

SARS-CoV-2 Infection (COVID-19)

Signs and Symptoms	<ul style="list-style-type: none"> • Estimated 25-40% of cases asymptomatic • Usual: fever, cough, short of breath, chills, fatigue, myalgia, headache, sore throat, loss of smell / taste • Severe: pneumonia, respiratory failure, septic shock, blood clots, multisystem inflammatory syndrome
Incubation	The median incubation period for Omicron subvariants is 3-4 days (range 2-14 days)
Case classification (for full details see Section 3)	<p>Confirmed – Not a previous confirmed or probable case in the prior 90 days AND:</p> <ul style="list-style-type: none"> • Detection of SARS-CoV-2 RNA in a clinical or post-mortem specimen using a molecular amplification detection test performed by a CLIA-certified provider; OR SARS-CoV-2 detection by genomic sequencing <p>Probable – Not a previous confirmed or probable case in the prior 90 days AND:</p> <ul style="list-style-type: none"> • Detection of SARS-CoV-2 antigen in a clinical or post-mortem specimen using a test performed by CLIA-certified provider; OR • Compatible clinical syndrome AND epidemiologic link to a laboratory positive case; OR • Death certificate includes “COVID-19” or “SARS-CoV-2” <p>Suspect – Not a prior confirmed or probable case AND: SARS-CoV-2 antibody detection; OR post-mortem immunocytochemistry positive; OR SARS-CoV-2 antigen or molecular positive result without CLIA oversight (e.g., self-tests performed at home)</p>
Treatment	Vaccine first available 12/2020. Oral antiviral agents. Monoclonal antibodies (may not work for all variants). Pre-exposure prophylaxis available for immunocompromised persons.
Duration	Likely contagious ~2 days before and up to 10 days after symptom onset (or test date if asymptomatic), 20 days if immunocompromised; asymptomatic case may be contagious. Isolation period for the general public per CDC guidance is 5 days (so long as symptoms improving and no fever in past 24 hours without fever-reducing medication) with additional 5 days of masking (longer isolation if severe illness or immunosuppressed). Reinfection uncommon within 90 days.
Exposure	Primarily through inhalation of or mucous membrane exposure to fine respiratory droplets and aerosol particles; potential risk from touching mucous membranes with contaminated hands. Longer-range aerosol transmission can occur, especially in poorly ventilated spaces.
Laboratory testing	<p>COVID-19 testing is widely available at clinical laboratories and through over-the-counter test kits.</p> <ul style="list-style-type: none"> • Best specimens (collect using appropriate infection prevention) <ul style="list-style-type: none"> ○ Nasal (not NP) swab using synthetic swab in 2-3 ml viral transport media (See DOH Nasal Swab Instructions) ○ If intubated, lower respiratory sample (sputum, BAL or tracheal aspirate) in sterile container ○ Also consider second nasal swab for rapid flu and respiratory panel at a clinical laboratory
Public health actions URGENT	<p>Determine if a case was likely exposed or infectious in a facility or group. Prioritize healthcare-associated cases and clusters/outbreaks. In most settings, public health contact tracing for individual cases in the community is no longer routine.</p> <p>Inform the case to stay home while symptomatic except to get medical care; to call the provider before visiting and identify themselves as having COVID-19; to separate themselves from others (particularly sleeping area and bathroom) to avoid sharing household items such as dishes, towels, or bedding; and to practice respiratory etiquette and frequent hand hygiene. See DOH guidance on What to do if you test positive for COVID-19.</p> <p>Provide the following education materials as needed to cases and contacts: people who test positive for COVID-19 and people exposed to COVID-19.</p> <p>For additional COVID-19 information see additional CDC resources and DOH resources</p>

COVID-19 Infection – General

1. DISEASE REPORTING

A. Purpose of Reporting and Surveillance

1. To identify infections due to COVID-19.
2. To prevent the spread of COVID-19.

B. Legal Reporting Requirements

1. Healthcare providers: **immediately notifiable to local health jurisdiction including point-of-care tests**
2. Healthcare facilities: **immediately notifiable to local health jurisdiction**
3. Laboratories: **immediately notifiable to local health jurisdiction** including **negative results** <https://doh.wa.gov/emergencies/covid-19/healthcare-providers/reporting-test-results>
4. Local health jurisdictions: **immediately notifiable to Washington State Department of Health (DOH) Office of Communicable Disease Epidemiology (CDE)** <https://www.doh.wa.gov/Portals/1/Documents/1600/coronavirus/EmergencyRuleReportingCOVIDTesting.pdf>
5. There are [additional reporting requirements specific to schools and childcare facilities](#)

C. Local Health Jurisdiction Investigation Responsibilities

1. Contact CDE (206-418-5500 or 877-539-4344) with concerns about COVID-19 clusters.
2. Take action to investigate and control outbreaks; provide recommendations for high-risk settings during outbreaks that may differ from general population guidance (e.g., widespread testing, use of quarantine)
3. For outbreak reporting to Department of Health:
 - a. Create an outbreak event in WDRS including summary information (e.g., [total case count](#)) using the [COVID-19 Outbreak Determination/Investigation Form](#) as a guide. LHJs can link outbreak-associated cases in WDRS. Do not link household contacts of outbreak-associated cases or others not actually present at the outbreak setting. For additional information on outbreak creation and case linking in WDRS, please see the [Outbreak Events Training Guide](#). To get WDRS Outbreak Manager permission contact covid19wdrsdevs@doh.wa.gov OR
 - b. To request DOH outbreak data support and receive assistance with bulk outbreak and/or case creation and linking, use the Line List Upload Tool for Epidemiologists (LUTE) REDCap [tool](#)
 - c. Additionally, LHJs have the option of using two different Facility Outbreak Notification Tools (FONTs) to gather outbreak details from healthcare facilities and non-healthcare facilities. If your LHJ is interested information on healthcare FONT, contact HAIEpiOutbreakTeam@doh.wa.gov and for information on non-healthcare FONT contact nhcs-covid@doh.wa.gov.

2. THE DISEASE AND ITS EPIDEMIOLOGY

A. Etiologic Agent

Coronaviruses were named for crown-like surface spikes. Six coronavirus strains were previously known to infect humans: alpha coronaviruses, 229E and NL63 (cause mild to moderate upper respiratory illness); and beta coronaviruses, SARS-CoV (severe acute respiratory syndrome [SARS]), OC43 and HKU1 (upper respiratory illness), and MERS-CoV (Middle East respiratory syndrome). In December 2019, China first reported SARS-CoV-2 (initially called 2019 novel coronavirus) cases. The World Health Organization (WHO) named the illness due to SARS-CoV-2 as CoronaVirus Disease-2019 (COVID-19).

Mutations result in new SARS-CoV-2 variants. Although most mutations are not clinically important, of particular concern are variants that transmit more easily; cause more severe disease; or escape diagnostic, therapeutic, or vaccine measures.

B. Description of Illness

Initial common symptoms may include fever, cough, and shortness of breath, as well as chills, headache, fatigue, muscle aches, sore throat, congestion or runny nose, nausea, diarrhea and loss of taste or smell. 25-40% of all infections may be asymptomatic. Test results may be positive while a person is presymptomatic. Severe to critical complications include pneumonia, respiratory distress, arrhythmias, myocarditis, organ damage such as to liver or kidneys, blood clots (hypercoagulability), encephalomyelitis, stroke, and secondary infections.

Risk of severe illness increases for many factors including age > 65 years; males; women who are pregnant; or those who are overweight or with underlying conditions, such as diabetes, heart disease, lung disease or smoker, neurologic condition, cancer, or immunocompromised (see [CDC page](#) for further details). People who are unvaccinated also have a higher risk of severe illness. Pregnancy complications include pre-eclampsia, coagulopathy, sepsis, and stillbirth (see [CDC guidance](#) for more information). Those negatively impacted by long-standing systemic health and social inequalities are also at higher risk of severe or fatal infection.

Recurrence (or “rebound”) of COVID-19 symptoms and test positivity can occur after resolution of initial symptoms, with potential for transmission to others. Recurrence has been observed in patients treated with nirmatrelvir/ritonavir (Paxlovid) but can also occur independent of treatment with nirmatrelvir/ritonavir (Paxlovid).

Post-COVID conditions, also referred to as post-acute sequelae of COVID-19 (PASC) or “long COVID,” refer to symptoms that persist or occur at least four weeks after onset of infection. Post-COVID symptoms may differ from those of the acute infection. See CDC’s [public-facing](#) and [healthcare provider](#) pages.

A rare pediatric multisystem inflammatory syndrome (MIS-C) has been associated with COVID-19 with symptoms including fever, rash, conjunctivitis, vomiting, diarrhea, and abdominal and musculoskeletal pain; see CDC [public-facing](#) and [healthcare provider](#) pages for more information. Adult multisystem inflammatory syndrome (MIS-A) cases have also been reported, affecting multiple organs; see CDC [public-facing](#) and [healthcare](#)

[provider](#) pages for more information.

C. COVID-19 in Washington

WHO declared a pandemic on March 11, 2020. For updated case counts see below.

Washington: [WA DOH COVID-19 Data Dashboard](#)

US: [CDC COVID-19 Data Tracker](#)

Global: [WHO COVID-19 information](#)

D. Reservoirs

The reservoir for SARS-CoV-2 is unknown but may be pangolins or bats. Sequencing found the virus is most closely related to SARS-CoV so may share its reservoirs. Cats, dogs, mink, and zoo and wild animals (e.g., deer) have had documented SARS-CoV-2 infections but are not considered to have a significant role in contributing to outbreaks among humans.

E. Modes of Transmission

The infectious dose has not been established for SARS-CoV-2, but brief exposures have resulted in transmission. Most transmission appears to occur early in the infection. The principal mode of transmission is exposure to respiratory fluids in one of three main ways:

- Inhalation of very fine respiratory droplets and aerosol particles (with greatest particle concentration and risk within 3-6 feet of the source)
- Deposition of respiratory droplets and particles on exposed mucous membranes by direct splashes or sprays (e.g., coughed on)
- Touching mucous membranes (eyes, nose, or mouth) with hands that have been contaminated directly or from touching surfaces (probably a lesser route)

Very fine droplets and aerosol particles can remain suspended in the air for minutes to hours. Exposure at greater than 6 feet does occur, typically involving closed spaces with inadequate ventilation or air handling, increased exhalation of respiratory fluids, and exposures that are prolonged (typically over 15 minutes) or briefly intense (e.g., passing through a person's breathing space). Implicated settings with transmission include fitness facilities, buses, restaurants, and indoor group singing sessions.

Recommendations to prevent transmission include physical distancing, community use of well-fitting masks (e.g., barrier face coverings, procedure/surgical masks), adequate ventilation, and avoidance of crowded indoor spaces. Practicing good hand hygiene and environmental cleaning are also recommended. Appropriate PPE should be used by healthcare personnel (see [CDC guidance on PPE](#)).

F. Incubation Period

For variants before Omicron the estimated incubation period is 2-14 days, with a median of 5-6 days. For Omicron subvariants, the estimated median incubation period 3-4 days.

G. Period of Communicability

Two days before to 10 days after symptom onset (some evidence of transmission events occurring >2 days before symptom onset); up to 20 days if immunocompromised or severe COVID-19 illness; clinicians should also consider a test-based strategy for

immunocompromised patients. Asymptomatic people are communicable. Isolation period per CDC guidance is 5 days for people who are not immunosuppressed and do not have moderate or severe illness, as long as their symptoms are improving, and they have not had a fever for at least 24 hrs. After completing 5 days of isolation, people should wear a mask in public settings for an additional 5 days. People who are immunosuppressed or who experienced moderate or severe illness should isolate for at least 10 days and should consult a healthcare provider before ending isolation. WA DOH recommends a 10-day isolation period in certain settings; see WA DOH guidance on [What to do if you test positive for COVID-19](#) for further details.

Additionally, as mentioned above, some people can experience a COVID-19 “rebound,” with potential for transmission to others. People with recurrence of COVID-19 symptoms or a new positive viral test after having tested negative should restart isolation and isolate again for at least 5 days, and then follow the above recommendations.

Reinfections with SARS-CoV-2 are unlikely within 90 days of infection but can occur. See Testing section for information on testing within 90 days of a prior infection.

H. Treatment

For most non-hospitalized adults at high risk of severe disease, nirmatrelvir/ritonavir (Paxlovid) is first-line treatment. Monoclonal antibody therapy may be appropriate for certain patients; see [WA DOH guidance on monoclonal antibody access](#).

For an overview of treatment options, see [NIH COVID-19 treatment guidelines](#) and [IDSA COVID-19 guidelines](#)

For information on COVID-19 vaccines, see [CDC guidance on COVID-19 vaccines](#).

3. CASE DEFINITIONS

A. Case Classification (see [CDC guidance](#) as well)

Clinical Criteria

In the absence of a more likely diagnosis:

- Acute onset or worsening of at least **two** of the following symptoms or signs: fever (measured or subjective); chills; rigors; myalgia; headache; sore throat; nausea or vomiting; diarrhea; fatigue; or congestion or runny nose OR
- Acute onset or worsening of any **one** of the following symptoms or signs: cough; shortness of breath; difficulty breathing; olfactory disorder; taste disorder; confusion or change in mental status; persistent pain or pressure in the chest; pale, gray, or blue-colored skin, lips, or nail beds, depending on skin tone; or inability to wake or stay awake OR
- Severe respiratory illness with at least **one** of the following: clinical or radiographic evidence of pneumonia; or acute respiratory distress syndrome (ARDS)

Laboratory Criteria

Laboratory evidence – method approved or authorized (e.g., Emergency Use

Authorization) by US Food and Drug Administrations (FDA) or designated authority.*

Confirmatory** laboratory evidence:

- Detection of SARS-CoV-2 RNA in a clinical specimen or a post-mortem respiratory swab using a diagnostic molecular amplification test performed by a Clinical Laboratory Improvement Amendments (CLIA)-certified provider OR
- Detection of SARS-COV-2 by genomic sequencing***

Presumptive** laboratory evidence:

- Detection of SARS-CoV-2 specific antigen in a clinical specimen or post-mortem respiratory swab using a diagnostic test performed by a CLIA-certified provider

Supportive** laboratory evidence

- Detection of antibody in serum, plasma, or whole blood specific to natural infection with SARS-CoV-2 (antibody to nucleocapsid protein), **OR**
- Detection of SARS-CoV-2 specific antigen by immunocytochemistry in an autopsy specimen, **OR**
- Detection of SARS-CoV-2 RNA or specific antigen using a test performed without CLIA oversight

** On March 13, 2020, the President issued a Memorandum on Expanding State-Approved Diagnostic Tests: "Should additional States request flexibility to authorize laboratories within the State to develop and perform tests used to detect COVID-19, the Secretary shall take appropriate action, consistent with law, to facilitate the request."*

*** The terms confirmatory, presumptive, and supportive are categorical labels used here to standardize case classifications for public health surveillance. The terms should not be used to interpret the utility or validity of any laboratory test methodology.*

**** Some genomic sequencing tests that have been authorized for emergency use by the FDA do not require an initial polymerase chain reaction (PCR) result to be generated. Genomic sequencing results may be all the public health agency receives.*

Epidemiologic Linkage

One or more of the following exposures in the 14 days before testing or before onset of symptoms:

- Close contact[†] with a confirmed or probable case of COVID-19 disease, **OR**
- Member of an exposed cohort as defined by public health authorities during an outbreak or during high community transmission

† Close contact is generally defined as being within 6 feet for at least 15 minutes (cumulative over a 24-hour period). However, it depends on the exposure level and setting; for example, in the setting of an aerosol-generating procedure in healthcare settings without proper personal protective equipment (PPE), this may be defined as any duration.

Criteria to Distinguish a New Case from an Existing Case

The following should be enumerated as a new case:

- SARS-CoV-2 sequencing results from the new positive specimen and a positive specimen from the most recent previous case demonstrate a different lineage, **OR**
- Person was most recently enumerated as a confirmed or probable case with onset date (if available) or first positive specimen collection date for that classification >90 days prior[‡], **OR**
- Person was previously reported but not enumerated as a confirmed or probable case (i.e., suspect)^{‡‡}, but now meets the criteria for a confirmed or probable case.

‡Some individuals, e.g., severely immunocompromised persons, can shed SARS-CoV-2 detected by molecular amplification tests >90 days after infection. For severely immunocompromised individuals, clinical judgment should be used to determine if a repeat positive test is likely to result from long-term shedding and, therefore, not be enumerated as a new case. CDC defines severe immunocompromise as certain conditions, such as being on chemotherapy for cancer, combined primary immunodeficiency disorder, untreated human immunodeficiency virus (HIV) infection with CD4 T lymphocyte count <200, or receipt of prednisone >20mg/day for > 14 days.

‡‡Repeat suspect cases should not be enumerated.

Vital records criteria:

A death certificate that lists COVID-19 disease or SARS-CoV-2 as an underlying cause of death or a significant condition contributing to death.

Confirmed Case – Not a previous confirmed or probable case in the prior 90 days AND:

Meets confirmatory laboratory evidence.

Probable Case – Not a previous confirmed or probable case in the prior 90 days AND:

- Meets clinical criteria AND epidemiologic evidence with no confirmatory laboratory testing performed for SARS-CoV-2 **OR**
- Meets presumptive laboratory evidence **OR**
- Meets vital records criteria with no confirmatory laboratory testing performed for SARS-CoV-2.

Suspect Case

Meets supportive laboratory evidence with no prior history of being a confirmed or probable case. Suspect cases are not included in surveillance counts.

B. Multisystem inflammatory syndrome in children (MIS-C)

Case classification:

- An individual aged <21 years presenting with fever*, laboratory evidence of inflammation**, and evidence of clinically severe illness requiring hospitalization, with multisystem (≥ 2) organ involvement (cardiac, renal, respiratory, hematologic, gastrointestinal, dermatologic, or neurological); AND
- No alternative plausible diagnoses; AND
- Positive for current or recent SARS-CoV-2 infection by RT-PCR, serology, or antigen test; or exposure to a suspected or confirmed COVID-19 case within the 4 weeks prior to the onset of symptoms.

**Fever $\geq 38.0^{\circ}\text{C}$ for ≥ 24 hours, or report of subjective fever lasting ≥ 24 hours*

***Including, but not limited to, one or more of the following: an elevated C-reactive protein (CRP), erythrocyte sedimentation rate (ESR), fibrinogen, procalcitonin, d-dimer, ferritin, lactic acid dehydrogenase (LDH), or interleukin 6 (IL-6), elevated neutrophils, reduced lymphocytes, and low albumin*

Additional comments about reporting MIS-C:

- Enter the case in WDRS as an MIS-C event, not as coronavirus. If needed, copy from the coronavirus to the MIS-C event to carry over demographic and laboratory entries.
- Some individuals may fulfill full or partial criteria for [Kawasaki disease](#) but should be reported if they meet the case definition for MIS-C.
- Consider MIS-C in any pediatric death with evidence of SARS-CoV-2 infection.
- For details see [CDC MIS-C guidance](#) and DOH's [monthly MIS-C report](#).

4. LABORATORY DIAGNOSIS AND SERVICES

A. Laboratory Diagnosis

SARS-CoV-2 testing is widely available at clinical laboratories and through over-the-counter test kits, as well as at Washington State Public Health Laboratories (PHL). For uncommon specimen types, PHL can facilitate shipping of specimens to CDC (e.g., autopsy tissues).

Note that coinfections can occur with other agents, such as SARS-CoV-2 and influenza.

B. SARS-CoV-2 Test Types

A number of tests are available for SARS-CoV-2.

1. Viral tests are either nucleic acid amplification tests (NAAT – also called “molecular tests”) or antigen tests (also called immunoassays). Methods used for NAAT are reverse transcription polymerase chain reaction (RT-PCR) and isothermal

amplification (multiple technologies).

NAAT and antigen tests both may be laboratory-based with about a minimum 12-hour turnaround or field-deployable (referred to as rapid tests) with about a 15-minute turnaround. Home self-tests are rapid antigen tests and [can be reported online](#).

For information about NAAT see [CDC guidance](#); APHL also provides [guidance on cycle threshold \(Ct\) values](#).

For information about antigen testing see [CDC antigen testing guidance](#).

2. Antibody/serology tests may detect spike protein, which occurs with either vaccination or infection, or nucleocapsid protein, which occurs only with infection. Antibody tests may identify IgM, IgG, or total antibody.
3. SARS-CoV-2 sequencing (genomic analysis) is not typically used for clinical decisions but has a variety of uses for public health. Statewide, national, and international sequencing data are used to monitor the evolution of the SARS-CoV-2 virus. Sequencing can also be used for outbreak investigation (e.g., to determine if epidemiologically linked cases are all genetically similar or represent multiple distinct chains of transmission). Further information on SARS-CoV-2 sequencing in Washington and instructions on submitting specimens are available on the [DOH Molecular Epidemiology](#) webpage.

It is important to use tests only if they have an FDA Emergency Use Authorization (EUA) or Approval, and to understand characteristics of tests being used. Available products may not have specificity and sensitivity information available. The FDA website has [extensive information](#).

While a Medical Test Site license is generally required to provide SARS-CoV-2 testing, in certain situations, businesses and other establishments without a Medical Test Site license can provide self-tests to individuals to use on-site. See WA DOH [guidance on the use of self-tests](#).

C. Test Interpretation

1. Nucleic acid amplification tests

Nucleic acid amplification tests (NAATs) including PCR may be laboratory-based, which are usually more sensitive, or point-of-care, which are usually more rapid. False-positive results are thought to be rare but can occur from cross-contamination. Because NAAT tests can remain positive for weeks, if testing is indicated for a person with a prior SARS-CoV-2 infection within the last 90 days then an antigen test should be used.

2. Antigen tests

Authorized SARS-CoV-2 antigen tests include point-of-care, laboratory-based, and self-tests. Evaluating an antigen test result depends on the clinical and epidemiological context (e.g., symptoms, exposure to others with COVID-19, vaccination status, previous infection, or setting in which they live such as congregate housing). Antigen tests may be less sensitive than PCR; test performance is more

dependent on viral load. False negative results can occur if specimens are taken early in infection or late in the illness (i.e., times when viral load is low).

Public health actions based on test results depend on symptoms, immune status, and exposure of the person being tested. Recommendations may differ for a congregate setting, for persons with low likelihood of infection, or for persons with high likelihood of infection.

3. Repeat positive tests – criteria to distinguish a new case from an existing case

The following should be enumerated as a new case:

- SARS-CoV-2 sequencing results from the new positive specimen and a positive specimen from the most recent previous case demonstrate a different lineage, **OR**
- Person was most recently enumerated as a confirmed or probable case with onset date (if available) or first positive specimen collection date for that classification >90 days prior*, **OR**
- Person was previously reported but not enumerated as a confirmed or probable case (i.e., suspect)**, but now meets the criteria for a confirmed or probable case.

** Some individuals, e.g., severely immunocompromised persons, can shed SARS-CoV-2 detected by molecular amplification tests >90 days after infection. For severely immunocompromised individuals, clinical judgment should be used to determine if a repeat positive test is likely to result from long-term shedding and, therefore, not be enumerated as a new case. CDC defines severe immunocompromise as certain conditions, such as being on chemotherapy for cancer, combined primary immunodeficiency disorder, untreated human immunodeficiency virus (HIV) infection with CD4 T lymphocyte count 20mg/day for > 14 days.*

*** Repeat suspect cases should not be enumerated.*

See CDC guidance for additional information on the [case definition](#).

4. At-home antigen COVID-19 tests (for reporting self-tests, see [WA DOH guidance](#))

A positive at-home test is evidence of SARS-CoV-2 infection.

A negative at-home test means SARS-CoV-2 was not detected at the time of that test. Any subsequent positive test is most likely SARS-CoV-2 infection. If a person has symptoms consistent with COVID-19 and the initial home test is negative, they should retest every 24-48 hours through at least five days after symptom onset. Alternatively, a molecular test or individual consultation with a healthcare provider can be considered.

5. Non-COVID-19 respiratory infections

If symptoms are compatible with other agents during periods with high levels of respiratory virus infections, when testing for COVID-19 also consider obtaining a second nasal swab or specimen for rapid influenza testing and a viral respiratory panel. As applicable to the clinical situation, also consider testing for infections with

specific treatment available (e.g., legionellosis, other bacterial pneumonia, influenza, RSV). Dual infections of COVID-19 and influenza are documented, as well as parainfluenza virus. A particular concern is a dual outbreak in a healthcare or congregate setting (see [WA DOH guidance](#) for further information).

D. Specimen Collection

It is recommended that a healthcare provider should wear a NIOSH approved and fit tested N95 or higher-level respirator, eye protection, and gloves when actively collecting clinical specimens for SARS-CoV-2 testing or when within 6 feet from the person being tested (see [CDC guidance on planning testing](#)). Instructing the patient on [self-collection of the specimen](#) can help to limit staff exposure during testing. Respirator, eye protection, and gloves should still be used when assisting a patient to self-collect a specimen. If a healthcare provider needs to perform specimen collection, have the patient masked except when taking the specimen and stand to one side of the patient to avoid direct coughs or sneezes. The patient's mask should still cover the mouth when taking a nasal specimen. Refrigerate all specimens at 2-8°C and ship cold for receipt within 72 hours; if exceeding 72 hours holding time, freeze at $\leq -70^{\circ}\text{C}$ and ship on dry ice.

Specimens from Living Patients:

Acceptable specimens for PHL testing include:

- Nasal swab (preferred)
- Nasopharyngeal swab
- Mid-turbinate swab
- Lower respiratory tract fluid (BAL, tracheal aspirate, or sputum) – if intubated

See [PHL instructions](#) for specimen collection and submission under COVID-19. When testing at a commercial or academic laboratory, see their website for collection and submission instructions.

Post-mortem Specimens:

A medical examiner or coroner can submit specimens directly to CDC. Testing at CDC takes at least four to six weeks. Follow all infection prevention guidance if COVID-19 is possible or confirmed. For details see [CDC guidance](#).

If an autopsy is NOT performed, collect the following post-mortem specimens:

- Only upper respiratory tract swab: nasopharyngeal swab
- Separate NP swab and OP swab specimens for testing of other respiratory pathogens (e.g., rapid influenza testing and respiratory panel – not at PHL)

If an autopsy is performed, collect the following post-mortem specimens:

- Upper respiratory tract: nasopharyngeal swab in viral transport medium (VTM)
- Lower respiratory tract: lung swab from each lung in separate VTM tubes
- Separate clinical specimens for testing of other respiratory pathogens such as influenza and as indicated for other infectious disease testing
- Formalin-fixed autopsy tissues from lung, upper airway, and other major organs (e.g., heart, liver, kidney) as indicated in [CDC guidance](#)

CDC may request additional specimens, such as serum or stool, in cluster investigations.

E. Shipping to PHL

Store and ship specimens at temperatures indicated above. For details see Coronavirus in the [DOH Lab Test Menu](#).

Note that PHL requires all clinical specimens have **two** patient identifiers, a name **and** a second identifier (e.g., date of birth) on both the specimen label and on the submission form. Due to laboratory accreditation standards, specimens will be rejected for testing if not properly identified. Also include specimen source and collection date.

Specimen submission forms should be completed electronically via QRP. To enroll, contact wacovidtest@doh.wa.gov or 206-418-5419. Before submitting more than 50 specimens at a time to PHL call 206-418-5419. Along with the patient and submitter names, include the dates of collection and illness onset, race and ethnicity (providing demographic data specified in [Coronavirus Aid, Relief, and Economic Security Act](#), or CARES Act), and patient address and phone. Also make sure there is contact information for the submitter.

F. Free or Low-Cost Testing and Testing Reimbursement

HRSA provides information about [testing and billing requirements](#).

G. Available Commercial Tests for SARS-CoV-2

A large number of tests including the one in use at PHL have received FDA Emergency Use Authorization; FDA provides [further information on authorizations for diagnostic tests](#).

5. ROUTINE CASE INVESTIGATION

COVID-19 reporting was first required under emergency rule WAC 246-101-017 effective 8/6/2020. The emergency rule:

- Explicitly designates SARS-CoV-2 (COVID-19) as a notifiable condition
- Requires health care providers, health care facilities, laboratories, and local health jurisdictions to report race, ethnicity, and other essential information for cases or suspected cases of COVID-19
- Requires reporting of negative laboratory results

See [WA DOH reporting guidance](#) for further information.

A. Case investigation and contact tracing

In most settings, public health case investigation and contact tracing for the general public is no longer routinely performed. However, individuals and establishments are encouraged to notify others of exposures. For jurisdictions that still perform case investigation and contact tracing, a [separate case investigation document](#) is available.

B. Outbreak investigations

See [separate outbreak investigation guidance](#) for a healthcare setting or non-healthcare workplace outbreaks.

Note that a person who is part of one outbreak (e.g., large gathering) who then becomes the index case for a new outbreak (e.g., their workplace) should be entered into WDRS for both outbreaks.

1. Definitions for COVID-19 outbreaks in various settings

- a. Long-term care facility, inpatient hospital setting, or outpatient healthcare setting: see posted [outbreak definition](#) for more information
- b. Non-healthcare congregate setting (such as farms, workplaces, places of worship, or restaurants, but not including schools, correctional facilities, or community settings)
 - Two or more COVID-19 cases who tested positive by a [viral test](#), AND
 - At least two cases have symptom onsets (or positive test specimen collection dates if asymptomatic) within 14 days of each other, AND
 - Cases were epidemiologically linked in the congregate setting (e.g., cases share a work shift or building), AND
 - There is no plausible epidemiological linkage suggesting transmission is more likely to have occurred in another setting (e.g., household) outside of the congregate setting.
- c. School and childcare:

All outbreaks or suspected outbreaks of COVID-19 in a school or child care setting are **required** to be reported to the local health jurisdiction ([WAC 246-101](#)). The DOH defines an outbreak as follows, in alignment with the Council of State and Territorial Epidemiologists (CSTE) [guidance for classification of school outbreaks](#):

- At least **5 cases within a specified core group**¹ meeting criteria for a COVID-19 case from a positive [viral test](#)
- OR
- Multiple COVID-19 cases from positive viral tests comprising at least **20% of students, teachers, or staff within a specified core group**;¹

AND

- The following three criteria are met:
 1. Cases have a symptom onset or positive test result within 7 days of each other, AND
 2. There is no evidence that transmission was more likely to have occurred in another setting (e.g., household or outside social contact) outside of the school or child care, AND
 3. Cases were epidemiologically linked² in the school or child care setting or a school- or child care-sanctioned extracurricular activity³.

¹ A “core group” includes but is not limited to an extracurricular activity³, cohort group, classroom, before/after school care, etc.

² All groups of 5 cases or 20% within a specified core group that meet criteria 1 and 2 will be presumed to have an epi-link and **must be reported to the LHJ as a suspected outbreak**. The LHJ will make the final determination for classifying an outbreak.

³ *A school- or child care-sanctioned extracurricular activity is defined as a voluntary activity sponsored by the school, local education agency (LEA), organization sanctioned by the LEA, or child care. Extracurricular activities include, but are not limited to, preparation for and involvement in public performances, contests, athletic competitions, demonstrations, displays, and club activities.*

- d. Correctional facility (e.g., jail, prison, detention center):
- Two or more COVID-19 cases who tested positive by a [viral test](#), AND
 - At least two cases have symptom onsets (or positive test specimen collection dates if asymptomatic) within 14 days of each other, AND
 - Cases were epidemiologically linked in the correctional facility (e.g., cases reside in the same living area or work together), AND
 - There is no plausible epidemiological linkage suggesting transmission is more likely to have occurred in another setting (e.g., staff share household) outside of the correctional facility


Incarcerated individual COVID-19 cases occurring in intake separation areas are not included in the definition above unless new COVID-19 transmission is thought to be occurring within the intake separation area or elsewhere in the facility.

- e. Community (includes college housing such as a dormitory or fraternity; large gathering such as a demonstration or rally [note that an event in a stadium or arena are included as a service-providing industry]; and private event such as a wedding or family reunion):
- Five or more COVID-19 cases who tested positive by a [viral test](#), AND
 - Cases were epidemiologically linked at a community setting (e.g., common event or venue), AND
 - There is no plausible epidemiological linkage suggesting transmission is more likely to have occurred in another setting (e.g., household, workplace) outside of the community setting, AND
 - Cases had interactions with each other for a period shorter than 2 days

2. Reporting investigations

Outbreaks in workplaces or other congregate settings should be reported to DOH.

- Create an outbreak event in WDRS including summary information (e.g., total case count) using the COVID-19 Outbreak Determination/Investigation Form as a guide. LHJs can link outbreak-associated cases in WDRS. Do not link household contacts of outbreak-associated cases or others not actually present at the outbreak setting. For additional information on outbreak creation and case linking in WDRS, please see the Outbreak Events Training Guide. To get WDRS Outbreak Manager permission contact covid19wdrsdevs@doh.wa.gov.

- To request DOH outbreak data support and receive assistance with bulk outbreak and case creation and linking, use the [Line List Upload Tool for Epidemiologists \(LUTE\)](#) REDCap tool.
- To create an outbreak event in WDRS, a user with “outbreak manager permissions” can click the  icon. Email covid19wdrsdevs@doh.wa.gov for help getting this permission.

Please see WDRS [Outbreak Events Training Guide](#) for additional details.

Naming convention:

Name an outbreak using the following format, replacing italicized items as appropriate, based on the year of first case onset:

Year of outbreak¹ *jurisdiction* COVID-19 *facility name*² (*outbreak number*)³

Example: 2022 Clark COVID-19 Johnson’s Care Center 3

¹Year of outbreak: This is the year when the current outbreak started.

²Facility unique id: For facilities with multiple locations, add city, street name, or facility number as appropriate

³Outbreak number: If there are multiple outbreaks at the same facility, add the number of outbreaks since the start of the pandemic. This number does not start over for a new year.

Do NOT put any PHI in outbreak names, including names, house numbers, or any other personally identifiable information.

- a. Complete the “COVID-19 Outbreak” question package. Critical fields in the COVID-19 Outbreak question package include:
 - i. Accountable County
 - ii. Lead Investigator Information
 - iii. Site category and subcategory
 - iv. Site name and address
 - v. Earliest case symptom onset date (if known)
 - vi. Aggregate case count
- b. Provide information about outbreak cases by completing the case count fields in the “COVID-19 Outbreak- Summary Numbers” question package ([see link for further instructions](#)). Cases arising from secondary transmissions of cases associated with the cluster should not be counted.

- c. In addition to adding the total case count to the Summary Numbers Section in the “COVID-19 Outbreak” question package, you can also link an existing WDRS case to the outbreak event (detailed instructions available on the [WDRS User Group SharePoint](#)) if this information is known:
 - i. Open the outbreak event
 - ii. Click on **(View)** for ‘linked event(s)/contact(s)’
 - iii. Change operation to ‘Link to Existing Event’
 - iv. Click on button to Select Event
 - v. Navigate to the WDRS case (person) by entering name, birthdate or WDRS number and click to select the person
 - vi. Change Link Type to appropriate link type “Staff, Student, etc.” or “Cluster” if link type is unknown.
 - vii. Go to bottom of page and click ‘Save’
 - viii. Repeat steps i-vii for each WDRS case (person) being linked to the outbreak event
- d. If you would like to link multiple cases to an outbreak event in WDRS please fill out the following csv and send the completed csv to COVID19WDRSDevs@doh.wa.gov.
 - i. [RosterTemplate link cases to outbreaks.csv \(sharepoint.com\)](#)
 - ii. Column 1: Case ID, Column 2: Outbreak Event ID, Column 3: Link Type (i.e., Staff, Student, Resident/Inmate, Cluster, etc.).
- e. For notification of cross-border (multi-county, state, or country) outbreaks, LHJs can contact the DOH Non-healthcare Congregate Settings (NHCS) team at nhcs-covid@doh.wa.gov. If needed, NHCS will reach out to the DOH Travel Epi Team.

Additional resources for outbreak investigations are below:

- An employer must not reveal confidential employee health information (CFR [Code of Federal Regulations] § 1630.14 Medical examinations and inquiries specifically permitted). See [US Equal Employment Opportunity Commission guidance](#) for more information.
- Resources to code facility type and subtype are available from the [US Census Bureau](#) and the [US Bureau of Labor Statistics](#).
- To report a workplace safety hazard or complaint, [contact Washington Department of Labor and Industries](#). Employees at the affected worksite can report the hazard or complaint directly to Labor and Industries or LHJ staff can report as well. For an issue that does not require immediate attention, LHJ staff can also contact regional Labor and Industries staff for assistance.

6. INFECTION PREVENTION

A. Healthcare Settings

For infection control guidance for healthcare professionals see [CDC guidance](#).

B. Community-wide Measures

1. Workplace measures

Department of Labor & Industries provides [requirements and guidance for preventing COVID-19 in work settings](#).

See also [OSHA guidance](#) and [CDC guidance for businesses](#).

For WA DOH guidance for businesses, see: [Guidance for Non-Healthcare Businesses and Organizations during COVID-19](#)

2. Individual actions

Information on masks

See Washington State [masking recommendations and current mandates](#) and additional [WA DOH mask guidance](#). Also check for local recommendations in a county or city. Depending on state and local requirements and [diseases levels](#), in some settings masks may be required indoors for all persons, regardless of vaccination status. However, in such settings masks are not required for children younger than 2 years; children ages 2-4 years unable to wear masks; and persons with any medical, developmental, cognitive, or incapacitating condition that prevent wearing a mask safely. For a list of exemptions see the [Secretary of Health Order](#). Department of Labor and Industries may have additional requirements (see Workplace measures above).

Unvaccinated persons and any person taking added precautions are encouraged to use masks in crowded settings, especially indoors.

N95 masks offer the most protection, followed by international standard respirators such as KN95 or KF94 and surgical or procedure-type masks, followed by cloth masks. Masks should not have a vent or exhaust port. Mask effectiveness can be increased by double masking (using a cloth mask over a disposable mask), the use of a mask brace, or knotting and tucking the ear loops of a disposable mask; KN95 or N95 masks should not be combined with other masks. Face shields alone do not substitute for face masks. See [WA DOH mask guidance](#) for more information.

For background see:

[CDC MMWR](#)

[CDC Science Brief](#)

For recommendations about choice and handling of masks see:

[CDC guidance on mask use](#)

[CDC guidance on types of masks](#)

For local health jurisdictions who need to order PPE see [WA DOH guidance](#)

Information for people who have symptoms of COVID-19

Stay home if fever, cough or other [symptoms](#) of COVID-19 develop. Keep apart from others (if possible, use separate sleeping and bathroom areas). Do not share dishes, towels, or

bedding. Before visiting a healthcare setting, tell them of any fever or respiratory symptoms. People should **not** attend a gathering or be in public settings (except for essential medical care) if they are in isolation with COVID-19; experiencing symptoms of COVID-19; or awaiting COVID-19 test results. WA DOH also provides [guidance for people who were exposed to someone with COVID-19 and develop symptoms](#).

Information for people who have been exposed to someone with COVID-19

People who have been exposed to someone with COVID-19 should wear a mask in public settings, get tested, watch for symptoms, and avoid being around people at high risk of severe disease (including healthcare facilities); see [WA DOH guidance for people exposed](#). Quarantine is no longer recommended for the general population but may be considered in high-risk settings under certain circumstances.

C. Travel Measures

Staying [up-to-date with COVID-19 vaccinations](#) can help protect against SARS-CoV-2 infection and especially against severe disease. Precautions such as mask use, social distancing, and hand hygiene are recommended to help reduce the risk of infection. Mask are recommended for people who are in indoor areas of public transportation including airplanes, ships, ferries, trains, subways, taxis, or ride-shares (see [CDC guidance](#)).

People who are experiencing symptoms consistent with COVID-19, test positive for COVID-19, or were recently exposed to someone with COVID-19 should follow [CDC recommendations for travel](#).

Those planning travel should check for all travel requirements and recommendations, especially for international travel requirements.

[CDC domestic travel guidance](#)

[CDC international travel guidance](#)

ADDITIONAL RESOURCES

Public Health Guidance for Healthcare Providers:

[WA DOH guidance](#)

[CDC guidance](#)

Public Health Guidance for Businesses and Other Sites

[WA DOH recommendations](#) (general, businesses and workers, school, childcare, and farm and agricultural workers)

[CDC guidance materials](#) for multiple settings including workplaces, schools, child care, colleges, and gatherings and community events

WA [Labor & Industry recommendations](#)

WA [Confidential L&I consultation information](#)

Guidance for Public Queries

[WA DOH guidance on what to do if you test positive for COVID-19](#)

[WA DOH guidance on what to do if you are exposed to someone with COVID-19](#)

[WA DOH COVID-19 FAQs](#)**ACKNOWLEDGEMENTS**

This document was created from [information from the Centers for Disease Control and Prevention](#)

UPDATES

May 2020: document created

June 5, 2020: Appendix 2 added

June 16, 2020: LTC outbreak definition expanded to include single case among resident or staff

July 26, 2020: added symptoms and complications; added comments of use of cloth masks in the definition of a close contact and in Appendices; self-collection of nasal swabs allowed without medical provider observation; added information for sources of free or low cost testing; added information about homelessness; changed return to work criteria; updated discontinuation of transmission-based precautions in healthcare settings; limited contact tracing for Probable cases to household members; ending isolation and quarantine added to Appendix 1 Section D; expanded Appendix 2

August 13, 2020: case definition (Section 3) includes new olfactory disorder or new taste disorder as a consistent symptom, case definition includes presumptive laboratory evidence as antigen test in respiratory specimen, case definition includes antibody test or detection of antigen by immunocytochemistry in autopsy specimen as supportive laboratory evidence, presumptive laboratory evidence (positive antigen) alone is sufficient for a Probable classification, case definition epi linkage no longer includes travel or residence to an area with sustained ongoing transmission; added specific approach for a suspected false positive result (Section 4A); added details about reinfection (Section 4A); includes new reporting requirements in WAC 246-101-017 (Section 5); updated ending transmission-based precautions (Section 6B); updated recommendations for ending isolation (Appendix 1 Section D)

August 25, 2020: case definition (Section 3) includes new olfactory disorder or new taste disorder as a consistent symptom, case definition includes presumptive laboratory evidence as antigen test in respiratory specimen, case definition includes antibody test or detection of antigen by immunocytochemistry in autopsy specimen as supportive laboratory evidence, presumptive laboratory evidence (positive antigen) alone is sufficient for a Probable classification, case definition epi linkage no longer includes travel or residence to an area with sustained ongoing transmission; expanded case investigation for a Probable case with an antigen positive test results to be the same as for a Confirmed case; CDC dropped the recommendation that returning international travelers have a 14 day quarantine period.

October 9, 2020: specified that laboratories should report negative results; LHJ outbreak reporting options added (Section 1C4); Section 2 updated information on potential airborne transmission and on recurrent infection; updated information on animal infections; Section 4B interpretation of laboratory tests includes potential false positive and false negative results, investigating a case of potential reinfection, and optimal timing for specimen collection; Infection Prevention from Section 5 was separated into a new document; outbreak definitions were summarized in Section 5B; Section 6 specified that incoming international travelers do not need public health monitoring; Appendices on case investigation and on long-term care or workplace cluster investigation were separated into new documents.

November 3, 2020: Section 2 specifies contagious period; close contact specified as *cumulative* 15 minutes of contact *over 24 hours*; Section 4C update for investigation of a reinfection; section 5B school outbreak definition change to include the definition of a close contact

December 11, 2020: Section 2I includes contact information for acquiring non-vaccine therapeutics; Section 4B adds link to CDC algorithm for PCR follow-up testing of antigen results; Section 4C3 added to include CDC recommendations for confirmatory testing; Section 4C4 about delays between symptoms and testing was shortened and clarified; Section 4C7 summarizes investigation of suspected reinfection; Section 6B has updated community-wide and prevention measures in Washington – Section 6B2 states face shields are not masks, cloth masks are not medical grade protection, and the risk of a gathering should be evaluated;

Section 6C updates travel measures with CDC recommendation for international travelers to test before and after travel and to self-quarantine, and for domestic travelers to consider testing

December 22, 2020: recommends genomic analysis for suspected variants sections 2A and 4B; link for influenza testing in long-term care added Section 4C8; attendance at private gatherings recommended to be capped at 200, Section 5B3; updated travel guidance related to countries with circulating variants (Section 6C)

February 18, 2021: description of illness expanded to include persisting symptoms (section 2B); case definition added for MIS-C (Section 3); update that vaccination will not give a positive PCR or antigen result (Section 4); added criteria for genomic analysis of specimens (Section 4C7); outbreak naming convention for 2021 provided (Section 5B3); CDC masking recommendations (Section 6B1); mask requirements for any travel within the country (Section 6); testing requirements for arriving travelers and reporting ill cases who attempt to travel or who traveled (Section 6C)

March 24, 2021: updated protocol for suspected reinfection (Section 4B7); additional CDC links for mask recommendations (Section 6B1); updated mask recommendations including for fully vaccinated persons (Section 6B2); updated travel recommendations include testing before and after travel, and self-quarantine for seven days after a negative result after travel (Section 6C)

April 5, 2021: update on post-COVID conditions, long-term sequelae and multisystem inflammatory condition (Section 2B); for travel within the United States, fully vaccinated travelers do not need testing before or after travel and do not need to self-quarantine (Section 6C); for international travel fully vaccinated travelers do not need to self-quarantine but should be tested before and after the flight (Section 6C)

May 17, 2021: transmission information updated (Section 2E), updated recommendations for masking for fully vaccinated persons (Section 6B)

June 22, 2021: updated recommendations for interpreting antigen test results (Section 4C); updated mask recommendations (Section 6B)

July 1, 2021: updated masking, travel and business recommendations (Sections 6B and 6C)

July 19, 2021: updated masking guidance (Section 6B2).

August 30, 2021: updated case definition (Section 3), added links to therapeutic references (Section 2H)

September 22, 2021: updated resources for monoclonal antibodies (Section 2H)

October 18, 2021: updated Probable case definition on front page; updated SARS-CoV-2 tests (Section 4B), new definition of a school-associated outbreak and cluster (Section 5B)

October 28, 2021: case definition updated on front page

November 22, 2021: case definition further updated on front page

2/22/22: testing section streamlined (Section 4); outbreak case definitions updated (Section 5B1); travel measures updated (Section 6C)

March 2022: updated masking section

June 2022: undated travel information removing mask requirements

August 2022: updated outbreak definition for schools and child care (Section 5B)

November 2022: Incubation period updated to reflect Omicron-specific data. Available treatments updated. Updated with current guidelines for isolation and for people exposed to someone with COVID-19. Updated with current public health practices for COVID-19 (e.g., contact tracing no longer routine in most settings). Outbreak reporting process updated. Added discussion of COVID-19 rebound. Updated COVID-19 testing guidance to reflect current use of self-tests and use of antigen tests within 90 days of a prior infection. Updated SARS-CoV-2 sequencing guidance. Updated school and childcare outbreak definition.

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email civil.rights@doh.wa.gov.