1. DISEASE REPORTING

1.1 Purpose of Reporting and Surveillance

1. To identify persons with COVID-19, prevent transmission to others, improve health outcomes and better understand the epidemiology of this disease.

2. To identify those with significant exposure to COVID-19 as described in §3.1 and §3.2, below, and to monitor them for signs of infection.

1.2 Laboratory and Physician Reporting Requirements

Healthcare providers and laboratories are required to report test results indicative of and specific for COVID-19 to the local public health authority (LPHA) within 24 hours. Laboratories are required to report negative results of COVID-19 testing within one local public health working day.

Healthcare providers are additionally required to report within 1 working day:

- All hospitalizations among persons with COVID-19, whether or not the case was previously reported
- All deaths, defined in §7, among persons with COVID-19, whether or not the case was previously reported
- All cases of Multiorgan Inflammatory Syndrome in Children (§3.7)
- Administrations of remdesivir acquired through state distribution

All of this reporting must be done through an “Online Morbidity Report,” which can be found at www.healthoregon.org/howtoreport.

1.3 Local Public Health Authority Reporting and Follow-Up Responsibilities

Close contacts

1. Follow guidance on monitoring and movement control as described in §4 below, including active monitoring for all identified close contacts.

2. Educate and consult with local providers and facilities to promote compliance with quarantine, isolation, and infection-control procedures.

3. If a close contact develops symptoms compatible with a presumptive case, follow the steps below.

Suspect COVID-19 cases

1. Suspect cases are created one of three ways:
   a. Automatically from electronic laboratory reports (ELRs)
   b. When contact tracing identifies a symptomatic contact who does not meet the presumptive case definition
   c. After providers report a symptomatic person without an epi-link.

2. Encourage symptomatic persons who have not been tested to get tested.

3. Otherwise, there is no follow-up for suspect cases.

Confirmed and Presumptive COVID-19 cases
1. Begin investigation of confirmed and presumptive COVID-19 cases, as defined in §3 below, immediately.
2. Report all confirmed and presumptive cases immediately by entering them into Orpheus with disease “Coronavirus” and subtype “COVID-19.”
3. Investigate outbreaks of COVID-19 among residents and in settings within their jurisdiction.
4. Consult with ACDP as needed about patient isolation and protection of contacts, including healthcare personnel, and about strategies for public-health response, testing, and contact investigation.
5. Educate and consult with local providers and facilities to promote compliance with isolation and infection-control procedures.
6. Educate confirmed and presumptive cases on how to protect their close contacts through self-isolation, and how to inform those contacts how to watch for symptoms and how to seek care safely.
7. Enter details of the investigation and contact follow-up into Orpheus.
9. Process electronic case reports (eCRs) in Orpheus, including updating test results and hospitalization status; and recording deaths and administrations of remdesivir.

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, or other states.
3. Process eCRs in Orpheus, including creating a case and approving testing for patients who meet testing criteria, adding hospitalization status, and recording deaths and administrations of remdesivir.
5. Assist LPHAs in processing ELRs of COVID-19 test results.
6. Forward confirmed case data to state Emergency Medical System (EMS) Program for identification of any potentially exposed EMS transports; and forward such information to LPHA for follow-up.
7. Develop and maintain information systems for case and contact surveillance and to ensure adequacy of response activities.
8. Identify close contacts from CDC Division of Global Migration and Quarantine (DGMQ) notifications as appropriate.
9. Advise LPHA, Tribal, and private-sector health professionals concerning:
   - Quarantine of asymptomatic exposed persons (close contacts);
   - Isolation of cases and symptomatic persons;
   - Protection of healthcare personnel;
   - Diagnostic evaluation;
   - Required reporting and surveillance activities;
   - Contact identification and follow-up.
10. Coordinate interjurisdictional monitoring plans for close contacts who move out of county or state.
12. As resources allow, provide surge capacity for contact and case investigation if the scope of response overwhelms LPHA resources.
13. Arrange consultation with infectious disease specialists and CDC as needed.
14. Report confirmed COVID-19 cases and deaths to CDC.

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 since 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.”

2.2 Description of Illness
Symptoms may include fever (defined throughout as a temperature of ≥100.4°F or 38.0°C), sore throat, dry cough, dyspnea, myalgias, fatigue, and loss of smell (anosmia) or taste (ageusia). Fever may not be present in the very young, very old, immunosuppressed, or people taking antipyretics. Pneumonia generally presents with patchy, multilobar infiltrates on chest X-ray. Gastrointestinal symptoms are not uncommon and may include nausea, vomiting and diarrhea. Cases tend to have lymphopenia. Reported complications have included acute respiratory distress syndrome, cardiac events, and death.

Cases of a COVID-19-associated “multisystem inflammatory syndrome in children” (MIS-C), which may resemble Kawasaki Disease, have been reported in children from several jurisdictions. In addition to a positive COVID-19 test, the syndrome includes fever, multisystem involvement (cardiac, renal, respiratory, hematologic, gastrointestinal, dermatologic or neurologic), and laboratory evidence of inflammation.

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 transmission is probably rare. The prevalence of animal infection with the COVID-19 virus is unknown.

2.4 Sources and Routes of Transmission
This virus probably originated from an animal source—bats are currently suspected—but extensive person-to-person spread ensued. Person-to-person transmission is likely primarily via respiratory droplets produced when an infected person coughs or sneezes, as is the case with influenza and pertussis. Other coronaviruses (e.g., MERS and SARS) have spread between close contacts. 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 thought to be the main route of transmission. Studies (including preliminary studies of the COVID-19 virus) suggest that coronaviruses may persist on surfaces for up to several days. The degree of airborne transmission is currently unknown. The virus is commonly detectable in feces of infected persons; and the possibility of transmission from feces, blood, or other body fluids has not been ruled out.

Healthcare personnel caring for COVID-19 patients or any patient with undiagnosed respiratory infection should observe standard, contact, and droplet precautions, with facemask and eye protection (face shield or goggles). During aerosol-generating procedures (see §7) on such patients, airborne precautions should be observed.

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

2.6 Period of Communicability
Our understanding is still developing. Some cases are acquired from infected asymptomatic persons, and virus is detectable in some patients for weeks following resolution of symptoms. That said, transmission appears most likely when patients are coughing. At this time, replication-competent virus has not been successfully cultured >9 days after onset of illness. The statistically estimated likelihood of recovering replication-competent virus approaches zero by 10 days.

2.7 Treatment, Prevention, and Limitation of Spread
There are currently no FDA-approved treatments for COVID-19, though remdesivir has been shown in a clinical trial to reduce the duration of illness and has an Emergency Use Authorization. There is no vaccine. Methods such as staying home, physical distancing (see §7), and using a mask, face shield, or face covering when physical distancing cannot be maintained are recommended for all people to limit the spread of disease. People are encouraged to practice good hand hygiene and to disinfect high-touch surfaces regularly.

3. CASE DEFINITIONS, DIAGNOSIS, AND LABORATORY SERVICES
See Figure 1 for visual representation of case definitions and Appendix 1 for a grid that explains how to interpret test results.

3.1 Close Contact
A close contact is a person with an epidemiologic exposure to the COVID-19 virus. The exposure may be close contact (see §7 for details) with a confirmed or presumptive case – in short, being within 6 feet of a COVID-19 case for ≥15 minutes – or contact with their infectious secretions or clinical specimens; a close contact (e.g., aboard an airline flight) might also be reported to us by CDC.

See §4.2 for guidance on classifying and monitoring close contacts.
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.

### 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\* 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:
  - A negative or indeterminate nucleic acid amplification test (NAAT)\(^\dagger\) test result;
  - A positive antigen test without either COVID-19 symptoms or close contact with a confirmed case;
  - A serologic test – any result – as their only laboratory test; and
  - A close contact who is getting tested

These criteria are for epidemiologic classification and are not meant to direct clinician testing. Healthcare providers can identify individuals they suspect to have COVID-19 and test these patients at clinical laboratories.

### 3.3 Confirmed Case

A confirmed case is someone with COVID-19 laboratory-confirmed by NAAT at any laboratory that has successfully verified the CDC testing panel; or by a Laboratory Developed Test under the FDA Emergency Use Authorization. Any positive result on a NAAT platform, even if conducted as asymptomatic screening, is considered a positive result. A follow-up test which is negative does not negate the first positive test.

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

Note: If the electronic case report does not clearly identify a lab result, consider the person a suspect case with a pending test. See §4.3 for details.

\* 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.

\(^\dagger\) e.g., a polymerase chain reaction (PCR) test.
If a person is diagnosed with MIS-C (see §3.7), create a confirmed case. (If their only diagnostic test was serology, they are still a confirmed case, but do not initiate contact tracing; testing will be offered to household members.)

3.4 Presumptive Case
A presumptive case is a person without a positive COVID-19 NAAT 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
- Within the 14 days before illness onset, lived in the same household or congregate setting, or had close contact (see §7) with a confirmed case.

OR

- A positive COVID-19 antigen test that is covered under an FDA Emergency Use Authorization
  AND EITHER
  o 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
  o Within the 14 days before illness onset, lived in the same household or congregate setting, or had close contact (see §7) with a confirmed case.

If a presumptive case tests positive for COVID-19 by NAAT, update the case’s status to confirmed. If a presumptive case tests negative for COVID-19 by NAAT, the case remains presumptive.

3.5 Laboratory Testing
1. Testing Guidance for Local Health Departments
   Testing through the Oregon State Public Health Laboratory (OSPHL) must be approved by ACDP. Requests for testing at OSPHL should be submitted through the eCR portal.

2. Testing Guidance for Clinicians and Health Systems
   Guidance has been established to provide criteria for testing in commercial laboratories versus at OSPHL. Current guidance and the electronic report form to gain approval for testing at OSPHL can be found at OHA COVID-19 homepage.

3. Testing at the Oregon State Public Health Laboratory

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* 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.
† Fever can be objective (>100.4°F) or subjective.
Guidance for specimen collection, handling, and transport is changing often and may have changed since publication of this guideline. As of this publishing, here is the Guidance for Providers Regarding COVID-19 Testing and the Criteria for COVID-19 Testing at OSPHL. OSPHL offers two tests for SARS-CoV-2, the CDC Real-Time RT-PCR Diagnostic Panel, and the Hologic Aptima SARS-CoV-2 Assay. Current guidance for specimen collection, handling, and transport is posted on OSPHL’s Lab Test Menu.

In consideration of its testing capacity and demand, OSPHL requests that only one specimen be submitted per patient. If several specimens from a single patient are submitted, OSPHL will test only the most preferred specimen.

For the CDC PCR assay, specimens from the lower respiratory tract (e.g., bronchial lavage, endotracheal aspirate, sputum) are preferred. Upper respiratory tract specimens are also acceptable for testing. A nasopharyngeal (NP) swab is the preferred upper respiratory specimen. Other acceptable respiratory specimens include combined NP and oropharyngeal (OP) swabs, OP swab alone, nasal mid-turbinate swab, anterior nares specimen, nasopharyngeal wash or nasal aspirate. This platform is best used for hospitalized patients, small-volume specimen collections, and surveillance testing.

For the Hologic Aptima (NAAT) assay, nasal or oropharyngeal (throat) swabs are accepted. This platform is best used for large-group specimen collection events, such as a large-scale contact investigation or in congregate-living settings.

Choice of specimen collection may rely upon where the specimen is collected and any clinical considerations. 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.
- 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.
- Submit one OSPHL Virology/Immunology Test Request Form or COVID-19 Test Request Form per specimen. In the Other/Molecular section, check the “Other” box and write or type in “COVID-19.”
- 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. Collecting Specimens
Specimens should be collected while using proper PPE:

- For non-aerosol-generating procedures: gowns, gloves, regular mask, and eye protection
- For aerosol-generating procedures (§7): gowns, gloves, N95 or powered air-purifying respirator (PAPR), and eye protection; and conducted in the proper room.
- Using an airborne infection isolation room (AIIR) during aerosol-generating procedures is ideal, but if one is not available, use a private room and keep the door closed. Mask the patient with a regular 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. See §4.3 for additional information.

3.6 Guidance Regarding Serologic Tests
Serologic tests are still being evaluated. As we learn more, we will update this guidance. OSPHL also performs serology (IgG) testing. Availability of this test is currently limited to surveillance.

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

3.7 Multisystem Inflammatory Syndrome in Children
Multisystem Inflammatory Syndrome in Children (MIS-C) is defined as:

- 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;
- No alternative more likely diagnosis;
- Evidence for current or recent SARS-CoV-2 infection by NAAT, serology, or 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.

* Fever can be objective (> 100.4°F) or subjective.
† Including, but not limited to, one or more of the following: an elevated C-reactive protein (CRP), erythrocyte sedimentation rate (ESR), fibrinogen, procalcitonin, D-dimer, ferritin, lactic acid dehydrogenase (LDH), or interleukin 6 (IL-6), elevated neutrophils, reduced lymphocytes and low albumin
4. CASE INVESTIGATION

4.1 Data Access and Processing

Because of the importance of awareness and likelihood that contacts and cases might move, all counties will have “All View/All Edit” access to cases of Person Under Monitoring and Coronavirus in Orpheus.

Unless someone meets the criteria for a truly separate case (see §5.2), they should only have one Coronavirus case. 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.

If an LPHA processes an eCR that is a request for testing at OSPHL, create a To-do in Orpheus and assign it to an ACDP epidemiologist involved in the response. See Figure 2 for a visual representation of this workflow.

If an LPHA processes an eCR that is a test result, manually create a laboratory result with the information on the Labs tab for the case. Do not wait for the ELR to arrive.

A web-based platform, known as ARIAS, has been created to support contact tracing. Until your jurisdiction has onboarded ARIAS, Orpheus will be used to trace contacts using the Person Under Monitoring condition. 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.

4.2 LPHA Follow-Up with Close Contacts

The below guidance applies whether your jurisdiction is tracing contacts in Orpheus or ARIAS. For counties that have onboarded with ARIAS, Persons Under Monitoring and contacts of cases will be exported from Orpheus to ARIAS daily. Management of contacts in Orpheus is essential to make both systems operate properly.

As a reminder, this only applies to persons who have close contact with a confirmed or presumptive case. It does not apply to persons whose only contact is with a contact.

1. Notifications from CDC’s Division of Global Migration and Quarantine (DGMQ) and other Federal and State Partners

   LPHAs are required to follow up with 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. These contacts will be entered into Orpheus and assigned to the LPHA for follow-up. See Figure 3 for a visual representation of this workflow.

   LPHAs are no longer required to monitor residents who return from “affected geographic regions,” however CDC does recommend that passengers returning from international travel quarantine for 14 days upon arrival.
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.

2. Persons Identified During Contact Investigations

LPHA resources should be focused on identifying and monitoring all close contacts of COVID-19 cases. (see §7).

Once you identify a close contact, enter the person into Orpheus using the Contact tab. If you find that a contact lives in another jurisdiction, promptly transfer the contact to that jurisdiction in Orpheus. If your jurisdiction has activated ARIAS, those contacts 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.

Active monitoring is required for all close contacts—"Persons Under Monitoring" in Orpheus or “Contacts” in ARIAS. Provide a Contact Letter (Appendix 2) to the person. If your jurisdiction has not yet activated ARIAS, create a Person Under Monitoring case, designate the risk level as “High Risk,” and use the PUM module for daily active monitoring. LPHAs should coordinate with close contacts to identify a communication plan for daily check-ins. Phone, email, and text are all acceptable methods of communication. Close contacts should measure their temperature twice daily and monitor themselves for symptoms during the 14-day monitoring period. The LPHA should record temperature and symptom information in the contact tracing tool. If close contacts report that they have developed fever or other symptoms consistent with COVID-19, they should coordinate with the LPHA to determine a plan to seek care safely and access COVID-19 testing. See Figure 4 for a visual representation of this workflow.

On the 14th day after their last exposure, the LPHA should confirm with close contacts that they have remained afebrile and asymptomatic. If they remained asymptomatic, they have completed monitoring. If they developed symptoms, evaluate whether they meet the definition of a presumptive case (§3.4).

If a contact cannot be reached, mail a contact letter (Appendix 2) to the contact’s last known address.

3. When a Close Contact Becomes Symptomatic

If a close contact who was exposed to a confirmed case develops symptoms consistent with COVID-19, that person meets the presumptive case definition (see §3.4). This new presumptive case should be entered into Orpheus, and the case and contact investigations should be initiated. 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 a confirmed case. Presumptive cases who test negative will remain a presumptive case 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 Orpheus. 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.

4. Monitoring of Persons Identified in Contact Investigations
Guidance on monitoring and restrictions of contacts differs for healthcare workers (HCW) and non-healthcare workers.

A. Healthcare Workers Identified as Contacts
Given the ongoing transmission of COVID-19 in communities across the United States and the role that asymptomatic and pre-symptomatic individuals with COVID-19 play in transmission, the feasibility and benefits of formal contact tracing for exposures in healthcare settings are likely limited.

Healthcare facilities should consider forgoing contact tracing for exposures in a healthcare setting in favor of universal source control for asymptomatic HCW and screening for fever and symptoms of COVID-19 at the beginning and end of every shift. Additional infection prevention and control recommendations, including more details about universal source control in healthcare settings, are available from the CDC.

Asymptomatic HCW identified as contacts – whether the exposure happened at work or outside of work – may, in consultation with their occupational health program, work during their quarantine period. They should otherwise observe quarantine outside of work.

Symptomatic HCW identified as contacts must stay home from work until 72 hours after both fever and cough have resolved. Testing of the HCW is the responsibility of the employer: it may be undertaken at employer discretion and expense.

B. Non-Healthcare Workers Identified as Contacts
Non-healthcare workers who are identified as contacts are advised to quarantine themselves for 14 days after their last contact with a confirmed or presumptive case. These persons should be encouraged to seek testing should symptoms develop. See §4.2.2 for details.

Consult §6.5 and 6.6 for guidance on recommendations for contacts identified during investigation of a workplace outbreak.

4.3 LPHA Follow-Up with Suspect Cases
Suspect cases are persons as defined in §3.2. Broadly, these are persons who do not meet the presumptive case definition and do not have a positive test for COVID-19; it might be negative, pending, or indeterminate. Antigen testing is case-defining in conjunction with clinical signs or epidemiologic link (see §3.4). Serology might be the only documented test; except in the case of MIS-C, a positive serologic result is not case-defining (see §3.6).

If a provider calls about a patient with compatible symptoms who has not been tested for COVID-19, encourage them to pursue testing.
If the suspect case is created from an ELR for a negative result, no follow-up is required. We expect to identify and follow contacts through contact tracing. See Figure 5 for a visual representation of this workflow.

1. **Management in Orpheus**
   For all suspect cases identified by an indeterminate test result, create a new case in Orpheus with the condition “Coronavirus,” subtype/state “COVID-19/Indeterminate,” status “Indeterminate.”

   For all suspect cases reported by providers, create a new case in Orpheus with the condition “Coronavirus,” subtype/stage “COVID-19/Pending test,” status “Suspect.” If test results are negative, update subtype/stage to “COVID-19/Negative test”; if positive, refer to §4.4. All suspect cases should remain isolated while hospitalized or until 72 hours after fever is gone and symptoms resolving, whichever is longer (see §5.1 for details).

2. **Following Up Specific Test Results**
   Two types of test results that create a suspect case require LPHA follow-up: Positive antigen tests and indeterminate or inconclusive NAAT results.

   If a case is created from a positive antigen test, it will be counted as a suspect case. LPHAs should investigate to determine if the person meets the definition of a presumptive case. That is, are they epi-linked to a confirmed case, or were they experiencing 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 – at the time of their test. If they were, they are a presumptive case; see §4.4 for details. If they were not, they remain a suspect case.

   If the case is created from an indeterminate or inconclusive result, it will be counted a suspect case. LPHAs should investigate to determine why the result was indeterminate and whether a follow-up test will be performed. Indeterminate or inconclusive results can suggest the presence of SARS-CoV2 RNA in quantities insufficient for the NAAT to be positive. If no additional testing is to be performed, a contact investigation should be initiated (§4.4.2), though suspect cases indeterminate test results will not be included in counts of confirmed and presumptive cases. Contact with a suspect, indeterminate case is not enough of an epi-link for a symptomatic person to be considered a presumptive case.

3. **Testing Suspect Cases**
   OSPHL testing is prioritized for high-priority individuals, defined in §7, 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.

   We expect that healthcare facilities and other employers will take responsibility for any testing needed by their own staff.
LPHAs should call OHA for pre-approval for any specimens being sent to OSPHL from patients who do not meet prioritization criteria. Testing at clinical laboratories may be ordered by clinicians at their discretion and does not require OHA approval.

4.4 LPHA Follow-Up with Confirmed and Presumptive Cases

Presumptive cases who have not been tested should be encouraged to seek testing.

When following up with confirmed cases that do not have an associated lab report (i.e., they have verbal or eCR report of a positive case), LPHAs should endeavor to find the lab report as soon as possible. If a paper or .pdf version is obtained, please attach it to the Orpheus case and create a manual laboratory report. See Figure 6 for a visual representation of this workflow.

For confirmed cases created for MIS-C cases whose only positive test is serology, do not pursue contact tracing. Offer testing to household contacts.

1. Interviewing

LPHAs should attempt to interview all confirmed and presumptive cases to ascertain clinical and epidemiologic details, to try to ascertain source of the infection, and to identify any close contacts. LPHAs should also provide the Case Letter (Appendix 3) to confirmed cases.

If the confirmed or presumptive case has not already been entered as a suspect coronavirus case in Orpheus, create a new case in Orpheus with the condition “Coronavirus,” subtype “COVID-19,” status “Confirmed” or “Presumptive.” If a person who tested positive was already entered as a suspect case, first delete the “Pending Test,” then update the status to “Confirmed.” All symptomatic persons, including confirmed and presumptive cases, should remain isolated while hospitalized or until 72 hours after fever is gone and symptoms resolving, whichever is longer (see §5.1 for details).

2. Contact Investigations

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.

These people should be entered into Orpheus as Contacts. See §4.2.2 for information on how to manage these contacts.

3. Isolation of Confirmed and Presumptive Cases

All confirmed and presumptive cases, including asymptomatic cases, should be isolated until they meet criteria for discontinuation of isolation (see §5.1.2 and 5.1.3). In short, cases should avoid contact with other people until at least 10 days since their symptom onset or first positive test have passed, and they have been afebrile without the use of antipyretics with other symptoms resolving for at least 72 hours.
A test-based strategy for release from isolation can be employed, but it is not generally recommended. Many confirmed cases in Oregon and elsewhere have tested persistently positive for many weeks after their first positive test; but they are highly unlikely to be contagious. To meet the criteria for test-based discontinuation of isolation, a confirmed case must have two negative NAAT results at least 24 hours apart, after the case has become afebrile without the use of antipyretics, and other symptoms have improved.

4.5 LPHA Follow-Up on Positive Serologic Tests
No follow-up is required in response to a positive serology. If a positive serology report is received, it might be worthwhile to contact the provider to determine why the serology was ordered and whether a NAAT was also ordered.

4.6 Assessment of Recovery
ACDP has contacted confirmed cases identified before May 1, 2020, to assess whether they met the definition of recovery that applied to them (being afebrile without the use of antipyretics and having resolution of cough, shortness of breath, and diarrhea for at least 72 hours). This status, as well as the recovery date, has been updated as recovery was identified. If a case had met the definition of recovery, and then suffered a COVID-19-related death (§7), recovery status was be marked “no.”

Any confirmed or presumptive case who is alive 60 days after the earlier of their onset of symptoms or collection of their first positive test will be considered recovered (§7).

Criteria for recovery and discontinuation of isolation have been disentangled. See §5.1.3 for details.

4.7 OPHD Reporting to CDC
ACDP 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 immediately at 770-488-7100 only if assistance or guidance is needed.

5. CONTROLLING FURTHER SPREAD

Below is a description of how to manage isolation of cases and quarantine of contacts. Testing above and beyond this guidance is neither recommended by public health nor should it be required. That is, once a case has met criteria for discontinuation of isolation, or a contact has completed their quarantine period, they should not be required to test negative before return to school or work.

5.1 Isolation of Cases

1. Hospitalized Cases
Transmission of SARS-CoV-2 is presumed to occur primarily via respiratory droplets. Patients with suspected COVID-19 should be placed under standard, contact, and droplet precautions, and HCW should also use eye protection. Any necessary aerosol-generating procedures (§7) should be undertaken in an airborne infection isolation room. For confirmed cases, unless negative COVID-19 test results are obtained on specimens.
collected at least 24 hours apart, this isolation should be continued for the duration of the patient’s hospitalization.

2. **Cases not requiring hospitalization**

COVID-19 cases who do not require hospitalization should isolate themselves at home except to receive medical care; and should follow the [Interim Guidance for Implementing Home Care of People Not Requiring Hospitalization for Coronavirus Disease 2019 (COVID-19)](https://www.cdc.gov/coronavirus/2019-ncov/community/home-care.html). 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](https://www.cdc.gov/coronavirus/2019-ncov/your-health/illness-in-progress.html) for comprehensive guidance.

3. **Discontinuation of isolation**

Confirmed and presumptive COVID-19 cases should remain under home isolation for at least 10 days after illness onset and until 72 hours after fever is gone, without use of antipyretics, and COVID-19 symptoms (cough, shortness of breath, and diarrhea) are improving. If a confirmed case is asymptomatic or only has symptoms other than fever, cough, shortness of breath, and diarrhea, they should be isolated for 10 days after the collection date of the specimen that tested positive. At this time, replication-competent virus has not been successfully cultured >9 days after onset of illness. The statistically estimated likelihood of recovering replication-competent virus approaches zero by 10 days.

There is no exception for confirmed and presumptive cases who are HCW to be released early from isolation.

Once confirmed and presumptive cases meet the criteria for discontinuation of isolation, they may return to their regular lives. As discussed above, additional testing or isolation is not recommended.

5.2 **Cases Do Not Have to Quarantine for 90 Days After Discontinuation of Isolation**

If a confirmed or presumptive case achieves discontinuation of isolation and is later exposed to another case, we do not recommend monitoring and quarantine if the exposure happened within 90 days of release from isolation for their original case. If they develop symptoms during this period, they should remain in isolation until they have been afebrile without the use of antipyretics and have improving cough, shortness of breath, or diarrhea for 72 hours.

If a previously confirmed or presumptive case meets either case definition more than 90 days after release from isolation for their original case, create a new, separate case for them in Orpheus, and proceed accordingly.

5.3 **Managing Outbreaks**

When two or more confirmed or presumptive cases in different households are identified with an epi-link, contact ACDP to report the outbreak. Investigate the [Respiratory Disease Outbreak](https://www.cdc.gov/coronavirus/2019-ncov/outbreaks/management.html) including attaching the outbreak code to each confirmed, presumptive, and suspect case in the Orpheus case record. If 28 days have elapsed since the last onset of a confirmed or presumptive case, the outbreak will be considered closed.
LPHAs must disclose the identity of cases to employers when there is an outbreak, as they will have information necessary to assist in identifying individuals who may have been exposed. For purposes of this disclosure requirement, an outbreak includes one case in a congregate care setting (§6.4), a workplace with two or more cases (§6.5), one case in a food-processing or agricultural setting (§6.6), and one case in a childcare setting. When disclosing information to an employer it is a best practice to share the information with a person in the Human Resources or Employee or Occupational Health department or, if no such department exists, someone in management.

See §6 for how to manage outbreaks in special situations, including workplaces, congregate residential facilities, and agricultural production operations.

5.4 Assessing the Potential for Worksite Outbreaks
Worksites have been a major setting of outbreaks. It is important to ask cases and contacts about their place of employment. Orpheus has fields for Industry and Occupation that can help guide this conversation. It is helpful to ask about factors like the density of workers and patrons, the frequency of handling shared items or equipment, whether masks are required, and how easily high-touch surfaces are decontaminated.

6. MANAGING SPECIAL SITUATIONS

6.1 Healthcare Facility Infection Control
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.

6.2 Pregnant Persons
Information is currently insufficient to determine whether pregnant persons are more susceptible than others to COVID-19, nor is there information on how having COVID-19 might affect pregnancy outcomes. Pregnant persons should engage in usual preventive actions to avoid infections, including frequent hand washing and avoiding people who are sick.

Information about vertical transmission of COVID-19 is also limited. To our knowledge the virus has not been detected in amniotic fluid or the breast milk of persons with COVID-19. The virus could presumably be transmitted to a newborn via close contact. 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. See the CDC guidance Evaluation and Management Considerations for Neonates At Risk for COVID-19 for details.

6.3 Transportation by EMS
If a confirmed case is transported by EMS, LPHAs should inform the EMS agency about the case for the purpose of contact tracing and risk assessment by the agency. Additionally, LPHAs should inform EMS agencies in their jurisdiction if a confirmed case is identified at a long-term health care facility such as a nursing home so that EMS may take appropriate precautions when responding to additional calls from these locations. Complete risk questions in Orpheus to indicate whether a patient arrived at a healthcare facility “by ambulance.”

6.4 Investigating Outbreaks of COVID-19-like Illness in Congregate Residential Settings
COVID-19-like illness (CLI) has been defined as with fever, along with cough, shortness of breath, or difficulty breathing. Because CLI and influenza-like illness (ILI: fever, along with cough or sore throat) are similar, it is a priority to investigate any CLI or ILI in LTCFs, prisons, jails, and other congregate settings because they may indicate an outbreak of either. 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 perhaps for other pathogens.

To support early identification of outbreaks, response to even a single suspect case in these settings should include the following:

- entering the suspect COVID-19 case into Orpheus;
- verifying the absence of additional suspect cases that would warrant immediate “outbreak” designation; and
- providing the facility with appropriate infection control recommendations (see LTCF COVID-19 Response Toolkit at www.healthoregon.org/coronavirus).

If the confirmed or presumptive case is identified in a resident or staff member of a congregate residential setting, LPHA should request an outbreak number from ACDP 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 more cases are identified within 14 days of the single case, the outbreak will be closed.

It is preferable to use the test-based strategy in order to discontinue isolation and other transmission-based precautions for residents of congregate care settings.

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.

6.5 Workplace Outbreak Recommendations for COVID-19 Testing

In general, workplace outbreaks of two or more people are situations that may warrant testing of some of the employees who work in the affected facility. Each situation is different, and this decision should be made in collaboration between the affected facility and the LPHA. The facility and the LPHA should coordinate on logistics of collecting and shipping the specimens. Initial testing should focus on high-risk workers, including those with respiratory symptoms and coworkers potentially exposed to known cases.

Consult the forthcoming guidance on workplace outbreak recommendations for COVID-19 testing for details on responsibilities of the workplace and LPHA. In specific situations, cases and contacts may be allowed to work during their quarantine or isolation period.

6.6 Investigating Outbreaks of COVID-19-like illness in food-processing or agricultural settings

It is a priority to investigate any 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. ACDP will coordinate communication with other state agencies and inform regulatory partners, including ODA and OR-OSHA as
appropriate. Consult the Playbook for Joint Timely Response Protocol for COVID-19 Outbreak in Food Processing Establishments for details of interagency coordination.

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

- Requesting an outbreak number from ACDP 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.)
- Excluding cases of COVID-19 from work until they have recovered. As appropriate, the LPHA may contact employers to facilitate the exclusion of cases.
- Collecting respiratory specimens from all ill persons to be tested for COVID-19.
- Providing the facility with appropriate infection-control recommendations.

6.7 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 (§6.7.2 below).

When ODOC knows that a case or contact will be released soon, they will contact ACDP 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 Community Corrections.

1. Counting and reporting of cases in Corrections
   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.

2. Managing and investigating cases and contacts
   ACDP will create confirmed and presumptive cases based on ODOC information. If any close contacts are going to be released during their quarantine period, ACDP will create a Person Under Monitoring case in Orpheus. Consult ARIAS workflow documents for guidance on how to ensure that Persons Under Monitoring are properly exported from Orpheus on the appropriate date.

   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.

   Upon release, LPHAs should establish contact with cases and contacts and follow the relevant guidance in §4. Any close contacts the case encounters during their isolation period should be added to Orpheus as Contacts, and they will be actively monitored in Orpheus or ARIAS like any other contact.

6.8 Cases who fly or travel across state lines
If a confirmed or presumptive case is determined to have flown during their transmissible period (see §7), 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 Orpheus. Create a to-do in the Notes section for that case and assign it to Steven Rekant who will relay the information to CDC’s DGMQ.

Similarly, if a confirmed or presumptive case travels to another state, create a to-do in the Notes section for that case with the details of the case’s travel and assign it to Steven Rekant.

7. 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)
- Induction of sputum
- Medication administration via continuous nebulizer

Close contact:
- Being within 6 feet of a COVID-19 case during their period of transmissibility (see below) for a prolonged period of time. For purposes of LPHA investigation we are arbitrarily drawing the line at ≥15 minutes; persons exposed for shorter periods may be considered “close contacts” at LPHA discretion. “Close” contact can include caring for, living with, visiting, or sitting within 6 feet of a confirmed COVID-19 patient; or
- Having direct contact with infectious secretions of a COVID-19 case (e.g., being coughed on).

COVID-19-related death:
- For community: 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; or someone with a COVID-19-specific ICD-10 code listed as a primary or contributing cause of death on a death certificate
- For hospitalized: death from any cause in a hospitalized person during admission or in the 60 days following discharge AND a COVID-19 positive laboratory diagnostic test at any time since 14 days prior to hospitalization.
Discontinuation of isolation: Discontinuation of isolation can be assessed in two ways:

**Symptom-based discontinuation of isolation:** Someone who was symptomatic is considered no longer contagious when it has been 10 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 72 hours. If the person was never symptomatic, they are considered recovered 10 days after the first specimen that tested positive was collected.

**Test-based discontinuation of isolation:** Someone is considered no longer contagious when they have been afebrile without use of antipyretics, their other symptoms have improved, and they have had two negative tests, collected at least 24 hours apart. This is not recommended for use in the general public and should be reserved for hospital and long-term care facility settings to inform infection prevention practices.

**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, 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-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.

**Recovery:** If a presumptive or confirmed case is alive 60 days after the earliest of illness onset or first positive test, they will be marked as recovered. If someone has a COVID-19-related death, they will not be considered recovered. See §4.6 for details.

Note: “Recovery” and “discontinuation of isolation” are now disentangled.

**REFERENCES**


**UPDATE LOG**

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

**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 Revised: Interpreting test results

Note: This assumes the patient does not meet the presumptive case definition with symptoms and epi-link (§3.4).

<table>
<thead>
<tr>
<th>Test type</th>
<th>Result</th>
<th>Epi-link to a confirmed case</th>
<th>Clinical signs</th>
<th>Orpheus Subtype/Result</th>
<th>Orpheus Status</th>
<th>Investigate</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAAT</td>
<td>Positive</td>
<td>NA/Epi-link to a confirmed case</td>
<td>NA</td>
<td>COVID-19</td>
<td>Confirmed</td>
<td>YES</td>
</tr>
<tr>
<td>NAAT</td>
<td>Indeterminate or Inconclusive</td>
<td>NA/Epi-link to a confirmed case</td>
<td>NA</td>
<td>COVID-19/Indeterminate</td>
<td>Suspect</td>
<td>YES</td>
</tr>
<tr>
<td>NAAT</td>
<td>Negative</td>
<td>NA/Epi-link to a confirmed case</td>
<td>NA</td>
<td>COVID-19/Negative</td>
<td>Suspect</td>
<td>NO</td>
</tr>
<tr>
<td>Antigen</td>
<td>Positive</td>
<td>YES/At least two of: shortness of breath, cough, fever, new loss of taste or smell, radiographic evidence of viral pneumonia</td>
<td>NA</td>
<td>COVID-19/Positive antigen</td>
<td>Presumptive</td>
<td>YES</td>
</tr>
<tr>
<td>Antigen</td>
<td>Positive</td>
<td>NO/Less than two of: shortness of breath, cough, fever, new loss of taste or smell, radiographic evidence of viral pneumonia</td>
<td>NA</td>
<td>COVID-19/Positive antigen</td>
<td>Suspect</td>
<td>NO</td>
</tr>
<tr>
<td>Antigen</td>
<td>Negative</td>
<td>NA/Epi-link to a confirmed case</td>
<td>NA</td>
<td>COVID-19/Negative</td>
<td>Suspect</td>
<td>NO</td>
</tr>
<tr>
<td>Serology</td>
<td>Positive</td>
<td>NA/Epi-link to a confirmed case</td>
<td>NA</td>
<td>COVID-19/Positive serology</td>
<td>Suspect</td>
<td>NO</td>
</tr>
<tr>
<td>Serology</td>
<td>Equivocal</td>
<td>NA/Epi-link to a confirmed case</td>
<td>NA</td>
<td>COVID-19/Testing not done†</td>
<td>Suspect</td>
<td>NO</td>
</tr>
<tr>
<td>Serology</td>
<td>Negative</td>
<td>NA/Epi-link to a confirmed case</td>
<td>NA</td>
<td>COVID-19/Testing not done†</td>
<td>Suspect</td>
<td>NO</td>
</tr>
</tbody>
</table>

### Appendices 2 & 3: Contact and Case Letters

Letter templates are available on our COVID-19 Healthcare Partner page [http://healthoregon.org/coronavirushcp](http://healthoregon.org/coronavirushcp) in the section for Local Public Health Authorities and Tribes.

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* e.g., a polymerase chain reaction (PCR) test.
† This status refers to NAAT testing.
**Figure 1: Case Definitions**

**C** Confirmed case
- Positive NAAT test
- OR
- Diagnosis of MIS-C

**P** Presumptive case
- ANY TWO OF
  - Specific COVID-19 symptoms
  - Positive antigen test
  - Epi-linked to confirmed case

**S** Suspect case
- Someone who does not meet the confirmed or presumptive case definition who has any of the following:
  - ANY TWO OF
    - Any COVID-19 symptoms
    - Negative or indeterminate NAAT
  - AND
    - No test
    - No COVID-19 symptoms
  - AND
    - No epi-link to a confirmed case
  - AND
    - Test is pending

**July** 2020
Figure 2: Flowchart: Processing eCR test requests

- eCR is submitted
  - The patient meets testing criteria
  - The patient does not meet testing criteria
    - OHA creates a case (Suspect case, Pending test) and adds a note
    - OHA creates a case (No case), and adds a note
  - Testing approved and email notification sent to OSPHL
  - Testing not approved at OSPHL*

* If LPHA reviews the details and wants to pursue testing at another laboratory, they should contact the submitter.

Figure 3: Flowchart: DGMQ notifications

- Notification from CDC DGMQ
  - Flight from an affected geographic area
  - Sitting within 6 ft. of a confirmed case on a flight
  - Taking a cruise where a confirmed case was aboard
  - We are no longer receiving these notifications
  - OHA makes a Contact and sends a note to an LPHA epi
Figure 4: Flowchart: Symptom checks for close contacts of Confirmed and Presumptive cases

- **Symptomatic**: Daily call for a symptom check
  - **Yes**: At least two of: shortness of breath, cough, fever, new olfactory or taste disorder, radiographic evidence of viral pneumonia
    - **Yes**: This person becomes a presumptive case
      - Encourage testing and conduct a case interview
    - **No**: This person stays in the pool for daily calls until end of quarantine
  - **No**: Stays in the pool for daily calls until end of quarantine

- **Asymptomatic**: Until quarantine has completed
Figure 5: Flowchart: Negative test results for people not identified in contact tracing

- A specimen tests negative
  - LPHA or OHA processes the ELR to create a Suspect case, Negative test
  - No additional follow-up by LPHA is required
  - The submitting provider is notified by ELR

Figure 6: Flowchart: Positive test results

- A specimen tests positive
  - LPHA or OHA processes the ELR to create a Confirmed case
  - LPHA contacts the case for interview
  - LPHA identifies all close contacts of the case and creates contacts in the contact tracker
  - The submitting provider is contacted* and receives an ELR

* The method of contact (phone call, fax, electronic report) varies by laboratory.