

DR. LATWEIKA A.T. SALMON-TREJO

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Portfolio



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Dr. LATWEIKA A.T.
SALMON-TREJO

EXPERT SKILLS

- CURRICULUM DEVELOPMENT
- STRATEGIC PLANNING & PARTNERSHIP DEVELOPMENT
- ORGANIZATION & PROJECT MANAGEMENT
- COMMUNITY HEALTH NEEDS ASSESSMENT
- COMMUNITY BENEFIT REPORTING
- HEALTH EQUITY & SOCIAL DETERMINANTS OF HEALTH
- STAKEHOLDER & COMMUNITY ENGAGEMENT
- DATA ANALYSIS & VISUALIZATION (SAS, R, SQL, POWER BI)
- PROGRAM PERFORMANCE METRICS & EVALUATIONS
- BUDGET & FINANCIAL OVERSIGHT
- POLICY/LEGISLATIVE ANALYSIS (WHITE/GREY PAPERS)
- GRANT WRITING & MANAGEMENT
- STAKEHOLDER ENGAGEMENT
- HEALTH EDUCATION & COMMUNICATIONS
- CROSS-AGENCY COLLABORATION (PRIVATE/PUBLIC)
- AI- AUTOMATED WORKFLOWS & SYSTEMS THINKING

CURRICULUM DEVELOPMENT

DEVELOPED STANDARDS-ALIGNED CURRICULUM AND INSTRUCTIONAL RESOURCES FOR MIDDLE SCHOOL LIFE SCIENCE, INTEGRATING INQUIRY-BASED LEARNING, HEALTH LITERACY, STORYTELLING, LABORATORY INVESTIGATIONS, AND FORMATIVE ASSESSMENT. DESIGNED LESSONS THAT TRANSLATED COMPLEX BIOLOGICAL CONCEPTS INTO ENGAGING, AGE-APPROPRIATE LEARNING EXPERIENCES WHILE ALIGNING INSTRUCTION WITH STATE STANDARDS AND MEASURABLE LEARNING OBJECTIVES.

Course Name and Number: M/J Life Science Advanced (#2000020)

Quarter: 1

Measurement Topic Plan: Types of Cells

Duration of MTP/Unit: (Days)

Approximately 10 days

Standard(s)/Access Point(s):

Essential Standards: Essential Standards are the standards included in the unit scales, however, they are not the only standards needed to meet the desired level of scale proficiency.

- SC.912.L.14.2 - Components' Structure/Function of Plant/Animal Cells; Cell Membranes
- SC.912.L.14.3 - Plant, Animal, Prokaryote, and Eukaryote Cells

Supporting Standards: Although not formally assessed as part of the unit scale, supporting standards create a foundation or support structure for the essential standards.

There are no supporting standards for these Essential Standards.

Embedded Standards: Content, or the topic of embedded standards can be taught in tandem with essential standards, is foundational and should not be taught in isolation. Mathematical Practices, while modeled by the teacher, are always considered to be observed student behaviors.

- SC.6.N.1.1 - Solving Scientific Problems
- SC.6.N.2.2 - Scientific Knowledge
- SC.6.N.3.1 - Scientific Theories
- SC.6.N.3.4 - Role of Models

Additional Mathematical Practices, Math Florida Standards, English Language Development Standards and Language Arts Florida Standards are embedded throughout the course and can be found on the Scope & Sequence.

Essential Question(s):

- How does an organism's structure enable it to survive in its environment?
- How does cell organization relate to the organization of other systems?

Learning Goal(s): (Based on Standards)

The students will:

- SC.912.L.14.2 - relate structure to function for the components of plant and animal cells. Explain the role of cell membranes as a highly selective barrier (passive and active transport).
- SC.912.L.14.3 - compare and contrast the general structures of plant and animal cells. Compare and contrast the general structures of prokaryotic and eukaryotic cells.

Unit Scale:

4.0 Through independent work beyond what was taught in class, students could (examples include, but are not limited to):

- compare and contrast active and passive transport in cells.
- investigate how the availability of organelles present in particular cells impacts the function of that cell.

3.0

The students will:

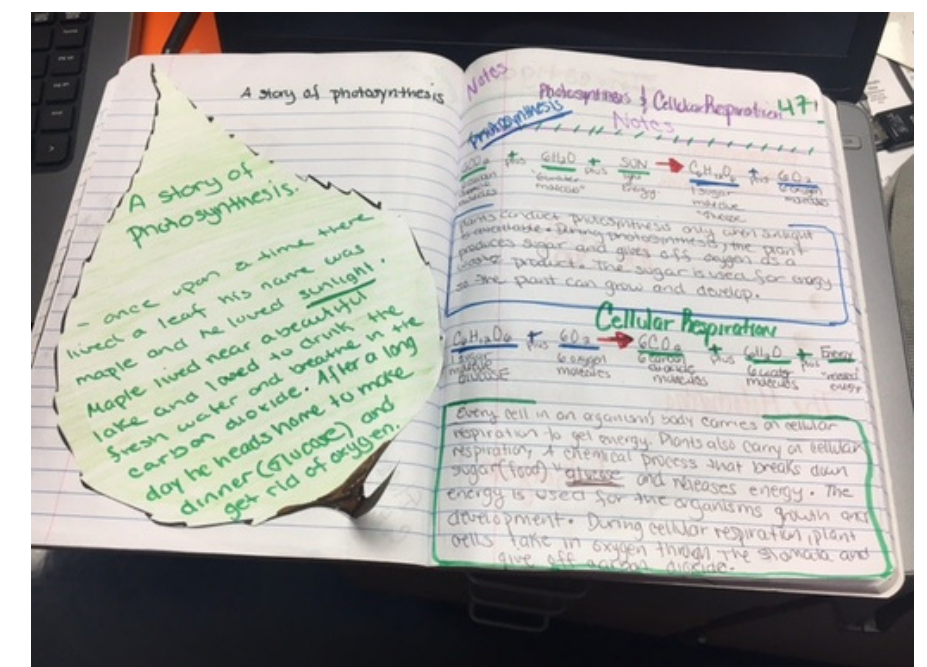
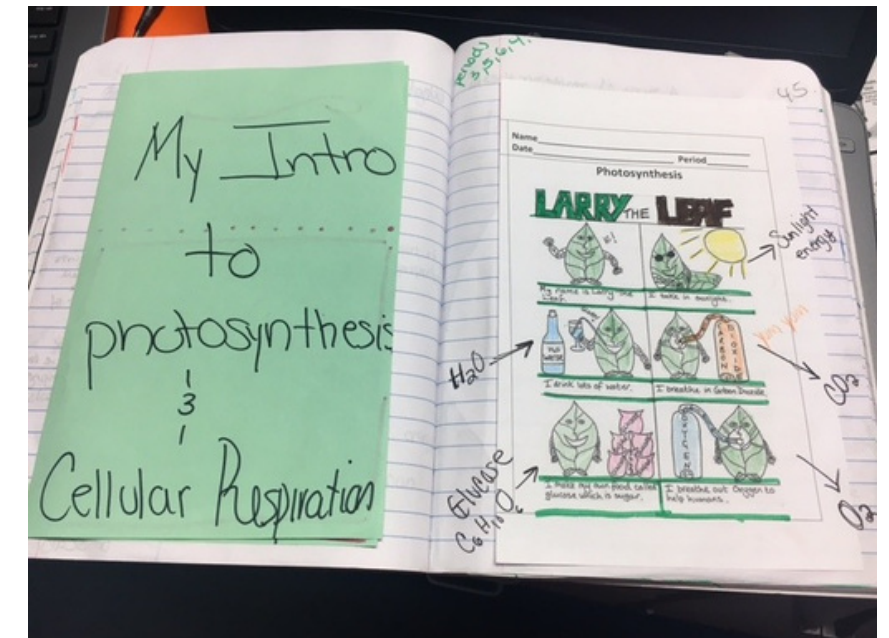
- SC.912.L.14.2 - relate structure to function for the components of plant and animal cells. Explain the role of cell membranes as a highly selective barrier (passive and active transport). (Content Complexity Level 2)
- SC.912.L.14.3 - compare and contrast the general structures of plant and animal cells. Compare and contrast the general structures of prokaryotic and eukaryotic cells. (Content Complexity Level 2)

2.0

The students will:

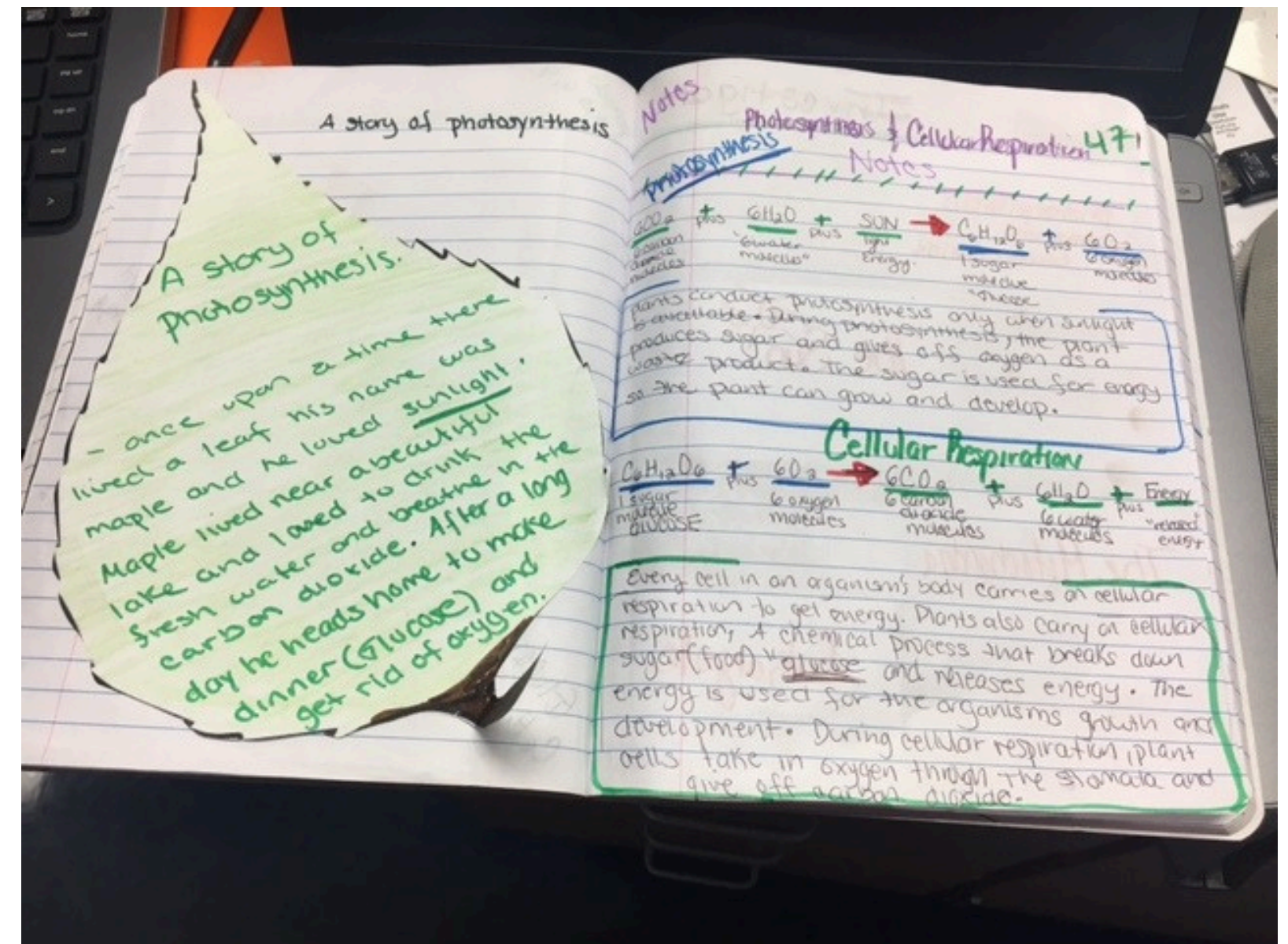
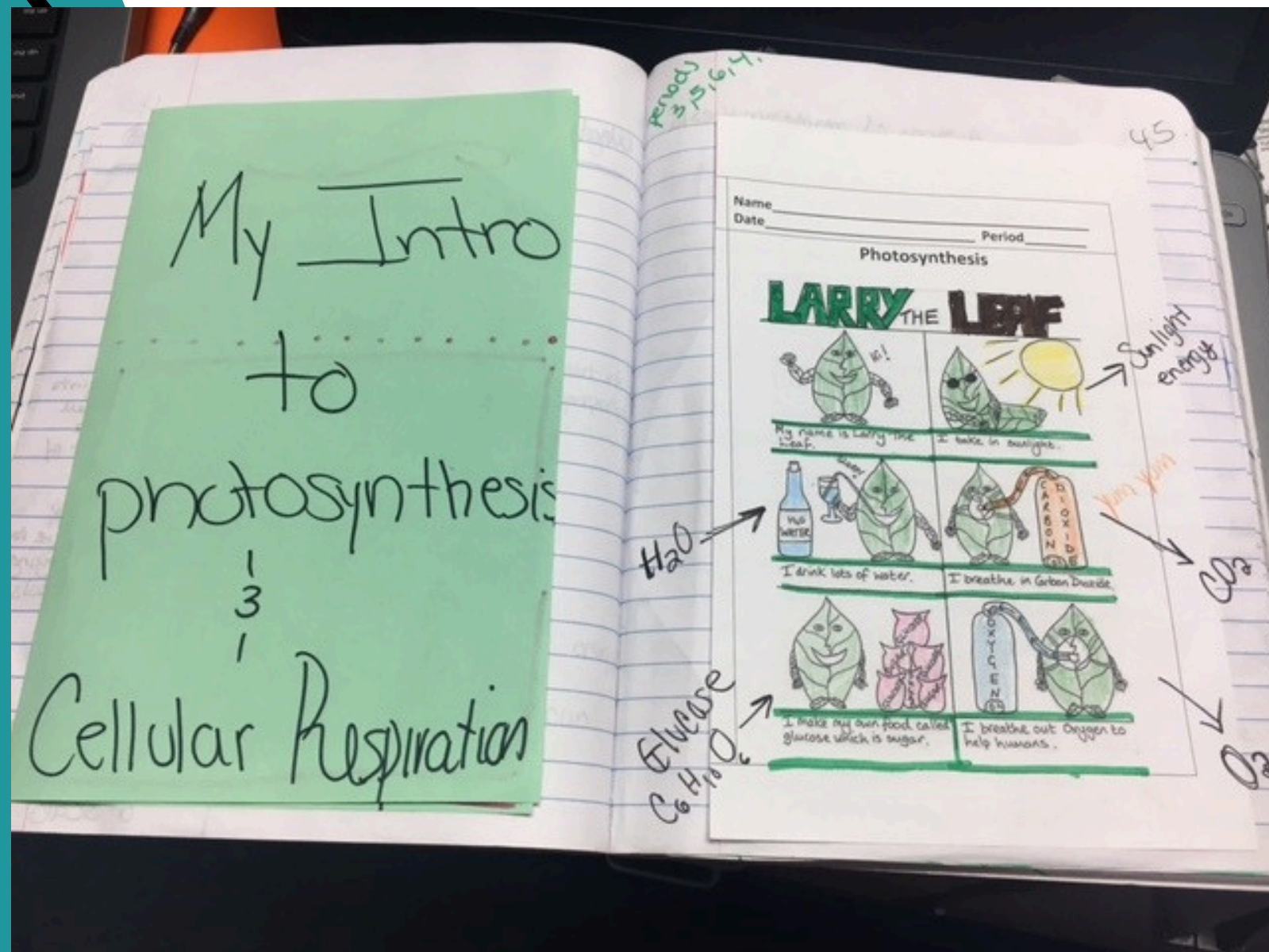
- determine the meaning of symbols, key terms, and other life science specific words and phrases as they are used in a specific technical context relevant to grades 6-8 texts and topics (see Academic Vocabulary below).

	• identify cell structures when given a corresponding cell function. (SC.912.L.14.2) • describe a highly selective barrier. (SC.912.L.14.2) • describe the key structures in plant and animal cells. (SC.912.L.14.3) • describe the key structures in prokaryotic and eukaryotic cells. (SC.912.L.14.3)	
1.0	The students will: • identify from a list, the key structures in plant and animal cells. (SC.912.L.14.3) • identify from a list, the key structures in prokaryotic and eukaryotic cells. (SC.912.L.14.3)	
Academic Vocabulary:		
active transport	chloroplasts	nucleus
cell	cytoplasm	organism
cell membrane	environment	passive transport
cell wall	eukaryote	prokaryote
characteristic	mitochondria	vacuoles
Misconceptions:		
The students may: • believe that living things only carry out observable processes such as movement and breathing. • believe that only multi-cellular organisms are living. • believe that single celled organisms are not living because they do not carry out life functions. • believe that cells are not made of molecules. • believe that there are only two types of cells; plant and animal. • believe that living things contain cells rather than they are made of cells. • believe that cells and molecules are the same size. • believe that all cells are the same size.		
Teaching Resources: (Learning Objects Located in SAFARI Montage)		
• Types of Cells - A variety of preselected resources located in SAFARI Montage including, but not limited to, whiteboards, interactive fillable documents, images, lesson notes, activities, guided practice, challenge problems, videos, quizzes, digital lessons, and audio files. • DiSpezio, M., Frank, M., Heithaus, M., & Ogle, D. (2012). Florida Science Fusion: New Energy for Life Science. U.S.A.: Holt McDougal. - Unit 2 The Cell - Lesson 1 The Characteristics of Cells - Student Edition pages 72-81 - Digital Lesson 1 - Teacher Edition pages 90, 96, 104-116 - Lesson 3 - Cell Structure and Function - Student Edition pages 92-103 - Digital Lesson 3 - Virtual Lab: Analyzing Cells - Teacher Edition pages 90, 98, 132-145		



CURRICULUM DEVELOPMENT

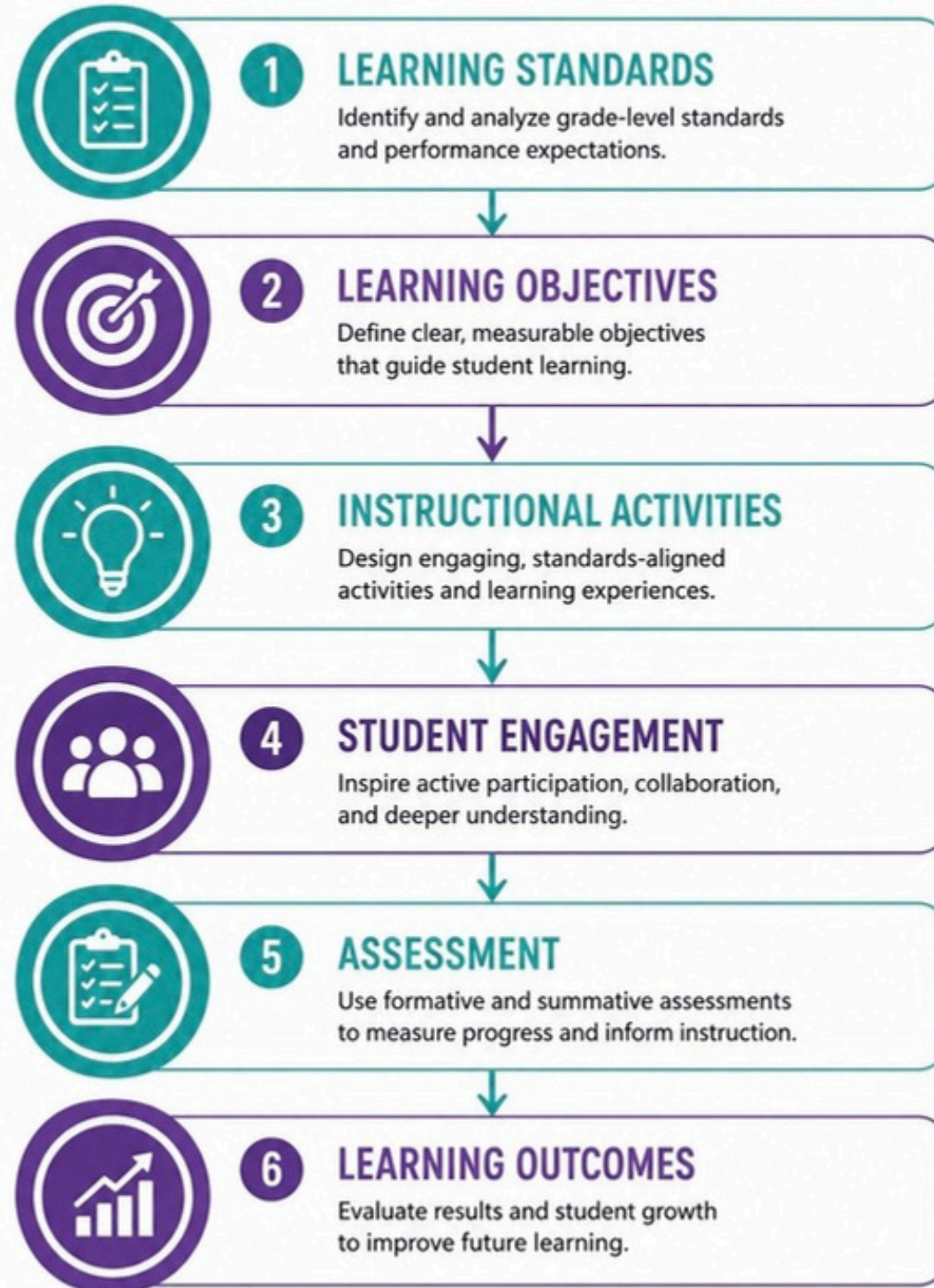
STUDENTS TRANSFORMED COMPLEX BIOLOGICAL CONCEPTS INTO STORIES, DIAGRAMS, INVESTIGATIONS, AND INTERACTIVE NOTEBOOKS THAT REINFORCED SCIENTIFIC UNDERSTANDING THROUGH MULTIPLE LEARNING MODALITIES.



CURRICULUM DEVELOPMENT

CURRICULUM DEVELOPMENT PROCESS

A Strategic Approach to Student Learning and Success



Lake Nona Middle School Lesson Plan

Teacher: Ms. Salmon	Course: Life Science	Start Date: 12/7/15	End Date: 12/18/15
MTP Unit Title: Heredity and Reproduction		Duration of Unit: 10 days	
Standard(s): SC.7.L.16.1 - DNA, Genes, and Chromosomes • SC.7.L.16.2 - Probabilities of Genotypes and Phenotypes			
Learning Goals: *Understand and explain that every organism requires a set of instructions that specifies its traits, that this hereditary information (DNA) contains genes located in the chromosomes of each cell, and that heredity is the passage of these instructions from one generation to another. • determine the probabilities for genotype and phenotype combinations using Punnett Squares and pedigrees.			
Essential Questions: What makes an organism unique?			
Unit Vocabulary: allele chromosome DNA dominant gene generation genotype heredity inheritance pedigree phenotype Punnett Square recessive traits			

Day	FOCUS/Targets DQ/Element & Desired Effect Progression	Strategy To Support Each Element	Lesson Progression Extended Learning/Technology/Resources	Student Evidence
1 Mon 12/07	DQ2: Helping Students Interact with New Knowledge E8: Previewing New Content -Element- -Element- Desired Effect(s): Students make a link from what they know to what is about to be learned: activating prior knowledge. Learning Target: Students will be able explain the relationship between DNA, genes, and chromosomes.	Think- pair -share •Narrative activities	Bell Work: Think- pair -share: Baby Mice - Paige Keely probe Activity: (1) Bill Nye DNA, Genes, chromosomes https://www.youtube.com/watch?v=V9BZ3zx8b8I (2) DNA, Genes, and Chromosomes worksheet Exit: Extended Learning: Technology/Resources: Smartboard Reteach/Reflection:	Student Evidence: Students will complete coloring worksheet.
2 Tues 12/08	DQ2: Helping Students Interact with New Knowledge E9: Chunking Content into "Digestible Bites" E10: Helping Students Process New Content	Presenting content in small chunks	Bell Work: Look at the pictures below. Order the following pictures from smallest to largest then explain how you think they are related to each other.	Student Evidence: Students will complete Genetics with a smile

Introduction to dominant ,recessive traits, pes. (2) Genetics with a smile Activity (days)	activity sheet and drawing of smiley.
Smart Board	
complete Bellwork handout. review notype, and phenotype. smile Activity (This activity will take 2 imiley on the board. What do you think the ong all the smiley's are? Why?	Student Evidence: Students will complete Genetics with a smile activity sheet and drawing of smiley.
Smart Board	
w a punnett square m/watch?v=prkHKjfUmMs (3) Basic worksheet # 1	Student Evidence: Students will complete the Punnet square worksheet.
ces: Smartboard	
e the folowing punnet square if B= Brown b= blue eyed male marries a heterozygous brown probability: Students will use completed Punnett m Thurs (12/10) to complete the genotypic and ilities.	Student Evidence: Students will complete the probability portion of punnettsquare worksheet.

INSTRUCTIONAL DESIGN

I DEVELOPED A YEAR-LONG, STANDARDS-ALIGNED LIFE SCIENCE CURRICULUM THAT ORGANIZED COMPLEX SCIENTIFIC CONCEPTS INTO A LOGICAL SEQUENCE TO SUPPORT STUDENT LEARNING AND MASTERY. THE CURRICULUM INTEGRATED LABORATORY INVESTIGATIONS, INTERACTIVE LEARNING ACTIVITIES, AND FORMATIVE ASSESSMENTS WHILE ALIGNING INSTRUCTIONAL OBJECTIVES WITH FLORIDA SCIENCE STANDARDS. THIS EXPERIENCE STRENGTHENED MY EXPERTISE IN CURRICULUM DEVELOPMENT, INSTRUCTIONAL DESIGN, AND CREATING ENGAGING, EVIDENCE-BASED EDUCATIONAL MATERIALS FOR ADOLESCENT LEARNERS.

M/J Life Science Advanced (#2000020) Scope & Sequence 2015-16

First 9 Weeks	Second 9 Weeks	Third 9 Weeks	Fourth 9 Weeks
Establishing Classroom Routines Orientation and Lab Safety (Approximately 10 days) Lab Rules, Procedures, and Safety SC.6.N.1.1 - Solving Scientific Problems Introduction to Cells (Approximately 5 days) *SC.6.L.14.1 - Cellular Organization *SC.6.L.14.2 - Cell Theory Cells (Approximately 20 days) **SC.6.L.14.3 - Cell Processes *SC.6.L.14.4 - Organelles Types of Cells (Approximately 10 days) SC.912.L.14.2 - Components' Structure/Function of Plant/Animal Cells; Cell Membranes SC.912.L.14.3 - Plant, Animal, Prokaryote, and Eukaryote Cells	Classification (Approximately 14 days) *SC.6.L.15.1 - Classification of Living Organisms SC.912.L.15.6 - Domains and Kingdoms Human Body Systems and Homeostasis (Approximately 25 days) *SC.6.L.14.5 - Human Body Systems Maintain Homeostasis Infectious Agents (Approximately 6 days) HE.6.C.1.8 - Risky Behaviors and Health HE.7.C.1.3 - Environmental Factors and Health **SC.6.L.14.6 - Infectious Agents	Heredity and Reproduction (Approximately 15 days) *SC.7.L.16.1 - DNA, Genes, and Chromosomes **SC.7.L.16.2 - Probabilities of Genotypes and Phenotypes SC.912.L.16.2 - Inheritance Patterns Mitosis and Meiosis (Approximately 10 days) **SC.7.L.16.3 - Compare/Contrast Sexual and Asexual Reproduction (Mitosis and Meiosis) SC.912.L.16.14 - Cell Cycle and Mitosis SC.912.L.16.16 - Meiosis Biotechnology (Approximately 5 days) HE.7.C.1.7 - Heredity and Health SC.7.L.16.4 - Impact of Biotechnology Evolution (Approximately 15 days) **SC.7.L.15.1 - Theory of Evolution *SC.7.L.15.2 - Factors of Evolution and Genetic Diversity	Ecology (Approximately 18 days) **SC.7.L.17.1 - Food Webs *SC.7.L.17.2 - Relationships Between Organisms **SC.7.L.17.3 - Limiting Factors SC.912.L.17.6 - Relationships Between Organisms SC.912.L.17.9 - Food Webs Photosynthesis and Cellular Respiration (Approximately 18 days) **SC.8.L.18.1 - Photosynthesis **SC.8.L.18.2 - Cellular Respiration *SC.8.L.18.4 - Laws of Conservation of Mass and Energy SC.912.L.18.7 - Photosynthesis SC.912.L.18.8 - Cellular Respiration SC.912.L.18.9 - Relationship of Photosynthesis and Cellular Respiration Carbon Cycle (Approximately 9 days) **SC.8.L.18.3 - Carbon Cycle *SC.8.L.18.4 - Laws of Conservation of Mass and Energy

EXECUTIVE BRIEFS

PRESENTED PUBLIC HEALTH FINDINGS TO LEADERSHIP VIA EXECUTIVE BRIEFS, LEGISLATIVE BUDGET REQUEST, AND PREPARED PRESENTATIONS

Executive Brief — Impact Analysis for Expanding Florida's State Mental-Health Treatment Facilities (SMHTFs)

By: Dr. LaTweika A.T. Salmon-Trejo

Decision Required

Approve capital and operating funds to add ≈ 800 psychiatric beds (500 forensic / 300 civil) statewide, phased FY 2026-29.

Why Immediate Action Is Critical

Indicator (2025)	Situation	Consequence by 2029
State beds per 100 000 residents	11.3 total / 6.4 civil	Falls to 10.1 / 5.7 as population grows
Forensic utilization	100 % occupied; no surge capacity	Wait-list grows ~6 %/yr
Civil wait-list growth	7 % per year now	Exceeds 2 300-bed gap
Legal exposure	Rising risk of ADA / Olmstead consent decree	Potential fines & federal oversight (\$25–100 M/yr)

Investment Package

Item	Estimate (2025 \$)
Capacity	800 beds (500 forensic / 300 civil)
Capital cost	\$720 M (≈ \$0.9 M / bed)
Annual operating cost	\$200 M / yr at full scale
Financing	20-yr tax-exempt bonds @ 3.8 % (3 % discount rate for valuation)

Quantified Benefits — 10-Year Present Value (PV)

Benefit stream	Valuation logic	10-yr PV
Avoided consent-decree costs	35 % risk × \$60 M/yr	\$180 M
Medicaid federal match	New reimbursable	\$380 M

recaptured	inpatient-days	
ED boarding avoided	25 pts/day × 3 days × \$2 500	\$580 M
Jail holding cost reduction	40 d shorter stay × \$137	\$17 M
Productivity & victim-cost savings	Competency restorations	\$85 M
Total benefits		≈ \$1.24 B

Return on Investment (20-Year Horizon, 3 % discount)

Metric	Result
Net Present Value (NPV)	+\$520 M
Benefit-Cost Ratio (BCR)	1: 1.75
Pay-back Year	11
Stress test	BCR > 1: 1.2 even with lower ED savings & no decree

Equity & Stakeholder Impact

▪ Rural access: 300 civil beds target high-need North & Central Florida areas, cutting travel > 50 miles for ~1.2 M residents.

▪ Justice impact: Additional forensic beds shorten jail backlog, addressing racial disparities (Black males = 48 % of IST wait-list).

▪ Investor confidence: Clear performance metrics strengthen Florida's credit narrative during bond offerings, helping secure lower borrowing costs.

Recommended Actions

1. Authorize increased appropriation and/or phased bonding to meet bed capacity.
2. Establish a real-time performance dashboard tracking forensic wait-time, civil occupancy, cost per patient, and compliance scores.
3. Require a Year-5 ROI review to validate benefits and adjust bed mix if needed.

Summary

Investing now returns about \$1.75 for every public dollar spent. The new beds will open care sooner for people in crisis, keep individuals with mental illness out of jails and busy ERs, shield the State from costly federal penalties, and pay for themselves in roughly a decade.

Psychiatric Bed Capacity And Utilization — Examining Bed Availability And Usage Across Psychiatric Inpatient Facilities Among Children And Adolescents

93 facilities serve children and adolescents

1,965 beds

485,373 total bed days (statewide)

Facility Type	Number of Facilities	Total Number of Beds	Average Length of Stay	Occupancy Rate
Juvenile Incompetent to Proceed (JITP) Program	1	48	153	92%
Hospitals with psychiatric beds	18	406	6	63%
Specialty psychiatric hospitals (Class 3)	19	494	4.9	50%
Crisis stabilization units	22	237	3.7	73%
Residential treatment centers	19	636	209.3	81%
Short-term residential treatment unit	1	16	95.2	38%
Specialized therapeutic group home	13	128	249.6	65%

50,000 children and adolescents were discharged from psychiatric beds

97% from inpatient treatment services and crisis stabilization units



CY2029 projected bed capacity gaps vary across facility types and are informed by population growth rates, occupancy rates, utilization, and/or waitlists, **adults**

Region/Facility	Hospitals With Inpatient Psychiatric Units	Specialty Psychiatric Hospitals	Crisis Stabilization Units	Residential Treatment Facilities	Short-term Residential Treatment Facilities	Projected Bed Gaps
Northeast	31	17	7	41	N/A	96
Northwest	16	9	4	+	10	39
Central	32	62	27	25	+	146
Southeast	36	25	6	68	2	137
Suncoast	41	52	14	45	11	163
Southern	33	4	4	26	N/A	67
Projected Bed Gaps	190	169	62	205	23	

Notes: + indicates a projected surplus in bed capacity for the given region. N/A indicates that there were none of the given type of facility in the specified region and thus demand projections could not be calculated. Totals may appear not to sum due to rounding.

Assessing the projected gap in capacity in civil and forensic state mental health treatment facilities by CY2029, **adults**

Civil	Forensic
To maintain the current occupancy rate of 90% , state mental health treatment facilities need to add at least 770 additional civil beds within the next five years to meet demand. If civil state mental health treatment facilities maintain the industry standard occupancy rate of 85% , the gap is estimated to be 934 beds by CY2029.	To maintain the current occupancy rate of 98% , state mental health treatment facilities would need to add at least 1,602 additional forensic beds within the next five years to meet demand. If the state mental health treatment facilities maintain the industry standard occupancy rate of 85% , the forensic beds gap is projected to be 2,034 by 2029.

State mental health treatment facilities are facing increased waitlists for civil and forensic beds. Between 2021 and 2024, waitlists grew annually by 7% for civil beds and 6% for forensic beds, a trend expected to continue in the coming years.

HANDBOOKS & DOCUMENTS

FLORIDA OPIOID ALLOCATION AND STATEWIDE RESPONSE AGREEMENT

BETWEEN

STATE OF FLORIDA DEPARTMENT OF LEGAL AFFAIRS,
OFFICE OF THE ATTORNEY GENERAL

And

CERTAIN LOCAL GOVERNMENTS IN THE STATE OF FLORIDA

This Florida Opioid Allocation and Statewide Response Agreement (the "Agreement") is entered into between the State of Florida ("State") and certain Local Governments ("Local Governments" and the State and Local Governments are jointly referred to as the "Parties" or individually as a "Party"). The Parties agree as follows:

Whereas, the people of the State and its communities have been harmed by misfeasance, nonfeasance and malfeasance committed by certain entities within the Pharmaceutical Supply Chain; and

Whereas, the State, through its Attorney General, and certain Local Governments, through their elected representatives and counsel, are separately engaged in litigation seeking to hold many of the same Pharmaceutical Supply Chain Participants accountable for the damage caused by their misfeasance, nonfeasance and malfeasance as the State; and

Whereas, certain of the Parties have separately sued Pharmaceutical Supply Chain participants for the harm caused to the citizens of both Parties and have collectively negotiated settlements with several Pharmaceutical Supply Chain Participants; and

Whereas, the Parties share a common desire to abate and alleviate the impacts of that misfeasance, nonfeasance and malfeasance throughout the State; and

Whereas, it is the intent of the State and its Local Governments to use the proceeds from any Settlements with Pharmaceutical Supply Chain Participants to increase the amount of funding presently spent on opioid and substance abuse education, treatment, prevention and other related programs and services, such as those identified in Exhibits "A" and "B," and to ensure that the funds are expended in compliance with evolving evidence-based "best practices;" and

Whereas, the State and its Local Governments enter into this Agreement and agree to the allocation and use of the proceeds of any settlement described herein

Wherefore, the Parties each agree to as follows:

A. Definitions

As used in this Agreement:

1. "Approved Purpose(s)" shall mean forward-looking strategies, programming and services used to expand the availability of treatment for individuals impacted by substance use disorders, to: (a) develop, promote, and provide evidence-based substance use prevention strategies; (b) provide substance use avoidance and awareness education; (c) decrease the oversupply of licit and illicit opioids; and (d) support recovery from addiction. Approved Purposes shall include, but are not limited to, the opioid abatement strategies listed in Exhibits "A" and "B" which are incorporated herein by reference.

2. "Local Governments" shall mean all counties, cities, towns and villages located within the geographic boundaries of the State.

3. "Managing Entities" shall mean the corporations selected by and under contract with the Florida Department of Children and Families or its successor ("DCF") to manage the daily operational delivery of behavioral health services through a coordinated system of care. The singular "Managing Entity" shall refer to a singular of the Managing Entities.

4. "County" shall mean a political subdivision of the state established pursuant to s. 1, Art. VIII of the State Constitution.

5. "Dependent Special District" shall mean a Special District meeting the requirements of Florida Statutes § 189.012(2).

6. "Municipalities" shall mean cities, towns, or villages located in a County within the State that either have: (a) a Population greater than 10,000 individuals; or (b) a Population equal to or less than 10,000 individuals and that has either (i) filed a lawsuit against one or more Pharmaceutical Supply Chain Participants; or (ii) executes a release in connection with a settlement with a Pharmaceutical Supply Chain participant. The singular "Municipality" shall refer to a singular city, town, or village within the definition of Municipalities.

7. "Negotiating Committee" shall mean a three-member group comprised by representatives of the following: (1) the State; and (2) two representatives of Local Governments of which one representative will be from a Municipality and one shall be from a County (collectively, "Members") within the State. The State shall be represented by the Attorney General or her designee.

8. "Negotiation Class Metrics" shall mean those county and city settlement allocations which come from the official website of the Negotiation Class of counties and cities certified on September 11, 2019 by the U.S. District for the Northern District of Ohio in *In re National Prescription Opiate Litigation*, MDL No. 2804 (N.D. Ohio). The website is located at <https://allocationmap.iclaimsonline.com>.

9. "Opioid Funds" shall mean monetary amounts obtained through a Settlement.

THIS SAMPLE IS FROM THE FLORIDA OPIOID ALLOCATION AND STATEWIDE RESPONSE AGREEMENT, WHICH I CO-DEVELOPED AS LEAD EPIDEMIOLOGIST AT THE FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES. MY ROLE INCLUDED DRAFTING SECTIONS OF THE AGREEMENT.

THIS WORK REQUIRED TRANSLATING COMPLEX LEGAL AND FISCAL REQUIREMENTS INTO CLEAR, ACCESSIBLE LANGUAGE AND PRACTICAL DOCUMENTATION FOR STATE AND COUNTY PARTNERS.

STRATEGIC PLANNING & PARTNERSHIP DEVELOPMENT

INTERNAL FRAMEWORK DEVELOPED FOR STRATEGIC PLANNING & STAKEHOLDER APPEAL

Strategic Analytics Framework for Public Health Leaders to Make Decisions.

Prepared by Dr. LaTweka Salmon-Trejo

Introduction

Strategic analytics frameworks, including tools like SWOT analysis, cost-benefit analysis, logistic regression, and odds ratios, are crucial for public health leaders. They provide structured approaches for assessing internal and external factors, identifying needs and opportunities, predicting trends, and evaluating interventions. By providing data-driven insights and quantitative analysis, these frameworks inform resource allocation, policy decisions, and program optimization to maximize public health impact and achieve health equity.

This framework outlines 20 applied analysis methods for use by public health departments, hospitals, nonprofits, and mission-driven health organizations. It equips leaders with the tools to evaluate programs, guide strategic planning, assess policy impact, and drive data-informed decisions that improve community and system outcomes.

Objectives

Empower Evidence-Based Decision-Making:

The frameworks should provide public health leaders with the tools to analyze data, identify key factors affecting public health, and make informed, evidence-based decisions about resource allocation, intervention design, and program implementation.

Foster Strategic Planning and Adaptability:

The document should equip professionals to develop and refine their strategic plans, enabling them to anticipate challenges, adapt to changing environments, and align public health initiatives with overall goals and objectives.

Promote Effective Interventions and Improved Health Outcomes:

By presenting various frameworks, the document aims to facilitate the design, implementation, and evaluation of effective public health interventions that address community needs, reduce health disparities, and ultimately lead to improved health outcomes for the populations they serve.

MY FAVORITES

Biostatistical Analysis

1. **Logistic Regression:** Estimates the probability of a binary outcome (e.g., disease/no disease, converted/not converted). Useful in case-control studies or predicting health behaviors.
2. **Cox Proportional Hazards Model (Survival Analysis):** Analyzes time-to-event data (e.g., time to sputum conversion or mortality). Accounts for censored data in longitudinal studies.
3. **Latent Class or Latent Variable Modeling:** Identifies unobserved (latent) groups or traits influencing behavior or outcomes. Bridges psychometrics and econometrics (e.g., health-seeking typologies).

Economic Evaluation

4. **Cost-Benefit Analysis (CBA):** monetized benefits and costs of interventions. Supports "go/no-go" decisions on health policies or programs.
5. **Cost-Effectiveness Analysis (CEA):** Compares cost per unit of health outcome (e.g., cost per DALY or QALY gained). Ideal when benefits are health-based but not easily monetized.
6. **Budget Impact Analysis (BIA):** Estimates the financial consequences of adopting a new intervention. Important for short-term healthcare budgeting and Medicaid planning.

7. **Value of a Statistical Life (VSL) Modeling:** Quantifies willingness to pay to reduce mortality risk. Central in policy-level CBA for environmental health and pandemic response.

8. **Opportunity Cost Analysis:** Assesses trade-offs in resource allocation—what is forgone when funds are used for intervention A instead of B. Fundamental to all economic evaluation in healthcare.

Evaluation & Program Design

9. **SWOT Analysis:** Identifies internal strengths and weaknesses alongside external opportunities and threats. Supports organizational planning, funding strategies, and risk mitigation.
10. **Root Cause Analysis (RCA):** Investigates underlying causes of health system failures or adverse events. Often used in public health incident response and quality improvement.

11. **Feasibility Analysis:** Assesses whether a proposed intervention is practical, scalable, and acceptable. Includes resource, infrastructure, and stakeholder considerations.

12. **Program Evaluation using Propensity Score Matching (PSM):** Adjusts for observable differences between treatment and control groups. Enhances causal inference in non-randomized designs.

13. **Equity Impact Analysis:** Measures how costs and benefits are distributed across socioeconomic or racial/ethnic groups. Adds distributional equity lens to CEA or BIA.

Systems & Policy Analytics

14. **Interrupted Time Series Analysis (ITS):** Evaluates the effect of a policy or program implemented at a specific point in time. Useful for surveillance and policy impact.

15. **Difference-in-Differences (DiD):** Compares changes over time between intervention and control groups. Ideal for evaluating real-world implementation with pre/post data.

16. **Instrumental Variable (IV) Analysis:** Addresses endogeneity and confounding in observational data. Common in policy evaluations when randomization isn't feasible.

17. **Demand Elasticity Analysis:** Evaluates how changes in price or incentives affect health service utilization. Key in behavioral economics and drug pricing policy.

18. **Systems Dynamics Modeling:** Simulates feedback loops and complex system interactions (e.g., TB transmission under resource constraints). Useful for "what if" public health forecasting.

Scenario & Simulation Models

19. **Microsimulation or Markov Modeling:** Simulates long-term outcomes and costs for individual cohorts over time. Used for chronic disease modeling and vaccine schedules.

20. **Sensitivity and Scenario Analysis:** Tests how results change under different assumptions, parameter values, or perspectives. Important in CEA, simulation, and policy modeling.

STRATEGIC PLANNING & PARTNERSHIP DEVELOPMENT

INTERNAL FRAMEWORK DEVELOPED FOR STRATEGIC PLANNING & STAKEHOLDER APPEAL

Support to Optimize Intervention & Therapist Effectiveness Using Clinic-Collected Assessment Data (Remote, 3-Month Engagement)

1 Executive Summary

Your clinic already collects scores on 15 validated psychological instruments across symptom, functioning, and wellbeing domains. I will convert that information into statistically valid, clinician-friendly insights that reveal:

- which evidence-based interventions drive the largest reliable change for specific client profiles, and
- which therapists consistently achieve superior outcomes after adjusting for caseload complexity. All work is performed remotely, with secure data-transfer and live virtual briefings.

2 Objectives

Intervention Effectiveness – Quantify outcome change attributable to each treatment modality using mixed-effects growth-curve models and public-health incidence metrics.

Therapist Benchmarking – Isolate therapist-level effects (random effects + case-mix adjustment) to create fair “value-added” scores.

Actionable Reporting – Deliver an interactive dashboard plus two virtual walkthroughs so clinical staff can adapt treatment pathways in real time.

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3 Scope & Deliverables (Remote)

Phase (Weeks)	Core Tasks	Outputs
I. Data Audit & Prep (1-3)	• Review data dictionaries, timing of assessments, missingness. • De-identify PHI; set up HIPAA-compliant SFTP. • Derive baseline covariates (severity, comorbidity, demographics).	Data Quality Memo; cleaned dataset.
II. Analytical Design (4)	• Specify multilevel longitudinal model: client (Level-1), therapist (Level-2), modality (Level-3). • Inventory instruments and select core outcome domains with stakeholders. • Pre-register analysis plan.	Analysis Plan (≤ 10 pp) for approval.
III. Modeling & Validation (5-9)	• Fit Bayesian & frequentist mixed models. • Compute incidence, effect sizes, and predicted improvement curves by intervention. • Sensitivity checks: missing-data imputation, caseload severity weighting.	Results Workbook; code repository.
IV. Insight Translation (10-11)	• Build Power BI/Tableau dashboard (filter by therapist, modality, diagnosis). • Draft “Clinical Playbook” linking findings to QI actions.	Interactive Dashboard; 8-page Findings Brief.
V. Virtual Roll-Out & Support (12)	• Two 90-min Zoom sessions (leaders / all clinicians). • 30-day email/Slack support window.	Recorded training; Q&A log.

4 Implementation & Evaluation Plan

Step	Public-Health Technique	Application in Clinic Project
4.1 Define the Intervention (‘Exposure’)	Intervention classification & program logic modeling	Each treatment session is coded for its primary evidence-based modality (e.g., CBT, ACT, DBT, EMDR, MI, psychodynamic). A 10 % chart audit validates codes. We build a logic model linking modality → mechanisms → outcome domains.
4.2 Define the Population (‘Denominator’)	Dynamic open cohort design	All clients ≥16 years with ≥2 sessions in the 12-month window form the cohort. Person-time accrues from first session until discharge or last contact.
4.3 Inventory & Select Outcomes	Outcome domain mapping & core-outcome-set selection	During Data Audit we catalogue every instrument (name, construct, range, reliability). Stakeholders then pick primary outcome domains (mood, anxiety, trauma, functioning, wellbeing).
4.4 Standardise & Classify Outcomes	Z/T-score conversion & Reliable Change thresholds	Raw scores are standardised (z-scores) for cross-instrument comparison. Where RCIs exist we apply them; otherwise a 0.5 SD provisional threshold is used until validated.
4.5 Measures of Effect	Incidence rates & adjusted risk ratios via mixed models	Primary metrics: Incidence Rate Ratio (IRR) and adjusted Risk Ratio (aRR) of reliable improvement by modality. Models adjust for therapist clustering.
4.6 Confounding & Effect Modification	Propensity weighting & interaction terms	Inverse-probability weights balance age, baseline severity, comorbidity, SES. Interactions test modality effectiveness by diagnosis or severity.

STRATEGIC PLANNING

DEVELOPED A STANDARDIZED ORGANIZATIONAL READINESS ASSESSMENT TO STRENGTHEN CLOSED-LOOP REFERRAL SYSTEMS AND IMPROVE EQUITABLE ACCESS TO HEALTH-RELATED SOCIAL NEEDS.



HEALTHY ORANGE LOOP TASK FORCE WORKSHEET

Build the Ideal Referral Journey





SCENARIO

A resident comes to your organization with housing, food, and transportation needs.

INSTRUCTIONS

- Identify what needs to happen at each step.
- Identify who is responsible.
- Identify potential barriers.
- Be prepared to share one key barrier and one recommendation.

1

NEED IDENTIFIED

What needs to happen?

Who is responsible?

Potential barriers?

2

SCREENING

What needs to happen?

Who is responsible?

Potential barriers?

3

NAVIGATION

What needs to happen?

Who is responsible?

Potential barriers?

4

REFERRAL

What needs to happen?

Who is responsible?

Potential barriers?

5

FOLLOW-UP

What needs to happen?

Who is responsible?

Potential barriers?

6

NEED RESOLVED

What needs to happen?

Who is responsible?

Potential barriers?

REFERRAL JOURNEY MAP



NEED IDENTIFIED → SCREENING → NAVIGATION → REFERRAL → FOLLOW-UP → NEED RESOLVED

TABLE DISCUSSION

What is the biggest barrier your table identified?

What recommendation would improve the process?

At which step does the process most often break down?

☐ Need Identified	☐ Screening	☐ Navigation
☐ Referral	☐ Follow-Up	☐ Need Resolved

A successful closed-loop referral system does more than make referrals. It identifies needs, connects residents to services, addresses barriers, follows up, and measures whether needs were ultimately resolved.



HEALTHY ORANGE LOOP COMMUNITY PARTNER READINESS CHECKLIST

Building a closed-loop system that identifies needs, connects people to resources, and drives outcomes.

Organization: _____
Completed By: _____
Date: _____

1 SCREENING READINESS

- ☐ We use a standardized social needs screening tool
- ☐ We screen for:
 - Food insecurity
 - Housing instability
 - Transportation
 - Utilities
 - Employment/Income
 - Health insurance/Access to care
 - Childcare
 - Safety/Violence concerns
- ☐ Staff know when screening should occur
- ☐ Screening results are documented
- ☐ Screening is available in preferred languages
- ☐ Screening is culturally appropriate

SCORE: ____ / 6

2 NAVIGATION CAPACITY

- ☐ We have an identified navigator or referral coordinator
- ☐ Staff know how to search for community resources
- ☐ Staff understand eligibility requirements for key services
- ☐ We have written referral workflows
- ☐ We can assist people with:
 - Low digital literacy
 - Limited internet access
 - Disabilities

SCORE: ____ / 6

3 RESOURCE QUALITY

- ☐ Resource information is reviewed regularly
- ☐ Resource information is verified at least annually
- ☐ Resource listings include:
 - Eligibility requirements
 - Contact information
 - Hours of operation
 - Service area
 - Languages available
- ☐ Staff know which resources currently have waitlists
- ☐ Staff know alternative resources when services are unavailable

SCORE: ____ / 5

4 REFERRAL MANAGEMENT

- ☐ Referrals are documented
- ☐ We track:
 - Referral date
 - Referral destination
 - Referral reason
 - Referral status
- ☐ We have a process for urgent referrals
- ☐ We have escalation procedures when services are unavailable

SCORE: ____ / 5

5 FOLLOW-UP & ENGAGEMENT

- ☐ We follow up after referrals
- ☐ Follow-up occurs within a defined timeframe
- ☐ Multiple contact methods are available:
 - Phone
 - Text
 - Email
 - In-person
- ☐ Follow-up attempts are documented
- ☐ Barriers encountered are documented
- ☐ Participant-reported outcomes are collected

SCORE: ____ / 5

6 OUTCOME MEASUREMENT

- ☐ We can report:
 - Number screened
 - Number with identified needs
 - Number referred
 - Number connected
 - Number receiving services
 - Number with unresolved needs
 - Number with resolved needs
 - Participant satisfaction

SCORE: ____ / 8

7 SELF-DETERMINATION & PARTICIPANT CHOICE

- ☐ Participants choose which resources they want to pursue
- ☐ Participants may decline referrals
- ☐ Participants may self-navigate if preferred
- ☐ Participant goals are documented
- ☐ Staff use person-centered language
- ☐ Participant autonomy is measured
- ☐ Participant decisions are respected, even when services are declined

SCORE: ____ / 7

8 EQUITY READINESS

- ☐ Services are available in multiple languages
- ☐ Translation services are available
- ☐ Accessibility accommodations are available
- ☐ Transportation barriers are assessed
- ☐ Digital access barriers are assessed
- ☐ Data reviewed by: Race/Ethnicity, Age, Language, ZIP Code, Insurance Status
- ☐ Data used to identify and address inequities

SCORE: ____ / 6

9 DATA & TECHNOLOGY READINESS

- ☐ Staff are trained on Healthy Orange Loop
- ☐ Data-sharing procedures are established
- ☐ Staff understand privacy requirements
- ☐ Outcomes can be documented
- ☐ Reports can be generated
- ☐ Referral performance reviewed quarterly

SCORE: ____ / 6

10 COMMUNITY PARTNERSHIP READINESS

- ☐ Healthy Orange Loop point of contact identified
- ☐ Organization attends task force meetings
- ☐ Organization participates in resource verification
- ☐ Organization shares feedback on system barriers
- ☐ Organization participates in quality improvement activities
- ☐ Organization shares success stories and lessons learned

SCORE: ____ / 6

TOTAL SCORE

____ / 60

Add your scores from all 10 domains

READINESS LEVELS

 EMERGING PARTNER 0-15 POINTS Building foundational referral and screening capacity	 DEVELOPING PARTNER 16-30 POINTS Core processes exist but need strengthening	 OPERATIONAL PARTNER 31-45 POINTS Consistently implementing referral and follow-up activities	 HEALTHY ORANGE LOOP READY PARTNER 46-60 POINTS Strong closed-loop referral, outcome measurement, equity, and participant-centered practices
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FIVE CORE CAPACITY DOMAINS

 1 SCREENING READINESS	 2 NAVIGATION CAPACITY	 3 DATA & MEASUREMENT CAPACITY	 4 EQUITY CAPACITY	 5 FOLLOW-UP & OUTCOME CAPACITY
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TOGETHER, WE CLOSE THE LOOP ON HEALTH. | Identify needs. Connect people. Drive outcomes. Build healthier Orange County.

ORGANIZATIONAL MANAGEMENT

Office Development

Task or Project	Project Status	Est. Completion Date
Organization		
Unit Concept Plans		
Documentation		
Staffing		
Recruitment		
Skills Assessment		
Resource Acquisition		
Data Acquisition		
Contract Execution		
Tools and Software		
Service Broadcasting		
SAMH Orientation		

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THE OFFICE OF OPIOID RECOVERY (OOR): OORT Progress Tables

Collaborative Needs Assessment
Project and Support Prioritization

Current and Upcoming Projects

Task or Project	Project Status	Est. Completion Date
Research and Dissemination		
Research		
Applied Research		
Abstracts		
Manuscripts		
Reports		
REARs		
CaREARs		
SCOA		
MOM		
A-OMS		
F-OMS		
E-COT		
Collaboration and Education		
Recurring Webinars		
Conference Attendance		
Committee Participation		
Training and Capacity Building		
Data Literacy and Visualization		



The Office of Opioid Recovery (OOR)
Reference to Major Functions and Organization

The Office of Opioid Recovery provides the Department of Children and Families, Office of Substance Abuse and Mental Health opportunities to incorporate modern public health practices greatly changing the landscape of the opioid crisis in Florida

The Office of Opioid Recovery (OOR): The Office of Opioid Recovery

Units

The two units within the OOR work collaboratively with one another to leverage data and research to inform the department's knowledge of the Florida opioid crisis landscape and the latest research and practice to substance use study and intervention. While the units often collaborate in the generation of reports and training programs, they have distinct operational functions.

EPIDEMIOLOGY AND GENERAL EVALUATION

This unit works with a variety of data from both within and outside of the agency to inform the department's understanding of the epidemiology of opioid use disorders and associated mental health issues. Under the direction of a public health analyst, this unit tracks trends, identifies needs, and provides data to inform the department's understanding of the opioid crisis. This unit also provides data to inform the department's understanding of the opioid crisis. This unit also provides data to inform the department's understanding of the opioid crisis.

APPLIED RESEARCH AND SPECIAL PROJECTS

Research analysts in this unit are tasked with a variety of projects, from supporting research efforts conducted by the department, performing independent research, writing case study products and reports, providing analysis of programmatic planning or initiatives, developing research tools and recommending new approaches, performing legislative bill analysis, identifying data sources, and performing evaluation of programs.

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- Reports 4
- Opium Habitability and Statistics Report (OHSR) 4
- Epidemiology Analysis Reports 4
- Monthly Opioid Florida Map (MOPM) 4
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- OORT Progress Table 4

List of Major Projects

Office Development

- Unit Development
- Staffing
- Resource Acquisition
- Service Broadcasting
- Current and Upcoming Projects
- Research and Dissemination
- Reports

Staffing

- Recruitment and retention
- Compensation and benefits

Resource Acquisition

- Staffing
- Equipment
- Software

Service Broadcasting

- Communication and outreach
- Collaboration and education
- Training and capacity building

Current and Upcoming Projects

- Research and Dissemination
- Reports

Reports

- Monthly Opioid Florida Map (MOPM)
- Opium Habitability and Statistics Report (OHSR)
- Monthly Opioid Florida Map (MOPM)
- Opium Habitability and Statistics Report (OHSR)

The Office of Opioid Recovery

Background

The Office of Opioid Recovery (OOR) was established and located through Florida's Office of the Attorney General, Office of Substance Abuse and Mental Health. The work of the OOR is to provide a coordinated, comprehensive, and integrated approach to the opioid crisis in Florida. The OOR is the only state agency that provides a comprehensive, integrated approach to the opioid crisis in Florida. The OOR is the only state agency that provides a comprehensive, integrated approach to the opioid crisis in Florida.

Organization

The OOR is organized into two main functional areas: the Office of Epidemiology and General Evaluation, and the Office of Applied Research and Special Projects. The Office of Epidemiology and General Evaluation is responsible for the collection, analysis, and dissemination of data related to the opioid crisis. The Office of Applied Research and Special Projects is responsible for the development and implementation of research and evaluation projects related to the opioid crisis.

Charts

The Office of Opioid Recovery

- Applied Research and Special Projects
- Epidemiology and General Evaluation

DEVELOPED SECTION
REFERENCE MANUAL
& TASK TRACKING
PRODUCTS FOR
ANNUAL
DELIVERABLES AND
STRATEGIC
ALIGNMENT.

THIS SUPPORTED THE
ESTABLISHMENT OF
DUTIES BETWEEN
DATA ANALYSTS AND
EPIDEMIOLOGIST.

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SALMON-TREJO

ORGANIZATIONAL MANAGEMENT

Readiness Assessment Tool Part II
Managing Entity (ME)/Proposing Entity (PE) for Substance Abuse and Mental Health Services

I. SCOPE OF SERVICE

1. Review roster of Proposing/Managing Entity's (PE/ME) sub-contractors.

2. Conduct a review of Proposing/Managing Entity's (PE/ME) sub-contracts to assess the range and capacity of the network.

3. Review sub-contractor qualifications.

PLACE AN 'X' IN THE APPLICABLE COLUMN FOR EACH REQUIREMENT

REQUIREMENT	REQUIREMENT MET	REQUIREMENT PARTIALLY MET	REQUIREMENT NOT MET	COMMENTS
1. Does the ME/PE deliver a comprehensive array of behavioral health services through sub-contracted providers to eligible individuals and families in the designated service area, which include but are not limited to:				
a) Crisis Intervention Services focusing on mobile crisis intervention, acute crisis stabilization in a secure setting, telephone intervention.				
b) Detoxification Services in residential and outpatient settings utilizing medical and clinical procedures.				
c) Forensic Services including diversion from the criminal justice system, in-jail services, competency restoration and monitoring of individuals on conditional release for compliance with court orders.				
d) Coordination of Substance Abuse and Mental Health Services for inmates approaching the End of Sentence (EOS).				
e) Mental health Services for individuals charged with misdemeanor offenses including diversion, case management services, and monitoring of individuals on conditional release for compliance with court orders.				
f) SAMH Treatment Services including various levels of residential, outpatient treatment, and recovery support services at varying levels of support; assessment, evaluation, screening, counseling, therapy, medication management, residential short-term treatment, and Community Comprehensive Services Teams.				
g) Rehabilitation Services such as Supported Employment, Transitional Employment				

FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
MYFLFAMILIES.COM

State of Florida
Department of Children and Families

E.2

To comply with the subcontract content requirements of Section C.2.2, the Managing Entity shall incorporate the Network Service Provider Measures in Table 4 into each Network Service Provider subcontract, as appropriate to the services and target populations in each subcontract. The Managing Entity is not required to apply the Network Targets to each individual subcontract. Rather, the Managing Entity shall establish specific targets for each measure in each subcontract, sufficient to ensure the Network cumulatively reaches the specified Network Targets.

TABLE 4. NETWORK SERVICE PROVIDER PERFORMANCE MEASURES

For each Network Service Provider Measure where Year to Date performance falls below the Minimum Acceptable Network Performance, the NSP must provide a brief narrative describing why the performance measure fell below the annual target/minimum acceptable network performance for the element.

1. Any provider-specific challenges, obstacles, or other operational considerations which are identified as significant factors underlying the unsatisfactory level of performance.

2. Any extenuating circumstances beyond the Managing Entity's scope which are identified as significant factors underlying the unsatisfactory level of performance.

3. Efforts the Managing Entity has undertaken to support improved performance during this reporting period.

4. Efforts the Managing Entity will undertake in the future to support improved performance during subsequent reporting periods.

5. Any region-wide guidance, capacity, training, or other logistical supports needed to support improved performance during subsequent reporting periods.

OUTCOME MEASURES	TARGE POPULATION & MEASURE DESCRIPTION	ANNUAL TARGET	ACCEPTABLE NETWORK PERFORMANCE	PERFORMAN CE THIS PERIOD	YEAR-TO- DATE PERFORMAN CE
ADULT COMMUNITY MENTAL HEALTH					
MH003	Average annual days worked for pay for adults with severe and persistent mental illness	40	38		
MH703	Percent of adults with serious mental illness who are competitively employed	24%	22.8%		
MH742	Percent of adults with severe and persistent mental illnesses who live in stable housing environment	90%	85.5%		
MH743	Percent of adults in forensic involvement who live in stable housing environment	67%	63.7%		
MH744	Percent of adults in mental health crisis who live in stable housing environment	86%	81.7%		

Exhibits B & B1

Exhibit C-Task List

Exhibit D-Deliverables

ME Perf Meas 2024-25

NSP Perf Meas 2024-25

SUPPORTED PROGRAMS AND COMMUNITY PARTNERS
BY DEVELOPING WORKFLOWS AND CREATING TOOLS TO
MANAGE DELIVERABLES FOR REGULATORY COMPLIANCE

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PROGRAM MANAGEMENT

SUPPORTED THE DEVELOPMENT OF PROGRAM GUIDANCE & IMPLEMENTATION PLANS

I. Background

a. Overview

Tuberculosis (TB) disease is caused by *Mycobacterium tuberculosis*, an airborne pathogen that spreads from person to person. An estimated one fourth of the world's population is infected with *M. tuberculosis* and 5-10% of those infected persons develop TB disease in their lifetime. In 2022, 10.6 million people around the world became sick with TB disease. Globally, TB is a leading cause of death: in 2022, there were 1.3 million TB-related deaths world-wide. TB is the leading killer of people living with human immunodeficiency virus (HIV). A total of 8,331 TB cases (a rate of 2.5 cases per 100,000 persons) were reported in the United States in 2022. After declining 20% in 2020, concurrent with the COVID-19 pandemic, TB incidence rates increased by 9.6% in 2021 and a further 5.5% in 2022. Current strategies alone will not achieve TB elimination in the United States in this century. Meeting the TB elimination goal will require a focus on testing and treating persons at higher risk of latent TB infection (LTBI) to prevent TB disease. Up to 13.0 million people in the United States have LTBI and over 80% of the TB cases result from LTBI that was not treated.

TB disproportionately affects certain populations, including persons who are non-U.S.-born, who have HIV infection or diabetes, who are experiencing homelessness, who are incarcerated, or who misuse substances such as alcohol or certain drugs. Non-U.S.-born persons had 73.8% of the cases in the United States in 2022: the incidence rate among non-U.S.-born persons in 2022 was 17.1 times greater compared to the rate among U.S.-born persons.

This NOFO supports finding and curing persons with TB disease and following up on exposures to TB. It includes targeted testing for preventing TB by finding and treating LTBI among groups such as the non-U.S.-born.

CDC is continuing its 40-year approach of funding priority activities in TB programs through cooperative agreements (CoAg)s. Officials in health departments are responsible for TB control and prevention activities and laboratory services under the statutes and regulations of states, cities, or territories. This funding should complement those efforts. It is not intended to replace or reduce state and local investment in priority activities and responsibilities such as diagnosing and treating TB, providing inpatient care, tracing contacts, finding, and treating LTBI, and managing health department clinics.

b. Statutory Authorities

This program is authorized under Section 317E(a) of the Public Health Service Act, 42 U.S.C. Section 247b-6(a), as amended.

c. Healthy People 2030

This NOFO addresses the Healthy People 2030 Immunization and Infectious Diseases topic area.

For more information, visit [Reduce tuberculosis cases — IID17 - Healthy People 2030 | health.gov](#)

d. Other National Public Health Priorities and Strategies

- National Center for HIV, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Strategic Plan –

[NCHHSTP Strategic Priorities | CDC NCHHSTP](#)

- Division of Tuberculosis Elimination Strategic Plan 2022-2026-DTBE

[Tuberculosis Elimination Priorities | CDC NCHHSTP](#)

- National Action Plan for Combating Multidrug-Resistant Tuberculosis –

[National Action Plan for Combating Multidrug-Resistant Tuberculosis | Document | U.S. Agency for International Development \(usaid.gov\)](#)

- U.S. National Strategy for Combating Antibiotic-Resistant Bacteria –

[U.S. Actions & Events to Combat Antimicrobial Resistance | Antimicrobial Resistance | CDC](#)

- National Stakeholder Strategy for Achieving Health Equity –

[National Stakeholder Strategy for Achieving Health Equity](#)

e. Relevant Work

This NOFO builds on the accomplishments achieved through past CDC TB prevention and control (P&C) and laboratory strengthening Cooperative Agreements (CoAg)s, which contributed to the reversal of TB resurgence in the U.S. during 1985–1992, 2021 and 2022. The earlier resurgence was driven in part by budget cuts, loss of program capacity, growing incidence of HIV infection, and transmission of multidrug-resistant TB (MDR TB) in hospitals and other settings, the latter resurgence by the COVID-19 pandemic. Current and previous CDC TB CoAg)s have reinforced the downward U.S. TB incidence trends of the past 40 years.

2. CDC Project Description

a. Approach

Bold indicates period of performance outcome.

Strategies and Activities	Short-Term Outcomes	Intermediate Outcomes	Long-Term Outcome
Diagnosis and treatment of persons with TB disease - Advise providers on TB diagnosis and treatment - Manage cases and ensure	Increased use of Nucleic Acid Amplification Testing (NAAT) - Decreased time between symptom onset and diagnosis Increased cases with HIV and	- Earlier patient diagnoses Increased patients completing treatment within 12 months - Decreased acquired drug resistance	Decrease incidence overall among population higher risk

treatment adherence Promote infection control	drug susceptibility testing results - Increased patients on and responding to appropriate treatment - Increased use of appropriate drug regimens matched to DST results	- Decreased TB recurrence - Decreased patient infectious period - Decreased TB transmission	- Decreased TB mortality - Decreased LTBI prevalence - Elimination of TB disease in the United States
Conduct contact investigations for infectious TB cases Elicit, examine, test, and treat contacts with TB infection	- Increased contacts elicited - Increased contacts examined - Increased treatment initiation and completion among contacts with LTBI started on LTBI treatment	Increased LTBI treatment completion among contacts	- Decreased contacts who progress from infection to disease - Increased health equity related to TB/ LTBI testing and treatment strategies - Increased ability to maintain program capacity toward TB elimination
Test and treat populations at higher risk for TB and LTBI - Select and conduct targeted testing among population(s) at higher risk for TB/ LTBI - Engage TB control program and local community organizations to reach populations at higher risk for TB/ LTBI and provide effective and culturally appropriate services	- Increased identification, testing, and treatment of persons at higher risk for developing TB - Increased networks and coalitions with local community groups, clinics, and primary care providers to effectively diagnose and treat TB/ LTBI, to advance equity and share information about TB/ LTBI - Increased follow-up medical examinations and	- Increased treatment initiation and completion among persons in high-risk populations diagnosed with TB / LTBI - Established and maintained networks and coalitions between partners and local communities that experience high TB incidence and LTBI prevalence - Improved access to medical and social services through partnerships to	Increased availability of well-trained and informed public health practitioners, laboratorians, and health providers with knowledge and experience to accurately diagnose, treat, and prevent TB

Examine immigrants and refugees with Class B notification	treatment initiation for persons with LTBI and prior pulmonary TB who are recommended for treatment	address TB/ LTBI disparities
Program planning, monitoring, evaluation, and improvement - Conduct program evaluation and implement remediation activities to improve performance - Implement TB elimination plans - Establish contingency plans to manage drug shortages and distribution issues	- Increased implementation of TB elimination plans - Increased identification and dissemination of best practices by state and local TB programs - Increased development and implementation of contingency plans to manage drug shortage and distribution issues.	- Increased programs meeting national TB performance targets - Increased use of findings to inform policy changes - Increased ability to manage drug shortages and distribution issues
Surveillance - Report TB cases in a timely, accurate, and complete manner - Link genotype results to surveillance records in a timely and complete manner - Routinely review TB genotype clusters and prioritize investigation and public health action	- Increased accuracy and completeness of surveillance data - Increased verified TB cases reported to CDC ≤ 1 week - Increased culture-confirmed cases with ≥ 1 isolate genotyped and linked to surveillance data - Increased capacity for timely and thorough cluster and outbreak identification and investigation	- Increased use of epidemiologic analyses of surveillance data to inform TB elimination activities - Reduced cluster- and outbreak-associated transmission - Increased standardized (voluntary) case-level surveillance for LTBI

PROGRAM MANAGEMENT

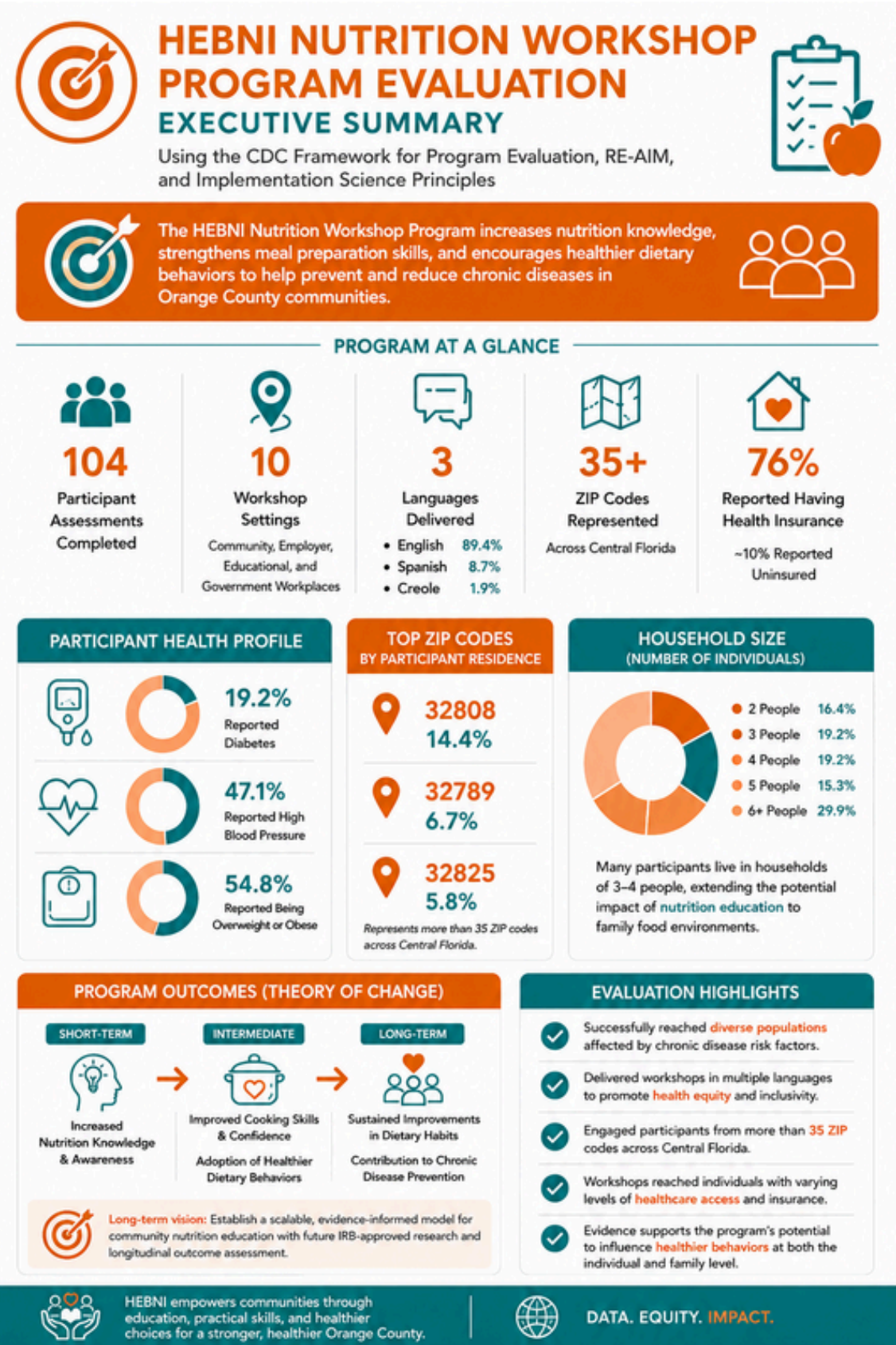
DEVELOPED & COORDINATED SEVEN STATE IMPLEMENTATION PLANS AT THE CENTERS FOR DISEASE CONTROL TO IMPROVE PROGRAM MONITORING FOR HEALTH OUTCOMES

File Home Insert Page Layout Formulas Data Review View Automate Help Acrobat			
C74			
<STATE> Program Implementation Work Plan			
Strategy 1: Diagnosis/Treatment of Persons with TB Disease			
List related outcome(s) from the Logic Model		How will your program measure success related to these outcome(s) [e.g., NTIP indicators]	
(1) Earlier patient diagnoses (2) Increase in cases with HIV and drug susceptibility testing results (3) Increase in patients on/responding to appropriate treatment		(1) Completion of Treatment (COT) in 12 months*[List all NTIP Objectives on Case Management and Treatment]	
List activities your program will perform to achieve the above outcome(s)	List What Your Measure of Success Will Be.	Responsible Staff/Party	Target Completion Date/Timeline
1.1 Advise providers on TB diagnosis and treatment	Case Management, Record Reviews, Consultation, Cohort Reviews	Nurse, Epidemiologist, Physician, Outreach Worker	95% by 2024/Quarterly Cohort Reviews
1.2 Manage cases and ensure treatment and adherence	Case Management, Record Reviews, Consultation, Cohort Reviews	Nurse, Epidemiologist, Physician, Outreach Worker	98% by 2024/Quarterly Cohort Reviews
* Reference: https://www.cdc.gov/tb/programs/evaluation/default.htm			
Strategy 2A: Contact Investigations for Infectious TB Cases			
List related outcome(s) from the Logic Model		How will your program measure success related to these outcome(s) [e.g., NTIP indicators]	
(1) Increase in contacts elicited/examined (2) Increase in patients initiating LTBI treatment		For TB patients with positive AFB sputum-smear results, increase the proportion who have contacts elicited. *[List all Objectives on Contact Investigations]	
List activities your program will perform to achieve the above outcome(s)	List What Your Measure of Success Will Be.	Responsible Staff/Party	Target Completion Date/Timeline

List activities your program will perform to achieve the above outcome(s)	List What Your Measure of Success Will Be.	Responsible Staff/Party	Target Completion Date/Timeline
2A.1 Conduct contact investigations for infectious TB cases	training staff and private providers, performing re-interviews, cohort reviews	Case manager and outreach worker	100% by 2024/Quarterly cohort reviews
* Reference: https://www.cdc.gov/tb/programs/evaluation/default.htm			
Strategy 2B: Evaluation of Immigrants and Refugees with TB or LTBI			
List related outcome(s) from the Logic Model		How will your program measure success related to these outcome(s) [e.g., NTIP indicators]	
(1) Increase in treatment initiation for patients with LTBI/prior pulmonary TB (2) Increase in TB diagnoses and high-risk patients who initiate treatment		For immigrants and refugees with abnormal chest radiographs (X-rays) read overseas consistent with TB, increase the proportion who initiated a medical examination within 30 days *[List all Objectives on Examination of Immigrants and Refugees]	
List activities your program will perform to achieve the above outcome(s)	List What Your Measure of Success Will Be.	Responsible Staff/Party	Target Completion Date/Timeline
2B.1 Examine immigrants/refugees with Class B notification	Data cleaning & quality control checks	Epidemiologist/Case managers	By 2024, 84% examined @ 30 days; 76% examined completed @ 90 days/Weekly checks
2B. 2. Submit EDN paperwork to LHD's	Generate status reports, phone calls	Epidemiologist/Case managers	quarterly
*Reference: https://www.cdc.gov/tb/programs/evaluation/default.htm			

PROGRAM EVALUATION

EVALUATED A COMMUNITY-BASED NUTRITION EDUCATION PROGRAM USING THE CDC FRAMEWORK FOR PROGRAM EVALUATION, RE-AIM, IMPLEMENTATION SCIENCE, AND UTILIZATION-FOCUSED EVALUATION PRINCIPLES TO ASSESS PROGRAM EFFECTIVENESS, HEALTH EQUITY, AND OPPORTUNITIES FOR CONTINUOUS QUALITY IMPROVEMENT. PROVIDED STRATEGIC RECOMMENDATIONS TO STRENGTHEN SURVEY DESIGN, PSYCHOMETRIC VALIDITY, IMPLEMENTATION FIDELITY, AND LONG-TERM OUTCOME MEASUREMENT THROUGH EVIDENCE-BASED EVALUATION AND INSTRUMENT REDESIGN



HEBNI Nutrition Workshop Program Evaluation

Executive Summary

This evaluation assessed the reach, effectiveness, implementation, health equity, sustainability, and measurement validity of The Health Education through Behavioral and Nutritional Initiatives (HEBNI) Nutrition Workshop Program using the CDC Framework for Program Evaluation, RE-AIM, and implementation science principles.

A total of 104 participant assessments were completed across 10 workshop settings, including community-based organizations, employer-sponsored programs, educational institutions, and government workplaces. Workshops were delivered in English (89.4%), Spanish (8.7%), and Creole (1.9%), demonstrating the program's commitment to increasing access to nutrition education among diverse populations. Participants represented more than 35 ZIP codes across Central Florida, with the greatest concentration residing in ZIP code 32808 (14.4%), followed by ZIP codes 32789 (6.7%) and 32825 (5.8%).

The evaluation findings indicate that the program successfully reached populations affected by chronic disease risk factors. Among participants, 19.2% reported diabetes, 47.1% reported high blood pressure, and 54.8% reported being overweight or obese. Additionally, approximately 76% reported having health insurance coverage, while nearly 10% reported being uninsured, highlighting the program's reach into populations experiencing varying levels of healthcare access.

Participant households were diverse, with the largest proportion reporting household sizes of three (19.2%) and four (19.2%) individuals, followed by two-person households (16.4%). These findings suggest that educational messages delivered through the workshops may have the potential to influence dietary behaviors beyond individual participants and extend to family-level food environments.

Background and Program Description

Poor nutrition contributes substantially to obesity, hypertension, diabetes, cardiovascular disease, and preventable mortality. Community-based nutrition education is a recognized strategy for improving health literacy and supporting healthier dietary choices. The Health Education through Behavioral and Nutritional Initiatives (HEBNI) Nutrition Workshop Program was developed by the Florida Department of Health in Orange County to address nutrition-related chronic disease risk through community-based nutrition education and cooking

PROJECT MANAGEMENT

CREATED NATIONAL WORK FLOWS

National TB Surveillance System Data Request Form

For Everyone
NOVEMBER 1, 2024

WHAT TO KNOW

CDC can fulfill aggregate requests for National Tuberculosis (TB) Surveillance System data. Use this form to submit a request. Please consult other public data sources, described below, before submitting your request.

Available data sources

The National TB Surveillance System (NTSS) contains data reported to CDC using a standard case report called the Report of Verified Case of Tuberculosis (RVCT).

Aggregate data tables, maps, charts, and other summaries previously published are accessible on the CDC's [public website for TB Data](#), including the [TB Surveillance Annual Report](#), the [Online Tuberculosis Information System \(OTIS\)](#) and the [NCHHSTP AtlasPlus](#). Before submitting a data request for NTSS data, please consult these sources.

The current RVCT instructional manual can be found online by accessing the following link [here](#) which includes guidance on the variables collected.

Aggregate data are generated by the CDC Division of Tuberculosis Elimination's Surveillance Team and provided to the requestor. Line-level data is restricted and is not available through an NTSS Data Request.

NTSS Data Request Form

* Required field

ON THIS PAGE

Available data sources

NTSS Data Request Form

Resources

RELATED PAGES

Provisional 2024 U.S. TB Data Report

2021 State and City TB Report

NTSS Data Request Confirmation

Archived TB Data Reports

VIEW ALL

Tuberculosis Data

PROJECT PLAN SUMMARY

<PROJECT NAME>

<AGENCY/ORGANIZATION NAME>

CONTACTS

NAME	PHONE	EMAIL

NOTES

The request is provided in a form that is intended to be completed by the project manager. The request is intended to be completed by the project manager. The request is intended to be completed by the project manager.

1. Project Name

2. Project Manager

3. Project Start Date

4. Project End Date

5. Project Budget

6. Project Description

7. Project Objectives

8. Project Deliverables

9. Project Risks

10. Project Status

SIGNATURE AND AUTHORIZATION PAGE

Signature of Project Manager

Signature of Agency Head

Signature of Project Manager

Signature of Agency Head

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DEVELOPED PROJECT CHARTERS

COMMUNITY HEALTH NEEDS ASSESSMENT



Office of Substance Abuse and Mental Health

Executive Brief: Methadone-Based MAT Needs Assessment for Florida Counties

Overview

This project was initiated to evaluate whether the geographic distribution of methadone-based Medication-Assisted Treatment (MAT) services across Florida meets the needs of adults with opioid use disorder (OUD). Using publicly available data from the 2023 National Survey on Drug Use and Health (NSDUH) and Florida's 2023 ACS county-level population estimates, the assessment applied a statistically sound and transparent methodology to estimate the number of adults per county who need—but do not receive—substance use treatment. This analysis directly supports planning and resource allocation for Florida's opioid response strategy.

Issue

Previous MAT planning models used a national estimate (5.3%) of adults with OUD who received MAT to calculate local need, resulting in estimates that substantially underestimated the size of the population needing treatment. For example, using this method yielded a statewide estimate of only 2 new facilities needed. However, this approach did not account for the rate of unmet treatment need—that is, the percentage of adults who needed treatment but did not receive it, a more direct and equity-relevant indicator for service planning. This gap led to under-resourced regions and insufficient coverage of MAT services.

Proposed Solution

We corrected the methodology by layering two key NSDUH estimates:

- 5.3% of Florida adults need substance use treatment (NSDUH 2023)
- Of those, 75.89% did not receive treatment (NSDUH Table 32, Florida-specific)

We then calculated a combined unmet need rate of 4.02% ($0.053 * 0.7589$) and applied it to each Florida county's 18+ population using 2023 ACS data. This produced precise county-level estimates of unmet need. From these values, we estimated the number of facilities required by dividing the total unmet need by 1,500 clients per OTP facility, a conservative upper-bound based on SAMHSA planning guidance. The final model estimated that 7 counties currently lack sufficient access to methadone-based MAT facilities.

Value Proposition

The refined needs assessment supports an equity-driven approach to MAT expansion and delivers a strong return on investment (ROI) for state funding. Based on published literature, methadone-based MAT yields \$4 to \$7 in societal savings for every \$1 invested, by reducing emergency care, hospitalizations, criminal justice involvement, and overdose mortality. Assuming treatment costs of approximately \$5,000 per person per year, and applying Florida's unmet need estimates, the state would gain 1.3–1.7 Quality-Adjusted Life Years (QALYs) per treated adult and avoid an average of \$25,000–\$35,000 per untreated individual in downstream costs. In total, expanding MAT access across the 7 identified counties could generate millions in net economic benefits annually—while also advancing public health equity and reducing opioid-related disparities.

Proposed Solution

We recommend that the Florida Department of Children and Families and policy stakeholders use this needs assessment to guide the equitable expansion of methadone-based MAT services, prioritizing the 7 counties with the highest unmet need. We further recommend that funding allocations, licensing decisions, and site selection criteria incorporate this data-driven model. A follow-up planning session is recommended to align stakeholders and secure resource commitments. This is an actionable opportunity to invest in evidence-based care, reduce overdose deaths, and close long-standing treatment equity gaps in high-need communities.

LaTweika A.T. Salmon-Trejo, DrPH, MPH

EXECUTIVE BRIEFS

PERFORMED NEEDS ASSESSMENT TO ADDRESS HEALTH COMMUNITY PROBLEM CONDUCTED A STATEWIDE COMMUNITY HEALTH NEEDS ASSESSMENT FOR METHADONE-BASED MEDICATION-ASSISTED TREATMENT (MAT), INTEGRATING NSDUH AND ACS POPULATION DATA TO PRODUCE COUNTY-LEVEL UNMET NEED ESTIMATES.

AUTHORED AN EXECUTIVE BRIEF OUTLINING A DATA-DRIVEN FACILITY EXPANSION PLAN, PRESENTED TO THE ASSISTANT SECRETARY TO INFORM EQUITABLE RESOURCE ALLOCATION AND COMMUNITY IMPLEMENTATION STRATEGY.

DEVELOPED IMPLEMENTATION PLAN TO SUPPORT LEGISLATIVE BUDGET REQUEST.

DIRECTLY INFORMED FY 2025–2026 APPROPRIATIONS BY GOVERNOR DESANTIS TO OPEN NEW AND EXPANDED TREATMENT SERVICES IN THE STATE'S HIGHEST-NEED COMMUNITIES.


LATWEIKA A.T.
SALMON-TREJO

KEY PERFORMANCE MEASURES

DEVELOPED PERFORMANCE MEASURES & DELIVERABLES FOR THE DEPARTMENT OF CHILDREN AND FAMILIES SUBSTANCE ABUSE AND MENTAL HEALTH PROGRAM MANAGING ENTITIES

EXHIBIT E – MINIMUM PERFORMANCE MEASURES

E.1 To demonstrate delivery of the Service Tasks detailed in **Section C.1**, the Managing Entity shall meet the annual performance measures in **Table 3**.

E.1.1 Financial consequences will be imposed consistent with **Table 3** for failure to satisfy the identified performance measures. Multiple financial consequences may be applied to a single invoice for that month's administrative costs if multiple performance measures are not met. The aggregate financial consequence for an invoice shall not exceed 10% of the Managing Entity administrative cost. The financial consequence for failure to satisfy a Performance Measure for business days one, two, or three is \$100 per incident. The financial consequence for failure to satisfy a Performance Measure for days four to 15 is \$200 per incident. The financial consequence for failure to satisfy a Performance Measure for after 15 days is \$500 per incident.

E.1.1.1 Any financial consequences incurred pursuant to this section shall generate a reduction in payment associated with the Managing Entity Administrative Cost other cost accumulator identified in **Exhibit F1**.

E.1.1.2 The Department, in its sole discretion, may waive financial consequences for extenuating circumstances.

Table 3 – Managing Entity Performance Measures		
Measure Description	Financial Consequence	Reporting Frequency
E.1.2 Development and Planning Function E.1.2.1 The Managing Entity actively seeks to expand its provider network and/or service capacity, based on service needs determined by the Triennial Needs Assessment or Department priorities and subject to the availability of funds, per C.1.1.1 , and the provider network is increased by 5% over its baseline in the first year and then greater than or equal to 2% per year thereafter. Numerator: Number of providers. Denominator: This is measured by the number of new providers added to the network E.1.2.2 Per C.1.1.3.2 , the Managing Entity shall increase diversions from acute care services. The readmission rate is equal to or less than 20% the first year and increases 1% thereafter. Numerator: Number of readmissions. Denominator: number of discharges all multiplied by 100. E.1.2.3 The Managing Entity shall ensure that 50% of individuals served within the service area meet the time and distance standards detailed in C.1.1.6.1 and C.1.1.6.2	Section E.1.1.	E.1.2.1 Annually E.1.2.2 Annually E.1.2.3 Monthly E.1.2.4 Monthly E.1.2.5 Annually

Table 3 – Managing Entity Performance Measures		
Measure Description	Financial Consequence	Reporting Frequency
Number of individual patients who traveled a maximum of 60 minutes and 30 miles to access care. Denominator: Total number of patients seen all multiplied by 100. E.1.2.3.2 Travel time for 50% or fewer individuals residing in the Region in rural counties and seeking services is within 50 miles and takes less than 120 minutes. This shall increase 10% per year thereafter, up to 70%. Numerator: Number of individuals who traveled a maximum 120 minutes and 50 miles to access care. Denominator: Total number of individuals seen multiplied by 100. E.1.2.4 The Managing Entity Actively seeks to expand the number of services added and it is increased by greater than or equal to 5% over its baseline in the first year and then greater than or equal to 2% per year thereafter.		
E.1.3 Administrative Function E.1.3.1 Per C.1.2.4 , the Managing Entity shall accept 90% of willing providers that meet standard credentialing requirements which may include an evaluation of past performance or satisfactory performance with: another Managing Entity Network, another health network or managed care plan, and within available funding and based on community need as identified in the Triennial Needs Assessment. When funding or community need does not support the addition of a new network service provider, the ME may adopt a prequalification process. E.1.3.2 Per C.1.2.10 , the Managing Entity shall respond within the 24-hours to 95% of requests received during business hours. E.1.3.3 Per C.1.2.10 , the Managing Entity shall respond to 95% of after-hours referral requests on the following business day. The Managing Entity is required to have a monitoring log available at the Department's request to establish this	Section E.1.1.	E.1.3.1 Monthly E.1.3.2 Monthly E.1.3.3 Monthly

EXHIBIT D – DELIVERABLES

D.1 SERVICE UNIT

D.1.1 The primary service unit is one month of the Managing Entity's performance of the functions specified in **Exhibits C, C1 and C2** and the delivery of Behavioral Health Services detailed in **Template 11 – Managing Entity Monthly Progress Report**.

D.1.2 In the event the Department authorizes Disaster Behavioral Health (DBH) Response services, as detailed in **Section C.1.6**,

D.1.2.1 A supplemental service unit is one month of subcontracted DBH services in any county identified by the Department in **Exhibit C1**.

D.1.2.2 Minimum performance for payment is one hour of actual service time documented as detailed in **Section F.8**, using **Template 24 - Disaster Behavioral Health Managing Entity Supplemental Invoice and Expenditure Report**.

D.2 GENERAL PERFORMANCE SPECIFICATIONS

The Managing Entity shall be solely and uniquely responsible for the satisfactory performance of the tasks described in this Contract. By execution of this Contract, the Managing Entity assumes responsibility for the tasks, activities, and deliverables described herein; and warrants that it fully understands all relevant factors affecting accomplishment of the tasks, activities, and deliverables; and agrees to be fully accountable for the performance thereof whether performed by the Managing Entity or its Network Service Providers.

D.3 PERFORMANCE MEASURE FOR ACCEPTANCE OF DELIVERABLES

D.3.1 To obtain approval of deliverables and services for payment,

D.3.1.1 The Managing Entity must document monthly progress toward compliance with the performance outcome targets specified in **Section E.1**; and

D.3.1.2 The Managing Entity must document the Network's monthly progress toward the annual fiscal year service output measure targets in **Section E.4**.

D.3.2 The Managing Entity is responsible and accountable for meeting all performance outcomes measure targets. The Managing Entity shall manage and oversee the collection of data from Network Service Providers in order to assure that targets are met, as a Network.

D.3.3 The performance measure targets shall be subject to periodic review by the Department and adjustments to the targets or the measures may be recommended as a part of **Template 4 – Managing Entity Annual Business Operations Plan**.

D.3.4 The Managing Entity agrees that the SAMH Data System will be the source for all data used to determine compliance with performance measures. Performance of Network Service Providers shall be monitored and tracked by the Managing Entity. The Managing Entity shall provide applicable technical assistance to Network Service Providers and initiate corrective actions, as required, and will report to the Department.

D.3.4.1 Department performance measure compliance determinations are final. Once performance measures have been calculated using the data submitted in the SAMH Data System, performance data may not be altered or amended. Subsequent performance data submission will not impact the initial performance measure compliance determination.

D.4 PERFORMANCE MEASURE TERMS

PAM 155-2 provides the definitions of the data elements used for various performance measures and contains policies and procedures for submitting the required data into the SAMH Data System.

D.5 PERFORMANCE MEASURE METHODOLOGY

The methodology and algorithms to be used in assessing the Managing Entity's performance are outlined in **Guidance 24 – Performance Outcomes Measurement Manual**.


LATWEIKA A.T.
SALMON-TREJO

SYSTEMS PERFORMANCE REPORTING

DEVELOPED STATEWIDE REPORTING TOOLS FOR THE CORE NETWORK THAT STRENGTHENED DATA QUALITY, STANDARDIZED COUNTY REPORTING, AND IMPROVED PERFORMANCE MONITORING ACROSS FLORIDA'S BEHAVIORAL HEALTH SYSTEM.

CORE Network Narrative Report

(Select ME)
(Select Region)

This report serves to track the progress and performance of CORE Networks statewide.
Kindly email completed spreadsheets to: HQW.SAMH.Core@myflfamilies.com

Community Outreach

Describe your community CORE outreach efforts. Community CORE outreach efforts can include activities such as scheduled days/locations for naloxone distribution, presentations at colleges/universities, health fairs, faith-based organizations, law enforcement activities or other community providers disseminating brochures, and other community events/activities. To illustrate your community outreach please send attachment of pictures, sample flyers, brochures, etc.



**Coordinated
Opioid Recovery**
A NETWORK OF ADDICTION CARE

Community Outreach	Describe your community CORE outreach efforts. Community CORE outreach efforts can include activities such as scheduled days/locations for naloxone distribution, presentations at colleges/universities, health fairs, faith-based organizations, law enforcement activities or other community providers disseminating brochures, and other community events/activities. To illustrate your community outreach please send attachment of pictures, sample flyers, brochures, etc.				
Innovation	Describe any new and innovative treatment methods or practices implemented.				
Community Partnerships	List any new formal or informal partnerships established in the reporting period (Sharing Agreements, common assessments, etc.) and what service they provide.				
Success Story	Provide a success story from the CORE Network (if applicable). The success story is a coordinated system of care where all CORE components work together, or an individual achievement including MAT. Success stories can also focus on an achievement within the CO and work within the CORE Network.				
Media Links	Provide media links (including social media) highlighting your CORE Network efforts.				

Fiscal Year:	(Select Fiscal Year)	Reporting Period:	(Select Reporting Period)	(Select County)
Community Outreach		Innovation		Community Partnerships
List and describe your community CORE outreach efforts conducted this quarter (IMRS, receiving clinics, law enforcement, etc.).		List and describe any new/innovative treatment methods or practices implemented.		List any new partnerships established in the reporting period (i.e., Memoranda of Understandings, Referral Agreements, Data Sharing Agreements, common assessments, etc.) and what service they provide.

Success Story	Media Coverage
Describe a success story if applicable.	Provide links to media coverage of your CORE Network for this reporting period.

[illegible]

²⁴ *Environment* was measured, please specify what kind of environment. If *Training* was measured, please specify what kind of training.

latweika.salmon@icloud.com

SYSTEMS PERFORMANCE REPORTING

DEVELOPED STATEWIDE REPORTING TOOLS FOR THE CORE NETWORK THAT STRENGTHENED DATA QUALITY, STANDARDIZED COUNTY REPORTING, AND IMPROVED PERFORMANCE MONITORING ACROSS FLORIDA’S BEHAVIORAL HEALTH SYSTEM.

Data Element	Description
Total number of unique individuals with SUD served at a CORE receiving clinic.	This value represents the total number of <u>unique</u> individuals with an SUD diagnosis who were served in a CORE receiving clinic during the reported timeframe.
Of the total number of unique individuals with SUD served, how many (unique) individuals had OUD?	This value represents the total number of <u>unique</u> individuals with an OUD diagnosis who were served in a CORE receiving clinic during the reported timeframe.
Of the total number of unique individuals with OUD served, how many received MAT in a CORE receiving clinic?	This value represents the number of <u>unique</u> individuals with an OUD diagnosis who received MAT in a CORE receiving clinic during the reported timeframe.
Number of unique individuals with SUD who were transferred from a 24/7 access point to a receiving clinic.	This value represents the number of <u>unique</u> individuals with an SUD diagnosis who were transferred from a 24/7 access point to a CORE receiving clinic during the reported timeframe.
Total number of MAT inductions.	The total number of MAT inductions count of <u>all MAT inductions</u> , not a count of unique individuals, during the reporting period.
Number of unique individuals with SUD who engaged with a Peer Specialist.	This value represents the number of <u>unique</u> individuals with an SUD diagnosis who engaged with a Peer Specialist during the reported timeframe. If the receiver is responsible for collecting this data from the provider, this value should be reported.
Number of unique individuals with SUD who remained in treatment for at least 1 month (30 days).	Of the total number of <u>unique</u> (new and existing) individuals with an SUD diagnosis who entered treatment at the clinic, how many remained in treatment for at least 1 month (30 days)?
Number of unique individuals with SUD who remained in treatment for at least 3 months (90 days).	Of the total number of <u>unique</u> (new and existing) individuals with an SUD diagnosis who entered treatment at the clinic and received treatment for 1 month (30 days), how many remained in treatment for at least 3 months (90 days)?
Number of unique individuals with SUD who remained in treatment for at least 6 months (180 days).	Of the total number of <u>unique</u> (new and existing) individuals with an SUD diagnosis who entered treatment at the clinic and received treatment for 3 months (90 days), how many remained in treatment for at least 6 months (180 days)?
Number of unique individuals with SUD who remained in treatment for at least 1 year (365 days).	Of the total number of <u>unique</u> (new and existing) individuals with an SUD diagnosis who entered treatment at the clinic and received treatment for 6 months (180 days), how many remained in treatment for at least 1 year (365 days)?
Comments	For additional notes, clarifications, or observations related to the listed data elements. It can be used to: Highlight any anomalies or trends observed in the data. Provide contextual explanations for variations in reported numbers. Offer insights on data collection challenges or methodology.

CORE Network Data Collection

Receiving Clinic

Coordinated
Opioid Recovery

A NETWORK OF ADDICTION CARE



Name of Provider:

Reporting Period:

(Select Reporting Period)

(Select Year)

County:

(Select County)

*Type in the provider name above.

*Use the drop-down boxes above to indicate reporting period, year, and county.

Total number of unique individuals with SUD served at a CORE receiving clinic.	Of the total number of unique individuals with SUD served, how many (unique) individuals had OUD?	Of the total number of unique individuals with OUD served, how many received MAT in a CORE receiving clinic?	Number of unique individuals with SUD who were transferred from a 24/7 access point to a receiving clinic.	Total number of MAT inductions.	Number of unique individuals with SUD who engaged with a Peer Specialist.	Number of unique individuals with SUD who remained in treatment for at least 1 month (30 days).	Number of unique individuals with SUD who remained in treatment for at least 3 months (90 days).	Number of unique individuals with SUD who remained in treatment for at least 6 months (180 days).	Number of unique individuals with SUD who remained in treatment for at least 1 year (365 days).	Comments

*Type in the numerical value for the questions above in the boxes provided.

EXAMPLE FOR 30/90/180/365 DAY DATA*

Client Name	Days in Treatment	Days in Treatment	# of Clients
JD	32	at least 30 days	1 (JD, James, Jack, Carol, and Karen)
James	45	at least 90 days	1 (Jack, Carol, and Karen)
Jack	126	at least 180 days	1 (Carol and Karen)
Carol	211	at least 365 days	1 (Karen)
Karen	368		

*Individuals can be counted in multiple categories for days in treatment. Example: If Carol was in treatment for 211 days, she would be counted in the 30, 90 and 180 group.

LEADERSHIP IN EQUITY

From: Anderson, Stefanie (CDC/NCHHSTP/DHP) <soa5@cdc.gov>
Sent: Thursday, July 18, 2024 3:20:49 PM
To: Salmon-Trejo, LaTweika (CDC/NCHHSTP/DTE) <psq2@cdc.gov>
Subject: RE: Character Reference

Hi LaTweika,

I don't want the end of the year to come without letting you know how much I appreciate and have enjoyed working with you on NCHHSTP's DEIAB Council. From our initial introduction to the present, you have been welcoming, provided valuable feedback, and offered insightful perspectives. Your collaborative spirit and eagerness to lead and steer council initiatives have been remarkable. I was particularly impressed by your leadership in supporting CDC's celebration of Black History Month.

You are consistent, reliable, easy to work with, and passionate about equity. Your advocacy for others, especially those who may not feel comfortable expressing themselves, has been commendable. Your presence on the council has made it more engaging, cooperative, and action-oriented.

I look forward to our continued collaboration within the council and as colleagues in NCHHSTP!

Cheers!

Stefanie

Stefanie K. Anderson, MPH (she/her/hers)
Diversity, Equity, Inclusion, and Accessibility (DEIA) Advisor



Office of the Director (OD)
Office of Program Management & Operations (OPMO)
Division of HIV Prevention (DHP)
National Center for HIV, Viral Hepatitis, STD, and TB Prevention (NCHHSTP)
US Centers for Disease Control and Prevention (CDC)
Email: soa5@cdc.gov
Tel: 404.639.4530



PROVIDED PROGRAM LEADERSHIP AND DEVELOPED THE 2024 AGENCY-WIDE BLACK HISTORY MONTH INITIATIVE WITH SEP AND OEEOWE—COORDINATED VENDORS, STAFF WORKGROUPS, AND A LIVE EXPERT PANEL TO EMBED DEIAB PRINCIPLES INTO ORGANIZATIONAL CULTURE, SHOWCASING THE CULTURALLY COMPETENT ENGAGEMENT SKILLS REQUIRED TO CONVENE THE CDC'S NATIONAL CENTER FOR HIV, VIRAL HEPATITIS, STD, AND TB PREVENTION (NCHHSTP) STAKEHOLDER COALITIONS.

CONCEIVED AND DELIVERED AN EQUITY FOCUSED ARTS AND CULTURE PROGRAM THAT EARNED A CDC WORKPLACE EQUITY INNOVATION AWARD NOMINATION, ILLUSTRATING THE ABILITY TO DESIGN HIGH-IMPACT, CROSS-SECTOR INITIATIVES AND MOBILIZE DIVERSE PARTNERS AROUND COMMUNITY-BENEFIT PRIORITIES.

latweika.salmon@icloud.com


LATWEIKA A.T.
SALMON-TREJO

FINANCE MANAGEMENT

DEVELOPED TOOLS TO SUPPORT BUDGET OVERSIGHT, TRANSACTION APPROVAL & EXPENDITURE REVIEW IN THE FORM OF DASHBOARDS AND MACRO-ENABLED SPREADSHEETS LEVERAGING SQL, POWER BI, AND VBA MACROS IN EXCEL

Grant	DEO Flag	Total Award	Current Balance	Projected Expenditures Till 6/30/26	Projected Balance 6/30/26	Projected Expenditures 7/1/26 - 9/30/26	Projected Balance 9/30/26	Projected Average Monthly Expenditures	Comments/Notes	Total Expenditures
UA22	Admin	\$ 449,503.40	\$ -	\$ -	\$ -	\$ -	\$ -		Fully expended	
UA22	External	\$ 98,101,991.30	\$ -	\$ -	\$ -	\$ -	\$ -		Fully expended	
UA23	Admin	\$ 857,652.48	\$ -	\$ -	\$ -	\$ -	\$ -			
UA23	External	\$ 104,637,952.82	\$ 5,240,450.93	\$ 5,240,450.93	\$ -	\$ -	\$ -			
UA24	Admin	\$ 8,975,047.34	\$ 3,995,457.25	\$ 193,363.44	\$ 3,202,299.81	\$ -	\$ 3,202,299.81		Possible issue to vendor in Sept. 2025	
UE24	External	\$ 104,700,155.86	\$ 53,552,405.11	\$ 53,552,405.11	\$ -	\$ -	\$ -	202.67	Expectation indefinite fully expends	
UA25	Admin	\$ 2,373,926.00	\$ 2,373,926.00	\$ 1,178,678.62	\$ 1,195,247.38	\$ 434,886.95	\$ 780,960.43	\$ 138,299.65		
UE25	External	\$ 109,713,322.00	\$ 109,713,322.00	\$ 109,713,322.00	\$ -	\$ -	\$ -		Only accounts for subsequent spending	
UE26	External	\$ 84,171,854.00	\$ 22,554,457.86	\$ 1,700,000.00	\$ 20,854,457.86	\$ -	\$ -			
UE22	External	\$ 5,785,953.00	\$ -	\$ -	\$ -	\$ -	\$ -			
UE23	External	\$ 4,126,870.00	\$ 1,174,738.49	\$ 500,000.00	\$ 674,738.49	\$ -	\$ -			
UE24	External	\$ 5,044,899.00	\$ 4,895,340.72	\$ 2,867,555.24	\$ 2,027,885.48	\$ -	\$ -			
UE25	External	\$ 3,962,057.00	\$ 3,962,057.00	\$ -	\$ 3,962,057.00	\$ -	\$ -			
UE27	Admin	\$ 570,083.00	\$ -	\$ -	\$ -	\$ -	\$ -			
UE28	External	\$ 5,872,854.70	\$ 1,335,427.22	\$ 1,335,427.22	\$ -	\$ -	\$ -			
Total Grant Award		\$ 543,743,141.50	\$ -	\$ 307,797,852.58	\$ 175,881,402.56	\$ 33,916,450.82	\$ -			
*GRANT Incorrect - balances from each balance report										
GL	(All)		LEAF Carry In	New						
ICAT	(blank)	\$ 8,975,047.34	7.895%	\$ 885,422.12	\$ 2,373,926.00	\$ 570,083.00				
OFI	(blank)	\$ 104,700,155.86	92.105%	\$ 4,449,543.87	\$ 113,675,379.00	\$ 5,872,854.70				
GRANT	(Multiple Items)	\$ 113,675,223.00		\$ 4,830,965.99	\$ 114,046,885.00	\$ 6,442,737.70				

		Values		Projected Expenditures Till 06/30/26	Projected SFY 25-26 Expenditures	Projected Expenditures 07/01/26 - 09/30/26
GRANT2	OBJECT2	Sum of SLTD	Sum of SYTD			
LEA	Refunds	\$ (42,833.47)	\$ (85.73)	\$ -	\$ -	\$ -
	Prior Year Refunds	\$ (361.85)	\$ -	\$ -	\$ -	\$ -
	Salaries - FTE	\$ 1,160,814.78	\$ 51,658.02	\$ 596,240.73	\$ 647,898.75	\$ 180,910.00
	Salaries - OPS	\$ 335,404.26	\$ 17,791.20	\$ 184,614.88	\$ 202,406.08	\$ 55,409.00
	Contractual Services	\$ 838,057.65	\$ 70.46	\$ 230,977.75	\$ 231,048.21	\$ 57,762.00
	Expenses	\$ 260,315.67	\$ 398.47	\$ -	\$ 47,166.50	\$ 11,792.00
	Federal Financial Assistance	\$ 186,892,335.34	\$ 109,267.92	\$ -	\$ -	\$ -
	Indirect	\$ 706,490.04	\$ 14,263.10	\$ 360,208.69	\$ 392,245.62	\$ 109,013.95
LEA Total		\$ 190,150,222.42	\$ 193,363.44	\$ 1,372,042.06	\$ 1,520,765.16	\$ 414,886.95
LEE	Federal Financial Assistance	\$ 47,713,918.36	\$ 463,257.15	\$ 46,787,404.06	\$ 47,250,661.21	\$ 11,812,665.00
LEE Total		\$ 47,713,918.36	\$ 463,257.15	\$ 46,787,404.06	\$ 47,250,661.21	\$ 11,812,665.00
LEI	Contractual Services	\$ 1,093.24	\$ -	\$ -	\$ -	\$ -
	Expenses	\$ 846.06	\$ -	\$ -	\$ -	\$ -
	Federal Financial Assistance	\$ 6,794,725.92	\$ 137,097.00	\$ 3,230,458.24	\$ 3,367,555.24	\$ 841,889.00
LEI Total		\$ 6,796,665.22	\$ 137,097.00	\$ 3,230,458.24	\$ 3,367,555.24	\$ 841,889.00
LEW	Prior Year Refunds	\$ (154.59)	\$ -	\$ -	\$ -	\$ -
	Salaries - FTE	\$ 196,380.89	\$ -	\$ 28,381.55	\$ 28,381.55	\$ 7,925.00
	Salaries - OPS	\$ 18,453.32	\$ -	\$ 2,363.89	\$ 2,363.89	\$ 647.00
	Contractual Services	\$ 13,646.39	\$ -	\$ -	\$ -	\$ -
	Expenses	\$ 52,021.82	\$ -	\$ 2,432.82	\$ 2,432.82	\$ 608.00
	Federal Financial Assistance	\$ 5,264,455.40	\$ -	\$ 3,117,338.99	\$ 3,117,338.99	\$ 779,335.00
	Indirect	\$ 96,100.04	\$ -	\$ 14,182.87	\$ 14,182.87	\$ 3,954.26
LEW Total		\$ 5,640,903.27	\$ -	\$ 3,164,700.13	\$ 3,164,700.13	\$ 792,469.26
LEF	Federal Financial Assistance	\$ 51,117,668.12	\$ 172,016.96	\$ 136,505,064.63	\$ 136,677,081.59	\$ 34,126,266.00
LEF Total		\$ 51,117,668.12	\$ 172,016.96	\$ 136,505,064.63	\$ 136,677,081.59	\$ 34,126,266.00
Grand Total		\$ 301,419,377.39	\$ 965,734.55	\$ 191,059,669.12	\$ 191,980,763.33	\$ 47,988,176.22

Certificate of Completion

Awarded to

LATWEIKA SALMON-TREJO

For successful completion of

Statewide - Governmental Accounting Basics

Presented by the

Florida Department of Financial Services



16 June 2025

Completed

Rose Hemmeling

Division Director

Certificate of Completion

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For successful completion of

Statewide-Governmental Accounting: Reconciliation & Corrections Training

Presented by the

Florida Department of Financial Services



16 June 2025

Completed

Rose Hemmeling

Division Director

ASSESSMENT OF BEHAVIORAL HEALTH SERVICES - FLORIDA DCF

The following sections provide descriptions of the priority needs identified by the MEs. In their needs assessments, the organizations reported areas requiring additional funding varying from expanding services. In addition, the quantity of identified needs varied between MEs. The MEs continue to cite housing and housing coordination as the greatest need, as well as Care Coordination and case management, jail, forensic facility diversion, and the expansion of behavioral health services. Depending on the region, each ME faces unique challenges and proposes specific solutions to overcoming them.

Managing Entity	Priority Needs	Associated Budget
Broward Behavioral Health Coalition (BBHC)	Increase Funding Levels to Prior to the Spending of the Supplemental Block Grant	\$ 11,691,327
	Ensure Recurrent funding for the Operational Integrity of the Managing Entity***	\$ 1,865,665
	Community Treatment and Support Services - Broward Forensic Alternative Center	\$ 3,358,000
	Community Treatment and Support Services - Short-term Residential Treatment (SRT) Services for Jail Diversion Persons Served	\$ 3,358,000
	Community Treatment and Support Services - Stepping-Up Initiative for Jail Diversion	\$ 510,400
	Community Treatment and Support Services - Housing and Care Coordination Teams, and Family/Peer Navigator	\$ 2,050,000
	Community Action Treatment (CAT) Team for Ages 0-10	\$ 750,000
	We Are Supported: Baker Act Care Coordination Integrated Data System Pilot Expansion	\$ 650,000
	BBHC Total	\$ 24,233,392
Central Florida	Operations	\$ 2,423,671
	Housing	\$ 2,419,800

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Behavioral Health Network (BHN)	Prevention	\$ 942,500
	Substance Misuse Disorder and Mental Health:	\$ 4,175,000

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Behavioral Health Network (CFBHN)	Prevention	\$ 942,500
	Substance Misuse Disorder and Mental Health: Services	\$ 4,175,000
	CFBHN Total	\$9,960,971
Central Florida Cares Health System (CFCHS)	Substance Exposed Newborn (SEN) Program	\$ 350,000
	Adult Substance Abuse Residential Treatment	\$ 765,606
	S.T.R.I.V.E.- Family Stabilization Program	\$ 630,000
	School-Based Intervention Program	\$ 377,950
	School-Based Substance Abuse Prevention Program	\$ 580,000
	CFCHS Total	\$ 2,703,556
Lutheran Services of Florida Health Systems (LSF Health Systems)	Workforce Recruitment, Retention, and Sustainability Plan	\$ 5,516,528
	Housing: Care Coordination/Housing Coordination	\$ 4,081,000
	Daysprings Village - State Mental Health Treatment Facility Discharge/Diversion Placement	\$ 2,542,853
	Block Grant Community-Based Services	\$ 14,226,766
	ME Operating Resources	\$ 6,380,230
	LSF Health Systems Total	\$ 32,747,377
South Florida Behavioral Health Network dba Thriving Mind South Florida (Thriving Mind)	Housing	\$ 1,400,000
	Care Coordination: System Level Care-Coordination	\$ 750,000
	Expanding Behavioral Health Services: Youth Respite Program	\$ 582,400
	Expanding Behavioral Health Services: Youth Crisis Stabilization Unit	\$ 2,920,000
	Suicide Prevention	\$ 610,000
	Thriving Mind South Florida Total	\$ 6,262,400
Southeast Florida Behavioral Health Network (SEFBHN)	Housing: Expansion of Supported and Transitional Housing	\$ 1,000,000
	Increased Substance Use Funding for Areas of Prevention, Non-Residential and Residential Treatment***	\$ 4,000,000
	Increased Administrative Funding for the Managing Entity Budget***	\$ 1,000,000
	Funding for Zero Suicide	\$ 500,000
	SEFBHN Total	\$ 6,500,000
Northwest	Forensic Multidisciplinary Team (FTM)	\$ 2,600,000
	SOAR Dedicated Process Pilot	\$ 250,000

A	B	C	D	E
FYEND	(All)			
Sum of AMOUNT FLAIR/ACTUAL				
DESCR	ACTUAL	FLAIR	Grand Total	
C3672	197,600.00	197,600.00	395,200.00	
C3673	146,475.00	146,475.00	292,950.00	
C3674	139,912.50	139,912.50	279,825.00	
C3676	92,283.75	92,283.75	184,567.50	
C3677	176,320.00	176,320.00	352,640.00	
C3678	161,840.00	161,840.00	323,680.00	
C3681	149,035.00	149,035.00	298,070.00	
C3685	177,652.00	177,652.00	355,304.00	
C3686	136,990.00	136,990.00	273,980.00	
C3688	166,230.00	166,230.00	332,460.00	
C3689	150,280.00	150,280.00	300,560.00	
C3690	136,500.00	136,500.00	273,000.00	
C3693	142,594.00	142,594.00	285,188.00	
C3695	130,425.00	130,425.00	260,850.00	
C3701	186,770.00	186,770.00	373,540.00	
C3702	190,995.00	190,995.00	381,990.00	
C3703	176,795.00	176,795.00	353,590.00	
C3704	157,590.00	157,590.00	315,180.00	
C3707	190,285.00	190,285.00	380,570.00	
C3708	193,200.00	193,200.00	386,400.00	
C3709	147,475.00	147,475.00	294,950.00	
C3711	140,267.00	140,267.00	280,534.00	
C3712	177,075.00	177,075.00	354,150.00	
C3716	168,810.00	168,810.00	337,620.00	
C3717	181,884.00	181,884.00	363,768.00	
C3718	140,080.00	140,080.00	280,160.00	
C3719	186,210.00	186,210.00	372,420.00	
C3721	165,616.00	165,616.00	331,232.00	
C3722	150,727.50	150,727.50	301,455.00	
C3724	171,000.00	171,000.00	342,000.00	
C3763	153,578.00	153,578.00	307,156.00	
Grand Total	4,982,494.75	4,982,494.75		

RESEARCH & PUBLICATIONS

RESEARCH COMPLETED USING SAS, SQL, R & EXCEL

Comparative Study > BMC Infect Dis. 2025 Jan 16;25(1):74. doi: 10.1186/s12879-024-10358-4.

Genotyped cluster investigations versus standard contact tracing: comparative impact on latent tuberculosis infection cascade of care in a low-incidence region

Michael Asare-Baah^{1,2}, Marie Nancy Séraphin^{2,3}, LaTweika A T Salmon-Trejo^{3,4}, Lori Johnston⁵, Lina Dominique⁵, David Ashkin⁶, Krishna Vaddiparti¹, Awewura Kwara^{6,7}, Anthony T Maurelli^{2,8}, Michael Lauzardo^{9,10}

Affiliations + expand

PMID: 39819477 PMCID: PMC11740335 DOI: 10.1186/s12879-024-10358-4

Abstract

Background: Cluster and contact investigations aim to identify and treat individuals with tuberculosis (TB) and latent TB infection (LTBI). Although genotyped cluster investigations may be superior to contact investigations in generating additional epidemiological links, this may not necessarily translate into reducing infections. Here, we investigated the impact of genotyped cluster investigations compared to standard contact investigations on the LTBI care cascade in a low incidence setting.

Methods: A matched case-control study nested within a cohort of 6,921 TB cases from Florida (2009-2023) was conducted. Cases (n = 670) underwent genotyped cluster investigations, while controls (n = 670) received standard contact investigations and were matched 1:1 by age. The LTBI care cascade outcomes were compared using Pearson's chi-square tests.



Morbidity and Mortality Weekly Report (MMWR)

Search



Epidemiologic and Clinical Features of Mpox in Adults Aged >50 Years — United States, May 2022–May 2023

Weekly / August 18, 2023 / 72(33):893–896

[Print](#)

Patrick C. Eustaquio, MD^{1,2}; LaTweika A.T. Salmon-Trejo, MPH¹; Lisa C. McGuire, PhD³; Sascha R. Ellington, PhD¹ ([VIEW AUTHOR AFFILIATIONS](#))

[View suggested citation](#)

Summary

What is already known about this topic?

Childhood smallpox vaccination confers some cross-protection against mpox. Although persons aged >50 years likely received childhood smallpox vaccination, they might have more comorbidities and a higher risk for severe mpox compared with persons aged <50 years.

Understanding cross-protective immunity and how this might affect risk for severe mpox is important.

Recommendations for Use of Video Directly Observed Therapy During Tuberculosis Treatment — United States, 2023

Weekly / March 24, 2023 / 72(12):313–316

[Print](#)

Joan M. Mangan, PhD¹; Rachel S. Woodruff, MPH¹; Carla A. Winston, PhD¹; Scott A. Nabity, MD¹; Maryam B. Haddad, PhD¹; Meredith G. Dixon, MD¹; Farah M. Parvez, MD¹; Carissa Sera-Josef, MS¹; LaTweika A. T. Salmon-Trejo, MPH¹; Chee Kin Lam, MS, MPH¹ ([VIEW AUTHOR AFFILIATIONS](#))

[View suggested citation](#)

Summary

What is already known about this topic?

Directly observed therapy (DOT) for tuberculosis treatment involves observing a patient ingest medication, monitoring the patient for adverse events, and providing support for treatment completion. DOT has typically been conducted in person; however, scheduling in-person DOT can present logistical challenges.

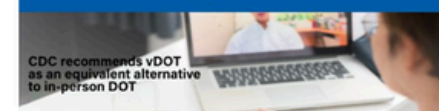
What is added by this report?

Based on published evidence evaluating treatment adherence and completion and microbiologic resolution of disease, CDC recommends video DOT (vDOT) as equivalent to in-person DOT for persons undergoing treatment for diagnosed tuberculosis.

What are the implications for public health practice?

vDOT can assist health department tuberculosis programs meet the U.S. standard of care for patients undergoing tuberculosis treatment, while using resources efficiently.

Video directly observed therapy (vDOT) provides flexibility during TB treatment, saving time and costs



CDC recommends vDOT as an equivalent alternative to in-person DOT

Article Metrics

Altmetric:

News (5)
Policy documents (1)
X (20)
Facebook (2)
Clinical guidelines (1)
Mendeley (70)

11 Total citations
10 Recent citations
8.48 Field Citation Ratio
2.46 Relative Citation Ratio

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Article Metrics

Altmetric:

25
News (2)
Policy documents (1)
X (7)
Facebook (1)
Mendeley (16)

22 Total citations
20 Recent citations
14 Field Citation Ratio
2.51 Relative Citation Ratio

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LATWEIKA A.T.
SALMON-TREJO

LEADERSHIP IN RESEARCH

TECHNOLOGY AND CODE article

Front. Public Health, 20 June 2021
Sec. Infectious Diseases: Epidemiology and Prevention
Volume 9 - 2021 | <https://doi.org/10.3389/fpubh.2021.667337>

Logically Inferred Tuberculosis Transmission (LITT): A Data Integration Algorithm to Rank Potential Source Cases

Kathryn Winglee^{1*} Clinton J. McDaniel¹ Lauren Linde² Steve Kammerer¹ Martin Clinis²
Kala M. Raz¹ Wendy Noboa^{1,3} Jillian Knorr⁴ Lauren Cowan¹ Sue Reynolds¹
James Posey¹ Jeanne Sullivan Meissner⁴ Shameer Poonja^{1,3} Tambi Shaw² Sarah Talarico¹
Benjamin J. Silk¹

¹ Division of Tuberculosis Elimination, Centers for Disease Control and Prevention, Atlanta, GA, United States

² TB Control Branch, California Department of Public Health, Richmond, CA, United States

³ Los Angeles County Department of Public Health, Los Angeles, CA, United States

⁴ New York City Department of Health and Mental Hygiene, Queens, NY, United States

Understanding tuberculosis (TB) transmission chains can help public health staff target their resources to prevent further transmission, but currently there are few tools to automate this process. We have developed the Logically Inferred Tuberculosis Transmission (LITT) algorithm to systematize the integration and analysis of whole-genome sequencing, clinical, and epidemiological data. Based on the work typically performed by hand during a cluster investigation, LITT identifies and ranks potential source cases for each case in a TB cluster. We evaluated LITT using a diverse dataset of 534 cases in 66 clusters from 2007–2019, which were investigated months to years after onset. LITT identified source cases in 48 of 66 clusters (73%) and ranked them by likelihood of being the source case. LITT was able to identify source cases in 48 of 66 clusters (73%) and ranked them by likelihood of being the source case.

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Edited by

Marco Cassone
Michigan Medicine, University of Michigan, United States

Reviewed by

Andrew Tibbs
Massachusetts Department of Public Health, United States

LaTweika A.T. Salmon
Florida Department of Health, United States

AS A RECOGNIZED SUBJECT MATTER EXPERT, I SERVED AS A PEER REVIEWER FOR FRONTIERS IN PUBLIC HEALTH, EVALUATING A HIGH-IMPACT MANUSCRIPT ON THE LITT ALGORITHM—A NOVEL TOOL DESIGNED TO INFER TB TRANSMISSION USING WHOLE-GENOME SEQUENCING, CLINICAL, AND EPIDEMIOLOGIC DATA. MY REVIEW EMPHASIZED THE INTEGRATION OF FIELD-BASED LOGIC WITH ADVANCED STATISTICAL METHODS, ASSESSING MODEL VALIDITY, ALGORITHMIC TRANSPARENCY, AND THE PUBLIC HEALTH UTILITY OF AUTOMATED CLUSTER INVESTIGATIONS.

THIS EXPERIENCE REFLECTS MY ONGOING LEADERSHIP IN APPLIED EPIDEMIOLOGY, COMMITMENT TO SCIENTIFIC RIGOR, AND ABILITY TO CRITICALLY EVALUATE COMPLEX DATA SCIENCE TOOLS WITH REAL-WORLD IMPLICATIONS FOR POPULATION HEALTH.

[MANUSCRIPT LINK](#)

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LATWEIKA A.T.
SALMON-TREJO

REFERENCES

Bonnie Donihi
Executive Director
Women's & Girls Cancer Alliance
1855 West SR 434 Ste. 282
Longwood, FL 32750

05/03/2016

I am the Executive Director of the Women's and Girls' Cancer Alliance and this letter is in response to a reference request for LaTweika A.T. Salmon. I have had the pleasure of working with this young lady for over a year and a half as she interned with us for her Master of Public Health working with our Program Manager and was later hired as Health Communications Manager.

LaTweika has already practiced and demonstrated epidemiological concepts such as data analysis while working for the organization with her thorough examination of gynecological trends in Florida, in particular HPV incidence and prevalence rates and a regard to vaccine education as she assisted in the development of programs and educational presentations in the community. In addition to assisting, "Making the Rounds", a program designed to increase gynecological cancer education across Central Florida targeting at risk communities.

As our Health Communications Manager, her attention to detail continued as she educated the community on determinants such as the BRCA 1 gene mutation, connections between breast and ovarian cancer, and HPV-cervical cancer in addition to being responsible for reviewing current research findings and conveying new information to the public.

I have always found LaTweika to be so personable, honest, hardworking, goal oriented and career driven. I was personally able to witness LaTweika develop into a public health professional as she faced personal adversity and still graduated with a 4.0, taking on small projects here at WGCA, and thrilled to gain experience and practice. I am confident LaTweika has the knowledge and every ability to be an asset.

Sincerely,
Bonnie Donihi

July 27, 2025

Hiring Manager,

I am pleased to recommend Dr. LaTweika A. T. Salmon-Trejo, who partnered with Higher Heights Consulting Group, Inc. from May 2024 through January 2025 as a senior public-health consultant. Contracted to assist several client organizations, she collaborated with local clinics and school districts to design and launch two high-impact programs—a mobile diabetes-screening service and a school-based asthma-education series—supported by interactive data dashboards. She also produced infographics, executive briefs, and presentations that kept leadership and community partners engaged, while training more than 25 staff members to apply logic models, outcome metrics, and phased timelines for continuous evaluation.

Additionally, Dr. Salmon-Trejo led a data-driven community-health assessment that combined hospital-discharge records, BRFSS statistics, and CDC social-vulnerability data. She condensed the findings into a 30-page report and then conducted a VMOSA- and SWOT-based performance review to pinpoint capacity gaps and craft a six-month improvement plan centered on health equity. Employing budget-impact analysis, she projected the financial implications of each recommended intervention, while root-cause analysis helped identify underlying barriers in Black and Hispanic health centers; the resulting board-level brief now guides grant strategy and funding alignment. She supported the formation of a 20-member advisory panel spanning hospitals, nonprofits, faith leaders, and public agencies, steering the group toward three new priority interventions.

Dr. Salmon-Trejo consistently converts complex data into measurable community benefit and excels at uniting diverse stakeholders around shared goals. She would be an excellent addition to any organization committed to improving population health.

Sincerely,

Rakinya Hinson, DrPH
Owner & President
Higher Heights Consulting, Inc.
386.401.2800

Trisha Gunderson
Former Manager, Office of Opioid Recovery
Florida Department of Children and Families

July 27, 2025

To Whom It May Concern:

It is with great enthusiasm that I recommend Dr. LaTweika A.T. Salmon-Trejo for the position. I had the privilege of supervising Dr. Salmon-Trejo during her time as Lead Epidemiologist for the Florida Department of Children and Families' Office of Opioid Recovery. Her combination of analytical brilliance, strategic vision, and authentic community-centered leadership makes her an exceptional candidate for this role.

At DCF, Dr. Salmon-Trejo played a central role in designing and implementing the statewide data infrastructure for the CORE Network—Florida's primary vehicle for distributing and tracking opioid settlement funds. She defined and trained internal and external partners in a virtual setting on standardized reporting templates that quantified regional and county-level expenditures, enumerated program counts, and tracked community-based interventions, including law-enforcement-integrated services. These performance tools became the backbone of how Florida aligned its opioid settlement investments with real-time community needs and ensured compliance with state-mandated reporting across 67 counties.

LaTweika also conducted a comprehensive statewide analysis of psychiatric hospital capacity using multidisciplinary data sources, revealing major service gaps in Florida's behavioral health infrastructure. Her findings informed a Legislative Budget Request and reshaped how the state prioritizes mental health system investments—evidence of her ability to turn data into action at the policy level.

Beyond her technical expertise, Dr. Salmon-Trejo has a rare gift for engaging others with empathy, cultural competence, and vision. She collaborated with law enforcement, community-based organizations, health systems, and state officials to ensure our programs were not only evidence-based, but truly community-responsive.

Dr. Salmon-Trejo's ability to bridge data and community, strategy and heart, is precisely what makes her such a compelling fit for a leadership role focused on measurable, equity-driven community benefit. I recommend her without hesitation and with the utmost confidence. Please feel free to contact me directly should you have any questions.

Sincerely,
Trisha Gunderson
Former Manager, Office of Opioid Recovery
Florida Department of Children and Families

latweika.salmon@icloud.com


LATWEIKA A.T.
SALMON-TREJO

EMPLOYEE DEVELOPMENT

LaTweika was our team lead in the Case Data Team when we were in the Mpox response together from December 28, 2022 – January 27, 2023. She ensured that we do all our day-to-day task in the very time-intensive response work. Before I joined the team, she comprehensively briefed me about the objectives of our team and the tasks and duties we need to perform as a group, and she delegated tasks efficiently among our team. Given the very steep learning curve that entails in response work, it was helpful that she was provided a lot of opportunities to ask questions. She was very approachable as our team lead; she has a comfortable, welcoming, inclusive, and engaging tone. She was also open to supporting my personal goals in my career; in fact, she helped me develop, write, and publish a report in CDC's Mortality and Morbidity Weekly, so far the journal I was able to publish in which has the highest impact factor. She also helped me to submit our analysis work as a presentation in an international conference in Brisbane, Australia. She was very conscientious about keeping important files organized and secured; for instance, we have standard operating procedures, a repository of important links and files, and meeting agenda and notes.



Patrick C. Eustaquio, MD, MPH
ORISE Post-doctoral Fellow in Epidemiology and Data Management
Behavioral and Clinical Surveillance Branch
Division of HIV Prevention
National Center for HIV, Viral Hepatitis, STD, and TB Prevention
Centers for Disease Control and Prevention
1600 Clifton Road NE
peustaquio@cdc.gov

July 15, 2024

To Whom It May Concern:

I am writing this character reference for Ms. LaTweika Salmon-Trejo whom I've worked with since November 2022 while she was the DTBE Surveillance Point of Contact (POC) and I was the DTBE Field Services Branch Project Officer/Program Consultant. We work together to support the needs of one of our state grantees, her area of focus is on addressing surveillance and reporting issues while my focus has been on providing programmatic support and grant management.

As part of her regular duties, LaTweika coordinates quarterly check-in meetings with our grantees to address data discrepancies with reported case data. She always tries to accommodate the needs of grantees by utilizing doodle polls to select meeting days and times and always follows up her meetings with detailed minutes. She is very thorough in her responses to grantee questions and follows up on any surveillance issues that require further consultation with other surveillance staff. Her communication during the meetings is always upbeat and personable. She approaches these meetings with an open mind to new perspectives and is open to suggestions. All in all, I think her interactions with our grantees have been very positive and her meetings very much appreciated by our grantees.

Sincerely,

Shameer Poonja, MPH
Public Health Advisor / Project Officer
Division of Tuberculosis Elimination, Field Services Branch
National Center for HIV, Viral Hepatitis, STD, and TB Prevention
Centers for Disease Control and Prevention

latweika.salmon@icloud.com



LATWEIKA A.T.
SALMON-TREJO

EMPLOYEE DEVELOPMENT

1. GROW FRAMEWORK

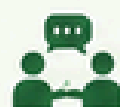
DEVELOPMENT & PROBLEM SOLVING

Best for: One-on-one meetings, performance coaching, career development, project barriers.



EXAMPLE

"I'm struggling to increase participation in our tobacco cessation classes."



Use GROW to guide the conversation and help the employee develop their own plan of action.

2. SBI + FEEDFORWARD FRAMEWORK

PERFORMANCE FEEDBACK

Best for: Giving constructive feedback after meetings, presentations, projects, or interactions.



EXAMPLE

-  During yesterday's coalition meeting (Situation), you presented the data without explaining the trends (Behavior).
-  Several partners appeared confused and asked clarifying questions afterward (Impact).
-  For the next presentation, begin with two or three key takeaways before showing the graphs (Feedforward).

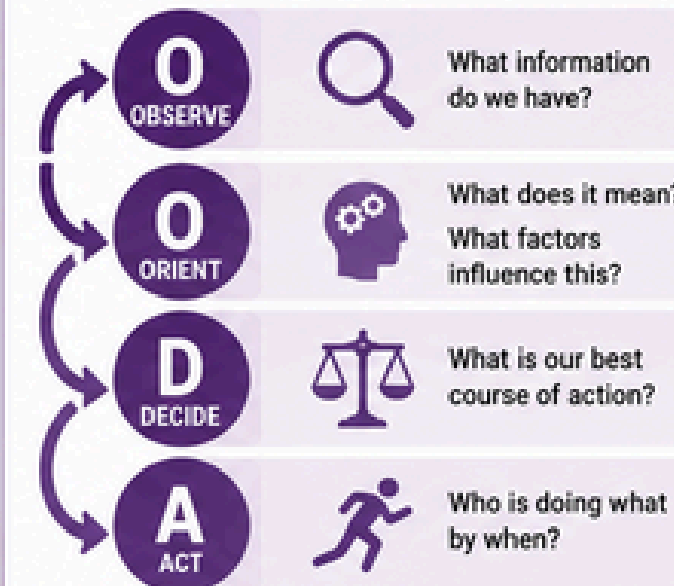


Focus on behaviors, not personality. Offer specific, actionable feedforward for future success.

3. OODA LOOP FRAMEWORK

OPERATIONAL DECISION-MAKING

Best for: Project implementation, event planning, operational challenges, rapid decision making, grant implementation.



EXAMPLE

A vendor cancels before an event.



Continuously loop back: After you act, observe the results and adjust as needed.

DATA-INFORMED DECISIONS

LED PROJECT SUPPORTING CDC'S \$27M UNITING FOR UKRAINE TB INITIATIVE BY IDENTIFYING MDR-TB RISK AMONG UKRAINIAN PAROLEES; ALIGNED FUNDING STRATEGY WITH EMERGENT PUBLIC HEALTH PROGRAM NEEDS AND INFORMED NATIONAL SCREENING PROTOCOLS THROUGH STAKEHOLDER-DRIVEN, DATA-INFORMED DECISION-MAKING.

Uniting for Ukraine – Drug Resistance Background and Recommendations

WHAT TO KNOW

The letter provides guidelines for tuberculosis screening and treatment of Ukrainian parolees, directing healthcare professionals to follow specific protocols and consult with TB experts on cases of suspected drug-resistant latent TB infection.

Dear Colleague Letters

August 1, 2022

Dear Colleagues,

Overview and Summary

This letter is in follow up to the [letter](#) of June 21, 2022 about tuberculosis (TB) screening in the Uniting for Ukraine program. In the [Uniting for Ukraine](#) program, Ukrainian parolees are required to undergo testing with a TB-specific interferon-gamma release assay (IGRA) and subsequent TB diagnostic studies as needed. Parolees are also required to be vaccinated for several other infections.

On July 14, the U.S. Department of Homeland Security extended the time period for completing the TB requirement from [14 days to 90 days](#).

The Division of Tuberculosis Elimination (DTBE), Centers for Disease Control and Prevention (CDC), has received questions about preventive treatment regimens for Ukrainian parolees who are diagnosed with latent TB infection following post-arrival testing because of reports of prevalent drug-resistant TB in Ukraine.

The data from CDC and the World Health Organization (WHO) indicate a prevalence rate of multidrug-resistant (MDR) TB among Ukrainians who had culture-confirmed TB in the United States or in Ukraine of 13% to 32.6%. These rates underlie concerns that have been raised that drug resistance could be common among persons coming from Ukraine who have latent TB infection.

Latent TB infection in Ukrainian parolees should be treated in accordance with [current guidelines](#) from the National Tuberculosis Controllers Association (NTCA) and CDC, unless drug susceptibility test results for the presumed source case support a conclusion of drug-resistant latent TB infection.

Drug Resistance Data from the CDC

For 2014–2020 in CDC's National TB Surveillance System, 122 cases of TB were reported in non–U.S.-born persons with Ukraine as the place of birth. Of these cases, 104 (85%) were culture confirmed, and 102 had susceptibility results for at least isoniazid and rifampin.

Any isoniazid resistance was reported for 24 (24%), any rifampin resistance for 13 (13%), and MDR TB for 13 (13%), which included XDR or pre-XDR TB for 3 (3%). The pre-2021 definitions for XDR and pre-XDR TB were used.

From U.S. immigration panel sites in Ukraine during 2016–2021, the results of [medical examinations](#) for 54,493 Ukrainians who were applying for immigrant or refugee admission to the United States were reported to CDC's Division of Global Migration and Quarantine: 36 applicants had Class A Active TB, for a prevalence rate of 66/100,000 persons examined. Of the 36 cases, 31 (86%) were culture confirmed: 6 (19%) were drug resistant besides MDR or XDR TB, and 7 (23%) were MDR TB, which included 2 (6%) XDR TB. Two of the five cases that were not culture confirmed were diagnosed with rapid molecular tests that indicated rifampin resistance.

The TB epidemiology of the Uniting for Ukraine parolees might be dissimilar to that of the Ukraine-born persons already in the United States or to that of the applicants at the immigration panel sites in Ukraine. Still, the data from WHO and CDC indicate that drug resistance could be common among the parolees who have latent TB infection or TB disease.

[UNITING FOR UKRAINE LINK](#)

DECISION SCIENCE | MENTORSHIP

SUPERVISED AND MENTORED JUNIOR EPIDEMIOLOGISTS IN CONDUCTING COMPLEX TREND ANALYSES ON NATIONAL SURVEILLANCE DATA. WE IDENTIFIED SIGNIFICANT POST-PRIDE EVENT SPIKES IN INCIDENCE, TRANSLATING FINDINGS INTO ACTIONABLE RECOMMENDATIONS FOR LOCAL JURISDICTIONS. OUR EVIDENCE DIRECTLY INFORMED SEVERAL HEALTH DEPARTMENTS' DECISIONS TO DEPLOY BOOTHS OFFERING FREE MPOX TESTING, VACCINATION, AND EDUCATION DURING 2024 PRIDE FESTIVITIES—STRENGTHENING EQUITY-FOCUSED OUTREACH TO DISPROPORTIONATELY AFFECTED COMMUNITIES.

Introductory paragraph

Existing concerns regarding increases in international travel, the exportation of mpox cases, and human to human transmission continue to inform public health response efforts when it comes to travel-associated diseases (1). The first suspected cases of mpox was reported in the northeast region of the U.S. on May 17, 2022. Approximately 30,174 cases have been reported as of February 8, 2023 (footnote 1). Much of the information on the outbreak and cases in the United States have centered around sexual transmission and the disproportionate impact among persons of the LGBTQ+ community. Few conclusions have been drawn on the effects large events during pride festival season may have had on mpox case counts and incidence. Because gay, bisexual, and other men who have sex with men (MSM) have made up a high proportion [Insert proportion if known for dataset or study] of mpox cases, large LGBTQ+ Pride gatherings may have contributed to changes in transmission. Exploring the role of community-inspired large events not only provides insight into early transmission patterns and trends, but also provides relevant information essential to improving health equity in marginalized persons. This study leverages mpox data in the context of the recent mpox outbreak to inform public health decision making processes using risk-based approaches, and support community outreach and education.

rates. All models included a two-week lag period (incubation period) between the event week and any anticipated change in mpox incidence rate to allow for symptom onset, diagnosis, and reporting. In all models, the evaluation period included a 2-4 week baseline period before the first event and 6 weeks of follow up after the last event. Incidence rate ratios (IRR) were estimated for the baseline trend and for the effect of events relative to the baseline trend.

A sensitivity analysis excluded cases who reported international travel in the three weeks prior to symptom onset.

week in all U.S. Census regions in the first Pride events took place in early June

no weeks later, by a slowing down of the (CI=0.52–0.93, p=0.0143).

ociated with any significant change in the as associated with a 46% immediate (I=1.14–1.87, p=0.0025) followed by a I (IRR 0.52, 95% CI=0.45–0.60,

ot associated with any significant change associated with a 127% immediate (I=1.70–3.03, p<0.0001) followed by a I (IRR 0.77, 95% CI=0.60–0.98, p=0.032).

with a 51% immediate increase in the slowing incidence rate, relative to the

South and West in the weeks before th regions, October and November events the incidence rate.

Overall, 2.3% of cases reported any international travel in the 3 weeks prior to symptom onset. Cases reporting recent international travel made up the largest proportion of weekly cases in the South (43.2%) and Northeast (30.9%) prior to the first LGBTQ+ Pride events in those regions. The proportion of cases reporting recent international travel quickly declined. Excluding cases reporting international travel had no effect on the observed association between events and incidence rates.

Discussion

Across all 4 U.S. Census regions, LGBTQ+ Pride events occurring in late June were more strongly associated with a change in mpox incidence than events occurring in early June. Where a significant association between the event and incidence was observed, the relationship was a one-time immediate increase two weeks after the event, followed by a slower increasing trend relative to the weeks prior to the event. This is likely a reflection of the interval between successive cases characterized by contact rate, clinical onset time, and other factors that contribute to the propagation of cases in an outbreak.

Events in October and November in the South and West were not associated with a change in the incidence rate trend, which had begun to decline.

Heitz, Elizabeth (CDC/DDPHSS/ NCHS/DAE)

Plan to cut this down/revise

While writing this, I think it might be clearest to drop Tables 1 and 2 and replace with a

Reply

Salmon-Trejo, LaTweika (CDC/ DDID/NCHHSTP/DTE)

We may want to move this to the discussion or introduction since it's not explicitly seen in our results. Or perhaps discuss the baseline period (mean weekly case counts, travel, Irate)

Heitz, Elizabeth (CDC/DDPHSS/NCHS/DAE)

February 09, 2023, 5:12 PM

Heitz, Elizabeth (CDC/ DDPHSS/NCHS/DAE)

Can do, the trends (baseline, post Event 1, post Event 2) are currently in Table 2. If we re-org, the baseline trend can go in the table with the other event effect estimates since it's relevant to interpreting the IRR

February 09, 2023, 5:23 PM

Reply

Heitz, Elizabeth (CDC/DDPHSS/ NCHS/DAE)

678 cases between weeks starting May 15 and December 4

Salmon-Trejo, LaTweika (CDC/DDID/NCHHSTP/DTE)

Interesting, I'm trying to think of a way to incorporate this into the introduction to help set the stage that although international travel was reported early in

Reply

Discussion

Across all 4 U.S. Census regions, LGBTQ+ Pride events occurring in late June were more strongly associated with a change in mpox incidence than events occurring in early June. Where a significant association between the event and incidence was observed, the relationship was a one-time immediate increase two weeks after the event, followed by a slower increasing trend relative to the weeks prior to the event. This is likely a reflection of the interval between successive cases characterized by contact rate, clinical onset time, and other factors that contribute to the propagation of cases in an outbreak.

Events in October and November in the South and West were not associated with a change in the incidence rate trend, which had begun to decline.

The data here suggest that sharp increases in the incidence rate of mpox cases associated with LGBTQ+ Pride events ranged from 46% to 127% and immediately occurred 2 weeks later. Public health efforts have diligently prioritized this population working to address health inequities, stigma, and reduce the disproportionate effects of mpox. However, the current findings provide evidence for community-inspired opportunities to impact events that may potentially alter mpox transmission levels. This information should guide public health agencies in novel collaborations centered around event-based outreach and education on harm reducing actions, safe practices, and flexible modifications in behavior that are custom and respectful. A recent survey that reviewed the strategies adopted by gay, bisexual, and MSM to prevent mpox virus transmission showed that 57.4% did not change behavior their of going to sex venues or events, and 64.4% did not change behavior to visit social events with close contacts, such as dance parties or raves (9).

Vaccination remains a key strategy to prevent severe mpox complications that may require medical attention, hospitalization, and death(5,7). One novel strategy to support communities at higher risk for exposure to mpox virus includes the continued expansion on partnerships with local jurisdictions at community events, particularly, events where marginalized populations with complex health inequities potentially gather. Improvements in vaccination among Black and Hispanic persons were observed by increasing the access to vaccines through community-lead events to focus on health equity(6). The JYNNEOS vaccine has demonstrated effectiveness at reducing the risk of mpox disease and shown that unvaccinated person were 14 times as likely be infected with mpox virus over those who have received at least a single dose of the two-dose regimen(5,7).

The findings in this report are subject to at least four limitations. First, data from this report does not address domestic travel that may account for persons diagnosed with mpox that traveled to another state or U.S. Census region to attend an event. Second, this type of regression analysis does not account for other events or unmeasured factors, such as, how many people explicitly attended the events or other activities surrounding the events. Third, the timing of June events occurred during a time when community spread of mpox in the US was low prior to the outbreak, this circumstance may not apply to future outbreaks and may limit the generalizability of outcomes. October-November events offer additional information here: in the context of decreasing incidence rates, large events did not appear to have a significant impact on incidence which may be due to public health counter measures performed e.g., local vaccination campaigns prior to the timing of events.

PARTNERSHIP DEVELOPMENT



Implementation Plan Non-Qualified County

Funding Amount: \$727,545 – FY 24-25
Counties of service: LEON

Core Strategy (From Schedule A)	Allowable Use (From Schedule B)	Service Provider/Vendor	24-25 Contract amount	25-26 Projected	26-27 Projected
b. Medication-Assisted Treatment ("MAT") Distribution and other Opioid Related Treatment (B1, B4)	A. Treat Opioid Use Disorder A1, A2, A3, A6, A7	Disc Village	\$0	\$400,000	\$0
	I. Leadership, Planning and Coordination II. Research III. Administrative Support for Program Operations, data collection, recordkeeping, reporting, monitoring, surveillance, and evaluation of programs and strategies described in the opioid abatement strategy list.	Leon County	\$36,377* *admin allowance from NWFHN	\$0	\$0
	G. Prevent Misuse of Opioids G1, G2, G8 Support efforts to discourage or prevent misuse of opioids through evidence-based or evidence-informed programs or strategies.	Disc Village	\$41,168	\$0	\$0

COUNTY/CITY IMPLEMENTATION PLANS



	B. Support People in Treatment and Recovery B1, B2, B4, B7, B8 C. Connect People Who Need Help to the Help they Need Support people in recovery from OUD and any co-occurring SUD/MH conditions through evidence-based or evidence informed programs or strategies.	Disc Village	\$0	\$25,000	\$0
	D. Address the Needs of Criminal Justice Involved Persons D1 Address the needs of persons with OUD and any co-occurring SUD/MH conditions who are involved in, or are transitioning out of the criminal justice system through evidence-based or evidence-informed programs or strategies.	Disc Village	\$50,000	\$50,000	\$0

LEVERAGED 50+ COUNTY/CITY OPIOID IMPLEMENTATION PLANS FROM QUARTERLY OPIOID ABATEMENT REPORTS TO CREATE LEGLISTATIVE REPORTS FOR THE OFFICE OF THE GOVENOR AND SUGGESTED PROGRAMMATIC IMPROVEMENTS WHILE PERFORMING COMPREHENSIVE EVALUATION FOR PROGRAM PLANNING



B. Medication-Assisted Treatment ("MAT") Distribution and other Opioid Related Treatment (B2.) Provide education to school-based and youth-focused programs that discourage or prevent misuse	G. PREVENT MISUSE OF OPIOIDS (G9) School-based or youth-focused programs or strategies that have demonstrated effectiveness in preventing misuse of prescription medications and seem likely to be effective in preventing the uptake and use of opioids.	Leon County Sheriff's Office	\$25,000	\$0	\$0
	D. ADDRESS THE NEEDS OF CRIMINAL JUSTICE INVOLVED PERSONS (D4) Provide evidence-informed treatment, including MAT, recovery support, harm reduction, or other appropriate services to individuals with OUD and any co-occurring SUD/MH conditions who are incarcerated in jail or prison, parole, are under community corrections supervision, or are in re-entry programs or	Leon County Sheriff's Office	\$100,000	\$0	\$0



- Scope of Work and Desired Outcome:
- Contract with Disc Village, Inc. for intensive outpatient or inpatient treatment including medication assisted treatment (MAT), group therapy sessions, etc. to provide access to all citizens regardless of insurance. **Desired Outcome:** Reduce the number of untreated individuals with OUD diagnosis, any co-occurring SUD or mental health (SUD/MH) and overdoses in the community.
 - County staff will be responsible for day-to-day administration of the program to include data compilation, analysis, and development of annual reporting as required by the Opioid Abatement Council.
 - Engage local stakeholders to enhance referrals and access to substance abuse treatment and education to reduce instances of opioid use and overdoses. **Desired Outcome:** Educate the public on OUD and the symptoms of OUD observable in family and friends as well as treatment options available in the community.
 - Provide assistance with access to support services such as housing, transportation, education/vocational training, job placement assistance, and childcare. **Desired Outcome:** Remove barriers for citizens so that their primary focus is on treatment.
 - The Leon County Sheriff's Office will provide training for School-Based Personnel including School Resource Deputies (SRD) and the Council on the Status for Men and Boys (CSMB) on Opioid use prevention and misuse information and how best to deliver that message to youth they encounter daily. **Desired Outcome:** Reduction in youth that use or experiment with opioids.
 - The Leon County Sheriff's Office will provide 12 weeks of outpatient-level substance use disorder treatment and prevention to individuals incarcerated at the Leon County Detention Facility with opioid addiction in accordance with vendor contract terms. The number of cohorts and individuals served annually will be contingent upon available funding. **Desired Outcome:** Treat and prevent opioid use and addiction that contributes to incarceration through treatment and peer support, leading to more successful outcomes and reduced recidivism.

STAKEHOLDER ENGAGEMENT



Council Members

Attorney General James Uthmeier
Chair

Sheriff Dennis M. Lemma
Delegate Chair

Secretary Taylor Hatch
Vice Chair

Amy Romhausen
Governor's Appointee

Major Todd M. Shear
Senate President's Appointee

Sheriff Robert A. Hardwick
Office of the Speaker's Appointee

Commissioner Chris Dougherty
Florida Association of Counties

Commissioner Lee Constantine
Florida Association of Counties

Commissioner Kathleen Peters
Florida Association of Counties

Vice Mayor Kimberly Glas-Castro
Florida League of Cities Appointee

Vice Mayor Julian Canaballo
Florida League of Cities Appointee

Statewide Council on Opioid Abatement

Virtual Meeting Minutes
March 11, 2025
2:00 P.M. – 4:00 P.M. EST

Welcome/Call to Order
The meeting was called to order at 2:00 PM Delegate Chair, Sheriff M. Lemma. Roll call was taken by LaDarius Gammage.

Attendance Summary
Sheriff Lemma, Delegate Chair
Attorney General James Uthmeier, Chair
Assistant Secretary Erica Floyd Thomas on behalf of Secretary Taylor Hatch, Vice Chair
Amy Romhausen, Governor's Appointee
Major Todd Shear, President's Appointee
Tara Wildes on behalf of Sheriff Robert Hardwick, Office of the Speaker's Appointee
Commissioner Lee Constantine, Florida Association of Counties
Commissioner Kathleen Peters, Florida Association of Counties
Vice Mayor Kimberly Glas-Castro, Florida League of Cities Appointee
Vice Mayor Julian Canaballo, Florida League of Cities Appointee
Todd Hockett, Subject Matter Expert
Laura Viafara Ray, Subject Matter Expert
Dr. Samantha Thompson, Subject Matter Expert

Opening Remarks
Sheriff Dennis Lemma opened the March 11, 2025, meeting by welcoming council members, staff, and public attendees, expressing gratitude for their continued dedication to the Council's work. Sheriff Lemma acknowledged the postponement of the originally scheduled February meeting, offering a formal apology. The reason, he explained, was his invitation to testify before the U.S. Senate Special Committee on Aging, chaired by Senator Rick Scott where he presented a comprehensive review of Florida's opioid epidemic, and the coordinated statewide response led by the Opioid Abatement Council. Sheriff Lemma congratulated Secretary Shevaun Harris on her appointment as Secretary of the Agency for Health Care Association and welcomed Secretary Taylor Hatch to the Department of Children and Families leadership and the Council. Attendance was taken and a quorum was established.

Approval of Previous Meeting Minutes
Motion passed to approve minutes from the October 30, 2024, meeting.
Motion: Commissioner Kathleen Peters
Second: Major Todd Shear

Attorney General James Uthmeier, Council Chair
Direction of the Statewide Council on Opioid Abatement
Attorney General Uthmeier commended the Council's impressive progress and stated that its performance has exceeded expectations laid out when the Council was created by executive order. Attorney General Uthmeier outlined several key principles and goals that will guide his leadership of the Council:

- Access to Treatment: Develop strategies to ensure every Floridian has access to high-quality treatment.



Statewide Council on Opioid Abatement

- Youth Protection and Prevention from Opioid Exposure: Emphasized the importance of protecting children from the dangers of opioid misuse and vowed that his administration would center youth in its prevention messaging and increase efforts to restrict youth access.
- Support for First Responders and Healthcare Providers: He committed to prioritizing the needs of front-line personnel by ensuring they have the tools and support to effectively respond to overdoses and related crises.
- Public Education and Awareness: Stressed the need to expand public education efforts, including use of PSAs and multimedia campaigns to raise awareness about the risks of opioid misuse and the availability of treatment resources.

Fiscal Year 2025 Citrus County Opioid Settlement Funds
Presenter: Todd Hockett, Department of Health Citrus & Marion; Chair, Citrus Opioid Task Force
Todd shared the FY 24-25 Citrus County Opioid Settlement Funds plan. The plan included:

- LSF Health Systems partnership to oversee fund allocation.
- Establish tracking mechanisms for program effectiveness, with an annual progress review meeting.
- Prioritize "one and done" projects to ensure sustainability as funding decreases annually.
- Highlighted projects included:
 - CORE team expansion
 - SUD treatment services via Langley Health
 - Recovery housing by Zero Hour Life Center
 - Youth prevention through school-based programs

City of Jacksonville Strategic Use of Opioid Settlement Funds
Presenter: Laura Viafara Ray, Program Coordinator, Jacksonville Fire & Rescue
Jacksonville's Opioid Settlement Funds Strategic Approach includes:

- Administered through Jacksonville Fire and Rescue Department
- The grant program prioritizes prevention, treatment, and recovery support.
 - Implement mobile outreach programs to address gaps in services, particularly in high-risk zip codes.
 - After-school programs to support healthy decision-making attitudes and skills to prevent substance misuse.
 - Strong data tracking and site monitoring

The ATRAC Program
Presenter: Dr. Samantha Thompson, Jacksonville ACE Medical ATRAC Program
Jacksonville ACE Medical ATRAC Program includes:

- Mobile treatment services to underserved communities in Jacksonville.
- Expand Remote Life Health Support (RLH) program to track patients' health data in real-time.
- Conduct opioid prevention education sessions at middle and high schools, including Narcan training.
- Host community health fairs to increase outreach and engagement.

Highlighted youth training, community events, and gaps in health insurance access.

Statewide Opioid Recovery Efforts
Presenter: Erica Floyd Thomas, Assistant Secretary for the Office of Substance Abuse and Mental Health
The Assistant Secretary provided high-level overview of opioid abatement data for the state of Florida.

- Florida saw a 14% decrease in opioid-related deaths in Florida from 2021 to 2023.
- Major drivers:
 - Overdose Prevention Programs increased naloxone access.



Statewide Council on Opioid Abatement

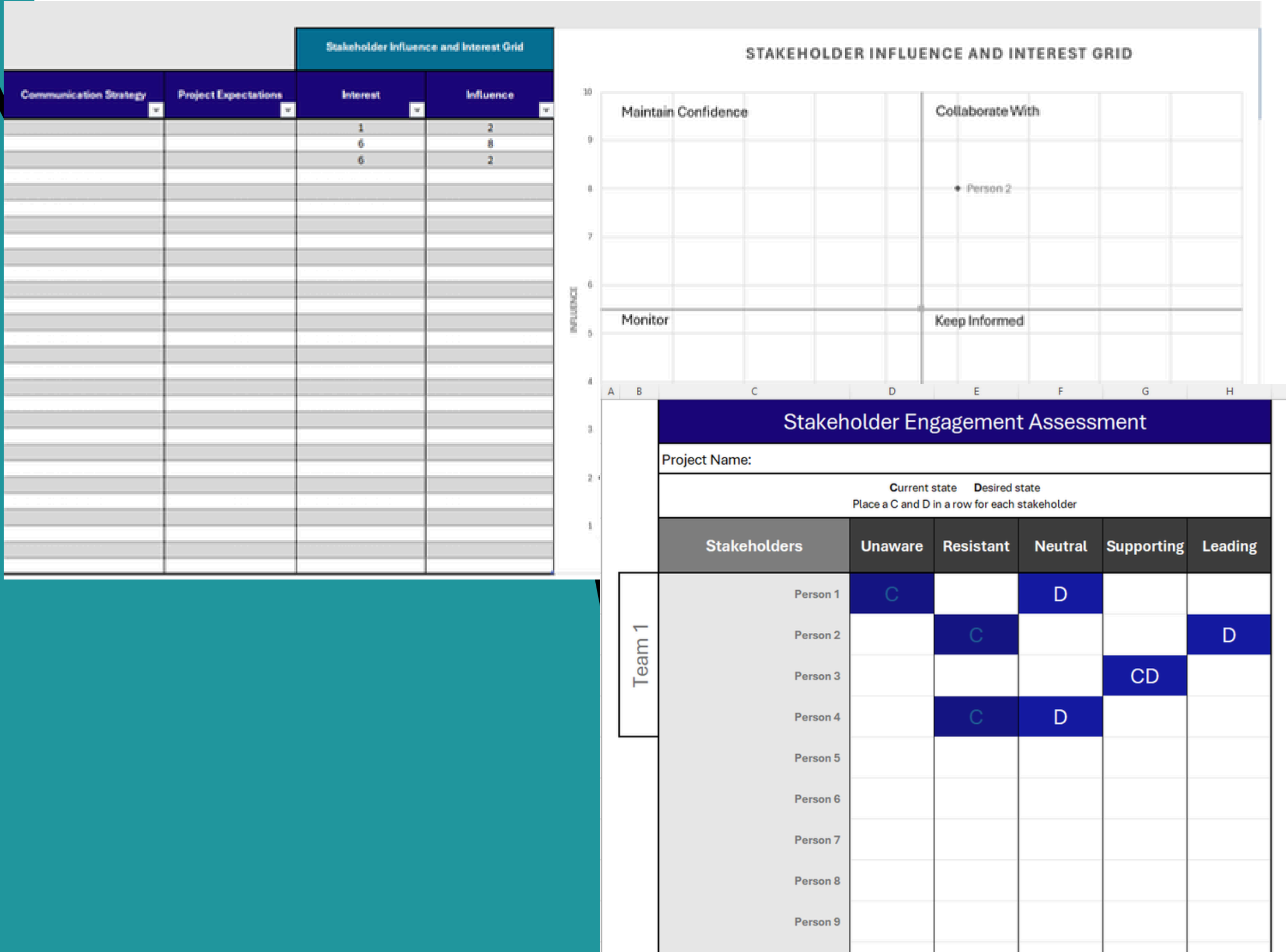
- CORE Network expanded to 30 counties: 96.3% population coverage by the end of Fiscal Year 2024-2025.
- Continued support for Medication-Assisted Treatment programs; over 18,000 individuals received MAT, 45% initiated in treatment settings.
- 33% increase in certified peer recovery workforce.

Open Forum
Council Member Commissioner Kathleen Peters proposed a statewide opioid education campaign, modeled after the "Truth" tobacco initiative. It was confirmed that active efforts are underway via:

- The "Fact Your Future" campaign and toolkit.
- Multiple grants awards.
- Statewide prevention messaging.

Closing Remarks
Sheriff Lemma ended the meeting by calling on the Council to remain laser-focused on saving lives, strengthening communities, and ensuring every dollar of settlement funding yields measurable results. He thanked everyone again for their participation and officially adjourned the meeting at 3:54 PM.

STAKEHOLDER ENGAGEMENT



I DEVELOPED A STRUCTURED EXCEL TOOL TO EVALUATE STAKEHOLDER ENGAGEMENT, INFLUENCE, AND INTEREST ACROSS PUBLIC HEALTH INITIATIVES.

THE TOOL INTEGRATES THREE COMPONENTS—A STAKEHOLDER REGISTER, INFLUENCE-INTEREST GRID, AND ENGAGEMENT ASSESSMENT—TO CLASSIFY ENGAGEMENT LEVELS.

IT INCLUDES BUILT-IN DEFINITIONS, AUTOMATED CONDITIONAL FORMATTING, AND A USER GUIDE TO ENSURE CONSISTENT APPLICATION. THIS FRAMEWORK SUPPORTS EVIDENCE-BASED ENGAGEMENT PLANNING, ALIGNING EPIDEMIOLOGIC MAPPING WITH ECONOMIC DECISION MODELS TO STRENGTHEN COLLABORATION AND ACCOUNTABILITY IN PUBLIC HEALTH PROGRAMS.

DEVELOPED REPORTS

Travel-Related Illnesses

number of reportable disease and condition cases identified in people with exposures in Haiti more than doubled from the previous year (114 cases identified in 2009, 253 cases in 2010, 111 cases in 2011). Another contributing factor was a change in the giardiasis case definition in 2010, which allowed for asymptomatic infections to be counted as confirmed cases. Asymptomatic infections are commonly identified as part of refugee health screening. In 2011, the case definition reverted back to requiring symptoms to meet the surveillance case definition. As a result, there was a large spike in giardiasis cases reported in 2010 relative to other years.

Over the past 10 years, 71% of cases with travel-related illnesses were exposed outside the U.S., though this varies annually from a low of 65% in 2007 to a high of 81% in 2010 (Figure 1). Generally, 1-2% of cases with travel-related illnesses were exposed in U.S. territories each year. The number and percentage of cases exposed in U.S. territories increased in 2013, 2014, and 2016 due to widespread transmission in Puerto Rico of dengue fever, chikungunya fever, and Zika fever, respectively.

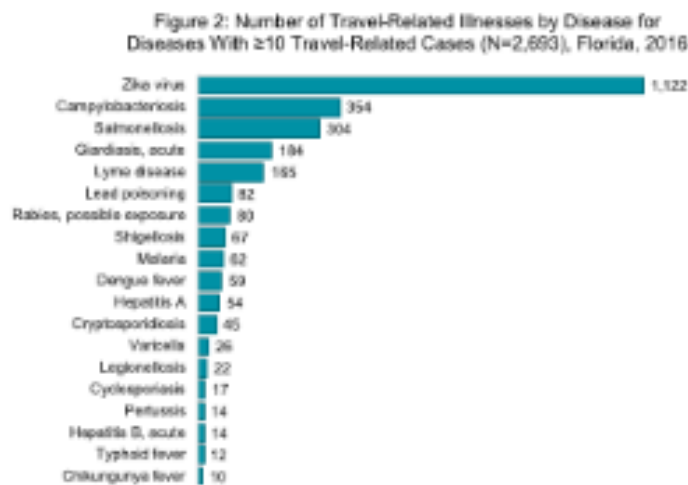


Note that 19 cases were excluded from Figure 1 because they fell into more than one exposure category (e.g., exposure may have occurred in another U.S. territory or outside the U.S.).

Summary of 2016 Data

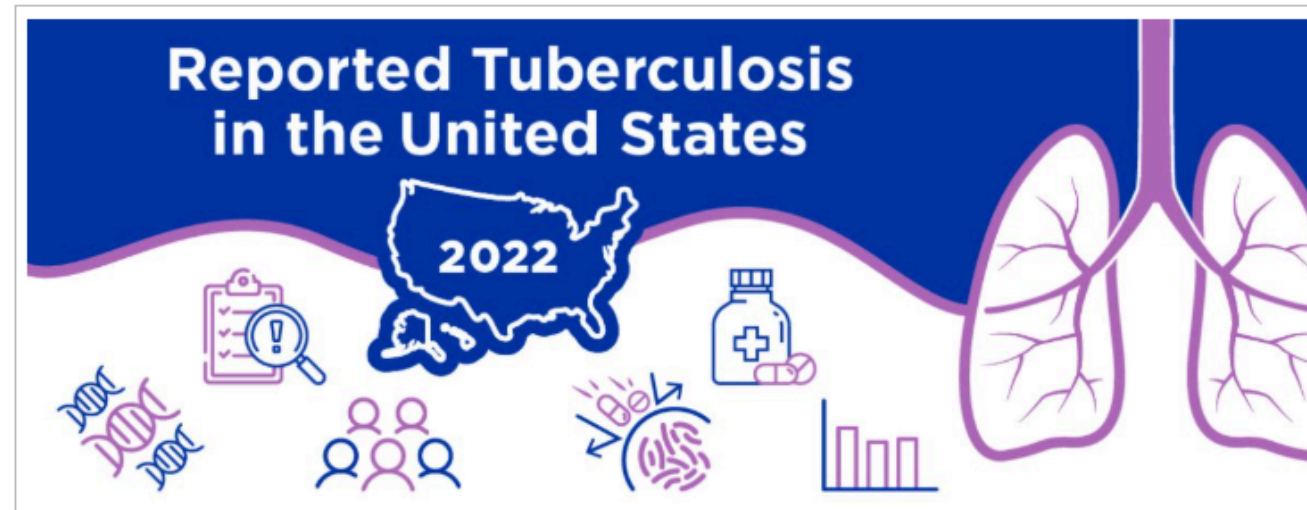
Nineteen diseases accounted for 98% of the 2,756 cases with travel-related illnesses reported in 2016 (Figure 2). There were <10 cases with travel-related illnesses reported for each of 22 diseases which were excluded in the subsequent summaries here based on the low number of cases that were travel-associated.

Areas of endemicity contribute to travel-related infection patterns and vary by disease; some diseases are endemic in other parts of the U.S., and others are more commonly seen in other U.S. territories or countries. However, travel-related infection patterns can also reflect travel patterns among people. Illnesses acquired in other southern U.S. states are likely to be identified in Florida residents due to proximity and frequency of travel. Florida has a large Hispanic population, and travel between Florida and Central and South America, Mexico, and the Caribbean is very common. The large numbers of travelers to and from these areas contribute to the number of cases associated with travel-related illnesses reported in Florida.



Reported Tuberculosis in the United States, 2022

[Print](#)



TB incidence appears to be gradually returning to pre-pandemic levels, but ongoing effects of the pandemic persist.

In 2022, reported TB cases and incidence rates (number of TB cases per 100,000 persons) in the United States increased for the second year in a row, but remained lower than levels reported prior to the COVID-19 pandemic.

Anyone can get TB, but some people are at greater risk of TB than others.

TB disproportionately affects some [groups](#) depending on various demographic, health, and social factors.

Birth outside of the United States remains a key risk factor for TB, with a TB incidence rate 17.1 times higher among non-U.S.-born persons compared with U.S.-born persons.

Successful completion of treatment for TB disease is important to cure TB disease,

Reported Tuberculosis in the United States, 2023

[Data Tables](#) [About the Data](#) [Executive Commentary](#) [Communication Resources](#) [VIEW ALL >](#)



[View Larger](#)



[View Larger](#)

About the Data

In 2023, reported U.S. tuberculosis disease cases and incidence rates increased for a third year.

[Learn More >](#)

2023 REPORTED TUBERCULOSIS IN THE UNITED STATES

For Professionals



Data Tables

Access data tables with information on cases of tuberculosis disease reported to CDC since 1993.



Executive Commentary

CDC describes cases of tuberculosis disease in the United States reported in 2023.

Learn more

- National Data
- Reporting Area Data
- Risk Factors
- Demographics
- Tuberculosis Treatment and Case Outcomes
- Drug-Resistant Tuberculosis Disease

Florida

FLU REVIEW

2017-18 Season

Summary

Week 48: November 26 – December 2, 2017

State influenza and influenza-like illness (ILI) activity:

- Influenza activity has been steadily increasing over the last few weeks. In week 48:
 - Visits to EDs among pregnant women increased notably and was well above levels observed during the previous two flu seasons at this time.
- Five outbreaks were reported: (3) influenza, (1) ILI, and (1) respiratory syncytial virus (RSV); 32 outbreaks of influenza and ILI have been reported since the start of the 2017-18 season. More outbreaks have been reported so far this season than in previous seasons at this time, which may be an early indication of a more severe influenza season.
- All regions are currently in RSV season. RSV activity remains high and well above previous seasons (see page 12).

National influenza activity:

- Influenza activity has continued to increase and was above the national baseline for the first time this season. The Centers for Disease Control and Prevention (CDC) noted that several flu activity indicators were higher than typically observed for this time of year.
- As in Florida, influenza A (H3) has been the most common influenza subtype reported to the CDC. The CDC has continued to report extensive genetic diversity in the HA genes of influenza A (H3) viruses submitted to CDC for phylogenetic analysis.

Immunizations and prevention:

- Flu vaccines can vary in effectiveness from season to season but they continue to be the best way to prevent influenza infection and serious influenza complications.
- Interim vaccine effectiveness (VE) estimates for Australia's 2017 influenza season revealed very low VE estimates for influenza A (H3) viruses. VE estimates were higher for influenza A 2009 (H1N1) viruses (50%) and influenza B viruses (57%).
- VE estimates for the United States are not currently available, and while influenza A (H3) viruses have been most common so far this season, it is still unknown what viruses will predominate this season.

Treatment:

- The CDC recommends the use of antiviral treatment as soon as possible for all persons with suspected influenza who are at higher risk for complications: children <2 years, adults age ≥65, and pregnant women, and those with underlying medical conditions; administer treatment within 48 hours of illness onset.

Weekly State Influenza Activity

Regional

For more information see page 2 >

Predominately Circulating Strain

A (H3)

For more information see page 7 >

Influenza and ILI Outbreaks

Reported as of 12/2/2017

Outbreaks

Week 48 Outbreaks (5)

0 Outbreaks

1-2 Outbreaks

3-4 Outbreaks

5+ Outbreaks

For more information see page 5 >

County Influenza Activity

County Activity (N)

No Activity (0)

Wild Activity (1-2)

Moderate Activity (3-4)

Elevated Activity (5-6)

Unknown (0)

For more information see page 4 >

Table of Contents on the next page >

[Q SEARCH](#)

DATA MANAGEMENT

LED DEVELOPMENT OF NATIONAL TUBERCULOSIS SURVEILLANCE SYSTEM DATA DICTIONARY AND DATA REFERENCE GUIDE DOCUMENTS

8120

RUSCOMMUNO

	A	B	C	D	E	F	G	H	I	J	K	L	M
	Categories	Current SAS Variable Name	Field Description	V1	V2	V3	V3 States	Calculated/ Derived	Data Type	Displayed Values	Value Description	Notes	Subsetting/ Analytic Considerations
1			<u>Report date</u> : Full date Month, day, and year that a reporting area first became aware that this person might have TB		01	01	active	—	date	MMDDYYYY	2-digit month, 2-digit day, and 4-digit year	• use update, 'V1' • 2-digit day is replaced with '01' when missing	
2	Administrative	REPORTDATE											
3			<u>Report date</u> : Month/year Month and year that a reporting area first became aware that this person might have TB	05	01	01	active	Yes	char	YYYYMM	4-year used only during update	None. Restricted data. Update	
4	Administrative	RPTDATE											
5			<u>Report date</u> : Year Year that a reporting area first became aware that this person might have TB	05	01	01	active	Yes	char	YYYY			
6	Administrative	RPTYEAR											
7			<u>Report date</u> : Month Month that a reporting area first became aware that this person might have TB	05	01	01	active	Yes	char	MM			
8	Administrative	RPTMONTH											
9			Month, day, and year the RCVT was initially submitted to the CDC by the reporting area	03	02		discontinued	—	date	MMDDYYYY			
10	Administrative	DATESUBM											
11			<u>Count date</u> : Full date Month, day, and year the reporting area verified that the case met the TB case definition		06		inactive	Yes	date	MMDDYYYY			
12	Administrative	COUNTDATE											
13			<u>Count date</u> : Month/year Month and year the reporting area verified that the case met the TB case definition	06	06		inactive	Yes	char	YYYYMM			
14	Administrative	CNTDATE											
15			<u>Count date</u> : Year Year the reporting area verified that the case met the TB case definition	06	06		inactive	Yes	char	YYYY			
16	Administrative	YEAR											
17			Week of the epidemiologic year to which the Nationally Notifiable Diseases Surveillance System case report is assigned			02	active	—	char	##			
18	Administrative	MAWVWEEK											

AbbreviationsDictionaryCounty CodesState CodesCountry CodesDetailed RaceSite of Disease CodesSpecimen Source CodesUnits of Measure

Introduction to the NTSS Data Dictionary:

The NTSS Data Dictionary has been updated to an Excel file format. This new format is designed to provide comprehensive information on variables found in the frozen NTSS dataset across three RVCT versions. The goal of this approach is to create a dictionary that is easier to use but far more detailed; to make analyses easier to plan and execute for those with varying levels of experience and knowledge working with NTSS data. This spreadsheet cannot be edited, but each tab can be sorted and filtered. A Data Reference Guide is currently in development as a supplementary resource to be used in conjunction with the data dictionary, and provide additional technical notes and context surrounding data variables.

This Data Dictionary has been designed to align with the NTSS SAS datasets. The 3 types of NTSS SAS datasets are the 1) standard frozen analytic dataset, 2) restricted frozen analytic dataset, and the 3) production dataset. The standard and restricted frozen analytic datasets contain only verified, counted, cases of TB reported to NTSS. The production dataset contains all cases submitted to CDC.

TAB: COLUMN DESCRIPTIONS

Describes the content of each column in the *Restricted Variables* and *Dictionary* tabs.

TAB: ABBREVIATIONS

Contains a list of common CDC and Division of Tuberculosis Elimination (DTBE) abbreviations.

TAB: DICTIONARY - ABBREVIATED

Contains information for each variable, but only a limited number of columns. The information provided is identical to the *Dictionary-Expanded* tab; however, it is streamlined for quick reference. Details of each column are outlined in the *Column Descriptions* tab.

TAB: DICTIONARY

Contains information for each variable and indicates the version of the RVCT that include the data element, the variable name and any name changes, descriptions of each variable, the available response options, and data type and response option displayed values. Details of each column are outlined in the *Column Descriptions* tab.

TAB: RESTRICTED VARIABLES

List of production variables and restricted variables that are not included the general use SAS analytic files.

Production variables are used for data management (e.g., clean up rules) or are variables not typically utilized for analyses of verified, counted, cases of TB disease.

Restricted variables are those containing potentially identifiable information for persons represented in the NTSS dataset. These data are protected through strict data security standards as well as an Assurance of Confidentiality. Collected for the purposes of data management, restricted variables are not included in the general use analytic files, but are archived in a restricted access version of the file. Under limited circumstances, these variables can be considered for analytic purposes if a strong enough justification can be provided to the Analytic Steering Committee, or ASC, during the application process.

TAB: COUNTY CODES

Technical Introduction

Column Descriptions

Abbreviations

Dictionary

County Codes

State Codes

Country Codes

Detailed Race

Site of Disease Codes

Specimen Source Codes

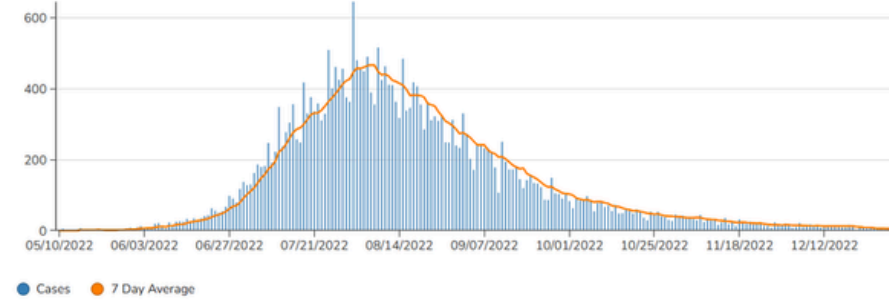
DATA ANALYSIS

Trends of clade II mpox cases reported to CDC by date*

Select a year from the filter below to update the visualization

2022

Apply Clear Filters



TABLES AND FIGURES

Table 1. Average weekly mpox case counts and incidence rates per 100,000 residents in the weeks preceding and following large events, May–December 2022, by US Census Regions

Region		Baseline (pre-event)			Post Event 1			Post Event 2					
		Dates (week starting)	Mean Weekly Case Count	Mean Weekly Incidence Rate	Percent of Cases Reporting International Travel	Dates (week starting)	Mean Weekly Case Count	Mean Weekly Incidence Rate	Percent of Cases Reporting International Travel	Dates (week starting)	Mean Weekly Case Count	Mean Weekly Incidence Rate	Percent of Cases Reporting International Travel
Midwest		05/15-06/19	17.83	0.03	9.35%	08/28-07/24	197.4	0.29	2.03%	–	–	–	–
Northeast		05/15-06/05	13.75	0.02	30.90%	08/12-07/03	211.8	0.37	10.50%	07/10-08/07	673.4	1.18	1.31%
South	June events	05/15-06/05	9.25	0.01	43.20%	08/12-06/26	122.7	0.1	13.00%	07/03-07/31	873.8	0.68	3.43%
South	October-November events	09/04-10/09	398.2	0.31	0.72%	10/16-11/06	120.8	0.09	1.04%	–	–	–	–
West	June events	05/15-06/19	30.67	0.04	14.70%	08/28-07/24	451.8	0.57	2.39%	–	–	–	–
West	October-November events	10/02-11/06	94.83	0.12	1.41%	11/13-12/04	33.5	0.04	1.49%	–	–	–	–
0.00 Quantity more than zero but less than 0.05													

Table 2. Trends in weekly mpox incidence in the weeks preceding and following large events, May–December 2022, by US Census Regions

Region		Baseline Trend (IRR) (95% CI)	p	Post Event 1 Trend (IRR) (95% CI)	p	Post Event 2 Trend (IRR) (95% CI)	p
Midwest		1.92 (1.46, 2.54)	<.0001	1.34 (0.88, 2.03)	0.1732	–	–
Northeast		2.11 (1.19, 3.75)	0.011	1.95 (0.84, 4.54)	0.1228	1.02 (0.43, 2.41)	0.9874
South	June events	2.01 (1.11, 3.65)	0.0221	1.66 (0.69, 3.98)	0.257	1.27 (0.51, 3.17)	0.6072

Table 3. Association between mpox incidence and large events, May–December 2022, by US Census Regions

Region		Step Change Post Event 1 (IRR) (95% CI)	p	Trend Change Post Event 1 (IRR) (95% CI)	p	Step Change Post Event 2 (IRR) (95% CI)	p	Trend Change Post Event 2 (IRR) (95% CI)	p
Midwest		1.44 (0.85, 2.45)	0.177	0.70 (0.52, 0.93)	0.0143	–	–	–	–
Northeast		1.00 (0.42, 2.35)	0.9976	0.92 (0.52, 1.65)	0.7876	1.46 (1.14, 1.87)	0.0025	0.52 (0.45, 0.60)	<.0001
South	June events	2.12 (0.76, 5.93)	0.1528	0.83 (0.45, 1.50)	0.5323	2.27 (1.70, 3.03)	<.0001	0.77 (0.60, 0.98)	0.032
South	October-November events	1.05 (0.90, 1.21)	0.5594	0.98 (0.93, 1.04)	0.588	–	–	–	–
West	June events	1.51 (1.05, 2.18)	0.0258	0.80 (0.66, 0.98)	0.0272	–	–	–	–
West	October-November events	1.22 (0.76, 1.95)	0.4042	0.95 (0.79, 1.14)	0.6009	–	–	–	–

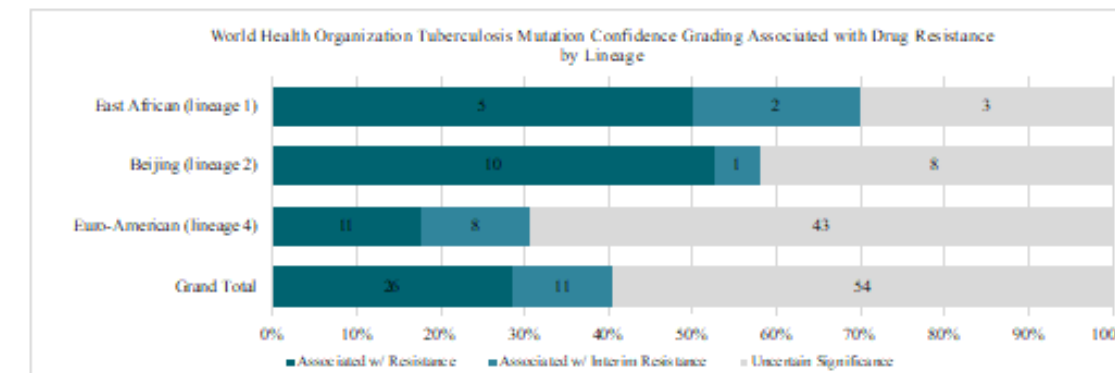
IRR = incidence rate ratio

Table 2. Adjusted Hazard Ratios from Cox Regression Models for Time to Sputum Culture Conversion at 30, 60, and 90 Days

Variables	TTSC at 30 Days			TTSC at 60 Days			TTSC at 90 Days		
	taHR (95% CI)	p-value	Delayed Sputum Conversion	taHR (95% CI)	p-value	Delayed Sputum Conversion	taHR (95% CI)	p-value	Delayed Sputum Conversion
Unadjusted Mutation Status									
Mutation-Undetected	Reference			Reference			Reference		
Mutation-Detected	0.50 (0.29-0.87)	0.013	50%	0.53 (0.37-0.74)	<.0001	47%	0.70 (0.53-0.93)	0.012	30%
Race/Group									
White, Non-Hispanic	Reference			Reference			Reference		
Asian, Non-Hispanic	26.69 (3.54-201.38)	0.001		17.23 (4.19-70.91)	<.0001		17.82 (4.62-68.81)	<.0001	
Black, Non-Hispanic	1.59 (0.75-3.14)	0.246		1.67 (1.09-2.56)	0.115		1.33 (0.93-1.91)	0.116	
Hispanic	1.35 (0.26-7.07)	0.720		0.66 (0.21-1.99)	0.437		0.7 (0.28-1.72)	0.437	
Birth Region									
North America	Reference			Reference			Reference		
Asia	0.14 (0.02-0.83)	0.030	86%	0.11 (0.03-0.41)	0.001	89%	0.11 (0.03-0.40)	0.001	89%
Central & South America	6.31 (1.38-28.73)	0.017		5.15 (1.04-4.43)	0.006		4.65 (1.66-12.98)	0.021	
Caribbean	1.27 (0.54-3.01)	0.588		1.47 (0.83-2.29)	0.178		1.82 (1.09-3.03)	0.003	
Age Group (yr)									
Ages 0-17	0.66 (0.18-2.45)	0.530		1.6 (0.67-3.83)	0.287		1.80 (0.78-4.12)	0.168	
Ages 18-44	Reference			Reference			Reference		
Ages 45-64	0.84 (0.47-1.50)	0.549		0.87 (0.59-1.29)	0.497		0.79 (0.56-1.10)	0.164	
Ages 65+	1.3 (0.56-3.00)	0.546		1.07 (0.61-1.88)	0.803		0.87 (0.54-1.42)	0.583	
Sex									
Male	Reference			Reference			Reference		
Female	0.54 (0.30-0.98)	0.042	46%	0.66 (0.45-0.97)	0.036	34%	0.75 (0.54-1.04)	0.036	
Four Drug Therapy									
Yes	Reference			Reference			Reference		
No	2.59 (0.53-12.65)	0.259		3.70 (1.15-11.93)	0.029		3.72 (1.20-11.54)	0.023	
Lineage									
East African (lineage 1)	Reference			Reference			Reference		
Beijing (lineage 2)	0.24 (0.09-0.64)	0.005	76%	0.35 (0.20-0.64)	0.001	65%	0.28 (0.17-0.48)	<.0001	72%
Euro-American (lineage 4)	1.29 (0.44-3.78)	0.638		0.67 (0.34-1.32)	0.251		0.70 (0.39-1.26)	0.237	
Homeless/Past Year									
No	Reference			Reference			Reference		
Unknown	4.00 (1.20-13.29)	0.024		3.39 (1.46-7.89)	0.005		3.02 (1.36-6.65)	0.006	
Yes	0.62 (0.30-1.29)	0.202		1.01 (0.68-1.52)	0.945		0.99 (0.70-1.40)	0.938	
Alcohol/Past Year									
No	Reference			Reference			Reference		
Yes	0.50 (0.25-0.99)	0.047	50%	0.89 (0.59-1.33)	0.574		1.1 (0.77-1.58)	0.606	
Drugs/Past Year									
No	Reference			Reference			Reference		
Yes	1.79 (0.84-3.82)	0.129		1.19 (0.76-1.87)	0.448		1.19 (0.80-1.79)	0.389	
Carbonyl TB									
No	Reference			Reference			Reference		
Unknown	1.06 (0.32-3.52)	0.918		1.05 (0.40-2.77)	0.920		0.81 (0.35-1.91)	0.635	
Yes	0.21 (0.12-0.38)	<.0001	79%	0.47 (0.33-0.67)	<.0001	53%	0.48 (0.35-0.66)	<.0001	52%
Diabetic									
No	Reference			Reference			Reference		
Yes	1.27 (0.61-2.65)	0.523		1.15 (0.68-1.84)	0.587		1.33 (0.85-2.10)	0.211	
HIV Positive									
No	Reference			Reference			Reference		
Unknown	1.21 (0.36-4.06)	0.764		0.45 (0.11-0.55)	0.083		0.52 (0.23-1.17)	0.115	
Yes	0.45 (0.20-1.01)	0.054		0.81 (0.47-1.11)	0.386		0.73 (0.45-1.17)	0.185	
Non-HIV Immune Suppression									
No	Reference			Reference			Reference		
Yes	2.56 (0.98-6.65)	0.054		2.18 (1.15-4.16)	0.018		2.43 (1.36-4.33)	0.003	
Resident Correctional									
No	Reference			Reference			Reference		
Yes	1.24 (0.52-2.95)	0.623		1.18 (0.65-2.13)	0.587		1.07 (0.63-1.82)	0.810	
Mutation Status									
Mutation-Undetected	Reference			Reference			Reference		
Mutation-Detected	0.54 (0.30-0.96)	0.036	46%	0.60 (0.42-0.85)	0.005	40%	0.82 (0.61-1.10)	0.181	

Backward Cox regression was performed to calculate adjusted HR with variables that satisfied the criterion of $P < 0.20$ in the model.
*Only statistically significant results indicative of delay are provided in Change in TTSC column.
†aHR < 1 indicates longer time to sputum culture conversion compared to the reference group.
aHR: Adjusted hazard ratio; CI: Confidence interval; HIV: Human immunodeficiency virus.

Figure 3: World Health Organization Tuberculosis Mutation Confidence Grading Associated with Drug Resistance by Lineage



DATA VISUALIZATION

ILI Activity and Outbreaks by Setting

Page 5

Reported Influenza and ILI Outbreaks

ILI = Influenza-like illness

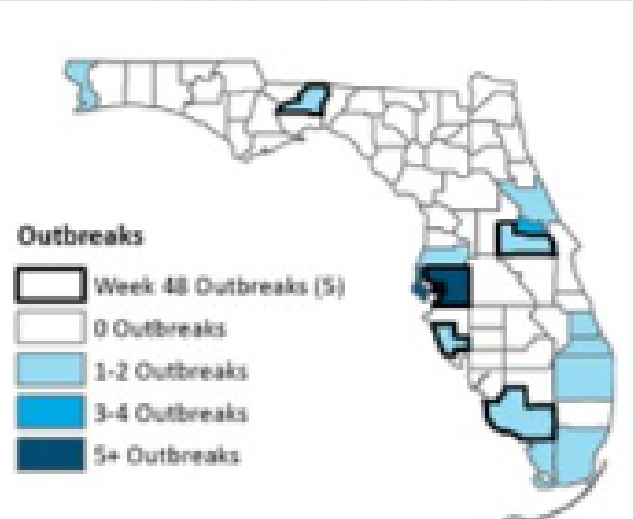
Map 3 shows influenza and ILI outbreaks by county for week 40, 2017 through week 48, 2017, as reported into Marlin.

In week 48, five outbreaks were reported: (3) influenza, (1) ILI, and (1) respiratory syncytial virus (RSV). As of week 48, 32 outbreaks of influenza and ILI have been reported since the start of the 2017-18 influenza season. More outbreaks have been reported so far this season than at this time previous seasons.

Nearly all of the outbreaks (93.9%) reported so far this season have been in facilities serving people at higher risk for complications due to influenza infection (children and adults aged 65 years). While these early season outbreaks are expected, the detection of these early outbreaks is important as it can serve as early indicators of unusual or more severe strains of influenza. Based on the data available for the outbreaks that have been reported thus far, this flu season may be more severe; this trend will be monitored closely.

For more detailed information on influenza and ILI outbreaks reported in week 48, see page 6. Data presented on outbreaks are preliminary and subject to change as outbreak investigations progress.

Map 3 Influenza and ILI Outbreaks by County Week 40, 2017 through Week 48, 2017



Statewide ILI Outpatient Visits and P&I Deaths

Page 3

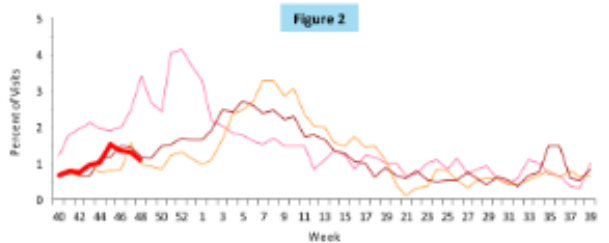
2017-18 2016-17 2015-16 2014-15

Visits for ILI to Outpatient Providers by Flu Season

ILI = Influenza-like illness

Figure 2 shows the percent of visits for ILI reported by ILINet outpatient providers statewide (n=46), week 40, 2014 to week 48, 2017. For ILINet, influenza-like illness (ILI) is defined as a fever $\geq 100.4^{\circ}\text{F}$ AND sore throat and/or cough in the absence of another known cause.

In week 48, the percent of visits for ILI reported by ILINet outpatient providers decreased but remained similar to levels seen in previous seasons at this time.



P&I Deaths* from Vital Statistics by Flu Season

P&I = pneumonia and influenza

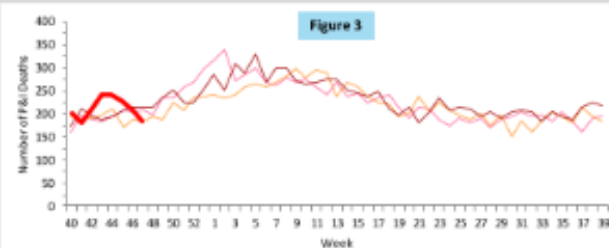


Figure 3 shows P&I deaths* for all Florida counties from the Bureau of Vital Statistics, as reported into ESSENCE-FL, week 40, 2014 to week 47, 2017.

In week 47 (ending November 25, 2017), 184 P&I deaths were reported.

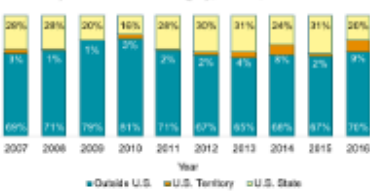
The preliminary number of P&I deaths decreased and was slightly below levels seen in previous seasons at this time.

Travel-Related Illnesses

number of reportable disease and condition cases identified in people with exposures in Haiti more than doubled from the previous year (114 cases identified in 2009, 253 cases in 2010, 111 cases in 2011). Another contributing factor was a change in the giardiasis case definition in 2010, which allowed for asymptomatic infections to be counted as confirmed cases. Asymptomatic infections are commonly identified as part of refugee health screening. In 2011, the case definition reverted back to requiring symptoms to meet the surveillance case definition. As a result, there was a large spike in giardiasis cases reported in 2010 relative to other years.

Over the past 10 years, 71% of cases with travel-related illnesses were exposed outside the U.S., though this varies annually from a low of 65% in 2007 to a high of 81% in 2010 (Figure 1). Generally, 1-2% of cases with travel-related illnesses were exposed in U.S. territories each year. The number and percentage of cases exposed in U.S. territories increased in 2013, 2014, and 2016 due to widespread transmission in Puerto Rico of dengue fever, chikungunya fever, and Zika fever, respectively.

Figure 1: Percent of Travel-Related Illnesses by Exposure Location Category, Florida, 2007-2016



Note that 19 cases were excluded from Figure 1 because they fell into more than one exposure category (e.g., exposure may have occurred in another U.S. territory or outside the U.S.).

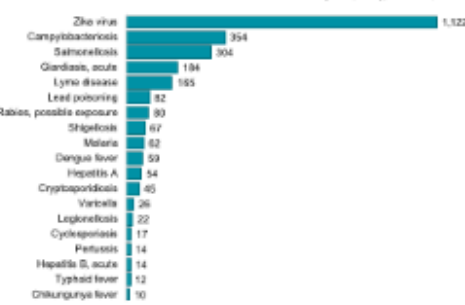
Summary of 2016 Data

Nineteen diseases accounted for 98% of the 2,756 cases with travel-related illnesses reported in 2016 (Figure 2). There were <10 cases with travel-related illnesses reported for each of 22 diseases which were excluded in the subsequent summaries here based on the low number of cases that were travel-associated.

Areas of endemicity contribute to travel-related infection patterns and vary by disease; some diseases are endemic in other parts of the U.S., and others are more commonly seen in other U.S. territories or countries.

However, travel-related infection patterns can also reflect travel patterns among people. Illnesses acquired in other southern U.S. states are likely to be identified in Florida residents due to proximity and frequency of travel. Florida has a large Hispanic population, and travel between Florida and Central and South America, Mexico, and the Caribbean is very common. The large numbers of travelers to and from these areas contribute to the number of cases associated with travel-related illnesses reported in Florida.

Figure 2: Number of Travel-Related Illnesses by Disease for Diseases With ≥ 10 Travel-Related Cases (N=2,663), Florida, 2016



Progress Towards TB Elimination, United States, 1982-2023

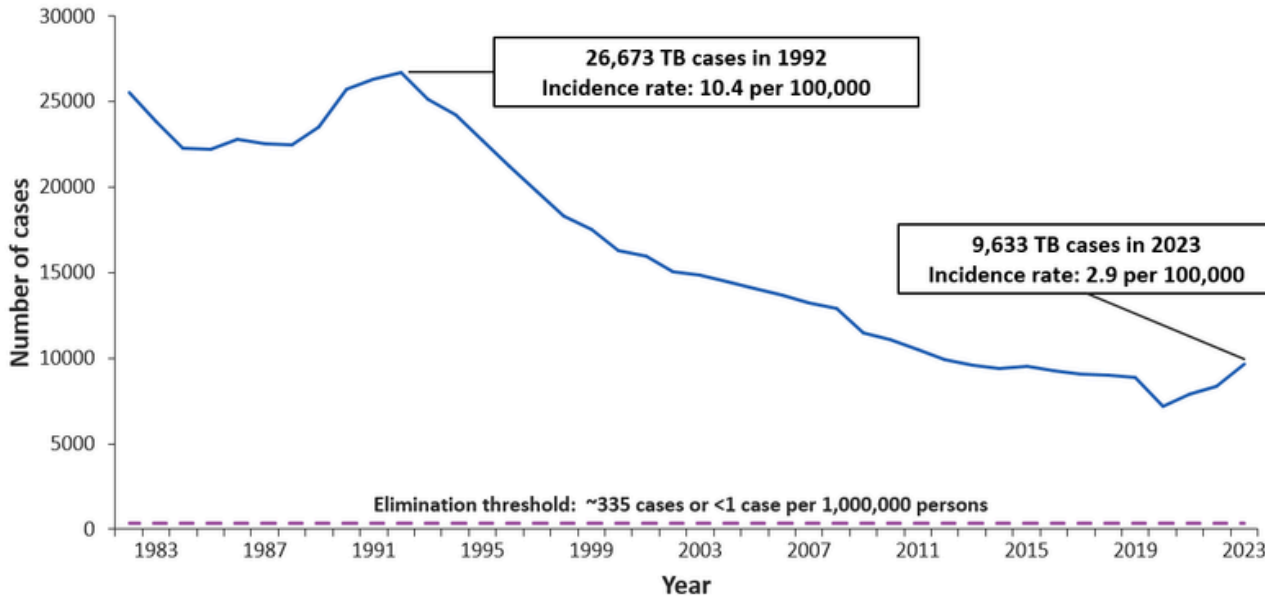
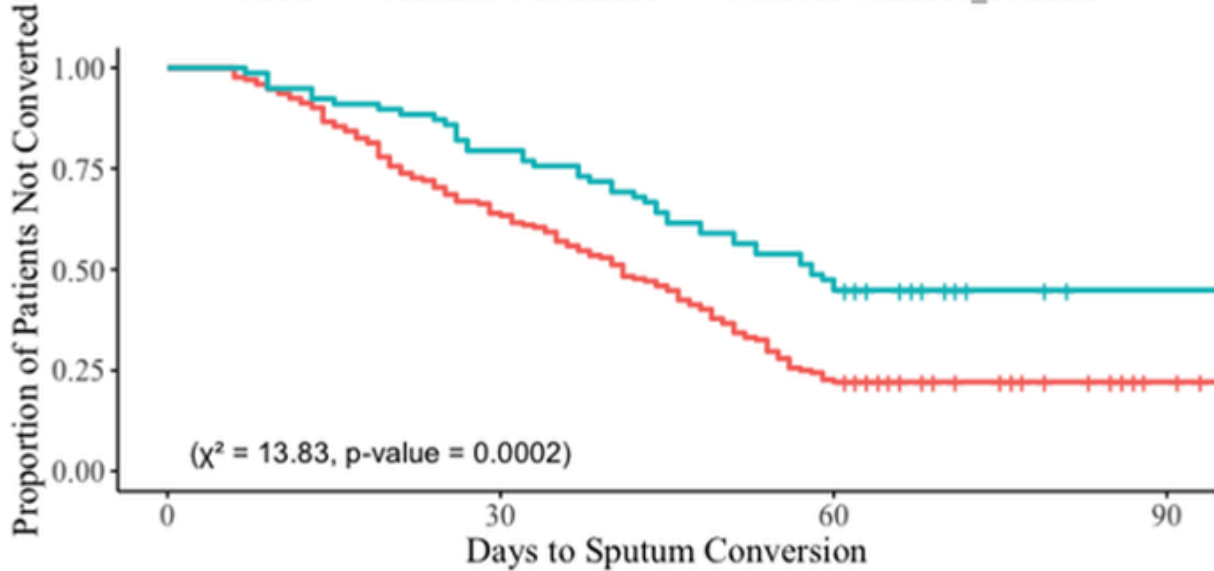


Figure 1. Kaplan-Meier survival curves comparing time to sputum conversion among TB patients with and without detected drug resistance mutations.

Time to Sputum Conversion by Genetic Mutation Status

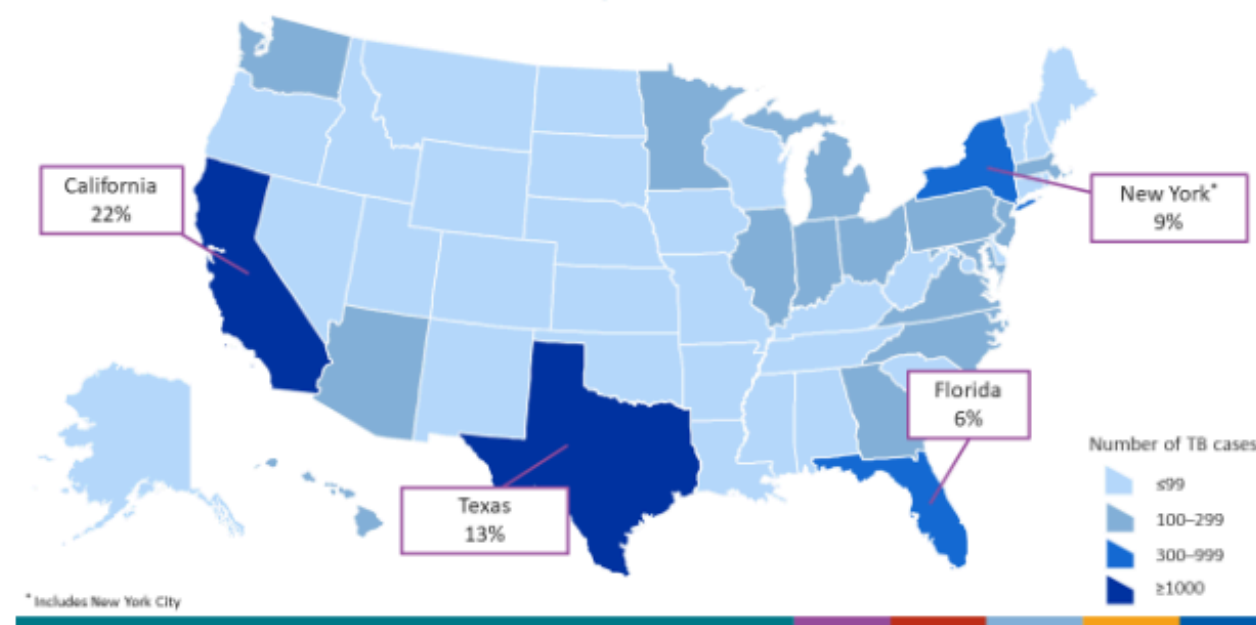
Strata + Mutation=NoMutation + Mutation=Mutation_Detected



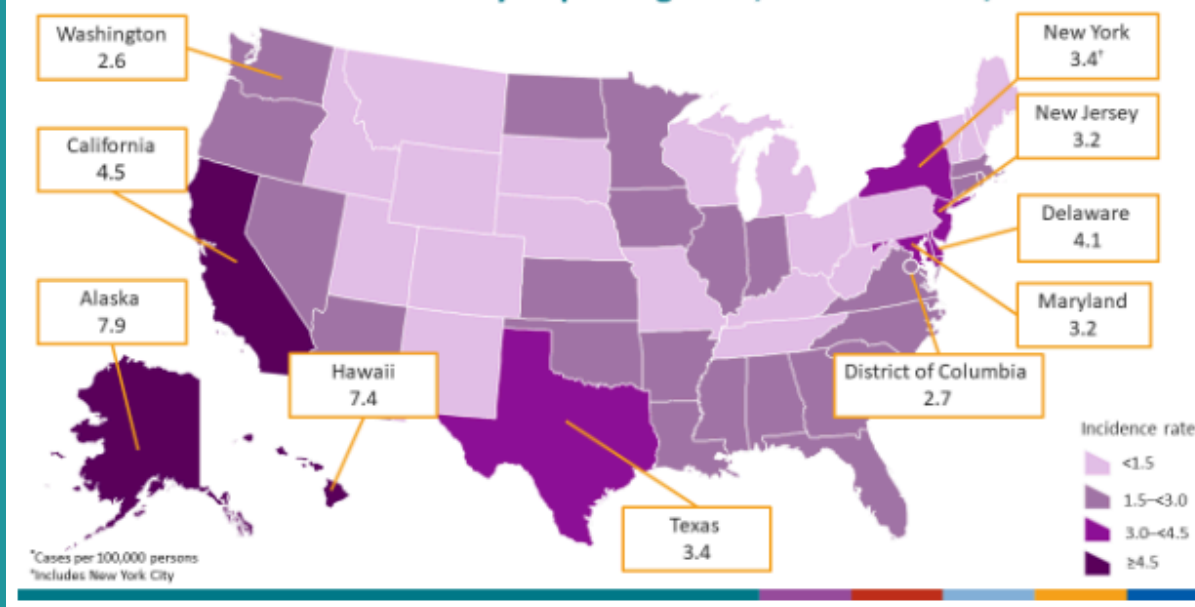
Latweika A.T. Salmon-Trejo
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SALMON-TREJO

DATA VISUALIZATION: MAPS

TB Cases by Reporting Area, United States, 2021



TB Incidence Rates* by Reporting Area, United States, 2021



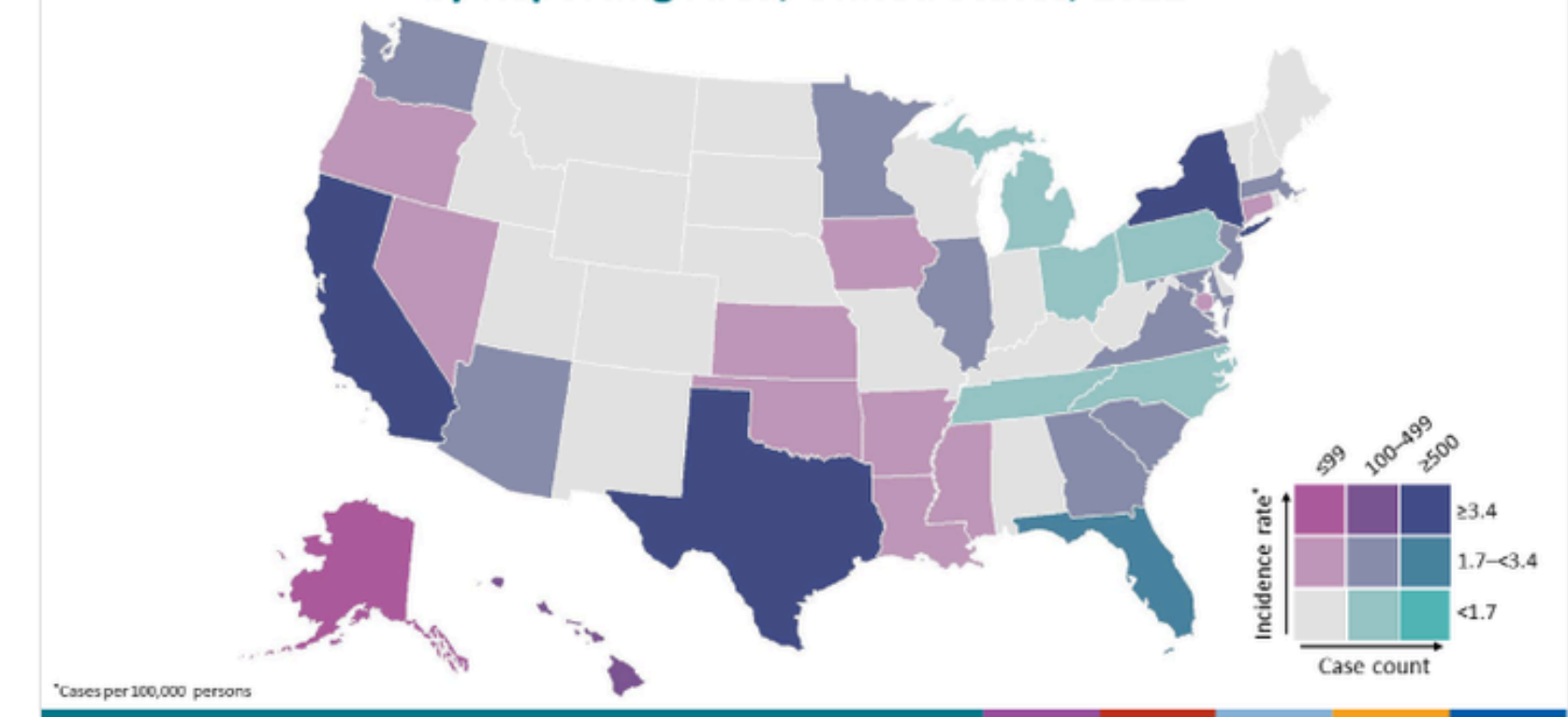
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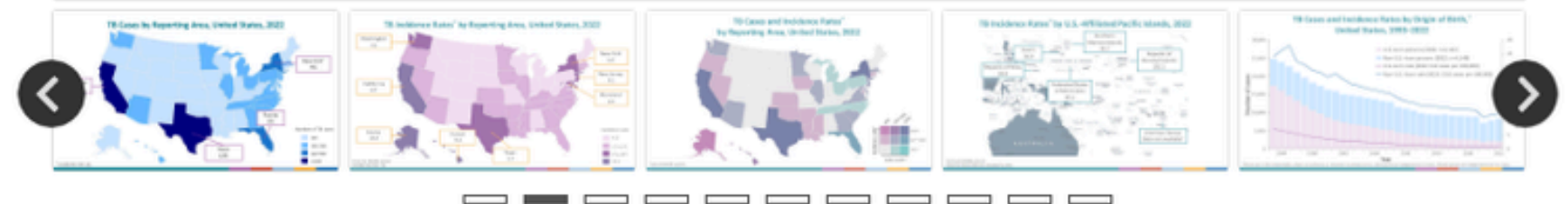
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TB Cases and Incidence Rates*
by Reporting Area, United States, 2022



Slide - 8



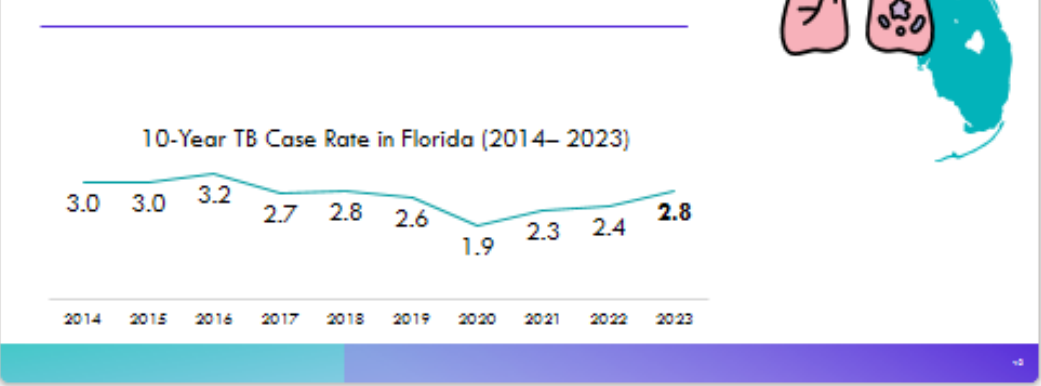
PRESENTATIONS

Born Persons¹ by the Top 30 Countries² of Birth: United States, 2018–2022

See surveillance slide [#13](#).

Country of birth ³	Year									
	2022		2021		2020		2019		2018	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Total cases	6,148		5,629		5,141		6,367		6,352	
Mexico	1,161	(18.9)	1,054	(18.7)	927	(18.0)	1,190	(18.7)	1,208	(19.0)
Philippines	670	(10.9)	692	(12.3)	641	(12.5)	795	(12.5)	780	(12.3)
India	541	(8.8)	566	(10.1)	531	(10.3)	577	(9.1)	632	(9.9)
Vietnam	504	(8.2)	424	(7.5)	421	(8.2)	506	(7.9)	512	(8.1)
China	371	(6.0)	314	(5.6)	260	(5.1)	390	(6.1)	381	(6.0)
Guatemala	283	(4.6)	218	(3.9)	170	(3.3)	232	(3.6)	209	(3.3)
Honduras	184	(3.0)	134	(2.4)	129	(2.5)	192	(3.0)	142	(2.2)
Haiti	162	(2.6)	149	(2.6)	128	(2.5)	163	(2.6)	130	(2.0)
Ethiopia	77	(1.3)	124	(2.2)	105	(2.0)	138	(2.2)	150	(2.4)
El Salvador	103	(1.7)	73	(1.3)	100	(1.9)	98	(1.5)	109	(1.7)
Myanmar	83	(1.4)	104	(1.8)	81	(1.6)	105	(1.6)	109	(1.7)
Nepal	97	(1.6)	87	(1.5)	83	(1.6)	97	(1.5)	100	(1.6)
Pakistan	82	(1.3)	79	(1.4)	74	(1.4)	110	(1.7)	104	(1.6)
Peru	125	(2.0)	63	(1.1)	63	(1.2)	79	(1.2)	78	(1.2)
Korea Republic Of	70	(1.1)	85	(1.5)	70	(1.4)	96	(1.5)	83	(1.3)
Ecuador	105	(1.7)	87	(1.5)	60	(1.2)	58	(0.9)	77	(1.2)
Cambodia	67	(1.1)	62	(1.1)	57	(1.1)	94	(1.5)	67	(1.1)
Bangladesh	59	(1.0)	74	(1.3)	67	(1.3)	64	(1.0)	61	(1.0)
Afghanistan	123	(2.0)	80	(1.4)	32	(0.6)	42	(0.7)	39	(0.6)
Dominican Republic	65	(1.1)	55	(1.0)	56	(1.1)	59	(0.9)	56	(0.9)
Nigeria	52	(0.8)	50	(0.9)	47	(0.9)	67	(1.1)	72	(1.1)
Somalia	39	(0.6)	43	(0.8)	67	(1.3)	65	(1.0)	73	(1.1)
Laos	47	(0.8)	61	(1.1)	43	(0.8)	53	(0.8)	56	(0.9)
Marshall Islands	67	(1.1)	51	(0.9)	44	(0.9)	45	(0.7)	41	(0.6)
Colombia	71	(1.2)	45	(0.8)	31	(0.6)	50	(0.8)	48	(0.8)

IN 2023, 624 CASES OF TB WERE REPORTED WITH A RATE OF 2.8 CASES PER 100,000 POPULATION.



Epidemiologic Characteristics of Pediatric Cases in the U.S., May 17–September 24, 2022

Characteristic	% by age group, yrs		
	0–4 (n = 16)	5–12 (n = 12)	13–17 (n = 55)
Sex			
Male	75%	50%	89%
Female	25%	50%	11%
Race or ethnicity			
Black, non-Hispanic	44%	42%	49%
Hispanic or Latino	31%	42%	34%
White, non-Hispanic	19%	17%	9%
Asian, non-Hispanic	—	—	4%
American Indian or Alaska Native, non-Hispanic	—	—	2%
Native Hawaiian or other Pacific Islander, non-Hispanic	6%	—	—
Other, non-Hispanic	—	—	2%
Exposure setting and route			
Sexual contact	—	—	97%
Household contact	93%	100%	—
Other	7%	—	3%

PHASE 1 & PHASE 2 OF

Phases	Research Question	Key Aim
Phase 1: Epidemiology & Exposure Type Analysis	RQ1/2: Birth Region, Exposure Type, and Epidemiological Linkages	Association between birth region, TB lineage, and exposure type; impact on epidemiological linkages
	RQ3: Exposure Type and Predictability of TB-Contact-Based Detection	Does exposure type predict TB-contact-based cases after controlling for demographic factors?
Phase 2: Genetic & Phylogenetic Analyses	RQ4/5: SNP Threshold and Genetic Relatedness	Effect of SNP threshold on genetic relatedness across exposure types and epidemiologically linked cases

Thank You For Coming!

Women's & Girls' Cancer Alliance

THE ONLY ORGANIZATION IN CENTRAL FLORIDA THAT ADVOCATES FOR GOOD GYNECOLOGICAL HEALTH FOR WOMEN AND GIRLS THROUGH EDUCATION AND ADVOCACY

LA ÚNICA ORGANIZACIÓN EN EL CENTRO DE FLORIDA QUE ABOGA POR UNA BUENA SALUD GINECOLÓGICA PARA LAS MUJERES Y NIÑAS A TRAVÉS DE LA EDUCACIÓN Y LA PROMOCIÓN.

Strategic Planning with Actionable Data for Board of Directors

Leveraging Language Models

Key Benefits of Language Models

- Increased Efficiency
- Improved Accuracy
- Enhanced Scalability

About Language Learning Models Inc.

Empowering to get started with language models

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Transform Your Business with Language Learning Models

Latweika A.T. Salmon-Trejo

LATWEIKA A.T. SALMON-TREJO

HEALTH EDUCATION

DEVELOPED AND PRESENTED CLINICAL HEALTH, AND EPIDEMIOLOGICAL PRINCIPLES TRAINING TO 67 COUNTY HEALTH DEPARTMENTS, INCLUDING NURSES, EPIDEMIOLOGIST, AND SOCIAL WORK STAFF TO SUPPORT WORKFORCE DEVELOPMENT & INCREASE DISEASE INTERVENTION STRATEGIES.

Molecular Surveillance: TB Genotyping

LATWEIKA A.T. SALMON, MPH
DIVISION OF DISEASE CONTROL AND HEALTH PROTECTION
BUREAU OF COMMUNICABLE DISEASE
TUBERCULOSIS CONTROL SECTION
FLORIDA DEPARTMENT OF HEALTH

1

What is genotyping?

TB genotyping is a lab-based approach used to analyze the genetic material of *Mycobacterium tuberculosis* (TB). The total genetic content is referred to as the genome. Specific sections of the *M. tuberculosis* genome form distinct genetic patterns that help distinguish different molecular traits.

2



3

Two types of molecular analysis are available

Genotyping:

- Examines 39 loci on the TB genome through examination of the results of three molecular tests; Spoligotyping (15 loci), MIRU 1 (12 loci) and MIRU 2 (12 loci)
- Consistent results across all three results share a "GENType".

Whole genome sequencing (WGS):

- Examines the entire TB genome, approximately 3 million loci with detailed molecular resolution amongst TB cases sharing a common "GENType" and support the identification of recent transmission.

4

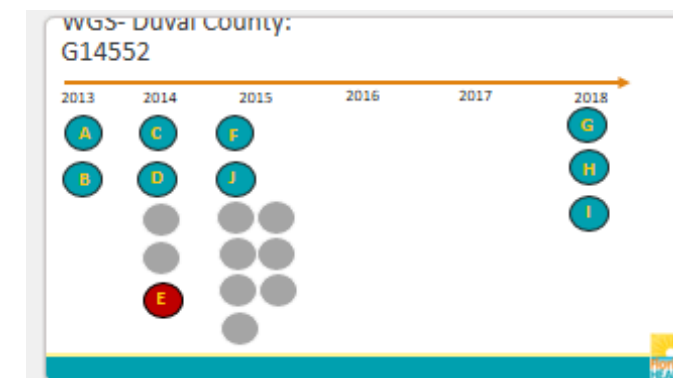
How are genotyping results used?

- Genotyping results are combined with epidemiological data to identify clusters in FL involved in the same chain of transmission
- To provide evidence for (or against) previously suspected (or unsuspected) epidemiological links between TB cases.
- To provide evidence for (or against) previously suspected (or unsuspected) laboratory cross-contamination.

5

All results are reported electronically through the CDC developed, TB Genotyping Information Management System (TBGIMS)

6



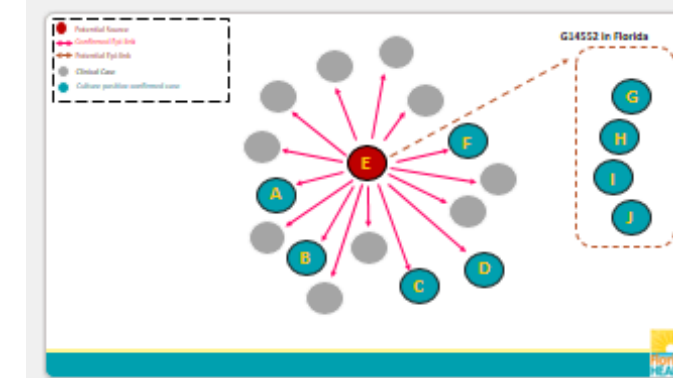
15

WGS- Duval County: G14552

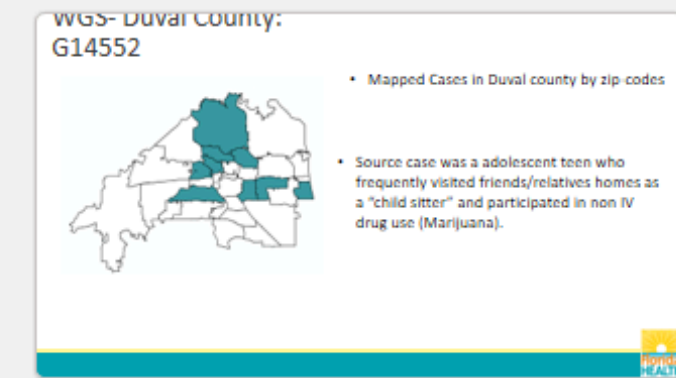
Epidemiological information is combined with whole genome sequencing to further support analysis of the cluster in efforts to identify, evaluate, and confirm TB cases and associated contact exposure.

- Source case was a adolescent teen who frequently visited friends/relatives homes as a "child sitter" and participated in non IV drug use (Marijuana).

16



17



18

What are some strategies for prioritizing cluster investigations?

Prioritize "clusters" that most likely represent recent transmission

- Has it grown rapidly?
- Is it new to the county or state?
- Is it rare nationally?
- Does it include children under the age of five?
- Are there clinical cases?

Prioritize "clusters" with concerning characteristics

- Is a congregate setting involved?
- Do the cases and contacts have risks for progression to active disease?
- Did any recent cases have prolonged infectious periods?
- Are epidemiologic links between the TB cases unclear?

19

What strategies are most effective at interrupting an expanding cluster?

- Identify, evaluate, and treat all cluster associated TB cases and contacts.
- Expand the contact investigation to frequent social and/or worksite contacts (this would include extended family members, restaurants, bars)
- Re-interview each previous TB case in the cluster whenever new information is identified during the cluster investigation

20

PRESENTATIONS

DEVELOPED A NATIONAL TRAINING FOR 50+ STATES & TERRITORIES ON LEVERAGING ETHNOGRAPHIC CONTACT INTERVIEWING SKILLS AND HEALTH EQUITY TO SUPPORT COMMUNITY INITIATIVES AND SURVEILLANCE ON SENSITIVE ISSUES RELATED TO SOCIAL DETERMINANTS OF HEALTH.

Usual Residence and Counting Cases for RVCT

By: LaTasha A.J. Salmon-Dryjs, DrPH(c), MPH
Division of TB Elimination
Surveillance, Epidemiology, Outbreak Investigation Branch

Agenda

- Reporting Verified Tuberculosis Cases
- Usual Residence CSTE Guidelines
- Counting Cases
- Categorize concepts of establishing usual residence
- Review Case Scenarios
 - Common Scenario
 - Complex Scenario
- Questions

The goal of this presentation is to provide education on the process of deconstructing case scenarios for the reporting and counting of cases.

Objectives

- Describe the general process for reporting verified cases
- Identify and categorize concepts of "establishing usual residence" for counting cases
- Explain important decision-making steps in the process of counting cases

Reporting Verified Tuberculosis Cases

Reporting Verified Tuberculosis Cases

Reporting Verified Tuberculosis Cases

Appendix 1 – Tuberculosis Case Definition for State Health Surveillance
Consistent with the National Tuberculosis Surveillance System (NTSS) Case Definition

General Examples:

- A person who is not a resident of the United States, but who is in the United States for a period of time that is sufficient to establish usual residence.
- A person who is a resident of the United States, but who is not a resident of the United States for a period of time that is sufficient to establish usual residence.

General Notes:

- A case that meets all the following criteria:
- A person who is not a resident of the United States, but who is in the United States for a period of time that is sufficient to establish usual residence.
- A person who is a resident of the United States, but who is not a resident of the United States for a period of time that is sufficient to establish usual residence.
- A person who is a resident of the United States, but who is not a resident of the United States for a period of time that is sufficient to establish usual residence.
- A person who is a resident of the United States, but who is not a resident of the United States for a period of time that is sufficient to establish usual residence.

Exclusion Criteria for Report:

- A person who is not a resident of the United States, but who is in the United States for a period of time that is sufficient to establish usual residence.
- A person who is a resident of the United States, but who is not a resident of the United States for a period of time that is sufficient to establish usual residence.
- A person who is a resident of the United States, but who is not a resident of the United States for a period of time that is sufficient to establish usual residence.
- A person who is a resident of the United States, but who is not a resident of the United States for a period of time that is sufficient to establish usual residence.

Usual Residence CSTE Guidelines

- CSTE Positive Statement (11-12-04) re-established guidelines with the concept of a "reference point" as time for identifying cases created in an area. At which the patient's usual residence would be established for surveillance reporting purposes.
- For the purposes of the RVCT, for consistency with historical practice, the reference point is the date when the TB diagnostic evaluation was initiated.
- "Usual residence" is defined as "...the place where the person lives and sleeps most of the time, which is not necessarily the same as the person's voting residence, legal residence, or the place where they became infected with a reportable disease."**

The place where the person lives and sleeps most of the time.

Usual Residence	
The Place	Lives & Sleeps
Home	Living
College	Living
Prison	Living
Hotel	Living
Boarding house	Living
Rooming house	Living
Apartment	Living
Condominium	Living
Mobile home	Living
Trailer	Living
RV	Living
Boat	Living
Summer home	Living
Winter home	Living
Second home	Living
Third home	Living
Fourth home	Living
Fifth home	Living
Sixth home	Living
Seventh home	Living
Eighth home	Living
Ninth home	Living
Tenth home	Living

Common Scenario

- Person who travels from Canada to Florida every winter to escape the cold temperatures November through February

Common Scenario

- Person who migrates throughout the world following the seasonal agricultural trade throughout the United States

Complex Scenario

- Background: A person who travels from Canada to Florida every winter to escape the cold temperatures November through February

DEVELOPED INFOGRAPHICS



wgcancer
December 8, 2015



TAKE THE
#PantyPledge



We're challenging women to shift their focus from what goes on the outside to what is happening on the inside.

EDUCATE



Sit down and learn the signs and symptoms of female cancers and where to go for a exam.

ADVOCATE



Tell a friend about WGCancer and why you're passionate about fighting female cancers.

DONATE



Donate to WGCancer and support our survivor and education programs.

Take the #PantyPledge and schedule your well-woman exam today!

19 2



wgcancer Visit [WGCancer.org/donate](https://www.wgcancer.org/donate) to make your pledge today!

#ignitethefight #Wgcancer

Latweika A.T. Salmon-Trejo
LATWEIKA A.T.
SALMON-TREJO

TAKE ON
TB

Too many people still suffer from tuberculosis (TB).

TB IN THE U.S.



Up to **13 million** people could have latent TB infection



9,633 people were diagnosed with TB disease in 2023, a 15.6% increase compared with 2022



565 people died of TB-related causes in 2022

The increase in TB disease highlights the need to regain momentum toward the United States' goal of eliminating TB.



www.cdc.gov/tb
NOVEMBER 2024

HEALTH CARE PROVIDERS CAN TAKE ACTION TO END TB

1 Think TB



Recognize risk factors and symptoms of TB.

2 Test for TB



Use the TB blood test for people at increased risk of TB infection.

3 Treat TB



Prescribe shorter regimens to help patients finish treatment.

TB CAN HAPPEN ANYWHERE & TO ANYONE

But some groups are at greater risk of TB than others. To eliminate TB, we must prioritize groups at increased risk of TB.

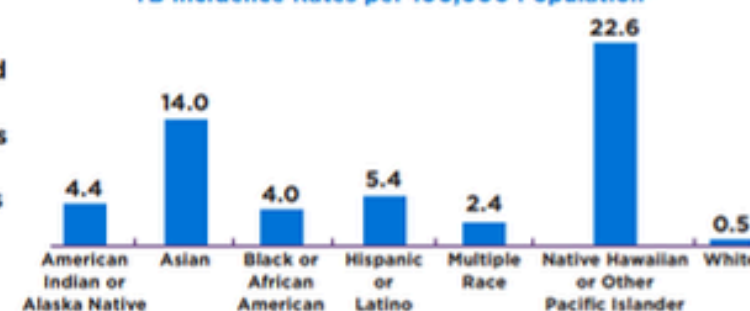
7 out of 10



TB cases occurred among non-U.S.-born persons

Racial and ethnic disparities in TB diagnoses continue to exist.

TB Incidence Rates per 100,000 Population*



*All persons are non-Hispanic except for those who identified as Hispanic or Latino.

CDC IS COMMITTED TO ENDING TB IN THE UNITED STATES

CDC supports finding and treating TB disease and expanding testing and treatment for latent TB infection through:



Conducting vigilant surveillance



Researching better diagnostics & treatment options

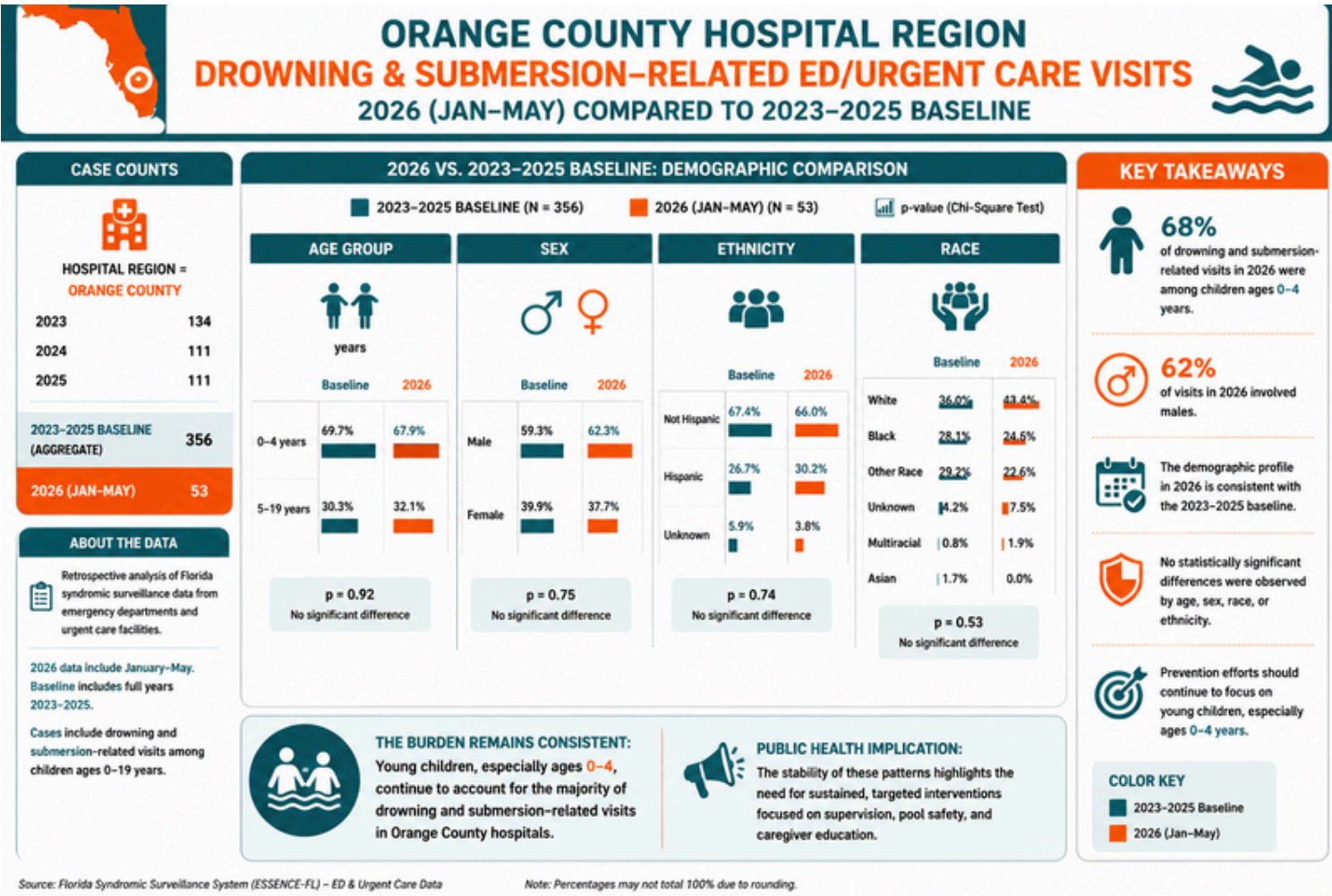
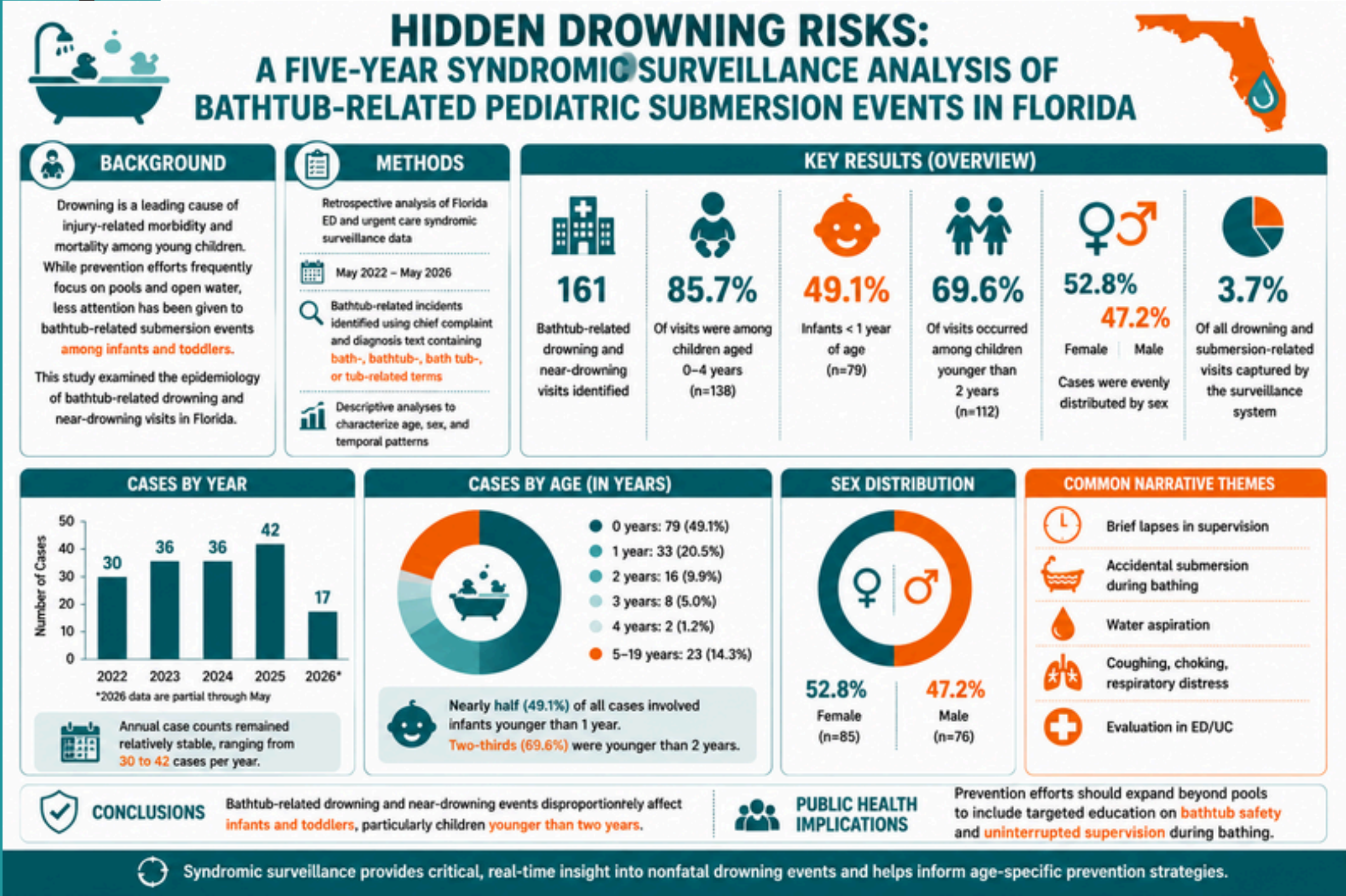


Engaging affected communities & medical providers



Supporting local & state health departments

DATA ANALYSIS

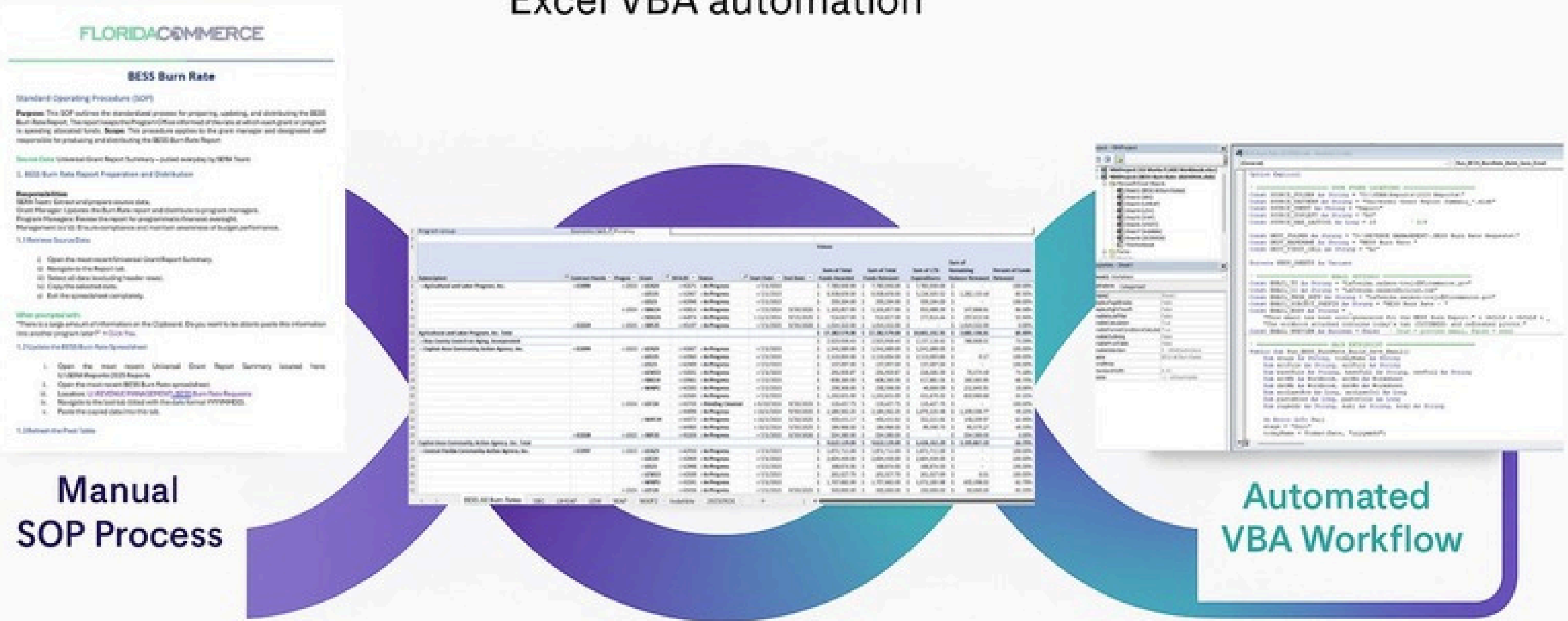


LATWEIKA A.T.
SALMON-TREJO

OPTIMIZATION

Automating the BESS Burn Rate Report

From manual to automated — accelerating fiscal reporting through
Excel VBA automation

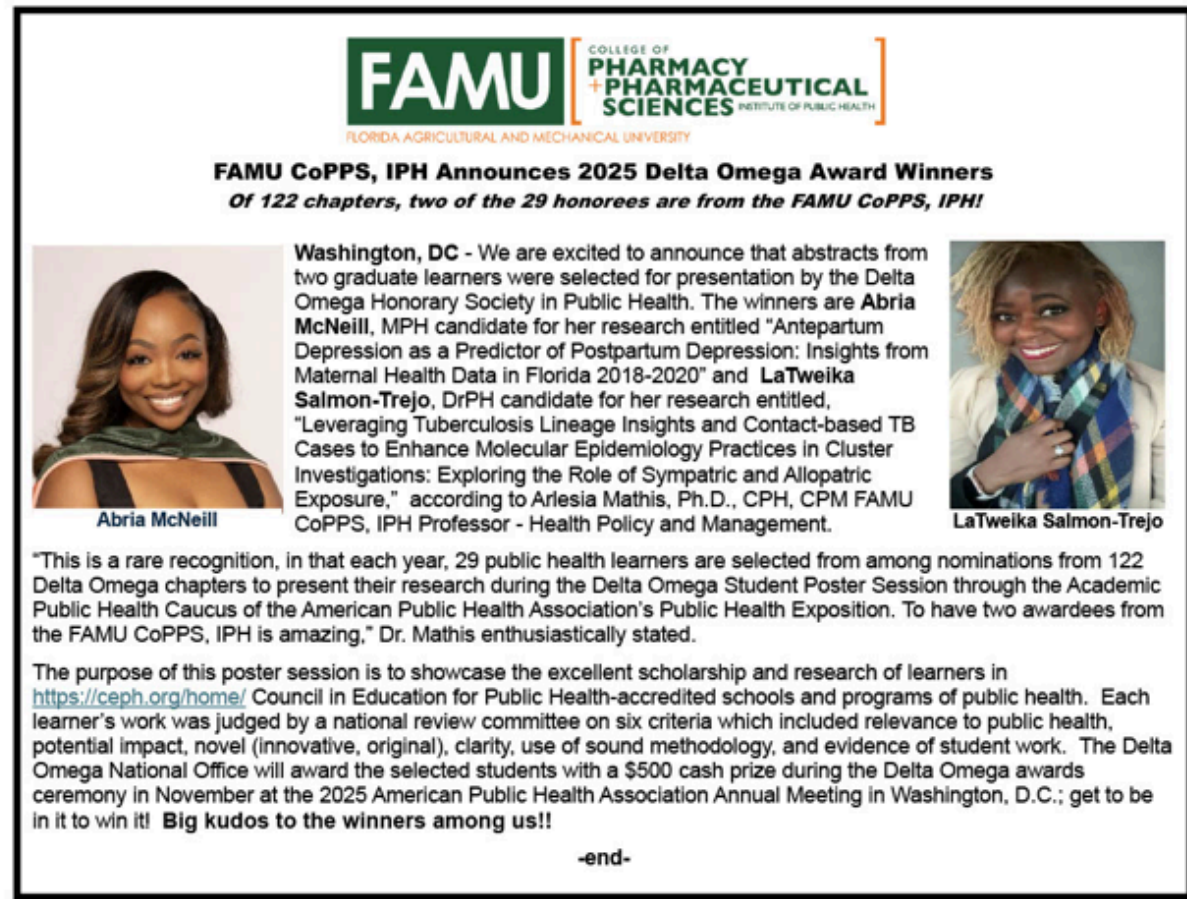


I BUILT A VBA-DRIVEN EXCEL SYSTEM THAT AUTOMATED THE ECONOMIC SELF SUFFICIENCY (BESS) GRANTS BURN RATE REPORT PULLING THE LATEST DATA, CREATING NEW DATE STAMPED TABS, REPOINTING PIVOT TABLES, AND EMAILING THE FINISHED FILE AUTOMATICALLY.

BEFORE THIS, THE PROCESS TOOK ABOUT 30 MINUTES AND RELIED ON REPETITIVE COPY-AND-PASTE STEPS.

NOW IT RUNS IN ABOUT ONE MINUTE - NO MANUAL WORK REQUIRED. I CODED. I OPTIMIZED. I SIMPLIFIED. AND I PROVED THAT DATA-DRIVEN THINKING ISN'T LIMITED TO PUBLIC HEALTH, IT CAN MAKE GOVERNMENT FINANCIAL SYSTEMS SMARTER, FASTER, AND MORE EFFICIENT.

COMMUNITY ACTION



NTCA/SETC, 2025



CENTRAL FLORIDA WATER SAFETY TASK FORCE, 2026



UNIVERSITY OF FLORIDA 2018

COMMUNITY PARTNERSHIPS FOR HEALTH

FEMALE CANCER HEALTH EVENT

DANCE FOR FEMALE CANCERS!

September Gynecological Cancer Awareness Month | October Breast Cancer Awareness Month

MONICA COMMIT, LULU ZUMBA, MARISOL ZUMBA, JEN Turn Up

SATURDAY, SEPTEMBER 28TH
1:00PM-3:00PM
@ DGBEK STUDIOS
4677 LB MCLEOD RD | UNIT 10 | ORLANDO, FL 32811

\$12 Proceeds will benefit The Gynecologic Cancer Support Group.

Embrace Your Power, Own Your Health. Take the #pantypledge today!

The Fit Epic

FEMALE CANCER HEALTH EVENT



HEART DISEASE EVENT



KIDNEY DISEASE AWARENESS EVENT

@ YouFit on Mahan

BEGINS MARCH 5TH

Strong by Zumba® Goes Green For Kidney Disease Awareness

PREPARE TO WEAR GREEN EVERY CLASS!!

Guest are only 5\$



latweika.salmon@icloud.com

Latweika A.T. Salmon-Trejo
LATWEIKA A.T.
SALMON-TREJO

GRANTS & POLICY

CONSTRUCTED GRANT PROPOSALS

2A. General Methodology & Scope of Work

Phase I – Analysis (Weeks 1-4): Comprehensive Curriculum Review

- ☐ Analyze the current narrative format of all curriculum materials.
- ☐ Evaluate the alignment between existing content and the established Course, Terminal Course, and Topic Objectives.
- ☐ Assess the effectiveness of the current assessment process managed via iGrade.
- ☐ Review the current facilitator evaluation (quarterly) and student critique (daily) processes for fidelity and responsiveness.
- ☐ Examine 2024 performance data: average test scores (90.2 %), individual pillar scores (> 80 %), absentee rate (2.6 classes), and retention rate (72 %).
- ☐ Evaluate the curriculum's overall effectiveness in advancing LLC's mission of self-sufficiency.
- ☐ Deliverable A-1: **Data-Driven Curriculum Assessment Report** summarizing findings and recommending whether formalization/enhancement is warranted—without presuming any change is needed.

Phase II – Design (Weeks 5-8): Curriculum Formalization Framework

- ☐ Restructure curriculum content to explicitly incorporate Course, Terminal Course, and Topic Objectives.
- ☐ Develop a structured lesson-plan template (objective → activity → assessment → reflection) for all materials.
- ☐ Integrate assessment tools—test questions and emphasized discussion prompts—directly into lessons, ensuring alignment with learning objectives.
- ☐ Draft summary sections with comprehension checks for each lesson.
- ☐ Embed visual aids (e.g., participant worksheet images) within facilitator guides.
- ☐ Map opportunities to incorporate insights from daily student critiques.

Phase III – Development (Weeks 9-18): Lesson Plans, Guides & Resources

- ☐ Produce 40+ facilitator-ready lesson plans reflecting the redesigned structure.
- ☐ Create comprehensive facilitator guides with embedded visuals and key discussion cues.
- ☐ Generate participant resources (fillable PDFs and print-ready versions) that mirror lesson objectives and comprehension checks.

Phase IV – Implementation (Weeks 19-24): Pilot & Facilitator Training

• Evaluation for Strategic Application

Deliver synthesized results that inform future programs, campaigns, and funding proposals, ensuring that the dataset yields both narrative power and measurable impact.

Our proposed approach is grounded in ethical research practice, health equity principles, and deep respect for the communities BWHI serves. We are committed to producing findings that are not only methodologically sound, but also strategically useful in BWHI's ongoing fight to advance the health and wellness of Black women nationwide.

• Evaluation for Strategic Application

Deliver synthesized results that inform future programs, campaigns, and funding proposals, ensuring that the dataset yields both narrative power and measurable impact.

Our proposed approach is grounded in ethical research practice, health equity principles, and deep respect for the communities BWHI serves. We are committed to producing findings that are not only methodologically sound, but also strategically useful in BWHI's ongoing fight to advance the health and wellness of Black women nationwide.

Project Approach

Phase I – Preparation & Data Review (Weeks 1–2)

- ☐ Receive dataset, establish Zotero reference library, and complete initial data cleaning.
 - ☐ Conduct a quality audit assessing completeness, missingness, and data integrity.
 - ☐ Confirm variables of interest, stratification factors, and coding schemes.
- Deliverable A-1:** Data-Quality Memo and Cleaned Dataset.

Phase II – Analysis & Synthesis (Weeks 3–5)

- ☐ Run descriptive statistics, group comparisons, and regression models (R or SAS).
 - ☐ Code qualitative responses and identify convergent themes.
 - ☐ Conduct exploratory factor analysis and k-means clustering to identify symptom patterns.
 - ☐ Integrate quantitative and qualitative findings in a mixed-methods matrix.
- Deliverable D-1:** Preliminary Findings Deck with visual themes and key patterns.

Phase III – Reporting & Insight Development (Weeks 6–8)

- ☐ Develop full evaluation report, including executive summary, appendices, and visuals.
 - ☐ Create 10-slide PowerPoint deck for presentations and advocacy use.
 - ☐ Produce infographics using Canva, Piktochart, and Infogram tools.
 - ☐ Finalize and deliver de-identified dataset and qualitative codebook.
- Deliverable DEV-1:** Final Evaluation Report, Slide Deck, Infographics, and CSV Dataset.

GRANT MANAGEMENT

5 year(s)

year(s)

7. Expected Number of Awards:

57

8. Approximate Average Award:

\$1,313,880

Per Budget Period

Of special note: The actual range of individual awards is \$142,891 to \$8,717,737 and are based on a funding estimator. The funding for prevention and control is allocated using a formula approach to ensure equitable distribution of resources based on changing TB epidemiology and program performance. A fixed funding amount is allocated for Human Resource Development based on the TB incidence level in each project area. Laboratory funding is allocated using a workload-based formula approach to ensure equitable distribution of resources.

9. Award Ceiling:

\$0

Per Period of Performance

This amount is subject to the availability of funds.

10. Award Floor:

\$0

Per Period of Performance

11. Estimated Award Date:

December 01, 2024

12. Budget Period Length:

12 month(s)

Throughout the period of performance, CDC will continue the award based on the availability of funds, the evidence of satisfactory progress by the recipient (as documented in required reports), and the determination that continued funding is in the best interest of the federal government. The total number of years for which federal support has been approved (period of performance) will be shown in the "Notice of Award." This information does not constitute a commitment by the federal government to fund the entire period. The total period of performance comprises the initial competitive segment and any subsequent non-competitive continuation award(s).

13. Direct Assistance

Direct Assistance (DA) is available through this NOFO.

Direct Assistance (DA) is available through this NOFO.

Applicants may request federal personnel, medication from the TB Emergency Drug Stockpile (TEDS) [during emergency situations] and equipment, or supplies as Direct Assistance (DA).

Page 34 of 76

Applicants may also convert Financial Assistance (FA) to DA for host-site travel for federal personnel.

If you are successful and receive a Notice of Award, in accepting the award, you agree that the award and any activities thereunder are subject to all provisions of 45 CFR part 75, currently in effect or implemented during the period of the award, other Department regulations and policies in effect at the time of the award, and applicable statutory provisions.

C. Eligibility Information

1. Eligible Applicants

Eligibility Category:

00 (State governments)

01 (County governments)

02 (City or township governments)

25 (Others (see text field entitled "Additional Information on Eligibility" for clarification))

99 (Unrestricted (i.e., open to any type of entity above), subject to any clarification in text field entitled "Additional Information on Eligibility")

Additional Eligibility Category:

Government Organizations:

State governments or their bona fide agents (includes the District of Columbia)

2. Additional Information on Eligible Government Organizations:

- Territorial governments or their b and the Virgin Islands.

Non-government Organizations:

Other:

In accordance with the statutory authority 247b-6(d):

The applicant must provide evidence that and authority to conduct TB disease surveillance, contain emerging TB disease intervention, and follow-up and perform which funding is sought.

The applicant must upload two attachments "Prevention and Control Elimination Plan Infrastructure" that includes the following:

FLORIDACOMMERCE		Don Orlando Executive Director	J. Adam Kelly Executive Director
CDBG-DR & CDBG-MIT Monthly Progress Report (MPR)			
Grant No. - Sub.	R1000 - City of Annapolis		
Project Title:	General Infrastructure Project		
Funding Awarded:	\$8,000,000.00		
Agreement Period:	01/15/2021 - 01/05/2025		
Primary Points of Contact Information:	Grant Manager name: GPI Phone # / GPI email: Office of Long-Term Resiliency	Primary project manager: Phone # / Email Title	
Activity Reporting Period: AUGUST 2025			
An update of this report shall be submitted to FloridaCommerce Inc (FIC) calendar days after the end of each month.			
Section One - Financial Data:			
	Amount	Funds used this period	Funds used to date
Leverage Funds (A)			
CDBG-MIT Funds (B)			
TOTAL Project Funds (A+B)			
* PLEASE SUBMIT COPIES OF SUPPORTING DOCUMENTATION FOR LEVERAGE FUNDS USED TO YOUR GRANT MANAGER ON A MONTHLY BASIS.			
Please include the date the first/next invoice will be submitted for this project and the amount of the invoice:			
Date:	Amount \$:		
Section Two - Accomplishments within the (past) Month:			
A narrative MUST be included			

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DEVELOPED GUIDANCE DOCUMENTS FOR GRANT CRITERIA'S AND MONTHLY PROGRESS REPORTS FOR COMMUNITY PROGRAM MANAGERS

Section Three - Issues or risks that have been faced with resolutions:		
Section Four - Projected activities to be completed within the following Month:		
A narrative MUST be included.		
Section Five - Required Submissions:		
Attachment B - Project Budget	Yes ☐	No ☐
Has the Project Budget changed?		
If answered "Yes", please submit: - The Revised Attachment B for review and approval - The explanation for the change.		
Attachment C - Activity Work Plan	Yes ☐	No ☐
Has the Activity Work Plan/Project Timeline changed?		
If answered "Yes", please submit: - The Revised Attachment C for review and approval - The explanation for the change.		
Staffing Plan	Yes ☐	No ☐
Were there any Staffing changes?		
If answered "Yes", please submit the Revised Staffing Plan which will include the Revised Org Chart and Updated names and Job descriptions .		
Equipment Transfer/Disposal and Tracking (If Construction is part of the Project)	Yes ☐	No ☐
Were there Equipment Transferred/Disposed?		
If answered "Yes", please request a copy of the Equipment Transfer/Disposal Form and disposition instructions from your grant Manager. Complete and submit the Equipment Transfer/Disposal form .		
Any Equipment purchased specifically for this project?	Yes ☐	No ☐
If answered "Yes", please submit an update Equipment Inventory Tracking Log listing the current equipment inventory, equipment service dates, etc. for monitoring purposes.		

Disclaimer: This document is for informational purposes only and does not constitute an offer of any financial product or service. It is not intended to be used as a basis for investment decisions. The information contained herein is not to be construed as an offer of any financial product or service. It is not intended to be used as a basis for investment decisions. The information contained herein is not to be construed as an offer of any financial product or service. It is not intended to be used as a basis for investment decisions.

Environmental Review		Yes ☐	No ☐
Is FULL Environmental Review completed and approved ?			
If "Yes", please provide the AUP (MUP/TEEL-16) Commerce's execution (signed) date on the bottom.			
AUP Status: _____			
If "No", please explain where you are in the environmental process:			
Was the AUP issued with "Special Conditions"?			
If "Yes", have the Special Conditions been fulfilled?			
If "No", please provide the estimated date the Special Conditions will be fulfilled (MUST be completed PRIOR to beginning of Construction):			
Date: _____			
Section Six - Construction/Plan Updates (APPLIED to ALL PCT Agreements)			
Have you started Construction (CWP/COP) or Plan Development (OPS)?		Yes ☐	No ☐
If "Yes", please provide Estimated Construction Start Date below:			
Date: _____			
If answered "Yes", please answer next 3 questions:			
Percentage of Overall Construction/Plan CURRENTLY completed? (Approximate)		_____%	
Percentage of Overall Construction/Plan EXPECTED to be completed next month? (Approximate)		_____%	
Have you provided 3 to 5 photos showing Construction or Planning Activities (Outreach meetings, etc...) progress for this month? - if not please attach photos to this report.		Yes ☐	No ☐
Please remember to submit, 3 to 5 different photos each month showing Construction progress.			

Disclaimer: This document is for informational purposes only and does not constitute an offer of any financial product or service. It is not intended to be used as a basis for investment decisions. The information contained herein is not to be construed as an offer of any financial product or service. It is not intended to be used as a basis for investment decisions. The information contained herein is not to be construed as an offer of any financial product or service. It is not intended to be used as a basis for investment decisions.

ADDITIONAL SKILLS

- MICROSOFT SUITE OFFICE PRODUCTS
- SAS/ R/ SPSS
- SQL/ SNOWFLAKE
- TABLEAU/ VISIO/ PUBLISHER/ ADOBE/ CANVA
- ADOBE/ FOX-IT PHANTOM
- GIT HUB
- DATA SYSTEMS
 - MERLIN, HEALTH INFORMATION SYSTEMS, NNDSS, DCIPHER,
 - MAVEN, MYSIDEWALK
- APPLICATIONS
 - MFMP, FLAIR, STMS, AXIOM PRO, SALESFORCE, FIRS
- WRIKE, ASANA

ALL SKILLS ARE NOT LIST



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