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Reporting of Influenza for the 2011-12 Season Update for Local Health Jurisdictions

This CDPH Update for Local Health Jurisdictions addresses new **Influenza Reporting requirements for the 2011-2012 Season**. CDPH would like to thank our local health jurisdiction partners for their continued high level of participation in influenza surveillance. The information you provide has helped CDPH in our efforts to identify circulating types and strains of influenza viruses and characterize the populations at greatest risk of complications from infection. Information gathered from surveillance has led to new prevention measures, education campaigns and strategies for vaccine and antiviral use that will help protect the health of the public.

A summary of surveillance findings from the 2010-11 influenza season will soon be available at: [http://www.cdph.ca.gov/HealthInfo/discond/Pages/Influenza\(Flu\).aspx](http://www.cdph.ca.gov/HealthInfo/discond/Pages/Influenza(Flu).aspx).

For questions regarding respiratory outbreaks and critically ill or fatal cases, please contact CDPH at email InfluenzaSurveillance@cdph.ca.gov or Meileen Acosta [(510) 620-3442; meileen.acosta@cdph.ca.gov] or Janice Louie [(510) 307-8657; janice.louie@cdph.ca.gov].

For questions regarding respiratory virus testing at the CDPH Viral and Rickettsial Diseases Laboratory (CDPH-VRDL), contact Hugo Guevara at hugo.guevara@cdph.ca.gov or 510 307-8565/ 510-248-9855 (cell).

A. Change in the California reportable disease list for medical providers (Section 2500) to include reporting of laboratory-confirmed influenza in fatal cases age 0-64 years

This August 2011, Section 2500 of the California Code of Regulations (Title 17) was amended to include mandatory reporting by medical providers of any laboratory-confirmed influenza-associated deaths in cases age 0-64 years. Reports should be sent to the local health jurisdiction of the case's residence; the local health jurisdiction will then send the reports to CDPH. The attached case report form should be used to report fatal cases to CDPH*.

Laboratory confirmation can include any positive test performed by any clinical, commercial or local public health laboratory (LPHL), including by positive rapid antigen test (as rapid antigen tests may yield a relatively high proportion of false positive results when influenza prevalence is low, it is recommended that a positive rapid antigen test result be followed up with confirmatory testing using one of the other indicated methods), direct fluorescence

assay, culture or polymerase chain reaction (PCR). Reported cases will be encouraged to have specimens sent for further sub-typing/characterization to the LPHL** or the CDPH-VRDL, which will enable CDPH to closely monitor the strains of influenza viruses that may be causing severe disease or novel pandemic viruses and the emergence of antiviral resistance.

B. Request for voluntary reporting of laboratory-confirmed influenza cases age 0-64 years requiring intensive care

Laboratory-confirmed influenza cases age 0-64 years who were hospitalized in the intensive care unit remain reportable on a voluntary basis*. CDPH requests continuation of this enhanced surveillance. This information will assist in monitoring and characterizing populations at highest risk for severe disease. The California Committee for the Protection of Human Subjects (CPHS) has reviewed this project and determined that it is not research, as defined in 45 Code of Federal Regulations, 46.102(d), but public health surveillance. It is therefore currently exempt from CPHS review (a copy of the CPHS letter is available upon request).

As above, laboratory confirmation can include any positive test performed by any clinical, commercial or local public health laboratory (LPHL), including by rapid antigen test, direct fluorescence assay, culture or polymerase chain reaction (PCR). As rapid antigen tests may yield a relatively high proportion of false positive results when influenza prevalence is low, it is recommended that a positive rapid antigen test result be followed up with confirmatory testing using one of the other indicated methods. Reported cases should have specimens sent for further sub-typing/characterization to the LPHL** or CDPH-VRDL, which will enable CDPH to closely monitor the strains of influenza viruses that may cause severe disease or novel pandemic viruses and the emergence of antiviral resistance.

C. Acute Respiratory Outbreaks (institutional, congregate and community settings)

CDPH requests preliminary reporting of any respiratory outbreaks in the following situations:

1. Outbreaks in institutions (e.g. long term care facility, prison, sleepover camp) with at least **two** cases of ILI with laboratory confirmation for influenza in the setting of a cluster (≥ 4 cases) of ILI within a three day period.
2. Outbreaks in institutions or congregate settings (e.g. schools, day camps) associated with hospitalizations or fatalities. If the setting is a hospice or long term care facility, the LHJ should use their judgement as to whether the number of hospitalizations and/or fatalities is above baseline for that institution or setting.
3. Outbreaks in the community assessed by the LHJ as having public health importance

For those LHJs who will be reporting in CalREDIE, you may enter any available information using the "Preliminary" outbreak form (located in the Electronic Filing Cabinet- EFC). Other LHJs should continue to use the paper form entitled "Preliminary Report of Communicable

Disease Outbreak Form” and either email CDOUTBREAK@cdph.ca.gov or fax a copy to (510) 620-5896

D. Respiratory Laboratory Network laboratories are advised to continue broadened surveillance testing for all influenza viruses, including subtyping

Reports of circulation of 2009 H1N1 influenza, seasonal influenza A/H3 and influenza B have been reported in the Southern Hemisphere this summer, with Australia reporting an unusually high number of cases. CDPH advises all Respiratory Laboratory Network (RLN) laboratories to continue broad testing, especially in severely ill and fatal cases. **We strongly encourage LPHLs to work with clinical laboratories in your jurisdiction to make them aware of the importance of saving specimens in critically ill cases. Weekly e-mail reminders or phone conversations can help ensure that these valuable specimens are saved before they are discarded, so that further subtyping can be performed at the LPHL.**

In addition, RLN laboratories should:

1. Report all results to CDPH on a weekly basis using the attached excel sheet entitled RLN PCR and R-mix Results 2011-2012 (Appendix B). Please include, if possible, estimates of what proportion of specimens you test are from outpatients, hospitalized cases, or ICU/fatal cases.
2. Refer to CDPH-VRDL available autopsy tissue/s of fatal cases for further testing and histopathologic analysis at CDC.
3. On a case-by-case basis, refer to CDPH-VRDL specimens for antiviral resistance testing (e.g., persistently positive PCR on treatment).

E. Testing performed at CDPH-VRDL

Testing at CDPH-VRDL for the 2011-2012 season will include continued monitoring of outpatient influenza-like illness visits from specimens submitted by sentinel providers and reference testing as requested by LPHLs. In addition, on a subset of specimens, CDPH-VRDL and CDC will perform surveillance testing for antiviral resistance and strain-typing.

1. In order to detect swine origin influenza viruses and possible reassortants it is important that RLN laboratories use a full subtyping panel (Inf A; H1; H3; pdm InfA and pdm H1) when attempting subtyping of influenza positive samples. At this time LPHLs using the CDPH-VRDL protocol in the Roche Light Cycler platform are unable to perform rRT-PCR testing for influenza A (2009 H1N1) and are advised to send any A/H3 (+) or unsubtypeable (H1,H3) specimens to the VRDL for further testing.
2. RLN laboratories should refer to the attached Influenza Reference Examination form (Appendix C) for instructions on submission of specimens for further characterization at CDPH-VRDL.

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3. Recommendations for submitting unusual specimens to CDPH-VRDL include:
 - Unsubtypeable results with crossing threshold (Ct) value for Flu A \leq 35.
 - Inconclusive results for influenza 2009 AH1N1 with Inf A Ct \leq 35.
 - Specimens showing Inf A (+) but negative subtyping results for either H1; H3 or 2009 AH1N1.
 - Specimens with results suggesting presence of more than one influenza virus (co-infections).
 - Specimens with results suggesting presence of swine origin A/H3 virus; Inf A (+), H3 (+); pdm A (+) and pdm H1 (neg).

4. Recommendations for submitting strain-typing specimens to CDPH-VRDL include:
 - Submit one each of the first or very early detections of influenza A/H1, A/H3, A/2009 H1N1 and influenza B. Please do not batch these early specimens; send those to us as they are identified.
 - Submit one each of influenza A/H1, A/H3, A/2009 H1N1 and influenza B collected during the high point of the season, and;
 - Submit one each of the last or late detections in the season of influenza A/H1, A/H3, A/2009 H1N1 and influenza B.
 - Submit original specimens and, if virus has been cultured, also submit cultured virus.

*The attached Severe Influenza Case History Form (ICU and Fatal Cases Age 0-64 Years) (Appendix A) should be used for reporting severely ill (those admitted to the ICU) and fatal influenza cases and faxed to (916) 440-5984. This form can also be downloaded from <http://www.cdph.ca.gov/pubsforms/forms/Pages/CD-Report-Forms.aspx>. **Clinicians should be reporting cases directly to their local health jurisdiction.** If clinical information is not available, CDPH requests that the minimal information requested in the top boxed section be filled out so that follow-up collection of data from hospital medical records units or coroners offices can be performed. Once received, CDPH will share this data with the reporting local health jurisdiction. **CDPH will not contact clinicians or infection control practitioners directly, unless first given permission from the local health jurisdiction.**

**** We strongly encourage LHJ Communicable Disease Groups and LPHLs to work with your partners- hospital clinicians and clinical laboratories- in your jurisdictions to make them aware of the importance of saving specimens in critically ill or fatal cases. Weekly e-mail reminders or phone conversations can help ensure that these valuable specimens are saved before they are discarded, so that further subtyping and characterization can be performed at the LPHL.**