**SUPPLEMENTAL MATERIALS: Full Survey and Responses**

**Survey introduction**

Definitions. For the purpose of this survey, consider:

* Universal masking: all individuals are required to wear a well-fitted mask that includes cloth, medical (or “procedural”) mask, N95, or other respiratory protection. This may include limited exceptions, for example, inability to wear a mask for medical reasons. Do not consider “universal masking” to include specific situations for prevention of transmission including interactions with COVID-19 exposed or contagious individuals, or interactions with immunocompromised patients.
* Patient care areas: locations in the facility where patients transit or receive care
* Community transmission level: defined by CDC, accessible at [this CDC link](https://covid.cdc.gov/covid-data-tracker/#county-view?list_select_state=all_states&list_select_county=all_counties&data-type=Risk&null=Risk)

**Background**

On September 23, 2022, the Centers for Disease Control and Prevention (CDC) updated guidelines for infection control of COVID-19 in healthcare settings: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html>. The new guidelines state:

When SARS-CoV-2 [*Community Transmission*](https://covid.cdc.gov/covid-data-tracker/#county-view?list_select_state=all_states&list_select_county=all_counties&data-type=Risk) levels are high, source control is recommended for everyone in a healthcare setting when they are in areas of the healthcare facility where they could encounter patients.

* + HCP could choose not to wear source control when they are in well-defined areas that are restricted from patient access (e.g., staff meeting rooms) if they do not otherwise meet the criteria described below and [*Community Levels*](https://covid.cdc.gov/covid-data-tracker/#county-view?list_select_state=all_states&list_select_county=all_counties&data-type=CommunityLevels&null=CommunityLevels) are not also high. When [*Community Levels*](https://covid.cdc.gov/covid-data-tracker/#county-view?list_select_state=all_states&list_select_county=all_counties&data-type=CommunityLevels&null=CommunityLevels) are high, source control is recommended for everyone.

When SARS-CoV-2 [*Community Transmission*](https://covid.cdc.gov/covid-data-tracker/#county-view?list_select_state=all_states&list_select_county=all_counties&data-type=Risk) levels are ***not*** high, healthcare facilities could choose not to require universal source control.  However, even if source control is not universally required, it remains recommended for individuals in healthcare settings who:

* + Have suspected or confirmed SARS-CoV-2 infection or other respiratory infection (e.g., those with runny nose, cough, sneeze); or
  + Had [*close contact*](https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html#closecontact) (patients and visitors) or a [*higher-risk exposure*](https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html) (HCP) with someone with SARS-CoV-2 infection, for 10 days after their exposure; or
  + Reside or work on a unit or area of the facility experiencing a SARS-CoV-2 outbreak; universal use of source control could be discontinued as a mitigation measure once no new cases have been identified for 14 days; or
  + Have otherwise had source control recommended by public health authorities

Individuals might also choose to continue using source control based on personal preference, informed by their perceived level of risk for infection based on their recent activities (e.g., attending crowded indoor gatherings with poor ventilation) and their potential for developing severe disease… HCP and healthcare facilities might also consider using or recommending source control when caring for patients who are moderately to severely immunocompromised.

**Survey questions and responses**

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| --- | --- | --- | --- |
| **Question** | **Response options** | **Frequency** | **(%)** |
| In response to the CDC guidance described above, what approach is your facility taking to universal masking in patient-care areas? [Select one] | Prior to 9/23/22 the facility did not require universal masking in patient care areas. | 0 |  |
| The facility has discontinued, or plans to discontinue, universal masking in patient care areas, regardless of the community transmission level of COVID-19 disease. | 0 |  |
| The facility has discontinued, or plans to discontinue, universal masking when/if community transmission levels of COVID-19 disease are not high (defined by CDC, other organization, or the facility). | 1 | (2.9) |
| The facility will discontinue universal masking in select patient care locations, and/or for select individuals. (Examples: masks no longer required in lobby and waiting rooms; masks no longer required for visitors) | 0 |  |
| The facility has no immediate plans to discontinue universal masking. | 33 | (97.1) |
| The facility has not yet considered changes incorporating updated CDC guidance. | 0 |  |
| Please describe the circumstances where universal masking is no longer required:  *Branching logic – question offered to one respondent* | [Full response omitted to maintain confidentiality. Portions of the response pertaining to circumstances retained.]  “Our PPE policy has strived to use objective measures to inform the levels of intervention… When community transmission levels are high, we recommend universal masking throughout the healthcare facility regardless of whether it is patient care…When community transmission level decreases to substantial, masking will become optional in locations where patients do not transit, When levels are moderate or low, we will likely have masking optional in all areas.” | 1 | (2.9) |
| What reasons informed your facility's decision to maintain universal masking? [Select all that apply]  *Branching logic – question offered to 33 respondents* | 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 (including, but not limited to, state-specific regulations) | 14 | (42.4) |
| Potential ramifications of COVID-19 disease (e.g., long COVID or post-COVID, hospitalization, mechanical ventilation, death) | 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) |
| Please describe the other factors informing the decision to continue universal masking:  *Branching logic – question offered to seven respondents* | “standardize approach; minimize changes in policy; concern for future variants” |  |  |
| “1. We are in a high community transmission geographic area so changes to masking do not apply 2. We already allow employees to be non masked and non distanced in non public/non common and non clinical areas (conference rooms, office suites without patient access) so long as they are compliant with vaccination (primary + 1 boosster) and we have > 99% compliance. 3. Operationally very challenging to conceive of loosening masking in our public/common areas (lobbies) and then ensuring masking in clinical locations.” |  |  |
| “Concern for new COVID spike with emerging variants; worry about staff confusion with turn on/ turn off guidance; uncertainty with OSHA and impending infectious diseases standard” |  |  |
| “Challenges of operationalizing unmasking followed by re-masking as we assume COVID transmission likely to go back up high this fall/winter even if it drops below high soon” |  |  |
| “Impractical to track community transmission week to week and pivot guidance for our healthcare system. Seems a bit weak to base guidance on community transmission when you known the majority of testing is not being captured.” |  |  |
| “presence of immunocompromised patients and staff in all areas of the hospital (clinics, waiting areas, cafeterias, pharmacy, etc)” |  |  |
| “high risk patient population served” |  |  |
| Other than patient care areas, does your facility permit unmasking under any circumstances? [Select all that apply] | Outdoor areas | 30 | (88.2) |
| Buildings that do not provide patient care | 28 | (82.4) |
| Locations within a patient-care building where patients do not transit (e.g., an administrative floor, employee breakrooms) | 19 | (55.9) |
| Dependent on COVID-19 vaccination status | 3 | (8.8) |
| Individuals with a negative test within a specified period | 0 |  |
| Other | 0 |  |
| Please describe the locations within a patient care building where universal masking is no longer required: | “Admin areas” |  |  |
| “personal offices where patients are not present” |  |  |
| “Break rooms, private offices,” |  |  |
| “Break rooms, conference rooms” |  |  |
| “Break rooms, meeting /conference rooms etc.” |  |  |
| “Purely non patient care areas (break rooms, conference rooms, administrative areas not on patient care unit, etc)” |  |  |
| “in a location where there is no reasonable expectation of encountering a patient - e.g. conference room” |  |  |
| “Any places that are not public/where patients do not go that can be closed off by a door (like breakrooms, labs, et cetera)” |  |  |
| “Any location that a patient or visitor cannot transit through or see into: labs, conference rooms, staff only break rooms, hallways in buildings with limited (non-patient) access, etc.” |  |  |
| “’where patients and visitors are not encountered’ eg administrative space; break rooms with doors that separate them from hallways; 'back of house' pharmacy and lab spaces where no patient or visitor presence/interactions” |  |  |
| “We are planning to transition to ‘masks opitonsl’ in well-designated areas of clinical buildings where patients cannot enter. This includes - meeting rooms, administrative office suites, and may include employee break rooms.” |  |  |
| “Admin areas. Break rooms. Charting bullpens. Nursing stations. Conference rooms. Hallways where patients do not transit. "Behind the scenes" areas such as the food prep area of kitchen, laundry rooms, laboratory.” |  |  |
| “Masking is not required in only selected areas. The main application is in employee break rooms where wearing a mask would be essentially impractical while drinking a beverage or taking a meal. Up until recently, the number of persons in the break rooms was limited to 5 or less.” |  |  |
| “administrative areas but team members must be healthy (green screen on daily redcap screen)- those with valid exemptions are always yellow screen so must wear mask in all locations“ |  |  |
| “Depending on community levels, our policy is to not mandate universal masking in non-patient care areas like conference rooms, break rooms, etc.” |  |  |
| “See details above.” |  |  |
| “Please see above” |  |  |
| Please indicate the region where your facility is located (or primarily located for health systems in multiple regions): [Select one] | Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont | 3 | (8.8) |
| New Jersey, New York, Puerto Rico, and the Virgin Islands | 8 | (23.5) |
| Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, and West Virginia | 5 | (14.7) |
| Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee | 4 | (11.8) |
| Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin | 5 | (14.7) |
| Arkansas, Louisiana, New Mexico, Oklahoma, and Texas | 1 | (2.9) |
| Iowa, Kansas, Missouri, and Nebraska | 2 | (5.9) |
| Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming | 3 | (8.8) |
| Arizona, California, Hawaii, Nevada, American Samoa, Commonwealth of the Northern Mariana Islands, Federated States of Micronesia, Guam, Marshall Islands, and Republic of Palau | 2 | (5.9) |
| Alaska, Idaho, Oregon, and Washington | 0 |  |
| Location not listed | 0 |  |
| *[Missing]* | 1 | (2.9) |
| Please indicate your facility's inpatient bed size: [Select one] | 0-100 beds | 1 | (2.9) |
| 101-499 beds | 1 | (2.9) |
| ≥500 beds | 6 | (17.6) |
| Health system with multiple acute care hospitals | 26 | (76.5) |