



Epi Update



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Epidemiology: The study of the distribution and determinants of health-related states or events in specified populations, and the application of this study to control health problems.

Stedman's Medical Dictionary, Ed. 27

Bureau of Epidemiology's Annual Florida Epidemiology Conference Scheduled

by Debora Campbell, MS, CHES

The 12th Annual Florida Epidemiology Conference has been scheduled for May 22-24, 2007 in Daytona Beach. The theme of this year's conference is *Preparing for Tomorrow's Public Health Challenges*, and its purpose is to increase knowledge, skills, and competencies of epidemiology professionals by providing a forum for learning and networking through sessions, workshops, social events, poster presentations, and meetings. The conference objectives are 1) To enhance awareness of new technologies and innovative concepts that are key to the skills needed by the epidemiologist in various settings to prevent outbreaks; 2) To increase understanding of new and updated information and research in the fields of epidemiology, infection prevention and control, disaster/emergency preparedness, and chronic disease prevention and control; 3) To increase the epidemiologic knowledge of today's public health workforce to enable it to respond to any challenge.

The conference will begin at 12:00 p.m. on May 22 and end at 12:00 p.m. on May 24. We're also pleased to host this year's Florida Epidemic Intelligence Service graduation ceremony on the evening of May 22nd.

As at past conferences, we plan a juried poster session. During the coming weeks, we will post abstract guidelines and a submission form on our Internet site. Abstracts will be due to the poster coordinator (to be named at a later date) by close of business on March 23. We will also seek nominations for Golden Partnership Awards and will distribute information about making nominations for these important awards in the near future.

More details will be available on the Bureau of Epidemiology website beginning March 2. Once active, the address will be: http://www.doh.state.fl.us/disease_ctrl/epi/index.html.

Debora Campbell is the training and education manager at the Bureau of Epidemiology in Tallahassee. She can be reached at 850.245.4409.

Age Group Difference in Influenza-like Illnesses (ILI) Observed from Emergency Department (ED) Visits in Miami-Dade County

by Rodlescia Sneed, MPH; Guoyan Zhang, MD, MPH; Erin O'Connell, MPH; Claudio Micieli, MPH, Rene Borroto-Ponce; Fermin Leguen, MD, MPH, Miami-Dade County Health Department

Objective

The purpose of this study was to describe the usefulness of the ESSENCE syndromic surveillance system in determining age group differences for influenza-like illness (ILI) activity in Miami-Dade County.

Background

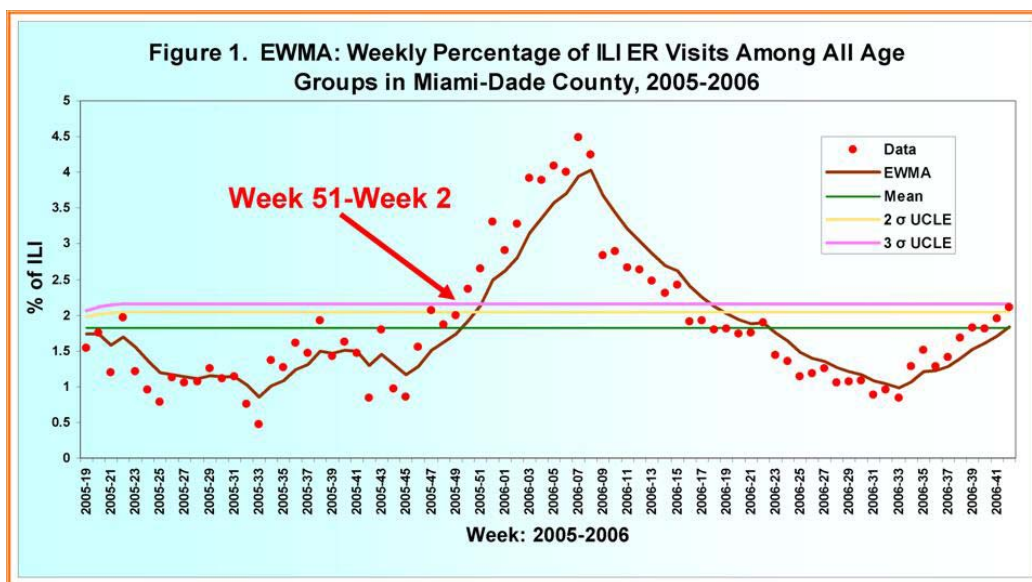
The threat of pandemic and seasonal influenza has drawn attention to syndromic surveillance systems for early detection of influenza-like illness⁽¹⁾. Since 2005, the Miami-Dade County Health Department has implemented ESSENCE to monitor emergency department data for ILI. This study describes ILI surveillance methods in Miami-Dade County.

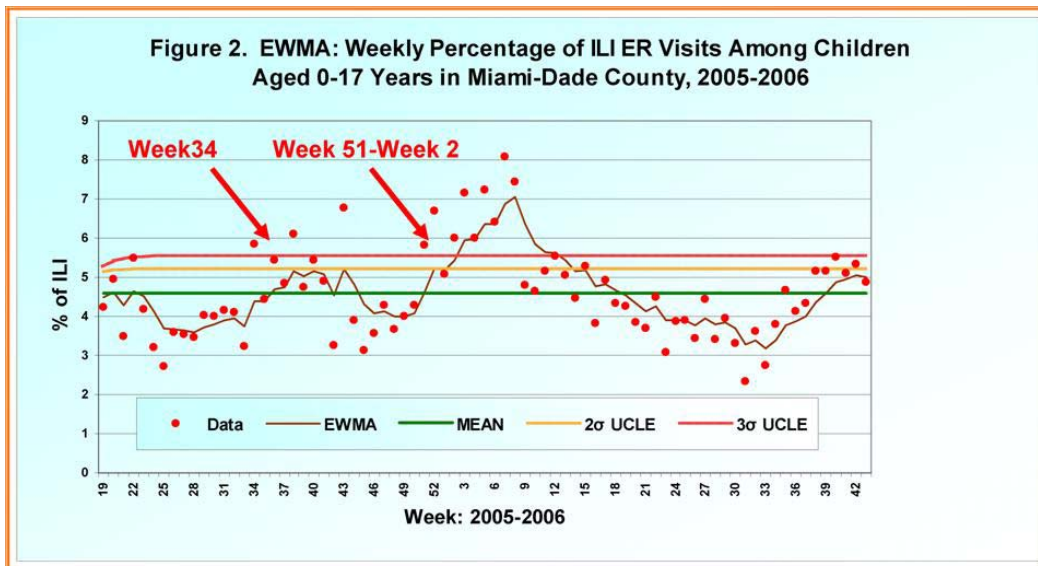
Methods

On a daily basis, eleven Miami-Dade County hospitals automatically transmit ED chief complaint data to the Office of Epidemiology and Disease Control. Complaints are categorized into one of ten clinical syndromes. The ILI category includes a chief complaint of fever with either cough or sore throat. It can also include a chief complaint of flu. Two methods are used to monitor ILI: daily surveillance and weekly surveillance. With the daily method, daily values for ILI are evaluated within the ESSENCE system using a 28-day exponentially weighted moving average (EWMA). This method is meant to detect acute events indicative of a possible outbreak. With the weekly method, an EWMA is calculated in SAS 9.1 using the weekly percentage of ILI visits. The threshold upper control limits for the EWMA (UCLE) are 2 and 3 σ above the mean. This method allows us to monitor long-term trends consistent with the start and end of the influenza season.

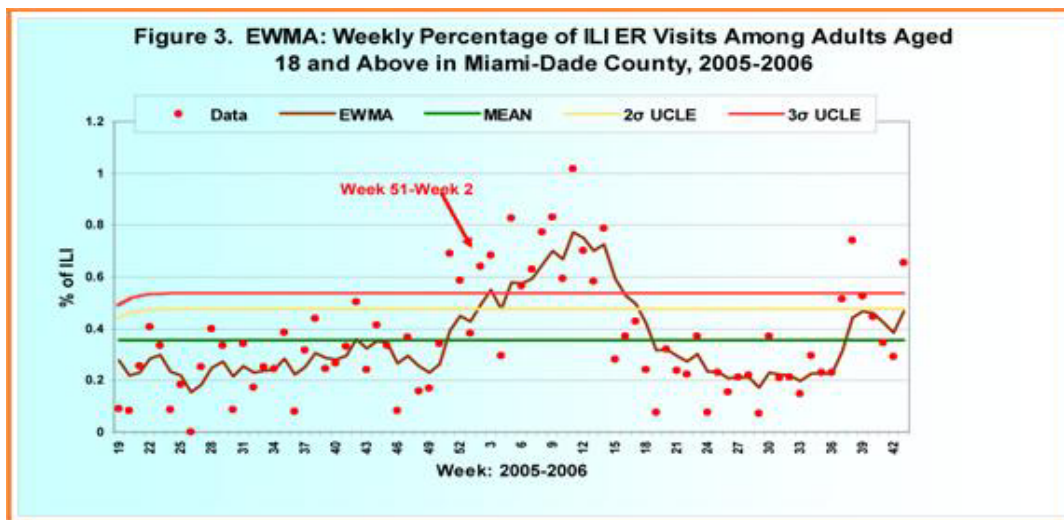
Results

During 2005 and 2006, weekly ILI surveillance showed that influenza activity began to increase in November 2005 (Week 46). Across all age groups, activity began to reach the UCLE between week 51 of 2005 and week 2 of 2006, peaking in February 2006 (Week 8-9, Figure 1). At this peak, ILI visits represented 4% of total ED visits. The onset of peak activity varied by age group. Among children, there was a gradual increase in August, when the percentage of visits exceeded the 2 σ UCLE in week 34. The percentage of visits among children exceeded the 3 σ UCLE between week 51 in 2005 and week 2 in 2006, peaking in February 2006 (Week 5-9, see Figure 2).





Among adults, there was a gradual increase in ILI beginning in December 2005. The percentage of visits exceeded the 2 and 3 σ UCLE between week 51 of 2005 and week 2 of 2006, peaking in February 2006 (Week 6-8, see Figure 3). During the peak period, 6-7% of all ED visits among children and 0.7-0.8% of all visits among adults were for ILI.



Conclusions

This study demonstrates that there are some differences in ILI activity among pediatric and adult populations. There was a small peak in ILI activity among children at the end of August 2005, with a much larger peak in February 2006; the virus responsible for the two separate peaks in children is not known for sure. The only peak in ILI activity among adults occurred in February 2006. This peak was three weeks after the peak seen among children. Further, the percentage of ED visits attributable to ILI was much higher among children than adults. The ESSENCE system has demonstrated that it is an innovative element in seasonal influenza surveillance, and could represent a valuable surveillance tool for early detection of outbreaks.

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Highlights from Re-write of Chapter 64D-3, Florida Administrative Code (FAC)

by Janet J. Hamilton, MPH

The Florida Department of Health recently completed an extensive re-write of Chapter 64D-3, *Florida Administrative Code (FAC)* which governs notifiable diseases and conditions reporting in the state of Florida. The purpose of the re-write was to update, clarify, and streamline language within Chapter 64D-3, *FAC* in order to enhance disease reporting efficiency for health care providers including practitioners, laboratories, hospitals and other entities. These revisions became effective November 20, 2006. To access an online version of the updated document as well as other important disease reporting documents, log on to http://www.doh.state.fl.us/disease_ctrl/epi/topics/surv.htm.

The adoption process for the revisions began in October 2005. Changes were filed in September 2006 and published in the *Florida Administrative Weekly* the same month. The filing for adoption of the changes to Chapter 64D-3 occurred in October 2006, with final adoption on November 20, 2006. The entire revision process was lengthy as the last major revision of Chapter 64D-3 occurred in the 1970s. The revision process included workshops with laboratories to discuss the inclusion of mandatory electronic laboratory reporting. Workshops were also held with practitioners to discuss changes concerning new statutory requirements regarding sexually transmitted disease testing during pregnancy, and reporting human immunodeficiency virus (HIV) exposed infants. The re-write process also included public hearings as well as five official public comment periods.

The revised Chapter 64D-3 includes a single definitions section. Additionally there are specific reporting sections for practitioners, laboratories, and medical facilities such as hospitals. With the revision, Florida becomes the first state in the nation to designate a reporting timeframe, "Suspect Immediately," that requires diseases to be reported upon initial suspicion, prior to confirmatory diagnosis. This will aid in the public health response to diseases of a highly infectious origin and designated of urgent public health importance. There are now three main reporting timeframes in which to report diseases or conditions: Suspect Immediately (report immediately upon initial suspicion or laboratory test order, 24 hours a day, 7 days a week by phone), Immediately (report upon diagnosis 24 hours a day, 7 days a week by phone, and next business day, previously 72 hours (report upon diagnosis not later than the close of the county health department next business day)).

New diseases were added to the list of reportable diseases or conditions for both practitioners and laboratories. These include:

- Reportable by practitioners: HIV-exposed infants or newborns and conjunctivitis in neonates ≤ 14 days;
- Reportable by laboratories: CD-4 counts, HIV viral load, and STARHS (for detection of early HIV infection); abnormal cervical cytologist/histologies; ALL blood lead tests performed;
- Reportable by practitioners and laboratories (newly added): California serogroup viruses; HPV cancer-associated strains; novel or pandemic influenza virus strains (isolated from a human); influenza-associated pediatric mortality; hepatitis D, E, and G; Severe Acute Respiratory Syndrome; typhus fever (epidemic); varicella; varicella mortality; and cancer, including benign and borderline intracranial and central nervous system tumors.

In response to the extensive re-write of Chapter 64D-3, *FAC*, education efforts are underway. Many county health departments have completed a number of education efforts related to communicating information to providers in their areas. Some of these efforts include speaking at local infection control practitioner (ICP) meetings, holding special individual education sessions with local laboratorians and ICPs, distributing letters to providers summarizing changes, writing articles in epidemiology newsletters, and distributing the new practitioner list of reportable diseases with local fax, phone and after-hours numbers.

The Bureau of Epidemiology, Division of Disease Control, and Division of Environmental Health have also been working on material development to assist in education efforts both statewide and locally. All completed materials related to these

changes in and reporting requirements are published on the Bureau of Epidemiology *Internet* site at http://www.doh.state.fl.us/disease_ctrl/epi/topics/surv.htm. Information currently available includes:

- Updated Practitioner List of Reportable Diseases or Conditions
- Laboratory Reporting Guidelines for Notifiable Diseases or Conditions Reporting in Florida
- Letter from the Secretary regarding the effective date of the revision of Chapter 64D-3, *FAC*

In addition to the materials now available, work efforts are underway on the following items: Healthcare Practitioner Reporting Guidelines for Notifiable Diseases or Conditions in Florida, and a poster of the practitioner list of reportable diseases. Thank you for your partnership in working for public health in Florida!

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Community-based Mass Prophylaxis Drill: The University of Central Florida Experience

by Michael Deichen, MD, University of Central Florida Health Services; Claudia Witcher, RN, BS, UCF Health Services, and Linda M. Hennig, EdD, RN, UCF College of Nursing



The threat of a severe influenza pandemic occurring in the next few years is very real. The Department of State, US Centers for Disease Control and the Florida Department of Health have called for communities to formulate pandemic plans. Effective planning for any disaster, bioterrorism, or catastrophic event such as flu pandemic, requires collaboration among many community members and identification of accessible/available resources. On August 28, 2006 members of the University of Central Florida (UCF) community conducted a mock Pandemic Flu Mass Prophylaxis Drill.

The University of Central Florida is located in Orlando, Florida. With a student enrollment of approximately 48,000 students, it ranks as one of the 7th largest universities in the United States.

Planning for the mass prophylaxis drill was initiated in March 2006 when a UCF emergency management group met with representatives of the Orange County Health Department (CHD) to discuss UCF pandemic preparedness. Amongst other recommendations, Orange County public health officials advised planning for a mass vaccination drill. They further suggested that community vaccinations be accomplished within a 48-hour timeframe to also meet bioterrorism mass prophylaxis recommendations.

In April 2006, a UCF Mass Prophylaxis Planning Committee was formed. This committee consisted of community stakeholders from the University's Health Services Continuity of Operations Committee, Environmental Health and Safety, campus police, news and information representatives, the College of Nursing, and staff from the Orange CHD. The group also served as the Incident Command for the drill. Planning assumptions included that sustained human to human

transmission had begun four months prior to the availability of vaccine, and endemic illness was present locally. In addition, the community size estimated for vaccination was 50,000 people.

The resultant plans were consistent with those outlined by the Agency for Healthcare Research and Quality. Four strategically-located campus sites were identified to serve as the Dispensing/Vaccination Centers (DVCs). These sites were chosen for ease of access, size, security, local storage, utility/communications capacity, back-up generator availability, campus location, and proximity to the campus health center, which would serve as Command Central and the stockpile staging and distribution site. Campus administrators agreed to provide alphabetized lists of all registered students, faculty, and staff. For the drill, the student union ballroom DVC was activated. Although the entire DVC structure was set up, only partial staffing was planned.

The UCF Pandemic Mass Vaccination Plan calls for 74 people to staff each DVC for two 10-hour periods of time. These plans call for the DVCs to be staffed with 4 greeters, 8 check-in persons, 24 triage persons, 24 dispensing persons, 4 crowd-flow directors, 7 medical triage consultants and 3 check-out persons. Patients will be processed through various stations (check-in, form completion, screening/triage, vaccination and checkout). The rate limiting step is estimated to be two minutes for form completion. Such staffing will allow 12,500 persons to be processed at each site over two days (or 625 vaccinations per hour). These staffing allocations do not include campus police, who will secure the site and control the crowd. The calculations take into account essential break times for staff.

“Patient” volunteers were recruited from faculty, staff and students. Participants could proceed through the drill as many times as they desired and were registered for lottery prizes in exchange for participation. Approximately every 20th person was given a mock problem (possibly pregnant, fever, sore throat without fever, person on chemotherapy, person with close contact with individual who died of Avian flu and person who returned from travel from Vietnam in the past 10 days). “Worker” volunteers were largely made up of health service personnel and faculty and students from the College of Nursing.

The UCF drill positioned two greeters outside the DVC who directed people toward check-in stations and identified the potentially ill. Signage was posted outside the DVC requesting people to self-identify sickness or potential Avian flu exposure. People who self-identified had their temperature taken and were given a surgical mask. If febrile, they were referred to the health center. Afebrile persons continued to check-in. Check-in tables were positioned just outside the entry point. Each check-in worker identified people on the printed lists. Once checked in, patient volunteers were given a Spanish or English vaccine consent form. This form integrated WHO identifiers for Avian flu and standard CDC influenza vaccination consent information. Patients were directed to tables within the dispensing site for completion of the consent form. Posted conspicuously on the tables was CDC information that distinguished colds from influenza, and a list of countries with known cases of Avian flu.

After completing the questionnaire, people were directed to the screening/triage station where a healthcare worker reviewed the consent form. Those with risk for Avian flu were given a surgical mask to wear and were referred to the onsite medical unit (problem table). People with potential contraindications (pregnancy or pharmaceutical) were also referred to the onsite medical unit for consultation. Medical professionals who assessed the appropriateness of vaccination staffed the medical unit. Those who had possible Avian flu exposure with fever were referred to the health center. Once cleared by the screening or medical units, the patient volunteers were then directed to the vaccination stations. Two workers were at each station; one worker drew up vaccine and the other dispensed vaccine. M & M candy was dispensed in place of vaccination. N-95 face masks were worn by all workers and alcohol-based hand sanitizers were available throughout the building. There were also cots for acutely ill persons.

Command Central was contacted via walkie-talkie either when individuals were referred to the health center or if someone required transportation to the center via golf cart. Following successful vaccination, participants reported to the check-out stations and were qualified for a lottery and other favors.

The drill took place over a 3.5-hour timeframe and local media were on hand to record the event. Three hundred seventy-five individuals (or 107 per hour) were processed using approximately ¼ of the dispensing site workstations that would be staffed during an actual event. A steady-state operation was achieved, with uninterrupted flow and very little perceived wait times. With full dispensing site staffing, an equivalent of 429 individuals per hour would have been serviced, or 4,290 over 10 hours, or 8,580 over two projected days at this DVC. This was somewhat less than the initial goal of 625 vaccinations per hour, but still a successful outcome.

On-site observations suggest that extra capacity was achievable. It would appear that in the event of an actual mass prophylaxis, projected UCF staffing plans would be adequate. A debriefing by the planning committee identified the following needs: Better segregation of vaccination stations; larger letters on signage; develop a plan to recruit volunteers and identify all future mass vaccination workers; project 30-40% excess staffing to accommodate absenteeism; periodic

pre-print student/faculty/staff rosters (took one working day to print); define a single building entry and exit, and specific lines leading to the check-in area; provide DVC workers with vaccine prior to mass vaccination event; address discomfort associated with sustained use of N-95 masks by workers; set up a telephone tree for all work groups and update monthly.

The drill served not only to heighten UCF preparedness planning for a pandemic or bioterrorism event, but also helped to significantly raise awareness within the campus community. Both university leadership and community members now better understand pandemic contingency plans. After the drill, campus officials approved funding for further significant pandemic preparedness that includes stockpiling supplies and a large-scale hand-washing campaign. Communications with the Orange CHD have been further strengthened. The UCF Mass Prophylaxis Planning Committee will continue to meet on a regular basis to review CDC recommendations, update plans as needed, and establish target dates for future drills.

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Assessing the Utility of the Rapid Inquiry Facility (RIF) to Evaluate Birth Defects in Florida

by Greg Kearney, DrPH, MPH, RS; Chris Duclos; David Johnson, MD,
Division of Environmental Health

Background

The Rapid Inquiry Facility is an exploratory, hypothesis-generating tool. Under a CDC cooperative agreement, the Florida Department of Health and other states are developing an Environmental Public Health Tracking (EPHT) Network national health tracking system. Recently, DOH had the opportunity to evaluate the utility of the RIF using selected congenital malformations and hazardous waste sites. The RIF shows expanding promise in the US and abroad, as an epidemiological tool that can quickly calculate rates with confidence intervals around point source hazards.

In November 2005, staff in the Division of Environmental Health began working with the CDC on an environmental public health initiative to link environmental hazards with health outcomes using the RIF software. This software is an automated tool that utilizes a combination of statistics and a geographic information system for disease mapping. The purpose of RIF is to rapidly address epidemiological and public health questions using routinely-collected health and population data.

The RIF was originally developed in the UK as a response to cancer in children developed by the Small Area Health Statistics Unit (SAHSU) at the Department of Epidemiology and Public Health, Imperial College, London. The RIF was subsequently transformed for use by several European countries as part of the European Health and Environment Information System project. Currently, the Centres for Disease Control and Prevention and SAHSU are collaborating to evaluate the RIF software for use in CDC's EPHT Network. The DOH was selected to beta-test the RIF and is evaluating the utility of the software using selected birth defects.

Methods

The RIF can perform risk analyses around putative hazardous sources, and can be used for disease mapping. It generates standardized rates and relative risks for any given health outcome, for specified age and year ranges, and for any given geographical area.

Principal features of the RIF:

- The software is designed to be database independent.
- In addition to the point source risk analysis and disease mapping options, it is also possible to import detailed exposure data, such as output from dispersion modeling.
- RIF provides a tool that allows users with skills in epidemiology to take advantage of the many functions that a GIS offers without requiring an in-depth knowledge of GIS.
- Since the application is embedded in ArcGIS, those with GIS skills will be able to use all the additional functionality that ArcGIS offers.
- Within the disease mapping tool, the RIF performs empirical Bayes smoothing of the relative risks.

In addition, the tool can export data for further analysis in other (statistical) software packages such as WinBUGS.

Results

Recently, the RIF program was enhanced to work alongside additional software programs that can be used to explore spatial and temporal trends in data, and to detect statistically significant clusters of disease. In addition to evaluating birth defects near hazardous waste sites, Florida EPHT will be adding other health outcomes such as selected cancers into the RIF for future disease mapping and risk analysis applications.

The environmental public health team found the RIF an ideal and easy-to-use tool with good potential for EPHT network implementation for exploring birth defects around putative source emissions. In addition to risk analysis, the RIF can perform disease mapping analysis. Similar to risk analysis, the disease mapping feature can be used to explore spatial patterns of health outcomes, identify potential issues regarding surveillance quality by geographical area, and identify areas which need additional resources or remediation. The Florida results produced by the RIF are still preliminary. Overall, the utility of RIF proved beneficial and shows great promise as an environmental public health tracking tool.

Release of this software is planned but a firm date has not been announced. For more information, click on the Imperial College website at <http://www1.imperial.ac.uk/medicine/about/divisions/ephpc/eph/projects/eresh/sahsu/>

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Mosquito-borne Disease Summary February 11-17, 2007 ***Rebecca Shultz, MPH, Caroline Collins, Daneshia Roberts, Carina Blackmore, PhD***

During the period February 11-17, 2007, the following arboviral activities (St. Louis Encephalitis [SLE] virus, Eastern Equine Encephalitis [EEE] virus, Highlands J [HJ] virus, West Nile [WN] virus, California Group [CE] virus) were recorded in Florida:

EEE virus activity There were two sentinel chicken seroconversions to EEE in Orange County. Two of 18 wild birds captured in Okaloosa and one of 14 captured in Santa Rosa tested positive for antibodies to EEE.

WN virus activity There was one sentinel chicken seroconversions to WN virus in North Walton County. One of 18 wild birds captured in Okaloosa County tested positive for antibodies to undetermined flavivirus.

SLE virus activity None

HJ virus activity None

Sentinel Chickens There were two seroconversions to EEE (Orange, collection date 2/1) and one seroconversion to WN (Walton, collection date 1/11)

Wild Live Birds Of 63 wild birds capture from four counties between February 2-5, two blue jays (Okaloosa) and one house sparrow (Santa Rosa) tested positive for antibodies to EEE and one sparrow (Okaloosa) tested positive for antibodies to undetermined flavivirus.

Dead Bird Reports The Fish and Wildlife Conservation Commission (FWC) collects reports of dead birds, which can be an indication of arbovirus circulation in an area. This week, 25 reports representing 96 dead birds were received from 18 counties. Three birds were identified as a type of raptor, and 93 were identified as other species. The FWC collects reports of birds that have died from a variety of causes, not only arboviruses. Dead birds should be reported to www.myfwc.com/bird/.

See the web page for more information at <http://www.doh.state.fl.us/environment/community/arboviral/index.html>. The Disease Outbreak Information Hotline offers recorded updates on medical alert status and surveillance at 888.880.5782.



This Month on EpiCom

by Christie Luce

The Bureau of Epidemiology encourages *Epi Update* readers to not only register on the EpiCom system at <https://www.epicomfl.net>, but to sign up for features such as automatic notification of certain events at EpiCom_Administrator@doh.state.fl.us and contribute appropriate public health observations related to any suspicious or unusual occurrences or circumstances. EpiCom is the primary method of communication between the Bureau of Epidemiology and other state medical agencies during emergency situations.

- Chikungunya confirmed in traveler to Volusia County
- Six cases of confirmed Pertussis in Citrus County
- Suspected, unrelated Legionnaires in St. Lucie County
- Mercury exposure in Escambia County
- Suspected bacterial infection resulting in death in Martin County

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Weekly Disease Table

by D'Juan Harris, MSP

Go to http://www.doh.state.fl.us/disease_ctrl/epi/Disease_Table/2007_Weeks/dt_Week220071.HTML to review the most recent disease figures provided by the Florida Department of Health, Bureau of Epidemiology.

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