



ELC CARES 2020

Emerging Issues (E) Project funding for adjusting
community mitigation in response to COVID-19

CONTENTS

Background 1

Process 1

Activities 2

Appendix A: Draft indicators 4

Appendix B: Infection Prevention and Control Assessment Tool (Tele-ICAR) 6

**ELC CARES
EMERGING ISSUES (E) PROJECT**

BACKGROUND

As part of the “Coronavirus Aid, Relief, and Economic Security Act” or the “CARES Act” of 2020, ELC is awarding a total of nearly \$631 million to our recipient base in a program-initiated component funding under the Emerging Issues (E) Project of CK19-1904, henceforth ‘ELC CARES’. The intention of this funding is to rapidly establish and monitor key activities related to COVID-19 in the areas of epidemiology, laboratory, and informatics. Monitoring the indicators associated with these activities are intended to assist State, local, and territorial governments in making data-driven policy decisions regarding testing, mitigation, and prevention efforts.

PROCESS

This funding is intended to support ELC CARES activities and associated indicator reporting for Budget Period 1 under CK19-1904; however, recipients are reminded that expanded authority applies, and activities are likely to take 24 months for completion due to the nature of COVID-19. Within 30 days of receipt of the Notice of Award (NOA), the recipient is required to submit a workplan and budget describing their ELC CARES activities.

To facilitate recipients meeting the 30-day requirement:

- (1) Workplan entries will be completed in the ‘ELC CARES’ portal in REDCap; and
- (2) Revised budgets will be completed by using the template provided via GrantSolutions Grant Notes at time of NOA issuance.
 - a. Funds will be awarded under the ‘Other’ cost category;
 - b. Recipients will adjust the cost category allocations of awarded funds to reflect the areas where financial assistance is needed; and
 - c. Recipients will upload the revised budget into GrantSolutions in the form of a Grant Note, with a courtesy copy into REDCap ‘ELC CARES’ portal, by the 30-day post award deadline.

ACTIVITIES

1. Establish or enhance ability to aggressively identify cases, conduct contact tracing and follow up, as well as implement recommended containment measures.
 - a. Enhanced contact tracing including contact elicitation/identification, contact notification, and contact follow-up. Activities could include traditional contact tracing methods as well as healthcare-specific and other proximity/location-based methods.
2. Improve morbidity and mortality surveillance, including:
 - a. Establish or enhance community-based surveillance
 - i. Surveillance of populations and individuals without severe illness, travel to high-risk locations, or contacts to known cases.
 - b. Monitor and report daily incidence rate.
 - c. Track and send Emergency Department and outpatient visits for COVID-like illness, as well as other illnesses, to CDC. Send copies of all admit, discharge, and transfer (ADT) messages to CDC National Syndromic Surveillance Program (NSSP).
 - d. Monitor and utilize NHSN acute care, long-term care, and ambulatory care setting data for confirmed COVID-19 infection or for COVID-like illness.
 - e. Provide accurate accounting of COVID-19 associated deaths. Establish electronic death reporting to CDC.
 - f. Establish or enhance electronic case reporting from healthcare facilities to public health, including for COVID-19
3. Enhance laboratory testing and reporting capacity:
 - a. Establish or expand capacity to test all symptomatic individuals, and secondarily expand capacity to achieve community-based surveillance.
 - b. Screen for past infection (e.g., serology) for health care workers, employees of high-risk facilities, critical infrastructure workforce, and childcare providers.
 - c. Obtain all jurisdictional laboratory test data electronically, including from new, non-traditional testing settings, and using alternative file formats (e.g., .csv or .xls) to help automate. In addition to other reportable results, this should include all COVID-19 – related testing data, including all tests to detect SAR-CoV-2 and serology testing.
 - d. Report all COVID-19 – related line level testing data (negatives, positives, indeterminants, serology) daily to CDC.
4. Prevent and control COVID-19 in healthcare settings and protect other vulnerable or high-risk populations:
 - a. Assess and monitor infections in healthcare workers across the healthcare spectrum.
 - b. Perform preparedness assessment to ensure interventions are in place to protect high-risk populations
 - c. Monitor and help implement mitigation strategies for COVID-19 in all high-risk healthcare facilities (e.g., hospitals, dialysis clinics, cancer clinics, nursing homes, and other long-term care facilities, etc.).
 - d. Monitor and help implement mitigation strategies for other high-risk employment settings (e.g., meat processing facilities), and congregate living settings (e.g., prisons, youth homes, shelters).
5. Monitor and mitigate COVID-19 introductions from connected jurisdictions (i.e., neighboring cities, states; including air travel).
6. Work with healthcare system to manage and monitor system capacity.
 - a. Assess and monitor the number and availability of critical care staff, necessary PPE and potentially life-saving medical equipment, as well as access to testing services.
 - b. Utilize eCR data to enhance morbidity and mortality surveillance and to help monitor the health of the community and inform decisions for the delivery of public health services.
 - c. Leverage NHSN data to monitor healthcare worker staffing, testing, and treatment supplies.
7. Improve understanding of jurisdictional communities with respect to COVID-19 risk:

- a. Build understanding of population density and high-risk population density (i.e. population of >65 yrs., proportion of population with underlying conditions, households with limited English fluency, healthcare seeking behavior, populations without insurance and below poverty level.
- b. Monitor compliance indicators (Number of Violations / complaints related to mandatory or recommended community mitigation).

See Appendix A for draft indicators to be reported to CDC; these will be finalized following the release of awards.

APPENDIX A: DRAFT INDICATORS

Public Health Capacity

Category	Indicator	Threshold
Capacity for case identification, follow up and containment	No barriers to SARS-CoV-2 testing in jurisdiction	Testing availability of 100% symptomatic individuals and exposed contacts
	Rapid identification of all newly identified COVID-19 cases by jurisdiction	Daily identification of all newly identified COVID-19 cases in the jurisdiction is achieved through active surveillance of labs and healthcare facilities.
	Rapid interviewing of new cases with full assessment of contacts	Interviews are rapidly attempted for every newly identified case, resulting in contacts being ascertained for >90% of newly identified illnesses.
	Rapid and complete follow up for identified contacts of newly identified cases	Rapid follow up (isolation, self-monitoring, and testing when indicated) initiated for >90% of identified contacts of newly identified cases.
Reduced disease burden	Consistent downward trajectory in newly identified COVID-19 cases	Consistent reductions in newly identified cases of COVID-19 over a 28-day period that represent a significant decline from peak.
	Incidence drops to a manageable level	Average daily incidence rate over the last 14 days reaches a level that does not overwhelm healthcare and public health capacity (determined locally based on resources available.)
Corroborate reductions in disease burden with other data	Reductions observed in case report data are also observed in other data	Sustained reductions also observed in one or more of the following: <ul style="list-style-type: none"> • ED and outpatient visits for COVID-like illness (fever, cough or shortness of breath) and absence of other cause) • Hospital admissions for confirmed COVID-19 infection or for COVID-like illness

		<ul style="list-style-type: none"> • Percent of SARS-CoV-2 positive tests (in the absence of major changes in how testing is being implemented locally) • COVID-19 deaths
Demonstrate control in healthcare facilities and other high-risk settings	Infections rare in healthcare personnel	Daily number of newly identified infections in healthcare personnel is near zero for 15 days and HCP infections are not causing staffing shortages.
	Decline in COVID-19 activity in high risk healthcare facilities (e.g., nursing homes, dialysis centers, long term care facilities etc.) and congregate living settings (e.g. prisons, youth homes, shelters etc.)	Sustained decline in new COVID-19 illnesses acquired in healthcare facilities and congregate living settings over the past 30 days such that potential facility outbreaks are identified rapidly and mitigated.
Assess disease burden in connected jurisdictions	The risk of introduction of a significant number of new cases from neighboring jurisdictions or air travel is low	Disease burden and trajectory in “connected jurisdictions” is not significantly different than in the home jurisdiction

APPENDIX B: INFECTION PREVENTION AND CONTROL ASSESSMENT TOOL (TELE-ICAR)

The Infection Prevention and Control Assessment Tool (Tele-ICAR) can be found [here](#).

(<https://www.cdc.gov/coronavirus/2019-ncov/downloads/hcp/assessment-tool-nursing-homes.pdf>)