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SHEA Town Hall 98
Overview
SARS-CoV-2 Variants, US, CDC

Data from 2/17/24 – 5/25/24

EMERGENCY DEPARTMENT VISITS DUE TO COVID-19

COVID-19 Rates of Test Positivity

Source: CDC https://covid.cdc.gov/covid-data-tracker/#trends_weeklyhospitaladmissions_testpositivity_00
7/1-2024
COVID-19 WASTEWATER VIRAL ACTIVITY

Source: CDC https://covid.cdc.gov/covid-data-tracker/#wastewater-surveillance 7-1-2024
Hospitalizations increased by 60% from our last Town Hall

Source: https://covid.cdc.gov/covid-data-tracker/#covidnet-hospitalization-network 7-2-24
WEEKLY PROVISIONAL DEATHS FROM COVID-19 IN THE UNITED STATES

CDC https://covid.cdc.gov/covid-data-tracker/#trends_weeklydeaths_select_00 7-17-2024
Influenza Activity by State in the United States

Source: CDC [https://www.cdc.gov/flu/weekly/usmap.htm](https://www.cdc.gov/flu/weekly/usmap.htm) 7-6-2024
1. An opinion piece in *The New England Journal of Medicine* discusses ‘academic freedom’ in the context of controversial statements about COVID made by a Stanford faculty member in 2020 that were viewed as possibly endangering the public health.

2. A paper in *Lancet’s eClinical Medicine* evaluated the effect of digitalizing the contact tracing process, concluding that digitalization improved exposure notification and facilitated the tracing of a greater number of contacts of individuals infected with SARS-CoV-2 in a resource-limited setting.

3. An editorial published in *Lancet’s eBioMedicine* discusses the current state of knowledge about the so-called brain fog and severe fatigue associated with long COVID and identifies the need for additional studies.

4. A letter to the editor in *Lancet Infectious Diseases* describes the virological characteristics of the SARS-CoV-2 KP.3, LB.1, and KP.2.3 variants.

5. A large cohort study published in *JAMA Network Open* found that, among 3568 patients younger than 18 years hospitalized with acute SARS-CoV-2 or MIS-C, severe neurological manifestations were common and were associated with new neurocognitive or functional morbidity at hospital discharge.

6. A series of five papers published in *Infection Control and Hospital Epidemiology* provides SHEA societal position statements on several aspects of pandemic preparedness for policymakers.

7. A study published in the *Annals of Internal Medicine* reported that short-term systemic side effects of SARS-CoV-2 mRNA vaccination were associated with greater long-lasting neutralizing antibody responses.

References available in the chat
Today’s Emerging Infectious Disease News

8. Results of an electronic survey of public health practices for H$_5$N$_1$ found that nearly all states and territories reported ability to monitor and test persons exposed to H$_5$N$_1$. Jurisdictions varied: in capacities to monitor exposed persons, in recommendations for use of antivirals, and in potential use of H5N1 vaccines, if available.

9. A multicenter, cluster-randomized, investigator-masked, crossover, noninferiority trial compared preoperative skin preparation with povidone iodine in alcohol with chlorhexidine gluconate in alcohol. published in JAMA found povidone iodine in alcohol to be noninferior to chlorhexidine in preventing SSIs after cardiac or abdominal surgery.

10. A paper in JAMA Pediatrics evaluating 451,443 infants from 322 NICUs provides estimated incidence rates, clinical characteristics, and attributable mortality of hospital-onset bacteremia among infants in NICUs. The study found that hospital-onset bacteremia conferred a significant absolute increase in attributable mortality.

11. A study in Clinical Infectious Diseases of patients being treated for infection with multidrug-resistant Pseudomonas aeruginosa bacteremia or pneumonia found those treated with ceftazidime-avibactam were more likely to develop resistance than those treated with ceftolozane-tazobactam.

12. A cohort study of 311 older adults hospitalized for acute COVID-19 illness published in JAMA Network Open found that in-hospital delirium was associated with both functional disability and cognitive impairment over the 6 months after hospital discharge.

13. A study of youth with presymptomatic type 1 diabetes published in JAMA reported COVID infection was associated with accelerated progression to clinical type 1 disease.

References available in the chat
Panelists:

Dr. David Henderson  
*NIH Consultant*

Dr. Sarah Haessler  
*Baystate Health*

Dr. Kristina Bryant  
*University of Louisville*

Dr. David Weber  
*UNC School of Medicine*
HCP MASKING TO PREVENT TRANSMISSION OF VIRAL RESPIRATORY PATHOGENS: CURRENT OPTIONS

David J. Weber, MD, MPH, FIDSA, FSHEA, FRSM (London)
Sanders Distinguished Professor of Medicine, Pediatrics and Epidemiology
Associate Chief Medical Officer, UNC Medical Center
Medical Director, Hospital Epidemiology, UNC Medical Center
University of North Carolina at Chapel Hill

Disclosures: Consultancy-Pfizer, GSK, PDI, BD, Germitec; Speaker’s Bureau-Merck, BD, GAMA
Goal: To evaluate the effectiveness of infection control measures, including universal masking.

Results: Among 250 potentially exposed patients and staff, 14 confirmed cases of coronavirus disease 2019 (COVID-19) were identified. Patient roommates and staff with prolonged patient contact were most likely to be infected. The last potential date of transmission from staff to patient was day 22, the day universal masking was implemented. Subsequent point-prevalence surveys in 126 patients and 234 staff identified 0 patient cases and 5 staff cases of COVID-19, without evidence of healthcare-associated transmission.

Conclusion: Universal masking with medical face masks was effective in preventing further spread of SARS-CoV-2 in our facility in conjunction with other traditional infection prevention measures.

Thompson ER, et al. ICHE 2021:1-7
Association of institutional masking policies with healthcare-associated SARS-CoV-2 infections in Swiss acute care hospitals during the BA.4/5 wave (CH-SUR study): a retrospective observational study

Background: We investigated the association of variation in institutional mask policies with healthcare-associated SARS-CoV-2 infections in acute care hospitals in Switzerland during the BA.4/5 2022 wave.

Methods SARS-CoV-2 infections in hospitalized patients between June 1 and September 5, 2022, were obtained from the “Hospital-based surveillance of COVID-19 in Switzerland”-database and classified as healthcare- or community-associated based on time of disease onset. Institutions provided information regarding institutional masking policies for healthcare workers and other prevention policies. The percentage of healthcare-associated SARS-CoV-2 infections was calculated per institution and per type of mask policy. The association of healthcare-associated SARS-CoV-2 infections with mask policies was tested using a negative binominal mixed-effect model.

Results We included 2'980 SARS-CoV-2 infections from 13 institutions, 444 (15%) were classified as healthcare associated. Between June 20 and June 30, 2022, six (46%) institutions switched to a more stringent mask policy. The percentage of healthcare-associated infections subsequently declined in institutions with policy switch but not in the others. In particular, the switch from situative masking (standard precautions) to general masking of HCW in contact with patients was followed by a strong reduction of healthcare-associated infections (rate ratio 0.39, 95% CI 0.30-0.49).

Universal masking during COVID-19 outbreaks in aged care settings: A systematic review and meta-analysis

Aged care facilities (ACF) are a high-risk COVID-19 transmission setting, and older residents are at greater risk of severe outcomes. This systematic review and meta-analysis assessed whether universal masking and COVID-19 vaccination reduce SARS-CoV-2 attack rates (ARs) in ACF. Articles published between 1 December 2019 and 28 February 2022 were screened across five databases (Medline, Embase, PubMed, Scopus, Web of Science and Cumulative Index to Nursing and Allied Health Literature (CINAHL)). Risk of bias was assessed using relevant Joanna Briggs Institute critical appraisal tools. Meta-analysis of single proportions, subgroup analysis, and metaregression were performed to compare the effects of universal masking and vaccine doses on pooled SARS-CoV-2 ARs. Of 99 included articles, SARS-CoV-2 ARs for residents were available in 86 studies (representing 139 outbreaks), and for staff in 49 studies (78 outbreaks). Universal masking was associated with lower SARS-CoV-2 ARs in ACF outbreaks (AR = 34.9% [95% CI: 27.2–42.6%]) compared to facilities without universal masking (67.3% [54.2–80.4%], p < .0001). In ACF with universal masking prior to outbreak onset, facility-wide testing, and documentation of asymptomatic infection, the asymptomatic AR at time of testing was 11.4% (6.5–17.4%) in residents. Receipt of zero, one and two vaccination doses were associated with ARs of 64.9% (49.6–80.2%), 54.9% (33.7–76.1%) and 45.2% (29.2–61.3%), respectively. To protect residents from COVID-19, ACF should provide vaccination of residents and staff, universal masking for staff, and facility-wide testing during times of heightened community transmission.

Universal Masking in Health Care Settings: A Pandemic Strategy Whose Time Has Come and Gone, For Now

Erica S Shenoy 3, Hilary M Babcock 2, Karen B Brust 3, Michael S Calderwood 4, Shira Doron 3, Anurag N Malani 6, Sharon B Wright 7, Westyn Branch-Elliman 8

Considerations for de-escalating universal masking in healthcare centers

Caroline Lendell 1, Gabriel Birgand 2, James R Price 4, Nico T Mutters 5, Daniel J Morgan 6, 7, Jean-Christophe Lucet 8, Solen Kernéis 8, Walter Zingg 9

For Patient Safety, It Is Not Time to Take Off Masks in Health Care Settings

Tara N Palmer 1, David K Henderson 2
During the COVID-19 pandemic in the United States, the use of facemasks has been mandated in all health care settings for individuals older than 2 years, whether present as health care personnel, patients, or visitors. In this commentary, a group of health care epidemiologists, infectious diseases physicians, and researchers argue for the withdrawal of the universal masking policy given the current status of the COVID-19 pandemic.

Shenoy ES, et al
Ann Intern Med 2023;176:859-861
Back to the future: Redefining “universal precautions” to include masking for all patient encounters

Despite recent guidance from the Centers for Disease Control and Prevention (CDC) allowing institutions to relax in-facility masking strategies and due to our evolving understanding of respiratory pathogen transmission during the coronavirus disease 2019 (COVID-19) pandemic, we propose an updated standard for universal precautions in healthcare settings: permanently including universal masking in routine patient-care interactions. Such a practice prioritizes safety for patients, healthcare providers (HCPs), and visitors.

Kalu IC, et al. ICHE 2023;44:1373-1374
Considerations for De-escalating Universal Masking in Healthcare Centers

Three years after the beginning of the COVID-19 pandemic, better knowledge on the transmission of respiratory viral infections (RVI) including the contribution of asymptomatic infections encouraged most healthcare centers to implement universal masking. The evolution of the SARS-CoV-2 epidemiology and improved immunization of the population call for the infection and prevention control community to revisit the masking strategy in healthcare. In this narrative review, we consider factors for de-escalating universal masking in healthcare centers, addressing compliance with the mask policy, local epidemiology, the level of protection provided by medical face masks, the consequences of absenteeism and presenteeism, as well as logistics, costs, and ecological impact. Most current national and international guidelines for mask use are based on the level of community transmission of SARS-CoV-2. Actions are now required to refine future recommendations, such as establishing a list of the most relevant RVI to consider, implement reliable local RVI surveillance, and define thresholds for activating masking strategies. Considering the epidemiological context (measured via sentinel networks or wastewater analysis), and, if not available, considering a time period (winter season) may guide to three gradual levels of masking: (i) standard and transmission-based precautions and respiratory etiquette, (ii) systematic face mask wearing when in direct contact with patients, and (iii) universal masking. Cost-effectiveness analysis of the different strategies is warranted in the coming years. Masking is just one element to be considered along with other preventive measures such as staff and patient immunization, and efficient ventilation.

# Factors for and against De-escalating or Maintaining Universal Masking in Healthcare Centers

<table>
<thead>
<tr>
<th>Targeted population</th>
<th>De-escalating universal masking</th>
<th>Maintaining universal masking</th>
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</thead>
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<tr>
<td>Adherence</td>
<td>Lack of adherence and compliance with universal masking related to fatigue, discomfort, and tolerability</td>
<td>Rare hospital transmission with good adherence and compliance of universal masking policy</td>
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<tr>
<td>Epidemiology</td>
<td>Decreasing benefit of universal masking in healthcare settings during low community transmission</td>
<td>Policy driven by imperfect epidemiological data (no real-time data, testing bias); challenge of back-and-force reinstitution of universal masking</td>
</tr>
<tr>
<td>Immunity and treatment options</td>
<td>High level of vaccine and infection-induced immunity and availability of effective treatment and prevention tools</td>
<td>Vaccine hesitancy and waning immunity</td>
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<tr>
<td>Community measures</td>
<td>Inconsistencies with non-pharmaceutical measures in the population</td>
<td>Prevention of transmission by asymptomatic and presymptomatic individuals; anticipating the occurrence of variants or emerging respiratory viruses</td>
</tr>
<tr>
<td>Cost and logistics</td>
<td>Rupture of supply chains, high cost, and ecological concerns</td>
<td>Counterbalancing costly installation of ventilation systems or investments to improve infrastructure</td>
</tr>
<tr>
<td></td>
<td>Absenteeism and presenteeism</td>
<td>Absenteeism due to occupational transmission of respiratory viruses; presenteeism</td>
</tr>
<tr>
<td>HCP perspective</td>
<td>Universal masking applying to the occupational setting only</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Staff without patient contact</td>
<td>Unclear benefit for HCP without direct patient contact</td>
</tr>
<tr>
<td>Patient perspective</td>
<td>Improved HCP-patient relationship in the absence of face covering</td>
<td>Protection of vulnerable patients</td>
</tr>
</tbody>
</table>

### Example of Advantages and Disadvantages of Alternative Strategies to Permanent Universal Masking in Healthcare Centers

<table>
<thead>
<tr>
<th>Strategies</th>
<th>Description</th>
<th>Advantages of the strategy</th>
<th>Disadvantages of the strategy</th>
</tr>
</thead>
</table>
| Symptom-based precautions         | Wearing a surgical mask in addition to standard precautions by patients with respiratory symptoms | - Better compliance with policy  
- Lower utilization of supplies  
- Better HCP-patient relationship | - Does not prevent asymptomatic and presymptomatic transmission  
- Requires high levels of vaccine and infection-induced immunity |
| Targeted masking                  | Wearing a face mask in direct patient contact (either all patients or immunocompromised patients only) | - Better compliance with policy  
- Protection of vulnerable patients | - Does not prevent staff-to-staff transmission  
- Interferes with HCP-patient relationship |
| Epidemiology-based universal masking | Wearing surgical masks by all staff (clinical and nonclinical), patients, and visitors during high level of community transmission | - Adjustment to the risk of transmission, more acceptable by HCPs  
- Increased adherence and compliance with policy  
- Responsible utilization of supplies | - Difficult to implement in regions without sentinel data or wastewater surveillance  
- Challenge of back-and-force institution of a radical intervention in a complex environment |
| Season-based universal masking    | Wearing a surgical mask by all staff (clinical and nonclinical), patients, and visitors during seasonal respiratory viral periods | - Adjustment to the theoretical risk of transmission of all respiratory viruses with a seasonal pattern  
- Takes into account the risk of asymptomatic and presymptomatic respiratory infections  
- Prevents hospital functioning | - Decreased adherence from HCPs during low level of community transmission  
- Not covering non-seasonal respiratory infections  
- Utilization of supplies |
| Targeted continuous masking       | Wearing of a face mask by all HCPs during their entire shifts in areas with patient care | - Prevents HCP-patient and patient-patient asymptomatic and presymptomatic transmission  
- Increased adherence due to consistency of the strategy  
- Prevents presenteeism or absenteeism in clinical areas  
- Mitigates presenteeism in clinical areas  
- Preserves patient safety  
- Maintains clinical activity | - Utilization of supplies  
- Not preventing staff-to-staff transmission in nonclinical areas  
- Interferes with HCP-patient relationship |
| Permanent universal masking       | Wearing a surgical mask by all staff (clinical and nonclinical), patients, and visitors at any time | - Prevents asymptomatic and presymptomatic transmission in the hospital  
- Prevents absenteeism - Mitigates presenteeism  
- Preserves patient safety  
- Maintains hospital activity | - Lack of adherence and compliance related to fatigue, discomfort and tolerability  
- Large utilization of supplies |

Note: HCPs: healthcare professionals.
The time has come to protect healthcare workers and patients from aerosol transmissible disease

In order to protect patients and healthcare workers from aerosol transmissible diseases, healthcare facilities should improve ventilation and air purification and in addition should consider universal use of respirators (e.g., N95, FFP2 or equivalent) when aerosol transmissible pathogens are widespread in the community. A study of SARS-CoV-2 within 288 United States hospitals documented more than 14,000 infections potentially acquired in the hospital over a 2-year period and found that more than 8% of patients hospitalized with SARS-CoV-2 may have acquired their infection in the hospital (1). Despite the frequency of nosocomial respiratory viral transmission most countries have no national mandate for masks or respirators in healthcare facilities. We propose that healthcare facilities should anticipate that aerosol transmissible disease will continue to be of major importance to public health for the foreseeable future.

The incidence of healthcare-associated viral respiratory infections in a pediatric hospital decreased from 1.6/1,000 patient-days in 2019 to 0.2/1,000 patient-days in 2020 (P < .01), and this was maintained in 2021 despite an increase in community circulation of respiratory viruses. Universal masking, stricter infection control measures, and pandemic public health interventions likely accounted for this improvement.

**Fig 1.** Evolution of healthcare-associated viral respiratory infection (HA-VRI) incidence at a tertiary care pediatric center in Montreal, Canada, before and since the COVID-19 pandemic. Run chart displaying annual HA-VRI incidence from 2005 to 2022. Two astronomical data points are seen in 2020-2021 and 2021-2022, indicating non-random signals of change.

**Table 1**

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>RSV, n (%)</td>
<td>26 (34.7)</td>
<td>3 (42.9)</td>
<td>3 (13.0)</td>
</tr>
<tr>
<td>Rhinovirus/Enterovirus, n (%)</td>
<td>16 (21.3)</td>
<td>1 (14.3)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Adenovirus, n (%)</td>
<td>10 (13.3)</td>
<td>0 (0)</td>
<td>1 (4.3)</td>
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<tr>
<td>Influenza A, n (%)</td>
<td>7 (9.3)</td>
<td>0 (0)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>RSV, n (%)</td>
<td>7 (9.3)</td>
<td>0 (0)</td>
<td>4 (17.4)</td>
</tr>
<tr>
<td>Enterovirus, n (%)</td>
<td>5 (6.7)</td>
<td>0 (0)</td>
<td>3 (13.0)</td>
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<tr>
<td>Parainfluenza virus type 1, n (%)</td>
<td>1 (1.3)</td>
<td>0 (0)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Parainfluenza virus type 3, n (%)</td>
<td>1 (1.3)</td>
<td>0 (0)</td>
<td>2 (8.7)</td>
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<tr>
<td>Influenza B, n (%)</td>
<td>1 (1.3)</td>
<td>0 (0)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>HMPV, n (%)</td>
<td>1 (1.3)</td>
<td>0 (0)</td>
<td>1 (4.3)</td>
</tr>
<tr>
<td>Coronavirus 6/43, n (%)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>1 (4.3)</td>
</tr>
<tr>
<td>SARS-CoV-2, n (%)</td>
<td>0 (0)</td>
<td>3 (42.8)</td>
<td>8 (34.8)</td>
</tr>
</tbody>
</table>

*RSV, respiratory syncytial virus; HMPV, human metapneumovirus; SARS-CoV-2, severe acute respiratory syndrome coronavirus 2.
*The denominator in this table is the total number of respiratory viruses isolated. Of note, some HA-VRI were caused by more than 1 virus.
*These may represent co-infections or infections with either virus that cannot be differentiated by PCR due to genetic homology between rhinovirus and enterovirus species.
Healthcare-associated respiratory viral infections after discontinuing universal masking

In November 2022, our pediatric hospital replaced the requirement for universal masking of all healthcare personnel and visitors in all clinical buildings with a requirement for masking only during patient encounters. Following this change, we observed an immediate, substantial, and sustained increase in healthcare-associated respiratory viral infections.

Figure 1. Trend in healthcare-associated and community respiratory viral infections over time at a pediatric hospital. (A) Statistical process control chart showing incidence of healthcare-associated respiratory viral infections (HARVs) by month. Solid blue line: centerline. Red dashed lines indicate upper control limit (−3 sigma) and lower control limit (−3 sigma). Centerline shifts occurred when there were 2 consecutive months above or below the centerline, according to Institute for Healthcare Improvement control chart rules. Numbers mark (1) initiation of universal masking and SARS-CoV-2 admission testing; (2) discontinuation of SARS-CoV-2 admission testing for asymptomatic individuals with no known coronavirus disease 2019 (COVID-19) close contacts; and (3) replacement of universal masking with masking during all patient encounters. HARV case definitions are provided in the Supplementary Appendix (online). (B) Time chart of definite (gray bars) and possible (black bars) healthcare-associated COVID-19 cases by month. (C) Hospital census of patients admitted with SARS-CoV-2 infection by day. (D) Test positivity rate for several respiratory viruses in the hospital microbiology laboratory by week.

Most ZM, et al. ICHE 2024;45:247-249
CONCLUSIONS

• Rationale for masking for all direct patient care (preferred option; personal opinion):
  • Hospitals provide care for patients at high risk for morbidity and mortality from viral respiratory infections
  • Transmission based precautions do NOT prevent transmission for asymptomatic or pre-symptomatic infected patients
  • Presenteeism is common among HCP with viral respiratory diseases (30%-50%)
  • Protects patients and HCP for transmission of ALL droplet & airborne-transmitted infections during direct patient care
  • Does NOT prevent healthcare provider-to-provider transmission

• Potential triggers for masking for with all direct patient care:
  • Include as part of Standard Precautions (i.e., year-round)
  • Time based (i.e., during viral respiratory season)
  • Community burden based (i.e., during community surges: triggers = hospitalizations, deaths, wastewater measures)
  • Other: Percent positive tests in community or HCP; HCP absences; others
  • Additional research (data/studies) required to assess proper trigger(s) and levels to increasing masking (except for inclusion in Standard Precautions)

• Universal masking (i.e., masking by all HCP while in the hospital/healthcare facility or in selected units)
  • Should be considered during pandemic with highly pathogenic respiratory pathogens (e.g., HPAI, novel coronaviruses)
  • Not practical/feasible as a routine precaution