Masking Consensus Statement for Acute Care and Outpatient Clinics
2024-2025 Respiratory Season
Posted: 10/22/2024
Coordinated by the Northwest Healthcare Response Network (NWHRN)

Summary

This body of work was developed by the NWHRN Acute Infectious Disease Masking Workgroup. This Summary section is a brief overview. For more in-depth discussion see below.

"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 respiratory infections including COVID-19 and benefits the user and the people around them. 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 review of the recent COVID-19, influenza and respiratory syncytial virus (RSV) ED discharge diagnosis surveillance data, the transmission alert thresholds for the 2024-2025 respiratory season have been updated, reviewed and agreed upon for Snohomish, King and Pierce counties. Participating healthcare organizations (see signatory list below) have agreed to implement healthcare worker masking policies when the following occurs:

1. At least one pathogen (RSV, influenza, or COVID-19) reaches or exceeds the transmission alert threshold for emergency department visits

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.

2. 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 for at least 2 weeks.

Some healthcare organizations may consider changes to masking policies outside these agreed upon parameters (for example implementing masking before thresholds reached or ending masking before the 2 week time period). These decisions should be based on facility and/or system data which may include but not limited to laboratory summaries of respiratory viral testing data, COVID-19 patient census, healthcare facility outbreak activity, or other local healthcare facility metrics reports, and/or limitations in healthcare facility staffing capacity. The Masking Workgroup firmly agrees to a data defined approach.

3. Recent data support the efficacy and need for permanent (year-round) masking in high-risk healthcare areas (e.g. oncology and transplant areas, dialysis or infusion centers). Participating signatories agree to review the data and consider permanent masking especially in high-risk areas. Given the unique nature of each organization's care delivery settings, patient populations and organizational needs, each institution will determine "high risk areas" appropriate for their setting.

Our understanding of COVID-19 health impacts continues to grow, healthcare seeking behavior continues to change, and SARS-CoV-2 epidemiology continues to evolve. These recommendations are based on the current best knowledge and will continually be re-evaluated and updated as new data are available.

Background

On April 3, 2023, the Washington state Secretary of Health Mask Order requiring universal masking in healthcare facilities was discontinued. Recognizing the ongoing importance of masking in these spaces to protect the health and well-being of patients and employees, the Acute Infectious Disease Masking Workgroup (Masking Workgroup) was formed. This Workgroup consists of adult and pediatric infectious disease and public health subject matter experts (SME) representing the major healthcare systems and jurisdictions in our regional coalition and whose goal is to establish an approach to universal masking in healthcare facilities by incorporating lessons learned from the COVID-19 pandemic. Their work has been predicated on the following principles:

A. The highest priority is the health and safety of patients and employees in healthcare settings

B. The recommended action is based on the best available, most recent scientific evidence.

The goal of these recommendations is to decrease transmission between patients and providers in healthcare settings where greater numbers of high-risk people seek care. It is the consensus of the Masking Workgroup that universal masking in healthcare settings is an important patient and healthcare worker safety intervention particularly in times of higher respiratory virus transmission. It is not the intent of these recommendations to decrease transmission or impact transmission rates within the broader community.

Since its inception in March 2023, the Masking Workgroup has met on a regular basis and has produced three consensus statements in March 2023, June 2023 and September 2023. A summary of the 2023-2024 Respiratory Season approach and future planning can be found in this report.

COVID-19, Influenza and RSV Transmission Alert Thresholds

The Masking Workgroup agreed that a data informed threshold to objectively identify when high or sustained transmission of respiratory infections is occurring is essential in guiding masking policies.

In developing these thresholds, the group focused on community metrics that are reliable, available, timely and serve as indicators of community burden of RSV, influenza and COVID-19. These three (3) pathogens heavily impact healthcare organizations and cause severe disease burden especially among those at high-risk. 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. Refer to the September 2023 consensus statement for details about the development of the transmission alert thresholds.

In September 2024, recent trends of COVID-19, influenza and RSV emergency department data were evaluated by Public Health Seattle & King County (PHSKC). Different factors that change over time may influence recent trends and include but are not limited to respiratory virus epidemiology, healthcare seeking behavior, and clinician diagnostic approaches. To ensure thresholds incorporate the most recent data, thresholds are re-assessed each year. For the 2024-2025 season, transmission alert thresholds were re-calculated and updated using the MEM approach.

To best communicate timely information on community respiratory viral burden, Snohomish, King and Pierce counties publish their respective county-specific data on their websites. These dashboards are updated on a weekly basis.

Current Action

Participating healthcare organizations will implement healthcare worker masking policies when the following occurs:

1. At least one pathogen (RSV, influenza, COVID-19) reaches or exceeds the transmission alert threshold for emergency department visits

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.

2. 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 for at least 2 weeks.

As reported in the 2023-2024 Respiratory Season summary, there was a prolonged influenza season which led to some organizations reversing masking policies prior to the 2-week agreed upon timeframe. Also, during the August 2024 COVID-19 surge, Snohomish county required masking to be re-instated for a 2 week period due to the county rate being above the threshold. The Masking Workgroup recognizes that these are difficult situations to navigate with healthcare staff, but also firmly agree to this data defined approach.

Therefore, healthcare organizations when considering changes to masking policies outside these agreed upon parameters (for example implementing masking before thresholds reached or ending masking before the 2 week time period), these decisions should be based on facility and/or system data which may include but not limited to laboratory summaries of respiratory viral testing data, COVID-19 patient census, healthcare facility outbreak activity, or other local healthcare facility metrics reports, and/or limitations in healthcare facility staffing capacity.

Regional ED visit data will continue to be posted by participating public health agencies on their respective respiratory illness websites. Healthcare facilities outside of the Puget Sound region interested in adopting this masking approach can consider local, regional or state level burden measures to inform their masking policies. 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.

In addition, recent data demonstrate the effectiveness of universal masking policies in reducing morbidity associated with healthcare-associated respiratory viral infections especially in hospital units with high-risk patients. Universal masking may result in significant reductions of hospital-onset respiratory viral infections, time admitted to the hospital and need for other medical interventions (e.g. CT scans).

3. Participating signatories agree to review the data and consider permanent (year-round) universal masking especially in high-risk areas. Given the unique nature of each organization's care delivery settings, patient populations and organizational needs, each institution will determine "high-risk areas" appropriate for their settings.

Conclusion:
Respiratory viruses, including COVID-19, pose an ongoing health risk to patients and healthcare workers that include acute and long-term adverse health outcomes. Masking policies have an important role to play in reducing healthcare associated infections especially during periods of higher community burden. Masking policies based on community burden metrics will require continuous evaluation of the data and incorporate the evolving respiratory viral landscape. This includes but is not limited to evolutions in COVID-19 epidemiology, healthcare seeking behavior, clinical diagnostic approaches, health impacts of respiratory infections, novel community burden metrics, and availability of effective treatments. We support the continued collaborative efforts of this regional Masking Workgroup and the decisions as outlined in this document.

Signatories (in alphabetical order by organization)

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