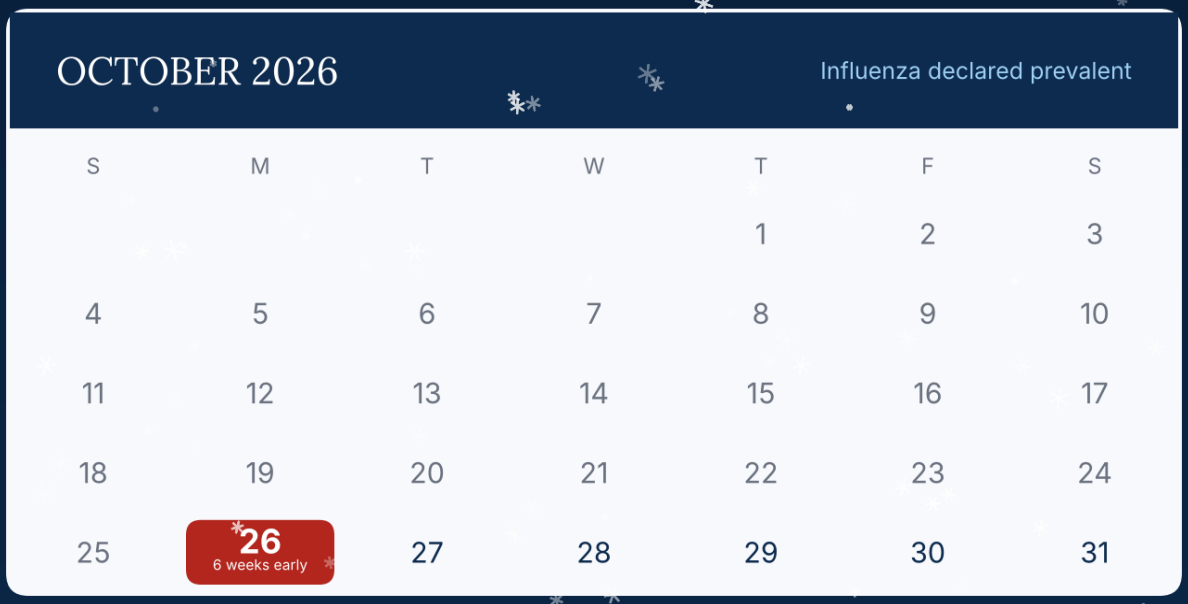
AN INVESTIGATIVE REPORT

October 29, 2026

WINTER CAME EARLY

The 2026-27 flu season arrived six weeks ahead of schedule, driven by a virus no one was watching. The system it met was thinner than at any point in a decade.



What the surveillance data actually show

An H1N1 mutation called G155E, not last winter's subclade K | Zero high-activity states, yet positivity six times last year's | Vaccination coverage 12 points below 2019 | A CDC one-third smaller | Hospitals at 75% occupancy before the peak

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The 2026-27 Flu Season Arrived Six Weeks Ahead of Schedule, Driven by a Virus No One Was Watching, and Met a System Thinner Than at Any Point in a Decade

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Abstract

On October 26, 2026, New York's Health Commissioner declared influenza prevalent statewide, 44 days earlier than the average of the three preceding seasons. Headlines attributed the early start to a "superflu," last winter's H3N2 subclade K. The surveillance record says otherwise. Of 241 influenza A viruses subtyped by public health laboratories in the week ending October 17, 239 were H1N1, and none were H3N2. The virus driving the early season carries a single mutation, G155E, that appears to slip past the immunity of teenagers and young adults who were imprinted by the 2009 pandemic strain. National activity remains low, with no state at high activity and no pediatric deaths. The danger this report documents is not the virus but the ground it lands on: pediatric vaccination coverage 12 points below 2019-20, a CDC with nearly a third fewer staff and no functioning vaccine advisory committee, a wastewater surveillance network whose funding runs out this fall, and hospitals already operating near 75 percent occupancy before the first peak. This report reconstructs the evidence from 111 primary and secondary sources, weighs the strongest counterarguments, and introduces the EARLY Readiness Model, a five-domain, 100-point instrument hospital and public health leaders can use to find and close their own gaps before the season peaks.

Key findings

1. New York's October 26 declaration came 37, 53, and 41 days earlier than its 2025-26, 2024-25, and 2023-24 declarations, an average of 44 days, with no case figures published alongside it. It activated a standing regulation requiring unvaccinated health care workers to mask.
2. The circulating virus is A(H1N1)pdm09, 99.2 percent of subtyped viruses in Week 41, not last winter's H3N2 subclade K, which accounted for 2.0 percent of subtyped viruses cumulatively. A new mutation, G155E, first flagged in Seattle in September, was present in 13 of 17 H1N1 samples sequenced at the University of Washington.
3. Early does not mean severe. Outside the 2009 pandemic, US seasons since 1982-83 have almost never peaked before December, CDC's September outlook rated a severe season no more likely than usual, and Australia's 2026 winter ran well below its 2025 record. The two worst recent seasons, 2017-18 and 2024-25, peaked in late January and February.

4. The real exposure is structural: flu vaccination coverage of 51.4 percent in children and 64.4 percent in adults 65 and older, a CDC civil service down about 30 percent, three canceled ACIP meetings and no new federal flu recommendation, and measles at 4,588 cases, double the 2025 record.
5. Hospitals enter the season with mean occupancy near 75 percent, 16 percent fewer staffed beds than the 2009-2019 average, 30 percent fewer pediatric units than 2008, and more than half of admitted emergency patients boarding four hours or longer. A moderate season is enough to break a system with no slack.

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Executive Summary

This investigates a headline that was half right. Winter did come early. The reason given for it was wrong, and the real reasons to worry were left out.

In the last week of October 2026, New York declared influenza prevalent, a legal designation it usually makes on December 1. Local and national coverage, including the premise that prompted this investigation, attributed the early arrival to the "superflu," the H3N2 subclade K variant that drove a record-breaking 2025-26 season 13,41. The Centers for Disease Control and Prevention's own weekly surveillance report, published three days before New York's announcement, shows a different virus. In the week ending October 17, public health laboratories subtyped 241 influenza A viruses. 239 were A(H1N1)pdm09. Two were H5, associated with a single human case in a Washington dairy worker. Zero were H3N2[7].

The H1N1 now spreading carries a mutation called G155E, first flagged in Seattle in September by the laboratory of Jesse Bloom at Fred Hutchinson Cancer Center and detected in 13 of 17 sequenced samples at the University of Washington[15]. A preprint's serology on 260 blood samples suggests teenagers and young adults recognize it poorly with antibodies, a cohort whose first encounter with H1N1 was the 2009 pandemic strain itself[15,16]. The vaccine was formulated in the spring, before the mutation spread. Whether it is a meaningful mismatch will not be known until midwinter 15,16.

None of this makes the season severe. National outpatient illness is below baseline. No jurisdiction is at high activity. No child has died[7]. CDC's September outlook, informed by 25 subject-matter experts, expected a moderate season and found no evidence that a severe one was more likely than usual[10]. Australia, which previews the Northern Hemisphere each year, finished its 2026 winter with 231,473 confirmed cases against more than 410,000 reported by early November 2025[49,109].

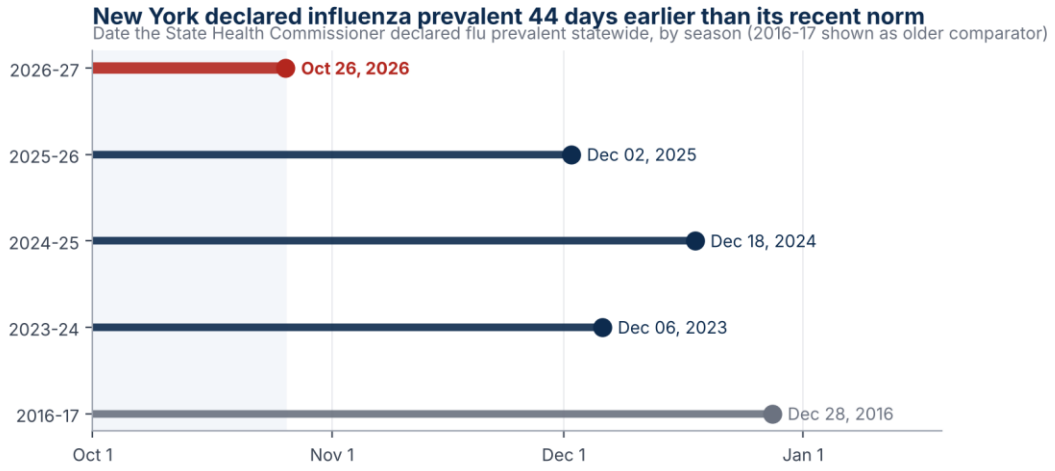
This season is dangerous because of where it lands. This report finds that the United States enters the 2026-27 respiratory season with pediatric flu vaccination 12.3 points below 2019-20 and coverage in adults 65 and older at 64.4 percent, below the national target[54]; with a CDC that has lost roughly 30 percent of its civil service staff, whose deputy director resigned this week about four months after starting, and whose vaccine advisory committee has not met since December 2025 because its membership is frozen by a federal court[57,58,66,70]; with $11 billion in state and local public health grants clawed back in 2025 and another $600 million in 2026[72,73]; with a national wastewater surveillance network whose one-time pandemic funding runs out this fall[75]; with measles at 4,588 cases, double the post-1991 record set only last year[77]; and with hospitals averaging 75 percent occupancy, 16 percent fewer staffed beds than the 2009-2019 average, and more than half of admitted emergency patients waiting four hours or longer for a bed[82,83].

The report closes with the EARLY Readiness Model, a five-domain instrument (Eyes on the signal, Antivirals and testing, Reserve capacity, Labor, Your community) that produces a 100-point Early Season Readiness Index. It is offered as a leadership tool, not a forecast. The season's course is uncertain. The system's slack is not.

1. The Declaration

The New York State Department of Health's October 26, 2026 press release was, on its face, an announcement about a website. It unveiled a new Seasonal Respiratory Virus Dashboard. In the same release, Commissioner James V. McDonald declared influenza prevalent statewide, said the season was "starting earlier than usual," and noted that reported flu vaccination doses were lower than in previous years, with fewer than half of adults vaccinated last season. The release included no case counts, hospitalization figures, or mention of any strain or variant.

How much earlier than usual? The release didn't say, so this investigation reconstructed the answer from the State's prior declarations. New York declared flu prevalent on December 2, 2025; on December 18, 2024; and on December 6, 2023[2,3,4]. The 2026 declaration came 37, 53, and 41 days earlier than those three, averaging 44 days, or just over six weeks. The only older comparator located, December 28, 2016, would put the gap at nine weeks[5]. The widely reported phrase "six weeks early" is therefore defensible, but it is arithmetic from declaration dates, not a figure any official published.



Source: NYS DOH press releases, Dec 28, 2016; Dec 6, 2023; Dec 18, 2024; Dec 2, 2025; Oct 26, 2026. Average of 2023-24 through 2025-26 is Dec 9; 2026-27 is 44 days earlier.

Figure 1. New York's influenza prevalence declarations by season. The 2026 declaration came 44 days earlier than the average of the three preceding seasons.

The declaration matters beyond symbolism. Under section 2.59 of the State Sanitary Code, it obligates hospitals, nursing homes, home care agencies, and other regulated facilities to ensure that personnel who have not received the current season's flu vaccine wear a surgical or procedure mask wherever patients or residents may be present, for as long as the declaration stands. In prior seasons, that trigger came in December, after weeks of steep increases: hospitalizations had nearly doubled week over week before the 2025 declaration, and risen 48 percent before the 2024 one 2,3. This year, the trigger came in October, with no numbers.

The numbers that do exist come from news reports citing the new State dashboard. For the week ending October 17, 2026, New York recorded 3,526 laboratory-confirmed cases (by news accounts not yet verified

against the State dashboard), up from 668 in the same week of 2025, and 233 hospitalizations, up from 46, with cases in 59 of 62 counties[12]. The following week, cases rose 19 percent and hospitalizations 17 percent[13]. At Niagara Falls Memorial Medical Center, the masking protocol took effect, and staff vaccinated 150 in the two days before an October 28 report[14]. Those are real increases from a low base. In the week ending December 20, 2025, by comparison, New York recorded 71,123 cases, the most in any week since flu became reportable in 2004[33]. The October numbers are roughly one twentieth of last winter's peak, a winter that left nearly 27,000 New Yorkers hospitalized and nearly 600 dead[104]. McDonald's message on October 9, before the declaration, was that "last year does not have to be this year"[104].

What "prevalent" means in New York

The designation is a regulatory switch, not a severity rating. It activates 10 NYCRR 2.59, which requires unvaccinated personnel in regulated health care and residential facilities to wear masks in patient and resident areas until the Commissioner rescinds the declaration. The October 26, 2026 release did not restate the rule; the mechanism is verified from prior-season declarations and county health advisories[6].

New York is not alone. Colorado's weekly flu hospitalizations rose from one in late August to eight in early September to 46 in early October, and the state recorded its first pediatric flu death of the season on October 16[21,22]. Louisiana's test positivity in the week ending October 3 was 6.5 percent, nearly double the 3.4 percent of a year earlier[23]. Seattle Children's reported 150 pediatric flu cases in two weeks, against 10 in the same window last year, and described the season as two months early[19]. In Snohomish County, Washington, 63 people were hospitalized with flu between late August and early October, 31 of them in a single week, and King County recorded nine flu deaths in September 20.

Nationally, CDC's Week 41 report described activity as "increasing in many parts of the country but remains low," and higher than typically observed for the time of year[7]. Clinical laboratory positivity was 5.7 percent, up from under 1 percent the same week in 2025; two weeks earlier, it was 3.6 percent, up from 0.6 percent[24]. Admissions were rising in four of ten federal regions. Forty-four states were growing or likely growing[15]. The weekly hospitalization rate in CDC's FluSurv-NET network, 1.1 per 100,000, was the highest recorded for Week 41 since the network began in 2010-11[7].

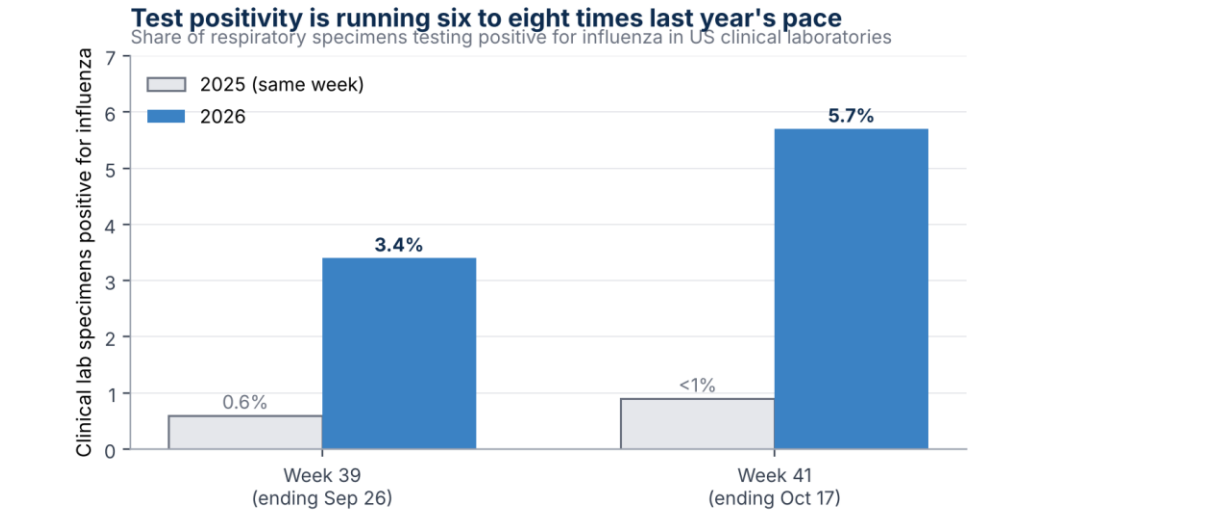


Figure 2. Clinical laboratory test positivity for influenza, 2026 versus the same weeks of 2025.

Table 1. The national picture in the week before New York's declaration. Sources: CDC FluView Week 41[7]; Becker's[15]; FluView Week 39[9].

Indicator	Week 41, 2026 (ending Oct 17)	Context
Outpatient visits for influenza-like illness	2.2%	Below the 2.9% national baseline; higher than the prior two seasons at this point
Clinical lab positivity	5.7% (2,918 of 51,490)	Under 1% in the same week of 2025
Subtyped influenza A viruses	239 H1N1, 0 H3N2, 2 H5 (n = 241)	Cumulative since Oct 4: 97.7% H1N1, 2.0% H3N2
FluSurv-NET weekly hospitalization rate	1.1 per 100,000	Highest Week 41 rate since 2010-11
FluSurv-NET cumulative rate	2.1 per 100,000	Last season ended at 87.2 per 100,000
Jurisdictions at high or very high activity	0	Louisiana and Hawaii at moderate
Pediatric deaths, 2026-27	0	198 reported for 2025-26 as of Oct 9
States with growing or likely growing infections	44	CDC estimate as of Oct 21

2. The Wrong Villain

This season's story began with a true story from last season. In June 2025, after the strains for the 2025-26 vaccine had already been chosen, a drifted H3N2 variant, formally J.2.4.1 and informally subclade K, was first detected in New York[41]. The World Health Organization dates its global emergence to August 2025[52]. It carried 11 changes in the hemagglutinin protein relative to the vaccine strain, eight at antibody-binding sites, and provoked three- to eight-fold lower neutralizing antibody responses than non-K strains[102]. It spread through Japan, Hong Kong, and the United Kingdom in the autumn and reached the United States in force around Thanksgiving[41]. By season's end it accounted for 93 percent of all characterized H3N2 viruses in the

country[26,28]. The label "superflu," which Nicola Lewis of the Francis Crick Institute told Gavi is not a scientific term, stuck anyway[43].

That history made it the obvious suspect when flu returned early in 2026. It is the wrong suspect. CDC's public health laboratory data for the current season show H3N2 at 16 of 798 subtyped viruses cumulatively, 2.0 percent, and at zero of 241 in Week 41, after 9 of 251 the week before 7,8. Subclade K is indeed the dominant form of H3N2 wherever H3N2 appears: 89 of 94 characterized H3N2 viruses this season belong to it[7]. But a 94.7 percent share of a 94-virus denominator within a subtype that is 2 percent of detections does not show a subclade K season. This suggests subclade K is still around and H1N1 is in charge.

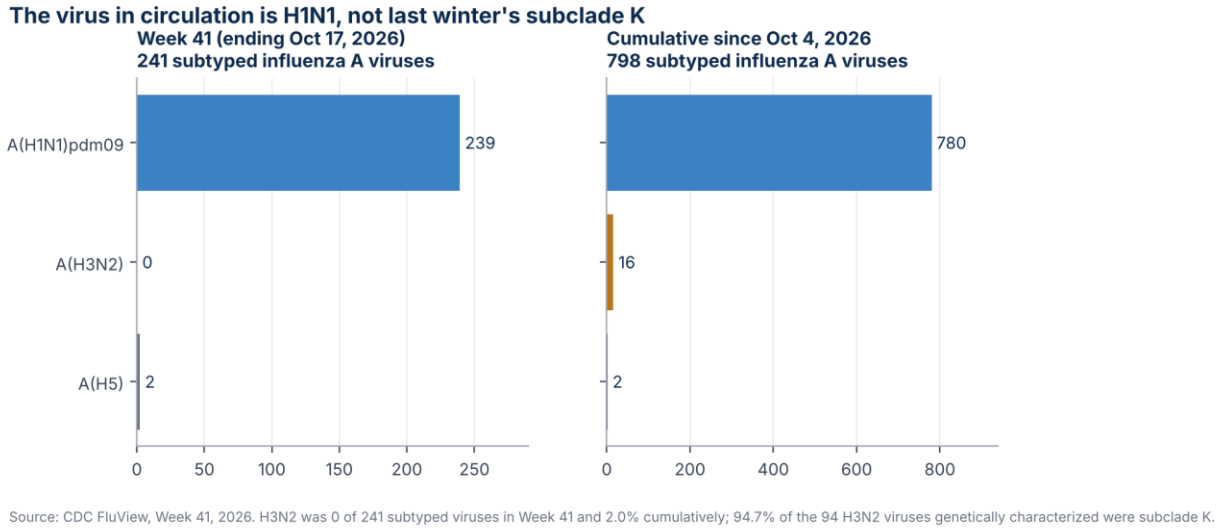


Figure 3. Influenza A subtypes identified by US public health laboratories, Week 41 and cumulative for the 2026-27 season.

Why did the error travel so far? Three reasons. First, CDC's own 2026-27 vaccine announcement noted that the H3N2 component was changed to protect against "the influenza A(H3N2) subclade K virus that spread widely during the 2025-2026 season," keeping the name in circulation[53]. Second, Australia's 2026 winter, the Northern Hemisphere's usual preview, was reported in September as a subclade K season, before H1N1 overtook H3N2 in at least two Australian states by mid-October 49,50. Third, early local reporting in New York referred to a "new strain" without naming it, and a familiar name filled the gap[13].

The distinction is not pedantic. H3N2 seasons and H1N1 seasons hurt different people. CDC's own summary of the 2014-15 season observed that H3N2-dominant seasons typically produce higher hospitalization rates and more deaths, especially among older adults and children[103]. In 2025-26, adults 65 and older were hospitalized at 274.2 per 100,000 and children 5 to 17 at the highest cumulative rate since FluSurv-NET began in 2010-11[26,28]. H1N1, the lineage of the 2009 pandemic, has historically fallen hardest on younger people, and the current mutation appears to sharpen that tilt[15]. A hospital that prepares for a repeat of last winter prepares for the wrong patients.

3. The Mutation That Matters

The virus driving the season is A(H1N1)pdm09, subclade D.3.1.1, which accounted for 316 of 317 H1N1 viruses the CDC characterized genetically this season. Within it, a single amino acid substitution at position 155 of the hemagglutinin protein, glycine to glutamic acid, has drawn the attention of leading influenza laboratories. Andrew Pekosz of the Johns Hopkins Bloomberg School of Public Health described the site to NBC News as one that is important for generating protective antibodies[17]. Japan's national infectious disease institute detected the mutation as early as May 2026 and watched it spread gradually from August; by the week ending October 4, Japanese clinics were seeing about 11 flu patients each, roughly seven times the prior year's rate, and schools were closing[16]. In Seattle, Alex Greninger's laboratory at the University of Washington found G155E in 13 of 17 H1N1 samples complete enough to sequence[15].

The key evidence comes from a bioRxiv preprint led by Bloom. His group tested blood from 260 people in Australia and the United States against 148 influenza A viruses circulating by mid-2026. In some cases, existing antibodies recognized strains carrying G155E less well, and antibodies from teenagers and young adults recognized the variant especially poorly[15]. Samuel Scarpino of Northeastern University explained the pattern through immune imprinting: the first influenza strain a person meets shapes the antibodies they rely on for life, and for people born in the early 2000s or later, that first H1N1 was likely the 2009 pandemic strain or its descendants. The mutation "hits a spot" those immune systems tend to focus on[16]. People born earlier, imprinted by the older seasonal H1N1 that circulated from 1977 to 2009, carry a broader repertoire that G155E does not disturb as much.

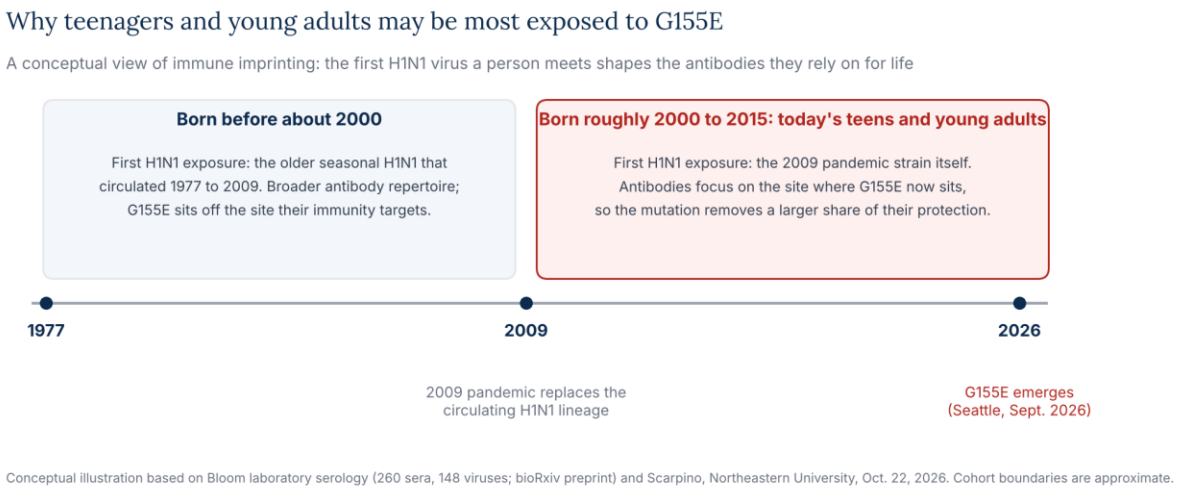


Figure 4. A conceptual illustration of why immune imprinting may leave teenagers and young adults more exposed to the G155E mutation.

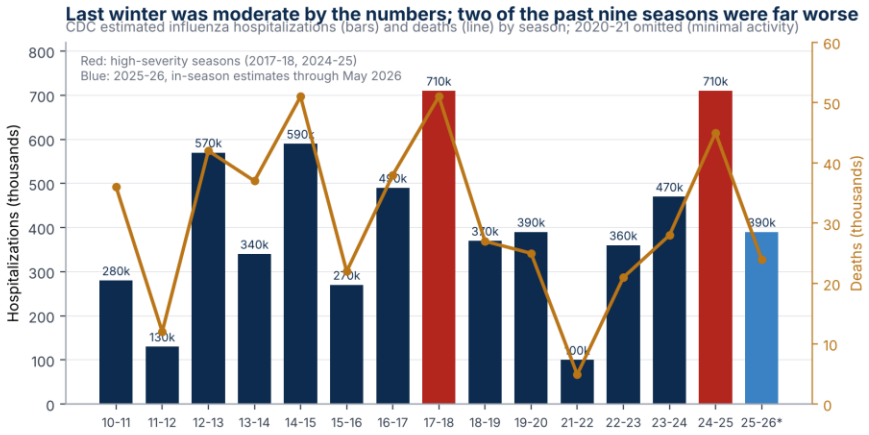
The preprint is not peer-reviewed, and its authors say so. Bloom told Nature that if the mutation comes to dominate, the H1N1 component of this year's vaccine may be poorly matched, and that it is too early to know[15]. Scott Hensley of the University of Pennsylvania said the H3N2 and influenza B components appear

well matched[15]. CDC's antigenic testing offers reassurance: 93.2 percent of H1N1 isolates characterized this season remained well recognized by antisera raised against the 2026-27 vaccine reference virus[7]. Pekosz put it plainly: "A mismatch is not a black-or-white situation. We may have less immunity, not no immunity"[17].

Three operational facts follow. First, the population most exposed is not the one hospitals traditionally brace for in flu season. Second, vaccine effectiveness will not be known until midwinter, which argues for treating every high-risk patient as unprotected and treating early[16]. Third, Greninger has warned that a second, more conventional wave of H3N2 or influenza B could follow once H1N1 peaks, which would shift the burden back toward older adults in the depths of winter[15]. The vaccine was updated specifically for that H3N2[53]. The early season may therefore be the first of two.

4. What Last Winter Taught

The 2025-26 season is the reference point against which every October number is being read, so it is worth being precise about what it was. By CDC's preliminary estimates, it caused at least 32 million illnesses, roughly 390,000 hospitalizations, and 24,000 deaths 25. Those are large numbers. They are also well below the 710,000 hospitalizations and 45,000 deaths of 2024-25, which CDC classified as high severity in every age group, the first such season since 2017-18[30]. CDC rated 2025-26 moderate overall, and high only for children 25,27.



Source: CDC Past Seasons Estimated Influenza Disease Burden; CDC 2024-25 season summary; CDC FluView Week 20, 2026 (*2025-26 preliminary: at least 32 million illnesses, 390,000 hospitalizations, 24,000 deaths).

Figure 5. CDC estimated influenza hospitalizations and deaths by season, 2010-11 through 2025-26.

Two things made last winter feel worse than its totals. The first was speed. Hospitalizations began rising in mid-November and peaked in the week ending December 27, 2025, when the FluSurv-NET weekly rate hit 12.8 per 100,000, the second-highest peak week since 2010-11[106], and 33,301 patients were admitted with laboratory-confirmed flu in a single week as first reported, a count later revised to more than 40,000[27,48]. Outpatient visits for influenza-like illness reached 8.2 percent that week[27]. The second was who got sick. Children 5 to 17 had the highest cumulative hospitalization rate since FluSurv-NET began in 2010-11, children under 5 the second highest, and the pediatric peak week of 7.3 per 100,000 was the highest since 2010-11[106]. As of October 9, 2026, 198 pediatric deaths had been reported for the season, with late reports still arriving.

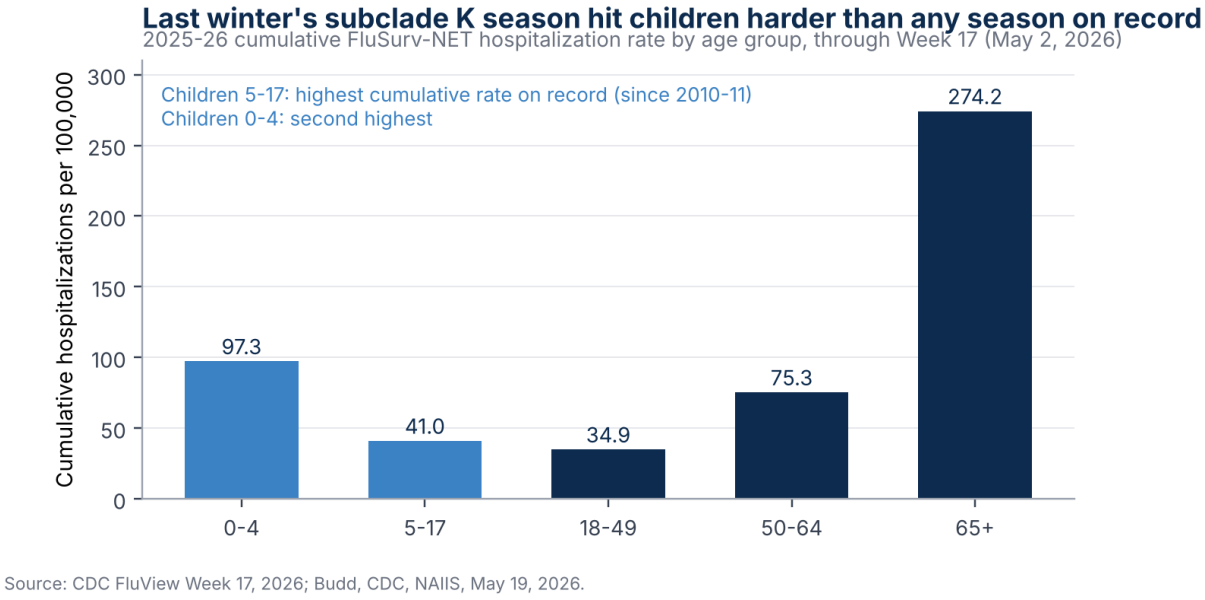


Figure 6. Cumulative 2025-26 hospitalization rates by age group.

The hospital record from that peak previews what an early season without slack would look like. New York set a record of 4,546 flu hospitalizations in the week ending December 27, 2025, announced January 2[32]. Buffalo General, a 456-bed hospital, had about 600 patients bedded or being seen on January 8; Erie County Medical Center was at 93 percent of medical-surgical and 100 percent of critical care capacity; ten-bed Lockport Memorial was full with seven more patients holding in its emergency department[35]. UnityPoint Health in Des Moines postponed surgeries requiring overnight admission through January 13. UNC Children's described itself as "bursting at the seams." Michigan's flu admissions ran 40 percent above the prior year. Children's Hospital Colorado logged about 600 flu admissions in three months, against 800 for all of the previous season 34,36. Banner Health reinstated universal masking across its facilities on December 31[98]. New York's Commissioner summed up the winter in a sentence: "This is going to be a long, hard flu season"[33].

The vaccine helped less than usual and more than nothing. CDC's interim estimates, published in March, put effectiveness against H3N2 in children at 35 percent for outpatient illness and 38 percent against hospitalization; the adult outpatient estimate of 11 percent was not statistically different from zero[37]. Canada's sentinel network estimated 37 percent against subclade K specifically[38]. The United Kingdom reported 70 to 75 percent protection against hospital attendance in children and 30 to 40 percent in adults[39]. A pooled analysis of nine European studies found all-age effectiveness of 25 to 45 percent and 47 to 72 percent in children[40]. The vaccine strain, chosen before subclade K was identified, was antigenically distinct from it[37]. It still cut severe disease in the group that needed it most.

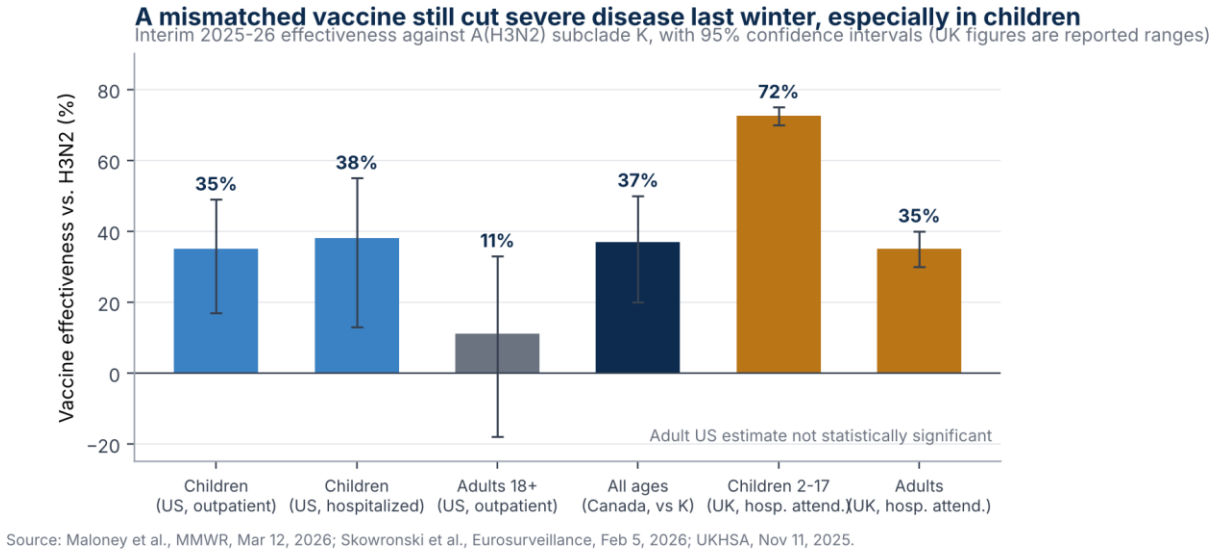


Figure 7. Interim 2025-26 vaccine effectiveness against H3N2 subclade K, by population and study.

Table 2. Last winter and this autumn, side by side. Sources: CDC FluView Weeks 17, 20, 41[7,25,26]; Budd[28]; Becker's[15].

Measure	2025-26 season	2026-27 to date (Week 41)
Predominant virus	A(H3N2), 86.6% of subtyped A; 93% subclade K	A(H1N1)pdm09, 99.2% of subtyped A in Week 41
Season onset	Mid-November rise	Late August rise on the Pacific coast; positivity above 3% by late September
Peak week	Week ending Dec 27, 2025 (12.8 per 100,000)	Not yet reached
Cumulative FluSurv-NET rate	87.2 per 100,000 (third highest since 2010-11)	2.1 per 100,000
Severity (CDC)	Moderate overall; high in children	Not rated; outlook expects moderate
Pediatric deaths	198 reported (as of Oct 9, 2026)	0
Hospitalizations	About 390,000	4,811 admissions in Week 41
Hardest-hit age groups	65+ (274.2 per 100,000); children 5-17 record rate	Early signals point to teens and young adults (G155E)

5. Early Does Not Mean Severe

The instinct to read an early start as a bad omen is understandable and, on the evidence, mistaken. CDC's tabulation of seasons from 1982-83 through 2023-24 shows that influenza most often peaked in February (17 seasons), followed by December (seven), January (six), and March (six)[45]. Peaks before December are rare: the 2009 pandemic season peaked in October, and CDC's own review counts one pre-pandemic season that peaked in November 28. Since the pandemic, the calendar has shifted somewhat, with three of five seasons peaking in December, but the peak still falls in winter[28].

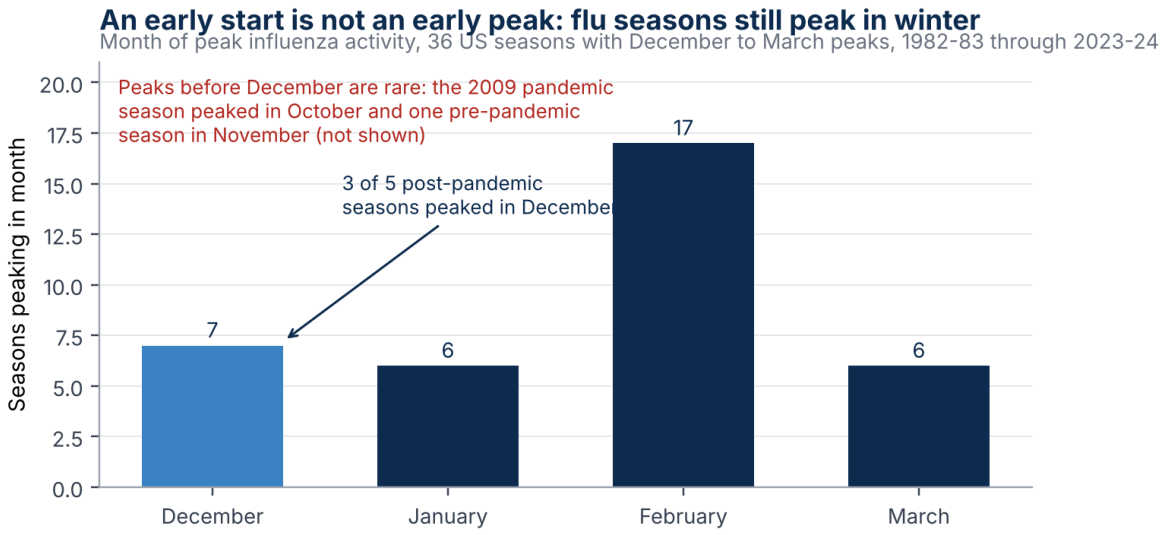


Figure 8. Month of peak influenza activity across 36 US seasons.

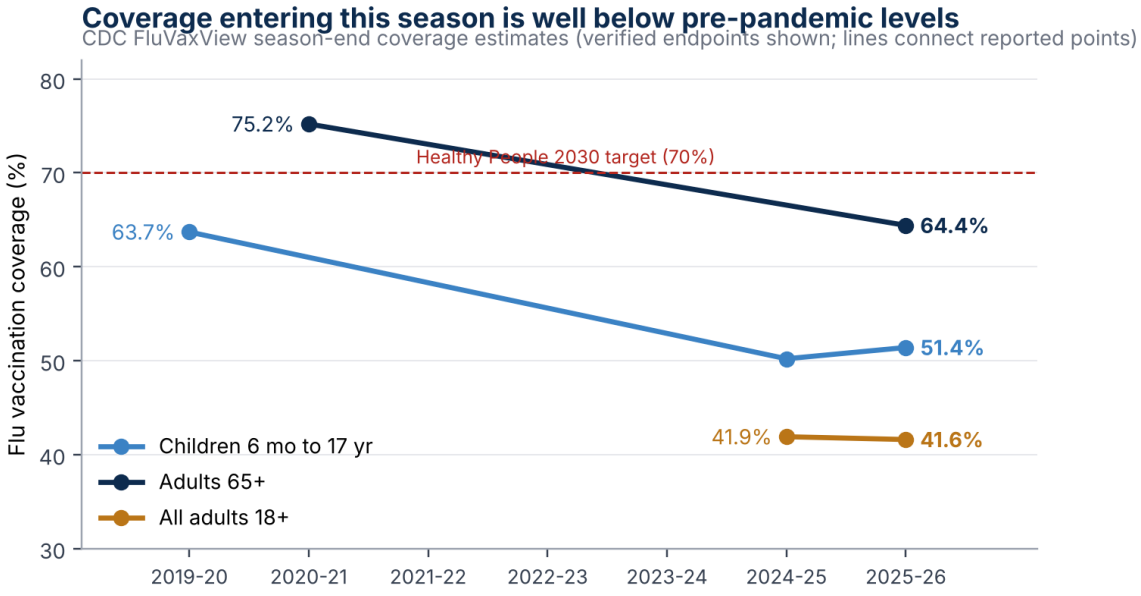
Seasons that started unusually early were not the worst. In 2003-04, a drifted H3N2 and a vaccine that CDC called a less-than-optimal match drove positivity above 10 percent by late October, and laboratory positivity peaked in the week ending November 29; CDC classified the season as moderately severe, with 152 pediatric deaths[46]. In 2022-23, the "tripledemic" year, flu rose in early October, and hospitalizations peaked the week ending December 3, with outpatient illness peaking a week earlier, the earliest peak since ILINet began in 1997; that season ended with 360,000 hospitalizations, mid-range by any standard 47,29. The two most severe seasons of the past decade, 2017-18 and 2024-25, both peaked in winter rather than autumn 29,30,31. Amesh Adalja of Johns Hopkins told the Advisory Board in October: "An early start tells you little about when the season will end or how bad it will be"[18]. Scarpino's framing was that the season is early but "still within that window"[16].

The Southern Hemisphere points the same way. Australia's 2025 winter was a record. Its 2026 winter was not. The Immunization Coalition's tally of laboratory-confirmed notifications stood at 231,473 on October 26, 2026, against more than 410,000 reported by early November 2025, with Queensland down 48 percent, 49,109. Ian Barr of the WHO Collaborating Center in Melbourne had predicted as much in March, calling two huge years in a row "very unusual"[51]. Gavi's October review quoted Ruth Harvey of the Francis Crick Institute's Worldwide Influenza Center saying the 2026 Southern Hemisphere season was, "within the variation of flu seasons," nothing "to write home about," with fewer global detections between February and August than in 2025[44]. CDC's own September outlook, informed by that data and by 25 experts, expected the combined peak of flu, COVID-19, and RSV hospitalizations to land within 20 percent of last season's and rated influenza severity as likely moderate, with "no evidence to indicate that a severe season is more likely" than observed historically[10]. As of October 23, CDC's data channel rated influenza low nationally, COVID-19 declining, and RSV very low[11].

Two caveats belong here, and they return in Section 11. CDC's outlook was written before the H1N1 surge was visible and does not mention G155E, H1N1, H3N2, or subclade K[10]. An early, mild season can still be hard because it compresses the calendar. A peak arriving in late November coincides with the Thanksgiving and December holiday staffing troughs, overlaps with the RSV and COVID-19 seasons that have not yet begun, and leaves room for a second wave in February 15. Leaders do not need to ask whether this will be a bad season. It is whether the system can absorb an ordinary one.

6. The Vaccination Gap

CDC's final coverage estimates for 2025-26, published October 8, 2026, show where the country starts. Children 6 months to 17 years: 51.4 percent, the first increase since the pandemic, but still 12.3 points below 63.7 percent in 2019-20. Adults 18 and older: 41.6 percent. Adults 65 and older: 64.4 percent, down from 75.2 percent in 2020-21 and below the 70 percent Healthy People 2030 target. Pregnant women: 37.7 percent[54]. The American Academy of Pediatrics notes that historically about 85 percent of children who die of flu were not vaccinated[61].



Source: CDC FluVaxView, Flu Vaccination Coverage, United States, 2025-26 (published Oct 8, 2026) and prior-season comparisons cited therein.

Figure 9. Season-end influenza vaccination coverage, verified CDC estimates.

Early indicators for this season are not encouraging. New York's Commissioner said doses reported to the State were lower than in previous years[1]. Virginia reported 9.9 percent of residents vaccinated by mid-October, against about 20 percent by the end of October last season; Commissioner Cameron Webb called it "peak time to make sure you get protected"[55]. A CVS-commissioned survey in August found 63 percent of adults intending to get a flu shot, flat for three years[105]. The National Foundation for Infectious Diseases found that only 44 percent of adults had sought a flu vaccine in the prior year and that 22 percent of those who tried encountered a barrier[65]. KFF's October tracking poll found majorities confident in flu vaccine safety, with

a partisan gap of roughly 20 points and only 54 percent of self-described MAHA supporters, who make up 42 percent of the public, confident in the flu vaccine for children[64].

An institutional vacuum underlies the behavior. The Advisory Committee on Immunization Practices, which has issued the nation's annual flu vaccine recommendation for decades, has not met since December 2025. In June 2025, Secretary Robert F. Kennedy Jr. removed all 17 members and appointed replacements; in March 2026, a federal judge in Massachusetts stayed 13 of those appointments and set aside the reconstituted panel's votes, including its January cut to the childhood schedule[58]. The Justice Department appealed, and the First Circuit heard argument on October 6 with no ruling as of this writing[59]. CDC lists all three of its scheduled 2026 ACIP meetings, in March, June, and October, as canceled[57]. In place of a formal recommendation, CDC published "interim clinical considerations" on September 1 stating that, "because of legal uncertainties and inquiries," the July 2025 recommendations remain in effect: everyone 6 months and older should be vaccinated, with enhanced vaccines preferred for those 65 and older[56]. The American Academy of Pediatrics, the American Academy of Family Physicians, the American College of Obstetricians and Gynecologists, and the Infectious Diseases Society of America issued their own universal recommendations in August and September 60,61.

The practical consequences run through insurance and pharmacies. The Affordable Care Act's no-cost vaccine coverage is tied to ACIP recommendations adopted by the CDC director; the nation's health insurers pledged in May to keep covering all previously recommended immunizations without cost sharing through the end of 2027, a voluntary commitment any member could revisit 62,63. Moderna's mRNA flu vaccine, approved in August for adults 50 and older, has no ACIP review and uncertain coverage 62,63. Pharmacist vaccination authority and billing in many states remain tied to ACIP language, and KFF counted 30 states that had moved to accept other recommending bodies by August 107. Bruce Gellin of the Vaccine Integrity Project put the stakes in September: "We cannot allow the breakdown of a federal process to create a vacuum in evidence-based vaccine guidance"[60].

Supply is not the constraint. Manufacturers projected up to 135 million doses for the United States, all trivalent, 99 percent thimerosal-free[53]. CSL Seqirus reported completing its campaign ahead of schedule while acknowledging "reported supply challenges affecting portions of the U.S. and global influenza vaccine market" that it had helped backfill[100]. The first generic single-dose baloxavir was approved in May 101. The doses exist. Recommendations, trust, and the delivery system have thinned.

7. A Public Health System Running Thin

On October 27, the day after New York's declaration, CDC confirmed that its deputy director and chief medical officer, Jennifer Shuford, was resigning; she had been named in April and had been in the post for about four months. Her last day is November 12. Shuford, who ran the Texas health department through the 2025 West Texas measles outbreak, said she was leaving to spend more time with her family; the agency is simultaneously in a public dispute with Pennsylvania over how many of that state's measles patients have died 70,71. Her departure is a data point in a larger pattern.

The agency she leaves is smaller than the one that managed any recent flu season. An analysis by the Public Data Observatory, confirmed by the CDC employees' union, counted 12,705 civil service staff in March 2025 and 8,895 active in May 2026, with 3,539 departures and 271 more on paid leave, a loss of roughly 30 percent against 19.4 percent government-wide[66]. The Department of Health and Human Services' March 2025 restructuring aimed to cut its full-time workforce from 82,000 to 62,000. When Erica Schwartz was confirmed as CDC director in August, by a 51-to-44 vote after nearly a year without a confirmed director, she told staff at her first all-hands meeting that she had inherited a short-staffed and worn-out agency; the Associated Press reported the agency had lost more than 3,000 employees, over a quarter of its workforce 68,69. Former immunization chief Demetre Daskalakis counts more than 20 political appointees in the director's office[71].

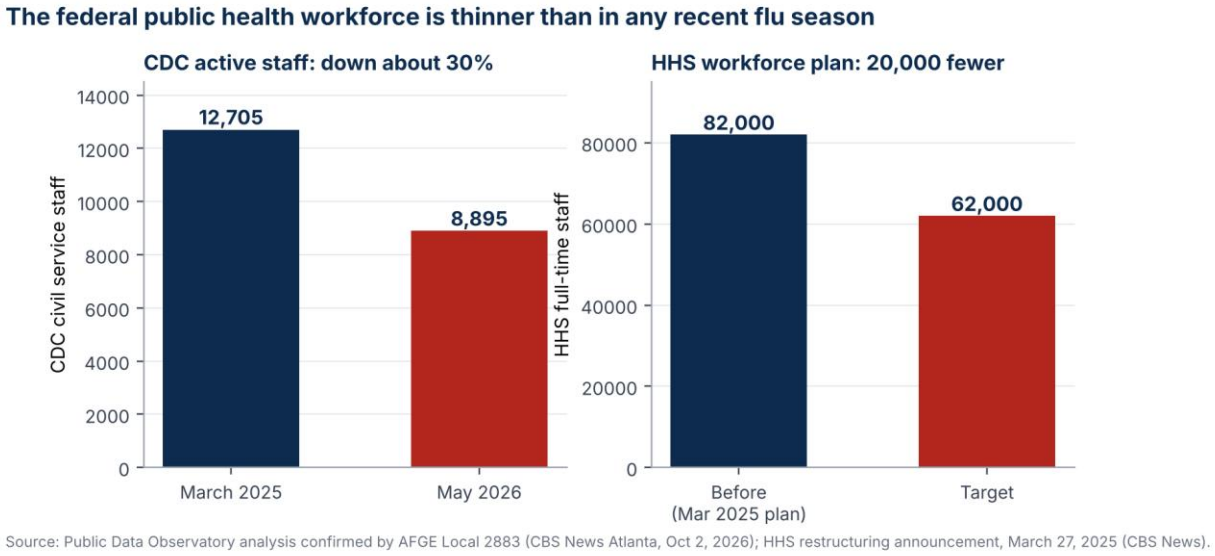


Figure 10. Federal public health workforce reductions, 2025 to 2026.

The money that reaches states and counties has thinned too. In March 2025, HHS terminated about $11 billion in pandemic-era grants to state and local health departments, more than $8.9 billion of it for epidemiology and laboratory capacity and about $2 billion for immunization[72]. A federal judge in Rhode Island enjoined the clawback, but the effects had already landed: Mecklenburg County, North Carolina, lost 180 employees including all eight of its mobile vaccine staff; Columbus, Ohio, laid off nine disease intervention specialists and dropped to a quarter of its contact-tracing capacity; Nashville ended free flu and COVID

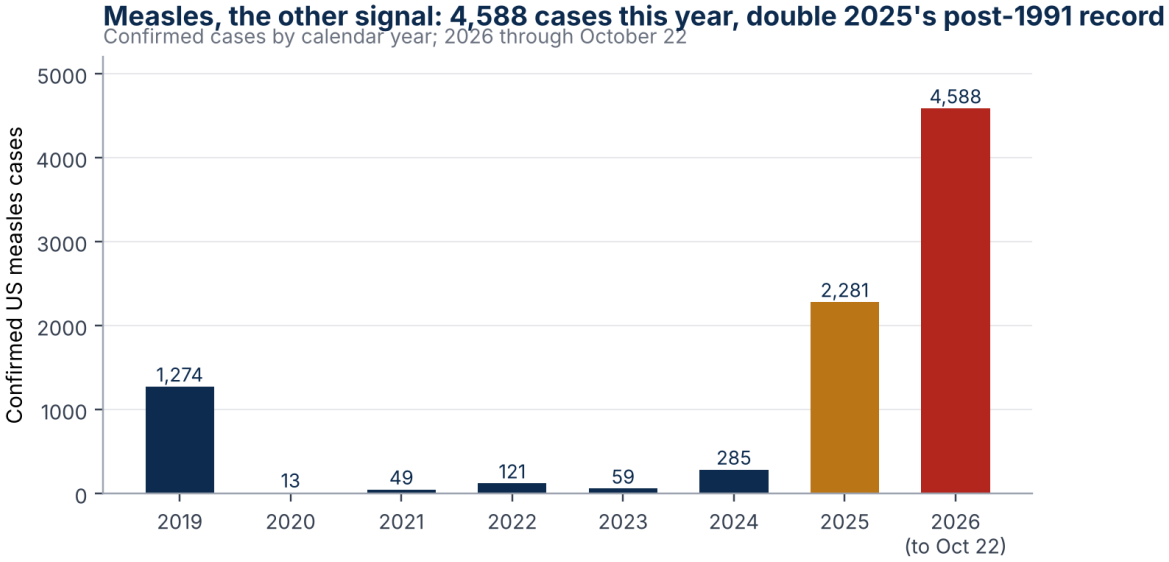
testing; Minnesota issued 170 layoff notices on a $226 million loss[72]. In February 2026, HHS ended roughly $600 million more in CDC grants to California, Colorado, Illinois, and Minnesota, including the Public Health Infrastructure Grant that funded more than 400 positions in California alone; the four states sued[73]. CDC's FY2026 appropriation of $9.2 billion was described by state health officials as relatively level[74], and FY2027 is running on a continuing resolution through December 11[110].

The surveillance instruments themselves are fraying at the edges. The National Wastewater Surveillance System, which monitors about 1,300 sites covering 144 million people, has never had a dedicated appropriation; its 2021 one-time funding runs out around October 2026, and a coalition of city health departments has asked for at least $120 million to keep it alive[75]. Its testing contract was extended only to mid-September pending a recompete, and as of October 20, some sites remained dark during what CDC called "a gap between testing contracts," with five of Oregon's 33 sites reporting[76]. CDC's own Week 41 FluView cautioned that a decline in one region "may be a result of delayed reporting" and listed 199 metropolitan areas with insufficient data[7]; its Week 39 report noted that long-term care facility hospitalization data would no longer be reported in FluView this season[9].

Table 3. The public health timeline that preceded this season. Sources[57,58,66,67,68,70,72,73,75,80].

Date	Event	Why it matters for this season
Mar 27, 2025	HHS restructuring: 82,000 to 62,000 full-time staff; about $11 billion in state and local grants terminated	Epidemiology, lab, and immunization capacity cut as the 2025-26 season approached
Jun 2025	All 17 ACIP members removed and replaced	Begins the chain that leaves no federal flu recommendation for 2026-27
Aug 2025	CDC Director Monarez ousted	Nearly a year without a confirmed director
Feb 2026	About $600 million in CDC grants to four states ended; states sue	Loss of Public Health Infrastructure Grant positions
Mar 16, 2026	Federal judge stays 13 ACIP appointments and sets aside votes	ACIP cannot meet; all 2026 meetings canceled
Aug 5, 2026	Erica Schwartz confirmed as CDC director, 51-44	Agency has lost more than 3,000 employees
Sep 1, 2026	CDC interim flu vaccine considerations carry over 2025 recommendations	Universal recommendation stands, but without ACIP's formal vote
Oct 2026	Wastewater surveillance funding runs out; sites go dark between contracts	Early-warning system degraded as flu arrives early
Oct 27, 2026	CDC deputy director resigns about four months after starting	Leadership turnover during the season's opening weeks
Nov 10-13, 2026	PAHO review of US measles elimination status	A loss would be the first since the US achieved elimination in 2000

Measles is the other signal, and it is loud. CDC counted 4,588 confirmed cases in 2026 as of October 22 across 47 jurisdictions, with 479 hospitalizations and 96 percent of cases in unvaccinated or unknown-status people77. That is double the 2,289 cases in 2025, the most since 1991[77,78]. Pennsylvania alone reports more than 1,300 cases and five deaths; CDC, which since September counts a measles death only after verification by the National Center for Health Statistics, lists three, and removed two Lancaster County deaths after the Secretary questioned their cause[79]. The Pan American Health Organization will review whether the United States retains its measles elimination status at its November 10 to 13 meeting, after postponing a special review originally set for April 80. CNBC's October 27 report on the resurgence quoted Scott Weaver of the University of Texas Medical Branch describing a public health infrastructure "really decimated by Covid" and noted kindergarten MMR coverage of 92.4 percent with a record 4.2 percent exemption rate[81]. Measles and influenza share the same delivery system: clinics, county nurses, school programs, and data pipelines. What has failed for one is available to the other.



Source: CDC measles cases and outbreaks (2019-2024 annual totals); CDC via Contagion Live, Oct 23, 2026, and CIDRAP (2025 total 2,281).

Figure 11. Confirmed US measles cases by year, 2019 through October 22, 2026.

8. Hospitals With No Slack

The final layer absorbs whatever the first seven fail to prevent. A UCLA analysis published in JAMA Network Open in February 2025 found that mean US inpatient occupancy rose from 63.9 percent in 2009 through 2019 to 75.3 percent in the year from May 2023 to April 2024, while staffed beds fell 16 percent, from about 802,000 to 674,000. The authors projected 85 percent occupancy, a level widely treated as a bed shortage, by 2032[82]. Federal data cited by Becker's put occupancy near 69 percent in the week ending December 27, 2025, at the height of last winter's surge, and above 70 percent for most of the period since 2023[34]. Different denominators produce different numbers; each is far above the pre-pandemic norm.

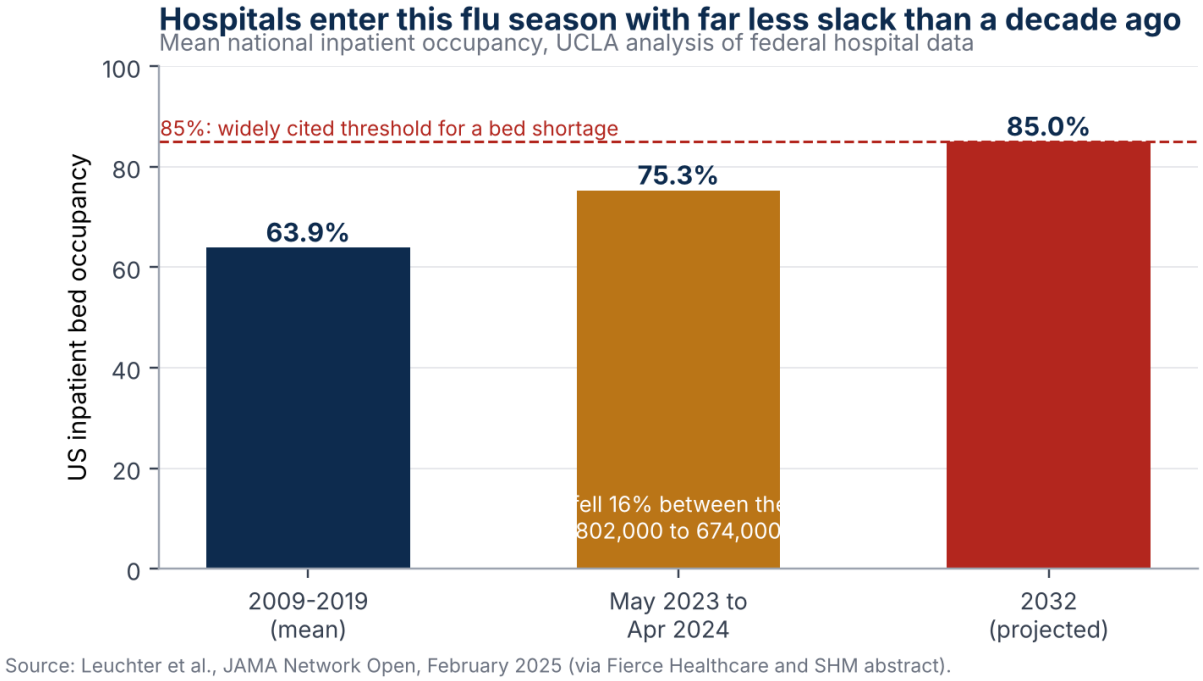


Figure 12. Mean US inpatient bed occupancy, 2009-2019, 2023-24, and projected 2032.

Occupancy shows up first in the emergency department. A JAMA study published in August 2026 examined roughly 492,000 admissions across 56 emergency departments in 17 health systems between June 2024 and May 2025. More than half (53.6 percent) boarded for four hours or longer. About 85,000 patients waited four hours or more without an inpatient team assigned; 23,000 waited 12 hours or longer; and 4,500 waited a full day. Patients 65 and older made up about 55 percent of the long waits[83]. A separate Health Affairs analysis of 46 million visits found that more than a quarter waited four hours or longer for a bed, rising to 35 percent in peak winter months[83]. The Centers for Medicare and Medicaid Services' new four-hour boarding measure is voluntary in 2027 and mandatory in 2028, which means this season's boarding will be invisible in federal data[83].

The capacity that matters most for an H1N1 season is pediatric, and it has been disappearing. A JAMA Pediatrics study found that the number of US hospitals with pediatric inpatient units fell from 1,749 in 2008

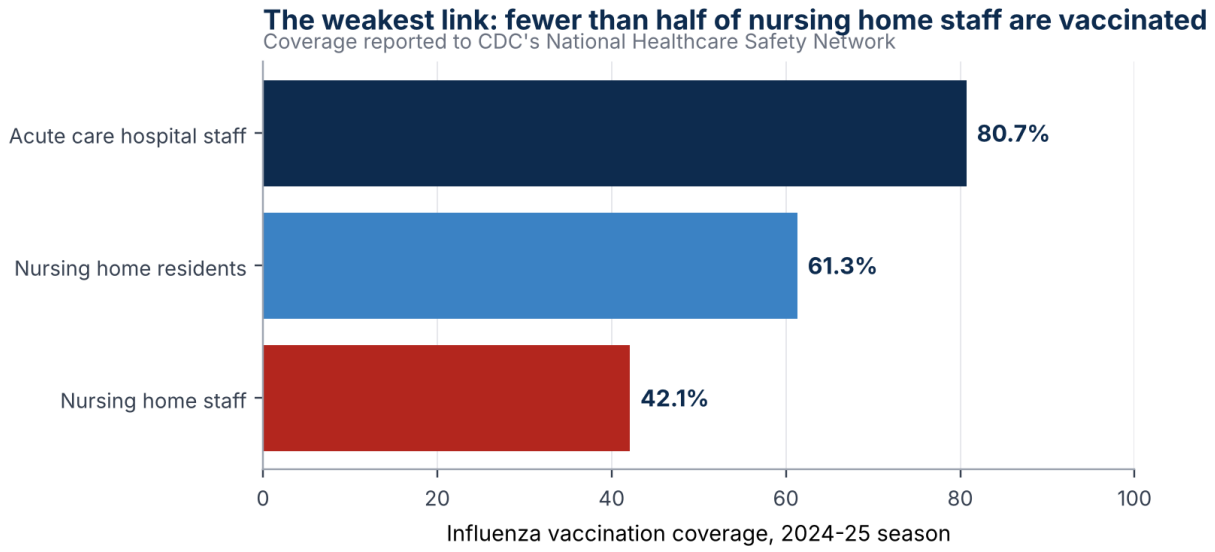
to 1,226 in 2022, a 29.9 percent decline; pediatric beds fell 19.5 percent, while adult beds fell 4.4 percent 84. During the 2022-23 surge, nearly half of hospitals exceeded 85 percent pediatric occupancy in a typical week, yet in two-thirds of those instances a hospital nearby had open pediatric beds, a distribution failure rather than an absolute shortage[88]. Rady Children's converted its gift shop to a triage space. Comer Children's in Chicago accepted 30 transfers and turned away 60 in a single day[108].

Staffing is the binding constraint on all of it. NSI Nursing Solutions' 2026 survey reported registered nurse turnover of 17.6 percent; a vacancy rate of 8.6 percent; 33.1 percent of hospitals with vacancy at or above 10 percent; an average of 43 unfilled RN positions per hospital; and emergency department RN turnover of 20.7 percent[85]. When surges hit, hospitals buy labor at a premium: the American Hospital Association documented contract nurses rising from 4.7 percent of median nurse labor expense in 2019 to 38.6 percent in January 2022, with billed hourly rates up 213 percent[93]. Rural hospitals have less to buy with. Chartis counts 417 rural hospitals vulnerable to closure and 41.2 percent operating in the red; closures slowed in 2026, to six hospital and emergency department closures through September against 21 a year earlier, but hospital leaders describe "quiet closures" of service lines and expect the pace to pick up in 2027 as Medicaid cuts and expired premium tax credits take hold 86,87.

Table 4. Hospital and long-term care capacity indicators entering the 2026-27 season.

Indicator	Value	Source
Mean inpatient occupancy, 2023-24	75.3% (63.9% in 2009-2019)	Leuchter et al., JAMA Netw Open 82
Staffed beds	674,000, down 16% from 802,000	Leuchter et al.[82]
Admitted ED patients boarding 4+ hours	53.6%	Janke et al., JAMA, Aug 2026[83]
Hospitals with pediatric units, 2008 to 2022	1,749 to 1,226 (down 29.9%)	JAMA Pediatrics[84]
RN turnover / vacancy, 2026	17.6% / 8.6%; ED RN turnover 20.7%	NSI 2026[85]
Rural hospitals vulnerable to closure	417; 41.2% in the red	Chartis 2026[86]
Nursing home staff flu vaccination, 2024-25	42.1% (hospital staff 80.7%)	CDC MMWR, Apr 2026[89]
Mean cost per flu hospitalization	$16,000 (HCUP); $22,849 to $32,231 (commercial claims)	AHRQ[90]; AJMC/Flunomics[91]

The weakest link sits outside the hospital. Nursing homes report influenza vaccination of 61.3 percent among residents and 42.1 percent among staff, down from 45.4 percent the prior year and barely half the 80.7 percent reported by acute care hospitals[89]. Every nursing home outbreak becomes a hospital transfer, and every delayed discharge back to an outbreak-affected facility becomes a boarded bed. The federal Nurses for Nursing Homes program, announced on October 23, offers $275 million in loan repayment and stipends for more than 4,000 nurses who commit to three years, funded by civil monetary penalties collected from nursing homes and opened for applications on October 26[99]. It will not change staffing this season.



Source: CDC MMWR 75(15), April 23, 2026. Nursing home staff coverage fell from 45.4% the prior season.

Figure 13. Influenza vaccination coverage in nursing homes and acute care hospitals, 2024-25.

9. The Price of Being Early

A flu hospitalization is expensive. The Agency for Healthcare Research and Quality's most recent national statistical brief reported a mean cost of an influenza stay of about $16,000, a mean length of stay of 6.3 days, and an in-hospital mortality rate of 3.6 percent[90]. An industry-funded analysis of commercial claims for 2024-25 found $22,849 per admission for adults 65 and older, $25,113 for adults 18 to 49, and up to $32,231 for high-risk adults 50 to 64, across roughly 770,000 admissions[91]. The most cited academic estimate of influenza's total annual economic burden is $11.2 billion, of which $3.2 billion is direct medical cost and $8 billion is lost productivity[92]. At 390,000 hospitalizations, last winter's moderate season cost between $6.2 billion and $8.9 billion in inpatient care alone, depending on which per-stay figure one accepts.

Being early does not multiply those numbers. It concentrates them. Three mechanisms matter to a hospital's finances. First, timing: a peak in late November or December lands on the holiday staffing trough, when agency labor is scarcest and most expensive. Second, overlap: an early flu peak increases the chance that flu, RSV, and COVID-19 crest together rather than in sequence, as they did in 2022-23. Third, displacement: when flu fills medical beds, elective procedures that carry the margin are postponed, as UnityPoint did last winter and California's hospitals did in 2017-18[34,111]. A moderate season spread over 16 weeks is a budget line. Compressing the same season into eight weeks is a crisis.

The arithmetic for a single hospital is sobering even at last winter's moderate levels. In the peak week of 2025-26, 33,301 patients were admitted nationally with confirmed flu as first reported (later revised above 40,000) against about 674,000 staffed beds, roughly 49 admissions per 1,000 beds per week on the initial count of 27,48,82. For a 300-bed hospital, that is about 15 flu admissions in the peak week; at a mean stay of 6.3 days, about 13 beds occupied by flu patients at any moment, or 4.4 percent of capacity. A hospital running at the national mean of 75 percent occupancy moves to roughly 80 percent on flu alone, before RSV,

before COVID-19, before the staff who are themselves sick. At $16,000 per stay, those 15 admissions represent $240,000 in care in one week, much of it reimbursed at Medicare rates that don't cover agency premiums. The example is illustrative; a hospital's own admission share, length of stay, and payer mix will move every figure. The problem structure does not move.

Table 5. Illustrative peak-week arithmetic for a 300-bed hospital at 2025-26 national intensity. Figures are calculations from the cited sources and will vary with local admission share, length of stay, and payer mix.

Assumption or result	Value	Basis
National peak-week flu admissions, 2025-26 (initial report)	33,301 (later revised above 40,000, which would raise the example to about 18 admissions and 16 beds)	CDC FluView Week 52[27]; FluSight evaluation[48]
National staffed beds	674,000	Leuchter et al.[82]
Peak-week admissions per 1,000 staffed beds	49	Calculated
300-bed hospital: peak-week flu admissions	15	Calculated
Mean length of stay	6.3 days	AHRQ HCUP[90]
Beds occupied by flu at peak	13 (4.4% of capacity)	Calculated
Occupancy, before and after flu	75.3% to about 80%	Leuchter et al.[82]; calculated
Inpatient cost of peak-week flu admissions	$240,000 at $16,000 per stay; $343,000 at $22,849	AHRQ[90]; AJMC[91]

10. The EARLY Readiness Model

A leader cannot change the virus, the vaccine match, or the federal budget. A leader can change what her organization knows, stocks, staffs, and reaches before the peak. The EARLY Readiness Model organizes those choices into five domains and scores each from 0 to 20. The sum is the Early Season Readiness Index, ESRI, on a 100-point scale. The model is built on the evidence assembled in this report; it rewards only interventions with measured effect sizes.

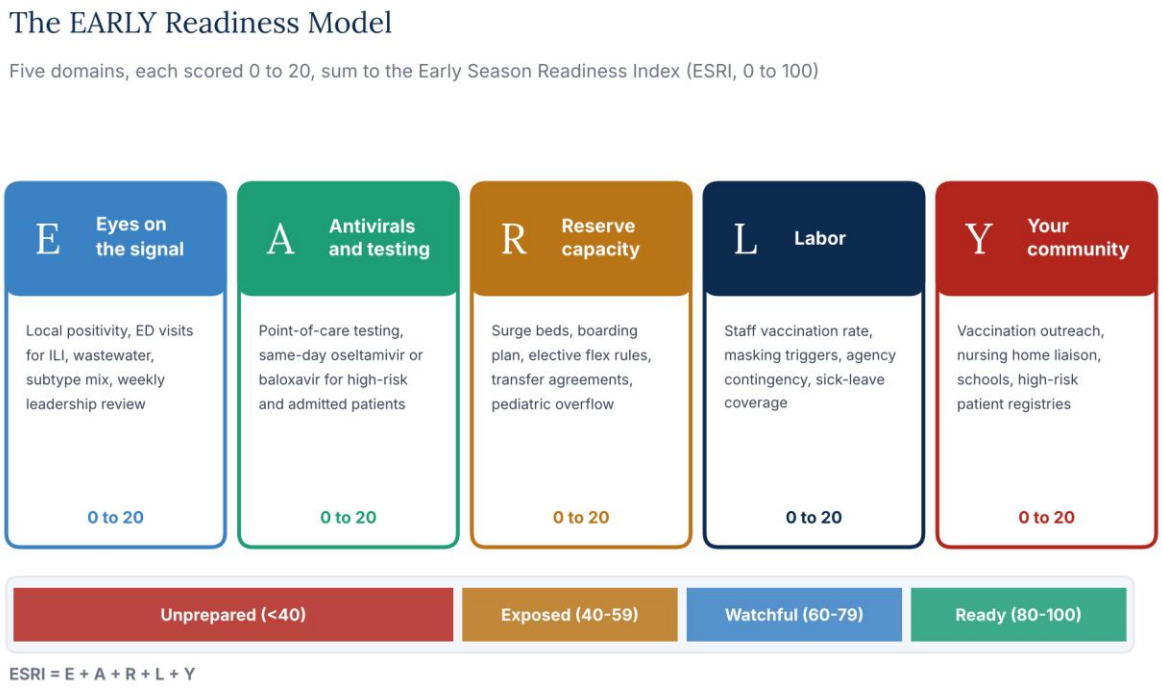


Figure 14. The EARLY Readiness Model and the Early Season Readiness Index.

E. Eyes on the signal (0 to 20)

National surveillance is thinner this year, and it was never local. The organizations that saw this season coming were the ones watching their own test positivity and emergency department visits for influenza-like illness from late August 19, 20. Full marks require a weekly review of local positivity, ED ILI share, admissions by age group, regional wastewater where it still reports, and the subtype mix from the state laboratory, with a named owner and a trigger threshold that activates the rest of the model.

A. Antivirals and testing (0 to 20)

The strongest single intervention the hospital can control is early treatment. An Ontario study of 11,073 hospitalized influenza patients across nine seasons, published in JAMA Network Open in 2025, found in-hospital mortality of 3.5 percent with oseltamivir started on the day of admission or the next, against 4.9 percent without, an adjusted absolute reduction of 1.8 percentage points, with shorter stays and fewer intensive care transfers[94]. The drugs work: only 8 of 520 viruses tested this season, 1.5 percent and all of them H1N1, showed reduced oseltamivir inhibition, and none showed baloxavir resistance[7]. Full marks require point-of-care testing in the emergency department and urgent care, a standing order for same-day antivirals in high-risk and admitted patients, and weekly stock verification rather than assumptions.

R. Reserve capacity (0 to 20)

Surge plans fail on the details: which units convert, who decides to curtail electives and at what trigger, where pediatric overflow goes, and which neighbor has beds. The 2022-23 experience, in which two-thirds of

overloaded hospitals had a neighbor with open pediatric beds, argues that regional transfer agreements are worth more than any single hospital's hallway stretchers[88]. Full marks require a written boarding escalation plan with a four-hour standard, named elective curtailment triggers, pediatric transfer agreements, and a discharge acceleration plan for the post-acute facilities that will have their own outbreaks.

L. Labor (0 to 20)

The evidence on health care worker vaccination is contested; a CDC meta-analysis found a 29 percent reduction in all-cause patient mortality while a Cochrane review found the evidence weak[95]. The operational case is not contested: a vaccinated workforce is a workforce that is present. Full marks require staff vaccination at or above the 80.7 percent hospital benchmark, with the nursing home figure of 42.1 percent treated as the warning it is[89]; masking triggers tied to the surveillance signal rather than to a state declaration (Los Angeles County's standing order, which requires unvaccinated health care personnel to mask from November 1 through April 30, is one model[97]); an agency labor contingency with pre-negotiated rates; and sick-leave coverage that does not punish a febrile nurse for staying home.

Y. Your community (0 to 20)

Every hospital admission begins outside the hospital. School-located vaccination in Oakland was associated with 37 fewer flu hospitalizations per 100,000 among non-elementary residents and 160 fewer per 100,000 among adults 65 and older in 2017-18[96]. Nursing home outbreaks become transfers. The G155E cohort suggests that teenagers and young adults are least likely to see themselves as flu patients. Full marks require active outreach to the local health department, school districts, and nursing homes; a registry of high-risk patients with a plan to reach them; and a vaccination message that names the population at risk this year.

Table 6. Early Season Readiness Index tiers.

Score	Tier	Interpretation
80 to 100	Ready	Signal, treatment, capacity, labor, and community plans are in place and tested; the organization can absorb a moderate season compressed into eight weeks
60 to 79	Watchful	Most elements exist on paper; one or two domains, usually labor or community, are untested
40 to 59	Exposed	The organization will know it is in trouble only after boarding exceeds four hours and electives are canceled
Below 40	Unprepared	No local surveillance review, no antiviral standing orders, staff vaccination below 60 percent, no pediatric transfer agreement

Each domain is scored on four observable criteria worth 5 points apiece, listed in Table 7. The instrument is designed for an operations leader to complete in an hour, with access to the organization's own data, and to be repeated every two weeks through the season.

Table 7. ESRI scoring criteria. Each criterion met in full scores 5; partially met scores 2 or 3; absent scores 0.

Domain	Criterion 1	Criterion 2	Criterion 3	Criterion 4
E	Weekly local positivity and ED ILI review with a named owner	Admissions tracked by age group	Subtype and wastewater signal obtained from state or regional sources	Written activation threshold
A	Point-of-care flu testing in ED and urgent care	Standing order for same-day antivirals in high-risk and admitted patients	Antiviral stock verified weekly	Testing and treatment turnaround audited
R	Boarding escalation plan with a four-hour standard	Named elective curtailment triggers	Pediatric and adult transfer agreements	Post-acute discharge acceleration plan
L	Staff flu vaccination at or above 80 percent	Masking triggers tied to local signal	Agency labor contingency with pre-negotiated rates	Sick-leave coverage plan
Y	Liaison with local health department and schools	Nursing home outbreak communication channel	High-risk patient registry and outreach	Public message that names this year's at-risk population

11. The Strongest Case Against This Report

An investigation that does not test its own conclusion is an argument. Here is the best case for this report overstating the danger, followed by the best case for it understating it.

The case that this is an ordinary season with an early calendar

Every official forecast says moderate. CDC's September outlook found no evidence that a severe season was more likely than usual[10]. Its October data channel rated influenza low, COVID-19 declining, and RSV very low[11]. Australia's winter came in far below 2025[49]. The historical record shows no relationship between early starts and severe outcomes; 2003-04 and 2022-23 were moderate, and the worst recent seasons peaked late 29,46,47. Gavi's review of Europe's early 2025-26 start found severity that varied by country and "wasn't uniformly more severe than previous winters"[44]. Neither subclade K nor G155E has been shown to cause more severe illness per infection; CDC said as much about subclade K in January, and no one has claimed it for G155E[41,42]. The vaccine still prevented severe disease last winter at effectiveness levels that mirrored a decade of ordinary seasons, and CDC's antigenic testing shows 93 percent of this year's H1N1 isolates are still recognized by the vaccine reference virus 7,37. Hospitals absorbed 710,000 hospitalizations in 2017-18 and again in 2024-25[30,31]. Two consecutive hard winters may have left the population with more immunity, not less; a Francis Crick Institute study found more pre-existing immunity to subclade K than laboratory assays had implied, though that finding concerns H3N2 and says nothing about G155E[44]. By this reading, the right response to October 2026 is to get vaccinated and go about one's business.

The case that this report is too calm

CDC's outlook was written on September 23, before the H1N1 surge was visible, and does not mention the virus now circulating[10]. The G155E serology, if it holds, describes an immunity gap in a large, mobile, under-vaccinated cohort. Greninger's warning of a second H3N2 or B wave after the H1N1 peak would place the heaviest burden on older adults in February, when hospitals are fullest[15]. The surveillance system that would detect either event is weaker than it has been in any recent season: a CDC nearly a third smaller, a wastewater network losing sites, a weekly report that now warns about its own reporting gaps 7,66,75. The vaccination infrastructure has no federal recommending body, a voluntary insurer pledge, and 30 states improvising on pharmacist authority 57,62,63,107. Measles at 4,588 cases shows what happens when coverage and trust erode at the same time 77. And the hospital system's margin is gone: 75 percent occupancy, half of admitted patients boarding, nearly a third fewer pediatric units 82,83,84. By this reading, a moderate season is precisely the scenario in which a system with no slack fails, because no one declares an emergency for a moderate season.

This report's judgment sits between the two, closer to the second. The virus is probably ordinary. The system is not. The policy response to an ordinary virus arriving at an extraordinary moment is measured, repeated readiness, not alarm.

12. What Leaders Should Do Now

Table 8. Actions by role, sequenced to the season.

Role	This week	Before Thanksgiving	Through the season
Hospital and health system executives	Score the organization on the ESRI; name an owner for each domain below 15	Confirm antiviral stock, point-of-care testing, elective curtailment triggers, and pediatric transfer agreements	Re-score every two weeks; publish boarding hours to the board
Chief nursing and medical officers	Push staff vaccination toward 80 percent; set masking triggers tied to local positivity	Standing orders for same-day antivirals; audit time from test to treatment	Protect sick leave; track staff absence as a leading indicator
Emergency department leaders	Activate the four-hour boarding escalation plan now, not at the peak	Rehearse the surge conversion with inpatient and transfer partners	Report boarding daily; escalate at 12 hours without exception
Nursing home and post-acute leaders	Staff vaccination campaign; outbreak communication line to referring hospitals	Antiviral prophylaxis protocol ready; accept-back criteria agreed with hospitals	Weekly outbreak status shared with regional hospitals
State and local public health officials	Publish declaration thresholds and the data behind them; name the circulating virus	Fund wastewater sites through the season; target vaccination messaging at teens and young adults	Weekly public reporting that does not depend on federal data alone
Federal policymakers	Restore ACIP's ability to meet or designate an interim recommending process	Appropriate dedicated wastewater surveillance funding; stabilize state grants	Rebuild CDC's epidemiology and immunization staffing before the next season

The actions in Table 8 share a logic. They shift the decision point from the peak, when every option is expensive, to the opening weeks, when most are cheap. New York's declaration, whatever one thinks of its timing, did exactly that: it forced thousands of health care workers to choose between a vaccine and a mask in October rather than December. The rest of the country faces the same choice, with only a few weeks to decide.

13. Methods and Source Quality

This report was researched on October 29, 2026, drawing on four parallel research streams: the current status of the 2026-27 season and the viruses in circulation; the 2025-26 season as a retrospective and historical context; the condition of the public health system and vaccination policy; and hospital operational readiness together with the counter-case. Each stream was instructed to prefer primary sources, record exact figures with dates and URLs, flag what could not be verified, and note conflicts between sources. An initial framing of the season as driven by H3N2 subclade K was tested against CDC's Week 41 surveillance data and rejected; the report was reframed around the verified record.

Sources are weighted in three tiers. Primary surveillance and policy documents from CDC, the World Health Organization, state health departments, peer-reviewed journals, and federal appropriations summaries anchor every quantitative claim. Established news organizations and trade publications (Becker's, STAT, CIDRAP, Advisory Board, Fierce Healthcare) provide information on events, interviews, and figures they attribute to primary sources. Local news reports are used only for local observations and are identified as such. Industry-funded analyses, notably the Sanofi Flunomics cost figures, are labeled where used[91]. The Bloom laboratory serology on G155E is a preprint and is described as one throughout.

Several items could not be verified against a primary source and are presented with that caveat: New York's current-season case counts, which appear only in news reports citing the State dashboard and differ between reports[12,13]; Australia's predominant subtype for October 2026, because the Australian Respiratory Surveillance Report could not be retrieved; the formal outcome of the FDA advisory committee's March 12 vote, since only the pre-meeting briefing was available[52,53]; and CDC's end-of-season vaccine effectiveness estimates for 2025-26, which have not been published. The "six weeks early" figure is this report's calculation from New York's declaration dates and should be cited that way. FluView Week 42, covering the week ending October 24, is expected October 30 and will supersede the Week 41 figures used here.

When sources conflict, we report the conflict rather than resolve it. CDC counts three measles deaths in 2026; Pennsylvania counts five[79]. The 2024-25 burden figures used here are CDC's season summary values, which supersede earlier preliminary estimates[30]. The CDC workforce analysis contains an internal inconsistency between its departure total and its category breakdown; the total is used[66].

No part of this report constitutes medical advice. Patients and their clinicians make vaccination and treatment decisions.

References

1. New York State Department of Health. New York State Department of Health Announces the Launch of a Comprehensive Seasonal Respiratory Virus Dashboard; Commissioner declares influenza prevalent. Press release, October 26, 2026. https://www.health.ny.gov/press/releases/2026/2026-10-26_respiratory_virus_dashboard.htm

2. New York State Department of Health. New York State Department of Health Declares Flu Prevalent Across the State. Press release, December 2, 2025. https://www.health.ny.gov/press/releases/2025/2025-12-02_flu_prevalent.htm

3. New York State Department of Health. New York State Department of Health Declares Flu Is Prevalent Across the State. Press release, December 18, 2024. https://healthweb-back.health.ny.gov/press/releases/2024/2024-12-18_flu.htm

4. New York State Department of Health. New York State Department of Health Declares Flu Is Prevalent. Press release, December 6, 2023. https://healthweb-back.health.ny.gov/press/releases/2023/2023-12-06_flu.htm

5. WKBW. New York health officials declare flu widespread. December 28, 2016. https://www.wkbw.com/news/new-york-health-officials-declare-flu-widespread

6. Erie County Department of Health. Influenza Declared Prevalent in New York State (health advisory citing 10 NYCRR 2.59). December 2023. https://www3.erie.gov/health/sites/www3.erie.gov.health/files/2023-12/357fluprevalent.pdf

7. Centers for Disease Control and Prevention. Weekly US Influenza Surveillance Report: Key Updates for Week 41, ending October 17, 2026. FluView. https://www.cdc.gov/fluview/surveillance/2026-week-41.html

8. Centers for Disease Control and Prevention. Weekly US Influenza Surveillance Report: Key Updates for Week 40, ending October 10, 2026. FluView. https://www.cdc.gov/fluview/surveillance/2026-week-40.html

9. Centers for Disease Control and Prevention. Weekly US Influenza Surveillance Report: Key Updates for Week 39, ending October 3, 2026. FluView. https://www.cdc.gov/fluview/surveillance/2026-week-39.html

10. Centers for Disease Control and Prevention, Center for Forecasting and Outbreak Analytics. 2026-2027 Respiratory Disease Season Outlook. September 23, 2026. https://www.cdc.gov/cfa-qualitative-assessments/php/data-research/season-outlook26-27.html

11. Centers for Disease Control and Prevention. Respiratory Illnesses Data Channel. Data as of October 23, 2026. https://www.cdc.gov/respiratory-viruses/data/

12. Scott M. Flu cases surge 400% in New York. Democrat and Chronicle via Yahoo News, updated October 28, 2026. https://www.yahoo.com/news/us/articles/flu-cases-surge-400-york-173922814.html

13. CBS6 Albany. New York flu season arrives six weeks early as state tracks new strain. October 27, 2026. https://cbs6albany.com/news/wellness-watch/new-york-flu-season-arrives-six-weeks-early-as-state-tracks-new-strain

14. Spectrum News. New York State hospitals prepare for early flu season. October 28, 2026. https://spectrumlocalnews.com/nys/watertown/news/2026/10/28/new-york-state-hospitals-prepare-for-early-flu-season

15. Becker's Hospital Review. 6 notes on G155E, the mutation fueling an earlier flu season. October 26, 2026. https://www.beckershospitalreview.com/quality/public-health/6-notes-on-g155e-the-mutation-fueling-an-earlier-flu-season/

16. Northeastern University (Northeastern Global News). A mutated flu strain is driving an early season, Northeastern experts say. October 22, 2026. https://news.northeastern.edu/2026/10/22/mutated-flu-strain-flu-season/

17. NBC News / TODAY. Flu activity is ramping up early this year. Is a mutated H1N1 strain to blame? October 25, 2026. https://www.nbcboston.com/news/health/flu-season-early-mutated-h1n1-strain/4036894/

18. Advisory Board. Daily Briefing: flu update. October 12, 2026. https://www.advisory.com/daily-briefing/2026/10/12/flu-update

19. Becker's Hospital Review. Seattle Children's sees early flu surge as US activity climbs. October 5, 2026. https://www.beckershospitalreview.com/quality/public-health/seattle-childrens-sees-early-flu-surge-as-us-activity-climbs/

20. FOX 13 Seattle. It's already here: Western Washington's early flu season. October 15-16, 2026. https://www.fox13seattle.com/news/its-already-here-western-wa-early-flu

21. Medical Daily. Colorado flu hospitalizations reach 46 in a week (citing CDPHE). October 13, 2026. https://www.medicaldaily.com/colorado-flu-hospitalizations-46-week-october-2026-479857

22. Medical Daily. Colorado reports first child flu death of 2026-27 season. October 18, 2026. https://www.medicaldaily.com/colorado-first-child-flu-death-202627-season-480085

23. KPEL. Louisiana flu rate doubles in 2025 (citing Louisiana Department of Health). October 13, 2026. https://kpel965.com/louisiana-flu-rate-double-2025/

24. Axios. Flu cases rise early; CDC urges shots. October 9, 2026. https://www.axios.com/2026/10/09/flu-cases-rise-shot

25. Centers for Disease Control and Prevention. Weekly US Influenza Surveillance Report: Key Updates for Week 20, ending May 23, 2026. FluView. https://www.cdc.gov/fluview/surveillance/2026-week-20.html

26. Centers for Disease Control and Prevention. Weekly US Influenza Surveillance Report: Key Updates for Week 17, ending May 2, 2026. FluView. https://www.cdc.gov/fluview/surveillance/2026-week-17.html

27. Centers for Disease Control and Prevention. Weekly US Influenza Surveillance Report: Key Updates for Week 52, ending December 27, 2025. FluView. https://www.cdc.gov/fluview/surveillance/2025-week-52.html

28. Budd A. Influenza season update. National Adult and Influenza Immunization Summit, May 19, 2026. https://www.izsummitpartners.org/wp-content/uploads/1b-1_Budd_V3.pdf

29. Centers for Disease Control and Prevention. Past Seasons Estimated Influenza Disease Burden. https://www.cdc.gov/flu/about/burden/past-seasons.html

30. Centers for Disease Control and Prevention. 2024-2025 Influenza Season Summary and Vaccination Impact. https://cdc.gov/flu-burden/php/data-vis-vac/2024-2025-prevented.html

31. Centers for Disease Control and Prevention. Estimated Influenza Illnesses, Medical Visits, Hospitalizations, and Deaths in the United States, 2017-2018 Influenza Season. https://archive.cdc.gov/www_cdc_gov/flu/about/burden/2017-2018.htm

32. New York State Department of Health. New York State Department of Health Confirms Highest Number of Flu Hospitalizations in a Week. Press release, January 2, 2026. https://www.health.ny.gov/press/releases/2026/2026-01-02_flu_hospitalizations.htm

33. New York State Department of Health. Press release on record weekly flu cases. December 26, 2025. https://healthweb-back.health.ny.gov/press/releases/2025/2025-12-26_flu_cases.htm

34. Becker's Hospital Review. Hospitals postpone elective surgeries as flu strains capacity. January 8, 2026. https://www.beckershospitalreview.com/care-coordination/hospitals-postpone-elective-surgeries-as-flu-strains-capacity/

35. WXXI News. Unprecedented: Western New York hospitals overwhelmed by influenza A outbreak. January 8, 2026. https://www.wxxinews.org/2026-01-08/unprecedented-western-new-york-hospitals-overwhelmed-by-influenza-a-outbreak

36. Advisory Board. Daily Briefing: flu update. January 13, 2026. https://www.advisory.com/daily-briefing/2026/01/13/flu-update

37. Maloney SM, et al. Interim Estimates of 2025-26 Seasonal Influenza Vaccine Effectiveness. MMWR Morb Mortal Wkly Rep. 2026;75(9). March 12, 2026. https://www.cdc.gov/mmwr/volumes/75/wr/mm7509a2.htm

38. Skowronski DM, et al. Interim influenza vaccine effectiveness against A(H3N2) subclade K, Canada, 2025/26. Euro Surveill. 2026;31(5). February 5, 2026. https://pmc.ncbi.nlm.nih.gov/articles/PMC12881843

39. UK Health Security Agency. Flu vaccine providing important protection despite new subclade. November 11, 2025. https://www.gov.uk/government/news/flu-vaccine-providing-important-protection-despite-new-subclade

40. Eurosurveillance. Volume 31, Issue 7 (pooled European interim influenza vaccine effectiveness, 2025/26). February 19, 2026. https://www.eurosurveillance.org/content/10.2807/1560-7917.ES.2026.31.7.2600109

41. STAT News. Flu season 2026: welcome to the winter of subclade K. January 6, 2026. https://www.statnews.com/2026/01/06/flu-season-2026-subclade-k-explained-by-influenza-experts/

42. CSIRO. Super K: what to know about the subclade K flu variant. January 22, 2026. https://www.csiro.au/en/news/all/articles/2026/january/super-k

43. Gavi, the Vaccine Alliance (VaccinesWork). Superflu or same old flu? How subclade K influenza is playing out worldwide. December 19, 2025. https://www.gavi.org/vaccineswork/superflu-or-same-old-flu-how-subclade-k-influenza-playing-out-worldwide

44. Gavi, the Vaccine Alliance (VaccinesWork). How bad will the upcoming flu season be? October 14, 2026. https://www.gavi.org/vaccineswork/how-bad-will-upcoming-flu-season-be

45. Centers for Disease Control and Prevention. The Flu Season (month of peak activity, 1982-83 through 2023-24). https://www.cdc.gov/flu/about/season/

46. Centers for Disease Control and Prevention. Update: Influenza Activity, United States and Worldwide, 2003-04 Season. MMWR. 2004;53(25). https://www.cdc.gov/mmWR/preview/mmwrhtml/mm5325a1.htm

47. Centers for Disease Control and Prevention. 2022-2023 Influenza Season Summary, Technical Report. https://www.cdc.gov/flu/whats-new/22-23-summary-technical-report.html

48. Centers for Disease Control and Prevention. 2025-2026 FluSight Evaluation Report. https://www.cdc.gov/flu-forecasting/evaluation/2025-2026-report.html

49. Immunization Coalition (Australia). Influenza Statistics, NNDSS data to 26 October 2026. https://immunisationcoalition.org.au/influenza-statistics/

50. ABC News (Australia). Flu season is peaking later than usual, and we don't exactly know why. September 25, 2026. https://www.abc.net.au/news/2026-09-25/flu-season-late-peak-what-is-going-on/107175858

51. AusDoc. Flu likely back to normal after last year's strange season, Aussie expert says. March 25, 2026. https://www.ausdoc.com.au/news/flu-likely-back-to-normal-after-last-years-strange-season-aussie-expert/

52. World Health Organization. Recommendations for influenza vaccine composition for the 2026-2027 northern hemisphere season. February 27, 2026. https://www.who.int/news/item/27-02-2026-recommendations-for-influenza-vaccine-composition-for-the-2026-2027-northern-hemisphere-season

53. Centers for Disease Control and Prevention. 2026-2027 Flu Season (vaccine composition and supply). Updated September 29, 2026. https://www.cdc.gov/flu/season/2026-2027.html

54. Centers for Disease Control and Prevention. Flu Vaccination Coverage, United States, 2025-26 Influenza Season. FluVaxView, October 8, 2026. https://www.cdc.gov/fluvaxview/coverage-by-season/2025-2026.html

55. Cardinal News. State health officials urge Virginians to get flu shots as some states show early surge of infections. October 19, 2026. https://cardinalnews.org/2026/10/19/state-health-officials-urge-virginians-to-get-flu-shots-as-some-states-show-early-surge-of-infections/

56. Centers for Disease Control and Prevention. Interim Clinical Considerations for the Use of Seasonal Influenza Vaccines, 2026-2027. September 1, 2026. https://www.cdc.gov/flu/hcp/vax-summary/seasonal-influenza-vaccines.html

57. Centers for Disease Control and Prevention. ACIP Meeting Information (2026 meetings listed as canceled). https://cdc.gov/acip/meetings/

58. NPR. Federal judge halts RFK Jr.'s changes to children's vaccine policies. March 16, 2026. https://www.npr.org/2026/03/16/nx-s1-5749530/judge-blocks-rfk-jr-vaccine-changes

59. Reuters (via Cyprus Mail). US appeals court weighs block on Kennedy's vaccine panel appointments. October 6, 2026. https://cyprus-mail.com/2026/10/06/us-appeals-court-weighs-block-on-kennedys-vaccine-panel-appointments

60. UPI. Doctors issue vaccine advice as CDC stays silent. September 2, 2026. https://www.upi.com/Top_News/US/2026/09/02/doctors-vaccine-advice-cdc/3641788370905/

61. American Academy of Pediatrics (HealthyChildren.org). AAP Flu Prevention and Treatment Recommendations for 2026-27. August 10, 2026. https://www.healthychildren.org/English/news/Pages/aap-(influenza)-flu-prevention-recommendations-for-2026-27.aspx

62. KFF. Recent Changes in Federal Vaccine Recommendations: What's the Impact on Insurance Coverage? December 16, 2025. https://www.kff.org/other-health/recent-changes-in-federal-vaccine-recommendations-whats-the-impact-on-insurance-coverage/

63. Immunize.org. IZ Express, Issue 1877 (AHIP commitment to cover ACIP-recommended immunizations through 2027). June 3, 2026. https://www.immunize.org/news/iz-express/issue/1877/

64. KFF. KFF Tracking Poll on Health Information and Trust: Fall 2026 Update on Vaccine Views. October 20, 2026. https://www.kff.org/public-opinion/kff-tracking-poll-on-health-information-and-trust-fall-2026-update-on-vaccine-views/

65. National Foundation for Infectious Diseases. 2026 National Survey on Respiratory Diseases. September 24, 2026. https://www.nfid.org/resource/2026-national-survey-on-respiratory-diseases/

66. CBS News Atlanta. CDC staffing drops 30% as layoffs, retirements and resignations reshape agency. October 2, 2026. https://www.cbsnews.com/atlanta/news/cdc-staffing-drops-30-as-layoffs-retirements-and-resignations-reshape-agency/

67. CBS News. Trump administration to shrink federal health agencies by 20,000 employees. March 27, 2025. https://www.cbsnews.com/news/job-cuts-federal-health-agencies-rfk-jr/

68. Healio. Senate confirms Schwartz as CDC director. August 5, 2026. https://www.healio.com/news/pediatrics/20260805/senate-confirms-schwartz-as-cdc-director

69. Associated Press (via TheGrio). New CDC director acknowledges exhausted staff at first meeting. August 20, 2026. https://thegrio.com/2026/08/20/erica-schwartz-cdc-director-first-staff-meeting/

70. ABC News. CDC's deputy director resigns after being hired in April. October 27, 2026. https://abcnews.com/Health/cdcs-chief-medical-officer-resigns-after-hired-april/story?id=137611532

71. WBUR / WFAE. CDC deputy director resigns as the agency faces mounting criticism. October 28, 2026. https://www.wfae.org/health/2026-10-28/cdc-deputy-director-resigns-as-the-agency-faces-mounting-criticism

72. Associated Press (via PBS NewsHour). Trump administration's deep cuts to public health leave system reeling. May 31, 2025. https://www.pbs.org/newshour/health/trump-administrations-deep-cuts-to-public-health-leave-system-reeling

73. CalMatters. California sues as Trump cuts $600M in public health grants to four states. February 12, 2026. https://calmatters.org/health/2026/02/600-million-public-health-trump-bonta-lawsuit/

74. ASTHO. Summary of FY26 Labor-HHS Appropriations Bill. January 2026. https://www.astho.org/advocacy/federal-government-affairs/leg-alerts/2026/summary-fy26-lhhs-bill-january-2026/

75. The Sick Times. Wastewater testing is vital for public health; it needs sustained funding to continue beyond fall 2026. June 30, 2026. https://thesicktimes.org/2026/06/30/wastewater-testing-is-vital-for-public-health-it-needs-sustained-funding-to-continue-beyond-fall-2026/

76. The Sick Times. National COVID-19 trends, October 20, 2026. https://thesicktimes.org/2026/10/20/national-covid-19-trends-october-20/

77. Contagion Live. Measles Update, October 23, 2026. https://www.contagionlive.com/view/measles-update-october-23-2026

78. CIDRAP. US exceeds 1,900 measles cases as outbreaks expand (2025 totals). December 2025. https://www.cidrap.umn.edu/measles/us-exceeds-1900-measles-cases-outbreaks-expand

79. Al Jazeera. Pennsylvania seeks CDC help amid dispute over US measles deaths. September 17, 2026. https://www.aljazeera.com/amp/news/2026/9/17/pennsylvania-seeks-cdc-help-amid-dispute-over-us-measles-deaths

80. CNN (via ABC17). Meeting to determine US measles elimination status pushed back to November. March 2, 2026. https://abc17news.com/cnn-health/2026/03/02/meeting-to-determine-us-measles-elimination-status-pushed-back-to-november/

81. CNBC. A 'canary in the coal mine': Measles resurgence exposes weaknesses in U.S. public health, experts say. October 27, 2026. https://www.cnbc.com/2026/10/27/us-measles-public-health.html

82. Leuchter RK, et al. National staffed hospital bed shortage and projected occupancy. JAMA Network Open. February 2025 (via Fierce Healthcare). https://www.fiercehealthcare.com/providers/national-hospital-occupancy-could-hit-dangerous-85-threshold-2032-researchers-warn

83. Becker's Hospital Review. ED boarding: patients often wait hours for an inpatient team, 7 study notes (Janke et al., JAMA, August 2026). August 17, 2026. https://www.beckershospitalreview.com/care-coordination/ed-boarding-patients-often-wait-hours-for-an-inpatient-team-7-study-notes/

84. Becker's Hospital Review. Hospitals have lost nearly 30% of pediatric units since 2008 (JAMA Pediatrics). January 21, 2025. https://www.beckershospitalreview.com/care-coordination/hospitals-have-lost-nearly-30-of-pediatric-units-since-2008/

85. Becker's Hospital Review. The cost of nurse turnover in 10 points, 2026 (NSI Nursing Solutions). April 22, 2026. https://www.beckershospitalreview.com/workforce/the-cost-of-nurse-turnover-in-10-points-2026/

86. Chartis. 2026 Rural Health State of the State. February 10, 2026. https://www.chartis.com/insights/2026-rural-health-state-state

87. Becker's Hospital Review. Hospital closures slow in 2026: a calm before the storm? September 30, 2026. https://www.beckershospitalreview.com/finance/hospital-closures-slow-in-2026-a-calm-before-the-storm/

88. Yale News. During the tripledemic, some hospitals overflowed while others had empty beds (JAMA Network Open). October 9, 2025. https://news.yale.edu/2025/10/09/during-tripledemic-some-hospitals-overflowed-while-others-had-empty-beds

89. Centers for Disease Control and Prevention. Influenza and COVID-19 vaccination coverage among nursing home residents and staff, 2024-25. MMWR. 2026;75(15). April 23, 2026. https://cdc.gov/mmwr/volumes/75/wr/mm7515a1.htm

90. Agency for Healthcare Research and Quality. HCUP Statistical Brief 253: Influenza-related hospitalizations and emergency department visits, 2006-2016. October 2019. https://hcup-us.ahrq.gov/reports/statbriefs/sb253-Influenza-Hospitalizations-ED-Visits-2006-2016.pdf

91. American Journal of Managed Care. Older adults drive hospitalizations, costs in the US 2024-2025 influenza season (Sanofi Flunomics). November 24, 2025. https://www.ajmc.com/view/older-adults-drive-hospitalizations-costs-in-the-us-2024-2025-influenza-season

92. Putri WCWS, Muscatello DJ, Stockwell MS, Newall AT. Economic burden of seasonal influenza in the United States. Vaccine. 2018;36(27):3960-3966 (as summarized in medRxiv preprint, December 2025). https://www.medrxiv.org/content/10.64898/2025.12.23.25342685.full.pdf

93. American Hospital Association. Massive Growth in Expenses and Rising Inflation Fuel Continued Financial Challenges for America's Hospitals and Health Systems. April 2022. https://www.aha.org/system/files/media/file/2022/04/2022-Hospital-Expenses-Increase-Report-Final-Final.pdf

94. CHEST Physician. Oseltamivir beats supportive care for patients hospitalized with seasonal influenza (Bai et al., JAMA Network Open, 2025). August 20, 2025. https://www.chestphysician.org/oseltamivir-beats-supportive-care-for-patients-hospitalized-with-seasonal-influenza/

95. CIDRAP. Analysis finds limited evidence for HCW flu vaccination (summary of CDC meta-analysis and Cochrane review). https://www.cidrap.umn.edu/influenza-vaccines/analysis-finds-limited-evidence-hcw-flu-vaccination

96. UC Berkeley School of Public Health. School flu vaccine program reduces community-wide influenza hospitalizations (PLOS Medicine). August 18, 2020. https://publichealth.berkeley.edu/news-media/research-highlights/school-flu-vaccine-program-reduces-community-wide-influenza-hospitalizations

97. Los Angeles County Department of Public Health. Respiratory Virus Season Health Officer Order. http://ph.lacounty.gov/acd/respvirusseasonhoo.htm

98. Denver7. A Colorado hospital brought back mask mandates as flu hospitalizations surged. January 30, 2026. https://www.denver7.com/lifestyle/health/a-colorado-hospital-brought-back-mask-mandates-as-flu-hospitalizations-surged-will-others-follow

99. Skilled Nursing News. CMS, states partner to launch $275M nursing home workforce initiative. October 23, 2026. https://skillednursingnews.com/2026/10/breaking-cms-states-partner-to-launch-275m-nursing-home-workforce-initiative/

100. CSL Seqirus. CSL Seqirus expands US availability of influenza vaccine following successful completion of the 2026/27 manufacturing campaign. PR Newswire, September 29, 2026. https://www.prnewswire.com/news-releases/csl-seqirus-expands-us-availability-of-influenza-vaccine-following-successful-completion-of-the-202627-manufacturing-campaign-302892920.html

101. U.S. Pharmacist. FDA approves first generic single-dose influenza treatment. May 19, 2026. https://www.uspharmacist.com/article/fda-approves-first-generic-singledose-influenza-treatment

102. Beth Israel Deaconess Medical Center. Influenza strain partially dodges existing immunity and current vaccine, BIDMC-led study finds (JAMA Research Letter, March 10, 2026). https://bidmc.org/news-stories/all-news-stories/news/2026/03/influenza-strain-partially-evades-immunity-vaccine-bidmc-study

103. Centers for Disease Control and Prevention. 2014-2015 Flu Season Wrap-Up (H3N2 seasons and older adults). https://archive.cdc.gov/www_cdc_gov/flu/spotlights/archived/2014-2015-flu-season-wrapup.htm

104. New York State Department of Health. Press release on COVID, influenza and seasonal immunizations (2025-26 toll: nearly 27,000 hospitalized, nearly 600 deaths). October 9, 2026. https://www.health.ny.gov/press/releases/2026/2026-10-09_covid_influenza_seasonal_immunizations.htm

105. CVS Health. CVS Pharmacy and MinuteClinic now offering updated flu vaccines nationwide (survey of vaccination intent). Press release, August 27, 2026. https://www.cvshealth.com/news/pharmacy/cvs-pharmacy-and-minuteclinic-now-offering-updated-flu-vaccines-nationwide.html

106. Centers for Disease Control and Prevention. Weekly US Influenza Surveillance Report: Key Updates for Week 2, ending January 10, 2026. FluView. https://cdc.gov/fluview/surveillance/2026-week-02.html

107. KFF. Tracking State Actions on Vaccine Policy and Access. Updated August 11, 2026. https://www.kff.org/state-health-policy-data/tracking-state-actions-on-vaccine-policy-and-access/

108. Fortune. The tripledemic is sickening kids across the U.S.; hospitals are getting creative with capacity. November 8, 2022. https://fortune.com/well/2022/11/08/tripledemic-sickening-kids-across-us-united-states-hospitals-get-creative-capacity-issues-pediatrics-covid-coronavirus-covid19-flu-rsv-ilis-influenza-capacity

109. Murray Pioneer. Record-breaking flu numbers as vaccination rates stall. November 9, 2025. https://www.murraypioneer.com.au/record-breaking-flu-numbers-as-vaccination-rates-stall/

110. ASTHO. Summary of FY27 Continuing Resolution. September 2, 2026. https://www.astho.org/advocacy/federal-government-affairs/leg-alerts/2026/summary-of-fy27-continuing-resolution/

111. Healthcare Dive. Flu season on track to be worst in a decade; California hospitals cancel surgeries and triage in tents. January 30, 2018. https://www.healthcaredive.com/news/flu-season-on-track-to-be-worst-in-a-decade/515825/