



Coronavirus Disease 2019 (COVID-19)

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

Interim Guidance

Updated July 17, 2020

[Print](#)

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 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](#).

[Previous Updates](#)

Limited information is available to characterize the spectrum of clinical illness, transmission efficiency, and the duration of viral shedding for persons with COVID-19. [This guidance is based on available information about COVID-19](#) and subject to change as additional information becomes available.

For Persons with COVID-19 Under Isolation:

The decision to discontinue home isolation for persons with confirmed or suspected COVID-19 should be made in the context of local circumstances. Options include a symptom-based (i.e., time-since-illness-onset and time-since-recovery strategy) or a test-based strategy. Of note, there have been reports of prolonged detection of RNA without direct correlation to viral culture.

1). Symptom-based strategy

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 symptoms first appeared* **and**
- At least 24 hours have passed *since last fever* without the use of fever-reducing medications **and**
- Symptoms (e.g., cough, shortness of breath) have improved

2). Test-based strategy Previous recommendations for a test-based strategy remain applicable; however, a test-based strategy is contingent on the availability of ample testing supplies and laboratory capacity as well as convenient access to testing.

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

- Resolution of fever **without** the use of fever-reducing medications **and**
- Improvement in symptoms (e.g., cough, shortness of breath), **and**
- Negative results of an FDA Emergency Use Authorized COVID-19 molecular assay for detection of SARS-CoV-2 RNA 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 \(COVID-19\)](#). Of note, there have been reports of prolonged detection of RNA without direct correlation to viral culture.

For Persons Who have NOT had COVID-19 Symptoms but Tested Positive and are Under Isolation:

Options now include both a 1) time-based strategy, and 2) test-based strategy.

1). Time-based strategy

Persons with laboratory-confirmed COVID-19 who have not had any symptoms and were directed to care for themselves at home may discontinue isolation under the following conditions:

- At least 10 days have passed since the date of their first positive COVID-19 diagnostic test assuming they have not subsequently developed symptoms since their positive test. If they develop symptoms, then the symptom-based or test-based strategy should be used. Note, because symptoms cannot be used to gauge where these individuals are in the course of their illness, it is possible that the duration of viral shedding could be longer or shorter than 10 days after their first positive test.

2). Test-based strategy A test-based strategy is contingent on the availability of ample testing supplies and laboratory capacity as well as convenient access to testing.

Persons with laboratory-confirmed COVID-19 who have not had any symptoms and were directed to care for themselves at home may discontinue isolation under the following conditions:

- Negative results of an FDA Emergency Use Authorized COVID-19 molecular assay for detection of SARS-CoV-2 RNA 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 \(COVID-19\)](#). Note, because of the absence of symptoms, it is not possible to gauge where these individuals are in the course of their illness. There have been reports of prolonged detection of RNA without direct correlation to viral culture.

Other Considerations

The symptom-based, time-based, and test-based strategies may result in different timeframes for discontinuation of isolation post-recovery. For all scenarios outlined above, the decision to discontinue isolation should be made in the context of local circumstances.

Note that recommendations for discontinuing isolation in persons known to be infected with COVID-19 could, in some circumstances, appear to conflict with recommendations on when to discontinue quarantine for persons known to have been **exposed** to COVID-19. 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.

This recommendation will prevent most, but cannot prevent all, instances of secondary spread. The risk of transmission after recovery is likely substantially less than that during illness; recovered persons will not be shedding large amounts of virus by this point, if they are shedding at all. Employers and local public health authorities can choose to apply more stringent criteria for certain persons where a higher threshold to prevent transmission is warranted.

For certain populations, a longer timeframe after recovery may be desired to minimize the chance of prolonged shedding of replication-competent virus. Such persons include:

- [healthcare personnel](#) in close contact with vulnerable persons at high-risk for illness and death if those persons get COVID-19 and
- [persons who have conditions that might weaken their immune system](#) which could prolong viral shedding after recovery.

Experience from other respiratory viral infections, in particular influenza, suggests that people with COVID-19 may shed detectable viral materials of unknown infectious potential for an extended period of time after recovery. The best available evidence suggests that most persons recovered from illness with detectable viral RNA (either persistent or recurrent) are likely no longer infectious, but conclusive evidence is not currently available. Prolonged viral shedding has been demonstrated without direct correlation with replication competent virus. Although persons may produce PCR-positive specimens for up to 6 weeks, it remains unknown whether these PCR-positive samples represent the presence of infectious virus. Such persons should consult with their healthcare provider; strategies to address this might include additional PCR testing. When a test-based strategy is not feasible or desired, consider consultation with local infectious disease experts about discontinuing home isolation for patients who might have prolonged viral shedding, including those who are immunocompromised.

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 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

NOTE: Specific guidance for return to work for healthcare facilities for healthcare personnel can be found at: [Return to Work for Healthcare Personnel with Confirmed or Suspected COVID-19](#)

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

References

- Arons MM, Hatfield KM, Redd SC, Kimball A, James A, Jacobs JR, et al. (2020). Presymptomatic SARS-CoV-2 infections and transmission in a skilled nursing facility. *N Engl J Med*. doi:10.1056/NEJMoa2008457.
- Chan JF, Yuan S, Kok KH, et al. A familial cluster of pneumonia associated with the 2019 novel coronavirus indicating person-to-person transmission: a study of a family cluster. *Lancet*. 2020 Jan 24; 395(10223):514–23. doi: 10.1016/S0140-6736(20)30154-9.
- Holshue ML, DeBolt C, Lindquist S, et al. First case of 2019 novel coronavirus in the United States. *N Engl J Med*. 2020

Jan 31. doi: 10.1056/NEJMoa2001191.

- Huang C, Wang Y, Li X, et al. Clinical features of patients infected with 2019 novel coronavirus in Wuhan, China. *Lancet*. 2020 Jan 24;395(10223):497–506. doi: 10.1016/S0140-6736(20)30183-5
- Korea Centers for Disease Control and Prevention. <https://www.cdc.go.kr/board/board.es?mid=a30402000000&bid=0030>
- Midgley CM, Kujawski SA, Wong KK, Collins, JP, Epstein ., Killerby ME et al. (2020). Clinical and Virologic Characteristics of the First 12 Patients with Coronavirus Disease 2019 (COVID-19) in the United States. *Nature Medicine*,
- Wölfel R, Corman VM, Guggemos W, Seilmaier M, Zange S, Müller MA, et al. (2020). Virological assessment of hospitalized patients with COVID-2019. *Nature*. doi:10.1038/s41586-020-2196-x
- Xiao AT, Tong YX, Zhang S. Profile of RT-PCR for SARS-CoV-2: a preliminary study from 56 COVID-19 patients [published online ahead of print, 2020 Apr 19]. *Clin Infect Dis*. 2020; ciaa460. doi:10.1093/cid/ciaa460
- Young BE, Ong SWX, Kalimuddin S, et al., “Epidemiologic Features and Clinical Course of Patients Infected with SARS-CoV-2 in Singapore.”, *JAMA*. 2020 Mar 3. doi: 10.1001/jama.2020.3204.
- Zhu N, Zhang D, Wang W, et al. A novel coronavirus from patients with pneumonia in China, 2019. *N Engl J Med*. 2020 Jan 24. doi: 10.1056/NEJMoa2001017
- Zou L, Ruan F, Huang M, Liang L, Huang H, Hong Z, et al. (2020). SARS-CoV-2 Viral Load in Upper Respiratory Specimens of Infected Patients. *N Engl J Med*, 382(12), 1177-1179. doi:10.1056/NEJMc200173

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