

Background

The *Florida Morbidity Statistics Report* is the official record of the occurrence of reportable diseases in Florida and this edition marks the 59th publication since 1945. While numerous reports describing the disease burden are produced throughout the year, this report is noteworthy as the data contained here are final. The mission of the Florida Department of Health is to protect, promote, and improve the health of all people in Florida through integrated state, county, and community efforts. Per section 381.003, Florida Statutes “The Department shall conduct a communicable disease prevention and control program as part of fulfilling its public health mission.” This report directly supports the mission of the Department by identifying patterns and trends in the incidence of disease that are used as the scientific basis for development of disease control and prevention strategies and policies.

Disease control and prevention are core functions of any public health agency. Protection of the public’s health from existing, emerging, and re-emerging diseases requires diligence in all aspects of public health. Public health partners identifying and characterizing emerging trends in disease are the physicians, nurses, laboratorians, hospital infection preventionists, and other health care professionals who participate in reportable disease surveillance. Without their participation, the ability to recognize and intervene in emerging public health issues would be much more limited.

Acknowledgements

The Bureau of Epidemiology thanks all program areas within the Florida Department of Health that contributed to this report including the sections of HIV/AIDS, Immunization, Sexually Transmitted Diseases (STDs) and Viral Hepatitis, and Tuberculosis Control. Finally, many thanks are extended to the local health office staff and other public health professionals who are involved in reportable disease surveillance, either through disease control activities, case investigations, data collection, laboratory testing, or other essential functions.

Purpose

The *Florida Morbidity Statistics Report* is compiled in a single reference document to:

- Summarize annual morbidity from reportable communicable diseases and diseases of environmental origin in Florida.
- Describe patterns of disease that can be assessed over time, compared with trends from other states, and act as an aid in directing future disease prevention and control efforts.
- Provide a resource to medical and public health authorities at county, state, and national levels.

Data Sources

Data presented in this report are based on reportable disease information received by county and state health department staff from physicians, hospitals, and laboratories throughout the state obtained through passive and active surveillance. Reporting of suspected and confirmed reportable diseases and conditions in the state of Florida is mandated under section 381.0031, Florida Statutes and Florida Administrative Code Chapter 64D-3. People in charge of laboratories, hospitals, medical facilities, or other facilities providing health services (which can include schools, nursing homes, and state institutions) are required to report certain diseases and conditions and the associated laboratory test results as listed in the Table of Notifiable Diseases or Conditions to be Reported, Florida Administrative Code Chapter 64D-3. Reporting of test results by a laboratory does not nullify a practitioner’s obligation to report the disease or condition. These data are the basis for providing useful information on reportable diseases and conditions in Florida to health care workers and policymakers, and would not be possible without the cooperation of the extensive network involving both private and public sector participants.

Data are collected by multiple means:

- Passive surveillance relies on physicians, laboratories, and other health care providers to report diseases to the Florida Department of Health confidentially in one of three forms: electronically, by telephone, or by facsimile. Increasingly, information about cases of reportable diseases and conditions is passed from providers, especially laboratories, to the Department as electronic records. This occurs automatically, without the involvement of a person after the electronic transmission process has been established between the Department and the reporting partner.
- Active surveillance entails Department staff regularly contacting hospitals, laboratories, and physicians in an effort to identify all cases of a given disease or condition.

References

The following references were used in many of the disease-specific chapters within Section 2: Data Summaries for Selected Reportable Diseases/Conditions of Frequent Occurrence.

Centers for Disease Control and Prevention. CDC A-Z Index. Available at www.cdc.gov/az/a.html.

Centers for Disease Control and Prevention. 2015. *Epidemiology and Prevention of Vaccine-Preventable Diseases*, 13th ed. Washington, D.C.: Public Health Foundation. Available at www.cdc.gov/vaccines/pubs/pinkbook/index.html.

Centers for Disease Control and Prevention. 2012. *Manual for the Surveillance of Vaccine-Preventable Diseases*, 5th ed. Available at www.cdc.gov/vaccines/pubs/surv-manual/index.html.

Centers for Disease Control and Prevention. 2016. *CDC Health Information for International Travel 2016*. New York: Oxford University Press. Available at wwwnc.cdc.gov/travel/page/yellowbook-home.

Centers for Disease Control and Prevention. 2014. National, State, and Selected Local Area Vaccination Coverage Among Children Aged 19-35 Months – United States, 2013. *Morbidity and Mortality Weekly Report*, 63(34);741-748. Available at www.cdc.gov/mmwr/preview/mmwrhtml/mm6334a1.htm?s_cid=mm6334a1_w.

Heymann DL (ed). 2015. *Control of Communicable Diseases Manual*. 20th ed. Washington, D.C.: American Public Health Association Press.

Interpreting the Data

Information in this report should be interpreted in light of the limitations below.

1. Under-reporting

The data presented in this report are primarily based on passive reporting by health care providers and laboratories across Florida. Case reporting is most often dependent upon a person becoming ill, seeking medical attention, the health care provider ordering laboratory testing, and finally the health care provider or laboratory reporting the case. Frequently, not all steps in this process occur, so the number of reported cases represents a fraction of the true number of cases of reportable illnesses occurring in Florida each year. Evaluations of infectious disease reporting systems have indicated that the completeness of reporting varies by disease. The less common but more severe reportable diseases such as bacterial meningitis, diphtheria, polio, botulism, anthrax, tuberculosis, and congenital syphilis are more completely reported than the more common diseases with less severe symptoms such as hepatitis A or campylobacteriosis. Variation in identified disease incidence at the local level probably reflects, to varying degrees, both differences in the true incidence of disease and differences in the vigor with which surveillance is performed.

2. Reliability of Rates

All incidence rates in this report are expressed as the number of reported cases of a disease or condition per 100,000 population unless otherwise specified. All population estimates are from the Community Health Assessment Resource Tool Set (CHARTS), a Florida Department of Health web-based data query system with community tools, health indicators, and data queries for public consumption (www.floridacharts.com/charts/default.aspx). Population estimates within CHARTS are provided by the Florida Department of Health, Division of Public Health Statistics and Performance Management, in consultation with the Florida Legislature's Office of Economic and Demographic Research. Estimates in CHARTS are updated at least once per year, and population data were extracted from CHARTS for this report on August 7, 2015, after the annual update in CHARTS. Note that previous editions of this report may show somewhat different populations for a given year than the ones shown here, as these estimates are revised periodically. This is especially true given the recent 2010 census.

Animal rabies is not expressed as a rate; it is only expressed as the number of cases because no reliable denominators exist for animal populations.

Rates for diseases with only a few cases reported per year can be unstable and should be interpreted with caution. The observation of zero events is especially difficult to interpret. Rates were not generally calculated in this report when there were less than 20 cases, except as part of graphs and maps. In some cases, even though maps and graphs (e.g., by year, gender, race) may have small individual counts, rates were calculated. These maps include footnotes as a reminder that rates based on less than 20 cases are not reliable.

3. Determining How Cases are Counted: Reporting Period and Cases Included

There are important differences by disease that determine how cases are “counted” and summarized in this report. The date of illness onset or the date of diagnosis may not be available for all cases. Cases reported early in 2014 may have actually had onset or been diagnosed in 2013; rarely, cases reported in 2014 may have onset or diagnosis dates prior to 2013. Additionally, cases with illness onset or diagnosis late in 2014 may not have been reported to public health by the end of the 2014 report year, and thus would not be included in this report for most diseases. Information by disease is listed below.

AIDS and HIV Infection

Year: Data are aggregated by calendar year.

Cases included: HIV infection cases are assigned to a report year based on the date of the first confirmed HIV test. AIDS cases are assigned to a report year based on the date of an AIDS defined opportunistic infection and/or a CD4 count below 200 on a person with HIV infection. The 2014 AIDS and HIV infection dataset was frozen on December 31, 2015. Changes occurring after that point that affect the number of cases in 2014 or earlier will be updated in the following year's dataset.

Please note that prior to 2014, HIV infection and AIDS cases were assigned to a report year based on the date the case was entered into the surveillance system.

Sexually Transmitted Diseases (STDs)

Year: Data are aggregated by the standard reporting year as outlined by the Centers for Disease Control and Prevention (CDC), where every year has at least 52 reporting weeks and some years have 53 (there were 53 weeks in 2014). This is referred to as the Morbidity and Mortality Weekly Report (MMWR) year.

Cases included: Cases are assigned to a report year based on the date the case was entered into the surveillance system. Occasionally, STD reports are received after the end of the reporting year that should have been included based on the laboratory result date. For these cases, the laboratory result date is used for the report date.

Tuberculosis

Year: Data are aggregated by MMWR year (see STD report year above for explanation of MMWR year).

Cases included: Cases are assigned to a report year based on the date when the suspected diagnosis is confirmed by clinical, radiographic, and laboratory testing (often referred to as “date counted”).

All Other Diseases

Year: Data are aggregated by MMWR year (see STD report year above for explanation of MMWR year).

Cases included: Cases are assigned to a report year based on the date the case was determined to have enough information to be submitted by local health office epidemiology staff to the Bureau of Epidemiology for state-level review.

Data in this report are consistent with national surveillance data published weekly by CDC in the MMWR. Additionally, disease-specific reports describing data by other dates, such as disease onset and diagnosis dates, may also be published and available on the Florida Department of Health website.

4. Case Definition

Cases of most diseases are classified as confirmed, probable, or suspect at the state level using a published set of surveillance case definitions consistent with national case definitions where appropriate (*Surveillance Case Definitions for Selected Reportable Diseases in Florida*, available at www.FloridaHealth.gov/DiseaseCaseDefinitions). Case classifications are reviewed at the state level for most diseases. Following CDC *Morbidity and Mortality Weekly Report* (MMWR) print criteria (available at www.cdc.gov/nndss/script/downloads.aspx), only confirmed and probable cases have been included (i.e., suspect cases are excluded) in this report unless otherwise specified.

Changes to case definitions can affect the number of cases reported, which can impact calculated incidence rates, but ultimately case definition changes do not change the true incidence of a disease. Each year case definitions are evaluated for necessary revisions. A number of changes were made to reportable disease case definitions in 2014 as a result of position statements approved by the Council of State and Territorial Epidemiologists (CSTE) in 2013.

Summary of case definition changes effective January 2014:

- a. Acute arboviral disease (neuroinvasive and non-neuroinvasive): revised the clinical criteria (removed fever and added chills) and refined laboratory criteria.
- b. Malaria: expanded the confirmed case classification to include detection of unspicied malaria parasite by microscopy.
- c. Pertussis: added apnea to clinical criteria for infants aged <1 year and expanded probable case classification to include infants with acute cough of any duration and one other symptom who have a positive polymerase chain reaction (PCR) test or an epidemiological link to a confirmed case or a PCR-positive probable infant case.
- d. Trichinellosis: added a probable case classification for people with clinically compatible illness and appropriate exposure and a suspect case classification for people with clinically compatible illness with a positive serologic test and appropriate exposure (note that suspect cases are not included in this report).

- e. Saxitoxin: added a probable case classification for people with clinically compatible illness who have appropriate exposure or are epidemiologically linked to confirmed cases (previously captured in the suspect case classification) and revised the suspect case classification to include people with clinically compatible illness whose exposure history is unknown.
- f. Shiga toxin-producing *Escherichia coli*: expanded the epidemiological linkage criteria for the probable case classification.

5. Assigning Cases to Counties

Cases are assigned to Florida counties following national guidance and based on the county of residence at the time of the disease identification, regardless of where they became ill or were hospitalized, diagnosed, or exposed. Cases who reside outside of Florida are not counted as Florida cases regardless of whether they became ill or were hospitalized, diagnosed, or exposed in Florida. Cases in out-of-state residents are not included in this report, unless specifically noted. These cases are referred through an interstate reciprocal notification system to the state where the person resides.

6. Population Estimates

All population estimates are from the Community Health Assessment Resource Tool Set (CHARTS), a Florida Department of Health web-based data query system with community tools, health indicators, and data queries for public consumption (www.floridacharts.com/charts/default.aspx). Population estimates within CHARTS are provided by the Florida Department of Health Division of Public Health Statistics and Performance Management, in consultation with the Florida Legislature's Office of Economic and Demographic Research. Estimates in CHARTS are updated at least once per year, and population data were extracted from CHARTS for this report on August 7, 2015. Note that previous editions of this report may show somewhat different populations for a given year than the ones shown here, as these estimates are revised periodically. This is especially true given the recent 2010 census.

7. Florida Disease Codes in Merlin

Reported case data for most reportable diseases (excluding HIV/AIDS, STDs, and tuberculosis) are stored in Merlin, Florida's web-based reportable disease surveillance system. When entering case data into Merlin, users assign a Florida Disease Code based on the disease. Due to changes in case definitions over time, new codes have been added and outdated codes have expired. In addition, some diseases have multiple disease codes that represent different clinical manifestations.

Diseases that include cases from multiple or expired Florida Disease Codes in this report:

- a. California Serogroup Virus Disease
 - California Serogroup Virus Neuroinvasive Disease - 06250
 - California Serogroup Virus Non-Neuroinvasive Disease - 06251
- b. Dengue Fever
 - Dengue Fever - 06100
 - Dengue Fever, Severe - 06101
- c. Eastern Equine Encephalitis
 - Eastern Equine Encephalitis Neuroinvasive Disease - 06220
 - Eastern Equine Encephalitis Non-Neuroinvasive Disease - 06221
- d. Ehrlichiosis
 - Ehrlichiosis (*Ehrlichia ewingii*) - 08383
 - Ehrlichiosis, HME (*Ehrlichia chaffeensis*) - 08382

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- e. *Haemophilus influenzae* Invasive Disease in Children <5 Years Old
Haemophilus influenzae Invasive Disease - 03841
Cellulitis (*Haemophilus influenzae*) - 69290 (EXPIRED)
Epiglottitis (*Haemophilus influenzae*) - 46430 (EXPIRED)
Meningitis (*Haemophilus influenzae*) - 32000 (EXPIRED)
Pneumonia (*Haemophilus influenzae*) - 48220 (EXPIRED)
Septic Arthritis (*Haemophilus influenzae*) - 71100 (EXPIRED)
- f. Hantavirus Infection
Hantavirus Infection, Non-Pulmonary Syndrome - 07870
Hantavirus Pulmonary Syndrome - 07869
- g. Listeriosis
Listeriosis - 02700
Meningitis (*Listeria monocytogenes*) - 32070 (EXPIRED)
- h. Plague
Plague, Bubonic - 02000
Plague, Pneumonic - 02050
- i. Poliomyelitis
Poliomyelitis, Nonparalytic - 04520
Poliomyelitis, Paralytic - 04590
- j. Q Fever (*Coxiella burnetii*)
Q Fever, Acute (*Coxiella burnetii*) - 08301
Q Fever, Chronic (*Coxiella burnetii*) - 08302
Q Fever - 08300 (EXPIRED)
- k. Rocky Mountain Spotted Fever and Spotted Fever Rickettsiosis
Rocky Mountain Spotted Fever and Spotted Fever Rickettsiosis - 08309
Rocky Mountain Spotted Fever - 08200 (EXPIRED)
- l. Rubella
Rubella - 05690
Rubella, Congenital Syndrome - 77100
- m. Shiga Toxin-Producing *Escherichia coli* Infection
Shiga Toxin-Producing *Escherichia coli* (STEC) Infection, Non-O157 - 41602 (EXPIRED)
Shiga Toxin-Producing *Escherichia coli* (STEC) Infection, O157:H7 - 41601 (EXPIRED)
- n. St. Louis Encephalitis
St. Louis Encephalitis Neuroinvasive Disease - 06230
St. Louis Encephalitis Non-Neuroinvasive Disease - 06231
- o. Typhus Fever
Typhus Fever, Epidemic (*Rickettsia prowazekii*) - 08000
Typhus Fever, Endemic (*Rickettsia typhi*) - 08100 (EXPIRED)
Typhus Fever - 08190 (EXPIRED)
- p. Venezuelan Equine Encephalitis
Venezuelan Equine Encephalitis Neuroinvasive Disease - 06620
Venezuelan Equine Encephalitis Non-Neuroinvasive Disease - 06621

- q. Vibriosis (Excluding Cholera)
 - Vibriosis (*Grimontia hollisae*) - 00196
 - Vibriosis (*Vibrio alginolyticus*) - 00195
 - Vibriosis (*Vibrio cholerae* Type Non-O1) - 00198
 - Vibriosis (*Vibrio fluvialis*) - 00194
 - Vibriosis (*Vibrio mimicus*) - 00197
 - Vibriosis (*Vibrio parahaemolyticus*) - 00540
 - Vibriosis (*Vibrio vulnificus*) - 00199
 - Vibriosis (Other *Vibrio* Species) - 00193

- r. Viral Hemorrhagic Fever
 - Crimean-Congo Hemorrhagic Fever - 06591
 - Ebola Hemorrhagic Fever - 06592
 - Guanarito Hemorrhagic Fever - 06593
 - Junin Hemorrhagic Fever - 06594
 - Lassa Fever - 06595
 - Lujo Virus - 06596
 - Machupo Hemorrhagic Fever - 06597
 - Marburg Fever - 06598
 - Sabia-Associated Hemorrhagic Fever - 06599
 - Viral Hemorrhagic Fever - 06590 (EXPIRED)

- s. West Nile Virus Disease
 - West Nile Virus Neuroinvasive Disease - 06630
 - West Nile Virus Non-Neuroinvasive Disease - 06631

- t. Western Equine Encephalitis
 - Western Equine Encephalitis Neuroinvasive Disease - 06210
 - Western Equine Encephalitis Non-Neuroinvasive Disease - 06211

Summary of Key Disease Trends in 2014

Sexually transmitted diseases (STDs), HIV infection, and AIDS are the most common reportable diseases in Florida, particularly among 20- to 54-year-olds. Chlamydia incidence has been increasing over the past 10 years, with over 84,000 cases reported in Florida in 2014. As chlamydia has increased, the number of gonorrhea cases has consistently decreased nationally and in Florida since 2006. However, in 2013, there was a slight increase in gonorrhea cases compared to 2012. The incidence rate in 2014 was lower than 2013, but still higher than 2012 and slightly higher than the 5-year average incidence rate. The syphilis incidence rate has been increasing since 2009 and increased more in 2014, with a 37.0% increase in 2014 compared to the past five years. The incidence of HIV infection and AIDS has also decreased overall in the last 10 years, though both AIDS and HIV infection increased in 2013, partially due to an expansion of electronic laboratory reporting in 2012 which resulted in receiving more laboratory reports. Incidence of HIV infection increased again in 2014, partially due to a statewide increase in infections in white and Hispanic men who have sex with men, while the incidence of AIDS decreased in 2014.

In the mid-1980s, tuberculosis (TB) re-emerged as a public health threat in the U.S. Since 1994, the number of cases of TB in Florida has decreased every year. The incidence rate in 2014 decreased 22.9% compared to the past five years. Over the past 20 years, the number of TB cases counted in foreign-born people has remained relatively constant while decreasing dramatically in U.S.-born people. Now the proportion of all Florida TB cases that are made up of people born in a foreign country has grown to 62.4% of all TB cases in 2014.

Florida consistently has one of the highest rates of enteric disease in the nation, with 10,000 to 12,000 cases reported annually. Enteric diseases disproportionately affect children less than five years old. Over 13,000 enteric disease cases were reported in 2014, more than any prior year. While salmonellosis was still the largest volume disease with over 6,000 cases, the overall increase in 2014 was primarily due to large increases in cryptosporidiosis and shigellosis. Outbreaks of cryptosporidiosis were identified in swimming pools, a recreational water park, and kiddie pools, and additional community-wide outbreaks were associated with daycares and person-to-person transmission. Historically, shigellosis has a cyclic temporal pattern with large, community-wide outbreaks, frequently involving daycare centers, every three to five years. Shigellosis activity peaked in 2007, 2011, and again in 2014. The incidence of Shiga toxin-producing *E. coli* (STEC) has generally increased since 2006, partially due to widespread implementation of a laboratory screening test that identifies Shiga toxin, prompting additional testing. Though there was a slight decrease in 2014, the incidence rate was still 14.5% higher than the 5-year average.

Despite high vaccine coverage in Florida, vaccine-preventable diseases (VPDs) continue to occur. Vaccination coverage in Florida and nationally for 2014 was published by the Centers for Disease Control and Prevention in the Morbidity and Mortality Weekly Report in August 2014 (see National, State, and Selected Local Area Vaccination Coverage Among Children Aged 19–35 Months — United States, 2014 available at www.cdc.gov/mmwr/preview/mmwrhtml/mm6433a1.htm). In 2014, VPD incidence decreased slightly overall in Florida compared to 2013. Acute hepatitis A and hepatitis B incidence has declined drastically over the past 15 years, largely due to increased vaccination coverage. Though there was a slight increase in hepatitis A in 2013, the incidence rate in 2014 decreased and was 29.0% lower than the previous 5-year average. The acute hepatitis B incidence rate increased 29.0% compared to the previous 5-year average, partially due to an enhanced surveillance project that focuses on chronic hepatitis in young adults. The additional follow-up has resulted in identifying acute cases that would otherwise have been misclassified as chronic. Varicella incidence has been steadily declining since 2008 due to effective vaccination programs. Beginning with the 2008-2009 school year, children entering kindergarten were required to receive two doses of varicella vaccine. Pertussis incidence has increased nationwide over the past 10 years, despite routine vaccine use. In Florida, there was a sharp increase in reported pertussis cases in 2012 and 2013. Incidence decreased slightly in 2014, but was still 43.1% higher than the previous 5-year average.

Tick-borne diseases continued to be a threat in Florida in 2014. Lyme disease, transmitted by ticks, increased in 2014. Consistent with past years, most infections identified in 2014 were acquired in other states (primarily in the Northeast and upper Midwest U.S.). However, while the number of imported cases remained the same in 2014 compared to 2013, there was an increase in the number of reported infections acquired in Florida. Mosquito-borne diseases also continued to occur in Florida in 2014. West Nile virus (WNV) disease incidence decreased dramatically compared to 2012, when a large number of cases were reported in Duval County. The 2012 outbreak likely resulted from many factors, including higher-than-normal temperatures that influenced mosquito and bird abundance, viral replication in host mosquitoes, and interactions of birds and mosquitoes. Dengue fever cases decreased in 2014 and the incidence rate was 26.1% lower than the 5-year average. In 2014, there were five unrelated local introductions in Miami-Dade County, resulting in seven locally acquired dengue fever cases. The first autochthonous transmission of chikungunya virus in the Americas was reported on the island of St. Martin in December 2013. Since then, local transmission was identified in countries throughout the Caribbean and the Americas. Prior to 2014, Florida had five imported cases of chikungunya, all of whom had traveled to Asia. Chikungunya fever became reportable in Florida in June 2014 and over 400 cases were reported.

Starting in March 2014, West Africa experienced the largest outbreak of Ebola virus disease (EVD) in history, with over 28,000 confirmed, probable, and suspect cases identified as of January 2016. In response to the large outbreak, Florida implemented active case finding by conducting in-person twice

-daily temperature monitoring for any traveler returning from Guinea, Liberia, Mali, and Sierra Leone for 21 days. From October 2014 to January 2016, over 760 travelers were monitored in Florida; no EVD cases were identified among these travelers.

Chronic hepatitis C continues to account for a large bulk of infectious disease burden in Florida with over 19,000 confirmed and probable cases reported annually. Over 22,000 cases were reported in 2014, more than any previous year, likely due to improved case ascertainment from electronic laboratory reporting and new automated case classification and reporting logic added to the reportable disease surveillance system, Merlin. Collection of risk factor information has also been improved for chronic hepatitis C cases. In response to an increased rate of chronic hepatitis in young adults, an enhanced surveillance project focusing on chronic hepatitis in young adults was funded and implemented in 2012 in Florida. The additional follow-up has resulted in identifying acute cases that would otherwise have been misclassified as chronic. A large number of new hepatitis C infections in young adults in Florida are due to injection drug use (IDU). In Florida and other states, the dual increases in newly identified hepatitis C infections and IDU among young adults has been associated with the proliferation of highly addictive prescription opioid painkillers.¹

For additional information on disease-specific trends, see Section 1: Summary of Selected Reportable Diseases/Conditions, Section 2: Data Summaries for Selected Reportable Diseases/Conditions of Frequent Occurrence and Section 3: Narratives for Selected Reportable Diseases/Conditions of Infrequent Occurrence.

Suryaprasad AG, White JZ, Xu F, Eichler BA, Hamilton J, Patel A, et al. 2014. Emerging Epidemic of Hepatitis C Virus Infections Among Young Non-Urban Persons who Inject Drugs in the United States, 2006–2012. *Clinical Infectious Diseases*, 59(10):1411-1419.

Zibbell JE, Iqbal K, Patel RC, Suryaprasad A, Sanders KJ, Moore-Moravian L, et al. 2015. Increases in Hepatitis C Virus Infection Related to Injection Drug Use Among Persons Aged ≤30 Years — Kentucky, Tennessee, Virginia, and West Virginia, 2006–2012. *Morbidity and Mortality Weekly Report*, 64(17):453-458. Available at www.cdc.gov/mmwr/preview/mmwrhtml/mm6417a2.htm.

List of Reportable Diseases/Conditions in Florida, January 2014

Section 381.0031 (2), Florida Statutes, provides that “Any practitioner licensed in this state to practice medicine, osteopathic medicine, chiropractic medicine, naturopathy, or veterinary medicine; any hospital licensed under part I of Chapter 395, Florida Statutes; or any laboratory licensed under Chapter 483, Florida Statutes that diagnoses or suspects the existence of a disease of public health significance shall immediately report the fact to the Department of Health.” Local health offices serve as the Department’s representatives in this reporting requirement. Furthermore, section 381.0031 (4), Florida Statutes, provides that “The Department shall periodically issue a list of infectious or noninfectious diseases determined by it to be a threat to public health and therefore of significance to public health and shall furnish a copy of the list to the practitioners . . .” This list of reportable diseases and conditions is maintained in Florida Administrative Code Rule 64D-3.029. The list below reflects diseases and conditions that were reportable in January 2014. The Rule was revised in June 2014; a summary of the changes and the updated list are on the following page.

Any disease outbreak	Leptospirosis
Any grouping or clustering of disease	Listeriosis
Acquired immune deficiency syndrome (AIDS)	Lyme disease
Amebic encephalitis	Lymphogranuloma venereum (LGV)
Anthrax	Malaria
Arsenic poisoning	Measles (rubeola)
Botulism	Melioidosis
Brucellosis	Meningitis, bacterial or mycotic
California serogroup virus disease	Meningococcal disease
Campylobacteriosis	Mercury poisoning
Cancer (excluding non-melanoma skin cancer and including benign and borderline intracranial and CNS tumors)	Mumps
Carbon monoxide poisoning	Neurotoxic shellfish poisoning
Chancroid	Pertussis
Chlamydia	Pesticide-related illness and injury, acute
Cholera (<i>Vibrio cholerae</i> type O1)	Plague
Ciguatera fish poisoning	Poliomyelitis
Congenital anomalies	Psittacosis (ornithosis)
Conjunctivitis in neonates <14 days old	Q fever
Creutzfeldt-Jakob disease (CJD)	Rabies (human, animal, possible exposure)
Cryptosporidiosis	Ricin toxin poisoning
Cyclosporiasis	Rocky Mountain spotted fever
Dengue fever	Rubella
Diphtheria	St. Louis encephalitis
Eastern equine encephalitis	Salmonellosis
Ehrlichiosis/anaplasmosis	Saxitoxin poisoning (paralytic shellfish poisoning)
Encephalitis, other (non-arboviral)	Severe acute respiratory syndrome (SARS) associated with coronavirus infection
<i>Escherichia coli</i> infection, Shiga toxin-producing	Shigellosis
Giardiasis, acute	Smallpox
Glanders	Staphylococcal enterotoxin B poisoning
Gonorrhea	<i>Staphylococcus aureus</i> , intermediate or full resistance to vancomycin (VISA, VRSA)
Granuloma inguinale	<i>Staphylococcus aureus</i> , community-associated mortality
<i>Haemophilus influenzae</i> invasive disease	Streptococcal invasive disease (Group A)
Hansen’s disease (leprosy)	<i>Streptococcus pneumoniae</i> invasive disease
Hantavirus infection	Syphilis
Hemolytic uremic syndrome (HUS)	Tetanus
Hepatitis A	Toxoplasmosis
Hepatitis B, C, D, E, and G	Trichinellosis (trichinosis)
Hepatitis B surface antigen in pregnant women or children <2 years old	Tuberculosis
Herpes simplex virus (HSV) in infants <60 days old with disseminated infection and liver involvement; encephalitis; and infections limited to skin, eyes, and mouth; anogenital HSV in children <12 years old	Tularemia
Human immunodeficiency virus (HIV) infection	Typhoid fever (<i>Salmonella</i> serotype Typhi)
Human papillomavirus (HPV), associated laryngeal papillomas or recurrent respiratory papillomatosis in children <6 years old; anogenital papillomas in children <12 years old	Typhus fever, epidemic and endemic
Influenza A, novel or pandemic strains	Vaccinia disease
Influenza-associated pediatric mortality in children <18 years old	Varicella (chickenpox)
Lead poisoning	Venezuelan equine encephalitis
Legionellosis	Vibriosis (excluding cholera)
	Viral hemorrhagic fevers
	West Nile virus disease
	Western equine encephalitis virus disease
	Yellow fever

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List of Reportable Diseases/Conditions in Florida, June 2014

Florida Administrative Code Rule 64D-3.029 was updated in 2014 to modify the list of reportable diseases and conditions and changes became effective June 4, 2014. Additions and modifications are highlighted below in red. Diseases removed were non-arboviral encephalitis, group A Streptococcal invasive disease, community-associated *Staphylococcus aureus* mortality, endemic typhus fever, and toxoplasmosis. Data in this report reflect the updated list below. Updates may be made to the list of reportable diseases and conditions in future years and these updates will continue to be reflected as appropriate in future *Florida Morbidity Statistics Reports*.

Any disease outbreak	Malaria
Any grouping or clustering of disease	Measles (rubeola)
Acquired immune deficiency syndrome (AIDS)	Melioidosis
Amebic encephalitis	Meningitis, bacterial or mycotic
Anthrax	Meningococcal disease
Arsenic poisoning	Mercury poisoning
Arboviral diseases not otherwise listed	Mumps
Botulism	Neonatal abstinence syndrome (NAS)
Brucellosis	Neurotoxic shellfish poisoning
California serogroup virus disease	Pertussis
Campylobacteriosis	Pesticide-related illness and injury, acute
Cancer (excluding non-melanoma skin cancer and including benign and borderline intracranial and CNS tumors)	Plague
Carbon monoxide poisoning	Poliomyelitis
Chancroid	Psittacosis (ornithosis)
Chikungunya fever	Q Fever
Chlamydia	Rabies (human, animal, possible exposure)
Cholera (<i>Vibrio cholerae</i> type O1)	Ricin toxin poisoning
Ciguatera fish poisoning	Rocky Mountain spotted fever and other spotted fever rickettsioses
Congenital anomalies	Rubella
Conjunctivitis in neonates <14 days old	St. Louis encephalitis
Creutzfeldt-Jakob disease (CJD)	Salmonellosis
Cryptosporidiosis	Saxitoxin poisoning (paralytic shellfish poisoning)
Cyclosporiasis	Severe acute respiratory disease syndrome associated with coronavirus infection
Dengue fever	Shigellosis
Diphtheria	Smallpox
Eastern equine encephalitis	Staphylococcal enterotoxin B poisoning
Ehrlichiosis/anaplasmosis	<i>Staphylococcus aureus</i> infection, intermediate or full resistance to vancomycin (VISA, VRSA)
<i>Escherichia coli</i> infection, Shiga toxin-producing	<i>Streptococcus pneumoniae</i> invasive disease in children <6 years old (all ages for electronic laboratory reporting laboratories)
Giardiasis, acute	Syphilis
Glanders	Tetanus
Gonorrhea	Trichinellosis (trichinosis)
Granuloma inguinale	Tuberculosis (TB)
<i>Haemophilus influenzae</i> invasive disease in children <5 years old (all ages for electronic laboratory reporting laboratories)	Tularemia
Hansen's disease (leprosy)	Typhoid fever (<i>Salmonella</i> serotype Typhi)
Hantavirus infection	Typhus fever, epidemic
Hemolytic uremic syndrome (HUS)	Vaccinia disease
Hepatitis A	Varicella (chickenpox)
Hepatitis B, C, D, E, and G	Venezuelan equine encephalitis
Hepatitis B surface antigen in pregnant women or children <2 years old	Vibriosis (infections of <i>Vibrio</i> species and closely related organisms, excluding <i>Vibrio cholerae</i> type O1)
Herpes B virus, possible exposure	Viral hemorrhagic fevers
Herpes simplex virus (HSV) in infants <60 days old with disseminated infection and liver involvement; encephalitis; and infections limited to skin, eyes, and mouth; anogenital HSV in children <12 years old	West Nile virus disease
Human immunodeficiency virus (HIV) infection	Yellow fever
HIV, exposed infants <18 months old born to an HIV-infected woman	
Human papillomavirus (HPV), associated laryngeal papillomas or recurrent respiratory papillomatosis in children <6 years old; anogenital papillomas in children <12 years old (all HPV DNA for electronic laboratory reporting laboratories)	Electronic laboratory reporting laboratories only:
Influenza A, novel or pandemic strains	Antimicrobial susceptibility results for isolates from a normally sterile site for <i>Acinetobacter baumannii</i> , <i>Citrobacter</i> species, <i>Enterococcus</i> species, <i>Enterobacter</i> species, <i>Escherichia coli</i> , <i>Klebsiella</i> species, <i>Pseudomonas aeruginosa</i> , and <i>Serratia</i> species
Influenza-associated pediatric mortality in children <18 years old	Hepatitis B, C, D, E, and G viruses, all test results (positive and negative) and all liver function tests
Lead poisoning	Influenza virus, all test results (positive and negative)
Legionellosis	Respiratory syncytial virus, all test results (positive and negative)
Leptospirosis	<i>Staphylococcus aureus</i> isolated from a normally sterile site
Listeriosis	
Lyme disease	
Lymphogranuloma venereum (LGV)	

Florida County Boundaries



Florida Population Estimates¹ by Year, Age Group, Gender, Race, and Ethnicity

Year	Population	Age Group	2014 Population	Gender	2014 Population
2005	17,876,663	<1	217,026	Female	9,992,462
2006	18,237,596	1-4	886,618	Male	9,555,569
2007	18,500,958	5-9	1,132,972	Race 2014 Population	
2008	18,636,837	10-14	1,146,040	White	15,286,521
2009	18,711,844	15-19	1,192,611	Black	3,263,817
2010	18,820,278	20-24	1,312,024	Other	997,693
2011	18,934,175	25-34	2,448,462	Ethnicity 2014 Population	
2012	19,042,458	35-44	2,345,727	Non-Hispanic	14,861,999
2013	19,318,859	45-54	2,699,859	Hispanic	4,686,032
2014	19,548,031	55-64	2,574,936	Total	19,548,031
		65-74	1,951,625		
		75-84	1,142,703		
		85+	497,428		
		Total	19,548,031		

¹ All population estimates are from the Community Health Assessment Resource Tool Set (CHARTS), a Florida Department of Health web-based data query system with community tools, health indicators, and data queries for public consumption (www.floridacharts.com/charts/default.aspx). Population estimates within CHARTS are provided by the Florida Department of Health Division of Public Health Statistics and Performance Management, in consultation with the Florida Legislature's Office of Economic and Demographic Research. Estimates in CHARTS are updated at least once per year, and population data were extracted from CHARTS for this report on August 7, 2015. Note that previous editions of this report may show somewhat different populations for a given year than the ones shown here, as these estimates are revised periodically. This is especially true given the recent 2010 census.

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