1. DISEASE REPORTING

1.1 Purpose of Reporting and Surveillance

1. To identify persons with novel coronavirus infection, prevent transmission to others, improve health outcomes where possible, and better understand the epidemiology of this emerging disease.
2. To identify those with risk of exposure to novel coronavirus 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 COVID-19 cases to the local public health authority (LPHA) within 24 hours. They should immediately notify infection control personnel at their healthcare facility. 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 all hospitalizations and deaths among persons with COVID-19 within 1 working day—whether or not the case was previously reported. 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

Persons under monitoring (PUMs)

1. Follow guidance on monitoring and movement control as described in §4 below, including sending a Contact Letter to each PUM.
2. Educate and consult with local providers and facilities to promote compliance with quarantine, isolation, and infection-control procedures.
3. If a PUM develops symptoms compatible with a suspect case, follow the steps below.

Suspect and Confirmed COVID-19 cases

1. Begin investigation of confirmed COVID-19 cases, as defined in §3 below, immediately.
2. Report all suspect and confirmed cases immediately by entering them into Orpheus with disease “Coronavirus” and subtype “COVID-19.”
3. 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.
4. Educate and consult with local providers and facilities to promote compliance with isolation and infection-control procedures.
5. Educate confirmed 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.
6. Enter details of the investigation and contact follow-up into Orpheus.
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 and confirmed cases and PUMs received from CDC or other states.
3. Process electronic case reports (eCRs) in Orpheus, including creating a case in Orpheus and approving testing for patients who meet testing criteria, adding hospitalization status, and recording deaths.
4. Assist LPHAs in processing Electronic Laboratory Reports of COVID-19 test results.
5. 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.
6. Develop and maintain information systems for case and contact surveillance and to ensure adequacy of response activities.
7. Create PUM cases from CDC DGMQ notifications as appropriate.
8. Advise LPHA, Tribal, and private-sector health professionals concerning:
   • Quarantine of asymptomatic exposed persons (PUMs);
   • Isolation of symptomatic exposed persons (suspect cases) and confirmed cases;
   • Protection of healthcare personnel;
   • Diagnostic evaluation;
   • Required reporting and surveillance activities;
   • Contact identification and follow-up.
9. Coordinate interjurisdictional monitoring plans for PUMs who move out of county or state, as described in §4.1.
11. As resources allow, provide surge capacity for contact and case investigation if the scope of response overwhelms LPHA resources.
12. Arrange consultation with infectious disease specialists and CDC as needed.
13. 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. Early cases were associated with a large seafood and live animal market. The market was closed January 1, 2020, and person-to-person spread has since been confirmed. 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 COVID-19 virus has been named “SARS-CoV-2.”

2.2 Description of Illness
Symptoms may include fever (defined throughout as a temperature of ≥100°F or 37.8°C), sore throat, dry cough, dyspnea, myalgias, and fatigue. Fever may not be present in the very young,
very old, immunosuppressed, or people taking antipyretics. Gastrointestinal symptoms have been reported by some patients prior to developing fever and lower respiratory signs and symptoms—i.e., pneumonia, generally with patchy, multilobar infiltrates on chest X-ray. Published case series indicate that cases tend to have lymphopenia. Reported complications have included acute respiratory distress syndrome, cardiac events, and death.

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 probably 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 a few hours or up to several days. Experimental studies have also indicated that when intentionally aerosolized the virus may be detectable in aerosols for a prolonged period, but transmission through the airborne route by coughing patients has not been conclusively demonstrated. 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, eye protection (e.g., face shield or goggles). During aerosol-generating procedures (see §7) on such patients, airborne precautions should be observed.

2.5 Incubation Period
Published data from 425 patients found a mean incubation period of 5 days with a 95th percentile of the distribution of 12 days. From this study and what we know of other coronaviruses, the typical incubation period is 4–6 (range, 2–14) days.

2.6 Period of Communicability
Our understanding is still developing. There are reports of transmission from asymptomatic patients, and virus is detectable in many patients for a few weeks following resolution of symptoms. That said, transmission appears most likely when patients are coughing.
3. CASE DEFINITIONS, DIAGNOSIS, AND LABORATORY SERVICES

3.1 Person Under Monitoring (PUM)
A PUM is an asymptomatic person with an epidemiologic exposure to the COVID-19 virus. The exposure may be close contact (see §7 for details) with a confirmed case or with their infectious secretions or clinical specimens; or designation as a PUM by CDC. See §4.2 for guidance on classifying and monitoring PUMs.

3.2 Suspect Coronavirus Case
A suspect case is a person
- with fever, cough, shortness of breath, or respiratory-tract illness (pneumonia) AND
  - a history of close contact (§7) with a laboratory-confirmed COVID-19 patient within 14 days of symptom onset
  OR
  - a history of exposure to a high-risk setting (e.g., cruise ship, long-term care facility, or other institutional setting) within 14 days of symptom onset
  OR
  - hospitalized with apparent viral pneumonia (Note: A negative influenza test is no longer required.)

Suspect cases may be tested for the COVID-19 virus at commercial laboratories or at OSPHL (see §4.3 for OSPHL testing criteria). If test results are positive at OSPHL or another lab (as defined in §3.3), the suspect case will become a confirmed case. If test results are negative the individual should remain a suspect case with result “Negative test.”

These criteria provide a strategy for evaluation but aren’t set in stone. Individuals may be identified as suspect COVID-19 cases and tested at clinical laboratories at the discretion of healthcare providers. Contacts identified by LPHAs can be evaluated and discussed with ACDP on a case-by-case basis if their clinical presentation or exposure history is equivocal (e.g., uncertain exposure history).

3.3 Confirmed Case
A case with COVID-19 laboratory-confirmed by PCR at any laboratory that has successfully verified the CDC testing panel or a Laboratory Developed Test under the FDA Emergency Use Authorization.

For public health purposes, treat a person with an Indeterminate test result as if their specimen tested positive. See Appendix 3 for details on how to interpret test results.
Note: Indeterminate test results will not be included in case counts.

3.4 Laboratory Testing
Testing Guidance for Local Health Departments.
Testing through the Oregon State Public Health Laboratory (OSPHL) must be approved by ACDP. Please call ACDP at 971-673-1111 for approval.
Testing Guidance for Clinicians and Health Systems.

OSPHL has limited capacity for testing, so we have established criteria for testing there. Current guidance and the electronic report form to gain approval for testing at OSPHL can be found at www.oregon.gov/oha/PH/DISEASESCONDITIONS/DISEASESAZ/Pages/COVID-19.aspx.

Guidance is changing often and may have changed since publication of this guideline. Current guidance for specimen collection, handling, and transport is posted on OSPHL’s Lab Test Menu (www.healthoregon.org/labtests) and in the CDC guidance on specimen collection, storage, and handling: www.cdc.gov/coronavirus/2019-ncov/lab/guidelines-clinical-specimens.html.

Specimens from the lower respiratory tract (e.g., bronchial lavage, endotracheal aspirate, sputum) are preferred. Upper respiratory tract specimens (nasopharyngeal or oropharyngeal swab, nasal wash) are also acceptable for testing. 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.

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 suspect case is identified, regardless of symptom onset date.

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.

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

- All specimens should be stored at 2–8°C and shipped on an ice pack for receipt at OSPHL as soon as possible. If specimens will not arrive at OSPHL within 72 hours of collection, freeze at -70°C or lower and transport on dry ice.
- 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 per specimen. In the Other/Molecular section, check the “Other” box and write or type in “2019-nCoV” or “COVID-19.”
- Transport specimens and required forms to OSPHL as soon as possible.
Whenever possible, existing courier systems (e.g., hospital system couriers) should be used for specimen transport. If other courier systems are not available, contact OSPHL (503-693-4100) for help with specimen transport on the next available courier route.

Note: 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.

4. CASE INVESTIGATION

4.1 Data Access in Orpheus

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

4.2 LPHA Follow Up with PUMs

1. Travel Notifications from CDC’s Division of Global Migration and Quarantine (DGMQ)

   **Airline Travel:** LPHAs are required to follow up only 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. LPHAs are no longer required to monitor residents who return from affected geographic regions via airline flights with no known COVID-19 cases on board; OHA will no longer make PUMs from these DGMQ notifications.

   **Cruise Ship Travel:** LPHAs are required to follow up with individuals who are reported by DGMQ as travelers on a cruise ship with known COVID-19 exposures. Passengers should be sent a Contact Letter (Appendix 1) and instructed to practice social distancing (§7) while monitoring themselves for symptoms (cough, difficulty breathing, or fever). If symptoms develop, they should contact their medical provider and LPHA to determine next steps for evaluation.

2. PUMs Identified during Contact Investigations

   LPHA resources should be focused on identifying household contacts of COVID-19 cases and contacts who are High-Priority Individuals (see §7).

   Once you identify a PUM, enter the person into Orpheus using the Contact tab. You do not need to create a separate Person Under Monitoring case for each person. Provide a Contact Letter (Appendix 1) to the person.

3. A contact investigation is not required for PUMs.

   Because PUMs are, by definition, asymptomatic, and we are interested only in close contacts (§7) of symptomatic cases, a contact investigation of each PUM is not required.
4.3 LPHA Follow Up with Suspect Cases

Suspect cases are persons as defined in §3.1 with compatible symptoms and without a positive test for COVID-19; the test result may be pending or indeterminate.

1. Interviewing

LPHAs should briefly interview suspect cases who were identified by public health to ascertain whether they are High-Priority Individuals (see #2, below, and §7 for details). LPHAs should also provide the Case Letter (Appendix 2) to these suspect cases. This does not include suspect cases identified through submission of a test request or results.

For all suspect cases, 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. If this person was a PUM who developed symptoms, create a Coronavirus case for the person in Orpheus. Consult with ACDP as to whether testing at OSPHL is approved. All suspect cases should remain isolated while hospitalized or until 72 hours after fever is gone and symptoms resolve, whichever is longer (see §5.1 for details).

2. High-Priority Individuals

These persons, as defined in §7, are high priority for investigation and, if symptomatic, for testing.

3. Testing

OSPHL testing is prioritized for

- Symptomatic persons in a congregate-care setting with a vulnerable population, or part of a cluster in a facility or group. We will test specimens from 1–5 persons in a congregate setting, and we might test more in persons requiring hospitalization (to aid in choosing appropriate precautions in hospital settings).
- Persons who have been hospitalized with what appears to be viral pneumonia. While influenza is circulating, patients should also be tested for it, because oseltamivir might be used for treatment or prophylaxis.
- Persons who died following unexplained respiratory illness; or whose death was unattended and not otherwise explained.

We do not recommend testing of asymptomatic persons or those with symptoms that do not necessitate medical evaluation. Individuals with mild symptoms should remain at home until symptoms resolve. 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 from non-hospitalized patients being sent to OSPHL. 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 Cases

1. Interviewing

April 2020
LPHAs should attempt to interview all confirmed cases to ascertain clinical and epidemiologic details, to try to ascertain source of the infection, and to identify any High-Priority contacts (§7). LPHAs should also provide the Case Letter (Appendix 2) to confirmed cases.

If the confirmed 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.” If this person was already entered as a suspect case, first delete the “Pending Test,” then update the status to “Confirmed.” All symptomatic persons, including confirmed cases, should remain isolated while hospitalized or until 72 hours after fever is gone and symptoms resolve, whichever is longer (see §5.1 for details).

2. Contact Investigations
Obtain the name, address, and telephone number of all household contacts and of High-Priority Contacts (§7) who have had close contact (§7) to the confirmed COVID-19 case from 48 hours prior to a case’s symptom onset to the time the case was placed in isolation.*

These people should be entered into Orpheus as Contacts and should be further evaluated as suspect cases if at any time they develop symptoms compatible with COVID-19.

3. Monitoring of Persons Identified in Contact Investigations
Guidance on monitoring and restrictions differs for healthcare workers and non-healthcare workers.

A. Healthcare Workers Identified as Contacts
   **Asymptomatic:** In consultation with Occupational Health at the facility, individuals must monitor themselves closely for any signs of fever or respiratory illness and must withdraw from patient care immediately upon development of any symptoms. Facilities may decide to exclude exposed, asymptomatic healthcare workers who work with high-risk populations (e.g. geriatric patients, stem-cell transplant patients, etc.).

   **Symptomatic:** The individual must stay home from work until 72 hours after both fever and cough have resolved. Testing of the healthcare worker is the responsibility of the employer: it may be undertaken at employer discretion and expense.

B. Non-Healthcare Workers Identified as Contacts
   **Asymptomatic:** Individuals should practice social distancing, taking special care if they are in regular contact with any High-Priority Individuals (§7). They should monitor themselves closely for fever, cough, or shortness of breath. They must withdraw from work, school, and social activities immediately upon development of any symptoms.

   **Symptomatic:** The individual must isolate at home until 72 hours after both fever and cough resolve.

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* CDC extended the period of exposure to include 48 hours prior to a case’s symptom onset on 3/31/2020.

April 2020
4.5 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

5.1 Isolation of Cases

1. Hospitalized Cases
Transmission of SARS-CoV-2 (the COVID-19 virus) is presumed to occur primarily via respiratory droplets. Patients with suspected COVID-19 should be placed under standard and contact precautions, and healthcare workers 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 2019 Novel Coronavirus (2019-nCoV). When possible, COVID-19 cases should take care to not handle pets or other animals while sick. Refer to the Interim Guidance for Preventing the Spread of Coronavirus 2019 (COVID-19) in Homes and Residential Communities for comprehensive guidance.

Discontinuation of isolation
Suspect and confirmed COVID-19 cases should remain under home isolation until 72 hours after fever is gone, without use of antipyretics, and symptoms resolve.

5.2 Protection of Contacts
Contacts of cases should be identified and entered in Orpheus as Contacts, as described in §4.2. Cases and contacts should be educated regarding basic preventive measures: social distancing (§7), cough etiquette, hand washing, sanitizing of frequently touched surfaces, and how to self-isolate if they develop symptoms.

6. MANAGING SPECIAL SITUATIONS

6.1 Healthcare Facility Infection Control
Key considerations for infection control can be found in the Provisional Guidance: 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.

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 ILI outbreaks in Congregate Residential Settings
Along with influenza and other viral infections, COVID-19 is in the differential diagnosis of outbreaks of influenza-like illness (ILI) in LTCFs, prisons, jails, and other congregate settings. Respiratory specimens should be collected from 5 ill persons in such outbreaks to be tested for influenza, COVID-19, and perhaps other viral 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 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 healthoregon.org/coronavirus).

If the suspect case tests positive, LPHA should strongly consider requesting an outbreak number from ACDP to facilitate tracking and linking to other suspect cases as they arise. Often, identification of a single case has led to the recognition of other cases and prompt institution of control measures. Outbreak numbers can easily be removed from ACDP’s “Outbreaks” database after 14 days if no other cases are identified.

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), also called high-flow nasal cannula
• Induction of sputum
• Medication administration via continuous nebulizer

Close contact:
• Being within 6 feet of a COVID-19 case for a prolonged period of time. CDC has not defined "prolonged," but for purposes of LPHA investigation we are arbitrarily drawing the line at ≥60 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 in a healthcare waiting area, or on an airplane; or
• Having direct contact with infectious secretions of a COVID-19 case (e.g., being coughed on).

Note: “healthcare personnel exposure” is defined as the provision of patient care to or prolonged, close contact with a COVID-19 case without appropriate personal protective equipment. Be sure to follow up on any EMS contact with the case when notified by OHA.

High-Priority Individuals
Persons who warrant closer investigation. They include, but are not limited to:
• residents, inmates, or staff in long-term-care facilities, correctional facilities, and other high-risk congregate settings
• workers in critical infrastructure
• persons hospitalized with otherwise unexplained, apparently viral, pneumonia; and unattended deaths
• persons at risk for severe complications of COVID-19:
  o Persons ≥60 years of age
  o Persons with underlying medical conditions (e.g. those who have cardiac or respiratory conditions, are diabetic, have blood disorders, or are immunocompromised).
• pregnant women

Social distancing: Remaining out of congregate settings, avoiding mass gatherings, and maintaining distance (approximately 6 feet) from others to the greatest extent possible. When remaining 6 feet from others is not practical (e.g. buying something at the grocery store), individuals should try to maintain a minimum distance of 3 feet. Social 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**

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. (Steven 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)
Appendices 1 & 2: Contact and Case Letters

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

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Appendix 3: Table: Interpreting test results

<table>
<thead>
<tr>
<th>Test result</th>
<th>Orpheus Subtype/Result</th>
<th>Orpheus Status</th>
<th>Public health follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive</td>
<td>COVID-19</td>
<td>Confirmed</td>
<td>Investigate to identify close contacts who are high-risk individuals</td>
</tr>
<tr>
<td>Indeterminate</td>
<td>COVID-19/Indeterminate test</td>
<td>Suspect</td>
<td>Investigate the case as if it were a positive.</td>
</tr>
<tr>
<td>Negative</td>
<td>COVID-19/Negative test</td>
<td>Suspect</td>
<td>No investigation needed</td>
</tr>
<tr>
<td>Pending test</td>
<td>COVID-19/Pending test</td>
<td>Suspect</td>
<td>No investigation needed</td>
</tr>
<tr>
<td>No test</td>
<td>COVID-19/Testing not done</td>
<td>No case</td>
<td>No investigation needed</td>
</tr>
</tbody>
</table>
Appendix 4: Flowchart: DGMQ notifications

1. 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
         - OHA makes a PUM and sends an unassigned note to the LPHA unless the LPHA has identified specific persons to assign notes to
   - We are no longer receiving these notifications
Appendix 5: Flowchart: Processing eCR test requests

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

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

LPHA identifies high-risk contacts of the case and distributes the Contact Letter

* The method of contact (phone call, fax, electronic report) varies by laboratory.
Appendix 7: Flowchart: Negative test results

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