November 2025

Vol. 45, No. 5

# Connecticut Epidemiologist

CONNECTICUT
PUBLIC HEALTH

## Celebrating 30 Years of the Emerging Infections Program (EIP) in Connecticut

This year marks the 30th anniversary of the Emerging Infections Program (EIP). The EIP is a network of 12 US sites working to translate knowledge learned from infectious disease surveillance and applied research into informed policy and public health practice. Each site is a collaboration between state health departments, academic institutions, and other key public health partners. This edition of the Connecticut Epidemiologist is dedicated to looking back to the beginning of the EIP in Connecticut and the future of the EIP as a critical surveillance network.

To understand the context for the EIP network and cooperative agreement that started in 1995, we reached out to Dr. James Hadler and Dr. Matthew Cartter, both previous State Epidemiologists for Connecticut and former Principal Investigators for the CT EIP, who helped to write the successful application that made Connecticut one of the first two EIP sites (along with California). We asked them to reflect on what was happening in public health when the EIP was being created that allowed Connecticut to be competitive for this cooperative agreement.

A description of what we now know as the Connecticut EIP was first published in the Connecticut Epidemiologist Newsletter in November 1994.

### Q. What were the most pressing public health concerns the US faced in 1994 when CDC launched EIP?

**Dr. Hadler**: The most pressing infectious disease public health concerns to me in 1994 were human immunodeficiency virus (HIV), the emergence of multidrug-resistant tuberculosis and the documentation that young children <2 years old were way behind on recommended early childhood immunizations, highlighted by recent widespread measles outbreaks. These challenges were in part addressed by categorical funding to support related research, surveillance and prevention activities. Hidden beneath these visible challenges was the actuality and potential for many more emerging infections brought about by the societal dynamics outlined in Emerging Infections. These included changes in demographics and behavior; international travel and commerce; technology and industry; microbial adaptation and change; economic development and land use and breakdown of public health measures. There were no dedicated resources to monitor trends in those emerging infections recently recognized or to quickly assess the magnitude of threat they might pose.

**Dr. Cartter**: In addition, Connecticut had also been dealing with many new types of infections over the previous decade including Lyme disease, babesiosis, parvovirus B19 in pregnancy, streptococcal toxic shock syndrome, and drug-resistant infections such as pneumococcal disease.

## EIP Q & A with Drs. Hadler and Cartter

### Q. Why did you think Connecticut was positioned to do this work so that you decided to apply?

**Dr. Cartter**: Surveillance initiatives and outbreak investigations that we conducted in the early 1990's made it possible for us to successfully apply to be one of the first two EIP sites. These activities showed that we could be innovative and willing and able to work with other institutions in the state and with CDC. The first was successfully applying for the first CDC Lyme disease cooperative agreement in 1991, in which the state health department was funded to conduct enhanced public health surveillance for Lyme disease and develop educational materials for the public. The work was done in collaboration with the Connecticut Agricultural Experiment Station (CAES) and the University of Connecticut. The second was a cat-scratch disease study in 1992, which was done in collaboration with CDC. The goal of this study was to estimate the incidence of cat scratch disease and conduct a case-control study to understand risk factors for disease. This study resulted in an article in the New England Journal of Medicine.

**Dr. Hadler**: Between a supportive Commissioner, an infectious disease reporting law that could rapidly adapt to changing needs, a strong working relationship with the clinical infectious disease and laboratory community and an ongoing desire to measure and understand the epidemiology of emerging infectious disease issues in Connecticut, we were well positioned to apply. We had already developed voluntary surge capacity to explore new challenges through the support of Epidemic Intelligence Service Officers and Yale and University of Connecticut MPH student community projects and theses. An already strong relationship with the Yale School of Public Health was particularly important, as a component of the initial application was having an academic partner.

### Q. What benefits has Connecticut achieved as a result of being an EIP site for the past 30 years?

**Dr. Hadler**: Some of the biggest benefits for Connecticut have been enhanced partnerships with infectious disease clinicians and laboratories (EIP requires this) and having our own data on a population-level basis for selected emerging infections issues. These data are of value to everyone working in infectious disease including clinicians, laboratorians, local health departments, and academic researchers.

**Dr. Cartter**: Working for the Connecticut EIP, either at the Yale School of Public Health or at the Connecticut Department of Public Health (DPH), has provided talented, newly graduated students with entry level job opportunities in Connecticut, many of whom continue to work in public health in Connecticut.

### Connecticut EIP staff

## EIP Q & A with Drs. Hadler and Cartter

### Q. Can you provide a couple of concrete examples of real-world impact that EIP has had in the past 30 years, related to public health policy, practice, evaluation, and intervention.

**Dr. Cartter**: There are many examples of the impact of the EIP over the last 30 years. Epidemiologists and laboratorians working for the Connecticut EIP provided critical public health surge capacity numerous times. Notable examples include during the influenza H1N1 pandemic in 2009, the response to Ebola and the monitoring of travelers from West Africa to Connecticut in 2014–2016, and the COVID-19 pandemic.

**Dr. Hadler**: EIP data have also directly contributed to vaccine policy by providing high quality data to evaluate the effectiveness of recently introduced vaccines, which has contributed to vaccine recommendations including for pneumococcal disease, human papillomavirus infection, influenza and COVID-19. FoodNet population survey data have been used as the initial control group for foodborne disease outbreak hypothesis generation for many years.

### Q. What do you consider to be the greatest accomplishment(s) of the EIP?

**Dr. Hadler**: I think there are two major accomplishments of the EIP. The first was the demonstration of what enhanced epidemiology and laboratory capacity can do. The EIP enabled states to conduct a level of surveillance and response they did not previously have, including the ability to do their own laboratory testing for emerging pathogens. The EIPs were a precursor to having epidemiology and laboratory capacity grants in all states. The second accomplishment was the demonstration of the synergistic effect of state health department and academic collaboration. Academic institutions expand the expertise to investigate and respond to emerging infections and provide the person-power to conduct surveillance. Health departments provide the practical public health perspective and have the authority and experience in running public health programs. The ability to collect and analyze real life public health data provides practical public service experience for many MPH and some PhD students, expanding their horizons and, ultimately, the public health workforce.

**Dr. Cartter**: The greatest accomplishment of the Connecticut EIP has been to create a supportive work environment for a new generation of epidemiologists and public health professionals. This includes introducing the possibility of career paths for those who want to continue in public health and help lead the response to emerging infectious disease threats, outbreaks, and epidemics in the future.

**From Left to Right: Dr. Linda Niccolai (Current Yale EIP PI), Dr. Jim Hadler, Dr. Matt Cartter, Dr. Lynn Sosa (CT EIP PI), Jim Meek (EIP Associate Director)**

# 30 Years of the Connecticut Emerging Infections Program: Past, Present and Future

The Emerging Infections Program (EIP) represents a multi-faceted collaboration between the Centers for Disease Control and Prevention (CDC) and 12 state health departments, along with their academic partners. Collectively, these states represent nine of the ten US Department of Health and Human Services planning regions, and their combined catchment areas cover more than 10% of the US population. The goal of the EIP is to conduct enhanced public health surveillance and applied epidemiology research to inform the detection, prevention, and control of numerous infectious diseases. By merging data across sites, the EIP provides a robust understanding of national trends and investigates regional differences. Through a unique combination of attributes, the EIP has contributed to many public health success stories in reducing morbidity and mortality and improving population health for over three decades.

## Gold-standard public health surveillance

A distinguishing feature of the EIP is the focus on active surveillance. This involves active case finding rather than relying on passive reports, ensuring the most complete and accurate case counts possible. In addition to case-finding, we conduct follow-up on cases through medical record reviews, interviews, and linkages to other data sources such as immunization registries and vital statistics. EIP surveillance is also population-based, meaning that we define geographic catchment areas and record cases of infectious diseases based on the residence of the person. This allows us to use population denominators to calculate incidence rates and then compare across jurisdictions and over time. Additionally, our work is often linked to laboratory-based surveillance, where we collect disease-causing isolates for further testing and link with epidemiological data to gain a better understanding of transmission patterns.

This combination of activities results in the gold standard for surveillance for which EIP sites are known. Notably, this work is made possible by the successful collaborations with and invaluable contributions of many partners throughout the state including healthcare facilities, laboratories, and local health departments. The EIP would not be possible without the collaboration among these groups and the success of the EIP going forward is only possible by continuing to strengthen these relationships while also forging new ones.

Another important feature of EIP sites is the partnerships they create between state health departments and academic institutions. The Connecticut EIP is a collaboration between the Connecticut Department of Public Health (DPH) and the Yale School of Public Health (YSPH). This arrangement offers several benefits. State health departments have the legal authority to conduct surveillance, while academic partners contribute additional scientific expertise to the development and implementation of surveillance and research. Significantly, academic partners also assist the EIP in fulfilling its mission to provide public health training, as they can identify and support students and other trainees as they gain valuable public health experience through their work with the EIP. Consequently, EIPs play a vital role in public health workforce development.

## EIP impact over the past 30 years

There are multiple ways in which EIP work has advanced population health. Some notable examples include responding to public health emergencies, outbreak detection and control, informing vaccine policy and recommendations, and monitoring antimicrobial resistance.

### *Public health emergency response*

The EIP infrastructure allows us to conduct flexible and nimble responses to emerging public health issues. Established partnerships within the network and with our community partners, along with having a highly qualified staff enables us to quickly respond to emerging issues. Notable examples include establishing surveillance for variant Creutzfeldt-Jakob disease, a fatal prion disease associated with beef consumption after it was first identified in the UK in 1996, evaluating the impact of the *Haemophilus influenzae* type b vaccine shortage due to a voluntary recall by the manufacturer in 2008, and surveillance to monitor incidence of Guillain-Barré Syndrome after receipt of pandemic influenza A (H1N1) vaccine in 2009.[1–3]

# 30 Years of the Connecticut Emerging Infections Program: Past, Present and Future

The EIP response to the COVID-19 pandemic demonstrates how rapidly we can respond to a public health emergency. The COVID-19 Hospitalization Surveillance Network (COVID-NET) platform was created using the existing infrastructure of the surveillance systems for influenza (FluSurv-NET) and respiratory syncytial virus (RSV-NET). A Morbidity and Mortality Weekly Report (MMWR) based on COVID-NET data reporting hospitalization rates and clinical data on patients during March 2020, was released online during the first week of April 2020 and published April 17, 2020.[4] This was one of the first scientific reports of COVID-19 disease hospitalization patterns in the US and it has been referenced over 3,000 times.

Another recent example is mpox, an endemic viral infection in many regions of Africa that emerged in a worldwide outbreak in the summer of 2022. Because of concern about limited vaccine supply, a dose-sparing regimen that had evidence of an immunologic response was approved by the Federal Drug Administration for Emergency Use Authorization during the outbreak. EIP launched a case-control study to estimate vaccine effectiveness with this dose-sparing regimen and provided reassuring evidence of comparable real-world effectiveness.[5]

## *Outbreak investigation and control*

The EIP has played an important role in identifying and responding to outbreaks for many pathogens. The FoodNET project detects clusters of foodborne illness and identifies contaminated food sources in partnership with public health laboratories. For example, in 2021, CDC announced a listeria outbreak involving multiple states including Connecticut. CT EIP collaborated with federal and state agencies to investigate the source by interviewing ill people about foods they recently ate. A student interviewer collected essential information that pointed to a particular brand of queso fresco as the possible source, allowing CT State Public Health Laboratory (SPHL) scientists to identify the outbreak strain of *Listeria monocytogenes* through whole genome sequencing (WGS) resulting in swift embargo of the contaminated cheese.[6]

In another example, four cases of late-onset Group B *Streptococcus* (GBS) disease were reported to DPH from a concerned facility in 2023. Isolates from the four cases were closely related by WGS differing by no more than 12 single nucleotide polymorphisms (SNPs). SNP comparison of isolates collected since 2020 from the same facility identified seven additional closely related isolates. Comparison of these 11 isolates with others from Connecticut and all participating Active Bacterial Core surveillance (ABCs) project sites did not identify any additional closely related isolates, confirming the outbreak was occurring at one facility.[7] Rapid WGS analysis of banked GBS isolates collected from ABCs sites over many years was crucial to identifying the scope of this outbreak and was ultimately used to guide implementation of control measures.

## *Informing vaccine policy*

EIP data have routinely been used to inform vaccine policy and recommendations, such as for pneumococcal disease, meningococcal disease, human papillomavirus (HPV), influenza, respiratory syncytial virus and COVID-19. For pneumococcal disease, EIP data collected through the ABCs project have informed nearly every recommendation since 2000. Early EIP data served as an important baseline for assessing the benefits of the introduction of a 7-valent pneumococcal conjugate vaccine (PCV7) in 2000.[8] In the following years, data from the EIP network detected an increase in rates of disease caused by serotypes not included in the PCV7 vaccine.[9] To address this, PCV13 was introduced in 2010 and reductions in PCV13-type infections were subsequently found by EIP sites.[10] EIPs continue to monitor changing pneumococcal disease epidemiology to provide data for new vaccines brought to market.

EIPs have also informed recommendations and practices for vaccination against HPV. HPV is a common infection that can lead to at least six types of cancers. The first report about declines in cervical precancers during the HPV vaccine era in the US came from the Connecticut site of HPV-IMPACT, the EIP HPV vaccine monitoring project.[11]

# 30 Years of the Connecticut Emerging Infections Program: Past, Present and Future

Vaccine recommendations have changed several times since vaccine introduction in 2006 including target populations, doses, and recommended ages for routine and catch-up vaccination, thus necessitating ongoing monitoring. Multi-site analyses have produced vaccine impact estimates that have been used to monitor effectiveness in real-world populations.[12–13] Going forward, these data will continue to be important in evaluating updated vaccine recommendations including a one-dose recommendation and earlier age for routine vaccination.

### *Monitoring antimicrobial resistance*

The Healthcare-Associated Infections-Community Interface (HAIC) project has many components aimed at collecting information on healthcare-associated infections (HAIs) and antimicrobial resistance to inform national strategies to combat these threats. Surveillance for bacteria resistant to carbapenems, an important class of antibiotics, has been ongoing since 2018 and has been instrumental in monitoring the different mechanisms of resistance these bacteria can acquire by testing isolates submitted to the SPHL. This surveillance has facilitated the identification of outbreaks among organ transplant patients and burn victims, allowing for rapid containment and control.[14–15] The Connecticut EIP has also participated in periodic surveys of hospitals since 2009 that have evaluated the prevalence of HAIs and antimicrobial use that provide unique data in understanding the prevalence and risk factors for HAIs and how antimicrobial use has evolved.[16] This prevalence study has now also been conducted in nursing homes which contributes to characterizing the burden of these infections and identifying effective strategies for HAI prevention in these settings.

## Do we still need the EIP?

Yes, now more than ever. The context and situations that existed when the EIP network was created are still present. The EIP has proven itself to be a robust yet nimble framework that remains prepared to respond to future emerging diseases as they arise. The need for accurate data to track diseases and detect outbreaks is continuing to increase. The COVID-19 pandemic and mpox are recent examples of emerging infectious disease threats for which the EIP was able to provide critical information rapidly. Newer diseases like H5N1 influenza and new world screwworm remind us that pathogens will change to survive and that we need to be ready. The effects of climate change might also affect the disease patterns for which we have many years of experience monitoring. For example, we have been monitoring *Vibrio* infections, a type of bacteria that lives in water and can affect shellfish, as part of FoodNET for almost 30 years. In 2023, an increase in *Vibrio* cases related to exposure to Long Island Sound waters was identified and was attributed to increased water temperatures during that period.[17] Extreme weather events may also increase human exposures to contaminated water. Other infections are expanding their geographic ranges such as tickborne diseases, Chikungunya and Zika in response to climate change.

We also need to remain positioned to monitor the impact of public health interventions including recently introduced and updated vaccines. For example, COVID-19 and influenza vaccines are designed to protect against different strains in any given year, and thus the need to monitor impact and effectiveness continues. Recent introduction of a pentavalent vaccine for meningococcal disease requires monitoring of the distribution of circulating serotypes. New vaccines are under development for Lyme disease and several enteric pathogens and the EIP is poised to evaluate their impact on population health.

Finally, it is critical that the EIP continues to be an important training ground for future public health practitioners.[18] The Connecticut EIP is proud to have trained over 300 students across many different levels in its 30-year history. Our graduates have gone on to be Epidemic Intelligence Service officers, health care providers, academic researchers, and critical members of the public health workforce at state and local health departments and the CDC. It is imperative that we sustain and build the passionate and dedicated workforce that is needed for public health.

# 30 Years of the Connecticut Emerging Infections Program: Past, Present and Future

## Strengthening the EIP for the future

To do this important work of responding to public health threats and emergencies, evaluating the impact of public health interventions, and training the public health workforce, we must understand what the EIP needs to do to remain flexible and relevant so it can continue to position itself as a network that can make significant contributions to public health. Just as pathogens evolve with time, so have data collection methods used by EIP. We have gone from primarily paper-based surveillance systems to ones that are mostly electronic with electronic laboratory reporting for most of our diseases and we continue to make progress with electronic case reporting. We can review medical records and charts from remote locations, and we can send data to CDC almost instantaneously with direct data feeds. At the same time, what we in public health call "data modernization" continues to change. This will require leveraging systems such as health information exchanges: secure electronic systems that allow different health care organizations, providers and public health officials to access patient information. Efficient sharing of relevant clinical information will improve not only patient care but also improve accuracy and efficiency for public health. This is critical to obtaining information for public health action as quickly as possible and ultimately is good for the public, our laboratory and healthcare provider partners, and public health.

We also need to provide training in methods that are current and relevant to keep up with the diseases we monitor and try to prevent and control. We have been focused on our data systems in this transition to electronic surveillance methods but this evolution necessarily means the skill set of our epidemiologists will need to change. In addition to epidemiologists, more informaticians will be required. Artificial intelligence (AI) will be a tool that will be used increasingly in all aspects of data collection, analysis and interpretation. Learning how to apply AI in smart and ethical ways will need to be a focus of training for everyone working in public health.

We will also need to diversify the data sources we use for public health surveillance beyond the person level data we have been focused on for the past 30 years. Just like the EIP is a network, there are now large networks of data that can provide additional information and context that can complement the data the EIP collects. Epic Cosmos brings together data from many Epic hospital systems from across the country and can provide even more robust and granular data. Learning how to use these large datasets to inform the work of public health surveillance will only be useful as we move forward. Exploring how we can use our data to be more predictive through modeling is an important area. The growth of infodemiology, the use of online information to understand disease patterns, presents another opportunity to assess population health.[19]

While these digital and automated systems can produce volumes of potentially useful data, the focus of the EIP on the individual patient and the human workforce cannot go away. Even though we are collecting data more quickly and efficiently than ever, the need to talk to people and obtain individual level data from multiple sources cannot always be replaced by automated data systems. Public health has always been about keeping people healthy. We will continue to need to talk to people to understand the causes of an illness or outbreak. These are also opportunities to provide information to people, answer their questions and prevent misinformation. We will also need trained epidemiologists to evaluate the data obtained and interact with healthcare providers and laboratorians. This is vital to public health's ability to build and maintain trust among the residents of the states we serve and the healthcare providers and other professionals who are caring for them. This is a critical complement to the use of technology for public health surveillance.

In conclusion, diseases evolve with time and we need to be able to evolve with them. The context and environment that led to the establishment of the EIP have not gone away. The EIP has been successful in adapting to change over its 30 years to provide robust data that has led to healthier populations over that time. Public health and the EIP remain as important as ever as a network dedicated to protecting and advancing the health of populations everywhere. The EIP will need to continue to evolve in its methods and capacities so that it can continue to provide critical information that our local and national partners can rely on for another 30 years and beyond.

# 30 Years of the Connecticut Emerging Infections Program: Past, Present and Future

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# CONNECTICUT EPIDEMIOLOGIST

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**Epidemiology Section, Susan S. Addiss, MPH, MUrS, Commissioner**

November 1994 — Volume 14 No. 5


## *EMERGING INFECTIONS PROGRAM*

The National Academy of Sciences has declared an urgent need to improve our ability to identify infectious disease threats and to respond to them effectively (1). The Academy called for a recognition that the health of the American people is inextricably linked to the health of people in other nations: infectious diseases can and do spread rapidly around the globe. To limit the potential for related crises, it strongly urged an improvement of the public health infrastructure at the local, State and federal levels.

With a diverse population of 3.3 million people and a relatively small geographic size, Connecticut is uniquely suited for studies of emerging infections. Over the last 10 years, the Connecticut Department of Public Health and Addiction Services (DPHAS) has used various surveillance techniques and resources to study the epidemiology of Lyme disease, parvovirus B19 infection during pregnancy, babesiosis, cat-

The goals of the Connecticut EIP are to assess the public health impact of emerging infections and to evaluate methods for their prevention and control. The following projects are included in the Connecticut EIP:

1. Active population-based laboratory surveillance for invasive disease caused by: antibiotic-resistant pneumococci, *Haemophilus influenzae*, *Neisseria meningitidis*, and Group A and B streptococci.

2. Population-based prospective surveillance and retrospective analysis of unexplained deaths of possible infectious etiology in previously healthy people.

3. Population-based surveillance of community-acquired pneumonia due to emerging or re-emerging infectious agents.

4. Active surveillance of human infections from *Ehrlichia* to define the spectrum of disease symptoms associated with such infections and deter-


**CONNECTICUT PUBLIC HEALTH**

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