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

British Columbia Influenza Surveillance Bulletin

Influenza Season 2014-15, Number 19, Weeks 9-10
March 1 to 14, 2015

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Low-level Influenza B Circulation in BC

In weeks 9-10 (March 1 to 14, 2015), increasing but still low-level influenza B activity was detected throughout the province. Surveillance indicators remain at expected seasonal levels.

At the BC provincial laboratory, influenza B positivity increased to 8% in week 9 and 11% in week 10. Although at low levels, influenza B now comprises the majority of influenza detections in the province, although A(H3N2) and respiratory syncytial virus continue to co-circulate also at low levels.

Since our last bulletin 2 weeks ago, 4 laboratory-confirmed influenza outbreaks were reported from long-term care facilities, 2 due to influenza A(H3N2) and 2 due to influenza B. The total number of facility outbreaks this season (n=168) now exceeds by more than 80% the prior full season record of dominant, mismatched A(H3N2) in 2012-13 (n=91).

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Report Disseminated: March 19, 2015

Provincial Health Services Authority
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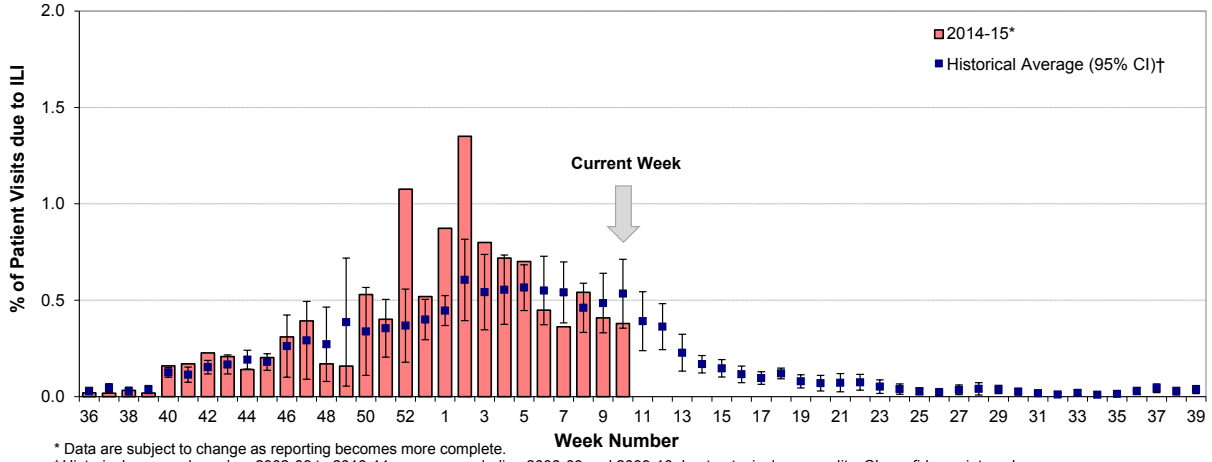
A research and teaching centre affiliated with UBC

British Columbia

Sentinel Physicians

In weeks 9-10, the proportion of patients with influenza-like illness (ILI) among those presenting to sentinel physicians was 0.4%, below historical averages but within expected ranges for this time of year. So far, 71% and 40% of sentinel sites have reported data for weeks 9 and 10, respectively.

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

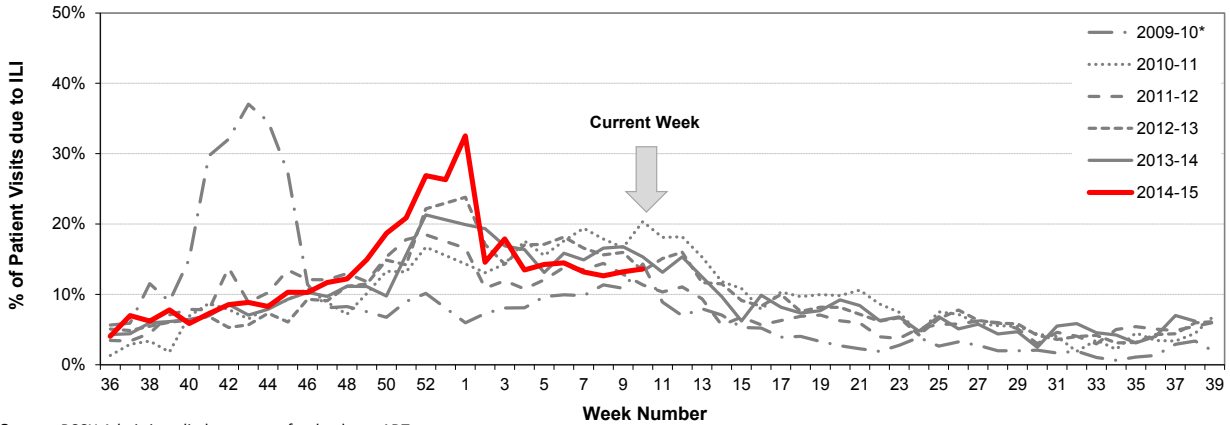


* Data are subject to change as reporting becomes more complete.
† Historical average based on 2002-03 to 2013-14 seasons, excluding 2008-09 and 2009-10 due to atypical seasonality; CI=confidence interval.

BC Children's Hospital Emergency Room

The proportion of visits to BC Children's Hospital Emergency Room (ER) attributed to ILI remained stable around 13-14% in weeks 9-10, consistent with rates observed in previous seasons for this time of year.

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

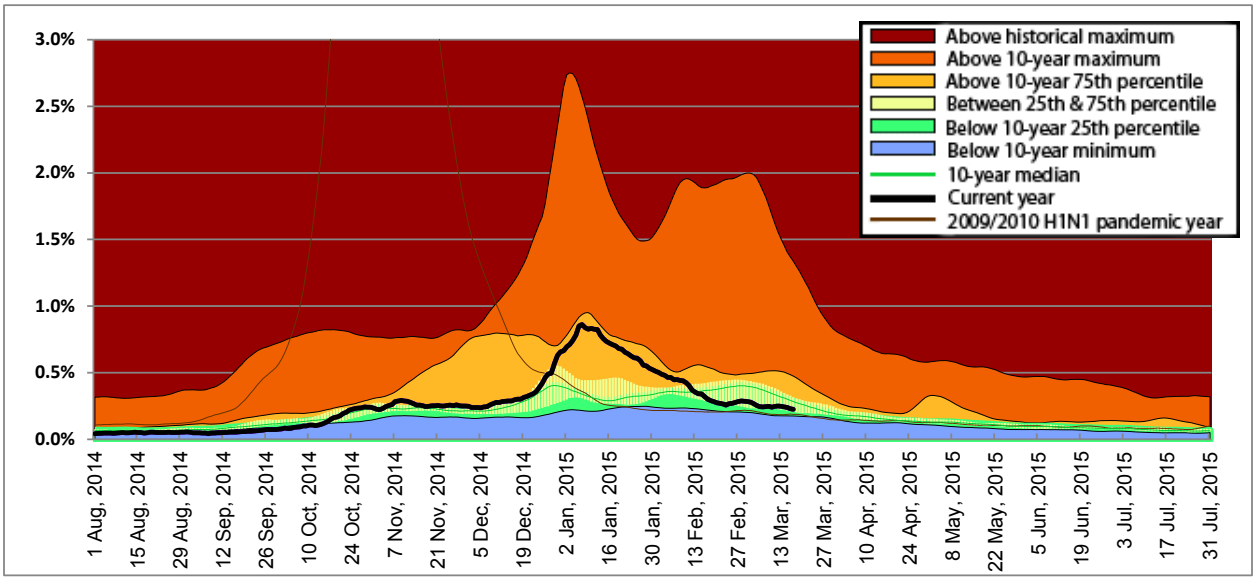


Source: BCCH Admitting, discharge, transfer database, ADT
* Data from 2010-11 to 2014-15 are based on new variable (Triage Chief Complaint) for capturing ILI symptoms and are not directly comparable to data for 2009-10. In week 9 of the 2011-12 season, the BCCH ER implemented a new data collection system,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

Medical Services Plan

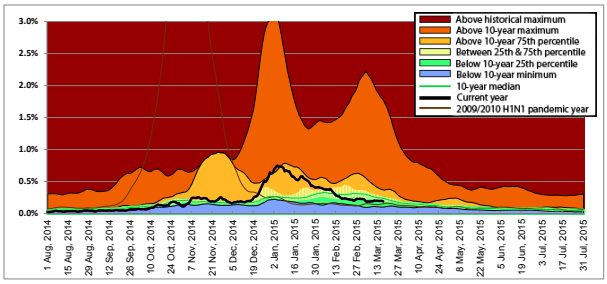
In weeks 9-10, BC Medical Services Plan (MSP) general practitioner claims for influenza illness (II), as a proportion of all submitted MSP claims, remained stable within expected historical ranges for the province overall and in all regional Health Authorities.

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

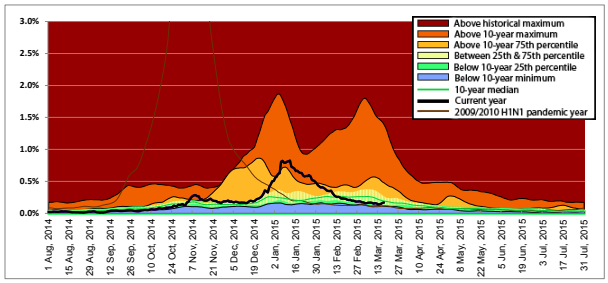


* Influenza illness is tracked as the percentage of all submitted MSP general practitioner claims with ICD-9 code 487 (influenza).
Data provided by Population Health Surveillance and Epidemiology, BC Ministry of Health Services.
Note: MSP week beginning 3 August 2014 corresponds to Sentinel ILI week 32; data current to March 17, 2015.

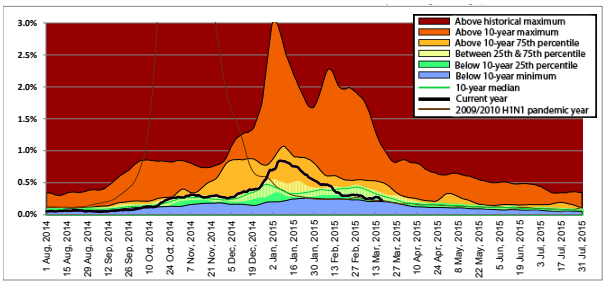
Interior



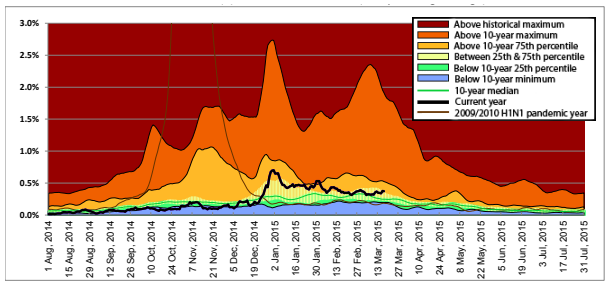
Vancouver Island



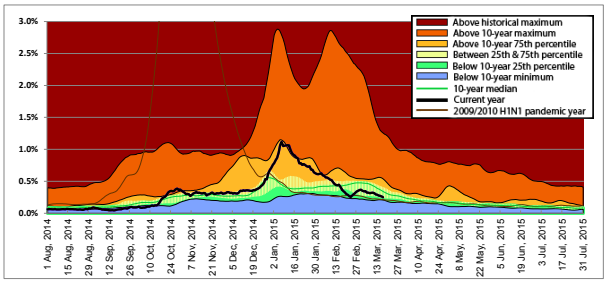
Fraser



Northern



Vancouver Coastal



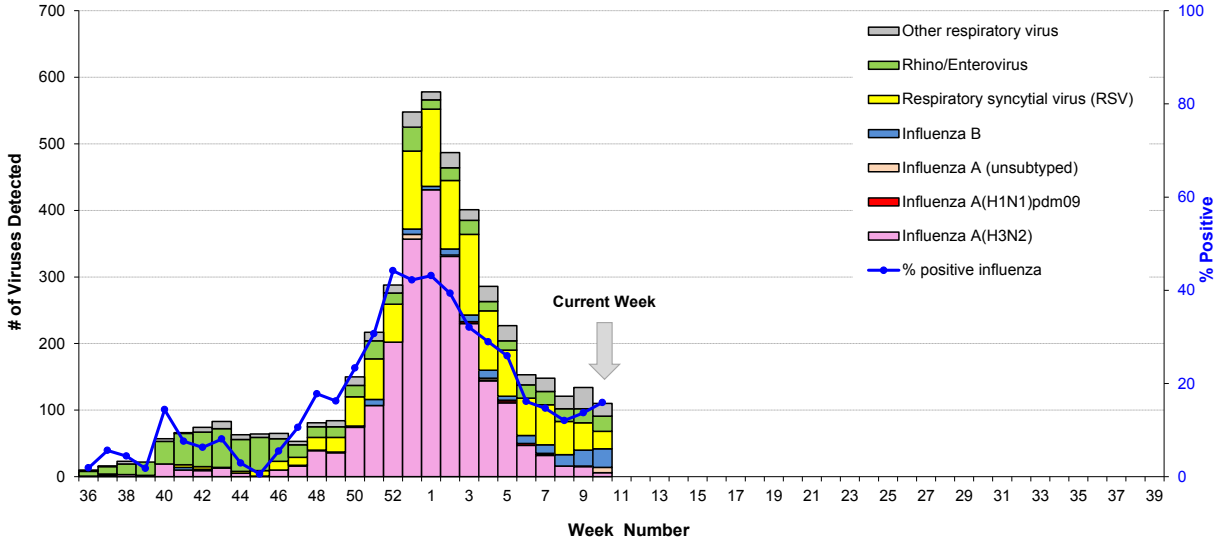
Laboratory Reports

BC Public Health Microbiology & Reference Laboratory (PHMRL)

In weeks 9-10, the BC Public Health Microbiology & Reference Laboratory (PHMRL) tested 553 patients for respiratory viruses. Of these, 82 (15%) tested positive for influenza, including 30 (37%) influenza A [21 A(H3N2), 1 A(H1N1)pdm09, and 8 with subtype pending] and 52 (63%) influenza B. Influenza positivity increased slightly from a low of 12% in week 8 to 14% in week 9 and to 16% in week 10. Influenza B has comprised an increasing proportion of influenza detections in recent weeks, although remains at low levels. In weeks 9 and 10, 8% and 11% of patients were positive for influenza B, respectively, compared to ~5% for influenza A. Respiratory syncytial virus (RSV) positivity declined during this period from 14% in week 9 to 10% in week 10.

Cumulatively, during the 2014-15 influenza season (since week 40, starting September 28, 2014), 2,433 (28%) patients have tested positive for influenza at the BC PHMRL, including 2,272 (93%) with influenza A [2,241 A(H3N2), 14 A(H1N1)pdm09, 2 A(H7N9), and 15 subtype pending] and 161 (7%) with influenza B.

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

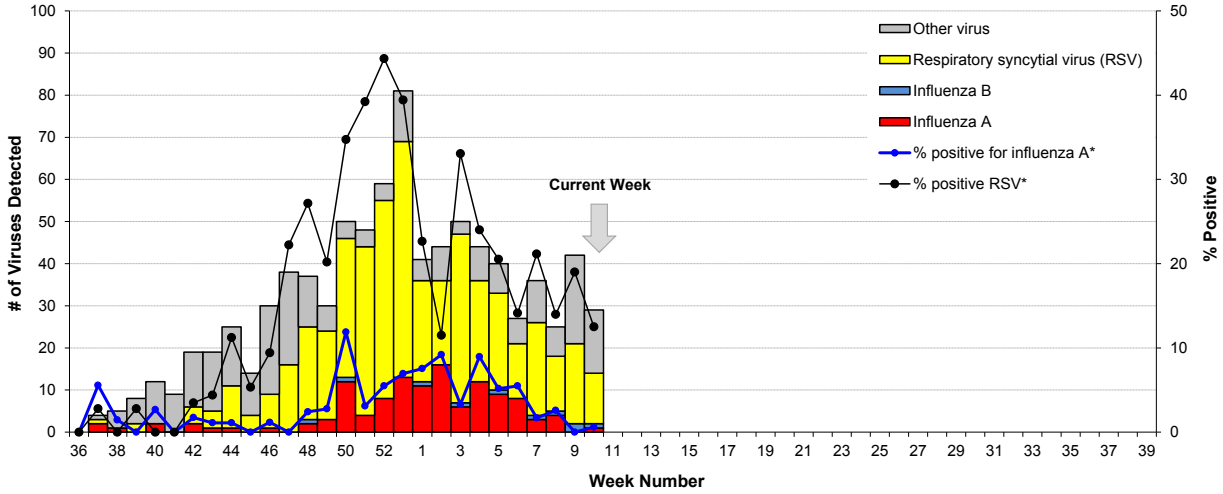


Note: Data current to March 18, 2015.

BC Children's and Women's Health Centre Laboratory

In weeks 9-10, the BC Children's and Women's Health Centre Laboratory conducted 328 tests for influenza A and 196 tests for influenza B. Of these, one (0.3%) was positive for influenza A and 3 (1.5%) were positive for influenza B. RSV continued to be 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.

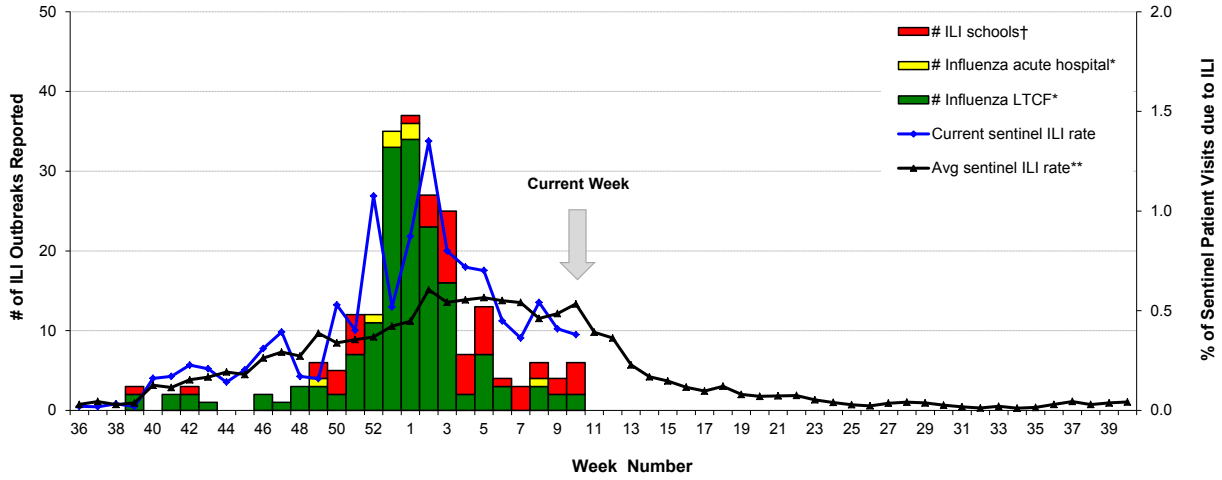
Influenza-like Illness (ILI) Outbreaks

Since our last bulletin issued 2 weeks ago, 4 new laboratory-confirmed influenza outbreaks were reported in long-term care facilities (LTCFs), including 2 due to influenza A(H3N2) and 2 due to influenza B. Of the influenza A(H3N2) outbreaks, one had onset in week 8 in IHA and one in week 9 in NHA. Both influenza B outbreaks had onset in week 10 (1 FHA and 1 VCHA). One new laboratory-confirmed influenza B outbreak in a school was also reported from NHA in week 10.

Cumulatively, since week 39 (starting September 21, 2014), 168 facility outbreaks due to laboratory-confirmed influenza have been reported, including 161 from LTCFs and 7 from acute care. All but 9 of these outbreaks were due to influenza A [all A(H3N2) where subtype information is available]; 9 were due to influenza B (4 of which had onset in weeks 8-10) or both influenza A and B. A total of 7 school outbreaks due to laboratory-confirmed influenza have also been reported so far this season, including 6 due to influenza A and 1 due to influenza B.

The number of year-to-date facility outbreaks reported during the 2014-15 season is about double the same period (week 40 – week 10) during the last 2012-13 season of dominant, mismatched H3N2 activity (n=85), and has surpassed by more than 80% 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



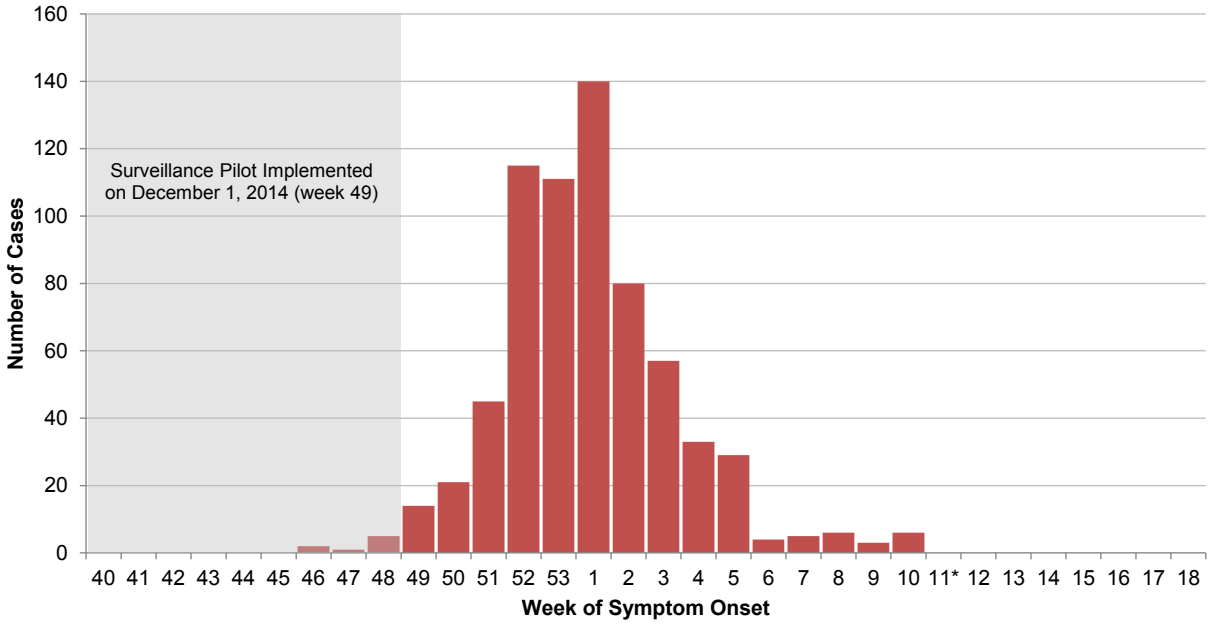
* Facility-based influenza outbreaks defined as 2 or more ILI cases within 7-day period, with at least one **laboratory-confirmed** case of influenza.
† School-based ILI outbreak defined as >10% absenteeism on any day, most likely due to ILI.
** Historical values exclude 2008-09 and 2009-10 seasons due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

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.

Elderly adults are disproportionately represented among influenza-related hospitalizations this season, as is typically observed during A(H3N2)-dominant seasons. The median age of cases is 79 years (range: <1 year to >100 years). While individuals ≥65 years of age comprise <20% of the BC population, they comprise >70% of influenza hospitalizations reported to date in BC. Similarly, while individuals ≥80 years old make up <5% of the BC population, they comprise about half of all influenza-related hospitalizations. The majority (>80%) of cases have had one or more pre-existing chronic comorbidities. Almost all cases have been due to influenza A, predominately 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 March 19, 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 9)

In week 9, all influenza indicators remained similar to or declined from the previous week. Elevated influenza activity was mostly reported in the Central and Atlantic provinces. Influenza B detections continue to increase steadily, particularly in the West, the Prairies and in Quebec. Influenza B is mainly affecting individuals less than 64 years of age. However, influenza A(H3N2) continues to be the most common influenza virus this season. Seniors continue to have the highest number of positive laboratory detections, hospitalizations and deaths. In week 9, 1,081 (9%) influenza viruses were detected, including 572 (53%) influenza A [122 A(H3N2), 6 A(H1N1)pdm09, and 444 un-subtyped] and 509 (47%) influenza B. Details are available at: www.phac-aspc.gc.ca/fluwatch/14-15/index-eng.php.

National Microbiology Laboratory (NML): Strain Characterization

From September 1, 2014 to March 19, 2015, the NML has antigenically characterized 373 influenza viruses [152 A(H3N2), 5 A(H1N1)pdm09, and 216 influenza B] and genetically characterized 913 influenza A(H3N2) viruses that were received from Canadian laboratories.

Influenza A(H3N2): Of the 1,065 A(H3N2) viruses characterized so far this season by the NML, 1,062 (~100%) showed antigenic or genetic evidence of antigenic drift (i.e. vaccine mismatch). Of the 152 A(H3N2) viruses antigenically characterized by haemagglutinin inhibition (HI) assay: 146 (96%) were similar to A/Switzerland/9715293/2013, the WHO-recommended A(H3N2) component for the 2015-16 Northern 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 (3%) 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 913 A(H3N2) viruses that did not grow to sufficient titres for antigenic characterization by HI assay. Of the 913 A(H3N2) viruses genetically characterized, 911 (~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 5 A(H1N1)pdm09 viruses characterized, all 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 216 influenza B viruses characterized, 207 (96%) 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; 3 (1%) viruses showed reduced titres with antiserum produced against B/Massachusetts/2/2012, signalling antigenic drift from the vaccine strain; and 6 (3%) 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 March 19, 2015, the NML received influenza viruses from Canadian laboratories for drug susceptibility testing. Of the 1,145 influenza A viruses [1,141 A(H3N2) and 4 A(H1N1)pdm09] tested against amantadine, all but one virus was resistant; one A(H3N2) virus was sensitive to amantadine. Of the 946 influenza viruses [773 A(H3N2), 4 A(H1N1)pdm09, and 169 B] tested against oseltamivir, all but one virus was sensitive; one A(H3N2) virus was resistant to oseltamivir. Of the 943 influenza viruses [770 A(H3N2), 4 A(H1N1)pdm09, and 169 B] tested against zanamivir, all were sensitive.

Interim Estimates of 2014/15 Influenza Vaccine Effectiveness, Canada

Canadian Sentinel Physician Surveillance Network (SPSN), Community-based

On January 29, the Canadian Sentinel Physician Surveillance Network (SPSN) published interim estimates of vaccine effectiveness (VE) against medically attended, laboratory-confirmed influenza infection 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.

Canadian Immunization Research Network (CIRN), Hospital-based

On February 5, the Serious Outcomes Surveillance Network of the Canadian Immunization Research Network (CIRN) published interim estimates of VE against influenza-associated hospitalizations for laboratory-confirmed influenza for the 2014/15 influenza vaccine. Influenza A(H3N2) was the predominant influenza virus detected among hospitalized cases, accounting for 99% of influenza A viruses with known subtype. Unmatched VE estimates adjusted for age and comorbidity were -17% (95% CI: -56 to 13%) overall and -22% (95% CI: -77 to 16%) for influenza A(H3N2). Among elderly adults ≥65 years old, adjusted VE estimates were -25% (95% CI: -74 to 10%) and -33 (95% CI: -104 to 13%), respectively. Among non-elderly adults <65 years old, VE estimates were 11% (95% CI: -66 to 52%) and 8% (95% CI: -102 to 58%), respectively. Details are available at: http://www.eurosurveillance.org/ViewArticle.aspx?ArticleId=21024.

Final End-of-season Estimates of 2013/14 Influenza Vaccine Effectiveness, Canada

Canadian Sentinel Physician Surveillance Network (SPSN)

On March 17, the Canadian Sentinel Physician Surveillance Network (SPSN) published final end-of-season estimates of vaccine effectiveness (VE) against medically attended, laboratory-confirmed influenza infection for the 2013/14 influenza vaccine. The 2013/14 influenza season in Canada was characterized by resurgent and dominant A(H1N1)pdm09 activity, followed by a late-season influenza B/Yamagata wave. Adjusted VE against antigenically well-conserved influenza A(H1N1)pdm09 viruses was 71% (95% CI: 58 to 80%). Two phylogenetic clades of influenza B/Yamagata viruses were detected: 83% clustered with the prior 2012-13 season's B/Wisconsin/01/2010-like (clade 3) vaccine strain, while 17% clustered with the current 2013-14 season's B/Massachusetts/02/2012-like (clade 2) vaccine strain. Adjusted VE against influenza B/Yamagata overall was 73% (95% CI: 56 to 83%), with lower VE found against clade-level mismatched B/Wisconsin/01/2010-like (clade 3) viruses. Details are available at: http://jid.oxfordjournals.org/content/early/2015/03/17/infdis.jiv177.abstract.

International

USA (week 9)

During week 9, influenza activity continued to decrease, but remained elevated in the United States. Of the 14,634 specimens tested, 1,670 (11%) were positive for influenza, including 800 (48%) influenza A [376 A(H3N2), 4 A(H1N1)pdm09, and 420 with subtyping not performed] and 870 (52%) influenza B. Of the 902 A(H3N2) influenza viruses collected since October 1, 2014, and characterized by HI assay, 238 (26%) were characterized as A/Texas/50/2012-like, the A(H3N2) component of the 2014-15 Northern Hemisphere influenza vaccine, and 664 (74%) 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 2015-16 Northern Hemisphere influenza vaccine. The proportion of outpatient visits for ILI was 2.4%, above the national baseline of 2.0%, and the proportion of deaths attributed to pneumonia and influenza was also above the epidemic threshold. Seven influenza-associated paediatric deaths were reported in week 9. Details are available at: www.cdc.gov/flu/weekly/.

Influenza B-associated rash, USA

On March 17, the US Centers for Disease Control and Prevention (US CDC) issued an alert in ProMED-mail (www.promedmail.org/direct.php?id=3238651), an online international infectious diseases reporting forum, regarding cases of laboratory-confirmed influenza (primarily influenza B virus infection) in measles-negative patients with morbilliform (i.e. maculopapular) rash from multiple states. Cases of morbilliform and other rash presentations due to influenza B were previously identified during school outbreaks of influenza-like illness in a rural BC community in the spring of 2014 and published in *Influenza and Other Respiratory Viruses* (available from: http://onlinelibrary.wiley.com/doi/10.1111/irv.12296/full). As always, clinicians with concerns about febrile rash illness may consult with their local health authority/Medical Health Officer.

WHO (as of March 9, 2015)

Globally, influenza activity remained high in the Northern Hemisphere with influenza A(H3N2) viruses predominating. Some countries in Africa, Asia and southern Europe reported increased influenza A(H1N1)pdm09 activity. In North America, the influenza activity remained elevated following the influenza peak. Influenza A(H3N2) remained the dominant virus detected this season. In Europe, the influenza season was at its height, particularly in central and western countries. Influenza A(H3N2) virus continued to predominate this season. In northern Africa and the Middle East, influenza activity was decreasing in most of the region. Influenza A was predominant in the region. In the temperate countries of Asia, influenza activity decreased from its peak in northern China and Mongolia, but continued to increase in the Republic of Korea. Influenza A(H3N2) virus predominated. In tropical countries of the Americas, influenza activity remained low in most countries. In tropical Asia, influenza activity continued to increase in India and Lao People's Democratic Republic. Influenza activity remained high in southern China, China Hong Kong Special Administrative Region, and the Islamic Republic of Iran. In the southern hemisphere, influenza activity continued at inter-seasonal levels. The WHO Global Influenza Surveillance and Response System (GISRS) laboratories tested more than 133,895 specimens. Of these, 34,056 (25%) were positive for influenza viruses: 25,455 (75%) were typed as influenza A and 8,601 (25%) as influenza B. Of the sub-typed seasonal influenza A viruses, 2,382 (21%) were influenza A(H1N1)pdm09 and 9,253 (79%) were influenza A(H3N2). Of the characterized B viruses, 1,656 (97%) belonged to the B-Yamagata lineage and 49 (3%) to the B-Victoria lineage. Details are available at: www.who.int/influenza/surveillance_monitoring/updates/en/.

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 2015-16 Northern Hemisphere Influenza Vaccine

On February 26, 2015, the WHO announced the recommended strain components for the 2015-16 Northern 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.§

* These recommended strains are the same as those that will be used for the 2015 Southern Hemisphere vaccine.

† Recommended strain has been retained as the A(H1N1) component since the 2009 pandemic and has been included 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_16_north/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

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