Considerations for Cohorting COVID-19
Patients in Post-Acute Care Facilities

COVID-19 has had a major impact on healthcare facilities, especially in the post-acute care setting. COVID-19 has a broad clinical presentation, long incubation period, and is transmissible through asymptomatic or pre-symptomatic infected people, including patients/residents and healthcare personnel (HCP). Therefore, cohorting using traditional symptom-based screening alone should be avoided. When necessary, cohorting should be done with caution, given the risk of asymptomatic or pre-symptomatic infection. Cohorting is most effective when resources permit rapid identification, isolation, and dedicated HCP and equipment per cohort. Please note that this document is intended to help guide decisions in consultation with the clinical team and facility-specific resources. Highlight reflects content revisions.

Cohorting is only one element of infection prevention and control measures used for outbreak control. The facility should routinely monitor and update its facility-specific cohorting plan. This plan should consider resources, including the availability of testing, vaccines, personal protective equipment (PPE), equipment, and staffing. Facilities should identify space in the facility that could be dedicated to monitoring and caring for patients/residents with confirmed SARS-CoV-2 Infection. Patients/residents who have confirmed SARS-CoV-2 infection should be placed in a separate and distinct COVID-19 care unit/area. Management of patients/residents includes:

a) SARS-CoV-2 positive patients/residents (i.e, COVID-19 care unit/area)

These individuals consist of both symptomatic and asymptomatic patients/residents who test positive for SARS-CoV-2, regardless of vaccination status, including any new or re-admitted patients/residents known to be positive who have not met the criteria for discontinuation of transmission-based precautions. If feasible, care for SARS-CoV-2 positive patients/residents on a separate closed unit. Patients/residents who test positive for SARS-CoV-2 are known to shed virus, regardless of symptoms; therefore, all newly positive* patients/residents would be placed in the COVID-19 care unit/area.

The facility should establish a plan (including appropriate placement and PPE use) to manage patients/residents exposed to SARS-CoV-2, those suspected of COVID-19, and those who are new or readmissions. Management of these patients/residents includes:

b) Unvaccinated, SARS-CoV-2 negative, close contact patients/residents

These individuals consist of all symptomatic and asymptomatic unvaccinated patients/residents who test negative for SARS-CoV-2 with an identified exposure (i.e., close contact) to someone SARS-CoV-2 positive. All symptomatic patients/residents should be evaluated for causes of their symptoms. Patients/residents who test negative for SARS-CoV-2 could be incubating and later test positive. To the best of their ability, facilities should separate symptomatic and asymptomatic patients/residents, ideally having symptomatic housed in private rooms. Even though symptomatic SARS-CoV-2 negative patients/residents might not be a threat to transmit SARS-CoV-2, they still may have another illness, such as influenza. Asymptomatic patients/residents with close contact to a COVID-19 case should be closely monitored for symptom development.

Unvaccinated patients/residents identified as close contacts* should be quarantined for 14 days and have a series of two viral tests. In these situations, testing is recommended immediately (but not earlier than 2 days after the exposure) and, if negative, again 5–7 days after the exposure. If testing remains negative,
unvaccinated close contact patients/residents should complete the remainder of their 14-day quarantine period. Testing at the end of this period could be considered to increase the certainty that the person is not infected. However, fully vaccinated patients/residents identified as close contacts* should continue to follow the Centers for Disease Control and Prevention (CDC) infection prevention and control measures, including wearing well-fitting source control, getting tested as described above, and monitoring for symptoms for 14 days after exposure.

c) Unvaccinated, new or readmission observation:

These individuals consist of all unvaccinated new patients/residents from the community or other healthcare facilities and unvaccinated re-admitted patients/residents who left the facility for ≥24 hours. This cohort serves as an observation area where persons remain for 14 days to monitor for symptoms that may be clinically compatible with COVID-19. Testing at the end of this period could be considered to increase the certainty that the person is not infected. In most circumstances, quarantine is not recommended for unvaccinated patients/residents who leave the facility for <24 hours and do not have close contact with a suspected or known COVID-19 positive person.

*EXCEPTIONS TO CONSIDER: Individuals who remain asymptomatic have met the criteria for discontinuation of transmission-based precautions for SARS-CoV-2 infection, and it has been <3 months after the date of symptom onset or positive viral test (for asymptomatic) of prior infection generally require no further restrictions based on their history of COVID-19. Consideration needs to be given to determine whether there is concern that there may have been a false positive viral test, whether the patient/resident is immunocompromised, and whether there is evidence of exposure to a novel SARS-CoV-2 variant. If a patient/resident experience new signs or symptoms consistent with COVID-19 and an evaluation fails to identify a diagnosis other than SARS-CoV-2 infection (e.g., influenza), then repeat viral diagnostic testing and isolation may be warranted even if they have clinically recovered within 3 months. Additionally, healthcare facilities should continue to follow the infection prevention and control recommendations for unvaccinated individuals when caring for fully vaccinated individuals with moderate to severe immunocompromise due to a medical condition or receiving immunosuppressive medications or treatments. This includes using transmission-based precautions for those who have had close contact with someone with SARS-CoV-2 infection.

Frequently asked questions

What if space in our facility does not allow us to create a “separate wing/unit” for these cohorts?

Facilities should do their best to designate separate wings/units or floors for cohorts when available; however, any general physical separation may be acceptable. This may include one side of a wing/unit or a group of rooms at the end of a wing/hallway. However, patients/residents colonized with or infected with multi-drug resistant organisms, including Clostridioides difficile, should not be placed in a semi-private room when possible unless their potential roommate(s) is/are colonized or infected with the same organism(s).

What does it mean to dedicate HCP to these cohorts?

To the extent possible, the same HCP should be responsible for the care and services provided within individual cohorts. Ensure HCP prioritize rounding in a “well to ill” flow to minimize the risk of cross-contamination (i.e.,
beginning with standard precaution care areas and working toward transmission-based precaution, then finally outbreak areas). **HCP caring for COVID-19 positive patients/residents should be dedicated to this care unit/area when it is in use.**

**Can equipment be used across cohorts?**

Dedicate equipment to the COVID-19 positive care unit/area. To the best of your ability, equipment **should not be shared across cohorts.** If this is not possible, equipment should be used by rounding in a “well to ill” flow to minimize the risk of cross-contamination. All equipment should be **appropriately cleaned and disinfected** according to the manufacturer’s instructions between patient/resident use. Refer to the Environmental Protection Agency (EPA) website for more information on **List N: Disinfectants for Coronavirus (COVID-19)** at [https://www.epa.gov/pesticide-registration/list-n-disinfectants-coronavirus-covid-19](https://www.epa.gov/pesticide-registration/list-n-disinfectants-coronavirus-covid-19) and **Selected EPA-Registered Disinfectants** at [https://www.epa.gov/pesticide-registration/selected-epa-registered-disinfectants](https://www.epa.gov/pesticide-registration/selected-epa-registered-disinfectants) to ensure coverage for commonly seen pathogens.

**Do patients/residents who are fully vaccinated require quarantine?**

In general, the current updated CDC guidance does not require quarantine for **asymptomatic** fully-vaccinated individuals. However, there are circumstances when quarantine may be considered:

- Patient/resident is moderate to severely immunocompromised;
- If the previous diagnosis of SARS-CoV-2 infection might have been based on a false-positive test result; or
- In the event of ongoing transmission within a facility that is not controlled with initial interventions, strong consideration should be given to the use of quarantine for fully vaccinated patients/residents on affected units.

New or re-admitted patients/residents who are fully vaccinated do not require a 14-day quarantine for observation.

**Can a fully vaccinated patient/resident be roomed with an unvaccinated or partially vaccinated roommate?**

“Fully vaccinated” refers to a person who is ≥2 weeks after receipt of the second dose in a 2-dose series (Pfizer-BioNTech and Moderna), or ≥2 weeks after receipt of the single-dose Janssen Vaccine, per the CDC Public Health Recommendations for Vaccinated Persons at [https://www.cdc.gov/vaccines/covid-19/info-by-product/clinical-considerations.html](https://www.cdc.gov/vaccines/covid-19/info-by-product/clinical-considerations.html). A fully-vaccinated patient/resident could be placed with an unvaccinated or partially vaccinated roommate upon assessment of risk. Facilities should consult with their healthcare team and infectious disease physician to determine appropriate placement on a case-by-case basis. Other routine infection prevention and control practices should also apply, including:

- If either patient/resident roommate has symptoms consistent with COVID-19, they should be placed in a single room, if available, and isolated pending results of SARS-CoV-2 testing.
- Continue to monitor all patients/residents at least daily for signs and symptoms clinically compatible with COVID-19.
- Patients/residents should be reminded to practice **basic infection prevention and control measures such as hand hygiene and cough etiquette.**
Do the CDC options to reduce quarantine apply to healthcare settings?

Adoption of the CDC options for shortening the duration of quarantine is not preferred for healthcare settings. There may be circumstances when facilities may consider these alternatives to mitigate staffing shortages, space limitations, or PPE supply shortages. Shortening quarantine time may increase the risk of SARS-CoV-2 transmission when compared to the currently recommended 14-day quarantine. The variability of SARS-CoV-2 transmission observed to date indicates that there may be settings (e.g., with high contact rates) where even a small risk of post-quarantine transmission could still result in substantial spread.

When can patients/residents be removed from isolation and the COVID-19 care unit/area?

CDC recommends that patients/residents diagnosed with COVID-19 who have met the criteria for discontinuation of transmission-based precautions be removed from the COVID-19 care unit/area. Decisions to extend or remove persons from transmission-based precautions should be made in consultation with a healthcare provider and/or public health professional and is subject to change based on differences in disease course, symptoms, living situation, available resources, and clinical management. Refer to CDC Ending Isolation and Precautions for People with COVID-19: Interim Guidance at https://www.cdc.gov/coronavirus/2019-ncov/hcp/duration-isolation.html for recommended strategies.

How do we determine close contacts to a COVID-19 case?

Contact tracing should be conducted for close contacts (any individual spending at least 15 cumulative minutes at a distance of less than 6 feet to an infected person during a 24-hour period) of laboratory-confirmed or probable COVID-19 cases.

- For symptomatic individuals, contact tracing efforts should focus on any exposures to the case from 48-hours prior to symptom onset until the case meets the criteria for discontinuation of transmission-based precautions.
- For asymptomatic individuals who had no identifiable exposure, contact tracing should include exposures to the case from 48-hours before the first positive viral test until the case meets the criteria for discontinuation of transmission-based precautions.
- For asymptomatic cases with an identifiable exposure, the case should be considered potentially infectious 48-hours after the exposure until they meet the discontinuation of isolation criteria per CDC.

Unvaccinated patients/residents who are identified as a close contact should be:

- Restricted to their room until 14 days after last exposure (quarantine)
- Cared for using all recommended COVID-19 PPE
- Tested immediately (but not earlier than 2 days from exposure). The patient/resident should be tested again 5-7 days after exposure if testing is negative. Testing at the end of this period could be considered to increase the certainty that the person is not infected.

Lab confirmed COVID-19 positive patients/residents should be relocated to the COVID-19 care unit/area.

Asymptomatic individuals who have clinically recovered from confirmed SARS-CoV-2 infection in the last 90 days* would not need to be quarantined due to a potential exposure or identified as a close contact or tested during this time frame unless they develop symptoms of COVID-19, are diagnosed with SARS-CoV-2 infection, or the facility is directed to do so by the jurisdiction’s public health authority; they should continue to wear well-

**Do patients/residents who routinely leave the facility need to be quarantined?**

Fully vaccinated individuals and individuals within 90 days of a SARS-CoV-2 infection generally do not need to quarantine when returning to the facility. Facilities should defer to the established policy and procedures based on their population and assessment of risk to determine if quarantine is indicated (e.g., spending at least 15 cumulative minutes of exposure at a distance of less than 6 feet to an infected person during a 24-hour period) for unvaccinated patients/residents. In most circumstances, **quarantine is not recommended for unvaccinated individuals who leave the facility for less than 24 hours** (e.g., for medical appointments, community outings with family or friends) and have not had close contact with someone with SARS-CoV-2 infection. In general, the focus should be on adherence to recommended infection prevention and control measures (e.g., audits of process monitoring) with monitoring **upon return and daily** for any development of symptoms. These residents may be prioritized for a private room or cohorted with others who frequently leave the facility if available.

**What should we do about roommates of patients/residents who are symptomatic or SARS-CoV-2 positive?**

Roommates may already be exposed. Ensure **appropriate use of engineering controls** such as curtains to reduce or eliminate exposures between roommates. Roommates of a laboratory-confirmed SARS-CoV-2 positive patient/resident should be assessed to determine if they are a close contact. **The SARS-CoV-2 positive patient/resident should be transitioned to the COVID-19 care unit/area.** Note: When movement would otherwise introduce SARS-CoV-2 to another occupied wing/unit, do not relocate them. **The unvaccinated roommate who is a close contact** should be cared for using all recommended COVID-19 PPE until 14 days after last exposure and tested **immediately but not earlier than 2 days from date of last exposure, if known.** The patient/resident should be tested again 5-7 days after exposure if testing is negative and continue quarantine for the full 14 days. Testing at the end of this period could be considered to increase the certainty that the person is not infected. If testing is positive, the patient/resident should be isolated and placed in the COVID-19 care unit/area.

**What types of precautions should be used in each cohort or circumstance?**

Regardless of the cohort, all HCP should adhere to standard precautions and any necessary transmission-based precautions according to clinical presentation and diagnosis when caring for all patients/residents. **Full transmission-based precautions and all recommended COVID-19 PPE should be used for all patients/residents who are:**

- COVID-19 positive
- Suspected of having COVID-19
- **Unvaccinated** new and re-admitted patients/residents from the community or other healthcare facilities
- **Unvaccinated** close contacts* to a COVID-19 positive person (e.g., HCP, visitor, roommate)
COVID-19 recommended PPE includes a NIOSH-approved N95 or equivalent or higher-level respirator, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face). Public health authorities may recommend full use of COVID-19 recommended PPE, regardless of the presence of symptoms when uncontrolled transmission is identified, with strong consideration for inclusion of fully vaccinated patients/residents. A facility-wide or group-level approach, including full COVID-19 recommended PPE, may be considered if all potential close contacts cannot be identified or managed with contact tracing or when contact tracing fails to halt transmission. Facilities should refer to CDC Optimizing PPE Supplies at https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html when PPE supplies are stressed, running low, or absent.

* Individuals who remain asymptomatic have met the criteria for discontinuation of transmission-based precautions for SARS-CoV-2 infection, and it has been <3 months after the date of symptom onset or positive viral test (for asymptomatic) of prior infection generally require no further restrictions based on their history of COVID-19. Consideration needs to be given to determine whether there is concern that there may have been a false positive viral test, whether the patient/resident is immunocompromised, and whether there is evidence of exposure to a novel SARS-CoV-2 variant. If a patient/resident experience new signs or symptoms consistent with COVID-19 and an evaluation fails to identify a diagnosis other than SARS-CoV-2 infection (e.g., influenza), then repeat viral diagnostic testing and isolation may be warranted even if they have clinically recovered within 3 months. Additionally, healthcare facilities should continue to follow the infection prevention and control recommendations for unvaccinated individuals when caring for fully vaccinated individuals with moderate to severe immunocompromise due to a medical condition or receiving immunosuppressive medications or treatments. This includes using transmission-based precautions for those who have had close contact with someone with SARS-CoV-2 infection.

Resources


