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# BRIEF REPORT: COVID-19 EPIDEMIC TRENDS AND PROJECTIONS IN OREGON

*Results as of 9-2-2020 4:15 pm*

## **ACKNOWLEDGEMENTS**

This is an update to the Oregon Health Authority's (OHA's) previous modeling reports. This report was based on Covasim modeling software, developed by the Institute for Disease Modeling (IDM). IDM provided OHA with initial programming scripts for the models and has provided extensive support and technical assistance to OHA. OHA especially wishes to thank Cliff Kerr, Katherine Rosenfeld, Brittany Hagedorn, Dina Mistry, Daniel Klein, Assaf Oron, Prashanth Selvaraj, Jen Schripsema, and Roy Burstein at IDM for their support.

## **RESULTS UPDATED BIWEEKLY**

Please note that the COVID-19 data used for the modeling are continually being updated. (For daily up-to-date information, visit the [OHA COVID-19 webpage](#).) The results in this brief are updated biweekly as more data become available, the science to inform the model assumptions expands, and modeling methods continue to be refined. While these results can be used to understand the potential effects of different scenarios, it is important to note that the 80% forecast intervals for estimates are wide, so point estimates should be interpreted with caution.

## KEY FINDINGS

### Changes after Oregon has begun to reopen

- Based on data through August 27, the model is consistent with transmission increases throughout May, followed by transmission decreases from late-June through mid-July.
- The current effective reproduction number ( $R_e$ ) – the expected number of secondary cases that a single case generates – is estimated to be 0.9. Indeed, the number of COVID-19 cases has been declining for over a month, as have severe cases for about two weeks.
- It takes an estimated 12 days on average from when a person becomes infected until they develop severe disease; therefore, it is unclear from hospitalization or death data if transmission changed after August 15. Because it is dependent on testing practices, diagnosis data does not, by itself, indicate a change in transmission.

### Future scenarios

We modeled three future scenarios with different assumptions about transmission starting August 28 and continuing over the next month.

- Transmission continues as-is: If we assume transmission continues at the current level over the next month, the COVID-19 outcomes will decrease. The model projects that by September 24:
  - The number of new daily infections (currently 560) will decrease to 410.
  - The number of existing infections that are newly diagnosed each day (i.e., newly diagnosed cases) will decrease to 150, assuming current testing practices continue.
  - The number of new severe cases each day will decrease to 6.
  - There will be about 122,000 cumulative infections.
  - The  $R_e$  will remain at 0.90.
- Transmission decreases: If we assume that transmission decreases by 5 percentage points and continues at that level over the next month, the COVID-19 outcomes will decrease more dramatically. The model projects that by September 24:
  - There will be approximately 170 fewer new daily infections (240 vs. 410), 60 fewer new diagnosed cases each day (90 vs. 150), and 1 fewer new severe case each day (5 vs. 6) compared to the continued as-is scenario.
  - There will be about 118,000 cumulative infections.
  - The  $R_e$  will be 0.77.
- Transmission increases: If we assume that transmission increases by 5 percentage points and continues at that level over the next month, the estimated numbers of new infections and newly diagnosed cases increases. The model projects that by September 24:
  - There will be approximately 380 more new daily infections (790 vs. 410), 30 more diagnosed cases each day (180 vs. 150), and 5 more new severe cases each day (11 vs. 6) compared to the continued as-is scenario.

- There will be about 128,000 cumulative infections.
- The  $R_e$  will be 1.05.

Each of these scenarios is based on different assumptions, as indicated above. The “transmission continues as-is” scenario most closely resembles a forecast. The two other scenarios assume a 5 percentage point change in either direction. Please note that the choice of 5 percentage points is somewhat arbitrary; the scenarios are meant to illustrate the effect of changing transmission on COVID-19 trends and should not be interpreted as a forecast range.

## Conclusions

These results suggest that transmission increased substantially during May, then decreased in late-June through late-July. Our model estimates the  $R_e$  is currently about 0.9. The efforts of Oregonians have once again helped reverse the trend of rising infections. If transmission remains at current levels, we expect a steady reduction in new infections. However, as we have seen since the beginning of this epidemic, the trends remain very sensitive to small changes in transmission levels.

## PURPOSE OF THIS REPORT

This report describes trends in COVID-19 since Oregon began to re-open, and projects trends over the next month assuming different scenarios. This report complements the extensive epidemiologic data (e.g., demographic trends in cases, testing patterns) available at the [OHA COVID-19 webpage](#).

## METHODS

This report presents analyses conducted using methods consistent with the previous August 21, 2020 report, with some key updates:

- Newer data from Oregon Pandemic Emergency Response Application (Opera) on COVID-19 cases ([Opera description](#)) were used. The Opera data file for this report was obtained on August 31, but data after August 27 were considered incomplete because of lags in reporting and were not used.
- In the analytic files for these models, we are updating daily test counts for the past month but are not updating older test counts for model stability.
- All models were run using an updated version of Covasim (v1.5.2). This update involved newer assumptions based on the literature, with virus infectivity now assumed to be highest toward the beginning of an individual’s infectious period.
- We updated various parameters based on updated local data, including hospital length-of-stay values, age-specific susceptibility ratios, and age-specific death rates.

- For our scenarios, we assumed transmission continued as-is and 5 percentage point changes in either direction (rather than 10 points) because transmission changes in the recent past have typically been closer to 5 percentage points. The amount of percentage point change is otherwise somewhat arbitrary; the scenarios are meant to illustrate the effect of changing transmission on COVID-19 trends and should not be interpreted as a forecast range.

More information about the methods is in Appendix 1.

NOTE: Given the updates to our methods, results presented in this report are not directly comparable to past reports. The changes affected how the model fit to the data; thus, some of the estimated transmission changes over time are different from past reports.

## **PUBLIC HEALTH INTERVENTIONS**

Since the beginning of the pandemic, Oregon has implemented numerous public health measure to slow the transmission of COVID-19. Appendix 2 lists dates of specific interventions before and after reopening (reopening plans were announced on May 1, 2020). Together, these efforts comprise a comprehensive approach to protect the public's health and wellbeing – with not only direct client services (e.g., testing and contact tracing), but also policy implementation (e.g., face covering requirements, limits on gathering sizes), educational campaigns, culturally responsive approaches, support of community action, systems change to address barriers and inequities, and ongoing epidemiologic surveillance and evaluation. These interventions continue to evolve as the science expands, we learn about specific community needs, and more funding becomes available. As with other comprehensive public health interventions, it is difficult to determine the contribution of any one component because each is essential and they act synergistically; and, in the case of COVID-19, various components were implemented simultaneously or in quick succession.

## **RESULTS**

The results in this brief report will be updated as more data become available, the science to inform the model assumptions expands, and modeling methods continue to be refined (see Appendix 3 for information on the limitations). The models simulate the spread of COVID-19 in Oregon statewide under different scenarios. They do not model regional variability, and they do not take into account the complex disease spread or intervention effectiveness within and between specific populations over time, such as for communities of color, workers in certain occupations, or people in congregate settings. The models use average transmission levels; hence they do not, for example, model outbreaks in work settings differently than other types of transmission.

## Epidemiologic trends to date

The model was calibrated (Figure 1) by modifying the assumptions from the literature to best fit data from Opera on daily counts of COVID-19 total cases<sup>1</sup>, tests completed, severe cases<sup>2</sup>, and deaths for Oregon. The model was calibrated to observed data based on the average of 11 randomized runs. The dates on which model transmission levels change were selected based on key policy enactment dates, but after March 23 they were based on data observation. The degree of changes in transmission were informed by the COVID-19 data, not by the assumed effect of any policy. It is important to note that the estimated reductions in transmission over time are imprecise and cannot be attributed to any particular action (e.g., policy or event); some are based on few data points and sometimes multiple actions co-occurred.

As in previous modeling reports, the calibration provides evidence that Oregon's aggressive interventions -- combined with increased hygiene and other measures that appear to have begun earlier -- dramatically reduced the burden of COVID-19 in Oregon during the spring (Figure 1). Specifically:

- The data are consistent with a stepped reduction in transmission in Oregon, beginning with a 5% decrease in transmission after March 8, up to a maximum 80% decrease in transmission after March 23. Indeed, while the interventions before March 23 appeared to have slowed epidemic growth, the additional aggressive measures implemented on March 23 (i.e., "Stay Home, Save Lives") appeared to have further curtailed that growth. The reductions were likely due to people spending more time at home, as well as an increase in hygiene and disinfection practices, wearing of face coverings, and physical distancing outside the home; however, the data to determine the relative contribution of each change are lacking.
- The data suggest that these dramatic reductions in transmission waned somewhat in April, but the number of new daily infections was still declining until early-May.

The current calibration provides evidence that transmission increased substantially during May, then decreased somewhat in late-June through mid-July (Figure 1). Specifically:

- New severe cases stopped declining in mid-May before beginning to increase starting early in June. The trends were consistent with a 5 percentage point increase in transmission after April 12, a 10 percentage point increase after May 15 (the start of reopening), and a 5 percentage point increase after May 24 (the day before Memorial Day).
- Transmission appears to have then decreased by 5 percentage points after June 22 and by another 5 percentage points after July 14. The current effective reproduction number ( $R_e$ ) – the expected number of secondary cases that a single case generates –

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<sup>1</sup> Total cases include confirmed cases (positive test) and presumptive cases (symptoms with epidemiologic link).

<sup>2</sup> Severe cases include both cases admitted to the hospital and individuals who died but were not hospitalized. Approximately 6% of severe cases are non-hospitalized deaths.

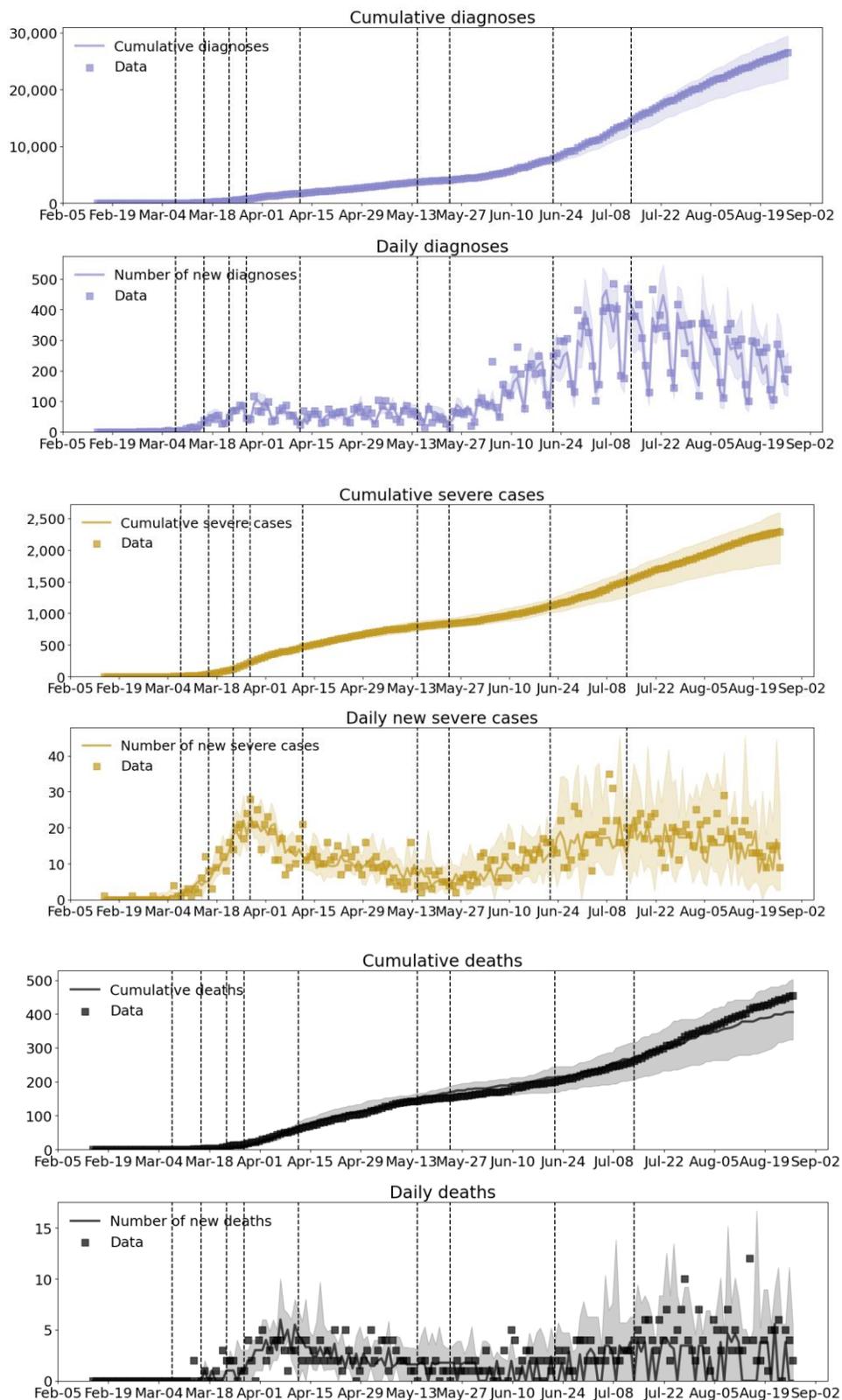
is estimated to be approximately 0.9. Indeed, the number of COVID-19 cases has been declining for over a month, as have severe cases for about two weeks.

- The effects of changes in transmission after mid-August on new severe case numbers may not be apparent until after our August 27 data cutoff, given potential reporting delays and an assumed average of 12 days between people becoming infected and onset of severe symptoms.
- We would expect changes in transmission in August to be reflected in new diagnoses about eight days later, on average (given the time to develop symptoms among those who develop symptoms, and the average time between symptom onset and testing). Daily diagnoses (Figure 1) in August are thus far consistent with no August change in transmission, assuming testing practices have stayed the same.
- With this calibration, the model appeared to be slightly underpredicting death trends in mid-July to mid-August. This could be due to random model fluctuation in simulating how many severe cases progress to fatal, but we will continue to monitor these trends and adjust model calibration, as needed.

The model estimates that, as of August 27, a total of 107,100 cumulative infections have occurred in Oregon (80% forecast interval<sup>3</sup>: 79,600 – 115,300), but only 26,500 have been diagnosed according to available data.

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<sup>3</sup> “The forecast intervals used correspond to the 10th and 90th percentiles of the simulated trajectories. Although these forecast intervals bear some similarities to confidence or credible intervals, since they are typically produced through a combination of stochastic variability and parameter uncertainty, they do not have a rigorous statistical interpretation.” (p 18 of IDM Covasim report).



**Figure 1:** Model calibration with Oregon data. Dotted vertical lines correspond, from left to right, to estimated reductions in transmission relative to baseline of 5% (March 8), 55% (March 16), 80% (March 23), 75% (March 28), 70% (April 12), 60% (May 15), 55% (May 24), 60% (June 22), and 65% (July 14). Raw data are presented as squares; estimates from the calibration are presented as lines. The shaded areas represent variability among calibration runs (i.e., 10<sup>th</sup> and 90<sup>th</sup> percentiles of the calibration).

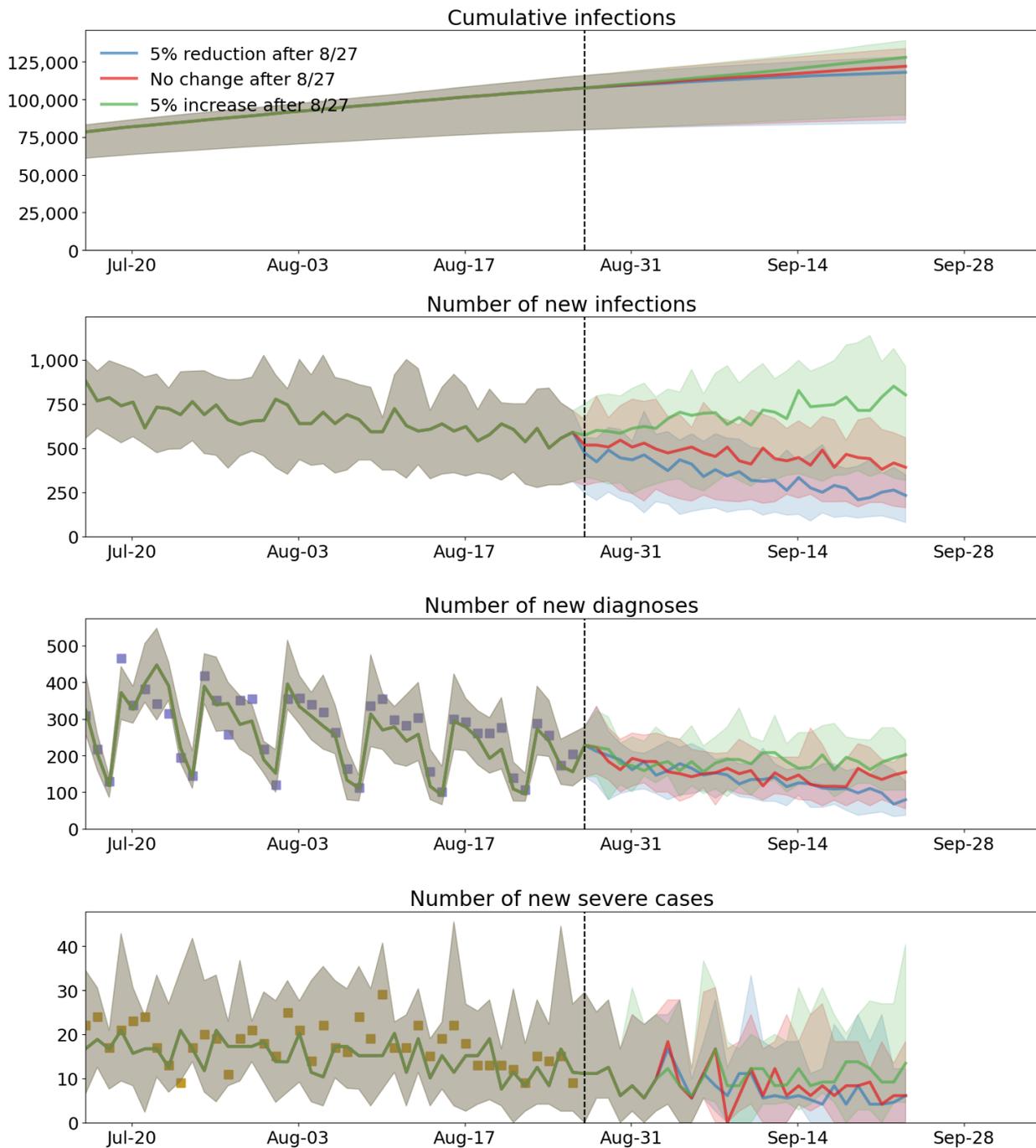
## Scenario projections

It is not possible to confidently predict future COVID-19 trends because of significant gaps in knowledge. For example, we do not have comprehensive measures of adherence to the physical distancing, face covering, hygiene, isolation, and quarantine guidance, do not know how adherence will change over time, and do not know what the effects of seasonal changes will be. Therefore, we modeled three future scenarios (Figures 2 and 3) through September 24 by making different assumptions about future transmission levels starting August 28. The estimates and forecast intervals are based on results from 11 randomized runs. For all scenarios, we assumed 4,500 tests per day to reflect recent levels ([8/24 Testing Summary](#)).

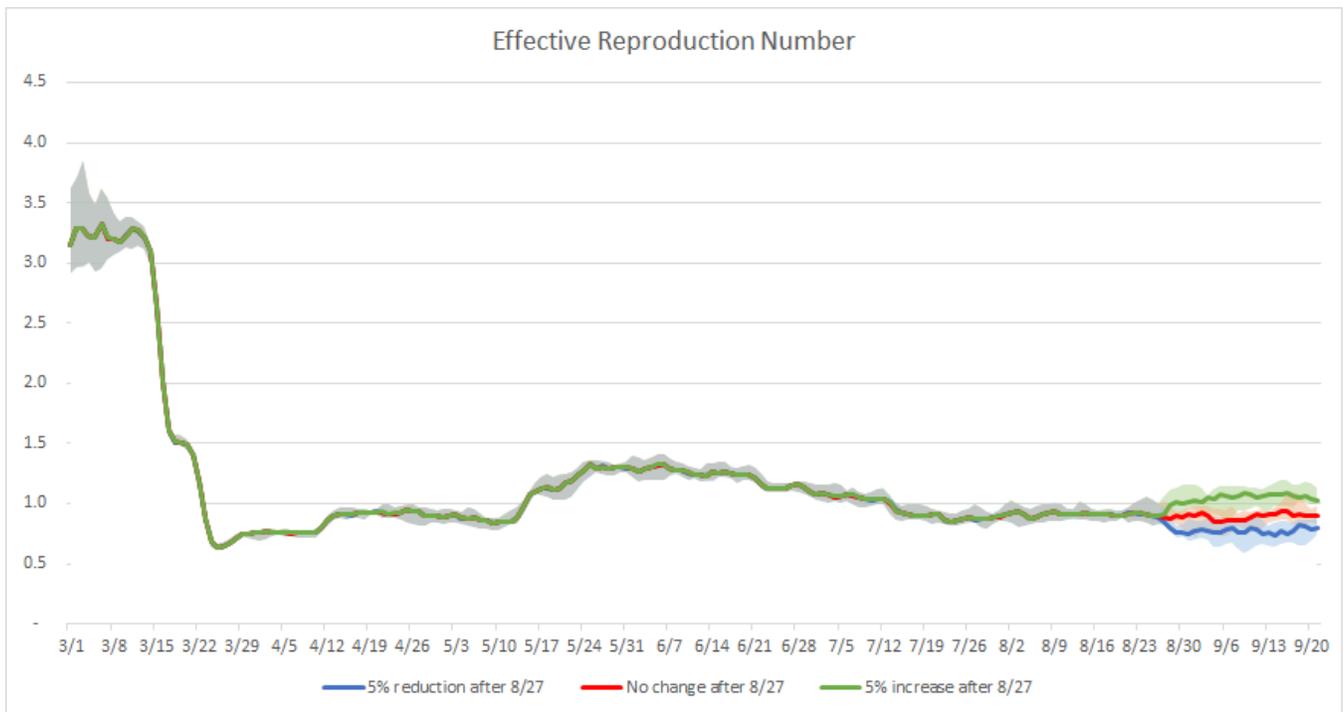
- Transmission continues as-is: If we assume transmission continues at the current level over the next month, the COVID-19 outcomes will decrease. The model projects that by September 24:
  - The number of new daily infections (currently 560) will decrease to 410.
  - The number of existing infections that are newly diagnosed each day (i.e., newly diagnosed cases) will decrease from 210 to 150, assuming current testing practices continue.
  - The number of new severe cases each day will decrease from 12 to 6.
  - There will be about 122,000 cumulative infections.
  - The  $R_e$  will remain at 0.90.
- Transmission decreases: If we assume that transmission decreases by 5 percentage points and continues at that level over the next month, the COVID-19 outcomes will decrease more dramatically. The model projects that by September 24:
  - There will be approximately 170 fewer new daily infections (240 vs. 410), 60 fewer new diagnosed cases each day (90 vs. 150), and 1 fewer new severe case each day (5 vs. 6) compared to the continued as-is scenario.
  - There will be about 118,000 cumulative infections.
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- Transmission increases: If we assume that transmission increases by 5 percentage points and continues at that level over the next month, the estimated numbers of new infections and newly diagnosed cases increases. The model projects that by September 24:
  - There will be approximately 380 more new daily infections (790 vs. 410), 30 more diagnosed cases each day (180 vs. 150), and 5 more new severe cases each day (11 vs. 6) compared to the continued as-is scenario.
  - There will be about 128,000 cumulative infections.
  - The  $R_e$  will be 1.05.

Each of these scenarios is based on different assumptions, as indicated above. The “transmission continues as-is” scenario most closely resembles a forecast. The two other scenarios assume a 5 percentage point change in either direction. As previously mentioned, the choice of 5 percentage points is somewhat arbitrary; the scenarios are meant to illustrate

the effect of changing transmission on COVID-19 trends and should not be interpreted as a forecast range.



**Figure 2:** Model projections for the next 4 weeks, assuming that after August 27: 1) transmission does not change (red line), 2) transmission decreases by 5 percentage points (blue line), and 3) transmission increases by 5 percentage points (green line). The lighter shaded areas correspond to 80% forecast intervals (i.e., 10<sup>th</sup> and 90<sup>th</sup> percentiles of the projection).



**Figure 3:** Projected effective reproduction number (Re) through September 24, assuming that starting August 28: 1) transmission does not change (red line), 2) transmission decreases by 5 percentage points (blue line), and 3) transmission increases by 5 percentage points (green line). The lighter shaded areas correspond to 80% forecast intervals (i.e., 10<sup>th</sup> and 90<sup>th</sup> percentiles of the projection). Re is the expected number of secondary cases that a single case generates.

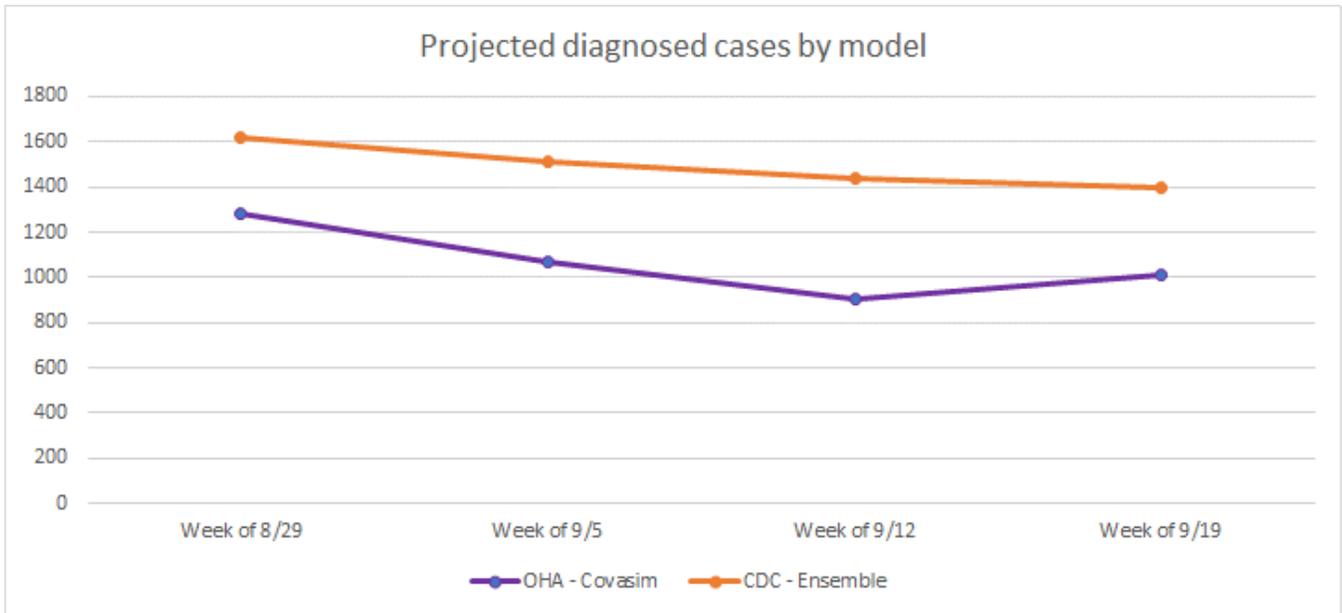
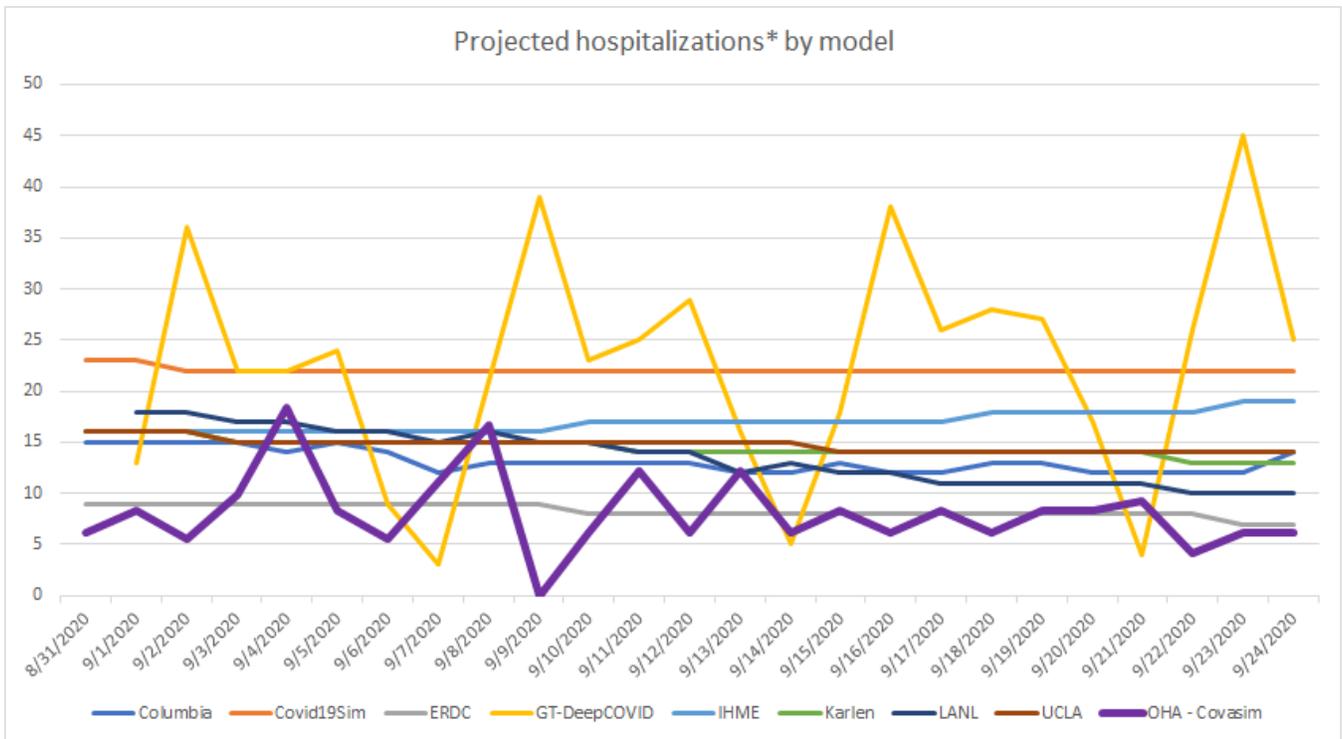
#### Comparison with other model results<sup>4</sup>

The latest results from [CovidActNow](#) and [RT Live](#) estimate the Re for Oregon to be 0.93 and 0.98, respectively, compared to our estimate of 0.90 (80% forecast interval: 0.80 to 1.0).

CDC compiles [hospital forecasts](#) from numerous modelers. Compared to CDC’s August 25 compilation, our scenario that assumed transmission continues as-is appears toward the bottom of these forecasts (Figure 4a).

CDC recently began compiling [forecasts of newly reported cases](#), as well. Compared to CDC’s August 25 ensemble model, our scenario that assumed transmission continues as-is predicts fewer weekly diagnoses (Figure 4b).

<sup>4</sup> These websites mentioned in this section were accessed on 9/2/2020. [Imperial College London's](#) Re estimates have not been updated since July so were not included.



**Figure 4a and b:** Projected (a) daily new hospitalizations and (b) daily new diagnosed cases in Oregon through September 24 for the current report’s scenario that assumed estimated transmission “continues as-is” (OHA Covasim) and other models included in CDC’s forecast compilations<sup>5</sup>. \*Note: OHA forecast in (a) is for severe cases, of which approximately 6% led to non-hospitalized deaths.

<sup>5</sup> CDC compilation for new hospitalizations was dated August 31 and for new diagnosed cases was dated August 24. The Johns Hopkins model was not included in Figure 4a because recent projections were at a much higher level than observed data.

## Discussion

It is important to note that some of the 80% forecast intervals for these predictions are wide, reflecting their uncertainty. In addition, we cannot confidently predict future COVID-19 trends because of significant gaps in knowledge. For example, we do not have comprehensive measures of adherence to the physical distancing, face covering, hygiene, isolation, and quarantine guidance, do not know how adherence will change over time, and do not know what the effects of seasonal changes will be. Nevertheless, the results in this report provide a summary of current trends and can be used to understand potential trends in COVID-19 under different scenarios.

These results suggest that transmission increased substantially during May, then decreased in late-June through late-July. Our model estimates the  $R_e$  is currently about 0.9. The efforts of Oregonians have once again helped reverse the trend of rising infections. If transmission were to remain at the current estimated level, new infections will decline steadily over the next month from 560 to 410 per day by the end of September. If between one-third and one-half of infections are diagnosed, we would expect about 140 to 205 of the existing infections would be diagnosed per day by the end of September. This corresponds to about 23 to 34 diagnosed cases per 100,000 population each week.

The state's comprehensive approach to controlling this epidemic after reopening and individuals' behavior changes to protect others appear to be reducing our recent transmission levels, but we still have work to do to control this epidemic. This model projects statewide averages, but examining disparities is critical to inform interventions. For example, case trends vary by county ([Data dashboard](#)), and the Latinx and other communities of color have been disproportionately impacted ([OHA Weekly COVID Report](#)). In addition, the scenarios indicate that this virus remains very sensitive to changes in transmission, and our past reports have demonstrated that a relatively small increase in transmission can cause a return to exponential growth. Even with testing, treatment, and contact tracing, transmission levels are still dependent on adherence to the guidance regarding physical distancing, face coverings, hygiene, self-quarantining of contacts, and self-isolation of cases. Collaborating with community partners to understand the structural, workplace, social network, and individual-level barriers to adherence to that guidance and addressing those barriers is essential to reducing transmission. Although we do not have measures on adherence to all the guidelines in Oregon, crowd-sourced data on a convenience sample in Oregon from the Institute from Health Metrics and Evaluation (IHME) and Premise ([Methods](#)) suggest that the percentage of people always wearing a mask in public has been increasing since early spring, and between early-July and late-August roughly 40-50% reported always doing so ([IHME Oregon Estimates](#)). IHME projections suggest that increased universal mask wearing could lead to further reductions in transmission ([IHME Paper](#)).

## APPENDICES

### Appendix 1: Detailed transmission model methods

We applied Covasim version 1.5.2, an individual-based (i.e., “agent-based”) COVID transmission model with parameters informed by the literature; the full source code is available on [GitHub](#). The methods and assumptions for Covasim are described in detail [here](#).

The model was calibrated by modifying the assumptions to best fit data from Opera on numbers of COVID-19 total cases, tests completed, and severe cases (hospitalizations and deaths) for Oregon.

Our model assumed random network connections, zero noise, and used default Covasim parameters, except for the following changes:

- 1) Population age distribution was based on American Community Survey 2018 single-year estimates for Oregon. We used a simulation population size of 420,000 with Covasim’s population rescaling functionality enabled.
- 2) The COVID-19 virus had a pre-intervention Beta value<sup>6</sup> of 0.021, instead of 0.016 (based on observed severe cases before interventions took effect).<sup>7</sup>
- 3) We adjusted Covasim’s age-specific severe outcome probability parameters among all infections to be consistent with CDC’s suggested parameter values for pandemic planning scenarios ([CDC Planning Scenarios](#) as of May 20, 2020). Specifically, we used the CDC parameter values for age-specific hospitalization probabilities among symptomatic infections and adjusted them based on Covasim’s age-specific symptomatic probability parameters. After applying Oregon’s age distribution and time-varying age-specific susceptibility ratios (see point #4), our model estimates overall proportions of infections that become severe as 2.8% prior to May, and 2.0% for May-onward.
- 4) We adjusted Covasim’s age-specific probability of death parameters based on local ratios of deaths to severe cases by age.
- 5) Parameter assumptions were modified to vary susceptibility by age and time, such that the age distribution of severe cases in the model follows that of severe cases in Oregon over two time periods: February-April and May-July. The susceptibility odds ratios used in these respective time periods were: [2.84, 3.40] for age 0-9, [0.66, 1.19] for age 10-19, [1.17, 1.03] for age 20-29, [0.46, 0.52] for age 30-39, [0.50, 0.43] for age 40-49, [0.86, 0.66] for age 50-59, [0.77, 0.40] for age 60-69, [0.87, 0.54] for age 70-79, and [1.12, 0.88] for age 80 and higher. These ratios may partially correspond to biological susceptibility by age but are also a reflection of social behavior and testing activity. The populations of both diagnosed and severe cases have become younger over time in

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<sup>6</sup> Whenever a susceptible individual comes into contact with an infectious individual on a given day, transmission of the virus occurs according to probability Beta ( $\beta$ ).

<sup>7</sup> With an average of 20 contacts per individual per day and a mean duration of infectiousness of 8 days, this per-day probability roughly translates to a basic reproduction number (R0) of 3.

Oregon, implying a lower overall severe case risk among infections and thus more total infections per severe case in recent months.

- 6) To assess our parameter assumptions, we compared our model estimates of cumulative infections with what we might expect from a local seroprevalence study. That study ([MMWR article](#)) reported a crude seroprevalence of 1.0% (95% confidence interval: 0.2% – 1.8%) among a sample of people in Oregon interacting with the medical system between May 11 and June 15, 2020. Given the seroprevalence in that study varied by age and the sample was older than the general Oregon population, we calculated an age-adjusted seroprevalence for comparison and found it to be slightly lower (0.6%), but within the confidence bounds of the crude estimate. In the current report, the model estimated 32,400 cumulative infections on May 15. This would translate to a seroprevalence of  $32,400 / 4.2\text{million} = 0.8\%$ , which is similar to the seroprevalence estimate from the MMWR article.
- 7) We determined transmission levels through mid-July based on severe case incidence and adjusted the assumptions about testing practices to reflect the observed test positivity rates. Specifically, the relative probability of symptomatic individuals being tested was adjusted to match actual diagnoses counts given our inputted number of tests, with changes in relative odds occurring on April 7, April 28, June 11, July 1, and July 22.

It is not possible to calibrate the model with a single importation event near the first diagnosis (February 21, 2020), which was a community acquired infection. To match observed epidemic trend, we started the model with 75 infected individuals on February 15, 2020.

## Appendix 2: Public Health Interventions in Oregon

Oregon has implemented numerous measures to slow the transmission of COVID-19. Since the beginning of the epidemic in Oregon, the state and local public health system has:

- Implemented educational campaigns to increase public awareness about the epidemic and to encourage adherence to guidance.
- Gathered and reported data, as part of public health surveillance, to inform interventions.
- Collaborated with the health care systems, local public health, and other sectors (e.g., education).
- Conducted outbreak investigations and implemented control measures to prevent future outbreaks in similar settings (e.g., congregate settings, workplaces).
- Collaborated with the federal government and health systems to expand access to key supplies (e.g., personal protective equipment (PPE), testing, and medications).
- Routinely investigated diagnosed cases, asked those cases to identify their close contacts, and then notified those contacts of their exposure (i.e., contact tracing). Because of limited public health resources in Oregon early in the epidemic, public health staff had only been able to actively follow up with contacts in households and congregate settings. Contact tracing efforts expanded starting with reopening plans, as mentioned below. Contacts have been asked to voluntarily stay in quarantine for 14 days after their last known exposure. Any diagnosed cases were originally asked to voluntarily isolate for at least 72 hours after symptoms resolve, but this changed over time: they are now asked to voluntarily isolate for at least 10 days after diagnosis or 24 hours after symptoms resolve, whichever is longer.

Specific dates for interventions are given below.

### Before Reopening

- On March 8, 2020: Governor Brown declared an emergency due to the public health threat.
- On March 12, 2020: A large number of measures were put in place, such as bans on gatherings of more than 25 people, as detailed [here](#).
- On March 16, 2020: Schools were closed statewide, as detailed [here](#). Further measures were put in place on March 16 and 17, including the closure of restaurants and bars and gatherings of more than 25 people, as detailed [here](#).
- On March 19, 2020: Non-urgent health care procedures were suspended to conserve personal protective equipment and hospital beds.
- On March 23, 2020: Aggressive interventions, namely the [“Stay Home, Save Lives” recommendations](#), were put in place.
- On April 21, 2020: Testing guidelines were revised to allow for expanded testing, including testing of people who are asymptomatic and work in care settings or live in

congregate settings; they were refined on May 1, 2020 and again on June 2, 2020 ([Revised testing guidelines](#)).

## Reopening

On May 1, 2020, Oregon announced plans for phased relaxation of community mitigation strategies, with additional expansion of testing and contact tracing to keep transmission low ([Reopening Plans May 1, 2020](#)). Some key changes have included:

- On May 1, 2020: Certain elective and non-urgent medical procedures resumed ([Medical Procedures May 1, 2020](#)).
- On May 2, 2020: The widespread use of face coverings was encouraged.
- On May 5, 2020: Some parks, outdoor recreation facilities, and areas across Oregon were opened for day use ([Parks May 5, 2020](#)).
- On May 7, 2020: Governor Brown published detailed guidance on reopening. This included requirements for counties to reopen, such as having sufficient capacity for testing and contact tracing. The guidance also called for the widespread public use of face coverings, maintaining physical distance of six feet between individuals as much as possible, and following good hygiene and disinfection practices ([Reopening Guidance May 7, 2020](#)).
- On May 15, 2020: Some counties began to reopen, and certain restrictions were eased statewide, such as allowing social gatherings of under 10 people and cultural/civic/faith gatherings of up to 25 people with physical distancing, as detailed [here](#) and [here](#).

Briefly:

- On May 15, 31 of the 36 counties in Oregon had been approved for Phase 1 of reopening.
- By June 1, 35 counties were approved for Phase 1 reopening. The most populous county (Multnomah) had not yet reopened.
- On June 5 and 6, 28 counties were approved for Phase 2 reopening, as well as one more on June 8.
- On June 11, due to a rise in COVID-19 cases, the Governor temporarily halted approvals for additional phased reopening.
- On June 17, the Governor approved Multnomah County's plan for Phase 1 reopening, starting on Friday, June 19.
- On June 23, 2020: An update on the expansion of contact tracing efforts was issued [here](#), reporting about 600 county and state contact tracers.
- On June 24, 2020: Implementation began of a new plan for testing at long-term care facilities, as described [here](#).
- On June 25, 2020: The Governor required people living in Oregon's seven most populous counties to wear a face covering when in indoor public spaces, with some exceptions (e.g., young children, people with disabilities, while eating), as described [here](#). This requirement extended to all Oregon counties on July 1, as described [here](#).

- On July 15, 2020: Face coverings became required outdoors in situations where people are unable to maintain a distance of at least six feet from others, and most indoor gatherings of more than 10 people were not allowed, as described [here](#).
- On July 23, 2020: OHA announced grants to more than 170 community-based organizations (CBOs) to help respond to COVID-19 in culturally- and linguistically-responsive ways. Their work will include outreach and community engagement; contact tracing together with local public health authorities; and providing people with social services/wraparound supports, as described [here](#).
- On July 24, 2020: Face coverings were required for exercising indoors, and they became required for all children over 4 years old. Capacity limit for restaurants, gyms, venues was reduced to 100. Bars and restaurants were required to close at 10pm, as described [here](#).
- On July 28, 2020: The Governor released metrics to guide school district decisions about when it is safe to resume in-person instruction, and when a transition to comprehensive distance learning is necessary, as described [here](#).
- On July 31, 2020: Morrow County returned to Phase 1, and Umatilla County returned to Baseline/Stay Home because of increases in cases, as described [here](#).
- On August 1, 2020: Governor Brown announced the launch of a new source of financial assistance for agricultural workers who must self-quarantine to slow the spread of COVID-19, as described [here](#).
- On August 13, 2020: New face covering guidance required individuals to wear face coverings in any area within an office where six feet of distance cannot be consistently maintained, including in hallways, bathrooms, elevators, lobbies, break rooms and other common spaces, as described [here](#).
- On August 17, 2020: Malheur County returned to Phase 1 because of increases in cases, as described [here](#).
- On August 21, 2020: Umatilla County succeeded in reducing the spread of COVID-19 to the point that it was moved from Baseline Stay Home status to Phase 1, as described [here](#).
- On August 28, 2020: Oregon Department of Education’s Early Learning Division released the new “Health and Safety Guidelines for Child Care and Early Education Operating in COVID-19”. The updated guidelines take effect Tuesday, September 1, 2020, as described [here](#).

### Appendix 3: Limitations

- The results in this report will be updated as more data become available, the science to inform the model assumptions expands, and modeling methods continue to be refined. The report uses the best available local data as of August 31, 2020; however, the local epidemiologic data on COVID-19 cases may lag in ways we did not account for. Data improvement efforts are ongoing.
- The Opera data file for this report was obtained on August 31, but data after August 27 were considered incomplete because of lags in reporting and were not used. Therefore, we lack data for the past week. However, [trends in hospital occupancy](#) in Oregon from the HOSCAP data system, which is updated daily, suggest a continued decline in occupancy from August 27 through September 2.
- Our parameter assumption for the proportions of all infections (diagnosed or not) that become severe cases was based on CDC's hospitalization-among-symptomatic estimates and Covasim default symptomatic-among-infection estimates, then adjusted to observed local severe cases by age. However, there is considerable variability in this estimate in the literature. Underestimating this proportion would inflate our estimates of total number of infections (diagnosed or not), while overestimating would deflate the number.
- After the initial imported infections, the model assumes that no additional infections were imported from elsewhere over time. Any such infections would inflate local transmission levels, though any actual resulting diagnoses and severe cases in Oregon from imported infections are included in the data used for model calibration.
- For simplicity, we assumed random network connections and a combined effect of various interventions for the future scenarios (e.g., physical distancing, expanded testing and contact tracing) on overall transmission, but Covasim does have the ability to incorporate more complex network dynamics and specific intervention effects (as described [here](#)).
- We assumed that individuals who were diagnosed subsequently reduced their transmission by 80%, but this reduction may vary as social norms change.
- Our model assumed that diagnoses occur uniformly among individuals experiencing symptoms. On any given day, those with mild symptoms were assumed to be as likely to be diagnosed as those with more severe symptoms. We do not expect this to have a major effect on the model's estimate of transmission, however, because although severe cases are infectious longer, they are assumed to be less infectious over time.
- Although our model was calibrated to track actual numbers of tests and diagnoses, it assumed both occurred entirely among symptomatic individuals. It also did not explicitly account for reduced transmission from individuals who are not tested but undergo quarantine due to contact tracing efforts.
- Given the fairly low number of cases in Oregon, trends in cases and the age distribution (and therefore prognosis) are sensitive to a single outbreak or super spreader event. Such outbreaks would be expected to affect a younger population than outbreaks in

nursing homes, which occurred beginning early in Oregon's epidemic ([OHA Weekly COVID Report](#)).

- These models simulated the spread of COVID-19 in Oregon statewide under different scenarios. They did not take into account regional variability, nor the complex disease spread or intervention effectiveness within and between specific populations over time, such as for communities of color, workers in certain occupations, or people in congregate settings. However, the demographics of cases diagnosed over time in Oregon have been changing, as documented in [OHA Weekly COVID Report](#).
- Our model includes COVID-19 deaths who were never hospitalized as severe cases. However, available data do not allow us to account for cases who reach severe medical status but recover without hospitalization.

Finally, significant unknowns remain, including information about public adherence to guidance (e.g., physical distancing, face coverings, hygiene, isolation, quarantine), the disease dynamics, and treatment. As CDC stated ([CDC Planning Scenarios](#)) "new data on COVID-19 are available daily; information about its biological and epidemiological characteristics remain limited, and uncertainty remains around nearly all parameter values."