

**ADVISORY: Universal Message Regarding Cohorting of Residents in Skilled Nursing Facilities**



<b>DATE:</b>	4/14/2020
<b>TO:</b>	Health Alert Network
<b>FROM:</b>	Rachel Levine, MD, Secretary of Health
<b>SUBJECT:</b>	<b>ADVISORY: Universal Message Regarding Cohorting of Residents in Skilled Nursing Facilities</b>
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**This transmission is a Health Advisory:**

**HOSPITALS:** PLEASE SHARE WITH ALL MEDICAL, PEDIATRIC, NURSING AND LABORATORY STAFF IN YOUR HOSPITAL; **EMS COUNCILS:** PLEASE DISTRIBUTE AS APPROPRIATE; **FQHCs:** PLEASE DISTRIBUTE AS APPROPRIATE **LOCAL HEALTH JURISDICTIONS:** PLEASE DISTRIBUTE AS APPROPRIATE; **PROFESSIONAL ORGANIZATIONS:** PLEASE DISTRIBUTE TO YOUR MEMBERSHIP; **LONG-TERM CARE FACILITIES:** PLEASE SHARE WITH ALL MEDICAL, INFECTION CONTROL, AND NURSING STAFF IN YOUR FACILITY

Cohorting of residents with COVID-19 in dedicated units within skilled nursing facilities can be an effective transmission prevention strategy, but it must be done deliberately to be effective.

Once COVID-19 is identified in a nursing care facility, there are three types of residents to consider: confirmed or probable cases, exposed residents, and unexposed residents.

Cohorting decisions should consider all three groups of residents, with the first priority being to restrict the mixing of residents who are cases **or** are exposed with those who are thought to be unexposed.

This HAN provides examples of situations in which cohorting residents or use of a dedicated COVID-19 unit may be beneficial.

The Pennsylvania Department of Health is committed to a unified message regarding cohorting of residents in skilled nursing facilities with cases of COVID-19. Existing guidance regarding cohorting of residents includes [CDC guidance for long-term care facilities](#), [CMS guidance for long term care facilities](#) and the [PA-HAN 492](#). These guidance documents have been interpreted in ways that conflict with the intended unified message from the Department. Science behind cohorting is also informed by a recent [MMWR publication](#) about asymptomatic and presymptomatic shedding of virus in skilled nursing facilities and communications with CDC and other health jurisdictions regarding experiences in the field.

This unified message has been vetted and agreed upon by the Division of Nursing Care Facilities and the Bureau of Epidemiology. The message provides additional details to supplement the existing guidance in [PA-HAN 492](#).

In most instances, once COVID-19 has been confirmed in a resident of a skilled nursing facility, *it is likely to have already spread to other residents in the unit* where the resident lives. Immediate action according to established guidance is the key to preventing further spread. Cohorting residents is one prevention strategy, but it must be done deliberately to be effective.

**Once COVID-19 is identified in a skilled nursing facility, there are three types of residents to consider:**

- **Cases:** Those with confirmed or probable COVID-19. This includes residents who were exposed to COVID-19 and are exhibiting symptoms consistent with COVID-19 but have not yet been tested or will not be tested
- **Exposed:** Those who have been exposed to COVID-19 but are not yet exhibiting symptoms
- **Unexposed:** Those who are not known to have not been exposed to COVID-19

Cohorting decisions should consider all three groups of residents. **The primary goal of cohorting is to restrict mixing of residents who are cases or are exposed with those who are thought to be unexposed. Separating cases from exposed residents is a secondary goal of cohorting.**

**For all units that house residents who are cases or exposed:**

- All recommended PPE (gown, gloves, mask, and eye protection) must be worn per [PA-HAN 492](#).
- Actively monitor all case or exposed residents every 8 hours for fever ( $T \geq 100.0^{\circ}\text{F}$ ) and symptoms of COVID-19 (shortness of breath, new or change in cough, sore throat, muscle aches).
  - Older adults with COVID-19 may not show typical symptoms such as fever or respiratory symptoms. Atypical symptoms may include new or worsening malaise, new dizziness, or diarrhea. Identification of these symptoms should prompt further evaluation for COVID-19.
- Dedicate staff to these units. If shared staff working between wings/units is unavoidable, staff should be sure to change all PPE and perform hand hygiene when moving between affected and unaffected units. This should be limited to key staff that must cover more than one area (e.g. RNs).
- If healthcare workers have recovered from COVID-19 infection and meet the [requirements for return-to-work](#) outlined by CDC, they should be prioritized to work with case residents. They should continue to wear all recommended PPE. Considerations for return to work sooner under crisis standards should align with CDC recommendations for [mitigating staffing shortages](#).

With regard to moving residents and cohorting residents, it is imperative that facilities follow the guidance in [PA-HAN 492](#). **Consider all residents in units with COVID-19 cases as exposed and potentially infectious.** [Recent information about COVID-19 spread in LTCF shows about half of residents testing positive for COVID-19 are not symptomatic.](#) Spread of the virus could have been occurring undetected long before a positive test is reported.

Creating a designated area of the building or a designated unit for COVID-19 positive residents, may be an option in some facilities. If implemented, this strategy must be used in conjunction with maintaining the original affected unit under all previously mentioned precautions; many residents of that unit might already be COVID-positive (even without symptoms).

### Examples of When Cohorting may be Beneficial

1. A unit designated for COVID-19 positive residents who are new admissions and were not in the facility prior to hospital admission. Residents would be cared for using all recommended PPE and until they could be removed from transmission-based precautions based on [CDC guidance](#).
2. A unit designated for monitoring of new admissions and readmissions for the first 14 days of their stay. This unit would be for residents with unknown exposure to COVID-19. All recommended PPE should be used for these residents.
3. A COVID-19 positive resident is identified in an extremely high-risk unit, for example in a designated ventilator unit. Moving a resident from a high-risk unit to a designated COVID-19 unit may reduce the *ongoing* risk to other residents in the original unit. Do not move the COVID-19 positive resident to a unit with residents who are unexposed to COVID-19. The original unit must be maintained as above for exposed residents.
4. The first positive COVID-19 resident is identified in a unit where no other residents have symptoms. The facility is able to move this resident to an isolated area of the unit (e.g. end of the hallway) or a designated COVID-19 unit that is not yet in use or contains only COVID-19 cases.
  - a. Some facilities have successfully implemented a policy to move the first positive COVID-19 resident from a unit into a dedicated space. This is a reasonable approach if the case is identified early. The original unit must be maintained as above for exposed residents. As more residents become symptomatic or are confirmed positive for COVID-19, the benefit of moving residents is outweighed by the risk.

### Examples of When Cohorting has Limited Benefit

1. The first positive COVID-19 resident is identified in a unit where there are also other residents with possible symptoms or several positive residents are identified in the same unit within a few days. This suggests transmission has likely occurred to many others in the unit. Testing of symptomatic residents may be pending or planned. Moving the positive residents to a dedicated unit, even a unit that already has several positive COVID-19 residents, has minimal benefit.
  - a. All residents in the original unit must be treated as infectious and cared for using full PPE (gown, gloves, mask, and eye protection) per [PA-HAN 492](#).
  - b. In most facilities using this process, newly identified symptomatic residents present over the following week, and moving residents becomes no longer feasible. Urgent room changes may negatively impact the health and well-being of the residents and should occur when benefits outweigh the risk.

Categories of Health Alert messages:

**Health Alert:** conveys the highest level of importance; warrants immediate action or attention.

**Health Advisory:** provides important information for a specific incident or situation; may not require immediate action.

**Health Update:** provides updated information regarding an incident or situation; unlikely to require immediate action.

This information is current as of April 14, 2020 but may be modified in the future. We will continue to post updated information regarding the most common questions about this subject.