BC Centre for Disease Control
An agency of the Provincial Health Services Authority

British Columbia Influenza Surveillance Bulletin

Influenza Season 2014-15, Number 15, Week 3
January 18 to 24, 2015

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Passed Peak of A(H3N2) Epidemic but Activity Still Elevated in BC

In week 3 (January 18 to 24, 2015), most surveillance indicators show declining influenza-like illness activity in BC, suggesting that the epidemic peak has passed. However, activity remains elevated across most regions of the province. Influenza A(H3N2) remains the predominant circulating influenza virus, with co-circulation of respiratory syncytial virus (RSV).

The proportion of patients testing positive for influenza at the BC provincial laboratory has declined gradually since a peak of 44% in week 52 to 32% in week 3. Most influenza detections continue to be in elderly adults aged ≥65 years driven in part by a record number of influenza outbreaks reported from long-term care facilities (LTCFs). Since our last bulletin one week ago, 10 new confirmed influenza outbreaks have been reported from LTCFs, bringing the cumulative tally of facility outbreaks this season to 136, about 50% higher than the prior 2012-13 full season record (n=91).

On January 29, the Canadian Sentinel Physician Surveillance Network (SPSN) published interim estimates of vaccine effectiveness (VE) for the 2014/15 influenza vaccine. Consistent with substantial vaccine mismatch in circulating viruses, little to no protection was found against influenza A(H3N2), with a VE estimate of -8% (95% confidence interval: -50 to 23%). See: http://www.eurosurveillance.org/ViewArticle.aspx?ArticleId=21022.

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Report Disseminated: January 29, 2015

Provincial Health Services Authority
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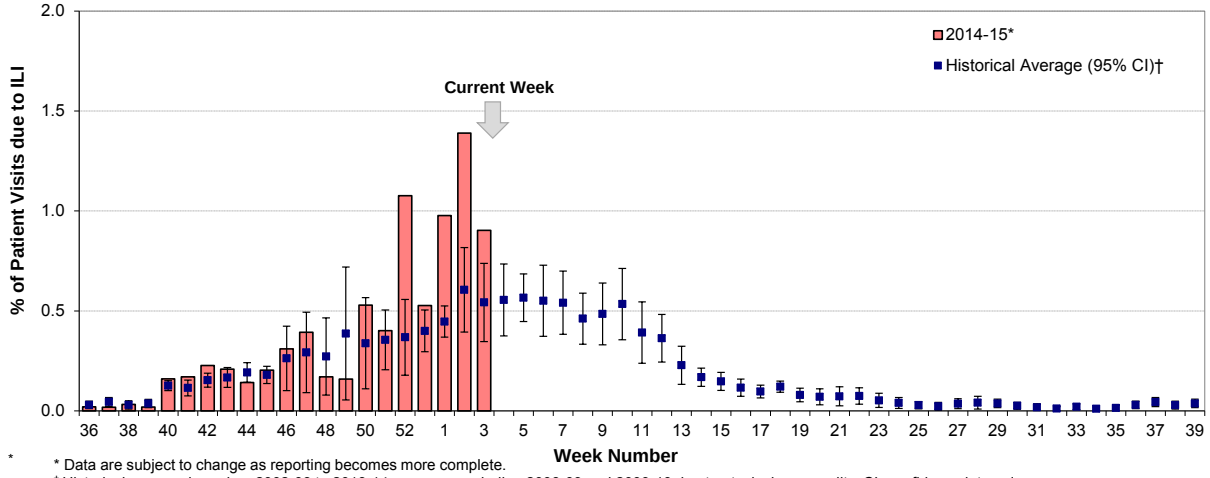
British Columbia

Sentinel Physicians

In week 3, the proportion of patients with influenza-like illness (ILI) among those presenting to sentinel physicians was 0.9%, significantly above the historical average for this time of year for the fifth consecutive week. So far in week 3, 58% of sentinel sites have reported data.

Percent of patient visits to sentinel physicians due to influenza-like illness (ILI) compared to historical average, British Columbia, 2014-15

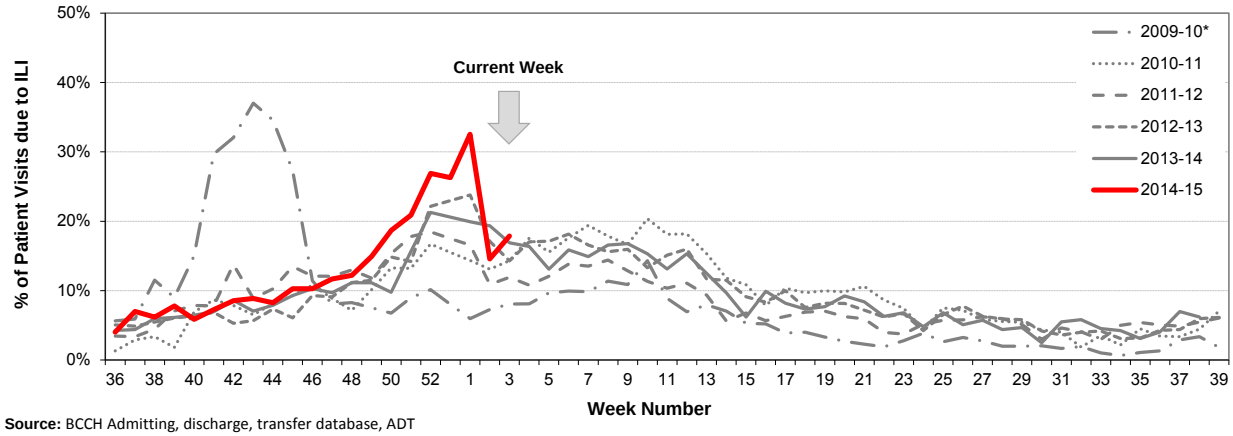


* Data are subject to change as reporting becomes more complete.
† Historical average based on 2002-03 to 2013-14 seasons, excluding 2008-09 and 2009-10 due to atypical seasonality; CI=confidence interval.

BC Children's Hospital Emergency Room

In week 3, the proportion of visits to BC Children's Hospital Emergency Room (ER) attributed to ILI increased slightly to 18% concurrent with increased respiratory syncytial virus (RSV) detection (see page 6) but remained consistent with the rates observed in previous seasons for this time of year, following a sharp decline from week 1 to week 2.

Percent of patients presenting to BC Children's Hospital ER with triage chief complaint of "flu," "influenza" or "fever/cough," British Columbia, 2014-15

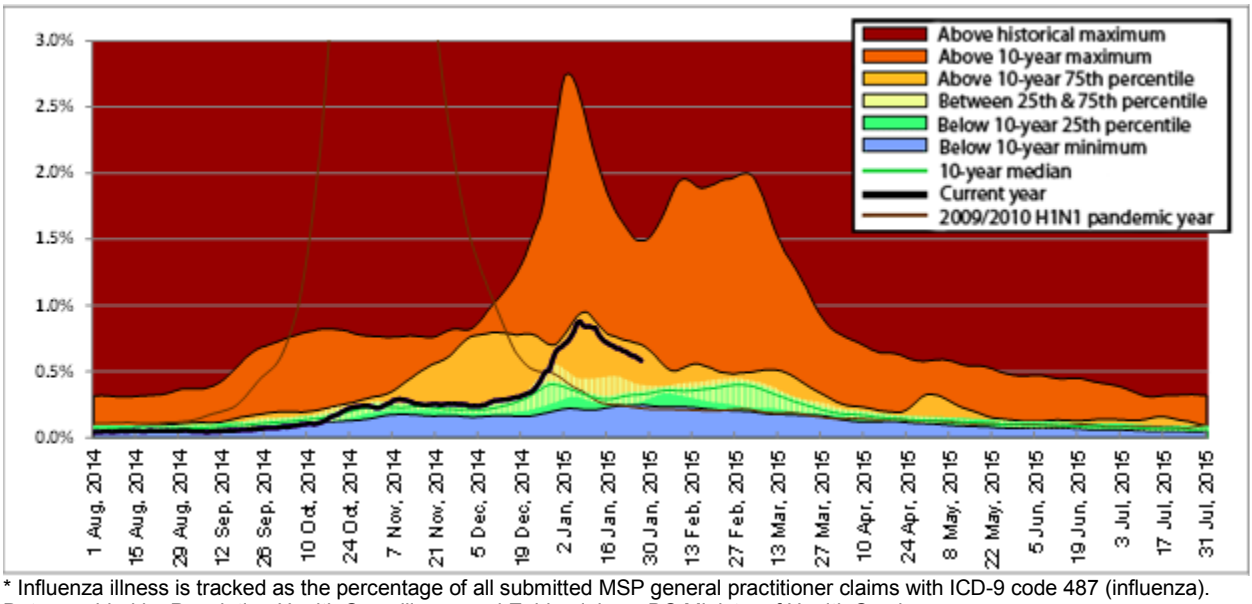


Source: BCCH Admitting, discharge, transfer database, ADT
* Data from 2010-11 to 2014-15 are based on new variable (Triage Chief Complaint) for capturing ILI symptoms and are not directly comparable to data for 2009-10. In week 9 of the 2011-12 season, the BCCH ER implemented a new data collection system, the National Ambulatory Care Reporting System (NACRS); data are not directly comparable to data collected using old system.

Medical Services Plan

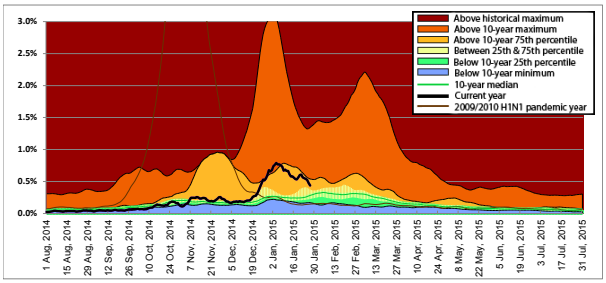
In week 3, BC Medical Services Plan (MSP) general practitioner claims for influenza illness (II), as a proportion of all submitted MSP claims, continued a gradual decline for the province overall and in most regional Health Authorities, with the exception of NHA where rates remained stable. In VIHA and NHA, rates were above 10-year maximums for this time of year, while in all other Health Authorities, rates were above 10-year 75th percentiles.

Service claims submitted to MSP for influenza illness (II)* as a proportion of all submitted general practitioner service claims, British Columbia, 2014-15

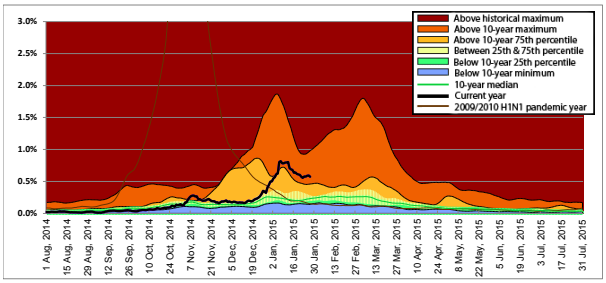


* Influenza illness is tracked as the percentage of all submitted MSP general practitioner claims with ICD-9 code 487 (influenza).
Data provided by Population Health Surveillance and Epidemiology, BC Ministry of Health Services.
Note: MSP week beginning 3 August 2014 corresponds to sentinel ILI week 32; data current to January 27, 2015.

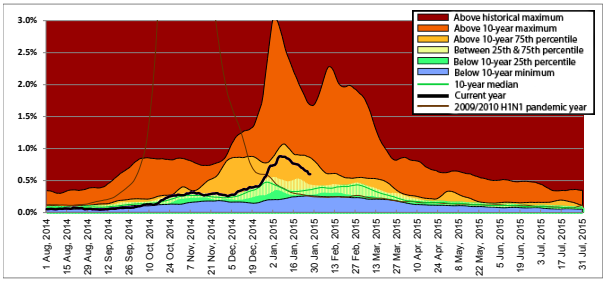
Interior



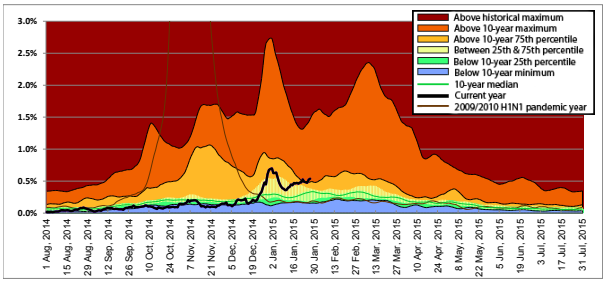
Vancouver Island



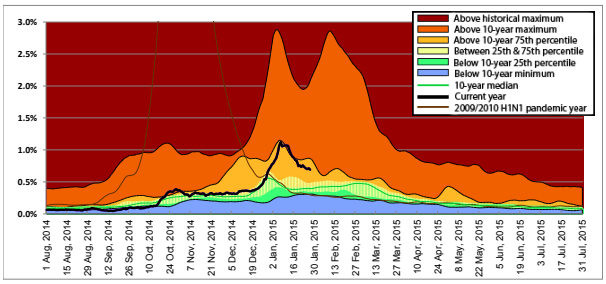
Fraser



Northern



Vancouver Coastal



Laboratory Reports

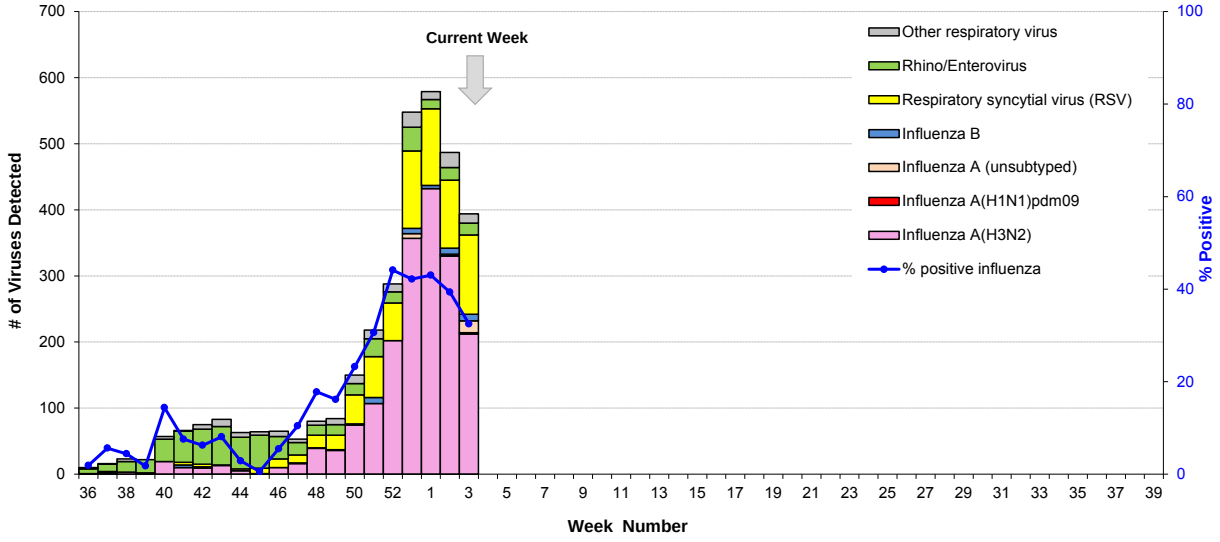
BC Public Health Microbiology & Reference Laboratory (PHMRL)

In week 3, the BC Public Health Microbiology & Reference Laboratory (PHMRL) tested 745 patients for respiratory viruses. Of these, 241 (32%) tested positive for influenza, including 231 (96%) influenza A [212 A(H3N2), 2 A(H1N1)pdm09, and 17 with subtype pending] and 10 (4%) influenza B. Influenza percent positivity continued a gradual decrease in week 3 concurrent with a decrease in test volumes. Influenza positivity peaked in week 52 at 44% but has remained above 30% since week 51. Respiratory syncytial virus (RSV) activity remained stable during this period and, after influenza, was the most commonly detected other respiratory virus.

Cumulatively, during the 2014-15 influenza season (since week 40, starting September 28, 2014), 1933 (31%) patients have tested positive for influenza at the BC PHMRL, including 1881 (97%) with influenza A, 51 (3%) with influenza B, and 1 (0%) with an influenza A(H1N1)pdm09 and influenza B co-infection. So far this season, A(H3N2) has been the dominant subtype in BC, with lesser co-circulation of influenza B and minimal detection of A(H1N1)pdm09.

The majority of influenza detections continue to be in elderly adults (≥65 years of age), driven in part by reports of influenza outbreaks in long-term care facilities (LTCFs).

Influenza and other virus detections among respiratory specimens submitted to BC Public Health Microbiology & Reference Laboratory, PHSA, 2014-15

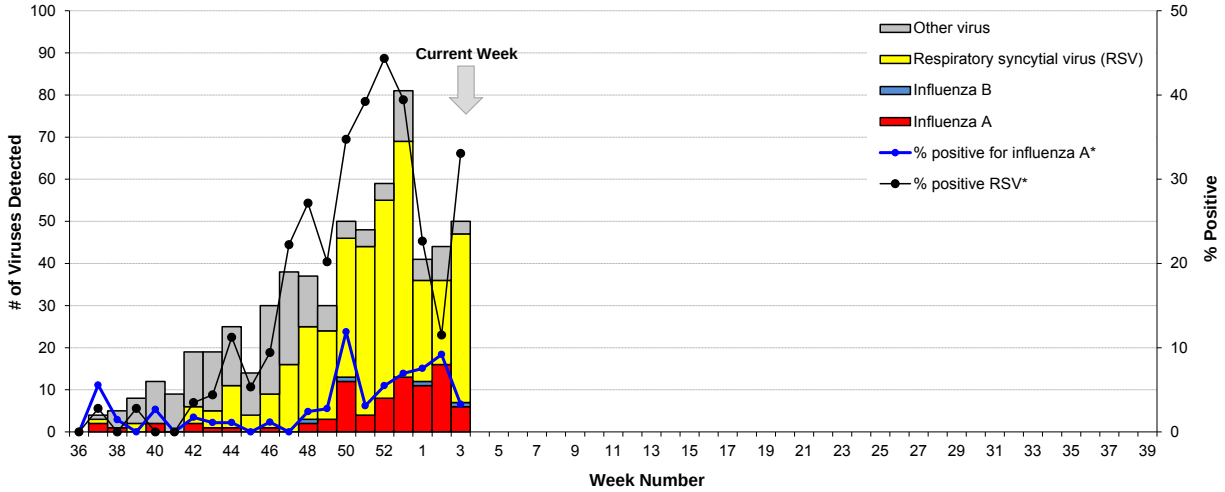


Note: Data current to January 27, 2015.

BC Children's and Women's Health Centre Laboratory

In week 3, the BC Children's and Women's Health Centre Laboratory conducted 183 tests for influenza A and 121 tests for influenza B. Of these, 6 (3%) were positive for influenza A and 1(1%) was positive for influenza B. The percent positive for influenza A decreased in week 3 after a steady increase from week 51 to week 2. The percent positive for RSV increased sharply from 12% in week 2 to 33% in week 3 after a sharp decline from week 52 to week 2. RSV remained the most commonly detected respiratory virus during this period.

Influenza and other virus detections among respiratory specimens submitted to BC Children's and Women's Health Centre Laboratory, 2014-15



* Positive rates were caculated using aggregate data. The denominators for each rate represent the total number of tests; multiple tests may be performed for a single specimen and/or patient.

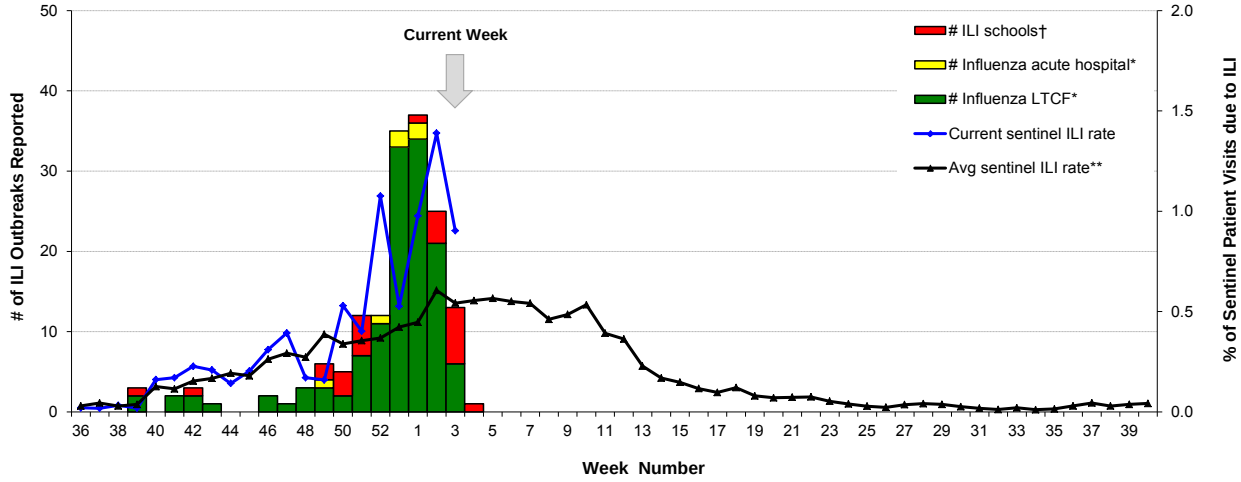
Influenza-like Illness (ILI) Outbreaks

Since our last bulletin, 10 new laboratory-confirmed influenza outbreaks in LTCFs were reported, including 1 due to influenza B and 9 due to influenza A, of which 3 with subtype information available were A(H3N2). Of the new LTCF outbreaks, one had symptom onset in week 53 in FHA, 3 had symptom onset in week 2 (1 IHA and 2 VIHA), and 6 had symptom onset in week 3 (2 FHA, 2 IHA, 1 VCHA, and 1 VIHA).

Cumulatively, since week 39 (starting September 21, 2014), 136 facility outbreaks due to laboratory-confirmed influenza have been reported, including 130 from LTCFs and 6 from acute care. All but five of these outbreaks were due to influenza A (all A(H3N2) where subtype information is available); three were due to influenza B and two were due to both influenza A and B detected in separate units.

The number of year-to-date facility outbreaks reported during the 2014-15 season is now more than double the same period (week 40 – week 3) during the last 2012-13 season of dominant, mismatched H3N2 activity (n=64), and has surpassed by almost half the total number of facility influenza outbreaks reported across the entire 2012-13 season (week 40 – week 17) (n=91), which had previously been the year of record facility outbreak reports, now supplanted by the 2014-15 season.

Number of influenza-like illness (ILI) outbreaks reported, compared to current sentinel ILI rate and historical average sentinel ILI rate, British Columbia, 2014-15



* Facility-based influenza outbreaks defined as 2 or more ILI cases within 7-day period, with at least one **laboratory-confirmed** case of influenza.
† School-based ILI outbreak defined as >10% absenteeism on any day, most likely due to ILI.
** Historical values exclude 2008-09 and 2009-10 seasons due to atypical seasonality.

Updated AMMI Guidelines: LTCF Outbreak Control

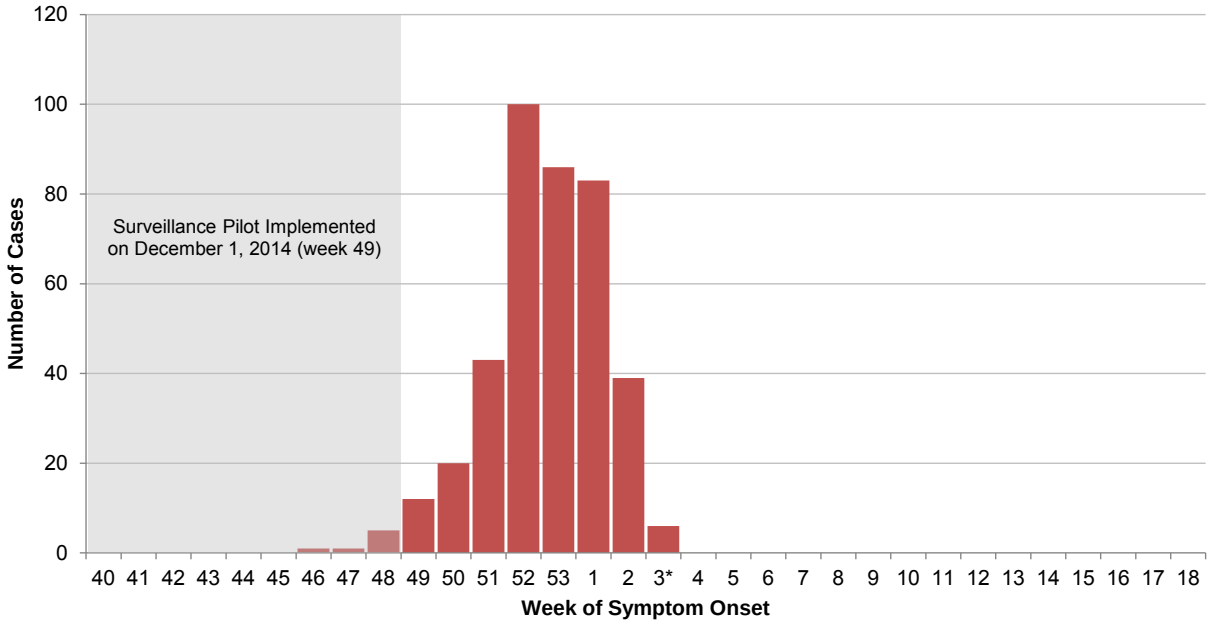
In the context of documented vaccine mismatch to circulating A(H3N2) viruses, all of which retain sensitivity to the neuraminidase inhibitor drugs, the Association of Medical Microbiology and Infectious Disease (AMMI) Canada has posted updated recommendations for antiviral use, notably in relation to LTCF outbreak control, available here: www.ammi.ca/guidelines.

Laboratory-confirmed Influenza Hospitalizations

On December 1, 2014, the BC Centre for Disease Control and the regional Health Authorities implemented an influenza severe outcome surveillance (SOS) pilot in BC for monitoring laboratory-confirmed influenza hospitalizations. An epidemic curve of hospitalized influenza cases by week of symptom onset is shown below, mirroring trends observed in other surveillance indicators. Of note, reporting delays should be taken into account in interpreting trends, particularly for the most recent weeks of the epidemic curve displayed.

The median age of cases is 80 years (range: <1 year to >100 years). Three-quarters of cases have been reported in elderly adults ≥65 years and about one-half reported in those ≥80 years. The majority (>80%) of cases have had one or more pre-existing comorbidities. Almost all cases have been due to influenza A, all A(H3N2) among those with subtype information available, with a minority due to influenza B.

Number of laboratory-confirmed influenza hospitalizations by week of symptom onset, British Columbia, 2014-15



* Based on partial week; data are subject to change as reporting becomes more complete. Includes influenza SOS case report forms received as of 3:00 PM PST on January 27, 2015.

Symptom onset date was imputed as hospital admission date minus two days where symptom onset was unknown.

Only severe cases of laboratory-confirmed influenza admitted to an intensive care unit (ICU) are reported in FHA; in all other Health Authorities, both hospitalizations and ICU admissions are reported.

National

FluWatch (week 2)

In week 2, influenza activity levels decreased slightly from the previous week with fewer regions reporting widespread activity. Many regions continue to report localized and sporadic influenza activity; however, widespread activity was reported from 17 regions in BC, AB, MB, ON, QC, and NF. Several indicators (number of laboratory detections, outbreaks and hospitalizations, and the ILI consultation rate) declined from the previous week, indicating that peak of the influenza season in Canada may have passed. The percent of tests positive for influenza increased slightly from 26% in week 1 to 30% in week 2 but remained below the peak of 36% in week 52. In week 2, 3,761 (30%) influenza viruses were detected, including 3,602 (96%) influenza A [1,455 A(H3N2) and 2,147 unsubtyped] and 159 (4%) influenza B. RSV was the second most frequently detected virus after influenza and since week 38 detections of RSV have been higher than in the previous season. Influenza A(H3N2) continues to be the most common subtype of influenza affecting Canadians. In both laboratory detections, hospitalizations and deaths, the majority of cases have been among seniors ≥65 years of age. To date, the NML has found that the majority of A(H3N2) influenza specimens are not optimally matched to the vaccine strain. This may result in reduced vaccine effectiveness against the A(H3N2) virus. Details are available at: www.phac-aspc.gc.ca/fluwatch/14-15/index-eng.php.

Interim Estimates of 2014/15 Influenza Vaccine Effectiveness: Canadian Sentinel Physician Surveillance Network

On January 29, the Canadian Sentinel Physician Surveillance Network (SPSN) published interim estimates of vaccine effectiveness (VE) for the 2014/15 influenza vaccine. Of the characterized viruses contributing to VE analysis, virtually all (99%) clustered with phylogenetic clades that are considered antigenically distinct from the vaccine strain. Consistent with this substantial vaccine mismatch in circulating viruses, little to no protection against the dominant circulating A(H3N2) viruses was found by the Canadian SPSN. VE against medically attended laboratory-confirmed A(H3N2) infection was estimated at -8%, with 95% confidence intervals (CIs) spanning -50% to 23%. When analyses were restricted to non-elderly adults 20-64 years old, VE was 2% (95% CI: −49 to 36%). Details are available at: www.eurosurveillance.org/ViewArticle.aspx?ArticleId=21022.

National Microbiology Laboratory (NML): Strain Characterization

From September 1, 2014 to January 29, 2015, the NML has antigenically characterized 132 influenza viruses [68 A(H3N2), 2 A(H1N1)pdm09, and 62 influenza B] and genetically characterized 474 influenza A(H3N2) viruses that were received from Canadian laboratories.

Influenza A(H3N2):

Of the 542 A(H3N2) viruses characterized so far this season by the NML, 539 (99%) showed antigenic or genetic evidence of antigenic drift (i.e. vaccine mismatch).

Of the 68 A(H3N2) viruses antigenically characterized by haemagglutinin inhibition (HI) assay: 62 (91%) were similar to A/Switzerland/9715293/2013, the WHO-recommended A(H3N2) component for the 2015 Southern Hemisphere influenza vaccine; one (1%) was similar to A/Texas/50/2012, the WHO-recommended A(H3N2) component for the 2014-15 Northern Hemisphere influenza vaccine used this season; and 5 (7%) showed reduced titres to A/Texas/50/2012 but could not be further characterized in relation to A/Switzerland/9715293/2013 due to insufficient titres.

Genetic characterization was performed on 474 A(H3N2) viruses that did not grow to sufficient titres for antigenic characterization by HI assay. Of the 474 A(H3N2) viruses genetically characterized: 472 (~100%) belonged to a genetic group that typically shows reduced titres to A/Texas/50/2012 due to amino acid mutations at antigenic sites. The remaining two (<1%) viruses belonged to a genetic group that does not show reduced titres to A/Texas/50/2012.

Influenza A(H1N1)pdm09:

Of the 2 A(H1N1)pdm09 viruses characterized, both were antigenically similar to A/California/7/2009, the WHO-recommended A(H1N1)pdm09 component for the 2014-15 Northern Hemisphere influenza vaccine.

Influenza B:

Of the 62 influenza B viruses characterized, 56 (90%) viruses were antigenically similar to B/Massachusetts/2/2012 (Yamagata-lineage), the WHO-recommended influenza B vaccine component for the 2014-15 Northern Hemisphere influenza vaccine, three (5%) viruses showed reduced titres with antiserum produced against B/Massachusetts/2/2012, signalling antigenic drift from vaccine strain, and 3 (5%) were antigenically similar to B/Brisbane/60/2008 (Victoria-lineage), the WHO-recommended influenza B/Victoria vaccine component for the quadrivalent 2014-15 Northern Hemisphere influenza vaccine.

National Microbiology Laboratory (NML): Antiviral Resistance

From September 1, 2014 to January 29, 2015, the NML received influenza viruses from Canadian laboratories for drug susceptibility testing. Of the 606 influenza A viruses [604 A(H3N2) and 2 A(H1N1)pdm09] tested against amantadine, 603 A(H3N2) viruses and both A(H1N1)pdm09 viruses were resistant; one A(H3N2) virus was sensitive to amantadine. Of the 317 influenza viruses [274 A(H3N2), 2 A(H1N1)pdm09, and 41 influenza B] tested against oseltamivir, all were sensitive. Of the 313 influenza viruses [270 A(H3N2), 2 A(H1N1)pdm09, and 41 influenza B] tested against zanamivir, all were sensitive.

International

USA (week 1)

During week 1, influenza activity remained elevated in the United States. Of the 26,205 specimens tested, 5,104 (20%) were positive for influenza, including 4,800 (94%) influenza A [1,821 A(H3N2), 3 A(H1N1)pdm09, and 2,976 with subtyping not performed] and 304 (6%) influenza B. Of the 395 A(H3N2) influenza viruses collected since October 1, 2014, and characterized by HI assay, 141 (36%) were characterized as A/Texas/50/2012-like, the A(H3N2) component of the 2014-15 Northern Hemisphere influenza vaccine, and 254 (64%) either showed reduced titres with antiserum produced against A/Texas/50/2012 or belonged to a genetic group that typically shows reduced titres to A/Texas/50/2012. Among viruses that showed reduced titres with antiserum raised against A/Texas/50/2012, most were antigenically similar to A/Switzerland/9715293/2013, the A(H3N2) virus selected for the 2015 Southern Hemisphere influenza vaccine. The proportion of outpatient visits for ILI was 4.5%, above the national baseline of 2.0%, and the proportion of deaths attributed to pneumonia and influenza was above the epidemic threshold. Eleven influenza-associated paediatric deaths were reported. Details are available at: www.cdc.gov/flu/weekly/.

WHO (as of 26 January 2015)

Globally, influenza activity was high in the Northern Hemisphere with influenza A(H3N2) viruses predominating so far this season. Antigenic characterization of most recent A(H3N2) viruses thus far indicated differences from the A(H3N2) virus used in the influenza vaccines for the Northern Hemisphere 2014-2015. Based on tests to date, the influenza A(H3N2) viruses are expected to be sensitive to neuraminidase inhibitors. In North America, the influenza season was ongoing with still high levels of influenza activity in most countries. Influenza A(H3N2) virus predominated. The influenza activity might have peaked in the USA. In Europe, influenza activity was still on the rise with the highest activity observed in the north-western region. Influenza A(H3N2) predominated this season. In northern and western Africa, influenza activity seemed to have peaked with influenza B virus predominating, while Egypt reported mainly influenza A(H3N2) detections. In eastern Asia, influenza activity started to decrease with influenza A(H3N2) virus predominating. In central Asia, influenza activity remained low. In western Asia, Bahrain and the Islamic Republic of Iran reported mainly influenza A(H1N1)pdm09 activity. In tropical countries of the Americas, influenza activity was low in most countries of the Caribbean, Central America and in the tropical countries of South America. In the Southern Hemisphere, influenza activity remained at inter-seasonal levels. During week 53 and week 1 (December 28, 2014 to January 10, 2015), the Global Influenza Surveillance and Response System (GISRS) laboratories tested more than 133,812 specimens, of which 32,903 (25%) were positive for influenza viruses: 30,926 (94%) were typed as influenza A and 1,977 (6%) as influenza B. Of the sub-typed influenza A viruses, 453 (3%) were influenza A(H1N1)pdm09 and 12,678 (97%) were influenza A(H3N2). Of the characterized B viruses, 495 (98%) belonged to the B-Yamagata lineage and 10 (2%) to the B-Victoria lineage. Details are available at: www.who.int/influenza/surveillance_monitoring/updates/en/.

Emerging Respiratory Pathogens

Avian Influenza A(H7N9), Human Cases, British Columbia

On January 26, the BC Centre for Disease Control reported two cases of avian influenza A(H7N9) in a BC couple who had recently returned from travelling in China. One case was laboratory confirmed; the other case is probable pending confirmatory laboratory results from the National Microbiology Laboratory. Both cases developed acute respiratory symptoms and have recovered from their illness; neither individual was hospitalized. These are the first documented cases of human infection with A(H7N9) imported to North America. Since the emergence of this novel pathogen in February 2013, more than 500 human cases have been reported globally with at least 185 deaths (case fatality 37%). This tally includes 134 cases that occurred during the first wave spanning February to May 2013, 322 during last year's more substantial epidemic spanning October 2013 to September 2014, and more than 50 cases from October 2014 onwards that has not yet officially been declared a third wave by the World Health Organization. Given ongoing activity in the affected region, further cases are anticipated through the late winter and spring period, as observed each year since 2013, although it is not yet evident whether the very large number of cases seen last winter will be repeated in the coming months of 2015. Although multiple clusters of limited transmission among close contacts have been reported, there remains no evidence of sustained human-to-human transmission and the risk to Canadians remains low. Clinicians should remain vigilant for patients presenting with acute respiratory symptoms with recent travel or epidemiological links to affected areas. Details are available at: http://www.bccdc.ca/resourcematerials/newsandalerts/news/Government+of+Canada+and+British+Columbia+confirm+case+of+H7N9+avian+influenza+in+Canada.htm.

WHO Recommendations for Influenza Vaccines

WHO Recommendations for 2014-15 Northern Hemisphere Influenza Vaccine

On February 20, 2014, the WHO announced the recommended strain components for the 2014-15 Northern Hemisphere trivalent influenza vaccine (TIV):*

- an A/California/7/2009 (H1N1)pdm09-like virus;
- an A/Texas/50/2012 (H3N2)-like virus;
- a B/Massachusetts/2/2012-like (Yamagata-lineage) virus.

*These recommended strains are the same as those used for the 2013-14 Northern Hemisphere vaccine.

For further details: www.who.int/influenza/vaccines/virus/recommendations/2014_15_north/en/.

WHO Recommendations for 2015 Southern Hemisphere Influenza Vaccine

On September 25, 2014, the WHO announced the recommended strain components for the 2015 Southern Hemisphere trivalent influenza vaccine (TIV):

- an A/California/7/2009 (H1N1)pdm09-like virus;*
- an A/Switzerland/9715293/2013 (H3N2)-like virus;†
- a B/Phuket/3073/2013-like (Yamagata-lineage) virus.‡

*Recommended strain has been retained as the A(H1N1) component since the 2009 pandemic and has been included in the Southern Hemisphere vaccine since 2010 and in the Northern Hemisphere vaccine since 2010-11.

†A/South Australia/55/2014, A/Norway/466/2014, and A/Stockholm/6/2014 are A/Switzerland/9715293/2013-like viruses. Recommended strain is considered antigenically distinct from the A/Texas/50/2012-like virus recommended for the 2014-15 Northern Hemisphere vaccine and clusters within the emerging phylogenetic clade 3C.3a.

‡ Recommended strain is the same influenza B-Yamagata lineage as the B/Massachusetts/2/2012-like virus recommended for the 2014-15 Northern Hemisphere vaccine but represents a phylogenetic clade-level change from clade 2 to clade 3.

For further details: www.who.int/influenza/vaccines/virus/recommendations/2015_south/en/.

Additional Information

List of Acronyms:

ACF: Acute Care Facility
AI: Avian influenza
FHA: Fraser Health Authority
HBoV: Human bocavirus
HMPV: Human metapneumovirus
HSDA: Health Service Delivery Area
IHA: Interior Health Authority
ILI: Influenza-Like Illness
LTCF: Long-Term Care Facility
MSP: BC Medical Services Plan
NHA: Northern Health Authority
NML: National Microbiological Laboratory
A(H1N1)pdm09: Pandemic H1N1 influenza (2009)
RSV: Respiratory syncytial virus
VCHA: Vancouver Coastal Health Authority
VIHA: Vancouver Island Health Authority
WHO: World Health Organization

Current AMMI Canada Guidelines on the Use of Antiviral Drugs for Influenza:
www.ammi.ca/guidelines

Web Sites:

BCCDC Emerging Respiratory Pathogen Updates:
www.bccdc.ca/dis-cond/DiseaseStatsReports/EmergingRespiratoryVirusUpdates.htm

Influenza Web Sites

Canada – Flu Watch: www.phac-aspc.gc.ca/fluwatch/
Washington State Flu Updates: www.doh.wa.gov/Portals/1/Documents/5100/fluupdate.pdf
USA Weekly Surveillance Reports: www.cdc.gov/flu/weekly/
European Influenza Surveillance Scheme:
ecdc.europa.eu/EN/HEALTHTOPICS/SEASONAL_INFLUENZA/EPIDEMIOLOGICAL_DATA/Pages/Weekly_Influenza_Surveillance_Overview.aspx
WHO – Weekly Epidemiological Record: www.who.int/wer/en/
WHO Collaborating Centre for Reference and Research on Influenza (Australia):
www.influenzacentre.org/
Australian Influenza Report:
www.health.gov.au/internet/main/publishing.nsf/content/cda-surveil-ozflu-flucurr.htm
New Zealand Influenza Surveillance Reports: www.surv.esr.cri.nz/virology/influenza_weekly_update.php

Avian Influenza Web Sites

WHO – Influenza at the Human-Animal Interface: www.who.int/csr/disease/avian_influenza/en/
World Organization for Animal Health: www.oie.int/eng/en_index.htm

Contact Us:

Tel: (604) 707-2510
Fax: (604) 707-2516
Email: InfluenzaFieldEpi@bccdc.ca

Communicable Disease Prevention and Control Services (CDPACS)
BC Centre for Disease Control
655 West 12th Ave, Vancouver BC V5Z 4R4

Online: www.bccdc.ca/dis-cond/DiseaseStatsReports/influSurveillanceReports.htm

version: 26 Oct 2011

Influenza-Like Illness (ILI) Outbreak Summary Report Form

Please complete and email to ilioutbreak@bccdc.ca

Note: This form is for provincial surveillance purposes.
Please notify your local health unit per local guidelines/requirements.

ILI: Acute onset of respiratory illness with fever and cough and with one or more of the following: sore throat, arthralgia, myalgia, or prostration which *could* be due to influenza virus. In children under 5, gastrointestinal symptoms may also be present. In patients under 5 or 65 and older, fever may not be prominent.

Schools and work site outbreak: greater than 10% absenteeism on any day, most likely due to ILI.

Residential institutions (facilities) outbreak: two or more cases of ILI within a seven-day period.

A — Reporting Information

Health unit/medical health officer notified? ☐ *Yes* ☐ *No*

Person Reporting: _____ Title: _____

Contact Phone: _____ Email: _____

Health Authority: _____ HSDA: _____

Full Facility Name: _____

Is this report:

☐ First Notification *(complete section **B** below; Section **D** if available)*

☐ Update *(complete section **C** below; Section **D** if available)*

☐ Outbreak Over *(complete section **C** below; Section **D** if available)*

B — First Notification

Type of facility: ☐ LTCF ☐ Acute Care Hospital ☐ Senior's Residence

(if ward or wing, please specify name/number: _____)

☐ Workplace ☐ School (grades:) ☐ Other (_____)

Date of onset of first case of ILI (dd/mm/yyyy): DD/MMM/YYYY

Numbers to date	Residents/Students	Staff
Total		
With ILI		
Hospitalized		
Died		

C — Update AND Outbreak Declared Over

Date of onset for most recent case of ILI (dd/mm/yyyy): DD/MMM/YYYY

If over, date outbreak declared over (dd/mm/yyyy): DD/MMM/YYYY

Numbers to date	Residents/Students	Staff
Total		
With ILI		
Hospitalized		
Died		

D — Laboratory Information

Specimen(s) submitted? ☐ Yes (location: _____) ☐ No ☐ Don't know

If yes, organism identified? ☐ Yes (specify: _____) ☐ No ☐ Don't know

Communicable Disease Prevention & Control Services
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Fax: (604) 707-2516
ilioutbreak@bccdc.ca