



Maine Center for Disease Control and Prevention  
Division of Disease Surveillance

**Prevention and Control of Influenza  
In Long-Term Care Facilities  
2025-2026**

November 2025

**Background:**

Influenza (flu) can severely impact long-term care facilities. Persons living in long-term care facilities are considered at high risk for complications due to influenza infection. Infection among healthcare workers during outbreaks is also common. Annual influenza vaccination is the most effective method for preventing influenza virus infection and its complications and is recommended for all persons  $\geq 6$  months old who do not have a contraindication to vaccination. Antiviral medications are an adjunct to vaccination and are effective when administered as treatment and when used for chemoprophylaxis after an exposure to influenza virus.

People 65 years and older are at high risk of developing serious complications from influenza, due in part to changes in immune defenses with increasing age. In recent years, U.S. CDC estimates that between 70 percent and 85 percent of seasonal influenza-related deaths have occurred in people 65 years and older, and between 50 percent and 70 percent of seasonal influenza-related hospitalizations occurred among people in this age group. (<https://www.cdc.gov/flu-burden/php/about/index.html>)

This report summarizes a multi-faceted approach to influenza outbreak management in long-term care facilities to enable a timely and effective response. This guidance applies to the 2025-2026 influenza season.

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## Executive Summary

Preventing transmission of influenza viruses and other infectious agents within healthcare settings, including long-term care facilities, requires a multi-faceted approach that includes the following:

### 1. Vaccination

- a. **Vaccinate residents** for influenza; make sure they are up to date with pneumococcal vaccine and COVID-19 vaccine; and that they have been vaccinated for Respiratory Syncytial Virus (RSV), when appropriate.
  - i. **Influenza** is an annual vaccine and can be given anytime during the season, ideally by the end of October.
  - ii. **Pneumococcal** vaccine: U.S. CDC recommends that adults 50 years or older are vaccinated with both the pneumococcal conjugate vaccine (PCV15, PCV20, or PCV21) and pneumococcal polysaccharide vaccine (PPSV23, Pneumovax®23).
  - iii. **COVID-19** vaccine: Maine CDC recommends everyone over 6 months of age should get at least 1 dose of an updated COVID-19 vaccine. People 65 years and older and those who are moderately or severely immunocompromised should receive a second dose of 2025-2026 COVID-19 vaccine 6 months after their first dose.
  - iv. **RSV vaccine:** Maine CDC recommends a single dose of the RSV vaccine for all adults aged 75 years and older and for adults aged 50–74 years who are at increased risk for severe RSV disease.
- b. **Vaccinate staff** for influenza. All staff should be vaccinated for seasonal influenza and vaccine status should be documented and provided to Maine CDC annually.
  - i. Vaccination is recommended for all pregnant women or women who will become pregnant.

### 2. Testing

- a. Influenza testing should occur when any resident has signs and symptoms that could be due to influenza, especially when two residents or more develop respiratory illness within 72 hours of each other. Residents with respiratory illness should also be tested for SARS-CoV-2.

### 3. Infection Control

- a. Implement standard and droplet precautions for all residents with suspected or confirmed influenza.

### 4. Antiviral Treatment

- a. All long-term care facility residents with confirmed or suspected influenza should receive antiviral treatment immediately.
- b. Treatment should not wait for laboratory confirmation of influenza.

### 5. Antiviral Chemoprophylaxis

- a. When at least two patients are ill within 72 hours of each other and at least one resident has laboratory-confirmed influenza (by any testing method), the facility should promptly initiate antiviral chemoprophylaxis to all non-ill residents, regardless of whether they received influenza vaccination.

**If you suspect an outbreak** (two or more residents develop respiratory illness within 72 hours of each other):

- a. Report the outbreak to Maine CDC via phone at 1-800-821-5821 or email at [disease.reporting@maine.gov](mailto:disease.reporting@maine.gov) (no patient information)
- b. Review this document for additional guidance
- c. Collect 2-5 samples for influenza testing
- d. Follow the Outbreak checklist (Appendix 1)

## Section I: Key Recommendations and Information for 2025-2026

### 1. Promote and administer vaccine.

Maine Center for Disease Control and Prevention recommends vaccinating residents and staff against influenza, pneumococcal pneumonia, COVID-19, and RSV to prevent infection of other respiratory illness during influenza season. Vaccinate all residents and staff against respiratory viruses when vaccine is available, preferably by the end of October. Nursing and long-term care facilities should prioritize ordering and administering respiratory season vaccinations to protect their vulnerable populations, including elderly residents who are at higher risk for severe complications from influenza, pneumococcal pneumonia, COVID-19, and RSV. Immunizing residents on site ensures a higher vaccination rate, reducing the likelihood of outbreaks that can lead to serious complications and increased healthcare costs. Influenza vaccination should be offered as long as influenza viruses are circulating and unexpired vaccine is available. Ensure that all residents have received two doses of pneumococcal (PPV) vaccine according to guidelines.

- The Centers for Medicaid and Medicare Services (CMS) requires long-term care facilities to offer all residents seasonal influenza and pneumococcal vaccines and to document results. Each resident is to be vaccinated unless medically contraindicated, the resident or legal representative refuses, or there is a vaccine shortage. Maine requires reporting of vaccine rates for residents to the Maine Immunization Program.
- Maine requires staff of long-term care facilities to be vaccinated annually for seasonal influenza (22 M.R.S.A. §802). This helps protect the staff, their patients, and their families, enhancing patient and worker safety. Maine requires reporting of vaccine rates for health care workers to the Maine Immunization Program.

### Influenza Vaccination

Each influenza season, healthcare workers become infected with influenza. Influenza is often introduced into or spread through a facility by staff or visitors. Additionally, influenza vaccine may be less effective in the very elderly and although they are immunized, some residents may remain susceptible to influenza. By vaccinating long-term care facility staff, morbidity and mortality among elderly patients is reduced.

### Influenza Vaccine Composition for 2025-2026

- All 2025-2026 influenza vaccines licensed in the United States will be trivalent. Trivalent flu vaccines are formulated to protect against three flu viruses (an A(H1N1) virus, an A(H3N2) virus, and a B/Victoria virus). B/Yamagata flu viruses have not circulated in the population after March 2020, so protection from trivalent and previous seasons' quadrivalent flu vaccines that contained the B/Yamagata strain is expected to be similar. For more information on the trivalent influenza vaccine: <https://www.cdc.gov/flu/vaccine-types/trivalent.html>
- For 2025-2026, egg-based vaccines are recommended to contain:
  - A/Victoria/4897/2022 (H1N1)pdm09-like virus;

- A/Croatia/10136RV/2023 (H3N2)-like virus; and (Updated)
- B/Austria/1359417/2021 (B/Victoria lineage)-like virus.
- For 2025-2026, cell- or recombinant-based vaccines are recommended to contain:
  - A/Wisconsin/67/2022 (H1N1)pdm09-like virus;
  - A/District of Columbia/27/2023 (H3N2)-like virus; and (Updated)
  - B/Austria/1359417/2021 (B/Victoria lineage)-like virus.

Additional safety measures are no longer recommended for influenza vaccination of people with an egg allergy beyond those recommended for receipt of any vaccine, regardless of the severity of previous reaction to egg. All vaccines should be given in settings where allergic reactions can be recognized and treated quickly.

### **Pneumococcal Vaccination**

In October 2024, the Advisory Committee on Immunization Practices (ACIP) recommended the use of pneumococcal conjugate vaccine (PCV) or pneumococcal polysaccharide vaccine for adults who are 50 years or older (previously 65 and older) as well as younger adults with certain risk factors (this recommendation has not changed). Shared clinical decision making is recommended for adults 65 years and older who already completed the series with a dose of PCV13 and a dose of PPSV23.

1. Adults  $\geq 50$  who have either **never received a pneumococcal vaccine OR who only received PCV7** should:
  - a. Receive 1 dose of PCV20 or PCV21 OR
  - b. One dose of PCV15 followed by a dose of PPSV23  $\geq 1$  year later.
    - i. If PPSV23 is not available, PCV20 or PCV21 may be used in its place.
    - ii. If an **individual has an immunocompromising condition, cochlear implant, or cerebrospinal fluid (CSF) leak** an 8-week minimum interval should be considered rather than  $\geq 1$  year for the dose of PPSV23.
2. Adults  $\geq 50$  who **previously received PPSV23 and no other pneumococcal vaccines** should receive:
  - a. PCV20 or PCV21 no sooner than 1 year after PPSV23 was administered
    - i. If PCV20 and PCV21 are unavailable PCV15 can be used
3. Adults  $\geq 50$  who **only received PCV-13** should receive:
  - a. PCV20 or PCV21 no sooner than a year after PCV13 administration
4. Adults  $\geq 50$  who received **PCV13 at any age and PPSV23 before the age of 65** should receive:
  - a. PCV20 or PCV21  $\geq 5$  years after the last dose of pneumococcal vaccine was administered
5. Adults  $\geq 65$  who have received **PCV13 at any age and PPSV23 at or beyond age 65** should use shared clinical decision making with their health care provider to determine if they receive additional pneumococcal vaccination. If additional vaccination is agreed upon the patient should receive:
  - a. PCV20 or PCV21  $\geq 5$  years after the last dose of pneumococcal vaccination.
6. Adults 19-49 who have a CSF leak, OR a specified immunocompromising condition (chronic renal failure, congenital or acquired asplenia, congenital or acquired immunodeficiency, generalized malignancy, HIV infection, Hodgkin Disease, iatrogenic immunosuppression, leukemia, lymphoma, multiple myeloma, nephrotic syndrome, sickle cell disease/other hemoglobinopathies, and/or solid organ transplant), OR a specified chronic condition (alcoholism, chronic heart disease including congestive heart failure and cardiomyopathies; chronic liver disease, chronic lung disease including chronic obstructive pulmonary disease, emphysema, and asthma; cigarette smoking, or diabetes mellitus) should check with their health care provider to ensure they receive appropriate vaccination according to previously received vaccines and their specific condition.

For additional information see <https://www.cdc.gov/vaccines/vpd/pneumo/hcp/who-when-to-vaccinate.html> or [U.S. CDC's job aid for pneumococcal vaccination: https://www.cdc.gov/pneumococcal/downloads/Vaccine-Timing-Adults-JobAid.pdf](https://www.cdc.gov/pneumococcal/downloads/Vaccine-Timing-Adults-JobAid.pdf)

### **COVID-19 Vaccination**

During the 2025–26 influenza season, it is expected that SARS-CoV-2 will continue to circulate in the United States. Vaccination remains the best defense against severe COVID-19 disease. Maine CDC issued COVID-19 immunization recommendations and a [standing order for the 2025- 2026 COVID-19 vaccine products](#) (Pfizer, Moderna, and Novavax) on September 12, 2025. Information about the standing order can be viewed at [www.maine.gov/covid19](http://www.maine.gov/covid19).

- **People ages 19 -64:**
  - Should receive one (1) dose of age-appropriate 2025–2026 COVID-19 vaccine.
- **People ages 65 or older:**
  - Should receive two (2) doses of age-appropriate 2025–2026 COVID-19 vaccine, spaced 2 - 6 months apart, regardless of prior COVID-19 vaccination history.
- **Pregnant or recently pregnant or lactating individuals or those contemplating pregnancy:**
  - Should receive one (1) dose of age-appropriate 2025–2026 COVID-19 vaccine.
- **People who are moderately or severely immunocompromised:**
  - Should receive a multidose initial series with an age-appropriate 2025–2026 COVID-19 vaccine. Additional doses may be necessary under the direction of a health care provider.

### **Respiratory Syncytial Virus Vaccination**

In June of 2025, ACIP recommended a single lifetime dose of any FDA-approved RSV vaccine for all adults aged 75 years and older and for adults aged 50–74 years who are at increased risk for severe RSV disease.

- This expands the 2024 ACIP recommendation that adults aged  $\geq 60$  years who are at increased risk, to include those 50 through 59 at years of age at increased risk receive a single dose of an RSV vaccine. Adults who have previously received RSV vaccine should not receive another dose.
- Maternal RSV vaccine (ABRYSSVO™) is recommended as a one-time single dose for pregnant people 32 through 36 weeks gestation, during the months of September through January, to prevent RSV lower respiratory tract infection in infants.

For additional information about RSV vaccine recommendations visit [www.cdc.gov/rsv/vaccines](http://www.cdc.gov/rsv/vaccines).

## **2. Take steps to minimize potential exposures.**

- Implement respiratory hygiene and cough etiquette.
- Post visual alerts (e.g. signs, posters) at the entrance and in strategic places to instruct patients, healthcare personnel (HCP), and visitors on respiratory hygiene and cough etiquette.
- Provide face masks and hand sanitizer.

## **3. Monitor and manage ill healthcare personnel (HCP).**

- Develop sick leave policies for HCP that are non-punitive, flexible and consistent with public health guidance to allow and encourage HCP with suspected or confirmed influenza to stay home.
- Establish procedures for tracking absences.

- HCP who develop fever and respiratory symptoms should be excluded from work until at least 3 days have passed from symptom onset, they are fever free for at least 24 hours without the use of fever reducing medication, symptoms are improving, and they feel well enough to return to work.
  - If symptoms begin at work, the staff member should stop patient-care activities, don a facemask, and promptly notify their supervisor before leaving work.
  - Adherence to respiratory hygiene and cough etiquette after returning to work is always important. The HCP should wear a facemask upon return to work until the end of day 7 following symptom onset (day 0).

#### **4. Adhere to infection control precautions for all patient care activities and aerosol-generating procedures.**

Standard precautions assume that every person is potentially infected or colonized with a pathogen that could be transmitted in a healthcare setting. Elements of standard precautions that apply to patients with respiratory infections, including those caused by the influenza virus, are summarized below.

##### **Hand Hygiene**

- HCP should perform hand hygiene frequently, including before and after all patient contact, contact with potentially infectious material, and before putting on and upon removal of personal protective equipment, including gloves. Hand hygiene in healthcare settings includes washing with soap and water or using alcohol-based hand rubs. If hands are visibly soiled, use soap and water, not alcohol-based hand rubs.
- Healthcare facilities should ensure that supplies for hand hygiene are available.

##### **Gloves**

- Wear gloves for any contact with potentially infectious material. Remove gloves after contact, followed by hand hygiene. Do not wear the same pair of gloves for the care of more than one patient. Do not wash gloves for the purpose of reuse.

##### **Gowns**

- Wear gowns for any patient-care activity when contact with blood, body fluids, secretions (including respiratory), or excretions is anticipated. Remove gown and perform hand hygiene before leaving the patient's environment. Do not wear the same gown for care of more than one patient.

##### **Droplet Precautions**

- Droplet precautions should be implemented for patients with suspected or confirmed influenza for 7 days after illness onset or until 24 hours after the resolution of fever and respiratory symptoms, whichever is longer.
- Place patients with suspected or confirmed influenza in a private room or area if possible. If not possible, attempt to cohort ill individuals together or leave with original roommate.
- HCP should wear a facemask when entering the room of a patient with suspected or confirmed influenza. If the patient needs to leave their room, have the patient wear a facemask, if possible, and follow respiratory hygiene, cough etiquette, and hand hygiene.
- Communicate information about patients with suspected or confirmed influenza to appropriate personnel before transferring them to other areas in the facility or to other facilities.

## **5. Manage visitor access and movement within the facility.**

- Limit visitors for patients in isolation for influenza to persons who are necessary for the patient's emotional well-being and care.
- All visitors should follow proper respiratory hygiene, cough etiquette, and hand hygiene.

## **6. Monitor influenza activity.**

- Establish mechanisms and policies by which HCP are promptly alerted about increased influenza activity in the community or if an outbreak occurs.
- Designate a specific person who is responsible for communication with public health officials and dissemination of information to HCP.

## **7. Implement environmental and engineering infection control measures.**

- Standard cleaning and disinfection procedures are adequate for influenza virus environmental control.
- Consider designing and installing engineering controls to reduce or eliminate exposures including installing physical barriers such as partitions or curtains.
- Verify cleaning products are effective against influenza.

## **8. Train and educate healthcare personnel.**

- Ensure that all HCP receive job- or task-specific education and training on preventing transmission of infectious agents, including influenza. Competency should be documented initially and repeatedly, as appropriate, for the specific staff positions.

# **Section II: Prevention Measures**

## **1. Vaccinate all residents and staff using a systematic approach to increase immunization levels.**

- Vaccinate all residents and staff once the vaccine is available (usually September through October) and continue to vaccinate new residents throughout the season.
- Ensure your facility has a written policy on immunizations that includes annual influenza vaccination for all residents and staff, and pneumococcal vaccine for all residents.
- Obtain consent for vaccination from residents or their family members upon admission. Include Vaccine Information Statements (VIS) in admission packets. Instructions and examples of VIS are available at <https://www.cdc.gov/vaccines/hcp/vis/index.html>
- Implement standing orders for administration of vaccines as they become available to long-term care facilities. If your facility does not currently have a standing order, a template can be found at <https://www.immunize.org/catg.d/p3074.pdf>.
- Inactivated influenza, pneumococcal, COVID-19, and RSV vaccines are safe and effective when administered at the same time by using separate syringes and given at different anatomical sites.
- Perform chart audits to ensure that there is documentation in every chart that the resident has been offered annual influenza vaccine and both pneumococcal (PCV and PPSV23) vaccines.
- Facilities should consider implementing a respiratory vaccine checklist protocol upon intake of new residents to ensure residents have received influenza, COVID-19, RSV, as well as pneumococcal vaccines, if appropriate.

- Consider residents with uncertain immunization histories NOT immunized and vaccinate accordingly. The benefits of vaccination far outweigh any concerns about revaccination.
- 2. Encourage family members and visitors to receive an influenza vaccine.**
- Make them aware of their role in the transmission of influenza to residents.
  - To locate a flu vaccine clinic, family members may contact their healthcare providers, visit <https://www.vaccines.gov/find-vaccines/>, or dial 211.
- 3. Encourage family members, visitors, and all staff to practice respiratory etiquette to prevent the transmission of respiratory illnesses.**
- Post educational materials on respiratory etiquette.
  - Promote frequent hand washing and the use of alcohol-based hand gel.
  - Educational materials on respiratory hygiene are available at <https://www.maine.gov/dhhs/order> and <http://www.cdc.gov/flu>.

## Section III: Early Detection of Influenza

Despite clear benefits, vaccination does not offer complete protection against influenza viruses, and outbreaks can still occur. Imperfect matching between the vaccine and circulating strains may limit vaccine effectiveness. Information on current vaccine match is available on the U.S. CDC website at <http://www.cdc.gov/flu>. The diminished immune response that sometimes occurs with advanced age and underlying medical conditions may further decrease overall vaccine effectiveness.

- Prompt recognition of influenza and the initiation of infection control measures can help prevent influenza from spreading.
- Reliable, timely detection depends upon prompt recognition of clinical signs and symptoms and submissions of respiratory specimens for laboratory diagnosis.

### Suspect an outbreak when:

- Any resident tests positive for influenza, by any method.
- Two residents or more develop respiratory illness within 72 hours of each other.

### Testing:

- Even if it is not influenza season, influenza testing should occur when any resident has signs and symptoms that could be due to influenza, especially when two residents or more develop respiratory illness within 72 hours of each other.
- Test for influenza in the following:
  - Ill persons who are in the affected unit as well as previously unaffected units in the facility,
  - Persons who develop acute respiratory illness symptoms more than 72 hours after beginning antiviral chemoprophylaxis.
  - Note that elderly persons and other long-term care residents, including those who are medically fragile and those with neurological or neurocognitive conditions, may manifest atypical signs and symptoms with influenza virus infection, and may not have fever.
- While SARS-CoV-2 and influenza viruses are co-circulating, residents with respiratory illness should be tested for both.

- Influenza testing is available free of charge through Maine’s Health and Environmental Testing Laboratory (HETL) [www.mainepublichealth.gov/lab](http://www.mainepublichealth.gov/lab).

### **What to do if an outbreak is suspected or identified?**

Follow the checklist for influenza outbreaks in Long-Term Care (Appendix 1).

### **What to do if a resident is hospitalized for influenza?**

Work with the health care provider to determine when the patient is no longer in need of critical care and can be discharged. Residents’ eligibility to return from the hospital should be based on stability, not length of time on antiviral medication. Following return, the resident should be placed in a private room or with other ill individuals for 7 days after onset, or 24 hours after the resolution of fever and respiratory symptoms, whichever is longer.

## **Use of Antiviral Medications**

### **1. Treatment**

- Four antiviral medications are recommended for the treatment of influenza:
  - Oral oseltamivir
  - Inhaled zanamivir (not recommended for individuals with underlying respiratory conditions)
  - Intravenous peramivir
  - Oral baloxavir
- Initiate treatment within 48 hours of illness onset.
- Recommended duration of treatment using oseltamivir or zanamivir is 5 days. Peramivir and baloxavir are one dose treatments.
- Treatment should not wait for laboratory confirmation of influenza.

The initiation of antiviral medications for treatment of influenza is approved by MaineCare and should be initiated prior to laboratory confirmation.

- The formulary allows for the use of oseltamivir.
- MaineCare currently does not require a prior authorization for the use of oseltamivir chemoprophylaxis at a long-term care facility.

### **2. Chemoprophylaxis**

Oseltamivir, zanamivir, and baloxavir can be used as chemoprophylaxis for the prevention and control of influenza. Using antiviral medications as chemoprophylaxis is not a substitute for vaccination.

### **When at least 2 patients are ill within 72 hours of each other and at least one resident has laboratory-confirmed influenza, antiviral chemoprophylaxis should be:**

- Administered to all non-ill residents, regardless of influenza vaccination status.
  - Priority should be given to residents living in the same unit or floor as an ill resident. However, since staff and residents may spread influenza to residents on other units, floors, or buildings of the same facility, all non-ill residents are recommended to receive antiviral chemoprophylaxis to control influenza outbreaks.
- Offered to unvaccinated staff who provide care to persons at high risk.

- Prophylaxis should be considered for all staff if the outbreak is caused by an influenza virus that is not well matched by the vaccine. Information on current vaccine match is available on the U.S. CDC website at <http://www.cdc.gov/flu>.
- Continued for a minimum of 2 weeks and continuing for at least 7 days after the last known case was identified.
- The dosage for each resident should be determined individually because recommendations vary by age group and medical conditions (see antiviral manufacturer’s prescribing information).

### **Drug Resistance**

- To limit the potential transmission of an antiviral drug-resistant influenza virus, measures should be taken to reduce contact between ill persons taking antiviral drugs for treatment and other persons, including those receiving antiviral chemoprophylaxis.

### **Consider the following additional measures to reduce transmission among residents and healthcare personnel:**

- Have symptomatic residents stay in their own rooms as much as possible, including restricting them from common activities, and have their meals served in their rooms when possible.
- Limit the number of large group activities in the facility and consider serving all meals in resident rooms, if possible, when the outbreak is widespread (involving multiple units of the facility).
- Avoid new admissions or transfers to wards with symptomatic residents.
- Limit visitation and exclude ill persons from visiting the facility via posted notices. Consider restricting visitation by children during community outbreaks of influenza.
- Monitor personnel absenteeism due to respiratory symptoms and exclude those with respiratory illness from work until at least 3 days have passed from symptom onset, they are fever free for at least 24 hours without the use of fever reducing medication, symptoms are improving, and they feel well enough to return to work.
- Restrict personnel movement from areas of the facility experiencing illness to areas not affected by the outbreak.
- Administer the current season’s influenza vaccine to unvaccinated residents and healthcare personnel as per current recommendations.
- When an ill individual has appointments or is being transferred (to another facility or a hospital) notify the receiving facility of the patient’s illness so that appropriate precautions can be taken.

## **Section IV: References and Other Sources of Information**

1. “Infection Prevention and Control Strategies for Seasonal Influenza in Healthcare Settings.” *Centers for Disease Control and Prevention*, U.S. Department of Health & Human Services, 28 April 2025, [https://www.cdc.gov/flu/hcp/infection-control/healthcare-settings.html?CDC\\_AAref\\_Val=https://www.cdc.gov/flu/professionals/infectioncontrol/healthcaresettings.htm](https://www.cdc.gov/flu/hcp/infection-control/healthcare-settings.html?CDC_AAref_Val=https://www.cdc.gov/flu/professionals/infectioncontrol/healthcaresettings.htm)
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8. “Testing and Management Considerations for Nursing Home Residents with Acute Respiratory Illness Symptoms when SARS-CoV-2 and Influenza Viruses are Co-circulating.” *Centers for Disease Control and Prevention*, U.S. Department of Health & Human Services, 14 November 2023, [https://www.cdc.gov/flu/hcp/testing-methods/nursing-homes.html?CDC\\_AAref\\_Val=https://www.cdc.gov/flu/professionals/diagnosis/testing-management-considerations-nursinghomes.htm](https://www.cdc.gov/flu/hcp/testing-methods/nursing-homes.html?CDC_AAref_Val=https://www.cdc.gov/flu/professionals/diagnosis/testing-management-considerations-nursinghomes.htm)

**For questions or consultations or to report an outbreak please contact Maine CDC via phone at: 1-800-821-5821 or email at [disease.reporting@maine.gov](mailto:disease.reporting@maine.gov).**

**For downloadable flu materials including posters visit:**

<https://www.maine.gov/dhhs/order>

## Appendix 1: Checklist for Influenza Outbreaks in Long-Term Care

### Recognition, Reporting & Testing

- Upon suspicion of an influenza outbreak, notify Maine CDC by calling 1-800-821-5821 or emailing [disease.reporting@maine.gov](mailto:disease.reporting@maine.gov)
- Obtain an outbreak number from Field Epidemiologists for identification purposes: #
- Maintain a line listing of symptomatic residents and staff
- Collect and submit specimens from affected residents and staff as soon as an outbreak is suspected
- Follow HETL guidelines for specimen collection, handling, and transport; label specimens with outbreak #
- Notify facility medical director that an influenza outbreak is suspected

### Control Measures for Facility

#### Infection Control:

- Re-offer vaccine to all unvaccinated staff and residents
- Institute droplet precautions for symptomatic residents
- Cohort ill residents as much as possible and suspend group activities
- Minimize resident and staff movement between affected and unaffected units/wards
- Enforce strict hand hygiene for all facility staff
- Supplement hand washing with soap and water with ethanol or alcohol-based hand sanitizers
- Begin treatment doses of antivirals to all symptomatic residents and staff, and begin prophylactic doses of antivirals to all residents and unvaccinated staff (within 48 hours)

#### Environmental Controls:

- Clean all high traffic areas and high touch items (i.e. faucets, door handles, and toilet or bath rails)
- Use EPA-registered disinfectants or detergents/disinfectants approved for use against influenza for routine cleaning and disinfection

#### Administrative Controls:

- Exclude ill staff from work for at least 24 hrs after symptoms resolve without the use of anti-pyretics
- Suspend group activities as much as possible until after the outbreak is contained
- Post signage about the outbreak and proper hand hygiene
- Limit new admissions to a non-infected wing, or close to new admissions altogether

#### Recommendations for Residents & Visitors

- Encourage ill residents to stay in their room/apartment for at least 24 hours after symptoms resolve without the use of anti-pyretics
- Promote good hand hygiene for residents: after using the toilet, having contact with an ill individual, and before preparing food, eating or drinking
- Consider restricting visitation until the outbreak is contained

#### Internal and External Communications

- Identify a single point of contact for internal communications
- Identify a single point of contact for external communications
- Notify staff of outbreak and control measures and conduct enhanced surveillance for ill staff
- Notify residents/guardians of outbreak and control measures and request ill residents report to nursing staff
- Consider a final communication to staff, residents, and guardians when the outbreak is over

**Appendix 2: Sample Line List of Residents with Acute Respiratory Illness and/or Pneumonia**

Facility Name:			Patient Location	Vaccination		Illness Description				Laboratory Testing		Illness Complications			
Name	Age	Sex		Room #, Bed designation	Influenza	Pneumococcal	Onset Date	Fever (>100° F)	Cough	Sore Throat	Rapid antigen	PCR	Pneumonia	Hospitalized	Died
		<input type="checkbox"/> F <input type="checkbox"/> M		<input type="checkbox"/>	<input type="checkbox"/>	/ /	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> + <input type="checkbox"/> -	<input type="checkbox"/> + <input type="checkbox"/> -	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/ /
		<input type="checkbox"/> F <input type="checkbox"/> M		<input type="checkbox"/>	<input type="checkbox"/>	/ /	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> + <input type="checkbox"/> -	<input type="checkbox"/> + <input type="checkbox"/> -	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/ /
		<input type="checkbox"/> F <input type="checkbox"/> M		<input type="checkbox"/>	<input type="checkbox"/>	/ /	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> + <input type="checkbox"/> -	<input type="checkbox"/> + <input type="checkbox"/> -	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/ /
		<input type="checkbox"/> F <input type="checkbox"/> M		<input type="checkbox"/>	<input type="checkbox"/>	/ /	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> + <input type="checkbox"/> -	<input type="checkbox"/> + <input type="checkbox"/> -	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/ /
		<input type="checkbox"/> F <input type="checkbox"/> M		<input type="checkbox"/>	<input type="checkbox"/>	/ /	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> + <input type="checkbox"/> -	<input type="checkbox"/> + <input type="checkbox"/> -	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/ /
		<input type="checkbox"/> F <input type="checkbox"/> M		<input type="checkbox"/>	<input type="checkbox"/>	/ /	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> + <input type="checkbox"/> -	<input type="checkbox"/> + <input type="checkbox"/> -	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/ /