



Influenza Surveillance Report – 2021-2022 Season – Week 52

Data from December 25 – January 01, 2022

Introduction

The purpose of this report is to provide ongoing description and assessment of the activity and types of circulating influenza viruses, and to assess morbidity, hospitalization and mortality related to influenza. It is meant to provide healthcare providers and facilities, public health professionals, policy makers, the media and the public with a general understanding of the severity and burden of the current flu season on a weekly basis in Nevada and nationwide. Data from several surveillance programs analyzed in this report is provisional and may change as additional information becomes available.

If you have questions or comments about this report, are interested in having your medical facility join the sentinel provider program or have any questions about your facility’s participation or reporting, please contact Max Wegener, MPH at mwegener@health.nv.gov.

Influenza activity: Due to the impact of COVID-19 on ILI surveillance, and the fact that reporting relies heavily on ILI activity, reporting will be suspended for the 2020-21 influenza season.

Table 1:

Week 52 Summary					
	ILI Current Activity	ILI Activity Baseline	Influenza -related Hospitalization	Influenza -related Mortality	Pneumonia and Influenza Mortality
Nevada	3.6%	1.3%	7 (0.23 per 100,000)	0/371 (0%)	71/371 (19.1%)
Region 9	4.1%	2.4%	pending	2/4,834 (0.04%)	644/4,834 (13.3%)
National	4.8%	2.5%	pending	74/36,650 (0.2%)	4,819/36,650 (13.2%)

*CDC data based on cause of death listed in vital records

Local Health Authority (LHA) reports

Weekly influenza reports from the three LHAs are available on the respective websites:

- Southern Nevada Health District: <https://www.southernnevadahealthdistrict.org/stats-reports/influenza-surveillance.php>
- Washoe County Health District: https://www.washoecounty.us/health/programs-and-services/communicable-diseases-and-epidemiology/statistics_surveillance_reports/influenza-surveillance/index.php
- Carson City Health & Human Services: Western NV Regional Influenza Report: <http://gethealthycarsoncity.org/seasonalflu/>

Sentinel Provider Program Description

The sentinel provider program is a partnership between clinicians, healthcare facilities, local health authorities (LHA), the Nevada Division of Public and Behavioral Health, and the Centers for Disease Control and Prevention (CDC). Sentinel providers voluntarily submit a weekly report to the CDC of the number of patients seen at their facility with influenza-like illness (ILI) by age group as well as the total number of patients seen for any reason.

An updated ILI definition will be implemented this season and is defined as fever ($\geq 100^{\circ}\text{F}$, 37.8°C) in the presence of cough and/or sore throat. This updated definition omits the previous criteria of *without a known cause other than influenza* to increase the number of other respiratory illnesses captured by surveillance.

Sentinel providers may also submit nasal, throat, and/or nasopharyngeal swabs for selected patients to the Nevada State Public Health Laboratory (NSPHL) for viral testing and subtyping at no cost to the patient or provider.

Sentinel Provider Influenza-Like Illness (ILI) Activity:

Figure 1 shows the percent of ILI patients by age group for week 52. Those aged 0-4 represented 30% of all reported ILI cases in Nevada. 22% of cases were ages 5-24, 31% ages 25-49, 9% ages 50-64, and 8% ages 65 and older.

In week 52, 9,605 patient visits were reported by sentinel providers in Nevada, of which 347 met criteria for ILI, representing 3.6% of the sample. ILI activity was above the Nevada baseline of 1.3%. **Figure 2** shows the percent of reported visits statewide for which the patient met clinical criteria for ILI. The current influenza season (2021 week 40 – 2022 week 20), in bold, is overlaid with the prior four seasons.

For week 51, 4.1% of patients reported in Region 9 (AZ, CA, HI, NV, and US Pacific Islands) and 4.8% of patients reported nationally met criteria for ILI. The regional activity level is higher than the regional baseline of 2.4% and the national activity level is higher than the national baseline of 2.6%.

Figure 3 displays a comparison of the percent of visits which met ILI criteria for Nevada, Region Nine, and nationally.

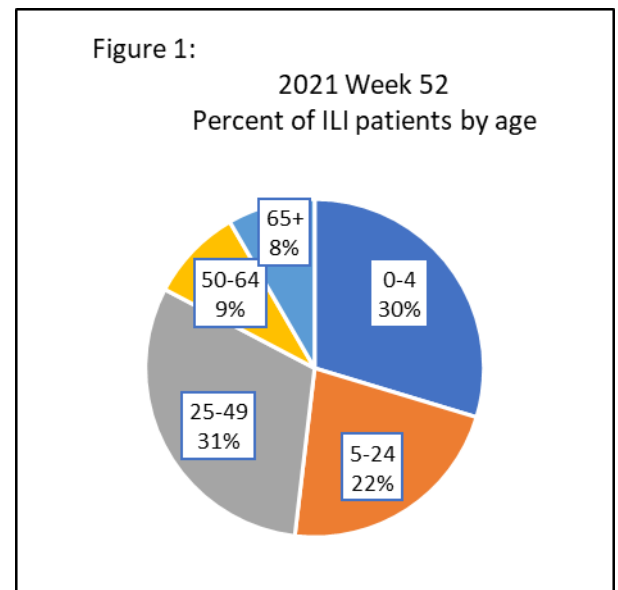


Figure 2:

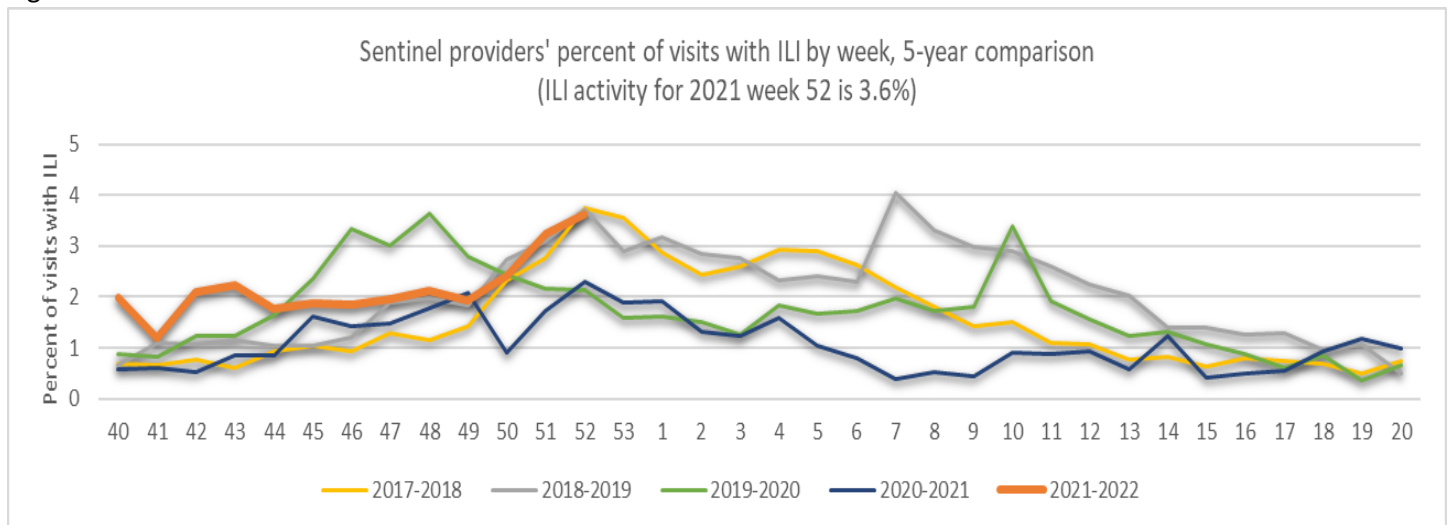
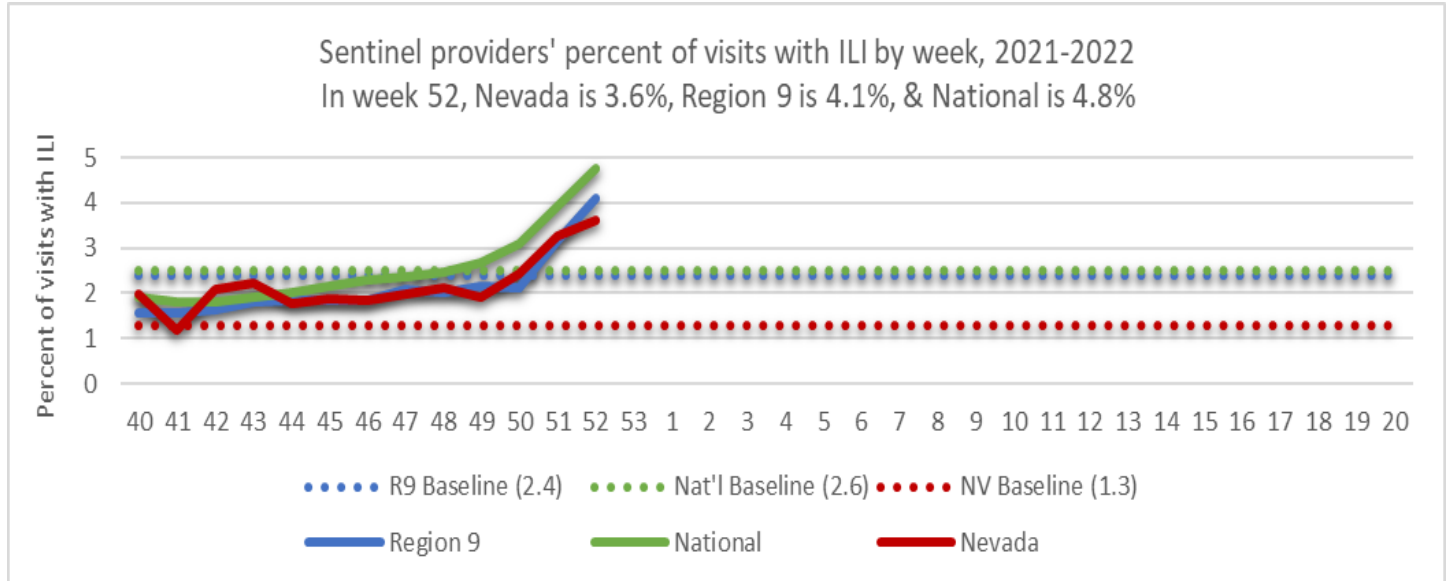


Figure 3:



Sentinel Providers Virologic Testing

The Nevada State Public Health Laboratory (NSPHL) and other laboratories provide influenza virus testing and subtyping for specimens submitted by sentinel providers. For week 52, 15 specimens were positive of 1,722 submitted (0.89%). From week 40 to date, 150 specimens were positive of 38,496 submitted (0.39%). **Figure 4** shows the number of laboratory-confirmed influenza cases by subtype expressed as a percentage of all laboratory-confirmed specimens tested. Of the 150 positive specimens to date, 5 are typed as influenza B (subtyping not performed) [3.3%], 107 are typed as influenza A (subtyping not performed) [71.3%], and 38 are typed as influenza A H3N2 [25.3%]. **Table 2** shows the number of sentinel site specimens tested by laboratory this season and the number and percent positive for influenza of any type.

Figure 4

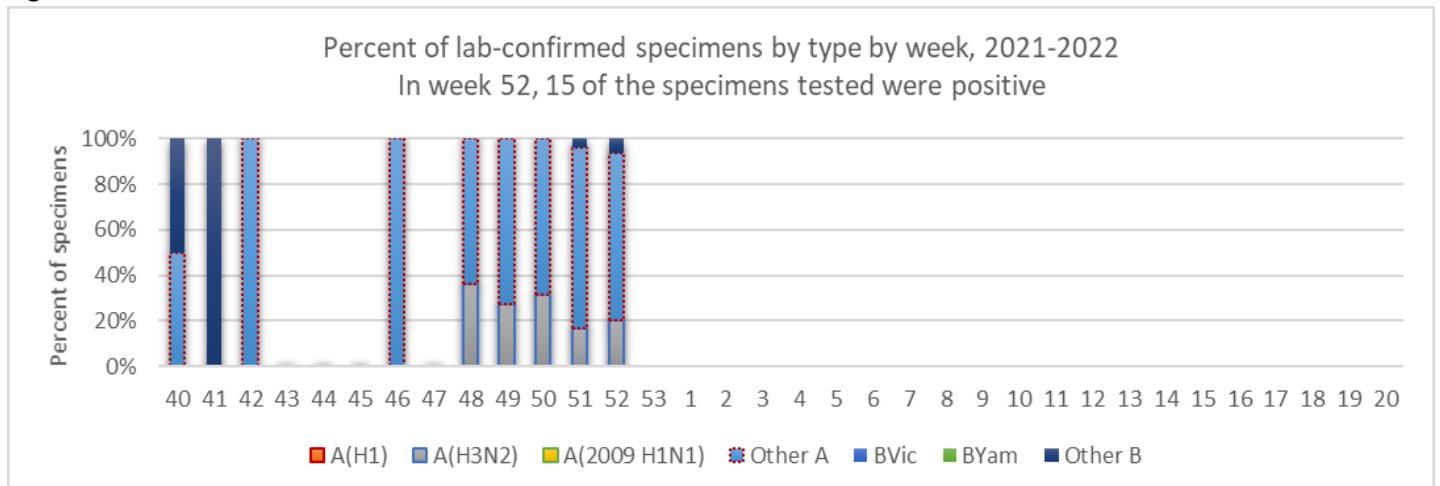


Table 2:

Lab	# of tests performed	# positive	% positive
Nevada State Public Health Lab (NSPHL)	38,324	147	0.38%
Southern Nevada Public Health Lab (SNPHL)	148	0	0%
All other labs	24	3	15.8%
Total	38,496	150	0.39%

Influenza Hospitalizations

LHAs investigate and report to DPBH Influenza-associated hospitalizations. **Figure 5** shows the number of patients hospitalized with influenza by jurisdiction. In week 52, the Southern Nevada Health District reported 2 hospitalizations, the Washoe County Health District reported 2 hospitalizations, and the Carson City Health and Human Services reported 3 hospitalizations. Rural Health Services reported no hospitalizations. From week 40 to date, 40 hospitalizations have been reported statewide. **Figure 6** shows the number of hospitalized patients by influenza type. **Table 3** shows the characteristics of those who have been hospitalized in the state as of week 52.

Figure 5

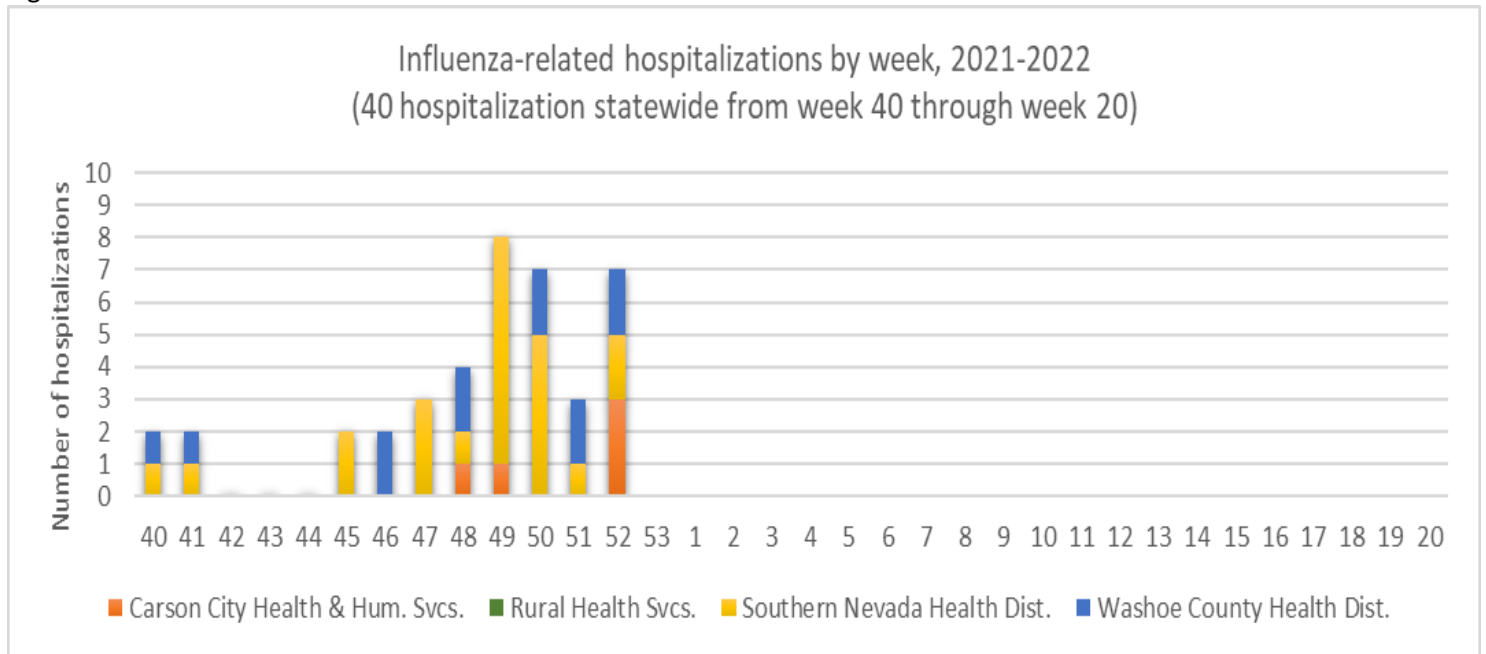


Figure 6:

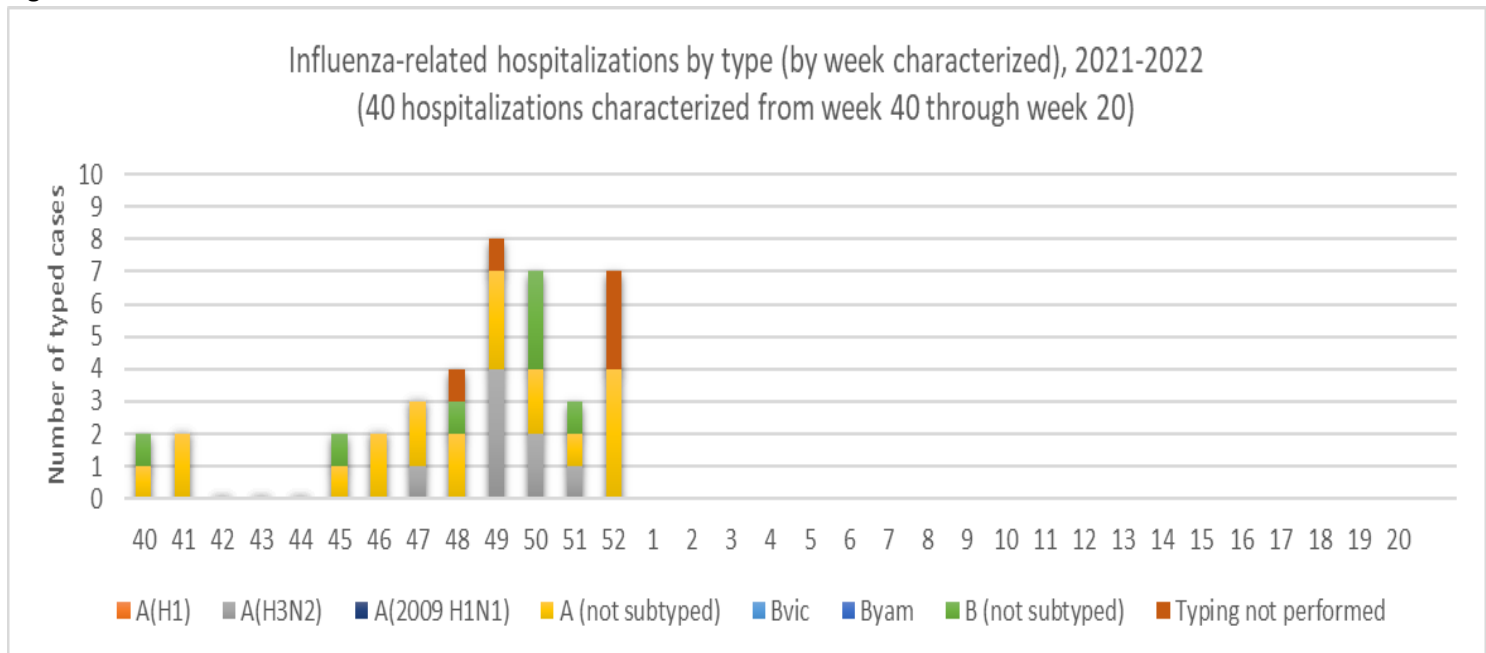


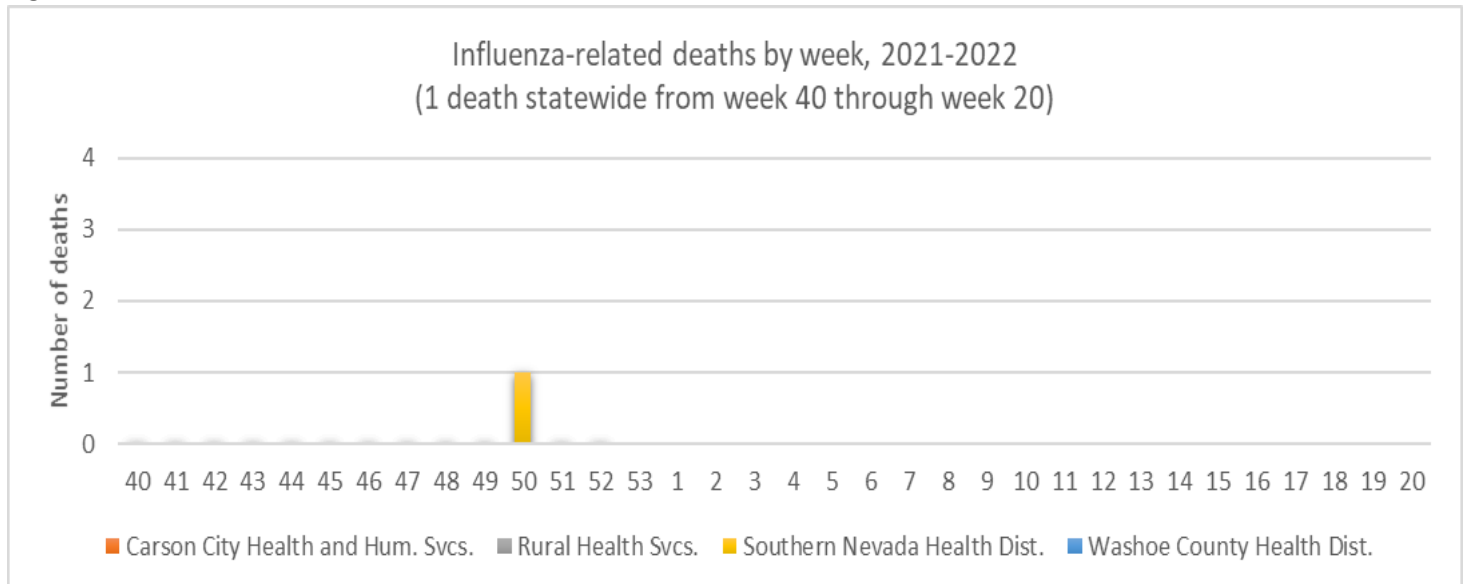
Table 3:

Characteristics of Hospitalized	N=40
Age-groups	
0-24	15.0%
25-54	30.0%
55+	55.0%
Hospitalized 24hrs or more	100.0%
Needing ventilator	5.0%
Flu vaccine prior	27.5%
Antiviral during	77.5%
Admitted to ICU	22.5%
Pregnant ¹	2.5%
LTC resident ²	0.0%
Underlying medical condition ³	70.0%
COVID Test Performed	92.5%
COVID positive	13.5%
1. Includes those 2 weeks postpartum 2. Includes all residential care facility types 3. Highest 3 in order: diabetes, chronic lung disease, and obesity	

Influenza Deaths

Influenza-associated deaths are deaths from a clinically compatible illness that was confirmed to be influenza by an appropriate laboratory or rapid diagnostic test with no period of complete recovery between illness and death. LHAs investigate all influenza deaths and typically review medical records retroactively up to 30 days from the date of death for an influenza diagnosis. **Figure 7** shows the number of influenza deaths by region for this flu season. No deaths were reported in week 52. One death has been reported this season.

Figure 7:



Syndromic Surveillance

Syndromic surveillance uses near real-time, pre-diagnostic health data to analyze disease incidence. It may support the identification and characterization of outbreaks as supplemental data or as an early indicator of a possible outbreak. DPBH uses the National Syndromic Surveillance Platform (NSSP) Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE), a CDC web application, to collect these data from hospitals and urgent care facilities within the state. Chief complaint is used for immediate analysis; discharge diagnosis is used as it becomes available.

Syndromic Surveillance ILI Activity

Figure 8 shows the number of visits with ILI for emergency, inpatient, and outpatient settings. While ILI syndrome is typically indicative of influenza activity, COVID-19 disease would typically meet criteria to be classified as ILI, so it is anticipated that ILI activity will continue to remain elevated while COVID-19 is circulating. For week 51 there were 817 emergency visits, 26 hospital admissions, and 286 outpatient visits reported. **Figure 9** shows the number of emergency visits with ILI by week over five years; **figure 10** shows the number of inpatient visits with ILI by week over five years. **Figure 11** shows the percent of all visits with ILI by age group. For week 52, 18.6% of visits were for ages 0-4, 21.8% for ages 5-24, 38.4% for ages 25-49, 13.4% for ages 50-64, and 7.8% for ages 65 and up.

Figure 8:

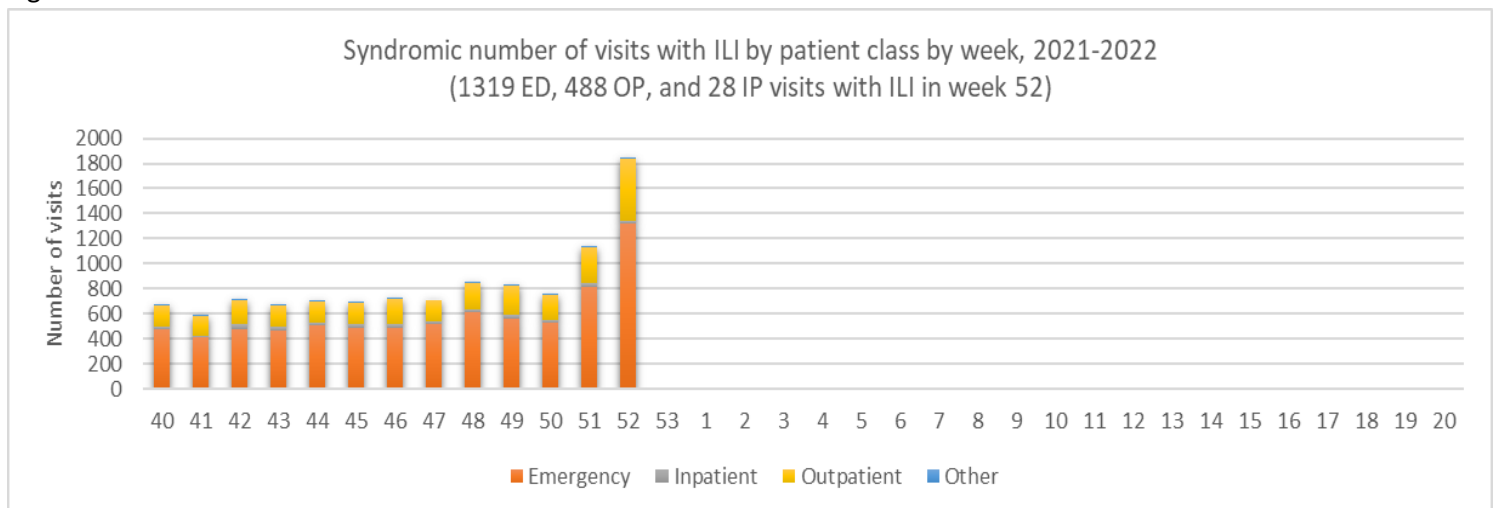


Figure 9:

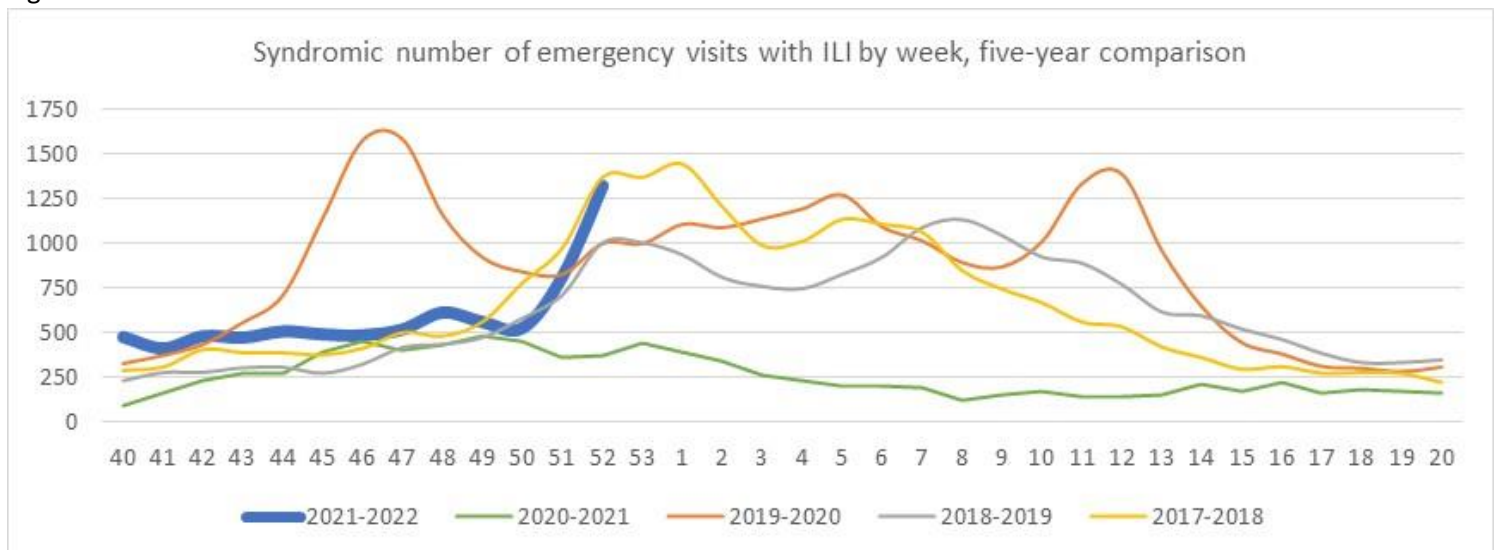


Figure 10:

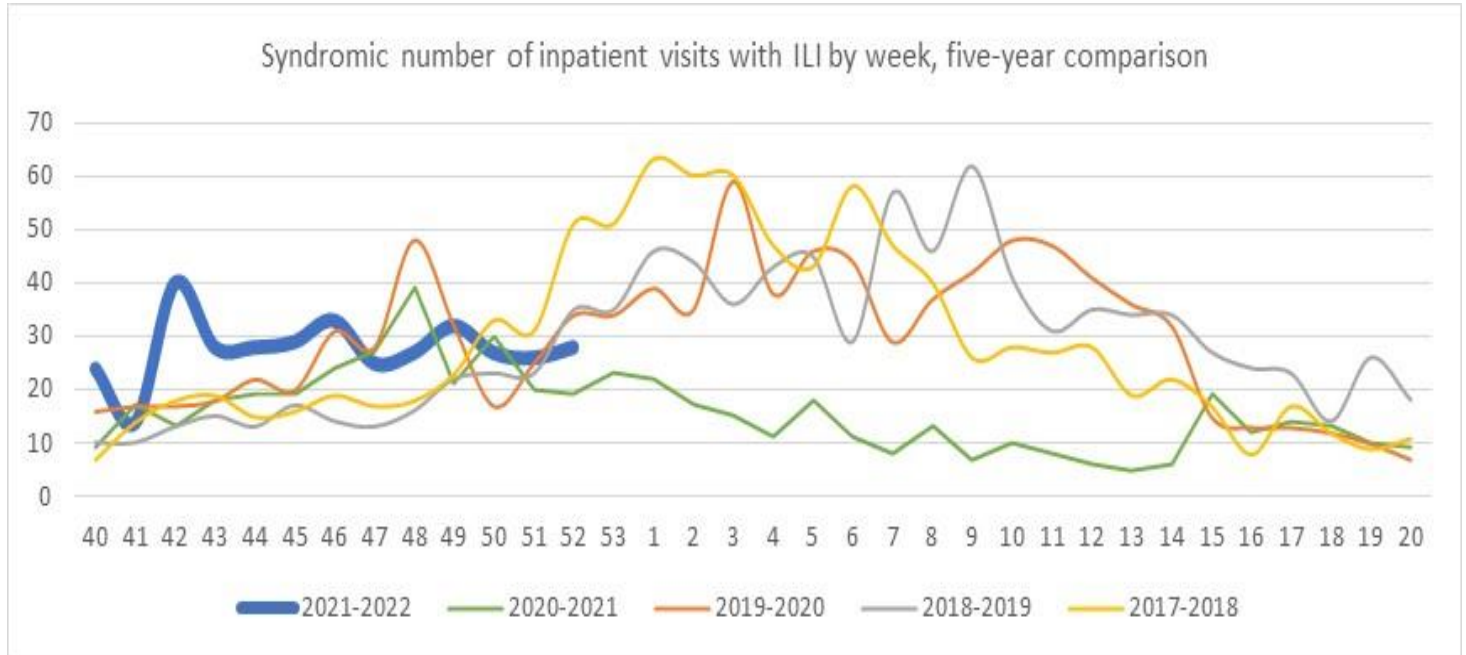
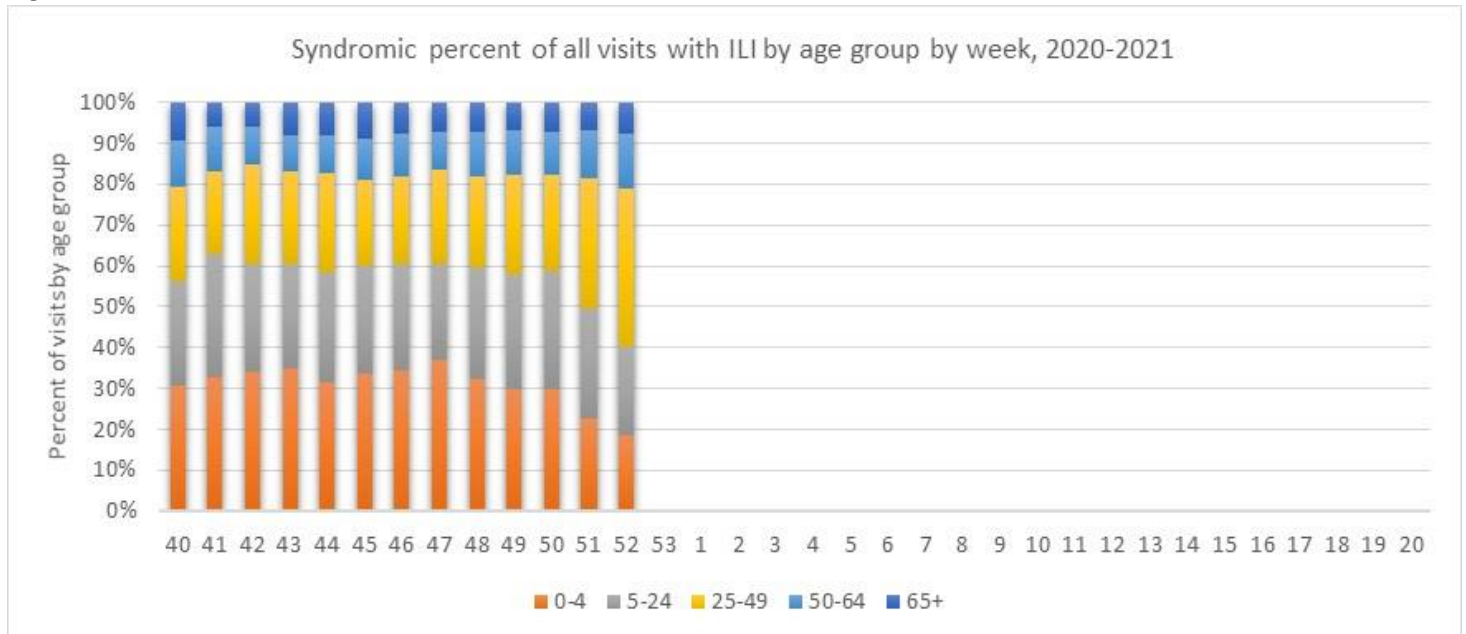


Figure 11:



Pneumonia and Influenza (P&I) Mortality Surveillance

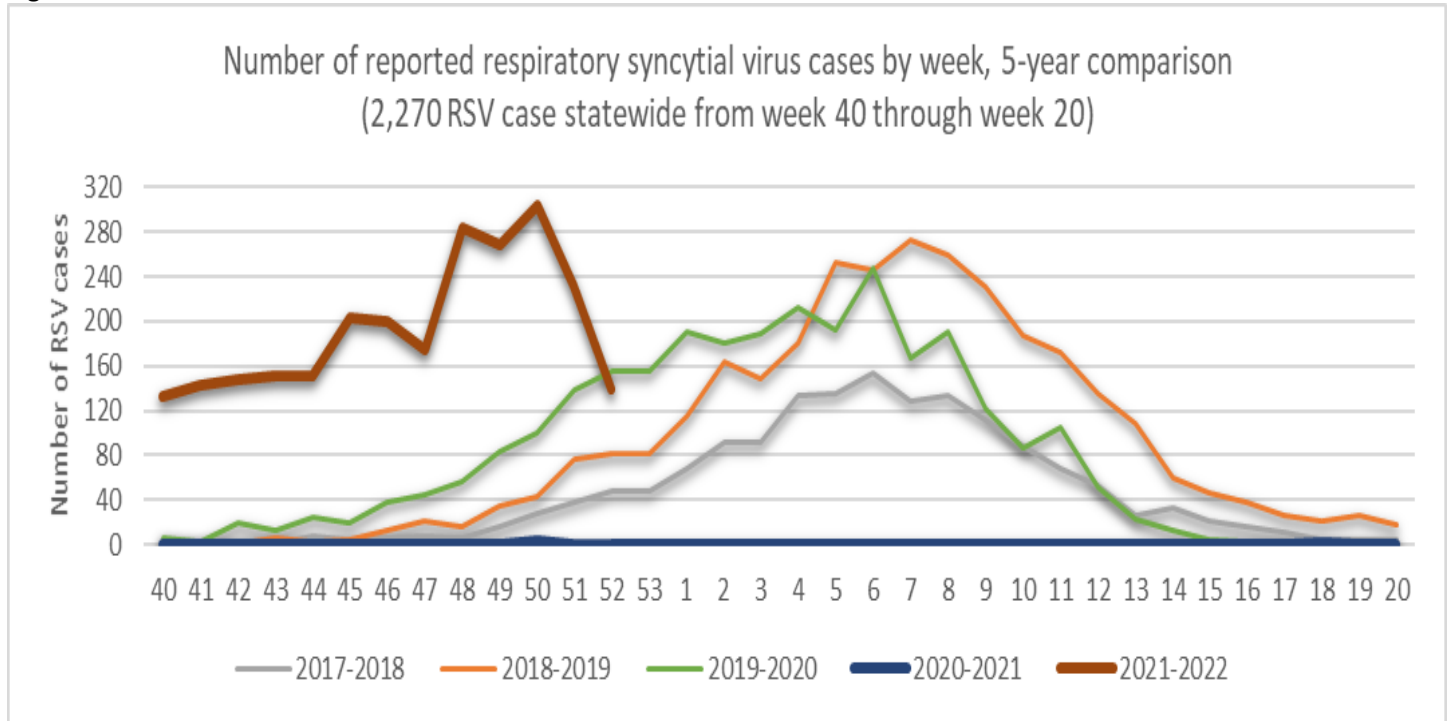
Death certificate data are used to calculate pneumonia and influenza deaths. The Division of Public and Behavioral Health is presently evaluating its data extraction methodology and will report P&I deaths in the future from internal data.

The CDC makes P&I death information available in its FluView Interactive GIS application. According to data from the CDC, Nevada’s P&I mortality is 19.1% of all deaths reported (71 out of 371) for the most recent week. Region 9’s P&I mortality is 13.3% of all deaths reported, which is above its baseline of 5.7%; nationally 13.2% of all deaths are due to P&I, which is above its baseline of 5.4%. Region 9’s influenza-related mortality is 0.04% (2 out of 4,834) and nationally 0.2% of all deaths are influenza-related (74 out of 36,650).

Respiratory syncytial virus (RSV)

So far this season, 2,531 Respiratory Syncytial Virus (RSV) cases has been reported. **Figure 12** shows the number of reported RSV cases for the current season compared with the number reported in the past four seasons. Due to a lag in reporting the case count for recent weeks is expected to increase. There were 140 RSV cases reported in week 52.

Figure 12:



COVID Like-Illness (CLI)

Data were collected using ESSENCE syndromic surveillance system along with a definition created by the CDC that counts CLI cases using chief complaint and discharge diagnosis data. Yellow or red dots on the graphs below indicate alerts, signaling a higher than expected percentage of CLI visits using the exponentially weighted moving average (EMWA) statistic built into ESSENCE.

Figure 13 shows the percentage of CLI by MMWR week starting with week 01 of 2020. For week 52, CLI percentages are at the highest values seen during the pandemic at 12.2%. **Figure 14** shows the percentage of CLI patients for each visit type by MMWR week starting at week 20 of 2021. For week 52 2021, 9.6% of inpatient visits met CLI criteria, 16.6% of ED visits, 5.9% of outpatient visits, and 1.8% of observstion patient visits. **Figure 15** shows the age-group percent for those with CLI begining week 20 2021. For week 52, 10.4% of visits were for ages 0-4, 17.0% for ages 5-24, 42.0% for ages 25-49, 17.8% for ages 50-64, and 12.8% for ages 65 and up.

Figure 13:

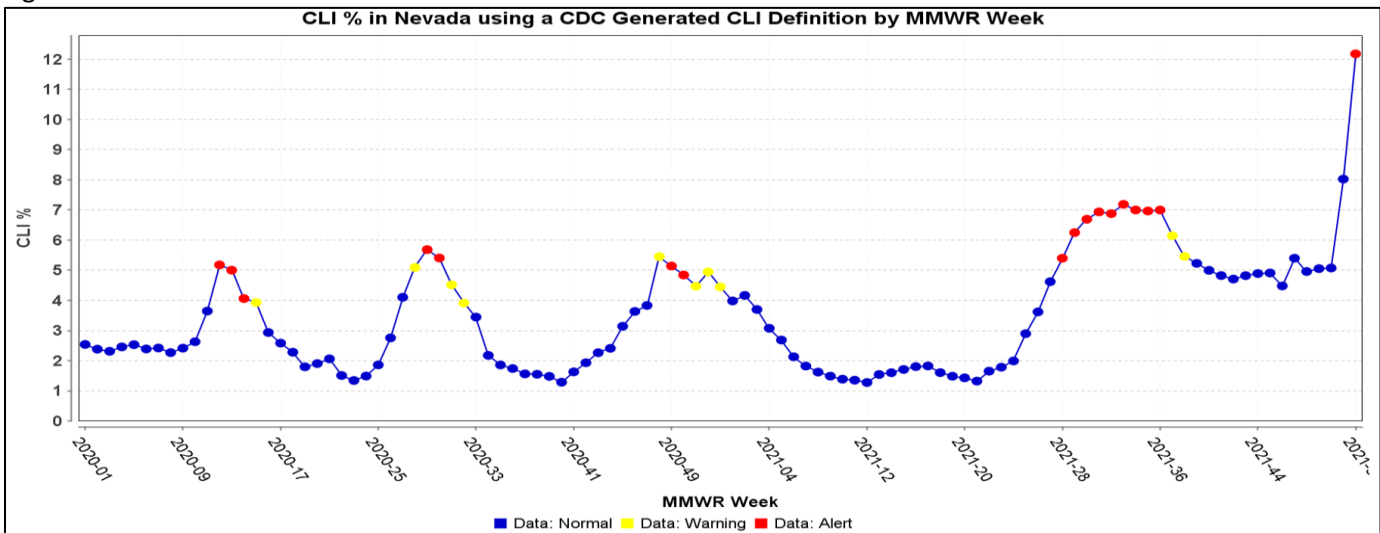


Figure 14:

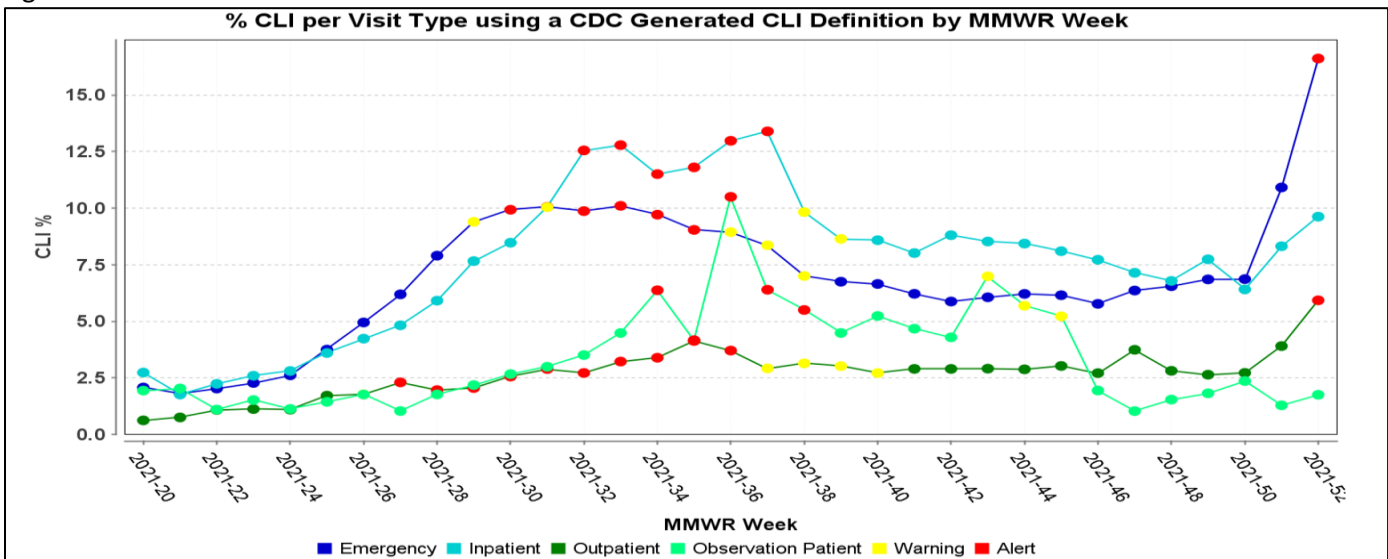
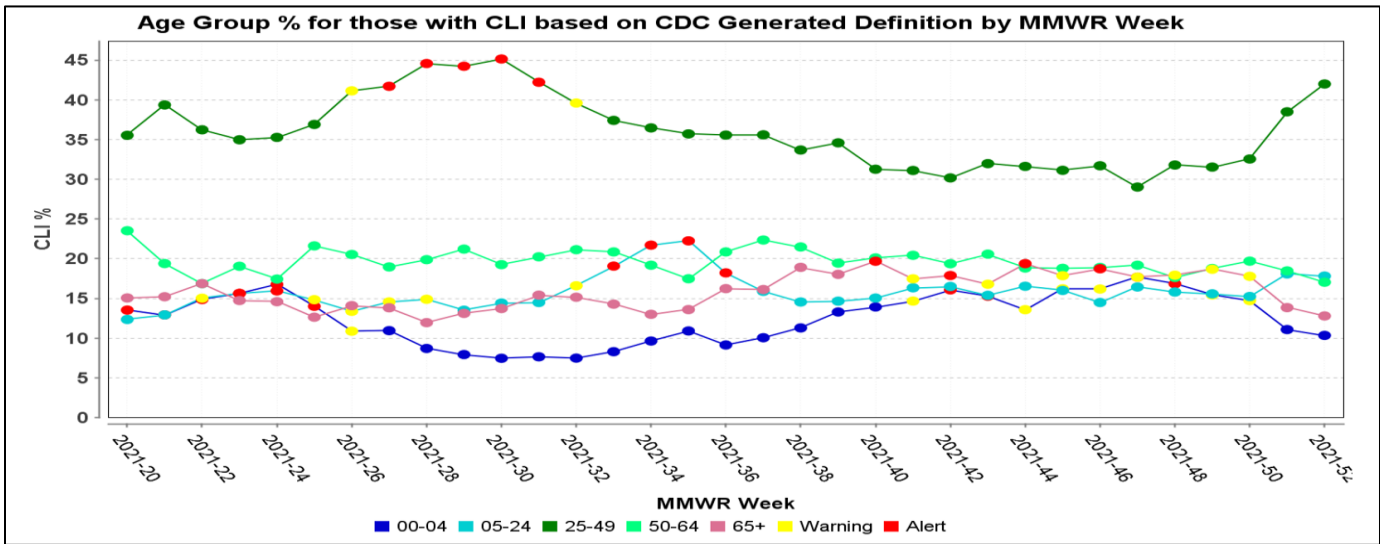


Figure 15:



References

Figures 1, 2, and 3, and Table 1 are derived from ILINet sentinel surveillance data submitted by sentinel providers directly to the CDC.

Table 1 also uses data from CDC’s FluView Interactive GIS application.

Figure 4 and Table 2 use ILINet laboratory surveillance data.

Figures 5, 6, 7, and Table 3 are compiled from data collected by local health authorities and abstracted from medical records.

Figures 8, 9, 10, 11, 13, 14, and 15 are populated from the National Syndromic Surveillance System (NSSP) Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE).

Figure 12 is generated from data submitted to Nevada’s NBS/NETSS reporting systems.