



Health Alert



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UPDATED Isolation Period Recommendations for Congregate, Non-Congregate, and Healthcare Settings

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Summary and Action Items

- New data is available on COVID-19 transmissibility while current local epidemiology reveals slowed community transmission and the approach of a deceleration phase.
- During pandemic deceleration, a stricter “release from isolation” requirement is recommended to strategically reduce risk of transmission from recovered persons.
- CDC has updated their guidance, with an [updated recommended isolation period](#) of 10 days from symptom onset and 3 days from recovery (“10-and-3”) to provide a uniform single recommendation that can be applied in healthcare and non-healthcare settings.

Background: In most community settings, new COVID-19 infections and overall requirement for isolation will decline as local testing capacity increases and social distancing efforts have led to an attenuated case count doubling time. However, as efforts to limit the risk of recurrent waves of COVID-19 infection increase, a stricter “release from isolation” requirement may strategically reduce risk of transmission from recovered persons without substantial added societal burden. As new data becomes available on COVID-19 transmissibility, CDC has proposed an updated recommended isolation period of 10 days from symptom onset and 3 days from recovery (“10-and-3”) to provide a uniform single recommendation that can be applied in healthcare and non-healthcare settings. See [Symptom-Based Strategy to Discontinue Isolation for Persons with COVID-19 Decision Memo](#). This new isolation period applies prospectively from the date of this health alert (5/4/20) to decisions related to release from Transmission-based precautions, discharge, and alternative housing solutions. For specific recommendations on return to work for healthcare personnel see <https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html>.

Key Points on Viability of COVID-19 in Respiratory Specimens: Attempts to culture virus from upper respiratory specimens have been largely unsuccessful when viral burden is in low but detectable ranges (i.e., Ct values higher than 33-35, CDC unpublished data). Following recovery from clinical illness, many patients no longer have detectable viral RNA in upper respiratory specimens¹⁻⁴. Among those who continue to have detectable RNA, concentrations of detectable RNA 3 days following recovery are generally in the range at which replication-competent virus has not been reliably isolated³. No clear correlation has been described between length of illness and duration of post-recovery shedding of detectable viral RNA in upper respiratory specimens^{1,2}. Infectious virus has not been cultured from urine or reliably cultured from feces; these potential sources pose minimal if any risk of transmitting infection^{1,2}.

- Viral burden measured in upper respiratory specimens declines after onset of illness. At this time, replication-competent virus has not been successfully cultured greater than 9 days after onset of illness^{1,5}.
- The statistically estimated likelihood of recovering replication-competent virus approaches zero by 10 days^{1,5}.

New Isolation Period Recommendation for Congregate and Non-Congregate Settings

For persons recovered from COVID-19 illness, CDC, and CDPH recommend that isolation be maintained for **at least 10 days after illness onset and at least 72 hours after recovery**. Recovery is defined as resolution of fever without the use of fever-reducing medications and improvement in respiratory symptoms (e.g., cough, shortness of breath).

While this strategy can apply to most recovered persons, CDPH recognizes there are circumstances where there is an especially low tolerance for post-recovery SARS-CoV-2 shedding and risk of transmitting infection.

- Consider consulting with local infectious disease experts when making decisions about [discontinuing Transmission-Based Precautions for individual cases of severe immunocompromise](#) [immunosuppressive medical treatment (e.g., biologics, chemotherapy, prolonged corticosteroid use), inherited disorder, or HIV infection] or complex reentry into other high-risk community settings where there may be increased risk of transmission and/or increased morbidity and mortality from infection. This includes residents of congregate living facilities like correctional/detention facilities, assisted living facilities, and long-term care facilities.
- Individual clinician decisions to extend Transmission-Based Precautions beyond the “10-and-3” period may supersede public health recommendations in these cases.

Discontinuation of Transmission-Based Precautions and Disposition of COVID-19 Patients in Healthcare Settings

The decision to discontinue Transmission-Based Precautions for patients with confirmed COVID-19 should be made using either a test-based strategy or a symptom-based (i.e., time-since-illness-onset and time-since-recovery strategy) or time-based strategy as described below. **Meeting criteria for discontinuation of Transmission-Based Precautions is not a prerequisite for discharge.** See <https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html> for additional details on management of suspect COVID-19 patients as well as guidance on discharge to congregate settings. Congregate living facilities may not refuse individuals back into housing as long as appropriate social distancing or infection control, including ability to cohort and use of Transmission-Based Precautions, can be maintained.

Symptomatic patients with COVID-19 should remain in Transmission-Based Precautions until either:

- Symptom-based strategy (*preferred*)
 - At least 3 days (72 hours) have passed since recovery defined as resolution of fever without the use of fever-reducing medications and improvement in respiratory symptoms (e.g., cough, shortness of breath); and,
 - At least 10 days have passed since symptoms first appeared
- Test-based strategy
 - Resolution of fever without the use of fever-reducing medications and
 - Improvement in respiratory 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 for 2019 Novel Coronavirus \(2019-nCoV\)](#). Of note, there have been reports of prolonged detection of RNA without direct correlation to viral culture.

Asymptomatic Patients with laboratory-confirmed COVID-19 should remain in Transmission-Based Precautions until either:

- Time-based strategy (*preferred*)
 - 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. 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.
- Test-based strategy
 - 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). Note, because of the absence of symptoms, it is not possible to gauge where these individuals are in the course of their illness.

If a patient suspected of having COVID-19 is never tested, the decision to discontinue Transmission-Based Precautions can be made based upon using the symptom-based strategy described above.

References:

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3. Young et al. (2020). Epidemiologic Features and Clinical Course of Patients Infected With SARS-CoV-2 in Singapore. *JAMA*. doi:10.1001/jama.2020.3204
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