

2014 County Health Department (CHD) Preparedness Expectations Guidance Document

June 16, 2014; Version 1.7

Introduction:

The Florida Department of Health (FDOH) is an integrated public health system, with the County Health Departments (CHDs) being statutory entities under the direction of FDOH headquarters. This creates a structure that provides services and programs in a more standardized manner, with seamless alignment of electronic data management and reporting systems. Florida's structure also enhances integration and coordination between other local and state entities, such as emergency management and domestic security. This integrated public health system is a key strength allowing Florida to respond more efficiently and effectively during a disaster.

The County Health Department Preparedness Expectations measure the CHD's emergency preparedness and response capabilities. The numeric average of the CHD Preparedness Expectations is used as the CHD's single emergency readiness score on the annual County Performance Snapshot. The intent of this document is to help define and clarify expectations for local preparedness and response activities as outlined by current federal and state guidance, policy, statute, and funding guidelines. In addition, these expectations align with Florida's Domestic Security Strategy and the *2012-2014 Public Health and Health Care Preparedness Strategic Plan*. Ensuring preparedness for our citizens and visitors requires a continuous cycle of: organizing; equipping; planning; training to plans, testing the plans through exercises or real events; evaluating outcomes through After Action Reports and implementing Improvement Plans. The public looks to the health care system for information, guidance and care during any situation that threatens to impact their health.

References:

Health care Preparedness Capabilities: National Guidance for Health Care Systems Preparedness, Assistant Secretary for Preparedness and Response (ASPR), Hospital Preparedness Program (HPP), January 2012.

Public Health Preparedness Capabilities: National Standards for State and Local Planning, Centers for Disease Control and Prevention (CDC), March 2011.

Florida Public Health and Health Care Preparedness 2012-14 Strategic Plan, Florida Department of Health, January 2012.

Florida Comprehensive Emergency Management Plan - Health and Medical Services, Appendix VIII: Emergency Support Function (ESF) 8 – Health and Medical Services, February 2010.

Budget Period 1 Performance Measure Specifications and Implementation Guidance; Version 1.1 - Centers for Disease Control and Prevention, Public Health Emergency Preparedness (CDC PHEP), July 2012.

Performance Measure Manual - Guidance for Using the New Performance Measures-Version 2.0 - Assistant Secretary for Preparedness and Response (ASPR), HPP, July 2012.

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Background:

The 2013 CHD Preparedness Expectations were developed utilizing the national standards outlined in the CDC's Public Health Preparedness Capabilities guidance document. Select capabilities were highlighted within the CDC guidance as priority capabilities for development by all states. Leaning forward, the Department aligned CHD Expectations to both federal and state initiatives. In addition, CHD performance relative to these preparedness expectations will provide critical information regarding local level capabilities and opportunities for improvement. These expectations were developed with input from the Regional Domestic Security Task Force Health and Medical Co-Chairs, the CHD Directors/Administrators, the public health preparedness planners and the PHHP Program Managers and were designed to capture relevant information about local level preparedness capabilities with minimal burden to the CHD staff that collect and report expectation information.

Improvements:

Recent improvements to the CHD Preparedness Expectations include the addition of a numbering convention to the individual expectations found under the Category Column. Each expectation will have a two or three letter identifier (for example, PL for Planning) and a number which identifies the expectation within the general capability grouping; for example, PL1 is assigned to the expectation "CHD Emergency Operations Plan" as the first expectation within the general capability grouping of Planning. The numbering convention helps identify the numerous preparedness expectations. The numbering conventions are summarized as follows:

• PL	Planning	PL1, PL2, PL3, PL4
• EO	Emergency Operations Coordination	EO1, EO2, EO3, EO4
• CP	Community Preparedness	CP1, CP2, CP3
• MC	Mass Care	MC1, MC2, MC3
• CE	Crisis & Emergency Risk Communications	CE1, CE2, CE3
• RS	Responder Safety & Health	RS1, RS2
• MP	Medical Countermeasures Dispensing (Mass Prophylaxis)	MP1
• EPI	Public Health Surveillance & Epidemiological Investigation	EPI1, EPI2, EPI3

Also, expectations EO4 and EPI3 were improved to better reflect the underlying information data systems and their field use.

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Category	2014 Expectation Definition	Scoring Methodology
Planning		
<p>PL1 - CHD Emergency Operations Plan (EOP)</p> <p>Should address the following elements:</p> <ul style="list-style-type: none"> • Hazard/Vulnerability Analysis • Continuity of Operations • Alert/Notification Process • Data/Voice Communications Crisis & Emergency Risk Communications • Isolation/Quarantine • Mass Prophylaxis. • Special Needs Sheltering 	<p>All county, regional and state all hazard response plans will align with requirements of the National Response Framework (NRF) and National Incident Management Systems (NIMS) requirements. In addition, these plans will be developed in collaboration with community stakeholders and clearly identify linkages to larger community planning activities/processes. Exercises testing any of the EOP annexes require testing of the EOP base plan and would meet the After Action Report and Improvement Plan (AAR/IP) expectation.</p> <p>Included within the plans should be:</p> <ul style="list-style-type: none"> • Identification and prioritization, based on lethality and large population exposure of hazards that potentially impact human health. • Continuity of public health operations. • A process for alerting and notifying internal incident response information using an established system. This system shall collect, manage, and coordinate information about the event and response activities and be available 24/7/365 to reach at least 90% of key stakeholders. • An interoperable communications process for the county health department that ensures redundancy through multiple systems. • Systems and processes for communicating public information that are able to handle large call volumes (at least 1% of the county's households), contain formats appropriate for vulnerable populations, including those with disabilities and those that are non-English speaking, and effectively disseminate health and safety information to the public. • Isolation and quarantine processes that include coordination of law enforcement, provision of services and monitoring of those under isolation and quarantine and management of public information releases. • Plans for supporting/accommodating vulnerable needs populations, including Special Needs Sheltering plans, developed in collaboration with local emergency management and other appropriate agencies that define the community's approach to sheltering persons with special needs. 	<p>Pass / Fail 1 = Fail 5 = Pass</p> <p>County should be able to produce a written plan that has been updated at least once within the last 36 months and that addresses, at a minimum, the elements listed.</p> <p>Note: CHDs with Project Public Health Ready (PPHR) certification within past 3 years meet this expectation.</p>
PL2 - County Comprehensive Emergency Management Plan (CEMP)	The roles and responsibilities of the CHD should be documented in the CEMP. Some county CEMPs do not designate the roles/responsibilities of the CHD, but instead, designate the roles and responsibilities of Emergency Support Function (ESF) 8 (for which the CHD has the lead).	<p>Pass / Fail 1 = Fail 5 = Pass</p>
PL3 - Response Workforce Development	The intent of this expectation is to ensure CHDs have a training plan for response workforce development. Many counties have undergone PPHR certification wherein a documented training is required. Additionally, DOH required trainings include basic level response training for all employees.	Not scored in 2014.

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	Workforce development standards will be revisited in 2014.	
PL4 - After Action Report and Improvement Plan (AAR/IP)	<p>Each CHD either conducted an exercise or engaged in real-life incident/event activation within the past 24 months, and documented the activity in a Homeland Security Emergency Evaluation Program (HSEEP) compliant AAR/IP within 60 days of the end of the activation/event/incident.</p> <p>While this standard is found for other capabilities throughout the CHD Expectations document, the intent of this expectation is to ensure the county has a documented process for completing an AAR/IP.</p>	<p>Within the past 24 months:</p> <p>1 = CHD conducted an exercise or real event activation.</p> <p>3 = CHD completed an AAR/IP of the exercise or activation.</p> <p>5 = CHD completed AAR/IP within 60 days of exercise or activation.</p>
Emergency Operations Coordination		
EO1 - CHD Decision-Maker for Emergency Operations Center (EOC) Operations	<p>Each CHD should have written plans that include, but are not limited to, activation procedures and levels, including who is authorized to activate the plan and under what circumstances. The key CHD decision-maker(s) are identified by the CHD and are based on current planning assumptions and standard operating procedures outlining local EOC operations.</p> <p>The identified decision-maker(s) must be able to respond/report for duty within 60 minutes of request. Responding/reporting for duty via phone or virtually (video conference) may be acceptable to local emergency management based on the needs of the incident/event.</p> <p>The CHD must demonstrate and document this capability via an exercise or test within the last 12 months.</p>	<p>This expectation will be scored as follows:</p> <p>1 = CHD decision-maker identified to support EOC operations.</p> <p>3 = CHD decision-maker identified to support EOC operations and can report for duty within 60 minutes.</p> <p>5 = CHD decision-maker identified, can report to duty within 60 minutes and has been tested within last 12 months.</p>
EO2 - Continuity of Operations	<p>Each CHD has an approved Continuity of Operations Plan (COOP) that has been exercised or activated within the last 24 months, with the exercise or activation documented in an HSEEP-compliant AAR/IP. Consistent with HSEEP standards, the AAR/IP should include the type of exercise conducted (i.e., drill, tabletop, full scale, etc.) and exercise outcomes. HSEEP provides several different exercise types, and a full-scale exercise is not required to meet the expectation unless specified.</p>	<p>This expectation will be scored as follows:</p> <p>1 = COOP is approved within last 24 months, but not exercised.</p> <p>3 = COOP is approved and exercised/activated within past 24 months.</p> <p>5 = COOP is approved, exercised/activated and documented in AAR/IP within past 24 months.</p>
EO3 - Notification Contacts	<p>Key contacts for notification of public health issues would be determined by local operations. Each CHD shall maintain a list of these key contacts and this list will be updated at least annually. However, the CHD may establish more frequent updates based on their environment and preparedness needs.</p>	<p>Pass / Fail</p> <p>1 = Fail</p> <p>5 = Pass</p>

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	<p>Key contacts should include entities, groups, agencies, businesses, professional associations or other service providers, as well as individual service providers that the CHD deems critical. For example, the entity:</p> <ul style="list-style-type: none"> • Provides health and human services (e.g., food, shelter/housing, social services, mental/behavioral) to vulnerable or at-risk populations during a significant disaster or public health emergency. • Is an essential vehicle for community outreach, information dissemination or other similar communications with vulnerable and hard-to-reach populations, as well as the general public, during response or recovery following an incident. • Is an essential primary partner in a jurisdiction-wide disaster or public health emergency response in terms of resource sharing, provision of goods or services, surge capacity, representation in the Incident Management Structure (e.g., the Emergency Operations Center) or other type of formal integration into a CHD's response to a public health emergency. 	
<p>EO4 - Everbridge SERVFL Notification System Alerts</p> <p>Note: FDENS was replaced by Everbridge SERVFL Notification System in 2014.</p>	<p>CHD Leadership Team members are CHD leaders who are designated to receive and confirm statewide notification alerts from the state. CHDs will ensure Leadership Team members are registered Everbridge SERVFL users and are identified to receive and confirm state-level Everbridge SERVFL Notification System Alerts. The Leadership Team may include: the CHD Director/Administrator, Business Manager, Nursing Director, Environmental Health Director, Medical Director, Everbridge SERVFL Administrator and Public Information Officer (PIO).</p> <p>The identified CHD Leadership Team must respond to state-level alerts, drills and real events in less than 30 minutes to demonstrate this capability.</p> <p>Numerator: Number of identified CHD Leadership Team members registered in Everbridge SERVFL, who responded to state level alerts, drills, and real events in less than 30 minutes.</p> <p>Denominator: Total number of identified CHD Leadership Team members registered in Everbridge SERVFL.</p>	<p>Actual time is reported from Everbridge SERVFL notification history log. Expectation will be scored as follows:</p> <p>% of identified individuals responding in less than 30 minutes:</p> <p>1 = 0% - 20% 2 = 21% - 40% 3 = 41% - 60% 4 = 61% - 80% 5 = 81% - 100%</p> <p>CHDs with multiple state level alerts, drills, and real events should report the best percentage score.</p>
Community Preparedness		
<p>CP1 – Risk Assessment</p>	<p>The intent of this expectation is to determine if the CHDs are considering hazard vulnerabilities or risk assessments in local planning.</p> <p>The Department is working on development of an online risk assessment tool that will be piloted this year. It is expected that 2014 criteria will focus on CHD training for use of the tool once it is ready for use.</p> <p>This expectation will be revisited in 2014.</p>	<p>This expectation is under development, and will not be scored in 2014.</p>

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CP2 - Vulnerable Populations	<p>At risk or vulnerable populations are often defined as groups whose unique needs may not be fully integrated into planning for disaster response. These populations include, but are not limited to, those who are physically or mentally disabled, blind, deaf, hard-of-hearing, cognitively impaired or mobility challenged. Non-English (or not fluent) speakers, geographically or culturally isolated, medically or chemically dependent, homeless, frail elderly and children are included in this group.</p> <p>The CHD is responsible to identify and assess the vulnerable populations within its county. Local planners are encouraged to utilize the Vulnerable Populations toolkit, which includes county-specific, vulnerable populations profiles, to facilitate the identification and needs of local vulnerable populations, www.doh.state.fl.us/demo/bpr/VulnerablePopulations.html.</p> <p>The County Planning Assessment Tool is used to meet this expectation; its location is: http://www.floridahealth.gov/preparedness-and-response/health-care-system-preparedness/vulnerable-populations/documents/vp-assessmenttool.doc. The assessment tool provides assessment criteria for all 10 priority target populations. The intent of this expectation is to encourage planners to assess priority vulnerable populations utilizing this standard assessment tool. The criterion only assesses the self-reported use and/or completion of the checklist and there is no penalty if some criteria within the checklists have not been addressed. It is anticipated that CHDs can utilize their assessment to identify activities needed to ensure the needs of their vulnerable populations can be met.</p> <p>Utilizing the Local Vulnerable Population Assessment Tool, the CHD is responsible to assess up to 10 populations and to assign values for the numerator and denominator as follows:</p> <p>Numerator: The number of priority vulnerable populations fully identified and assessed.</p> <p>Denominator: 10, The number of priority target populations which can be assessed from the Local Vulnerable Population Assessment Tool.</p>	<p>Expectation will be scored as follows:</p> <p>CHD determines actual numerator and denominator. Percentage calculated and scored as follows:</p> <p>1 = 0% - 20% 2 = 21% - 40% 3 = 41% - 60% 4 = 61% - 80% 5 = 81% - 100%</p>
CP3 - Community Engagement	<p>The CHD will work with key organizations and community agencies to engage their participation in public health, medical and/or mental/behavioral health-related emergency preparedness efforts.</p> <p>Key organizations are often characterized as:</p> <ul style="list-style-type: none"> • Having a significant 'footprint' or service area in a community. • High-volume or throughput in terms of goods or services provided. • Serving hard-to-reach, vulnerable or at-risk populations 	<p>Expectation will be scored as follows:</p> <p>CHD determines actual numerator and denominator. Percentage calculated and scored as follows:</p> <p>1 = 0% - 20% 2 = 21% - 40% 3 = 41% - 60%</p>

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	<ul style="list-style-type: none"> Historically significant institutions or key figures/icons with a community, often with significant influence within one or more cultural or affinity groups (e.g., community leaders). Providers of narrow or unique but critical services to the community (e.g., media outlets, hospitals). <p>Representatives of the key organizations should be in a position to commit their organization and/or its resources to local community preparedness and recovery efforts.</p> <p>The following numerator and denominator should be used:</p> <p>Numerator: Number of community sectors in which CHD identified key organizations have been engaged to participate in public health, medical and/or mental/behavioral health-related emergency preparedness efforts.</p> <p>Denominator: The 11 community sectors: businesses, community leadership, cultural and faith-based groups/organizations, education and childcare settings, emergency management, health care, housing and sheltering, media, mental/behavioral health, social services and senior services. (From the National Guidance.)</p>	<p>4 = 61% - 80%</p> <p>5 = 81% - 100%</p>
Mass Care		
MC1 - Special needs Sheltering (SpNS) Operations	Each CHD has a SpNS Operations plan that must be revised, updated and approved within the past 36 months. In addition, the CHD is responsible to test, through exercise or activation, the plan's validity. The exercise or activation should be documented in an HSEEP compliant AAR/IP within 30 days of the exercise or activation. The AAR/IP should include the type of exercise conducted (i.e. drill, tabletop, full scale, etc.) and exercise outcomes. A full-scale exercise is not required to meet the expectation.	<p>Expectation will be scored as follows:</p> <p>1 = Plan is approved within last 36 months, but not tested.</p> <p>3 = Plan is approved and exercised/activated within past 36 months.</p> <p>5 = Plan is approved, exercised/activated and documented in AAR/IP within past 36 months.</p>
MC2 - Functional Needs Support Services (FNSS)	Each CHD is responsible for participation in local FNSS planning activities. For more information regarding FNSS, see www.fema.gov/pdf/about/odc/fnss_guidance.pdf .	<p>Pass / Fail</p> <p>1 = Fail</p> <p>5 = Pass</p>
MC3 - Shelter Surveillance	<p>Department of Health, Bureau of Preparedness and Response (BPR) will research and review standard shelter surveillance tools share these tools with the CHDs.</p> <p>Expectation will be revisited in 2014.</p>	Not scored in 2014.
Crisis & Emergency Risk Communications		
CE1 - Risk Communication	The CHD is responsible for disseminating appropriate and timely information to the public and address media needs in	Expectation will be scored as follows:

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Messaging Development and Dissemination	<p>collaboration with response partners during emergency situations. Within the past 24 months, the CHD has conducted and documented the following activities:</p> <ul style="list-style-type: none"> • Documenting risk communication message development and dissemination procedures. • Testing procedures to ensure message can be disseminated to the public within 3 hours of an incident. • Recording exercise outcomes in an HSEEP compliant AAR/IP. 	<p>1 = Processes are documented, but not tested within last 24 months.</p> <p>3 = Processes are documented and exercised/activated within past 24 months.</p> <p>5 = Processes are documented, exercised/activated and documented in AAR/IP within past 24 months.</p>
CE2 - Public Information Officer (PIO) and Spokespersons	<p>CHD has a designated PIO trained to DOH Crisis and Emergency Risk Communications (CERC) standards, as well as, epidemiology and environmental health (EPI/EH) spokesperson(s) trained to DOH CERC standards.</p> <p>Documented plans/agreements to use Regional PIOs and/or spokespersons are acceptable, so long as those individuals meet DOH CERC standards.</p>	<p>Expectation will be scored as follows:</p> <p>1 = PIO designated but not trained.</p> <p>3 = PIO designated and trained.</p> <p>4 = PIO designated /trained and EPI/EH spokesperson(s) designated but not trained.</p> <p>5 = PIO designated and trained and EPI/EH spokesperson designated and trained.</p>
CE3 - Joint Information Center/Joint Information System Participation	<p>The CHD should have a ready contact list of health and medical contacts that is reviewed and updated at least annually, which is provided to the local ESF8 lead and Joint Information Center/Joint Information System Operations lead. The CHD may establish a more frequent review/update schedule based on community needs.</p> <p>The list may include, but is not limited to, points of contact for potential surge operation partners, including emergency medical services, fire service, law enforcement, and health care organizations.</p>	<p>Pass / Fail</p> <p>1 = Fail</p> <p>5 = Pass</p>
Responder Safety & Health		
RS1 - N-95 Fit Testing	<p>The CHD has procedures for conducting medical clearance that are reviewed and updated annually.</p> <p>In addition, the CHD maintains a roster of qualified and trained staff to conduct N-95 fit testing that is reviewed and updated annually.</p>	<p>Pass / Fail</p> <p>1 = Fail</p> <p>5 = Pass</p>

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RS2 - Responder Risk and Mitigation	DOH BPR will finalize the Responder Safety and Health Annex to standardize risk and mitigation guidance and will disseminate Annex to the CHDs. Expectation will be revisited in 2014.	Not scored in 2014.
Medical Countermeasures Dispensing (Mass Prophylaxis)		
MP1 - Medical Countermeasure Dispensing	The CHD should have a Medical Countermeasures Dispensing plan that outlines activities need to minimize the time needed to dispense mass therapeutics and/or vaccines, and align with the requirements of the Strategic National Stockpile guidance. In addition, the plan must include processes that ensure mass dispensing/vaccination requirements for highly infectious diseases can be accomplished in the appropriate timeframes. Within the past 36 months, the CHD will: <ul style="list-style-type: none"> Have a Medical Countermeasure Dispensing Plan, outlining how the county will request, receive, dispense, report dispensing of medical countermeasures and report the adverse events. Have the plan approved and tested through exercise or activation. Document the results in an HSEEP compliant AAR/IP. 	Expectation will be scored as follows: 1 = Plan is approved within last 36 months, but not tested. 3 = Plan is approved and exercised/activated within past 36 months. 5 = Plan is approved, exercised/activated and documented in AAR/IP within past 36 months.
Public Health Surveillance & Epidemiological Investigation		
EPI1 - Competencies and Skills in Applied Epidemiology	The data for these expectations are reported by the Bureau of Epidemiology in the Core Epidemiology Measures Performance and Education/Training Report. <ul style="list-style-type: none"> Counties with population greater than 100,000: Epidemiologist calls in to at least 20 Bi-weekly Epidemiology Conference calls or regional calls per year and attends 3 Grand Rounds presentations per year. Counties with population less than 100,000: Epidemiologist calls in to at least 12 Bi-weekly Epidemiology Conference calls or regional calls during year and attends 3 Grand Rounds presentations per year. 	Pass / Fail 1 = Fail 5 = Pass
EPI2 - 24/7 Health Department Access to Collect, Review and Respond to Reports of Selected Diseases	Processes must be in place and maintained for 24/7/365 reporting to the required public health agencies of suspicious symptoms, illnesses, or circumstances. In addition, processes must be in place to minimize delays in disease reporting in order to expedite the initiation of appropriate mitigation and control interventions. The data for these expectations are reported by the Bureau of Epidemiology in the Core Epidemiology Measures Accessibility and Timeliness Reports. <ul style="list-style-type: none"> Process exists to ensure 24/7/365 reporting of cases and suspected cases. Data provided via 77% or higher rate of disease 	Pass / Fail 1 = Fail 5 = Pass

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	<p>reporting within 14 days.</p> <ul style="list-style-type: none"> 30% or less annual error rate or unknown values for selected diseases. 	
<p>EPI3 - Using Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE).</p>	<p>Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE) is a critical state resource for epidemiological surveillance, identification, and monitoring. This expectation assesses the County Health Department's assigned personnel's frequency of use and familiarity with ESSENCE-FL.</p> <p><u>2014</u></p> <ul style="list-style-type: none"> The CHD is expected to have designated and trained a primary and secondary ESSENCE-FL contact person to use this system to support local epidemiology functions. Small counties with population less than 200,000 have logged into ESSENCE-FL once per week for no less than 40% of all weeks in the calendar year. Large counties with population greater than or equal to 200,000 have logged into ESSENCE-FL 3 times per week for 75% of all weeks. <p><u>2015</u></p> <ul style="list-style-type: none"> The CHD is expected to have designated and trained a primary and secondary ESSENCE-FL contact person to use this system to support local epidemiology functions. Small counties with population less than 200,000 have logged into ESSENCE-FL once per week for no less than 75% of all weeks in the calendar year. Large counties with population greater than or equal to 200,000 have logged into ESSENCE-FL 3 times per week for 85% of all weeks. 	<p>Pass / Fail 1 = Fail 5 = Pass</p> <p>By 2014: 100% of the counties will designate a primary and secondary ESSENCE-FL user; 90% of the CHDs will meet the 2014 expectation for logging into and using the system.</p> <p>By 2015: 100% of the counties will designate a primary and secondary ESSENCE-FL user; 100 % of the CHDs will meet the expectation for logging into and using the system.</p>