, the case remains presumptive.

Note: Isolation should not be based on case definitions. If an individual develops any symptoms associated with COVID-19 after a known exposure (even if those symptoms are mild and do not meet the presumptive case definition), that individual should be instructed to isolate for at least 5 days (unless they qualify for a longer isolation period per the guidelines in §5).

### 3.5 Vaccine Breakthrough Case

A vaccine breakthrough case is defined as a person who has:

- SARS-CoV-2 RNA or antigen detected on respiratory specimen ≥14 days after completing the primary series of an FDA-authorized COVID-19 vaccine (where date of final vaccine dose is counted as day zero)
  AND
- Has not had SARS-CoV-2 RNA or antigen detected on a respiratory specimen collected <45 days before the most recent positive test.

### 3.6 Multisystem Inflammatory Syndrome in Children (MIS-C)

- An individual aged <21 years presenting with fever, laboratory evidence of inflammation, and evidence of clinically severe illness requiring hospitalization, with involvement of at least 2 of the following organ systems: cardiac, renal, respiratory, hematologic, gastrointestinal, dermatologic, or neurological;
  AND
- No alternative more likely diagnosis;
  AND
- Evidence for current or recent SARS-CoV-2 infection by RT-PCR, NAAT, serology, or

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10 Fever can be objective (≥100.4°F) or subjective.
11 Including, but not limited to, one or more of the following: an elevated C-reactive protein (CRP), erythrocyte sedimentation rate (ESR), procalcitonin, D-dimer, ferritin, lactic acid dehydrogenase (LDH), or interleukin 6 (IL-6), elevated neutrophils, reduced lymphocytes and low albumin.
antigen testing; or COVID-19 exposure within the 28 days prior to the onset of symptoms.

Some individuals may fulfill full or partial criteria for Kawasaki disease but should be reported if they meet the case definition for MIS-C. Consider MIS-C in any pediatric death with evidence of SARS-CoV-2 infection.

3.7 Multisystem Inflammatory Syndrome in Adults (MIS-A)

- An individual ≥21 years with fever, laboratory evidence of inflammation, and evidence of clinically severe illness requiring hospitalization with at least 3 of the following clinical criteria, one of which must be a primary clinical criterion
  - Primary clinical criteria
    - Severe cardiac illness (e.g., myocarditis, pericarditis, coronary artery dilatation, new ventricular dysfunction, 2nd/3rd degree AV block, or ventricular tachycardia)
    - Rash or non-purulent conjunctivitis
  - Secondary clinical criteria
    - New-onset neurologic signs and symptoms (e.g., encephalopathy, seizures, meningeal signs, peripheral neuropathy)
    - Shock or hypotension not attributable to medical therapy
    - Abdominal pain, vomiting or diarrhea
    - Thrombocytopenia

AND
- No alternative more likely diagnosis;
AND
- Evidence for current or recent SARS-CoV-2 infection by RT-PCR, NAAT, serology, or antigen testing; or COVID-19 exposure within the 28 days prior to the onset of symptoms.

OHA has launched MIS-A surveillance. This new surveillance will function like MIS-C surveillance—reporting will occur through OCRP and no case investigation will be required. Clinical chart review will occur at OHA. In sum, no burden should be placed upon local jurisdictions. Please contact Melissa Sutton with questions or concerns.

OHSU’s Dr. Holly Villamagna will be offering a series of webinars for clinical providers statewide and offering telephone consults for providers with suspected cases. You can read more about MIS-A here: https://www.cdc.gov/mis/mis-a/hcp.html.

4.0 LABORATORY TESTING

4.1 Testing at Commercial Laboratories
Guidance has been established to provide criteria for testing at a commercial laboratories versus OSPHL. Current guidance can be found at OHA COVID-19 Healthcare Partner Resources.

4.2 Testing at the Oregon State Public Health Laboratory
Testing through the Oregon State Public Health Laboratory (OSPHL) must be approved by the CRRU testing branch or the CRRU epidemiologist supporting the outbreak. The Criteria for COVID-19 Testing at OSPHL provides general information about testing policies and targeted populations tested at OSPHL. Current guidance for specimen collection, handling, and transport
is posted on OSPHL’s [Lab Test Menu](#).

OSPHL performs the Aptima SARS-CoV-2 NAAT assay and the CDC Influenza/SARS-CoV-2 (Flu SC2) PCR assay. The assays cannot distinguish between new SARS-CoV-2 variants and the original pandemic virus strain.

Whole genome sequencing for SARS-CoV-2 is available at OSPHL. Please review the [Criteria for Requesting COVID-19 Sequencing at OSPHL](#) for details on how to make a request, the approvals process, and required specimen types.

Specimens should be collected as soon as possible after a presumptive or suspect case is identified, regardless of symptom onset date.

Please share the following information with the facility or laboratory that is packing and shipping the specimens for testing at OSPHL:

- Heed the specimen storage and transport temperatures required for the specimen being collected. All requirements are posted at [www.healthoregon.org/labtests](http://www.healthoregon.org/labtests).
- Ensure the cap of the specimen container is properly threaded and sealed.
- Label each specimen container with two unique patient identifiers (e.g., full name, date of birth, medical record number), unique specimen ID (e.g., laboratory requisition number), specimen type (e.g., NP, OP) and the date the sample was collected. The unique patient identifiers on the specimen must match those on the corresponding Test Request Form.
- Submit one COVID-19 and Flu Test Request Form per specimen (available at [www.bitly.com/phl-forms](http://www.bitly.com/phl-forms)).
- Place the Test Request Form in the outer pocket of the specimen transport bag. Do not put the form in the sealed portion of the bag with the specimen.
- Transport specimens and required forms to OSPHL as soon as possible.

Whenever possible, existing courier systems (e.g., hospital system couriers) or shipping options (e.g., FedEx) should be used for specimen transport. If other transport systems are not available, contact OSPHL (503-693-4100) for help with specimen transport on the next available courier route.

**4.3 Collecting Specimens**
Specimens should be collected while using proper PPE. See CDC’s [healthcare infection control guidance](#).

For specimen collection that involves an aerosol-generating procedure (§10): Using an airborne infection isolation room (AIIR) is ideal, but if one is not available, use a private room and keep the door closed. Mask the patient with a surgical facemask during any movement within clinic or facility. See [OHA guidance on infection prevention and control for COVID-19](#).

Many common respiratory infections present with symptoms similar to those of COVID-19. Encourage clinicians to perform in-house diagnostic testing for these more common pathogens as clinically indicated. If a person tests positive for a common respiratory pathogen, it still might be indicated to test for COVID-19, as co-infections may occur.

**4.4 Guidance Regarding Serologic Tests**
The role of serologic tests in relation to the pandemic response is still being evaluated. As we learn more, we will update this guidance. OSPHL has three serology assays available for surveillance only at this time: an anti-nucleocapsid IgG, an anti-spike protein IgG assay, and
a total neutralizing antibody test. Serologic test results do not currently alter case classifications and serology should not be used for diagnosis of COVID-19 infection.

Some serologic tests will be positive in uninfected but vaccinated people; others will not, depending on the target antigen (spike versus nucleocapsid protein). A list of EUA authorized serologic tests is available here.

Except where specifically identified, all references in this guide to a “test” or “testing” refer to RT-PCR, NAAT, or antigen tests and not to serology.

4.5 Guidance Regarding At-Home Test Kits and Point-of-Care Tests

At-home COVID-19 test kits are widely available. Patients with positive test results should be encouraged to follow-up with a medical provider if they have questions or require medical evaluation.

At-home COVID-19 test kits performed by prescription (e.g., Lucira) or as a point-of-care test under a CLIA waiver should be treated as a laboratory-based test. These would have the same reporting requirements as any other laboratory-based test (i.e., a physician or laboratory would be required to report positive test results) and should be counted as a confirmed case.

5.0 Quarantine and Isolation

5.1 Quarantine for the General Population

Note: The general population includes students and staff associated with K-12 and childcare settings and most other individuals and settings. Details on individuals and settings excluded from the general population can be found on CDC’s webpage and throughout this document. The K-12 and childcare settings have additional guidance §8.

As of March 12, 2022, most people exposed to COVID-19 (i.e., close contacts) no longer need to quarantine (i.e., stay away from other people during the time they are most likely to become infected). However, close contacts should be aware of their potential to become infected and infect others around them.

- All close contacts, regardless of vaccination status or prior infection with COVID-19 are recommended to:
  - Watch for COVID-19 like symptoms for 10 days after their last exposure.
  - Stay home and get tested if symptoms develop.
  - Wear a well-fitting mask around other people for the 10 days following their last exposure.
  - Avoid unnecessary visits with high-risk individuals (e.g., residents of congregate care facilities, persons with immunocompromising conditions, etc.)
  - Consider testing approximately five days after their exposure.
  - Follow guidance for isolation (§5.2) if they test positive or develop COVID-19 symptoms12.

12 If a close contact develops any symptoms associated with COVID-19, regardless of vaccination status, even if they do not meet the presumptive case definition, they should isolate for 5 days following the onset of their symptom(s). However, if they do not ultimately meet the confirmed or presumptive case definitions, they may not be excluded from quarantine if they are exposed again in the 90 days following their current illness, unless they are up to date with their COVID-19 vaccines.
5.2 Isolation

5.2.1 Recommendations for the General Population:

- All confirmed and presumptive cases, including asymptomatic cases, should isolate until they meet criteria for discontinuation of isolation. Cases should stay home and away from other people at least 5 days since their symptom onset, and until 24 hours after fever is gone without use of antipyretics, and other COVID-19 symptoms are improving.

- Cases should also wear a mask when they are around other people in the 10 days after they become sick or test positive.
  - This includes wearing a well-fitting mask around others at home and in public for 5 additional days (day 6 through day 10) after the end of their 5-day isolation period.
  - Individuals who cannot or do not mask during days 6–10 of their isolation period should stay home for 10 days.

- Cases should avoid people who are at increased risk for severe disease as well as nursing homes and other high-risk congregate settings for 10 days.

- If the case is asymptomatic or discrete onset of symptoms cannot be determined, they should stay home for five days following the specimen collection date of their positive test.

- If an asymptomatic case develops symptoms compatible with COVID-19 (e.g., fever, cough, diarrhea, new loss of taste or smell, or shortness of breath) before the end of their initial isolation period, the five-day isolation and 10-day masking period should be restarted on the date of symptom onset. Subsequent positive tests in the 90 days after the earlier of first positive test or symptom onset do not affect the recommended period of isolation.

- When possible, COVID-19 cases should take care to not handle pets or other animals while sick. Refer to CDC’s guidance on what to do If You Are Sick or Caring for Someone for comprehensive guidance.

- For further guidance on what to do when isolating at home, see Interim Guidance for Implementing Home Care of People Not Requiring Hospitalization for Coronavirus Disease 2019 (COVID-19)

5.2.2 Isolation Recommendations for Individuals with Severe Illness or who are Immunocompromised

For cases with severe to critical illness—including cases hospitalized for their COVID-19 illness—or who are severely immunocompromised (see §10), the period of isolation is at least 10 days and up to 20 days. Individuals who were severely ill or who are immunocompromised should consult with their healthcare provider to determine when they should resume being around other people. Attribution of hospitalization to COVID-19 should be made by the treating clinician and OHA is available for consultation.

As described in the CDC Decision Memo, an estimated 95% of severely or critically ill patients, including some who are severely immunocompromised (see §10), no longer had replication-competent virus 15 days after onset of symptoms; no patients had replication-competent virus more than 20 days after onset of symptoms. Based on this research, it is recommended to use symptom-based release from isolation rather than the test-based strategy.
5.2.3 Discontinuation of Isolation

Symptom-based discontinuation of isolation:
Someone who was symptomatic is considered no longer contagious when it has been at least five days from their symptom onset, and they have been afebrile without use of antipyretics and have had improving cough, shortness of breath, or diarrhea for 24 hours. If the person was never symptomatic, they are released from isolation five days after the first specimen that tested positive was collected. If an asymptomatic case develops symptoms compatible with COVID-19 (e.g., fever, cough, diarrhea, new loss of taste or smell, or shortness of breath) before the end of their initial isolation period, the five-day isolation period should be re-started on the date of symptom onset. For those with severe to critical illness—including those who were hospitalized for their COVID-19 illness—or who are severely immunocompromised, the recommended period of isolation is 20 days.

Test-based discontinuation of isolation:
In general, the test-based strategy is not recommended for discontinuing isolation. CDC does provide two scenarios in which a test-based strategy could be considered:

- In rare instances, for early discontinuation of transmission-based precautions in healthcare settings. This should be used with caution as individuals may have prolonged shedding without clear link to sustained transmission risk, which limits the utility of this approach. Could be considered in scenarios where the risk of isolation may outweigh the benefits.
- To inform discontinuation of isolation if concerns are present that the individual may be infectious for more than 20 days (e.g., if severely immunocompromised). Recommended that it be conducted in consultation with local infectious disease experts.

CDC criteria for test-based strategy:

- Resolution of fever without the use of fever-reducing medications and
- Symptoms (e.g., cough, shortness of breath) have improved, and
- Results are negative from at least two consecutive respiratory specimens collected ≥24 hours apart (total of two negative specimens) tested using an antigen test or NAAT.

5.2.4 Becoming a case after 90 days have passed since onset of the original case
If a previously confirmed or presumptive case meets the confirmed or presumptive case definition more than 90 days after symptom onset or first positive test for their original case, create a new, separate case for them in Opera.

5.3 Isolation and Quarantine for Groups and Settings Not Included in the General Population
Please see the sections below for specialized quarantine guidance in the following populations:

- Healthcare workers (§8.1) (OHA guidance / CDC guidance)
- Inpatient healthcare settings (e.g., hospitals, inpatient hospice) (§8.1) (OHA guidance / CDC guidance)
- Long-term care facilities (LTCFs) (§8.2) (OHA guidance / CDC guidance)
- Adult family/foster homes (AFHs) (§8.1) (OHA guidance / CDC guidance)
- Residential healthcare settings (e.g., child and adult behavioral health residential treatment facilities, intellectual or developmental disabilities 24 hour residential programs) (§8.1) (OHA guidance / CDC guidance)
6.0 LPHA Case Management

6.1 Suspect Cases

Suspect cases are persons as defined in §3.2. Broadly, these are persons who do not meet the presumptive case definition either because they self-identified as having COVID-19 and submitted a REDCap survey or do not have a positive test for COVID-19; it might be pending or indeterminate. Serology might be the only documented test; except in the case of MIS-C or MIS-A, a positive serologic result is not case-defining (see §3.6 and §3.7).

Suspect cases created from REDCap surveys may be periodically reviewed and reclassified to Presumptive or Confirmed cases as is feasible (see §3.3 and §3.4)

OSPHL Testing of Suspect Cases

OSPHL testing is prioritized for high-priority individuals, defined in §10, and in support of outbreak investigations. Testing is generally reserved for symptomatic persons, but testing may be approved for asymptomatic persons in support of outbreak investigations. See Guidance for providers regarding COVID-19 testing for details. It is expected that healthcare facilities and other employers take responsibility for any testing needed for their staff.

6.2 Confirmed and Presumptive Cases

6.2.1 Interviewing

Universal case interviews are no longer required. LPHAs should prioritize interviewing cases at highest risk for severe morbidity and mortality and transmitting disease in high-consequence facilities. Identification of these cases is expected to be done passively, primarily as outbreaks in high-consequence settings are reported to the LPHA. Once a high-priority case has been identified, interviews may be completed by phone or REDCap survey, and CRRU case support team staff may be able to assist with individual interviews as resources allow.

6.2.2 Contact Investigations

Universal contact tracing is no longer recommended. Elicitation of close contacts is recommended during investigation of high-consequence outbreaks. As resources allow, obtain the name, address, and telephone number of all persons who have had close contact to the confirmed or presumptive COVID-19 case from 48 hours prior to a case’s symptom onset, or for asymptomatic cases prior to the collection of the first specimen that tested positive, to the time the case was placed in isolation. This information may be used to help direct facility infection control practices, exclusion of close contacts, and health education.

7.0 OUTBREAK RESPONSE

7.1 Opening Outbreaks

LPHAs should open an outbreak record when made aware of:
• One or more cases living or working in a congregate residential setting (e.g., long term care facility (LTCF), skilled nursing facility (SNF), assisted living facility (ALF), memory care (MC), residential care facility (RCF), adult foster homes (AFH), child and adult behavioral health facilities, transitional housing, corrections, shelters).
• One or more cases associated with food chain or other agricultural settings (e.g., grocery stores\textsuperscript{13}, farms, packing houses, food processing, distribution centers, plant nurseries or employer-provided congregate housing or transportation associated with these workplaces).
• Two or more epidemiologically-linked cases from different households in a K–12 or Early Learning Division (ELD) setting.
• Two or more epidemiologically-linked cases from different households in other settings of concern, as determined by the LPHA.

7.2 Outbreak Response Expectations

At present, outbreak reporting has reached pre-Delta variant surge levels, and LPHAs should return to conducting routine outbreak response activities in high-consequence settings. This includes linking all known primary and secondary cases to the outbreak record, tracking testing plans (e.g., whether facility has a plan in place, planned testing dates, requests for assistance, etc.), case and facility vaccination status, and documenting other response activities in the outbreak database. For more detail on outbreak data management see § 9.6.

See §8 for how to manage outbreaks in special situations.

8.0. MANAGING SPECIAL SITUATIONS

8.1 Healthcare settings

8.1.1. Quarantine for Healthcare Workers, Patients, and Residents in Healthcare Settings

This section applies to healthcare settings and healthcare workers and staff as defined in OAR 333-019-1010.

For additional healthcare specific guidance, please see:

• **OHA Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure**
• **CDC Interim Infection Prevention and Control Recommendations** for discontinuation of transmission-based precaution guidance
• Key considerations for infection control can be found in the OHA provisional guidance document: **Clinical Care and Healthcare Infection Prevention and Control for COVID-19**.

Note: Healthcare workers should follow the isolation and quarantine guidance provided in the above documents.

\textsuperscript{13} Grocery stores do not include quick marts, gas station markets, bodegas, convenience stores, or other small food shops where broad transmission is unlikely.
In general, transmission-based precautions (quarantine) are recommended for healthcare facility inpatients and residents following an exposure to someone with suspected or confirmed COVID-19, regardless of vaccination status. These settings include:

- Long-term care facilities (LTCFs)
- Adult foster homes (AFHs) providing healthcare services (e.g., behavioral health and those licensed by ODHS Aging and People with Disabilities (APD))
- Residential healthcare settings (e.g., child and adult behavioral health residential treatment facilities, intellectual or developmental disabilities 24-hour residential programs)
- Inpatient healthcare settings (e.g., hospitals, inpatient hospice)

This exception is due to the higher risk of severe disease and death in healthcare settings. Patients or residents can be removed from transmission-based precautions after day 10 following exposure or day 7 following exposure if a viral test (collected between days 5-7) is negative for SARS-CoV-2, assuming they do not develop symptoms. Testing recommendations for patients or residents with exposure or during outbreak scenarios can be found in CDC Interim Infection Prevention and Control Recommendations. Healthcare facilities could opt to forgo quarantine for patients or residents that are up to date with vaccination as a strategy to mitigate critical issues (e.g., lack of space, staff, or PPE to safely care for exposed patients or residents) when other options are unsuccessful or unavailable. These decisions should be made in consultation with infection control experts.

Residents of congregate healthcare settings that work outside of that setting are allowed to return to work after exposure to a confirmed or presumptive COVID-19 case, presuming that they remain asymptomatic. These residents should continue to quarantine away from other residents in the congregate environment to the extent possible.

Outpatients that have been exposed to COVID-19 should be cared for using appropriate Transmission-Based Precautions. Considerations for outpatient visits can be found in Clinical Questions about COVID-19: Questions and Answers | CDC.

**8.1.2 Contact Tracing in Healthcare Settings**

Healthcare facilities should conduct a risk assessment of HCW exposures and apply work restriction according to level of risk as outlined in CDC's Interim Guidance for Managing Personnel with SARS-CoV-2 Infection or Exposure.

Formal contact tracing for exposures in healthcare settings may be infeasible and of limited benefit when community transmission of COVID-19 is high and staffing is insufficient to maintain this work. In these scenarios, healthcare facilities should consider forgoing contact tracing for exposures in a healthcare setting in favor of broad infection control measures (e.g., well-fitting masks), universal source control for both patients and HCW, and screening of HCW for fever and symptoms of COVID-19 before every shift. Additional infection prevention and control recommendations, including more details about universal source control in healthcare settings, are available from the CDC.

In cases of healthcare worker exposures of staff or patients in healthcare systems in which a designated individual or team, qualified by education, training, and experience or certification, is responsible for carrying out facility infection prevention protocols and is available to serve as primary point of contact for the facility regarding COVID-19 outbreaks, a risk assessment that takes into account presence of symptoms, proximity and duration of encounters, and the use of
personal protective equipment may be performed. The healthcare system will take the lead on contact tracing and exposure notifications and will consult their local public health authority as needed. Healthcare systems have some discretion in identifying exposures that are higher risk and warrant notification and quarantine. Risk stratification should be aligned with CDC guidance.

Features of higher-risk exposures:
- Longer duration of exposure
- Healthcare provider close contact with patient airway, e.g., intubation, pharyngeal examination, bronchoscopy, laryngoscopy
- Patient unmasked

Features of lower-risk exposures:
- Shorter duration of exposure
- No close contact with airway or mucous membrane
- Patient masked

In addition to any determination made due to the above factors, healthcare systems must notify contacts of healthcare providers with COVID-19 if either of the following are true:
1) an infection control breach is identified (i.e., the healthcare provider with COVID-19 did not wear appropriate source control during the encounter), or
2) the hospitalized patient resides or will be transferred to a congregate care setting.

8.1.3 Caring for Hospitalized COVID-19 Cases
HCW who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to standard precautions and use a fit-tested N95 or higher-level respirator (or a facemask if respirator supply is genuinely limited and measures to obtain N95-level or higher respiratory protection via local or state resource requests have been exhausted), gown, gloves, and eye protection. Performing or assisting with an aerosol-generating procedure warrants airborne precautions, including an N95 or higher-level respiratory protection. Any necessary aerosol-generating procedures (§10) should be undertaken in an airborne infection isolation room, if available. Additional PPE considerations are provided in CDC Interim Infection Prevention and Control Recommendations. Transmission-based precautions should continue to be followed until discontinuation of isolation criteria are met.

8.1.4 Identifying Outbreaks in LTCFs (SNF, ALF, MC, RCF)
COVID-19 can present with a broad range of symptoms (see §3.2), making identification of outbreaks difficult. LPHAs should have a low threshold for investigation when there is a cluster of illnesses in a congregate residential setting. Because COVID-like illness (CLI) and influenza-like illness (ILI) are similar, it is a priority to investigate any CLI or ILI in LTCFs and other congregate settings because they may indicate an outbreak of either; see §8.2 and §8.4 for guidance specific to outbreaks in other congregate settings and correctional facilities, respectively. Respiratory specimens should be collected from all ill persons in such outbreaks to be tested for COVID-19; and, during influenza season, for influenza; and testing for other pathogens may be considered.

When a case is identified in a resident or staff member of a congregate setting, provide the facility with the COVID-19 case log for LTCFs and appropriate infection control recommendations.
If the confirmed or presumptive case is identified in a resident or staff member of a congregate setting, the LPHA should create an outbreak in the Opera Outbreaks database to facilitate tracking and linking to other residents or staff who become symptomatic or get tested. Often, identification of a single case has led to the recognition of other cases and prompt institution of control measures. If no additional cases are identified within 14 days of the single case, the outbreak should be closed.

For LTCFs (skilled nursing facilities, assisted living facilities, and residential care facilities), LPHA should collect vaccination uptake rates for residents and staff. If the facility is not already tracking COVID-19 vaccination status for all residents and staff, send the OHA-developed vaccine tracking tools to the facility, which will assist the facility to monitor both individual- and facility-level vaccine status information. The Resident Tracking Tool can be found here, and the Staff Tracking Tool here.

Please remember that while influenza itself is not reportable, ILI outbreaks are reportable. If an ILI outbreak is identified, call the regular ACDP line (971-673-1111) to report the outbreak.

8.1.5 Testing guidance in LTCFs
Please be aware of Oregon Administrative Rules, Chapter 411, Division 60 regarding COVID-19 testing in licensed assisted living facilities, nursing facilities, and residential care facilities. The rule states:

Facility must implement COVID-19 testing of all Residents, Facility Staff and Associated Staff within 72 hours of identification of a new case of COVID-19 in either a Resident, Facility Staff or Associated Staff. A testing strategy should be developed with the Facility’s Local Public Health Authority as new cases are identified.

As resources allow, facilities should conduct weekly serial testing on all residents and staff who have previously tested negative until two consecutive weeks with no new positive cases in either staff or residents.

When feasible, coordinate with facility and the CRRU Regional Epidemiologist to schedule outbreak-associated testing of staff and residents at the OSPHL. Once outbreak-associated testing has been completed, routine screening of staff for COVID-19 should return to the facility’s contracted commercial laboratory. If assistance with specimen collection is needed, CRRU Regional Epidemiologists can coordinate new specimen collection in collaboration with CRRU Testing Team staff. Coordination of this task is not expected to occur outside of regular business hours.

8.2 Non-healthcare congregate settings (including, but not limited to, homeless shelters, supported/supportive living, temporary/transitional housing, employer-provided congregate housing, cruise ships)

8.2.1 Quarantine recommendations for non-healthcare congregate settings
Following an exposure to COVID-19, residents (regardless of vaccination status) and staff (who are not up to date on COVID-19 vaccination) of non-healthcare congregate facilities are recommended, to the extent possible, to complete a 10-day quarantine within or from the facility, respectively.

Residents of non-healthcare congregate living settings who attend school or work outside of that setting are allowed to return to work or school after exposure to a confirmed or
presumptive COVID-19 case, presuming that they remain asymptomatic.

**8.2.2 Isolation recommendations for non-healthcare congregate settings**

Due to the high risk of secondary transmission and difficulties in cohorting individuals, a 10-day isolation period is recommended for residents and staff of congregate facilities. During periods of critical staffing shortages, facilities may consider shortening the isolation period for staff to ensure continuity of operations. Decisions to shorten isolation in these settings should be made in consultation with the LPHA or OHA.

Residents of congregate living settings may return to work or school after completion of their 5-day isolation period provided they have been fever-free for at least 24 hours, their symptoms are improving, and they are able to mask while around other people for the remaining 5 days of their isolation period. They should, however, continue to isolate from other residents in the congregate living setting for the full 10-day isolation period.

**8.2.3 Responding to outbreaks in non-healthcare congregate settings**

Similar to healthcare settings, non-healthcare congregate settings with COVID-19 cases benefit from early intervention. This includes providing guidance for testing, infection control practices (e.g., cohorting, ventilation, PPE use), and access to vaccines and medical care.

Although not required, non-healthcare congregate settings should strive to test all staff and residents if a case of COVID-19 is identified among staff or residents in the facility. Testing should occur at least twice, one week apart, and ideally should continue weekly until at least two rounds of testing result in no new positive cases. LPHAs are encouraged to offer infection control consultations in collaboration with the OHA HAI team. If the LPHA experiences challenges with facilities, they should work with their CRRU Regional Epidemiologist to elevate concerns and connect with the appropriate licensing and regulatory body.

**8.3 Food chain or agricultural settings**

It is a priority to investigate any known cases of COVID-19 in these settings, because the identification of a single case has often led to the recognition of many other cases and represents an opportunity to enact control measures promptly. CRRU will coordinate communication with other state agencies and inform regulatory partners, including ODA and OR-OSHA as appropriate.

To support early identification and investigation of outbreaks, response to a single confirmed or presumptive case in these settings should include the following:

- Creating an outbreak in the Opera Outbreaks database to facilitate tracking. (If a single case is used to initiate an investigation, and no other cases are identified after 14 days, the outbreak will be closed.)
- General population quarantine (§5.1) and isolation (§5.2) guidance applies to close contacts and cases in food chain or agricultural workplace settings. Congregate residential quarantine and isolation guidance (§8.3) applies to close contacts and cases in employer-provided congregate housing.
- The LPHA is encouraged to contact the employer early to provide appropriate infection control recommendations and confirm quarantine and isolation guidance to avoid impacts to continuity of operations.

**8.4 Carceral settings (prisons, jails, youth detention facilities)**
8.4.1 Quarantine recommendations for carceral settings
To the extent possible, residents and staff of carceral facilities are recommended to complete a 10-day quarantine. The quarantining of individuals in custody should not interfere with their ability to receive essential services, including mental health counseling. During periods of critical staffing shortages, facilities may consider shortening the quarantine period for staff to ensure continuity of operations. Decisions to shorten quarantine in these settings should be made in consultation with the LPHA or OHA. See §5.2.1.

8.4.2 Isolation recommendations for carceral settings
Due to the high risk of secondary transmission and difficulties in cohorting individuals, a 10-day isolation period is recommended for residents and staff of carceral facilities. During periods of critical staffing shortages, facilities may consider shortening the isolation period for staff to ensure continuity of operations. Decisions to shorten isolation in these settings should be made in consultation with the LPHA or OHA.

8.4.3 Managing cases associated with the Oregon Department of Corrections
When there is a case of COVID-19 in an Oregon Department of Corrections (ODOC) facility, ODOC will perform a contact investigation within the facility, including a preliminary case interview to identify basic information about the case and contact tracing. Upon release, LPHAs can use this information to support their efforts (§While the case is incarcerated, set the institution of residence to the ODOC facility).

When ODOC knows that a case or contact will be released soon, they will contact CRRU with the pertinent information. ODOC will also contact Community Corrections with contact information and the person’s status. LPHAs are encouraged to establish relationships with their local Community Corrections office.

If a case is identified in a local correctional facility not under ODOC jurisdiction, the LPHA should work with Community Corrections to investigate the case.

Counting and reporting of cases in ODOC
Cases are counted in the county in which they are diagnosed. ODOC might move adults in custody between ODOC facilities for case management purposes, but these cases do not transfer jurisdictions for reporting purposes.

Managing and investigating cases and contacts
CRRU will create confirmed and presumptive cases based on ODOC information that is reported through the Oregon COVID-19 Reporting Portal (OCRP).

For LPHAs who have not opted into auto-processing of ELRs, cases among adults in custody that are reported via ELR should be processed by the LPHA where the corrections facility is located. While the case is incarcerated, the LPHA should set the institution of residence to the corrections facility by clicking the “Set” button in the ‘Address’ pop-up window in Opera and selecting the corrections facility from the list.

LPHAs are encouraged to coordinate with Community Corrections ahead of the release of a case or contact from the ODOC facility to establish a plan to connect with the case or contact upon release.

8.5 K–12 school settings
For the 2021–22 school year, schools have been directed to plan to provide full-time, in-person education for all students every school day. The Oregon Department of Education Ready Schools, Safe Learners Resiliency Framework for the 2021-22 School Year and related documents (https://www.oregon.gov/ode/students-and-family/healthsafety/Pages/RSSL-Guidance.aspx) outline the recommendations that schools and school districts can implement to ensure the health and safety of students, teachers, staff and visitors.

Isolation and quarantine recommendations for the general population apply in K-12 settings (see quarantine (§5.1) and isolation (§5.2)).

8.5.1 Opening outbreaks in K–12 school settings
LPHAs should open an outbreak when in-school transmission of COVID-19 is suspected. OHA has adopted the Council of State and Territorial Epidemiologists definition for in-school transmission, which assumes that two or more cases from more than one household were most likely exposed in a school setting or school-sanctioned extracurricular activity (e.g., athletics, clubs, performances, etc.).

8.5.2 Additional Mitigation Strategies for K–12 Settings
To the extent possible, schools are encouraged to continue implementing available mitigation measures for the added safety benefits they provide. Additional information on mitigation measures in schools is available in the Oregon Department of Education Ready Schools Safe Learners Resiliency Framework.

Physical distancing
Where feasible, schools should strive to maintain at least 3 feet between students throughout the school day to the extent possible. To encourage distancing, schools can add markings on the floor and limit time standing in lines.

Assigned Seating
If feasible, schools should consider establishing or continuing the use of assigned seating in classrooms and school buses. This facilitates exposure notifications when cases occur and may help reduce the transmission of COVID-19.

Cohorting
When possible, it is recommended that students be grouped into stable cohorts to reduce the opportunity for transmission. Cohorts should be as small as feasible. Cohorting may be particularly useful during and extracurricular activities. During extracurricular activities, organizers should consider establishing cohorts for bus rides, meetings, practices, games, performances, etc. Staggering the presence of cohorts in similar spaces (e.g., small weight rooms, restrooms, locker rooms) can also help reduce disease transmission.

Exposure Testing
Following an exposure to COVID-19, schools enrolled in the Diagnostic Testing Program, in consultation with their LPHA can offer:
- Test to stay enhanced exposure testing to cohorts which include individuals at increased risk of severe COVID-19 (e.g., individuals with underlying medical conditions or immunocompromised status, individuals age 65 and older, and those who live with individuals at increased risk)
- General exposure testing to any student and staff following any exposure in the
8.6 Childcare Settings
The below guidance applies to the following childcare settings:
- In-home childcare (infant–5 yrs)
- Childcare centers (infant–5 yrs)
- Preschool programs (36 mos–5 yrs)
- School age programs not associated with K-12 settings (5–13 yrs)

Isolation and quarantine recommendations for the general population apply in childcare settings (see quarantine (§5.1) and isolation (§5.2)).

8.6.1 Additional Mitigation Strategies for Childcare Settings
To the extent possible, childcare programs are encouraged to continue implementing available mitigation measures for the added safety benefits they provide. Additional information on mitigation measures in childcare is available from the Oregon Department of Education Early Learning Division.

**Physical distancing**
Where feasible, childcare programs should strive to maintain at least 3 feet between students throughout the day to the extent possible. To encourage distancing, schools can add markings on the floor and limit time standing in lines.

**Assigned Seating**
If feasible, childcare programs may consider establishing or continuing the use of assigned seating in classrooms and buses. This facilitates exposure notifications when cases occur and may help reduce the transmission of COVID-19.

**Cohorting**
When possible, it is recommended that children be grouped into small cohorts to reduce the opportunity for transmission. Cohorts should be as small as feasible.

8.7 Notifications from CDC’s Division of Global Migration and Quarantine and other Federal and State Partners
Individuals who are reported by DGMQ as close contacts (e.g., seated within 6 feet) of a confirmed COVID-19 case on a flight, or of passengers on a cruise ship with identified cases, will be notified of the potential exposure by CRRU staff. Contact letters will be disseminated as resources allow.

As contacts are identified through investigations in other jurisdictions—for example, if an Oregon resident has close contact with a case in a neighboring state—OHA will create a Person Under Monitoring record for those contacts.

8.8 Pregnant Persons
Pregnant persons are at increased risk for severe COVID-19. Pregnant persons who develop COVID-19 are also at increased risk of pregnancy complications. Vertical transmission of SARS-CoV-2 has been associated with cesarean delivery, but not with breast feeding.\(^{14}\)

Pregnant persons should be vaccinated and take additional precautions to avoid infections, including masking, frequent hand washing and avoiding people who are sick. Testing is recommended for all neonates born to women with confirmed or presumptive COVID-19, regardless of whether there are signs of infection in the neonate.

9.0 DATA MANAGEMENT

9.1 Data access and processing

Because of the likelihood that contacts and cases will move or have connections across counties, all counties will have “All View/All Edit” access to cases of Person Under Monitoring and Coronavirus in Opera.

Unless someone meets the criteria for a truly separate case (see §5.2), they should only have one Coronavirus case created for them. For example, if someone was a suspect case and then tests positive by PCR, do not create a separate confirmed case. Update the status of the existing case to the most accurate status.

9.2 REDCap platform

The REDCap platform will be maintained by CRRU. Completed REDCap surveys will be reviewed for data quality and imported into Opera Monday through Friday (note: data from REDCap surveys will be pushed to matching cases in Opera after business hours M–F).

- If a matching Confirmed or Presumptive case is found, the REDCap survey will be linked to the case and data will be imported from the survey into Opera.
- Suspect cases will be created from REDCap surveys that do not match an existing case in Opera.

Data from the REDCap survey are mapped to matching variables in Opera. Survey data from REDCap will not override any existing data in Opera.

9.3 Cases who fly or travel across state lines

If you are aware of a confirmed or presumptive case who flew during their transmissible period (see §10), collect details about the travel, including the dates and times of the flight or flights, departure and arrival airports, the airlines, the flight numbers, and the case’s seat numbers. Include all of this in the Travel section of the Risks tab in Opera.

9.4 Managing Close Contacts

A web-based platform, known as ARIAS, has been created to support contact tracing. All counties have been onboarded to ARIAS. Training to support contact tracing, including ARIAS training, is available at the Contact Tracing Resources page. For questions regarding ARIAS, contact ARIAS.support@dhsoha.state.or.us; or consult the ARIAS guidance documents.

If you identify a close contact and choose to enter the person into Opera, be sure to use the Contacts tab. If you find that a contact lives in another jurisdiction, update the contact’s address and promptly transfer the contact to that jurisdiction in Opera. When transferring a Person Under Monitoring between jurisdictions, the receiving LHD must update the name in the “LHD Epi” field to that of any Opera user in their jurisdiction. Contacts and Persons Under Monitoring will be exported to ARIAS once per day, and all follow-up will occur in that system. Refer to ARIAS workflow documents for guidance on how to manage those contacts.
If a close contact who was exposed to a confirmed case develops symptoms consistent with COVID-19, that person may meet the presumptive case definition (see §3.4). This new presumptive case should be entered into Opera. Do not simply change the condition from Person Under Monitoring to Coronavirus; create a new coronavirus case for that person. Presumptive cases who test positive for COVID-19 will become confirmed cases. Presumptive cases who test negative will remain presumptive cases unless a more likely alternative diagnosis is made (e.g., influenza).

If a close contact who was exposed to a presumptive case develops symptoms consistent with COVID-19, that person meets the suspect case definition (see §3.2). This new suspect case should be entered into Opera. We do not recommend a full case and contact investigation for suspect cases (see §4.3), but we do recommend that this new suspect case and their source presumptive case be tested for COVID-19.

9.5 MIS-C and MIS-A Case Management in Opera
All MIS-C and MIS-A cases entered in Opera should be classified as suspect; ACDP staff will change the classification to confirmed, as appropriate, once chart review is complete. Cases should be routed to Nasreen Abdullah for investigation.

9.6 Outbreak Data Management
Use the epi-link type for all cases to indicate the type of exposure. When linking cases to an outbreak, include the outbreak number for all first- and second-generation cases associated with the outbreak. These terms describe a case’s proximity to the place of exposure. First-generation cases are those that have the shared exposure; for example, these are workers at a worksite outbreak, or children and staff at a daycare that has an outbreak, even if those cases have onsets spread over time. Second-generation cases do not share the original exposure but have close contact to a first-generation case. Cases beyond the second generation should not have the outbreak number added to their case. See Appendix 1 for a list of minimum outbreak reporting elements.

9.7 OHA Reporting to CDC
OHA will electronically report all known COVID-19 cases and deaths to CDC through the National Notifiable Diseases Surveillance System (NNDSS). CDC’s Emergency Operations Center (EOC) will be notified at 770-488-7100 only if assistance or guidance is needed.

10.0 GLOSSARY OF TERMS

Aerosol-generating procedures:
Include, but are not limited to:
- Intubation, extubation, and related procedures such as manual ventilation and open suctioning
- Cardiopulmonary resuscitation
- Tracheotomy and tracheostomy procedures (insertion, open suctioning, removal)
- Bronchoscopy
- Surgery and post-mortem procedures involving high-speed devices
- Some dental procedures (such as high-speed drilling)
- Non-invasive ventilation (NIV) such as bi-level positive airway pressure (BiPAP) and continuous positive airway pressure ventilation (CPAP)
- High-frequency oscillating ventilation (HFOV)
- High-flow nasal oxygen (HFNO) [i.e., oxygen delivered through high-flow nasal cannula]
(HFNC) at ≥15L/min.

- Induction of sputum
- Medication administration via continuous nebulizer

**COVID-19-related death**: A death is considered to be related to COVID-19 in any of the following circumstances:

- Death of a confirmed or probable COVID-19 case within 60 days of the earliest available date among exposure to a confirmed case, onset of symptoms, or date of specimen collection for the first positive test;
- Death from any cause in a hospitalized person during their hospital stay or in the 60 days following discharge and a COVID-19-positive laboratory diagnostic test at any time since 14 days prior to hospitalization; or
- Death of someone with a COVID-19-specific ICD-10 code listed as a primary or contributing cause of death on a death certificate, regardless of the dates of diagnosis or death.

**COVID-19-related hospitalization**: If the patient is admitted to an acute care facility following an ER or outpatient visit, then the patient has been hospitalized. A case would not be considered hospitalized if admitted for a <24-hour observation period only. A case would be considered hospitalized if admitted for ≥24 hours in an observation unit or ER. A COVID-19-related hospitalization is defined as:

- Any confirmed case hospitalized within 14 days of any positive test or who tests positive during their hospitalization; or
- Any presumptive case hospitalized within 14 days of their illness onset.

**Health care worker (HCW)**: Any paid or unpaid person serving in a healthcare setting who has the potential for direct or indirect exposure to patients or infectious materials, including body substances (e.g., blood, tissue, and specific body fluids); contaminated medical supplies, devices, and equipment; or contaminated environmental surfaces. HCWs may include, but are not limited to, emergency medical service personnel, nurses, nursing assistants, physicians, technicians, therapists, personal support workers, home care workers, phlebotomists, pharmacists, students and trainees, veterinarians, dentists, contractual staff not employed by the health care facility, and persons (e.g., clerical, dietary, environmental services, laundry, security, maintenance, engineering and facilities management, administrative, billing, and volunteer personnel) not directly involved in patient care but potentially exposed to infectious agents that can be transmitted between HCWs and patients.

**High-consequence settings**: Congregate settings where there is an increased risk of widespread secondary transmission among vulnerable populations, increased risk of severe illness, or risk of community destabilization. Includes, but is not limited to:

- Long term care facilities (SNF, ALF, RCF, MC)
- Adult foster homes
- Child and adult behavioral health facilities
- Residential treatment facilities
- Intellectual and developmental disabilities 24 hour residential programs
- Carceral settings
- Homeless shelters
- Temporary/transitional housing
- K-12 and early learning settings (public and private schools, childcare)
- Other congregate living settings (e.g., employer-provided communal housing, supported/supportive living)
• Agricultural and food chain facilities (e.g., farms, packing houses, processing facilities, etc.)

**High-Priority Individuals:**
People with symptoms in the groups listed below should be prioritized for testing.

- Healthcare workers and first responders (EMS, public safety workers)
- Residents, staff, children, or other people in a congregate setting (e.g., healthcare facility, residential care facility, school, agricultural workers, food-packing plants, childcare, corrections, shelters, etc.)
- Workers who provide direct care or service in multiple group facilities or who provide in-home services (e.g., hospice care workers, physical or occupational therapists, in-home personal care workers, etc.)
- Essential front-line service workers who have regular contact with large numbers of people (e.g., those working in grocery stores, pharmacies, food service, transportation, delivery, and other critical infrastructure services)
- People 65 years of age or older
- People with underlying medical conditions, including, but not limited to hypertension, diabetes, cardiovascular disease, lung disease, and immunocompromising conditions
- People who identify as Black, African-American, Latino, Latina, Latinx, American Indian/Alaska Native, Asian, Asian-American, or Pacific Islander
- People who identify as having a disability
- People whose first language is not English
- Pregnant women
- People whose condition requires hospitalization
- People who within 14 days of their symptom onset had close contact with a person with laboratory-confirmed COVID-19 or a person determined by a public health authority to be a presumptive case

**Period of transmissibility:** This is the time when cases can transmit disease to others. For symptomatic cases, this begins 48 hours prior to symptom onset. For asymptomatic cases, this begins 48 hours prior to the collection of the first specimen that tested positive. The period of transmissibility extends until the case has met criteria for discontinuation of isolation.

**Physical distancing:** Remaining out of congregate settings, avoiding mass gatherings, and maintaining distance (approximately 6 feet) from others to the greatest extent possible. Physical distancing measures reduce opportunities for person-to-person virus transmission and can help slow the spread of the disease, as well as save lives.

**Severely immunocompromised person:** Those who require care in a protected environment, (e.g., bone marrow transplant recipients, individuals with severe combined immunodeficiency”) and HIV+ persons with CD4+ percentages <15% or CD4+T lymphocyte counts <200. Immunocompromised persons include but are not limited to those who:

- Are in an immunocompromised state (weakened immune system)
- Have AIDS or HIV
- Are receiving cancer treatments, anticancer drugs, or chemotherapy
- Are undergoing radiation therapy
- Are undergoing or have had stem cell treatments
- Received an organ transplant
- Take corticosteroids and other immune suppressing medications
REFERENCES


UPDATE LOG

March 12, 2022. Removed requirement for quarantine among the general population; updated K-12 and childcare guidance sections; formatting changes in the healthcare and other congregate settings sections; updated vaccines section


December 29, 2021. Adopted new CDC shortened quarantine and isolation guidance for the general population and HCW; updated vaccine and treatment section; removed guidance regarding active monitoring; removed 7-day shortened quarantine with test; removed outbreak guidance regarding general workplaces; added language and intention for prioritizing public health response for COVID-19. (Amanda Faulkner, Paul Cieslak, Becca Pierce, Tom Jeanne).

December 6, 2021. Defined extracurricular activities in the test to stay guidance; clarified that masked staff on school buses are also eligible for test to stay. (Amanda Faulkner, Melissa Sutton).

December 2, 2021. Added language regarding the risk of outdoor exposures and variables to consider when determining if quarantine is needed for contacts; added language for a modified quarantine option for exposures in K-12 settings where universal masking is
in place, updated test interpretation table (Lee Peters, Tom Jeanne, Paul Cieslak, Melissa Sutton, Amanda Faulkner)

November 18, 2021. Updated presumptive case definition to specify symptoms for persons who test positive using an at-home test; removed recommendation for people who test positive at-home to follow-up with a confirmatory test; recommended use of 7-day quarantine with negative test option for close contacts who work in or attend K-12 schools (Amanda Faulkner, Lee Peters, Tom Jeanne, Melissa Sutton).

October 19, 2021. Added language about close contact exceptions for outdoor K–12 settings; revised ideal post-exposure test window to 5–7 days (Meagan McLafferty, Amanda Faulkner).

September 24, 2021. Added language about new case investigation protocol; clarified school outbreak management; modified presumptive case definition symptom requirements for people who test positive with an at-home test; lab updates (Sarah Humphrey, Shane Seavey, Becca Pierce, Lee Peters, Amanda Faulkner).

August 6, 2021. Added new CDC close contact exemption in school settings; added school-specific outbreak response section; updated testing recommendations for close contacts regardless of vaccination status; added information on MIS-A surveillance (Amanda Faulkner, Becca Pierce, Lee Peters, Paul Cieslak).

July 6, 2021. Changed response time for case interviews to one local public health working day; removed requirement for outbreak record to be opened for all schools with more than 1 case; defined testing strategy parameters for discontinuation of isolation. (Amanda Faulkner, Becca Pierce).

June 3, 2021. Updated quarantine guidelines to allow local public health to adopt shortened quarantine periods of 10 or 7 days with a negative test among the general population with exceptions in certain high-risk settings. (Amanda Faulkner).

April 29, 2021. Updated duration of quarantine to 14 days for all unvaccinated close contacts; updated surge conditions guidance section. Added detail to vaccination/treatment section. (Amanda Faulkner).

March 22, 2021. Added clarification surrounding vaccine breakthrough case surveillance follow-up; clarified use of test-based discontinuation of isolation; provided language regarding upcoming OSPHL whole genome sequencing capacity; clarified at-home test kits. (Amanda Faulkner).

February 17, 2021. Added Surge Conditions Guidance section; refined new quarantine guidance for fully-immunized close contacts in health care settings to match CDC’s; updated infection control language to align with OHA Clinical and Infection Control Guidance; added breakthrough case surveillance project information. (Amanda Faulkner, Rebecca Pierce).

January 20, 2021. Updated treatment, prevention and limitation of spread section; provided new quarantine guidance for fully-immunized close contacts; clarified timing of isolation period for asymptomatic cases who subsequently develop symptoms. (Amanda Faulkner).

December 9, 2020. Removed language regarding creation of suspect cases based on negative test results; added options for shorter quarantine, adopting CDC options in part (Amanda Faulkner, Melissa Sutton, Paul Cieslak).

November 25, 2020. Added clarification for assessment and notification regarding persons exposed to cases among healthcare workers, removed test-based discontinuation of
isolation, modified close contact definition to include '24-hour' time frame in line with CDC, included direction for sharing case information with schools, directed LPHA to classify MIS-C cases as Suspect until chart review is complete. (Kristen Hollywood, Melissa Sutton, Amanda Faulkner).

September 18, 2020. Clarified the recommended isolation period for cases who live in congregate settings, updated language to reflect that all jurisdictions are on ARIAS, defined first- and second-generation in the context of linking cases to outbreaks, added required data elements for outbreak reporting, added the definition of COVID-19-related hospitalization, sundry edits (Steve Rekant).

July 23, 2020. Changed all mentions of Orpheus to Opera, updated discontinuation of isolation criteria for symptoms from 72 hours to 24 hours, deemphasized test-based discontinuation of isolation and added the longer minimum period for specific groups, included new testing rules and guidance, added positive antigen tests to the confirmed case definition and added language about any test developed under an FDA EUA, added description of criteria for possible work exemptions for quarantine and isolation, sundry edits (Steve Rekant)

July 2, 2020. Clarified language around using test-based discontinuation of isolation in LTCFs, added requirement for LPHAs to share information with employers (Steve Rekant)

June 24, 2020. Added details about investigating outbreaks, added references to ARIAS, clarified definition of suspect and presumptive cases including information about antigen testing, added MIS-C, disentangled discontinuation of isolation and assessment of recovery, harmonized language across sections, sundry edits (Steve Rekant)

May 1, 2020. Added presumptive case definition and revised recommended follow-up with contacts, defined recovery and clarified release from isolation, defined COVID-19-related deaths, clarified language around testing, added required follow-up for close contacts. (Steve Rekant, Kelly Cogswell)

April 1, 2020. Added language for emergency rule regarding reporting deaths and hospitalizations; reduced expectations for follow-up of potentially exposed persons; clarified language regarding testing in clusters; removed negative influenza test as a requirement for automatic testing approval at OSPHL; modified exposure period per new CDC guidance; added revised flowcharts. (Steve Rekant, Madeline LeVasseur, Amanda Faulkner, Rebecca Pierce)

March 23, 2020. Changed requirements for LPHA follow-up and investigation of PUMs, suspect cases, and confirmed cases. Updated guidance on monitoring and restrictions of exposed persons. Updated criteria for testing at OSPHL and overall testing prioritization recommendations. Changed language from PUI to suspect case and changed suspect and confirmed case definitions (Madeline LeVasseur, Steve Rekant, Amanda Faulkner, Orion McCotter)

March 12, 2020. Added information about other laboratories. Sundry edits. (Steve Rekant)

March 8, 2020. Edited testing criteria, PUM, PUI definitions. Updated guidance for discontinuation of isolation. Sundry edits. (Kelly Cogswell, Alexia Zhang)

February 28, 2020. Updated PUI case definition and testing criteria. Updated testing availability at the OSPHL. Added current list of geographic areas with widespread or sustained community transmission. (Tasha Poissant, Madeline LeVasseur)

February 20, 2020. Provided guidance on discontinuation of isolation for PUIs or COVID-19 cases and pregnant persons, and revised figures. (Alexia Zhang, Madeline LeVasseur, Steve Rekant)

February 12, 2020. Clarified expectations of LPHAs regarding contacting PUMs, provided guidance on interpreting testing, and revised figures. (Amanda Faulkner, Steve Rekant, Alexia Zhang)

February 7, 2020. Provided minor clarifications to date of PUM guidance implementation, DGMQ PUM forms, and Figures. (Amanda Faulkner, Steve Rekant)


January 2020. First draft. (Nicole West, Amanda Faulkner, Steve Rekant)

**Appendix 1: Outbreak reporting elements**

- **Basics tab**
  - Etiology
  - Case counts
  - First and last onset date (for asymptomatic cases, onset date should be the first specimen collection date)
  - Location details
    - Exposure locations (i.e., location of outbreak)
    - Residence locations (i.e., where do cases live)
    - Contact information for outbreak site
    - Number of employees and/or persons in a facility
    - Exposure sites (i.e., type of location)
  - Brief overview

- **Etiology tab**
  - Etiology = Coronavirus
  - Type of testing performed
  - Identified sequence, if any

- **Cases tab**
  - All the Opera cases linked with the outbreak number
  - If used, a case log should also be completed
  - Confirmed and presumptive case counts
  - Age
  - Sex
  - Deaths

- **Methods tab**
  - Check all that apply
  - Be sure to identify if a HAI investigation was performed
    - Note by whom: facility, LPHA, OHA HAI

- **Documentation tab**
  - Provide a basic timeline of the outbreak and investigative communications or pertinent notes. The more information provided in this field, the better as we are trying to be as
thorough as possible with documentation.

- Attach any relevant records such as provider notifications, press releases
- Attach external investigation documents like epi curves and inspection reports