

Coronavirus Disease 2019 (COVID-19)

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Discontinuation of Isolation for Persons with COVID-19 Not in Healthcare Settings Ending Home Isolation

Interim Guidance

Updated July 20, 2020

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CDC guidance for COVID-19 may be adapted by state and local health departments to respond to rapidly changing local circumstances.

Summary Page

Who this is for:

Healthcare providers and public health officials managing persons with coronavirus disease 2019 (COVID-19) under isolation who are not in healthcare settings. This includes, but is not limited to, at home, in a hotel or dormitory room, or in a group isolation facility.

For Hospitalized Patients, see ([Discontinuation of Transmission-Based Precautions and Disposition of Patients with COVID-19 in Healthcare Settings \(Interim Guidance\)](#)).

Summary of Recent Changes

Updates as of July 20, 2020

- A test-based strategy is no longer recommended to determine when to discontinue home isolation, except in certain circumstances.
- Symptom-based criteria were modified as follows:
 - Changed from “at least 72 hours” to “at least 24 hours” have passed *since last* fever without the use of fever-reducing medications.
 - Changed from “improvement in respiratory symptoms” to “improvement in symptoms” to address expanding list of symptoms associated with COVID-19.
- For patients with severe illness, duration of isolation for up to 20 days after symptom onset may be warranted. Consider consultation with infection control experts.
- For persons who never develop symptoms, isolation and other precautions can be discontinued 10 days after the date of their first positive RT-PCR test for SARS-CoV-2 RNA.

A summary of current evidence and rationale for these changes is described in the [Duration of Isolation and Precautions for Adults with COVID-19](#).

[Previous Updates](#)

The CDC is learning more about COVID-19 every day, and as new information becomes available, CDC will update the information below. [This guidance is based on available information about COVID-19](#) and is subject to change as additional information becomes available.

The approach outlined below may differ from that recommended for healthcare personnel or patients in healthcare settings with COVID-19 due to different susceptibilities and risks associated with onward transmission in a healthcare setting.

Other Resources:

- Specific guidance for return to work for healthcare personnel can be found at: [Return to Work for Healthcare Personnel with Confirmed or Suspected COVID-19](#).
- [Guidance for Discontinuation of Transmission-Based Precautions and Disposition of Patients with SARS-CoV-2 Infection in Healthcare Settings \(Interim Guidance\)](#) is also available.

Discontinuing Home Isolation for Persons with COVID-19:

Accumulating evidence supports ending isolation and precautions for persons with COVID-19 using a symptom-based strategy. Specifically, researchers have reported that people with mild to moderate COVID-19 remain infectious no longer than 10 days after their symptoms began, and those with more severe illness or those who are severely immunocompromised remain infectious no longer than 20 days after their symptoms began. Therefore, CDC has updated the recommendations for discontinuing home isolation as follows:

Persons with COVID-19 who have symptoms and were directed to care for themselves at home may discontinue isolation under the following conditions:

- At least 10 days* have passed since symptom onset **and**
- At least 24 hours have passed since resolution of fever without the use of fever-reducing medications **and**
- Other symptoms have improved.

*A limited number of persons with severe illness may produce replication-competent virus beyond 10 days, that may warrant extending duration of isolation for up to 20 days after symptom onset. Consider consultation with infection control experts. See [Discontinuation of Transmission-Based Precautions and Disposition of Patients with COVID-19 in Healthcare Settings \(Interim Guidance\)](#).

Persons infected with SARS-CoV-2 who never develop COVID-19 symptoms may discontinue isolation and other precautions 10 days after the date of their first positive RT-PCR test for SARS-CoV-2 RNA.

Role of testing for discontinuing isolation or precautions:

RT-PCR testing for detection of SARS-CoV-2 RNA for discontinuing isolation could be considered for persons who are severely immunocompromised¹, in consultation with infectious disease experts. For all others, a test-based strategy is no longer recommended except to discontinue isolation or other precautions earlier than would occur under the symptom-based strategy outlined above.

The test-based strategy requires negative results using RT-PCR for detection of SARS-CoV-2 RNA under an FDA Emergency Use Authorization (EUA) for COVID-19 from at least two consecutive respiratory specimens collected ≥ 24 hours apart (total of two negative specimens).[†] See [Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens from Persons for Coronavirus Disease 2019 \(COVID-19\)](#).

[†]All test results should be final before isolation is ended. Testing guidance is based on limited information and is subject to change as more information becomes available.

Other Considerations

Note that recommendations for discontinuing isolation in persons known to be infected with SARS-CoV-2 could, in some circumstances, appear to conflict with recommendations on when to discontinue quarantine for persons known to have been **exposed** to SARS-CoV-2. CDC recommends 14 days of quarantine **after exposure** based on the time it takes to develop illness if infected. Thus, it is possible that a person *known* to be infected could leave isolation earlier than a

person who is quarantined because of the *possibility* they are infected.

These recommendations will prevent most, but cannot prevent all, instances of secondary spread. The best available evidence suggests that recovered persons can continue to shed detectable SARS-CoV-2 RNA in upper respiratory specimens for up to 3 months after illness onset, albeit at concentrations considerably lower than during illness, in ranges where replication-competent virus has not been reliably recovered and infectiousness is unlikely. Studies have not found evidence that clinically recovered persons with persistence of viral RNA have transmitted SARS-CoV-2 to others.

Footnotes

*All test results should be final before isolation is ended. Testing guidance is based upon limited information and is subject to change as more information becomes available. In persons with a persistent productive cough, SARS-CoV-2-RNA might be detected for longer periods in sputum specimens than in respiratory specimens.

Previous Updates

Updates as of July 17, 2020

- Symptom-based criteria were modified as follows:
 - Changed from “at least 72 hours” to “at least 24 hours” have passed *since last* fever without the use of fever-reducing medications
 - Changed from “improvement in respiratory symptoms” to “improvement in symptoms” to address expanding list of symptoms associated with COVID-19
- A summary of current evidence and rationale for these changes is described in a [Decision Memo](#).

Updates as of May 29, 2020

Added information around the management of persons who may have prolonged viral shedding after recovery.

Updates as of May 3, 2020

- Changed the name of the ‘non-test-based strategy’ to the ‘symptom-based strategy’ for those with symptoms. Added a ‘time-based strategy’ and named the ‘test-based strategy’ for asymptomatic persons with laboratory-confirmed COVID-19. Extended the home isolation period from 7 to 10 days *since symptoms first appeared* for the symptom-based strategy in persons with COVID-19 who have symptoms and from 7 to 10 days after the date of their first positive test for the time-based strategy in asymptomatic persons with laboratory-confirmed COVID-19. This update was made based on evidence suggesting a longer duration of viral shedding and will be revised as additional evidence becomes available. This time period will capture a greater proportion of contagious patients; however, it will not capture everyone.
- Removed specifying use of nasopharyngeal swab collection for the test-based strategy and linked to the [Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens for Coronavirus Disease 2019 \(COVID-19\)](#), so that the most current specimen collection strategies are recommended.

Updates as of April 4, 2020

- Revised title to include isolation in all settings other than health settings, not just home.

Additional Resources

- [Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens from Persons for Coronavirus Disease 2019 \(COVID-19\)](#)
- [Interim Guidance for Implementing Home Care of People Not Requiring Hospitalization for Coronavirus Disease 2019 \(COVID-19\)](#)

- [Guidance for Healthcare Workers about COVID-19 Testing](#)
- [Guidance for Health Departments about COVID-19 Testing in the Community](#)

¹ The studies used to inform this guidance did not clearly define “severely immunocompromised.” For the purposes of this guidance, CDC used the following definition:

- Some conditions, such as being on chemotherapy for cancer, untreated HIV infection with CD4 T lymphocyte count < 200, combined primary immunodeficiency disorder, and receipt of prednisone >20mg/day for more than 14 days, may cause a higher degree of immunocompromise and inform decisions regarding the duration of isolation.
- Other factors, such as advanced age, diabetes mellitus, or end-stage renal disease, may pose a much lower degree of immunocompromise and not clearly affect decisions about duration of isolation.
- Ultimately, the degree of immunocompromise for the patient is determined by the treating provider, and preventive actions are tailored to each individual and situation.

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Last Updated July 20, 2020