

**Responding to Today's Gaps for Tomorrow's Health Emergencies:
2026 Ready or Not Report
Trust for America's Health
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2:00-3:00 PM Eastern Time**

Live captioning Transcript by AI-Media

TIM HUGHES:

Good afternoon and welcome to our Congressional briefing and national webinar on the report Ready or Not: Protecting the public's health from diseases, disasters, and bioterrorism.

Hosted by Trust for America's Health, commonly known as TFAH. My name is Tim Hughes, the outreach manager. We would like to thank our speakers and unions for being here with us today. Next slide. Real-time captioning is provided by Ashley from AI-Media's.

For captions click more with the three dots on the bottom of your screen, next click on closed caption. Next slide. For ASL interpretation provided by Liz and Hannah, click interpretation at the bottom of your screen and select American sign language.

We encourage all to share your thoughts and questions about today's presentation by typing them into the Q and a box. We will try to answer as many as we can as time permits. To open the Q and a box, click on the Q and a icon on the bottom of your screen.

Select enter when you are ready to submit your question. And now it is my pleasure to introduce the moderator of this event, Dr. J Nadine Gracia.

She is the president and CEO. She is a national public health equity leader with extensive leadership experience in the federal government, the nonprofit Center, -- sector, and other associations. She leads the work to advance sound public health policy and our mission of promoting optimal health for every person and community.

Before, she served as a deputy assistant secretary for minority health and director of the HHS office of minority health in the Obama administration. Welcome.

J NADINE GRACIA:

Thank you all for joining us. I will begin with an overview of the findings and recommendations of our ready or not 2026 report. Then we will have presentations from each of our speakers and move into the Q and A.

It goes without saying that this is a critical moment for the nation's political-- public health and ministrations. Over the past year the United States has faced the most severe flu season in over a decade, the highest measles case County since 1991, continued age 5 and avian flu -related concerns, devastating weather related emergencies and now virus cases as well as an Ebola outbreak which has been determined a public health emergency of international concern.

At the same time, federal public health staffing, funding, and operational support were significantly destabilized, putting preparedness at risk. That is the environment that shaped this year's ready or not protecting the public health from diseases, disasters, and bioterrorism report.

The findings and recommendations are as important to the nation's health, economy, and national security as they were when this support series was first launched in 2003.

As we look ahead, those dates are only becoming clearer.-- Stakes are only becoming clearer. We remain under strain and the US is prepared to host large-scale events and mass gatherings such as the 2026 FIFA World Cup matches in the world ahead.

Events that will bring large crowds from around the country and international travellers and will underscore the importance of strong coordinated prepared system.

Let me begin with a few key takeaways from this year's report. First, a strong public health system protect not only help, but also economic security and national security.

Second, as a nation, we remain less prepared for public health emergencies than we need to be. There is wide variation in preparedness across states and those gaps lead-- leave the nation as a whole more vulnerable. Third, federal workforce reduction, ranch terminations, and funding and stability are straining state and local readiness.

Because state and local health departments rely heavily on federal funding, expertise and partnership, these disruptions affect their ability to plan for, respond to, and recover from emergencies.

The ready or not report evaluates the nation's readiness for public health emergencies through 10 indicators of state preparedness. These indicators examine areas such as healthcare workforce mobility, state public funding, laboratory research planning, access to paid sick leave, and community water system safety.

The goal of the report is to provide federal, state, and local policymakers and health officials with benchmarks that they can use to measure and strengthen preparedness.

This year's report also includes a special feature examining how federal workforce reductions in funding and stability could weaken preparedness nationwide.

One of the report headline findings is that 30 states and the District of Columbia placed in the middle or low performance just for preparedness. Our analysis placed in 20 states in the high-performance tier, 17 states and the District of Columbia in the middle performance tier, and 13 states in the low performance tier.

Most states remained in the same year as the reports prior edition. We know that policy decision sustained investment and attention to multiple areas of preparedness can strengthen a state's performance.

Overall, the report found several areas in which states are performing relatively well. These include nurse licensure compact, 41 states have adopted the compact, which enables interstate nursing mobilization during emergencies.

And public health and emergency management accreditation, most states have achieved through the public state management Board or the emergency management accreditation or both.

Public health laboratory capacity, almost in every state reported having a written plan for having and most residents consider-- continue to receive water although important inequities remain.

The report also identified several areas where improvement is needed. Those include access to paid sick leave, which varies widely across the country. That limits states abilities to transmission during outbreaks it and as a result, weekend workforce resilience.

Seasonal vaccination rates are too low, during the 2024 to 2025 flu season, only 44% of residents it is six months and older received a flu vaccine, which is a continuing downward trend.

Hospital patient safety also remains uneven. Nationally, only about 27% of graded hospitals earned an A from the Leapfrog safety grade. And avoidable mortality.

That continues to vary substantially across states with racial, ethnic disparities across state. Even before an emergency occurs.

This year's report also includes a special feature examining how federal workforce reductions, funding instability and program disruptions have we can preparedness nationwide.

As the report documents, we have seen reductions in the federal health staffing, including at the leadership level, branch terminations, curtailed investment in research and development, diminished collaboration with our global partners, and less visibility and situational awareness across levels of government. This type of prolonged and certainly

put at risk the preparedness infrastructure that decades of bipartisan investment helped build.

The report also offers recommendations for federal, state, and local policymakers and health officials. I encourage you to prove-- explore the report for more detailed recommendations.

I will summarize some of them here. They include providing stable, flexible, and sufficient funding for public health preparedness efforts.

Ensuring that there is an effective federal leadership and coordination, including reauthorizing the pandemic and all hazards preparedness act, which is commonly known as PAHPA.

And restoring federal workforce capabilities that were reduced in 2025. Strengthening outbreak and pandemic readiness through

immunization, public health surveillance, and antimicrobial efforts. Advancing equity and community resilience as core components of preparedness.

Accelerating the development, stockpiling, and distribution of vaccines, therapeutics, diagnostics, and other medical countermeasures. Bolstering our healthcare system readiness, including prostate credentialing and readiness programs.

And expanding our preparedness for extreme weather and other environmental health threats. Now without overview, of the 2026 ready or not report, I am pleased to welcome our esteemed panel. I'm so excited to have the speakers with us today.

They are true colleagues, respected leaders, and I hope you glean from their participation today the multisector representation in this panel with public health, healthcare, and the business sectors all represented. Because preparedness absolutely requires this type of cross sector partnership and collaboration.

First, we have Stella Fogelman, the director of the emergency room-- emergency preparedness and response division for the Los Angeles County Department of Public Health and has been leading readiness activities to prepare for emerging threats and natural disasters as well as act of biological, radiological, and chemical terrorism for over 11 years.

She also served as the department planning section please-- chief in January 2025 where she coordinated and organized the many activities that public health leaders stood up to support impacted communities.

Next will be Dr. Dave Chokshi which is a practicing physician and public health leader who

serves as the Sternberg family professor and founding director of the health and opportunity leadership Institute at city College of New York.

As the chair of common health coalition and cochair of the health and political economy project. He is usually served as New York City's 43rd health commissioner, leading the city's COVID 19 response and vaccination campaign.

Also served as chief population health officer at NYC health and hospitals and continues to practice internal medicine at Bellevue Hospital.

Our third speaker will be Steven Levine, who is the co-CEO of the health action alliance, which mobilizes businesses to addressing public health challenges and co-CEO of media right, the from behind the health action alliance and other coalitions focused on health, client resilience, and civil engagement. His work includes the extreme weather and work initiative and the National commission on climate and workforce health, which are focused on protecting workers and strengthening business resilience and climate related threats. Previously, he served as the White House associate Dir. of Communications under Pres. George W. Bush where he helped establish the White House red ribbon tradition.

Is now my honor to welcome Stella Fogelman of the Los Angeles County Department of Public health is our first speaker. Welcome, I will turn over to you.

STELLA FOGELMAN:

Thank you so much for the report and opportunity, thank you to my co-panelists, and everyone part spitting today to hear us out. I'm going to touch on when it takes in LA County to protect the public health from diseases, disasters, and bioterrorism.

Here are some highlights about what I will be walking through. Los Angeles County, in a nutshell, we are massive both in land and in people.

We are diverse and we have a very large public health and medical system that we navigate and manage to be able to protect the health of the people in Los Angeles County. You all will be getting the slides, so I'm not going to go through every statistic here, but to summarize, there are nine 700000 Residents in Los Angeles County.

This is the largest county population in the United States. We have a 4000 mi.², which is larger than most states. And we have a different combination of law enforcement and fire agencies, depending on where you are within the county.

There are over 220 Languages Spoken in Los Angeles County. And 55.1% speak a different language in our homes beside English.

There are 13.3% of folks living at or below the poverty line. And we have some of the most

extreme for social-- socioeconomic status for poverty and wealth. There is a wide gap in life expectancy depending on your ZIP Code in Los Angeles County which provides a challenge for the health system.

We are the public health department for most of the cities, Pasadena also has their own health department. You can see we have over 100 hospitals, hundreds of community health centres, long-term care facilities, congregate living said-- living facilities, dialysis centres, ambulatory surgery centres, and a large group of licensed ambulance company.

We are working with our healthcare system and public healthcare system to manage all of this. We do rely on support from CDC and ASP are for our public health emergency prepared this program and for our Hospital preparedness program.

We are one of 62 awardees that get direct funding. We get \$21.4 million annually to protect public health emergency prepared this response capabilities. We work very closely with our state and federal partners that enhance our ability to do this work.

This piece, about 82 full-time equivalents for the work that I am about to share with you. This is an example of what we do overall for public health preparedness and response.

We perform our jurisdictional risk assessments looking at her words right and analyses and projections across the county. We develop plans and procedures for our partners to be able to address those threats.

This includes countermeasures programs. We do trainings and exercises according to that and respond to a variety of public health emergencies.

We work both internally and with a variety of partners. We have volunteers, we have a medical reserve port of a volunteer network. And we respond and coordinate with-- responses both internally and with our partners.

Here are some examples of our team out in the community doing the work that we do. And here are examples of our response efforts.

For many of the events that you know and love within Los Angeles County, the Oscars, the Emmys, the Grammys, the Marathon, etc., we are back in the background doing chemical, biological, radiological, nuclear readiness planning.

We also coordinate our responses to disease outbreaks and national disasters. A lot of this is occurring now. These are some examples over the years of the big ones but the 22... 2020 pandemic response was our biggest one.

Simultaneously to that, we responded to Mpox, the Super Bowl, and the Summit of the Americas here. That speaks to what we are doing now in the near future, preparing for the

FIFA World Cup, the Super Bowl and the Olympic and Paralympic games coming up.

Some more examples of our team out in the community working with our partners. When we are doing our mass gathering and sporting events, we focus in on the specific aspect of public health.

Disease surveillance and control, environmental health, weapons of mass destruction preparedness, again, while we are doing our day today operations, we do an enhanced operation for these funds.-- Events.

You are going to get the slides, some not going to go through all of the details, but the highlights from our public health lab, communicable disease programs and community field service programs are.-- Are doing a lot of regulation and control. We are doing our disease testing in our labs. If there is additional evidence of bio or chemical terrorism then they can do it additional environmental testing.

We had a medical liaison to our healthcare community. We will send out LA health alert and federal and state messaging as well. We have field teams go out and do outbreak management. We also seal teams during proactive community response and community education.

Our environmental health folks are out there doing food safety and inspections on a day-to-day basis, and then also for our big sporting events and our mass gathering events. They do outbreak response if there is evidence of a foodborne illness or environmental issue. And then they are doing hotel inspections-- inspections as well.

If they need to do additional environmental testing, they will do that as well. And then we do weapons of mass destruction preparedness. We have a technical advisory group, they have technical expertise in areas of weapons of mass destruction preparedness and response.

We are closely tied in with our LA fusion Center, which is the joint regional intelligence Center. We work closely with the FBI to conduct any bioterrorism or weapons of mass destruction investigation.

We respond closely with our partners in the joint hazard assessment team, this is with LAPD, the sheriff's department, the FBI, to respond to any suspicious substances or weapons of mass destruction.

We titled together with emergency management. As you can imagine, it takes a lot of coordination to be able to respond with all of these partners. We have presence in our department operational center where we are incarnating our departmental efforts. We also send representatives to our emergency operations Center at the county level to coordinate with our municipalities, we have folks at command post working with our public safety

response agencies to make sure that we are ready for any response efforts.

Again, we title together at our joint information Center to make sure that we have one voice messaging that goes out for the public at our different levels of our different audiences.

Altogether, it takes a lot to do all of this work and we rely heavily on our federal partners and our federal cooperative agreements to do this work. As I mentioned, the vast majority of this funding goes to people to do this.

With the president's fiscal year 27 proposed budget, that will mean half the amount of people to do all of this critical work. Because the proposal also eliminates the Hospital preparedness program.

Given the significant work that we need to do in LA County to protect the public health, the county and other partners are advocating instead to increase the funding at the amounts that are funding-- amounts that are shown here to support the critical work and the people that are needed to do the work here in LA.

I hope you have learned. Next slide, please. I hope you've learned a little bit about what it takes to do this work here in LA County and I will be here for additional questions. Thank you.

J NADINE GRACIA:

Thank you for providing a great overview, the breath and steps of what LA County is doing to protect the health of its residents. Looking forward to our questions later in the webinar. We are not going to hear from Dr. Chokshi from the common health coalition and the city College of New York. I will turn it over to you.

DAVE A CHOKSHI:

Thank you so much. I want to start with a genuine expression of gratitude to the whole Trust for America's Health team for another terrific report ready or not 2026.

For those who have not yet scanned it, I would direct particular attention to the policy recommendation section. I found myself rereading it in the context of the headlines of the last week between the virus and Ebola outbreak.

I think if there is a speaking through had to prioritize as making those recommendations a reality. There are also special sections on federal instability, as Nadine mentioned, but also World Cup preparedness and vaccination, which I found so useful.

Thank you for the team for that. For my part, I want to focus my brief remarks on what we believe through the common health coalition is needed to save lives and prevent suffering

in this uncertain new worlds that we are all navigating together.

As Nadine mentioned, I have the privilege of serving up--as as chair of the common health coalition, for those who are not familiar with it, the coalition is the largest multisector health collaborative, we are a first of its kind initiative. Relatively recent. We started in 2023.

Spans clinician groups, health departments, hospitals, and payers and community organizations. Our aim is by uniting leaders who rarely share the same table to turn alignment into action at a scale we believe that no single sector is able to reach alone.

The common goal across all of those different sectors is of course to improve the health of people and communities across the nation. And we think that a core aspect of that is to strengthen partnership and dissolve silos between the healthcare and public health systems.

We are a nonprofit and nonpartisan organization. You can check out our website, which is in the chat if you want to learn a little bit more about the coalition.

When we talk about partnership across healthcare and public health, I have to acknowledge that collaboration and partnership are these concepts that can sometimes feel a bit fuzzy, you know.

Who is against collaboration? It is one of the sort of motherhood and apple pie notions. Our aim is really to try to focus more on making it real.

Our attempt to do that is through this framework which we call the care framework which describes a handful of strategic priorities that cuts across what the disease and headlines might be today.

Or even, you know, some of the challenges that we have institutionally that have been so for many years or even decades.

I will give you a couple of examples of how we seek to make this real. We believe in doing things to turn over proof relationships, ensure that we codify coronation, for example between a hospital system and a health department so it does not rely solely on that personal relationship that may forge that collaboration in the first place.

We focus on ensuring that everyone is reading off of the same sheet of music during an emergency. That is what we mean by always on preparedness. There is a major focus as there was in the ready or not report on the importance of real-time data sharing so that we have visibility into how things are progressing in our communities.

Our read on the challenges before us and again, the report laid this out so well, we are in

this shoulder moment when it comes to public health and preparedness in our nation.

Organizations cannot shoulder the growing fiscal challenges alone. Public health departments of course have been under financial pressure for many years, but the healthcare system is also under a growing financial pressure.

We just have to look at the public response to the virus to know that there is an anxiety, justifiably so, with respect to how the public sees health officials and the health system writ large being responsive-- responsive to their needs and trusting that we actually have their back in an emergency situation.

We have to ensure that the lessons learned from the pandemic, the need for hyper-local initiatives, community health workers, embedded in our response are actually deployed and scaled to better serve our communities.

We believe there are these converging crises that require a new set of responses from us. As a former local health commissioner myself, I strongly believe it is a course that all health is local.

Stella, your remarks lay that out so well. But also, in this moment, we think that regional collaborations have immense potential to reshape how jurisdictions collaborate for the health of their residents.

One way that I think about this is it helps us move from brooding to building. There is a reason for worry, of course, but we need to channel that into regional action. Because we think it can be an antidote to the fragmentation and the instability that we are all feeling and in some cases, is flowing from the federal level.

There are a lot of burgeoning collaborations across the country. Some of them are named here on this slide, but we believe there needs to be a shared language with how we talk about them.

So that we can build those partnerships in a way that are robust and rigorous and can serve as an antidote to the scarcity mindset that would otherwise come to dominate our response.

Through the coalition, we have recently begun supporting what we call regional action networks, which are defined here. We have invested over \$750,000 in support for these types of regional action networks.

And have sought to start to build some strategy around what the most effective regional action networks consist of. You can see the four common elements that we have identified thus far.

Backbone organization that can sustain coordination and ensure that there is a shared strategy. Funding and particularly new shared investments in areas that unfortunately go under invested.

Regional data sharing infrastructure and equity goals, and then importantly, a strategy for meaningful community engagement and bidirectional communications, not just pushing a communication out, but doing radical listening to be able to understand what community needs actually are.

So, you can see here a few of the examples that are maybe less heralded, we have heard about the great work of the West Coast health lens, but we are very interested in spotlighting other approaches to regional collaboration.

Growing them so that they can serve as exemplars, and also finding what the key elements are so that everyone can build upon those who are in the vanguard.

The Northwest healthcare response network, for example, helps to prepare and respond to emergencies through ensuring that there is visibility and hospital capacity across jurisdictions. The Minnesota electronic health record Consortium unites healthcare systems and public health agencies around shared data.

It captures 95% of Minnesotans and so is a very robust way for everyone to be looking at the same dashboard when it comes to prioritization and response.

Based in Cincinnati, the health collaborative is a convener in Ohio that unites all of these different organizations around shared priorities as well. I encourage you to check out these QR codes either now or in the follow-up in the slides if you want to learn more about any of them.

I hope that gives you a little bit of the flavor of the type of regional cooperation we are talking about. I will wrap up here and the next minute or two.

We do believe that funding is so fundamental, you know? It is so critical and we have tried to ensure that showing the loss of funding that again was spotlighted in the report also helps us to give us a shared view of the problem.

For example, using these visualizations to show how funding cuts to public health reverberate across the system and ends up showing up in our emergency rooms and our clinics and hospitals.

We put out this report called more illness, greater cost, on childhood immunizations focusing on the MMR vaccine which shows that this does not just show up in terms of health effects but also on our economic bottomlands from-- bottomlands from medical costs, missed work, and productivity.

We aim to capture the entire cascade and thereby activate actors who may yet be a little bit on the sidelines so that we can all pull in the same direction on these important problems.

And we hope that this will help to motivate shared financing and investment in regional prevention efforts as well. We have put together a toolkit and are working with a handful of jurisdictions around the country to make this more real. Again, so much of what we are trying to organize written-- relies upon shared financing as well.

My last slide is just to say that we would love to stay in touch with folks who were working on these issues. Please reach out, follow us on social media.

The note I would like to end on is just to point out what I know so many of you know, which is that the health of Americans depends on how we navigate the uncertainty before us.

We cannot wait on Washington. It is not an acceptable response for any of the people that each of you are serving and so we believe that there are a number of steps that we can take together, particularly around regional cooperation, to ensure that we are forging new paths despite the uncertainty that we are all navigating.

Thank you so much.

J NADINE GRACIA:

Thank you for such an informative presentation and the resources that you shared. Looking forward to additional conversation on those opportunities. We are going to turn into our third speaker, and actually, let me say as well for those of you, if this is your first term-- I'm learning about the common health coalition, go to the website.

Learn more. We are probably a member of the collaboration and it is so vital, not just in emergency times, but also in nonemergency times as well. Our third speaker is Steven Levine, from the health action alliance. Before I turned it over, I see questions that we are getting in from the audience, please continue to submit your questions using the Q and a future.

We look forward to answering your questions when we move into that portion of the webinar. Let me turn it over to you.

STEVEN LEVINE:

Thank you so much. Stella, Dr. Chokshi, I'm so grateful to be here with both of you. We are part of the common health coalition as well and really appreciate the work that you're doing there as well.

And Stella, I'm one of the 9.7 million LA residents that you mentioned. And so much of the work that you have talked about is keeping my family safe. From challenges I will never think about.

I just want to say thank you for that work and your leadership. Both of you have painted the picture from where you sit in local public health and also across health systems.

My hope today is to bring the perspective of the employer or business to this conversation as well.

Every outbreak and emergency that we have heard about today from the virus to fears of Ebola show up not only in our communities, but also in American workplaces. Workers come to work alongside infected colleagues, parents are trying to figure out whether it is safe to send their children to school during an outbreak, and extreme weather is knocking out communities and business operations in one fell swoop.

Whether they are ready or not, employers are now an integral part of the public health response. I just want to note that this report ready or not 2026 is landing at such a critical moment and I am very grateful to Nadine and Dara, and the entire team to this work. Thank you.

A bit about who we are. At the health action alliance, we work with more than 11,000 employers. That reach over 50 million workers and their families. We were founded at the height of the COVID pandemic when companies vary visibly became a critical part of the public health system in ways they had never really been before.

The former CDC Dir. said at the time, employers gained incredible authority and credibility and trust and power during the pandemic.

And the work now is making sure that we do not lose that muscle. I will say, the reason why our theory of change goes through employers is what you see on the slide here.

Workers trust their employer to act. And increasingly, they are expecting them to act. According to this year's trust barometer, 78% of American workers say they trust their employer.

That is a higher level than the trust that business probably has overall. It is higher than the trust that Americans have in government, unfortunately.

It is higher than the trust that they have in media. Employers today are the most trusted institution in our country.

And workers are expecting, not just brooding, Dr. Chokshi, but expecting to translate that

trust into action. Let's take extreme weather, for example.

32% of workers say their employer is primarily responsible for protecting them from a climate-related health risks. That is surprising, I will say.

And it is surprising because it is a higher share than we are seeing that Americans expect their federal government or state and local government, or even expect their own responsibility to bear.

Extreme weather is where we have some of the freshest data from workers. And so, it is a pattern that we are seeing very clearly in this case. I want to say this has been a consistent trend that we have seen across a whole scope of health risks as well.

On the next slide, you will see that the readiness for that expectation is lacking. We just watched, yesterday and the day before, a tornado outbreak tear across the central plains.

We also are hearing from nowhere that the probability of a strong El Niño the summer is over 80%. 36 states are leaning above normal temperature outlooks for summer 2026.

And I think we are seeing across the board, these conditions intensify. Yet only 42% of employees say that they feel confident their employer has a plan to keep them safe.

Only 4% of employers have assessed their workforces vulnerability, whether it impacts-- Weather impacts. Meanwhile 82% of workers, including 90% of Gen Z, say that they have experienced a disruption at work that was caused by extreme weather in the past year alone.

That is really why we have launched extreme weather and work, just this past month, with partners from Mercer to the Hartford, we are founding members from Disney to Google and Bristol-Myers Squibb, CVS health.

This is a coalition of companies coming together to take steps to start identifying what can employers, companies due to strengthen the preparedness and the support for their workers as we see intensifying extreme weather risks across the country.

It is guided by a commission that I'm very grateful Dr. Garcia sits on, which is the climate and workforce health which is to close the readiness, help employers understand not only the expectations of their workers have, but the stuff that they can take in order to be more prepared for extreme weather risks.

If you substitute pandemics for climate or extreme weather, I think again, this picture looks similar. The demand for employer leadership I think from workers from Americans themselves, is clear and I think we have a real opportunity to strengthen the readiness of those employers and companies across the country and I think that is really the

opportunity that the ready or not report this year is pointing towards.

I will share is out a few years back, right after the height of the COVID pandemic, we published the pandemic preparedness plan for business.

I was very grateful to Trust for America's Health that we were referenced in the ready or not report this year. It lays out a four level framework for employers.

Level one on the bottom there is sort of baseline, it is protecting employee health in the workplace. I will say paid sick leave, vaccination support, mental health, care navigation, that is all included in that level. Paid sick leave is what I want to pause on for a moment.

Again, the ready or not report really elevated this is a key indicator this year. Access to paid sick leave, as Dr. Gracia mentioned, ranges from 67% to 98% in other regions.

The gaps and where we are seeing folks not have access to paid sick leave our following the hardest on the wage and service sector workers. Paid sick leave is not only a public health intervention, it is a business continuity strategy all in one.

And we really try to focus on painting the picture for why there is a return on this investment for companies by maintaining that continuity, by seeing retention rates and employees at some-- employee satisfaction rates by introducing interventions like paid sick leave. Level II is having ready to use response plans.

Pandemic response teams, Inc. scenario planning with your cross functional teams, having a communications playbook builds before the crisis actually comes so that you feel prepared.

Level 3 is the one that I think fades fastest when we are not in a crisis mode. That is actually having an active relationship with local public health departments.

And establishing relationships between public health departments and the employers in your community. I think companies that wait until the next outbreak to exchange business cards with your local public health leaders are already behind.

Finally level IV is going the extra mile, investing in community health alongside your public health partners.

And I think the companies we see move up the ladder are the ones whose people, whose customers, whose supply chains are strongest. When these emergencies hit.

On the next slide, wanted to share, before we wrap some resources. Everything we build is free and available for use on our website. I will share some links in the chat in a moment. My hope is that this is a set of resources that will help each of you establish new

relationships and partnerships with either employers in your community or local public health leaders in your area.

First is the pandemic preparedness plan for business, which I just mentioned. The second is our extreme weather and work initiative. That provides free guidance for companies and any employer to strengthen the preparedness for extreme weather.

It also includes a climate health cost forecaster, which is built in partnership with Mercer, to help employers actually quantify the workforce held cost of extreme weather.

And I want to note, again, we really tried to paint the business picture, the business case for why companies should be taking this seriously. This tool, the climate help cost forecaster helps you make the case with specific dollar amounts for the increase in costs you can expect to see as an employer in rising healthcare costs related to extreme heat and a whole variety of extreme weather impacts.

I also want to just say in my mind, the most powerful step that any of us can have is having an initial conversation with a public health leader, and I think that some of the resources that I share in the-- that I will share in the chat right now will help you close that step.

I want to share something that my cofounder at the health action alliance posted today on LinkedIn. He calls this trend the mass of decay. Which is a bold title, I will say.

It looks like this. Prevention infrastructure, which is really the work of public health. Prevention infrastructure is uniquely vulnerable because its success is invisible. When pandemic preparedness works, nothing happens.

When public health does its job, no outbreak will make the news. When companies invest in workforce health and a crisis never comes, the spending starts to look unjustified.

And that is the dynamic I think we are seeing playing out everywhere-- out really everywhere in our lives. That is why federal preparedness budgets get caught between Tracy's, why state and local health departments are often at the top of the chopping block in a downturn.

It is why companies eliminate chief health officer roles when the memory of the pandemic receipts. And honestly, it is why most of us postpone our annual physicals when we feel fine every year.

The challenge I think for each of us is to find ways that we start rewarding the invisible work of prevention. It goes against our human nature, I will say, because we are programmed, we are wired to celebrate crisis response.

But I think the work that keeps a crisis from becoming a crisis is the critical work of this preparedness planning that I want to say, the ready or not report this year, so vividly lays out.

I think if we want to stop living in endless cycles of crisis, response, and budget cuts, we will have to start training ourselves to reward the work that protects us from the things that we will never have to face.

I want to note that is a role that employers should be playing alongside public health leaders and so my hope is that today, you can think about how to strengthen those connections across those sectors in your own community.

Nadine, thank you very much for this opportunity. I'm excited for the conversation.

J NADINE GRACIA:

Thank you, I hope the audience is something but I shared at the beginning, why it was so great to bring these amazing leaders together. You are hearing someone who was working at the intersection of business and public health talking about the importance, the value of public health.

And why this is so critical, not only to the health sector, but really to our society overall. Thank you to all of you who have been putting questions in the Q and a panel, please continue to do so and we will get to as many questions now in the Q&A portion in our webinar.

I'm happy to be joined by my colleague Dara Lieberman who is a director of government relations who also leads our preparedness advocacy and she will also help to moderate the Q and A.

I am going to start with a question to Stella, Stella, you talked about and in particular, you showed just the number of events, mass gatherings, large-scale egg-- large-scale events and you highlighted at a large level how you engage in preparing for those types of events, I would love to hear you talk about some of the lessons from those recent major events that LA County, the way that LA County is both prepared and responded to them.

There is so much interest now in regards to the preparation for the World Cup. What are some of the lessons learned in terms of doing an effective preparation and response for those types of events?

STELLA FOGELMAN:

Thank you, that is a great question. Any time we do either an exercise or a real-time response to anything, we gather together, for the folks who leaned into those response and

those actions, we gather together and talk about what went well and what can we improve upon in the future.

One of the things we noted in the wildfires for instance is we had to move quickly from regular day-to-day operations to response, it is really helpful to have a team that you are regularly engaged with and partners that you are regularly engaged with that can move quickly so that you already know how to get a-- hold of each other and how to get a response together and move in to those action steps.

Within the health department, we are applying a new way to prepare and train for an incident command system, which is a fancy way of saying how we move from preparedness and response in a structured way. We are doing a community of practice.

With our teammates and recruiting additional folks, we have a deeper bench within the department to be able to respond. It is about those connections and as Stephen was talking about, working with partners before the crisis happens, looking back and reflecting on the lessons learned after each of the efforts in the training that you have done together, and building upon that.

We are trying to look for new ways to kind of break the traditional ways of our trainings and kind of lean more on our relationships and our coronation efforts to be able to do that. And then recruit additional folks within the department and the resources we have to be able to respond.

I hope that is helpful. That is kind of one way that we have been working to prepare.

J NADINE GRACIA:

Absolutely. What I hear you saying and I know Stephen and Dave would agree, the importance of these partnerships. Not trying to form these partnerships within the crisis, but putting the time and and developing relationships so you can work even more effectively in times of crisis. Thank you for that, Stella. Let me turn to Dara to pull one of the audience question.

DARA LIEBERMAN:

The transitions very well. When department works in a state where most of the counties are rural and there is very little infrastructure at the local level for public health and public preparedness and the critical access hospitals, of course, are in dangers of closing.

Dave, can you talk a little bit about how you would envision or improve preparedness in these types of counties?

DAVE A CHOKSHI:

I really appreciate this question. When we talk about the pressures that are being faced right now, they are often multiplied at the rural level.

In part because the baseline level of capacity, whether you are looking at public health or health care or just local government is at a lower level than metropolitan areas.

My core or-- argument would be everything we are talking about with respect to regional collaboration becomes even more important when you focus at a rural level.

We were deliberate in thinking about this for the regional action network that I mentioned. Three of the five regions that we gave our initial catalyst awards to have a focus on people who are living in rural areas for precisely this reason.

Those are the main use public mental health initiative, the North Dakota multi health collaborative, and then something called the common roots health exchange in North Carolina.

What I would distill out of all of that is the notion that you have to look to other partners to be able to drive resources and expertise. So, for example in Maine, and I also do want to shout out in the ready or not report, there is an interview with the main health director who also talks about how to actually make this work in rural areas, because main is actually the most rural state in the nation, in case that is not a well-known fact.

But the pieces that are common are to ensure that you are, for example, looking to schools when you are talking about addressing youth mental health.

Maine health is the largest healthcare system in that area. A big part of the partnership, because there is not the same level of local health capacity is to be able to draw upon those things from other folks. I wonder if Steve, maybe has something to adhere from the employer perspective as well.

STEVEN LEVINE:

First, I will say that is great advice. I will say from an employer perspective, what we often try to remind our public-health friends is that often, even in rural communities, employers are operating.

I will note Walmart is an active member in many of our initiatives, including in ending HIV in the US. 90% of Americans live within 10 miles of a Walmart.

I think as you look at, for example, identifying partners in your own local communities, I would encourage you to just take a moment to consider who are the entities that are operating in your rural communities as well.

I imagine that the store manager at Walmart in your community will be... I will say is a potential partner for somebody that can help you plan and also think about how that Walmart can serve as a community center, a hub for that community and a whole host of ways.

Not to pick on Walmart, I will say that they do not know that I said that statement, but I want to give an example of an employer that is very active in areas across the country, including rural.

J NADINE GRACIA:

Thank you Dave and Stephen, that was great information about rural. And thank you, yes, we interviewed the director of disease prevention in Maine, she is particular in many rural parts of

The state. I'm going to come back to you, I know that you just talked about the question about rural communities in areas, Dave, an area in particular, you talked about trust employers.

An area in particular around emergencies is also being assured that we can have strategies in place to really address when there are false claims and rumours. Especially in times of emergency.

We see that with so many outbreaks or other types of emergencies, what strategies have you found that are most effective for being able to combat some of those false claims and not polarize audiences? Because you are really trying to reach that connection between business and public health.

STEVEN LEVINE:

I think that is a really important question and one that we have seen become more important and urgent, particularly during critical crises moments or emergency moments.

I think from our perspective, one truth is that we always turned to his that the most important defence against misinformation is the relationship that becomes, I will say comes before the message.

Counter messaging in the middle of a crisis is almost always too late. I think what we have seen on the employer side is... One effective strategy is speaking to shared values.

For example, workers and their families always want to be safe, they want to be healthy, they want to be there for the people they love.

I think that is often where we see the conversation starting. It also looks like having local, trusted voices that you're lifting up in your own communications.

Whether it is an employees doctor themselves or in local public health official that the cost-- company has built a relationship with over months or years, a respected colleague or leader of the company.

At the end of the day, I think what is important to remember is that trust travels through people you already know. Not through message.

And it looks like showing up consistently. So, the companies that I think are most prepared to combat misinformation or bad actors are the ones that are more consistently talking openly about health or these different risks, extreme weather, with their workers year round.

Certainly before any crisis actually becomes a crisis. If your people trust you before, they will listen to you during.

J NADINE GRACIA:

Thank you, trust travels through people you know, not through the message. Excellent point. I know Stella and Dave, as healthcare providers, the trust in healthcare providers, Stella, the work that the healthcare department does, working with community organizations, you can be trusted messengers and community trust travelling through people you know in times of emergency.

We are remarkably already at the end of our webinar today. And I am just going to close with a few points and address the path forward.

First, the nation's preparedness, when we talk about the nation's preparedness, it depends not only on state capacity, but also on strong and stable federal health and preparedness systems.

I saw a question in the Q and A around the role of federal funding. It is vitally important, it is an interconnected system. And we know for example, CDC, its domestic budget, 80% of that funding goes to states and local communities. Two academic partners and others.

We need sustained ordination across all levels of government and long-term investment in public health infrastructure. Because truly, the choices that we make today will determine whether the nation enters the next emergency from a position of strength or a position of vulnerability.

Second, we know that the convergence of a severe flu season, measles outbreaks, continued infectious disease outbreak that we are seeing with the virus and eat the apple

outbreak, here again, the importance having coordination globally, extreme weather and the upcoming mass gatherings, this makes this a defining moment for preparedness.

When readiness remains uneven, the consequences are not shared equally. We know that gaps in funding, access and underlying health conditions, leave some communities far more vulnerable than others. And preparedness capabilities just cannot be assembled in the middle of a crisis.

They are the foundation of our national health security and they have to be built, they have to be maintained and they have to be strengthened over time.

That means it is critical that we sustain our federal investments to support states and localities, it is important that we maintain leadership and engagement globally for our health security.

Because that is how we ensure a stronger and healthier nation. As we close, a copy of our 2026 ready or not report can be accessed by scanning the QR codes that is on your screen.

And for more information you can also reach out to my colleague Dara Lieberman, our director of government relations and her email address is on the slide.

I would like to thank our panelists for their excellent presentations, experience, and information that they shared. I would also like to thank AI-Media captioning service, Keystone interpreting, our behind the scenes staff who is helping facilitate this webinar and all of our attendees.

Thank you for joining us and you can stay connected with us. Subscribe to our suite of newsletters that we have, as well as following us on our social media channels.

The recording and the slides from today will be available on our website within the next week. And we again, thank you all for joining. Take care.