



WEEKLY RESPIRATORY DISEASE SURVEILLANCE REPORT

Respiratory Season 2025-2026

Weekly Respiratory Disease Surveillance Report

March 29 – April 4, 2026 (MMWR Week 13)

Report created: 7th April 2026

Contents	
Introduction	3
At a Glance	3
1. Syndromic Surveillance	3
1.1 Diagnosed Acute Respiratory Illness	3
1.2 Influenza-Like Illness (ILI)	4
1.3 Diagnosed COVID-19	5
1.4 Diagnosed Influenza	6
1.5 Diagnosed Respiratory Syncytial Virus (RSV)	6
2. Outbreak Surveillance	7
2.1 Overall Respiratory Outbreaks by Week	7
2.2 Respiratory Outbreaks by Region	8
2.3 Respiratory Outbreaks by Etiologic Agent	8
3. Laboratory Surveillance	10
3.1 Lab Confirmed Influenza by Week	11
3.2 Lab Confirmed Influenza by Region	12
3.3 Demographic Distribution of Influenza Positive Labs	12
3.4 Seasonal Trend of Lab Confirmed Influenza in Virginia	13
Methodology	14
I. Syndromic Surveillance Methodology	14
II. Outbreak Surveillance Methodology	14
III. Laboratory Surveillance Methodology	14
Case Definitions	15
I. Syndromic Surveillance Definitions	15
II. Outbreak Surveillance Definitions	15
III. Laboratory Surveillance Definitions	15

Introduction

Respiratory disease surveillance involves monitoring a variety of data sources, including syndromic surveillance, outbreak surveillance, and laboratory surveillance. These data should be evaluated together to create a more complete picture of respiratory disease activity in Virginia.

Syndromic surveillance uses visit data from emergency departments (ED) and urgent care centers to help identify and monitor events of public health concern in near real time. However, many respiratory illnesses cause similar symptoms; for example, measures for flu activity may also reflect activity from other respiratory viruses.

Outbreak surveillance can provide an indicator for how much respiratory disease is spreading within a community and within specific settings. Any person in charge of a residential or day program, service, or facility licensed or operated by any agency of the Commonwealth, or a school, childcare center, or summer camp is required to report to the local health department the presence or suspected presence of people who have common symptoms suggesting an outbreak situation.

Laboratory surveillance for influenza provides insight into the burden of flu and which viruses are circulating at a given time. Annual vaccinations are updated regularly based on laboratory surveillance findings. However, only confirmatory laboratory results are reported to VDH and can provide information on the type or strain of flu, meaning the data for rapid tests is not included in public health surveillance.

At a Glance

For the 2025-26 season, 2 pediatric deaths associated with influenza have been reported in Virginia. More data and details can be found on the [Respiratory Disease Data webpage](#).

During the week of March 29 – April 4, 2026 (MMWR Week 13),

- ED and urgent care visits for
 - Acute Respiratory Illness: **Decreased** and were not significantly elevated
 - Influenza-like Illness: **Decreased** and were not significantly elevated
 - COVID-19: **Decreased** and were not significantly elevated
 - Influenza: **Decreased** and were not significantly elevated
 - RSV: **Decreased** and were not significantly elevated
- **7 respiratory outbreaks** (3 confirmed, 4 suspected, and 0 unknown) were reported this week.
- **814 confirmatory influenza labs** were received this week.

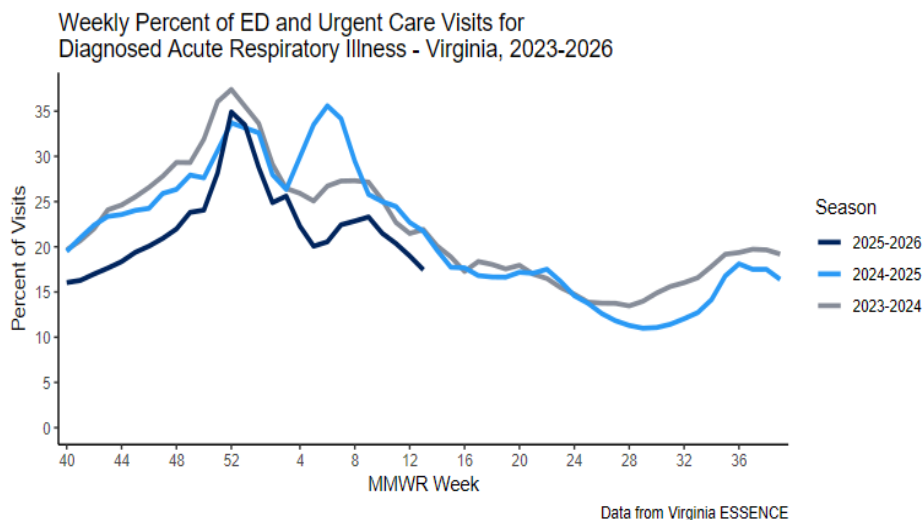
1. Syndromic Surveillance

VDH receives data from participating emergency departments (EDs) and urgent care centers through its syndromic surveillance program. The data includes visit date and location, patient demographics (e.g., age, race), chief complaint (why the patient is seeking care), and diagnosis. VDH uses chief complaint and discharge diagnosis to identify visits that meet certain criteria using [syndromic surveillance case definitions](#). This allows public health to monitor disease trends in real time. More information about syndromic surveillance, including data limitations, can be found on the [syndromic surveillance website](#).

1.1 Diagnosed Acute Respiratory Illness

During the week of March 29 – April 4, 2026, ED and urgent care visits for diagnosed acute respiratory illness in Virginia:

- **Decreased 1.5 percentage points** compared to the previous week from 19% to 17.5% of visits.
- **Were not significantly elevated** in Virginia’s syndromic surveillance system compared to a baseline of previous weeks.

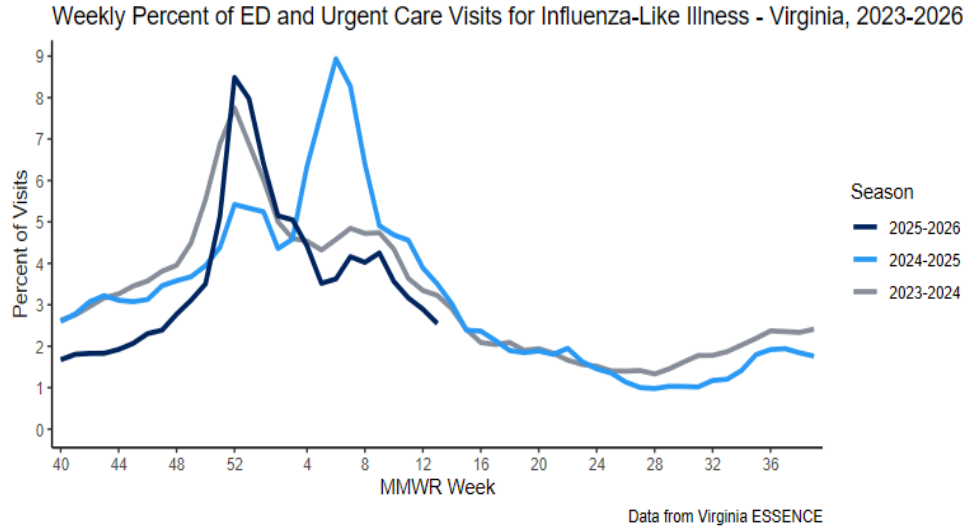


*These seasons (2023-2024 and 2024-2025) did not have a Week 53, so the Week 53 value is an average of Week 52 and Week 1.

1.2 Influenza-Like Illness (ILI)

During the week of March 29 – April 4, 2026, ED and urgent care visits for influenza-like illness in Virginia:

- **Decreased 0.4 percentage point** compared to the previous week from 2.9% to 2.5% of visits.
- **Were not significantly elevated** in Virginia’s syndromic surveillance system compared to a baseline of previous weeks.

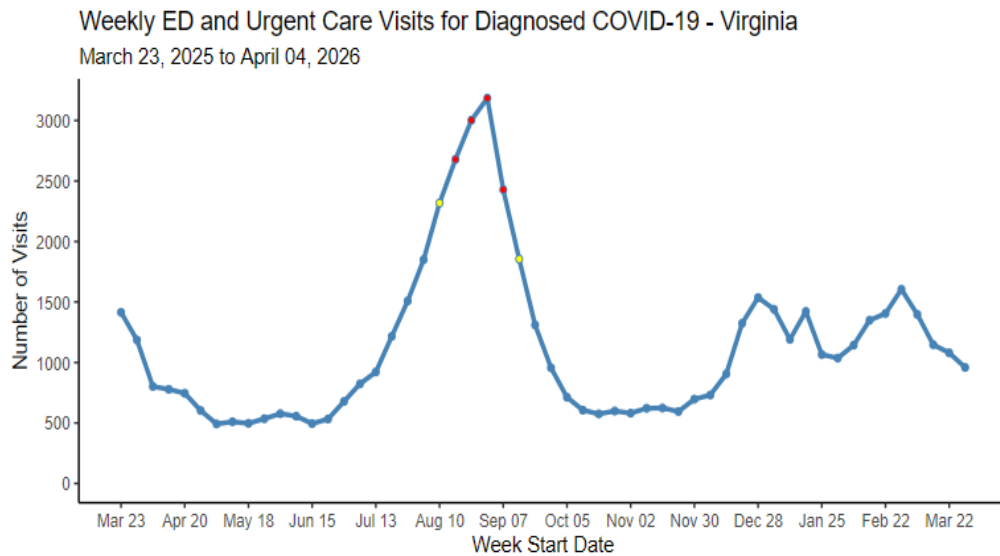


*These seasons (2023-2024 and 2024-2025) did not have a Week 53, so the Week 53 value is an average of Week 52 and Week 1.

1.3 Diagnosed COVID-19

During the week of March 29 – April 4, 2026, ED and urgent care visits for diagnosed COVID-19 in Virginia:

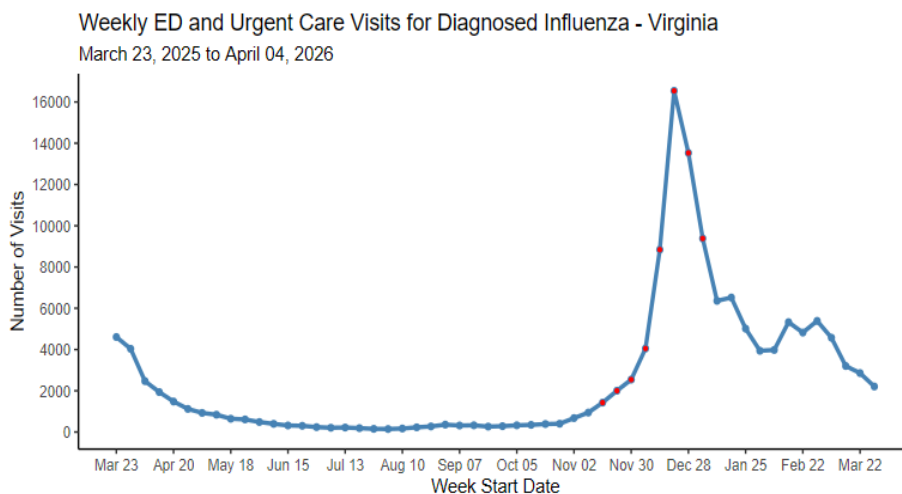
- **Decreased 11%** compared to the previous week from 1,080 to 959 visits.
- **Were not significantly elevated** in Virginia’s syndromic surveillance system compared to a baseline of previous weeks.



1.4 Diagnosed Influenza

During the week of March 29 – April 4, 2026, ED and urgent care visits with diagnosed influenza in Virginia:

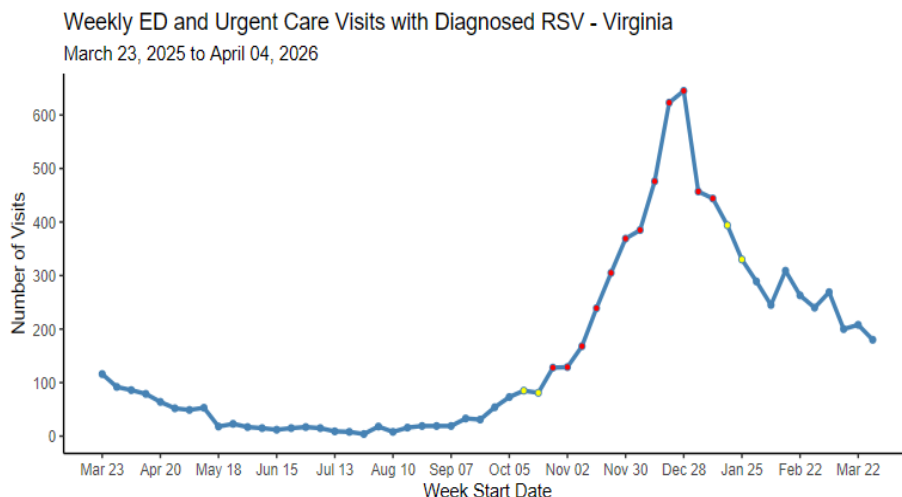
- **Decreased 23%** compared to the previous week from 2,858 to 2,207 visits.
- **Were not significantly elevated** in Virginia’s syndromic surveillance system compared to a baseline of previous weeks.



1.5 Diagnosed Respiratory Syncytial Virus (RSV)

During the week of March 29 – April 4, 2026, ED and urgent care visits with diagnosed Respiratory Syncytial Virus (RSV) in Virginia:

- **Decreased 13%** compared to the previous week from 208 to 180 visits.
- **Were not significantly elevated** in Virginia’s syndromic surveillance system compared to a baseline of previous weeks.

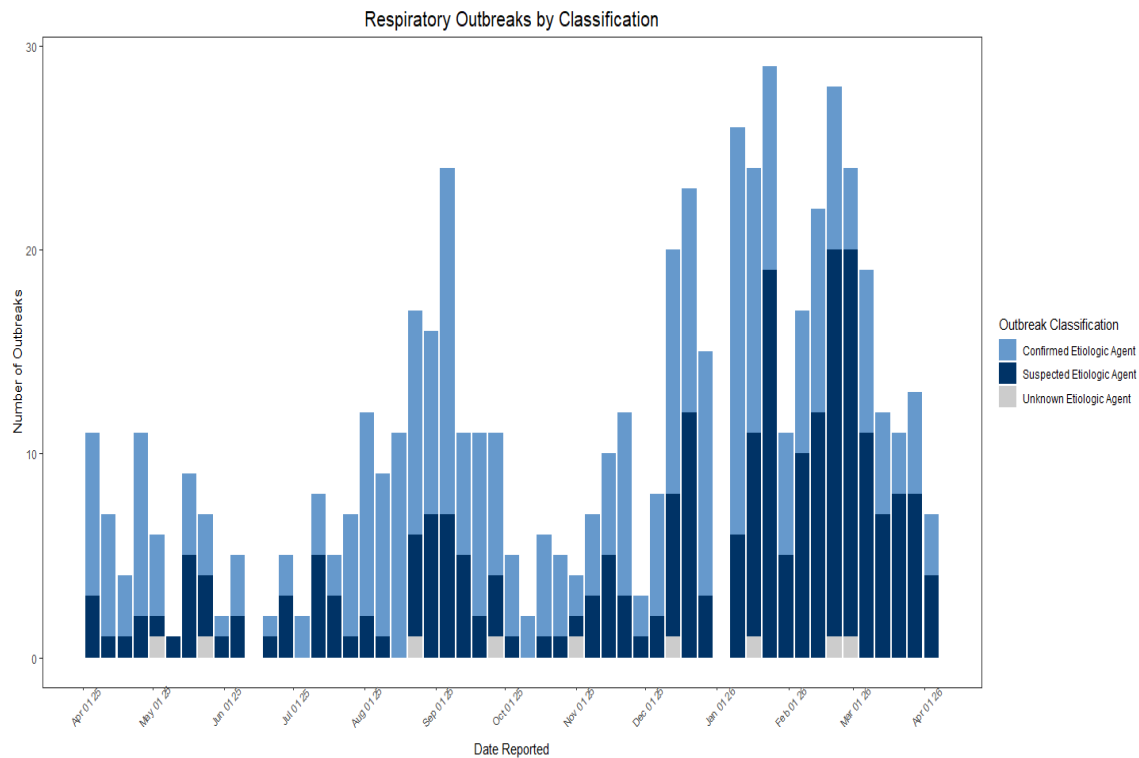


2. Outbreak Surveillance

VDH requires certain facilities or programs to report the presence or suspected presence of an outbreak to the local health department. Reported outbreaks can be a good indicator of how much respiratory disease is spreading within a community and within specific settings. Investigators try to collect laboratory evidence to identify the etiologic agent (disease) causing the outbreak. The lab evidence is used to classify the outbreak as either a ‘Suspected’ or ‘Confirmed’ outbreak using [outbreak surveillance definitions](#). If no lab evidence is collected, the etiologic agent will be marked as unknown and the outbreak will be classified as ‘Suspected.’

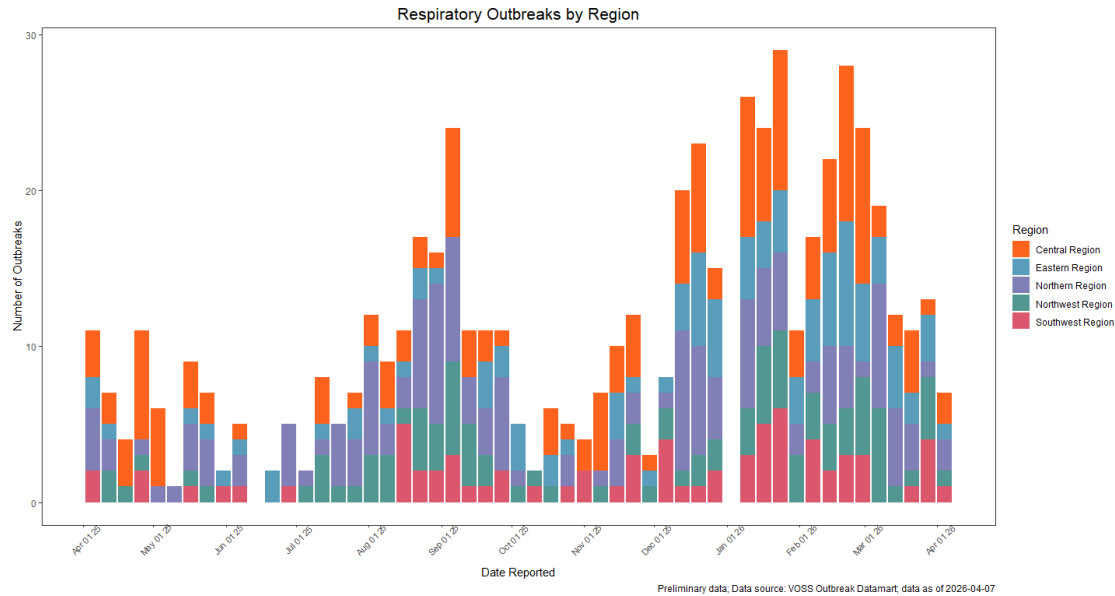
2.1 Overall Respiratory Outbreaks by Week

During the week of March 29 – April 4, 2026, there were 3 confirmed respiratory outbreaks, 4 suspected respiratory outbreaks, and 0 outbreak with an unknown etiologic agent reported to VDH.



2.2 Respiratory Outbreaks by Region

The graph below displays respiratory outbreaks by region from **April 2025** through **April 2026**. For the week ending April 4, 2026, there were **7** outbreaks reported.



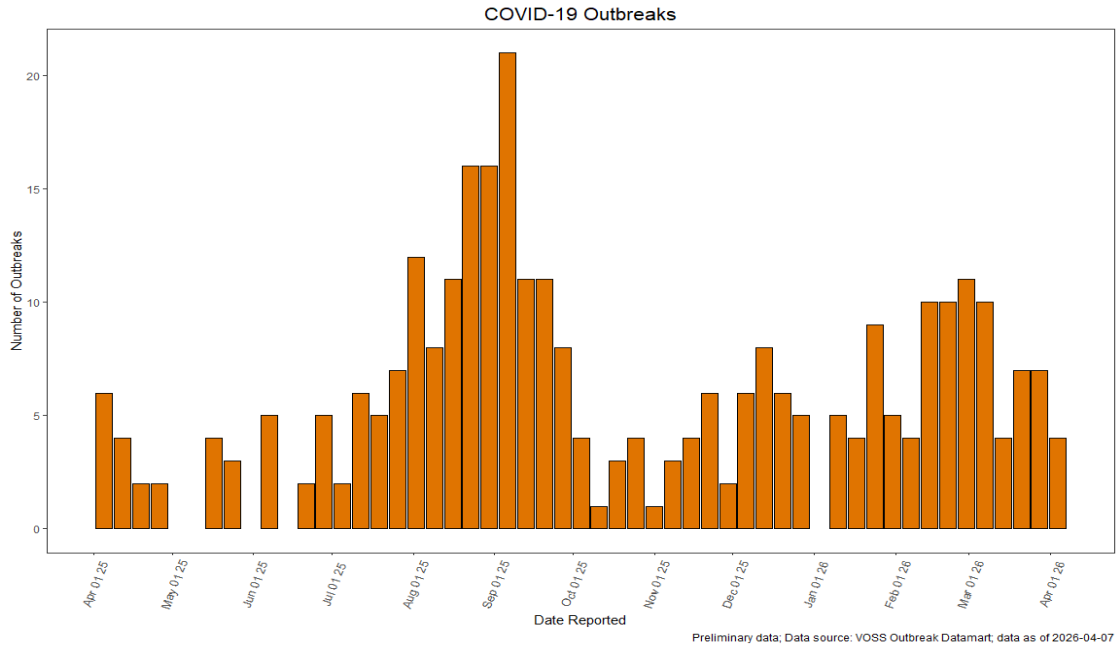
2.3 Respiratory Outbreaks by Etiologic Agent

Table 1: Number of Outbreaks by Region and Etiologic Agent During the Week of March 29 – April 4, 2026. During the week ending April 4, 2026, there were a total of 7 respiratory outbreaks in Virginia:

Region	Etiologic Agent	Number of Outbreaks
Central	Influenza	1
Central	SARS-CoV-2	1
Eastern	SARS-CoV-2	1
Northern	SARS-CoV-2	2
Northwest	Bordetella pertussis	1
Southwest	Respiratory Syncytial Virus	1

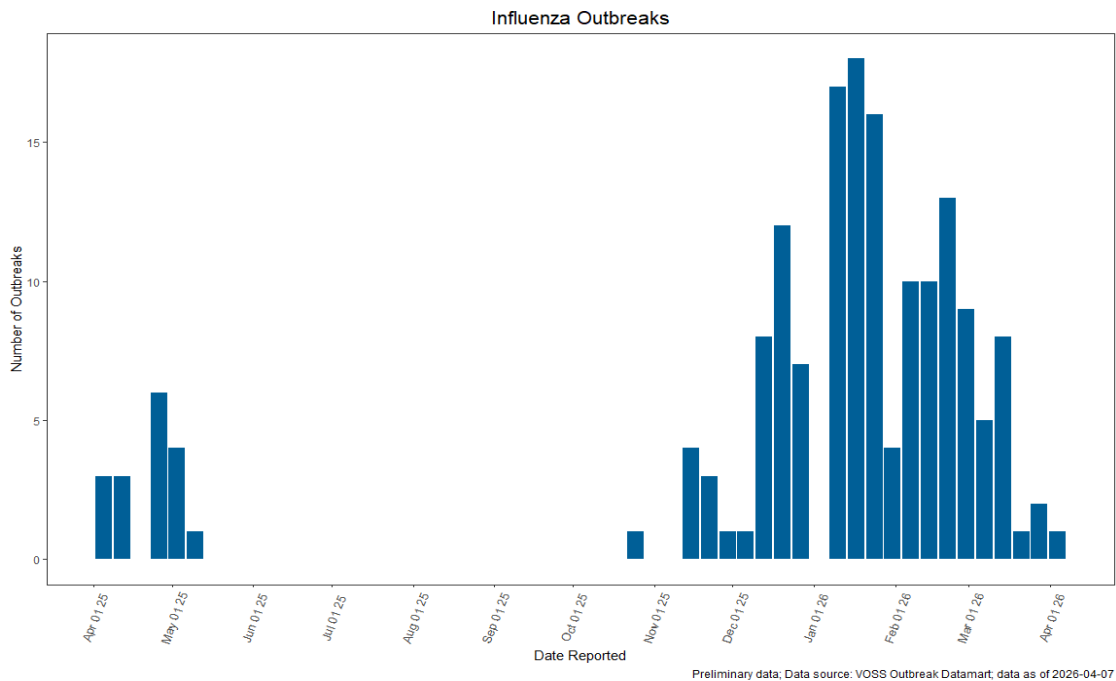
Weekly COVID-19 Outbreaks

The graph below displays both confirmed and suspected COVID-19 outbreaks from **April 2025** through **April 2026**. For the week ending April 4, 2026, there were **4** outbreaks reported.



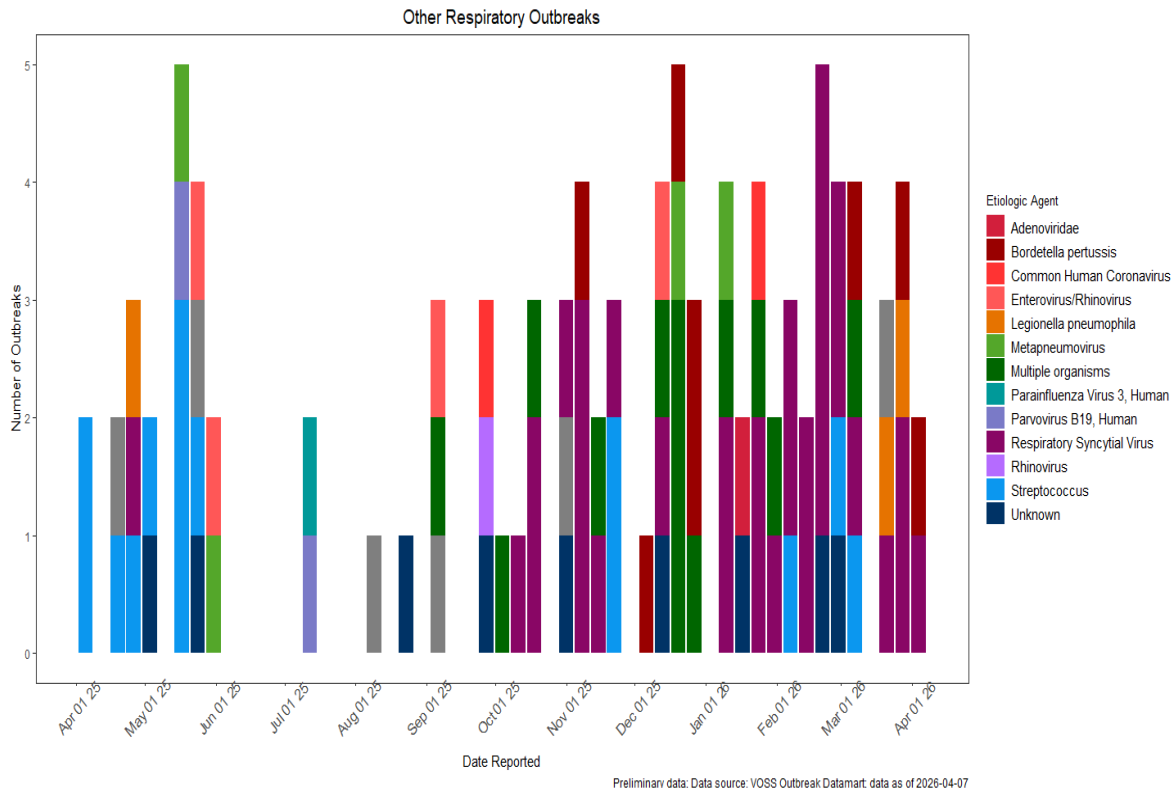
Weekly Influenza Outbreaks

The graph below displays both confirmed and suspected Influenza outbreaks from **April 2025** through **April 2026**. For the 2025-2026 season, there were **166** Influenza outbreaks reported.



Weekly Respiratory Outbreaks (Excluding COVID-19 & Flu)

The graph below displays both confirmed and suspected respiratory outbreaks from **April 2025** through **April 2026**. For the week ending April 4, 2026, there were **2** other respiratory outbreaks (excluding COVID-19 & Influenza) reported.



3. Laboratory Surveillance

Laboratory surveillance provides insight into the burden of flu and which viruses are circulating at a given time.

VDH receives reports of positive confirmatory influenza lab results. The confirmatory tests that are available (PCR, viral culture, and DFA [direct fluorescent antigen]) for the flu are not commonly used. For people who seek care for flu, most are diagnosed with a rapid influenza diagnostic test, or by their symptoms alone. These data are not reported to VDH. Therefore, influenza positive labs reported to public health represent only a small proportion of all people testing positive for influenza.

One of the major benefits of the confirmatory lab results is that they can provide more detailed information about what strain and subtype of flu viruses are circulating. Knowing whether we're experiencing a flu season with a certain type of flu can be important for identifying what communities are at highest risk for complications and negative outcomes. This information also helps us to evaluate the effectiveness of the vaccine each year.

3.1 Lab Confirmed Influenza by Week

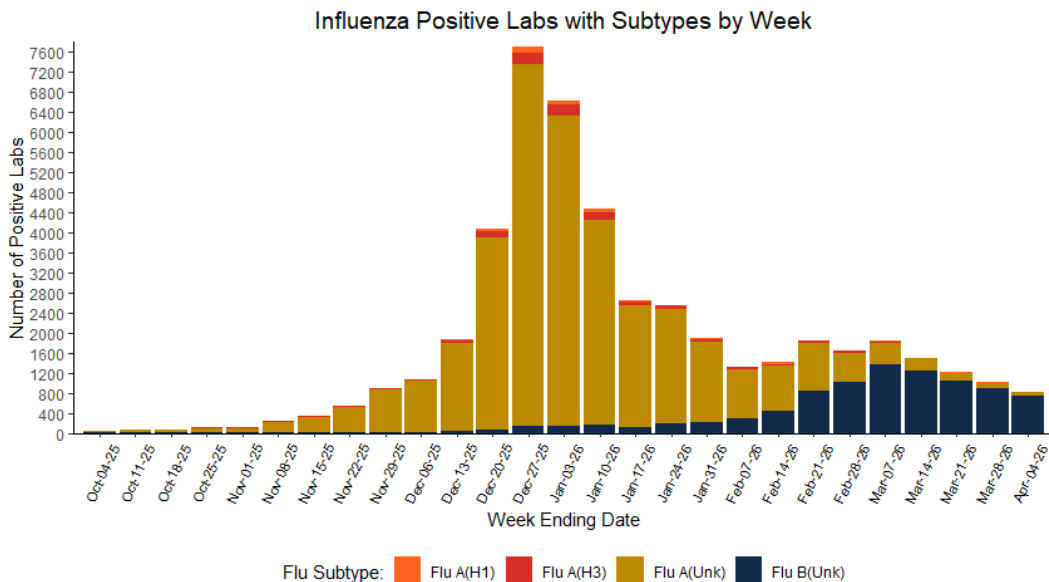
During the week of March 29 – April 4, 2026, VDH received **814** positive influenza lab results. For the 2025-2026 influenza season VDH received a total of 47,789 positive influenza lab results. Of the positive labs reported this flu season there were:

Table 3: Number of Influenza Positive Lab Reports by Subtype

Flu Subtypes & Lineages	Reporting Week	Cumulative
	N = 814	N = 47,789
A (H1)	2 (0.2%)	506 (1.1%)
A(H3)	2 (0.2%)	1,325 (2.8%)
A(Unk)	85 (10%)	36,998 (77%)
B(Unk)	725 (89%)	8,960 (19%)

Influenza Positive Labs with Subtypes by Week

The graph below displays influenza positive labs with subtypes by week from **October 2025** through **April 2026**. For the week ending April 4, 2026, Flu B was the most common subtype.



Data Source: VEDSS Lab Datamart

3.2 Lab Confirmed Influenza by Region

VDH received a total of 47,789 positive influenza labs from all 5 health planning regions of Virginia during the 2025-2026 influenza season. Northern region reported the highest number of labs (236, 29%) during the week of March 29 – April 4, 2026.

Influenza Positive Labs by Week and Region

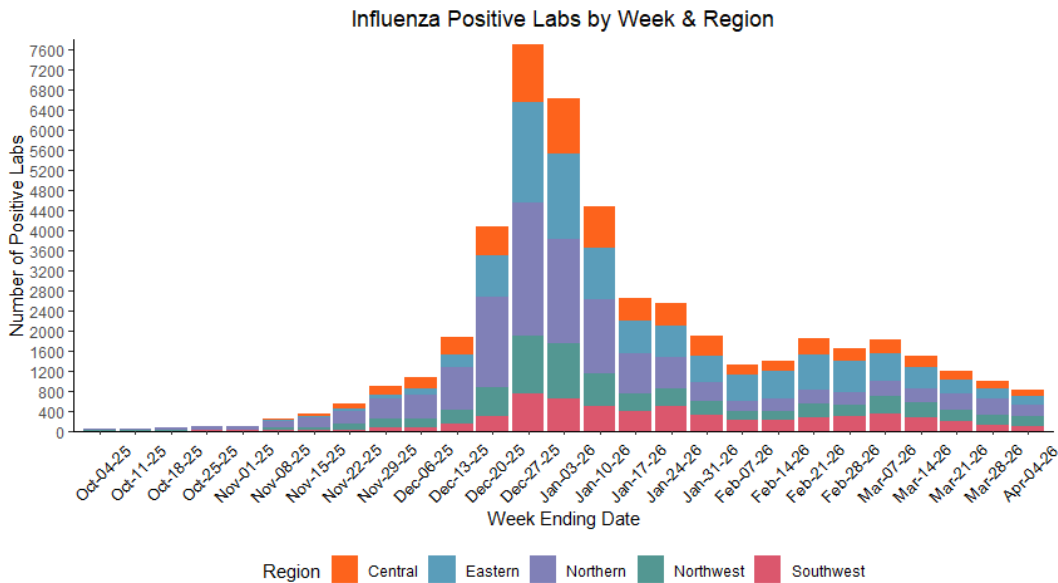


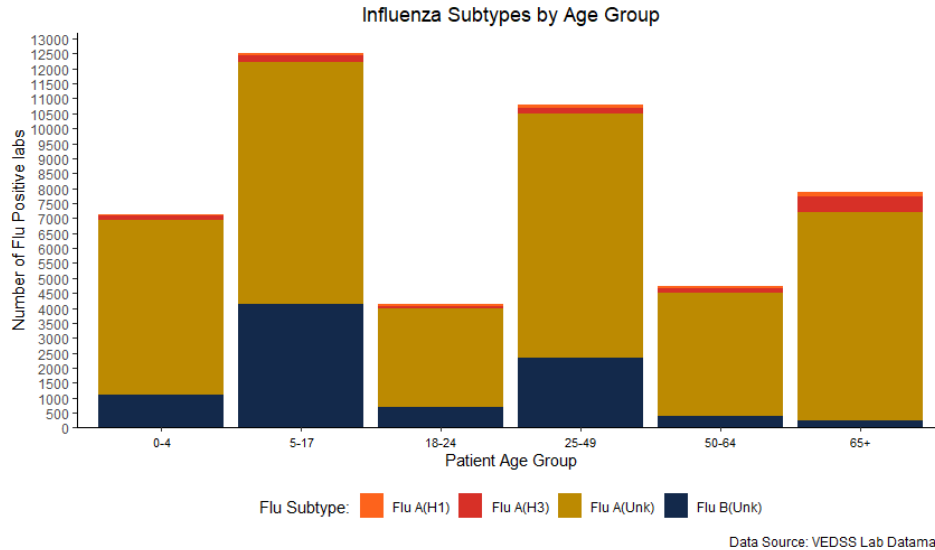
Table 4: Number of Influenza Positive Lab Reports by Region

Regions	N = 814
Central	119 (15%)
Eastern	167 (21%)
Northern	236 (29%)
Northwest	193 (24%)
Southwest	99 (12%)

3.3 Demographic Distribution of Influenza Positive Labs

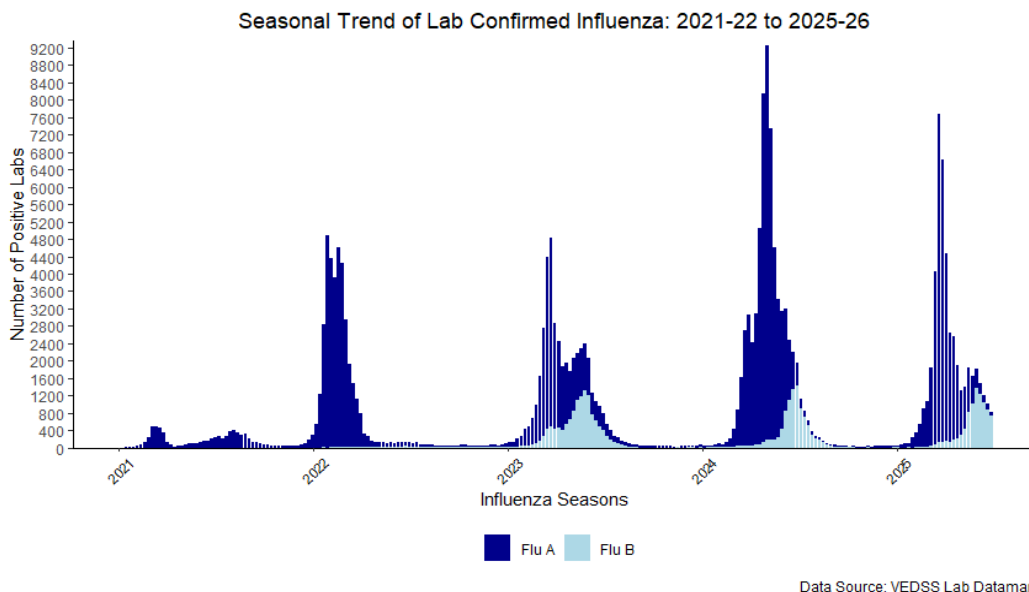
During the 2025-26 influenza season, those aged 5-17 years old (12,521; 26%) had the highest number of influenza positive labs reported to VDH.

Influenza positive labs with subtypes by age group, 2025-26 influenza season



3.4 Seasonal Trend of Lab Confirmed Influenza in Virginia

The graph below displays the seasonal trend of lab confirmed influenza by subtype for influenza seasons 2021-2022 to 2025-2026. Seasonal influenza trends continue to increase since 2021, with the highest seasonal peak occurrence in 2024.



Methodology

I. Syndromic Surveillance Methodology

VDH analyzes chief complaints and discharge diagnoses of ED and urgent care visits to identify and monitor issues of public health concern. The chief complaint is a free-text field capturing the patient's primary reason for seeking medical care. The discharge diagnosis is a coded field that uses standardized values outlined by the International Classification of Diseases (ICD) 10th Revision and SNOMED Clinical Terms (CT) code sets. Data in this report includes Virginia residents and out of state residents who visit facilities that send data to VDH. Readers are strongly encouraged to review [syndromic surveillance data limitations](#) when interpreting this report.

Data alerts (shown by yellow and red dots in graphs) indicate the number of ED and urgent care visits for that week was higher than the number of visits expected to occur compared to a baseline from the previous weeks (**red alert** = p-value <0.01, **yellow warning** = p-value <0.05).

Weekly visit counts for diagnosed COVID-19, influenza, and RSV with a zero to four percent change ($0 \pm 4\%$) compared to the previous week are defined as **stable**. Weekly visit percentages for acute respiratory illness and influenza-like illness that are within 0.5 percentage points from the previous week are considered **stable**.

II. Outbreak Surveillance Methodology

When a Local Health Department (LHD) is notified of an outbreak of any disease, the outbreak is entered into the Virginia Outbreak Surveillance System (VOSS). As the outbreak investigation continues, users update and add data to the outbreak record. Outbreaks are categorized by syndrome: Respiratory, Dermatological, Gastrointestinal, Sepsis, and Other. Respiratory syndrome outbreak data is pulled for this report.

The Earliest Outbreak Report Date (displayed as Date Reported) is the earliest date from among the following: 1) the date the local health department was notified of the outbreak, 2) the date VDH central office staff was notified of the outbreak, 3) the date the outbreak investigation began, or 4) the date the outbreak record was created in the Virginia Outbreak Surveillance System.

III. Laboratory Surveillance Methodology

Influenza positive labs are reported by laboratories and the providers via Electronic Lab Report (ELR) or fax. ELR submissions go directly in the Virginia Electronic Disease Surveillance System (VEDSS) and the faxed influenza positive labs (if confirmed by culture, antigen detection by direct fluorescent antigen (DFA), or nucleic acid detection) are entered in VEDSS manually. R version 4.1.1 was used to run this report. Flu+SARS CoV-2 multiplex tests are not included as of this report but will be added in the future reports.

Case Definitions

I. Syndromic Surveillance Definitions

Each of the definitions below includes visits to emergency departments (EDs) and urgent cares.

Diagnosed Acute Respiratory Illness: visits with any acute respiratory diagnosis, including specific respiratory infections (e.g. influenza, RSV, or coronavirus) and general respiratory illness diagnoses, such as bronchitis, upper respiratory infection, or pneumonia.

Influenza-like Illness: visits with a chief complaint of 'flu', fever and sore throat, or fever and cough.

Diagnosed COVID-19: visits that include COVID-19 in the discharge diagnosis.

Diagnosed Influenza: visits that include influenza in the discharge diagnosis.

Diagnosed Respiratory Syncytial Virus (RSV): visits that include RSV in the discharge diagnosis.

Note that data may not represent confirmed cases of these conditions, but they can assist with understanding the burden on healthcare systems and the community.

II. Outbreak Surveillance Definitions

Confirmed Outbreak: An outbreak with 2 or more positive confirmatory lab results² without a more likely source of exposure.

Suspected Outbreak: An outbreak with either 1 or more confirmatory and 1 or more non-confirmatory positive lab results¹ or case that meets the epidemiological case definition without a more likely source of exposure.

Unknown Etiologic Agent: An outbreak without a clear distinction or enough supportive laboratory confirmation results to declare a true etiologic agent. In this report, outbreaks with an unknown agent contain respiratory disease symptoms (cough, sneeze, headache, etc.) but do not have confirmatory lab information that proves a specific respiratory etiologic agent (negative flu panel or SARS-CoV-2 tests).

III. Laboratory Surveillance Definitions

Influenza Positive Lab Reports: Influenza positive lab reports include lab reports that were confirmed by PCR or viral culture or antigen detection by DFA to be positive for influenza virus. This does not include 'Flu Rapid Antigen' tests as those are not reportable in Virginia. 'Undetermined' test results are not included in this report.

¹ Dependent on the etiologic agent in question