

Novel Coronavirus Disease 2019 (COVID-19)

Interim Investigative Guidelines

Effective **May 22, 2023**

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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

Effective May 11, 2023, healthcare providers and laboratories, including entities who have a CLIA waiver, are no longer required to report test results indicative of and specific for COVID-19 to the local public health authority (LPHA).

Healthcare providers are - required to report, within 1 working day,

- All pediatric deaths, among persons with COVID-19.
- All cases of Multisystem Inflammatory Syndrome in Children (MIS-C; §3.7).

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 outbreaks of COVID-19 associated with high-consequence settings (see §7.2).
3. 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.
4. 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.

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. Support investigation and response to high-consequence outbreaks.
3. Advise LPHA, Tribal, and private-sector health professionals concerning:
 - Isolation of cases and symptomatic persons in high-consequence residential settings;
 - Protection of healthcare personnel;
 - Diagnostic evaluation;
 - Required reporting and surveillance activities.
4. Coordinate multi-jurisdictional outbreak responses.
5. Arrange consultation with infectious disease specialists and CDC as needed.
6. Report COVID-19 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 SARS-CoV-2 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 $\geq 100.4^{\circ}\text{F}$ or 38.0°C), chills, sore throat, cough, shortness of breath (dyspnea), myalgia, fatigue, loss of smell (anosmia) or taste (ageusia), headache, nasal congestion, runny nose (rhinorrhea), 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 SARS-CoV-2 infection.

COVID-19 associated multisystem inflammatory syndrome in adults (MIS-A) is defined by fever, multisystem involvement which must include severe cardiac illness or the combination of rash and conjunctivitis, laboratory evidence of inflammation and recent SARS-CoV-2 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. Since the start of the COVID-19 pandemic, SARS-CoV-2 infection has been confirmed in many animal species; whether any (other than *homo sapiens*) will become important reservoirs is unknown.

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. Although coronaviruses may persist on surfaces for up to several days, surfaces and fomites are probably not significant routes of transmission. 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

Most SARS-CoV-2 transmission occurs early in the course of illness, generally in the 1–2 days before symptom onset and during the 2–3 days thereafter. 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)—may 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 the [U.S. Food and Drug Administration's list of COVID-19 Drugs](#) or the [Administration for Strategic Preparedness & Response's Possible Treatments for COVID-19](#).

2.7.1 Vaccines against COVID-19

COVID-19 vaccination recommendations continue to change. The following vaccines have FDA Emergency Use Authorization or full approval for use in the United States:

- Moderna mRNA vaccine
- Pfizer-BioNTech mRNA vaccine
- Novavax adjuvanted protein subunit vaccine

See [CDC's Overview of COVID-19 Vaccines](#) and [CDC's Use of COVID-19 Vaccines in the United States](#) for up to date details regarding approved age ranges and recommended vaccination schedules.

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](#) and are not yet eligible for a booster are considered up to date. Visit 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 with the latter. Refer to the [Oregon COVID-19 Vaccine Immunization Protocol](#) for additional clinical information related to vaccine contraindications and considerations for administration of the Janssen vaccine.

2.7.2 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

Note: Oregon will no longer be requiring case surveillance for COVID-19. These case definitions remain for historical purposes and to provide a guideline for cases that may benefit classification.

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 minutes¹—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:

- 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, nasal congestion, rhinorrhea, nausea, vomiting, or diarrhea;
AND
- No more likely alternative diagnosis

Note: This includes people who had close contact with a presumptive² 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:
 - An indeterminate reverse transcriptase polymerase chain reaction (RT-PCR), other nucleic acid amplification test (NAAT)³ or antigen result;
 - 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. In outbreaks, LPHAs may 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 negative follow-up test does not negate the initial positive test.

¹ This time is cumulative over a 24-hour period and does not have to be consecutive.

² 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.

³ e.g., a polymerase chain reaction (PCR) test.

If a person is diagnosed with MIS-C (see §3.6), create a confirmed Coronavirus case in addition to their MIS-C case. Contact tracing **is not indicated for MIS-C**.

3.4 Presumptive Case

A presumptive case is a person without a positive **laboratory-based** COVID-19 RT-PCR, NAAT, or antigen test result,⁴ with:

- An acute illness featuring at least two of the following: shortness of breath, cough, fever,⁵ 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

3.5 Multisystem Inflammatory Syndrome in Children (MIS-C)

- An individual aged <21 years presenting with fever,⁶ laboratory evidence of systemic inflammation,⁷ and evidence of clinically severe illness requiring hospitalization, with new onset manifestations in at least 2 of the following categories: cardiac involvement, mucocutaneous involvement, shock, gastrointestinal involvement, or hematologic involvement;
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 60 days prior to the onset of symptoms

Consider MIS-C in any pediatric death with evidence of SARS-CoV-2 infection.

⁴ 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.

⁵ Fever can be objective ($\geq 100.4^{\circ}\text{F}$) or subjective.

⁶ Fever may be objective ($\geq 100.4^{\circ}\text{F}$) or subjective.

⁷ Indicated by C-reactive protein of ≥ 3.0 mg/dL (30mg/L).

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
 - Primary clinical criteria
 - Severe cardiac illness (e.g., myocarditis, pericarditis, coronary artery dilatation, new ventricular dysfunction, 2nd- or 3rd-degree AV block, or ventricular tachycardia)
 - Rash or
 - Non-purulent conjunctivitis
 - Secondary clinical criteria
 - New-onset neurologic signs and symptoms (e.g., encephalopathy, seizures, meningeal signs, peripheral neuropathy)
 - Shock or hypotension not attributable to medical therapy
 - Abdominal pain, vomiting or diarrhea
 - Thrombocytopenia
- AND
- No alternative more likely diagnosis;
- AND
- Evidence for current or recent SARS-CoV-2 infection by RT-PCR, NAAT, serology, or antigen testing; or COVID-19 exposure within the 28 days prior to the onset of symptoms.

MIS-A reporting is through the [Confidential Oregon Morbidity Report](#). No case investigation is required. OHA staff will review case medical records. Please contact [Nasreen Abdullah](#) with questions or concerns.

You can read more about MIS-A here: <https://www.cdc.gov/mis/mis-a/hcp.html>.

4.0 LABORATORY TESTING

4.1 Testing at the Oregon State Public Health Laboratory

Testing through the Oregon State Public Health Laboratory (OSPHL) must be approved by the Regional Epidemiologist supporting the outbreak. The [Criteria for COVID-19 Testing at OSPHL](#) provide general information about testing policies and targeted populations tested at OSPHL. Generally, OSPHL testing is prioritized for high-risk individuals and in support of outbreak investigations of public health significance. COVID-19 is an extremely common infection and OSPHL is not able to support testing for all outbreaks. 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.

4.2 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.

4.3 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.

4.4 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, require medical evaluation, or are at increased risk of severe disease and may be eligible for antiviral therapy.

5.0 QUARANTINE AND ISOLATION

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.

5.1 Quarantine for the General Population

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 then to 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.⁸
 - Avoid unnecessary visits with high-risk individuals (e.g., residents of congregate care facilities, persons with immunocompromising conditions, etc.).
 - Get tested at least 5 days after last exposure if they live or work with [high-risk individuals](#) (if already had COVID-19 within the past 90 days, see [specific testing recommendations](#)). Note: A single, negative antigen test result does not rule out infection.
 - If symptoms develop, get tested. Follow guidance for isolation (§5.2) after symptom development or a positive test.

5.2 Isolation for the General Population

Most people infected with COVID-19 (i.e., cases) do not need to isolate for a set number of days. However, they should be aware of their potential to infect others around them.

All cases, regardless of vaccination status or prior infection with COVID-19 are recommended to:

⁸ 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.

- Stay home until 24 hours after fever is gone without use of antipyretics and other COVID-19 symptoms are improving.
- Avoid contact with high-risk individuals (e.g., residents of congregate care facilities, persons with immunocompromising conditions, etc.) for 10 days.
- Mask when they are around other people in the 10 days after they become sick or test positive.⁹

5.2.1 Recommendations for individuals with severe illness or who are immunocompromised

Cases with severe illness—including cases hospitalized for their COVID-19 illness—or who are severely immunocompromised (see §10), should follow the above recommendations, but avoid contact with high-risk individuals and mask for 10- 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.

5.3 Isolation and Quarantine for Groups and Settings Not Included in the General Population

See §8.1 for specialized quarantine guidance in the following populations and settings ([CDC guidance](#)):

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

And §8.2 for specialized quarantine guidance in the following settings ([CDC guidance](#)):

- Carceral facilities (e.g., prisons, jails, youth detention facilities)
- Employer-provided congregate housing (called “labor housing” by OR-OSHA)
- Shelters, supportive/supported living, temporary/transitional housing

6.0 LPHA Case Management

Universal case interviews and contact tracing are not required and LPHAs will primarily receive case information for outbreaks via line list sent by a facility. However, LPHAs may opt to conduct interviews or support facilities in completing contact tracing during outbreaks of public health significance or where there are many high-risk individuals. During those instances, LPHAs should prioritize interviewing cases at highest risk for severe disease and transmitting disease in high-consequence facilities.

Elicitation of close contacts by the facility is recommended during investigation of high-consequence outbreaks (see §7.2). Facilities should maintain a list 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. LPHAs may request this list and should use it to provide guidance to facilities. This information may be used to help direct facility infection control practices and health education, as well as individual symptom monitoring and testing.

⁹ 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 10-day masking period should be restarted on the date of symptom onset.

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 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).*

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

- ODHS-regulated Nursing facilities report aggregate numbers of newly positive COVID-19 tests among residents or staff to public health via the National Healthcare Safety Network. Reporting cadence is currently weekly, but may be subject to change.
- 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 **when they are notified** (passive identification) of the following:

- In high-consequence congregate residential settings¹⁰:
 - ≥ 2 epi-linked confirmed or presumptive cases of COVID-19 within a 7-day period. Being from the same institutional cohort (e.g., unit, floor, shift, worksite) is sufficient to meet epi-link criteria.
- In K-12 schools or childcare settings:
 - 1 or more confirmed or presumptive cases of COVID-19 among staff or students with absenteeism that meets or exceeds the reporting thresholds described above.
- Other settings of concern as determined by the LPHA
 - ≥ 2 epi-linked confirmed or presumptive cases of COVID-19 within a 7-day period.

In the event of a report of an outbreak of respiratory illness without identified causative agent, pursue COVID-19 testing according to [CDC guidance](#) and refer to the [Respiratory Disease Outbreak Investigative Guidelines](#).

¹⁰ Including healthcare (i.e., long term care facilities, adult foster homes, child and adult behavioral health facilities, Intellectual and Development Disability and Child Welfare residential settings) and non-healthcare (i.e., shelters, jails or prisons, employer-provided housing) settings.

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 the settings identified 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 congregate residential** 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.
- Ensure facilities are applying appropriate isolation and in limited scenarios, quarantine, appropriately and according to CDC's [Healthcare Infection Control Guidance](#).
- Encourage vaccination of anyone not vaccinated and boosted, where appropriate.
- Conduct weekly check-in with facility to ensure continued awareness of new cases or fatalities until 14 days after last case is detected.
- Upload line list of confirmed and presumptive cases among staff and residents; may use online case log if facility is able to complete it.
- Summarize guidance or other resources provided to the facility.
- Document testing capacity and testing plans; include dates, testing laboratory **if applicable**.
- Update Opera with any fatalities or hospitalizations that occur among cases, **if applicable**.
- Document any staffing challenges, requests for crisis staffing support, or other concerns (e.g., need for facility decompression).
- Document any resources offered or provided (e.g., PPE, vaccination, therapeutics, etc.).
- Document any **coordination calls held among OHA, LPHA, and other agencies**.
- **If vaccination rates are not accessible via [OHA LTCF COVID-19 Vaccination Dashboard](#)**, collect vaccination rates for residents and staff.
 - 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](#).
- If infection control assistance needs are identified, offer and document infection control consultation with OHA HAI regional infection preventionist or COVID-19 population support epidemiologist. Infection control assistance can be requested via the [OHA Infection Control Consultation Request Form](#).

7.3.2 **K-12 school/ELD childcare outbreaks**

- Given the potential for ongoing transmission of multiple respiratory pathogens in school and childcare settings, LPHAs are not required to monitor outbreaks in these settings as with other settings. LPHAs should:
 - Open an outbreak record in Opera Outbreaks.
 - Provide appropriate guidance and respond to questions and concerns from schools and childcare facilities.
 - Escalate outbreaks in these settings as needed. This may include becoming aware of hospitalizations or deaths associated with the outbreak.
 - Outbreak records may be closed immediately.

- LPHAs may choose to take a more active role, including following-up with the school or childcare 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. If continuing to follow-up with a school or childcare, 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 14 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

The following **COVID-19-specific** Oregon Administrative Rules remain in effect:

- [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

NOTE:

- As of April 3, 2023, OHA has rescinded the requirements in OAR 333-019-1011 related to masking in health care settings. However, CDC continues to recommend masking in some situations and regulatory agencies (e.g., CMS) may choose to enforce this guidance in health care settings.
- As of May 11, 2023, although it remains strongly recommended that HCP are up to date with COVID-19 vaccination, HCP in health care settings will no longer be required to be vaccinated against COVID-19 under OHA rule.

For additional healthcare specific guidance, please see:

- [Infection Control: Severe acute respiratory syndrome coronavirus 2 \(SARS-CoV-2\) | CDC](#)
- [Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2 | CDC](#)
- [Strategies to Mitigate Healthcare Personnel Staffing Shortages | CDC](#)
- [Best practices for COVID-19 related admissions from hospitals to long-term care facilities | OHA](#)

8.1.1. Quarantine for healthcare personnel (see §10), patients, and residents in healthcare settings

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

HCP 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 HCP, or other members of the community outside of the workplace (e.g., household contacts) with confirmed SARS-CoV-2 and the HCP 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 HCP, 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 (e.g., 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 HCP 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.

HCP who are put under 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 may 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 who have been exposed to COVID-19 should be cared for using appropriate [Transmission-Based Precautions](#).

8.1.2 Isolation for healthcare personnel, patients, and residents in healthcare settings

HCP with COVID-19 should be restricted from work following the criteria outlined below. After returning to work, HCP should continue to monitor for symptoms and seek re-evaluation if symptoms recur or worsen. Table 3, HCP restrictions can be found on the next page.

Table 3. Healthcare personnel restrictions

Illness Severity* and Immune Status	Work Restriction Recommendations	Additional Notes
No symptoms or mild or moderate illness AND Not immunocompromised	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	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
Severe illness AND Not immunocompromised	At least 10 days and up to 20 days since symptoms began AND At least 24 hours fever free AND Other symptoms improving	Can consider using a test-based strategy in consultation with infectious disease expert to determine when the staff can return to work
Moderate or severely immunocompromised† AND Any level of symptom severity	Test-based strategy in consultation with infectious disease expert to determine when the staff can return to work	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
<p>* As defined by CDC: www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html † See §10</p>		

COVID-19 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 for at least 10 days but can be for 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 HCP, 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 HCP in table 3.

8.1.3 Contact tracing in healthcare settings

Contact tracing in healthcare settings, though not feasible in all scenarios, may be of benefit in high-risk settings **to halt early outbreak spread or when** being utilized to **guide** exposure testing. Formal contact tracing for exposures in healthcare settings may be infeasible and of limited benefit **during periods of high transmission** or when 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.

Where there is a known healthcare-associated exposure, healthcare facilities, including LTCFs, should conduct a risk assessment of HCW exposures and ensure exposure testing and/or work restrictions are implemented, if needed, as outlined in CDC's [Interim Guidance for Managing Personnel with SARS-CoV-2 Infection or Exposure](#).

In cases of HCP 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 **should** notify contacts of HCP with COVID-19 **if the patient with known exposure** resides **in** or will be transferred to a congregate care setting, **in order to inform testing efforts**.

8.1.4 Caring for hospitalized COVID-19 cases

HCP 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 individual influenza *cases* are 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 HCP, 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.

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 consider implementing quarantine for residents and HCP 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

ODHS is in the process of amending OAR 411-060 to align with the CDC testing recommendation. CDC recommendations include broad-based testing (“unit-wide”) or contact tracing options in response to identification of a staff or a resident COVID-19 case. ODHS is expected to adopt contact tracing or broad-based testing options, however, facilities should continue to utilize broad-based testing when the facility does not have the experience and resources to perform individual contact tracing or should contact tracing efforts fail to control ongoing transmission.

An outbreak investigation and initial testing would not be triggered when a resident with known COVID-19 is admitted directly into transmission-based precautions, or when a resident known to have close contact with someone with COVID-19 is admitted directly into transmission-based precautions and develops COVID-19 before precautions are discontinued.

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. HCP 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, but 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 [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 if symptoms are improving and

they have been fever-free for at least 24 hours. The viral test should be one negative NAAT 48 hours prior to returning to work or two negative antigen tests 48 hours apart and starting no sooner than day 5 of isolation. **For individuals with severe illness or that are immunocompromised, the isolation period may be extended to 20 days.** 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 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 outbreaks associated with the Oregon Department of Corrections

When there is an **outbreak** 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 are responsible for data management associated with the outbreaks. If an **outbreak** is identified in a local carceral facility not under ODOC jurisdiction, the LPHA should work with Community Corrections to investigate the **outbreak**.

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.¹¹ 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,

11 Villar J. JAMA Pediatr 2021; doi 10.1001/jamapediatrics.2021.1050

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 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.

9.3 Outbreak Data Management

When the LPHA is made aware of an outbreak of COVID-19, an outbreak record should be created in Opera Outbreaks. See §7.3 for a description of the information LPHAs should prioritize for documentation.

If cases are individually reported to Opera, the LPHA may opt to use the epi-link field in the Opera case record to link the case to the identified outbreak. 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.

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 etiology(ies) present by checking the appropriate boxes on the Basics tab.

When an LPHA is made aware of a respiratory disease outbreak in which both COVID-19 **and** another etiology has been identified, 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](#).

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 $\geq 15\text{L/min}$].
- Induction of sputum
- Medication administration via continuous nebulizer

COVID-19-related pediatric death: As of May 11, 2023, only COVID-19-related deaths in persons <18 years of age are reportable. 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.

Healthcare personnel (HCP): 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. HCPs 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 HCPs and patients.

Healthcare setting: Means any place where health care, including physical, dental or behavioral health care is delivered and includes, but is not limited to any health care facility or agency licensed under ORS chapter 441 or 443, such as hospitals, ambulatory surgical centers, birthing centers, special inpatient care facilities, long-term acute care facilities, inpatient rehabilitation facilities, inpatient hospice facilities, nursing facilities, assisted living facilities, residential facilities, residential behavioral health facilities, adult foster homes, group homes, pharmacies, hospice, vehicles or temporary sites where health care is delivered or is related to the provision of health care (for example, mobile clinics, ambulances) outpatient facilities, such as dialysis centers, health care provider offices, dental offices, behavioral health care offices, urgent care centers, counseling offices, offices that provide complementary and alternative medicine such as acupuncture, homeopathy, naturopathy, chiropractic and

osteopathic medicine, and other specialty centers.

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

- Are currently or have recently been receiving 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)
- Have a moderate or severe primary immunodeficiency (e.g., DiGeorge syndrome or Wiskott-Aldrich syndrome)
- Have advanced or untreated HIV infection
- Are receiving treatment with high-dose corticosteroids or other drugs that may suppress the immune response

Period of transmissibility: The time when cases can transmit disease to others. For symptomatic COVID-19 cases, this begins 48 hours prior to symptom onset. For asymptomatic cases, this is presumed to have begun 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

1. OHA main page for COVID-19: <https://govstatus.egov.com/OR-OHA-COVID-19>
2. CDC main page for COVID-19: www.cdc.gov/coronavirus/2019-ncov/index.html
3. COVID-19 Resource Centre at *The Lancet*: www.thelancet.com/coronavirus
4. 2019 Novel Coronavirus (COVID-19) at the *New England Journal of Medicine*: www.nejm.org/coronavirus

UPDATE LOG

May 22, 2023. Updated outbreak reporting threshold for congregate care settings; updates to section 2.7.1 to reflect updated vaccination recommendations; removed test reporting requirements; updated isolation recommendations for the general population; updates throughout to reflect these changes. (Becca Pierce, Lee Peters, Melissa Sutton, Paul Cieslak).

April 3, 2023. Updated healthcare masking information following rescission of the requirement in Oregon Administration Rule [333-019-1011](#); updates throughout for clarity. (Becca Pierce, Melissa Sutton, Paul Cieslak, Lee Peters).

January 27, 2023. Updated outbreak monitoring period for all outbreaks; removed outbreak monitoring for outbreaks in K-12 and childcare settings; added clarification around contact investigations in §6.2.2. (Lee Peters, Melissa Sutton, Meagan McLafferty, Kristen Hollywood).

January 6, 2023. Updated MIS-C case definition in alignment with recent CDC changes; updated links to OSPHL documents and treatment options; removed outdated links. (Lee Peters, Melissa Sutton, Paul Cieslak, Sarah Humphrey King).

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).

February 4, 2022. Added childcare isolation and quarantine guidance; updated recommendations for isolation and quarantine in healthcare settings; provided numerous clarifications throughout. (Amanda Faulkner, Lee Peters, Becca Pierce).

January 14, 2022. Updated K-12 exposure guidance; added mitigation strategies for K-12 settings; eliminated negative test reporting for certain testing entities; clarified isolation/quarantine guidance for other congregate settings and carceral settings (Amanda Faulkner, Lee Peters, Melissa Sutton, Tom Jeanne, Becca Pierce).

January 7, 2022. Changes to formatting throughout document; adopted new guidelines for case investigation and contact tracing; updated isolation and quarantine guidelines to match those released on January 4, 2022 by CDC; updated TTS protocol to align with new isolation and quarantine guidance (Amanda Faulkner, Lee Peters, Tom Jeanne, Becca Pierce, Lex Zhang).

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 personnel, 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)

March 3, 2020. Clarified contact tracing requirements. Added case classification table. Added definition of a presumptive case. Sundry edits. (Tasha Poissant, Madeline LeVasseur)

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)

February 6, 2020. Modification of PUM criteria, monitoring, and self-quarantine guidance. Updated §2.5 *Incubation Period*. Minor edits for clarity. (Amanda Faulkner, Steve Rekant, Alexia Zhang)

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