Maine CDC
2024–2025 Respiratory Virus Season Talking Points
Including Influenza, COVID-19, and RSV

Respiratory Season Outlook

- Influenza, RSV, and COVID-19 are now all considered as part of the respiratory virus season.
- U.S. CDC expects the upcoming fall and winter respiratory disease season will likely have a similar or lower number of combined peak hospitalizations due to COVID-19, influenza, and RSV compared to last season: 2024–2025 Respiratory Disease Season Outlook

Immunization

Getting vaccinated this year is especially important with three prominently circulating respiratory virus this fall. Influenza, COVID-19, and respiratory syncytial virus (RSV) will be circulating at the same time; illness from these viruses can be prevented by vaccines. Getting vaccinated will protect you and your family from becoming sick from one of these viruses and may also potentially save healthcare resources in a season that could be particularly taxing.

Influenza Vaccination

1. *Everyone six months of age and older should get a yearly flu vaccine.*
    - Children 6 months through 8 years of age, receiving the flu shot for the first time or those who have only previously gotten one dose of vaccine in this age range, should get two doses of vaccine this season—spaced at least 4 weeks apart.
    - Persons who are pregnant, who might be pregnant, or are postpartum during the influenza season should receive any licensed, recommended, and age-appropriate vaccine. LAIV4 should not be used during pregnancy but can be used postpartum. Vaccination during pregnancy is protective for the mother as well as infants during the first months of life.
    - Adults aged ≥65 years should receive trivalent high-dose inactivated influenza vaccine (HD-IIV3), trivalent recombinant influenza vaccine (RIV3), or trivalent adjuvanted inactivated influenza vaccine (aIIV3)). If these vaccines are not available at time of administration, then any other age-appropriate influenza vaccine should be administered.
2. Timing: For most persons who need only 1 dose of influenza vaccine for the season, vaccination should ideally be offered during September or October. However, vaccination should continue after October and throughout the influenza season as long as influenza viruses are circulating, and unexpired vaccine is available.
    - **Children who require 2 doses:** Certain children aged 6 months through 8 years require 2 doses of influenza vaccine for the season, these children should receive their first dose as soon as possible to allow the second dose (which must be administered ≥4 weeks later) to be received, ideally, by the end of October.
    - **Children who require only 1 dose:** Vaccination during July and August can be considered for children of any age who need only 1 dose of influenza vaccine for the season as many children in this group might visit health care providers during the late summer months for medical examinations before the start of school. Vaccination can be considered at this time because it represents a vaccination opportunity.
    - **Pregnant persons in the first or second trimester:** Vaccination during July and August should be avoided unless there is concern that vaccination later in the season might not be possible.
    - **Pregnant persons in the third trimester:** Vaccination during July and August can be considered for pregnant persons who are in the third trimester during these months because vaccination at this time may reduce the risk for influenza illness in their infants during the first months after birth.
    - **For most adults (particularly adults aged ≥65 years):** Vaccination during July and August should be avoided unless there is concern that vaccination later in the season might not be possible.

3. Manufacturers now produce influenza vaccine for the U.S. market through different technologies (e.g., egg-based, cell culture-based, and recombinant hemagglutinin vaccines, inactivated vaccine, High Dose, Intradermal, Intranasal). All vaccines for the 2023-2024 season are trivalent.
4. All influenza vaccines for the 2024–2025 respiratory season are trivalent.
    - The B/Yamagata strain was removed from the previous influenza vaccine as the B/Yamagata lineage influenza viruses have not been detected since before March 2020.
    - While it is unknown if the B/Yamagata virus is extinct, it is not actively circulating in people, and therefore the risk of infection with B/Yamagata is considered low.
    - Public Health experts will continue to conduct targeted surveillance for influenza B/Yamagata lineage viruses.
    - For more information on the change to trivalent vaccines: https://www.who.int/publications/m/item/recommended-composition-of-influenza-virus-vaccines-for-use-in-the-2024-2025-northern-hemisphere-influenza-season.
5. All 2024–2025 egg-based influenza and LAIV3 vaccine are made to protect against the following three viruses:
    - A/Victoria/4897/2022 (H1N1)pdm09-like virus;
    - A/Thailand/8/2022 (H3N2)-like virus; and (Updated)
    - B/Austria/1359417/2021 (B/Victoria lineage)-like virus.
6. For 2024–2025, cell- or recombinant-based vaccines contain:
    - A/Wisconsin/67/2022 (H1N1)pdm09-like virus;
    - A/Massachusetts/18/2022 (H3N2)-like virus; and (Updated)
    - B/Austria/1359417/2021 (B/Victoria lineage)-like virus.
7. Live attenuated influenza vaccine (LAIV) – or the nasal spray vaccine – is available for use during the 2024–2025 flu season.
    - The LAIV nasal spray can be administered to people between 2–49 years of age without contraindications to the nasal spray vaccine.
    - Self-administered FluMist was approved by the FDA on September 20, 2024, but will not be available until next year (2025–2026 season) for individuals 18 and older with a prescription.
8. Recommendations for people with egg allergies were updated in 2023:
    - It is no longer recommended that persons who have had an allergic reaction to egg involving symptoms other than urticaria should be vaccinated in an inpatient or outpatient medical setting supervised by a health care provider who is able to recognize and manage severe allergic reactions.
    - Egg allergy alone necessitates no additional safety measures for influenza vaccination beyond those recommended for any recipient of any vaccine, regardless of severity of previous reaction to egg.
    - All vaccines should be administered in settings in which personnel and equipment needed for rapid recognition and treatment of acute hypersensitivity reactions are available.
    - For more information on the changes regarding egg allergies: https://www.cdc.gov/mmwr/volumes/72/rr/rr7202a1.htm#:~:text=Regarding%20influenza%20vaccination%20of%20persons%20with%20egg%20allergy%2C%20ACIP%20recommends,health%20status%20can%20be%20used.
9. The U.S. Centers for Disease Control and Prevention (U.S. CDC), the Advisory Committee on Immunization Practices (ACIP), and the Healthcare Infection Control Practices Advisory Committee (HICPAC) recommend that all U.S. health care workers (HCW) get vaccinated annually against influenza. Since 2002, Maine state law requires that healthcare facilities report data on seasonal influenza vaccine coverage among healthcare workers in their facilities annually to the Maine Center for Disease Control

and Prevention (Maine CDC). As of 2021, healthcare workers employed by a licensed nursing facility, residential care facility, Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), multi-level healthcare facility, hospital, or home health agency licensed by the State of Maine are required to show proof of seasonal influenza vaccination:

- Immunization-Requirements-for-Health-Care-Workers.pdf

COVID-19 Vaccination

On August 22, 2024, the ACIP voted to approve the updated mRNA COVID-19 vaccines for the upcoming respiratory season. The Novavax vaccine was approved soon after on August 30. The Monovalent vaccine protects against KP.2 strain of the JN.1 (mRNA) and JN.1 strain (Novavax) The 2023-2024 vaccine is no longer authorized for use and any remaining doses should be appropriately discarded.

1. Everyone six months of age and older should receive the updated fall 2024-2025 COVID-19.
    - **Children ages 6 months–4 years are up-to-date with:**
        - 2 doses of Moderna or 3 doses of Pfizer-BioNTech (including at least 1 dose of the 2024–2025 COVID-19 vaccine)
    - **Children ages 5–11 years are up-to-date with:**
        - 1 dose of the 2024–2025 Moderna OR
        - 1 dose of the 2024–2025 Pfizer-BioNTech COVID-19 vaccine.
    - **People ages 12 years and older are up-to- date with:**
        - 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
            - 1st time getting a COVID-19 vaccine and receiving Novavax, you will need 2 doses of 2024–2025 Novavax COVID-19 vaccine to be up-to-date.
    - People age 6 months and older who are moderately to severely immunocompromised and not vaccinated are up-to-date with:
        - 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
2. Most people are able to be vaccinated now.
    - Individuals who have been recently vaccinated with another COVID-19 vaccine should wait two months post previous vaccination.
    - Individuals that have recently been infected with the COVID-19 virus: should wait three months post infection.
    - May consider administering the vaccine sooner if there is a strong likelihood the patient will not be back in the providers office at the end of the three-month suggested waiting period. Early vaccination does not pose a risk to the induvial, though the immune response may not be as robust with early vaccination.
3. Presentations: Currently, both Moderna and Pfizer have updated mRNA vaccines and a Novavax has a protein-based vaccine for 2024–2025.

Most of the Fall 2024–2025 COVID-19 vaccines are packed in single dose vials/syringes, except Pfizer's vaccine for children under 5 years old (3-dose vials).

Respiratory Syncytial Virus (RSV) Vaccination

On June 26, 2024, ACIP recommended a single dose of any FDA-approved RSV vaccine for all adults aged ≥75 years and for adults aged 60–74 years who are at increased risk for severe RSV disease. Adults who have previously received RSV vaccine should not receive another dose. *This replaces the 2023 ACIP recommendation that adults aged ≥60 years receive a single dose of an RSV vaccine, using shared clinical decision-making.*

As of August 2023, ACIP recommends a dose of nirsevimab to all babies under eight months old entering their first RSV season. ACIP also recommends a protective dose in their second RSV season for older babies, those 8 to 19 months old who remained at risk of severe RSV infection as well as for pregnant people.

1. Respiratory Syncytial Virus (RSV) Vaccines for Infants.
    - Nirsevimab (Beyfortus) is the first vaccine/monoclonal antibody approved for the general population of infants up to 24 months designed to protect infants from severe RSV disease.
    - Children at greatest risk for severe illness from RSV include the following:
    - Premature infants
    - Infants up to 12 months, especially those 6 months and younger
        - Children younger than 2 years with chronic lung disease or congenital heart disease
        - Children with weakened immune systems
        - Children who have neuromuscular disorders, including those who have difficulty swallowing or clearing mucus secretions
    - Who should get the vaccine:
    - Infants born during or entering their first RSV season
        - Children up to 24 months of age who remain vulnerable to severe RSV disease through their second RSV season.
    - Administered by intramuscular injection.
    - Single dose vial/pre-filled syringe (50mg and 100mg)
    - Dosing
        - 50mg for those weighing less than 5kg
        - 100mg for those weighing over 5kg
        - For older infants, up to 24 months, who remain at increased risk for RSV in their second RSV season, a single 200mg does is recommended
    - One Dose per RSV season
    - Provides protection for at least 5 months (the average length of one season)
2. Respiratory Syncytial Virus (RSV) Vaccines for Older Adult.
   ACIP and 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. There is no preferential recommendation; give whichever vaccine is available.
    - Arexvy (GSK) is a recombinant vaccine using the RSV F protein antigen
    - Abrysvo (Pfizer) is a recombinant vaccinee using the RSV F protein antigen
    - mResvia (Moderna)

3. Respiratory Syncytial Virus (RSV) Vaccines for Pregnant People
   ACIP approved administration of Abrysvo to pregnant people in the third trimester to provide protection to infants for the first five months after birth. Pregnant people should receive the vaccine between the 32 and 36 weeks of pregnancy.

Coadministration
Providers may simultaneously administer COVID-19, influenza, and respiratory syncytial virus (RSV) vaccines to eligible patients.

Clinical Recommendations

Influenza treatment
- Treatment is recommended as soon as possible for any patient with suspected or confirmed influenza who:
  - Is hospitalized;
  - Has severe, complicated, or progressive illness; or
  - Is at higher risk for influenza complications (including those ≥65 years).
- Treatment should not wait for laboratory confirmation of influenza.
- Oral oseltamivir, oral baloxavir, inhaled zanamivir, and intravenous peramivir can be used for older adults.
- Zanamivir not recommended for people with underlying respiratory disease (e.g., asthma, chronic obstructive pulmonary disease).
- Additional information on use of antivirals for treatment and chemoprophylaxis is available at: Influenza Antiviral Medications: Summary for Clinicians (https://www.cdc.gov/flu/professionals/antivirals/summary-clinicians.htm)

COVID-19 treatment
- There is strong scientific evidence that antiviral treatment of outpatients at risk for severe COVID-19 reduces their risk of hospitalization and death.
- The antiviral drugs Paxlovid (ritonavir-boosted nirmatrelvir) and Veklury (remdesivir) are the preferred treatments for eligible adult and pediatric patients with positive results of direct SARS-CoV-2 viral testing and who are at high risk for progression to severe COVID-19.
  - Paxlovid is preferred, followed by Remdesivir. Lagevrio (Molnupiravir) is an alternative therapy for use only when neither preferred therapy is available, feasible to use, or clinically appropriate.
- Clinicians should consider COVID-19 treatment in non-hospitalized patients who meet all of the following:
  - Test positive for SARS-CoV-2 (with PCR or antigen test, including at-home tests)
  - Have symptoms consistent with mild-to-moderate COVID-19. People with mild COVID-19 experience symptoms such as fever, sore throat, cough, or headache that do not affect the lungs and breathing. People with moderate illness have symptoms that affect the lungs like shortness of breath or difficulty breathing.
  - Are within 5 days of symptom onset for Paxlovid or 7 days of symptom onset for Veklury
  - Have one or more risk factors for severe COVID-19
- Risk factors for severe COVID-19 include:
  - Age over 50 years, with risk increasing substantially at age ≥ 65 years
  - Being unvaccinated or not being up to date on COVID-19 vaccinations
  - Specific medical conditions and behaviors
  - Immunocompromising conditions or use of immunosuppressive medications, such as chemotherapy
- Other factors may also be associated with severe COVID-19, such as a patient being a resident of a long-term care facility. Clinical judgment is needed to accurately assess a person's risk on a case-by-case basis and determine whether treatment is indicated. Some people from racial and ethnic minority groups are at risk of being disproportionately affected by COVID-19 from many factors, including limited access to vaccines and

healthcare. Healthcare providers can consider these factors when evaluating the risk for severe COVID-19 and use of outpatient therapeutics.

Infection Control

- Distinguishing between the different respiratory illnesses especially early in a person's illness can be very difficult. Patients, Residents, and HCP with respiratory infections may not have fever or may have fever alone as an initial symptom or sign. Therefore, facilities should have a comprehensive respiratory management plan to promptly identify, respond, and manage patients, residents, and HCW who present with respiratory symptoms to prevent spread. The plan should minimally address the following areas:
    - Respiratory hygiene and cough etiquette
    - When source control for HCP, patients, and residents should be implemented.
    - Process for rapidly identifying HCP, patients, and residents with respiratory symptoms.
    - Process for implementing and discontinuing the appropriate transmission-based precautions for the disease of concern (*examples could include Contact, Droplet, or Airborne based on disease).*
    - Workplace policies for work restriction for HCP with respiratory illnesses or fever by specific disease type guidelines. Noting, HCP with fever alone should follow workplace policy for HCW with fever until a more specific cause of fever is identified or until fever resolves. Manage ill healthcare personnel (HCP). Instruct ill personnel not to report to work and if at work to stop patient/resident-care activities, don a facemask and promptly notify their supervisor they are ill.
    - Availability of personal protective equipment and HCP training/education
    - Hand hygiene policies, education, and training for HCP, patients, residents, and visitors
    - Policies and process to maintain a safe environment of care, including but not limited to cleaning & disinfection, air handling and of Airborne Infection Isolation Room capabilities.
    - Vaccination (where applicable) promotion, education, and availability for HCP, patients, residents, and HCP.
    - Testing capabilities
    - Planning for potential surges with a facility
- Note, as of 2021, healthcare workers are required to show proof of seasonal influenza vaccination. Some facilities may choose to have vaccine exempt healthcare workers wear a mask. Initiation and discontinuing dates are dictated by facility policies, not by Maine CDC.
- Guidelines for Infection Prevention and Control of Respiratory illness and season outlooks for illnesses such as Influenza, SARS-CoV-2, and RSV can be found at the following websites:
    - SARS-CoV-2 Guidance:
        - U.S. CDC SARS-CoV-2 Infection Prevention and Control &
        - U.S. CDC Guidance for Managing Healthcare Personnel with SARS-CoV-2
    - Influenza Guidance: U.S. CDC Influenza Infection Prevention and Control Guidance
    - RSV Guidance: U.S. CDC RSV for Healthcare Providers & U.S. CDC Appendix A Transmission-Based Precautions
    - General Education – Project Firstline: Maine Infection Prevention Forum
    - Considerations for broader use of Masking:
        - Review general guidance: Preventing Transmission of Viral Respiratory Pathogens in Healthcare Settings - *AND* - any specific guidance on disease specific U.S. CDC websites
        - Data considerations to support decision making:
            - Facility and local level activity
            - Hospitalizations and emergency department/urgent care visits

    - National Emergency Department Visits for COVID-19, Influenza, and Respiratory Syncytial Virus
    - https://covid.cdc.gov/covid-data-tracker/#datatracker-home
    - RESP-NET interactive dashboard
  - Wastewater data
    - https://data.wastewaterscan.org/
    - https://publichealth.verily.com/?d=3m&v=SARS-CoV-2
    - https://biobot.io/
    - https://covid.cdc.gov/covid-data-tracker/#datatracker-home
  - Respiratory viral activity & Syndromic Surveillance
    - https://www.cdc.gov/flu/weekly/usmap.htm ILINet
    - https://covid.cdc.gov/covid-data-tracker/#datatracker-home
    - https://www.maine.gov/dhhs/mecdc/infectious-disease/epi/influenza/influenza-surveillance-weekly-updates.shtml
    - https://www.cdc.gov/nssp/index.html

Laboratory

- HETL offers respiratory virus real time PCR testing that includes:
  - Influenza A/B (no charge)
  - SARS-CoV-2 (no charge)
  - Adenovirus
  - Enterovirus
  - Parainfluenza viruses 1-4
  - Rhinovirus
  - RSV
- The respiratory viral panel costs $550 total, or $110 per specific agent. Influenza and SARS-CoV-2 can be tested separately at no cost.
- All specimens must be accompanied by the HETL requisition form.
- HETL is requesting that laboratories send up to 3 influenza A and 1 influenza B positive specimen to HETL each week for further analysis.
- Any suspect novel, or influenza strains which do not type, must be sent to HETL for confirmation.
  - Please send any samples on patients who have swine or avian contact to HETL as they are the only lab that can determine if the illness is due to swine or avian influenza.
  - Also, please submit any positive influenza samples from patients who have traveled to China or neighboring countries, have been exposed to poultry and develop flu-like symptoms.
- Please forward any suspected co-infections (positive for both A and B on a rapid test) to HETL for confirmation.
- Consider sending samples for PCR testing on any hospitalized patient with a clinically compatible illness and a negative rapid test with no other etiology determined.
- Facilities may be asked to submit extra specimens if the circulating strains are found to be different from the vaccine strains.

Reporting Requirements

- **Influenza outbreaks** are required to be reported.
  - Outbreak definitions differ by facility type, but any sudden or unusual increase should be reported.

  - Long-term care facilities
    - Two or more residents with respiratory illness when at least one has lab confirmation
      - Suspect an outbreak with one laboratory-confirmed influenza positive case (by any testing method).
    - Influenza and SARS-CoV-2 testing should occur when any resident has signs and symptoms that could be due to influenza or COVID-19, especially when two residents or more develop respiratory illness within 72 hours of each other.
  - Acute care facility nosocomial outbreak
    - One or more patients with laboratory-confirmed influenza with symptom onset greater than or equal to 48 hours post-admission.
  - School or childcare facilities
    - Greater than or equal to 15% absenteeism among students where the majority of those absent report influenza-like illness and no other etiology has been identified.
- **COVID-19 outbreaks** are required to be reported. COVID-19 outbreaks are defined by the facility type.
  - Acute care facilities
    - 5 or more cases of COVID-19 in staff or patients admitted at least 4 days prior to infection within a 14-day period.
  - K-12 schools
    - Greater than or equal to 15% absenteeism among students where the majority of those absent are due to COVID-19 and no other etiology has been identified.
  - All other facilities
    - 5 or more COVID-19 cases, from different households, within a 14-day period
- **RSV outbreaks** are required to be reported.
  - Long-term care facilities
    - One or more lab confirmed RSV case(s) in the setting of a cluster (≥2 cases) of acute respiratory illness within a 72-hour period
  - Acute care facilities
    - 3 or more lab confirmed cases in patients or staff, from different households, who became ill within a 72-hour period.
  - K-12 schools
    - ≥ 15% absenteeism among students or staff where the majority of those absent report respiratory symptoms and RSV has been lab confirmed in at least one case
  - Childcare facilities
    - 3 or more lab confirmed cases, from different households, who become ill within a 72-hour period
  - Non-healthcare, congregate residential facility with closed populations (such as prisons, assisted living facilities, group homes, etc.)
    - One lab confirmed RSV case in the setting of a cluster (≥2 cases) of acute respiratory illness within a 72-hour period
  - Non-healthcare, congregate residential facility with open populations (such as jails, shelters, college/university dormitory, etc.)
    - At least 3 or more laboratory confirmed cases who became ill within a 72-hour period.
- Please report all outbreaks by phone at 1-800-821-5821 or by e-mail to disease.reporting@maine.gov (no confidential information by e-mail).
- Pediatric influenza-associated deaths are required to be reported. Please report by **phone at 1-800-821-5821** or by **fax to 207-287-6865**.

- Laboratory confirmed influenza hospitalizations are required to be reported. These can be reported as they occur or in aggregate on a weekly basis.
    - Reporting through REDCap survey is the preferred method for reporting.
        - A reporting reminder and access to REDCap will be sent through the APIC listserv.
        - Please email Influenza.DHHS@Maine.gov for access or questions.
    - Individual lab reports with the hospitalization status (or patient location) indicated is sufficient.
    - Line lists submitted weekly are acceptable and preferred for facilities with high volume. Minimum information to be included on a line list is:
        - Facility name
        - Test date
        - Test result (A, B, subtyping if available)
        - Patient name (if lab submits reports electronically patient initials are sufficient)
        - Patient DOB
        - Gender
        - Some geography indicator (patient address, patient city, or patient zip)
        - Hospitalization status
    - If your facility reports influenza results through Electronic Laboratory Reporting (ELR), check with your IT department to determine what field in your electronic medical record could be used to denote hospitalization status (ie. patient status, patient class, patient location etc.). This field can then be mapped to the HL7 message used for reporting laboratory results.
        - For any IT questions regarding this requirement, contact your HealthInfoNet representative.
        - The HL7 field that will need to be populated is PV1 2 PatientClass.
        - ELR message will only include the status at the time of collection, so if a patient is tested in the ER and then admitted, the ELR might not be sufficient for reporting hospitalized cases.
    - Even if your facility reports electronically, a verification of hospitalizations is required. ELR information is not always correct and cannot be relied on as the sole information source.
- Novel influenza is reportable. Cases with high suspicion for novel influenza include patients with known agricultural exposures (swine, domestic birds, wild birds). Please notify Maine CDC and forward the sample to HETL for typing.
- CLIA approved or waived SARS-CoV-2 positive laboratory results are required to be reported to Maine CDC.
- Maine CDC appreciates reports of **all positive influenza** tests, by any testing method. These can be reported by fax to 207-287-6865, by phone to 1-800-821-5821, or through electronic laboratory reporting.

Emergency Preparedness

- Maine's Public Health Emergency Preparedness (PHEP) will conduct statewide bed availability polls upon request. You can contact Nate Riethmann, Maine CDC Emergency Communication Systems Coordinator, at nathaniel.riethmann@maine.gov or 207-287-6551 to request a poll. We are already capturing some bed availability data via our ongoing COVID-19 daily polls, but we can easily create a new event for any influenza-related surges that occur and can include additional bed types as needed.
- The Health Care Coalition of Maine may be able to provide logistical support to healthcare facilities in the event that a novel influenza strain is identified resulting in an abnormally high surge event.

  - Logistical support may include: emergency communications, Strategic National Stockpile (SNS) resources such as medical countermeasures, medical volunteers, personal protective equipment (PPE), and supplies.
- The Maine CDC Pandemic Influenza Operations Plan can be accessed on line at www.maineflu.gov.
- In the event of local or spot shortages of antiviral medications, please contact the Northern New England Poison Center (NNEPC) at 1-800-222-1222 to report any above-average antiviral shortages.
  - The poison center will work with local providers and Maine CDC to identify sources of antiviral medications
  - Please provide the NNEPC with the following information:
    - What drug and formulation are you having difficulty ordering?
    - How much are you attempting to order?
    - From what pharmaceutical vendor(s)?
    - Have you contacted any other facilities in the area?
    - Any other supporting information; how long it's back-ordered, etc.

Resources

- Weekly surveillance reports are available at www.maine.gov/dhhs/flu/weekly. If you would like to automatically receive these reports, please subscribe at https://public.govdelivery.com/accounts/MEHHS/subscriber/new?preferences=true
- Maine COVID-19 data can be found at https://www.maine.gov/dhhs/mecdc/infectious-disease/epi/airborne/coronavirus/data.shtml
  - General COVID-19 information can be found at https://www.cdc.gov/coronavirus/2019-ncov/index.html
- Maine and National RSV trends are published at https://www.cdc.gov/surveillance/nrevss/rsv/state.html
  - General RSV information can be found at https://www.cdc.gov/rsv/index.html
- Notifications of significant public health events and updates are sent through The Maine Health Alert Network System (HAN). This is the primary communication method for influenza events, including conference calls, widespread notices, and antiviral recommendation changes. If you're not already a member, joining the HAN is as simple as heading to www.mainehan.org, clicking the "Register Now" button, and filling out the registration form. If you have any questions about the registration process or the Health Alert Network in general please contact the Maine Health Alert Network Coordinator at nathaniel.riethmann@maine.gov
- Information on provider group specific testing, reporting, and influenza management, as well as information regarding vaccines, non-seasonal influenza, and general influenza facts and materials can be found at www.maineflu.gov.
  - Additional information on influenza vaccines can be found at https://www.immunizeme.org
- Influenza and respiratory season-related posters can be ordered from our website at https://www.maine.gov/dhhs/order.
- Maine CDC's influenza specific email address, influenza.dhhs@maine.gov, can be used for any influenza related questions, or to send de-identified line lists. This e-mail is not secure so please do not send any patient identifiable information without utilizing a secure protocol (locked spreadsheet, log in required etc.).