



New Jersey Department of Health and Senior Services Communicable Disease Service

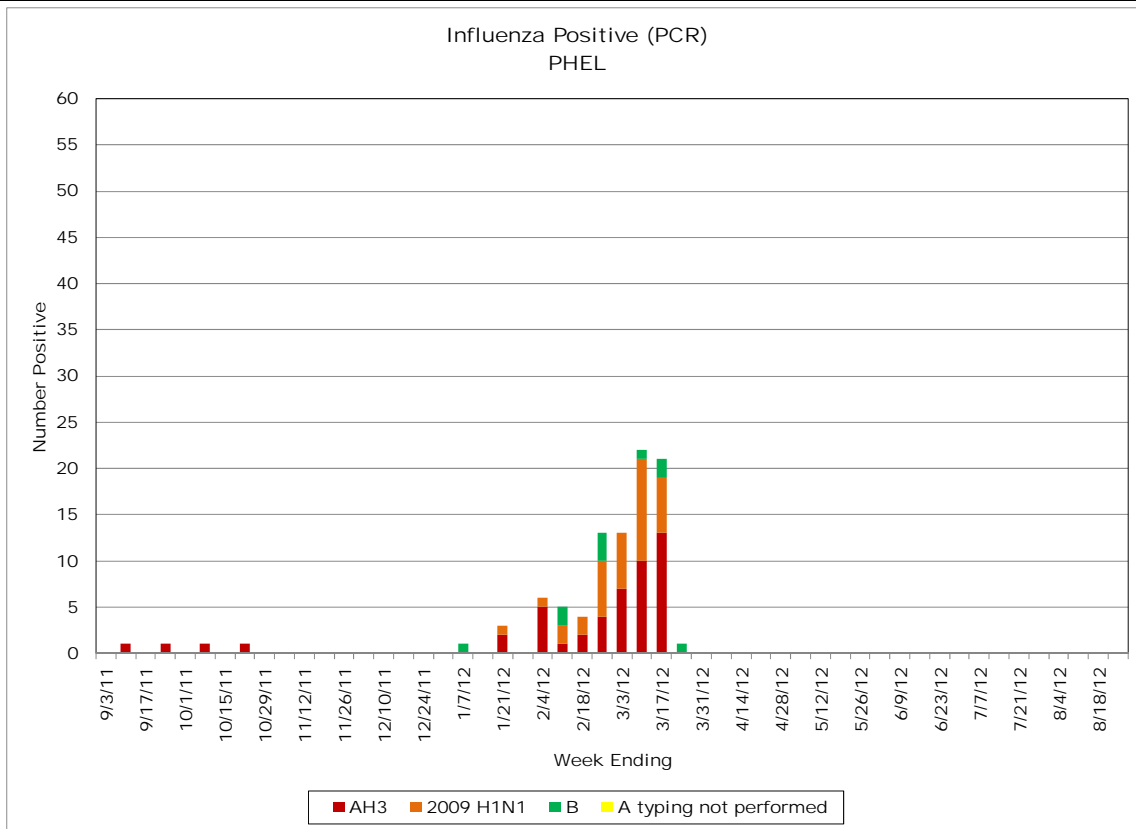


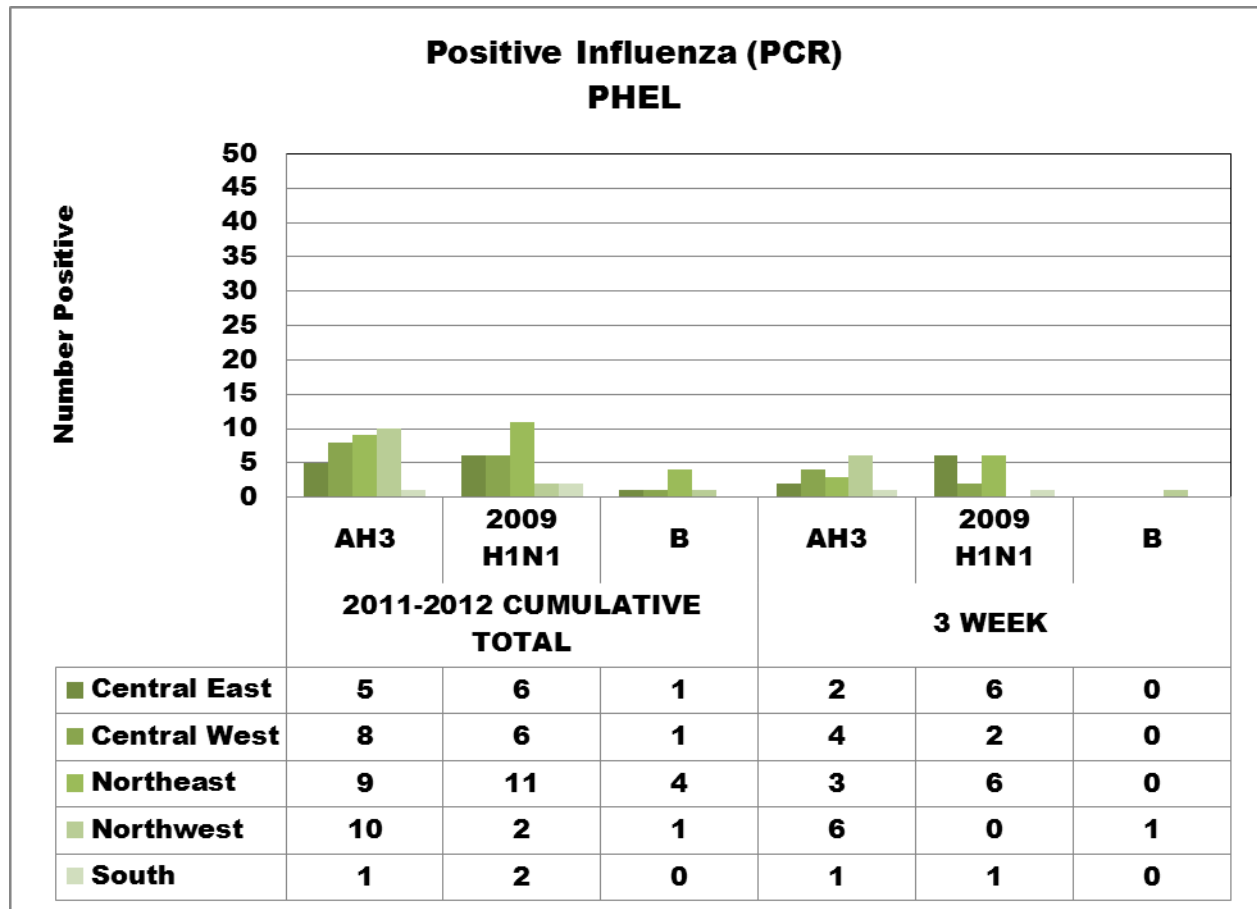
Respiratory Virus Surveillance Report (GRAPHS) Week ending March 24, 2012 (MMWR week 12)

Virologic Surveillance⁶

NJ Public Health and Environmental Laboratory (PHEL) Influenza Positive (PCR)

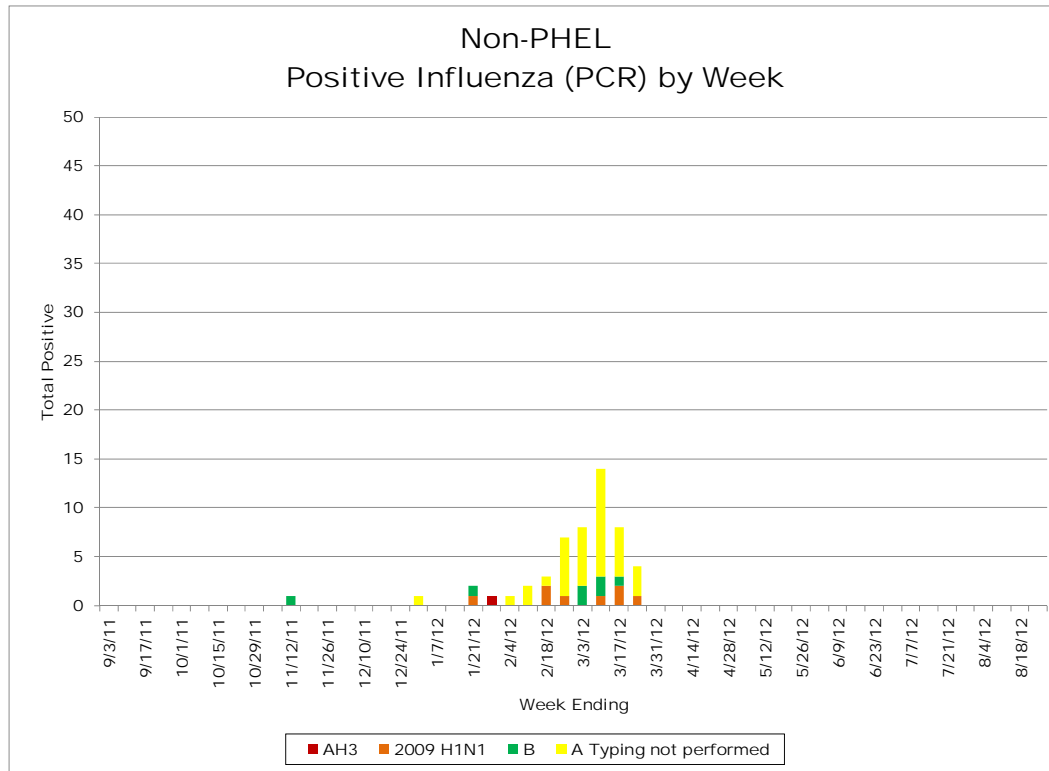
Result by Week



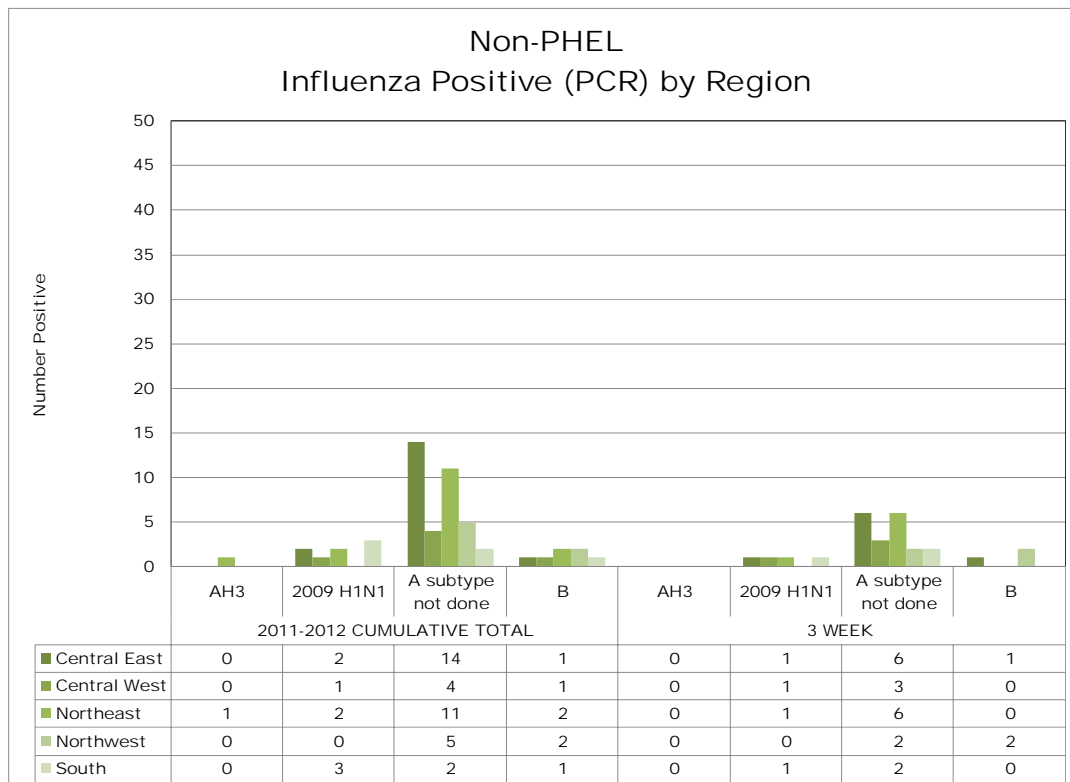


Influenza Positive (PCR) – Commercial/Acute Care Laboratories

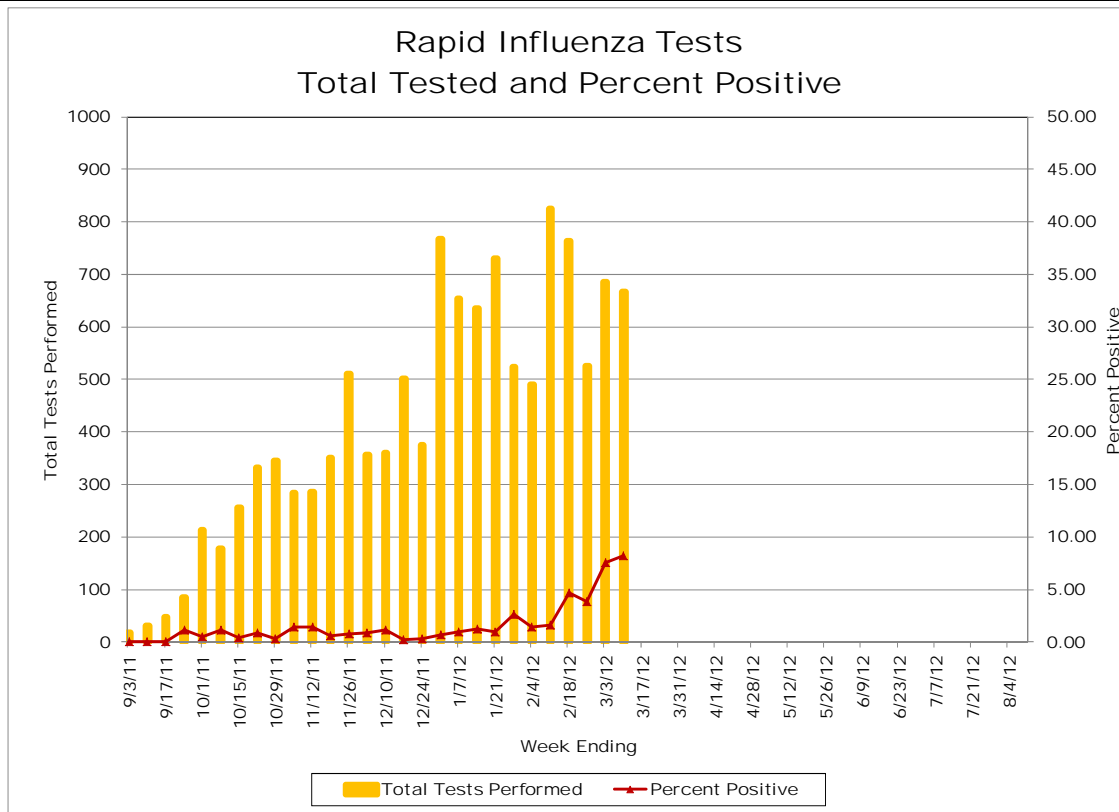
Result by Week



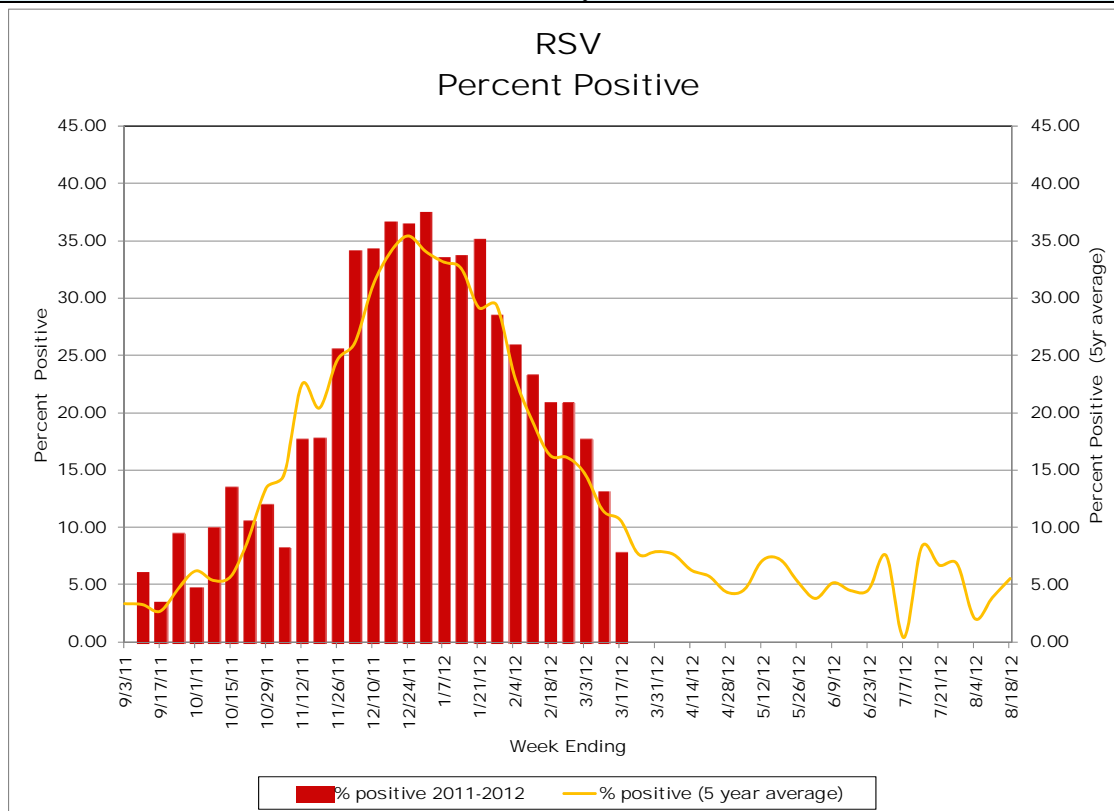
Result by Region³



Influenza Rapid Antigen Result by Week



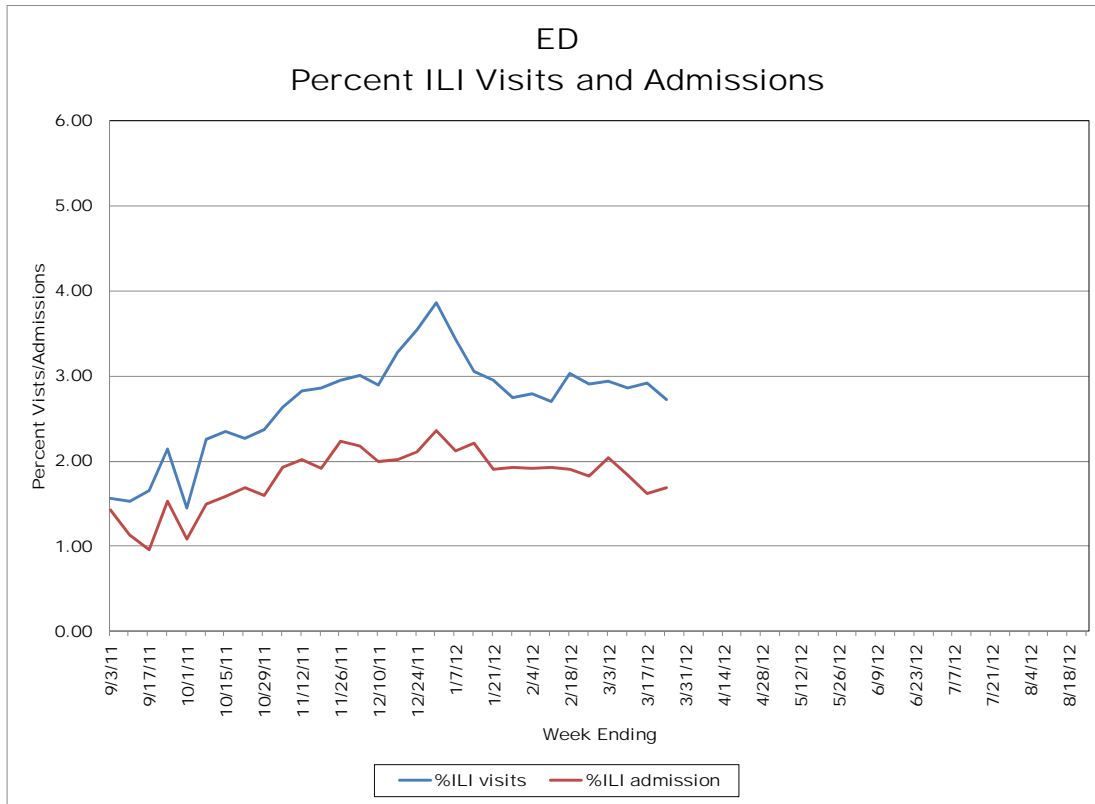
Respiratory Syncytial Virus (RSV) Results by Week



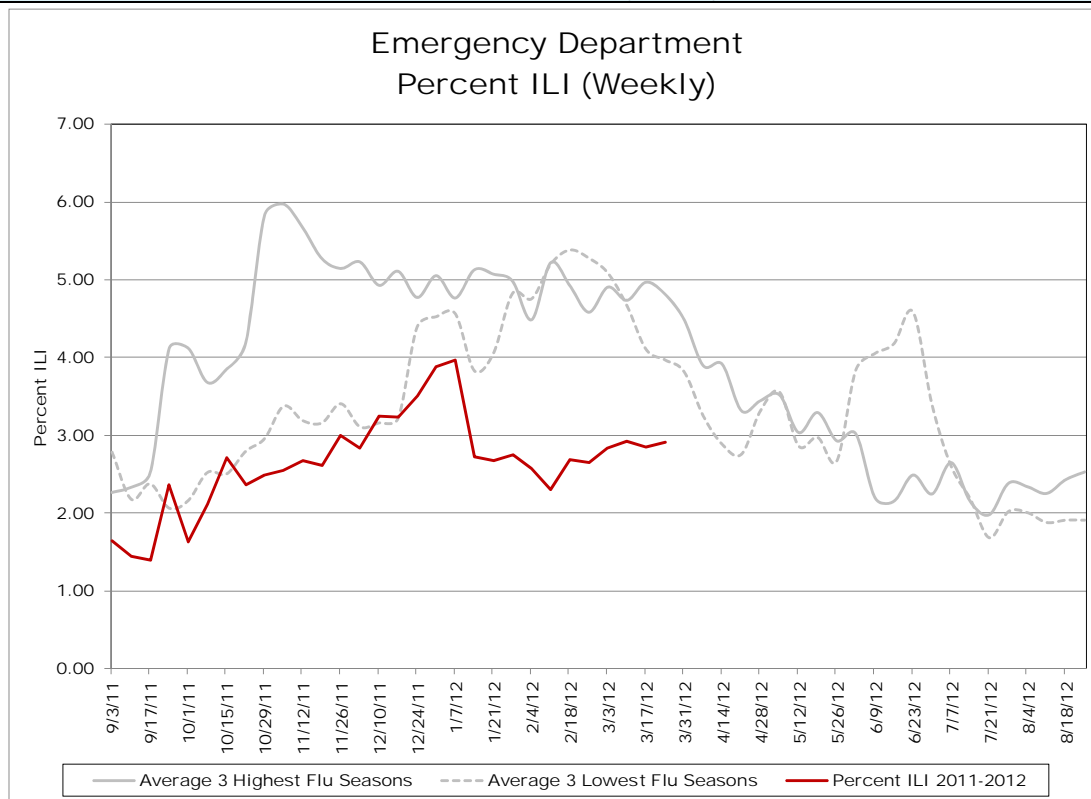
Influenza-like Illness Surveillance

Emergency Department⁷

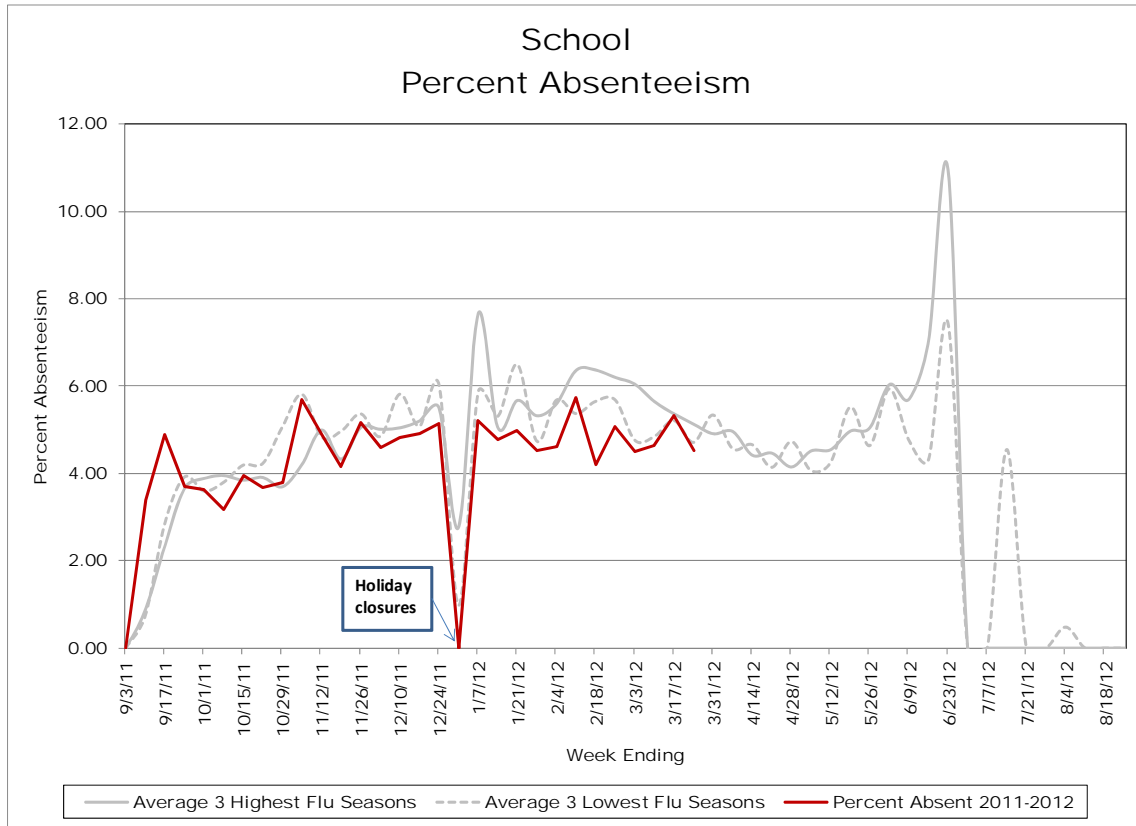
Daily Visits and Admission



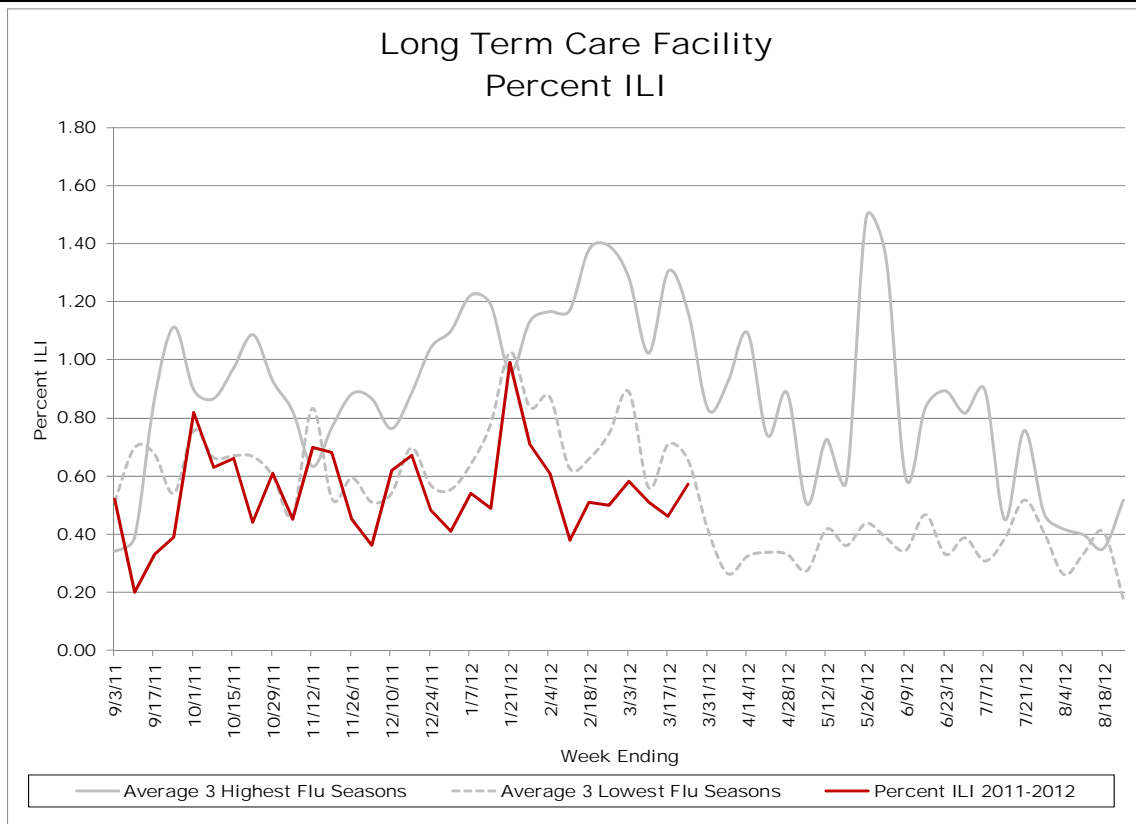
Visits – Tuesday Only



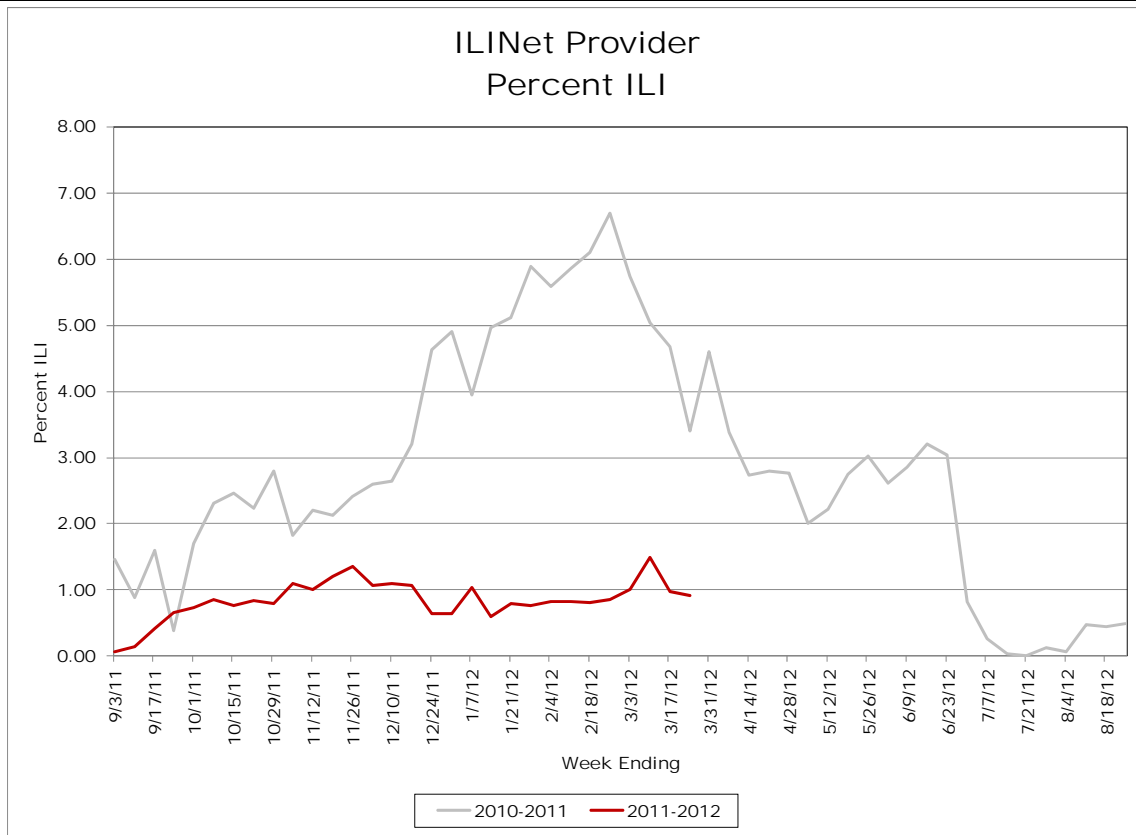
School Absenteeism



Long Term Care Facilities



ILINet Providers



Additional Information

A second report containing information about age specific illness, hospitalization and deaths will be produced on a monthly basis or as needed when important information needs to be disseminated.

For additional information regarding influenza surveillance please visit the following websites.

<http://nj.gov/health/flu/surveillance.shtml>

<http://www.cdc.gov/flu/>

Footnotes:

1. Influenza-like illness (ILI) is defined as fever ($> 100^{\circ}\text{F}$ [37.8°C], oral or equivalent) and cough and/or sore throat (in the absence of a known cause other than influenza). For long term care facilities, fever is defined as 2 degrees above baseline temperature.
2. Activity levels for the state and region are defined in Table 1 and 2 at the end of this document.
3. The following is a breakdown of counties contained within each public health region: Northwest: Morris, Passaic, Sussex, Warren; Northeast: Bergen, Essex, Hudson; Central west: Hunterdon, Mercer, Somerset; Central East: Middlesex, Monmouth, Ocean, Union; South: Atlantic, Burlington, Camden, Cape May, Salem, Cumberland, Gloucester
4. Non-season baseline is calculated by taking the average of statewide percentages of ILI for a 6 year (2006, 2007, 2008, 2009, 2010, 2011) period during months when influenza is less likely to be circulating (May-August).
5. Three year seasonal averages are determined by calculating the average percent ILI/absenteeism for each influenza season (October to May). These averages are ranked and the three highest and lowest overall season averages were selected. The three highest and lowest numbers were then averaged to obtain a single high and single low value. The season which contribute to the high and low value vary by entity type and are as follows : LTCF (High: 05-06,06-07,07-08; Low: 08-09,09-10,10-11), ED (High: 05-06,06-07,09-10; Low: 07-08,08-09,10-11) and schools (High: 06-07,07-08,08-09 ;Low: 05-06, 09-10,10-11). A week by week average was also calculated using the average of the seasons listed above for each entity type.
6. Viral activity: Real-time polymerase chain reaction (PCR) results are obtained from electronic laboratory transmission submitted by acute care, commercial and public health laboratories to CDRSS. Rapid influenza test data and respiratory syncytial virus data are acquired from facilities reporting rapid influenza tests via the National Respiratory and Enteric Virus Surveillance System (NREVSS) or CDRSS ILI module. Counts for cumulative totals begin with week ending October 8, 2011.
7. Daily visits and admission associated with ILI from emergency department data is collected via EpiCenter and Hippocrates. Prior to these systems, data on ILI visits were only recorded one day per week usually on Tuesday. This system is maintained as a large amount of historical data allows for better seasonal comparisons.
8. Only LTCF outbreaks reported to NJDHSS that received and outbreak number are recorded in this report.