

**Healthcare Worker Masking Consensus Statement for Acute Care and Outpatient Clinics**  
**2025-2026 Respiratory Season**  
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Coordinated by Northwest Healthcare Response Network (NWHRN)

## Note

This body of work was developed by the NWHRN Acute Infectious Disease Healthcare Worker (HCW) Masking Workgroup, hereafter referred to as the Masking Workgroup.

“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 in March 2023](#).

## Introduction

Beginning in March of 2023, infectious disease and public health leaders have been working together, as part of the Masking Workgroup, to develop evidence-based strategies to guide healthcare masking policies. Since its inception, the Masking Workgroup has met on a regular basis and has produced three additional HCW consensus statements in [June 2023](#), [September 2023](#) and [October 2024](#). The goal of this work is to mitigate the transmission of respiratory pathogens from patient to patient and between patients and providers in healthcare settings.

Masking remains an important intervention to reduce the spread of respiratory infections especially in healthcare settings where many high-risk people receive care. Additionally, masking protects healthcare workers who may have frequent close interactions with ill patients. These recommendations are not intended to impact transmission meaningfully in the broader community.

This 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 Masking Workgroup agrees that a data-informed approach should be used to guide masking policies by objectively identifying periods of high respiratory illness in the community. For the past two respiratory seasons (2023-2024 and 2024-2025), masking implementation was based on COVID-19, RSV and influenza Emergency Department (ED) data and a transmission alert threshold calculated using the Moving Epidemic Method (MEM). For more information and background please see [the September 2023 consensus statement](#).

Since the Masking Workgroup first met, it was acknowledged that COVID-19 epidemiology would continue to evolve over time and healthcare seeking behavior and testing practices would change and thus impact the surveillance of COVID-19 burden. Additionally, applying MEM to COVID-19 was a novel application of this methodology that needed to be continually evaluated against other potential epidemiologic approaches.

COVID-19 epidemiology has remained difficult to predict compared to the consistent autumn/winter peak seen for RSV and influenza. New COVID-19 variants have emerged and healthcare seeking behavior and COVID-19 testing practices have changed significantly since the end of the emergency phase of the COVID-19 pandemic. Additionally, the implementation of any intervention including masking must consider the various potential impacts. While masking has the benefit of reducing transmission of respiratory illness, it can impact communication and be associated with some adverse effects including headaches, discomfort, and skin irritation with prolonged use.

This year, the Masking Workgroup prioritized several goals when reviewing multiple metric options: alignment with national respiratory illness surveillance approaches; identification of a general respiratory illness metric that is inclusive of COVID-19, influenza, RSV and other respiratory infection burden; and the ability to quickly identify when respiratory infections are rising in the community. Based on these principles, for the 2025-2026 respiratory season the Masking Workgroup has agreed to base universal masking implementation on measurements of acute respiratory illness in EDs instead of individual disease (RSV, influenza, COVID-19) thresholds.

### **Acute Respiratory Illness (ARI) Metrics and Thresholds**

The ARI metric is reliable, broadly available, and timely. By using a broader respiratory illness metric, additional respiratory pathogens are reflected in the metric that could also be mitigated by masking in healthcare settings. Implementation of the ARI metric will include a transmission alert threshold that will identify periods of higher acute respiratory illness burden. The transmission alert threshold will be calculated following [CDC's baseline methodology](#) and will be applied to the ARI ED data. (For details, please see section on “Level of Respiratory Illness Activity” under “Data Notes” in the CDC link above.)

The CDC baseline methodology incorporates the periods of lowest acute respiratory illness activity from the previous two years; a mean is calculated using the periods of lowest ARI activity. The transmission alert threshold will be applied at two standard deviations above the calculated mean. For those facilities within King, Pierce, and Snohomish counties, ARI data for all three counties will be calculated as a single regional ARI metric with a corresponding transmission alert threshold.

Facilities who are in jurisdictions outside of King, Pierce and Snohomish counties should consult their local public health departments to determine whether county or regional data, such as the Washington State Department of Health Accountable Communities of Health (DOH ACH), would best guide their local healthcare facility masking strategies and how the ARI thresholds for their jurisdictions will be displayed. Respiratory dashboards will be updated on a weekly basis during respiratory season and can be found at the following hyperlinks for [King](#), [Pierce](#), [Snohomish](#), [Jefferson](#), [Thurston](#), [Island](#), [Spokane](#) counties, and [WA DOH as statewide data or by ACH region](#).

### **Conclusion**

The 2025-2026 universal masking strategy will be guided by acute respiratory illness (ARI) Emergency Department (ED) visits with a transmission alert threshold calculated using CDC Baseline methodology. Data for King, Pierce and Snohomish counties will be combined into a regional metric using data from the last two seasons. Facilities in other counties supporting this consensus statement agree to use the same ARI metric and CDC baseline methodology and will choose what they decide is the most appropriate data source.

Participating healthcare organizations (see signatory list below) have agreed to the following:

1. Universal masking policies\* will be implemented when ARI ED visit trends reach or exceed the transmission alert threshold calculated for the county or region.

Facilities should also strongly consider masking for visitors and healthcare workers in non-patient care areas in healthcare settings during periods of higher respiratory illness transmission activity.

2. Universal masking will remain in effect until the ED visits for ARI are below their respective transmission alert thresholds for at least two consecutive weeks.
3. 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 period). These decisions should be based on facility and/or system data which might include but are not limited to

laboratory summaries of respiratory pathogen testing data, respiratory illness patient census, healthcare facility outbreak activity, limitations in healthcare facility staffing capacity, or other local healthcare facility metrics. The Masking Workgroup firmly agrees with a data-driven approach.

- Continued 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.<sup>5,7</sup>

These recommendations are based on the current best knowledge and will be re-evaluated and updated as new data are available.

\* It is recognized that masking policies vary between institutions. This statement does not stipulate the content of individual masking policies.

### **Healthcare Signatories (listed in alphabetical order by organization)**

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## Supporting Public Health Jurisdictions (Listed by county in alphabetical order)

Clallam County Public Health

[Island County Public Health](#)

Jefferson County Public Health

[Public Health Seattle-King County](#)

[Skagit County Public Health](#)

[Snohomish County Health Department](#)

[Spokane Regional Health District](#)

[Tacoma-Pierce County Health Department](#)

## References

- <sup>1</sup>Landelle C, Birgand G, Price JR, Muters NT, Morgan DJ, Lucet JC, Kerneis S, Zingg W. Considerations for de-escalating universal masking in healthcare centers. *Antimicrob Steward Healthc Epidemiol*. 2023 Jul 26;3(1): e128. doi: 10.1017/ash.2023.200. Erratum in: *Antimicrob Steward Healthc Epidemiol*. 2023 Sep 15;3(1): e157. doi: 10.1017/ash.2023.438. PMID: 37592969; PMCID: [PMC10428150](#).
- <sup>2</sup>MacIntyre CR, Chughtai AA, Kunasekaran M, Tawfiq E, Greenhalgh T. The role of masks and respirators in preventing respiratory infections in healthcare and community settings. *BMJ*. 2025 Feb 27; 388: e078573. doi: 10.1136/bmj-2023-078573. [PMID: 40015737](#).
- <sup>3</sup>Munigala S, Ching PR, Wood H, Waken RJ, Fox J, Gasama H, Russell R, Yarbrough ML, Warren DK. Effect of Universal Masking on Non-Severe Acute Respiratory Syndrome Coronavirus 2 Healthcare-Associated Respiratory Viral Infections. *Open Forum Infect Dis*. 2024 Oct 14; 11(10): ofae617. doi: 10.1093/ofid/ofae617. PMID: 39474447; [PMCID: PMC11521325](#).
- <sup>4</sup>Pak TR, Chen T, Kanjilal S, McKenna CS, Rhee C, Klompas M. Testing and Masking Policies and Hospital-Onset Respiratory Viral Infections. *JAMA Netw Open*. 2024;7(11): e2448063. doi:10.1001/[jamanetworkopen.2024.48063](#)
- <sup>5</sup>Richardson, T., Schütte, D., Feyer, K. et al. Consistent FFP2-masking as part of reducing viral respiratory infections on medical wards for allogeneic hematopoietic stem cell transplantation. *Sci Rep* 14, 21481 (2024). <https://doi.org/10.1038/s41598-024-72646-y>
- <sup>6</sup>Whiteley TD, Stimson J, Brown CS, Robotham JV, Evans S. Modeling the impact of health care worker masking to reduce nosocomial SARS-CoV-2 transmission under varying adherence, prevalence, and transmission settings. *Infect Control Hosp Epidemiol*. 2025 Jun 27:1-7. doi: 10.1017/ice.2025.78. Epub ahead of print. [PMID: 40576073](#).
- <sup>7</sup>Yan J, McClure T, Aslam A, et al. Impact of universal masking in reducing the risk of nosocomial respiratory viruses among people with cancer. *Infect Control Hosp Epidemiol* 2024. 45: 1405–1409, doi: 10.1017/ice.2024.144; [PMID:39449613](#)