



October 2017

WISCONSIN EPI EXPRESS

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PROGRAM UPDATES

STAFF UPDATES:

- Ariel Greenway, Sentinel Site Business Analyst, 608-421-6038, Ariel.Greenway@dhs.wisconsin.gov
- Kim Kassander, Hepatitis C Surveillance Student, Kimberly.Kassander@dhs.wisconsin.gov
- Ashley Meyer, Vaccine Manager, 608-266-2346, Ashley.Meyer@dhs.wisconsin.gov
- Kailynn Mitchell, HCV Outreach Specialist, 608-266-9823, Kailynn.Mitchell@dhs.wisconsin.gov

“WHO CAN YOU PROTECT?” FLU VACCINE FLYERS:

Educational flyers with the theme of “Who Can You Protect” by getting the flu shot have been developed for four main population groups at risk for getting the flu: [infants](#), [families](#), [pregnant women](#), and [seniors](#). They are available in English, Hmong, and Spanish.

ONGOING OUTBREAK INVESTIGATIONS:

Check out the DHS website for up-to-date information: [Salmonella Heidelberg](#) and [Zika virus](#).

NEW EDUCATIONAL MATERIALS:

Please see our new flyers that have recently been developed: [Let’s change the way we Talk About HIV Infographic](#) and [Antibiotics Before Dental Procedures](#).

COMMUNICABLE DISEASE UPDATE WEBINAR SERIES:

There has been a schedule change for the Communicable Disease Update Webinar Series. It is now held on the **second Tuesday** of every month from 1-2 p.m. The link to join the webinar is the same every month: <https://connect.wisconsin.gov/monthly-webinar-series/>. No registration is necessary. Upcoming topics include: influenza update and reporting.

Wisconsin Tuberculosis (TB) Dispensary Program Update

By: Julie Tans-Kersten, MS, BSMT (ASCP)

Tuberculosis (TB) is a disease caused by bacteria that are spread from person to person through the air. TB usually affects the lungs, but it can also affect other parts of the body, such as the brain, kidneys, or spine. Although the incidence of TB is low in Wisconsin, 63 individuals (on average) are sickened with this potentially life-threatening illness every year. The Wisconsin TB Program (WTBP) oversees, manages, and facilitates the various activities and interventions necessary to assure identification and proper treatment of individuals with tuberculosis to eliminate subsequent spread to others.

The WTBP manages the Wisconsin TB Dispensary Program in accordance with Wisconsin Statute 252.07. The Wisconsin TB Dispensary Program uses state tax revenue funds to reimburse local health departments (LHDs) for medical management of patients with active TB, patients being evaluated for TB, patients with latent TB infection (LTBI) and patients exposed to TB. Uninsured or under-insured individuals may receive TB-related diagnostic services, medical services and anti-tuberculosis medications free of charge through this program.

Tuberculosis Ordering and Billing Interface (TOBI)



What is TOBI?

The Tuberculosis (TB) Ordering and Billing Interface (TOBI) is a secure, web-based system used by health care providers, local health departments, and the Wisconsin TB Program. TOBI has an electronic form that health care providers can use to order TB-related medications through the Wisconsin TB Dispensary Program. TOBI also allows Wisconsin health departments and pharmacies to enter invoices for TB-related medical services and drugs that are reimbursable through the Wisconsin TB Dispensary Program. The purpose of the Wisconsin TB Dispensary Program is to ensure that all persons in Wisconsin with suspected or confirmed TB infection or disease can receive appropriate evaluation, treatment, and monitoring.



Links to the TOBI Application

[Request for Medications for active tuberculosis \(TB\) disease: Electronic Form](#)

[Request for Medications for latent tuberculosis infection \(LTBI\): Electronic Form](#)

[TOBI Application](#)

In order to fully track and document Wisconsin TB Dispensary Program funding and facilitate reimbursement, a web-based application was created and implemented in August, 2017. The Tuberculosis Ordering and Billing Interface (TOBI) is a secure system used by health care providers, LHDs, and the WTBP.

TOBI has an electronic form that health care providers and clinics can use to order TB-related medications. TB medication orders are then processed through the appropriate LHD and approved by the WTBP. TB medications can be shipped to the LHD or clinic that will be administering therapy. Optionally, LHDs can pick up TB antimicrobials at a local pharmacy of their choice.

TOBI will facilitate processing and approval of invoices through the WTBP for rapid reimbursement.

TOBI also allows LHDs and pharmacies to enter invoices for TB-related medical services and drugs that are reimbursable through the Wisconsin TB Dispensary Program. During the process of managing the care of patients with active TB disease or LTBI, LHDs perform many key roles. They perform or assure patient screening and testing, they ensure that patients take their medications, they assess patients for medication side effects and they educate patients about TB. LHDs that have contracted with the Wisconsin TB Dispensary Program may submit bills into TOBI. TOBI will facilitate processing and approval of invoices through the WTBP for rapid reimbursement. In the future, TOBI users will have the capability to generate reports including a summary of LHD invoices, a summary of LHD reimbursements and a summary of costs (medical services and medications) for a specific patient. LHDs will also be able to download TOBI transactions to an Excel spreadsheet.

For more information about the Wisconsin TB Dispensary Program and TOBI, please visit the WTBP website at: <https://www.dhs.wisconsin.gov/tb/tobi.htm>

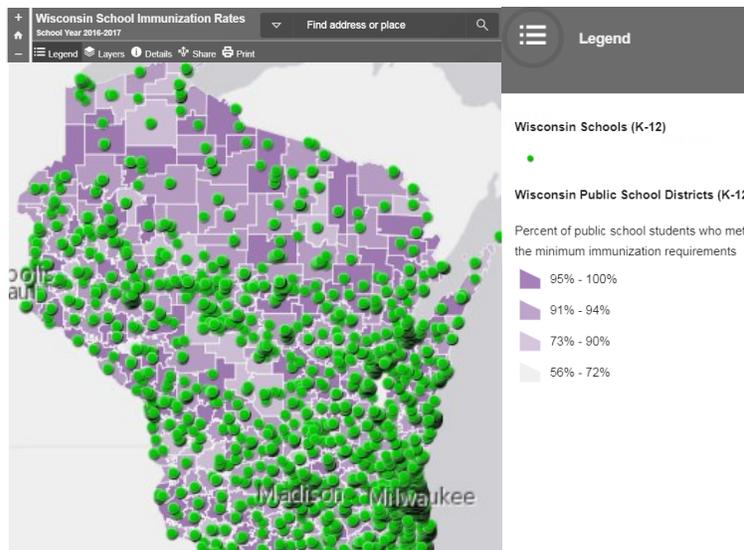
[View the new TOBI Webpage](#)

Wisconsin Student Immunization Rates—Now Online!

By: Ruth Koepke, MPH

Student immunization rates are now online for every school in Wisconsin. The purpose of sharing this information is to educate the public about how well immunized school children are in your/your child's school environment. Diseases that are preventable by immunization, including measles, mumps, pertussis, and chickenpox, are more likely to occur when student immunization rates are low. Therefore, parents, schools, health care and public health professionals are encouraged to search the [interactive web map](#) to view the immunization rates among students at public and private schools throughout Wisconsin for the 2016-2017 school year. Immunization rates for every public school district are also included on the map.

Every fall, Wisconsin schools are required to report the aggregate number of students at the school who have met the [minimum immunization requirements](#) or have a waiver. [Wisconsin law](#) allows immunizations to be waived for medical, religious, and personal conviction reasons. Since the 1997-1998 school year, the [percent of students with a personal conviction waiver to any vaccine has increased](#).



[Search the Interactive Student Immunization Map](#)

During the 2016-2017 school year, 4.2% of students had a personal conviction waiver for one or more immunizations, compared to only 1.2% of students during the 1997-1998 school year. During the 2016-2017 school year, for the first time schools were asked to report the number of students who had waived all immunizations. Statewide, only 1.0% of students waived all immunizations and were completely unvaccinated. However, this measure varies from school to school. To view this important information for a particular school or school district, search the [interactive web map](#) or download excel spreadsheets by [school](#) and [district](#).

Statewide, only 1.0% of students waived all immunizations and were completely unvaccinated.

Also for the first time this year, Wisconsin's immunization rates are now available through the [Environmental Public Health Tracking Portal](#). To access immunization rates for Wisconsin as a whole or by county, choose 'Immunization' from the drop-down menu and then select the vaccine, geography, and ages of interest. The portal includes immunization rates for most vaccines recommended for children, adolescents, and adults, including influenza. All rates are calculated based on data from the Wisconsin Immunization Registry. More details on the immunization data available through the portal can be found on the [tracking website](#).

Finally, please visit our updated [Immunization Rate Data page](#). It includes Wisconsin immunization rate information for children ages 0-18 years, adults, pregnant women, and it also includes influenza immunization rates. Please check back frequently as new information is added!

Environmental Public Health Tracking: Immunization Data



This page is for data users of the Wisconsin Environmental Public Health Tracking data portal. You can find [general immunization information](#) on the Bureau of Communicable Disease's webpage.

Immunizations, also called vaccinations, help prevent diseases like measles, chickenpox, and the flu.

Public health professionals track immunization data in order to identify areas of need and plan disease prevention efforts.

Below are frequently asked questions on the immunization data we host.

[Access immunization data](#)



Interested in environmental health data?

Join the environmental health listserv by sending a blank email to [join: envhealth@lists.wisc.edu](mailto:envhealth@lists.wisc.edu)

What are immunizations?	↑
How are immunizations related to environmental health?	↓
How can tracking immunizations improve public health?	↓
What is the data source?	↓
Which immunizations does Wisconsin Tracking have on the data portal?	↓
What are some considerations for interpreting the data?	↓
Where can I learn more about immunizations?	↓
Where can I learn more about the diseases prevented by immunizations?	↓

[View Immunization Data on the Environmental Public Health Tracking Portal](#)

Using Person-Centered Language to Address HIV-Related Stigma

By: Katarina Grande, MPH; Jacob Dougherty; and Hester Simons, MPH

*A [longer version of this article](#) was previously published as an article in the HIV Program's Program Notes series.

HIV prevention and care efforts are negatively impacted by stigma.^{1,2} When people living with HIV are faced with negative beliefs, feelings, or attitudes at healthcare facilities, they may be less likely to seek medical care.¹ When people in need of HIV prevention services face a similar environment, they may opt to forgo testing, which hinders HIV prevention efforts. While stigma must be addressed from many levels, one action taken by the AIDS/HIV Program has been to increase organizational awareness of its use of language. Through our reports, publications, and presentations, the AIDS/HIV Program is committed to signaling to partner organizations, health care providers, and people living with HIV the importance of using language that does not—intentionally or unintentionally—contribute to stigma. Here, we highlight ways in which the Wisconsin AIDS/HIV Program is implementing the use of language that is compassionate,³ accurate,⁴ trauma-informed, and responsive to the unique needs of individuals and communities affected by the HIV epidemic.

Stigma can be broken down into four elements:

Stigma can be broken down into four elements: labeling, stereotyping, prejudice, and discrimination.^{5,6}

labeling, stereotyping, prejudice, and discrimination.^{5,6} In brief, *labeling* is the act of assigning an attribute to someone. *Stereotypes* represent collectively agreed upon beliefs about groups of people learned by most members of a social group. People can have knowledge of stereotypes without agreeing that the stereotypes are valid. *Prejudice*, on the other hand, is the agreement with a negative stereotype or belief. Unlike stereotypes, which are beliefs, prejudicial attitudes involve an evaluation that is generally negative. Prejudice also creates emotional responses (e.g. anger or fear) to stigmatized groups. *Discrimination* involves behaviors and actions that align with the negative belief. Because HIV prevention and care efforts are negatively impacted by stigma, actively and consciously avoiding language that can contribute to stigma, particularly labeling and stereotyping, is extremely important in working with clients and communities.



Where stigma is present, discrimination (action generated from a place of stigma) frequently follows. HIV-related discrimination is the “unfair and unjust treatment of someone based on their real or perceived HIV status.”¹ Populations disproportionately impacted by HIV face prejudice and discrimination based on one or more facets of their identity. These include the lesbian, gay, bisexual, transgender, queer/questioning (LGBTQ+) community; people who use drugs; people who experience poverty; sex workers; and people of color.¹ HIV-related stigma compounds stigma already experienced by these groups. When this happens, people are less likely to seek HIV testing and information, adopt safer behaviors, or disclose their HIV status to sexual partners.^{7,8}

To better understand how stigma and public health practice impact HIV-related outcomes, the National Alliance of State and Territorial AIDS Directors (NASTAD) and the National Coalition of STD Directors partnered in 2011-2012 to conduct a survey of more than 1,300 health department and community-based organization staff, health care providers, and community members representing U.S. states and territories. The results showed high levels of perceived stigma (at both community and institutional levels) directed at Black and Latino gay men/men who have sex with men (MSM).⁹ Additionally, a focus group of health care providers and Black MSM showed that certain language regarding HIV, sex, and sexuality can contribute to these levels of perceived stigma and is prevalent among health care providers. The focus group also noted that developing meaningful relationships with patients is important in engaging Black MSM with health care.¹⁰ This is crucial since Black and other MSM communities of color are among those most impacted by HIV in Wisconsin and nationwide.

Using Person-Centered Language to Address HIV-Related Stigma (continued)

In alignment with a goal of the 2020 National HIV/AIDS Strategy to “reduce stigma and eliminate discrimination associated with HIV status,”¹¹ the Wisconsin AIDS/HIV Program is committed to ongoing training and critical discussion of its use of language. Learning to use person-centered language and other forms of compassionate communication is a process that takes time and practice. Part of this learning process is acknowledging when mistakes are made and learning from them. Even those with the best of intentions will sometimes use language that can contribute to stigma. The reality is that language that stigmatizes can lead to adverse outcomes regardless of the speaker’s intentions. Ongoing training and education is also necessary due to the constantly evolving nature of language.

One tangible approach to avoiding language that could be perceived as stigmatizing is to shift to “person-first” language—where the person is mentioned before the identity or action. For example, instead of “an injection drug user,” use the phrase “a person who injects drugs.” Person-first language is important because it explicitly acknowledges the person as a human being first, and a possibly stigmatizing term is not a defining label. Another concrete approach is to simply update language that is inaccurate or out of date. Examples of commonly used phrases, reasons the language is inaccurate or stigmatizing, and alternative phrases to practice are listed in the [infographic](#) (see below).

Interventions and approaches to reduce stigma are needed at multiple levels. This will not only reduce stigma toward people living with and at risk for HIV, including gay and bisexual men/MSM, but will also improve sexual health outcomes for these groups. Introducing language that is non-stigmatizing into training for HIV providers is an important step toward operationalizing trauma-informed care.

Use of non-stigmatizing language by providers will ultimately improve the delivery of services and increase the likelihood that persons will be retained in care or return for regular HIV/STI testing. This in turn will contribute to stopping the spread of HIV and achieving the goal of everyone living better, longer.

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- NASTAD webinar: The Power of Language and the Importance of its Appropriate Use. <https://www.nastad.org/webinars/power-language-importance-its-appropriate-use>
- National HIV/AIDS Strategy for the United States: Updated to 2020. Washington, DC: The White House Office of National AIDS Policy; 2-15. Accessed from: <https://www.aids.gov/federal-resources/national-hiv-aids-strategy/nhas-update.pdf>

Let's change the way we Talk about HIV

Tips to avoid using language that contributes to HIV-related stigma:

Avoid	Say	Why
HIV patient, AIDS patient, positive, affected person, AIDS or HIV carrier, victim, someone victim, suffers from HIV	Person living with HIV	Put the person first rather than the condition.
Addict, drug addict, drug addict, drug addict, user	People who inject drugs (PWID)	Put the person first rather than the substance.
Died of AIDS, to die of AIDS	Died of AIDS-related illness, or end stage HIV	Be accurate and don't contribute to the fear associated with HIV. Accurate can be: "I had a healthy life with HIV."
Fuck blown AIDS	AIDS or Stage 3 HIV	Be accurate and don't contribute to the fear associated with HIV. Accurate can be: "I had blown AIDS, which is a medical condition."
Compliant	Adherent	Focus on person's commitment to follow their medication regimen rather than their behavior.
Prostitute or prostitution	Sex worker, sale of sexual services	Avoid using words that are gendered and related to a commercial activity.
Promiscuous	Having multiple partners	Avoid words that imply a value judgment.
A transgender, transgendered	Transgender man, woman, or person	Be accurate and respectful. Transgender is an adjective for a gender identity, not a verb.

What is stigma? How can we prevent it?

What is stigma? HIV-related stigma refers to negative beliefs, feelings, and attitudes toward people living with HIV, their families, and people who work with them.

Labeling: "I'm HIV positive" or "I'm HIV infected" vs. "I have HIV" or "I'm living with HIV"

Stereotyping: "All HIV-positive people are gay" or "All HIV-positive people are drug users"

Prejudice: "I wouldn't want to be friends with someone who has HIV"

Discrimination: "I wouldn't want to be friends with someone who has HIV"

HIV prevention and care efforts are negatively impacted by stigma. When people living with HIV are faced with negative beliefs, feelings, or attitudes at health care facilities, they may be less likely to seek medical care.

What can we do?

- Use language that does not—intentionally or unintentionally—contribute to stigma.
- Develop genuine, meaningful relationships with clients to ensure they feel welcome and safe in health care settings.
- Participate in training and discussions around the use of language and how it impacts stigma.
- Practice compassionate communication. It takes time and practice, and it is important that we learn from our mistakes.

When providers use non-stigmatizing language, it improves service delivery and may increase the likelihood that people will be retained in care or return for regular HIV/STI testing.

[Download the “Let’s change the way we Talk about HIV” Infographic!](#)

Data in Action: Risk Factors Associated with *Giardia* Infection in Wisconsin

By: Amanda Koch, MPH, CSTE Applied Epidemiology Fellow

Giardiasis, a gastrointestinal illness with significant burden in Wisconsin, is a parasitic disease associated with frequent watery diarrhea caused by the protozoan *Giardia lamblia*. Infection occurs via consumption of water, food, or soil contaminated with cysts excreted in the stool of infected people and animals. The standardized demographic, clinical, and exposure information collected by public health staff statewide from persons with giardiasis are used to calculate incidence rates, inform descriptive and analytic studies, and identify and investigate outbreaks. This article describes findings from a recent analysis of exposure data to identify risk factors for giardiasis in Wisconsin.

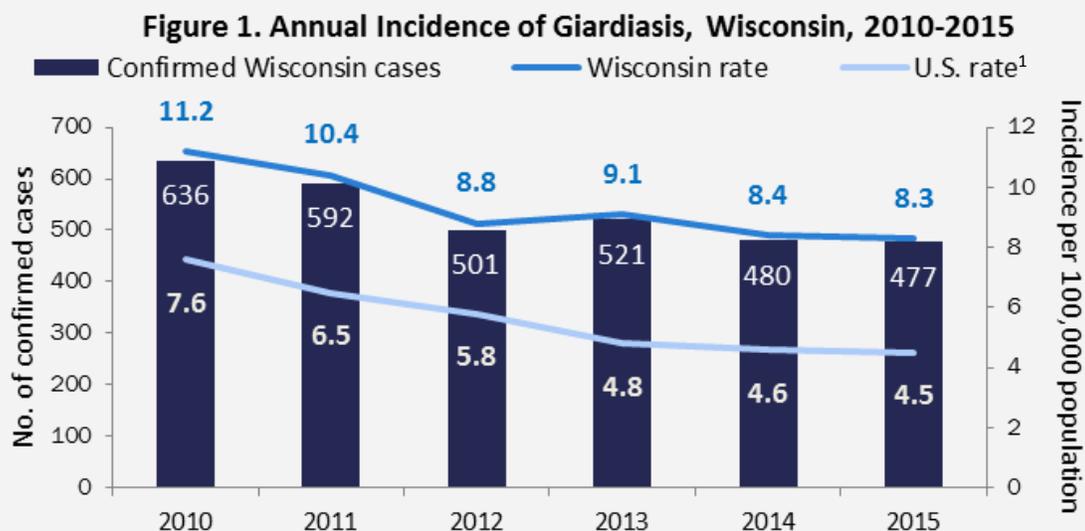
From 2010-2015, Wisconsin saw a median of 511 cases reportedly annually (Figure 1). Although annual incidence declined during these years, it was consistently 1.5-1.9 times the national rate.¹

Analysis Methods: To further characterize *Giardia* infection in Wisconsin and hypothesize risk factors for giardiasis among Wisconsinites, a case-case comparison was performed using surveillance data from confirmed cases of giardiasis and salmonellosis with illness onset during 2010-2015. Chi-square analysis of exposure frequencies between comparison groups was performed.



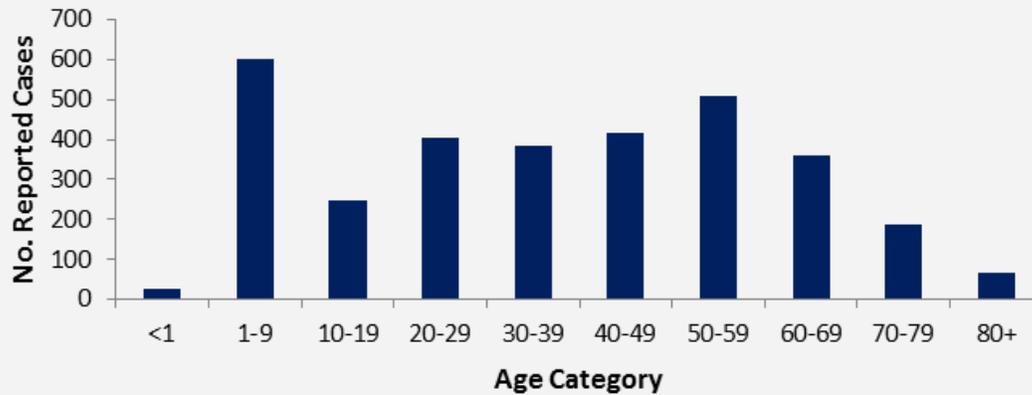
Significant associations ($p < 0.05$) of risk factors for developing giardiasis as opposed to salmonellosis were reported.

Analysis Results: Children between the ages of 1 to 9 years remain the age group with highest overall incidence followed by adults 50 to 59 (Figure 2). Analysis of exposure frequencies found that exposure to surface water (i.e., rivers, lakes, and ponds) as well as obtaining food from noncommercial sources (i.e., from farmer's markets, one's own garden, and hunting, fishing, and trapping) are important risk factors for giardiasis in Wisconsin. Other significant risk factors include exposure to adults or children in diapers and consuming water from a private well or common well/rural well system.



Data in Action: Risk Factors Associated with *Giardia* Infection in Wisconsin (continued)

Figure 2. Age distribution of Persons with Giardiasis, Wisconsin, 2010-2015



Results from this analysis continue to reinforce the importance of the following:

Proper handwashing: Wash your hands well after using the bathroom, changing diapers, participating in outdoor activities, touching animals or their living environment, and before preparing or consuming food.

Food hygiene: While any raw produce should be washed, foods from noncommercial sources (e.g., fruits and vegetables from a farmer's market or your own garden) should be washed well before consumption.

Safe swimming: Swimmers should avoid swallowing water while swimming. Besides *Giardia*, swimmers can be exposed to a number of other waterborne parasites, viruses, and bacteria.

Safe water: Travelers who are hiking, camping, or traveling in a place where the safety of the drinking water is unknown should drink bottled water or use an approved water treatment method. For more information on the filtration and treatment of untreated water visit https://www.cdc.gov/parasites/crypto/gen_info/filters.html

Well testing: Homeowners who obtain their drinking water from common or private wells should have their water tested annually for bacteria and nitrates which may indicate the presence of other harmful pathogens.

Results from this analysis also suggest future directions which may help further elucidate these findings. Among these are: enhanced surveillance investigating potential risk factors not collected during routine surveillance, increasing specificity of travel and water exposure variables, and potential projects evaluating risk of giardiasis in association with geological and meteorological variables.

References

1. MMWR: Summary of Notifiable Infectious Diseases. (2017, August 10). Retrieved from https://www.cdc.gov/mmwr/mmwr_nd/



Communicable Disease Case Counts

This report contains a selection of reportable conditions with inclusion based on public health significance and frequency of occurrence. The case counts reflect confirmed and probable cases, for all process statuses. These numbers are not final and are subject to change as confirmatory testing and case follow-up are completed.

Disease	2016 Case Counts		2017 Case Counts			
	Total	Q1	Q2	Q3	Q4	2017 YTD
Enteric/ Gastrointestinal (also includes suspect cases)						
Campylobacteriosis	1,730	266	436	461		1,163
Cryptosporidiosis	881	89	131	240		460
Cyclosporiasis	5	2	8	9		19
<i>E. coli, Shiga toxin-producing (STEC)</i>	416	33	69	124		226
Giardiasis	824	81	91	216		388
Hemolytic uremic syndrome	8	0	1	7		8
Listeriosis	16	1	1	3		5
Salmonellosis	946	161	185	98		444
Shigellosis	770	113	53	44		210
Typhoid fever	9	1	1	0		2
Vibriosis (non-cholera)	11	9	6	9		24
Yersiniosis	42	9	9	1		19
Invasive Bacteria						
Group A Streptococcal disease	208	97	92	47		236
Group B Streptococcal disease	546	112	130	129		371
Mycotic						
Blastomycosis	117	20	13	6		39
Coccidioidomycosis	14	0	1	2		3
Histoplasmosis	12	4	5	4		13
Respiratory						
Please refer to the weekly respiratory virus surveillance report: https://www.dhs.wisconsin.gov/influenza/weekly-influenza-report.pdf						
Influenza-associated hospitalizations	2,017	3,189	487	17		3,693
Influenza, novel	1	0	0	0		0
Legionellosis	116	23	43	76		142
Tuberculosis	40	12	14	13		39
Sexually Transmitted						
Chlamydia trachomatis	27,080	7,173	6,616	6697		20,486
Gonorrhea	6,548	1,761	1,752	1976		5,489
HIV	222	73	52	60		185
Syphilis (all stages)	426	133	135	99		367
Vaccine Preventable						
Diphtheria	0	0	0	0		0
<i>Haemophilus influenzae</i> invasive disease	127	31	27	20		78
Hepatitis B, acute (confirmed cases only)	9	6	8	5		19
Hepatitis B, perinatal	1	0	0	0		0

Communicable Disease Case Counts (cont.)

Disease	2016 Case Counts		2017 Case Counts			
	Total	Q1	Q2	Q3	Q4	2017 YTD
Vaccine Preventable (continued)						
Measles (rubeola)	0	0	0	0		0
Meningococcal disease	6	3	0	0		3
Mumps	48	30	11	2		43
Pertussis (whooping cough)	1,452	166	224	109		499
Poliomyelitis	0	0	0	0		0
Rubella	0	0	0	0		0
<i>Streptococcus pneumoniae</i> invasive disease	422	183	123	53		359
Tetanus	0	0	0	0		0
Varicella (chicken pox)	392	57	68	57		182
Vectorborne						
Babesiosis	68	4	20	50		74
Ehrlichiosis/ Anaplasmosis	699	11	392	251		654
Jamestown Canyon virus infection	7	1	11	10		22
La Crosse virus infection	4	0	0	0		0
Lyme disease	2,318	113	869	982		1,964
Malaria*	20	2	1	3		6
Powassan virus infection	5	0	1	1		2
Rocky Mountain spotted fever	19	0	6	7		13
West Nile virus infection	13	0	2	13		15
Yellow fever*	0	0	0	0		0
Zika virus infection**	62	3	1	3		7
Zoonotic						
Brucellosis	3	0	1	1		2
Hantavirus infection	0	3	0	0		3
Leptospirosis	1	0	0	0		0
Q Fever	7	1	5	1		7
Rabies (human)	0	0	0	0		0
Toxoplasmosis	2	2	2	0		4
Tularemia	1	0	0	0		0
Other						
Hepatitis A	7	2	3	3		8
Hepatitis C, acute	104	6	21	7		34
Hepatitis E, acute	5	0	0	0		0
Kawasaki disease	10	6	3	4		13
Lymphocytic choriomeningitis virus infection	1	0	0	0		0
Psittacosis	0	0	0	0		0
Transmissible spongiform encephalopathy (human)	10	3	6	4		13

¹ Denotes diseases where all cases in Wisconsin residents are travel-associated. No local transmission occurs.

² Due to enhanced surveillance, asymptomatic confirmed cases are included.

