**Discontinuation of Isolation for Nursing Home Residents with COVID-19**

CDC has recently released new guidance on discontinuation of isolation for COVID-19. Therefore, Nebraska ICAP is also revising the guidance for discontinuation of isolation for residents of long-term care facilities that is based on the updated information provided by the CDC.

Long-term care facilities can use the following guidance on making decisions on discontinuing isolation for the residents who are diagnosed with COVID-19.

- In general, isolation should be discontinued for all residents (including those with severe and critical illness) who were diagnosed with (or had symptom onset) of COVID-19 twenty (20) days ago as long as they are afebrile for more than 24 hours and other symptoms have improved.

However, the duration of isolation may be longer or shorter in some specific cases as mentioned below:

- If a resident continues to have significant symptoms on day 20, then extend the duration for isolation until the resident is afebrile for more than 24 hours and other symptoms have improved.

- Facilities may consider to discontinue isolation earlier for those residents who are: (a) not severely immunocompromised and (b) clearly had mild to moderate illness or were completely asymptomatic all along. The isolation for those residents (who meet both criteria (a) and (b)) can be discontinued at day 10 after the diagnosis (if they were asymptomatic) or symptoms onset (if they had symptoms and has now been afebrile for >24 hours with all other symptoms improved).

- Facilities may consider using testing-based strategy for discontinuation of isolation if they are considering discontinuation of isolation earlier than what is recommended above.

- Test based strategy may also be considered for severely immunocompromised residents, if concern exist for them being infectious for more than 20 days.

**Note:** In order to be considered afebrile, the fever should be absent without the use of fever-reducing medications.
Definitions:

**Mild Illness**: Individuals who have any of the various signs and symptoms of COVID-19 (e.g., fever, cough, sore throat, malaise, headache, muscle pain) without shortness of breath, dyspnea, or abnormal chest imaging.

**Moderate Illness**: Individuals who have evidence of lower respiratory disease by clinical assessment or imaging, and a saturation of oxygen (SpO2) ≥94% on room air at sea level.

**Severe Illness**: Individuals who have respiratory frequency >30 breaths per minute, SpO2 <94% on room air at sea level (or, for patients with chronic hypoxemia, a decrease from baseline of >3%), ratio of arterial partial pressure of oxygen to fraction of inspired oxygen (PaO2/FiO2) <300 mmHg, or lung infiltrates >50%.

**Critical Illness**: Individuals who have respiratory failure, septic shock, and/or multiple organ dysfunction.

**Severely immunocompromised**: 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 Transmission-Based Precautions.

Also note: 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 Transmission-Based Precautions. **Ultimately, the degree of immunocompromise for the patient is determined by the treating provider, and preventive actions are tailored to each individual and situation.**

References:

