DR. LATWEIKA A.T. SALMON-TREJO

Senior Public Health Leader
Epidemiologist & Data Scientist
Strategic Planning & Policy Advisor in Community Health, Programs, & Non-Profit Organizations

Portfolio

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LATWEIKA A.T. SALMON-TREJO

EXPERT SKILLS

- PUBLIC HEALTH LEADERSHIP
- 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

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LATWEIKA A.T.
SALMON-TREJO

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Senior public health leader and epidemiologist with 10 + years of experience directing community-benefit initiatives, population-health analytics, and cross-sector collaborations. Expert at translating complex health and fiscal data into strategic plans that advance health, mobilize stakeholders, and drive measurable outcomes. Proven success managing multidisciplinary teams and multimillion-dollar budgets to design, implement, and evaluate evidence-based programs addressing infectious disease, chronic conditions, and social drivers of health.

SKILLS

Leadership
Strategic Planning
Partnership Development
Organization Management
Project Management
Budget and Fiscal Management
Community Health Needs Assessment
Community Benefit Reporting
Team Development & Workflows
Social Determinants of Health
Community Engagement
Data Analysis & Visualization
(SAS, R, SQL, Power BI)
Program Performance Metrics
Budget & Financial Oversight
Policy/Legislative Analysis
Grant Writing & Management
Stakeholder Engagement
Health Communications
Health Education
Cross-Agency Collaboration

PROFESSIONAL EXPERIENCE

Florida Commerce | Tallahassee, FL | 06/11/2025 – present
BUREAU OF FINANCIAL MANAGEMENT- GOVERNMENT OPERATIONS CONSULTANT III (FINANCE)

- Executed and monitored drawdowns across multiple funding streams, independently determining timing, adjustments, and expenditure transfers to balance debits and credits; ensured compliance with budget authority and maximized cash-flow efficiency.
- Redesigned fiscal grant reporting and annual spending plans across 14 grants and 50 sub-recipients, leveraging SQL, Power Query, and Excel pivot tables to integrate time-elapsed benchmarks, variance analysis, and revenue/cost projections—enhancing executive reporting, risk monitoring, and oversight of multimillion-dollar disbursements.
- Reconciled three fiscal years (FY 2022–2025) of American Rescue Plan (ARP) accounts across multiple funding streams, producing schedules that informed strategic budget planning and maintained state and federal compliance.
- Performed routine multi-fund reconciliations and tracked spend-versus-budget in FLAIR, MFMP, and Axiom Pro, swiftly resolving variances that safeguarded audit readiness and guided transparent use of community-benefit dollars.
- Authorized and reviewed multi-million-dollar purchase requests, evaluating alignment with budget appropriations, cash-flow forecasts, fringe benefits, and delegated release authority for operational and community-benefit expenditures.
- Directed end-to-end grant operations (award → closeout), built calendarized SOPs, reconciled to PMS/NOO/NOA records, and partnered with procurement, contractors, and senior leaders to streamline disbursements, provide budget training, and ensure timely, compliant spending aligned with equity goals

University of Florida | Gainesville, FL | 02/18/2022 – 08/25/2025
DIVISION OF INFECTIOUS DISEASES & GLOBAL MEDICINE: RESEARCHER

- Led statewide WGS analysis of 250 tuberculosis cases, uncovering resistance mutations in 31.8% of isolates and documenting delayed sputum conversion (53 days vs 42 days; aHR 0.54 @ 30 days)—evidence that prompted counties to flag high-risk communities as priority targets in their health-improvement plans.
- Converted study findings into policy by partnering with health-department and academic leaders to set a 60-day sputum-conversion benchmark (observed 56 % vs national goal 83 %), embed equity KPIs in annual reports, and align community-benefit budgets with evidence-based screening and treatment priorities.
- Evaluated preventive-therapy adherence in 993 latent-TB patients across 15 clinics; showed higher discontinuation with 4-month rifampin vs 3-month isoniazid-rifapentine (31 % vs 14 %; $P < .0001$) and quantified social-risk multipliers such as substance misuse (HR 12.0) and congregate living (HR 21.0), supplying counties with data to target high-risk groups and guide community-benefit investments.

The Department of Children and Families (DCF) | Tallahassee, FL | 02/21/2025 – 04/29/2025
OFFICE OF OPIOID RECOVERY: EPIDEMIOLOGIST

- Architected performance-tracking tools (macro-enabled Excel workbooks & structured Word reports) to monitor $205.7 million dollars in opioid settlement expenditures strategically aligning investments with community health priorities and ensuring compliance under Statute 397.99.
- Developed and delivered virtual trainings on standardized reporting templates to 50+ partners—equipping program managers to quantify interventions, track county-level spending, and optimize resource allocation.
    - Authored SOPs and evaluation rubrics/templates to streamline team workflows, elevate data quality across agencies, and drive evidence-based decision making for executive leadership and internal/external partners.
- Led a statewide assessment of Florida's Hospital and Emergency Management Services (EMS) Bridge Programs for medication-assisted treatment (MAT); integrated hospital-discharge, BRFSS, TEDS-A, NSDUH, and DCF datasets to evaluate rapid buprenorphine initiation, behavioral health pathways, and provider capacity—identifying service gaps and recommending expanded MAT offerings that were adopted as high priority items in subsequent community health needs assessments (CHNA) and resource-allocation plans for underserved Opioid use disorder (OUD) populations.
- Conducted a statewide psychiatric capacity analysis—benchmarking forensic & civil bed availability and utilization—to inform CHNA infrastructure priorities and underpin a Legislative Budget Request (LBR) for expanded mental health treatment facilities informing the addition of two new facilities in strategic plans.

- Identified methodological gaps in a SIDR forecasting model and implemented a Bayesian MCMC alternative averting budget misallocation, strengthening actuarial projections, and bolstering predictive validity for community-benefit planning.
- Chaired cross-sector Community Collaborative Councils with Department of Health (DOH), Agency for Health Care Administration (AHCA), law enforcement, and behavioral healthcare providers—integrating stakeholder insights into CHNA-driven Community Health Plan development and execution.
- Contributed to the development of CSTE-aligned legislative guidance that standardized substance use disorder case definitions, driving improved data interoperability and enabling more coordinated, data-informed responses across healthcare and public health systems.

31 Health Consulting, LLC | Oakland, FL | 07/01/2020 – present
DIRECTOR

- Steered program budgeting and resource planning for community-health projects, matching dollars to social, operational, and health-driven priorities, i.e., long-range goals; leveraged budget impact analysis to articulate quantified community health benefits and strengthen fiscal accountability in prevention programming.
- Directed full business operations including finance, accounting, contracts, purchasing, and compliance; developed internal controls, supervised staff/contractors, and ensured long-term financial sustainability of consulting operations.
- Secured a $100,000 Foundation award (<13 % success rate) for public-health innovation, expanding education, research, and wellness initiatives across Central Florida.
- Provided financial forecasting and KPI tracking across a portfolio of community-health initiatives, realigning resources to hit performance targets, support sustainability, and maintain alignment with statutory and funding requirements.
- Created VMOSA-based toolkits and concept-mapping guides to support client organizations craft outcome-oriented funding proposals and measurable community-benefit interventions, integrating fiscal analysis with strategic public health planning.

Higher Heights Consulting, Inc | Daytona, FL| 05/03/2024 – 01/10/2025
SENIOR PUBLIC HEALTH CONSULTANT III

- Directed a full Community Health Needs Assessment —integrated hospital-discharge, BRFSS, and CDC Social vulnerability data; produced a 30-page report and interactive Power BI dashboards that conveyed priority health issues and informed divisional community-benefit strategy for social impact.
- Performed root-cause and budget-impact analyses on identified gaps, then designed a six-month, equity focused improvement plan with VMOSA/SWOT logic models, outcome indicators, phased Gantt timelines, and a $1.2 M resource-tracking dashboard that aligns expenditures with measurable health outcomes.
- Built a sustainable community-benefit infrastructure: supported formation of a 20-member cross-sector council, trained 25+ staff in logic-model evaluation, and guided launch of mobile diabetes-screening and school-based asthma-education initiatives—amplifying stakeholder engagement and driving data-informed population-health improvements
- Developed infographics, one-page briefs, and executive slide decks to translate program results for executive board, community partners, and C-suite leaders; authored foundation grant proposals that secured 60 % of implementation funding and strengthened partnership development.

The Centers for Disease Control | Atlanta, GA | 02/28/2022 – 11/7/2024
DIVISION OF TUBERCULOSIS (TB) ELIMINATION: EPIDEMIOLOGIST

- Delivered semi-annual surveillance briefings as CDC Public Health Officer for OR, FL, IN, OH, IL, KY, and WV—turned epidemiologic and community health insights into prioritized, evidence-based interventions, aligned community-benefit budgets with strategic goals, and produced region-specific impact reports that documented measurable gains in outcomes to address disparities.
- Translated complex epidemiologic and social-determinant data from 50 + jurisdictions into SAS/R/Power BI dashboards and a 10-year burden projection adopted by CDC leadership to steer national resource allocation and presented findings at the National TB Conference April 2024.
- Co-led the 2023 National Tuberculosis Surveillance System Annual Report, adding new SDOH indicators and mentoring state programs on data quality, performance metrics, and federal-reporting standards.
- Served as CDC surveillance liaison for OR, FL, IN, OH, IL, KY, and WV; delivered semi-annual analytic briefings that shaped state risk-management, targeted-testing strategies, and funding priorities.
- Engineered an automated data-request workflow for partners such as WHO, ACHA, and USAID—cut turnaround time 30 % and provided rapid, standardized metrics now used in community-impact tracking systems.
- Authored a plain-language surveillance guide and comprehensive data dictionary adopted by multiple health departments, ensuring consistent regional breakouts for public reports and executive briefings.
- Coordinated multi-state partnerships to align strategic-plan activities with federal funding requirements (e.g., TB ARPA key indicators); resolved IT/data-system errors and elevated reporting accuracy.
- Collaborated with federal, county, and academic teams to evaluate cluster-investigation tactics and cost-effectiveness of digital adherence tools; findings informed national treatment guidelines and directed funding toward equity-focused interventions.
- Conducted a systematic review and meta-analysis of Video Directly Observed Therapy (VDOT), contributing to 2023 CDC treatment guidelines by evaluating implementation effectiveness and cost-efficiency.
- Led surveillance analysis supporting CDC's $27M Uniting for Ukraine TB initiative by identifying MDR-TB risk among Ukrainian parolees; aligned funding strategy with emergent community health needs and informed national screening protocols through stakeholder-driven, data-informed decision-making.

The Centers for Disease Control (CDC)| Atlanta, GA | 02/28/2022 – 11/7/2024
Diversity, Equity, Inclusion, Accessibility & Belonging (DEIAB) | COUNCIL COMMITTEE HEAD

- 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 (NCHSSTP) 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.

The Centers for Disease Control (CDC) | Atlanta, GA | 10/7/2022 – 01/11/2023
MPOX OUTBREAK RESPONSE TEAM LEAD

- Directed a national outbreak response team of 17 public health practitioners (epidemiologists, data analysts, clinicians and information system programmers), overseeing surveillance reporting, data validation, and intergovernmental case coordination across 50+ U.S. jurisdictions.
- Led strategic briefings for CDC executives and global partners (including WHO), aligning outbreak metrics with public health response priorities and advancing international coordination strategies.
- Delivered daily and weekly surveillance updates to CDC leadership; resolved cross-system data discrepancies in partnership with Informatics and Epi Task Force teams, ensuring accurate and cohesive national reporting.
- Managed quality control for Mpox case data, supporting mortality investigations, validating daily case counts, and approving state-submitted reports for publication and public dissemination.
- Oversaw the development and refinement of technical guidance, data collection tools, and manuscript content for peer-reviewed publication (e.g., MMWR), strengthening state-level data collection and national reporting protocols.

Florida Department of Health | Tallahassee, Fl | 10/08/2018 – 02/22/2022 TB MOLECULAR SURVEILLANCE EPIDEMIOLOGIST

- Developed a statewide Structured Query Language (SQL)-driven alert platform that tracks patient progress and flags communities with rising transmission—giving leaders real-time metrics to target resources, evaluate program impact, and feed data into the next Community Health Needs Assessment (CHNA).
- Defined and rolled out performance indicators that tie treatment health outcomes and outbreak triggers to grant deliverables, ensuring surveillance spending stays aligned with strategic objectives and community benefit goals.
- Designed an integrated data warehouse and standardized review template that merge EMR, genomic, and epidemiologic information, improving decision support for county partners and accelerating response workflows.
- Conducted advanced SAS/R analyses across three surveillance systems to map disease trends and social determinant hot spots using Geographic Information System (GIS), supplying evidence for community-health planning sessions and equity-focused improvement plans.
- Delivered a statewide training curriculum to 67 counties across internal/external stakeholders on genomic epidemiology, molecular surveillance and data interpretation, strengthening county health-department capacity and building the cross-sector relationships needed for collaborative community-benefit initiatives.
- Authored monthly analytic reports using Microsoft office products and Adobe and Foxit Phantom to articulate sensitive community health findings regarding health outcomes and disease transmission (e.g., *Clusters of Interest*, *Molecular Surveillance Quarterly*) using GIS, Visio, and PowerPoint to inform CDC decision-making and guide national TB strategy.

Florida Department of Health | Tallahassee, FL | 03/12/2020-05/29/2021
COVID-19 SENIOR PUBLIC HEALTH ADVISOR III

- Led case investigation and contact tracing operations during Florida's COVID-19 emergency response, supporting outbreak control and surge capacity in Broward County for priority setting.
- Conducted field-based outbreak investigations and delivered rapid training on case identification and contact protocols to strengthen local response infrastructure in Broward County as an expert public health advisor.
- Assessed public health infrastructure gaps (e.g., staffing, protocols, data flows) and recommended improvements to enhance intervention efficiency, safety, and serve as content expert and lead.
- Oversaw lab data management for PCR and rapid tests in Merlin, ensuring timely, accurate reporting aligned with state surveillance protocols and federal reporting standards.

Florida Department of Health | Tallahassee, FL | 06/12/2017-01/06/2020 DIVISION OF DISEASE CONTROL HEALTH AND WELLNESS ADVOCACY PROGRAM EDUCATOR

- Designed and implemented employee wellness initiatives aligned with CDC's Employee Wellness Scorecard, supporting departmental goals around workforce development and chronic disease prevention.
- Launched workplace wellness programs focused on nutrition, physical activity, and mental health—e.g., "10,000 Steps a Day Challenge," health seminars, and peer-supported stress management initiatives.
- Developed a portfolio of behavior change interventions including weight loss challenges, recipe exchanges, and educational campaigns to promote healthy lifestyles and organizational morals to address employee community health needs to benefit division wellness.

Florida Department of Health | Tallahassee, FL | 06/12/2017-10/8/2018 TRAVEL ASSOCIATED DISEASE EPIDEMIOLOGIST

- Conducted syndromic surveillance across hospitals, urgent care facilities, and electronic medical transportation services to identify and evaluate key findings, monitoring patterns of infectious diseases statewide.
- Directed surveillance for for infectious diseases such as giardia, malaria, influenza, Zika, etc., while consulting with internal leadership weekly and 67 local county health departments biweekly to assess investigations and program directives and developed a health tool (survey) for outbreaks to conduct contact tracing and identify additional cases and transmission agents of epidemiological concern.
- Identified an area in syndromic surveillance to capture new variables for cases reported in Merlin designated for the country's cases traveled to and categories for exposure outside of Florida in the US, an outside of the U.S.
    - This contribution to the surveillance system supported work to understand the burden of travel associated diseases in the state of Florida.
- Managed and reviewed the states system for reporting outbreaks, Outbreak Module, in terms of syndromes, chief complaints in hospitalizations, geospatial analysis, and transmission rates based on reported travel locations to measure and assess timeliness and data quality for analysis using SAS and SQL
- Developed and monitored several data collection fields in the Florida case reporting database for travel associated cases e.g., travel history and origin of diseases in the state's repository of

reportable diseases, Merlin, to which systematic data collection enhancements were regularly implemented to streamline the collection, storage and analysis.

- Used advanced computer software i.e., Microsoft excel, SAS, and R for pivot reporting, and statistical analysis of structured and unstructured data to routinely code in SAS for short reports of descriptive summaries (e.g., measures of frequency such as incidence, prevalence, odds ratio e.g. zika cases in FL- Residents with recent travel to Brazil and other state outbreaks or the varicella outbreaks in school age children.

Women's and Girls' Cancer Alliance (WGCA) | Longwood, FL | 05/16/2014- 08/19/2016
HEALTH COMMUNICATIONS MANAGER

- Developed infographics and one-page toolkits that translated HPV-vaccination data, #PantyPledge social media analytics, and event ROI into clear snapshots for board members, community partners, and the Women's & Girls Cancer Alliance (WGCA) staff—proactively communicating program implementation, evaluation, and outcomes.
- Managed internal and external communication requests for the WGCA health-education team, producing slide decks, fact sheets, and press-ready "quick stats" that kept hospital partners, local businesses, and faith-based organizations aligned on community-benefit goals.
- Supervised three interns to lead and design a Giving Tuesday digital campaign in addition to charitable grants that secured $3,000 in funding for the first time at the nonprofit agency in less than 24 hours.
- Coordinated capital venture funding initiatives and grass roots programming i.e., the Teal Magnolia Luncheon & Silent Auction—generating $200,000, more than 50 percent of the nonprofit's annual operating budget, demonstrating bottom-line stewardship.
- Delivered epidemiology-focused lectures on gynecologic cancers to second-year nursing cohorts and onboarded 50+ volunteers, ensuring culturally competent engagement and expanding the coalition that supports WGCA's outreach across Central Florida.
- Led a multi-county study of HPV vaccination gaps in Orange and Seminole Counties; the findings informed targeted outreach and were embedded into local community-health plans and benefits to reduce cancer disparities through strategic partnership development with local nonprofit organizations and faith-based coalitions.
- Recruited, trained and onboarded 50+ volunteers on standard operating procedures and organizational history to support execution of two high-impact fundraising events in Central Florida, advancing the mission and visibility of the nonprofit.
- Developed and coordinate data-informed initiatives to enhance and improve the health of targeted populations of women and girls with cancer via the sharing of health-related educational or informational materials in the form of a communication health campaign, #PantyPledge, that increased awareness and established relationships and dialogue among stakeholders and Central Florida communities concerning HPV and Cervical cancer early detection for the Women's and Girls Cancer Alliance (WGCA).
    - The health campaign, the Panty Pledge (pantypledge.org), was conducted on social media platforms and successfully raised awareness for Gynecologic Cancer with 289k impressions and 395 new followers.
- Designed health information and created social media content including newsletters, blogs, marketing material, and fundraising ads for Giving Tuesday in addition to the WGCA website, and all social media platforms, and a monthly newsletter reaching over 22k viewers.
- Led a multi-county research study analyzing HPV vaccination rates, disease prevalence, and community awareness of female cancers among at-risk populations in Orange and Seminole counties to identify health risk and implement data evidence-based strategies to align with the organization's strategic priorities, strengthen nonprofit outreach and support community health.

DOCTORAL DISSERTATION

Leveraging Tuberculosis Lineage Insights and Contact-Based TB Cases to Enhance Molecular Epidemiology Practices in Cluster Investigations: Exploring the Role of Sympatric and Allopatric Exposure in Florida

- Led advanced molecular epidemiology research for my doctoral dissertation—applied whole-genome sequencing (WGS), phylogenetics, TransPhylo, and TransCluster to compare 5-SNP vs. 10-SNP thresholds, model TB transmission dynamics, and integrate demographic predictors (age, sex, race/ethnicity) to inform early-detection strategies and performance metrics in cluster investigations.
- Critically assessed CDC's SNP-threshold model and developed a state-level implementation framework accounting for lineage-specific mutation rates and host-pathogen relationships—translated findings into executive summaries, infographics, and slide decks that guided protocol enhancements, resource allocation, and programmatic priorities.

EDUCATION

DrPH | Public Health –Epidemiology & Biostatistics | Florida Agriculture & Mechanical University
MPH | Public Health –Epidemiology | Kaplan (Purdue) University
BS | Biology–Medical Science | Northwestern State University

CERTIFICATIONS & TRAINING

Government Accounting Basics | 2025
Reconciliation and Corrections | 2025
Microeconomics – The Power of Markets | 2025
Microsoft Office Project Planning | 2023
Computational Genomics | 2021
Project Management Professional ® Training Course | In Progress – 2025
Certification Board of Infection Control and Epidemiology | Certified in Infection Control | In Progress – 2025

PUBLICATIONS AND SCIENTIFIC RESEARCH

- Asare-Baah, M., Séraphin, M. N., **Salmon-Trejo, L. A. T.,** Johnston, L., Dominique, L., Ashkin, D., Vaddiparti, K., Kwara, A., Maurelli, A. T., & Lauzardo, M. (2025). Genotyped cluster investigations versus standard contact tracing: comparative impact on latent tuberculosis infection cascade of care in a low-incidence region. *BMC infectious diseases*, *25*(1), 74. https://doi.org/10.1186/s12879-024-10358-4
- Asare-Baah M, Séraphin MN, **Salmon-Trejo LAT**, Johnston L, Dominique L, Ashkin D, Vaddiparti K, Kwara A, Maurelli AT, Lauzardo M. Effects of the Beijing genotype on latent tuberculosis infection, TB disease risk, and clustering of TB cases. Infect Genet Evol. 2024 Sep;123:105648. doi: 10.1016/j.meegid.2024.105648. Epub 2024 Jul 25. PMID:39059734.
- Asare-Baah, M., **Salmon-Trejo, L. A. T.,** Venkatappa, T., Garfein, R. S., Aiona, K., Haas, M., &

Séraphin, M. N. (2024). Factors Associated With the Discontinuation of Two Short-Course Tuberculosis Preventive Therapies in Programmatic Settings in the United States. *Open forum infectious diseases*, *11*(6), ofae313. https://doi.org/10.1093/ofid/ofae313

- Eustaquio PC, **Salmon-Trejo LA**, McGuire LC, Ellington SR. Epidemiologic and Clinical Features of Mpox in Adults Aged >50 Years — United States, May 2022–May 2023. MMWR Morb Mortal Wkly Rep 2023;72:893– 896. DOI: http://dx.doi.org/10.15585/mmwr.mm7233a3
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  D., Feldpausch, A., Pavlick, J., English, A., Smith, M., Rehman, T., Lubelchek, R., Black, S., Collins, M., Mounsey, L., Blythe, D., … Guagliardo, S. A. J. **Salmon-Trejo LAT** (2023). Epidemiologic and Clinical Features of Mpox-Associated Deaths - United States, May 10, 2022March 7, 2023. MMWR. Morbidity and mortality weekly report, 72(15), 404–410. https://doi.org/10.15585/mmwr.mm7215a5
- Mangan, J. M., Woodruff, R. S., Winston, C. A., Nabity, S. A., Haddad, M. B., Dixon, M. G., Parvez,
  F. M., Sera-Josef, C., **Salmon-Trejo, L. A. T.,** & Lam, C. K. (2023). Recommendations for Use of Video Directly Observed Therapy During Tuberculosis Treatment - United States, 2023. MMWR.
  Morbidity and mortality weekly report, 72(12), 313–316. https://doi.org/10.15585/mmwr.mm7212a4
- Oakley, L. P., Hufstetler, K., O'Shea, J., Sharpe, J. D., McArdle, C., Neelam, V., Roth, N. M., Olsen, E.
  O., Wolf, M., Pao, L. Z., Gold, J. A. W., Davis, K. M., Perella, D., Epstein, S., Lash, M. K., Samson, O., Pavlick, J., Feldpausch, A., Wallace, J., Nambiar, A., **Salmon-Trejo, L. A. T.,** (2023). Mpox Cases Among Cisgender Women and Pregnant Persons - United States, May 11-November 7, 2022. *MMWR. Morbidity and mortality weekly report*, *72*(1), 9–14. https://doi.org/10.15585/mmwr.mm7201a2
- Asare-Baah M, Séraphin MN, **Salmon LAT**, Lauzardo M. Effect of mixed strain infections on clinical
  and epidemiological features of tuberculosis in Florida. Infect Genet Evol. 2021 Jan;87:104659. doi: 10.1016/j.meegid.2020.104659. Epub 2020 Dec 1. PMID: 33276149

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

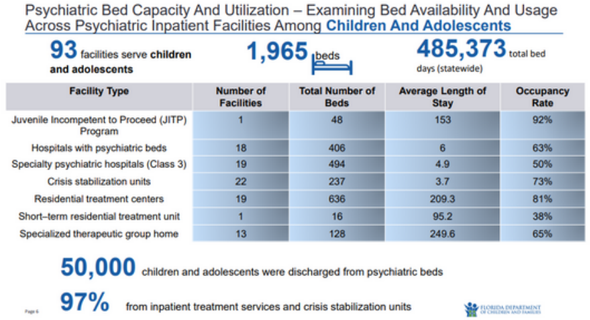
1. Authorize increased appropriation and/or phased bonding to meet bed capacity.

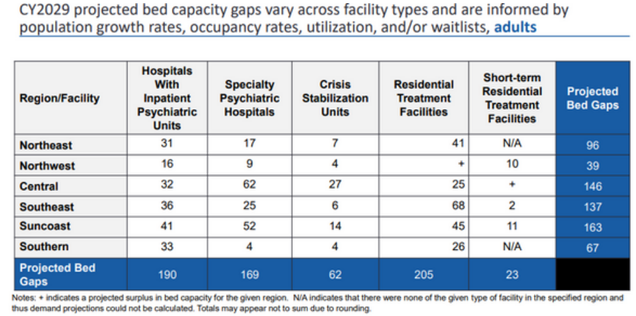
2. Establish a real-time performance dashboard tracking forensic wait-time, civil occupancy, cost per patient, and compliance scores.

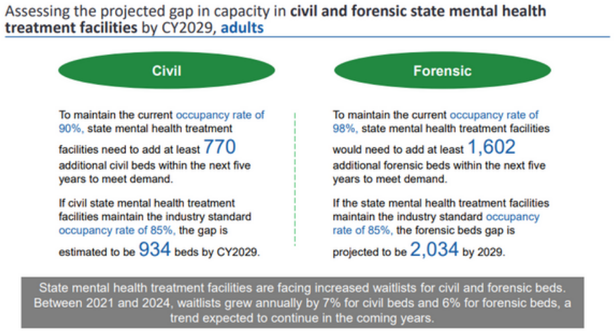
3. Require a Year-5 ROI review to validate benefits and adjust bed mix if needed.

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.







latweika.salmon@icloud.com

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. LaTweika 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.

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.

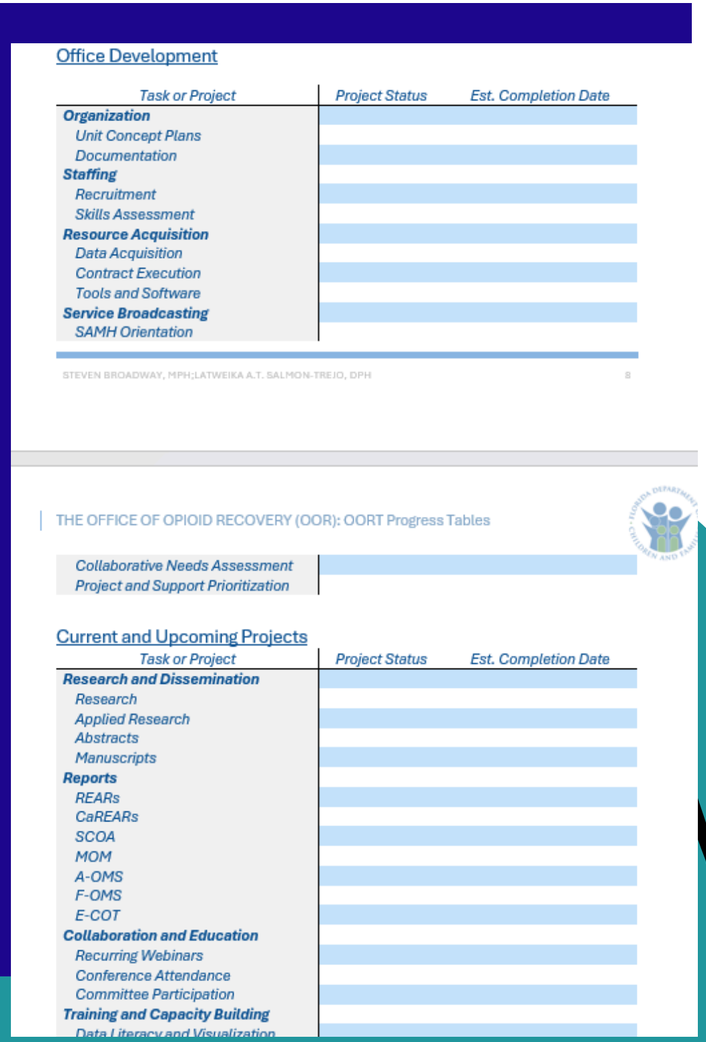
3 Scope & Deliverables (Remote)

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.

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		

STEVEN BROADWAY, MPH;LATWEIKA A.T. SALMON-TREJO, DPH 8

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

Table of Contents

The Office of Opioid Recovery

Background

Organization

Chats

List of Major Projects

Units

Reports

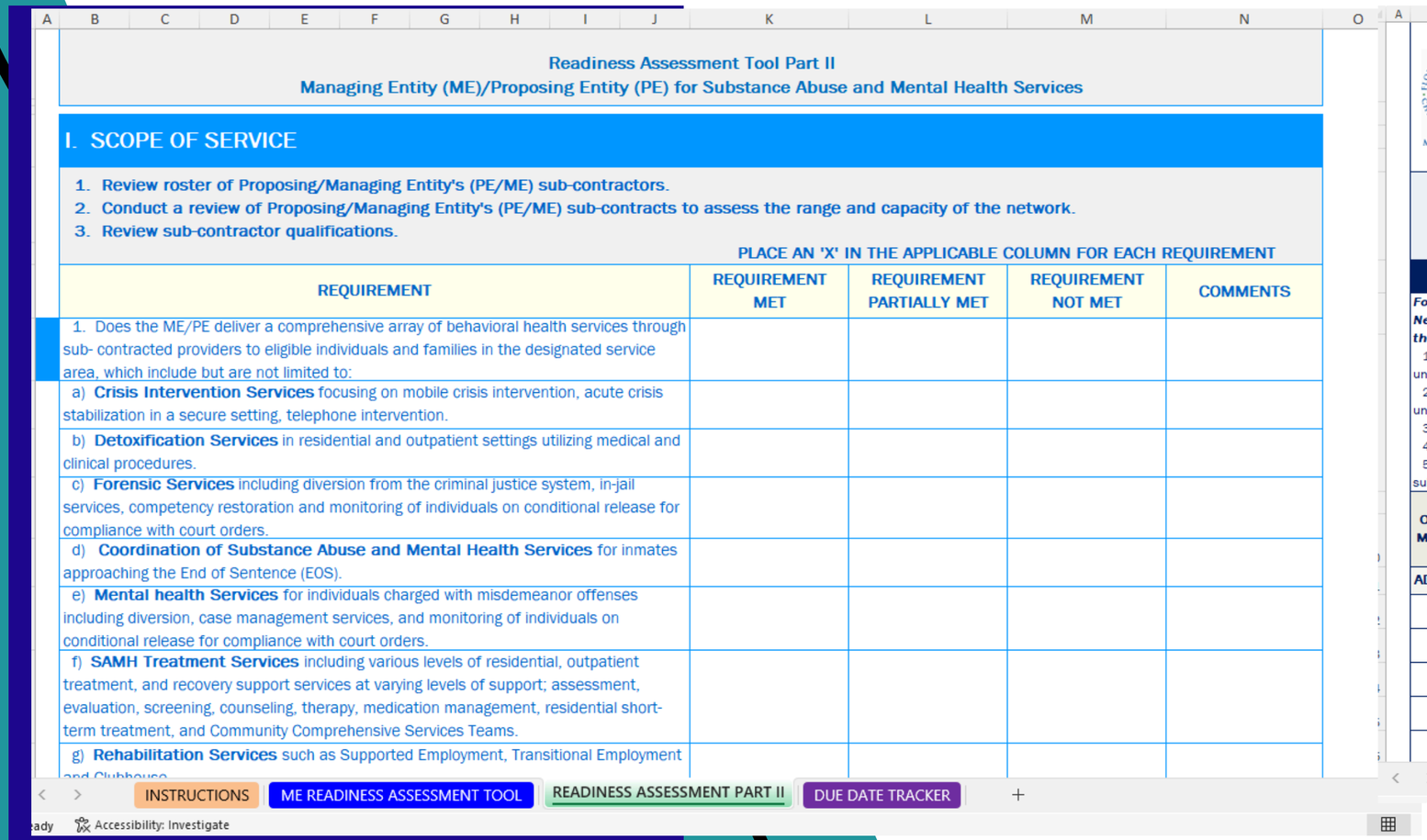
DEVELOPED SECTION REFERENCE MANUAL &TASK TRACKING PRODUCTS FOR ANNUAL DELIVERABLES AND STRATEGIC ALIGNMENT.

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

latweika.salmon@icloud.com

LATWEIKA A.T. 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

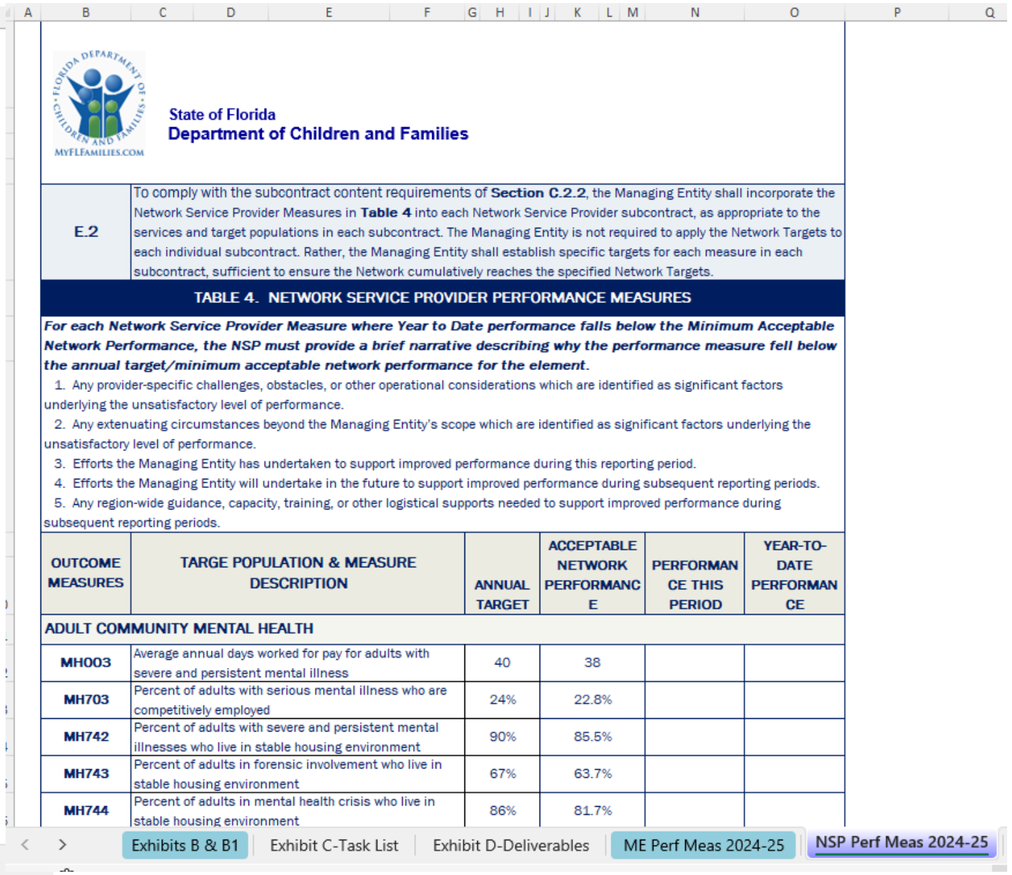
1. Review roster of Proposing/Managing Entity's (PE/ME) sub-contractors.
2. Conduct a review of Proposing/Managing Entity's (PE/ME) sub-contracts to assess the range and capacity of the network.
3. Review sub-contractor qualifications.

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 and Clubhouse				

INSTRUCTIONS | ME READINESS ASSESSMENT TOOL | READINESS ASSESSMENT PART II | DUE DATE TRACKER

Accessibility: Investigate



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	PERFORMANCE THIS PERIOD	YEAR-TO-DATE PERFORMANCE
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

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

LATWEIKA A.T. SALMON-TREJO

PROGRAM MANAGEMENT

SUPPORTED THE DEVELOPMENT OF PROGRAM GUIDANCE & IMPLEMENTATION PLANS

1. 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 (CoAgs). 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 (CoAgs), 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 CoAgs 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.

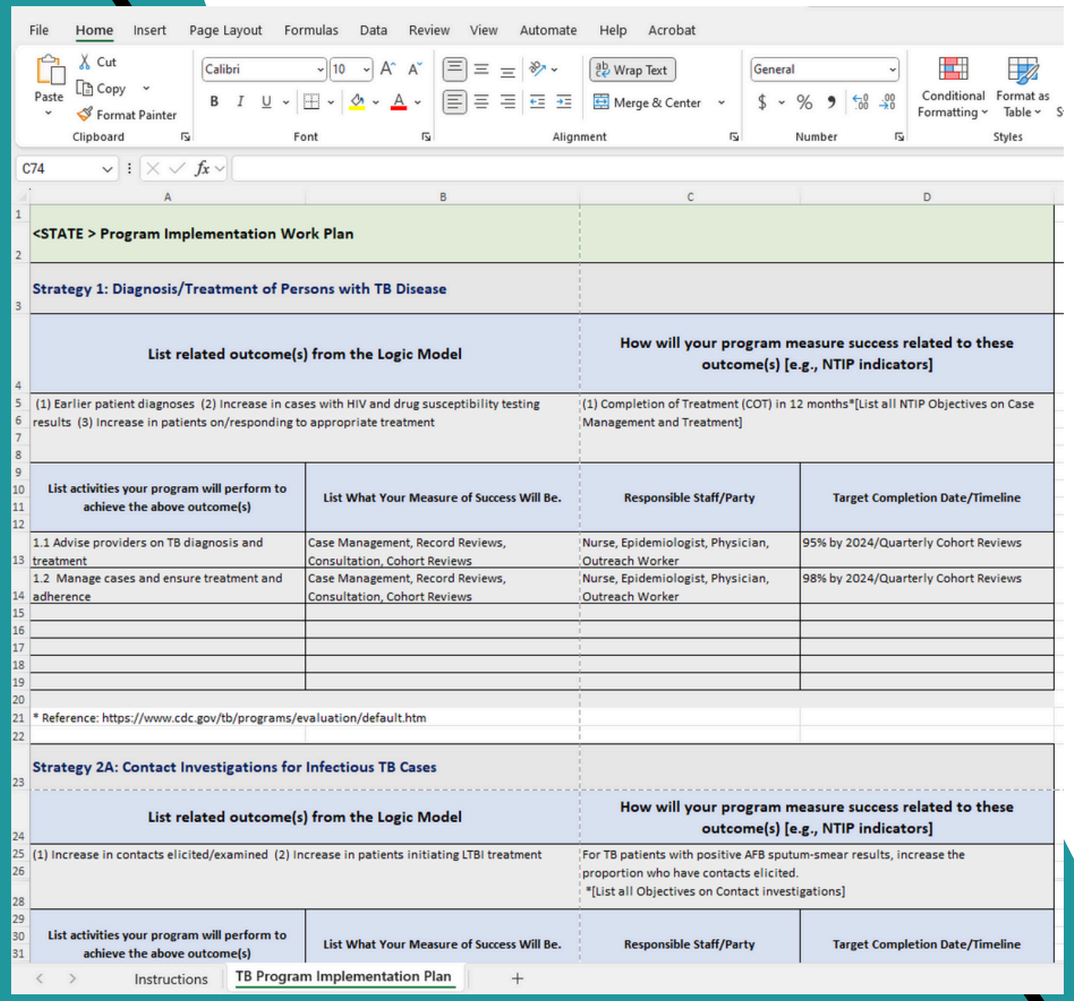
Strategies and Activities	Short-Term Outcomes	Intermediate Outcomes	Long-Ter Outcome
Diagnosis and treatment of persons with TB disease • Advise providers on TB diagnosis and treatment • Manage cases and ensure	• **Increased use of Nucleic Acid Amplification Testing (NAAT)** • Decreased time between 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 a among populatio higher ri**

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 • 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 • 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
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**	
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**	

• 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



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<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
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 LTBI 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 examinmnation within 30 days *[List all Objectives on Examination of Immigrants and Refugees]

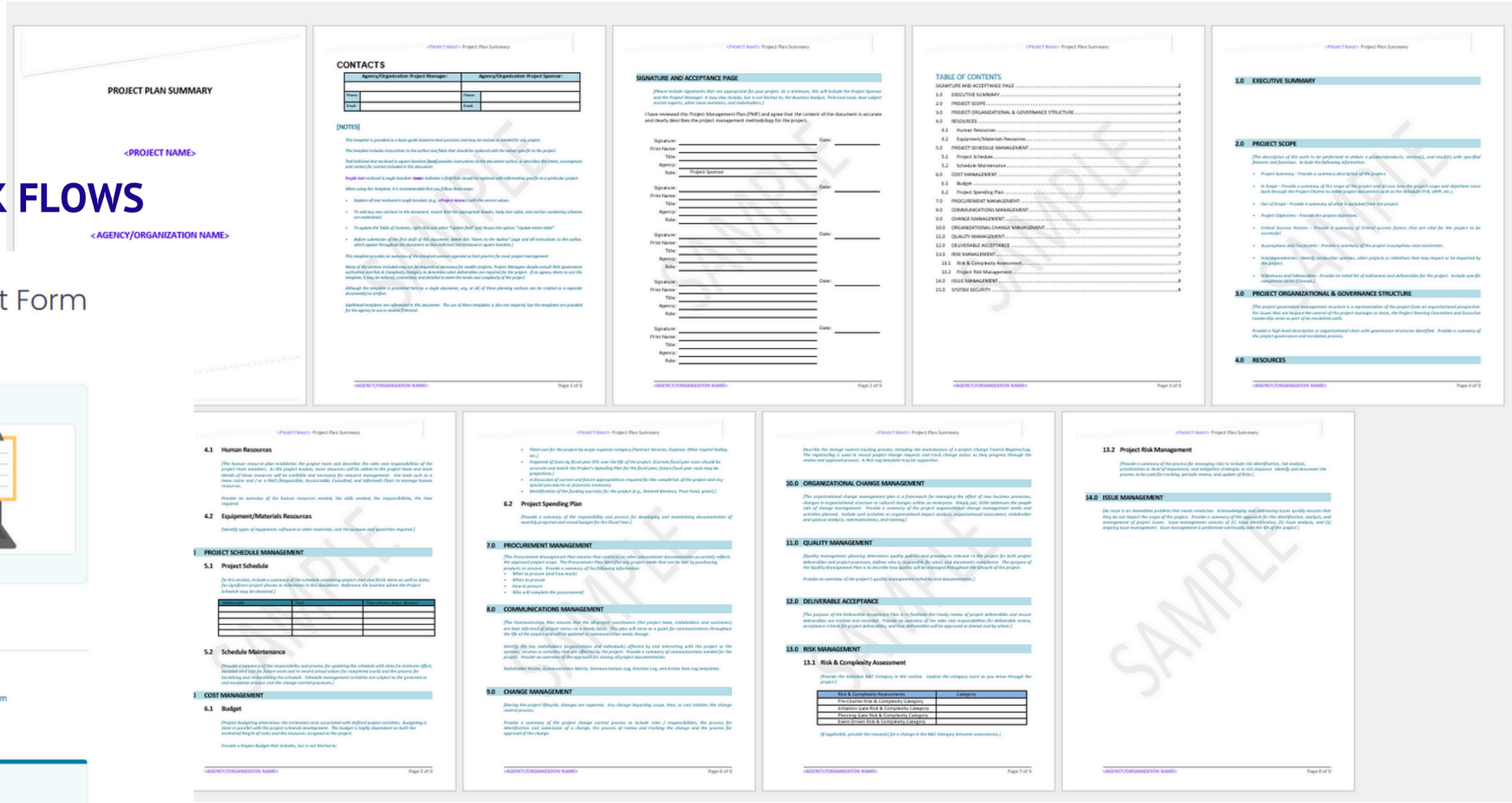
List activities your program will perform to achieve the above outcome(s)	List What Your Measure of Success Will Be.	Responsible Staff/Party	Target Completion Date/Timeline
2B.1 Examine immigrants/refugees with Class B notification	Data cleaning & quality control checks	Epidemiologist/Case managers	By 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

Instructions TB Program Implementation Plan

PROJECT MANAGEMENT

CREATED NATIONAL WORK FLOWS


PROJECT PLAN SUMMARY

<PROJECT NAME>

<AGENCY/ORGANIZATION NAME>

CONTACTS

SIGNATURE AND ACCEPTANCE PAGE

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1.0 EXECUTIVE SUMMARY

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3.0 PROJECT ORGANIZATIONAL & GOVERNANCE STRUCTURE

4.0 RESOURCES

4.1 Human Resources

4.2 Equipment/Materials Resources

5.1 Project Schedule

5.2 Schedule Maintenance

6.1 Budget

6.2 Project Spending Plan

7.0 PROCUREMENT MANAGEMENT

8.0 COMMUNICATIONS MANAGEMENT

9.0 CHANGE MANAGEMENT

10.0 ORGANIZATIONAL CHANGE MANAGEMENT

11.0 QUALITY MANAGEMENT

12.0 DELIVERABLE ACCEPTANCE

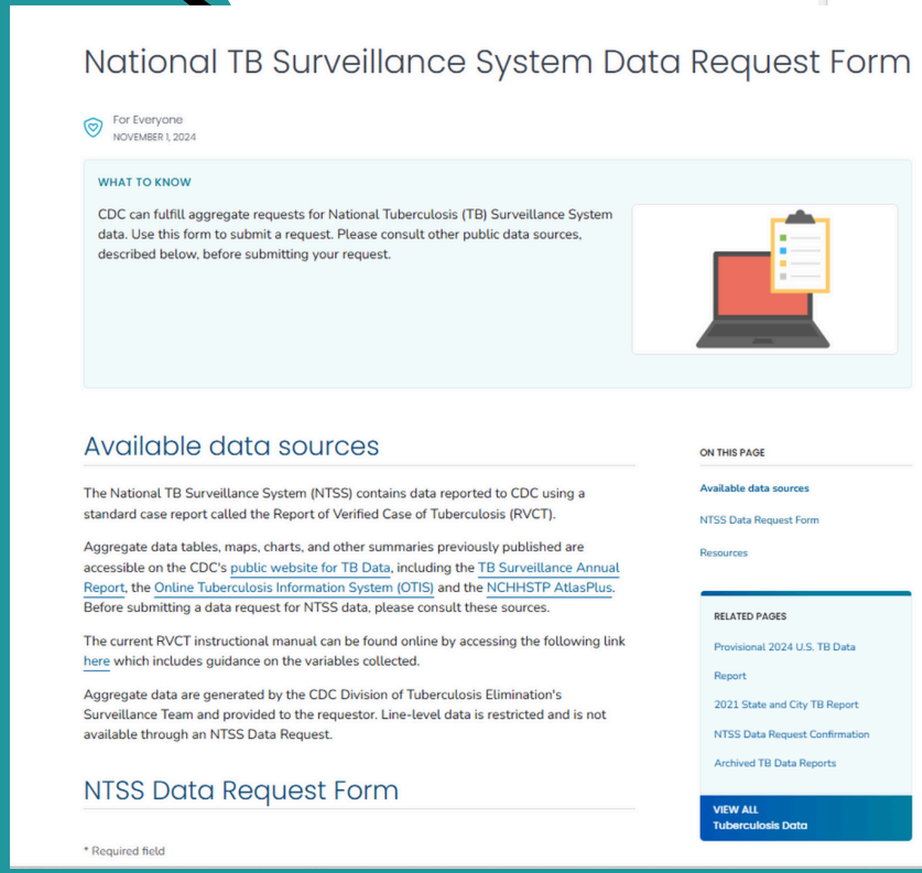
13.0 RISK MANAGEMENT

13.1 Risk & Complexity Assessment

13.2 Project Risk Management

14.0 ISSUE MANAGEMENT

SAMPLE


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

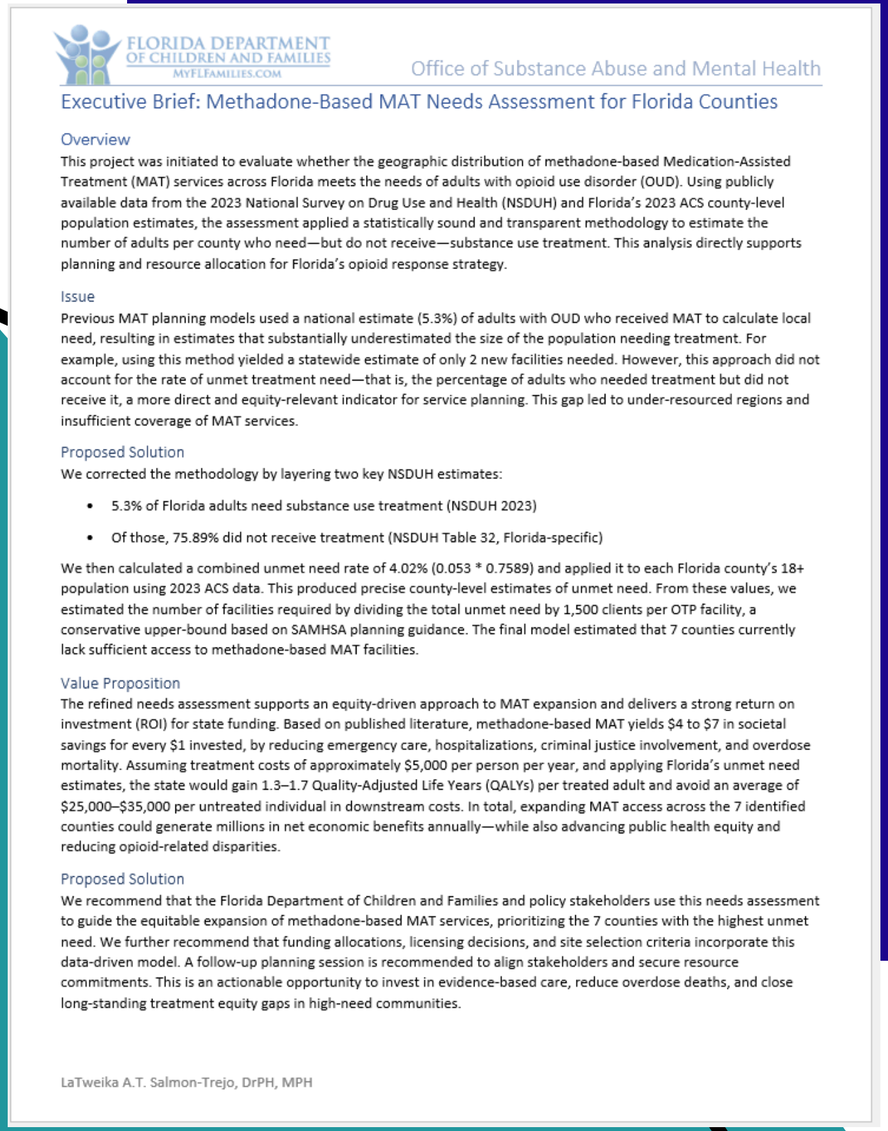
NTSS Data Request Confirmation

Archived TB Data Reports

VIEW ALL Tuberculosis Data

DEVELOPED PROJECT CHARTERS

COMMUNITY HEALTH NEEDS ASSESSMENT



FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
MYFLFAMILIES.COM

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 PROBLEMCONDUCTED 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 GOVENOR DESANTIS TO OPEN NEW AND EXPANDED TREATMENT SERVICES IN THE STATE'S HIGHEST-NEED COMMUNITIES.

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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.1.1.6.6.1 and**	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
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 credentialling 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**.

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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)

Coordinated Opioid Recovery
A NETWORK OF ADDICTION CARE

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.
Innovation	Describe any new and innovative treatment methods or practices implemente
Community Partnerships	List any new formal or informal partnerships established in the reporting perio Sharing Agreements, common assessments, etc.) and what service they provide
Success Story	Provide a success story from the CORE Network (if applicable). The success ston coordinated system of care where all CORE components work together, or an ir 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 f

Fiscal Year:	(Select Fiscal Year)	**Reporting Period**	(Select Reporting Period)	(Select County)		
Community Outreach		**Innovation**		**Community Patnerships**	**Success Story**	**Media Coverage**
List and describe your community CORE outreach efforts conducted this quarter (EMS, 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.	Describe a success story if applicable.	Provide Links to media coverage of your CORE Network for this reporting period.

SUMMARY OF LAW ENFORCEMENT PARTICIPATION

Provide a summary of expenditures using CORE-LE funding, specifying how the funds were utilized. Example: Crisis training for diversion efforts in the community, three laptops, etc.

Agency Awarded	Total CORE LE Funding Awarded	CORE LE Expenditures	Expenditure Description
TOTAL:			

*If equipment was purchased, please specify what kind of equipment. If training was purchased, please specify what kind of training.

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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 **unique** 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 numb receiving clinic during the reported ti
Of the total number of unique individuals with OUD served, how many received MAT in a CORE receiving clinic?	This value represents the **unique** nur received MAT in a CORE receiving cli
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 CORE receiving clinic during the repo
Total number of MAT inductions.	The total number of MAT inductions count of **all MAT inductions**, not a co more than once during the reporting
Number of unique individuals with SUD who engaged with a Peer Specialist.	This value represents the number of the reported timeframe. If the receiv responsible for collecting this data fr
Number of unique individuals with SUD who remained in treatment for at least 1 month (30 days).	Of the total number of **unique** (new a clinic, how many remained in treatm
Number of unique individuals with SUD who remained in treatment for at least 3 months (90 days).	Of the total number of **unique** (new a clinic and received treatment for 1 m (90 days)?
Number of unique individuals with SUD who remained in treatment for at least 6 months (180 days).	Of the total number of **unique** (new a clinic and received treatment for 3 m (180 days)?
Number of unique individuals with SUD who remained in treatment for at least 1 year (365 days).	Of the total number of **unique** (new a 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
Jill	32	at least 30 days	**5** (Jill, James, Jack, Carol, and Karen)
James	45	at least 90 days	**3** (Jack, Carol, and Karen)
Jack	126	at least 180 days	**2** (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.	

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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
National Center for HIV, Viral Hepatitis, STD, and TB Prevention
DEIAB
Diversity, Equity, Inclusion, Accessibility & Belonging Council

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

CDC
U.S. CENTERS FOR DISEASE CONTROL AND PREVENTION

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.

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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 Johnston [5], Lina Dominique [5], David Ashkin [6], Krishna Vaddiparti [1], Awewura Kwara [6 7], Anthony T Maurelli [2 8], Michael Lauzardo [9 10]

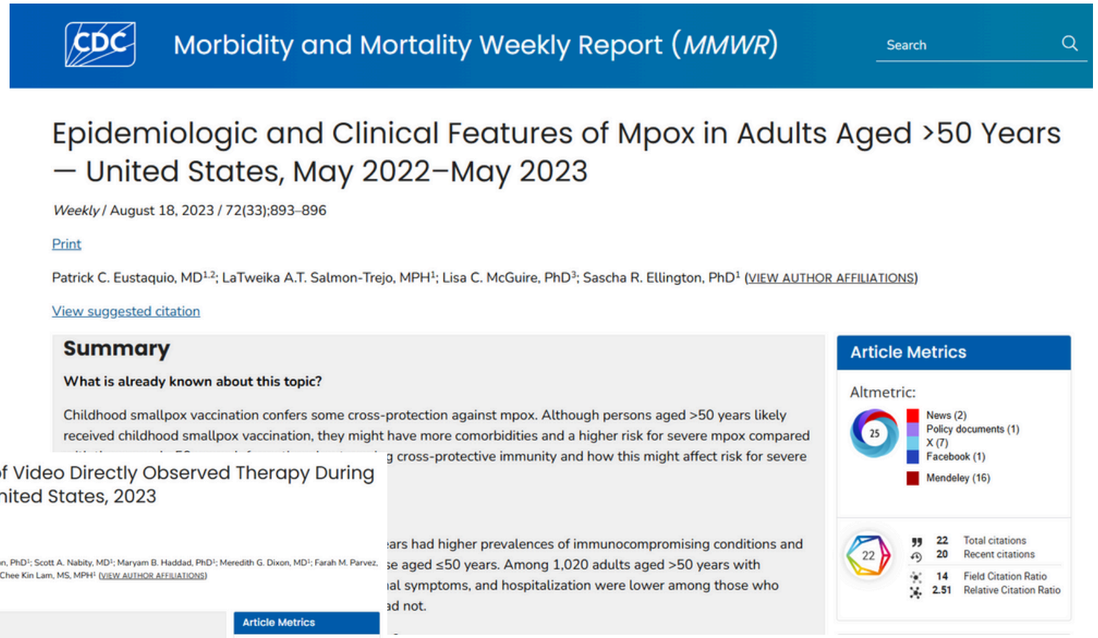
Affiliations + expand

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.



CDC 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, MPH[1]; Lisa C. McGuire, PhD[3]; Sascha R. Ellington, PhD[1] (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

g cross-protective immunity and how this might affect risk for severe

ars had higher prevalences of immunocompromising conditions and se aged ≤50 years. Among 1,020 adults aged >50 years with al symptoms, and hospitalization were lower among those who d not.

Article Metrics

Altmetric:

25

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

22

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

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, PhD[1]; Rachel S. Woodruff, MPH[1]; Carla A. Winston, PhD[1]; Scott A. Nabity, MD[1]; Maryam B. Haddad, PhD[1]; Meredith G. Dixon, MD[1]; Farah M. Parvez, MD[1]; Carissa Sera-Josef, MS[1]; LaTweika A. T. Salmon-Trejo, MPH[1]; Chee Kin Lam, MS, MPH[1] (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.

Article Metrics

Altmetric:

65

News (5)
Policy documents (1)
X (30)
Facebook (2)
Clinical guidelines (1)
Mendeley (70)

11

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

Table

Related Materials

Article PDF

Full Issue PDF

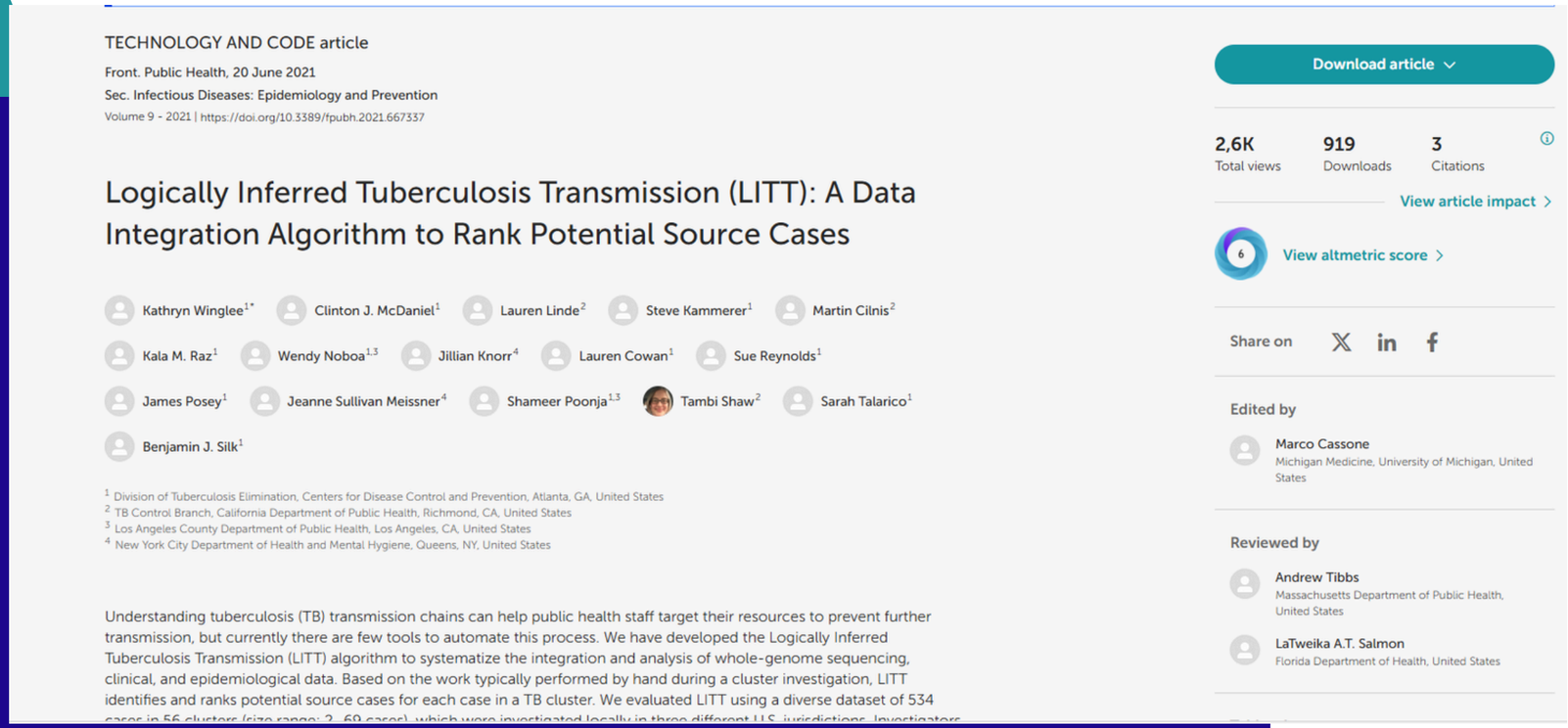
Video directly observed therapy (vDOT) provides flexibility during TB treatment, saving time and costs

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

latweika.salmon@icloud.com

LATWEIKA A.T. SALMON-TREJO

LEADERSHIP IN RESEARCH



TECHNOLOGY AND CODE article

Front. Public Health, 20 June 2021

Sec. Infectious Diseases: Epidemiology and Prevention

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

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Kala M. Raz[1] Wendy Noboa[1,3] Jillian Knorr[4] Lauren Cowan[1] Sue Reynolds[1]

James Posey[1] Jeanne Sullivan Meissner[4] Shameer Poonja[1,3] Tambi Shaw[2] Sarah Talarico[1]

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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

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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 BRACA 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-intenstive 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

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.

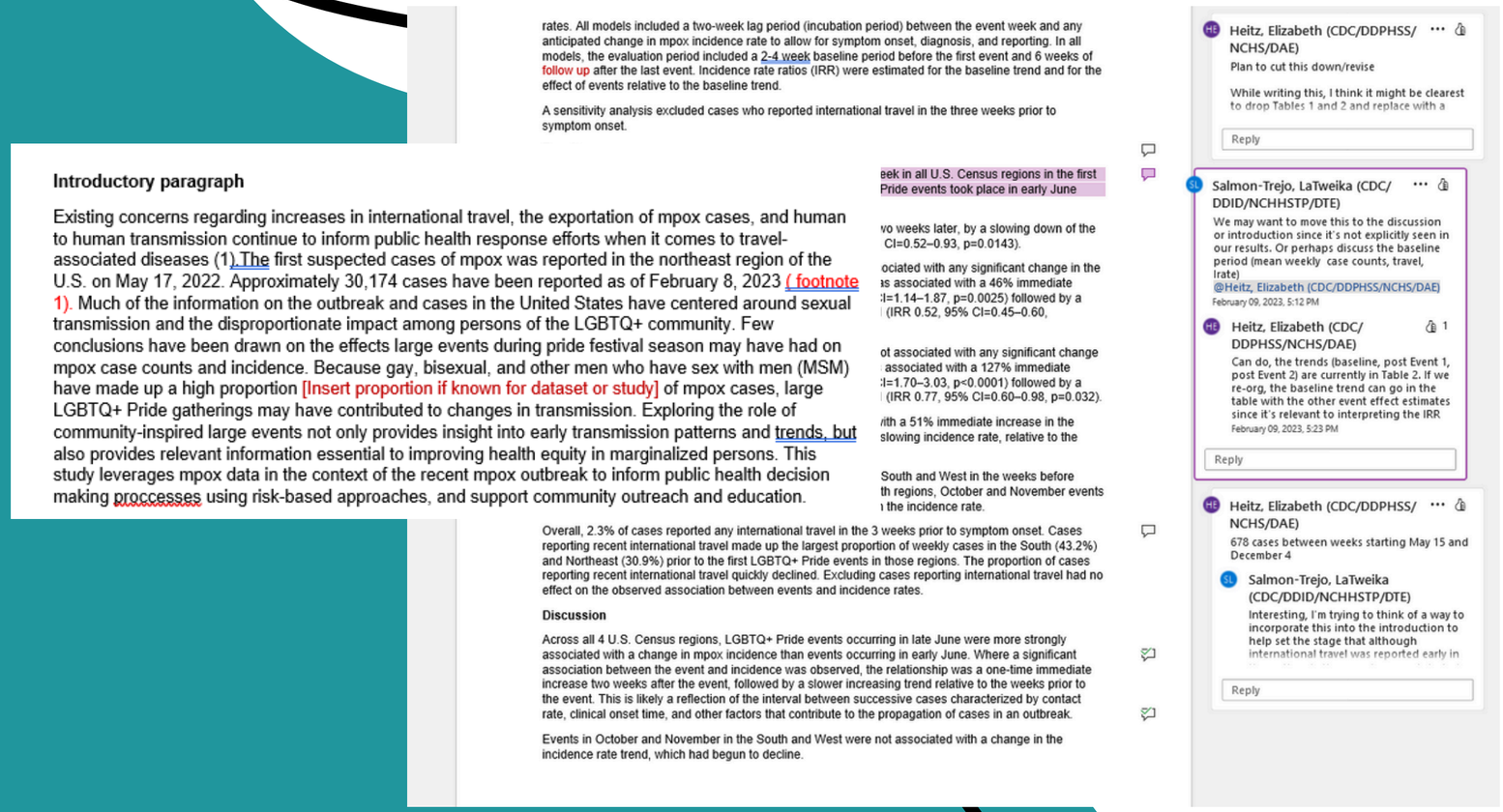
From U.S. immigration panel sites in Ukraine during 2016–2021, the results of medical examinations for 54,493 Ukrainians who were applying for immigrant or refugee admission to the United States were reported to CDC's Division of Global Migration and Quarantine: 36 applicants had Class A Active TB, for 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.



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.

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 proccesses using risk-based approaches, and support community outreach and education.

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

vo 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 (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 (IRR 0.77, 95% CI=0.60–0.98, p=0.032).

/ith 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) 1
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 or 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 DEVELOPMEMT

NWF Health Network

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
	J. Leadership, Planning and Coordination J3 L. Research L1 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

NWF Health Network

	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, are at risk of becoming 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

COUNTY/CITY IMPLEMENTATION PLANS

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

NWF Health Network

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 SUDMH 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

NWF Health Network

Scope of Work and Desired Outcome:

1. 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 overdoes in the community.

2. 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.

3. 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.

4. 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.

5. 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.

6. 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

		Stakeholder Influence and Interest Grid	
Communication Strategy	Project Expectations	Interest	Influence
		1	2
		6	8
		6	2

Stakeholder Engagement Assessment

Project Name:

Current state Desired state
Place a C and D in a row for each stakeholder

Stakeholders	Unaware	Resistant	Neutral	Supporting	Leading
Team 1					
Person 1	C		D		
Person 2		C			D
Person 3				CD	
Person 4		C	D		
Person 5					
Person 6					
Person 7					
Person 8					
Person 9					

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.

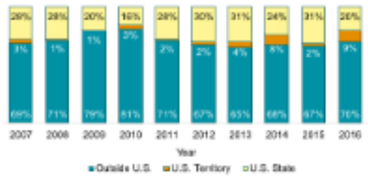
DEVELOPED REPORTS

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.

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

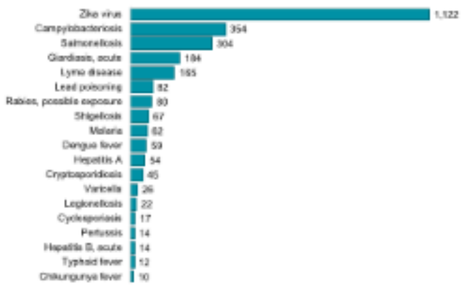


Note that 19 cases were excluded from Figure 1 because they fell into more than one exposure category (e.g., exposure may have occurred in another U.S. territory or outside the U.S.)

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.

Figure 2: Number of Travel-Related Illnesses by Disease for Diseases With ≥10 Travel-Related Cases (N=2,693), Florida, 2016

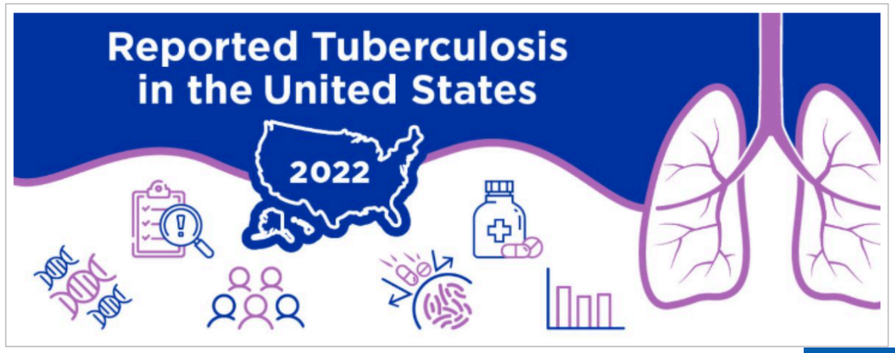


Areas of endemicity contribute to travel-related infection patterns and vary by disease; some diseases are endemic in other parts of the U.S., and others are more commonly seen in other U.S. territories or countries. However, travel-related infection patterns can also reflect travel patterns among people.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

Section 10: Travel-Related Illnesses

Reported Tuberculosis in the United States, 2022

Print



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

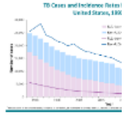
In 2022, reported TB cases and incidence rates (number of TB cases per 100,000 persons) in the United States increased for the second year in a row, but remained lower than levels reported prior to the COVID-19 pandemic.

View Larger

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.

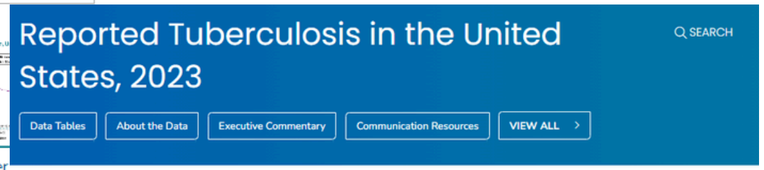
Birth outside of the United States remains a key risk factor for TB, with a TB incidence rate 17.1 times higher among non-U.S.–born persons compared with U.S.-born persons.

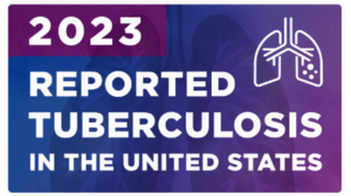


View Larger

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

Naloxone Distribution and Administration through the Department		
Year	**# of Naloxone Kits Distributed in the Community**	**# of Overdose Reversals**
2018	18,898	1,466
2019	36,703	1,592
2020	69,557	4,434
2021	132,269	7,860
2022	191,225	11,132
2023	405,392	16,352
***Source**: Florida Department of Children and Families*		





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

DATA ANALYSIS

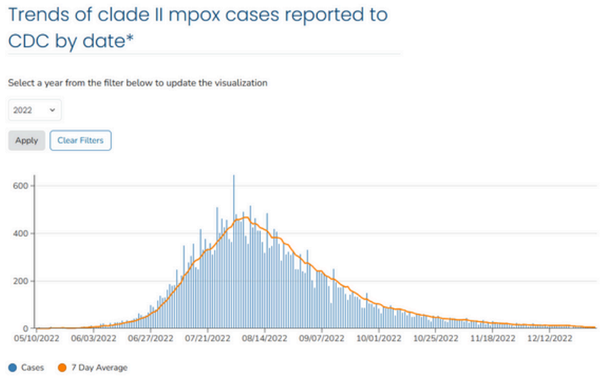


Table 3. Association between mpox incidence and large events, May–December 2022, by US Census Regions

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 †aHR (95% CI)	p-value	Delayed Sputum Conversion	TTSC at 60 Days †aHR (95% CI)	p-value	Delayed Sputum Conversion	TTSC at 90 Days †aHR (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%
RaceGroup									
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	1.53 (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 (0.85-2.29)	0.178		1.82 (1.09-3.03)	**0.003**	
Age Group (yrs)									
Ages 0-17	0.65 (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)	0.086	
Four Drug Therapy									
Yes	Reference			Reference			Reference		
No	2.59 (0.53-12.65)	0.239		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)	**<0.0001**	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	
HomelessPastYear									
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 PastYear									
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 PastYear									
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	
Cavitary TB									
No	Reference			Reference			Reference		
Unknown	1.05 (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)	**<0.0001**	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)	0.186		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.

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

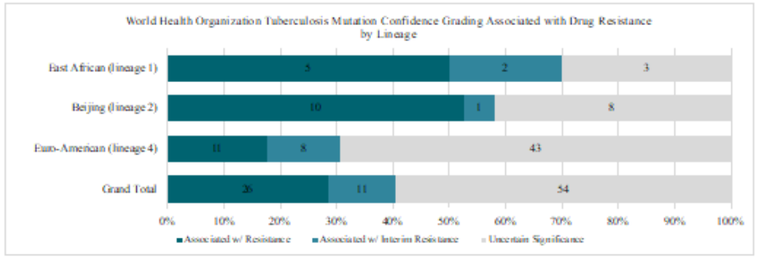
Region		Baseline (pre-event) Dates (week starting)	Mean Weekly Case Count	Mean Weekly Incidence Rate	Percent of Cases Reporting International Travel	Post Event 1 Dates (week starting)	Mean Weekly Case Count	Mean Weekly Incidence Rate	Percent of Cases Reporting International Travel	Post Event 2 Dates (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%	06/26-07/24	197.4	0.29	2.03%	–	–	–	–
Northeast		05/15-06/05	13.75	0.02	30.90%	06/12-07/03	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%	06/12-06/26	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%	06/26-07/24	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)	0.1226	1.02 (0.43, 2.41)	0.9674
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

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



LATWEIKA A.T. SALMON-TREJO

DATA VISUALIZATION

ILI Activity and Outbreaks by Setting

Page 5

Reported Influenza and ILI Outbreaks

ILI = influenza-like illness

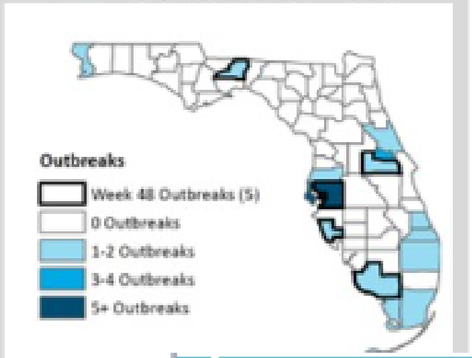
Map 3 shows influenza and ILI outbreaks by county for week 40, 2017 through week 48, 2017, as reported into Merlin.

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

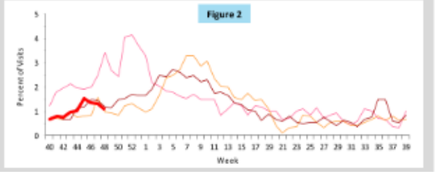
2017-18 | 2016-17 | 2015-16 | 2014-15

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 ≥100°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

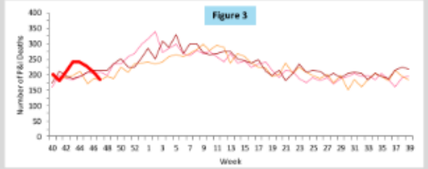


Figure 3 shows P&I deaths* for all Florida counties from the Bureau of Vital Statistics, as reported into ESSENCE-FL, week 40, 2014 to week 47, 2017.

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

Section 10: 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.

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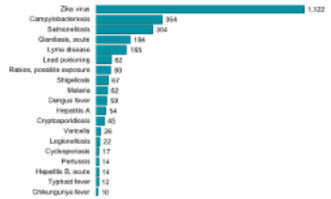
Figure 2: Number of Travel-Related Illnesses by Disease for Diseases With ≥10 Travel-Related Cases (N=2,693), Florida, 2016



Progress Towards TB Elimination, United States, 1982–2023

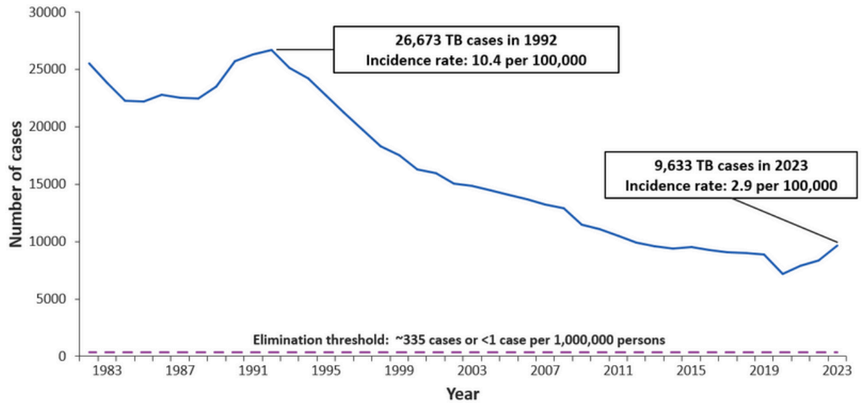
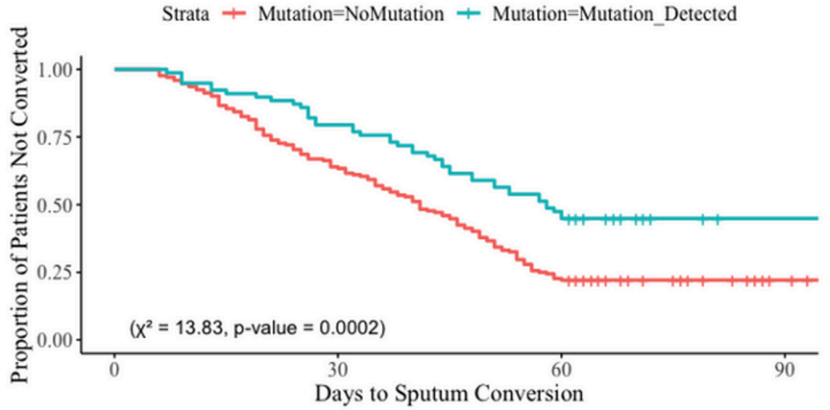


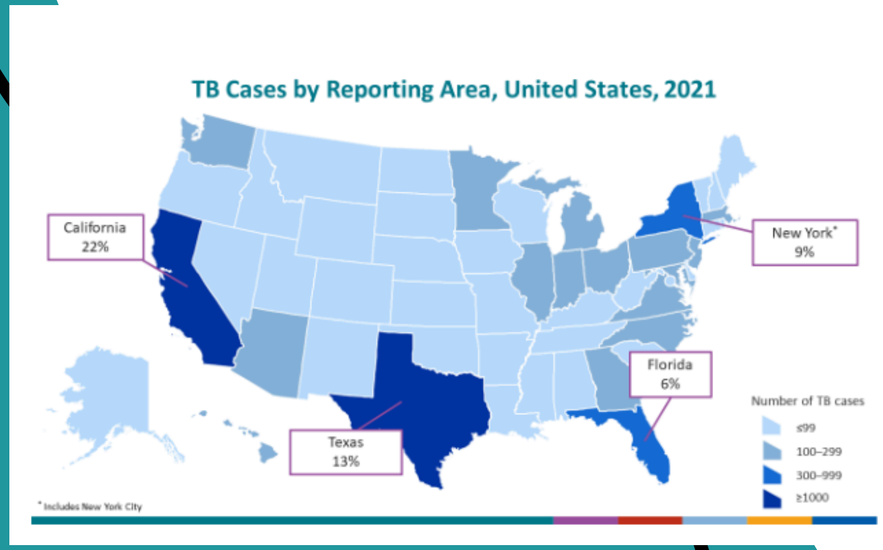
Figure 1. Kaplan-Meier survival curves comparing time to sputum conversion among TB patients with and without detected drug resistance mutations.

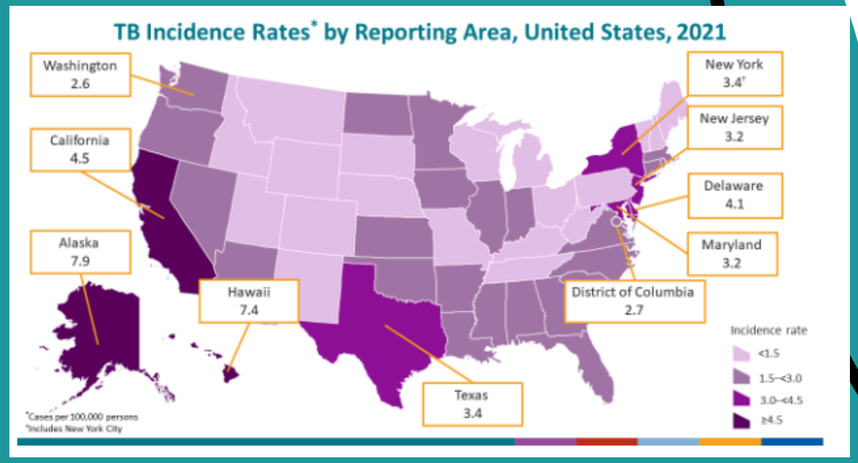
Time to Sputum Conversion by Genetic Mutation Status



LATWEIKA A.T. SALMON-TREJO

DATA VISUALIZATION: MAPS





Tuberculosis in the United States 2022 Slide Set

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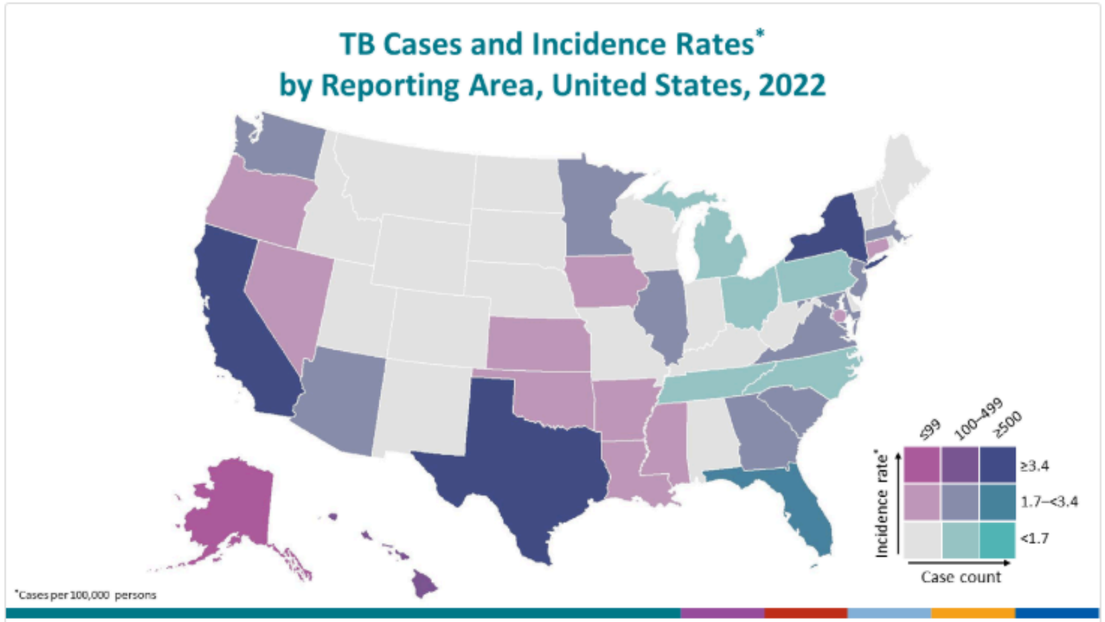
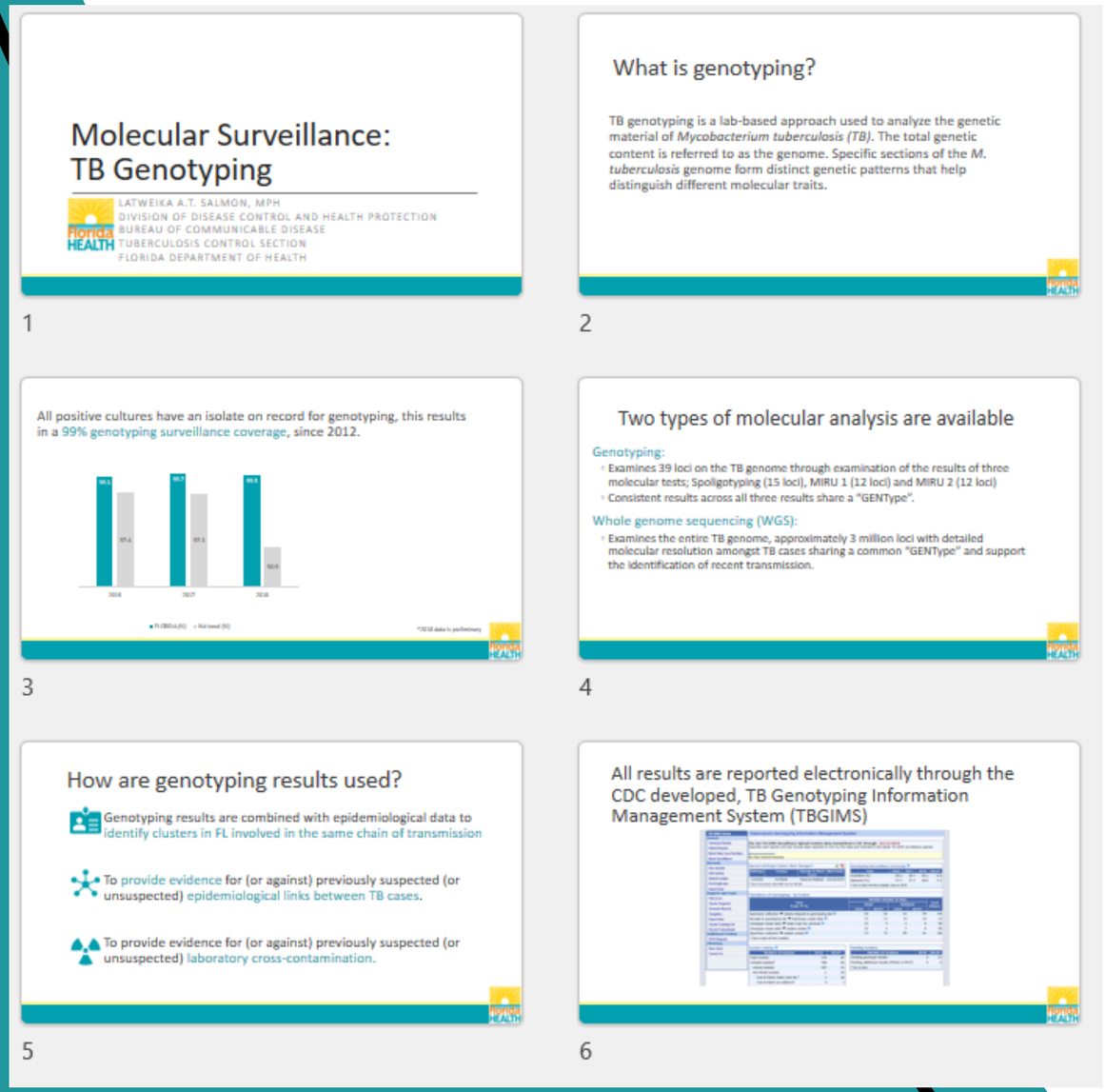
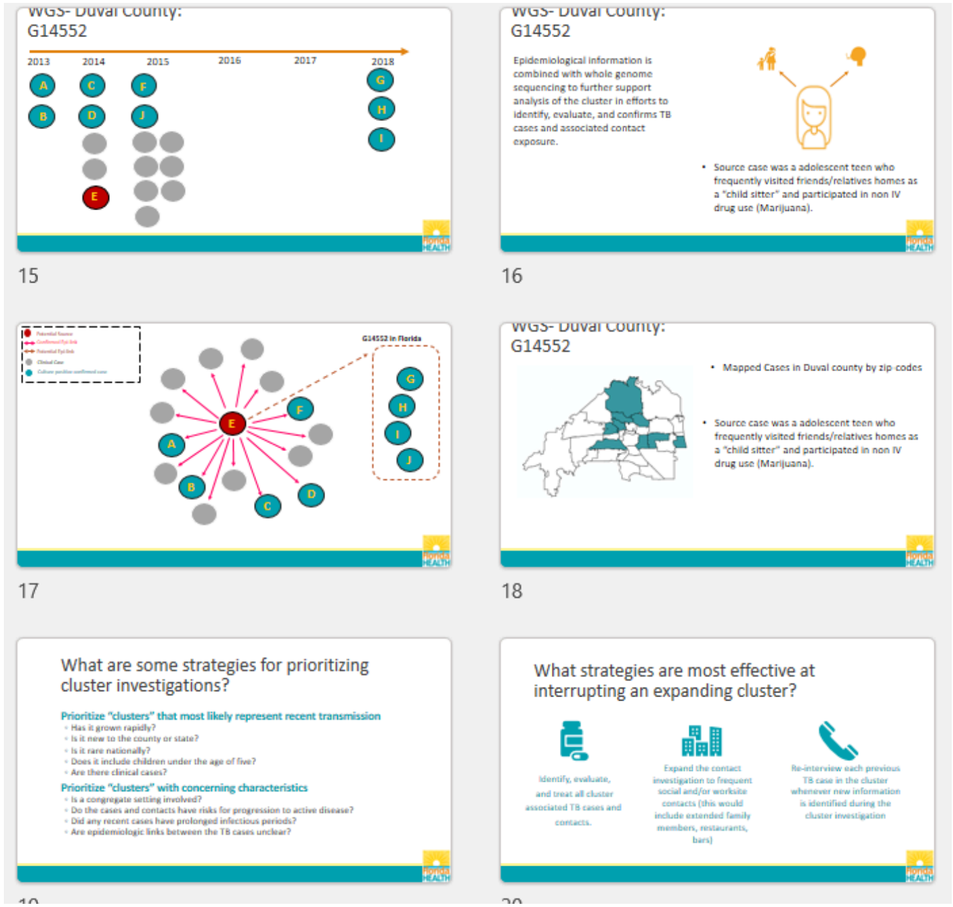


Slide - 8

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.





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.

National Center for HIV, Viral Hepatitis, STD, and TB Prevention
Division of Tuberculosis Elimination

Usual Residence and Counting Cases for RVCT

By: LaTweika A.T. Salmon-Trejo, DrPH(c), MPH
Division of TB Elimination
Surveillance, Epidemiology, Outbreak Investigation Branch

1 ★

Agenda

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

[CSTE] Council of State and Territorial Epidemiologists

2 ★

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

3 ★

Objectives

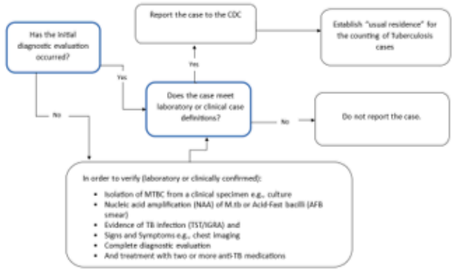
- ☐ Describe the general process for reporting verified cases
- ☐ Identify and categorize concepts of "establishing usual residence" for counting cases
- ☐ Explain important decision-making steps in the process of counting cases.

4 ★

Reporting Verified Tuberculosis Cases

5 ★

Reporting Verified Tuberculosis Cases



6 ★

Reporting Verified Tuberculosis Cases

Appendix A —
Tuberculosis Case Definition for Public Health Surveillance
Council of State and Territorial Epidemiologists (CSTE)
Position Statement 09-ID-65

Clinical description
A chronic bacterial infection caused by *Mycobacterium tuberculosis*, usually characterized pathologically by the formation of granulomas. The most common site of infection is the lung, but other organs may be involved.

Clinical criteria
A case that meets all the following criteria:
- A positive tuberculin skin test or positive interferon gamma release assay for *M. tuberculosis*
- Other signs and symptoms compatible with tuberculosis (TB) (e.g., abnormal chest radiograph, abnormal chest computerized tomography scan or other chest imaging study, or clinical evidence of current disease)
- Treatment with two or more anti-TB medications
- A completed diagnostic evaluation

Laboratory criteria for diagnosis
- Isolation of *M. tuberculosis* from a clinical specimen,* OR
- Demonstration of *M. tuberculosis* complex from a clinical specimen by nucleic acid amplification test,** OR
- Demonstration of acid-fast bacilli in a clinical specimen when a culture has not been or cannot be obtained or is falsely negative or contaminated.

7 ★

Usual Residence CSTE Guidelines

- ☐ CSTE Position Statement (11-SI-04) re-established guidelines with the concept of a "reference point" in time for identifying cases counted 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."

8 ★

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

Usual Residence

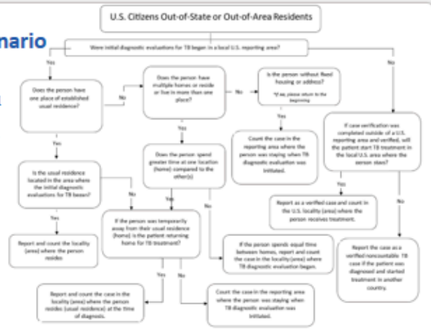
The Place		Lives & Sleeps	Time	
Location [Where]		Activities [What]	Frequency [How Often]	
House	Park	Sleep	Commonly	
Apartment	Car	Eat	Routinely	Every
Trailer	Mobile Home	Cook	Habitually	Day
Hotel	Camp	Customary	Week	
Quarters	Boat	Spend time with family	Regularly	Weekend
Shelter	RV	Store personal belongings	Typically	Month
Space	Cabin	Relax	Standardly	Season
Address	Room	Rest	Ordinarily	Year
Building	Home port	Clean	Familiar	
Dorm	Call port	Socialize	Pattern	
Structure	Vacation	Hang out	Frequent	
Corner	Cell	Vacation	Religiously	
Street	Military base		9-5	
Tent	Prison			

Common Scenario

- Persons who travel from Canada to Florida every winter to evade the cold temperatures November through February.

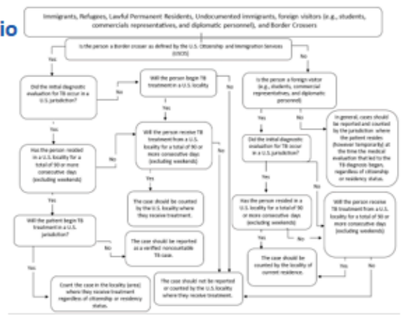
Common Scenario

- ☐ Persons who migrate (migrant) for work following the seasonal agriculture trends throughout the United States



Complex Scenario

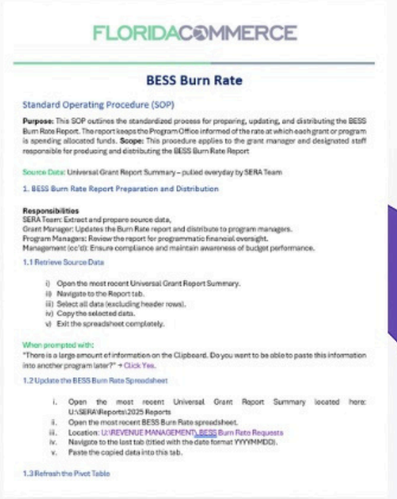
- ☐ Background: A Non-US born person originally from Tahiti developed hip pain in July 2023 in State [A] where they reside. Several encounters with their physician between July and September resulted in a biopsy from the hip and recommendations to see an orthopedic despite inconclusive results. In October, the person traveled to Tahiti where they were evaluated by an infectious disease physician who completed an ultrasound guided biopsy. RIPE therapy was soon after initiated in Tahiti after a positive PCR and culture.



OPTIMIZATION

Automating the BESS Burn Rate Report

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

Standard Operating Procedure (SOP)

Purpose: This SOP outlines the standardized process for preparing, updating, and distributing the BESS Burn Rate Report. The report keeps the Program Office informed of the rate at which each grant or program is spending allocated funds. **Scope:** This procedure applies to the grant manager and designated staff responsible for producing and distributing the BESS Burn Rate Report.

Source Data: Universal Grant Report Summary – pulled everyday by SERA Team

1. BESS Burn Rate Report Preparation and Distribution

Responsibilities
SERA Team: Extract and prepare source data.
Grant Manager: Updates the Burn Rate report and distribute to program managers.
Program Managers: Review the report for programmatic financial oversight.
Management (cc'd): Ensure compliance and maintain awareness of budget performance.

1.1 Retrieve Source Data

i) Open the most recent Universal Grant Report Summary.
ii) Navigate to the Report tab.
iii) Select all data (excluding header rows).
iv) Copy the selected data.
v) Exit the spreadsheet completely.

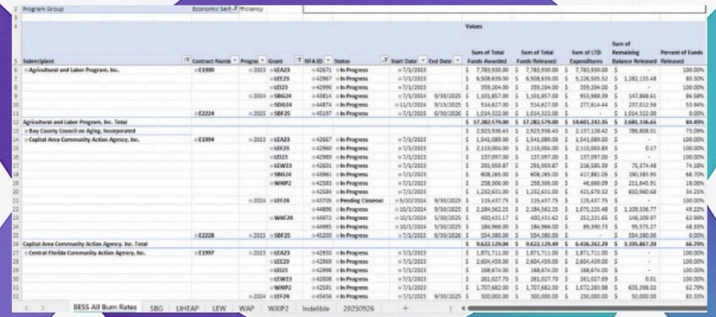
When prompted with:
"There is a large amount of information on the Clipboard. Do you want to be able to paste this information into another program later?" → Click Yes.

1.2 Update the BESS Burn Rate Spreadsheet

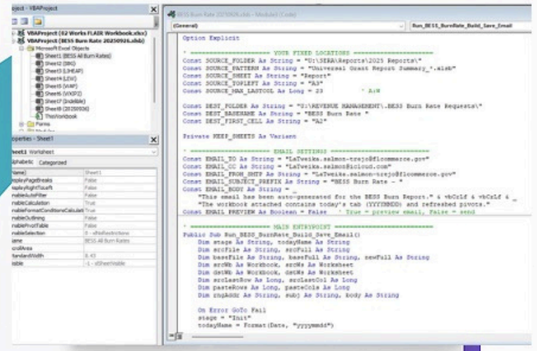
i. Open the most recent Universal Grant Report Summary located here: U:\SERA\Reports\2025 Reports
ii. Open the most recent BESS Burn Rate spreadsheet.
iii. Location: U:\REVENUE MANAGEMENT\..BESS Burn Rate Requests
iv. Navigate to the last tab (titled with the date format YYYYMMDD).
v. Paste the copied data into this tab.

1.3 Refresh the Pivot Table

Manual
SOP Process



Dynamic Excel
Burn Rate Report



Automated
VBA Workflow

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

FAMU COLLEGE OF PHARMACY + PHARMACEUTICAL SCIENCES INSTITUTE OF PUBLIC HEALTH
FLORIDA AGRICULTURAL AND MECHANICAL UNIVERSITY

FAMU CoPPS, IPH Announces 2025 Delta Omega Award Winners

Of 122 chapters, two of the 29 honorees are from the FAMU CoPPS, IPH!

Abria McNeill

LaTweika Salmon-Trejo

Washington, DC - We are excited to announce that abstracts from two graduate learners were selected for presentation by the Delta Omega Honorary Society in Public Health. The winners are **Abria McNeill**, MPH candidate for her research entitled "Antepartum Depression as a Predictor of Postpartum Depression: Insights from Maternal Health Data in Florida 2018-2020" and **LaTweika Salmon-Trejo**, DrPH candidate for her research entitled, "Leveraging Tuberculosis Lineage Insights and Contact-based TB Cases to Enhance Molecular Epidemiology Practices in Cluster Investigations: Exploring the Role of Sympatric and Allopatric Exposure," according to Arlesia Mathis, Ph.D., CPH, CPM FAMU CoPPS, IPH Professor - Health Policy and Management.

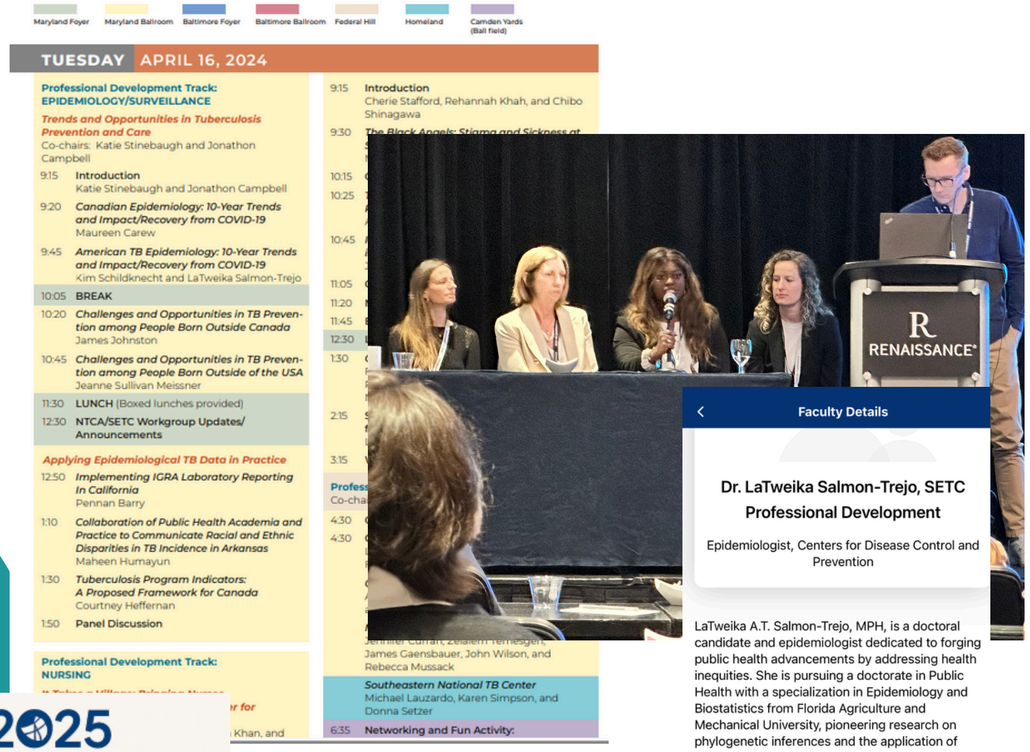
"This is a rare recognition, in that each year, 29 public health learners are selected from among nominations from 122 Delta Omega chapters to present their research during the Delta Omega Student Poster Session through the Academic Public Health Caucus of the American Public Health Association's Public Health Exposition. To have two awardees from the FAMU CoPPS, IPH is amazing," Dr. Mathis enthusiastically stated.

The purpose of this poster session is to showcase the excellent scholarship and research of learners in https://ceph.org/home/ Council in Education for Public Health-accredited schools and programs of public health. Each learner's work was judged by a national review committee on six criteria which included relevance to public health, potential impact, novel (innovative, original), clarity, use of sound methodology, and evidence of student work. The Delta Omega National Office will award the selected students with a $500 cash prize during the Delta Omega awards ceremony in November at the 2025 American Public Health Association Annual Meeting in Washington, D.C.; get to be in it to win it! **Big kudos to the winners among us!!**

-end-

APHA, WASHINGTON D.C., 2025

NTCA/SETC, 2025



Maryland Foyer | Maryland Ballroom | Baltimore Foyer | Baltimore Ballroom | Federal Hill | Homeland | Camden Yards (Ball Field)

TUESDAY APRIL 16, 2024

Professional Development Track: EPIDEMIOLOGY/SURVEILLANCE

Trends and Opportunities in Tuberculosis Prevention and Care
Co-chairs: Katie Stinebaugh and Jonathon Campbell

9:15 **Introduction**
Katie Stinebaugh and Jonathon Campbell

9:20 ***Canadian Epidemiology: 10-Year Trends and Impact/Recovery from COVID-19***
Maureen Carew

9:45 ***American TB Epidemiology: 10-Year Trends and Impact/Recovery from COVID-19***
Kim Schildknecht and LaTweika Salmon-Trejo

10:05 **BREAK**

10:20 ***Challenges and Opportunities in TB Prevention among People Born Outside Canada***
James Johnston

10:45 ***Challenges and Opportunities in TB Prevention among People Born Outside of the USA***
Jeanne Sullivan Meissner

11:30 **LUNCH** (Boxed lunches provided)

12:30 **NTCA/SETC Workgroup Updates/ Announcements**

Applying Epidemiological TB Data in Practice

12:50 ***Implementing IGRA Laboratory Reporting In California***
Pennan Barry

1:10 ***Collaboration of Public Health Academia and Practice to Communicate Racial and Ethnic Disparities in TB Incidence in Arkansas***
Maheen Humayun

1:30 ***Tuberculosis Program Indicators: A Proposed Framework for Canada***
Courtney Heffernan

1:50 **Panel Discussion**

Professional Development Track: NURSING

9:15 **Introduction**
Cherie Stafford, Rehannah Khah, and Chibo Shinagawa

9:30 ***The Black Angels: Stigma and Sickness at***

10:15

10:25

10:45

11:05

11:20

11:45

12:30

1:30

2:15

3:15

Profess

Co-cha

4:30

4:30

James Gaensbauer, John Wilson, and Rebecca Mussack

Southeastern National TB Center
Michael Lauzardo, Karen Simpson, and Donna Setzer

6:35 **Networking and Fun Activity:**

NTCA/SETC, 2024

Faculty Details

Dr. LaTweika Salmon-Trejo, SETC Professional Development

Epidemiologist, Centers for Disease Control and Prevention

LaTweika A.T. Salmon-Trejo, MPH, is a doctoral candidate and epidemiologist dedicated to forging public health advancements by addressing health inequities. She is pursuing a doctorate in Public Health with a specialization in Epidemiology and Biostatistics from Florida Agriculture and Mechanical University, pioneering research on phylogenetic inferences and the application of molecular epidemiology in state settings. As a graduate assistant with the University of Florida under Dr. Marie Seraphin she conducts impactful research on TB genomics. As an Epidemiologist at the Centers for Disease Control, LaTweika contributes expertise to surveillance and evidence-based guidelines. Complementing her professional endeavors, she actively
engages with minority communities, volunteering to promote health literacy, exercise, and education
Show less

FAMU, 2024

UNIVERSITY OF FLORIDA 2018

COMMUNITY PARTNERSHIPS FOR HEALTH

FEMALE CANCER HEALTH EVENT

FEMALE CANCER HEALTH EVENT

HEART DISEASE EVENT

KIDNEY DISEASE AWARENESS EVENT

latweika.salmon@icloud.com

LATWEIKA A.T.
SALMON-TREJO

GRANT MANAGEMENT

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

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).

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 Eli

Government Organizations:

- Territorial governments or their b and the Virgin Islands.

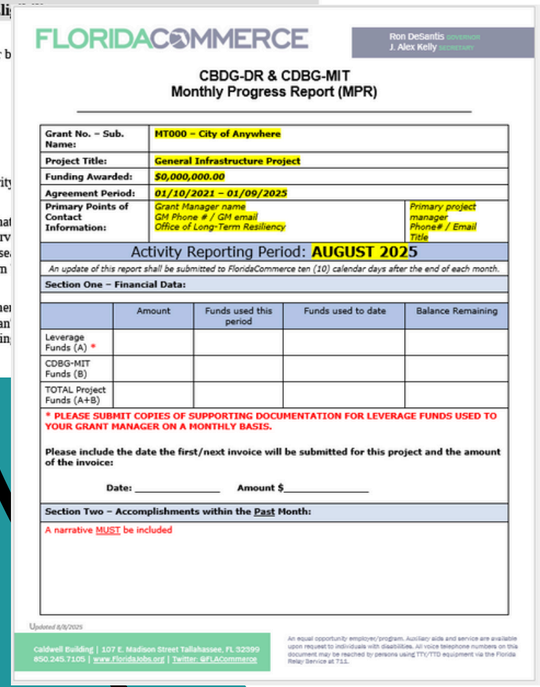
Non-government Organizations:

Other:

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

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

The applicant must upload two attachme Prevention and Control Elimination Plan Infrastructure" that includes the followin



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Ron DeSantis, GOVERNOR
J. Alex Kelly, SECRETARY

CBDG-DR & CBDG-MIT
Monthly Progress Report (MPR)

Grant No. – Sub. Name:	**MT000 – City of Anywhere**		
Project Title:	**General Infrastructure Project**		
Funding Awarded:	***$0,000,000.00***		
Agreement Period:	***01/10/2021 – 01/09/2025***		
Primary Points of Contact Information:	*Grant Manager name* *GM Phone # / GM 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 ten (10) calendar days after the end of each month.

Section One – Financial Data:

	Amount	Funds used this period	Funds used to date	Balance Remaining
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

Updated 6/8/2025

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850.245.7105 | www.FloridaJobs.org | Twitter: @FLACommerce

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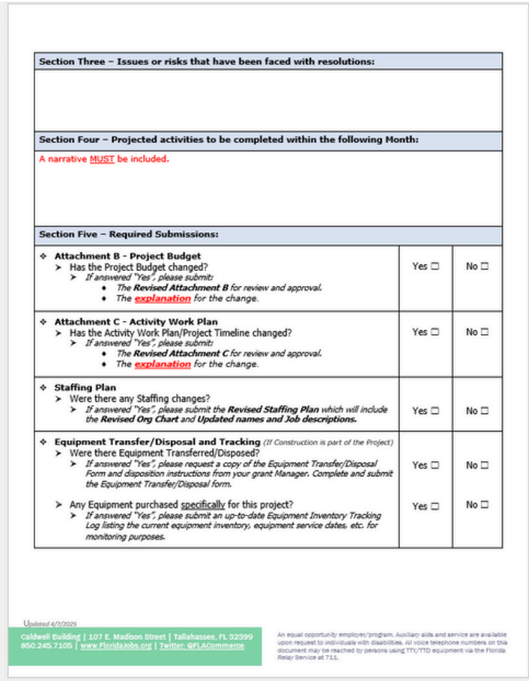

Section Three – Issues or risks that have been faced with resolutions:

Section Four – Projected activities to be completed within the following Month:

A narrative MUST be included.

Section Five – Required Submissions:

❖ **Attachment B - Project Budget** ➢ Has the Project Budget changed? ➢ *If answered "Yes", please submit:* • *The **Revised Attachment B** for review and approval.* • *The **explanation** for the change.*	Yes ☐	No ☐
❖ **Attachment C – Activity Work Plan** ➢ 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.*	Yes ☐	No ☐
❖ **Staffing Plan** ➢ 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.***	Yes ☐	No ☐
❖ **Equipment Transfer/Disposal and Tracking** *(If Construction is part of the Project)* ➢ 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.*	Yes ☐	No ☐
➢ Any Equipment purchased specifically for this project? ➢ *If answered "Yes", please submit an up-to-date Equipment Inventory Tracking Log listing the current equipment inventory, equipment service dates, etc. for monitoring purposes.*	Yes ☐	No ☐

Updated 4/7/2025

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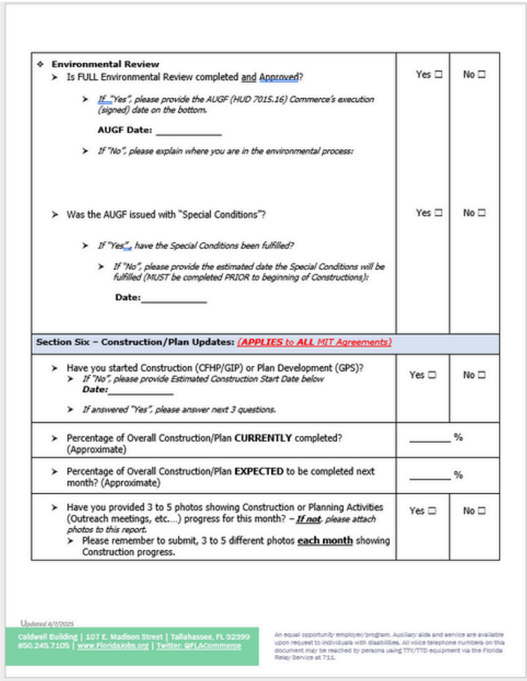

❖ **Environmental Review** ➢ Is FULL Environmental Review completed and Approved? ➢ *If "Yes", please provide the AUGF (HUD 7015.16) Commerce's execution (signed) date on the bottom.* **AUGF Date:** _____ ➢ *If "No", please explain where you are in the environmental process:*	Yes ☐	No ☐
➢ Was the AUGF 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 Constructions):* **Date:**_____	Yes ☐	No ☐

Section Six – Construction/Plan Updates: ***(APPLIES to ALL MIT Agreements)***

➢ Have you started Construction (CFHP/GIP) or Plan Development (GPS)? ➢ *If "No", please provide Estimated Construction Start Date below* ***Date:***_____ ➢ *If answered "Yes", please answer next 3 questions.*	Yes ☐	No ☐
➢ 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.* ➢ Please remember to submit, 3 to 5 different photos **each month** showing Construction progress.	Yes ☐	No ☐

Updated 4/7/2025

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