Weekly Influenza Activity Report
2025-2026 Flu Season

This report summarizes weekly influenza (flu) surveillance data collected during the 2025-2026 flu season and highlights the observed impact of flu in Vermont during that time.

If you need help accessing or understanding this information, contact: AHS.VDHEpiFluSurv@vermont.gov

In the United States, flu viruses spread year-round, although the period of peak activity most often occurs in the fall and winter. The Vermont Department of Health monitors flu activity throughout the year and uses enhanced surveillance methods during flu season to collect, compile, and analyze information on influenza activity. For the 2025-26 season, data were collected between September 28, 2025 and May 16, 2026. These are the Centers for Disease Control and Prevention (CDC) Morbidity and Mortality Weekly Report (MMWR) weeks 40-20 (**Detailed MMWR week information and term definitions are included in the references section**). The Health Department reports Vermont flu surveillance data to CDC to help establish weekly flu activity trends across the country.

In Vermont, as in most other states, individual cases of flu are not reported, except for pediatric deaths and instances of a newly identified influenza A strain. Because individual cases cannot be counted, surveillance relies on a variety of data sources to estimate the effect of flu on Vermonters:

Key Points

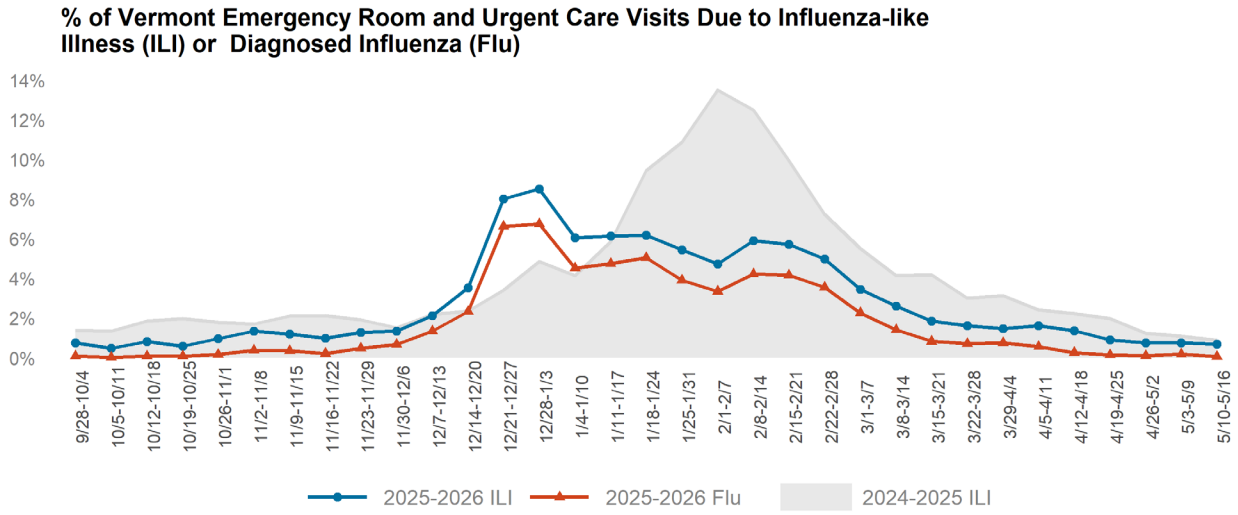
- **The flu surveillance season began 09/28/2025 and ended 05/16/2026.**
- **To track and prevent flu, Vermont uses a variety of surveillance data sources. Most individual cases of flu are not reportable.**
- **This flu season followed a more typical pattern of activity as observed before the COVID-19 pandemic, though activity peaked earlier compared to the 2024-2025 season.**

- Emergency department and urgent care visits for influenza-like illness (ILI)
- ILINet Service Providers
- National Respiratory and Enteric Virus Surveillance System (NREVSS)
- Vermont Department of Health Laboratory
- Reports of flu outbreaks by institutional settings (long-term care facilities, schools, etc.)

By analyzing information from these sources, the Health Department can track where and when flu is spreading to identify trends and communicate findings to health care providers and the public.

Nationally, the 2024-25 influenza season was the most severe since before the COVID-19 pandemic began (CDC). The preliminary burden estimate for the 2025-26 season is "moderate"; of the three metrics used to assess overall severity, only "percent of ILI visits out of all outpatient visits, all ages" was "high severity" (CDC). Vermont's ILI visit data aligns with overall national peak timing trends for the previous two seasons; however, Vermont's 2024-25 season saw a higher percentage of ILI visits during peak activity compared to the country overall. The 2025-26 season's ILI visit percentage was aligned with the national percentage reported.

Syndromic Surveillance Data



Syndromic surveillance is based on patient visit data from emergency and urgent care facilities in the state. These data allow public health to track syndromes, like "influenza-like illness" (ILI), to identify possible cases of disease or clusters.

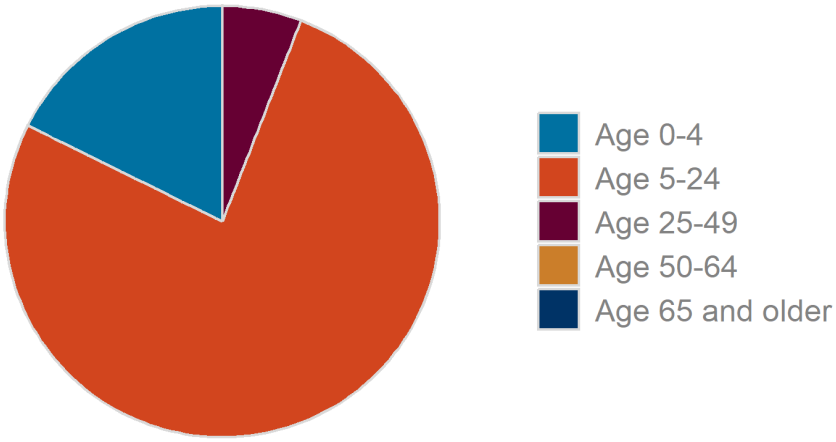
During the previous 2024-25 surveillance season, influenza-like illnesses closely matched pre-pandemic patterns with ILI activity highest between late January and early February 2025. This was followed by a gradual return to baseline levels by mid-May.

In comparison, for the 2025-26 season, a less sharp peak was observed earlier. Activity increased in mid-December and remained elevated through mid-January 2026 due to circulating influenza A virus. This was followed by a smaller increase in February likely due to an increase in influenza B. ILI visits returned to baseline in mid-May 2026. Throughout the period of elevated activity, fewer flu diagnoses (as indicated by the red line) compared to ILI visits (indicated by the blue line) suggest other respiratory viruses were also circulating and contributing to ILI visits (defined as febrile illnesses with a cough or sore throat).

Sentinel Provider Data

Vermont participates in the U.S. Outpatient Influenza-like Illness Surveillance Network (ILINet). The ILINet Sentinel Surveillance Program relies on a network of providers voluntarily reporting a count of the number of patients presenting with an influenza-like illness each week. On a weekly basis they may also submit specimens from patients presenting with ILI symptoms to the Vermont Department of Health Laboratory for further testing.

For most of the season, the age group with the highest percent of visits seeking care for influenza-like illness at sentinel provider offices was ages 5-24 years.



For the 2025-26 season, most weekly reports showed the highest percentage of patients seeking care for influenza-like illness were in the 5-24 age range, which is expected. The second highest age group seeking care for ILI at sentinel sites were patients between the ages of 0-4.

During the 2025-26 season, 7 providers and 8 emergency departments reported ILI data to the Vermont Department of Health, a decrease of one provider compared to the previous season. The sites provided weekly reports of their data on a range from 9% of the season to 100% of the season, and an average of 81% of the season. The average number of facilities reporting weekly improved between this and the previous season. ILI data is more robust when a higher percentage of provider reports are received.

Because these data are only reported by a sample of health care providers, they do not represent the full picture of ILI visits in the state. However, they are an important part of the surveillance system for monitoring which locations in the state flu may be having a substantial impact, and on which age groups.

Laboratory Data

Three hospitals in Vermont report to the National Respiratory and Enteric Virus Surveillance System (NREVSS): Central Vermont Medical Center, Southwestern Vermont Medical Center, and University of Vermont Medical Center. These hospital laboratories report all influenza tests performed at their facility and the test result.

NREVSS Reporting Hospitals	2024-25 Flu Season		2025-26 Flu Season	
Total PCR Tests	17,989		13,775	
Total Positive Results	2,831	15.7% of total tests	1,618	11.7% of total tests
Total positive flu A	2,565	91% of positive results	1,125	70% of positive results
Total positive flu B	266	9% of positive results	493	30% of positive results

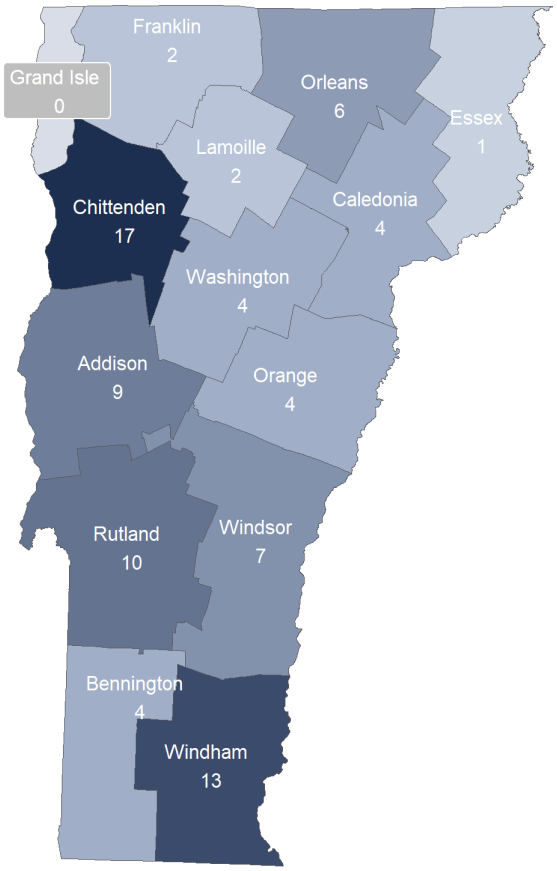
The Vermont Department of Health Laboratory (VDHL) performs PCR influenza testing on specimens submitted from sentinel sites, as well as those submitted from facilities during potential influenza outbreaks.

During the 2025-26 surveillance season, influenza A(H3N2) was the most frequently circulating subtype detected by VDHL. Influenza A(H1N1) and influenza B/Victoria were also detected. There were fewer positive specimens available for surveillance testing compared to last season, and influenza A(H3N2) was more prevalent than influenza A(H1N1). This differs from the two previous seasons where influenza A(H1N1) was more prevalent. An antigenic shift of influenza A(H3N2) occurred early in the influenza season, referred to as “subclade K”, which became the most prominent circulating virus strain.

VDHL received fewer specimens for influenza surveillance testing compared to the prior five seasons. The submitted samples’ were most frequently collected in December and January, corresponding with the peak of ILI visit activity during that time frame.

Vermont Department of Health Laboratory	2024-25 Flu Season		2025-26 Flu Season	
Total PCR tests	659		461	
Total positive results	597	91% of total tests	428	93% of total tests
Total positive subtypeable flu A	568	95% of positive tests	403	94% of positive tests
H1N1	373	66% of subtypeable flu A tests	37	9% of subtypeable flu A tests
H3N2	195	34% of subtypeable flu A tests	366	91% of subtypeable flu A tests
Total positive Flu B	29		25	

ILI Outbreak Data

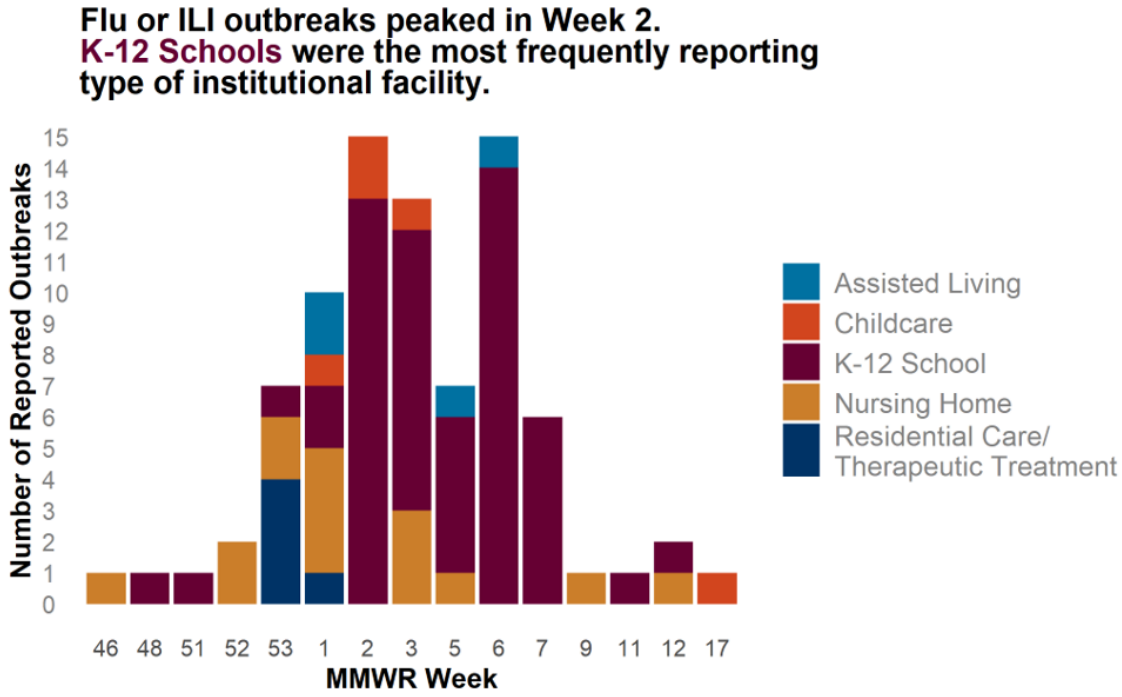


All suspected ILI outbreaks in institutional settings are required to be reported to the Vermont Department of Health.

During the 2025-26 surveillance season, 83 outbreaks were reported and confirmed. This is an increase in reported outbreaks compared to 63 confirmed outbreaks in the previous surveillance season. This continues a three-year trend of increased outbreak reporting.

The county with the highest number of reported outbreaks over the course of the surveillance season was Chittenden County in the northwest area of the state, followed by Windham County in the southeast. Rutland, Addison, and Windsor counties were the next-highest reporting counties, respectively. Only Grand Isle County had no reported outbreaks during the 2025-26 surveillance season.

For the 2025-26 season statewide, the reported outbreaks occurred most frequently in school settings, as was the case in the previous season. This data aligns with the ILINet sentinel provider reports of the 5–24-year-old age group as the most likely to seek care for ILI symptoms.



Reported outbreak activity decreased in frequency during late January and early February, but picked up again briefly in mid-February. This second peak of outbreak activity included reports of influenza B infections in K-12 school settings. Though a similar trend in syndromic surveillance was not observed, increased visits to primary care providers were observed in ILINet data during this time, suggesting patients were staying out of school if sick, but were not presenting to emergency or urgent care settings for severe symptoms.

As a component of the influenza surveillance system, flu specimens are requested from long-term or other healthcare facility outbreaks for subtyping analysis at VDHL. For the 2025-26 season, the results were assessed to better understand timing and strains of influenza affecting Vermonters in these settings.

Of the 24 confirmed outbreaks reported in long-term or other healthcare settings this season, specimens were received from 11 outbreaks in 8 counties. The majority of specimens were tested in January and February, slightly behind the overall influenza activity peak in December. For the 7 outbreak events with multiple patient specimens analyzed for subtype at VDHL, all 7 outbreaks were associated with a single subtype. The most common subtype to cause outbreaks in the facilities submitting specimens was the dominant strain for the 2025-26 season, influenza A(H3N2). Only the specimens from earlier outbreaks occurring in 2025 were identified as influenza A(H1N1), aligning with the national trend of the dominant influenza A subtype shift to influenza A(H3N2). No outbreak associated specimens were influenza B positive.

Vital Statistics Data

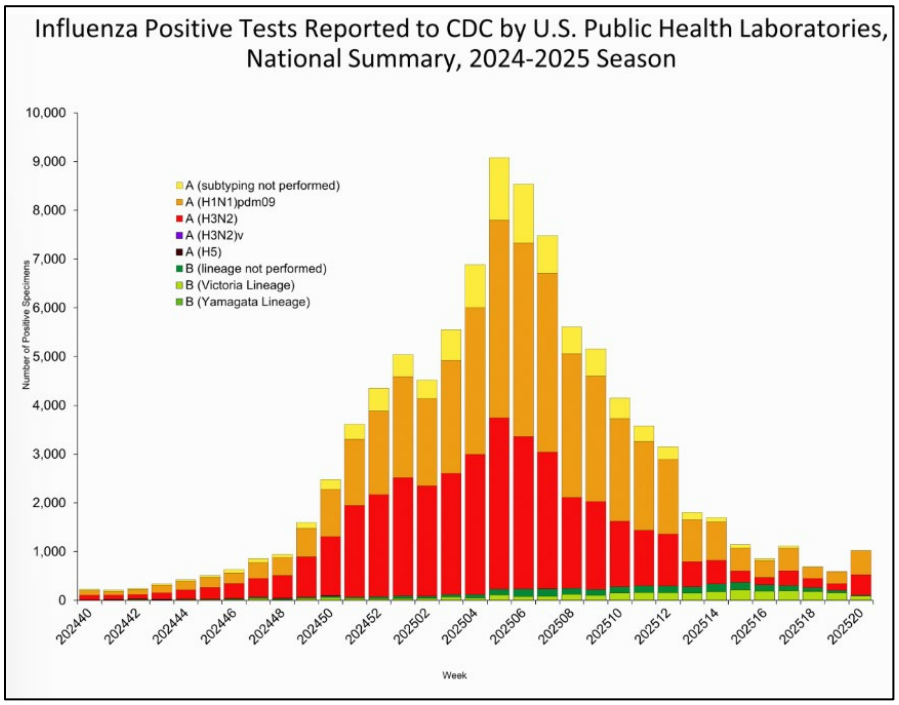
Beginning in 2025, the surveillance system for influenza expanded to include influenza cause-of-death data from death certificates. Though these data are likely to undercount the total number of influenza-related deaths due to lack of clinical testing or diagnosis of influenza infections, it is useful to understand the burden season-to-season of influenza on Vermont. Beginning in the 2026-27 surveillance season, this report will include a season-to-season comparison of influenza-related deaths. Preliminary data for the 2025-2026 season are not complete at the time of this report.

CDC Flu Activity Overview

The number of positive specimens reported to the CDC from public health laboratories nationwide decreased compared to the previous season. This aligns with Vermont's submission trends to VDHL. Clinical laboratory positive specimen reporting to the CDC also decreased compared to the previous season. A contributing factor to this change is the difference in flu activity between the two seasons; CDC categorized the 2024-25 season as high overall and the preliminary categorization for 2024-25 is moderate overall. With less influenza activity, there are fewer specimens available for surveillance testing.

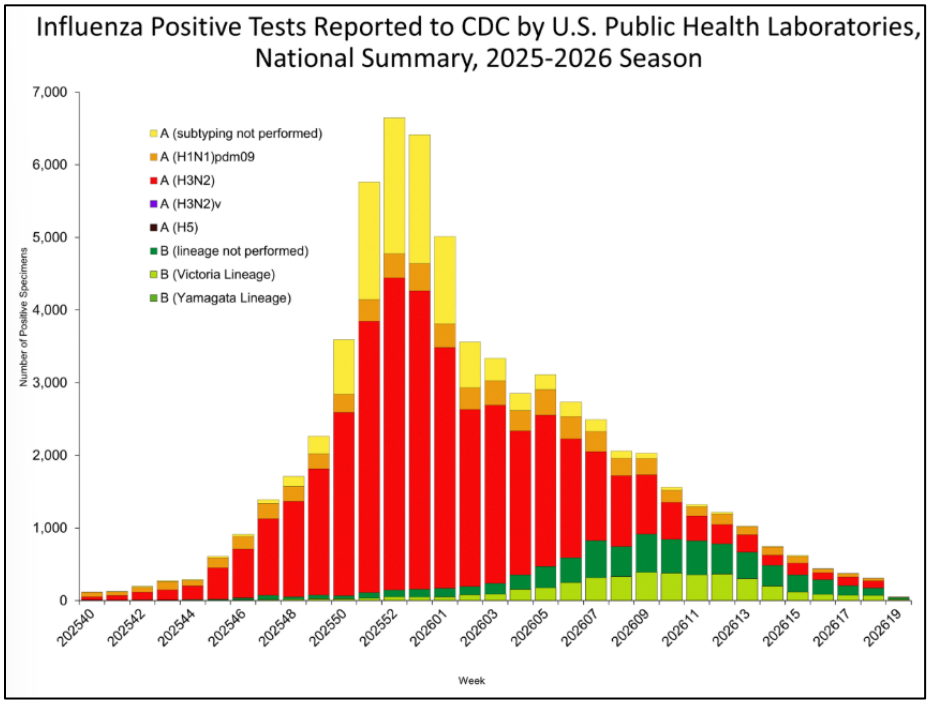
Compared to the 2024-25 season, influenza B was reported more frequently and more concentrated toward the end of the surveillance season. No detections of influenza B/Yamagata were reported to CDC during this 2025-26 surveillance period.

2024-2025 Season



Source: CDC

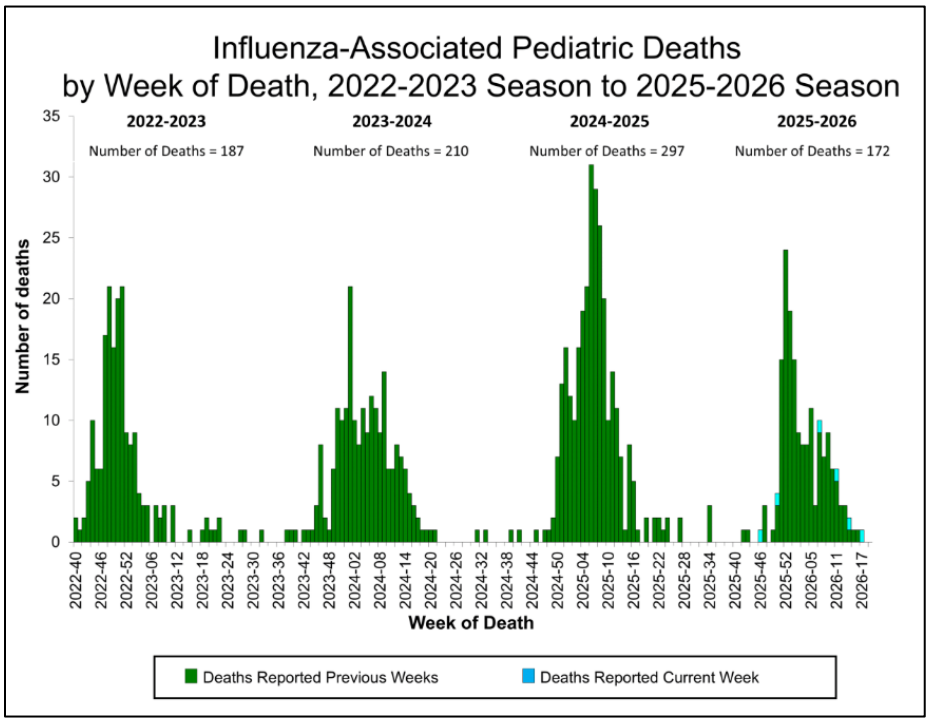
2025-2026 Season



Source: CDC

All data are preliminary and subject to change.

VERMONT DEPARTMENT OF HEALTH



Source: CDC

In the 2024-25 flu surveillance season there were 287 influenza-associated pediatric deaths reported nationally. This is the highest number of pediatric deaths reported in any non-pandemic influenza season since the condition became reportable in 2004. At the end of the 2025-26 flu surveillance season, 172 influenza-associated pediatric deaths were reported with more reports expected.

Among children who were eligible for influenza vaccination and with known vaccine status, 85% of reported pediatric deaths this season (compared to 90% during the 2024-2025 season) have occurred in children who were not fully vaccinated against influenza.

No influenza-associated pediatric deaths were reported to the Vermont Department of Health during the 2025-26 surveillance season.

Key Takeaways

The 2025-26 influenza surveillance season continued the pattern of more typical influenza activity since the COVID-19 emergency declaration ended in May 2023. Vermont activity remained closely aligned with national trends; as occurred nationally, Vermont experienced an increase in influenza-like illness (ILI) activity in late 2025, peaking in week 53 (12/28). Activity continued to be above the regional epidemic baseline (2.2% of total visits for ILI in a 1-week period) until mid-March (MMWR week 11, 3/15). ILI activity was at a lower percentage of syndromic surveillance visits compared to the previous surveillance season, but followed a similar peak and slow decline pattern as observed in the 2024-25 season. The 2025-26 season peaked five weeks earlier than in the previous season, and the

majority of specimens tested were positive for influenza A(H3N2) compared to the previously dominant influenza A(H1N1) strain in recent influenza seasons.

A concern early in the influenza season was an antigenic drift in the circulating influenza A(H3N2) strain, referred to as "subclade K". Drifts like this are a reason influenza virus vaccines are updated for each season; the late timing of subclade K's emergence made it impossible to include in the vaccine for the 2025-26 season, but it was estimated the vaccine formulation was still effective in producing antibodies against the virus strain (CIDRAP). Though the season started with influenza A(H1N1) dominant as had been the case for several seasons, within weeks influenza A(H3N2) subtypes overtook A(H1N1) to become the most commonly identified influenza virus. Of the specimens submitted to CDC for influenza virus characterization over the course of the season, over 90% were subclade K (CDC).

Nationally, the 2024-25 season was designated by CDC as high severity overall as well as high severity in the three age group designations (children, adults, and older adults). The 2025-26 season was designated by CDC to be a moderate severity flu season overall, with only the "children" age group reaching high severity. Though the overall flu and ILI illness in Vermont did not reach the same elevation as observed in other areas of the country, children were most likely to seek care for their ILI symptoms than any other age group for the majority of the season.

In Vermont, the influenza vaccination rates for adults and children fell below the three-year average, resulting in increased influenza illnesses and transmission over the course of the season. Vaccination remains the most effective tool to prevent flu and severe outcomes from flu, especially for the most vulnerable Vermonters like older adults and young children. Improving vaccination rates remains an important goal as influenza has resurged following the COVID-19 pandemic as a major contributor to fall and winter viral respiratory illness in Vermont and the United States as a whole.

Terms

Antigenic Drift (CDC): Drift consists of small changes (or mutations) in the genes of influenza viruses that can lead to changes in the surface proteins of the virus, HA (hemagglutinin) and NA (neuraminidase). Antigenic drift is an important reason why people can get flu multiple times over the course of their lives.

Centers for Disease Control and Prevention (CDC): The Influenza Division at CDC collects, compiles, and analyzes information on influenza activity year-round in the United States.

COVID-19: Defined by the World Health Organization (WHO), COVID-19 is a disease caused by a new strain of coronavirus. 'CO' stands for corona, 'VI' for virus, and 'D' for disease. Formerly, this disease was referred to as '2019 novel coronavirus' or '2019-nCoV.' The COVID-19 virus is a new virus linked to the same family of viruses as Severe Acute Respiratory Syndrome (SARS) and some types of common cold.

Highly pathogenic avian influenza: Highly pathogenic (HP) avian influenza (AI) (HPAI) is an extremely contagious, multi-organ systemic disease of poultry leading to high mortality in birds, and is caused by some H5 and H7 subtypes of type A influenza virus, family Orthomyxoviridae (National Institute of Health).

U.S. Outpatient Influenza-like Illness (ILI) Surveillance Network (ILINet): ILINet consists of approximately 3,000 outpatient healthcare providers around the country that report data to CDC on the total number of patients seen for any reason and the number of those patients with ILI by age group.

Influenza-like Illness (ILI): Determined by using the patient's chief complaint and/or discharge diagnosis. ILI is the presence of a fever equal to or exceeding 100°F with the addition of cough or sore throat. As of 2021, the ILI definition no longer excludes patients with another diagnosed non-influenza illness.

Institutional settings: Examples include schools (including higher education), long-term care facilities, childcare facilities, and correctional facilities.

Long-term Care Facility: Defined as a facility where services are provided to meet a person's health or personal care needs when they can no longer perform everyday activities on their own (National Institute on Aging).

MMWR (Morbidity and Mortality Weekly Report): The MMWR is the CDC's weekly scientific publication of public health information and recommendations. Weekly reports are numbered 1-52 or 1-53 depending on the number of weeks in the year.

NREVSS (National Respiratory and Enteric Virus Surveillance System): NREVSS collects data on the number of PCR flu tests performed by participating labs across the country, and how many tests were positive. This helps determine flu activity in the community.

PCR test (WHO): Polymerase chain reaction: a test, or assay, that is a rapid and sensitive method for detecting the genetic material of influenza viruses, and is now the first-choice laboratory test for influenza infection in both humans and animals.

Respiratory illness: Illnesses which affect the lungs and may cause coughing, wheezing, difficulty breathing and other symptoms. Examples: colds, flu, respiratory syncytial virus (RSV), bronchitis, pneumonia, and COVID-19.

Subtype: A more specific classification of the influenza A virus based on proteins unique to that strain of virus (example: influenza A(H1N1) is classified by its hemagglutinin and neuraminidase protein types H1 and N1). Influenza B strains are not subtyped. Influenza B strains are classified by their lineage, or where the strain was isolated (example: Victoria).