**Interim Update Regarding Masking in Acute Care and Outpatient Clinics**
**as of September 26, 2023**

Coordinated by the Northwest Healthcare Response Network

**Summary** from the Ad Hoc Working Group[1] on the Continuation of Masking in Healthcare Facilities. This body of work was coordinated by the *Northwest Healthcare Response Network*.

"Universal masking" as defined in this document pertains to staff, patient, and visitor masking in "patient care areas". Because of the wide-ranging variability within healthcare institutions "patient care areas" will be defined by each institution as was agreed upon in the initial consensus statement.

Masking reduces the risk of infection, and the level of protection increases with the level of mask used. For example, an N95 respirator provides a higher level of protection against COVID-19 compared to a surgical mask alone.

Based on current respiratory viral metrics and projections for the 2023-2024 respiratory virus season, participating healthcare organizations (see signatories to this letter) would activate required masking policies in the following situations, **whichever occurs first**:

- At least one pathogen (respiratory syncytial virus (RSV), influenza, COVID-19) reaches or exceeds the transmission alert threshold for emergency department visits (ED discharge diagnoses; see "Respiratory Viral Metrics" below);
- CDC COVID-19 Hospital Admission Levels are "medium" or ≥10 new COVID-19 hospital admissions per 100,000 population (7-day total) by county.

These metrics are indicators of higher transmission activity by which point required masking in patient care areas would be activated. Healthcare organizations may implement universal masking policies before these thresholds are met especially given ongoing severe disease and long-term complications associated with COVID-19.

Facilities should also strongly consider masking for visitors and healthcare workers in non-patient care areas in healthcare settings during periods of higher respiratory viral transmission activity. Participating facilities agree that universal masking will remain in effect until the ED visits for all three pathogens are below their respective transmission alert thresholds **AND** the CDC COVID-19 hospital admission levels are below "medium" for at least 2 weeks.

It is recognized that our understanding of COVID-19 as a disease, healthcare seeking behavior, and COVID-19 epidemiology continues to evolve. These recommendations are based on the current best knowledge and will continually be re-evaluated and updated as new science is available.

**Background and Current Situation**

In March 2023, the Northwest Healthcare Response Network (the Network) convened subject matter experts from across western Washington to discuss the April 3, 2023, discontinuation of the Secretary of Health Mask Order requiring universal masking in healthcare, long-term care, and adult correctional facilities for people aged 5 years and older. In response to the end of the Mask Order, healthcare organizations in our region began working together to establish an approach for continued masking in healthcare facilities. A consensus

statement on masking in acute care and outpatient care settings was released on March 24, 2023, that informed each organization's individual policies and procedures related to the continued protection of staff and patients. An update to the March statement was provided on June 29, 2023. Participating organizations across the region have continued to review their policies and procedures and adjust if needed, balancing community disease transmission rates and operational needs to support staff and patient safety.

These healthcare organizations remain consistent in adhering to priorities that promote patient safety including the following:

1. Patients should mask if they are symptomatic for respiratory illness.
2. There are vulnerable populations at higher risk of severe outcomes from COVID-19 and from other respiratory diseases, for whom universal masking in the healthcare setting is needed.
3. Healthcare providers should respect the autonomy of patients to protect themselves. If the patient is masked, healthcare providers should mirror this and be masked considering the implicit power dynamics of the patient-provider relationships.
4. Masking should be supported at any time if a healthcare worker wants to mask.

In addition to the above previously agreed upon priorities, it is the consensus of the Ad Hoc Working Group that universal masking in healthcare settings is an important patient and healthcare worker safety intervention in times of higher respiratory virus transmission. The group determined it would be of benefit to have a regionally agreed upon data informed threshold to objectively identify when high or sustained transmission of respiratory infections is occurring. This is especially important as we move into the fall and winter season during which respiratory virus transmission has historically increased.

**Respiratory Viral Metrics**

Based on the above consensus, the Ad Hoc Workgroup convened multiple meetings since June 2023 to identify regional data sources that would provide early indicators of periods of higher or sustained transmission of respiratory viruses. The group focused on community metrics that are reliable, available, timely and serve as indicators of community burden of respiratory syncytial virus (RSV), influenza and COVID-19. These three (3) pathogens heavily impact healthcare organizations and cause severe disease burden especially among those at high-risk. While RSV and influenza have seasonal circulation patterns with surges typically occurring in the fall and winter months, the trends of the ongoing COVID-19 pandemic remain unpredictable. After considering multiple potential metrics, it was decided that the state syndromic surveillance data focused on emergency department visits related to influenza, RSV, or COVID-19 met those criteria. Periods of higher levels of infection were evaluated using the Moving Epidemic Method (MEM), a method CDC uses to classify influenza transmission levels.[2]

Data from past years were evaluated by Public Health – Seattle & King County (PHSKC) using this MEM approach and found it helped identify imminent increases in both influenza and RSV emergency department (ED) visits. For COVID-19, there is less certainty about baseline circulation and future direction of the pandemic. However, assessment of ED COVID-19 discharge diagnoses was also a useful early metric ahead of prior surges or sustained increases during the pandemic. These threshold values will be routinely re-evaluated and adjusted as indicated including for COVID-19 as community trends transmission pattern evolve.

Other metrics that may also inform need for universal masking in facilities can include facility-level trends in percent positivity from internal laboratory summaries, COVID-19 patient census, healthcare facility outbreak activity, or other local healthcare facility metrics reports, and/or limitations in healthcare facility staffing capacity.

**Current Action**
Based on current respiratory viral metrics and projections for the 2023-2024 respiratory virus season, participating healthcare organizations (see signatories to this letter) would activate required masking policies in the following situations, **whichever occurs first**:

- At least one pathogen (RSV, Influenza, COVID-19) reaches or exceeds the transmission alert threshold for ED visits (ED discharge diagnoses);
- CDC COVID-19 Hospital Admission Levels are "medium" or ≥10 new COVID-19 hospital admissions per 100,000 population (7-day total) by county.

These metrics are indicators of higher transmission activity by which point required masking in patient care spaces would be activated. Healthcare organizations may implement universal masking policies before these thresholds are met especially given ongoing severe disease and long-term complications associated with COVID-19.

Facilities should also strongly consider masking for visitors and healthcare workers in non-patient care areas in healthcare settings during periods of higher respiratory viral transmission activity. Universal masking policies will remain in effect until the ED visits for all three pathogens are below their respective transmission alert thresholds **AND** the CDC COVID-19 hospital admission remain below medium for at least 2 weeks. Facilities may also consider earlier implementation or later extension of universal masking policies based on facility-level trends from internal laboratory summaries, COVID-19 patient census, healthcare facility outbreak activity, other local healthcare facility metrics reports, and/or limitations in healthcare facility staffing capacity.

Regional ED visit data will be published by participating public health agencies in Washington on their respective dashboards or routine respiratory virus surveillance reports. The workgroup continues to meet and collaborate as healthcare organizations and systems across the region work to refine shared guidance that will further inform future updates to institutional masking policies.

The health impacts of this pandemic continue to develop, and future policies will need to take into consideration multiple factors including the evolving epidemiology of COVID-19 and its health impact on our communities, potential new metrics for measuring the community burden of COVID-19 and other respiratory viral infections, available treatments, and new knowledge about COVID-19 related complications. We support the continued collaborative efforts of this regional Ad Hoc Working Group composed of regional experts to establish these recommendations.

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[1] Includes adult and pediatric hospital, outpatient, and public health infectious disease, infection prevention, and other clinical healthcare and public health leaders in western Washington.

[2] https://www.cdc.gov/flu/about/classifies-flu-severity.htm