Report to Clinicians

Public Health Updates and
2018 Communicable Diseases Summary

Alexandria Health Department

Our Vision
Healthy People, Healthier Communities

Our Mission
Protecting and Promoting Health and Well-Being in Our Communities

Our Values
Working Together, Improving Continuously, Making a Difference
Preface

September 16, 2019

Dear Colleague,

At Alexandria Health Department, our mission is “Protecting and Promoting Health and Well-Being in Our Communities.” We do this through our Public Health Specialty Clinics; through disease surveillance, investigation and prevention guidance; through helping families, businesses and organizations prepare for, respond to, and recover from public health emergencies; through environmental health practices that help ensure the safety of our food and pools; and through community partnerships in which we support policies, practices and systems that provide opportunities for every Alexandrian to enjoy complete physical, mental, social and spiritual well-being.

We recognize that practicing physicians, such as you, are a critical foundation of health and well-being, and we thank you and your staff for the work that you do every day to advance health for everyone. We hope that this Report to Clinicians 2018 will help you and your staff better understand some diseases that are most affecting Alexandrians, to better understand a couple of “hot topics” that you might be addressing in your exam rooms, and to better understand how to report diseases so that we can assist with prevention efforts (to protect both the public and your staff).

We welcome your feedback, comments, suggestions, and ideas for how we can improve the health of our residents and make a difference in your practice patterns. We look forward to collaborating with you in the future to serve as a model for community partnership and an example of what it means to be healthy.

Thank you,

Stephen A. Haering, MD, MPH, FACPM
Health Director
Alexandria Health Department
Public Health Updates and 2018 Communicable Diseases Summary

Introduction and Overview

This Alexandria Health Department (AHD) Report to Clinicians provides a summary of reportable disease investigations by AHD. This report includes data from 2018 and a summary of reports from calendar years 2014-2018. For this report, AHD presents sexually transmitted infections (STI) and tuberculosis (TB) separately from other reportable diseases. We also offer several timely and important public health updates on conditions of concern. These updates increase awareness of each topic area and provide clinicians with credible resources for additional information. This report is best read electronically, as it includes hyperlinked URLs to online resources.

Case Definitions

Public health case definitions are published by the Centers for Disease Control and Prevention (CDC) to standardize reporting of diseases across the country (CDC Case Definitions). These case definitions ensure that disease-specific morbidity is comparable between different states and jurisdictions. Public health case definitions are not intended for clinical diagnosis. Periodic changes to case definitions, as well as changes in diagnostic methods (e.g. culture independent diagnostic tests), may limit comparisons of case counts across years.

Disease Surveillance

The case counts presented in this report do not represent the true incidence of disease within the community, because not all ill persons seek medical care and not all cases are reported to the Health Department. AHD relies on providers and laboratories to report cases - or suspected cases - of reportable illnesses to improve our estimates of disease burden and our administration of essential public health services, including disease prevention and control. For more information about how and what to report to us, see pages 16 and 17.

Limitations

Rates should be interpreted with caution because of the effect of population size on rates. For communities like Alexandria with a small population and low disease incidence, a small increase in the number of cases of an illness can make the rate for the illness appear high, even though the absolute numbers have not increased substantially. This can make comparisons over time or with larger communities difficult.

Data Source

Unless otherwise noted, data represents Virginia Department of Health (VDH) primary surveillance data available in the Virginia Electronic Disease Surveillance System (VEDSS) as of April 25, 2019.

Acknowledgements

We would like to thank all of our community partners - including healthcare providers, infection control practitioners, laboratorians, and public safety personnel, who report cases to AHD. We also wish to acknowledge the hard work and dedication of the AHD employees who investigate and control communicable diseases, including STIs, HIV, and TB in Alexandria.

Epidemiologist Christina Chommanard, Population Health Epidemiologist Brandie Temple, TB Nurse Emily Astorga, Public Health Nurse, Tiyia Jean-Pierre, Public Health Planner Natalie Talis and Medical Director Dr. Kim Luk prepared this report. This report was approved by Deputy Health Director, Anne Gaddy MD, MPH, and Health Director Stephen A. Haering, MD, MPH, FACP. Any errors are solely the responsibility of AHD. Feedback is welcome and may be sent to alex_epi@vdh.virginia.gov.
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Summary of Selected Reportable Diseases

Program Highlights
In 2018, AHD’s Communicable Disease (CD) Division completed 485 disease investigations for conditions reportable by state law, and nine outbreak investigations (Chickenpox; Hand, Foot, and Mouth Disease; Influenza; Invasive Group A Streptococcus; Norovirus; and Carbapenem-resistant Enterobacteriaceae) This report provides a summary of all reported cases\(^1\) from 2014-2018 (Table 1).

Table 1: Total Number of Reportable Conditions in Alexandria, VA (2014-2018) \(^{a,b}\)

<table>
<thead>
<tr>
<th>CONDITION</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>5 Year Average</th>
</tr>
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<tbody>
<tr>
<td>Amebiasis</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Arsenic</td>
<td>3</td>
<td>0</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Botulism, infant</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
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<td>Campylobacteriosis</td>
<td>23</td>
<td>50</td>
<td>62</td>
<td>38</td>
<td>32</td>
<td>0.2</td>
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<td>Carbon monoxide</td>
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<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
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<td>Chagas disease</td>
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<td>0</td>
<td>0</td>
<td>0</td>
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<td>0</td>
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<td>0</td>
<td>0</td>
<td>0.6</td>
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<tr>
<td>CP-CRE (E. coli, Enterobacter and Klebsiella spp)(^a)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>7</td>
<td>1.4</td>
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<td>CP-CRE, other(^a)</td>
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<td>0</td>
<td>0</td>
<td>4</td>
<td>0.8</td>
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<td>CPO, no organism identified(^a)</td>
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<td>CPO, non-Enterobacteriaceae(^a)</td>
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<td>Cryptosporidiosis</td>
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<td>Dengue</td>
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<td>Dengue fever</td>
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<td>E. coli infection, shiga toxin-producing</td>
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<td>Encephalitis, CA serogroup virus, neuroinvasive</td>
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<td>Giardiasis</td>
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<td>4</td>
<td>13</td>
<td>16</td>
<td>23</td>
<td>12.8</td>
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<td>Haemophilus influenzae, invasive</td>
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<td>3</td>
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<td>1.6</td>
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<tr>
<td>Hepatitis A, acute</td>
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<td>Hepatitis B, acute</td>
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<td>0.8</td>
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<tr>
<td>Hepatitis B, chronic</td>
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<td>72</td>
<td>68</td>
<td>111</td>
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<td>Hepatitis B, perinatal</td>
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<td>Hepatitis C, chronic</td>
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<td>137</td>
<td>159</td>
<td>112</td>
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<td>Lead, elevated levels</td>
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<td>18</td>
<td>82</td>
<td>155</td>
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<td>Legionellosis</td>
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<tr>
<td>Lyme disease</td>
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<td>13</td>
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<td>22</td>
<td>17</td>
<td>15.6</td>
</tr>
<tr>
<td>Malaria</td>
<td>6</td>
<td>4</td>
<td>9</td>
<td>10</td>
<td>6</td>
<td>7</td>
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<td>Meningococcal disease (Neisseria meningitidis)</td>
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<td>1</td>
<td>0</td>
<td>0</td>
<td>0.4</td>
</tr>
<tr>
<td>Mercury, elevated levels</td>
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<td>1</td>
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</tr>
<tr>
<td>CONDITION</td>
<td>2014</td>
<td>2015</td>
<td>2016</td>
<td>2017</td>
<td>2018</td>
<td>5 Year Average</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>------</td>
<td>------</td>
<td>------</td>
<td>------</td>
<td>------</td>
<td>----------------</td>
</tr>
<tr>
<td>Mumps</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>4</td>
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<td>2.2</td>
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<tr>
<td>Pertussis</td>
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<td>7</td>
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<td>Pesticide poisoning</td>
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<td>0.2</td>
</tr>
<tr>
<td>Q fever, acute</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.2</td>
</tr>
<tr>
<td>Salmonellosis</td>
<td>16</td>
<td>28</td>
<td>28</td>
<td>23</td>
<td>18</td>
<td>22.6</td>
</tr>
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<td>Shigellosis</td>
<td>21</td>
<td>6</td>
<td>10</td>
<td>5</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>Spotted Fever Rickettsiosis (including RMSF)</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>1.2</td>
</tr>
<tr>
<td>Staph aureus, methicillin resistant (MRSA)</td>
<td>15</td>
<td>18</td>
<td>12</td>
<td>0</td>
<td>0</td>
<td>9</td>
</tr>
<tr>
<td>Streptococcus pneumoniae, invasive (age &lt; 5)</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0.4</td>
</tr>
<tr>
<td>Streptococcus, Group A, invasive</td>
<td>2</td>
<td>6</td>
<td>5</td>
<td>2</td>
<td>4</td>
<td>3.8</td>
</tr>
<tr>
<td>Toxic-shock syndrome, streptococcal</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>0.6</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>15</td>
<td>16</td>
<td>19</td>
<td>10</td>
<td>11</td>
<td>14.2</td>
</tr>
<tr>
<td>Typhoid fever (Salmonella typhi)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Unusual occurrence of public health concern</td>
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<td>2</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>1.4</td>
</tr>
<tr>
<td>Varicella (Chickenpox)</td>
<td>8</td>
<td>6</td>
<td>15</td>
<td>13</td>
<td>14</td>
<td>11.2</td>
</tr>
<tr>
<td>Vibriosis, non-cholera</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>West Nile infection, neuroinvasive</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0.8</td>
</tr>
<tr>
<td>West Nile infection, non-neuroinvasive</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0.4</td>
</tr>
<tr>
<td>Yersiniosis</td>
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<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0.6</td>
</tr>
<tr>
<td>Zika virus disease, non-congenital</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0.8</td>
</tr>
<tr>
<td>Zika virus infection, non-congenital</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>0.8</td>
</tr>
<tr>
<td>TOTAL</td>
<td>294</td>
<td>385</td>
<td>508</td>
<td>610</td>
<td>450</td>
<td>449.4</td>
</tr>
</tbody>
</table>

1 Total number of reported cases excludes sexually transmitted infections (STI); information on these conditions is presented separately.

a Carbapenemase producing (CP) organisms and Carbapenem Resistant Enterobacteriaceae (CRE) became voluntarily reportable in 2018.

b Staph aureus, methicillin resistant (MRSA) is no longer reportable as of 2016.
Trends in Reportable Conditions 2018

- **Elevated blood lead levels:** In 2018, there was a decrease in the number of individuals who had elevated blood lead levels compared to 2017.

- **Environmental Infections:** In 2018, there was an increase in the number of individuals experiencing Cryptosporidiosis, Giardiasis, and Legionella compared to the previous 5-year average. This increase from 2017 to 2018 follows trends also observed statewide.

- **Sexually transmitted infections:** Alexandria, similar to state and national trends, has experienced increased rates of STIs in the last 5 years. From 2014 to 2018, the rate of chlamydia increased from 403.1 to 486.7 per 100,000 people, and the rate of gonorrhea increased from 79.7 to 126.3 per 100,000. Between 2014-2018, the syphilis rate increased from 10 to 31.7 per 100,000 people, and the HIV rate decreased from 21.9 to 16.2 per 100,000.

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**Figure 1: Top Five Reportable Conditions in Alexandria, VA (2018)**

<table>
<thead>
<tr>
<th>Reportable Condition</th>
<th>5 Year Average (2014-2018)</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salmonellosis</td>
<td>18</td>
<td>18</td>
</tr>
<tr>
<td>Cryptosporidiosis</td>
<td>12</td>
<td>18</td>
</tr>
<tr>
<td>Giardiasis</td>
<td>12.8</td>
<td>23</td>
</tr>
<tr>
<td>Campylobacteriosis</td>
<td>32</td>
<td>41</td>
</tr>
<tr>
<td>Lead, elevated levels</td>
<td>66.4</td>
<td>69</td>
</tr>
</tbody>
</table>

Figure 1 displays the top five reportable conditions in Alexandria in 2018 and the 5-year average. Elevated blood lead levels were the most frequently reported, with 69 cases in 2018, followed by Campylobacteriosis (32 cases), Giardiasis (23 cases), Cryptosporidiosis (18 cases) and, Salmonellosis (18 cases).

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2 Figure 1 does not include chronic hepatitis, STI, or TB cases.

3 Number of Reported Cases indicates cases that were reported to Virginia’s Electronic Disease Surveillance System (VEDSS) and met case definition.
Sexually Transmitted Infections

Significant increases in rates of gonorrhea and syphilis have been reported since 2014, consistent with state and national increases in rates.

Figure 2 shows Alexandria, Northern Virginia (NOVA), and the Commonwealth of Virginia rates per 100,000 people for gonorrhea, chlamydia, syphilis, and HIV from 2014 to 2018.

For more comprehensive STI data, please consult VDH Division of Disease Prevention’s (DDP) annual reports on STIs (which summarize demographic and risk factor data). These reports can be accessed online (DDP Reports). CDC also offers updated STI resources (which include training, treatment information, and fact sheets).
West Nile and Other Vector Borne Diseases in Alexandria

In 2018, Virginia reported 48 West Nile Virus infections, including nine deaths. Of the West Nile infections reported in 2018, 16 were reported in Northern Virginia. If you have patients reporting symptoms of fever, headache, body aches, skin rash, and swollen lymph nodes, please consider testing for West Nile and other arboviruses. La Cross Virus (LACV) has similar symptoms to West Nile Virus and may be under reported in Virginia. If you suspect that your patient may have LACV, please contact the Alexandria Health Department to facilitate testing through our state public health laboratory, the Division of Consolidated Laboratory Services (DCLS).

Rocky Mountain Spotted Fever and Other Tick Borne Diseases

Did you know that, even in our urban environment, residents of Alexandria are at risk of contracting Rocky Mountain Spotted Fever (RMSF)? Contrary to popular belief, ticks can even be active in winter months if temperatures are above freezing. Deer ticks, which carry a variety of tick borne illnesses, can be a year round problem in Virginia. Symptoms of RMSF include fever, headache, rash, nausea, vomiting, and stomach pain. Rash begins 2-4 days after fever. Doxycycline is the recommended treatment for RMSF and other tick-borne diseases. Presumptive treatment in people with compatible symptoms and history of tick exposure is recommended for all ages\(^4\).

I have heard about Lyme disease. Do I also need to be concerned about Ehrlichiosis and Anaplasmosis in Virginia?

Yes. Although many cases of Lyme disease are diagnosed in Virginia each year, physicians should also consider testing for other tick borne diseases such as Ehrlichia, Anaplasma, and RMSF if a patient presents with history of tick bite and a nonspecific febrile illness. As with Lyme disease, Ehrlichiosis and Anaplasmosis are spread through the bite of an infected tick. Symptoms of Ehrlichiosis and Anaplasmosis are similar to Lyme disease and include fever, chills, headache, and muscle aches. Over 130 residents were diagnosed with either Ehrlichiosis or Anaplasmosis in Virginia in 2018. If you think your patient has a tick borne illness and tests negative for Ehrlichia and Anaplasma, consider testing for emerging tick borne viruses such as Powassan and Heartland through DCLS. This testing is free and can help the Virginia Department of Health and the CDC characterize the geographic spread of these new emerging viruses within the United States. We are asking physicians to be our disease detective partners! Consider Ehrlichiosis, Anaplasmosis and other tick-borne infections in your differential diagnosis for non-specific febrile illness, especially during spring and summer.\(^5\)

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Hot Topic: Candida Auris


The first known Candida auris (C. auris) case in Virginia was reported in October 2018. The Virginia Department of Health worked closely with the local health district and the facility where the case was identified to screen any other individuals who may have been in contact with the index case to stop the spread of C. auris.

**Background**

*C. auris* is a fungus that presents a serious global health threat and has emerged in the United States. *C. auris* can cause bloodstream and other types of invasive infections, particularly in patients in hospitals and settings where patients have multiple medical problems. It is more likely to affect immunocompromised patients, patients who receive lots of antibiotics, or who have devices (e.g., breathing tubes, feeding tubes, central catheters, or urinary catheters).

**Concerns**

- **Mortality**: More than 1 in 3 patients who have *C. auris* infection die within a month.
- **Resistance**: *C. auris* isolates in the U.S. belonging to the South Asian clade (primarily in NY and NJ) were resistant to fluconazole (90%), amphotericin B (40%), and echinocandins (3%).
- **Transmittable**: Healthcare workers should use standard and contact precautions for patients with *C. auris* and properly clean the environment of patients with *C. auris* every day.
- **Identification**: Difficulties with laboratory identification and lack of awareness of this emerging *Candida* species might result in transmission and outbreaks remaining unnoticed.

**Infection Prevention**

The patient care environment and equipment should be cleaned with an EPA-registered disinfectant that is effective against *C. auris* (i.e., those effective against *Clostridioides*) – See List K here: https://www.epa.gov/pesticide-registration/list-k-epas-registered-antimicrobial-products-effective-against-clostridium

Great care needs to be taken when transferring patients between facilities. Receiving facilities should be made aware of *C. auris* infection or colonization and what precautions should be taken when a patient is transferred to their facility. Consult Alexandria Health Department about the need for additional steps to prevent the spread of *C. auris*.

**Colonization Screening**

The purpose of screening is to identify asymptomatic carriers so additional control measures can be put into place to prevent further spread. The rationale for this testing is that clinical testing might only identify a small proportion of patients who are colonized.

The skin (specifically axilla and groin) appears to be the highest yield sites to swab to identify patients colonized with *C. auris*.

Colonization screening is available through the Antibiotic Resistant Laboratory Network at no charge to the patient or facility. Healthcare facilities and providers are encouraged to contact Alexandria Health Department by calling 703.746.4951 for more information.

For additional information: https://www.cdc.gov/fungal/candida-auris/recommendations.html
Alexandria has an HIV infection rate of 755.6 per 100,000 - the highest in Northern Virginia. Alexandria also has the 5th highest rate of persons living with HIV/AIDS in Virginia. The CDC estimates that 14% of all those living with HIV are unaware of their infection. Those unaware of their status may account for almost 40% of ongoing transmissions. In 2017-19, Alexandria Health Department (AHD) was awarded $929,000 from the Virginia Department of Health to increase access to HIV testing and linkages to care.

AHD developed a Citywide HIV initiative “Getting to Zero” with the aim of achieving Zero Infections | Zero HIV Deaths | Zero Stigma. Getting to Zero (GTZ) encourages all Alexandria healthcare providers to conduct universal testing in accordance with CDC recommendations – every person between 13 and 64 should be tested for HIV at least once as part of routine health care (persons at higher risk should be tested at least yearly, and more often as recommended by their healthcare provider).

GTZ expands access to HIV testing within Alexandria and its border communities; ensures linkages to treatment and supportive care services for those newly diagnosed with HIV infection; and locates persons with HIV who have been lost to care and require re-linkage. GTZ special targeted groups include African-American MSM, immigrant communities (mostly from East Africa), and youth. HIV screenings help identify people living with HIV and get them into care. Early treatment improves the health of that individual and significantly reduces the risk of HIV transmission to others.

GTZ utilizes outreach, community mobilization, education, community-testing events, and in-clinic testing during nontraditional hours. GTZ does HIV testing at colleges and universities, churches, homeless shelters, and during community events. GTZ does health promotion through education and area wide condom distribution. Trainings have been offered to local providers to enhance their knowledge on universal testing, pre-exposure prophylaxis, and STIs. To date, GTZ has reached and tested close to 6,000 people. Of public health interest is that the new cases of HIV that have been detected were not necessarily in the high-risk groups we normally think of for HIV, highlighting the importance of universal HIV testing.

Join us! Help get Alexandria to Zero! CDC recommends that everyone between the ages of 13 and 64 be tested at least once and that people with certain risk factors be tested more often. Make HIV testing as routine as getting a cholesterol test. Today, people with HIV live long healthy lives when they obtain early treatment.

Alexandria Health Department Medical Director, Dr. Kim Luk, has been visiting healthcare provider offices in Alexandria. Dr. Luk has been providing information about Opioid Prescribing and Narcan, as well as promoting universal testing for HIV and encouraging physicians to become PrEP prescribers. Our goal is to make connections with providers in our city and provide you with valuable information. If you have not had a visit from Dr. Luk, and want her to come to your next staff meeting or just to stop by for a few minutes, please email her at: km.luk@vdh.virginia.gov
Taking a Sexual History in Primary Care

The CDC recommends that primary care physicians take a sexual history of everyone in their practice. This helps to gauge someone’s risk for getting HIV and may be a segue for recommending PrEP. Taking a sexual history also gives you a more complete picture of your patient’s health. Remember the “5 Ps of Sexual Health”: Partners, Practices, Protection from STIs, Past History of STIs, and Prevention of Pregnancy. Taking a sexual history is a way that you and your practice can play a key role in preventing HIV and STI transmission within our community. For details, consult the CDC Guide to Taking a Sexual History: https://www.cdc.gov/std/treatment/sexualhistory.pdf

PrEP Resources for Clinicians


PrEP line: PrEP Consultation Service for Clinicians:
1.855.448.7737 (1.855.HIV.PREP): Monday – Friday, 11 a.m. – 8 p.m. ET (National Clinicians Consultation Center, ucsf.edu)

On May 15, 2018, the Food and Drug Administration approved an indication for Truvada for Pre-Exposure Prophylaxis (PrEP) in adults and adolescents who weigh at least 35 kg (77 lb). The indication for PrEP, initial and follow-up prescribing, and laboratory testing recommendations are the same for adolescents and adults.

2017 CDC UPDATE to Clinical Practice Guidelines


- Provide clear criteria for determining a person’s HIV risk and indications for PrEP use.
- Require patients receive HIV testing to confirm negative status before starting PrEP.
- Recommend regular monitoring of HIV infection status, side effects, adherence, and sexual or injection risk behaviors.
- Underscore importance of counseling about adherence and HIV risk reduction, including encouraging condom use for additional protection.
- Offer clinicians additional materials and tools for use when prescribing PrEP.
- Recommend that PrEP be offered to people who are HIV-negative and at substantial risk for HIV.

PrEP and STI Continuing Education Opportunities

Advancing PrEP in Practice: Practical Strategies for Everyday Challenges:
https://www.medscape.org/viewarticle/880821

CDC HIV/AIDS Learning Center for Clinicians: https://www.cdc.gov/hiv/training/learning.html
Tuberculosis (TB)

Alexandria has one of the highest rates of active tuberculosis (TB) disease among Virginia’s 35 health districts and the highest rate of active TB disease in Northern Virginia. Alexandria had a slight increase in active TB cases to 11 (rate: 6.8/100,000) in 2018 from 10 (rate: 6.2/100,000) in 2017. Alexandria’s rate of TB infections is 2.8 times greater than the state rate of 2.4 cases per 100,000 people.

Figure 3 compares rates of diagnosed active TB in Alexandria City, Northern Virginia and the Commonwealth of Virginia from 2011 to 2018. Case counts were obtained from the VDH Division of Surveillance and Investigation

Figure 3: Rate of Tuberculosis in Alexandria, Northern Virginia (NOVA), and Virginia (2011-2018)

TB Elimination: Reporting and Treating Latent Tuberculosis Infection (LTBI)

Beginning November 14, 2018, tuberculosis infection or latent TB infection (also known as “LTBI”) became reportable in Virginia among persons of any age and not just in children younger than four years of age. Diagnosing LTBI requires that active TB disease is ruled out. Results of a test for TB infection (tuberculin skin test or interferon gamma release assay) as well as chest x-ray results and a lack of active TB symptoms should be included in morbidity reports. See Table 2 (next page) for how to differentiate between Latent TB Infection and TB Disease.
Table 2: Differentiating Between Latent TB Infection and TB Disease

<table>
<thead>
<tr>
<th>LTBI</th>
<th>TB Disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>No symptoms or physical findings suggestive of TB disease.</td>
<td>Respiratory specimens are usually smear or culture positive. However, may be negative in persons with extrapulmonary disease or minimal or early pulmonary disease.</td>
</tr>
<tr>
<td>TST or IGRA result usually positive.</td>
<td>May spread TB bacteria to others.</td>
</tr>
<tr>
<td>Chest radiograph is typically normal.</td>
<td>Needs treatment for TB disease.</td>
</tr>
<tr>
<td>If done, respiratory specimens are smear and culture negative.</td>
<td></td>
</tr>
<tr>
<td>Cannot spread TB bacteria to others.</td>
<td></td>
</tr>
<tr>
<td>Should consider treatment for LTBI to prevent TB disease.</td>
<td></td>
</tr>
</tbody>
</table>

How to Report Presumptive or Confirmed Latent Tuberculosis Infection (LTBI)

Q. Who is required to report?
A. Healthcare practitioners and directors of laboratories

Q. How do I report LTBI?
A. Report by telephone, fax or by submitting an electronic morbidity report to the Alexandria Health Department


Call: 703.746.4960, press 2 to speak with a nurse

Q. What should I report for LTBI?
A. Document in the report
   a) Date and results of TST or IGRA
   b) Document that the patient’s chest x-ray was negative, and
   c) Document that the patient had no symptoms of TB disease.

Include all treatment information (if available).

Q. I have questions about reporting and treatment for LTBI, whom should I call?
A. Alexandria Health Department TB nurses would love to talk to you and answer any questions you may have. Please call 703.746.4960, press 2 to speak with a nurse.

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What Providers Should Know about Treating LTBI

CDC and the United States Preventive Services Task Force (USPSTF) recommend testing populations at increased risk for TB infection in order to help control and eliminate TB in the US. LTBI is now reportable in Virginia. Healthcare providers are advised to 1) choose the most effective treatment regime, and 2) ensure that persons complete the entire treatment for LTBI. Table 3 highlights the groups that should be given high priority for LTBI treatment.

When you treat a person for LTBI, remember: discuss the benefits and risk of treatment; review medical side effects and drug interactions; emphasize the importance of adherence; identify potential barriers to adherence; and establish a plan to ensure adherence.


Table 3 Groups who should be Given High Priority for Latent TB Infection Treatment.

<table>
<thead>
<tr>
<th>People who have a positive IGRA result or a TST reaction of 5 or more millimeters</th>
<th>People who have a positive IGRA result or a TST reaction of 10 or more millimeters</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV-infected persons</td>
<td>Persons from high-prevalence countries</td>
</tr>
<tr>
<td>Recent contacts of a TB case</td>
<td>Injection drug users</td>
</tr>
<tr>
<td>Persons with fibrotic changes on chest radiograph consistent with old TB</td>
<td>Residents and employees of high-risk congregate settings (e.g., correctional facilities, nursing homes, homeless shelters, hospitals, and other health care facilities)</td>
</tr>
<tr>
<td>Organ transplant recipients</td>
<td>Mycobacteriology laboratory personnel</td>
</tr>
<tr>
<td>Persons who are immunosuppressed for other reasons (e.g., taking the equivalent of &gt;15 mg/day of prednisone for 1 month or longer, taking TNF-α antagonists)</td>
<td>Children under 4 years of age, or children and adolescents exposed to adults in high-risk categories</td>
</tr>
</tbody>
</table>

Northern Virginia TB Campaign

Having one of the highest rates of TB in the state of Virginia, the Northern Virginia Health Districts of Alexandria, Arlington, Fairfax, Prince William and Loudoun collaborated on a region-wide tuberculosis awareness campaign. Most cases of TB in Northern Virginia occur among foreign-born persons and they are a specific target of the awareness campaign. The purpose of the campaign is to identify people with LTBI so they do not progress to active disease and spread TB to others. The Northern Virginia public health departments are addressing barriers to testing and getting early treatment for LTBI.

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Community Health Assessment: Alexandria’s Health Status

Alexandria's Community Health Assessment

How do we measure health in Alexandria?

Is it the number of doctors or how many people smoke cigarettes? Maybe it is the difference in diabetes hospitalizations between different racial or ethnic groups of residents. What about the poverty rate and housing affordability? From spring 2018 to summer 2019, the Alexandria Health Department has reviewed all of those indicators and dozens more through a Community Health Assessment or CHA. A CHA is a community-centered and data-driven approach to uncover Alexandria’s top health issues using surveys, local statistics, and public input. Alexandria Health Department also collaborated with other Northern Virginia health departments and Inova Health System to identify potential regional health issues.

While Alexandria is relatively healthy overall, we have significant disparities when it comes to race, gender, age, income, zip code, and education. The top ten health issues in our community are: chronic conditions; economic stability; health and healthcare access; injury and violence; mental health; neighborhood and built environment; obesity, nutrition, and physical activity; oral health; sexual and reproductive health; and, tobacco and substance use.

Using this information and public input, Alexandria Health Department and the Partnership for a Healthier Alexandria will develop a multi-year Community Health Improvement Plan (CHIP). The CHIP will feature measurable, actionable strategies to address Alexandria’s most pressing concerns. Everyone is encouraged to help determine the CHIP priority areas and craft solutions. Stay up-to-date on CHIP efforts and review the full CHA report through the Health Department’s website: www.alexandriava.gov/Health
Information for Healthcare Providers: Disease Reporting

Important changes to Reporting Processes and the Reportable Disease List for 2019

On November 16, 2018, the State Board of Health updated the Virginia Regulations for Disease Reporting and Control, specifically 12VAC 5-90-80. Some important updates include:

- Carbapenemase producing organisms and *Candida auris* were added to the reportable disease list
- Congenital syphilis is now a rapidly reportable condition
- Tuberculosis (TB) infection or latent TB is now reportable in all ages. Results of a test for TB infection (tuberculin skin test or interferon gamma release assay) should be reported.

Clinicians practicing in Virginia are required by law to report the conditions in Figure 4 (see next page) to their local health department. Timely reporting ensures prompt and appropriate public health action. If you have any questions about mandated reporting, please contact us. Reports should be directed to the patient’s local health department based on patient’s home address and should include:

- Patient’s Name
- Date of Birth
- Address
- Date of Diagnosis
- Date of Symptom onset

**Contact the Health Department** if you **suspect** a reportable disease such as mumps, measles, B. *pertussis*, an outbreak, or unusual occurrence of public health concern by calling **571-259-8549**.

If you suspect enough to test, call the health department.

Contact Information for Disease Reporting

<table>
<thead>
<tr>
<th>For diseases listed</th>
<th>For diseases listed</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Report Immediately</strong></td>
<td><strong>Report Within 3 Days</strong></td>
</tr>
</tbody>
</table>

**Timeframe:** Report immediately by the most rapid means available

**Report Method:** Phone

- *Monday-Friday, Evenings and Weekends (24/7):*
  - Cell phone: 571.259.8549

**NOTE:** This phone is **only** for healthcare providers and government officials.

**Timeframe:** Submit form within 3 days of suspected or confirmed diagnosis

**Electronic Report Form:**
[www.alexandriava.gov/DiseaseReporting](http://www.alexandriava.gov/DiseaseReporting)

**Report Method:** Phone, fax, or mail

- *Monday – Friday (8 a.m. – 4:30 p.m.)*
  - Office phone: 703.746.4951
  - Fax: 703.746.4953

- Mail: Alexandria Health Department
  - Attn: Communicable Disease
  - 4480 King Street
  - Alexandria, VA 22302
VIRGINIA REPORTABLE DISEASE LIST

Reporting of the following diseases is required by state law (Sections 32.1-36 and 32.1-37 of the Code of Virginia and 12 VAC 5-90-80 of the Board of Health Regulations for Disease Reporting and Control – http://www.vdh.virginia.gov/surveillance-and-investigation/division-of-surveillance-and-investigation/commonwealth-of-virginia/state-board-of-health/). Report all conditions when suspected or confirmed to your local health department (LHD). Reports may be submitted by computer-generated printout, Epi-1 form, CDC or VDH surveillance form, or upon agreement with VDH, by means of secure electronic submission.

BOLD = Laboratories must submit initial isolate or other initial specimen to the Division of Consolidated Laboratory Services (DCLS) within 7 days of identification. All specimens must be identified with patient and physician information, and the LHD must be notified within the timeframe specified below.

REPORT IMMEDIATELY

Anthrax (Bacillus anthracis) [a]
Botulism (Clostridium botulinum) [a]
Brucellosis (Brucella spp.) [a]
Cholera (Vibrio cholerae O1/O139) [a]
Coronavirus infection, severe (e.g., SARS-CoV, MERS-CoV) [a]
Diphtheria (Corynebacterium diphtheriae) [a]
Disease caused by an agent that may have been used as a weapon
Haemophilus influenzae infection, invasive [a]
Hepatitis A [a]
Influenza-associated deaths if younger than 18 years of age
Influenza A, novel virus [a]
Measles (Rubella) [a]
Meningococcal disease (Neisseria meningitidis) [a]
Outbreaks, all (including but not limited to foodborne, healthcare-associated, occupational, toxic substance-related, waterborne, and any other outbreak)
Pertussis (Bordetella pertussis) [a]
Plague (Yersinia pestis) [a]
Poliovirus infection, including poliomyelitis [a]
Pseudogardia (Chlamydia psittaci) [a]
Q fever (Coxiella burnetti) [a]
Rabies, human and animal [a]
Rubella [a], including congenital rubella syndrome [a]
Smallpox (Variola virus) [a]
Syphilis (Treponema pallidum), congenital, primary, and secondary [a]
Tuberculosis, active disease (Mycobacterium tuberculosis complex) [a,b]
Tularemia (Francisella tularensis) [a]
Typhoid/Paratyphoid infection (Salmonella Typhi, Salmonella Paratyphi) [a]
Unusual occurrence of disease of public health concern
Vaccinia, disease or adverse event [a]
Vibriosis (Vibrio spp.) [a,e]
Viral hemorrhagic fever [a]
Yellow fever [a]

REPORT WITHIN 3 DAYS

Amebiasis (Entamoeba histolytica) [a]
Arboviral infections (e.g., CHIK, dengue, EEE, LAC, SLE, WNV, Zika) [a]
Babesiosis (Babesia spp.) [a]
Campylobacteriosis (Campylobacter spp.) [a]
Candida auris, infection or colonization [a,c]
Carbapenemase-producing organism, infection or colonization [a,c]
Chancroid (Haemophilus ducreyi) [a]
Chickenpox (Varicella virus) [a]
Chlamydia trachomatis infection [a]
Cryptosporidiosis (Cryptosporidium spp.) [a]
Cyclosporiasis (Cyclospora spp.) [a]
Ehrlichiosis/Anaplasmosis (Ehrlichia spp., Anaplasma phagocytophila) [a]
Gardasil (Gardasil spp.) [a]
Gonorrhea (Neisseria gonorrhoeae) [a]
Granuloma inguinale (Calymmatobacterium granulomatis)
Hantavirus pulmonary syndrome [a]
Hemolytic uremic syndrome (HUS)
Hepatitis B (acute and chronic) [a]
Hepatitis C (acute and chronic) [a]
Hepatitis, other acute viral [a]
Human immunodeficiency virus (HIV) infection [a]
Influenza, confirmed seasonal strain [a]
Lead, blood levels [a]
Legionellosis (Legionella spp.) [a]
Leprosy/Hansen's disease (Mycobacterium leprae)
Leptospirosis (Leptospira interrogans) [a]
Listerosis (Listeria monocytogenes) [a]
Lyme disease (Borrelia spp.) [a]
Lymphogranuloma venereum (Chlamydia trachomatis)
Malaria (Plasmodium spp.) [a]
Mumps [a]
Neonatal abstinence syndrome (NAS)
Ophthalmia neonatorum
Rabies treatment, post-exposure
Salmonellosis (Salmonella spp.) [a]
Shiga toxin-producing Escherichia coli infection [a,c
Shigellosis (Shigella spp.) [a]
Spotted fever rickettsiosis (Rickettsia spp.) [a]
Streptococcal disease, Group A, invasive or toxic shock [a]
Streptococcus pneumoniae infection, invasive and <5 years of age [a]
Syphilis (Treponema pallidum), if not primary, secondary, or congenital
Tetanus (Clostridium tetani)
Toxic substance-related illness [a]
Trichinosis/Trichinellosis (Trichinella spiralis) [a]
Tuberculosis infection [a]
Vancomycin-intermediate or vancomycin-resistant
Staphylococcus aureus infection [a]
Yersiniosis (Yersinia spp.) [a]

ALEXANDRIA HEALTH DEPARTMENT
Communicable Disease Division

Report immediately: 703.746.4551 | Report online: alexandriava.gov/DiseaseReporting

Effective November 2018
Do I need to report Chickenpox (Varicella)? – Yes!

Clinicians and healthcare providers should report chickenpox cases to the Health Department as soon as it is diagnosed or suspected. Do not wait for confirmatory lab testing to report chickenpox.

Overview

Chickenpox (or Varicella) is a vaccine preventable illness caused by the varicella zoster virus (VZV). The virus that causes chickenpox also causes shingles (herpes zoster). Chickenpox incidence has declined, but is still one of the more commonly reported communicable diseases in Alexandria. Because clinicians diagnose most chickenpox cases without lab confirmation, healthcare providers are an important source of reporting for epidemiologists at the Alexandria Health Department.

Epidemiology of Chickenpox and Potential Sequelae

In 2017, there were 8,775 confirmed chickenpox cases in the U.S., including two deaths. Varicella incidence, outbreaks, hospitalizations, and deaths have dramatically declined since introduction of the varicella vaccine in 1995. Most chickenpox cases still occur in younger school-aged children.

Risk of chickenpox infection is low in persons who have received two doses of vaccine or who have had past infection. Second occurrences of chickenpox do happen for those who have had prior infection; these are often more mild than the previous infection. It is possible for persons who have been immunized to have “breakthrough” cases of chickenpox.

After a person recovers from chickenpox, the virus remains dormant in the nervous system and can reactivate years later causing shingles (herpes zoster). Risk factors include age (over 50 years) and immunocompromising conditions or medications. There are an estimated one million cases of shingles in the U.S. annually. Two vaccines are currently available in the U.S. to prevent shingles; the Advisory Committee on Immunization Practices recommends Shingrix® as the preferred shingles vaccine.

In Alexandria

In 2017 and 2018, the rate of chickenpox in Alexandria (8.3 per 100,000) was twice the rate in Virginia (4.0 per 100,000). Alexandria had the highest rate of chickenpox incidence compared with other Northern Virginia health districts in 2017. Note: Finalized data for 2018 was not available at the time of this report.

Important Information for Providers

High-risk populations

Complications of chickenpox are rare but can include encephalitis and meningitis. Persons who are at risk of severe complications if infected with chicken pox include pregnant women, the elderly, infants, and those with compromised immune systems. Post-exposure prophylaxis (varicella zoster immune globulin or VariZIG®) can reduce the severity of illness among high-risk persons without prior immunity exposed to chickenpox.

Reporting Chickenpox

Clinicians and healthcare providers should report chickenpox cases to the Health Department as soon as it is diagnosed or suspected. Do not wait for confirmatory lab testing to report chickenpox. With prompt reporting, AHD epidemiologist are better able to identify at-risk contacts of the patient and to more quickly facilitate prophylaxis and recommend infection control measures. Early reporting can help prevent the spread of chickenpox in our community.

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Additional Resources for Healthcare Professionals

**Public Health Services**
Alexandria Health Department provides many services to the community. An overview of our services - including program descriptions, locations, phone numbers, and hours of operation - is available in our *Guide to Services and Programs* (English and En Español).

Information about AHD clinical and public health nursing services is also available online. Please visit: [https://www.alexandriava.gov/health/info/default.aspx?id=11444](https://www.alexandriava.gov/health/info/default.aspx?id=11444)

**Free Training Opportunities**
AHD epidemiologists provide disease-specific infection control and prevention training. If you are interested in training or an in-service for your staff in these areas, please contact us at 703.746.4951 or alex_epi@vdh.virginia.gov.