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December 2024

Dear Director of Nursing,

Maine Center for Disease Control and Prevention (Maine CDC), Division of Disease Surveillance is pleased to provide you with the enclosed resource, **Prevention and Control of Influenza in Long-Term Care Facilities 2024-2025**, to assist in planning influenza infection control and outbreak preparation and response in your facility this season. Laboratory confirmed influenza hospitalizations are a reportable condition, as well as influenza outbreaks.

Vaccination, prompt recognition of influenza, initiation of infection control measures, and utilization of antiviral medications in long-term care facilities can help prevent influenza from spreading to patients and healthcare personnel. Monitoring residents for influenza-like illness (ILI) is important for prompt disease detection and control and limiting significant morbidity and mortality. The enclosed documents may be useful as your facility considers how to track influenza this year.

Additional influenza posters and materials can be ordered free of charge online at www.maine.gov/dhhs/order.

If you have questions about influenza surveillance activities; or if your facility is experiencing an outbreak of influenza (a single laboratory positive resident) or any cluster of illness, please report this by calling 1-800-821-5821 or by emailing disease.reporting@maine.gov.

Sincerely,

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Maine Center for Disease Control and Prevention
Division of Disease Surveillance

Prevention and Control of Influenza In Long-Term Care Facilities 2024-2025

December 2024

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 health care workers during outbreaks is also common. Annual flu vaccination is the most effective method for preventing flu virus infection and its complications. Vaccination is recommended for all persons ≥ 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 flu virus.

People 65 years and older are at high risk of developing serious complications from flu, 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 flu-related deaths have occurred in people 65 years and older, and between 50 percent and 70 percent of seasonal flu-related hospitalizations occurred among people in this age group. (https://www.cdc.gov/flu/about/burden/past-seasons.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 2024-2025 flu season.

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Executive Summary

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

1. **Vaccination**
    a. **Vaccinate residents** for flu, 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.
        ii. **Pneumococcal** vaccine: U.S. CDC recommends that adults 50 years or older are vaccinated for pneumococcal disease.
        iii. **COVID-19** vaccine: U.S. 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 2024-2025 COVID-19 vaccine 6 months after their first dose.
        iv. RSV vaccine: U.S. CDC recommends a single dose of the RSV vaccine for all adults aged 75 years and older and for adults aged 60–74 years who are at increased risk for severe RSV disease.
    b. **Vaccinate staff** for flu. All staff should be vaccinated for seasonal flu and vaccine status should be documented and provided to Maine CDC annually.

2. **Testing**
    a. Influenza testing should occur when any resident has signs and symptoms that could be due to flu, especially when two residents or more develop respiratory illness within 72 hours of each other. While SARS-CoV-2 and flu viruses are co-circulating, residents with respiratory illness should be tested for both.

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 flu 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 (no patient information)
b. Review this document for additional guidance
c. Collect 2-5 samples for flu testing
d. Follow the Outbreak checklist (Appendix 1)

Section I: Key Recommendations and Information for 2024-2025

1. Promote and administer vaccine.

Maine Center for Disease Control and Prevention (Maine CDC) recommends vaccinating residents and staff against influenza, pneumococcal pneumonia, COVID-19 and RSV to prevent infection of other respiratory illness during flu season. Vaccinate all residents and staff against respiratory illness 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 flu, pneumococcal pneumonia COVID-19 and RSV. Immunizing residents on site ensures a higher vaccination rate. It reduces the likelihood of outbreaks that can lead to serious complications and health care costs. Influenza vaccination should be offered as long as flu 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 flu 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 requests 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 flu (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, flu is often introduced into or spread through a facility by staff or visitors. Additionally, flu vaccine may be less effective in the very elderly and although they are immunized, some residents may remain susceptible to flu. By vaccinating long-term care facility staff, morbidity and mortality among elderly patients is reduced.

Influenza Vaccine Composition for 2024-2025

- All 2024-2025 flu 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 more information on the trivalent influenza vaccine: https://www.cdc.gov/flu/vaccine-types/trivalent.html
- For 2024-2025, egg-based vaccines are recommended to contain:
    - an A/Victoria/4897/2022 (H1N1)pdm09-like virus;
    - an A/Thailand/8/2022 (H3N2)-like virus; and (Updated)
    - a B/Austria/1359417/2021 (B/Victoria lineage)-like virus.

- For 2024-2025, cell- or recombinant-based vaccines are recommended to contain:
    - an A/Wisconsin/67/2022 (H1N1) pdm09-like virus;
    - an A/Massachusetts/18/2022 (H3N2)-like virus; and (Updated)
    - a B/Austria/1359417/2021 (B/Victoria lineage)-like virus.

Additional safety measures are no longer recommended for flu 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.

For adults 65 years and older, there are 3 flu vaccines that are preferentially recommended. These are Fluzone High-Dose inactivated flu vaccine, Flublok recombinant flu vaccine, and Fluad adjuvanted inactivated flu vaccine. If none of the 3 flu vaccines preferentially recommended for people 65 years and older is available at the time of administration, people in this age group can get any other age-appropriate flu vaccine instead.

Pneumococcal Vaccination

In October 2024, the 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. 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.

- Adults ≥ 50 who have either **never received a pneumococcal vaccine OR** who **only received PCV7** should receive:
    - PCV20 or PCV21 **OR**
    - PCV15 followed by a dose of PPSV23 ≥ 1 year later.
        - If PPSV23 is not available, PCV20 or PCV21 may be used in its place.
        - If an **individual has an immunocompromising condition, cochlear implant, or cerebrospinal fluid (CSF) leak** an 8-week minimum interval should be considered rather than ≥ 1 year for the dose of PPSV23.
- Adults ≥50 who **previously received PPSV23 and no other pneumococcal vaccines** should receive:
    - PCV20 or PCV21 no sooner than 1 year after PPSV23 was administered.
        - If PCV20 and PCV21 are unavailable PCV15 can be used.
- Adults ≥50 who **only received PCV-13** should receive:
    - PCV20 or PCV21 no sooner than a year after PCV13 administration
- Adults ≥50 who received **PCV13 at any age and PPSV23 before the age of 65** should receive:
    - PCV20 or PCV21 ≥5 years after the last dose of pneumococcal vaccine was administered
- Adults ≥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:
    - PCV20 or PCV21 ≥5 years after the last dose of pneumococcal vaccination.
- 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 job aid for pneumococcal vaccination: https://www.cdc.gov/pneumococcal/downloads/Vaccine-Timing-Adults-JobAid.pdf

COVID-19 Vaccination
During the 2024–25 flu season, it is expected that SARS-CoV-2 will continue to circulate in the United States.

Everyone aged 6 months and older should get at least 1 dose of the updated 2024-2025 COVID-19 vaccine, regardless of prior vaccination.

- People ages 12 years and older:
  - 1 dose of the 2024–2025 Moderna **OR**
  - 1 dose of the 2024–2025 Pfizer-BioNTech COVID-19 vaccine **OR**
  - 1 dose of the 2024-2025 Novavax COVID-19 vaccine
- Persons getting the Novovax COVID-19 vaccine who were not previously vaccinated for COVID-19 will need 2 doses of 2024–2025 Novavax COVID-19 vaccine to be up to date.
- Everyone aged 6 months and older with moderate or severe immunocompromise:
  - 2 or 3 doses of the same brand of updated COVID-19 vaccine.
  - For more detailed information, visit: https://www.cdc.gov/covid/vaccines/immunocompromised-people.html
  - **People 65 years and older and those who are moderately or severely immunocompromised should receive a second dose of 2024-2025 COVID-19 vaccine 6 months after their first dose.**
- There is no required waiting period between COVID-19 illness and getting a COVID-19 vaccine, however persons with recent COVID-19 infection can consider waiting up to 3 months after illness.
- U.S. CDC and the Maine CDC recommend health care workers get vaccinated against COVID-19.

Respiratory Syncytial Virus Vaccination
On June 26, 2024, ACIP recommended a single dose of any FDA-approved RSV vaccine for all adults aged 75 years and older and for adults aged 60–74 years who are at increased risk for severe RSV disease.

- ACIP and U.S. CDC recommend that adults ages 75 and older, and adults ages 60–74 at increased risk of severe RSV, receive a single lifetime dose of RSV vaccine. This replaces the 2023 ACIP recommendation that adults aged ≥60 years receive a single dose of an RSV vaccine, using shared clinical decision-making. There is no preferential recommendation; give whichever vaccine is available. Adults who have previously received RSV vaccine should not receive another dose.
- Maternal RSV vaccine (ABRYSVO™) is recommended for pregnant people during 32 through 36 weeks gestation, seasonally, to prevent RSV lower respiratory tract infection in infants.

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, health care personnel (HCP), and visitors on respiratory hygiene and cough etiquette.
- Provide face masks and hand sanitizer.

3. Monitor and manage ill health care personnel.

- 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 flu to stay home.
- Establish procedures for tracking absences.
- HCP who develop fever and respiratory symptoms should be excluded from work until 24 hours after fever resolves without the use of fever reducing medication (anti-pyretics).
    - If symptoms begin at work, the staff member should immediately excuse themselves from patient care and notify their supervisor.
    - Adherence to respiratory hygiene and cough etiquette after returning to work is always important. If symptoms such as cough and sneezing are still present after the exclusion period, the HCP should wear a facemask during patient care activities.
    - If COVID-19 is suspected, follow additional COVID-19 precautions and guidance.

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 health care setting. Elements of standard precautions that apply to patients with respiratory infections, including those caused by the flu 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 health care 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.
    - Health care 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 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 flu for seven (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 flu 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 flu. 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 flu 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 flu 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 flu 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 flu 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 flu.

8. Train and educate health care personnel.

- Ensure that all HCP receive job- or task-specific education and training on preventing transmission of infectious agents, including flu. 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 flu 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 flu, 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 flu vaccine and is up to date with pneumococcal vaccine(s).

- Facilities should consider implementing a respiratory vaccine checklist protocol upon intake of new residents to ensure residents have received flu, 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 a flu vaccine.

- Make them aware of their role in the transmission of flu to residents.
- To locate a flu vaccine clinic, family members may contact their health care 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 https://www.cdc.gov/flu-resources/index.html.

Section III: Early Detection of Influenza

Despite its clear benefits, vaccination does not offer complete protection against flu 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 flu and the initiation of infection control measures can help prevent flu 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 flu, by any method.
- Two residents or more develop respiratory illness within 72 hours of each other.

Testing:

- Even if it is not flu season, flu testing should occur when any resident has signs and symptoms that could be due to flu, especially when two residents or more develop respiratory illness within 72 hours of each other.
- Test for flu 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 flu virus infection, and may not have fever.
- While SARS-CoV-2 and flu viruses are co-circulating, residents with respiratory illness should be tested for both.
- Flu and SARS-CoV-2 testing are available free of charge through Maine's Health and Environmental Testing Laboratory (HETL) www.mainepublichealth.gov/lab.

What to do if an outbreak is suspected or identified?
Follow the checklist for flu 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 for the treatment of influenza

1. Treatment

- Four antiviral medications are recommended for the treatment of flu:
    - 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 flu.

The initiation of antiviral medications for treatment of flu 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 flu. 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 flu 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 flu to residents on other units, floors, or buildings of the

same facility, all non-ill residents are recommended to receive antiviral chemoprophylaxis to control flu 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 a flu 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 flu 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 health care 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 flu.
- Monitor personnel absenteeism due to respiratory symptoms and exclude those with flu-like symptoms from work until at least 24 hours after their fever subsides without the use of fever-reducing medications.
- Restrict personnel movement from areas of the facility experiencing illness to areas not affected by the outbreak.
- Administer the current season's flu vaccine to unvaccinated residents and health care 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 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, 12 December 2024, https://www.cdc.gov/flu/hcp/infection-control/healthcare-settings.html

2. Grohskopf LA, Ferdinands JM, Blanton LH, Broder KR, Loehr J. Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of the Advisory Committee on Immunization Practices — United States, 2024–25 Influenza Season. MMWR Recomm Rep 2024;73(No. RR-5):1–25. DOI: http://dx.doi.org/10.15585/mmwr.rr7305a1

3. Tokars, et al. Season Incidence of Symptomatic Influenza in the United States. *Clinical Infectious Diseases*, Volume 66, Issue 10, 15 May 2018, Pages 1511–1518. https://doi.org/10.1093/cid/cix1060

4. "Interim Guidance for Influenza Outbreak Management in Long-Term Care and Post-Acute Care Facilities." *Centers for Disease Control and Prevention,* U.S. Department of Health & Human Services, 12 December 2024, https://www.cdc.gov/flu/hcp/infection-control/ltc-facility-guidance.html

5. "Isolation Precautions Guideline." *Centers for Disease Control and Prevention,* U.S. Department of Health & Human Services, 12 December 2024, http://www.cdc.gov/hicpac/2007IP/2007ip_part4.html#4

6. Influenza (Flu). *Centers for Disease Control and Prevention*. U.S. Department of Health & Human Services, http://www.cdc.gov/flu/

7. Maine Influenza Webpage. *Maine Center for Disease Control and Prevention*. Maine Department of Health and Human Services, www.maineflu.gov

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, 12 December 2024, https://www.cdc.gov/flu/hcp/testing-methods/nursing-homes.html

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.

For downloadable flu materials including posters visit:
https://www.maine.gov/dhhs/order
https://www.cdc.gov/flu-resources/index.html

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
☐ 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	Date of Death
		☐ F ☐ M		☐	☐	/ /	☐	☐	☐	☐ + ☐ -	☐ + ☐ -	☐	☐	☐	/ /
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How to Wash Your Hands

Wash for at least 20 seconds. Sing or hum "Happy Birthday" twice to time yourself.

1 Wet hands

2 Get Soap

3 Scrub

20 sec

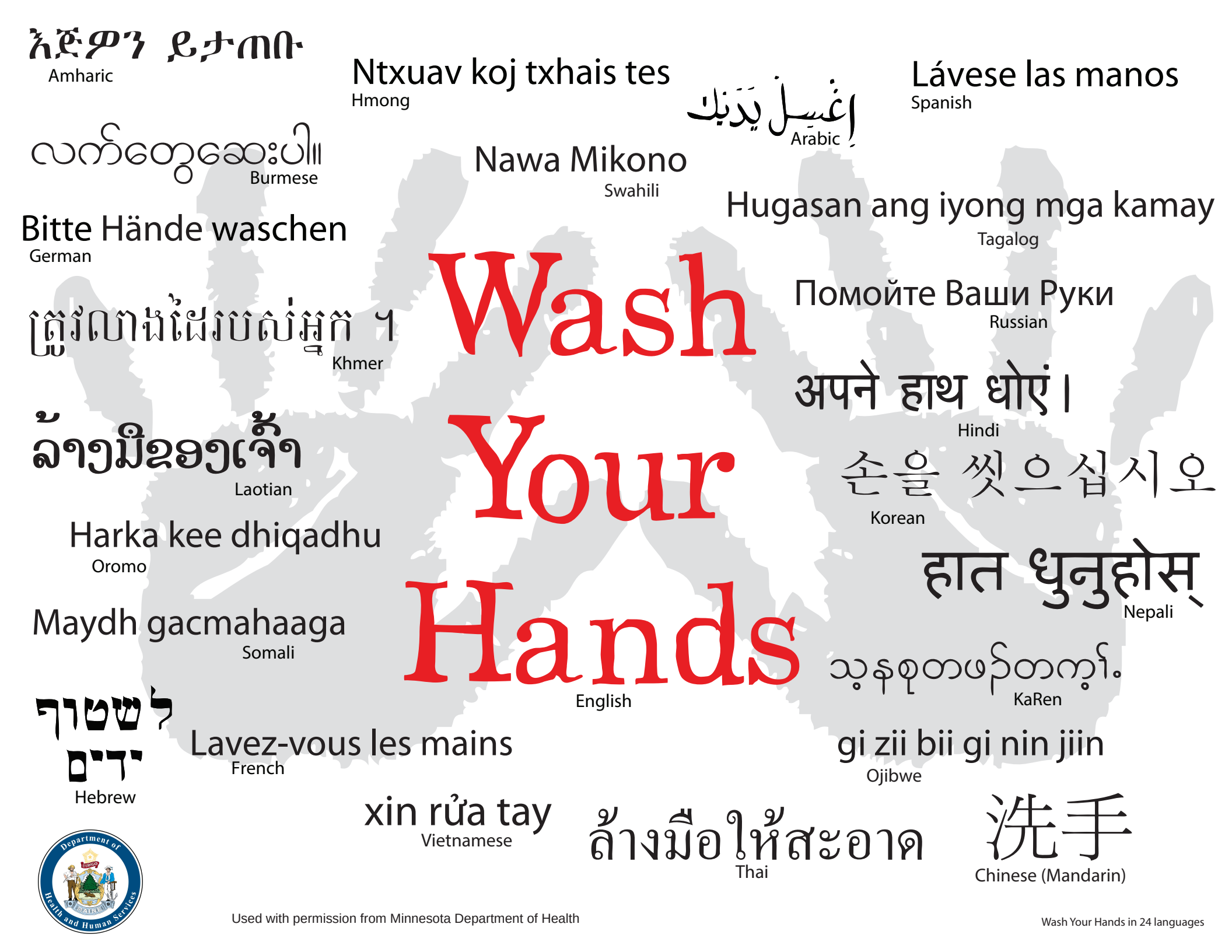
4 Rinse

5 Dry

Prevent illnesses by washing your hands often!

www.cdc.gov/handwashing/

Department of Health and Human Services



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