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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 www.healthoregon.org/howtoreport.

1.3 Local Public Health Authority Responsibilities
1. Educate and consult with local providers and facilities to promote compliance with outbreak reporting, isolation, and infection-control procedures.
2. Investigate cases and outbreaks of COVID-19 associated with high-consequence settings (see §7.2.1).
3. 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.”
4. Consult with the Oregon Health Authority (OHA) as needed about patient isolation and protection of contacts, including healthcare personnel, and about strategies for public health response, testing, and access to therapeutics.
5. 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.
6. If auto-processing by OHA not already adopted, process electronic laboratory reports (ELRs) of positive and indeterminate COVID-19 test results.
7. If auto-processing by OHA not already adopted, process electronic case reports (eCRs) in Opera. Manually update test results, hospitalization status, and death status.

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 presumptive and confirmed cases received from Oregon Department of Corrections, the Centers for Disease Control and Prevention (CDC), and other jurisdictions.
3. Assist LPHAs in processing eCRs in Opera, including creating cases, adding hospitalization status, and recording deaths.
4. Support investigation and response to high-risk cases and high-consequence outbreaks.
5. Assist LPHAs in processing ELRs of COVID-19 test results.
6. Develop and maintain information systems for case and contact surveillance.
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;
   - 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.

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. SARS-CoV-2, 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. Genomic 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. 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 (temperature of ≥100.4°F or 38.0°C) or chills, sore throat, cough, shortness of breath or dyspnea, myalgia, 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 likely a minor route of transmission. Studies 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, 3–6 (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.

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.

2.7.1 Vaccines against COVID-19
COVID-19 vaccination recommendations continue to change. As of December 2022, the following vaccines have FDA Emergency Use Authorization or full approval for use in the United States:

- Moderna (mRNA-1273, Spikevax®) monovalent mRNA vaccine
- Moderna bivalent mRNA vaccine
- Pfizer-BioNTech (BNT162b2, Comirnaty®) monovalent mRNA vaccine
- Pfizer-BioNTech bivalent mRNA vaccine
- Novavax (NVX-Cov2373) adjuvanted protein subunit vaccine
• Janssen (Ad.26.COV2.S) viral vector vaccine – not a preferred vaccine¹

See the CDC’s Overview of COVID-19 Vaccines and CDC’s Use of COVID-19 Vaccines in the United States pages for the most up-to-date details regarding approved age ranges and recommended schedules for the above vaccines.

Individuals are considered up to date with their COVID-19 vaccinations when they have received all recommended primary series and booster doses. Individuals who were vaccinated outside the United States and have completed the primary series (1 or 2 doses) of a vaccine accepted in the United States - AstraZeneca, BIBP/Sinopharm, Sinovac, Bharat Biotech (COVAXIN), Novavax/Covovax, or CanSino – and are not yet eligible for a booster are considered up to date. Visit the CDC’s Stay up to Date with COVID-19 Vaccines webpage for more information.

Each of the COVID-19 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. In most situations, Pfizer-BioNTech, Moderna, or Novavax vaccines are recommended over the Janssen vaccine for primary and booster doses due to the risk of serious adverse events. Refer to the Oregon COVID-19 Vaccine Model Standing Orders for additional clinical information related to vaccine contraindications and considerations for administration of the Janssen vaccine.

2.7.2 Pre-exposure prophylaxis
Please refer to the National Institutes of Health COVID-19 Prevention of SARS-CoV-2 Infection Guidelines for the most current information regarding COVID-19 pre-exposure prophylaxis.

2.7.3 Treatment
Please refer to the National Institutes of Health COVID-19 Treatment Guidelines for the most current information regarding COVID-19 therapeutics.

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 minutes²—or contact with their infectious secretions or clinical specimens.

Note:
• 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:

¹ EUA for persons aged ≥18 years for whom other FDA-authorized or approved vaccines are not accessible or clinically appropriate, and individuals 18 years of age and older who elect to receive the Janssen COVID-19 vaccine because they would otherwise not receive a COVID-19 vaccine.

² This time is cumulative over a 24-hour period and does not have to be consecutive.
• 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\(^3\) 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:
  o An indeterminate reverse transcriptase polymerase chain reaction (RT-PCR), other nucleic acid amplification test (NAAT)\(^4\) or antigen result;
  o A close contact who is getting tested

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 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

\(^3\) 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.
\(^4\) e.g., a polymerase chain reaction (PCR) test.
confirmed case, but do not initiate contact tracing.

3.4 Presumptive Case

A presumptive case is a person without a positive laboratory-based COVID-19 RT-PCR, NAAT, or antigen test result,\(^5\) with:

- An acute illness featuring at least two of the following: shortness of breath, cough, fever,\(^6\) 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:
  - Had close contact with a confirmed case OR
  - Lived in the same household or congregate setting as a confirmed case OR
  - 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 Multisystem Inflammatory Syndrome in Children (MIS-C)

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\(^5\) 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.

\(^6\) Fever can be objective (≥100.4°F) or subjective.
• 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 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.

3.6 Multisystem Inflammatory Syndrome in Adults (MIS-A)
• An individual ≥21 years with fever, laboratory evidence of inflammation (at least two of the following must be elevated: CRP, ferritin, IL-6, ESR, procalcitonin), 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
  o 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
  o 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.

MIS-A reporting is through OCRP and no case investigation is required. Clinical chart review will occur at OHA. Please contact Melissa Sutton with questions or concerns.

OHSU’s Dr. Holly Villamagna is 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

7 Fever can be objective (≥100.4°F) or subjective and must persist 24 hours.
8 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.
4.1 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 COVID-19 Field Operations/Testing Team or the COVID-19 Regional 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.

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.
- 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 a completed Test Request Form as instructed for the specimen(s) being submitted.
- 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 personal protective equipment (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 CDC Guidelines for Collection and Handling Specimens for COVID-19 Testing.

Many common respiratory infections present with symptoms similar to those of COVID-19. If a
person tests positive for a common respiratory pathogen, testing for COVID-19 remains indicated, as co-infections may occur.

4.4 Guidance Regarding Serologic Tests
Serologic test results do not currently alter case classifications and serology should not be used for diagnosis of COVID-19 infection.

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.

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.*

Most people exposed to COVID-19 (i.e., close contacts) do not 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.
  - If symptoms develop, stay home and test.
  - 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 at least five days after their exposure if no symptoms have developed.
  - Follow guidance for isolation (§5.2) if they test positive or develop COVID-19 symptoms.

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 (§5.2.3). 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.

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9 If an individual lives with someone with COVID-19, last exposure (i.e., day 0) is the final day of the case’s isolation period.

10 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).
• 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.
• If a case has a recurrence or worsening of symptoms after their isolation has ended, isolation should restart isolation at day 0.
• 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.

5.2.2 Isolation recommendations for individuals with severe illness or who are immunocompromised

For cases with severe 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.

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.

Table 2. General population isolation recommendations
<table>
<thead>
<tr>
<th>Symptom Severity and Immune Status</th>
<th>Isolation Recommendations</th>
<th>Additional Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>No or mild symptoms AND Not immunocompromised</td>
<td>Isolate for at least 5 days after first positive test or symptom onset; should be fever free for at least 24 hours and other symptoms improving Wear a mask around others for 10 days after first positive test or symptom onset</td>
<td>Individuals unable to wear a mask should isolate for 10 days If initially asymptomatic and symptoms develop, restart isolation If symptoms recur or worsen, restart isolation High risk congregate setting residents should isolate for 10 days regardless of symptom severity</td>
</tr>
<tr>
<td>Moderate (shortness of breath, difficulty breathing) or severe symptoms (hospitalized) AND Not immunocompromised</td>
<td>Isolate for at least 10 days after positive test or symptom onset</td>
<td>Severely ill patients may have a longer infectious period requiring isolation of up to 20 days. Serial testing prior to ending isolation in consultation with infectious disease experts</td>
</tr>
<tr>
<td>Moderate or severely immunocompromised AND Any level of symptom severity</td>
<td>Isolate at least 20 days after positive test or symptom onset</td>
<td>Use serial testing to determine isolation end date; patient should have 2 consecutive negative tests at least 24 hours apart with resolution of fever and improvement of other symptoms. Retest for SARS-CoV-2 if symptoms return or worsen</td>
</tr>
</tbody>
</table>

5.2.3 Discontinuation of Isolation

Symptom-based discontinuation of isolation:

Someone who was symptomatic can consider the discontinuation of isolation when it has been at least five days from their symptom onset, and they have been afebrile without use of antipyretics for at least 24 hours and other symptoms are improving (i.e., cough, shortness of breath, or diarrhea). 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 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 severe symptoms or 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.

If a previously confirmed or presumptive case has new or worsening symptoms or a positive test within 90 days of their original illness, they do not meet the criteria for creating a new case in Opera. New or worsening symptoms or a positive test result within 90 days of original case onset should be used to inform isolation and clinical recommendations, as well as identifying close contacts to monitor for symptoms. Test results within 90 days of initial symptom onset or positive tests should be linked to the case record associated with the original case. If the original case (i.e., positive test or symptom onset) was linked to an outbreak, additional illness episodes or positive tests before day 90, do not require creating a new outbreak. A new outbreak should only be created if there are individuals with new, **case-defining** illness onset.

### 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) ([CDC guidance](#))
- Inpatient healthcare settings (e.g., hospitals, inpatient hospice) (§8.1) ([CDC guidance](#))
- Long-term care facilities (LTCFs) (§8.1) ([CDC guidance](#))
- Adult family/foster homes (AFHs) (§8.1) ([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) ([CDC guidance](#))
- Carceral facilities (e.g., prisons, jails, youth detention facilities) (§8.2) ([CDC guidance](#))
- Employer-provided congregate housing (also called labor housing per OR-OSHA) (§8.2)
- Shelters, supportive/congregate housing (also called temporary/transitional housing (§8.2) ([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 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).

OSPHL Testing of Suspect Cases
OSPHL testing is prioritized for high-priority individuals 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 disease 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 information gathered from facilities via a line list.

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 and health education.

7.0 OUTBREAK RESPONSE
7.1 Outbreak Response
As with other respiratory disease outbreaks, an outbreak of COVID-19 can be defined generally
as ≥2 confirmed or presumptive cases who are in the same institutional cohort. In the absence
of active case investigation and contact tracing, however, most of these outbreaks will remain
unknown by public health. LPHAs are not required to conduct active outbreak identification but
are expected to respond to those in high-consequence settings that are brought to their
attention, according to the below thresholds (§7.2.1).

Some institutions and facilities report COVID-19 cases to public health using established
thresholds:

- Certain congregate care providers\textsuperscript{11} must report all confirmed cases of COVID-19 to their licensor and public health.
- K-12 schools and Early Learning Division (ELD) childcare providers are asked to report respiratory illnesses associated with unusually high levels of absenteeism (on any given day) to public health using the following thresholds:
  - At the school/facility level (e.g., K-12 school or center-based childcare program): $\geq 30\%$ absenteeism, with at least 10 students/children or staff absent
  - At the cohort level (e.g., classroom or home-based childcare program): $\geq 20\%$ absenteeism, with at least 3 students/children or staff absent

If an LPHA is notified of a school or childcare with elevated absenteeism but no identified illness profile (e.g., respiratory illness, gastrointestinal illness), an outbreak does not need to be opened until further information is gathered. Schools and childcares do not need to report elevated absenteeism to LPHAs when there is a non-disease related reason (i.e., day before or after a holiday or long weekend, students are participating in an out of school activity, etc.).

7.2 Creating Opera Outbreak Records

LPHAs should create an Opera Outbreaks record \textbf{when they are notified} (passive identification) of the following:

7.2.1 High-consequence settings

- \textbf{1 or more confirmed/presumptive cases of COVID-19 among staff or residents in a congregate residential care setting:}
  - Long Term Care Facilities (LTCFs):
    - Nursing Facilities (NF)
    - Assisted Living Facilities (ALF), including memory care (MC) facilities
    - Residential Care Facilities (RCF), including MC facilities
  - Adult Foster Homes (AFH)
  - Child and Adult Behavioral Health Facilities (BH)
  - Intellectual and Development Disability and Child Welfare Residential Settings (i.e., group homes)
- \textbf{2 or more confirmed/presumptive cases of COVID-19 in other high-risk or high-consequence settings}, including:
  - Shelters
  - Jails/Prisons
  - Employer-provided congregate housing
  - Agriculture settings (e.g., farms and dairies)
  - Food packing and processing facilities
  - Other settings of concern as determined by the LPHA

7.2.2 K-12 schools and childcare

\textsuperscript{11} Under ORS 433.004 healthcare providers must report all cases of COVID-19 to public health, which includes healthcare providers who diagnose or provide care to residents of congregate care facilities. The Oregon Department of Human Services Aging and People with Disabilities requires LTCFs to report all cases of COVID-19 among staff and residents in their facilities to the licensing team within the Safety, Oversight and Quality Unit and public health.

\textsuperscript{12} LPHAs are not required to open an Opera Outbreak record at one case if the initial case was not in the facility during their infectious period (i.e., two day prior to illness onset or positive COVID-19 test) nor had contact with other staff via carpools, cohabitating, or social events during their infectious period. However, if a second case is identified within the same facility within 14 days, the outbreak record should then be created.
• 1 or more confirmed/presumptive cases\textsuperscript{13} of COVID-19 among staff or students in K-12 schools or childcare settings with absenteeism that meets or exceeds the reporting thresholds described above

7.3 Outbreak Response Activities and Database Management

The following information is intended to describe the actions and documentation that is prioritized for COVID-19 outbreak response and situational awareness in high-consequence settings, as defined above. When LPHA capacity is limited, COVID-19 Regional Epidemiologists are available to support this work. Please ensure you are communicating with the OHA lead epidemiologist assigned to each COVID-19 outbreak to ensure appropriate collaboration.

7.3.1 For all High-Consequence Settings

• Encourage prompt testing for other people within the setting who have been exposed to a case(s) of COVID-19.
• Work with facilities, OHA and other partners to ensure prompt treatment is made available to those who are eligible.
• Encourage vaccination to anyone not vaccinated and boosted, where appropriate.
• Conduct weekly check in with facility to ensure continued awareness of new cases or fatalities until 28 days after last case is detected.
• Ensure all known confirmed and presumptive cases reported by the facility to the LPHA are in Opera and linked to the outbreak record.
• Summarize guidance or other resources provided to the facility.
• Document testing capacity and testing plans; include dates, testing laboratory and other resources to be used (e.g., specimen collection teams, on-site testing equipment/platform, etc.).
• Update Opera with any fatalities or hospitalizations that occur among cases.
• Document any staffing challenges or requests for crisis staffing support.
• Document any resources offered/provided (e.g., PPE, vaccination, therapeutics, etc.).
• Document any Interagency Support Team (IAST) calls held.

7.3.2 Congregate Residential Care Settings

• Upload line list of confirmed and presumptive cases among staff and residents; may use online case log if facility is able to complete it.
• Collect vaccination uptake rates for residents and staff.
  o For LTCFs, 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.
• Provide the facility with the COVID-19 case log for LTCFs and appropriate infection control recommendations (note: masking continues to be required in healthcare settings, including long-term care settings, per OAR 333-019-1011. FAQs available here).
• Offer and document infection control consultation with OHA HAI regional infection preventionist. Infection control assistance can be requested via the OHA Infection Control Consultation Request Form.

\textsuperscript{13} If there are no confirmed or presumptive cases of COVID-19 among students or staff, LPHAs should open a respiratory disease outbreak in OPERA Outbreaks and pursue laboratory testing to identify the etiology.
7.3.3 Carceral Setting Outbreaks
- Document vaccination status of staff and adults in custody (AICs)/youth if available.
- Document if there are significant staffing challenges or other concerns (e.g., need for facility decompression).

7.3.4 Other High-Consequence Outbreak Settings
- Document any consultations or collaboration with other state agencies (e.g., ODA, OR-OSHA, etc.)
- Document any collaboration with community-based organizations or other partners working to support the people affected by the outbreak.

7.3.5 K-12 School/ELD childcare Outbreaks
- Follow-up with school weekly to ascertain if continued absenteeism has led to staffing shortages, transition to remote learning, or temporary school or cohort closures; document findings in the outbreak record.
- Given the potential for long-term transmission of multiple respiratory pathogens in school and childcare settings, consider closing outbreaks when the facility or cohort absenteeism has remained below the reporting threshold (see §7.1) for the recommended outbreak monitoring period (assume 28 days for COVID-19). To do this, set the last onset date to the last date of high absenteeism at the school or early learning facility.

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

8.0. MANAGING SPECIAL SITUATIONS

8.1 Healthcare Settings
This section applies to healthcare settings and healthcare workers and staff as defined in OAR 333-019-1010. These settings include:
- Long-term care facilities (LTCFs), including nursing, assisted living, and residential care facilities
- 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)

The following Oregon Administrative Rules remain in effect:
- OAR 333-019-1011 – Masking requirement to control COVID-19 in healthcare settings
- OAR 333-019-1010 – COVID-19 vaccination requirement for healthcare providers and healthcare staff in healthcare settings
- OAR 411-061 – COVID-19 vaccination reporting requirements for licensed assisted living, nursing, and residential care facilities
- OAR 411-060 (under revision) – COVID-19 testing in licensed assisted living, nursing and residential care facilities

For additional healthcare specific guidance, please see:
8.1.1. Quarantine for healthcare workers, patients, and residents in healthcare settings

In general, transmission-based precautions (quarantine) are not recommended for asymptomatic healthcare facility inpatients and residents following an exposure to someone with suspected or confirmed COVID-19, regardless of vaccination status. Additionally, asymptomatic healthcare personnel no longer require work restrictions (quarantine) following close contact with someone suspected or confirmed COVID-19, regardless of vaccination status.

Healthcare personnel who have a higher-risk exposure should take additional steps to reduce the risk of spreading COVID-19. Generally, a higher-risk exposure is considered prolonged close contact with a patient, visitor, other healthcare worker, or other members of the community outside of the workplace (e.g., household contacts) with confirmed SARS-CoV-2 and the healthcare personnel was not:

- Wearing a respirator (or if wearing a mask, the person with SARS-CoV-2 was not wearing a mask);
- Wearing eye protection if the person with SARS-CoV-2 was not wearing a mask; or
- Wearing all recommended PPE while in the room for an aerosol-generating procedure

Following any close contact with someone with SARS-CoV-2 for asymptomatic patients and residents or following a higher risk exposure for asymptomatic healthcare personnel, the individual should:

- Complete a series of 3 viral tests (i.e., antigen or NAAT) for SARS-CoV-2 if they have not recovered from COVID-19 in the prior 30 days, typically at day 1 (where day of exposure is day 0), day 3 and day 5. That is at least 24 hours after the initial exposure, and if negative 48 hours later and again another 48 hours later if the second test is also negative;
- Wear well-fitting source control;
- Monitor themselves for fever or other symptoms of COVID-19; and
- Stay home when ill or if they test positive for SARS-CoV-2.

Note: Smaller congregate care facilities (i.e., adult foster homes) may not have routine and consistent access to the testing and specimen collection resources needed to conduct serial testing as recommended above. Though it is recommended that facilities that house high-risk or medically fragile residents test according to the testing schedule above, AFHs could otherwise follow testing strategies as outlined in CDC’s Additional Information for Community Congregate Living Settings.

Quarantine for patients and residents or healthcare workers should be considered when the individual:
• Is unable to test or wear source control (i.e., respirators or well-fitting masks);
• Is moderately to severely immunocompromised;
• Resides on or provides care on a unit with patients who are moderately or severely immunocompromised; or
• Resides on or provides care on a unit experiencing ongoing SARS-CoV-2 transmission that is not controlled with initial interventions.

Healthcare workers who are put under work restrictions (i.e., quarantine) can return to work and transmission-based precautions can be lifted for patients:
• After day 7 following the exposure if they remain asymptomatic and all viral testing conducted is negative; or
• After 10 days if testing is not performed and they remain asymptomatic.

Testing recommendations for patients or residents with exposure or during outbreak scenarios can be found in CDC Interim Infection Prevention and Control Recommendations.

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 and are not positive for COVID-19.

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 Isolation for healthcare workers, patients, and residents in healthcare settings
Healthcare workers should be restricted from work following the criteria outlined below. After returning to work, the healthcare worker should continue to monitor for symptoms and seek re-evaluation if symptoms recur or worsen. Table 3, healthcare worker restrictions can be found on the next page.

<table>
<thead>
<tr>
<th>Illness Severity* and</th>
<th>Work Restriction</th>
<th>Additional Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immune Status</td>
<td>Recommendations</td>
<td>Timeframe</td>
</tr>
<tr>
<td>---------------</td>
<td>----------------</td>
<td>-----------</td>
</tr>
<tr>
<td>No symptoms or mild or moderate illness AND Not immunocompromised</td>
<td>At least 7 days after symptoms began or first positive test if asymptomatic with a negative viral test within 48 hours of returning to work AND At least 24 hours fever free AND Other symptoms improving</td>
<td>10 days if no viral testing completed or test positive on day 5-7 If using antigen test, obtain a negative test on day 5 and day 7</td>
</tr>
<tr>
<td>Severe illness AND Not immunocompromised</td>
<td>At least 10 days and up to 20 days since symptoms began AND At least 24 hours fever free AND Other symptoms improving</td>
<td>Can consider using a test-based strategy in consultation with infectious disease expert to determine when the staff can return to work</td>
</tr>
<tr>
<td>Moderate or severely immunocompromised† AND Any level of symptom severity</td>
<td>Test-based strategy in consultation with infectious disease expert to determine when the staff can return to work</td>
<td>2 consecutive negative tests at least 24 hours apart If symptomatic, should be fever free for at least 24 hours and other symptoms improving to end isolation Retest for SARS-CoV-2 if symptoms return or worsen</td>
</tr>
</tbody>
</table>

† See § 10

Patients and residents of healthcare settings should isolate for at least 10 days. If the individual is asymptomatic or has mild or moderate illness and is not immunocompromised, isolation can end after 10 full days have passed since the first positive test or symptom onset if they have been fever free for at least 24 hours and other symptoms are improving. For patients with severe to critical COVID-19 illness, isolation is at least 10 days but can be up to 20 days since symptom onset with the individual being fever free for at least 24 hours and other symptoms improving. As is outlined in table 3 for healthcare workers, testing can be used to help inform the duration of isolation. Patients with COVID-19 and who are moderately to severely immunocompromised should consult with an infectious disease specialist to implement the testing strategy outlined for healthcare workers in the table 3.

**8.1.3 Contact tracing in healthcare settings**

Healthcare facilities, including LTCFs and AFHs, 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](https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assessment-hcp.html).

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, ventilation, frequent symptom monitoring, and readily accessible testing). 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 may be performed that takes into account presence of symptoms, proximity and duration of encounters, and the use of personal protective equipment. The healthcare facility or system will take the lead on contact tracing and patient exposure notifications and will consult their local public health authority as needed. Healthcare facilities or 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.

8.1.4 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.

8.1.5 Responding to a case or outbreak in LTCFs (SNF, ALF, RCF, MC)
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 for guidance specific to outbreaks in other congregate settings and correctional facilities. Respiratory specimens should be collected from all ill persons in such outbreaks to be tested for COVID-19; and, during influenza season, for influenza. Testing for other pathogens may be considered.

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

Following the identification of a single new case of COVID-19 in a resident or healthcare worker, LTCFs should determine if others in the facility are ill or have been exposed. LTCFs have the option to conduct contact tracing if resources and experience allow. However, a broad-based approach (e.g., unit, floor, full facility) is preferred if resources and experience in conducting contact tracing are not available within the LTCF, all potential contacts cannot be identified, or if contact tracing fails to halt transmission. OHA is in the processing of developing guides to aid LTCFs in contact tracing.

Broad-based testing or testing of all close contacts (if contact tracing implemented) is recommended regardless of vaccination status, as identified by the LTCF. Viral testing is recommended at days 1, 3, and 5, with the exposure occurring on day 0, Quarantine is recommended as outlined in §8.1.1, however all individuals being tested for a potential exposure should wear source control. If no additional cases are identified during contact tracing or broad-based testing, no further testing is indicated.

In the event of ongoing transmission that is not controlled with initial interventions, a facility should strongly consider implementing quarantine for residents and healthcare workers with higher-risk exposures. If additional cases are identified, facilities should strongly consider moving to broad-based testing and implementing quarantine for residents in affected areas of the facility.

**8.1.6 Testing guidance in LTCFs**

Oregon Department of Human Services (ODHS) is in the process of amending Oregon Administrative Rules, Chapter 411, Division 60 regarding COVID-19 testing in licensed assisted living facilities, nursing facilities, and residential care facilities, in light of recent CDC Guidance updates.

If additional cases are identified during the initial round of testing, a facility should strongly consider shifting to the broad-based testing approach, if not already in use, and implement quarantine for residents in affected areas of the facility. As part of the broad-based approach, testing should continue on affected unit(s) or facility-wide every 3-7 days until there are no new cases for 14 days. If antigen tests are being used, consider more frequent testing (every 3 days).

As needed, coordinate with facility and the COVID-19 Regional Epidemiologist to schedule outbreak-associated testing of staff and residents at the OSPHL. If assistance with specimen collection is needed, COVID-19 Regional Epidemiologists can coordinate new specimen collection in collaboration with COVID-19 Testing Team staff. Coordination of this task is not expected to occur outside of regular business hours.
8.2 Non-Healthcare Congregate and Carceral Settings (e.g., shelters, supported/supportive living, temporary/transitional housing, employer-provided congregate housing, prisons, jails, youth detention facilities)

The guidance below does not apply to dedicated patient care areas within these settings. Healthcare workers or individuals who are routinely in the patient care areas should refer to the healthcare recommendations in §8.1.

Below are general recommendations for these settings, however each facility should assess the risk for spread and severe illness among their staff and residents to determine the best prevention actions to implement within their specific setting. Considerations include COVID-19 community levels, risk of severe health outcomes, facility characteristics, and COVID-19 transmission within the facility. For additional information on assessing a facility’s risk and implementing enhanced prevention strategies, refer to the CDC’s Guidance on the Management of COVID-19 in Homeless Service Sites and in Correctional and Detention Facilities page and CDC’s Additional Information for Community Congregate Living Settings.

8.2.1 Quarantine recommendations for non-healthcare congregate and carceral settings

Quarantine of individuals in these settings who are exposed to a person with COVID-19 is no longer recommended. However, facilities may opt to continue to implement quarantine protocols for residents, staff, or volunteers. This decision can be based on a variety of factors, including risk assessment and tolerance, the health of staff and residents, or the impact of quarantine on mental health and staffing. Refer to the CDC links above for considerations for facilities implementing quarantine. If a facility chooses to implement quarantine, a 10-day quarantine period continues to provide the greatest protection, however they could consider a 5-day quarantine with a negative test and masking through day 10 to balance safety and facility operations. The quarantining of individuals in non-healthcare congregate and carceral settings should not interfere with their ability to receive essential services, including mental health counseling.

Individuals with an exposure to someone with known or suspected COVID-19 should be tested following the exposure. If an individual remains asymptomatic, they should be tested at least 5 days after the exposure. If an individual develops COVID-19 compatible symptoms, they should be tested immediately. Following an exposure to someone with COVID-19, individuals should monitor for symptoms and wear a mask while indoors for 10 days following the exposure.

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.

To identify potentially exposed individuals, facilities can implement person-based contact tracing (i.e., individuals identified through case investigation) or location-based contact tracing (i.e., identify individuals with known or potential exposure based on whether they were in the same area as an individual with COVID-19 during their infectious period).

8.2.2 Isolation recommendations for non-healthcare congregate and 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 these settings. If the individual has a negative viral test, isolation can be shortened to 7 days as long as symptoms are improving and they have been fever free for at least 24 hours. The viral test should be one negative NAAT test 48 hours prior to returning to work or two negative antigen tests 48 hours apart and starting no sooner than day 5 of isolation. Refer to § 5.2 for isolation recommendations for individuals with severe illness or who are immunocompromised. During periods of critical staffing shortages, facilities may consider shortening the isolation period for staff or residents 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 and carceral settings

Similar to healthcare settings, these settings benefit from early risk assessment and intervention when COVID-19 cases are identified in residents, staff or volunteers including providing guidance for testing, implementing infection control practices (e.g., cohorting, ventilation, PPE use), and access to vaccines and medical care. Enhanced COVID-19 prevention strategies include moving activities outdoors, requiring universal masking indoors, and increased physical distancing. Refer to the CDC’s guidance for congregate residential settings and shelters and carceral settings for additional considerations.

Although not required, non-healthcare congregate and carceral settings should test residents and staff who have been exposed or who have symptoms compatible with COVID-19. If additional cases are identified, consult with OHA to determine if more widespread testing or screening testing would be appropriate. LPHAs are encouraged to offer infection control consultations in collaboration with the OHA COVID-19 Congregate Care Epidemiologist. If the LPHA experiences challenges with facilities, they should work with their COVID-19 Regional Epidemiologist to elevate concerns and connect with the appropriate licensing and regulatory body.

8.2.4 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 and notify OHA of identified cases. OHA staff serve as the leads on outbreaks associated with ODOC facilities and data management associated with the outbreaks. 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**

OHA 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.

8.3 Pregnant and Recently 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.\(^\text{14}\) 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. For additional information on risk and steps these individuals can take to protect themselves from getting sick with COVID-19, see the CDC page on Pregnant and Recently Pregnant People.

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 Cases Identified in Another Jurisdiction
As cases are identified through investigations in other jurisdictions—for example, if an Oregon resident has tested positive in a neighboring state—OHA will create a case record for those individuals based on the information provided by the reporting jurisdiction.

9.3 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.

9.4 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 section 7.3 for a description of the information LPHAs should prioritize for documentation.

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.

When an LPHA is made aware of a respiratory disease outbreak with an unknown etiology, open the outbreak in Opera Outbreaks and select the ‘unknown’ etiology box on the Basics tab. If testing identifies COVID-19 or other respiratory pathogens among the ill individuals, change the outbreak etiology from ‘unknown’ to the etiolog(ies) present by checking the appropriate boxes on the Basics tab.

When an LPHA is made aware of a respiratory disease outbreak with COVID-19 present and another etiology present, open the outbreak in Opera Outbreaks and select the lab-confirmed etiologies present on the Basics tab to investigate as a mixed-pathogen outbreak. For additional guidance on how to investigate non-COVID-19 respiratory outbreaks, refer to the Respiratory Disease Outbreak Investigative Guidelines.

9.5 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.

Moderate or 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:
• Been receiving active cancer treatment for tumors or cancers of the blood
• Received an organ transplant and are taking medicine to suppress the immune system
• Received chimeric antigen receptor (CAR)-T-cell therapy (a treatment to help your immune system attach to and kill cancer cells) or received a stem cell transplant (within the last 2 years)
• Moderate or severe primary immunodeficiency (such as DiGeorge syndrome, Wiskott-Aldrich syndrome)
• Advanced or untreated HIV infection
• Active treatment with high-dose corticosteroids or other drugs that may suppress the immune response

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:** Maintaining distance 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.

**REFERENCES**


**UPDATE LOG**

December 15, 2022. Streamlined section 2.7 to reference federal guidance; removed recommendation to prioritize collection of a line list for outbreaks in K-12 and early learning settings; combined sections 8.2 and 8.3 to updated guidance for non-healthcare congregate and carceral settings in alignment with CDC; removed section 9.2 REDCap Platform and references throughout including presumptive case definition criteria following the retirement of the survey on December 9, 2022; added additional information on data management in Opera Outbreaks; removed links to retired guidance documents; updates throughout (Lee Peters, Meagan McLafferty, Becca Pierce, Melissa Sutton, Paul Cieslak).

October 20, 2022. Updated section 8.1 healthcare settings to align with CDC guidance released September 23rd including adding section 8.1.2 isolation for healthcare workers, patients, and residents in healthcare settings; updated vaccine information and moved to table format; removed vaccine up to date table and sections 3.5 breakthrough case definition, 8.4 managing special situations in K-12 and ELD childcare settings, 8.5 cases with recent or planned travel, and 9.4 managing close contacts; numerous updates throughout (Lee Peters, Melissa Sutton, Amanda Faulkner, Becca Pierce, Paul Cieslak).

May 27, 2022. Revised outbreak response section; updated treatment and vaccines section; removed historic K-12, ELD, and agriculture outbreak subsections; added new CDC guidance for outbreaks in carceral settings (Amanda Faulkner, Lee Peters, Paul Cieslak).

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. (Amanda Faulkner, Lee Peters, Becca Pierce, Melissa Sutton, Paul Cieslak).


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)