



Syndemic Infectious Disease Surveillance and Reporting in Chicago

Ashley Martell Becht, MPH | Director of Disease Investigations

Syndemic Infectious Disease (SID) Bureau Provider Conference

Malcolm X College | Chicago, IL

Tuesday, May 2, 2023



Disclosure Statement

I, Ashley Martell Becht, have no financial interest to disclose. This continuing education activity is managed by The St. Louis STI/HIV Prevention Training Center and accredited by Missouri State Medical Association (MSMA) in cooperation with the Chicago Department of Public Health.

Core Surveillance Information

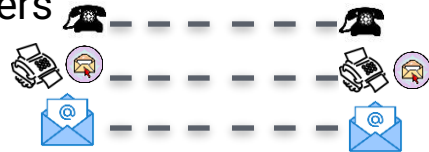
Flow How Surveillance Works



Individuals with Positive SID Tests

Sources of Reports

Hospital Practitioners
Private Practitioners
Public Clinics
Laboratories



Chicago Health Department



Illinois Health Department

Dissemination

Local Bulletins
CDC Semiannual Report
STI, HIV and other SID Websites
Public Information Data Set
Surveillance Reports



Centers for Disease Control & Prevention





Office of Syndemic ID Surveillance – Reportable Conditions

HIV & Perinatal HIV	Syphilis & Congenital Syphilis**	Gonorrhea	Chlamydia	Viral Hepatitis B	Viral Hepatitis C	Mpox
---------------------	----------------------------------	-----------	-----------	-------------------	-------------------	------

Tuberculosis*

*the TB program operates independently from the SID office of surveillance.

**Syphilis case reporting requirements and prenatal testing and CHIMS Provider Portal will be discussed in detail by E. Warren

- New conditions for the SID Surveillance Office
- Currently reportable in INEDSS
- By 2024, these conditions will be reportable in the **CHIMS Provider Portal**



The State of Illinois Administrative Code, Control of Communicable Diseases, Title 77

- The CDPH Office of Surveillance is responsible for reporting morbidity to the Illinois Department of Public Health [IDPH] and the Centers for Disease Control and Prevention [CDC].

The State of Illinois Administrative Code [**Title 77 § 693.30, Title 77 § 697.210, Title 77 § 690.451 & Title 77 § 690.452**] mandates that health care professionals and their designee[s] report specific information to the health department regarding STI, HIV and Viral Hepatitis B & C testing, diagnosis and/or treatment. For additional information regarding required reporting, please refer to:

- <https://www.ilga.gov/commission/jcar/admincode/077/077006930000300R.html> [STIs]
- <https://www.ilga.gov/commission/jcar/admincode/077/07700697sections.html> [HIV/AIDS]
- <https://www.ilga.gov/commission/jcar/admincode/077/077006900D04510R.html> [Hepatitis B]
- <https://www.ilga.gov/commission/jcar/admincode/077/077006900D04520R.html> [Hepatitis C]

Gonorrhea/Chlamydia Case Reporting

★ Requirements

Illinois Administrative Code | Section 693.30 | Reporting

Every health care professional should report each instance in which they have diagnosed and/or treated a case of gonorrhea or chlamydia.



The case report should be:

- ★ completed by a health care professional or designee;
- ★ reported electronically or on a case report form furnished by the Department; and
- ★ submitted within seven (7) days after the diagnosis or treatment.

The case report should contain the:

- ★ date of the report;
- ★ name, address, and phone number of the health care professional;
- ★ infected person's name, address, phone number, DOB, race, ethnicity, gender, and pregnancy status;
- ★ diagnosis, diagnostic classification, and any laboratory findings; and
- ★ medication name and dosage that the person is receiving, has received, or will receive, and whether treatment has been completed.

★ HIV/AIDS Case Reporting Requirements

Illinois Administrative Code | Section 697.210 | Reporting



Every health care professional should report each instance in which they have diagnosed and/or treated a case of AIDS or HIV.

The case report should be:

- ★ completed by a health care professional or designee;
- ★ reported electronically or on a case report form furnished by the Department; and
- ★ submitted within seven (7) days after the diagnosis or treatment.

HIV/AIDS Case Report Form

Illinois Administrative Code | Section 693.30 | Reporting

- Adult HIV cases can be reported electronically through CHIMS
- CDPH Acute HIV Reporting Hotline at 312 74-ACUTE (44223)

Patient Identification (record all dates as mm/dd/yyyy)				Reset Patient Identification	
*First Name	*Middle Name	*Last Name	Last Name Soundex		
Alternate Name Type (ex: Alias, Married)		*First Name	*Middle Name	*Last Name	
Address Type <input type="checkbox"/> Residential <input type="checkbox"/> Bad address <input type="checkbox"/> Correctional facility <input type="checkbox"/> Foster home <input type="checkbox"/> Homeless <input type="checkbox"/> Military <input type="checkbox"/> Other <input type="checkbox"/> Postal <input type="checkbox"/> Shelter <input type="checkbox"/> Temporary		*Current Address, Street		Address Date	
*Phone ()	City	County	State/Country	*ZIP Code	
*Medical Record Number	*Other ID Type		*Number		
U.S. Department of Health and Human Services		Adult HIV Confidential Case Report Form		Centers for Disease Control and Prevention (CDC)	
(Patients ≥13 years of age at time of diagnosis)		*Information NOT transmitted to CDC			
Health Department Use Only (record all dates as mm/dd/yyyy)				Form approved OMB no. 0920-0573 Exp. 11/30/2022	
Date Received at Health Department	eHARS Document UID		State Number		
Reporting Health Dept—City/County			City/County Number		
Document Source		Surveillance Method <input type="checkbox"/> Active <input type="checkbox"/> Passive <input type="checkbox"/> Follow up <input type="checkbox"/> Reabstraction <input type="checkbox"/> Unknown			
Did this report initiate a new case investigation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		Report Medium <input type="checkbox"/> 1-Field visit <input type="checkbox"/> 2-Mailed <input type="checkbox"/> 3-Faxed <input type="checkbox"/> 4-Phone <input type="checkbox"/> 5-Electronic transfer <input type="checkbox"/> 6-CD/disk			
Facility Providing Information (record all dates as mm/dd/yyyy)					
Facility Name			*Phone ()		
*Street Address					
City	County	State/Country	*ZIP Code		
Facility Type <input type="checkbox"/> Hospital <input type="checkbox"/> Other, specify	<i>Inpatient:</i> <input type="checkbox"/> Adult HIV clinic <input type="checkbox"/> Other, specify	<i>Outpatient:</i> <input type="checkbox"/> Private physician's office <input type="checkbox"/> Other, specify	<i>Screening, Diagnostic, Referral Agency:</i> <input type="checkbox"/> CTS <input type="checkbox"/> STD clinic <input type="checkbox"/> Other, specify	<i>Other Facility:</i> <input type="checkbox"/> Emergency room <input type="checkbox"/> Laboratory <input type="checkbox"/> Corrections <input type="checkbox"/> Unknown <input type="checkbox"/> Other, specify	
Date Form Completed	*Person Completing Form		*Phone ()		
Patient Demographics (record all dates as mm/dd/yyyy)					
Sex Assigned at Birth <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown		Country of Birth <input type="checkbox"/> US <input type="checkbox"/> Other/US dependency (please specify)			
Date of Birth	Alias Date of Birth		State of Death		
Vital Status <input type="checkbox"/> 1-Alive <input type="checkbox"/> 2-Dead	Date of Death	State of Death			
Current Gender Identity <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender male-to-female (MTF) <input type="checkbox"/> Transgender female-to-male (FTM) <input type="checkbox"/> Unknown <input type="checkbox"/> Additional gender identity (specify)					
Ethnicity <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Unknown		Expanded Ethnicity			
Race (check all that apply) <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Unknown		Expanded Race			
Residence at Diagnosis (add additional addresses in Comments) (record all dates as mm/dd/yyyy)				Go To Comments	
Address Event Type (check all that apply to address below) <input type="checkbox"/> Residence at HIV diagnosis <input type="checkbox"/> Residence at stage 3 (AIDS) diagnosis <input type="checkbox"/> Check if SAME as current address					
Address Type <input type="checkbox"/> Residential <input type="checkbox"/> Bad address <input type="checkbox"/> Correctional facility <input type="checkbox"/> Foster home <input type="checkbox"/> Homeless <input type="checkbox"/> Military <input type="checkbox"/> Other <input type="checkbox"/> Postal <input type="checkbox"/> Shelter <input type="checkbox"/> Temporary					
*Street Address					
City	County	State/Country	*ZIP Code		
Public reporting burden of this collection of information is estimated to average 20 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CDC, Project Clearance Officer, 1600 Clifton Road, MS D-74, Atlanta, GA 30333, ATTN: PRA (0920-0573). Do not send the completed form to this address.					

HIV/AIDS Reporting – Clinical Section

Clinical: Acute HIV Infection and Opportunistic Illnesses (record all dates as mm/dd/yyyy)

Suspect acute HIV infection? *If YES, complete the two items below; enter documented negative HIV test data in Laboratory Data section, and enter patient or provider report of previous negative HIV test in HIV Testing History section.* Yes No Unknown

Clinical signs/symptoms consistent with acute retroviral syndrome (e.g., fever, malaise/fatigue, myalgia, pharyngitis, rash, lymphadenopathy)? Date of sign/symptom onset ____/____/____ Yes No Unknown

Other evidence suggestive of acute HIV infection? *If YES, please describe:* Yes No Unknown
Date of evidence ____/____/____

Opportunistic Illnesses

Diagnosis	Dx Date	Diagnosis	Dx Date	Diagnosis	Dx Date
Candidiasis, bronchi, trachea, or lungs		Herpes simplex: chronic ulcers (>1 mo. duration), bronchitis, pneumonitis, or esophagitis		M. tuberculosis, pulmonary ¹	
Candidiasis, esophageal		Histoplasmosis, disseminated or extrapulmonary		M. tuberculosis, disseminated or extrapulmonary ¹	
Carcinoma, invasive cervical		Isosporiasis, chronic intestinal (>1 mo. duration)		Mycobacterium, of other/unidentified species, disseminated or extrapulmonary	
Coccidioidomycosis, disseminated or extrapulmonary		Kaposi's sarcoma		Pneumocystis pneumonia	
Cryptococcosis, extrapulmonary		Lymphoma, Burkitt's (or equivalent)		Pneumonia, recurrent, in 12 mo. period	
Cryptosporidiosis, chronic intestinal (>1 mo. duration)		Lymphoma, immunoblastic (or equivalent)		Progressive multifocal leukoencephalopathy	
Cytomegalovirus disease (other than in liver, spleen, or nodes)		Lymphoma, primary in brain		Salmonella septicemia, recurrent	
Cytomegalovirus retinitis (with loss of vision)		Mycobacterium avium complex or M. kansasii, disseminated or extrapulmonary		Toxoplasmosis of brain, onset at >1 mo. of age	
HIV encephalopathy				Wasting syndrome due to HIV	

¹If a diagnosis date is entered for either tuberculosis diagnosis above, provide RVCT Case Number:

★ Perinatal HIV/AIDS Repo

- **PUBLIC HEALTH (410 ILCS 335/) Perinatal HIV Prevention Act**
- Health care facilities caring for a newborn infant whose birth parent had been diagnosed with HIV prior to labor and delivery, or whose confirmatory test result is positive for HIV infection shall report a case of **HIV exposure in an infant** in accordance with the HIV/AIDS Registry Act and the Illinois Sexually Transmissible Disease Control Act.

<https://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=2483&ChapterID=35>

24/7 Illinois Perinatal HIV Hotline Resources:
<https://www.hivpregnancyhotline.org/content/resource/perinatal-hiv-reporting-requirements-illinois>

Patient Identification				
*Patient Name	*First Name	*Middle Name	*Last Name	Last Name Sounded
*Alternate Name Type (ex Birth, Call Me)	*First Name	*Middle Name	*Last Name	
Address Type <input type="checkbox"/> Residential <input type="checkbox"/> Bed Address <input type="checkbox"/> Correctional Facility <input type="checkbox"/> Foster Home <input type="checkbox"/> Homeless <input type="checkbox"/> Postal <input type="checkbox"/> Shelter <input type="checkbox"/> Temporary	*Current Street Address		*Phone ()	
City	County	State/Country	*ZIP Code	
*Medical Record Number	*Other ID Type	Number		

Pediatric HIV Confidential Case Report Form			
<small>(Patients 13 Years of Age or Younger at Time of Diagnosis) *Information NOT transmitted to CDC</small>			
Health Department Use Only			
Date Received at Health Department	eHARS Document UID	State Number	
Reporting Health Dept - City / County		00J Steno	
Document Source	Surveillance Method <input type="checkbox"/> Active <input type="checkbox"/> Passive <input type="checkbox"/> Follow-up <input type="checkbox"/> Reabstraction <input type="checkbox"/> Unknown		
Did this report initiate a new case investigation?	Report Medium <input type="checkbox"/> 1-Field Visit <input type="checkbox"/> 2-Mailed <input type="checkbox"/> 3-Faxed <input type="checkbox"/> 4-Phoned <input type="checkbox"/> 5-Electronic Transfer <input type="checkbox"/> 6-CDDisk		
Facility Providing Information (record all dates as mm/dd/yyyy)			
Facility Name		*Phone ()	
*Street Address			
City	County	State/Country	ZIP Code
Facility Type <input type="checkbox"/> Inpatient <input type="checkbox"/> Hospital <input type="checkbox"/> Outpatient <input type="checkbox"/> Private Physician's Office <input type="checkbox"/> Pediatric Clinic <input type="checkbox"/> Other Facility <input type="checkbox"/> Emergency Room <input type="checkbox"/> Laboratory <input type="checkbox"/> Other, specify	*Person Completing Form		
Date Form Completed		*Phone ()	
Patient Demographics (record all dates as mm/dd/yyyy)			
Diagnostic Status at Report <input type="checkbox"/> 3-Perinatal HIV Exposure <input type="checkbox"/> 4-Pediatric HIV <input type="checkbox"/> 5-Pediatric AIDS <input type="checkbox"/> 6-Pediatric Seroreverter	Sex assigned at Birth <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown	Country of Birth <input type="checkbox"/> US <input type="checkbox"/> Other/ US Dependency (please specify)	
Date of Birth	Alias Date of Birth		
Vital Status <input type="checkbox"/> 1-Alive <input type="checkbox"/> 2-Deed	Date of Death	State of Death	
Date of Last Medical Evaluation	Date of Initial Evaluation for HIV		
Ethnicity <input type="checkbox"/> Hispano/Latino <input type="checkbox"/> Not Hispano/Latino <input type="checkbox"/> Unknown	*Expanded Ethnicity		
Race (check all that apply) <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Unknown	*Expanded Race		
Residence at Diagnosis (add additional addresses in Comments)			
Address Type (Check all that apply to address below) <input type="checkbox"/> Residence at HIV diagnosis <input type="checkbox"/> Residence at AIDS diagnosis <input type="checkbox"/> Residence at Perinatal Exposure <input type="checkbox"/> Residence at Pediatric Seroreverter	*Check if SAME as Current Address		
* Street Address			
City	County	State/Country	*ZIP Code
Public reporting burden of this collection of information is estimated to average 20 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Please mail the case reporting form to your local health department in double envelopes - the inside envelope should be marked "Confidential - Open by Addressee Only." Various federal and state statutes, regulations and case law provide legal protections of the HIV/AIDS surveillance information.			

Viral Hepatitis B Reporting Requirements

Illinois Administrative Code | Section 690.451 | Reporting

Every health care professional should report each instance in which they have diagnosed and/or treated a case of viral hepatitis B.



The case report should be:

- ★ completed by a health care professional or designee;
- ★ reported electronically or on a case report form furnished by the Department; and
- ★ submitted within seven (7) days after the diagnosis or treatment.

Laboratories shall report to the local health authority:

- Are pregnant with evidence of acute or chronic hepatitis B infection (surface antigen positive).
- Have a positive result on any laboratory test indicative of and specific for detecting hepatitis B infection.
- Have results of alanine aminotransferase or aspartate aminotransferase testing within 30 days after the positive test for hepatitis B. These results should be reported concurrently with the positive assay.

Viral Hepatitis C Reporting Requirements

★ Illinois Administrative Code | Section 690.452 | Reporting



Every health care professional should report each instance in which they have diagnosed and/or treated a case of viral hepatitis C.

The case report should be:

- ★ completed by a health care professional or designee;
- ★ reported electronically or on a case report form furnished by the Department; and
- ★ submitted within seven (7) days after the diagnosis or treatment.

Laboratories shall report to the local health authority:

- Patients who are anti-HCV positive by immunoassay with a signal-to-cutoff ratio (S/C) or other parameter predictive of a true positive as determined for the particular assay. Or who test positive for hepatitis C by recombinant immunoblot assay, polymerase chain reaction (PCR) or any other supplemental or confirmatory test that may be used.
- Results of the alanine aminotransferase testing that are closest in time to the date of the positive hepatitis C result and within three months after the positive test for hepatitis C should be reported concurrently with the positive immunoassay, PCR, immunoblot or other confirmatory test results.
- Viral genotype results (when performed) should also be reported.
- Laboratories not performing confirmatory testing or tests to identify highly positive specimens (e.g., S/C) shall report selected hepatitis C results as requested by the Department.

Mpox Case Reporting Requirements

[Current Mpox Reporting Guidance from IDPH](#)

- Healthcare Providers should report to their local health department [within three hours](#) for any suspect or lab confirmed Mpox cases who are employed or attend/reside in a congregate setting (e.g., homeless shelter, senior facility, correctional facility, university dorm, day care, or school) or other situation that might result in many other individuals being exposed.
- All other cases should be reported within [24 hours](#).
- Laboratories should report Mpox cases within 24 hours of resulting the specimen through I-NEDSS (either ELR or provider reporting).

Mpox Provider Resources from IDPH:

<https://dph.illinois.gov/topics-services/diseases-and-conditions/mpv/provider-resources.html>

Mpox Suspect Case Checklist from IDPH

https://dph.illinois.gov/content/dam/soi/en/web/idph/forms/topics-services/diseases-and-conditions/mpv/MPV_Clinic_Checklist_7.2022.pdf

★ How to Report: Systems of Reporting

HIV	Syphilis & Congenital Syphilis	Gonorrhea	Chlamydia	Viral Hepatitis B	Viral Hepatitis C	Mpox
-----	--------------------------------	-----------	-----------	-------------------	-------------------	------

Tuberculosis*

*the TB program operates independently from the SID office of surveillance. For information regarding best practices and TB reporting, please reach out to the TB Program Director at Sylvia. Dziemian@cityofchicago.org

Reporting System:
Chicago Health Information Management System (CHIMS) Provider Portal

Reporting System:
Illinois Electronic Disease Surveillance System (INEDSS)





Illinois National Electronic Disease Surveillance System (INEDSS)

To register for an account or submit a case report, go to <https://portalhome.dph.illinois.gov/>.



- Chlamydia
- Gonorrhea
- Viral Hepatitis B & C*
- Mpox*



Ongoing Support from the Office of SID Surveillance

- The office of SID Surveillance can support Providers and their reporting designees by answering any questions they may have.
- CDPH can assist with electronic enrollment and reporting instructions for INEDSS and CHIMS.
- When in doubt, please reach out! CDPH wants to ensure Providers are reporting based on the guidelines for accuracy and timeliness.

★ Chlamydia & Gonorrhea

- Alandra Butts-McCoy | Supervisor of Data Entry [INEDSS] | [312.747.3567](tel:312.747.3567)

★ Viral Hepatitis B & C

- Ashley Becht | Director of Disease Investigations | [312.747.9678](tel:312.747.9678)

★ Syphilis & Congenital Syphilis

- Katherine Boss | Public Health Administrator III [Congenital Syphilis Cases] | [312.745.0384](tel:312.745.0384)
- Gabrielle Henley | Supervisor of Communicable Disease Control Investigators [Syphilis Cases] | [312.747.0697](tel:312.747.0697)
- Ibilola Adeka | Supervisor of Communicable Disease Control Investigators [Syphilis Cases] | [312.747.8877](tel:312.747.8877)
- Maria Vega | Communicable Disease Control Investigator [Out of Jurisdiction Cases] | [312.747.0372](tel:312.747.0372)

★ HIV/AIDS

- Donna Peace | HIV/AIDS Surveillance Epidemiologist | [312.747.9614](tel:312.747.9614)

★ Mpox

- Gordon Crisler | Public Health Administrator III | [312.744.5616](tel:312.744.5616)

★ CHIMS Technical Assistance & Support

- Send an email to chims@cityofchicago.org

★ Other Surveillance Reporting Assistance & Support

- Ashley Becht | Director of Disease Investigations | [312.747.9678](tel:312.747.9678)

★ Other Helpful Reporting Resources

- **SID Bureau Provider Conference Website:**
https://www.chicago.gov/city/en/depts/cdph/supp_info/sidb-provider-conference/faq-s.html
 - FAQs about reporting
 - Archived presentations
- **Chicago Health Alert Network** sign up: <https://www.chicagohan.org/diseases-and-conditions/sti>
- **CHIMS Provider Portal** sign up: <https://chims.cityofchicago.org/maven/portalLogin.do>
- **INEDSS Web Portal** sign up: <https://portalhome.dph.illinois.gov/>



Prenatal Testing and Syphilis Case Reporting in Chicago

Eric Warren, MPH | Public Health Advisor (CDC)

Syndemic Infectious Disease (SID) Bureau Provider Conference

Malcolm X College | Chicago, IL

Tuesday, May 2, 2023

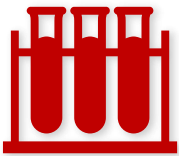


Disclosure Statement

I, Eric Warren, have no financial interest to disclose. This continuing education activity is managed by The St. Louis STI/HIV Prevention Training Center and accredited by Missouri State Medical Association (MSMA) in cooperation with the Chicago Department of Public Health.

★ Prenatal Syphilis Testing Requirements

Illinois Syphilis Prenatal Act | 410 ILCS 320



Section 1

Health care professionals are required to screen all pregnant persons for syphilis infection during the first prenatal visit and during the third trimester (28 – 32 weeks of gestation).



Section 2

Health care professionals are required to state, on the birth certificate or still birth certificate, whether a syphilis test was performed on a person who bore the child for which a birth or still birth certificate was filed, together with the date when the blood specimen was taken and the name of the laboratory that conducted the test.

★ Syphilis Case Reporting Requirements

Illinois Administrative Code | Section 693.30 | Reporting



Every health care professional should report each instance in which they have diagnosed and/or treated a case of syphilis.

The case report should be:

- ★ completed by a health care professional or designee;
- ★ reported electronically or on a case report form furnished by the Department; and
- ★ submitted within seven (7) days after the diagnosis or treatment.

Syphilis Case Reporting Requirements

Illinois Administrative Code | Section 693.30 | Reporting



The case report should contain the:

- * date of the report;
- * name, address, and phone number of the health care professional;
- * infected person's name, address, phone number, DOB, race, ethnicity, gender, and pregnancy status;
- * diagnosis, diagnostic classification, and any laboratory findings; and
- * medication name and dosage that the person is receiving, has received, or will receive, and whether treatment has been completed.

★ How to Report Syphilis and Congenital Syphilis



★ CHIMS Provider Portal Accounts

- ★ **Complete CHIMS Provider Portal Account Application**
<https://www.chicagohan.org/diseases-and-conditions/sti>



- ★ **Inquiries and Technical Assistance | M – F | 8 a.m. – 5 p.m.**
CHIMS@cityofchicago.org

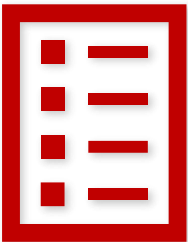


★ Exciting Things To Come This Year

- ★ CHIMS Provider Portal Instructional Videos



- ★ CHIMS Provider Portal Report Cards



Chicago Health Alert Network (HAN)

Keep abreast of important health information, alerts, trainings, and webinars by registering for the Chicago HAN.

www.ChicagoHAN.org

  **CHI | Health Alert Network**



Thank You!

Ashley Becht

Director of Disease Investigations
ashley.becht@cityofchicago.org

Eric Warren, MPH

Public Health Advisor
Eric.Warren@cityofchicago.org
bnu6@cdc.gov



[Chicago.gov/Health](https://chicago.gov/Health)



HealthyChicago@cityofchicago.org



[@ChicagoPublicHealth](https://www.facebook.com/ChicagoPublicHealth)



[@ChiPublicHealth](https://twitter.com/ChiPublicHealth)

Thank You!



Chicago.gov/Health



HealthyChicago@cityofchicago.org



[@ChicagoPublicHealth](https://www.facebook.com/ChicagoPublicHealth)



[@ChiPublicHealth](https://twitter.com/ChiPublicHealth)