

# Hamilton County Public Health Communicable Disease Surveillance Report

April 2026

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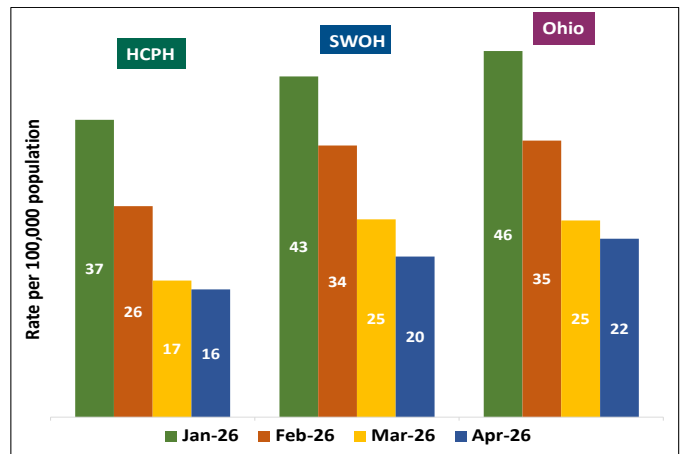
Report Details: Local public health departments receive reports of infectious diseases whose reporting is required by state and federal law. The Ohio Department of Health (ODH) details these diseases in their [Infectious Disease Control Manual \(IDCM\)](#). The IDCM includes case classifications for disease which include suspected, probable, and confirmed; any cases that do not meet the criteria for these classifications are not included in this report. The Southwest Ohio region (SWOH) consists of Adams, Brown, Butler, Clermont, Clinton, Hamilton, Highland, and Warren counties and the city local health departments that reside within these counties. Hamilton County Public Health (HCPH) has jurisdiction over City of Sharonville and those parts of Hamilton County that are not considered a part of the City of Cincinnati, Springdale or Norwood.

# REPORTABLE INFECTIOUS DISEASES IN SOUTHWEST OHIO - APRIL 2026

**Table 1. Comparison of the Number of Reported Cases of Notifiable Communicable Diseases by Location, April 2026**

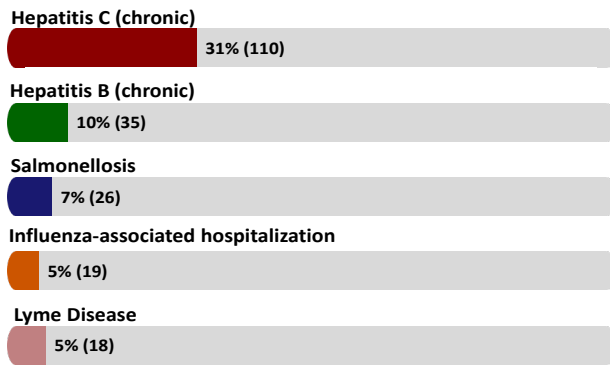
Location	HCPH	SWOH	Ohio
Number of Reported Cases	76	352	2579
Rate per 100,000	16.0	20.1	22.3
Rate Ratio <sup>†</sup>	0.72	0.90	.
Confidence Interval (99%) <sup>‡</sup>	0.53 - 0.97	0.78 - 1.04	..

**Figure 1. 30-Day Rates of Reported Communicable Diseases in Ohio, Southwest Ohio, and Hamilton County Public Health Jurisdiction, January 2026 - April 2026**

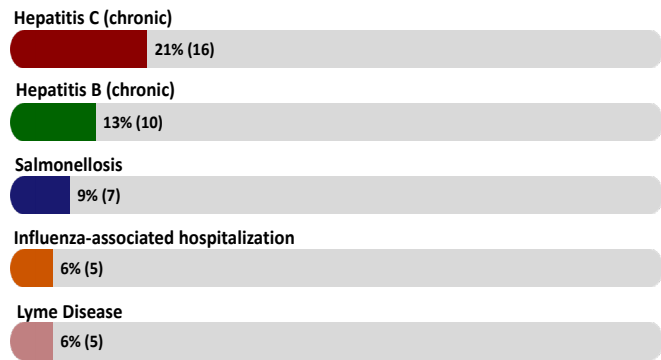


In April, the overall rates of reported communicable diseases for HCPH, SWOH, and Ohio decreased by **7%**, **19%**, and **9%** respectively compared to the rates in March (Figure 1). The Ohio rate (22.3) was the highest of the three rates, followed by the SWOH rate (20.1) and the HCPH rate (16.0) (Table 1).

**\*Figure 2a. SWOH Commonly Reported Communicable Diseases, April 2026**



**\*Figure 2b. HCPH Commonly Reported Communicable Diseases, April 2026**



\*The colors used to identify each disease here are used to identify the same diseases in Table 2.

**Chronic Hepatitis C** and **Chronic Hepatitis B** were the 1<sup>st</sup> and 2<sup>nd</sup>-most reported diseases in SWOH and in HCPH. Together, they accounted for 41% and 34% of all reported diseases in SWOH and HCPH respectively for the month of April. In SWOH, the total number of Hepatitis B and C cases for April (145), was 15.4% higher than the previous 12-month average (126). The rate per 100,000 people in SWOH was 8.3 cases, which was 57% higher than the HCPH rate of 5.3 cases.

**Salmonellosis** was the 3<sup>rd</sup> most frequently reported communicable disease, representing 9% and 7% of total disease for the month of April for SWOH and HCPH respectively. For SWOH, the case count for April (26) showed a 271% increase from the total in March (7) and was higher than the SWOH total from January to March (25). For HCPH, April's case count (7) was 250% higher than the case count in March (2) and accounted for 27% of all cases in SWOH for April. SWOH observed a higher rate per 100,000 people (1.5 cases) compared to HCPH jurisdiction (1.4 cases).

**Influenza-associated hospitalization** was the 4<sup>th</sup>-most reported disease in SWOH and in HCPH jurisdiction in April. Cases in HCPH (5) represented 26% of all the cases in SWOH (19). SWOH saw an 88% decrease in cases from March (164) to April (19), while HCPH saw a decrease of 86% in the same timeframe (37 to 5). SWOH also observed a higher rate per 100,000 (1.1 cases) than HCPH (1.0 cases). April is the first month in 2026 where influenza-associated hospitalization was not the most frequently reported condition for both SWOH and HCPH.

**Lyme Disease** was the 5<sup>th</sup>-most reported disease in SWOH (5% of total) and in HCPH jurisdiction (6% of total) in the month of April. 5 of the 18 cases (28%) in SWOH occurred within HCPH's jurisdiction, and the total in SWOH (18) was 80% higher than the total from March (10). In HCPH, April (5) saw an increase of 67% from the total cases in March (3). The rate per 100,000 people in SWOH (1.0) was the same as the rate in HCPH (1.0 per 100,000).

**NOTES:**

<sup>†</sup>Ratio of local rate to the Ohio rate. These rates are standardized to be 30-day rates.

<sup>‡</sup>Confidence intervals that do not contain the value of 1 are considered statistically significant.

# INFECTIOUS DISEASE HIGHLIGHT

Each month, a reportable disease or group of similar diseases will be selected to cover more in-depth details about their frequency, transmission, epidemiology, and risk factors. The intent is to inform and educate readers, to bring their attention to certain diseases that are known to have seasonal increases, have seen recent increases, or may occur rarely.

## April 2026 Highlight: Healthcare Associated Infections, Part 1

Healthcare associated infections (HAIs) are any infection that a patient acquires in any setting where medical care is provided, usually for other health conditions. Infections spread in medical settings are associated with insufficient handwashing and improper reuse of medical supplies. Those who undergo surgical procedures or who have medical devices such as central lines, urinary catheters, and ventilators have a higher risk of developing HAI.<sup>4</sup> Individuals who experience clinical complications from these infections commonly have several other comorbidities making their clinical course of treatment complex.<sup>2</sup> Healthcare associated infections that are reportable to public health include all screening and clinical cases of *Candida auris* and any organisms that produce enzymes (carbapenemases) that allow for resistance to carbapenem antibiotics, known as carbapenemase-producing organisms (CPO).<sup>4</sup> CPOs are organisms that have acquired the genes to develop carbapenemase resistance. These genes are commonly tested in samples from clinical cases and if found identifies the case as a confirmed case.

Screening cases are those where the organisms are detected in an individual without any signs of infection, whereas clinical cases are those with infection and symptoms where laboratory testing was conducted for diagnosis and subsequent treatment of those symptoms. Clinical specimens to be tested are typically urine, blood, sputum, or tissue samples from chronic wounds. Invasive infections may manifest clinically as pneumonia, bloodstream infections, urinary tract infections, intra-abdominal infections or surgical site infections. Clinical treatment can be complex and lengthy due to antibiotic resistance and other drug resistance.<sup>4</sup>

Public health response to these infections is targeted towards the at-risk close contacts of identified cases. When a single clinical case is identified, any healthcare or long-term care facilities that the individual was admitted to (defined as at least one overnight) in the 30 days prior to the day the positive lab specimen was collected should be evaluated. Most important to evaluate is if the correct transmission-based precautions were put in place based on if the admissions were in either acute or long-term care settings.<sup>3</sup> Acute care settings require contact precautions and isolation and in a long-term care or skilled nursing facility setting, enhanced barrier precautions are required. These are recommended to be in place for the remainder of the individual's life whenever they are admitted to such facilities. This is due to a lack of evidence that treatment of such infections is adequate enough to completely clear these organisms from the affected individuals. This leaves room for these infections to not only return to clinical level of infection but also that they could still be transmitted person to person.<sup>4</sup>

In the long-term care or skilled nursing setting, a single clinical case that was not on the proper transmission-based precautions for any period of time can prompt an evaluation for further action. General guidelines for evaluation include:

- Patients still admitted who overlapped on the same unit as the index case for at least 24 hours.
- Current or former roommates of the index case (if applicable).
- Patients who share a restroom with the index case (if applicable).
- Patients currently admitted to rooms previously occupied by the index case for at least 24 hours.
- Any other patients with an epidemiological link to the index case.<sup>4</sup>

These identified individuals are then swabbed to detect colonization; any positive results may indicate facility spread and therefore screening of a broader resident population would be recommended until such time that the same set of residents can be screened twice two weeks apart without any positive results. This broader screening moves concentrically outward from the index patient's unit until these negative rounds can be completed. These screenings can also take place in acute care settings, but more commonly when facility spread is already identified, for example if two patients had some overlap in their stay in the same unit and later both tested positive for the same organism (and resistance mechanism for CPOs). If other close contacts have been discharged at that time, a request can be made to flag these patient's charts to prompt screening whenever they are admitted again if possible.<sup>4</sup>

HAIs place on large burden on both the individual and their caregivers for the rest of their lives, but if handled properly, person to person spread can be prevented. With the surveillance work that is done by public health, colonized individuals can be identified and placed on the correct precautions as well as any clinical cases that are admitted back to their long-term care facilities. From this, lines of communication open up between public health and both acute and long-term care settings, which establishes a more robust response to any new cases in the future. Identifying cases, communicating needed action, and continuing to follow-up are critical to stop the spread of HAIs.

### To be continued next month with statistics for CPOs and *C. auris* in SWOH and HCPH.

#### References:

1. Centers for Disease Control and Prevention. (n.d.-a). 2023 changes to the National Notifiable Diseases Surveillance System (NNDSS) based upon approved 2022 Council of State and territorial epidemiologists (CSTE) position statements. Centers for Disease Control and Prevention. <https://stacks.cdc.gov/view/cdc/130750>
2. Centers for Disease Control and Prevention. (n.d.). Healthcare-associated infections (HAIs). Centers for Disease Control and Prevention. <https://www.cdc.gov/healthcare-associated-infections/index.html>
3. Interim guidance for a public health response to contain novel or targeted. (n.d.). <https://www.cdc.gov/healthcare-associated-infections/media/pdfs/health-response-contain-mdro-508.pdf>
4. Ohio Department of Health. (n.d.). Carbapenemase-Producing Organisms (CPO). Ohio Department of Health- Infectious Disease Control Manual. <https://odh.ohio.gov/know-our-programs/infectious-disease-control-manual/section3/section-3-cp-cre>

Table 2. Cases of Notifiable Diseases in Southwest Ohio as Reported in ODRS by County, April 2026 (Highlighted colors correspond to the top 5 diseases listed on Page 1)

Reportable Condition	County										Total	Percent Change
	Hamilton	Adams	Brown	Butler	Clermont	Clinton	Highland	Warren				
C. auris	7	.	.	.	2	.	2	.	.	2	11	83%
C. auris - Colonization Screening	1	.	1	1	.	.	1	.	.	1	4	0%
CPO	4	.	.	2	.	.	.	.	.	.	6	-14%
CPO - Colonization Screening	.	6	.	.	.	.	.	.	.	.	6	500%
Campylobacteriosis	4	.	2	2	2	.	.	6	.	.	16	33%
Coccidioidomycosis	1	.	.	.	.	.	.	.	.	.	1	0%
Cryptosporidiosis	3	.	.	1	1	.	.	.	.	.	5	25%
E.Coli (shiga toxin producing)	4	.	.	1	1	.	.	.	.	.	6	50%
Giardiasis	4	.	.	.	1	.	.	.	.	.	5	0%
Haemophilus influenzae (invasive)	2	.	.	.	.	.	.	.	.	.	2	-60%
Hepatitis A	1	.	.	1	.	.	.	1	.	.	3	0%
Hepatitis B (acute)	1	.	.	.	.	.	.	.	.	.	1	-80%
Hepatitis B (chronic)	22	.	1	7	2	.	.	3	.	.	35	30%
Hepatitis C (chronic)	52	2	6	28	11	.	3	8	.	.	110	29%
Influenza-associated hospitalization	7	1	.	3	5	.	1	2	.	.	19	-88%
Legionnaires' Disease	1	.	.	2	.	.	.	.	.	.	3	-25%
Listeriosis	1	.	.	.	.	.	.	.	.	.	1	0%
Lyme Disease	5	1	.	3	4	.	1	4	.	.	18	80%
Meningitis (bacterial, not N. meningitidis)	5	.	.	.	.	.	.	1	.	.	6	200%
Mumps	.	.	.	.	.	.	.	1	.	.	1	0%
Pertussis	8	.	.	4	1	.	.	5	.	.	18	29%
Salmonella Paratyphi Infection	.	.	.	1	.	.	.	.	.	.	1	0%
Salmonellosis	10	1	3	6	2	2	1	1	2	1	26	271%
Shigellosis	1	.	.	1	.	.	.	.	.	.	2	-33%
Spotted Fever Rickettsiosis (including Rocky Mountain spotted fever (RMSF))	.	.	1	.	.	.	.	.	.	.	1	0%
Streptococcal pneumoniae (invasive)	4	.	.	2	1	.	.	3	.	.	10	-52%
Streptococcal, Group A (invasive)	2	1	1	3	1	.	2	1	.	1	11	-39%
Tuberculosis	7	.	.	5	1	.	1	.	.	.	14	N/A
Varicella	4	.	.	.	.	.	.	.	.	.	4	N/A



Table 3. January - April 2026, Cases of Notifiable Diseases in Southwest Ohio as Reported in ODRS by County (Top 5 Increases Highlighted)

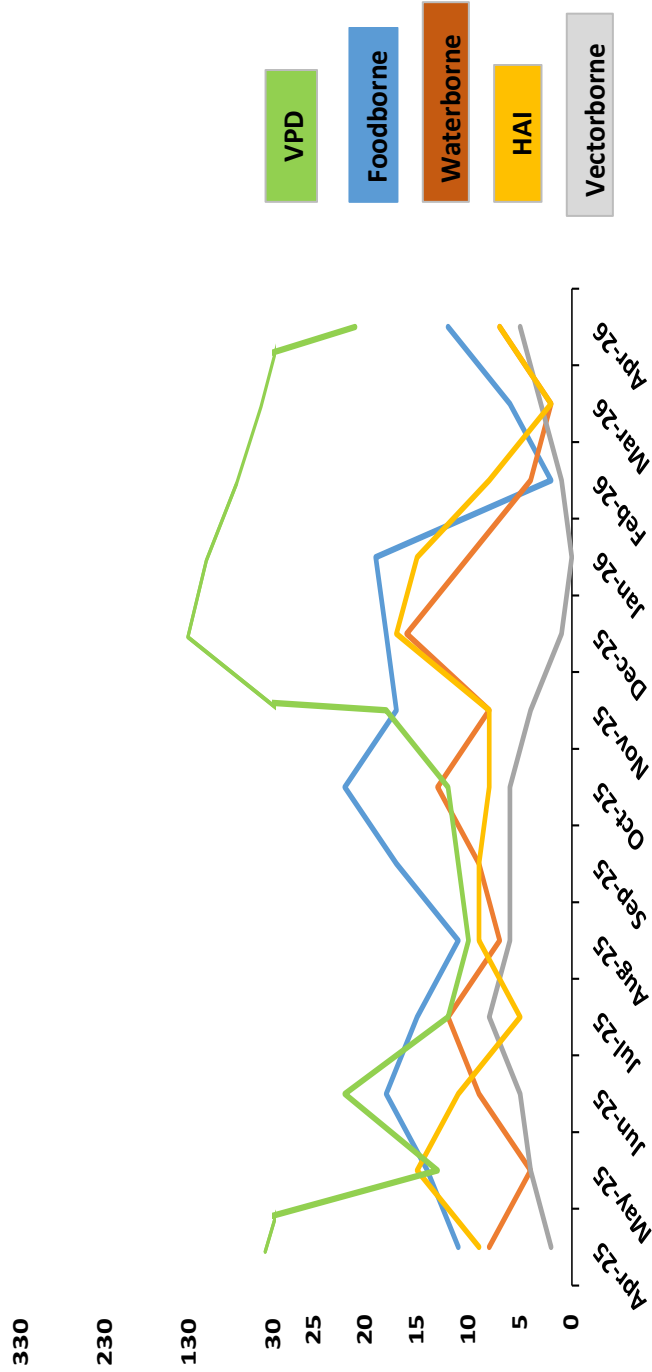
Reportable Condition	County										Total	Percent Change	
	Hamilton	Adams	Brown	Butler	Clermont	Clinton	Highland	Warren					
Babesiosis	.	.	.	1	.	.	.	.	.	.	.	1	0%
Botulism (infant)	.	.	.	.	.	.	1	.	.	.	.	1	0%
Brucellosis	1	.	.	.	.	.	.	.	.	.	.	1	0%
C. auris	22	.	.	4	4	1	3	.	.	.	.	34	48%
C. auris - Colonization Screening	8	.	1	3	.	1	2	7	.	.	.	22	22%
Campylobacteriosis	20	.	2	11	7	1	.	14	.	.	.	55	41%
Coccidioidomycosis	2	.	.	1	1	.	.	1	.	.	.	5	25%
CPO	27	2	.	8	2	1	1	7	.	.	.	48	14%
CPO - Colonization Screening	2	6	.	1	1	.	.	.	.	.	.	10	150%
Creutzfeldt-Jakob Disease	.	.	.	1	.	.	.	.	.	.	.	1	0%
Cryptosporidiosis	4	.	1	7	1	1	1	5	.	.	.	20	33%
E.Coli (shiga toxin producing)	8	.	.	2	6	.	.	1	.	.	.	17	55%
Ehrlichiosis/Anaplasmosis	0	.	1	.	1	.	.	.	.	.	.	2	0%
Giardiasis	13	.	.	8	2	1	1	4	.	.	.	29	21%
Haemophilus influenzae (invasive)	6	.	1	4	.	.	.	4	.	.	.	15	15%
Hantavirus	.	.	.	1	.	.	.	.	.	.	.	1	0%
Hepatitis A	7	.	.	6	.	.	4	1	.	.	.	18	20%
Hepatitis B (acute)	4	.	1	2	.	1	1	.	.	.	.	9	13%
Hepatitis B (chronic)	79	2	1	23	9	.	1	13	.	.	.	128	38%
Hepatitis C (chronic)	179	10	12	77	28	4	7	32	.	.	.	349	46%
Influenza-associated hospitalization	375	19	17	180	111	14	27	113	.	.	.	856	2%
Influenza-associated pediatric mortality	2	.	.	.	.	1	.	.	.	.	.	3	0%
Legionnaires' Disease	5	.	.	4	2	.	.	5	.	.	.	16	23%
Listeriosis	1	.	.	0	0	.	.	.	.	.	.	1	0%
Lyme Disease	12	2	3	6	6	.	3	7	.	.	.	39	86%
Measles	1	.	.	.	.	.	.	.	.	.	.	1	0%
Meningitis (bacterial, not N. meningitidis)	8	.	.	2	1	.	.	3	.	.	.	14	75%
Mumps	2	.	.	.	.	.	.	1	.	.	.	3	50%



Table 4a: Case Counts for Hamilton County Public Health Jurisdiction by Disease Category for Previous 12 Months

	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	Total	Rate per 100,000 People
Foodborne	11	14	18	15	11	17	22	17	18	19	2	6	12	182	37
Waterborne	8	4	9	12	7	9	13	8	16	10	4	2	7	109	22
Vectorborne	2	4	5	8	6	6	6	4	1	0	1	3	5	51	10
HAI*	9	15	11	5	9	9	8	8	17	15	8	2	7	123	25
VPD*	40	13	22	12	10	11	12	18	132	110	74	45	21	520	106
<b>Total</b>	<b>70</b>	<b>50</b>	<b>65</b>	<b>52</b>	<b>43</b>	<b>52</b>	<b>61</b>	<b>55</b>	<b>184</b>	<b>154</b>	<b>89</b>	<b>58</b>	<b>52</b>	<b>985</b>	<b>201</b>

Figure 4a: HCPH Counts of Disease Categories (excluding COVID-19) by Month

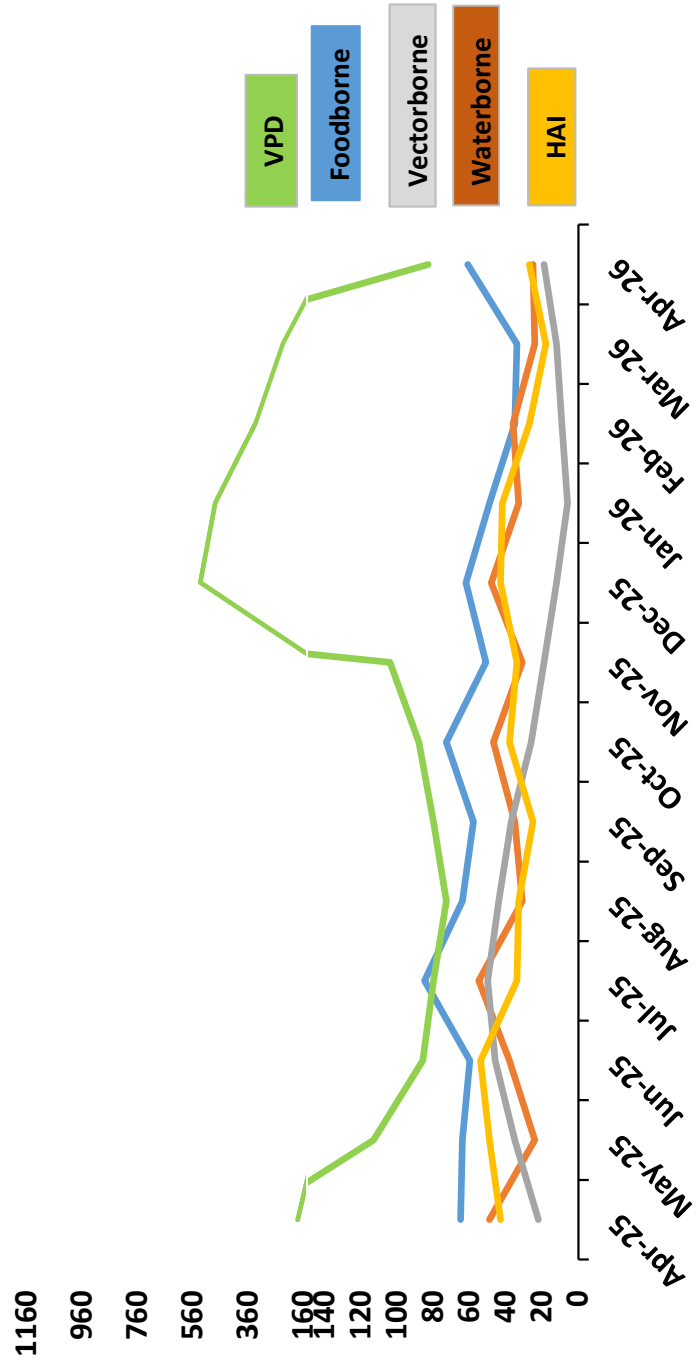


\*NOTES: The VPD category represents all Vaccine Preventable Diseases and HAI refers to Healthcare Acquired Infections. A list of all Notifiable Diseases that are included in each category can be found in the Data Notes section on page 9 of this report. As of October 1<sup>st</sup> 2025 individual case of COVID-19 are no longer reportable in the state of Ohio.

Table 4b: Case Counts for All Southwest Ohio Jurisdictions by Disease Category for Previous 12 Months

	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	Total	Rate per 100,000 People
Foodborne	65	64	60	85	64	58	73	51	62	49	35	34	61	761	41
Waterborne	49	24	38	55	31	35	47	31	48	33	36	24	25	476	26
Vectorborne	22	35	46	50	44	37	26	19	12	6	9	12	19	337	18
HAI*	43	49	54	34	33	25	38	34	43	42	27	18	27	467	25
VPD*	182	113	86	80	73	80	88	104	533	479	334	235	83	2470	134
<b>Total</b>	<b>361</b>	<b>285</b>	<b>284</b>	<b>304</b>	<b>245</b>	<b>235</b>	<b>272</b>	<b>239</b>	<b>698</b>	<b>609</b>	<b>441</b>	<b>323</b>	<b>215</b>	<b>4511</b>	<b>245</b>

Figure 4c: SWOH Counts of Disease Categories (excluding COVID-19) by Month

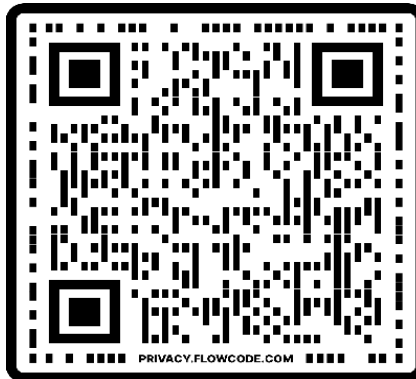


\*NOTES: The VPD category represents all Vaccine Preventable Diseases and HAI refers to Healthcare Acquired Infections. A list of all Notifiable Diseases that are included in each category can be found in the Data Notes section on page 9 of this report. As of October 1<sup>st</sup> 2025 individual case of COVID-19 are no longer reportable in the state of Ohio.

# CONTACT INFORMATION

For questions about this report please email  
HCPH.ID@hamiltoncountyohio.gov

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hamiltoncountyhealth.org/reports/ or use the QR code below.



## DATA NOTES

- Data are provisional and are subject to change as data becomes finalized. Suspected, probable and confirmed cases are included in counts except for arboviral encephalitis and Zika virus diseases, of which only probable and confirmed cases are reported. Only confirmed cases of Novel Influenza A are included. Chlamydia, Gonorrhea, HIV, and Syphilis are not reported within this report. The completeness of reporting varies by region and can impact the incidences of reported diseases.
- Starting on October 1, 2025, the Ohio Department of Health began using CliniSync to automatically report COVID, flu, and RSV hospitalizations directly from Ohio hospitals. Due to unexpected delays in this new reporting system, COVID, flu, and RSV hospitalizations should be considered under-reported for the 2025-2026 respiratory disease season while all local hospitals are onboarded into this system.
- This report reflects the time period of April 1 - 30, 2026. Data was accessed from the Ohio Disease Reporting System on 05/01/2026.
- Case counts include all cases with classification of suspected, probable, or confirmed. The categories listed are not mutually exclusive and some cases can be counted in multiple categories. The categories listed do not encompass all reportable diseases. The diseases counted in each category are as follows:
  - Foodborne: Botulism (foodborne), Campylobacteriosis, C. perfringens, E. coli O157:H7, Hepatitis A, Listeriosis, Salmonella, VRSA/VISA (S. aureus), Shigellosis, Toxoplasmosis (non-congenital), Trichinellosis, Vibriosis, and Yersinosis.
  - Waterborne: Amebiasis, Cholera, Cryptosporidiosis, Cyclospora, E. coli O157:H7, free living amoebae, Giardiasis, Hepatitis A, Legionnaire's disease, Norovirus, Shigellosis, and Vibriosis.
  - Vectorborne: Anaplasmosis, Ehrlichiosis, Babesiosis, Lyme disease, arboviral neuroinvasive and non-neuroinvasive disease (Chikungunya, EEE, LaCrosse Virus, Powassan virus disease, SLE, WNV, WEE, Yellow fever, Zika, other arthropod-borne diseases), Dengue, Malaria, Spotted Fever Rickettsiosis (including RMSF), Tularemia.
  - Vaccine Preventable: Diphtheria, Influenza-associated hospitalizations (pediatric mortalities), Measles, Mumps, Rubella, Pertussis, Meningococcal Disease, Varicella (Chickenpox/Shingles), Haemophilus influenzae, Polio, Pneumococcal disease, Tetanus, All Hepatitis B (perinatal, chronic, acute), Hepatitis A.
  - Healthcare Acquired Infections: CPO (clinical and screening), C. auris (clinical and screening).