

The Next Generation ELC 2019-2023

Update for Island Leadership

Alvin Shultz- Branch Chief
Division of Preparedness and Emerging Infections NCEZID

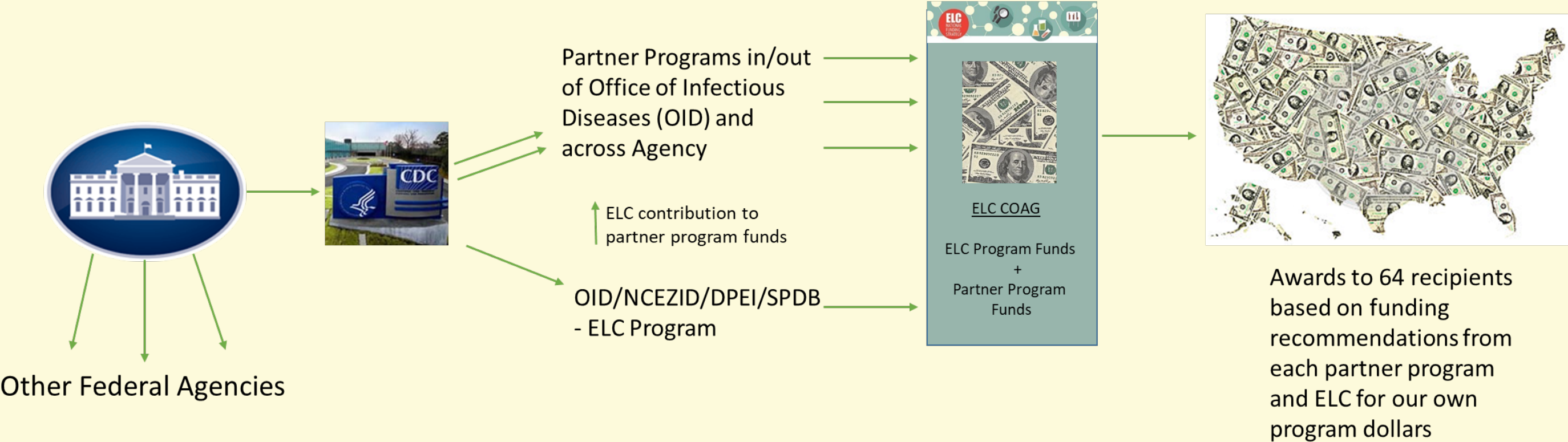
Angelica O'Connor - ELC Program Coordinator

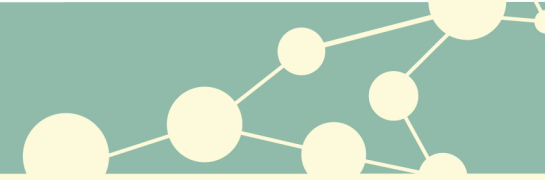
Amy Pullman (Pacific), Wayne Brathwaite (Caribbean)
ELC Advisors and Project Officers to Islands

November 20, 2019
PIHOA Annual Board Meeting



ELC Funding





PHEP

- 62 recipients
 - 50 states
 - 8 TFAS
 - 4 large localities (CHI, DC, LAC, NYC)
- Non-discretionary budget
- Formula-based
- NOFO supports 15 PHEP capabilities
- Supplements are rare

ELC

- 64 recipients
 - 50 states
 - 8 U.S. territories and freely-associated states
 - 6 large localities (PHL, CHI, LAC, NYC, HOU, and DC)
- Discretionary budget
- NOFO supports:
 - Cross-cutting (non-categorical)
 - Categorical programs/projects
- Flexibility to accommodate EOY, RAL, and supplemental funds

For nearly a quarter-century, the Epidemiology and Laboratory Capacity for Prevention and Control of Emerging Infectious Diseases (ELC) Cooperative Agreement has provided direct financial support in all 50 states, several cities, and U.S. territories and affiliates to detect, respond to, control, and prevent infectious diseases.

Notice of Funding Opportunity: ELC Cooperative Agreement, 2019 – 2023

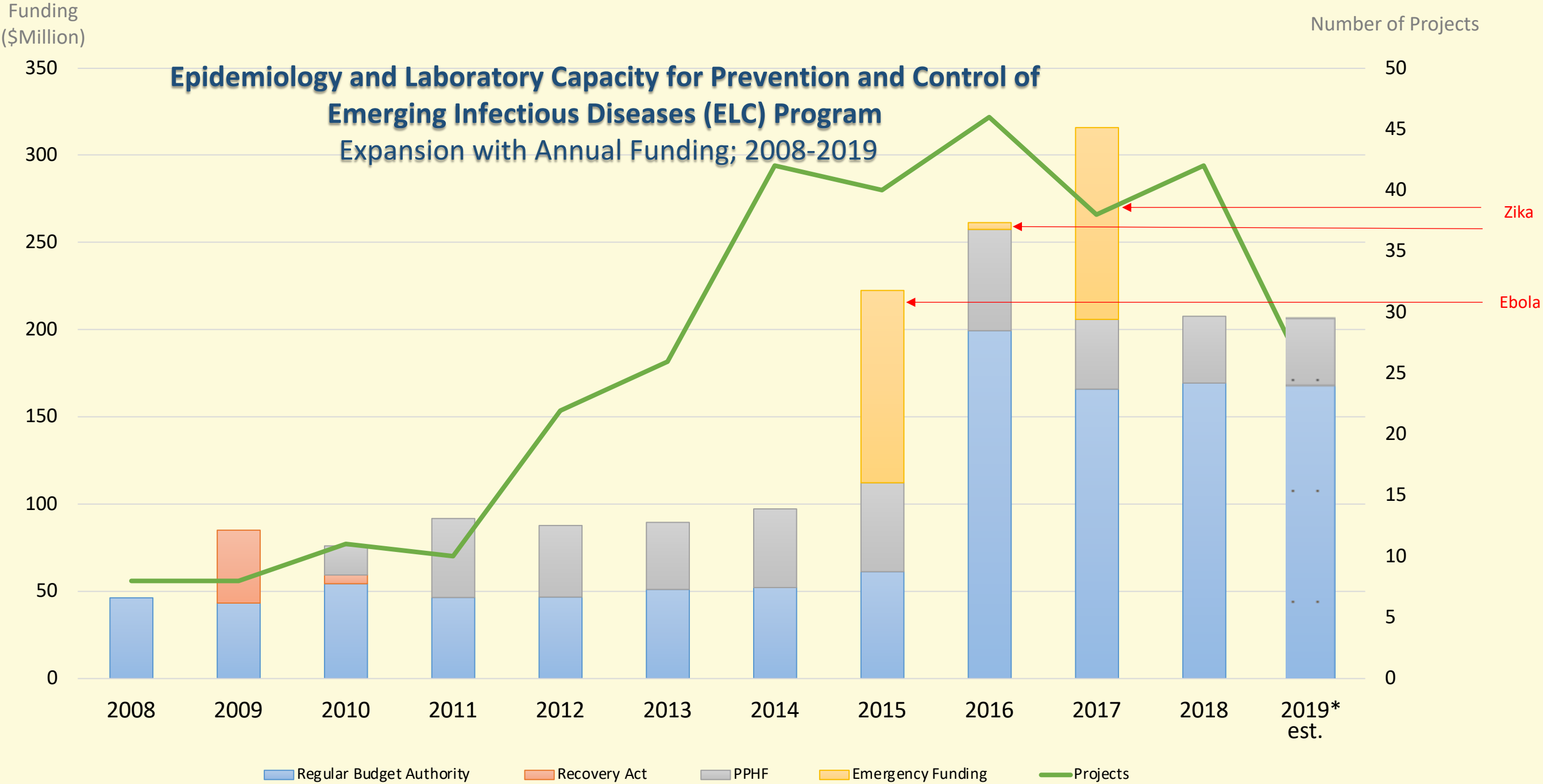
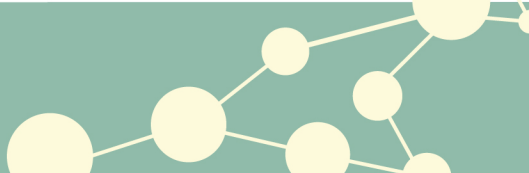
In March 2019, the Centers for Disease Control and Prevention (CDC) will release a Notice of Funding Opportunity (NOFO) for the ELC Cooperative Agreement. The NOFO announces a new, competitive 5 year cooperative agreement opportunity open to the 64 jurisdictions currently funded through the ELC. The new cooperative agreement incorporates feedback from recipients and partners that will:

- Improve coordination of the cooperative agreement and better support growth, while maintaining valued flexibility.
- Establish a stronger focus on public health programs while retaining the ability for recipients to work on discrete projects important to the health and wellness of their populations. Compatible cross-cutting activities from the prior NOFO project areas have been merged into four robust public health programs:
 - Cross-cutting Epidemiology and Laboratory Capacity Program
 - Foodborne, Waterborne, Enteric, and Environmentally Transmitted Diseases Program
 - Healthcare-associated Infections and Antibiotic Resistance Program
 - Vector-borne Diseases Program
- Offer opportunities to implement four cross-cutting prevention and intervention projects within the public health programs, with an increased focus on integration, leadership and flexibility:
 - ELC Leadership, Management and Administration Project – New in 2019
 - Health Information Systems Capacity Project
 - Impact and Evaluation Project
 - Cross-Cutting Emerging Issues Project: Enhanced Surveillance, Outbreak Investigation Response and Reporting, Surge Efforts and Interventions
- Utilize a tiered funding approach that will allow for varying levels of activity and regional approaches.

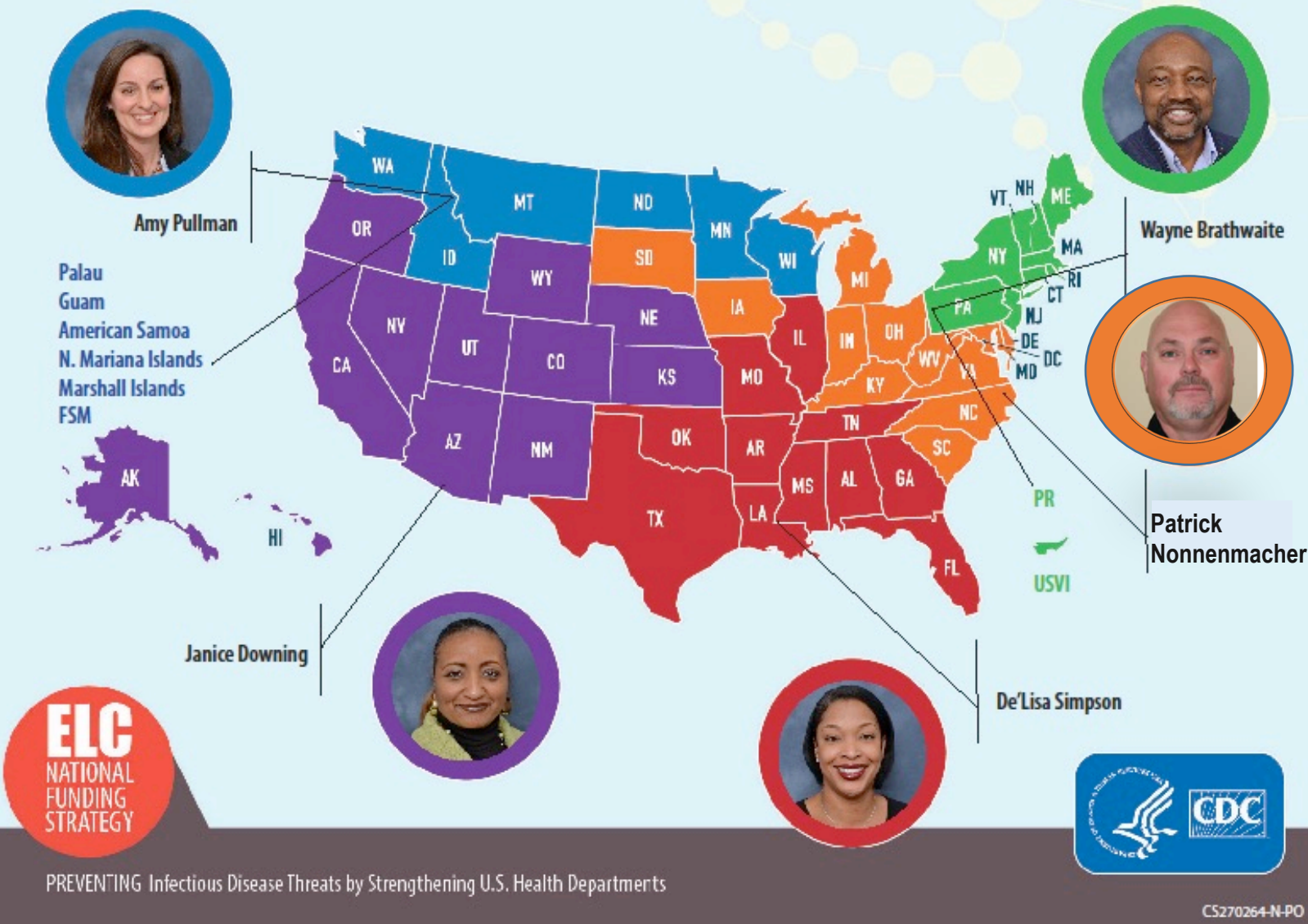
In August 2019, CDC expects to award approximately \$200M to 64 jurisdictions to detect, prevent and respond to the growing threats posed by infectious diseases through three core areas:



Program	Number of Awards	Funding Estimates
Cross-cutting Epidemiology and Laboratory Capacity Program	64	\$25,600,000
Foodborne, Waterborne, Enteric, and Environmentally Transmitted Diseases Program	56-59	\$33,000,000
Healthcare-associated Infections and Antibiotic Resistance Program	57	\$28,000,000
Vector-borne Diseases Program	60	\$16,000,000
Projects		
ELC Leadership, Management, and Administration	40	8,000,000
Health Information Systems Capacity	64	\$32,000,000
Impact and Evaluation	5	\$600,000
Cross-Cutting Emerging Issues Project: Enhanced Surveillance, Outbreak Investigation Response and Reporting, Surge Efforts and Interventions	Up to 64	\$0 (unless emerging issue arises)
Mycotics Detecting and Preventing Fungal Infections	20	\$600,00
Binational Border Infectious Disease Surveillance (BIDS) Program	1-4	\$750,000
Global Migration, Border Interventions and Migrant Health	3-5	\$230,000
Prion Surveillance	7	\$500,000
Rabies Surveillance	2	\$125,000
Parasitic Diseases Surveillance	10	\$100,000
Enhanced Vaccine-Preventable Disease (VPD)	64	\$6,400,000
Legionnaires' Disease Prevention	25	\$3,000,000
Influenza Surveillance and Diagnostic Testing	57	\$8,100,000
Non-Influenza Respiratory Diseases: Diagnostics, Reporting, and Surveillance	10-15	\$750,000
Threat of Antibiotic-Resistant Gonorrhea: Rapid Detection and Response Capacity	8	\$5,164,038

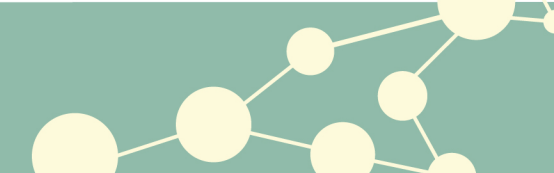


ELC Grantee/Program Advisor Map



National Capacity Building Cooperative Agreement

- Mission: To build the governmental public health system capacity for emerging infectious disease prevention, detection and response.
- ELC supports
 - State Health Departments = 50
 - Largest Local Health Departments = 6
 - Territories and affiliates = 8
- Customer-service focus and PO with state and local Epi and Lab experience



AS Reverse Site Visit ATL Feb. 2019

Direct support for
sustainable programs

TA tailored to jurisdictional
needs and priorities

Creative approaches to
meet needs ex. USVI Lab

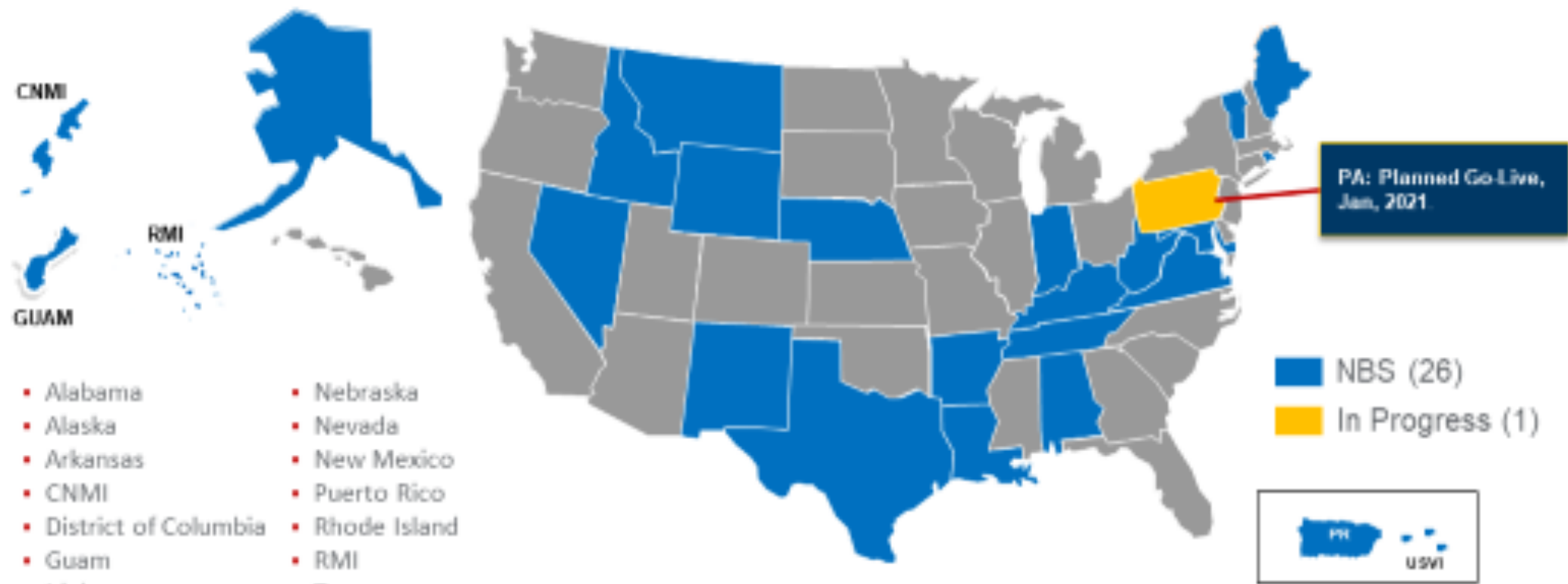
Guam, CNMI, FSM, RMI HIT Meeting





Growing Through Collaborative Development

The NBS Community



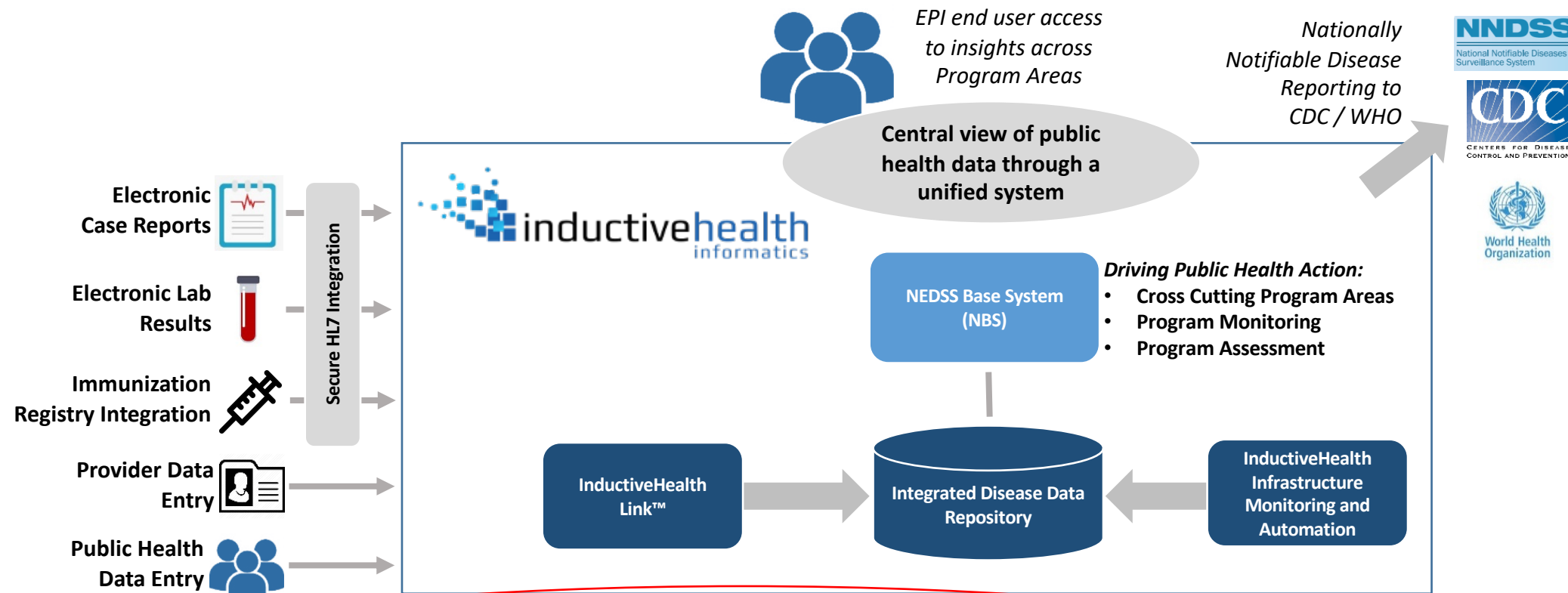
- Alabama
- Alaska
- Arkansas
- CNMI
- District of Columbia
- Guam
- Idaho
- Indiana
- Kentucky
- Louisiana
- Maine
- Maryland
- Montana
- Nebraska
- Nevada
- New Mexico
- Puerto Rico
- Rhode Island
- RMI
- Tennessee
- Texas
- USVI
- Vermont
- Virginia
- West Virginia
- Wyoming



The NBS is currently used by 26 of the 57 (46%) public health reporting jurisdictions, and NBS adoption continues to grow.

InductiveHealth – NBS SaaS

Modernization of Disease Surveillance



Key Facts of InductiveHealth's NBS SaaS solution:

- Currently used by Guam, Republic of Marshall Islands, and Commonwealth of Northern Mariana Islands and 8 other States and Jurisdictions
- 30 Days to fully implement including training, user provisioning of multi-factor authentication, and ELR onboarding
- Focuses your staff on public health action rather than data entry and information system management
- Existing data integrations with Diagnostic Laboratory Services (DLS) – primary reference laboratory to Pacific region
- Electronic laboratory reporting (ELR) average of 24 hours from release of results to public health notification.

- **Organizational Change:** Jurisdictions shifting from infrequent aggregate reporting driven by manual processes to near-real-time patient level reporting using the NBS requires organizational change.
- **System Usage:** Execution of surveillance activities in the NBS requires consistent data entry, workflow management, and standardized processes. While 'data entry' is important, daily use of the NBS is required up/down and across a jurisdiction to drive public health action.
- **System Consolidation:** Need for clear guidance from CDC/Program Areas to consolidate surveillance activities into the NBS to enable retirement of siloed CDC reporting systems.
- **Find a Starting Point:** Need for CDC/CSELS and CDC/Program Areas to fully support the transition to the NBS. Supporting System Usage and System Consolidation should be prioritized over data completeness which will naturally improve and provide a foundation for surveillance data.
- **Assuming Jurisdictions Know What To Do:** It is important to recognize that implementation of the NBS will likely identify the need for support on program best practices and public health interventions. This is less about what buttons to press in the NBS and more about the 'how' of disease surveillance and program administration. Collective need to make it safe for jurisdictions to request this type of assistance without the perception of funding implications.