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

This document has been significantly updated to align with current public health guidance.

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 only traditional symptom-based screening 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.

Cohorting is only one element of infection prevention and control measures used for outbreak control. The most effective tool to protect anyone from COVID-19 infection is to become up to date with all recommended COVID-19 vaccinations and booster doses when eligible. 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), medical 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.

Patient/resident management

1) 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. This also includes 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 should be placed in the COVID-19 care unit/area, regardless of symptoms, if they have confirmed SARS-CoV-2 infection.

The facility should establish a plan (including appropriate placement, staffing plan, 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:

2) Symptomatic patients/residents with suspected SARS-CoV-2 infection

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. Ideally, a patient/resident with suspected SARS-CoV-2 infection should be moved to a single-person room with a private bathroom while test results are pending. In general, it is recommended that the door to the room remain closed to reduce transmission of SARS-CoV-2 or other pathogens. This is especially important for patients/residents with suspected or confirmed SARS-CoV-2 infection being cared for outside of a designated space within the COVID-19 care unit/area. However, in some circumstances (e.g., memory care units), keeping the door closed may pose
patient/resident safety risks and the door might need to remain open. If doors must remain open, work with facility engineers to implement strategies to minimize airflow into the hallway. If limited single rooms are available, or if numerous patients/residents are simultaneously identified to have symptoms concerning for COVID-19, they should remain in their current location pending return of test results.

3) Asymptomatic patients/residents who are not up to date* with all recommended COVID-19 vaccine doses, have a viral test that is negative for SARS-CoV-2, and have had close contact with someone with SARS-CoV-2

These patients/residents should be placed in quarantine after their exposure and cared for using full PPE (gowns, gloves, eye protection, and NIOSH-approved N95 or equivalent or higher-level respirator). Testing** is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 5–7 days after the exposure. Patients/residents can be removed from quarantine, either:

1. After day 10 following the exposure (day 0) if they do not develop symptoms. Although the residual risk of infection is low, facilities may consider testing for SARS-CoV-2 within 48 hours before the time of planned discontinuation of quarantine. OR
2. After day 7 following the exposure (day 0) if a viral test is negative for SARS-CoV-2 and they do not develop symptoms. The specimen should be collected and tested within 48 hours before the time of planned discontinuation of quarantine.

4) Asymptomatic patients/residents who are up to date* with all recommended COVID-19 vaccine doses and have a viral test that is negative for SARS-CoV-2 OR had a viral test that was positive for SARS-CoV-2 in the past 90 days,** and have had close contact with someone with SARS-CoV-2***

These patients/residents should wear well-fitting source control based on CDC recommendations, and at minimum, for 10 days after their exposure. Testing** is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 5–7 days after the exposure. In general, these patients/residents do not need to be quarantined, restricted to their room, or cared for by HCP using the full COVID-19 recommended PPE 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. Quarantine might also be considered if the patient/resident is moderately to severely immunocompromised.

5) New or readmitted asymptomatic patients/residents who are not up to date* with all recommended COVID-19 vaccine doses and have a viral test negative for SARS-CoV-2 upon admission or readmission

These patients/residents should be placed in quarantine and cared for using full PPE (gowns, gloves, eye protection that covers the front and sides of face, and NIOSH-approved N95 or equivalent or higher-level respirator), even if they have a negative test upon admission. Testing is recommended immediately (upon admission) and, if negative, again 5–7 days after their admission. Quarantine may be discontinued after day 7 if a viral test is negative for SARS-CoV-2 and they do not develop symptoms. The specimen should be collected and tested within 48 hours before the time of planned discontinuation of quarantine. In most circumstances, quarantine is not recommended for patients/residents who are not up to date with all
recommended COVID-19 vaccine doses that routinely leave the facility for <24 hours and do not have close contact with a suspected or known COVID-19 positive person.

6) **New or readmitted asymptomatic patients/residents who are up to date* with all recommended COVID-19 vaccine doses and have a viral test that is negative for SARS-CoV-2 OR had a viral test positive for SARS-CoV-2 in the past 90 days***

Testing is recommended immediately (upon admission) and, if negative, again 5–7 days after their admission. In general, these patients/residents do not need to be quarantined, restricted to their room, or cared for by HCP using the full COVID-19 recommended PPE 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. Quarantine might also be considered if the patient/resident is moderately to severely immunocompromised.

* CDC defines **up to date** as a person receiving all recommended COVID-19 vaccines (e.g., fully vaccinated) including any booster dose(s) **when eligible** based on CDC Stay Up To Date with Your Vaccines (https://www.cdc.gov/coronavirus/2019-ncov/vaccines/stay-up-to-date.html).

**In general, testing is not necessary for asymptomatic people who have recovered from SARS-CoV-2 infection in the prior 90 days; however, if testing is performed on these people, an antigen test instead of a nucleic acid amplification test (NAAT) is recommended. This is because some people may remain NAAT positive but not be infectious during this period.

*** There may be circumstances when quarantine of asymptomatic patients/residents who are up to date with all recommended COVID-19 vaccine doses and have a viral test that is positive SARS-CoV-2 in the past 90 days might be recommended (e.g., patient is moderately to severely immunocompromised). In the event of ongoing transmission within a facility that is not controlled with initial interventions, strong consideration should be given to use of quarantine for these patients/residents on affected units, even if they are up to date with all recommended COVID-19 vaccine doses. In addition, there might be other circumstances for which the jurisdiction’s public health authority recommends these and additional precautions.

**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?**

**Facilities should create a staffing plan.** To the extent possible, the same HCP should be responsible for the care and services provided within individual cohorts. Ensure HCP prioritizes 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. If possible, HCP should avoid working on both the COVID-19 care unit and other units during the same shift.**

**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)** https://www.epa.gov/pesticide-registration/list-n-disinfectants-coronavirus-covid-19 and **Selected EPA-Registered Disinfectants** https://www.epa.gov/pesticide-registration/selected-epa-registered-disinfectants to ensure coverage for commonly seen pathogens.

**When can transmission-based precautions be discontinued for patients/residents who are moderately to severely immunocompromised?**

Patients/residents who are moderately to severely immunocompromised may produce replication-competent virus beyond 20 days after symptom onset or, for those who were asymptomatic throughout their infection, the date of their first positive viral test. Use of a test-based strategy and (if available) consultation with an infectious disease specialist is recommended to determine when transmission-based precautions could be discontinued for these patients/residents.

**Can a patient/resident who is up to date with all recommended COVID-19 vaccines be roomed with a roommate who is not up to date with all recommended COVID-19 vaccines?**

"Up to date" refers to a person who has received all recommended COVID-19 vaccines (e.g., fully vaccinated) including booster dose(s), when eligible. A patient/resident who is up to date with COVID-19 vaccines could be placed with a roommate who is not up to date with COVID-19 vaccines 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.

**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

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 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.

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

Individuals who are up to date with all recommended COVID-19 vaccinations 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 patients/residents not up to date with all recommended COVID-19 vaccinations. In most circumstances, quarantine is not recommended for individuals who are not up to date with all recommended COVID-19 vaccinations and 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 routine monitoring 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. Roommates of a laboratory-confirmed SARS-CoV-2 positive patient/resident should be assessed to determine if they are a close contact. Ensure appropriate use of engineering controls such as curtains to reduce or eliminate exposures between roommates or adding portable room air cleaners with high-efficiency particulate air (HEPA, H-13 or –14) filters. Refer to the Patient/resident management section above.

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. 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).
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
- New and re-admitted patients/residents from the community or other healthcare facilities who are not up to date with COVID-19 vaccines
- Patients/residents who are close contacts to a SARS-CoV-2 positive person (e.g., HCP, visitor, roommate) and not up to date with all recommended COVID-19 vaccines.
  - There may be additional circumstances when quarantine with full use of transmission-based precautions 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.
    - 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 patients/residents up to date with all COVID-19 recommended vaccines on affected units.
    - If the facility is instructed to do so by the public health department (e.g., based on the epidemiological investigation).

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.

Resources


CDC, Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings

CDC, Optimizing PPE Supplies

2 CDC, Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes

NJDOH, COVID-19: Information for Healthcare Professionals