



“Improving Public Health in Our Community Through Cooperation”

Alachua County Health Department
(352) 334-7900

Rabies Surveillance and Awareness

Submitted by: Nadia Kovacevich and Devin Myers
Epidemiologists at DOH-Alachua

To report a disease, phone or fax the appropriate office below:

Administrator
Paul Myers, MS
(352) 334-8892

Environmental Health
Director Anthony Dennis
(352) 334-7931

HIV/AIDS
Richard Willis, Surveillance
(352) 334-7968
Fax (352) 334-8867

Martha Buffington, Ryan White
(352) 334-7967

Epidemiology/Hepatitis
Nadia Kovacevich, MPH
(352) 225-4181
Fax (352) 955-6464

Immunizations
Michael Smith, RN
(352) 334-8827
Fax: (352) 334-7943

Sexually Transmitted Disease
Larissa Cantlin-Plemmons
(352) 334-7900 ext 3434
Fax: (352) 334-8818

Tuberculosis
Geneva Saulsberry, RN, BSN
(352) 225-4188
Fax(352) 955-6464

After Hours:
(352) 334-7900

Editor
Sheila Griffis

In Florida, 79 fatal cases of human rabies have been reported between 1881 and 2017. The first known human case of rabies in Florida was recorded as “hydrophobia” on the death certificate of a 38-year-old man from Key West in 1881. Historical documents indicate that rabies was considered rare in 1894 but was becoming more common in northern Florida counties. During the first quarter of the 20th century, rabies in dogs was a major problem. The disease in dogs was finally brought under control in the early 1950s as public concern stimulated passage of rabies vaccination and animal control ordinances in many Florida cities and counties. Among wildlife in Florida, raccoons, bats, and foxes are the animals most frequently diagnosed with rabies. The first reported case of rabies in raccoons occurred in 1947 in Brevard County. Dogs are the major source of animal bites in Florida, followed by cats, rodents, raccoons, bats, and other species (Florida Department of Health, 2016).

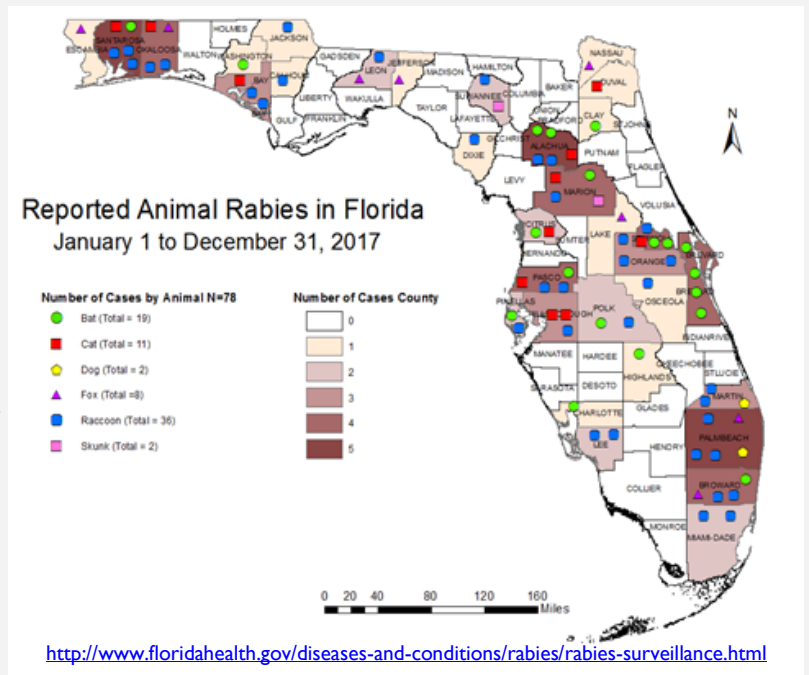
Reference:

Florida Department of Health. (2016). Rabies Background and General Virus Information. Retrieved from http://www.floridahealth.gov/diseases-and-conditions/rabies/_documents/rabies-prevention-and-control-guidebook/rabies-background-virus-information.pdf

Residents and visitors are advised to take the following precautions:

- Keep rabies vaccinations up to date for all pets.
- Keep your pets under direct supervision so they do not come in contact with wild animals. If your pet is bitten by a wild animal, seek veterinary assistance for the animal immediately and contact Alachua County Animal Services (ACAS) at 352-264-6870.

- Call ACAS to report any stray dogs in your neighborhood or private property owners can hire a nuisance wildlife trapper for removal of wildlife. For a list of wildlife trappers, visit <https://public.myfwc.com/HGM/NWT/NWTSearch.aspx>
- **Do not** handle, feed, or unintentionally attract wild animals with open garbage cans or litter.
- **Do not** leave food sources out for wildlife such as pet food or unsecured garbage.
- **Avoid** contact with stray and feral animals.
- **Never** adopt wild animals or bring them into your home.
- Teach children **never** to handle unfamiliar animals, wild or domestic, even if they appear friendly.
- Prevent bats from entering living quarters or occupied spaces in homes, churches, schools, and other similar areas, where they might come in contact with people and pets.
- Persons who have been bitten or scratched by wild or domestic animals should seek medical attention and report the injury to the Florida Department of Health in Alachua County at 352-225-4181.



<http://www.floridahealth.gov/diseases-and-conditions/rabies/rabies-surveillance.html>



Prevention and Control of Tuberculosis Among Homeless Persons Recommendations of the Advisory Council for the Elimination of Tuberculosis.

Submitted By: Geneva Saulsberry, RN, BSN
Senior CHN Supervisor, ACHD

SUMMARY

Because tuberculosis (TB) is a major problem among homeless persons, the Advisory Council for the Elimination of Tuberculosis has developed recommendations to assist health-care providers, health departments, shelter operators and workers, social service agencies, and homeless persons prevent and control TB in this population. TB should be suspected in any homeless person with a fever and a productive cough of more than 1-3 weeks' duration, and appropriate diagnostic studies should be undertaken. Confirmed or suspected TB in a homeless person should be immediately reported to the health department so that a treatment plan can be decided upon and potentially exposed persons located and examined. Patients with TB should be counseled and voluntarily tested for human immunodeficiency virus (HIV) infection because TB treatment recommendations are different for HIV-seropositive and HIV-seronegative persons (1). TB therapy should be directly observed whenever possible. This may require the establishment of special shelters or other long-term-care arrangements for homeless persons with TB. For each person with an infectious case, an investigation should be conducted to identify exposed persons, and those found to be infected should be considered for preventive therapy. Shelter staff should receive a tuberculin skin test when they start work and every 6-12 months thereafter. Those with positive skin test results should be considered for preventive therapy according to current guidelines. Shelters for the homeless should be adequately ventilated. The installation of ultraviolet lamps also may be useful to further reduce the risk of TB transmission.

INTRODUCTION

Since the early 1900s, tuberculosis (TB) has been recognized as an important health problem among homeless persons and among residents of inexpensive lodging houses, night shelters, single-room occupancy hotels, and common hostels. Subsequent reports have continued to call attention to this problem, especially in the United Kingdom. With the increase in homelessness in the United States during the 1980s, TB among homeless persons became a subject of heightened interest and concern.

There is no universally agreed-upon definition of homelessness; in general, however, the homeless can be defined as persons who do not have customary and regular access to a conventional dwelling or residence. The exact number of homeless persons at any given time is not known, and reported estimates have varied widely. According to the Urban Institute, there may have been more than 1 million persons in the United States who were homeless at some time during 1987.

From a national perspective, the overall incidence of active TB and the prevalence of latent tuberculous infection among the homeless are unknown. Based on screening at selected clinics and shelters, the prevalence of clinically active disease ranges from 1.6% to 6.8% and the prevalence of latent TB infection ranges from 18% to 51% (12,13,15-17). Clinical data from the National Health Care for the Homeless project indicated a point prevalence of active TB of 968/100,000 homeless adults. However, because of the selective nature of these screening activities, it is not appropriate to extrapolate these reported prevalence rates nationwide or to "special populations," such as single-parent families or runaway children.

Although shelters and other inexpensive housing for the homeless are vital to the survival of these persons, there is substantial potential for TB transmission in such facilities, especially in the winter when shelters are likely to be more crowded and ventilation from the outside may be diminished.

The recommendations in this document are intended for the entire medical community and the public, but are particularly targeted to health department TB-control programs and to those who provide health care and other services to homeless persons. Health departments and shelter operators are encouraged to implement these recommendations whenever applicable.

ASSESSMENT OF THE MAGNITUDE OF THE PROBLEM

Communities should assess the nature and magnitude of the TB problem in their area, specifically, the incidence and prevalence of TB among persons who are homeless. All patients with TB should be specifically asked whether they are homeless or live at a single-room occupancy hotel, shelter, or lodging house since they may not volunteer such information. Health departments should maintain, and regularly update, listings of single-room occupancy hotels and homeless shelters so that patients' addresses can be checked against these listings. Shelters should be encouraged to maintain lists of names of persons staying there. This will facilitate health department searches for patients in need of diagnostic or therapeutic services.

PRIORITIES FOR TB SERVICES

Priorities for TB prevention and control activities among homeless persons have been established on the basis of their clinical and public health importance and their cost-effectiveness.

Priorities for Tuberculosis Prevention and Control Activities Among Homeless Persons

1. The highest priority should be given to
 - a) detection, evaluation, and reporting of homeless persons who have current symptoms of active TB and
 - b) completion of an appropriate course of treatment by those diagnosed with active TB.
2. The second priority should be screening and preventive therapy for homeless persons who have, or are suspected of having, human immunodeficiency virus (HIV) infection.
3. The third priority should be the examination and appropriate treatment of persons with recent TB that has been inadequately treated.
4. The fourth priority should be screening and appropriate treatment of persons exposed to an infectious (sputum-positive) case of TB. Because contacts are difficult to define in a shelter population, it is usually necessary to screen all residents of a shelter when an infectious case is identified.
5. The fifth priority should be screening and preventive therapy for homeless persons with known medical conditions that increase the risk of TB, e.g., diabetes mellitus.

CONCLUSIONS

Homeless persons suffer disproportionately from a variety of health problems, including TB. Detecting, treating, and preventing TB in this special population benefit not only persons who are homeless, but society at large. The goal of prevention and control of TB among the homeless is difficult and challenging, but it can be achieved.

In an effort to detect and prevent the spread of Active TB disease within our homeless population, the FL DOH Alachua County Health Department has initiated a process to screen the residents and clients who utilize homeless shelters with our local community. So far the Alachua County Health Department has begun offering TST skin tests (PPDs) on clients who frequent the St. Francis Homeless Shelter as well as the Grace Marketplace and Dignity Village. In an effort to be proactive, it is our hope that we can detect TB infection and prevent the formation of active TB disease within our homeless population.

Portions of this article were taken directly from:

<https://www.cdc.gov/mmwr/preview/mmwrhtml/00019922.htm>

FLORIDA REPORTABLE DISEASES *Alachua County 2 year activity*

Disease Activity	2018	2017	2017	Cont'd.	2018	2017	2017
	Jan-Jun	Jan-Jun	Jan-Dec		Jan-Jun	Jan-Jun	Jan-Dec
AIDS	**	**	**	Meningitis, bacterial or mycotic	2	0	1
Anaplasmosis, HGA(<i>Anaplasma Phag</i>)	0	0	1	Meningococcal disease	0	0	1
Anthrax	0	0	0	Mercury poisoning	0	0	0
Botulism	0	0	0	Mumps	0	0	
Brucellosis	0	0	0	Neurotoxic shellfish poisoning	0	0	0
Campylobacteriosis	18	23	54	Pertussis	1	0	0
Carbon Monoxide Poisoning	0	1	6	Pesticide-related Illness and injury, acute	0	0	0
Chikungunya fever	0	0	0	Plague	0	0	0
Chlamydia	1164	1085	2192	Psittacosis (ornithosis)	0	0	0
Ciguatera	0	0	0	Q Fever	0	0	0
Creutzfeldt-Jakob Disease (CJD)	0	0	2	Rabies, animal or human	2	2	4
Cryptosporidiosis	0	3	7	Rabies, possible exposure	44	23	73
Cyclosporiasis	0	0	0	Ricin toxin poisoning	0	0	0
Dengue	0	0	0	Rocky Mountain spotted fever and other spotted fever rickettsioses	0	0	0
Diphtheria	0	0	0	Rubella	0	0	0
Ehrlichiosis, HME (<i>Ehrlichia chafeensis</i>)	1	0	2	Salmonellosis	26	20	55
Ehrlichiosis/anaplasmosis	0	0	1	Saxitoxin poisoning (paralytic shellfish poisoning)	0	0	0
<i>Escherichia coli</i> infection, Shiga toxin-producing	4	3	9	Severe acute respiratory disease syndrome associated with coronavirus infection	0	0	0
Giardiasis (acute)	3	3	12	Shigellosis	4	3	8
Gonorrhea	367	289	618	Smallpox	0	0	0
<i>Haemophilus influenzae</i> , invasive disease in children <5 years old	4	1	1*	Staphylococcal enterotoxin B poisoning	0	0	0
Hansen's Disease (Leprosy)	0	0	0	<i>Staphylococcus aureus</i> infection (VISA, VRSA)	0	0	0
Hantavirus infection	0	0	0	<i>Streptococcus pneumoniae</i> invasive disease in children (drug resistant) <6 years old	0	0	0*
Hemolytic uremic syndrome (HUS)	0	0	0	<i>Streptococcus pneumoniae</i> invasive disease in children (susceptible) <6 years old	0	1	1*
Hepatitis A	1	1	2	Syphilis	24	23	44
Hepatitis B Acute	1	0	1	Syphilis in pregnant women & neonates	0	0	0
Hepatitis B Chronic	19	28	58	Tetanus	0	0	0
Hepatitis B surface antigen in pregnant women or children <2 years old	0	1	8	Trichinellosis (trichinosis)	0	0	0
Hepatitis C Acute	2	0	2	Tuberculosis (TB)	1	2	6
Hepatitis C Chronic	132	101	180	Typhoid fever (<i>Salmonella</i> serotype Typhi)	3	0	0
Herpes B Virus, Possible Exposure	0	0	0	Typhus fever, epidemic	0	0	0
Herpes simplex virus (HSV) in infants	0	0	0	Varicella (chickenpox)	2	3	11
HIV	**	**	**	<i>Vibrio cholerae</i> type 01	0	0	0
Influenza A, novel or pandemic strains	0	0	0	<i>Vibrio cholerae</i> type Non-01	0	1	1
Lead Poisoning	5	5	8	<i>Vibrio (Parahaemolyticus, other)</i>	0	0	1
Legionellosis	1	0	3	<i>Vibrio fluvialis</i>	1	0	0
Listeriosis	0	0	0	<i>Vibrio vulnificus</i>	1	0	0
Lyme Disease	0	1	1	Zika Virus Disease and Infection, Non Congential	0	2	2
Lymphogranuloma Venereum (LGV)	0	0	0				
Malaria	0	1	3				
Measles	0	0	0				

The counts include suspect, probable, and confirmed cases reported in Alachua county residents (regardless of where infection was acquired) by date reported to the Department of Health. Counts are provisional and subject to change until their respective database closes.

* Changes to case definitions can affect the number of cases reported.

**Data from the most recent calendar year (2017) are considered provisional and therefore should not be used to confirm or rule out an increase in newly reported cases in Florida. The final year-end numbers are generated in July of the following year, after duplicate cases are removed from the dataset, as is customary of HIV surveillance in the US. Statistics can be found at <http://www.flhealthcharts.com/charts/communicablediseases/default.aspx>

◆ REGULAR BUSINESS HOURS (8AM-5PM, M-F): **352-225-4181**

◆ **After-hours and Holidays (24/7): 352-334-7900** (please listen to prompts to receive a callback).

The Epidemiology Program conducts disease surveillance and investigates suspected occurrences of infectious diseases and conditions that are reported from physician's offices, hospitals, and laboratories. Surveillance is primarily conducted through passive reporting from the medical community as required by Chapter 381, Florida Statutes. Data is collected and examined to determine the existence of trends. Our staff ensures that action is taken to prevent infectious disease outbreaks from occurring in Alachua County.



Persons Living With HIV Out of Care in Florida, 2018¹

Florida HIV/AIDS Comprehensive Planning Network (FCPN) Meeting
April 18–19, 2018

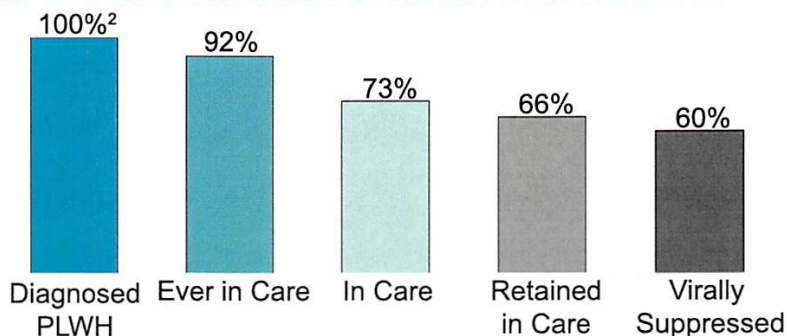
Persons living with HIV (PLWH) in Florida Year-end 2016

- 135,986** Estimated PLWH
- 114,772** Diagnosed PLWH
- 105,895** Ever in Care
- 84,105** In Care
- 75,895** Retained in Care
- 69,254** Virally Suppressed

In Care: Documented care ≥1 time in 2016.

Retained in Care: Documented care ≥2 times, ≥3 months apart in 2016.

The HIV Care Continuum, Florida, Year-end 2016



²The Centers for Disease Control and Prevention estimate **15.6% (N=21,214)** of Floridians are unaware of their HIV status but are not included in this continuum.

Diagnosed PLWH Currently¹ Out of Care in Florida

34,675

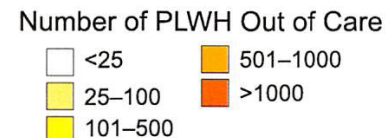
PLWH did not receive any HIV care in Florida in the last year

15,632

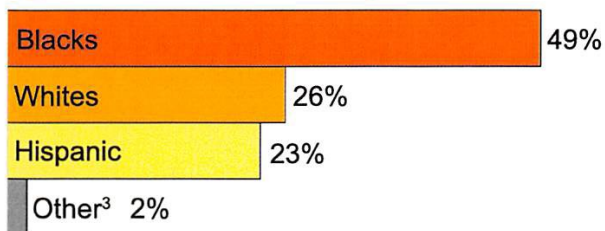
Of these PLWH are living with AIDS

¹Preliminary Data: PLWH diagnosed through 12/31/2017 and no care in the last 12 months as of 4/02/2018

Numbers of diagnosed PLWH currently out of care in Florida vary by county

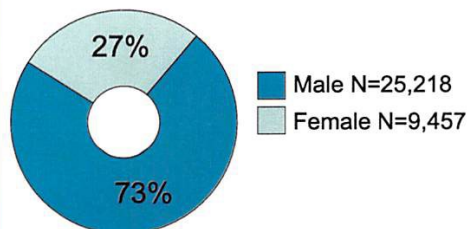


Blacks represent the highest proportion of diagnosed PLWH currently out of care

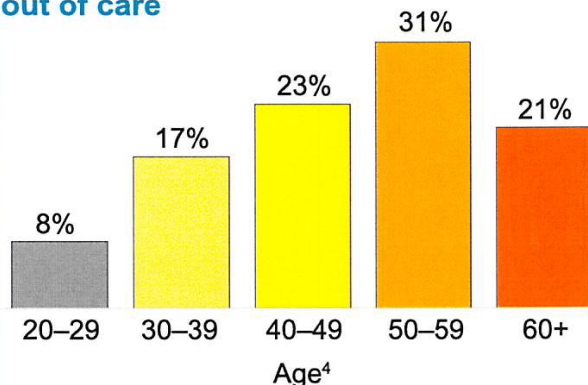


³“Other” includes Asian/Pacific Islanders, American Indians/Native Alaskans and mixed races.

More male diagnosed PLWH are currently out of care than female

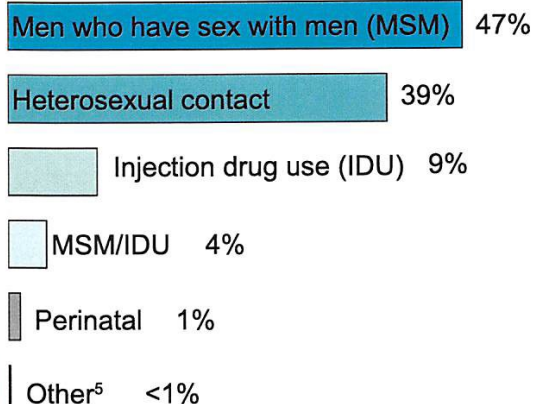


Diagnosed PLWH ages 50–59 represent the highest proportion of those currently out of care



⁴Ages Under 13 (N=17) and 13–19 (N=70) not shown because they represent less than 1 percent of data.

Diagnosed PLWH currently out of care vary by mode of HIV exposure



⁵"Other" includes hemophilia, blood transfusion, and no identified risk factor.

Florida's Current HIV Re-engagement in Care Efforts

The Florida Department of Health (DOH) HIV/AIDS Section currently employs the following programs to address linkage to and re-engagement in HIV medical care:

Linkage to Care Program

Florida's Linkage to Care Program assists PLWH who are aware of their status, who have newly tested HIV positive, and who are not currently accessing HIV care. The program goals are to increase the number of PLWH linked to care, retained in care on antiretroviral therapy and with a suppressed viral load.

Data to Care Program

Florida's Data to Care (D2C) Program is a High-Impact Prevention (HIP) strategy that relies on the use of surveillance and care indicator data to identify PLWH not in care. Those identified by D2C as not receiving treatment are offered services to help link them to the HIV care they need. Florida is a high morbidity state that has had a statewide D2C program since 2015 and is using D2C outcomes to determine potential barriers to care.

Re-engagement in Care Pilot

The Reengagement in Care Pilot is an extension of the D2C Program which works to identify PLWH who have previously received HIV medical care but have not been retained in care. This pilot will serve to re-engage PLWH that received Ryan White or AIDS Drug Assistance Program (ADAP) services from 11/01/2015–10/31/2016 but were out of care from 11/01/2016–10/31/2017.

For more information contact:
Emma Spencer, PhD
emma.spencer@flhealth.gov

For more Florida HIV data:
go to www.floridaaids.org/

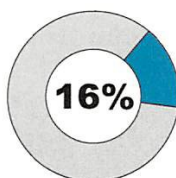


Data to Care Program (D2C)

Florida HIV/AIDS Comprehensive Planning Network (FCPN) Meeting
April 18–19, 2018

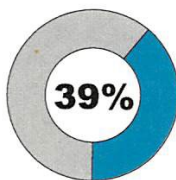
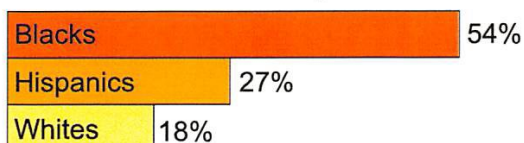
Florida's Data to Care (D2C) Program is a High-Impact Prevention (HIP) strategy that relies on the use of surveillance data and other care indicators to identify persons living with HIV (PLWH) not in care. Linkage services are offered to those identified by D2C not receiving treatment by connecting them with the HIV care they need. Florida is a high morbidity state that has implemented a statewide D2C program since 2015 and is using D2C outcomes to determine potential barriers to care.

Linkage Disparities in Florida



Of persons whose HIV was diagnosed in Florida in 2015 and 2016 (1,547 out of 9,680) were not in care within 3 months of HIV diagnosis

Blacks represented the highest proportion of the 1,547 persons not linked to care within 3 months of HIV diagnosis



Of the 1,547 persons not linked to care within 3 months of HIV diagnosis were ages 20–29

D2C is designed to improve upon the HIV Care Continuum and:

- Increase the percentage of PLWH who are engaged in care
- Increase the percentage of PLWH with a suppressed viral load
- Reduce HIV-related health disparities

Who are the priority populations?

D2C addresses priority populations comprised of PLWH who are not receiving HIV care and need to be linked to care. These populations include:

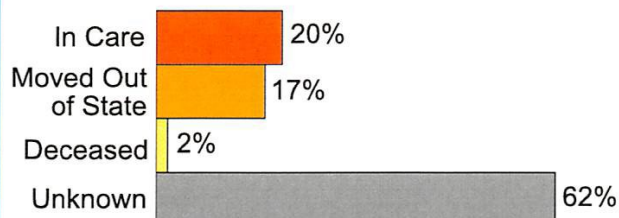
PLWH identified as part of a group susceptible to increased HIV transmission and drug resistance

Out of Care PLWH identified as sampled persons for the Medical Monitoring Project

Recently reported PLWH not linked to care within 90 days following their HIV diagnosis

Most Recent¹ D2C Program Outcomes

For Floridians who had an HIV diagnosis reported from April to June 2017, were out of care, and were placed on the D2C list for linkage and reengagement to HIV care, the D2C program updated their care status from out of care and living in Florida to:



"Unknown" refers to outcomes that could not be verified through lab reports or other documentation in eHARS

Persons reported as linked to care through D2C reported the following barriers to being previously linked to care, shown in order from most to least reported:

1. Lack of Insurance
2. Financial Issues
3. Lack of Knowledge
4. Fear of Disease
5. Client Reports Feeling Well

¹Preliminary data represent outcomes for persons whose HIV diagnosis was reported from April 2017 to June 2017 (n=113).



Older Adults Living with HIV in Florida, 2016

HIV Among Older Adults (Age 50+)

58,200

out of 114,772 Persons living with HIV (PLWH) in Florida were older adults

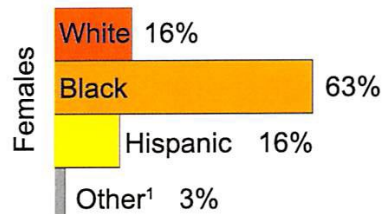
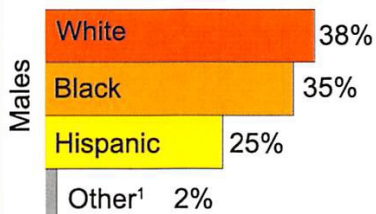
1,028

out of 4,972 persons with a diagnosis of HIV in Florida in 2016 were older adults

692

out of 2,119 persons with a diagnosis of AIDS in Florida in 2016 were older adults

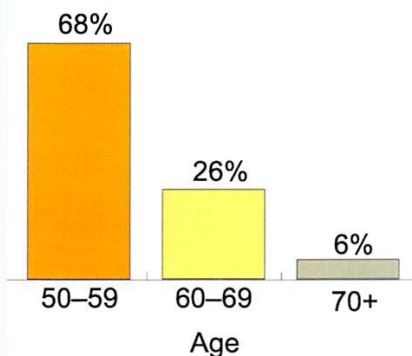
Whites represented the highest proportion of older males diagnosed with HIV in 2016



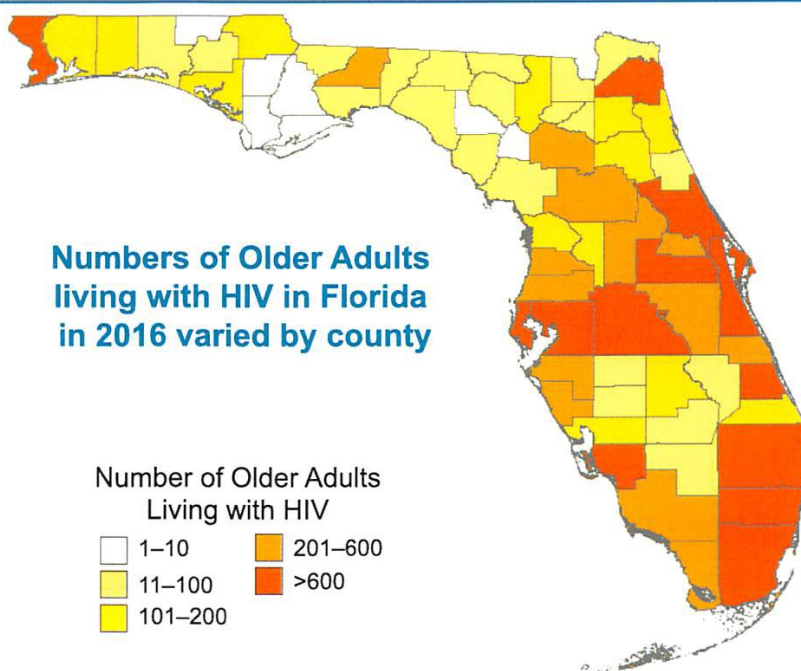
¹Other includes Asian/Pacific Islanders, American Indians/Native Alaskans and mixed races.

Blacks represented the highest proportion of older females diagnosed with HIV in 2016

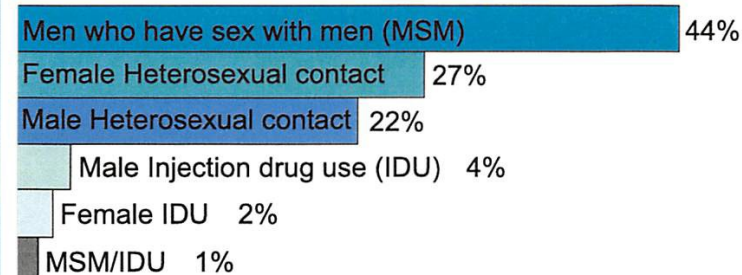
The highest proportion of older adults diagnosed with HIV in 2016 were ages 50–59



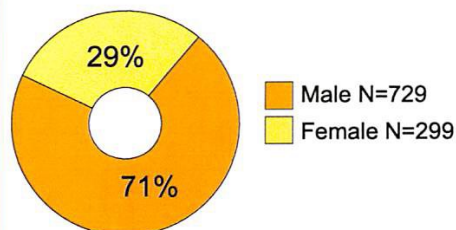
Numbers of Older Adults living with HIV in Florida in 2016 varied by county



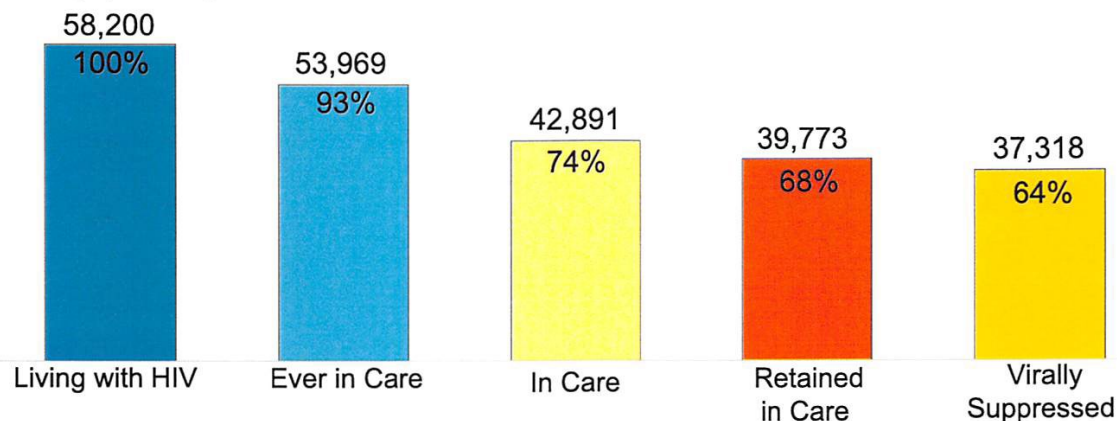
Older adults diagnosed with HIV in 2016 by mode of HIV exposure



Older males were more likely to be diagnosed with HIV than older females in 2016



Older Adults along Florida's 2016 HIV Care Continuum The HIV Care Continuum reflects the series of steps a person living with HIV (PLWH) takes from initial diagnosis to being retained in care and achieving a very low level of HIV in the body (viral suppression). A PLWH with a suppressed viral load is highly unlikely¹ to transmit the virus to others.



Blacks have the lowest proportion of older (age 50+) PLWH with a suppressed viral load (59%) compared to whites (70%), Hispanics (64%), and other races (68%).

In Care: Documented care ≥ 1 time in 2016. **Retained in Care:** Documented care ≥ 2 times, ≥ 3 months apart in 2016.

HIV Testing

All adolescents and adults (ages 13–64) should be tested for HIV at least once during their lifetime. Persons at increased risk for HIV should be tested **annually**. Per Florida law, all pregnant women are to be tested for HIV and other sexually transmitted diseases (STDs) at their initial prenatal care visit, again at 28–32 weeks and at labor and delivery if HIV status is unknown.

www.knowyourhivstatus.com

Pre-Exposure Prophylaxis (PrEP)

For persons at increased risk for HIV, a pill (Truvada®) once daily, can reduce the risk of acquiring HIV by over **90%**. Condoms are still recommended during sex to prevent other STDs, which are increasing in Florida, and which can increase HIV risk.

www.prelocator.org

Antiretroviral Therapy (ART)

For persons newly diagnosed with HIV, starting ART with a provider immediately after diagnosis improves health outcomes by preventing disease progression and reducing viral load, making transmission highly unlikely.

To find a care provider or to learn more about the resources available to persons living with HIV visit:

www.floridaaids.org

Florida HIV/AIDS Hotline

1-800-FLA-AIDS (352-2427) English
1-800-545-SIDA (545-7432) Spanish
1-800-AIDS-101 (243-7101) Haitian Creole
1-800-503-7118 Hearing/Speech Impaired

www.211bigbend.org/flhivaids hotline

Text 'FLHIV' or 'flhiv' to 898211

For more information contact:

DiseaseControl@flhealth.gov

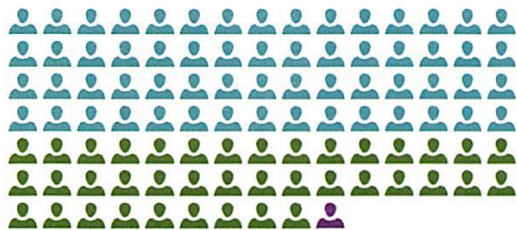
Data Sources:

For national facts, go to: www.cdc.gov/hiv/library/factsheets/index.html or www.kff.org/hivaids/
Florida data: FL Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section
For more Florida data, go to www.floridaaids.org/

¹Rodger et al. (2016). www.jamanetwork.com/journals/jama/fullarticle/2533066

Technology Use of People Living with HIV in Florida

Participant Demographics



Male (59.88%) Female (38.92%)
 Trans Male (0.40%) Trans Female (0.80%)



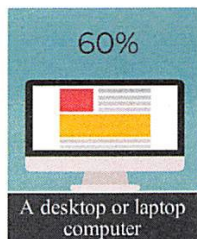
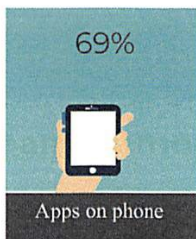
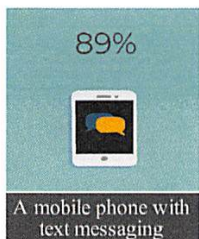
Age: 19-87
 M: 48.4



Black (54.27%) Hispanic or Latino (25.54%)
 White (27.06%) Native American (3.11%)
 Asian (0.64%)

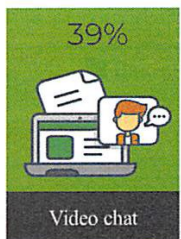
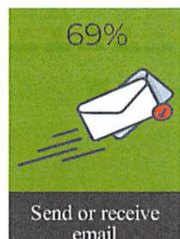
Technology use

Do you use...



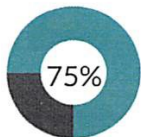
Use of the Internet

Do you use the Internet to do any of the following activities?

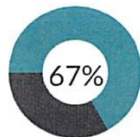


Use of technology to find out more about HIV

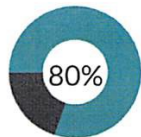
Would you be willing to use the following devices to access more information about HIV?



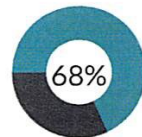
Desktop, laptop notebook, or notebook computer



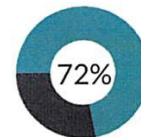
Tablet computer



Mobile phone with text messaging



Apps on phone



Internet on phone

For additional information or regionally specific data please contact floridaproject@health.usf.edu
 Principal Investigator: Stephanie Marhefka, PhD; smarhefk@health.usf.edu
 Reference: Marhefka, S.L, Turner, D, Lockhart, E, Vereen, S, Roig-Romero, R, Rupani, R. (2018, April, 18). *Technology Use of People Living with HIV in Florida* [Infographic]

