Introduction

Background

The *Florida Morbidity Statistics Report* is the official record of the occurrence of reportable disease in Florida and this edition marks the fifty-seventh publication since 1945. The data contained here are final, unless otherwise noted. Section 381.003, *Florida Statutes* "The Department shall conduct a communicable disease prevention and control program as part of fulfilling its public health mission." 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. 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 disease requires diligence in all aspects of public health. Public health partners in 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.

The Bureau of Epidemiology thanks all program areas within the Florida Department of Health that contributed to this report including the sections of Immunization, HIV/AIDS and Hepatitis, Sexually Transmitted Disease and Tuberculosis Control. Finally, many thanks are extended to the county health department 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 and environmental diseases 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* (*FAC*), 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, Chapter 64D-3, *FAC*. 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:

1. 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.

2. Active surveillance entails Department staff regularly contacting hospitals, laboratories and physicians in an effort to identify all cases of a given disease or condition.
3. 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.

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. http://www.cdc.gov/az/a.html.

Centers for Disease Control and Prevention. 1999. Combination Vaccines for Childhood Immunization. *Morbidity and Mortality Weekly Report*, 48(RR05);1-15. http://www.cdc.gov/mmwr/preview/mmwrhtml/rr4805a1.htm.

Centers for Disease Control and Prevention. 2012. *Epidemiology and Prevention of Vaccine-Preventable Diseases*, 12th ed. Washington, D.C.: Public Health Foundation. http://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. http://www.cdc.gov/vaccines/pubs/surv-manual/index.html.

Centers for Disease Control and Prevention. 2014. *CDC Health Information for International Travel 2014*. New York: Oxford University Press. http://wwwn.cdc.gov/travel/contentYellowBook.aspx.

Heymann DL (ed). 2008. *Control of Communicable Diseases Manual*. 19th 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. Underreporting

   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 web-based data query system with community tools, health indicators and data queries for public consumption (http://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 November 6, 2013. 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. Reporting Period
   To ensure consistent case counting, the data in this report are aggregated by the date the case was reported to the Bureau of Epidemiology unless otherwise noted. The date of illness onset or the date of diagnosis may not be available for all cases. Cases reported early in 2012 may have actually had onset or been diagnosed in 2011; rarely, cases reported in 2012 may have onset or diagnosis dates prior to 2011. Additionally, cases with illness onset or diagnosis late in 2012 may not have been reported to the Bureau of Epidemiology by the end of the 2012 reporting year, and thus would not be included in this report. The reporting year is defined by the standard reporting weeks 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 52 weeks in 2012. The data in this report are consistent with national surveillance data published weekly by CDC. 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. Diseases that use different dates to aggregate data in this report have an explanation of what date is used in the disease-specific chapter.

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 in line with national case definitions where appropriate (*Surveillance Case Definitions for Select Reportable Diseases in Florida*, available at http://www.floridahealth.gov/diseases-and-conditions/disease-reporting-and-management/disease-reporting-and-surveillance/index.html). Case classifications are reviewed at the state level for many diseases. Following CDC *Morbidity and Mortality Weekly Report* (MMWR) print criteria (available at http://www.cdc.gov/nndss/script/downloads.aspx), only confirmed and probable cases have been included for all diseases (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 2012 as a result of position statements approved by the Council of State and Territorial Epidemiologists (CSTE) in 2011.

Summary of case definition changes effective January 2012:

a. Amebic Encephalitis: removed the suspect case classification for *Naegleria fowleri* causing Primary Amebic Meningoencephalitis (PAM); removed the probable case classification for *Balamuthia mandrillaris* disease; removed the suspect case classification for *Acanthamoeba* disease (excluding keratitis); added a new case definition to capture *Acanthamoeba* keratitis.

b. Hepatitis A: added symptoms to the clinical case definition.

c. Acute hepatitis B: added symptoms to the clinical case definition; revised laboratory criteria to specify ALT levels >100 units per liter in the absence of jaundice; removed clinically acute disease as a requirement if the patient has a documented negative hepatitis B virus antigen laboratory test result followed within six months by a positive test result and no previous diagnosis of chronic hepatitis B.

d. Chronic hepatitis B: clarified that only one laboratory result of the three laboratory tests that meet the criteria for diagnosis of hepatitis B virus infection is required to meet the case definition.

e. Acute hepatitis C: added symptoms to the clinical case definition; removed clinically acute disease as a requirement if the patient has a documented negative hepatitis C virus antibody laboratory test result followed within six months by a positive test result.

f. Vibriosis: revised to include any infection that meets the clinical description where a species of the family Vibrionaceae (formerly included only species of the genus *Vibrio*) is isolated from a clinical specimen.

g. Cryptosporidiosis: clarified laboratory evidence section for confirmed and probable case classifications; removed clinical evidence requirement to meet the confirmed and probable case classification.

h. Melioidosis: removed clinical evidence requirement to meet the confirmed case definition; added a probable case definition that relies on clinical, supportive laboratory and epidemiologic evidence.

i. Mumps: removed epidemiologic link as an acceptable alternative to laboratory confirmation for confirmed cases; defined clinically compatible illness for probable and suspect cases; expanded “epidemiologic link” for probable cases to include membership in a group/community defined by public health during an outbreak.

j. Ricin toxin poisoning: added confirmed and probable case classification criteria; removed the suspect classification; added detection of ricin in environmental samples and detection of urinary ricinine to laboratory evidence.

k. Carbon monoxide poisoning: clarified that the case definition applies to acute carbon monoxide poisoning; revised formatting.

l. Acute pesticide-related illness and injury: clarified that the case definition applies to acute pesticide-related illness and injury; revised the clinical description and case classification criteria and overall formatting.

5. Assigning Cases to Counties

Cases are assigned to Florida counties based on the county of residence at the time of the disease identification. Cases are assigned to their county of residence 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 counted as Florida cases

and 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 web-based data query system with community tools, health indicators and data queries for public consumption (http://www.floridacharts.com/charts/default.aspx). Population estimates within CHARTS are provided by the Florida Department of Healthv 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 November 6, 2013. 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 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 Hemorrhagic Fever - 06101

   c. Eastern Equine Encephalitis Virus Disease
      Eastern Equine Encephalitis Virus Neuroinvasive Disease - 06220
      Eastern Equine Encephalitis Virus Non-Neuroinvasive Disease - 06221

   d. Ehrlichiosis/Anaplasmosis
      Ehrlichiosis/Anaplasmosis, HGA (*A. phagocytophilum*) - 08381
      Ehrlichiosis/Anaplasmosis, HME (*E. chaffeensis*) - 08382
      Ehrlichiosis/Anaplasmosis (*E. ewingii*) - 08383
      Ehrlichiosis/Anaplasmosis, Undetermined - 08384

   e. Encephalitis, Other (Non-Arboviral)
      Encephalitis (Other, Non-Arboviral) - 03236
      Encephalitis (Varicella) - 05200 (EXPIRED)
      Encephalitis (Herpes) - 05430 (EXPIRED)
      Encephalitis (Influenza) - 48780 (EXPIRED)
      Encephalitis (Measles) - 05500 (EXPIRED)
      Encephalitis (Mumps) - 07220 (EXPIRED)
      Encephalitis (Other) - 32390 (EXPIRED)

   f. *Haemophilus influenzae*, Invasive Disease in Children <5 Years Old
      H. influenzae Invasive Disease - 03841
      Meningitis (*H. influenzae*) - 32000 (EXPIRED)
      Epiglottitis (*H. influenzae*) - 46430 (EXPIRED)
      Pneumonia (*H. influenzae*) - 48220 (EXPIRED)
      Cellulitis (*H. influenzae*) - 69290 (EXPIRED)
      Septic Arthritis (*H. influenzae*) - 71100 (EXPIRED)

g. Listeriosis
   Listeriosis - 02700
   Meningitis (*L. monocytogenes*) - 32070 (EXPIRED)

h. Meningococcal Disease
   Meningococcal Disease - 03630
   Meningitis (*N. meningitidis*) - 03600 (EXPIRED)
   Meningococcemia, Disseminated - 03620 (EXPIRED)

i. Plague
   Plague, Bubonic - 02000
   Plague, Pneumonic - 02050

j. Poliomyelitis
   Poliomyelitis, Nonparalytic - 04520
   Poliomyelitis - 04590

k. Q Fever
   Q Fever, Acute - 08301
   Q Fever, Chronic - 08302
   Q Fever - 08300 (EXPIRED)

l. Shiga Toxin-Producing *E. coli* Infection
   Shiga Toxin-Producing *E. coli* (STEC) Infection - 00800
   Shiga Toxin-Producing *E. coli* (STEC) Infection, O157:H7 - 41601 (EXPIRED)
   Shiga Toxin-Producing *E. coli* (STEC) Infection, Non-O157 - 41602 (EXPIRED)

m. St. Louis Encephalitis Virus Disease
   St. Louis Encephalitis Virus Neuroinvasive Disease - 06230
   St. Louis Encephalitis Virus Non-Neuroinvasive Disease - 06231

n. Typhus Fever
   Typhus Fever, Epidemic (*R. prowazekii*) - 08000
   Typhus Fever, Endemic (*R. typhi* or *R. felis*) - 08100
   Typhus Fever - 08190 (EXPIRED)

o. Venezuelan Equine Encephalitis Virus Disease
   Venezuelan Equine Encephalitis Virus Neuroinvasive Disease - 06620
   Venezuelan Equine Encephalitis Virus Non-Neuroinvasive Disease - 06621

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

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

r. Western Equine Encephalitis Virus Disease
   Western Equine Encephalitis Virus Neuroinvasive Disease - 06210
   Western Equine Encephalitis Virus Non-Neuroinvasive Disease - 06211

Summary of Key Disease Trends in 2012

Sexually transmitted diseases (STDs), HIV, and AIDS are the most common reportable diseases in Florida, particularly among 15 to 54-year-olds. Chlamydia incidence has been increasing over the past 10 years, with almost 78,000 cases reported in Florida in 2012. As chlamydia has increased, the number of gonorrhea cases has consistently decreased over the past 10 years. A shift in treatment guidelines and recommendations for screening of women under the age of 25 contributed to the decrease in gonorrhea cases. The incidence of HIV and AIDS has also decreased over the last 10 years, though HIV increased slightly in 2011 and 2012. Syphilis incidence has remained relatively stable for the past 10 years, but has been increasing slightly since 2009, with a 7.5% increase in 2012 compared to the past five years.

In the mid-1980s, tuberculosis (TB) re-emerged as a public health threat in the U.S. The number of cases of TB in Florida has decreased every year since 1994. The incidence in 2012 decreased 23.4% 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. As a consequence, the proportion of all Florida TB cases that are made up of people born in a foreign country has grown to half of all TB cases in 2012.

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. Incidence continued to be high in 2012, particularly for salmonellosis and shigellosis. Historically, shigellosis has a cyclic temporal pattern with large, community-wide outbreaks, frequently involving daycare centers, every 2-3 years. Shigellosis activity increased in 2010 and 2011, but started decreasing in 2012. Incidence of other enteric diseases remained relatively stable in 2012.

Despite high vaccine coverage in Florida, vaccine-preventable diseases (VPDs) continued to occur. In 2012, VPD incidence decreased substantially overall in Florida compared to 2011. While both meningococcal disease and varicella decreased slightly, there was a sharp increase in reported pertussis cases in 2012, with the highest number of cases reported in 10 years and an 84% increase in cases compared to 2011. Pertussis has been increasing in Florida and nationally over the past 10 years, despite routine vaccine use. Acute hepatitis A and hepatitis B incidence has declined drastically over the past decade, likely due to increased vaccination coverage, however both increased slightly in 2012 compared to 2011. This was the first increase in acute hepatitis B in 10 years.

Arboviral diseases continued to be a threat in Florida in 2012. Lyme disease, transmitted by ticks, remained relatively stable with 60% of the infections likely acquired in other states (primarily in the Northeast and upper Midwest U.S.). West Nile virus (WNV) disease cases increased dramatically in 2012, with the second highest number of cases reported since the virus was introduced in 2001 in Florida. In Florida, cases were focused in Duval County and the Panhandle. 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. Imported malaria cases decreased substantially in 2012, and no infections were acquired in Florida. Dengue fever cases increased in 2012, and three isolated cases of locally-acquired dengue fever were identified in Miami-Dade (2) and Osceola (1) counties. Dengue virus infections were primarily acquired in Central America and the Caribbean, which is consistent with past years.

Chronic hepatitis continues to account for a large bulk of infectious disease burden in Florida with over 15,000 confirmed and probable cases reported annually. In 2012, the rate of reported newly diagnosed chronic hepatitis C cases was higher than any previous year. Overall, the highest rates occurred among people 45 to 64 years old, with these rates remaining stable since 2008. In contrast, the rate of chronic hepatitis C new diagnoses has continued to increase since 2005 among people aged 20 to 34 years. This trend is seen in acute hepatitis C cases as well. The majority of new hepatitis C infections in Florida are due to injection drug use (IDU). Nationally and in Florida, the dual

increases in hepatitis C incidence and IDU among young adults has been associated with the proliferation of highly addictive prescription opioid painkillers.

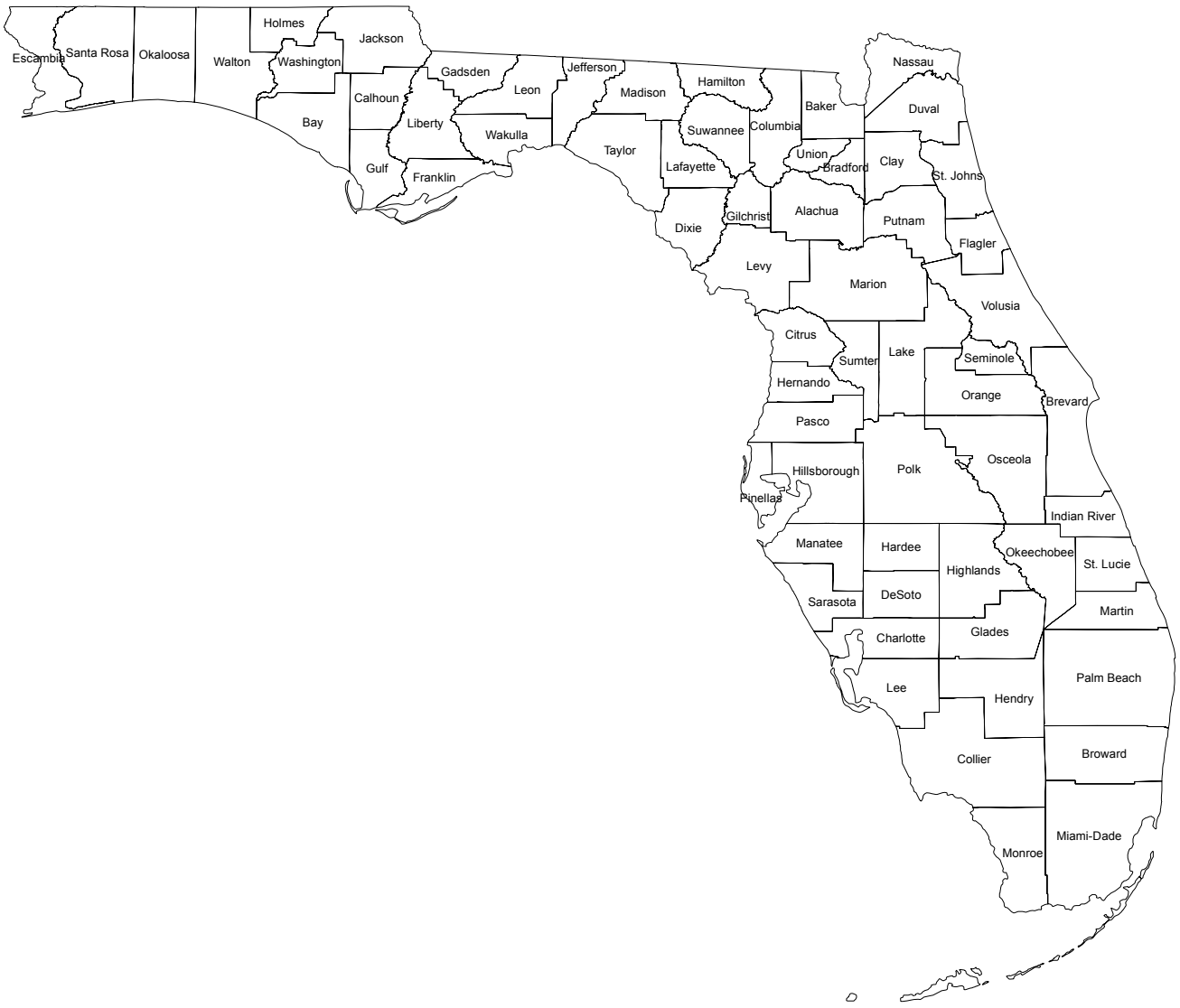
For additional information on disease-specific trends, see Section 1: Summary of Selected Reportable Diseases/Conditions, Section 2: Data Summaries for Selected Reportable Diseases/Conditions of Frequent Occurrence and Section 3: Narratives for Selected Reportable Diseases/Conditions of Infrequent Occurrence.

List of Reportable Diseases/Conditions in Florida, 2012

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; or any laboratory licensed under chapter 483 that diagnoses or suspects the existence of a disease of public health significance shall immediately report the fact to the Department of Health." County health departments serve as the Department's representative in this reporting requirement. Furthermore, Section 381.0031 (4) 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 listed in subsection (2)…". This list reflects diseases and conditions that were reportable in 2012. Updates may be made in future years; *Florida Morbidity Statistics Reports* for subsequent years will reflect changes in the list.

Acquired Immunodeficiency Syndrome (AIDS)
Amebic encephalitis
Anthrax
Arsenic poisoning
Botulism
Brucellosis
California serogroup virus disease (neuroinvasive and non-neuroinvasive)
Campylobacteriosis
Cancer (except non-melanoma skin cancer, and including benign and borderline intracranial and CNS tumors)
Carbon monoxide poisoning
Chancroid
Chlamydia
Cholera
Ciguatera fish poisoning
Congenital anomalies
Conjunctivitis (in neonates ≤14 days old)
Creutzfeldt-Jakob disease
Cryptosporidiosis
Cyclosporiasis
Dengue
Diphtheria
Eastern equine encephalitis virus disease (neuroinvasive and non-neuroinvasive)
Ehrlichiosis/anaplasmosis
Encephalitis, other (non-arboviral)
Enteric diseases due to:
Escherichia coli, O157:H7
Escherichia coli, other pathogenic *E. coli* including entero-toxigenic, invasive, pathogenic, hemorrhagic, aggregative strains and Shiga toxin producing strains
Giardiasis
Glanders
Gonorrhea
Granuloma inguinale
Haemophilus influenzae, invasive disease
Hansen's Disease (Leprosy)
Hantavirus infection
Hemolytic uremic syndrome
Hepatitis A
Hepatitis B, C, D, E, and G
Hepatitis B surface antigen in pregnant women or children ≤24 months old
Herpes simplex virus in infants ≤6 months old, anogenital in children ≤12 years old
Human immunodeficiency virus (HIV) infection
Human papillomavirus in children ≤6 years old, anogenital in children ≤12 years old, cancer associated strains
Influenza due to novel or pandemic strains
Influenza-associated pediatric mortality (in children <18 years old)
Lead poisoning
Legionellosis
Leptospirosis
Listeriosis
Lyme disease
Lymphogranuloma venereum
Malaria
Measles
Melioidosis
Meningitis (bacterial, cryptococcal, mycotic)
Meningococcal disease
Mercury poisoning
Mumps
Neurotoxic shellfish poisoning
Pertussis
Pesticide-related illness and injury
Plague
Poliomyelitis
Psittacosis
Q Fever
Rabies (human, animal, possible exposure)
Ricin toxin poisoning
Rocky Mountain spotted fever
Rubella (including congenital)
St. Louis encephalitis virus disease (neuroinvasive and non-neuroinvasive)
Salmonellosis
Saxitoxin poisoning (including paralytic shellfish poisoning)
Severe acute respiratory syndrome-associated *Coronavirus* (SARS-CoV) disease
Shigellosis
Smallpox
Staphylococcus aureus (with intermediate or full resistance to vancomycin)
Staphylococcus aureus, community-associated mortality
Staphylococcus enterotoxin B poisoning
Streptococcal invasive disease (Group A)
Streptococcus pneumoniae, invasive disease
Syphilis
Tetanus
Toxoplasmosis (acute)
Trichinosis
Tuberculosis
Tularemia
Typhoid fever
Typhus fever (epidemic and endemic)
Vaccinia disease
Varicella (including mortality)
Venezuelan equine encephalitis virus disease (neuroinvasive and non-neuroinvasive)
Vibriosis
Viral hemorrhagic fevers (Ebola, Marburg, Lassa, Machupo)
West Nile virus disease (neuroinvasive and non-neuroinvasive)
Western equine encephalitis virus disease (neuroinvasive and non-neuroinvasive)
Yellow fever
Any disease outbreak
Any grouping or clustering of disease

Florida County Boundaries



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

Year	Population
2003	17,074,368
2004	17,476,489
2005	17,876,663
2006	18,237,596
2007	18,500,958
2008	18,636,837
2009	18,711,844
2010	18,820,278
2011	18,934,175
2012	19,042,458

Age Group	2012 Population
<1	209,035
1-4	868,895
5-9	1,095,035
10-14	1,130,994
15-19	1,201,681
20-24	1,257,586
25-34	2,352,723
35-44	2,367,106
45-54	2,693,194
55-64	2,447,516
65-74	1,837,950
75-84	1,118,494
85+	462,249
Total	19,042,458

Gender	2012 Population
Female	9,733,064
Male	9,309,394
Race	**2012 Population**
White	14,930,936
Black	3,150,349
Other	961,173
Ethnicity	**2012 Population**
Non-Hispanic	14,629,656
Hispanic	4,412,802
Total	19,042,458

Florida Morbidity Statistics Report Editors and Contributors

Editors

Leah Eisenstein, MPH (Lead Editor)	Bureau of Epidemiology
Janet Hamilton, MPH (Senior Editor)	Bureau of Epidemiology
Robert Bernstein, MD, PhD, FACPM (Section Editor)	Bureau of Epidemiology
Jamie DeMent, MNS (Section Editor)	Bureau of Epidemiology
Beth Ann Eichler, MS (Section Editor)	Bureau of Epidemiology
Catherine Lesko, MPH (Section Editor)	Bureau of Epidemiology
Scott Pritchard, MPH (Section Editor)	Bureau of Epidemiology
Danielle Stanek, DVM (Section Editor)	Bureau of Epidemiology
Chad Bailey	Bureau of Epidemiology
Carina Blackmore, DVM, PhD, Dipl AVCPM	Division of Disease Control and Health Protection, Deputy State Epidemiologist
Mary Hilton, MNO	Bureau of Epidemiology
Nicole Kikuchi, MPH	Bureau of Epidemiology
Sharon Watkins, PhD	Bureau of Epidemiology, Chief
Michael Wydotis	Bureau of Epidemiology

Florida Department of Health (DOH) Contributors

Nathaly Acosta, MPH	DOH-Osceola County
Rebecca Alcantara, RN, BSN	DOH-Duval County
Olga Aponte, BSN	DOH-Sarasota County
Janay Armstrong, BA	DOH-Sarasota County
David Atrubin, MPH	Bureau of Epidemiology
Sydney Bailey, RN	DOH-Martin County
Dean Bodager, RS, DAAS, MPA	Bureau of Epidemiology
Patrice Boon, RN	DOH-Seminole County
Karen Card, MPH	Bureau of Communicable Diseases, Tuberculosis Control Section
Martha Casero, MPH, MA	DOH-Miami-Dade County
Philip Cavicchia, PhD	Bureau of Epidemiology
Lekisha Cohen, MPH	Bureau of Communicable Diseases, Sexually Transmitted Disease Section
Maura Comer, MPH, CPH	Bureau of Epidemiology
Alazandria Cruze, MPH, CPH	Bureau of Epidemiology
Gregory Danyluk, PhD, MPH, MS	DOH-Seminole County
Michael Drennon, MSPH	DOH-Sarasota County
Freta Dunn	DOH-Citrus County
Cristina Dusek, RN, BSN	Bureau of Communicable Diseases, Immunizations Section

Contributors (Continued)

Karen Elliott, MPH, CHES, CIC	DOH-Duval County
Tricia Foster, MPH	Bureau of Epidemiology
Mike Friedman, MPH	Bureau of Epidemiology
Maritza Godwin, MPH, RN, BSN	DOH-Orange County
Lillian Gomes, RN	DOH-Charlotte County
Ingrid Gray, MPH	Bureau of Communicable Diseases, Sexually Transmitted Disease Section
Megan Gumke, MPH, CPH	Bureau of Epidemiology
Terri Harder, RN, BSN	DOH-Collier County
Debra Hart, RN	DOH-Citrus County
Donald Hayes, CEPH	DOH-Lake County
Ken Kampert, MS, MPH	Bureau of Communicable Diseases, Sexually Transmitted Disease Section
Ruth Kim, MD, MPH	DOH-St. Lucie County
Diane King, MPSH, RN	DOH-Palm Beach County
Deborah Kirchenberg, BS, RS	DOH-Lake County
Kimberly Kossler, MPH, RN, CPH	DOH-St. Lucie County
Nadia Kovacevich, MPH, CHP	DOH-Alachua
Shamilla Lutchman	DOH-Palm Beach County
Tammy Lynn, RN	DOH-St. Lucie County
Kent Macci, MS, RS	DOH-Sarasota County
Lorene Maddox, MPH	Bureau of Communicable Diseases, HIV/AIDS and Hepatitis Section
Erin Mahler	Bureau of Epidemiology
Debra Mattas, BS	DOH-Lake County
Sarah Matthews, MPH	DOH-Orange County
James Matthias, MPH	Bureau of Epidemiology
Laura Matthias, MPH	Bureau of Epidemiology
Katherine McCombs, MPH	Bureau of Epidemiology
Álvaro Mejía-Echeverry, MD, MPH	DOH-Miami-Dade County
Madgene Moise, MPH	Bureau of Communicable Diseases, HIV/AIDS and Hepatitis Section
Holly Montejano, MS	DOH-Orange County
Stephanie Moody-Geissler, MPH	Bureau of Epidemiology
Angela Morgan, RN, BSN	DOH-Duval County
Helen Morin, RN	DOH-Seminole County
Prakash Mulay, MBBS, MPH	Bureau of Epidemiology
Michelle Nash, MPH	DOH-Volusia County
Marion Nowlin	DOH-Polk County
Andy Reich, MS, MSPH	Bureau of Epidemiology
Pamela Richardson, RN	DOH-Polk County

Contributors (Continued)

Edhelene Rico, MPH	DOH-Miami-Dade County
Jennifer Roth, MPH	Bureau of Epidemiology
Vincy Samuel, MPH	Bureau of Epidemiology
Enid Santiago	DOH-Seminole County
Ann Schmitz, DVM, AM	Bureau of Epidemiology
Ana Scuteri, MPH	DOH-Charlotte County
Valerie Shipley, RN, BSN	Bureau of Communicable Diseases, Immunizations Section
Tania Slade, MPH	DOH-Orange County
Rebecca Snider, MPH	Bureau of Epidemiology
Ewa Szczypinska, MD	DOH-Orange County
Robin Terzagian, BS	Bureau of Epidemiology
Lori Theisen, RN, BSN	DOH-Orange County
Karen Thomas, MD, MPH	DOH-Martin County
Thomas Török, MD, MPH	Bureau of Epidemiology
Janet Wamnes, MS	Bureau of Epidemiology
Barbara Will, MPH	DOH-Manatee County
Leah Williams	DOH-Orange County
Tiffany Winston, MPH	DOH-Osceola County

Selected Division of Disease Control and Health Protection Contacts

Bureau of Epidemiology
(850) 245-4401 (accessible 24/7/365)

Bureau of Communicable Diseases

HIV/AIDS and Hepatitis Section
(850) 245-4334

Immunization Section
(850) 245-4342

Sexually Transmitted Disease Section
(850) 245-4303

Tuberculosis Control Section
(850) 245-4350