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Hospital approaches to universal masking after public health "unmasking" guidance

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The Centers for Disease Control and Prevention (CDC) released updated guidance for the control and prevention of coronavirus disease 2019 (COVID-19) for healthcare personnel (HCP) and facilities on September 23, 2022. This major update allows facilities to opt out of universal source control use by HCP providing care in counties where the severe acute respiratory coronavirus virus 2 (SARS-CoV-2) transmission level is not high.[1] The CDC notes that this guidance does not apply to HCP caring for patients who have or are under evaluation for COVID-19, who have had recent close contact with someone with COVID-19 within 10 days, or are in a facility experiencing a COVID-19 outbreak; the guidelines also noted that facilities could choose not to opt out of source control when HCP are caring for immunocompromised people.[1]

Masking within healthcare facilities has been an evidence-based mainstay of COVID-19 risk mitigation.[2] In addition to continually emerging SARS-CoV-2 variants, increases in seasonal respiratory viruses including influenza are expected for the 2022–2023 season.[3] We hypothesized that acute-care hospitals may adopt approaches divergent from the new CDC masking guidance given these and other concerns.

Methods

We surveyed healthcare epidemiologists in the United States following release of the updated CDC healthcare COVID-19 guidance to understand their facilities' planned approach to universal masking and unmasking outside of patient care areas. The survey also explored the rationale for maintaining universal masking.

The full survey is included in the Supplementary Materials (online). From participants in an informal e-mail–based list serve, we invited one representative from each US-based, nonfederal, acute-care hospital or health system. Deidentified study data were collected using REDCap (Research Electronic Data Capture) hosted at the University of Pittsburgh Medical Center.[4] This project was granted approval as a quality improvement study by the UPMC Quality Improvement Review Committee (project no. 4111).

Results

Among 44 healthcare epidemiologists invited to participate, the 34 respondents (response rate, 77.3%) represented health systems from diverse US regions (Supplementary Materials online). Most worked for health systems with multiple acute-care hospitals (n = 26, 76.5%) or facilities with ≥500 beds (n = 6, 17.6%).

Overall, 33 respondents (97.1%) reported that their facility has no immediate plans to discontinue universal masking, and 1 respondent (2.9%) reported their facility had discontinued, or planned to discontinue, universal masking if or when community transmission levels of COVID-19 were not high. No respondents reported that their facility had discontinued or would discontinue universal masking regardless of community transmission levels. Preventing non– SARS-CoV-2 seasonal

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Table 1. Healthcare Epidemiologist Responses to the Survey Question "What Reasons Informed Your Facility's Decision to Maintain Universal Masking?"

Response	Responses, No. (%)
Prevent transmission of seasonal respiratory viral pathogens	30 (90.9)
Minimize impact on employee staffing capacity	24 (72.7)
Transmission patterns among employees and/or patients in the facility	18 (54.5)
Assessment of scientific evidence of mask effectiveness in healthcare settings	18 (54.5)
Regulatory or legal requirement	14 (42.4)
Potential ramifications of COVID-19	11 (33.3)
Employee sentiment in favor of masking	2 (6.1)
Patient sentiment in favor of masking	2 (6.1)
Other	7 (21.2)

Note: Respondents could choose >1 reason; therefore, percentages may total >100%.

respiratory viruses (90.9% of respondents) and impact on employee staffing capacity (72.7% of respondents) were the most cited reasons for continuing universal masking regardless of county-specific SARS-CoV-2 transmission levels (Table 1). The "other" reasons described by 7 facilities include several themes: standardizing approach across facilities; the operational challenges of variable or changing masking policies between facilities, within a facility, or as community transmission levels change; and the presence of high-risk individuals (Supplementary Materials online). Also, 7 respondents specifically cited inaccessibility to patients (or visitors) as defining locations where unmasking is permitted in patient care areas (Supplementary Materials online).

Discussion

In this survey of US hospital epidemiologists primarily representing large, acute-care facilities and multifacility health systems, 97% reported no plans to discontinue universal masking allowed for by the most recent CDC COVID-19 healthcare guidance. Their reasons ranged from risk of respiratory viral spread to healthcare staffing mitigation to facility operational concerns.

Healthcare facilities are tasked with synthesizing CDC recommendations in the context of other respiratory viral illnesses and healthcare worker burnout and staffing shortages. Our survey revealed significant concerns about operationalizing the updated recommendations. Updated masking guidance is tied to county-specific COVID-19 levels with the potential that masking guidance could change week to week. Hospitals within broader health systems must reconcile guidance that may vary depending on geography. Once-weekly reporting of COVID-19 levels may lead to delays in re-escalating universal masking when COVID-19 activity increases. Within-facility SARS-CoV-2 spread among unmasked patients and employees would trigger re-escalation of universal masking may not be detected in real time and potentially result in harm. These factors are consistent with the rationale supporting the Association for Professionals in Infection Control and Epidemiology (APIC) statement against de-escalating universal masking on October 3.[5]

Our survey had several limitations. Participants in the listserv are self-selected; therefore, these results do not provide a systematic representation of US healthcare facilities. The survey also represents a temporal snapshot immediately following release of the new CDC guidance. This survey was not designed to reflect the merits and risks of masking.

The CDC updated guidance allowing de-escalation of universal masking in healthcare settings based on county-specific COVID-19 transmission represents a major change. The overwhelming majority of healthcare epidemiologists in our survey do not currently agree with adopting this new guidance, and survey respondents relied on scientific evidence of mask effectiveness and transmission patterns in their facility. Clear public health communication relying on robust data is essential to inform infection prevention approaches in acute-care settings.[6,7] Based on our survey results and the APIC position statement, it may be prudent for facilities to wait to consider implementing the new guidance until the Spring of 2023.

Supplementary material. To view supplementary material for this article, please visit https://doi.org/10.1017/ice.2023.9

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