

Vermont Department of Health Division of Health Surveillance – Infectious Disease Section Grant Funding and Activities

Epidemiology Program

CDC Epidemiology and Laboratory Capacity for Infectious Diseases (ELC) Grant
Annual Funding Amount \$1,200,000

This grant funds surveillance and/or prevention in the following program areas: foodborne disease, arboviral disease, Lyme disease, healthcare-associated infections, influenza, vaccine-preventable and respiratory disease. In addition, the ELC grant funds positions and activities in the VDH Laboratory and in IT.

CDC Tuberculosis Control Grant
Annual Funding Amount \$150,000

This grant funds surveillance and prevention for TB, including case and contact investigation, ensuring completion of TB treatment, and laboratory testing.

Refugee Preventive Health Grant
Annual Funding Amount \$100,000

This grant helps ensure access to health (including mental health) screening for newly arrived refugees.

Office of Refugee Resettlement
Annual Funding Amount \$50,000

This funding is for VDH staff time to ensure that refugee domestic health assessments are completed in a timely way and necessary follow-up is obtained.

HIV/AIDS/STD/Hepatitis Program

CDC HIV Prevention Grant
Annual Funding Amount \$1,500,000

This grant provides funding for VDH and community-based organizations to implement HIV prevention activities including HIV testing, case management, and social support services.

CDC HIV Surveillance Grant
Annual Funding Amount \$125,000

This grant funds a VDH position to conduct HIV/AIDS surveillance.

HRSA HIV Care Grant
Annual Funding Amount \$900,000



This funding provides comprehensive care, access to medication, and case management for individuals in Vermont living with HIV and AIDS.

CDC Viral Hepatitis Prevention Grant

Annual Funding Amount \$90,000

This grant funds a VDH position to coordinate viral hepatitis prevention activities.

CDC STD Grant

Annual Funding Amount \$175,000

This grant provides comprehensive STD screening and treatment for at-risk and infected populations.

Immunization Program

CDC Immunization Grant

Annual Funding Amount \$1,500,000

The Immunization Program works to ensure optimal immunization coverage for all Vermonters by providing no-cost vaccine to healthcare providers, managing the Immunization Pilot Program established in 18 V.S.A. § 1130, conducting public education on the safety and efficacy of vaccines, and developing and implementing public health policies. This grant provides operational support for program management and evaluation, to assure access to vaccines for all Vermonters.

Non-CDC Funded

In the past certain members of the legislature have asked for a “public education” effort for immunizations. The *It’s OK to Ask* (www.oktoaskvt) campaign was developed and implemented for that purpose through Global Commitment funding.

The Vaccine Purchasing Pool Pilot allows VDH to provide vaccines at a reduced cost to provider practices for use in all populations. Federal vaccine funding combined with insurer funding are used to purchase vaccines for all who choose to be vaccinated; it does not set or change state vaccination policy or recommendations on who gets what immunizations when. Fifty percent (50%) of our vaccine funding for kids and 70% (+ 15% from Medicaid) for adults comes through from insurer funding. We need to move beyond the Pilot if we want to maintain a universal vaccine system in VT.

ELC Success Stories:

The Foodborne Epidemiologist funded under this grant investigated a cluster of campylobacter infections. The Vermont Department of Health laboratory (VDHL) conducted pulse-field gel electrophoresis (PFGE) on both clinical and food isolates, which helped to identify the cluster and strengthen the associations found in the epidemiology investigation. The investigation of this outbreak documented the first ever multistate outbreak of Campylobacter due to chicken liver consumption and is the first Campylobacter outbreak to find the outbreak strain in the livers. This investigation contributed to the knowledge of the causes of campylobacter outbreaks in the US and led to a change in both food service and farm practices. The Foodborne Epidemiologist conducted interviews with the cases and initiated traceback actions to find the source of the outbreak. The VDHL microbiologists conducted the PFGE on the isolates from the cases and livers collected from the farm helping to confirm that the cases could have been exposed to a common source. The outbreak was determined to be linked to the consumption of chicken livers traced back to the largest poultry farm in Vermont. Because of this investigation, the restaurant elected to stop serving chicken liver and the farm elected to stop selling the product. No additional illnesses related to chicken livers from this farm have been identified. The investigation involved a small number of cases in three states, but it was important to follow up on all possible connections among the cases in order to find the epidemiological link among them. In addition, we learned that even small outbreaks can significantly contribute to our knowledge about the causes of foodborne illnesses.

The Foodborne Epidemiologist funded by ELC investigated an unusual cluster of Salmonella Enteritidis cases. Vermont was the first state to identify this cluster of illnesses and the first to tie the outbreak to ground beef. The Foodborne Epidemiologist interviewed all Vermont cases involved in the outbreak and worked with these cases and a local grocery store chain to acquire purchase records for these cases from the store. The VDH Lab identified the outbreak strain of Salmonella in leftover ground beef. This outbreak investigation led to the first ever recall of a meat product due to non-multidrug resistant Salmonella. The product recall and the information released to the public about the outbreak likely lessened the burden of disease by alerting the public to the danger and removing the meat from stores. We learned that detailed financial records (receipts, etc.) are important in ground beef outbreaks so that grinding logs at stores can be accurately interpreted and traceback to a single plant can occur.

With the emergence of West Nile virus (WNV) in the U.S. in 1999, the need to implement a more robust surveillance system for mosquito-borne diseases was recognized. ELC funding has supported most of the mosquito surveillance and part of the human and veterinary surveillance activities in Vermont over the years. The mosquito surveillance has been done under an MOU with the State Entomologist at the Vermont Agency of Agriculture, Food and Markets. Even though this funding has decreased in recent years, it still supports the capability to do limited mosquito surveillance. This became very important in 2012, when Vermont recorded its first two human cases of Eastern equine encephalitis. The program started for the detection of WNV was able to be redirected to look for EEE virus in mosquitoes. ELC funds were used to develop limited mosquito surveillance capability in Vermont. Mosquito surveillance data is important for assessing the risk for human illness, and it was helpful in assessing the risk for illness in 2012 when the first human cases occurred. In addition, the Health Surveillance Epidemiologist, funded by ELC, is responsible for surveillance for human cases of arboviral diseases. She is the subject matter expert on these diseases for the Vermont Department of Health. She was instrumental in investigating the human cases and educating the public about this new disease, a process that continues. Mosquito surveillance is important for determining areas of increased risk for human illness. This is especially important with a disease like EEE which tends to be focal and locally recurrent. Mosquito data gathered since 2000 has provided information about which species are present in Vermont and where they have been found. This historical information has been crucial for

deciding where to focus the limited resources available. It provided information about the location of good habitats for the EEE virus enzootic vector so that the State Entomologist was able to focus the trapping program accordingly. This meant that mosquito trapping and testing was already in place in the area where the human cases eventually occurred.