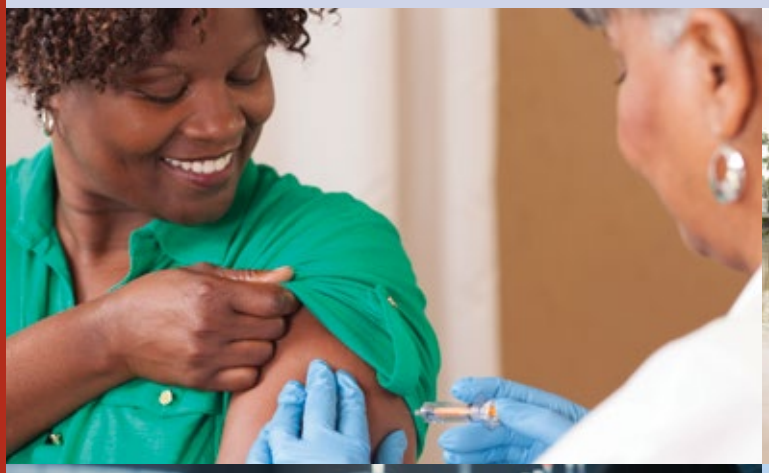
ISSUE REPORT

Ready or Not:

PROTECTING THE PUBLIC'S HEALTH FROM DISEASES, DISASTERS, AND BIOTERRORISM 2026

SPECIAL FEATURE: Preparedness at Risk: The Consequences of Federal Workforce and Funding Instability



Trust for America's Health 25 YEARS

MAY 2026

Acknowledgments

Trust for America's Health (TFAH) is a nonprofit, nonpartisan public health policy, research, and advocacy organization that promotes optimal health for every person and community and makes the prevention of illness and injury a national priority. For more information, please review *TFAH's 2023–2026 Strategic Plan* at tfah.org.

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Executive Summary

In 2025, the United States confronted a fundamental test of its public health emergency preparedness infrastructure. While states and communities continued managing routine disease surveillance, responding to natural disasters, and addressing ongoing health threats, a series of far-reaching federal funding, organizational, and policy changes—and proposed changes—created profound uncertainty about the foundation of the nation's health security enterprise.

The president's fiscal year (FY) 2026 budget proposed cutting the Centers for Disease Control and Prevention (CDC) budget by about half and restructuring components of the Administration for Strategic Preparedness and Response (ASPR), including proposed reductions to healthcare readiness programs. Congress rejected most of these proposals in the final FY 2026 appropriations. However, the U.S. Department of Health and Human Services (HHS) eliminated thousands of positions in 2025, including across CDC and ASPR. Coupled with announced terminations of more than $12 billion in pandemic-era public health grants—many of which were subsequently challenged in court—the sustainability of the nation's preparedness systems remains at risk. These systems, built and strengthened over two decades and interdependent across levels of government, require stability across time and budget cycles.

LOOKING BACK AT 25 YEARS OF PUBLIC HEALTH PREPAREDNESS

In 2026, Trust for America's Health is celebrating its 25th anniversary. This year also marks 25 years since the September 11 terrorist attacks and the subsequent anthrax incidents—tragedies that helped give rise to the modern public health preparedness system. Not long after, TFAH launched the *Ready or Not* report series as part of an effort to track the nation's progress in protecting communities from biological threats, infectious disease outbreaks, and other health emergencies, and to highlight areas where further investment and improvement are needed.

The past quarter century has brought meaningful progress. Federal, state, and local partners have worked together to strengthen surveillance systems, expand laboratory capacity, build stronger coordination between public health and healthcare systems, and improve the nation's ability to develop and deploy lifesaving medical countermeasures.

Several major policy and program milestones helped shape this progress. Congress passed the Pandemic and All-Hazards Preparedness Act in 2006 and subsequent reauthorizations, establishing the Assistant Secretary for Preparedness and Response and strengthening federal preparedness authorities. The Public Health Emergency Preparedness and Hospital Preparedness Program cooperative agreements have become the backbone of state, local, and territorial readiness. Over time, the nation built out the Public Health Emergency Medical Countermeasures Enterprise, accelerating the development and deployment of vaccines, therapeutics, and diagnostics. The United States has also engaged in sustained global cooperation to detect and address emerging infectious disease threats across borders.

These were not inevitable achievements. They reflect decades of sustained investment, bipartisan political will, and the dedicated work of policymakers and public health professionals at every level of government and in communities across the country.

As TFAH marks its 25th anniversary, the preparedness system faces new pressures. The infrastructure built over the past 25 years—the workforce, the funding streams, the institutional knowledge—requires continued commitment to sustain. The next 25 years will bring threats we cannot yet anticipate. Meeting them will depend on the foundation we protect today—including the underlying health of communities, which shapes how well populations can withstand and recover from outbreaks and disasters.

TFAH remains committed to the evidence-based policies and sustained investments that make preparedness possible—and to advocating for the public health infrastructure our communities deserve.

The convergence of these federal changes with ongoing public health challenges—including the most severe influenza season in nearly a decade, the highest number of annual measles cases since 1991, continued H5N1 avian influenza cases, and natural disasters ranging from wildfires to hurricanes—underscores a core reality: emergency preparedness capacity cannot be maintained through episodic crisis response alone. It requires sustained investment in workforce, infrastructure, data systems, and the policies, plans, and partnerships that enable rapid detection and coordinated response when threats emerge.

Ready or Not 2026: Protecting the Public's Health from Diseases, Disasters, and Bioterrorism evaluates how prepared the nation and states are to safeguard residents during health emergencies. This year's analysis examines 10 key indicators spanning healthcare workforce mobility, public health and emergency management accreditation, state public health funding, water system safety, paid sick leave access, vaccination coverage, hospital patient safety, laboratory surge capacity, and avoidable mortality. Improving performance on these measures requires sustained and coordinated efforts by federal, state, and local governments; health departments; the healthcare delivery system; and the public.

FY 2026 APPROPRIATIONS LAW REJECTS DEEP FUNDING CUTS FOR HHS AGENCIES

On February 3, 2026, President Trump signed into law a roughly $1.2 trillion spending package that ended a brief partial government shutdown and provided full-year funding for most federal agencies through September 30, 2026.[1]

For health security programs, the enacted appropriations largely rejected the administration's proposed deep reductions to federal public health agencies, including proposals that would have cut CDC funding by about half.[2] Instead, the final law provides relatively level funding for key preparedness agencies and programs, including approximately $9.2 billion for CDC and $3.7 billion for ASPR. Within ASPR, funding includes $1.1 billion for the Biomedical Advanced Research and Development Authority, $850 million for Project BioShield, and $1 billion for the Strategic National Stockpile. The budget also maintains core state and local preparedness support, including $735 million for CDC's Public Health Emergency Preparedness cooperative agreements and $307 million for ASPR's Hospital Preparedness Program.[3]

The law also did not enact proposed reorganizations of federal public health agencies, including ASPR.

However, funding stability does not quickly reverse capacity losses. In 2025, federal health agencies experienced significant workforce disruption amid broader restructuring efforts, including layoffs and partial and chaotic reinstatements at CDC. Delays, disruptions, and cancellation of funds for public health infrastructure and programs across the country undermine emergency preparedness.

The erosion of funding and expertise during 2025 has had real consequences for emergency readiness. Rebuilding a resilient public health system will require sustained, predictable investments and concerted efforts to restore staffing, expertise, and operational capacity at every level—from federal agencies to state and local health departments. Restoring funding for core health and preparedness programs is essential to reestablishing the operational continuity that effective emergency response depends on.

TABLE 1: Key Indicators of State Public Health Emergency Preparedness and Response Capacity

INDICATORS			
1	**Incident Management:** Adoption of the Nurse Licensure Compact to facilitate cross-state nursing practice.	6	**Workforce Resilience and Infection Control:** Employed population access to paid sick leave, supporting workforce health and reducing disease spread. *(Indicator modified this year — see below).*
2	**Institutional Quality:** Accreditation by the Public Health Accreditation Board, ensuring quality and accountability.	7	**Countermeasure Utilization:** Flu vaccination coverage, reflecting readiness to distribute and administer vaccines.
3	**Institutional Quality:** Accreditation by the Emergency Management Accreditation Program, demonstrating emergency response readiness.	8	**Patient Safety:** Percentage of hospitals earning an "A" grade on the Leapfrog Group's Hospital Safety Grade, indicating capacity to maintain quality care under stress.
4	**Institutional Quality (Funding):** Stability or increase in state public health funding, indicating sustained preparedness investments.	9	**Health Security Surveillance:** Laboratory surge capacity plans, promoting rapid diagnostic response.
5	**Water Security:** Population served by fully compliant community water systems, reflecting strong environmental health protections.	10	**Health Outcomes:** Avoidable mortality rates and disparities among racial/ethnic groups, illustrating underlying health inequities and system vulnerabilities.

The 10 indicators provide standardized, comparable signals of states' readiness to protect population health during emergencies. They reflect diverse dimensions of preparedness: the ability to mobilize personnel rapidly across jurisdictions, the presence of quality assurance systems and tested emergency plans, the adequacy of funding to support core functions, the resilience of critical infrastructure like water systems, workforce policies that protect against infectious-disease spread, immunization infrastructure and coverage, healthcare safety and quality under stress, laboratory capacity to sustain diagnostic surges, and underlying population health conditions that shape vulnerability during crises. Together, these indicators illuminate where states have built robust capacity and where critical gaps persist.

MODIFIED INDICATOR: ACCESS TO PAID SICK LEAVE

Beginning with this year's *Ready or Not* report, TFAH is modifying its paid sick leave indicator to better reflect workforce resilience and public health preparedness. In prior editions, the indicator measured reported use of paid time off, which captured whether workers took paid leave in a given month. That approach understated preparedness because many workers who have paid sick leave do not need to use it every month.

The revised indicator instead measures workers' access to paid sick leave, drawing on data from the U.S. Bureau of Labor Statistics' National Compensation Survey. Access to paid sick leave is a more direct and policy-relevant measure of preparedness capacity, reflecting whether workers can stay home when sick, comply with public health guidance, and support continuity of operations during emergencies.

Because nationally comparable state-level access data are not available, the indicator applies Census division-level estimates to states. This approach captures meaningful regional differences driven by labor market conditions and paid leave policies, among other factors, while using the most reliable data currently available.

A Year of Concurrent Challenges

Current and recent events demonstrate why sustained preparedness investments matter. The 2024–2025 influenza season was classified as high severity for the first time since 2017–2018, with hospitalization rates climbing to levels unseen since 2010–2011[4] and 280 pediatric deaths—the most since reporting began in 2004, excluding the 2009-10 H1N1 pandemic season.[5] Measles outbreaks surged dramatically, with 2,285 confirmed cases across 48 outbreaks in 2025—more than eight times the previous year's total and the highest annual count since 1991, predominantly affecting communities with low vaccination coverage.[6] H5N1 avian influenza surveillance continued as the virus spread across several states, with the nation's first known human death from the virus occurring in January 2025.[7]

In addition, natural disasters and extreme weather—and their effects on critical infrastructure—strained the public health and emergency response systems and put people at risk. The January 2025 Los Angeles–area wildfires caused widespread destruction and prompted multiple water utilities to declare supplies unsafe pending testing as toxic chemicals from the fires threatened water systems.[8] In late July 2025, extreme heat affected more than 130 million people nationwide, with more than 11 million people in southern Georgia and most of Florida under rare "extreme" heat warnings as heat index values exceeded 110 to 115 degrees Fahrenheit.[9] These events followed Hurricane Helene's September 2024 devastation across western North Carolina, which caused widespread infrastructure damage and left Asheville without safe drinking water for weeks after flooding overwhelmed treatment infrastructure with sediment.[10] Such incidents illustrate how extreme weather and wildfire events can trigger cascading infrastructure failures that demand coordinated emergency responses sustained over weeks or months.

These concurrent challenges occurred as state and local health departments navigated profound federal funding uncertainty. In late March 2025, HHS announced it would pull back about $11.4 billion in CDC-administered COVID-era funding and about $1 billion in Substance Abuse and Mental Health Services Administration (SAMHSA) grants and began issuing termination notices to grantees. The largest component—about $8.9 billion through CDC's Epidemiology and Laboratory Capacity program—supported disease surveillance, laboratory operations, and core functions that underpin routine public health work and emergency responses alike. While court orders blocked these terminations for plaintiff states and the District of Columbia,[11] the litigation remained unresolved through year's end, creating ongoing uncertainty for preparedness planning.

This year's special feature examines how recent and proposed changes to federal public health and emergency preparedness policy and investment have diminished, and could continue to diminish, the national and state-level capacity and infrastructure necessary to protect the nation's health and economic security.

The special feature highlights perspectives from Dr. Puthiery Va, Director of the Maine Center for Disease Control and Prevention, on managing preparedness amid federal policy shifts and funding uncertainty. Dr. Va emphasized in an interview with TFAH that preparedness requires building a "culture of preparedness across all of our teams," weaving readiness into everyday public health operations. She highlighted the importance of a unified data environment that allows critical information to reach patients, hospitals, response teams, and other key partners quickly.

Regarding federal policy changes, Dr. Va noted that "uncertainty about funding and the anxiety that creates for my teams are my biggest concern. Uncertain funding makes it difficult to plan and difficult to ensure a preparedness posture." She cited the temporary COVID funding clawbacks as an example of instability that impacted programs and created lingering uncertainty about future funding. She stressed the value of flexible, disease-agnostic funding like the Public Health Infrastructure Grant.

Despite federal uncertainties, Dr. Va pointed to Maine's strengths: strong state leadership supporting preparedness, robust partnerships with emergency management and healthcare systems, and regional collaboration through the Northeast Public Health Collaborative.

Key Findings Across 10 Indicators

Healthcare Workforce Mobility (Indicator 1): As of February 2026, 41 states had adopted the Nurse Licensure Compact (NLC), marking the framework's transition from emerging policy to established preparedness infrastructure. Pennsylvania and Connecticut achieved full implementation in 2025, and Massachusetts enacted the compact in November 2024 with implementation underway. The NLC's broad adoption—spanning diverse political and geographic contexts—reflects widespread recognition that interstate nurse mobility supports emergency response. The NLC facilitates interstate nurse mobility, which can support surge staffing during emergencies (e.g., large disasters and pandemics). However, gaps remain significant: California, New York, Illinois, Michigan, and other large population centers outside the compact represent substantial potential sources of nursing personnel who could surge to other jurisdictions if needed but face additional licensure steps to do so.

Public Health and Emergency Management Accreditation (Indicators 2 & 3): As of January 2026, 44 states and the District of Columbia hold accreditation from the Public Health Accreditation Board (PHAB) and/or the Emergency Management Accreditation Program (EMAP), demonstrating institutional commitment to meeting nationally recognized preparedness standards. Twenty-seven states plus the District of Columbia maintain dual accreditation, 12 states hold PHAB accreditation only, and five states hold EMAP accreditation only. Six states—Hawaii, New Hampshire, South Dakota, Texas, West Virginia, and Wyoming—lack accreditation from either program. Survey evidence shows that accredited health departments reported stronger emergency response planning, cross-sector partnerships, and organizational capabilities during the COVID-19 response. Broad funding and workforce pressures make the institutional quality that accreditation represents even more critical for maintaining preparedness in resource-constrained environments.

State Public Health Funding (Indicator 4): A majority of states maintained or increased their public health funding in FY 2025, but at least 12 states reduced funding amid an extraordinary period of federal disruption. The convergence of COVID-era funding terminations (approximately $12.4 billion across CDC and SAMHSA programs), proposed FY 2026 budget cuts of about 50 percent for CDC, and federal workforce reductions created a challenging environment for state investment decisions. The pandemic funding cliff—as emergency supplemental resources expired or were terminated—highlighted the critical role of federal public health funding and underscored the importance of sustained state investment. Federal funding constitutes a significant portion of state and local public health budgets. In an environment of uncertain federal support, state funding trends become increasingly critical determinants of whether jurisdictions can maintain core preparedness capacity or face growing constraints in workforce stability, surveillance systems, and emergency planning.

Community Water System Safety (Indicator 5): In 2024, an average of 6 percent of residents in each state were served by a community water system with at least one health-based violation recorded during the year. Water systems face converging threats: extreme weather, aging infrastructure requiring lead service line replacement,

emerging contaminants like per- and polyfluoroalkyl substances (PFAS) with evolving regulatory standards, and escalating cybersecurity risks. An Environmental Protection Agency (EPA) assessment found that 97 water systems serving 26.6 million people had critical cybersecurity vulnerabilities, and the sector faces heightened cyber risk, including from nation-state and criminal actors. States maintaining high compliance demonstrate organizational capacity to manage complex regulatory requirements, invest in infrastructure resilience, and respond effectively to contamination events—precisely the capabilities needed when disasters compromise water systems. The indicator also reveals persistent inequities: violations concentrate disproportionately in smaller, rural, and socioeconomically disadvantaged communities, meaning preparedness capacity remains unevenly distributed across populations.

Access to Paid Sick Leave (Indicator 6): Access to paid sick leave varies substantially across U.S. regions, from 98 percent of workers in Pacific states to 67 percent in East South Central states, with approximately 82 percent of civilian workers having access nationally. This year's indicator shifts from measuring usage to measuring access—the formal ability to stay home when ill rather than only observing who happened to take paid time off during a measurement period. Seventeen states plus the District of Columbia had enacted paid sick leave laws as of September 2025, with Alaska, Missouri, and Nebraska voters approving new standards through 2024 ballot initiatives. Research consistently shows that paid sick leave reduces disease transmission, with state laws decreasing influenza-like illness and the temporary federal emergency paid sick leave during COVID-19 associated with fewer confirmed cases. The business community increasingly recognizes paid sick leave as pandemic preparedness infrastructure, with the Health Action Alliance identifying it as foundational to keeping infectious diseases from spreading in workplaces.[12] However, persistent disparities concentrate access gaps among low-wage workers (61 percent access), part-time employees (56 percent), and service occupations (68 percent)—exactly the populations most likely to face economic pressure to work while ill during outbreaks.

Seasonal Influenza Vaccination (Indicator 7): During the 2024–2025 influenza season, an estimated 44 percent of U.S. residents ages 6 months and older were vaccinated against flu, continuing a multiyear decline from pre-COVID-19 pandemic levels and falling well short of the 70 percent Healthy People 2030 target. This occurred during the most severe flu season in nearly a decade, with cumulative hospitalization rates reaching 127.1 per 100,000—the highest since 2010–2011—and 280 pediatric deaths, the most in any non-pandemic season since reporting began in 2004. In January 2026, federal officials moved influenza vaccine from universal recommendation to "shared clinical decision-making" for children and made other revisions to the childhood immunization schedule, reducing the number of routinely recommended vaccines. However, a federal court in Massachusetts granted preliminary relief in March 2026, blocking implementation of these changes after finding they were likely made in violation of federal law by bypassing required scientific review processes. The seasonal flu vaccination infrastructure—distribution systems, provider networks, immunization information systems, and communication campaigns—strengthens

the foundation for pandemic response. Higher seasonal coverage reflects stronger access, delivery channels, and public acceptance of vaccination—factors directly relevant to states' readiness for respiratory disease emergencies.

Hospital Patient Safety (Indicator 8): In fall 2025, 27 percent of graded hospitals earned an "A" grade from the Leapfrog Hospital Safety Grade, unchanged from fall 2024 but with wide state variation—from over half of hospitals in New Jersey, Utah, and Virginia achieving top ratings to zero "A" grades in Iowa, North Dakota, Vermont, and Wyoming. The COVID-19 pandemic demonstrated that periods of severe hospital strain were associated with delayed care, disrupted clinical processes, and increased mortality, highlighting how foundational patient safety capabilities—infection prevention, standardized protocols, reliable information systems, strong safety culture—support hospitals' ability to maintain care quality under crisis conditions. Hospitals with stronger safety performance may be better positioned to safely manage surge capacity during emergencies while minimizing preventable harm.

Laboratory Surge Capacity (Indicator 9): In 2025, 49 states and the District of Columbia reported having written plans to handle six- to eight-week surges in laboratory testing capacity, while one state (Utah) reported lacking such a plan. The year tested public health laboratories extensively: measles outbreaks required confirmatory testing across 48 separate outbreaks, a tuberculosis outbreak in Kansas City, Kansas required a response, sustained H5N1 surveillance occurred nationally, and the severe influenza season demanded continuous virologic monitoring. These concurrent demands occurred as jurisdictions navigated federal funding terminations that affected more than $8.9 billion in Epidemiology and Laboratory Capacity program support, which states use for laboratory staffing, testing operations, and surveillance infrastructure. Written surge plans indicate that states have formally documented procedures and coordination mechanisms for expanding laboratory operations during elevated demand.

Avoidable Mortality (Indicator 10): Avoidable mortality declined nationally to 278 per 100,000 in 2022–2023, yet substantial state variation and pronounced racial and ethnic disparities persist. Massachusetts (201), New Jersey (203), and Utah (208) achieved the lowest rates of avoidable deaths, while West Virginia (445), Mississippi (430), and Oklahoma (410) experienced the highest. Black Americans and American Indian/Alaska Native populations face the highest avoidable mortality rates in the vast majority of states. The magnitude of racial and ethnic disparities varies dramatically by state, with South Dakota exhibiting the largest gap at 931 per 100,000—the difference between the state's highest- and lowest-rate racial/ethnic groups. Notably, low overall mortality does not equate to equity: Minnesota ranks fourth lowest nationally yet shows the second-largest racial disparity. The COVID-19 pandemic illustrated how communities with higher baseline avoidable mortality experienced disproportionate pandemic impacts, with the same populations facing elevated avoidable mortality under routine conditions suffering substantially higher age-adjusted COVID-19 mortality. Reducing premature, preventable deaths through effective public health measures and accessible, high-quality healthcare strengthens baseline population health—a foundation for community resilience when emergencies strike.

State Performance Tiers

The *Ready or Not* report groups states and the District of Columbia into three performance tiers based on their relative performance across the 10 indicators.

High-Performance Tier: Twenty states achieved high-tier scores, demonstrating consistent strength across multiple indicators. These states typically show strong institutional quality through public health and emergency management accreditation, widespread adoption of the Nurse Licensure Compact, and stable or increased public health funding. Many also demonstrate robust water system safety, strong hospital patient safety performance, and laboratory surge capacity planning. However, even states placed in the high tier show room for improvement in areas such as seasonal influenza vaccination coverage and reducing avoidable mortality disparities, underscoring that preparedness remains an ongoing effort requiring sustained attention across all domains.

Middle-Performance Tier: Seventeen states and the District of Columbia placed in the middle tier, with moderate results and clear opportunities for improvement. These jurisdictions typically show mixed performance, with strength in some domains—such as accreditation or water system safety—offset by gaps in others, including public health funding stability, paid sick leave access, or vaccination coverage. The varied patterns within this tier suggest that targeted investments in specific preparedness functions could yield meaningful gains in overall readiness.

Low-Performance Tier: Thirteen states placed in the low tier, underscoring ongoing challenges warranting targeted interventions and sustained investment. These states face multiple concurrent challenges, including gaps in institutional accreditation, constraints in public health funding, and elevated avoidable mortality rates. Many also show lower performance in hospital patient safety, vaccination coverage, and workforce policies supporting infection control. Addressing these interconnected vulnerabilities will require comprehensive approaches spanning policy, funding, infrastructure, and partnerships across sectors.

TABLE 2: State Public Health Emergency Preparedness
State performance, by scoring tier, 2025

Performance Tier	States	Number of States
High Tier	CA, CO, CT, DE, FL, IL, KS, MA, MD, ME, MT, NC, NH, NJ, PA, RI, UT, VA, VT, WI	20 states
Middle Tier	AR, AZ, DC, GA, HI, ID, IN, LA, MO, ND, NE, NV, NY, OH, OR, SC, TN, WA	17 states and DC
Low Tier	AL, AK, IA, KY, MI, MN, MS, NM, OK, SD, TX, WV, WY	13 states

Note: See "Appendix B: Methodology" for scoring details. Complete data were not available for U.S. territories.

Analysis of Tier Stability and Movement

A majority of states maintained their tier placement from the 2025 edition of this report. However, movement occurred among several states.

Montana achieved the most notable gain, advancing from the low tier to the high tier—the only jurisdiction to move two tiers. Montana's advancement was driven by an increase in its public health funding level and by gaining EMAP accreditation during the measurement period, joining the states with dual PHAB and EMAP accreditation. Seven additional states moved up one tier: California, Hawaii, Illinois, Kansas, Louisiana, Nevada, and Oregon.

Ten states and the District of Columbia moved down one tier: Alabama, DC, Georgia, Idaho, Iowa, Kentucky, Missouri, Ohio, Oklahoma, Texas, and Washington.

The stability of many states suggests that tier placement reflects durable patterns of preparedness capacity, but movement among others demonstrates that these patterns are not fixed—policy decisions, institutional investments, and attention to multiple preparedness domains can shift a state's relative position within a single measurement cycle.

See "Appendix B: Methodology" for complete scoring details.

Recommendations for Strengthening Preparedness

Based on data analysis, expert consultation, and lessons from recent emergencies, TFAH offers policy recommendations across seven priority areas.

1. Provide Stable, Flexible, and Sufficient Funding for Health Security.

- An estimated 80 percent of CDC's domestic budget goes to external partners, underpinning preparedness for health threats across the country.[13] TFAH recommends increasing overall CDC funding to at least $11.58 billion annually, expanding Public Health Emergency Preparedness funds to $1 billion, sustaining CDC's Public Health Infrastructure Grant program at a minimum of $1 billion annually, investing in modernized disease detection and data systems, and increasing ASPR's base budget.
- Strategies to recruit, train, and retain the public health workforce must be expanded at all levels of government.

2. Ensure Effective Leadership and Coordination.

- The federal health workforce and any capabilities eliminated in 2025 should be restored.
- Congress should reauthorize the Pandemic and All-Hazards Preparedness Act, providing the statutory framework for health emergency preparedness.
- The White House should ensure coordination through pandemic preparedness leadership.
- The administration should protect the scientific integrity of public health agencies, ensure timely demographic data-collection, reject laws weakening public health authorities, demonstrate a sustainable commitment to global health security, and invest in effective public health communications.

3. Prevent and Respond to Outbreaks and Pandemics.

- Outbreak readiness requires coordinated policy efforts across multiple domains. Congress should support funding and workforce for CDC's National Immunization Programs, enact legislation ensuring vaccine access for uninsured and underinsured adults, and support policies that enable universal childhood vaccinations.
- Congress should conduct oversight of changes to federal immunization schedules.
- Continued investment in disease detection—including wastewater surveillance, genomic sequencing, and outbreak forecasting—remains critical.
- Significant steps to address antimicrobial resistance are imperative, including new financing mechanisms for novel antimicrobials and increased support for CDC's Antimicrobial Resistance Solutions Initiative.
- Congress should create a national standard for job-protected paid sick, family, and medical leave.

4. Build Healthy and Resilient Communities to Strengthen Preparedness.

- Agencies must plan with communities rather than for them, providing resources to community-based organizations and coordination support for cross-sector efforts.
- Congress and the Centers for Medicare & Medicaid Services should invest in addressing nonmedical drivers of health, which affects those who are most vulnerable during disasters.
- All levels of government should adopt strategies incorporating community resilience and health equity into preparedness planning.
- HHS should reactivate advisory committees on children, individuals with disabilities, and seniors in disasters.
- Jurisdictions must address mental health and substance use gaps and incorporate behavioral health into disaster response.

5. Accelerate Development and Distribution of Medical Countermeasures.

- Congress should invest in medical countermeasures (MCM) research, development, stockpiling, and distribution for known and unknown threats.
- ASPR should lead coordinated, transparent MCM activities across HHS and with partners.
- HHS and its state, local, tribal, and territorial partners should improve MCM guidance, communication, and dispensing for groups at higher risk, engaging communities before events to ensure understanding and acceptance.

6. Ready the Healthcare System to Respond and Recover.

- Congress should increase investment in ASPR's Health Care Readiness programs, including the Hospital Preparedness Program, Regional Disaster Health Response System, and National Special Pathogen System.

- ASPR should strengthen program requirements to include crisis standards-of-care planning and pediatric readiness.
- States should adopt policies enabling cross-state provider credentialing and healthcare surge, including interstate compacts and emergency prescription refill protocols.
- Congress and states should expand health insurance access and affordability.

7. Prepare for Environmental Threats and Extreme Weather.

- Congress should support CDC's National Center for Environmental Health, expand the Agency for Toxic Substances and Disease Registry's emergency response capacity, and extend CDC's Environmental Public Health Tracking Program to every state.
- The administration should support interagency efforts addressing extreme heat through initiatives like the National Integrated Heat Health Information System.
- Federal and local authorities should establish indoor and outdoor air-quality standards.
- The administration should protect the Clean Water Rule and fund CDC's Safe Water Program.
- Every state should develop comprehensive climate vulnerability assessments and adaptation plans using CDC's Building Resilience Against Climate Effects framework.

The Path Forward

The convergence of active public health threats with unprecedented federal policy uncertainty creates a defining moment for the nation's preparedness architecture. The concurrent challenges of 2025—severe influenza, large measles outbreaks, continued avian influenza surveillance, and climate-driven disasters—demonstrated precisely why sustained preparedness investments matter: detection systems, laboratory capacity, trained workforce, and coordination mechanisms cannot be effectively assembled during crises.

Some preparedness capabilities, such as cross-jurisdictional disease surveillance, national laboratory networks, MCM development, and surge support during multistate emergencies, depend fundamentally on federal leadership and cannot be fully replicated through state or local action alone. Moreover, many of these functions are most efficiently and appropriately executed at the federal level: coordinating surveillance across jurisdictions avoids duplication and ensures interoperability, economies of scale in MCM development and procurement reduce costs, and centralized expertise and surge capacity can be deployed where needed rather than requiring every jurisdiction to maintain redundant capabilities. Federal withdrawal and disinvestment from public health shift responsibilities and risks to states, localities, healthcare systems, and private sectors—many of which face their own resource constraints and competing priorities.

Yet opportunity exists within challenges. States demonstrating strong performance across multiple indicators prove that preparedness capacity can be built and sustained even in difficult environments. The wide variation in state performance reveals that policy choices matter: states with greater and more consistent investment in public health infrastructure, higher institutional quality, and explicit attention to equity are associated with better health outcomes under routine conditions and stronger response capacity during emergencies.

Equity remains central to meaningful preparedness. Persistent disparities in avoidable mortality, water system safety, paid sick leave access, and other indicators mean that emergencies will continue to disproportionately impact certain states and communities unless underlying vulnerabilities are addressed.

The nation's ability to detect the next outbreak, respond to the next major hurricane, ensure safe water after the next wildfire, mobilize healthcare workers during the next surge, and protect the most vulnerable populations during the next crisis depends on choices made today. Sustaining and improving the preparedness infrastructure built over decades, maintaining and growing a skilled public health workforce to implement these systems, and ensuring that federal, state, and local partnerships function effectively will determine whether the United States enters the next emergency from a position of strength or vulnerability.

SPECIAL FEATURE:

Preparedness at Risk: The Consequences of Federal Workforce and Funding Instability

An effective and well-resourced public health system is foundational to the nation's ability to prepare for health emergencies, promote good health among all population groups, control healthcare spending, and support a strong economy. However, 2025 brought significant changes to federal agency operations with lasting implications for national health security and community-level preparedness.

These changes carry profound economic and national security consequences. A weakened public health infrastructure increases the nation's vulnerability to both natural and biological threats while driving up healthcare costs and reducing workforce productivity. Past emergencies have demonstrated that robust preparedness capabilities save lives and money, and that investments in pandemic preparedness yield economic benefits by preventing disease spread, maintaining business continuity, and avoiding the economic losses seen during inadequately controlled outbreaks.

Government agencies at all levels play a critical role in the nation's interconnected public health system—from tracking disease and environmental threats to supporting emergency preparedness and disaster response. The federal government has a particularly important role in funding, coordinating, and sustaining a strong national public health infrastructure. Since early 2025, however, funding instability, staff reductions, and proposed program eliminations have weakened the interconnected federal, state, and local public health system.

Federal agencies play key roles in protecting Americans' health from environmental and disease threats. These include the Centers for Disease Control and Prevention (CDC), the Food and Drug Administration (FDA), the Administration for Strategic Preparedness and Response (ASPR), the Federal Emergency Management Agency (FEMA), the Environmental Protection Agency (EPA), and the National Oceanic and Atmospheric Administration (NOAA). The U.S. Agency for International Development (USAID), prior to its dissolution and the transfer of its remaining functions to the U.S. Department of State, supported global health programs aimed at preventing and responding to infectious-disease threats abroad—efforts that historically contributed to U.S. health security by reducing the risk of cross-border outbreaks. During 2025, key elements of the federal public health infrastructure—particularly CDC—experienced substantial disruption due to changes in federal priorities, workforce reductions, and proposed shifts in funding for disease prevention, surveillance, and emergency preparedness and response.

CDC has been a pivotal leader in national and global public health since its creation in 1946, providing scientific expertise, data, and on-the-ground assistance throughout the United States and worldwide. Approximately 80 percent of CDC's domestic budget has historically flowed to states, localities, tribes, tribal organizations, healthcare systems, and other community partners to support health-promotion and disease-prevention programs.[14] Cuts to these programs will have direct impacts on Americans' health by reducing or eliminating initiatives that ensure food and water safety, prevent chronic disease, and protect people from environmental threats such as lead poisoning and exposure to toxins. Significant staffing losses at CDC in 2025, combined with proposed reductions and restructuring of federal public health programs, threaten the agency's ability to carry out its mission and are producing cascading effects on community-based public health programs nationwide.[15]

Proposed cuts and potential structural changes to FEMA also raise serious concerns about the nation's capacity to prepare for and respond to disasters. The agency has experienced substantial staffing reductions, alongside proposed or enacted changes affecting disaster response programs, including long-term housing assistance and community recovery. Planning documents from the Trump Administration proposed reducing the FEMA workforce by roughly half and shifting greater responsibility for disaster response from the federal government to states.[16]

Beyond workforce cuts, operational changes have created significant delays in disaster assistance. As of January 2026, approximately $17 billion in federal disaster funds reportedly awaited approval due to additional review requirements imposed by the U.S. Department of Homeland Security.[17] The backlog included funding already approved by regional FEMA offices for debris removal and

repairs to roads, bridges, and water and sewer systems—work that in some cases state and local governments had already completed at their own expense. Some outstanding aid dates to Hurricanes Harvey and Maria in 2017. These delays impose real economic costs on disaster-affected communities and slow the recovery process.

States were also waiting for more than $1.3 billion in mitigation grants—funding designed to reduce future disaster risks through projects such as flood risk reduction, elevation or demolition of flood-prone buildings, emergency generators, and tornado-resistant safe rooms. As of early 2026, the administration had not approved mitigation grants for any major disasters declared since March 2025.[18] Preparedness investments of this kind generate substantial returns; delays in both recovery funding and mitigation grants compound economic losses and leave communities more vulnerable to subsequent disasters.

A September 2025 report from the U.S. Government Accountability Office found that recent disasters—including Hurricanes Helene and Milton and the Los Angeles wildfires—highlighted challenges facing the federal disaster response workforce, particularly when concurrent disasters outpace agencies' budgetary and staffing resources, and that further staff reductions would exacerbate those challenges.[19] Research from the Carnegie Endowment for International Peace found that some states would be more severely affected than others if FEMA were further reduced or eliminated—particularly states that experience more natural disasters and those with higher concentrations of residents who have relied on direct federal disaster assistance.[20] From 2015 through April 2024, residents of Florida, Louisiana, and Texas received the most FEMA direct individual assistance payments of any states—and these same states had the most pending mitigation grants as of early 2026.[21,22]

THE PANDEMIC AND ALL-HAZARDS PREPAREDNESS ACT

The Pandemic and All-Hazards Preparedness Act (PAHPA), first enacted in 2006, provides the policy and programmatic foundation for the nation's health security enterprise. Now marking its 20th anniversary, the law's core provisions remain as relevant as ever: authorizing public health emergency medical countermeasures; defining the roles and authorities of the Assistant Secretary for Preparedness and Response; establishing advisory committees to address the needs of populations at higher risk during emergencies; and authorizing the Hospital Preparedness Program and Public Health Emergency Preparedness cooperative agreements. The legislation has been reauthorized periodically, with the most recent comprehensive reauthorization completed in 2019. While Congress has extended most expiring provisions through December 2026, a full reauthorization remains incomplete—leaving the policy foundation of the nation's health security enterprise without long-term certainty at a critical moment.

TFAH urges Congress to mark PAHPA's 20th anniversary by passing a bipartisan reauthorization that meets the nation's health security needs.

Federal Funding Cuts and Instability Impact State and Local Public Health

Federal funding accounts for a significant share of state and local health department budgets.[23] Funding instability, grant terminations, and the expiration of COVID-19 response funding have made tracking and containing infectious disease outbreaks more difficult and are putting Americans' health at risk.[24,25,26,27] Reductions in federal funding cascade to the state and local level, constraining resources for core public health activities such as health promotion, disease surveillance, and laboratory and response capacity.

In March 2025, HHS announced the termination of more than $12 billion in COVID-19-era grants—funding that, in addition to supporting the pandemic response, was intended to strengthen public health infrastructure more broadly, including infectious-disease monitoring, laboratory capacity, emergency preparedness, and mental health services.[28] While court orders blocked the grant terminations for plaintiff states and the District of Columbia,[29] litigation remained unresolved through year's end, creating ongoing uncertainty for preparedness planning. CDC and other agencies also experienced delays in receiving their full appropriations, which prevented timely awards to health departments and other partners.[30] When funding availability is unclear, state and local health agencies face difficult decisions about workforce retention and program continuity.

> "Uncertainty about funding and the anxiety that creates for my teams are my biggest concern. Uncertain funding makes it difficult to plan and difficult to ensure a preparedness posture."
>
> **Dr. Puthiery Va**
> Director of Maine's Center for Disease Control and Prevention

State and local health departments rely not only on federal dollars but on federal expertise. The loss of thousands of federal public health and emergency management staff erodes institutional knowledge and specialized expertise that states cannot readily replace. No state has the resources to replicate what the federal government has historically provided to support local disaster preparedness and recovery.[31]

STATES FORMING PUBLIC HEALTH COLLABORATIVES

During 2025, numerous states joined together to form public health collaboratives to support information exchange, cooperation, and resource-sharing.[32] Announced collaboratives include:

- West Coast Health Alliance (California, Hawaii, Oregon, and Washington).[33]
- Northeast Public Health Collaborative (Connecticut, Delaware, Maine, Maryland, Massachusetts, New Jersey, New York State and New York City,[34] Pennsylvania, Rhode Island, and Vermont[35]).
- Governors Public Health Alliance (Governors Bob Ferguson (WA), Josh Green (HI), Maura Healey (MA), Kathy Hochul (NY), Tina Kotek (OR), Ned Lamont (CT), Lou Leon Guerrero (GU), Dan McKee (RI), Matt Meyer (DE), Wes Moore (MD), Phil Murphy (NJ), Gavin Newsom (CA), Jared Polis (CO), JB Pritzker (IL), and Josh Stein (NC)).[36]

At least four states—California, Hawaii, Oregon, and Washington—have announced plans to coordinate vaccine recommendations.[37]

While these collaboratives may promote greater policy alignment and regional coordination, their scope and resources differ substantially from those of federal agencies. They do not replace the nationwide surveillance, funding mechanisms, and emergency authorities historically provided at the federal level.

Curtailed Investment in Health Research and Innovation

Investment in research that leads to new and better ways to protect health and fight disease has also been significantly curtailed. Public-private partnerships are a cornerstone of countermeasure development for national security threats. In August 2025, the administration announced the cancellation of nearly $500 million in contracts funding mRNA vaccine research and development[38]—technology that was pivotal in the development of several COVID-19 vaccines. The cancellation of existing contracts, combined with the logistical challenges of restructuring the nation's medical countermeasure enterprise as proposed by the Trump Administration, could disrupt the research, development, and deployment of countermeasures needed for the next public health emergency.

INFANT LIVES PROTECTED: A PUBLIC HEALTH SUCCESS STORY

As of March 2026, a total of 48 infants with suspected or confirmed infant botulism had been reported across 17 states as part of a multistate outbreak linked to ByHeart infant formula.[39] All affected infants required hospitalization but were successfully treated.[40] The Infant Botulism Treatment and Prevention Program—operated by the California Department of Public Health—identified a concerning increase in cases, including among infants who had reportedly consumed ByHeart infant formula, and alerted CDC.[41] FDA and CDC, in collaboration with California and other state and local partners, conducted a multistate investigation.[42] Epidemiologists quickly identified the common exposure, and state and federal laboratories began testing product samples. As evidence of a connection between the formula and the botulism cases grew, the manufacturer recalled the product and retailers began removing it from shelves—though, according to FDA, those removals should have happened more quickly in some cases.[43] CDC, FDA, and news media also advised parents on steps to protect their children's health.[44]

This response demonstrates the value of a strong public health system: the essential role of federal health agencies, coordinated surveillance, standing laboratory capacity, and cross-jurisdictional collaboration.

Reduction of the Federal Workforce Diminishes Support for Health Security Programs

The elimination of thousands of federal health and emergency management positions has reduced specialized expertise and institutional knowledge that took years to build. CDC lost approximately one quarter of its civilian workforce between FY 2024 and FY 2026,[45] including significant losses across global health, health promotion, public health infrastructure, scientific research, and communications—entities critical to national health security.[46] In some cases, the experts and laboratories affected by these reductions represent unique national capabilities with no ready replacement elsewhere in the public or private sector.

As demonstrated during numerous health emergencies, an effective response requires collaboration and expertise from across CDC. Experts in birth defects, vector-borne diseases, and maternal health worked together to protect Americans from the Zika virus. Chronic disease experts were integral to the COVID-19 response, and environmental health experts supported the response to the East Palestine, Ohio, train derailment. Public health emergencies routinely require a coordinated, cross-agency response—a capacity that depends on a robust and experienced federal workforce.

The elimination of the Office of Climate Change and Health Equity (OCCHE) within HHS[47] weakened federal operational capacity at a time of growing climate-related health risks. Established to coordinate climate and health work across HHS, OCCHE served as a focal point for strategy, interagency alignment, and technical expertise on issues such as extreme heat, air quality, and health equity. While modestly resourced, the office helped integrate climate considerations into existing public health programs and supported coordination with other federal agencies. Its closure has reduced HHS's ability to align efforts internally and provide coherent guidance to states and localities—limiting national capacity to address climate-related health risks, including extreme heat, air quality, and other environmental threats—in a consistent and coordinated way

Global Health Security Collaboration

Given that infectious diseases cross borders easily, global coordination and sustained relationships are critical to U.S. health security. In 2025, the Trump Administration eliminated support for numerous global health capabilities and partnerships. The United States announced its intent to withdraw from the World Health Organization (WHO) in January 2025 and formally completed its withdrawal in January 2026.[48] This move carries significant consequences for health security, including reduced U.S. access to global data sources that support outbreak tracking and response. In response, several U.S. states—including California, Colorado, Illinois, New York, and Wisconsin—as well as New York City, announced plans to join the WHO Global Outbreak Alert and Response Network,[49,50,51] with governors citing improved situational awareness of public health threats as a key benefit.

In 2025, the administration dissolved much of USAID and transferred its remaining functions to the U.S. Department of State. USAID has historically helped low-income nations address HIV, tuberculosis, malaria, and emerging infectious diseases such as Ebola and Marburg. The administration also reduced U.S. funding to Gavi, the Vaccine Alliance, which supports vaccination of children in low-income countries. In June 2025, HHS announced that the United States would withdraw its financial support for Gavi and would not fulfill a $1.2 billion pledge made by the Biden Administration, citing concerns about Gavi's approach to vaccine safety.[52] CDC's global health programs experienced staffing reductions as part of broader agency cuts,[53] and the FY 2026 budget proposed further reductions to CDC's global health work[54]—many of which were not adopted in the final spending legislation.[55] Disinvestment in global health, withdrawal from multilateral agreements, and the loss of federal expertise collectively put U.S. health security at greater risk. Poorly controlled outbreaks abroad significantly increase the likelihood of global pandemics, with major consequences for lives and livelihoods—including business disruptions, job loss, and increased federal emergency spending.[56,57]

Surveillance and Data Systems

The past year saw reduced federal health data-sharing, loss of federal expertise, and staffing disruptions that have impaired disease detection and surveillance. Proposed elimination of CDC programs responsible for chronic disease and injury surveillance and data analysis would further affect the nation's ability to detect emerging health threats and track progress toward national health goals.

Healthcare Access and Prevention Programs

Healthcare access is critical to emergency readiness: it improves people's underlying health and helps ensure continuity of care during disasters. According to data released by HHS in late January 2026, there were approximately 1.2 million fewer Affordable Care Act (ACA) marketplace plan selections for the 2026 coverage year compared with the same period in January 2025—a decline analysts have linked to rising premiums following the expiration of enhanced premium tax credits.[58]

Recent federal changes to Medicaid eligibility and enrollment policies are projected to affect both individual access to healthcare and the broader healthcare system's capacity to serve patients. The July 2025 federal budget reconciliation law (Public Law 119-21) includes new work and reporting requirements, additional eligibility verification procedures, and cost-sharing requirements for certain expansion enrollees.

Independent analyses—including Congressional Budget Office (CBO) estimates—project that these provisions will reduce Medicaid and ACA marketplace coverage relative to prior law.[59] CBO estimated that changes to Medicaid eligibility and ACA marketplace tax credits will result in roughly 15 million fewer people with health coverage by 2034.[60] These losses could also lead to contractions in healthcare capacity, particularly in rural communities where access is already limited.[61]

The Health Resources and Services Administration (HRSA), which supports community-level health services in otherwise underserved communities, lost approximately one quarter of its workforce due to staffing cuts and departures as of August 2025.[62] HRSA supports workforce development programs that train healthcare professionals for underserved areas and funds Federally Qualified Health Centers, which provide primary care in medically underserved communities.

Federal prevention programs addressing chronic diseases, substance misuse, and tobacco control also faced significant cuts in 2025. These programs reach millions of Americans each year. Changes to program structure and funding levels would affect ongoing efforts to address conditions such as diabetes, heart disease, and addiction—particularly in communities that have benefited from programs designed to reduce health disparities. The loss of federal staff leading these health-promoting programs has already weakened the nation's efforts to reduce chronic conditions.

These policy changes carry consequences that extend well beyond immediate budget cycles:

- **Increased Healthcare Costs:** Prevention programs reduce healthcare expenditures by addressing conditions before they require expensive treatment.[63] Eliminating these programs—or reducing access to preventive care through insurance coverage losses—would increase overall healthcare spending.[64]
- **Economic Impact:** Poor health outcomes and disability reduce workforce productivity.[65] Eliminating programs that keep Americans healthy carries negative economic consequences for businesses, communities, and the broader economy.
- **Reduced Life Expectancy:** The United States already lags behind other high-income nations in life expectancy.[66] Eliminating programs that address leading causes of death would worsen this trend.

Economic and National Security Implications

Public health preparedness is not only a health imperative—it is an economic and national security necessity. When outbreaks spread unchecked or disasters overwhelm response systems, the consequences extend far beyond the healthcare sector. The COVID-19 pandemic demonstrated how infectious disease can disrupt supply chains, close businesses, reduce workforce participation, and trigger trillions of dollars in federal emergency spending. Similarly, severe weather events and wildfires impose billions of dollars in annual recovery costs, strain insurance markets, and disrupt regional economies.

Reduced federal capacity for surveillance, laboratory testing, disaster coordination, and medical countermeasure development increases the risk that future emergencies will be detected later, spread further, and cost more to contain. Disinvestment in preparedness therefore carries fiscal consequences for federal and state governments, operational consequences for businesses, and strategic consequences for national security. A resilient public health infrastructure supports both economic and health security—reducing the likelihood that manageable crises escalate into national emergencies.

Implementation and Transition

Although Congress did not adopt the full scope of the president's proposed reductions in public health spending for FY 2026, significant challenges to the nation's public health capacity remain. These include how federal agencies will rebuild expertise following reductions in force, as well as ongoing questions about the timing and predictability of federal funding for public health programs. It also remains uncertain whether the administration will pursue further restructuring efforts requiring congressional action. Some impacts may be felt immediately, while others could unfold over months or years as existing grant periods expire and programs transition or wind down. These ongoing changes in workforce, policy direction, and funding stability complicate efforts to sustain readiness for public health emergencies. Policymakers should carefully weigh these operational and long-term implications as they evaluate next steps.

Adapted from TFAH's *Public Health Infrastructure in Crisis* report (2025). Read the full report at tfah.org.

Note: The President's Fiscal Year 2027 Budget Request was released on April 3, 2026, after this report was substantially complete. The proposed budget includes a $15.8 billion reduction in HHS discretionary funding—a 12.5 percent decrease from FY 2026 enacted levels—and proposes significant cuts to CDC. Of particular concern for preparedness, the proposed budget would eliminate the Hospital Preparedness Program and cut the Public Health Emergency Preparedness Cooperative Agreement by approximately 52 percent—two programs central to the nation's readiness.

Interview with Puthiery Va, D.O.

Director, Maine Center for Disease Control and Prevention

Dr. Puthiery Va was named Maine Department of Health and Human Services' Director of the Center for Disease Control and Prevention in August 2023. Before her Maine appointment, she was the Director of the Division of Public Health in Chinle, Arizona, part of the Indian Health Service. Prior to her work with the Indian Health Service, Dr. Va was an Epidemic Intelligence Service Officer with CDC.

TFAH: Maine is among the states placing in this report's high-performance tier for emergency preparedness. What are the factors that support your state's preparedness?

Dr. Va: The first thing I want to acknowledge is that our degree of preparedness and our culture of preparedness are a team effort. We would not be in the high-performance category if it weren't for my team—and that's across all divisions: our Office of Readiness and Response, our state Health and Environmental Testing Lab and its ability to surge as needed, our Divisions of Infectious Disease and Disease Surveillance, and the Maine Immunization Programs. Our team thinks innovatively about what's necessary to maintain a preparedness posture given the challenges of today's evolving public health landscape and asks, what do we need to do to continue to strengthen preparedness and response capabilities?

A culture of preparedness is particularly important when things are uncertain. It requires us to weave readiness into everyday public health operations. Anticipating, planning for, and responding to emergencies becomes a shared mindset rather than a one-time activity. Our ability to respond isn't just within our Office of Readiness and Response. It requires building a culture of preparedness across all of our teams, including strategies to address communicable and noncommunicable diseases, strengthening environmental health, and ensuring drinking water safety during emergencies.

Another lesson I brought from my prior work in the Indian Health Service, particularly during the COVID-19 pandemic, was the importance of communications and marketing. We have to think about communications and marketing through the lens of preparedness, and not only as a reactive tool. We've worked to build ongoing dialogue with the public and with our community partners in a strategic way. There are intentional communications down to the local level. The goal is to build and maintain public trust. When an emergency happens, we want the public to know who the trusted messengers are.

TFAH: In addition to your focus on a culture of preparedness, are there other aspects of preparedness you are continuing to work on?

Dr. Va: Data infrastructure and data modernization are really critical. My team and I understand that it is essential to build systems that best serve the people of Maine and the public health ecosystem. We are working on building a unified data environment so that critical information reaches patients, hospitals, response teams, public health teams, and other key partners quickly and reliably. For example, an integrated data environment will allow us to better understand vaccine coverage and ensure that we can immediately identify vulnerable populations and direct resources where they are most needed. It also supports our communications team in working with trusted messengers to deliver targeted, effective public health messaging to the communities most at risk.

TFAH: The nation's public health infrastructure experienced many challenges over the past year, from grant terminations to workforce and program cuts. Has the changing federal public health landscape impacted Maine's emergency preparedness?

Dr. Va: Those who work in public health know change can happen at any time, and we need to be prepared to adapt. That is especially the case in public health preparedness and response. Uncertainty can present challenges. But here in Maine, we are prepared to meet those challenges to ensure that we can continue to protect public health in our state.

Uncertainty about funding and the anxiety that creates for my teams are my biggest concern. Uncertain funding makes it difficult to plan and difficult to ensure a preparedness posture. An example was the COVID funding clawbacks. The clawbacks were eventually restored, but the upheaval impacted our programs and created lingering uncertainty about future funding. For instance, we're not sure whether PHEP [Public Health Emergency Preparedness cooperative agreement] funding will be level-funded or reduced—or whether we'll have any PHEP funding at all. We just learned we will have funding this year, but what about next year?

Another concern is that when funding is very constrained and very bucketed, it makes it difficult to be nimble and responsive to emerging threats. This is one of the reasons I'm such an advocate for PHIG [Public Health Infrastructure Grant], because it is disease-agnostic and very flexible, allowing us to strengthen foundational infrastructure and support local partners when they need to surge during a response.

TFAH: Are you concerned about a diminished federal role in public health?

Dr. Va: Yes, diminished federal support does create stress across our programs. But I also want to highlight Maine's strengths. We have strong state leadership that supports public health emergency preparedness and response. We also have strong state partners—we work very closely with MEMA [Maine Emergency Management Agency], our state districts and counties, and with hospital systems and clinicians. We have a very unified front that enables us to have honest and strategic discussions about how to manage uncertainty together.

TFAH: Many states are experiencing numbers of measles cases that haven't been seen in decades. How has Maine fared, and what strategies does Maine employ to address vaccine-preventable disease outbreaks, including measles?

Dr. Va: Maine has strong vaccine policies, so that's a really good start. It also has a strong culture of vaccine acceptance—another great start. I don't take these things for granted; they can change over time, so we need to work to make sure we maintain this strong culture.

In February of this year, we had our first measles case since 2019. We immediately worked with the families involved to understand where exposures occurred and then used contact tracing to identify close contacts and their vaccination status. The response was a partnership with the case and the community involved, healthcare providers, and local partners. This helped us contain the outbreak. Unfortunately, the first case did transmit to four additional close contacts who were unvaccinated, but we kept the incidence to five cases. While this situation has been resolved, we are prepared in the event we see more cases. We know there has already been some erosion nationally in vaccination levels due to mistrust, misinformation, and disinformation. We need to make sure we know where Maine's vulnerable populations are and engage with them in a thoughtful, patient, non-paternalistic way, leveraging trusted partners and sharing evidence-based information. We need to understand where a family is [regarding vaccination], listen, and address their concerns.

TFAH: Maine is a rural state, and you have a larger proportion of older adults than many other states. How does that impact your public health strategies?

Dr. Va: Maine is a rural state, so access to any primary care provider can be difficult for some residents. Building healthcare access in many communities is critical. As an example, our public health nurses work to bring vaccines to schools. We also recognize that not every child goes to public or private schools, as we have populations who are homeschooled. How do we reach children who are homeschooled and offer them the same [health] services they would be offered in school?

We are also working on increasing vaccine access in pharmacies. An older adult or a family may not have a healthcare provider, but there may be a pharmacy in their community. We want to think strategically about how to increase access to preventive services that help protect everyone.

Maine CDC also works closely with its health system partners. This includes meeting routinely with long-term care facilities, medical leadership, and our pharmacy association to ensure we support vaccine access and efforts to reach vulnerable populations.

TFAH: Weather-related emergencies—from hurricanes to extreme heat—are increasing nationally and are associated with numerous health risks. What's your biggest concern when it comes to climate-related events?

Dr. Va: I really appreciate this question. I've been fortunate to step into my role in Maine with many of the critical foundational elements for addressing the health impacts of weather already in place. One of the governor's priorities is focused on combatting climate change, and Maine has a Climate Council and a climate plan that includes public health. Public health therefore has a seat at the table when it comes to climate preparedness and response planning. That allows us to help our partners connect the dots between extreme weather and public health and ensure that families, communities, providers, nursing homes, other care facilities, and hospitals are prepared for extreme weather events.

TFAH: Ensuring the public's health, particularly during emergencies, requires coordination across levels of government and with community-based and private-sector partners. How does your department build and maintain these relationships?

Dr. Va: Public-private partnerships are absolutely central to our team's success. We meet routinely with partners to discuss priorities and identify opportunities for alignment and further collaboration. These partnerships allow us to be community- and culturally centered and to meet people where they are. They are particularly important in our work with tribal and refugee communities.

TFAH: Anything else you'd like to tell us?

Dr. Va: As we've said, public health is definitely a team sport here in Maine. In addition to that, we still have to communicate and coordinate with our federal partners—and we do. It's critical that we understand changes happening at the federal level so we have enough of a runway to transition and adapt. That degree of ongoing support and dialogue is necessary to mitigate harm. I understand that priorities change and that our federal partners must pivot. If we maintain strong dialogue, we can also pivot in ways that reduce harm.

Maine is also part of the Northeast Public Health Collaborative. The Collaborative's purpose is to foster regional coordination and information-sharing. Given the resource environment we've discussed, we are asking: how can we work together as health departments to operate more efficiently? One example is by working toward consistent vaccine messaging. As vaccine policy shifts, consistent guidance and messaging will help build vaccine confidence and public trust.

Finally, I want to recognize two volunteer groups that are components of our emergency preparedness and response program: Maine Responds and our Deployable Medical Assistant Strike Teams. These groups speak to the strong sense of community we have in Maine.

This interview was conducted in March 2026. It was edited for clarity and length.

Assessing States' Preparedness

In 2025, the United States confronted a convergence of active public health threats and profound federal policy uncertainty that tested the resilience of preparedness systems built over decades. These active responses unfolded as state and local health departments navigated major federal funding and programmatic disruptions. The resulting uncertainty about federal support—technical assistance, grants management, surge capacity, and partnership continuity—raised fundamental questions about the sustainability of preparedness infrastructure and highlighted the critical importance of state-level capacity and investment.

Understanding each state's preparedness capacity has never been more essential. As federal support becomes less predictable, state performance across multiple domains of preparedness—workforce mobility, institutional quality, funding stability, infrastructure resilience, and baseline population health—increasingly differentiates jurisdictions positioned to detect and respond effectively to threats from those facing growing vulnerabilities.

To guide policymakers, practitioners, and stakeholders, this report analyzes key indicators of state-level emergency readiness. These measures track diverse capabilities:

- enabling swift cross-state healthcare workforce deployment through interstate compacts,
- maintaining institutional quality through accreditation of public health and emergency management systems,
- sustaining state public health funding,
- ensuring safe community water systems,
- supporting workforce resilience through paid sick leave access,
- achieving influenza vaccination coverage that validates countermeasure distribution systems,
- maintaining hospital patient safety standards,
- ensuring laboratory surge capacity planning for diagnostic response, and
- reducing avoidable mortality and the disparities therein that reveal underlying health system effectiveness and equity.

Each indicator reflects a fundamental dimension of preparedness. Together, they illuminate where states have built robust capacity and where critical gaps persist. Healthcare workforce mobility enables rapid personnel deployment during surges. Accreditation demonstrates that agencies have tested plans, established partnerships, and maintained continuous improvement systems. Stable funding sustains the workforce, data systems, and coordination mechanisms that cannot be assembled during emergencies. Water system safety reflects infrastructure resilience and organizational capacity essential when disasters compromise basic services. Paid sick leave access supports infection control by enabling workers to stay home when ill. Vaccination

coverage indicates both immunization infrastructure strength and public trust. Hospital patient safety reveals whether healthcare systems can maintain quality under stress. Laboratory surge plans document capacity to sustain diagnostic operations during extended outbreaks. Avoidable mortality captures baseline population health conditions and health system effectiveness—factors that shape how communities fare during crises, as the COVID-19 pandemic starkly demonstrated.

As detailed in "Appendix B: Methodology," TFAH analyzed state performance across these indicators and grouped states into three tiers—high, middle, and low—based on their relative scores. Some indicators can be influenced directly by state policymakers or health agencies through legislation, funding decisions, or program management. Others require comprehensive, multisectoral approaches involving local governments, healthcare institutions, private-sector employers, community-based organizations, and residents themselves. By providing clear benchmarks and comparative performance data, these indicators help states evaluate their progress, identify priorities for improvement, and learn from peers facing similar challenges.

The indicators that follow offer both a current assessment of state preparedness capacity and a framework for understanding how different dimensions of readiness interact. In an environment where federal support may be less predictable, state performance across these measures provides critical insights into which jurisdictions are positioned to sustain core preparedness functions, and which face growing constraints that warrant targeted intervention and investment.

INDICATOR 1: ADOPTION OF THE NURSE LICENSURE COMPACT

KEY FINDING: 41 states have adopted the Nurse Licensure Compact, marking the compact's transition from emerging policy to established infrastructure for emergency preparedness.

The capacity to rapidly mobilize nursing personnel across state lines remains essential for effective healthcare response during public health emergencies and disasters. During the first year of the COVID-19 pandemic, many governors issued emergency orders easing licensing barriers, and at least 31 states plus the District of Columbia explicitly waived or loosened cross-state licensing restrictions for nurses.[67,68] This widespread acknowledgment of the need for workforce mobility underscored the value of permanent interstate licensure frameworks.

Healthcare workforce shortages continue to strain the nation's health systems. National projections indicated an expected shortage of more than 78,000 registered nurses in 2025, with some states projected to operate at more than 20 percent below need.[69,70] These shortfalls are projected to intensify.[71]

Recruitment of nurses into the field faces new challenges. First, the U.S. Department of Education has advanced a proposed rule that would revise its definition of "professional degree" programs for purposes of federal student loan limits.[72] As proposed, certain graduate-level nursing, public health, and other health programs could be excluded from the higher federal borrowing caps available to programs designated as professional degrees, potentially limiting borrowing levels for students pursuing those degrees. In addition, analysts have raised concerns that reductions in Medicaid funding under the July 2025 federal budget reconciliation law (Public Law 119-21) could contribute to financial strain on healthcare facilities, particularly in rural areas, and increase the risk of service reductions or closures.

This indicator evaluates state adoption of the Nurse Licensure Compact (NLC), established in 2000 by the National Council of State Boards of Nursing.[73] The NLC allows registered nurses and licensed practical nurses to practice in any member state with a single multistate license, reducing reliance on emergency licensure waivers between member states and lowering administrative barriers that impede rapid workforce deployment during crises.

The Emergency Preparedness Case for Interstate Licensure

Empirical evidence from recent emergencies demonstrates the critical role of interstate nurse mobility. For example, a study examining nurse staffing during Hurricane Sandy found that 19 of 21 counties in New Jersey experienced nursing shortages, and low nurse staffing was directly associated with poor patient outcomes.[74] The research showed that increased nursing hours per patient day could have reduced average length of stay and lowered the probability of in-hospital mortality. Significantly, New Jersey was not an NLC member during Hurricane Sandy, limiting nurses' ability to cross state lines to provide emergency care.

The COVID-19 pandemic further validated the compact's emergency preparedness value. Travel nurses played a pivotal role in filling acute staffing gaps across the country, with the compact enabling rapid deployment to overwhelmed facilities without the delays associated with state-by-state licensure applications.

The connection between nurse mobility and emergency preparedness is grounded in robust evidence linking nurse staffing levels to patient outcomes. A 2022 systematic review examining hospital studies found consistent associations between higher registered nurse staffing levels and better patient outcomes, including lower mortality and fewer adverse events.[75] Other research demonstrates that higher patient-to-nurse ratios are associated with increased in-hospital mortality, more deaths from treatable complications, and nurse burnout.[76] In addition to clinical outcomes, higher nurse staffing levels may also contribute to shorter hospital stays and fewer costly complications, while nurse burnout and turnover impose significant financial costs on health systems. Together, these findings underscore that adequate nurse staffing is both a clinical and economic component of emergency preparedness.

Membership in the NLC serves as a significant indicator of healthcare preparedness capacity for several reasons. First, it enables rapid mobilization of nursing staff across state lines during emergencies, enhancing a state's ability to respond quickly to disease outbreaks, natural disasters, and other health crises without the delays inherent in emergency licensure procedures. Second, the compact facilitates telehealth services across state borders, essential for delivering care in remote or underserved areas, particularly when in-person visits are impractical or dangerous. Third, by harmonizing licensure requirements, the NLC helps promote consistent licensure standards that support safe deployment of nonresident nurses during surge conditions.

Research on nurse mobility shows that compact nurses are more likely to work across state lines[77] and that NLC membership increases workforce flows among NLC states within the health and social assistance industry.[78] Survey evidence consistently shows strong support for the compact among nurses themselves.[79,80,81]

The NLC's role in emergency preparedness follows a clear causal pathway: compact adoption reduces regulatory friction for cross-state practice, which enables a greater ability to move nurses where they are needed during emergencies, which produces better staffing levels in surge areas, which ultimately leads to better patient outcomes.

Widespread Adoption

As of February 2026, 41 states have adopted the NLC, with 40 fully operational.[82] Two states achieved full implementation in 2025. Pennsylvania completed its implementation on July 7, 2025,[83] after a transition following legislative enactment in 2021.[84] Pennsylvania nurses can now obtain multistate licenses to practice throughout the compact. Connecticut implemented the NLC on October 1, 2025, after Governor Ned Lamont signed enabling legislation in May 2024.[85]

Massachusetts enacted the compact on November 20, 2024, when Governor Maura Healey signed legislation addressing the state's nursing shortage.[86] The Massachusetts Board of Registration in Nursing estimates implementation will require approximately 12 months from enactment, plus additional time for FBI approval for federal background checks. Until full implementation, nurses with multistate licenses from other compact states cannot practice in Massachusetts.

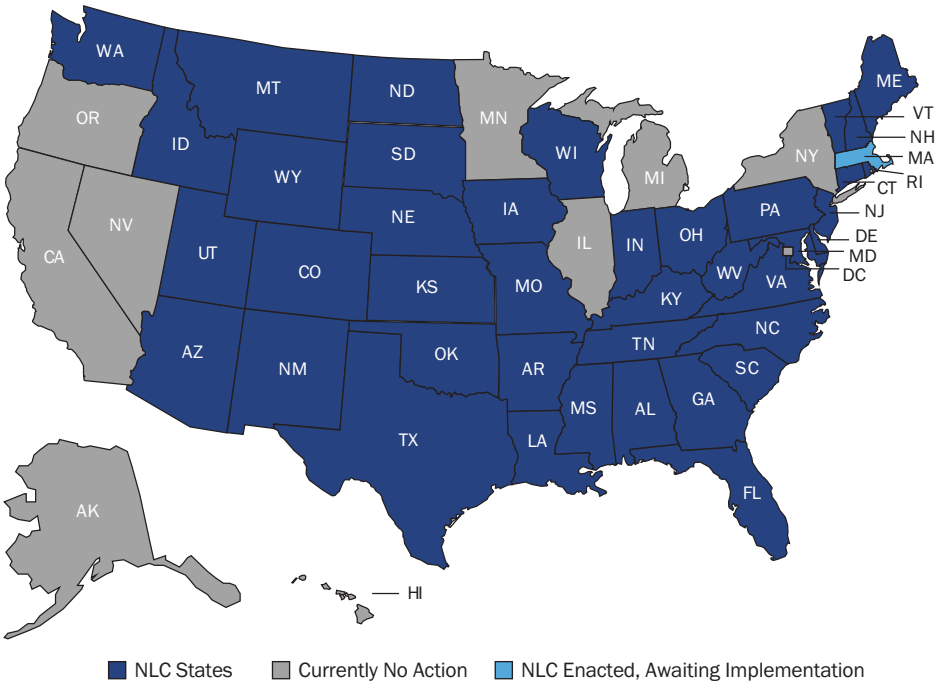
With 41 states having enacted the NLC, only nine states (Alaska, California, Hawaii, Illinois, Michigan, Minnesota, Nevada, New York, and Oregon) and the District of Columbia remain outside the framework. The geographic pattern of nonparticipating states is notable: large population centers, including California, New York, Illinois, and Michigan, remain outside the compact. These gaps have implications for surge capacity during national emergencies, as these states represent substantial potential sources of nursing personnel that cannot be rapidly deployed across state lines without additional licensure processes.

Evolving Governance

The NLC continues to evolve its governance structure. A regulatory change effective January 2, 2024, introduced a 60-day relocation rule requiring nurses who permanently move from one compact state to another to apply for licensure in their new primary state of residence within 60 days.[87] Nurses may continue practicing under their previous license while the new application is processed, and the rule does not apply to travel nurses on temporary assignments. This change reflects ongoing efforts to balance mobility with appropriate regulatory oversight and accountability.

The compact celebrated its 25th anniversary in 2025, having been originally implemented in 2000.[88] The expansion from an initial handful of early adopters to 41 states over this period represents a major example of interstate health policy coordination.

Figure 1: Nurse Licensure Compact Membership Across the United States



Note: As of January 2026, Massachusetts has enacted the NLC but is awaiting implementation, with no specific implementation date determined.

Source: National Council of State Boards of Nursing.[93]

Limitations and Complementary Policies

While the NLC significantly reduces administrative barriers to interstate practice, it does not eliminate all obstacles to nurse mobility or automatically resolve underlying workforce shortages. The compact facilitates legal authority to practice across state lines but works most effectively when combined with other preparedness investments.

The NLC covers registered nurses and licensed practical nurses but does not extend to advanced practice registered nurses (APRNs), who are governed by a separate APRN Compact with more limited adoption.[89,90] This represents a gap in workforce mobility infrastructure, particularly as APRNs increasingly provide primary care and specialty services in underserved areas and during emergencies.

Research shows that nurses often lack adequate preparation for disaster response. A large-scale survey and multiple other studies have found that many nurses report little or no familiarity with emergency preparedness and disaster response.[91,92] This skills gap underscores that the NLC's value lies in facilitating rapid deployment of available personnel, but states must complement interstate licensure with investments in emergency preparedness training, disaster drills, and maintenance of surge capacity infrastructure.

Conclusion

The NLC has transitioned from an innovative policy experiment to a widely adopted mechanism that supports healthcare emergency preparedness. With 41 states adopting it and growing empirical evidence showing that the compact reduces licensure barriers and facilitates interstate nurse mobility, NLC participation represents a meaningful component of state readiness. The broad adoption of the NLC—spanning diverse political and geographic contexts—reflects widespread recognition that interstate nurse mobility plays an important role in public health emergency response. The remaining nonparticipating states, particularly large population centers that could serve as major sources of emergency personnel during national emergencies, represent notable gaps in the nation's preparedness architecture.

INDICATORS 2 AND 3: ACCREDITATION STATUS OF STATE PUBLIC HEALTH AND EMERGENCY MANAGEMENT SYSTEMS

KEY FINDING: Most states are accredited by the Public Health Accreditation Board and/or the Emergency Management Accreditation Program; however, six states lack accreditation from either body.

Accreditation represents a state's commitment to maintaining systems that meet nationally recognized standards for public health performance and emergency preparedness and response. Accreditation assesses whether the institutional infrastructure—the policies, procedures, partnerships, and organizational capacity—exists to support effective public health and emergency preparedness and response practice. Two complementary accreditation programs provide this assessment: the Public Health Accreditation Board (PHAB) evaluates governmental public health departments, while the Emergency Management Accreditation Program (EMAP) evaluates emergency management programs that coordinate all-hazards response across sectors.

Understanding Public Health Accreditation

PHAB operates the nation's only voluntary national accreditation program for governmental public health departments. Since its establishment, PHAB has accredited about 450 health departments[94] covering approximately 90 percent of the U.S. population.[95] The program evaluates departments against standards spanning a broad range of public health functions, from community health assessment and policy development to emergency response and health equity.

PHAB's relevance to emergency preparedness has strengthened considerably in recent years. In 2022, PHAB implemented updated standards (Version 2022) that better align emergency operations planning requirements with Emergency Support Function 8, the federal framework for coordinating public health and medical services—including surveillance, medical surge, patient movement, and medical countermeasures—during disasters.[96,97] The updated framework incorporates more active emergency response preparation requirements and is explicitly aligned with the Centers for Disease Control and Prevention's (CDC) Public Health Emergency Preparedness (PHEP) program and the National Association of County and City Health Officials' Project Public Health Ready, building on existing crosswalks between PHAB standards, PHEP capabilities, and Project Public Health Ready criteria.[98,99,100] This alignment allows health departments working toward accreditation to draw on the same plans, capabilities, and documentation that federal preparedness frameworks identify as essential.

The accreditation process itself strengthens preparedness capacity. For example, Standard 2.2 requires health departments to maintain current emergency operations plans, continuity of operations plans, and risk communication plans; establish 24/7 communication and coordination processes with response partners; conduct regular exercises; and use after-action reports to drive improvements.[101] Standard 6.1 addresses the legal and regulatory enforcement functions of public health departments—functions that are also critical during public health emergencies.[102]

Understanding Emergency Management Accreditation

EMAP provides the only national accreditation process specifically designed for emergency management programs. Unlike PHAB, which evaluates entire health departments, EMAP focuses on the emergency management program—the system with formal responsibility for coordinating all-hazards preparedness, planning, and response across agencies. The U.S. Council of the International Association of Emergency Managers has officially endorsed EMAP's Emergency Management Standard as the standard for emergency management programs.[103]

EMAP's current standards (ANSI/EMAP 5-2022) establish 73 requirements covering the full emergency management cycle: prevention, preparedness, mitigation, response, and recovery.[104,105] The accreditation process combines self-assessment, independent peer review, and on-site evaluation by trained assessors.[106] Programs must demonstrate that they have the administrative structures, legal authorities, fiscal systems, trained personnel, exercised procedures, and continuous improvement mechanisms to implement those plans effectively.

The value of EMAP accreditation extends beyond process compliance. Analysis of FEMA's State Preparedness Report—a federal assessment of state capabilities—shows that EMAP-accredited states consistently report higher ratings across all core capabilities assessed.[107] Forty-five percent of EMAP-accredited states report high confidence in their planning, organization, equipment, training, and exercise functions.[108] A 2024 survey of emergency managers found that accreditation serves as a catalyst for standardization, operational efficiency, and enhanced support from executive leadership.[109]

Evidence Supporting Accreditation as a Preparedness Indicator

The case for using accreditation as a preparedness indicator rests on evidence that accredited agencies demonstrate stronger institutional capacity and, in some contexts, enhanced preparedness-related capabilities. Survey research provides the most direct evidence. When PHAB surveyed accredited health departments during the COVID-19 pandemic in 2020, 81 percent reported that accreditation helped their response overall. More specifically, 77 percent cited emergency response planning work as helpful, and 75 percent identified strengthened cross-sector partnerships—both activities commonly undertaken as part of the accreditation process—as beneficial during the crisis.[110] A separate study examining health departments one year after achieving accreditation found improvements in workforce development, quality improvement practices, evidence-based decision-making, partnerships, and accountability—organizational capabilities that support surge capacity and coordinated response during emergencies.[111]

The EMAP evidence follows a similar pattern. The program's association with higher FEMA State Preparedness Report scores suggests that accredited states possess more developed emergency management capabilities across multiple dimensions. The

2024 EMAP survey documented that accreditation supports standardization of policies and procedures, strengthens interagency coordination, and enhances executive-level support—factors that directly affect how effectively states can mobilize during crises.[112]

The evidence base has limitations that warrant acknowledgment. Research examining COVID-19 mortality outcomes found that neither PHAB nor EMAP accreditation showed strong associations with state death rates from January 2020 to January 2022 when controlling for other factors.[113] This finding likely reflects the complexity of pandemic outcomes, which are influenced heavily by baseline population health, political and behavioral factors, and the timing and nature of viral spread. The absence of a mortality signal does not invalidate accreditation as a measure of institutional capacity; rather, it suggests that emergency preparedness infrastructure, while necessary, is not sufficient to determine health outcomes when population-level and contextual factors dominate. (The same analysis found that states that placed in the high tier of *Ready or Not* more often than not had slightly lower COVID-19 death rates over the study period than states in the middle and low tiers.)[114]

A related analysis also examined whether accreditation of local health departments is associated with better COVID-19 outcomes, comparing adult vaccination, hospitalization, and death rates between counties with and without accreditation, adjusting for time, social vulnerability, state public health governance, and state policy environment. The researchers found that communities served by accredited departments had higher adult COVID-19 vaccination rates and lower COVID-19 death rates than those served by non-accredited departments, even after accounting for these contextual factors; hospitalization rates did not differ significantly by accreditation status.[115]

Current Accreditation Landscape

As of January 2026, 27 states plus the District of Columbia hold accreditation from both PHAB and EMAP.[116,117] This dual accreditation represents the strongest institutional commitment, demonstrating that both the public health department and the emergency management program have undergone rigorous external review and met nationally recognized standards. Twelve states are accredited by PHAB alone, indicating well-established public health infrastructure operating within emergency management systems that have not pursued or achieved EMAP accreditation. Five states hold EMAP accreditation without PHAB accreditation, reflecting robust emergency management programs alongside public health departments that have not completed the PHAB process. Six states lack accreditation from either program.

Over the past year, the overall distribution remained broadly stable, but with several noteworthy shifts in individual state status. The number of states with dual accreditation declined slightly—from 28 states plus DC to 27 states plus DC—as Idaho's and Washington's PHAB accreditation expired and Massachusetts's EMAP accreditation expired, while Louisiana (conditionally accredited) and Montana gained EMAP accreditation and moved into the dual-accredited category. PHAB-only states fell from 13 to 12, reflecting Louisiana's and Montana's shift to dual accreditation and Massachusetts's transition to PHAB-only status. EMAP-only states increased from three to five, driven by Idaho's and Washington's move from dual accreditation to EMAP-only. The number of states without accreditation—six—remained unchanged from the previous year, comprising the same states: Hawaii, New Hampshire, South Dakota, Texas, West Virginia, and Wyoming. The absence of accreditation may signal resource constraints or competing priorities that prevent agencies from undertaking the substantial work required to meet national standards.

Challenges and Context

The accreditation infrastructure faces significant stress from recent and proposed federal policy changes. Current and proposed budget reductions affecting CDC and other agencies that fund state and local preparedness activities, combined with major workforce cuts, threaten the technical assistance and financial support that help departments pursue and maintain accreditation—and prepare for emergencies. While both PHAB and EMAP continue to advance their programs—with PHAB's 2025–2026 strategic plan emphasizing accreditation as a trusted seal of quality and readiness[118] and EMAP continuing to recognize newly accredited programs—the broader ecosystem supporting state and local preparedness capacity is under considerable strain.

These pressures make the institutional quality that accreditation represents even more critical. In resource-

constrained environments, having documented policies, trained personnel, tested plans, and established partnerships improves coordination. PHAB has acknowledged this dynamic directly, noting in its 2025 guidance on public health system transformation that "recent resource shifts and federal funding uncertainties have forced staffing and program cuts at the state and local level," while emphasizing the importance of strengthening effective systems and finding innovative approaches to delivering foundational capabilities.[119]

The six states without accreditation from either PHAB or EMAP warrant particular attention. Their absence from both frameworks suggests either significant barriers to achieving or pursuing accreditation or a policy decision that accreditation does not align with state priorities. Understanding whether these states maintain strong preparedness systems through alternative means or face genuine capacity gaps remains an important question for assessing national preparedness.

Accreditation will never capture the full picture of a state's emergency preparedness—no single indicator can. But as measures of whether states have invested in the institutional infrastructure, established the partnerships, documented the procedures, and built the organizational capacity that national consensus standards identify as essential, PHAB and EMAP accreditation provide valuable signals about readiness. The challenge ahead lies in sustaining this infrastructure amid federal policy uncertainty.

TABLE 3: 44 States and the District of Columbia Accredited by PHAB and/or EMAP
Accreditation status by state, January 2026

PHAB and EMAP			PHAB ONLY	EMAP ONLY	No Accreditation
Alabama	Illinois	North Dakota	Alaska	Idaho	Hawaii
Arizona	Kansas	Ohio	Indiana	Michigan	New Hampshire
Arkansas	Louisiana (Conditional EMAP)	Oklahoma	Iowa	Nevada	South Dakota
California	Maryland	Pennsylvania	Kentucky	Tennessee	Texas
Colorado	Missouri	Rhode Island	Maine	Washington	West Virginia
Connecticut	Montana	South Carolina	Massachusetts		Wyoming
Delaware	New Jersey	Utah	Minnesota		
District of Columbia	New York	Vermont	Mississippi		
Florida	North Carolina	Wisconsin	Nebraska		
Georgia			New Mexico		
			Oregon		
			Virginia		
27 states + DC			**12 states**	**5 states**	**6 states**

Note: Louisiana has conditional EMAP accreditation, indicating substantial compliance with EMAP standards while working toward full accreditation. Lack of accreditation does not necessarily indicate a deficiency; it may reflect barriers such as workforce or financial limitations, or that a state's accreditation is in process. This analysis is limited to state-level accreditations and excludes local or tribal health departments, which may hold their own accreditations separate from state health departments.

Source: Accreditation data from PHAB[120] and EMAP[121] retrieved January 2026.

INDICATOR 4: STATE PUBLIC HEALTH FUNDING TRENDS

KEY FINDING: A majority of states maintained or increased their public health funding in fiscal year (FY) 2025, but at least 12 states reduced funding.

Recent public health emergencies have underscored the critical importance of adequate and flexible funding for public health systems. Adequate funding supports the infrastructure and workforce needed for disease surveillance and outbreak response and can strengthen capacity to mitigate health consequences from disasters. In 2025, this fundamental principle was tested, as state, local, tribal, and territorial health agencies faced a convergence of federal funding disruptions, workforce reductions, and the wind-down or termination of certain pandemic-era resources.

Core public health capabilities—including epidemiology, environmental hazard detection and control, infectious-disease prevention and control, and risk communication—are vital for maintaining routine operations and providing surge capacity during emergencies. The Public Health Activities and Services Tracking project at the University of Washington provides a standardized framework—the Uniform Chart of Accounts—for categorizing public health expenditures across programmatic areas. Within this framework, public health activities are commonly organized into areas such as communicable disease control; chronic disease prevention; injury prevention; environmental public health; maternal, child, and family health; and access to and linkage with clinical care.[122] Sustaining these core capabilities, together with targeted emergency response functions, depends on stable and predictable funding to support workforce capacity, operational readiness, and ongoing engagement with the communities served.

State Funding Amid Federal Funding Disruptions

State investments have long played a substantial role in financing governmental public health.[123,124] However, the operating context for state funding shifted sharply in 2025 amid federal funding disruptions and proposed reductions. The Trump Administration's proposed FY 2026 budget would have reduced CDC's budget by roughly half compared with FY 2024, with direct implications for state and local capacity because much of CDC's work is implemented through external partners.[125] CDC has reported that about 80 percent of its domestic budget supports activities conducted by states, localities, tribes and tribal organizations, healthcare systems, and community partners.[126] The president's FY 2026 budget also proposed reducing the PHEP Cooperative Agreement from $735 million to $350 million (a reduction of $385 million, or roughly 52 percent).[127]

Those proposed reductions were largely rejected in the final appropriations law enacted on February 3, 2026, which provided full-year funding for most federal agencies through September 30, 2026. The enacted legislation provides approximately $9.2 billion for CDC and maintains $735 million for the PHEP cooperative agreements, along with $307 million for the Administration for Strategic Preparedness and Response's Hospital Preparedness Program.[128] While the final law averted the most severe proposed cuts, the earlier budget proposals and funding uncertainty contributed to instability across the public health system.

Beyond proposed reductions, actual grant terminations, claw-backs, and delays created immediate disruption. Beginning March 2025, the U.S. Department of Health and Human Services (HHS) issued termination notices affecting roughly $11.4 billion in CDC-administered COVID-era grant funding and approximately $1 billion administered through the Substance Abuse and Mental Health Services Administration.[129] The largest share—more than $8.9 billion—was tied to CDC's Epidemiology and Laboratory Capacity cooperative agreements, which states and localities use to support disease surveillance, laboratory capacity, and related core functions.[130]

In April 2025, 23 states and the District of Columbia filed suit challenging the terminations and requesting emergency relief.[131] The court issued a temporary restraining order in early April 2025[132] and later granted a preliminary injunction on May 16, 2025, blocking termination of the covered funding with respect to the plaintiff states and the District of Columbia while the case proceeded. As of February 2026, the case remained ongoing.

These disruptions occurred alongside broader federal workforce reductions and restructuring affecting health agencies, which risked constraining the technical assistance, grants management, and surge support that state and local agencies rely on—effects that can compound the impact of funding instability even where nominal appropriations remain unchanged.[133]

Although FY 2026 appropriations ultimately provided relatively level funding for key preparedness programs, funding stability does not quickly reverse capacity losses. In 2025, federal health agencies experienced significant workforce disruption amid broader restructuring efforts, including layoffs and partial reinstatements at CDC. Delays, disruptions, and the cancellation of previously awarded funds for public health infrastructure and programs across the country undermined emergency preparedness. Rebuilding a resilient public health system will require sustained, predictable investments and concerted efforts to restore staffing, expertise, and operational capacity at every level—from federal agencies to state and local health departments.

Against this backdrop, at least 34 states and the District of Columbia either maintained or increased their public health funding in FY 2025, as indicated in Figure 2. However, at least 12 states reduced their funding, potentially compromising preparedness and responsiveness at a critical juncture. Four states—Georgia, Mississippi, North Carolina, and West Virginia—did not provide data for this indicator. (This indicator does not assess the adequacy of states' public health funding. Due to inflation and population growth, stable funding may effectively represent a reduction in real capacity.)

The Pandemic Funding Cliff and Its Consequences

Between FY 2019 and FY 2022, state-supported funding for public health services often shifted in response to the COVID-19 pandemic and the availability of significant federal aid. In some states, legislatures enacted one-time or short-term increases in state funding to support pandemic response activities. In others, state funding levels were held flat or temporarily reduced as substantial federal emergency funds became available, effectively altering the mix of state and federal financing supporting public health operations during this period.

By FY 2025, many of the most flexible COVID-era supplemental public health funding streams had ended or been terminated. These included emergency expansions of the Epidemiology and Laboratory Capacity program, time-limited workforce surge funding, and certain pandemic-related data-modernization investments. While some longer-term federal investments remained available, the expiration or withdrawal of major emergency funding streams created a pronounced funding cliff for many state and local health departments.

The pandemic experience underscored both the critical role of federal public health funding and the risks associated with heavy reliance on temporary federal aid. Much of the funding provided in response to COVID-19 was explicitly one-time or time-limited, and by 2025 had either been fully expended, reached the end of its period of availability, been rescinded by Congress, or been terminated by federal agencies. Even where substantial new federal investments were made, their limited duration complicated long-term planning and workforce stabilization, particularly for activities that require sustained capacity rather than episodic response. Most state budgets do not have the fiscal capacity to absorb the full cost of emergency preparedness programs once federal support expires, and the abrupt expiration

or termination of temporary funding created instability in staffing, infrastructure, and program continuity.

Emergency preparedness funding presents a structural challenge: the capabilities required to respond effectively to low-probability, high-consequence events generate limited immediate benefits during non-emergency periods, making them difficult to justify within constrained state budgets. State revenues alone are generally insufficient to sustain the full cost of maintaining readiness for infrequent but catastrophic events. This dynamic supports a continued federal role in supporting baseline preparedness capacity that states can activate and scale during emergencies.

A November 2023 Government Accountability Office (GAO) report examined CDC's two key annual preparedness programs—Epidemiology and Laboratory Capacity for Prevention and Control of Emerging Infectious Diseases and PHEP.[134] The GAO found that while supplemental COVID-19 appropriations in FY 2021 through FY 2023 provided about $7.1 billion to enhance infrastructure (with $3.5 billion available over five years for longer-term investment), jurisdiction officials identified several challenges to building and maintaining infrastructure.[135]

These challenges include the boom-and-bust pattern of federal funding, with increased resources during emergencies followed by decreases afterward—making it difficult for jurisdictions to invest in long-term sustainable preparedness efforts. Officials from eight jurisdictions expressed concerns about permanently increasing their workforces even with the five-year infrastructure award, citing uncertainty about longer-term funding. Officials and preparedness stakeholders told GAO that the temporary nature of supplemental funds meant infrastructure changes were mostly temporary, affecting jurisdictions' capacity to respond to future threats.[136]

CDC's Public Health Infrastructure Grant (PHIG) program illustrates both the scale and the limits of these investments. As of December 2024, CDC had awarded approximately $4.8 billion in PHIG funding to 107 health departments over a five-year period, including roughly $3.6 billion to state and territorial health departments to support workforce development, foundational public health capabilities, and data modernization.[137,138] Funded initially through the American Rescue Plan Act, PHIG awards are generally available to recipients only through November 30, 2027,[139] creating another potential funding cliff absent continued investment. In addition, in October 2025, CDC paused work associated with the PHIG Data Modernization Implementation Center Program, including the suspension of Wave 2 applications,[140] introducing further uncertainty for jurisdictions planning longer-term data-modernization efforts. In February 2026, CDC canceled PHIG and data-modernization grants in four states, along with other grants, although litigation sought to continue the funding.[141] The uncertainty created by these cancellations, reversals, and funding cliffs are disruptive to progress in modernizing public health systems.

Public health preparedness depends on a skilled workforce, modern data systems, and sustained planning, training, and coordination, all of which are difficult to maintain at scale without predictable and flexible funding.

Why This Indicator Matters for Preparedness

The trajectory of a state's public health funding is a meaningful proxy for its ability to sustain preparedness-relevant capacity over time. Experience during the COVID-19 pandemic underscored the importance of baseline public health infrastructure. At the same time, the pandemic highlighted the limits of emergency supplemental funding: short-term infusions were often difficult to deploy effectively, reinforcing the importance of sustained baseline investment rather than episodic funding alone.

Workforce capacity, which is central to preparedness, is particularly sensitive to funding stability. Disruptions in federal public health staffing and support in 2025 raised concerns about reduced federal technical assistance and surge capacity, potentially compounding the effects of flat or declining state investment.

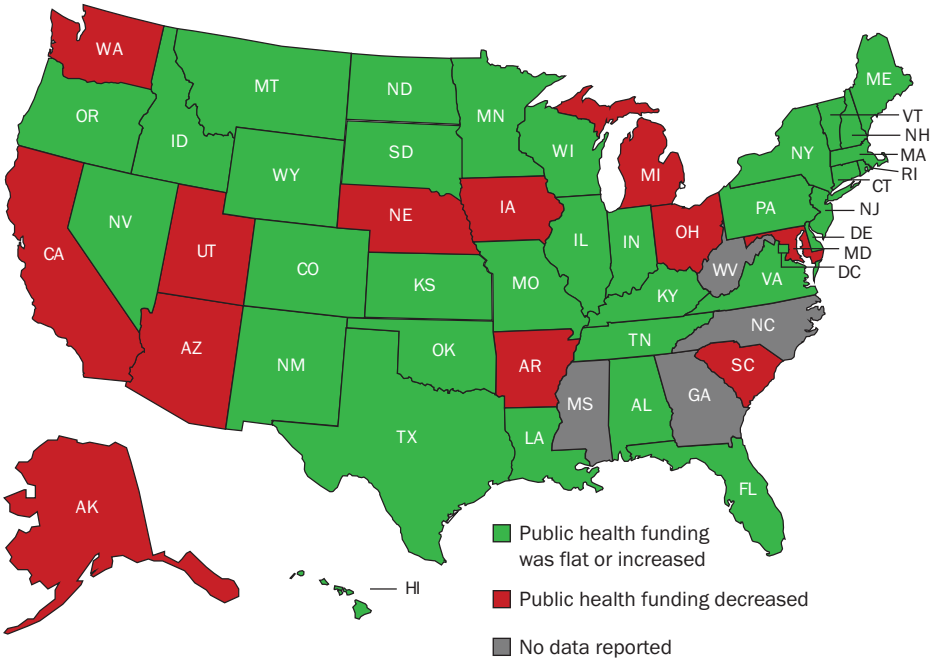
In an environment of unstable and uncertain federal public health support, state public health funding trends may increasingly differentiate jurisdictions that are able to maintain core preparedness capacity from those that face growing constraints. Stable or increasing state funding can help sustain public health systems and preserve readiness for emergencies. Conversely, declining or highly variable funding can heighten vulnerabilities by undermining workforce stability, planning, and the continuity of essential preparedness functions.

Methodology and Interpretation

For this indicator, TFAH measures state-supported public health funding—i.e., funding supported by states' own revenues—using a standardized definition of public health programming and services. It is intended to focus on state-generated revenue and to exclude federal funding streams to the extent they can be separated in state reporting, reflecting states' own fiscal commitment to preparedness-relevant public health capacity by focusing on state-supported funding and providing a view of state investment alongside—rather than driven by—fluctuating federal support.

Monitoring state funding trends provides critical insights into a state's readiness to protect its population's health in the face of unforeseen challenges. However, it is important to recognize that funding levels do not automatically translate to effective spending or optimal outcomes, and that states face different baseline needs, structural constraints, and balanced-budget requirements that affect their capacity to respond flexibly. Nonetheless, adequate and consistent funding remains the cornerstone of building and maintaining a robust public health infrastructure—making this a key metric for evaluating overall public health emergency preparedness.

Figure 2: State Public Health Funding Held Stable or Increased in at Least 34 States and DC



Note: To understand the nuances and methodology behind the data-collection, including TFAH's specific criteria for defining public health funding, please refer to "Appendix B: Methodology."

Source: TFAH analysis of state-reported public health funding data for FY 2024 and FY 2025. Data collected through a TFAH survey of state health officials based on a standardized definition of public health funding.

INDICATOR 5: COMMUNITY WATER SYSTEM SAFETY

KEY FINDING: In 2024, an average of 6 percent of residents in each state used community water systems that violated health-based drinking water standards, but performance varied.

Access to safe water is fundamental to public health emergency preparedness. Water systems provide not only drinking water but also support sanitation, hygiene, healthcare operations, firefighting capacity, and the functioning of other critical infrastructure. In the United States, the vast majority of the population relies on public water systems regulated under the Safe Drinking Water Act.[142,143] The U.S. Environmental Protection Agency (EPA) establishes legally enforceable drinking water standards and treatment techniques for contaminants, including microorganisms (such as bacteria and viruses), disinfectants and their byproducts, chemicals such as industrial pollutants and lead, and radionuclides.[144] States must regularly report community water system inventory and violation data to EPA, and systems must comply with—and are subject to enforcement for violating—monitoring schedules, treatment techniques, maximum contaminant levels, and customer-notification requirements.[145]

Water Systems as Critical Infrastructure Under Threat

While the United States maintains one of the world's safest drinking water supplies overall, significant vulnerabilities persist. CDC data indicate that waterborne pathogens alone cause approximately 7 million illnesses and more than $3 billion in healthcare costs annually.[146] When water-safety crises occur, they demand coordinated multisector emergency response and can persist for extended periods, as recent disasters have demonstrated.

Three categories of threats now converge to challenge water system resilience: climate-driven extreme weather events, emerging cybersecurity risks, and aging infrastructure.

Climate and Weather Extremes

The increasing frequency and intensity of extreme weather events create cascading risks for water systems. Recent incidents illustrate the vulnerability:

Hurricane Helene devastated western North Carolina in September 2024, leaving residents of Asheville without drinkable tap water for 53 days.[147,148] Catastrophic flooding and landslides overwhelmed the North Fork Reservoir with sediment, rendering treatment efforts ineffective. The prolonged crisis forced businesses and schools to close and imposed severe hardships on residents, who relied on bottled water and makeshift solutions for basic needs.[149]

When Hurricane Ian struck southwest Florida in September 2022 as a Category 4 storm,[150] wastewater spilled into watersheds, floodwaters and groundwater infiltrated sewer systems, and backup generators failed at treatment facilities.[151,152,153] The storm severed water lines in Lee County, leaving three hospitals without water and necessitating patient evacuations.[154] Plumes of contaminated runoff were visible from space,[155] and impacts threatened water quality for months.

The January 2025 Los Angeles–area wildfires prompted several California utilities to declare their drinking water supply unsafe pending testing,[156] as toxic chemicals created by the fires threatened to enter water supplies—a risk documented in previous wildfire events but growing more frequent as wildfire seasons intensify.[157]

Jackson, Mississippi, has experienced repeated water system failures, with heavy rainfall in August 2022 overwhelming infrastructure and leaving more than 150,000 residents

without water for days.[158] Subfreezing temperatures in December 2022 caused additional failures and boil-water orders.[159] Low-income areas were disproportionately affected, experiencing twice as many boil-water notices as higher-income areas between 2017 and 2022.[160] Congress ultimately allocated $600 million for repairs and a third-party administrator was appointed to oversee system operations.[161,162]

Drought and saltwater intrusion pose longer-term threats. Communities along the Mississippi River near New Orleans faced a crisis in 2023 when saltwater from the Gulf of Mexico moved upstream due to drought conditions, threatening drinking water supplies and potentially corroding aging pipes.[163,164] The Colorado River Basin which provides water to millions of people across seven states, continues to experience a crisis driven by prolonged drought and overuse, with reservoir levels remaining historically low and threatening both water supply and quality.[165,166]

Cybersecurity Vulnerabilities

Water systems now also face a rapidly escalating cybersecurity threat that has become a national security priority. A November 2024 EPA Office of Inspector General assessment of 1,062 drinking water systems serving 193 million people found that 97 systems serving 26.6 million people had critical or high-risk cybersecurity vulnerabilities, and an additional 211 systems serving 82.7 million people had medium or low vulnerabilities with externally visible access points.[167] The report concluded that malicious actors could "disrupt service or cause irreparable physical damage to drinking water infrastructure."[168]

The threat is not theoretical. Actors from Iran,[169] Russia,[170] and China[171,172] have actively targeted U.S. water systems.[173] In May 2024, EPA issued an enforcement alert noting that more than 70 percent of inspected water systems failed to comply with Safe Drinking Water Act cybersecurity requirements.[174] Common failures included unchanged default passwords, single logins shared among all staff, and failure to revoke access for former employees.

An August 2024 GAO report highlighted that nearly 170,000 U.S. water systems face increasing cybersecurity risks and found that EPA has largely relied on voluntary measures and limited existing authorities to promote cybersecurity protections—prompting GAO to urge a clearer strategy and potentially additional authority.[175] In response, EPA released updated cybersecurity guidance in October 2025[176] and previously announced more than $9 million in grant funding to help systems address cyber threats.[177] Bipartisan legislation temporarily reinstated through January 2026 restored liability protections for threat-sharing and extended certain federal cybersecurity grant programs that can benefit smaller utilities,[178] though permanent authorization remains uncertain as of the time of writing.

The cybersecurity dimension is particularly significant for emergency preparedness: a water system compromised by a cyberattack cannot effectively respond to physical emergencies, and the combination of cyber and physical threats creates compounding vulnerabilities.

Emerging Contaminants and Evolving Standards

Per- and polyfluoroalkyl substances (PFAS)—long-lasting human-made chemicals linked to cancer, liver damage, and immune system disruption[179]—represent a growing challenge for water systems.[180] Researchers have documented pervasive PFAS contamination, with approximately 31 percent of groundwater and 16 percent of surface water samples worldwide showing levels considered harmful to human health, including in areas distant from known contamination sources.[181]

In April 2024, EPA finalized the first National Primary Drinking Water Regulation for PFAS, establishing enforceable maximum contaminant levels and a hazard index for PFAS mixtures.[182] The final rule was expected to reduce PFAS exposure for approximately 100 million people, prevent thousands of deaths, and reduce tens of thousands of serious illnesses.[183] Initial monitoring was required by 2027, with systems expected to implement solutions by 2029 if maximum contaminant levels were exceeded.[184]

However, in May 2025, EPA announced plans to extend the compliance deadline to 2031 and rescind standards for several PFAS compounds.[185] Bipartisan legislation has been introduced to codify the original standards,[186] reflecting ongoing policy flux.

Lead Service Line Replacement

In October 2024, EPA finalized the Lead and Copper Rule Improvements,[187] marking one of the most significant updates to lead regulations in decades. The rule requires most water systems to replace all lead service lines within 10 years and lowers the lead action level. EPA's 2023 national estimate identified roughly 9.2 million lead service lines across thousands of community water systems,[188] although updated inventories submitted in 2024–2025 indicate that the current total is closer to about 4 million lead and galvanized lines.[189]

EPA estimates the rule will generate benefits of up to $25 billion annually—around 13 times greater than annual costs of $1.5 to $2 billion—by preventing thousands of premature deaths and reducing neurodevelopmental, cardiovascular, and other adverse health effects of lead exposure.[190] Systems that successfully navigate this transition are likely to demonstrate robust management capacity and infrastructure planning capabilities that are directly relevant to emergency preparedness.

Federal Investment and Progress

The Infrastructure Investment and Jobs Act, enacted in November 2021, allocated $24 billion in grants to states under the Clean Water Act and Safe Drinking Water Act,[191] and provided an additional $15 billion to replace lead pipes and service lines and $9 billion to address PFAS and other emerging contaminants.[192] As of November 2024, more than $40.3 billion had been announced for water infrastructure improvements,[193] marking the largest investment in clean water in U.S. history. Thousands of drinking water and wastewater projects have been funded to improve access to safe water and to enhance resilience to drought and other environmental challenges.[194]

Indicator Data

Based on TFAH's analysis of EPA data, in 2024, an average of 6 percent of residents in each state were served by a community water system with at least

one health-based violation recorded during the year, an increase from 5 percent in 2023. Performance varied dramatically across states. In six states—Delaware, Hawaii, North Dakota, Rhode Island, Washington, and Wisconsin—the proportion was effectively 0 percent. However, in New York, 48 percent of residents relied on community water systems with health-based violations. Louisiana (26 percent), Mississippi (25 percent), Oregon (17 percent), and New Mexico (15 percent) also showed elevated rates. (See Table 4.) Because this measure reflects the share of residents served by systems with violations, a single large city's violation can disproportionately affect its state's percentage. For example, New York's high percentage is largely driven by an unresolved violation within New York City's drinking water system, and violations in Shreveport, Boston, and Portland similarly contribute to elevated percentages in Louisiana, Massachusetts, and Oregon, respectively.

Key health-based standards tracked by EPA include safety limits for chemicals, pathogens, radioactive materials, disinfectants, and disinfection byproducts. Health-based violations can include noncompliance with treatment techniques or other preventive requirements, rather than necessarily indicating that finished drinking water is contaminated.

It is important to note that approximately 23 million U.S. households obtain drinking water from private wells,[195] which can be contaminated or rendered unusable following extreme weather events but are not captured in these data.

Significance of the Indicator

This indicator helps measure a state's capability to provide safe drinking water under normal conditions—a foundational requirement for emergency preparedness. Multiple lines of evidence indicate that water system compliance status is closely related to emergency response capacity.

Research analyzing responses to emergencies has consistently found that pre-disaster infrastructure condition is a key determinant of post-disaster recovery time.[196,197,198] After Hurricane Katrina, EPA estimated that more than 1,220 drinking water systems and about 200 wastewater treatment facilities were affected across Louisiana, Mississippi, and Alabama, with loss of electric power, flooding, and structural damage creating conditions that raised concerns about gastrointestinal illness.[199,200] When Hurricane Ian struck Florida in 2022, infrastructure damage and power outages shut down some treatment plants,[201] illustrating that systems unable to maintain operations under stress may lack the resilience required for effective disaster response.

A 2025 county-level study found that each additional health-based drinking water violation was associated with measurably worse self-reported physical and mental health and annual medical costs in the millions of dollars per county.[202] This evidence demonstrates that violations represent genuine health risks, not merely regulatory technicalities. Systems meeting compliance standards demonstrate organizational capability to plan, invest in infrastructure, maintain operational protocols, and execute complex requirements—precisely the capacities needed for emergency preparedness.

The complementarity principle strengthens this indicator's value: water service disruption during disasters multiplies impacts across all sectors, as water systems provide critical support for healthcare facilities, firefighting, sanitation, and economic activity.

Recent developments underscore the indicator's ongoing relevance. Regulatory actions establishing stricter lead and PFAS standards raise the bar for compliance, meaning that states maintaining high performance are demonstrating enhanced capacity. The emergence of cybersecurity as a critical threat adds a new dimension: systems must now protect against both physical and digital vulnerabilities to ensure continuity of operations during emergencies.

Research also reveals that water system violations are disproportionately concentrated in smaller, rural, and socioeconomically disadvantaged communities.[203] Similarly, according to a November 2024 EPA report to Congress, small community water systems, rural systems, tribal-owned systems, and systems using surface water have been significantly more likely to violate health-based standards. Over a five-year period (FY 2017–FY 2021), violations persisted disproportionately in disadvantaged communities. EPA found that low-income communities and communities of color were about 1.3 times more likely to be served by systems with health-based violations, and that rural community water systems were about 1.6 times more likely to incur such violations.[204] Overall, the report highlights that while national compliance is high, health-based violations remain concentrated, recurrent, and inequitable, posing persistent risks that require targeted oversight and support. States where a larger share of residents are served by fully compliant systems are not only better prepared overall but also more likely to provide equitable protection, avoiding the systematic neglect of marginalized populations that undermines comprehensive preparedness.

Effective management and regulation of water quality under routine conditions reflects the robust public health infrastructure, oversight capacity, and resource availability that enable effective emergency response when crises occur.

TABLE 4: In Most States, Fewer Than 5 Percent of Residents Were Served by Community Water Systems With Health-Based Violations
Percent of each state's population served by a community water system in violation of health-based standards, 2024

States	Percent of Population
DE, HI, ND, RI, WA, WI	0%
CO, CT, FL, IA, MN, MO, NH, NV, UT, VA	1%
AR, IL, MD, ME, MT, OH, TN	2%
DC, ID, MI, NE, VT	3%
AL, GA	4%
AZ, CA, IN, KS	5%
KY, SD, WY	6%
SC	7%
NJ, TX	9%
AK, PA	10%
MA	12%
OK	13%
NC, WV	14%
NM	15%
OR	17%
MS	25%
LA	26%
NY	48%

Note: More than 23 million U.S. households rely on private wells,[205] which are not represented in these data. Only regulated contaminants are included. Community water systems under tribal jurisdiction appear in EPA data but are not attributed to states and therefore are not reflected in state percentages. A single large city's violation can disproportionately affect its state's percentage (e.g., Shreveport, Louisiana; Boston, Massachusetts; New York City; and Portland, Oregon). New York's high percentage is largely driven by an unresolved violation within New York City's drinking water system, which does not comply with the Long-Term 2 Enhanced Surface Water Treatment Rule. Established by EPA, this rule requires additional treatment or protective measures for open reservoirs. This type of violation indicates noncompliance with required preventive safeguards, rather than necessarily indicating that the water is contaminated or unsafe. The underlying compliance obligations have not yet been fulfilled, meaning the city has not yet fully addressed the issue.

Source: TFAH analysis of EPA data.

INDICATOR 6: ACCESS TO PAID SICK LEAVE

KEY FINDING: Access to paid sick leave varies substantially across U.S. regions, ranging from 98 percent of workers in the Pacific division (a regional grouping of states) to 67 percent in the East South Central division. While national access has reached approximately 82 percent of civilian workers, significant gaps remain concentrated among low-wage workers, part-time employees, and those in high-exposure occupations such as food service and healthcare support roles.

Note on Methodological Evolution: This year's indicator shifts from measuring paid time off usage to measuring access to paid sick leave. While usage data can provide useful insights into workforce behavior, access more directly reflects a component of preparedness capacity–whether workers have the formal ability to stay home when ill, rather than only observing who happened to take paid time off during a particular measurement period.

Policy Landscape: Continued State-Level Momentum Amid Federal Stagnation

The United States has no federal law establishing a universal paid sick leave requirement. The Family and Medical Leave Act of 1993 provides up to 12 weeks of unpaid, job-protected leave for certain medical and family reasons but does not require compensation.[206] Over time, limited federal action has led to a patchwork system, with some states and localities passing their own paid sick leave laws. This approach, highly dependent on employers and regional mandates, stands in contrast to the national paid sick leave policies in place in most peer countries.

The Families First Coronavirus Response Act (FFCRA), which provided temporary emergency paid sick leave during 2020, expired at the end of that year despite evidence that it was associated with a reduction of roughly 400 confirmed COVID-19 cases per state per day.[207] The Healthy Families Act, which would have established a national standard of seven paid sick days annually, was introduced in 2023 but was not enacted.[208]

In the absence of federal action, states have continued to fill the gap. As of September 2025, 17 states plus the District of Columbia had enacted paid sick leave requirements,[209] which research shows have substantially expanded access, reduced inequalities in access (especially for part-time and low-wage jobs), and increased employees' use of paid sick time.[210] Three states approved new mandates through November 2024 ballot initiatives:

- **Alaska** voters approved paid sick leave effective July 1, 2025, requiring one hour of leave per 30 hours worked.[211]
- **Nebraska** voters passed Initiative 436, effective October 1, 2025, with the same accrual rate,[212,213] although Nebraska lawmakers have pursued legislative efforts to weaken the voter-approved law.[214]
- **Missouri** voters approved Proposition A in November 2024, but the state legislature subsequently repealed the statutory requirement, prompting advocates to pursue a constitutional amendment.[215,216]

Several states with existing mandates expanded their coverage recently. Connecticut extended coverage from employers with 50 or more employees to those with 25 or more (effective January 2025), with further expansions planned to include all employers by 2027.[217] California increased its minimum from three to five days of mandatory paid sick leave effective January 2024.[218] Michigan transitioned to the more expansive Earned Sick Time Act, with coverage phased in to include employers of all sizes.[219,220] Notably, some states have explicitly incorporated public health emergency–related provisions into their paid sick leave laws, recognizing the role of these policies in pandemic preparedness.[221,222]

However, state progress faces significant headwinds. Eighteen states have enacted preemption laws prohibiting local governments from establishing paid sick leave requirements.[223]

The Public Health Case for Paid Sick Leave

A substantial body of research supports paid sick leave as a relevant indicator of public health emergency preparedness. Studies examining both routine infectious-disease transmission and pandemic response demonstrate generally consistent effects.

Disease Transmission: Research on influenza-like illness shows that state paid sick leave laws reduce influenza-like illness rates by approximately 11 percent in the first year of implementation,[224] with particularly strong effects in states with more comprehensive policy designs, including broader employer coverage and allowance for multiple medical uses.[225] During the 2009 H1N1 pandemic, workers without paid sick leave were more likely to report influenza-like illness,[226] and public health analyses estimated that infected employees reporting to work contributed to millions of additional infections and thousands of deaths nationwide.[227] Workers with paid sick leave are also more likely to receive influenza vaccinations and to seek timely medical care.[228,229]

COVID-19 Evidence: The FFCRA's temporary emergency paid sick leave provided a natural experiment in the relationship between leave policies and pandemic outcomes. At least one study found that states benefiting from this policy—states where FFCRA materially expanded paid sick leave access relative to the pre-FFCRA baseline—saw reduced COVID-19 case counts,[230] and other studies found that the expansion of paid sick leave increased workers' ability to self-quarantine and care for ill family members,[231] directly supporting public health guidance. A large restaurant chain that provided paid sick leave during the pandemic saw decreased rates of workers reporting to work while sick compared with establishments without coverage.[232]

High-Risk Settings: The evidence is particularly compelling for workplaces where disease transmission poses elevated risks. Approximately 63 percent of restaurant workers reported cooking and serving food while ill.[233] In healthcare settings, lack of paid sick leave contributes to healthcare workers continuing to work while ill, increasing the risk of disease transmission to vulnerable patients.[234] Research suggests that paid sick leave policies may reduce infection transmission in nursing homes and hospitals.[235] A cost-effectiveness analysis of sick leave for healthcare workers during the 2009 H1N1 pandemic found that such policies could reduce the spread of infection within healthcare facilities.[236]

Preparedness Infrastructure: Beyond reducing disease transmission during active outbreaks, paid sick leave affects multiple dimensions of emergency preparedness. It enables compliance with isolation and quarantine recommendations, reduces workers continuing to work while ill—a practice that can trigger workplace clusters[237]—and supports continuity of operations by helping prevent larger outbreaks that disrupt business operations. The American Medical Association formally recognized these public health benefits in 2016, adopting a policy that explicitly identifies paid sick leave as essential for infection control.[238]

Business-Sector Recognition of Paid Sick Leave Importance

Parts of the business community have increasingly recognized paid sick leave as critical pandemic preparedness infrastructure. In its Pandemic Preparedness Plan for Business, the Health Action Alliance, a national partnership that helps employers advance workforce and community health, identifies quality paid sick leave as a foundational element of pandemic preparedness actions that companies should take to protect employee health in the workplace.[239]

The plan emphasizes that paid sick leave was "shown to be crucial during both the H1N1 and COVID-19 pandemics," noting that "allowing employees to stay home when they're not feeling well—and without risking their paycheck—helps keep infectious diseases from spreading among your workers."[240] The document points to research showing that people without paid sick leave had the highest rate of illness during the 2009 H1N1 pandemic, and that during COVID-19, three in 10 low-income workers went to work despite having symptoms or known exposure because they couldn't take time off—creating health inequity that "exposes all employees."[241]

The plan advises companies to not only provide paid sick leave but to "make sure employees feel empowered to use it," recognizing that policy alone is insufficient without a workplace culture supporting its use. It further recommends extending this benefit to allow employees to accompany family members to vaccination appointments and healthcare visits, acknowledging that "your workers are not safe from infectious disease if the people in their own homes are vulnerable."[242]

Economic research supports these business perspectives, suggesting that paid sick leave can generate measurable benefits for employers and the broader economy. Studies have found that paid sick leave policies reduce influenza-like illness and workplace "contagious presenteeism,"[243] with potential cost implications for employers. Analyses of jurisdictions that adopted paid sick leave requirements have generally found minimal negative effects on

employment and, in some cases, improved worker retention and stability.[244,245] The policies may also produce broader economic benefits by reducing emergency department utilization and limiting the productivity losses that occur when infectious diseases spread through workplaces.[246] These economic considerations complement paid sick leave's public health value, reinforcing its role as preparedness infrastructure that serves both worker protection and business continuity objectives.

Current Access Levels and Persistent Disparities

According to U.S. Bureau of Labor Statistics (BLS) data released in 2025, 82 percent of civilian workers (i.e., those who work in the private sector or for state or local governments) have access to paid sick time.[247] Encouragingly, this rate has steadily increased since 2014, when it was 67 percent,[248] but nearly one in five workers (approximately 29 million workers[249]) still lack even a single paid sick day. National averages, however, mask profound disparities:[250]

- Only 61 percent of workers in the lowest wage quartile have access, compared with 95 percent in the highest quartile.
- Access is 56 percent among part-time workers versus 90 percent among full-time workers.
- Just 68 percent of workers in service occupations have coverage, compared with 93 percent in management, professional, and related occupations.

These disparities are particularly consequential for emergency preparedness because they concentrate gaps among workers who are more likely to be in high-exposure occupations—such as food service, healthcare support, retail, personal care, and building cleaning roles—and more likely to face economic pressure to work while ill.

Regional variation is also substantial. According to BLS estimates for Census divisions (regional groupings of states), the Pacific division shows the highest access at 98 percent, while the East South Central division reports the lowest at just 67 percent—a 31 percentage point gap. The New England (90 percent), Middle Atlantic (88 percent), and Mountain (87 percent) divisions show relatively high access, all above the national average of 82 percent. The West North Central (78 percent) and East North Central (77 percent) divisions fall slightly below the national average. The West South Central (75 percent) and South Atlantic (74 percent) divisions show notably lower access rates.[251] (See Figure 3.)

From Access to Preparedness Capacity

This indicator measures access rather than utilization for several important reasons. First, access reflects a component of latent preparedness capacity—the formal ability of a state's workforce to respond when illness occurs, regardless of whether workers happened to be sick during a particular measurement window. Second, access data avoid the ambiguity inherent in usage statistics, which can reflect either good population health (low illness rates) or a constrained ability to take leave. Third, emergency preparedness requires surge capacity; a key consideration is whether workers can stay home during an outbreak, not simply whether they did so under routine circumstances.

However, this measure has limitations. Access statistics typically reflect employer-sponsored benefits and may not capture the experiences of gig workers, contractors, and others in nontraditional employment arrangements[252]—populations that can play important roles in service delivery during emergencies. Additionally, having formal access does not guarantee that workers feel able to use leave without repercussions or economic hardship. State-level variation in access reflects complex interactions among state policy mandates, employer practices, industry composition, and workforce demographics. States with strong paid sick leave laws typically show higher access,[253,254] but mandates are not the sole determinant.

Relevance to Emergency Preparedness

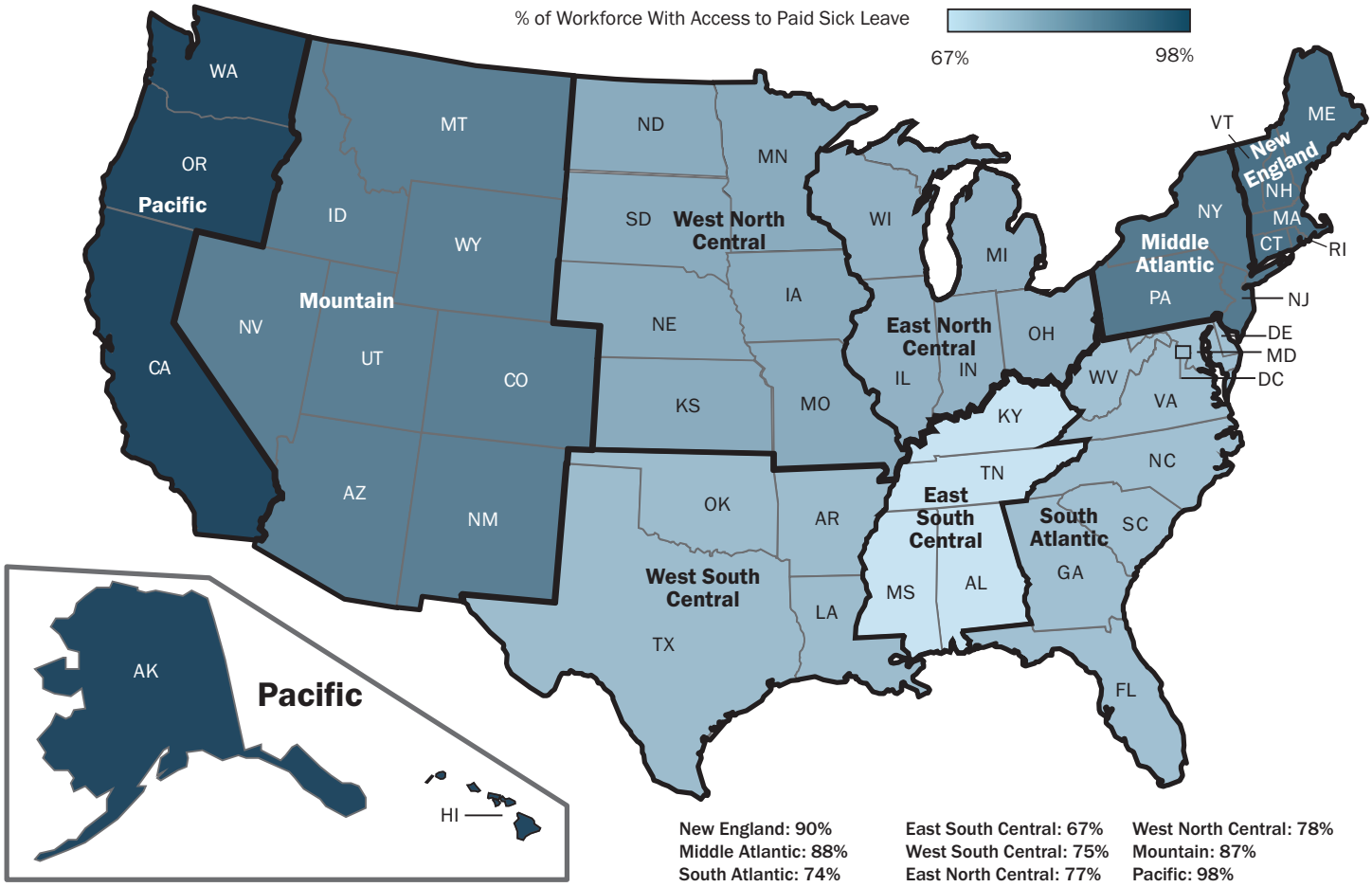
Access to paid sick leave is a measurable component of workforce resilience and infection-control capacity. During public health emergencies, the ability of workers to stay home without losing income or job security can affect disease transmission dynamics, healthcare system strain, and continuity of essential operations. Higher access

rates suggest that a state's policy environment and labor market are more supportive of appropriate illness behavior during outbreaks.

The indicator also reflects underlying inequities in preparedness capacity across the workforce. States with large gaps in access—particularly in high-exposure occupations—may face elevated risks of workplace-driven transmission during outbreaks. As recent state policy developments demonstrate, paid sick leave access is a modifiable dimension of preparedness infrastructure, responsive to policy intervention and increasingly recognized as an important component of effective pandemic response.

Figure 3: Wide Geographic Variation in Access to Paid Sick Leave

Access to Paid Sick Leave by Census Division, 2025



Note: Estimates are based on Census division-level data from the Bureau of Labor Statistics' National Compensation Survey (March 2025). All states within a Census division receive the same estimate. Rates reflect access to paid sick leave, not actual usage. Data include private industry and state and local government workers and exclude federal employees and the self-employed.

The nine Census divisions are: (1) **New England** (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont); (2) **Middle Atlantic** (New Jersey, New York, Pennsylvania); (3) **South Atlantic** (Delaware, District of Columbia, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, West Virginia); (4) **East South Central** (Alabama, Kentucky, Mississippi, Tennessee); (5) **West South Central** (Arkansas, Louisiana, Oklahoma, Texas); (6) **East North Central** (Illinois, Indiana, Michigan, Ohio, Wisconsin); (7) **West North Central** (Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, South Dakota); (8) **Mountain** (Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming); and (9) **Pacific** (Alaska, California, Hawaii, Oregon, Washington).

Source: U.S. Bureau of Labor Statistics.[255]

INDICATOR 7: FLU VACCINATION RATE

KEY FINDING: During the 2024–2025 influenza season, an estimated 44 percent of U.S. residents ages 6 months and older were vaccinated against the flu, continuing a multiyear decline from pre-pandemic levels and falling well short of the 70 percent annual vaccination target set by Healthy People 2030. This downward trend occurred against the backdrop of the most severe flu season in nearly a decade.

Seasonal Flu: Health and Economic Implications

The 2024–2025 influenza season demonstrated the substantial health burden that seasonal flu continues to impose on the United States. The season was classified as "high severity"—the most severe since 2017–2018.[256] The 2024–2025 season cumulative hospitalization rates reached 127.1 per 100,000 population, the highest observed since 2010–2011.[257] Peak weekly hospitalization rates reached 13.5 per 100,000, with rates across all age groups running 1.8 to 2.8 times higher than historical medians.[258] Adults ages 75 and older experienced particularly severe impacts, with hospitalization rates reaching 598.8 per 100,000.[259]

Tragically, a total of 280 influenza-associated pediatric deaths were reported—the highest number in any non-pandemic season since pediatric flu deaths became nationally notifiable in 2004 (the 2009–2010 H1N1 pandemic had 288).[260] Notably, among vaccine-eligible children with known vaccination status who died, 89 percent were not fully vaccinated, and among those with available medical history, about 44 percent had no reported underlying medical conditions.[261] Among hospitalized influenza patients across all ages with available data, about a third had received an influenza vaccine; vaccination status was missing for more than a quarter.[262]

Despite this severity, vaccine effectiveness remained substantial. The 2024–2025 vaccine reduced the likelihood of medically attended influenza by 37 to 56 percent and influenza-associated hospitalizations by 39 to 62 percent, depending on age group.[263] These protections prevented an estimated 9.4 to 16 million illnesses, 170,000 to 360,000 hospitalizations, and 12,000 to 39,000 deaths.[264]

Importance of Vaccination for Preparedness

Annual flu vaccination represents the primary public health strategy for reducing influenza's burden.[265] High vaccination coverage reduces the risk of influenza illness and illness severity, lowers the risk of hospitalization and flu-associated death, and—by preventing cases and hospitalizations—can help reduce seasonal strain on healthcare resources.[266,267] The infrastructure required to deliver seasonal flu vaccines at scale—including distribution systems, provider networks, immunization information systems, public communication campaigns, and supply-chain management—strengthens the foundation for pandemic preparedness and response.[268]

Experience from past pandemics suggests that countries and health systems with established seasonal influenza vaccination programs are better positioned to support pandemic vaccination efforts.[269] Sustained demand for seasonal vaccines helps support ongoing vaccine manufacturing capacity and related research capabilities, which are relevant to surge production during pandemics.[270,271,272] Prior seasonal influenza vaccination has been associated with higher uptake of pandemic influenza vaccination,[273] and consistent seasonal vaccination campaigns may help build public familiarity with vaccination processes and confidence in public health authorities over time. The annual flu vaccination cycle provides continuous opportunities to practice and strengthen response plans, refine distribution systems, and improve communication approaches.[274]

Recent Vaccination Trends and Disparities

Flu vaccination rates have declined substantially from pre-pandemic levels. Among children ages 6 months through 17 years, coverage dropped from 63.7 percent in the 2019–2020 season[275] to approximately 50.2 percent in the 2024–2025 season.[276] Among adults ages 65 and older—the age group at highest risk for severe outcomes—flu vaccination coverage had remained relatively stable since the 2019–2020 season, at approximately 70 percent, but fell to 63.8 percent in the 2024–2025 season.[277] These figures remain below national vaccination goals: Healthy People 2030 sets a target of 70 percent annual influenza vaccination coverage for both children and adults.[278]

Influenza vaccination coverage varies by age, with adults ages 18–49 consistently having the lowest uptake and adults ages 65 and older having the highest.[279] CDC data also document persistent racial and ethnic disparities in coverage, including lower vaccination rates among Black populations compared with white populations, and disparities affecting Hispanic populations in recent reporting.[280,281]

Geographic Variation

State-level vaccination coverage for the 2024–2025 season varied considerably, ranging from 60 percent in the District of Columbia, 59.2 percent in Vermont, and 57.7 in Massachusetts to 33.5 in Nevada, 30.6 in Idaho, and 29.7 in Mississippi.[282] (See Figure 4.)

Federal Investment in Pandemic Vaccine Development

In August 2025, HHS announced a "wind-down"— including the cancellation of some projects and the scaling back of others—of 22 mRNA vaccine development projects under the Biomedical Advanced Research and Development Authority, affecting approximately $500 million in federal investment.[283] This followed the cancellation in May 2025 of a nearly $600 million Moderna H5N1 mRNA vaccine contract.[284] Reducing federal support for mRNA vaccine development—which can shorten vaccine design and production timelines compared with traditional methods—could weaken the nation's ability to respond rapidly to future pandemic threats, including influenza and other emerging infectious diseases. The World Health Organization characterized the August decision as "a significant blow" to pandemic preparedness.[285]

Federal Policy Changes and State Responses

On January 5, 2026, federal health officials announced revisions to the childhood immunization schedule that reduced the number of vaccines recommended for all children from 17 diseases to 11.[286,287] In the wake of the deadliest non-pandemic flu season for children on record, the influenza vaccine was moved from the universal recommendation category to "shared clinical decision-making," meaning it was no longer recommended for all children but instead left to consultation between healthcare providers and parents.[288,289,290] These revisions followed a May 2025 Secretarial directive on COVID-19 vaccine recommendations[291] and a December 2025 decision by the Advisory Committee on Immunization Practices (ACIP) limiting Hepatitis B birth dose recommendations.[292]

The revisions took effect immediately and did not go through ACIP's usual review process. For decades, changes to the childhood immunization schedule have typically followed open discussion by ACIP, including review of scientific evidence and public deliberation over

benefits and risks. In announcing the change, federal officials did not cite new peer-reviewed scientific evidence supporting the revision. Federal officials indicated that vaccines in all three categories of the updated schedule—those recommended for all children, those recommended for only specific populations, and those subject to shared clinical decision-making—would continue to be covered without cost-sharing.[293] Officials stated that the revisions were intended to better align U.S. policy with approaches used in "peer nations" and to help address declining public confidence in vaccination programs.

Medical professional societies and public health experts raised substantial concerns about these changes. Because established regulatory processes were not followed, external experts were not given the opportunity for formal public comment through the usual ACIP deliberative process. The American Academy of Pediatrics stated that it would continue to recommend its existing childhood immunization schedule, including annual influenza vaccination for all children ages 6 months and older.[294]

On March 16, 2026, a federal court in Massachusetts granted preliminary relief blocking implementation of the January 2026 revision to the federal childhood immunization schedule and restricting actions taken by the reconstituted ACIP, finding that plaintiffs were likely to succeed in showing both actions violated federal law.[295] The court found that the schedule revision was likely unlawful because Congress has required ACIP's involvement in developing immunization recommendations, and federal officials bypassed that process, relying instead on officials without a statutory role in CDC vaccine policy. As to ACIP's reconstitution, the court found that the June 2025 mass termination and rapid replacement of all 17 members likely violated federal requirements that advisory committees be fairly balanced, noting concerns about the expertise of newly appointed members and the abandonment of longstanding vetting procedures. The court also granted relief affecting three vaccine recommendation votes the reconstituted ACIP had taken in 2025: a June vote on thimerosal in flu vaccines, a September vote downgrading the COVID vaccine recommendation to shared clinical decision-making, and a December vote recommending individualized decision-making for the hepatitis B birth dose.[296]

States retain authority over school vaccination requirements. By early 2026, a majority of states and the District of Columbia had indicated they would not fully adopt the revised federal schedule.[297] Connecticut, for example, which has required influenza vaccination for preschool children since 2010,[298] announced it would not change its requirement.[299] Following implementation of Connecticut's requirement, vaccination rates among children ages 6 months through 59 months increased from 67.8 percent to 84.1 percent, and flu-associated hospitalization rates for children ages 4 and under decreased by 12 percent—the largest decrease among 11 surveillance sites.[300]

However, the potential for increased state-level fragmentation in vaccination policies has emerged. Exemption rates for one or more required childhood vaccinations reached an all-time high of 3.6 percent in the 2024–2025 school year, compared with 2.5 percent in the 2019–2020 school year.[301,302]

Innovations in Access and Delivery

In September 2024, the Food and Drug Administration (FDA) approved FluMist, a nasal-spray influenza vaccine, for self-administration by adults ages 18 through 49 and for administration by a caregiver (ages 18 or older) to children and adolescents ages 2 through 17, allowing administration outside healthcare settings while remaining prescription-only.[303,304] This approval enables at-home administration and may reduce barriers to vaccination. In March 2025, Flublok, a protein-based influenza vaccine produced without using live influenza viruses, received approval for use in individuals ages 9 and older, expanding from its previous indication for adults ages 18 and older.[305,306]

Policy and Practice Strategies

Reversing declining flu vaccination rates will likely require addressing multiple barriers, including vaccine hesitancy, concerns or uncertainty about safety and effectiveness, and low perceived risk—factors that are often reported among younger adults. Potential strategies include:

- Expanding vaccine access through pharmacies, schools, workplaces, and community centers.
- Strengthening evidence-based public communication to counter misinformation and convey the potential health and economic impacts of influenza.
- Strengthening immunization information systems to enable targeted outreach to populations at higher risk.
- Implementing workplace policies (e.g., paid time off for preventive care or vaccination) to reduce time and cost barriers to getting vaccinated.

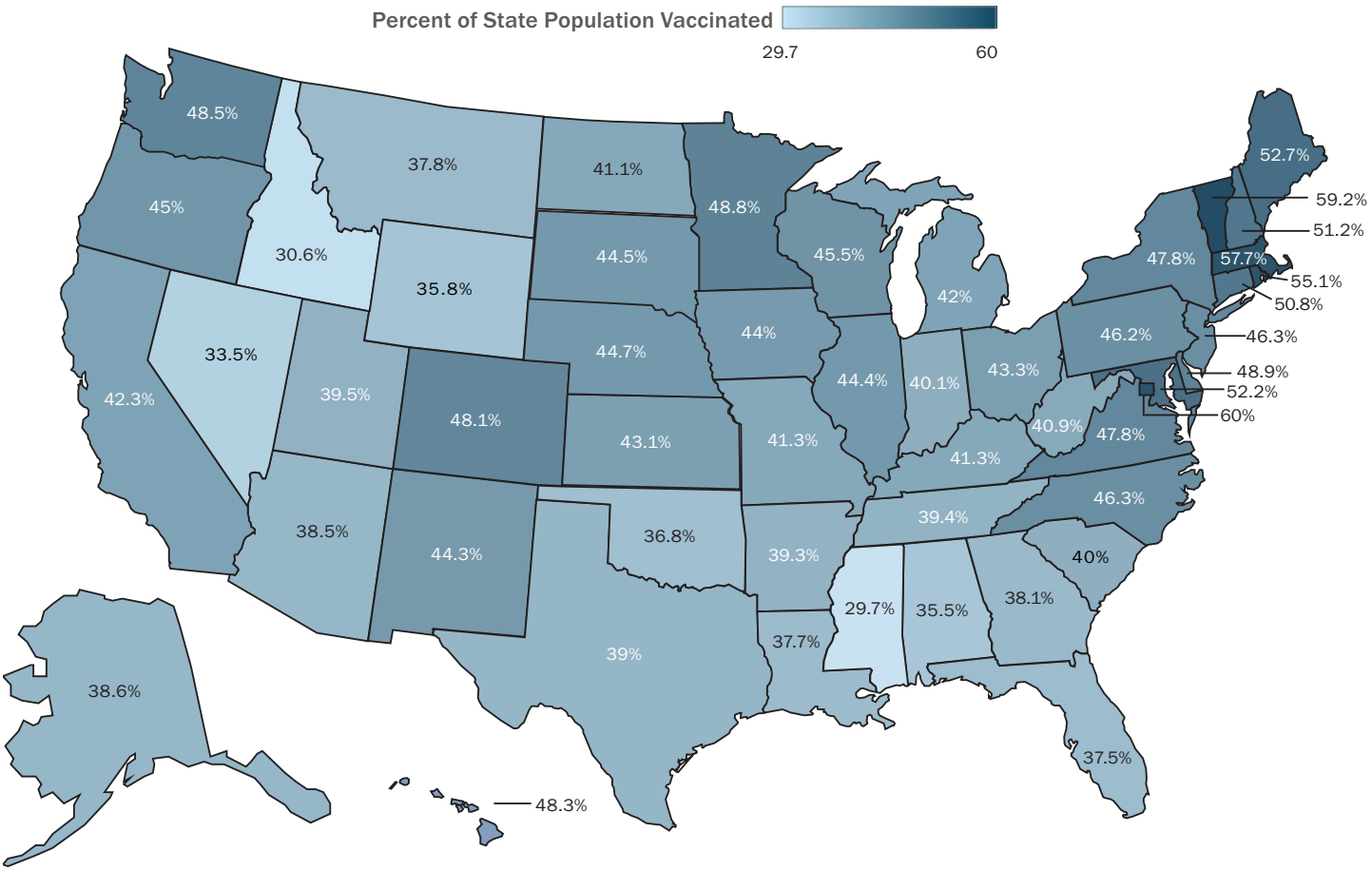
- Authorizing additional healthcare providers to administer vaccines.
- Maintaining influenza vaccination requirements in settings where states or localities have adopted them (e.g., healthcare facilities, certain childcare/preschool programs).

Indicator Significance for Emergency Preparedness

Seasonal flu vaccination rates can serve as a useful proxy for certain aspects of state preparedness—particularly the capacity to deliver preventive services at scale and to reach communities effectively. Higher coverage may reflect stronger access to vaccination, more effective delivery and distribution channels, and greater public acceptance of vaccination. Because pandemic vaccination efforts often build on existing immunization infrastructure (including provider networks, data systems, and communication channels), seasonal flu vaccination performance can provide a practical indicator related to a state's readiness to implement large-scale vaccination during respiratory disease emergencies.

Figure 4: Well Under Half of U.S. Residents Received a Seasonal Flu Vaccination

Seasonal flu vaccination rates for people ages 6 months and older, by state, 2024–2025



Note: Data are derived from a population-based survey and are subject to sampling error. "Flu vaccination" refers to the receipt of any seasonal influenza vaccine during the 2024–2025 flu season.

Source: Centers for Disease Control and Prevention.[307]

INDICATOR 8: PATIENT SAFETY IN HOSPITALS

KEY FINDING: In the fall 2025 Leapfrog Hospital Safety Grade assessment, 27 percent of U.S.-eligible general hospitals receiving a Leapfrog Safety Grade, on average, earned an "A"—unchanged from fall 2024. While three states (New Jersey, Utah, Virginia) saw more than half of graded hospitals achieve the highest rating, four states (Iowa, North Dakota, Vermont, and Wyoming) had none.

Historical Context and the Evolution of Patient Safety

The concept of hospital patient safety in the United States has evolved over the past century. Early technological advances and the introduction of antibiotics improved outcomes but also introduced new patient safety challenges. In the late 20th century, growing awareness of medical errors led to increased scrutiny of hospital care, culminating in the Institute of Medicine's *To Err Is Human* report.[308] This landmark study sparked a national conversation and contributed to the adoption of systematic safety protocols, quality-improvement strategies, and, over time, the expanded use of health information technologies such as electronic health records.[309] Most recently, the COVID-19 pandemic highlighted the critical importance of robust infection control and healthcare system resilience, reinforcing the need for continual patient safety improvement.

In 2023, the American Hospital Association launched a Patient Safety Initiative aimed at addressing systemic challenges in healthcare safety and improving outcomes across hospitals and health systems.[310,311] By emphasizing a culture of safety, addressing disparities in outcomes, and promoting workforce safety and well-being, the initiative highlights the importance of foundational conditions that support safe care delivery. From the perspective of public health and emergency preparedness, efforts to embed safety into operational strategies are significant because they can strengthen healthcare facilities' capacity to manage surges in demand during emergencies, helping to safeguard community health and trust in healthcare systems.

Effective January 1, 2026, the Joint Commission, an independent organization that accredits and certifies U.S. hospitals and other healthcare organizations and sets nationally recognized patient safety and quality standards, replaced its National Patient Safety Goals with National Performance Goals, reorganizing accreditation requirements into more salient, measurable topics with clearly defined goals.[312] This evolution in national standards reflects the field's continued operationalization of measurable safety expectations for hospital accreditation.

Patient and Staff Safety as a Component of Preparedness

Despite progress, some analyses estimate that preventable harms in hospitals—including errors, injuries, accidents, and infections—contribute to more than 200,000 deaths annually in the United States.[313,314] Ensuring patient safety is integral to preparedness. Hospitals that demonstrate strong patient-safety performance may be less likely to inadvertently harm patients or exacerbate a public health crisis. They may also be better positioned to maintain quality standards under stress, such as during infectious-disease outbreaks, natural disasters, or surges in patient volume.

Research on hospital surge capacity suggests that adequate medical surge preparedness can help reduce the severity of injuries and loss of life during emergencies or disasters.[315] Surge capacity requires optimization across four domains—staff, supplies, space, and systems—which are commonly cited as core components of surge planning and are closely linked to baseline hospital operations. The foundational elements of patient safety, including infection

control, medication safety, standardized protocols, hand hygiene compliance, and reliable clinical systems, are important for maintaining quality care during surge situations.

Lessons from the COVID-19 Pandemic

The COVID-19 pandemic placed extraordinary strain on hospitals, testing infection-control practices, staffing capacity, and core safety systems. Evidence from the pandemic consistently shows that periods of severe hospital strain and overcrowding were associated with delayed care, disruptions in clinical processes, and increased mortality.[316,317,318] These dynamics exposed vulnerabilities in hospital operations during surges, particularly when staffing, supplies, or standardized procedures were stretched beyond capacity. At the same time, the pandemic highlighted the importance of foundational patient-safety capabilities—such as effective infection prevention, clear clinical protocols, reliable information systems, and a strong safety culture—in supporting hospitals' ability to maintain quality of care under crisis conditions. Together, these experiences underscore the role of patient safety infrastructure as a critical component of health system readiness for public health emergencies.

The Leapfrog Group's Hospital Safety Grade

Established in 2000, the Leapfrog Group is a nonprofit organization focused on enhancing U.S. healthcare quality and patient safety. In 2025, marking its 25th anniversary, the organization continued its Hospital Safety Grade, which is issued twice a year and evaluates nearly 3,000 general acute-care hospitals using multiple national patient safety measures drawn from the Centers for Medicare & Medicaid Services (CMS), the Leapfrog Hospital Survey, and other supplemental data sources.[319] Each hospital's performance is distilled into a single letter grade (A through F), reflecting its success in preventing medical errors, infections, and other forms of harm. The Safety Grade brings together several well-established measures of patient safety—including indicators of medical errors and hospital-acquired infections—to provide a clear, overall picture of hospital safety performance.

Recent National Improvements in Core Safety Measures

Leapfrog's fall 2024 release documented significant national improvements in patient safety across several key measures.[320] Healthcare-associated infections (e.g., central line-associated bloodstream infections, catheter-associated urinary tract infections, MRSA infections) showed dramatic declines from their fall 2022 peak. Hand hygiene compliance improved substantially, with the percentage of hospitals meeting Leapfrog's standard rising from 11 percent in 2020 to 78 percent in 2024. Medication safety measures also improved.[321]

Variation Across States and the "Straight A" Benchmark

In fall 2025, 27 percent of graded hospitals, on average, received an "A" grade, but the distribution varied widely. Some states excelled, with over half of graded hospitals earning top marks—Utah at 61 percent (maintaining the top ranking for the fifth consecutive grading round[322]), Virginia at 54 percent, and New Jersey at 52 percent.[323] Meanwhile, four states—Iowa, North Dakota, Vermont, and

Wyoming—had no hospitals achieving the highest grade.[324] (See Figure 5.)

Leapfrog's spring 2025 release introduced a "Straight A" designation spotlighting hospitals that sustained an "A" grade for five or more grading rounds. Nationally, 346 hospitals (12 percent of all eligible hospitals) achieved this benchmark, with 11 hospitals earning an "A" grade for all 27 grading rounds since the program began in 2012.[325] State-level analysis showed Connecticut, Utah, and New Jersey leading in the percentage of Straight A hospitals since spring 2023.[326]

Measurement Considerations and Limitations

As with other composite ratings, Hospital Safety Grades can be affected by data availability, reporting participation, and periodic measure updates, so year-to-year changes should be interpreted cautiously. Leapfrog's 2025 hospital survey documentation explicitly discusses how results may be based on limited data in the event of reported cybersecurity events or natural disasters.[327]

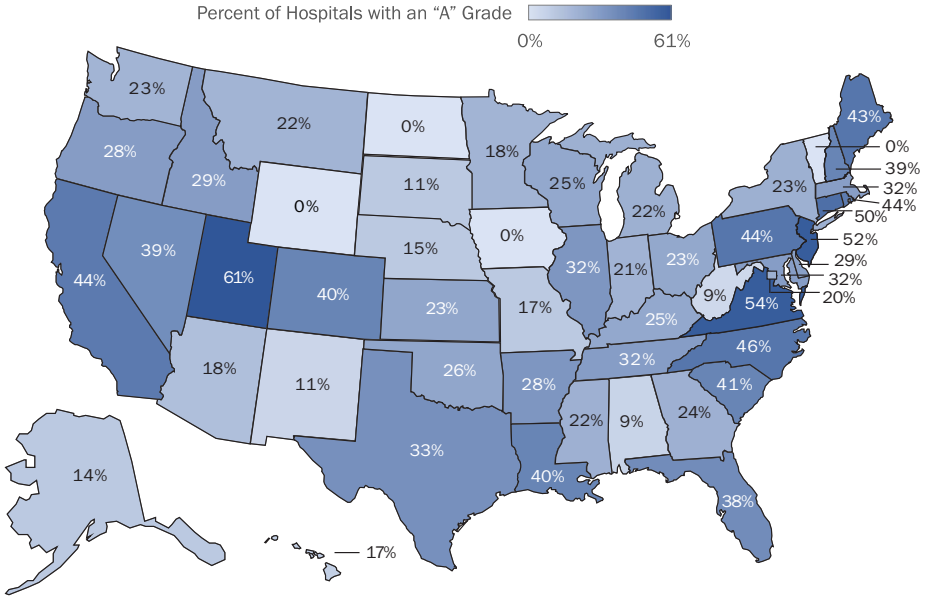
Academic research has raised concerns about hospital rating systems' validity and concordance. A 2024 peer-reviewed analysis examining concordance between hospital rating organizations, including Leapfrog and CMS star ratings, showed a non-trivial mismatch, suggesting that different rating systems may measure different constructs or be influenced by different inputs.[328] Earlier research has noted that patient safety grades can be affected by selection bias related to survey participation and may misrepresent performance for nonparticipating hospitals.[329,330] These limitations underscore that the Leapfrog grade represents a distinct lens on hospital safety—one built from evidence-based measures—rather than a definitive assessment of overall hospital quality.

Reinforcing Preparedness Through Patient Safety

The Leapfrog Hospital Safety Grade provides a standardized, evidence-based method for gauging hospital safety performance. Because safety performance is influenced by factors such as clinical protocols, staffing practices, infection-prevention capacity, and the reliability of clinical systems, variation in hospital safety may reflect differences in baseline operational capacity that are relevant during public health emergencies. Hospitals with stronger safety performance may be better positioned to maintain quality care during periods of stress, including surges in patient volume. By highlighting performance trends and identifying areas for improvement, these assessments can inform resource allocation and quality-improvement efforts that support healthcare system readiness for public health emergencies.

Figure 5: Hospital Patient Safety "A" Grades Remain Uneven Across States

Percentage of general acute-care hospitals earning an "A" grade, fall 2025



Note: This measure applies exclusively to general acute-care hospitals. Data are drawn from the Leapfrog Group's "Fall 2025 Hospital Safety Grade" assessments.

Source: The Leapfrog Group.[331]

INDICATOR 9: STATE PUBLIC HEALTH LABORATORY SURGE CAPACITY

KEY FINDING: In 2025, 49 states and the District of Columbia reported having a written plan to handle a surge in laboratory testing capacity for six to eight weeks in response to an outbreak or other public health event. One state (Utah) reported not having such a plan.

The Critical Role of Laboratory Surge Capacity in Emergency Response

State public health laboratories serve as essential frontline responders in detecting and mitigating health threats. During emergencies—whether infectious-disease outbreaks, bioterrorism events, or environmental contamination—these laboratories rapidly scale their operations to meet surging testing demands. The ability to sustain elevated testing volumes for multiple weeks can materially affect whether an outbreak is contained early or spirals into a broader crisis.[332]

Experience from past public health emergencies indicates that surge plans help jurisdictions expand testing capacity efficiently and consistently. Early in outbreaks, limitations in diagnostic testing capacity can delay case identification and hinder timely public health actions such as contact-tracing and targeted interventions. Both the H1N1 pandemic and the COVID-19 response underscored that expanding testing capacity depends not only on equipment and supplies, but also on the availability of trained laboratory personnel and the ability to sustain staffing over time.[333,334] Federal reviews of early COVID-19 testing emphasized that the absence of a coordinated plan for surge laboratory testing contributed to delays in scaling testing and slowed downstream public health actions.[335,336]

A written surge plan indicates that a state has formally documented assumptions, procedures, and coordination mechanisms for expanding laboratory operations during periods of elevated demand. In practice, internal surge capacity refers to a laboratory's ability to implement substantial operational changes—such as reallocating staff, extending work hours, and mobilizing available internal resources—to respond to rapid increases in testing volume.

Recent Developments Affecting Laboratory Capacity

The past year has brought significant challenges to state public health laboratory preparedness, driven by major federal funding disruptions and multiple infectious-disease responses that required sustained surveillance and testing.

In late March 2025, HHS issued termination notices for roughly $11.4 billion in COVID-era CDC grant funding that had been awarded to state and local recipients.[337] The largest share of the affected funding—approximately $8.9 billion—came from the Epidemiology and Laboratory Capacity program, which states and localities used to support laboratory staffing, testing operations, surveillance systems, and related preparedness infrastructure.

In response, multiple states filed a suit in federal court, arguing that the funds had been lawfully awarded, relied on for ongoing public health operations, and could not be withdrawn without violating administrative and statutory requirements. Court orders blocked the terminations for the plaintiff states and the District of Columbia while litigation proceeded. Because that relief did not automatically apply nationwide, impacts varied by jurisdiction, and the litigation remained unresolved as of February 2026.

Meanwhile, several concurrent infectious-disease responses created sustained testing and surveillance demands, even as jurisdictions faced uncertainty and disruption related to federal public health grant funding.

Measles outbreaks substantially increased demand for case confirmation and related laboratory support in many jurisdictions. For the full year of 2025, CDC reported 2,285 confirmed measles cases—more than eight times the 285 cases reported in 2024 and the highest annual total since 1991.[338] These cases occurred across 48 separate outbreaks, predominantly in communities with low vaccination coverage.[339]

Measles investigations often rely on laboratory confirmation (e.g., RT-PCR and/or serology), and molecular characterization (including genotyping) is used to help map transmission pathways. The volume and geographic distribution of these outbreaks demanded sustained laboratory operations across multiple states simultaneously—exactly the scenario that surge plans are designed to address.

Tuberculosis testing increased in response to a prolonged outbreak in the Kansas City metropolitan area that was first identified in early 2024. As of January 31, 2025, state and local health officials reported 67 active tuberculosis cases and 79 latent TB infections associated with the outbreak, which primarily affected Wyandotte County, Kansas, and was linked to two deaths.[340] The response required extensive contact tracing and sustained laboratory testing to identify cases, distinguish between active and latent infection, and monitor transmission over time.

H5N1 avian influenza also required sustained laboratory surveillance throughout 2025 as part of ongoing national monitoring of animal and human exposures. By early 2025, the outbreak had been detected in nearly 1,000 dairy herds across 17 states and had affected more than 90 million birds nationwide,[341] necessitating continued confirmatory testing, sequencing, and coordination across animal and human health systems. In January 2025, the United States reported its first known human death associated with H5N1; a second person died in November 2025 from the H5N5 strain, reinforcing the importance of maintaining laboratory capacity for sustained surveillance and rapid diagnostic response.[342] Notably, a CDC-led assessment published in 2024 found that 66 percent of jurisdictions reported difficulties monitoring H5N1-exposed individuals due to personnel shortages or lack of funding.[343]

The 2025–2026 seasonal influenza season added further pressure on public health laboratories. As of late December 2025, CDC estimated that there had been approximately 11 million influenza illnesses, 120,000 hospitalizations, and 5,000 deaths nationwide.[344] Surveillance showed that a version of the influenza A(H3N2) virus—different from the strain used to design the season's vaccine—became dominant, requiring continued laboratory testing to monitor how the virus was changing. During this period, many states reported very high levels of influenza-like illness activity, requiring sustained virologic surveillance, sequencing, and characterization at CDC and state public health laboratories.

What a Surge Plan Encompasses

Written surge plans are intended to support faster, more coordinated operational changes during a surge. Effective laboratory surge plans address multiple operational dimensions. They identify adequate physical space, up-to-date instruments, and reliable supply chains.[345,346] They establish staffing

protocols, including cross-training programs and procedures for rapidly reassigning staff and onboarding additional personnel. Plans can specify operational guidelines for maintaining accuracy and safety under increased testing loads, may include pre-negotiated agreements with academic and commercial laboratories,[347] and define clear communication channels with healthcare facilities, government agencies, and the public.

The presence of a written surge plan serves as a baseline measure of whether states have institutionalized laboratory surge preparedness rather than relying on ad-hoc crisis response. However, this indicator has important limitations. It reflects only the existence of documentation, not the plan's quality, comprehensiveness, testing frequency, or recency. A plan created years ago and not regularly updated may provide limited value during an actual emergency.

Moreover, a written plan does not guarantee execution. Actual surge capacity is shaped by current staffing levels, adequate supplies and equipment, functional facilities, active partnerships, and regular training exercises.

In the current fiscal environment, many states face constrained resources and limited flexibility to maintain laboratory surge capacity. As a result, preparedness depends on the ability to scale operations through advance planning rather than relying on standing surplus resources. In this context, the presence of a current written laboratory surge plan remains a meaningful indicator of emergency preparedness infrastructure.

TABLE 5: All But One State Have a Written Laboratory Surge Plan
State public health laboratories with or without a written plan for a six- to eight-week surge in testing capacity, 2025

Had a Plan				No Plan
Alabama	Illinois	Montana	Rhode Island	Utah
Alaska	Indiana	Nebraska	South Carolina	
Arkansas	Iowa	Nevada	South Dakota	
Arizona	Kansas	New Hampshire	Tennessee	
California	Kentucky	New Jersey	Texas	
Colorado	Louisiana	New Mexico	Vermont	
Connecticut	Maine	New York	Virginia	
Delaware	Maryland	North Carolina	Washington	
District of Columbia	Massachusetts	North Dakota	West Virginia	
Florida	Michigan	Ohio	Wisconsin	
Georgia	Minnesota	Oklahoma	Wyoming	
Hawaii	Mississippi	Oregon		
Idaho	Missouri	Pennsylvania		

Note: This indicator only reflects the existence of a written surge plan. It does not assess the plan's quality, comprehensiveness, or how frequently it is tested or utilized.

Utah reported that it has a completed Continuity of Operations Plan but has yet to finalize a written surge capacity plan. The state anticipates completing this as part of its federal public health preparedness requirements in the next funding cycle.

Source: Association of Public Health Laboratories.

INDICATOR 10: AVOIDABLE MORTALITY

KEY FINDING: Avoidable mortality declined nationally between 2020–2021 and 2022–2023, yet substantial variation across states and pronounced racial and ethnic disparities persist. Although the United States experienced worsening avoidable mortality trends from 2009 to 2021 while many peer nations saw improvements prior to the COVID-19 pandemic, recent national reductions provide a limited but noteworthy positive signal. At the same time, gaps remain wide, and Black Americans and American Indian/Alaska Native populations continue to experience markedly higher avoidable mortality rates in the vast majority of states. These patterns are consistent with underlying differences in health system performance, access to care, and longstanding structural inequities that shape both routine health outcomes and baseline preparedness for public health emergencies.

Understanding Avoidable Mortality

Avoidable mortality captures premature deaths occurring before age 75 from two distinct but complementary categories of causes, based on a standard methodology developed by the Organisation for Economic Co-operation and Development (OECD), an international organization that analyzes and compares economic and health system performance across countries, and Eurostat, the European Union's statistical office, which produces harmonized data for cross-country comparison.[348]

Preventable Causes: These are deaths that could be avoided through effective public health and primary-prevention interventions before disease or injury onset. Examples include fatalities from vaccine-preventable infectious diseases, injuries reducible through safety regulations and environmental safeguards, and conditions such as alcohol- or drug-related mortality that can be mitigated through robust prevention and early intervention strategies.[349]

Healthcare-Treatable Causes: Also called "amenable mortality," these are deaths that timely and effective healthcare interventions should prevent. These include conditions such as diabetes-related complications, certain cardiovascular diseases, and cancers (including colon and breast cancer) that, when identified early and managed appropriately, need not lead to premature death. These conditions test the accessibility, efficiency, and quality of a state's healthcare delivery system.

The age-75 threshold originates from international practices ensuring comparability across countries and has been adopted by the OECD and Eurostat in their joint methodology. The Commonwealth Fund—TFAH's data source for state avoidable mortality—employs this framework in its analyses. While this threshold ensures consistency and reflects contexts of countries with lower life expectancies, it may underestimate deaths potentially avoidable beyond age 75.

Together, these two domains offer a useful starting point for assessing states' capacity to reduce premature deaths through both prevention and healthcare—from upstream preventive measures at the community level to downstream treatments and chronic disease management in clinical settings. Approximately 70 percent of avoidable mortality stems from preventable causes, underscoring the critical importance of public health interventions, injury prevention, vaccination programs, and efforts to reduce environmental hazards.

The Connection to Emergency Preparedness

Avoidable mortality is not a direct measure of emergency operations, but it captures baseline conditions—health system effectiveness and preventable risk—that are associated with how communities fare during health emergencies. The COVID-19 pandemic illustrated this connection. Communities with higher baseline health burdens and structural inequities experienced disproportionate pandemic impacts.[350,351,352,353,354,355,356] Geographic patterns also overlapped: regions with historically higher rates of avoidable mortality—particularly the South[357]—also experienced elevated COVID-19 mortality and other adverse outcomes, reflecting underlying differences in population health, health system capacity, and structural inequities rather than emergency-response performance alone.

County-level studies found that markers of public health infrastructure (e.g., capabilities, expenditures, planning activities) were associated with COVID-19 mortality, independent of many county characteristics.[358,359] This is consistent with the idea that foundational prevention and care-delivery capacity—factors that also contribute to avoidable mortality—can shape crisis outcomes. Research demonstrates that baseline health system standards are foundational for emergency response.[360]

Troubling National Trends

A major 2025 study published in *JAMA Internal Medicine* found that avoidable mortality increased in all 50 U.S. states and the District of Columbia between 2009 and 2021, diverging from trends in most other high-income countries, where avoidable mortality generally declined from 2009 to 2019 before rising during the COVID-19 pandemic.[361] This indicates a marked divergence in U.S. trajectory from peer nations. State variation was substantial: from 2009 to 2019, avoidable mortality increased by 4.9 deaths per 100,000 in New York, compared with an increase of 99.6 deaths per 100,000 in West Virginia.[362] Increases in preventable mortality were the primary driver of overall worsening trends.

This deterioration occurred despite the United States spending more on healthcare per capita than any other country in the analysis.[363] Notably, the study found no statistically significant association between state-level healthcare spending and avoidable mortality across U.S. states, whereas among the high-income comparator countries included in the analysis, higher health spending was significantly associated with lower avoidable mortality.[364] This suggests broad, systemic factors and raises questions about the efficiency of health spending.

One potentially positive signal emerged from national injury trends: CDC provisional data showed substantial declines in overdose deaths during 2024, with most states experiencing reductions.[365] If sustained, this could contribute to lower preventable mortality.

The Critical Role of Equity

Equity is central to understanding avoidable mortality's preparedness implications. Even states with relatively low overall rates may harbor large disparities among racial and ethnic groups and among urban, suburban, and rural populations, signaling that not all communities benefit equally from prevention or treatment opportunities. The Commonwealth Fund's 2025 State Scorecard continued to document substantial income- and race/ethnicity-related disparities across states, including persistent gaps in potentially avoidable emergency department visits as well as in mortality measures commonly used to assess health system performance.[366] Persistent inequities are shaped by complex nonmedical drivers of health: differences in insurance coverage, neighborhood conditions, language barriers, cultural competency of healthcare providers, and underlying systemic biases.

Federal Policy Context

The federal policy environment in 2025 raised new concerns about states' capacity to address avoidable mortality. Proposed federal reorganization efforts within HHS, including proposed reductions and structural changes affecting CDC, could alter public health and health system infrastructure that supports efforts to reduce preventable and treatable deaths.[367]

Recent federal budget proposals and administrative actions have included reductions, consolidations, or uncertainty affecting CDC's prevention activities and the broader public health workforce, including programs that support injury and violence prevention, chronic disease prevention, and surveillance and response capacity. The Substance Abuse and Mental Health Services Administration has also faced similar disruptions. These functions play a central role in preventing premature mortality and ensuring timely identification and management of conditions that are amenable to effective intervention. Changes that reduce staffing levels, disrupt program continuity, or limit technical assistance to states may constrain states' ability to sustain prevention or treatment efforts and address longstanding drivers of avoidable mortality, particularly in underserved communities at high risk of drug overdose deaths, diabetes-related complications, cardiovascular disease, certain screen-detectable or treatable cancers, and other preventable and treatable causes of premature death.

These developments are concerning in light of empirical evidence showing that greater public health system investment is associated with lower mortality from preventable causes.[368] When prevention capacity, care coordination, and access to effective health services are weakened, populations already experiencing elevated avoidable mortality under routine conditions may face heightened risk—both in day-to-day health outcomes and during public health emergencies.

Results: Patterns Across States

The 2022–2023 data reveal a complex picture: while overall avoidable mortality rates declined nationally and across nearly all states compared with recent years, substantial variation persists and racial and ethnic disparities remain stark. Some encouraging improvements emerged alongside persistent inequities, demonstrating that progress is possible but unevenly distributed.

National and State-Level Improvements

The national avoidable mortality rate fell to 278 per 100,000 people in 2022–2023, representing a meaningful decline from recent years (322 in 2020–2021 and 317 in 2021–2022).[369] This improvement occurred across all but two states (Maine and Vermont), with reductions observed in both states with the lowest and highest rates. However, the magnitude of these improvements varied considerably, and the fundamental ranking of states remained largely stable. (See Table 6.)

Overall Avoidable Death Rates

Massachusetts (201 per 100,000 people), New Jersey (203 per 100,000 people), and Utah (208 per 100,000 people) lead the nation with the lowest avoidable mortality rates. New Jersey, in particular, showed substantial improvement, declining 21 percent from its 2020–2021 rate of 258 per 100,000. Minnesota (215 per 100,000 people) and Connecticut (216 per 100,000 people) round out the states with the lowest rates.[370] These states' success may reflect factors such as strong public health infrastructure, accessible primary care, comprehensive insurance coverage, and effective treatment services—fewer missed opportunities in preventing and managing disease.

At the other end of the spectrum, West Virginia (445 per 100,000 people), Mississippi (430 per 100,000 people), and Oklahoma (410 per 100,000 people) continue to experience the highest avoidable death rates. Notably, avoidable mortality rates in these states also declined substantially—by 17 percent in Mississippi (from 519 per 100,000 in 2020–2021), 10 percent in West Virginia (from 494 per 100,000), and 11 percent in Oklahoma (from 461 per 100,000). While encouraging, these reductions still leave these states far above the national average. Kentucky (396 per 100,000 people) and Tennessee (394 per 100,000 people) complete the states with the highest rates.[371]

Regional patterns persist. For example, northeastern states tended to have substantially lower rates than southern states. This pattern is consistent with longstanding regional differences in socioeconomic conditions, educational attainment, access to healthcare, and levels of public health investment, which are factors associated with population health outcomes.

Preventable causes continue to dominate avoidable mortality, accounting for 69 percent of total avoidable deaths nationally.[372] State-level proportions range from 64 to 75 percent, underscoring the continued importance of upstream interventions: strengthening community conditions that support health, reducing injuries, ensuring robust vaccination programs, mitigating environmental hazards, and controlling infectious diseases. Treatable deaths, while fewer, still represent nearly one-third of avoidable deaths and reflect the quality, accessibility, and timeliness of clinical care.[373]

Racial and Ethnic Disparities

The data continue to reveal a persistent and troubling pattern: Black Americans and American Indian/Alaska Native (AI/AN) populations experience the highest avoidable mortality rates in the vast majority of states. Across the country, Black populations face the highest rates in 27 states and the District of Columbia, while AI/AN communities experience the highest rates in 22 states. Only in Hawaii does Hispanic population mortality exceed other groups. In contrast, Asian American, Native Hawaiian, and Pacific Islander (AANHPI) communities have the lowest avoidable mortality rates in 42 states and the District of Columbia, with Hispanic populations showing the lowest rates in five states, and the AI/AN population in three states. (See Table 6.)

The magnitude of these disparities varies dramatically. South Dakota exhibits the largest gap at 931 per 100,000—the difference between AI/AN and Hispanic populations' avoidable mortality rates. Minnesota (767 per 100,000), North Dakota (697 per 100,000), Montana (646 per 100,000), and Wyoming (620 per 100,000) complete the five states with the largest disparities, largely reflecting substantially higher avoidable mortality rates among AI/AN populations compared with other racial and ethnic groups in those states. Compared with 2020–2021 data, these largest gaps have narrowed somewhat, indicating modest reductions in disparities in these states, although inequities remain pronounced. [Note: Disparity calculations for Hawaii, Vermont, and Wyoming include data from prior years for specific racial/ethnic groups where 2022-23 data were unavailable; see table note for details.]

At the other extreme, Hawaii (124 per 100,000), New Hampshire (197 per 100,000), and Massachusetts (206 per 100,000) have the smallest gaps between the racial/ethnic groups with the highest and lowest avoidable mortality rates. Rhode Island (222 per 100,000) and Florida (235 per 100,000) round out the five states with the smallest disparities. However, even these relatively smaller gaps remain substantial, and several widened compared with 2020–2021 (Hawaii increased from 105, New Hampshire from 185, and Rhode Island from 192). These patterns underscore that narrowing disparities requires sustained attention and continued efforts to promote equitable health outcomes.

The Persistent Challenge: Overall Performance Does Not Equate to Equity

The data confirm that low overall mortality does not automatically translate into equity. Minnesota exemplifies this paradox: ranking fourth-lowest nationally with an overall rate of 215 per 100,000, yet simultaneously experiencing the second-largest racial/ethnic gap at 767 per 100,000. Nebraska and Wisconsin demonstrate similar patterns, combining relatively low overall rates (236 and 249 per 100,000, respectively) with large gaps (562 and 451 per 100,000). In these states, AI/AN and Black communities face dramatically higher mortality while other populations benefit from strong overall systems. (See Table 6.)

Conversely, some states with high overall mortality show relatively narrow disparities. Alabama, Louisiana, and Kentucky all experience above-average overall rates but smaller-than-average gaps. This pattern suggests health challenges are more broadly distributed across populations in these states, meaning comprehensive system improvements could benefit all groups.

States Excelling—or Struggling—in Both Dimensions

A small group of states achieve strong outcomes across both metrics—overall rates of avoidable mortality and the size of disparities between racial and ethnic groups. Massachusetts, New Jersey, New York, Connecticut, New Hampshire, Rhode Island, and Hawaii maintain low overall mortality (all below 235 per 100,000) coupled with relatively small gaps (all below 280 per 100,000). (See Table 6.) These states demonstrate that robust, well-integrated systems emphasizing access, quality, and equity can deliver outcomes that protect all populations effectively—a critical capacity when public health emergencies test system resilience.

At the opposite end, West Virginia, Mississippi, and Oklahoma experience both high avoidable mortality (all at or above 410 per 100,000) and large disparities (all at or above 410 per 100,000). These patterns are consistent with broader structural challenges—such as economic disadvantage, healthcare workforce constraints, rural access barriers, and longstanding inequities in prevention and treatment—that are associated with poorer population health outcomes. Addressing these root causes will be essential not only for improving everyday health outcomes but also for bolstering preparedness capacity.

Toward Resilience

Reducing avoidable mortality and narrowing disparities typically involves multifaceted approaches, including sustained investment in public health infrastructure (such as surveillance systems and workforce capacity), strengthening primary care access, expanding insurance coverage and reducing financial barriers to care, improving cultural and linguistic responsiveness within health systems, and routinely measuring and reporting disparities by race, ethnicity, geography, and income to inform targeted action.

States with lower avoidable mortality rates and smaller disparities are generally characterized by stronger performance in prevention and care delivery under routine conditions. These baseline capacities are important during public health emergencies, as they can support timely detection of health threats, continuity of care, and effective engagement with diverse communities. Conversely, states with higher avoidable mortality and larger disparities may enter crises with greater underlying vulnerability, and existing inequities can widen under emergency conditions. Understanding these patterns can help policymakers, health system leaders, and communities prioritize investments and interventions that support lower premature mortality, more equitable health outcomes, and stronger preparedness.

TABLE 6: STATES' AVOIDABLE MORTALITY RATES AND RACIAL/ETHNIC DISPARITIES

Death rates from preventable and treatable causes of death before age 75, by state, including overall avoidable mortality, highest and lowest racial/ethnic group rates, and the resulting disparities, 2022–2023

	Death Rate from Treatable Causes (per 100,000 people)	Death Rate from Preventable Causes (per 100,000 people)	Total Avoidable Death Rate (per 100,000 people)	Rank by Total Avoidable Death Rate
Alabama	112	243	356	42
Alaska	82	246	327	38
Arizona	83	213	296	31
Arkansas	133	260	393	46
California	74	159	233	10
Colorado	65	180	246	13
Connecticut	63	153	216	5
Delaware	88	212	300	34
D.C.	108	250	357	43
Florida	82	188	270	24
Georgia	100	199	299	33
Hawaii	81	143	224	7
Idaho	66	167	233	11
Illinois	84	178	262	21
Indiana	98	231	329	39
Iowa	84	178	261	20
Kansas	90	208	298	32
Kentucky	117	279	396	48
Louisiana	119	264	383	45
Maine	72	213	286	28
Maryland	83	178	260	19
Massachusetts	57	145	201	1
Michigan	93	202	294	30
Minnesota	61	155	215	4
Mississippi	141	289	430	50
Missouri	102	237	339	41
Montana	77	199	276	26
Nebraska	75	161	236	12
Nevada	91	216	307	35
New Hampshire	64	168	232	8
New Jersey	68	135	203	2
New Mexico	97	282	379	44
New York	75	149	224	6
North Carolina	94	213	308	36
North Dakota	75	183	258	17
Ohio	96	225	321	37
Oklahoma	125	285	410	49
Oregon	71	195	265	22
Pennsylvania	82	187	269	23
Rhode Island	66	166	232	9
South Carolina	100	238	338	40
South Dakota	81	197	278	27
Tennessee	115	279	394	47
Texas	93	182	275	25
Utah	66	142	208	3
Vermont	66	187	252	15
Virginia	83	177	260	18
Washington	71	182	253	16
West Virginia	127	319	445	51
Wisconsin	72	178	249	14
Wyoming	81	208	289	29
United States	**86**	**192**	**278**	**N/A**

Note: Data represent broad racial and ethnic categories and may not reflect variations within these groups. Some avoidable mortality data were missing for certain racial and ethnic groups in specific states in the 2022-23 dataset. Where data for those groups were available in either 2020-21 or 2021-22, we used data from the latest available year: for Hawaii, American Indian/Alaska Native (AI/AN) data from 2020-21; for Vermont, Asian American, Native Hawaiian, and Pacific Islander (AANHPI) data from 2021-22 and AI/AN data from 2020-21; for Wyoming, AANHPI data from 2020-21. For ranking metrics, lower ranks (e.g., 1, 2, 3) indicate relatively lower death rates and smaller disparities, while higher ranks reflect poorer outcomes. Treatable and preventable death rates may not sum to total avoidable death rates due to independent rounding of component values.

TABLE 6: STATES' AVOIDABLE MORTALITY RATES AND RACIAL/ETHNIC DISPARITIES

Death rates from preventable and treatable causes of death before age 75, by state, including overall avoidable mortality, highest and lowest racial/ethnic group rates, and the resulting disparities, 2022–2023

	Race/Ethnicity with Highest Avoidable Death Rate	Race/Ethnicity with Lowest Avoidable Death Rate	Avoidable Death Rate Gap	Rank by Avoidable Death Rate Gap
Alabama	Black	AANHPI	318	17
Alaska	AIAN	AANHPI	542	45
Arizona	AIAN	AANHPI	515	43
Arkansas	Black	AIAN	399	32
California	Black	AANHPI	314	16
Colorado	AIAN	AANHPI	365	22
Connecticut	Black	AANHPI	253	8
Delaware	Black	AANHPI	292	13
D.C.	Black	AANHPI	542	44
Florida	Black	AANHPI	235	5
Georgia	Black	AANHPI	245	6
Hawaii	Hispanic	AANHPI	124	1
Idaho	AIAN	AANHPI	354	20
Illinois	Black	AANHPI	413	35
Indiana	Black	AIAN	378	26
Iowa	AIAN	Hispanic	380	27
Kansas	Black	AANHPI	385	29
Kentucky	Black	AANHPI	373	24
Louisiana	Black	AANHPI	362	21
Maine	AIAN	Hispanic	443	37
Maryland	Black	AANHPI	258	9
Massachusetts	Black	AANHPI	206	3
Michigan	Black	AANHPI	412	34
Minnesota	AIAN	Hispanic	767	50
Mississippi	AIAN	AANHPI	463	39
Missouri	Black	AANHPI	422	36
Montana	AIAN	AANHPI	646	48
Nebraska	AIAN	AANHPI	562	46
Nevada	AIAN	AANHPI	307	15
New Hampshire	Black	AANHPI	197	2
New Jersey	Black	AANHPI	278	11
New Mexico	AIAN	AANHPI	506	42
New York	Black	AANHPI	251	7
North Carolina	AIAN	AANHPI	397	30
North Dakota	AIAN	AANHPI	697	49
Ohio	Black	AANHPI	378	25
Oklahoma	AIAN	AANHPI	410	33
Oregon	AIAN	AANHPI	382	28
Pennsylvania	Black	AANHPI	349	19
Rhode Island	AIAN	AANHPI	222	4
South Carolina	Black	AANHPI	327	18
South Dakota	AIAN	Hispanic	931	51
Tennessee	Black	AIAN	399	31
Texas	Black	AANHPI	270	10
Utah	AIAN	Hispanic	370	23
Vermont	AIAN	AANHPI	305	14
Virginia	Black	AANHPI	279	12
Washington	AIAN	AANHPI	465	40
West Virginia	Black	AANHPI	494	41
Wisconsin	Black	AANHPI	451	38
Wyoming	AIAN	AANHPI	620	47
United States	**AIAN**	**AANHPI**	**377**	**N/A**

Source: Commonwealth Fund.[374,375]

TABLE 7: ALL STATES/ALL INDICATORS

	Nurse Licensure Compact (NLC)	Public Health Accreditation Board (PHAB)	Emergency Management Accreditation Program (EMAP)	Public Health Funding	Water Security	Paid Sick Leave	
	State participates in NLC, 2025	Accredited by PHAB, 2025	Accredited by EMAP, 2025	Funding change, FY 2024-25	Percent of population who used a community water system in violation of health-based standards, 2024	Access to Paid Sick Leave by Census Division, 2025	
Alabama	✓	✓	✓	↑	4%	67%	
Alaska		✓		↓	10%	98%	
Arizona	✓	✓	✓	↓	5%	87%	
Arkansas	✓	✓	✓	↓	2%	75%	
California		✓	✓	↓	5%	98%	
Colorado	✓	✓	✓	↑	1%	87%	
Connecticut	✓	✓	✓	↑	1%	90%	
Delaware	✓	✓	✓	↑	0%	74%	
D.C.		✓	✓	↑	3%	74%	
Florida	✓	✓	✓	↑	1%	74%	
Georgia	✓	✓	✓	No data reported	4%	74%	
Hawaii				↑	0%	98%	
Idaho	✓		✓	↑	3%	87%	
Illinois		✓	✓	↑	2%	77%	
Indiana	✓	✓		↑	5%	77%	
Iowa	✓	✓		↓	1%	78%	
Kansas	✓	✓	✓	↑	5%	78%	
Kentucky	✓	✓		↑	6%	67%	
Louisiana	✓	✓	✓	↑	26%	75%	
Maine	✓	✓		↑	2%	90%	
Maryland	✓	✓	✓	↓	2%	74%	
Massachusetts	✓	✓		↑	12%	90%	
Michigan			✓	↓	3%	77%	
Minnesota		✓		↑	1%	78%	
Mississippi	✓	✓		No data reported	25%	67%	
Missouri	✓	✓	✓	↑	1%	78%	
Montana	✓	✓	✓	↑	2%	87%	
Nebraska	✓	✓		↓	3%	78%	
Nevada			✓	↑	1%	87%	
New Hampshire	✓			↑	1%	90%	
New Jersey	✓	✓	✓	↑	9%	88%	
New Mexico	✓	✓		↑	15%	87%	
New York		✓	✓	↑	48%	88%	
North Carolina	✓	✓	✓	No data reported	14%	74%	
North Dakota	✓	✓	✓	=	0%	78%	
Ohio	✓	✓	✓	↓	2%	77%	
Oklahoma	✓	✓	✓	↑	13%	75%	
Oregon		✓		↑	17%	98%	
Pennsylvania	✓	✓	✓	↑	10%	88%	
Rhode Island	✓	✓	✓	↑	0%	90%	
South Carolina	✓	✓	✓	↓	7%	74%	
South Dakota	✓			↑	6%	78%	
Tennessee	✓		✓	↑	2%	67%	
Texas	✓			↑	9%	75%	
Utah	✓	✓	✓	↓	1%	87%	
Vermont	✓	✓	✓	↑	3%	90%	
Virginia	✓	✓		↑	1%	74%	
Washington	✓		✓	↓	0%	98%	
West Virginia	✓			No data reported	14%	74%	
Wisconsin	✓	✓	✓	↑	0%	77%	
Wyoming	✓			↑	6%	87%	
51-state average	**N/A**	**N/A**	**N/A**	**N/A**	**6%**	**81%**	

Note: See "Appendix B: Methodology" for a description of TFAH's data-collection process and scoring details. States with conditional or pending accreditation at the time of data collection were classified as having accreditation. Funding change symbols indicate direction of change in state public health funding from FY 2024 to FY 2025: ↑ increase, ↓ decrease, = no change. Some state residents use private drinking-water sources, rather than community water systems. Private sources are not captured by these data. Only regulated contaminants are measured. Paid sick leave estimates are based on Census division-level data from the Bureau of Labor Statistics' National Compensation Survey (March 2025).

TABLE 7: ALL STATES/ALL INDICATORS

		Seasonal Flu Vaccination	Patient Safety	Public Health Lab Capacity	Avoidable Mortality		Performance Tier
		Seasonal flu vaccination rate for people ages 6 months or older, 2024–25	Percentage of hospitals with "A" grade, fall 2025	Public health laboratories had a written plan for a six- to eight-week surge in testing capacity, 2025	Total avoidable death rate (per 100,000), 2022-23	Avoidable death rate gap (per 100,000), 2022-23	Scoring tier, 2025
	Alabama	35.5	9%	✓	356	318	Low
	Alaska	38.6	14%	✓	327	542	Low
	Arizona	38.5	18%	✓	296	515	Middle
	Arkansas	39.3	28%	✓	393	399	Middle
	California	42.3	44%	✓	233	314	High
	Colorado	48.1	40%	✓	246	365	High
	Connecticut	50.8	50%	✓	216	253	High
	Delaware	48.9	29%	✓	300	292	High
	D.C.	60	20%	✓	357	542	Middle
	Florida	37.5	38%	✓	270	235	High
	Georgia	38.1	24%	✓	299	245	Middle
	Hawaii	48.3	17%	✓	224	124	Middle
	Idaho	30.6	29%	✓	233	354	Middle
	Illinois	44.4	32%	✓	262	413	High
	Indiana	40.1	21%	✓	329	378	Middle
	Iowa	44	0%	✓	261	380	Low
	Kansas	43.1	23%	✓	298	385	High
	Kentucky	41.3	25%	✓	396	373	Low
	Louisiana	37.7	40%	✓	383	362	Middle
	Maine	52.7	43%	✓	286	443	High
	Maryland	52.2	32%	✓	260	258	High
	Massachusetts	57.7	32%	✓	201	206	High
	Michigan	42	22%	✓	294	412	Low
	Minnesota	48.8	18%	✓	215	767	Low
	Mississippi	29.7	22%	✓	430	463	Low
	Missouri	41.3	17%	✓	339	422	Middle
	Montana	37.8	22%	✓	276	646	High
	Nebraska	44.7	15%	✓	236	562	Middle
	Nevada	33.5	39%	✓	307	307	Middle
	New Hampshire	51.2	39%	✓	232	197	High
	New Jersey	46.3	52%	✓	203	278	High
	New Mexico	44.3	11%	✓	379	506	Low
	New York	47.8	23%	✓	224	251	Middle
	North Carolina	46.3	46%	✓	308	397	High
	North Dakota	41.1	0%	✓	258	697	Middle
	Ohio	43.3	23%	✓	321	378	Middle
	Oklahoma	36.8	26%	✓	410	410	Low
	Oregon	45	28%	✓	265	382	Middle
	Pennsylvania	46.2	44%	✓	269	349	High
	Rhode Island	55.1	44%	✓	232	222	High
	South Carolina	40	41%	✓	338	327	Middle
	South Dakota	44.5	11%	✓	278	931	Low
	Tennessee	39.4	32%	✓	394	399	Middle
	Texas	39	33%	✓	275	270	Low
	Utah	39.5	61%		208	370	High
	Vermont	59.2	0%	✓	252	305	High
	Virginia	47.8	54%	✓	260	279	High
	Washington	48.5	23%	✓	253	465	Middle
	West Virginia	40.9	9%	✓	445	494	Low
	Wisconsin	45.5	25%	✓	249	451	High
	Wyoming	35.8	0%	✓	289	620	Low
	51-state average	**43.7**	**27%**	**N/A**	**291**	**397**	**N/A**

All states within a Census division receive the same estimate. The patient safety measure captures only general acute-care hospitals. "Avoidable" deaths are those that could be prevented through effective public health measures or averted with timely, high-quality health care. The avoidable mortality rate gap reflects the difference between the racial/ethnic group in a state with the highest rate of premature deaths from preventable or treatable causes and the group with the lowest rate. AANHPI = Asian American, Native Hawaiian, and Pacific Islander; AIAN = American Indian and Alaska Native. 51-state averages reflect unweighted means of state-level values and may differ from population-weighted national figures cited elsewhere in this report.

Policy Recommendations

The profound changes in the federal public health infrastructure that have taken place over the past year will have consequences across America's health security enterprise. Cuts to funding for state and local public health, healthcare system readiness, and biomedical research will leave the nation more vulnerable. And the loss of expertise and workforce at all levels will mean slower detection and response to health threats. While these shifts may lead to increased responsibilities and collaboration within the private sector, healthcare delivery systems, nonprofits, and philanthropy, there are many preparedness capabilities that can only be led by governmental public health agencies—entities with specific legal authorities that operate across jurisdictions and sectors, including laboratory testing, disease surveillance, epidemiology, data-sharing, and resource distribution.

The nation's health security is foundational to the economic security, health, and well-being of every community. TFAH's recommendations for action by policymakers, public health officials, healthcare systems and providers, community leaders, and businesses are intended to build a nation that is safer, more resilient, and better prepared for longstanding and emerging health threats. Stable, sufficient funding and a skilled, sustained workforce are indispensable to the nation's health security.

TFAH based the following policy recommendations on research and analysis, consultation with experts, and a review of gaps in federal and state preparedness.

TFAH's recommendations span seven priority areas:

- **Priority Area 1: Provide Stable, Flexible, and Sufficient Funding for Health Security**
- **Priority Area 2: Ensure Effective Leadership and Coordination**
- **Priority Area 3: Prevent and Respond to Outbreaks and Pandemics**
- **Priority Area 4: Build Healthy and Resilient Communities to Strengthen Preparedness**
- **Priority Area 5: Accelerate Development and Distribution of Medical Countermeasures**
- **Priority Area 6: Ready the Healthcare System to Respond and Recover**
- **Priority Area 7: Prepare for Environmental Threats and Extreme Weather**

Priority Area 1: Provide Stable, Flexible, and Sufficient Funding for Health Security

Over two decades of progress in building the nation's health security infrastructure is at serious risk due to clawbacks in federal funding and proposed cuts to the budgets and staff of CDC, the Administration for Strategic Preparedness and Response, and other federal agencies. Funding cuts do not only affect federal agencies; they also threaten the health security of every state and community. More than 80 percent of CDC's domestic funding is allocated to states, localities, tribes, tribal organizations, territories, academic partners, and community-based organizations to protect the nation's health and contain health threats.[376] Jurisdictions have experienced cancellation or attempted cancellation of grants supporting public health infrastructure, data modernization, infectious disease prevention, and other programs critical to health security.[377,378] The boom-and-bust cycle of public health appropriations, unpredictable funding levels, and lack of federal funding flexibility create instability for the public health system and weaken national readiness.

RECOMMENDATIONS FOR FEDERAL GOVERNMENT:

- **Federal agencies must spend all funds appropriated by Congress, as required by law, and the Office of Management and Budget should release full-year funds to agencies following passage of appropriations legislation.** Impounding, delaying, freezing, or terminating public health funding that has been enacted into law leaves every community at risk, weakens the economy, and disrupts research. Even temporary funding delays cause health departments and nonprofit organizations to end programs and lose staff. Congress should conduct oversight to ensure that federal agencies expend all funds as directed.

- **Congress and the administration should strengthen CDC as the nation's leading public health agency, with clear responsibilities for detecting, preventing, and mitigating infectious diseases, chronic conditions, and other leading causes of preventable death, illness, and injury.** To fulfill its role in protecting the health of the American people and supporting state and local efforts to do the same, Congress should provide at least $11.58 billion for CDC per year, with increases to follow.

- **Congress and state lawmakers should ensure continuous improvement of public health infrastructure by funding CDC's Public Health Infrastructure Grant program at a minimum of $1 billion annually.** Jurisdictions use these grants to build foundational public health services, modernize data and mapping systems, and retain skilled workforces.[379] Congress should also enact legislation such as the Public Health Infrastructure Saves Lives Act, which would provide ongoing funding for CDC's Public Health Infrastructure Program to guarantee continuous support for these investments.[380]

- **Congress should expand Public Health Emergency Preparedness (PHEP) funding for state, tribal, local, and territorial jurisdictions.** CDC's PHEP cooperative agreement requires at least $1 billion per year in the near term. PHEP has strengthened the nation's

capacity to respond to health threats by building and sustaining a nationwide public health emergency management system that enables communities to prepare for and rapidly respond to public health emergencies, with demonstrated improvements in laboratory capacity, medical countermeasures distribution, and epidemiological infrastructure.

- **Congress should invest in public health data modernization.** CDC's Public Health Data Modernization work is designed to update and sustain data infrastructure at CDC and at state, local, tribal, and territorial health departments, enabling real-time, actionable data to improve epidemic responses and the effectiveness of related programs.

- **Congress should increase overall funding for the Administration for Strategic Preparedness and Response (ASPR).** Increasing ASPR's base budget would enable more effective preparedness and response. In addition to key preparedness program and policy work, ASPR deploys response teams for a range of emergencies—from wildfires to overwhelmed hospitals—but receives limited funding to carry out both its preparedness and response missions.

- **Congress should create a Health Defense Operations budget designation to exempt health defense programs central to health security from annual discretionary budget allocations, ensuring these critical activities receive the sustainable resources necessary to protect Americans' health, the U.S. economy, and national security.** Budget caps and competing priorities in the nondefense discretionary category consistently constrain annual appropriations, undermining the sustained investment that medium- and long-term health defense requires.

- **Policymakers at all levels should expand strategies to recruit, train, and retain public health personnel. Federal, state, and local governments must prioritize recruitment and retention of the health security workforce, including by addressing barriers to hiring and retention.** Congress can build the public health workforce by expanding CDC's Public Health Workforce line, which includes programs that embed professionals into state, tribal, local, and territorial health agencies. HHS should provide predictable support for public health fellowship and recruiting programs, such as the Public Health Associate Program and Epidemic Intelligence Service, both of which experienced cancellations and disruptions in 2025. Congress should also support workforce recruitment and retention by funding the Health Resources and Services Administration's Public Health Workforce Loan Repayment Program. The U.S. Department of Education and the U.S. Department of the Treasury should expand existing student loan repayment and forgiveness programs for public health workers. The Department of Education should also rescind the proposed rule excluding public health, nursing, and other healthcare degrees from the definition of "professional degree" programs tied to federal graduate student loan limits.

- **Congress should accelerate emergency response through existing crisis-response mechanisms and faster, more flexible supplemental funding.** Congress should continue a no-year infusion of funds into the Public Health Emergency Rapid Response Fund and/or the Infectious Diseases Rapid Response Reserve Fund to serve as a bridge between preparedness funding and supplemental emergency appropriations. When needed, Congress should also pass emergency supplemental funding quickly and allow sufficient flexibility so that awardees can leverage funds across overlapping emergencies.

Priority Area 2: Ensure Effective Leadership and Coordination

In 2025, the elimination of thousands of federal health positions increased the nation's vulnerability to future health emergencies by depleting expertise, reducing technical assistance to jurisdictions, and diminishing capacity for disease detection and emergency preparedness and response. The loss of national experts and capabilities hampers the detection of new threats and the support that these experts provided to jurisdictions across the country.

RECOMMENDATIONS FOR FEDERAL, STATE, AND LOCAL GOVERNMENT:

- **Congress and the administration should restore the federal health workforce and capabilities that were cut in 2025.** The rapid elimination of federal programs and loss of expertise across HHS is harming the public's health and eroding public health capabilities nationwide. HHS must maintain the staffing levels necessary to carry out all funded programs and agency functions, as required by Congress in the Consolidated Appropriations Act of 2026.
- **Congress and the administration should rebuild and strengthen the structure and capabilities of federal health agencies, which have specific, complementary, and distinct roles and expertise in protecting the nation's health security.** Proposals to fundamentally alter CDC, ASPR, and other federal public health agencies risk serious disruptions to disease detection and prevention, and to the delivery of services and other supports to communities.
- **Congress should reauthorize the Pandemic and All-Hazards Preparedness Act (PAHPA).** PAHPA provides the statutory framework for the nation's health emergency enterprise, including public health and healthcare readiness grants, medical countermeasures research and development, and situational awareness. Although Congress has extended authorities that would have lapsed without legislative action, there has not been a comprehensive reauthorization since 2019.[381]
- **The White House should ensure coordination and leadership on public health emergencies and biodefense.** The administration should restore the Office of Pandemic Preparedness and Response Policy to ensure that health security expertise is present at the White House to advise the president and coordinate interagency activities around biodefense.
- **The administration should protect the scientific integrity of public health agencies and their leaders.** HHS should ensure the independence, transparency, and accountability of scientific processes across the department. The administration and public health agencies should make policy decisions based on the best available science, in collaboration with experts in public health, communications, and policy, to produce guidance that is transparent, clear, and actionable.
- **Congress and the administration should ensure timely, accurate, and complete demographic data collection and reporting, including during public health emergencies.** Complete public health data, as outlined in Statistical Policy Directive No. 15: Standards on Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity, are vital to effective public health preparedness and response. HHS and public health departments should ensure that accurate and reliable demographic data are central to data modernization

and data-use efforts, including sustained community engagement in decisions about public health data system design and use.

- **Lawmakers and courts should reject laws that weaken or preempt public health authorities, as such laws could undermine basic public health protections including outbreak detection, vaccination, and emergency response.** To fulfill their core functions, public health agencies need the authority to act effectively and efficiently, including by collecting data to inform policy; administering programs and services that help reduce the spread of disease; and investigating and controlling disease spread through testing, contact tracing, and other proven measures. Courts and jurisdictions should uphold laws and policies that are reasonably related to public health and safety and that appropriately balance the common good against constitutionally guaranteed individual rights.

- **Congress and the executive branch should demonstrate a long-term, sustainable commitment to global health security and strengthen multilateral coordination.** Investment in global health security capabilities—including infectious disease prevention, detection, control, and outbreak response in partner countries—is necessary to containing outbreaks before they become international crises. Experts warn that the loss of U.S. Agency for International Development (USAID)-supported infrastructure and programs will exacerbate ongoing outbreaks of diseases such as tuberculosis and malaria and weaken responses to Ebola and other high-consequence events.[382,383] Congress should restore funding for global health security work across CDC and the U.S. State Department, including support for USAID. The United States should also advance its health and national security interests by rebuilding and strengthening partnerships with existing international bodies, such as the World Health Organization (WHO) and Gavi, the Vaccine Alliance, which provide established infrastructure for coordinated global surveillance, rapid response to health threats, vaccine stockpiling, and routine immunization.[384]

- **HHS agencies should develop public health guidance that is timely, grounded in science, and accessible to implementers across different regions and audiences, including tribes and territories.** During emerging health threats, HHS agencies should make clear that guidance reflects the best available information and will be updated as evidence evolves.

- **Congress, HHS, and the philanthropic sector should invest in and prioritize effective, accurate public health communications.** Agency communications with the public should be timely, clear, credible, and actionable for diverse audiences. HHS and philanthropies should also engage with and provide resources to a diverse group of community partners, maintaining a trusted messenger network to research and test effective messaging, counter intentional or unintentional false information, support message development, and conduct outreach.

Priority Area 3: Prevent and Respond to Outbreaks and Pandemics

Advances in clean water and food safety, sanitation, disease detection and testing, and vaccination contributed to a sharp decline in infant and child mortality and a nearly 30-year increase in life expectancy over the 20th century.[385] The spread of measles and other highly contagious and preventable infections demonstrates that the nation must redouble its efforts to control outbreaks.

RECOMMENDATIONS FOR FEDERAL AND STATE GOVERNMENT AND HEALTHCARE:

- **Congress should support the funding and workforce of CDC's National Immunization Programs.** Congress should provide significant funding increases for CDC's National Immunization Programs to support immunization infrastructure, outbreak response, and vaccine delivery across the country. Congress should facilitate the restoration of the workforce within the Immunization Services Division and conduct a comprehensive analysis of the impact of the 2025 cuts. Congress should also increase annual funding to study and address the causes of vaccine misinformation and to improve communications and community engagement.

- **Congress should enact legislation to ensure access to vaccines for uninsured and underinsured adults.** Uninsured and underinsured adults continue to face barriers to vaccination. A 2024 study found that adult vaccines could return up to 19 times their initial investment in health and economic benefits.[386] Congress should authorize a permanent program to provide all uninsured and underinsured adults with access to vaccines at no cost.

- **HHS, states, and healthcare systems should support universal childhood vaccination and increased vaccination of healthcare workers.** States should enact, protect, or strengthen policies that enable universal childhood vaccination to ensure that children, school personnel, and the broader public are protected from vaccine-preventable diseases. Healthcare personnel should receive vaccination recommendations based on the best available scientific evidence. Healthcare facilities should ensure access to and education about vaccines for all staff and contractors and should remove barriers to staff receiving vaccines.

- **Congress should conduct oversight of recent changes to federal vaccine policy and infrastructure.** Congressional oversight and investigations should examine changes to the childhood immunization schedule, the June 2025 dismissal and replacement of all Advisory Committee on Immunization Practices (ACIP) members, proposed changes to FDA's vaccine review standards,[387] and the resulting impact on access to immunizations and vaccination rates. A federal court in Massachusetts granted preliminary relief in March 2026 blocking implementation of the January 2026 revision to the childhood immunization schedule and restricting actions taken by the reconstituted ACIP, finding that plaintiffs were likely to succeed in showing both actions violated federal law.[388] The court also granted relief affecting three vaccine recommendation votes taken by the reconstituted ACIP in 2025, pertaining to thimerosal in influenza vaccines, the COVID-19 vaccine, and the hepatitis B birth dose vaccine.[389]

- **Congress should continue to modernize disease detection and tracking of health threats.** Congress should continue funding CDC's modernized outbreak detection capabilities, including sustainable support for expanded wastewater surveillance for infectious diseases and the national genomic sequencing infrastructure through the Advanced Molecular Detection Program. Congress should continue funding for the Center for Forecasting and Outbreak Analytics and the Response Ready Enterprise Data Integration platform, which are central to outbreak detection and predictive modeling to support decision-making at state, territorial, tribal, and local levels. Congress should also continue to invest in core infectious disease detection capabilities nationwide through the Epidemiology and Laboratory Capacity program.

- **Congress should take significant steps to address antimicrobial resistance (AMR).** Public-private partnership in drug, diagnostic, and vaccine development and antimicrobial stewardship is essential. Congress should enact a new financing mechanism for novel antimicrobials that delinks payment from volume used, to drive sustainable innovation. Congress should also provide resources to antimicrobial stewardship programs in healthcare facilities and increase funding for HHS initiatives to combat AMR, including CDC's Antimicrobial Resistance Solutions Initiative, which funds Healthcare-Associated Infection and Antimicrobial Resistance Programs, the Antimicrobial Resistance Laboratory Network, and global AMR and infection prevention and control programs.

- **Centers for Medicare & Medicaid Services (CMS), CDC, and other health entities should improve infection prevention and reduce the inappropriate use of antibiotics and antifungals by strengthening infection prevention and control efforts and bolstering antibiotic stewardship and use reporting.** CMS should enforce infection prevention and stewardship requirements for hospitals and long-term care facilities and work with public health stakeholders to track progress on healthcare-associated infections, antibiotic and antifungal prescribing rates, and resistance patterns.[390] CMS and CDC should work with relevant partners to improve infection prevention and control efforts and to strengthen Conditions of Participation programs, including by establishing staffing standards to ensure that infection prevention and stewardship programs are sufficiently resourced to meet their goals. CMS should also advance policies to improve outpatient antibiotic prescribing through quality measures and value-based reimbursement programs. All relevant facilities must improve reporting of infections and antimicrobial use and resistance through the National Healthcare Safety Network, adopt stewardship programs that meet CDC's Core Elements, and improve healthcare worker training on infection prevention and control and the appropriate use of antibiotics and antifungals across healthcare settings.[391]

- **Congress should establish a national standard requiring employers to provide job-protected paid sick, family, and medical leave for all employees, including leave to care for a sick family member or to remain home when ill.** Paid sick leave reduces the risk of spreading infections among employees and customers, while paid family leave is proven to improve maternal and child health.[392,393]

Priority Area 4: Build Healthy and Resilient Communities to Strengthen Preparedness

Some communities and populations face higher risk of negative health outcomes from outbreaks and disasters because of age, high rates of chronic disease, socioeconomic and health disparities, mental health conditions, and other factors. Keeping people healthier and engaging community groups before emergencies strike will contribute to more resilient populations when events occur.

RECOMMENDATIONS FOR FEDERAL, STATE, AND LOCAL GOVERNMENT AND COMMUNITY LEADERS:

- **Agencies at all levels of government and their grantees should plan with communities, rather than for them, and provide resources and technical assistance to community-based organizations to enhance resilience before, during, and after an event.** All sectors involved in emergency planning and response must conduct meaningful engagement, direct resources, and sustain ongoing listening efforts. Sectors should also work together to identify and plan with communities at higher risk of health impacts during an emergency, including older adults, people living in rural or underserved areas, people with disabilities, people experiencing homelessness, young people, and individuals with chronic health conditions.

- **Congress and CMS should invest in increased capacity to address the nonmedical drivers of health.** People at highest risk during disasters and those who face the greatest barriers to recovery are often those with unstable or substandard housing, limited access to transportation, and limited economic resources.[394] Addressing these nonmedical factors, sometimes called the social determinants of health, can improve community resilience. Congress should ensure that CDC is able to continue its research and incorporate best practices related to nonmedical drivers into its preparedness, infectious disease, and chronic disease work. CMS and other health insurance payers and providers should renew and expand support for efforts to address beneficiaries' health-related social needs.

- **All levels of government should adopt strategies and accountability metrics to incorporate community resilience and health equity into preparedness.** HHS, CDC, state, local, tribal, and territorial governments should strengthen internal infrastructure to reduce disparities in emergency responses by:
  - Identifying a dedicated leadership role within the emergency operations center and/or incident command structure for all-hazards events, focused on community resilience and health equity.
  - Developing and disseminating communications materials that are culturally and linguistically tailored, and collecting and leveraging data to identify unique community assets and measures of well-being before and during events.
  - Integrating nontraditional partners into community resilience planning, including the transportation, housing, and social services sectors.

- **Congress should extend the authorities of the National Advisory Committee on Children and Disasters, the National Advisory Committee on Individuals with Disabilities and Disasters, and the National Advisory Committee on Seniors and Disasters, and HHS should reactivate all three.** These committees advise the HHS Secretary on actions to meet the unique needs of these populations before, during, and after emergencies. The committees were paused in 2025, and their authorities are set to sunset in 2026 without congressional action. Congress should extend these authorities, direct the committees to meet regularly and publicly report their recommendations, and HHS should formally report on the status of implementation of those recommendations.

- **Jurisdictions, CMS, and the Substance Abuse and Mental Health Services Administration (SAMHSA) should address mental health and substance use gaps before disasters occur and incorporate behavioral health access into disaster response and recovery strategies.** All jurisdictions should assess existing mental health and substance use resources and gaps in advance of the next emergency, strengthen cross-sector partnerships, and incorporate these assets into preparedness planning. CMS and other policymakers should determine in advance what waivers may be needed to ensure continuity of care for people in treatment. SAMHSA can strengthen preparedness efforts by expanding research and monitoring of disaster behavioral health needs and post-disaster interventions.

For additional discussion of strengthening the prevention of alcohol, drug, and suicide deaths, see TFAH's Pain in the Nation report series at tfah.org.

Priority Area 5: Accelerate Development and Distribution of Medical Countermeasures

Public-private partnerships are essential to the pipeline of medical countermeasures (MCMs) that protect lives against high-consequence events. Policymakers must continue to support American innovation in this space so the country is equipped to protect health and economic security during future emergencies. The United States has made notable progress in MCM research, development, and procurement, but these gains remain precarious without sustained investment.

RECOMMENDATIONS FOR FEDERAL GOVERNMENT AND PRIVATE-SECTOR PARTNERS:

- **Congress should invest in MCM research, development, stockpiling, and distribution for a range of pathogens as well as for threat-agnostic products.** Supporting the entire MCM enterprise—from seed research through distribution—across HHS is necessary to address the risk of known and unknown health threats. Congress should provide additional funding for ASPR to address emerging infectious diseases, which remain a serious threat to human health. The United States should continue to expand its investment in innovative, flexible technologies, products, and platforms that enable faster production for a range of threats, rather than focusing solely on products for a single pathogen.
- **HHS and Congress should ensure the independence of the regulatory system that oversees the research, development, and approval of vaccines and other MCMs.** Real or perceived political interference with product review has a chilling effect on biomedical innovation and erodes public trust in the regulatory process.
- **HHS should continue to improve the leadership and transparency of the Public Health Emergency Medical Countermeasure Enterprise.** ASPR should continue to lead coordinated, aligned, and transparent MCM activities across HHS, with other relevant agencies, and with private-sector, public health, and academic partners. These activities should include regular interagency meetings; engagement with private-sector and nonprofit supply-chain partners; improved transparency and coordination with state, local, tribal, and territorial agencies; and collaborative long-term planning and evaluation.
- **HHS and state, local, territorial, and tribal partners should improve MCM guidance, communication, and dispensing for populations at higher risk of health impacts during an event.** HHS should consult with experts and work with healthcare professionals and state, local, tribal, and territorial public health partners to develop standardized guidance for dispensing MCMs to groups including infants, children, pregnant and postpartum people, older adults, people with disabilities, and people who are homebound. HHS and state, local, tribal, and territorial agencies should leverage public-private partnerships for both communications and the dispensing and administration of MCMs, with particular attention to communities at disproportionate risk. Community engagement before an outbreak or event is essential to building understanding of the risks, benefits, and distribution challenges involved in delivering a medical product to a large portion of the population—and to ultimately improving acceptance of and access to MCMs.

Priority Area 6: Ready the Healthcare System to Respond and Recover

Ensuring the healthcare system is equipped to continue care during emergencies is a significant and ongoing challenge, compounding the strain healthcare facilities face every day. Workforce shortages and hospital closures are disrupting how people receive care, especially in rural and underserved areas. A natural disaster, severe respiratory virus season, or serious disease outbreak can push many healthcare facilities beyond their capacity. Health system readiness is an essential element of health security and recovery.

RECOMMENDATIONS FOR FEDERAL GOVERNMENT AND HEALTHCARE:

- **Congress should strengthen the emergency readiness of the healthcare delivery system by providing at least $500 million in funding for ASPR's Health Care Readiness programs.** This portfolio includes the Hospital Preparedness Program, Regional Disaster Health Response System, and National Special Pathogen System. Collectively, these programs create a tiered system of preparedness for localized emergencies, regional disasters, and high-consequence pathogens, saving lives through coordinated planning, training, situational awareness, and patient movement.
- **ASPR should strengthen requirements under the Hospital Preparedness Program** to include crisis standards-of-care planning, planning for emerging threats such as extreme heat, and completion of a Pediatric Readiness Assessment by all hospital participants, consistent with recommendations from the National Advisory Committee on Children and Disasters.
- **States and healthcare-sector leaders should strengthen policies governing disaster healthcare delivery, surge capacity, and crisis standards of care.** States should review credentialing standards to ensure healthcare facilities can draw on providers from outside their borders, and health systems should ensure they can integrate outside providers quickly during a surge response. To promote healthcare readiness and expand the capacity to surge care and services, states should adopt policies such as the Nurse Licensure Compact,[395] the Interstate Medical Licensure Compact,[396] the Recognition of EMS Personnel Licensure Interstate CompAct,[397] the Uniform Emergency Volunteer Health Practitioners Act,[398] emergency prescription refill laws and protocols, and crisis standards-of-care guidelines,[399,400] along with provider education on their implementation. Jurisdictions must ensure transparent and equitable application of crisis standards of care so as not to create or exacerbate disparities.
- **Congress and state lawmakers should expand access to and improve the affordability of health insurance.** This includes extending marketplace subsidies that expired at the end of 2025 and supporting Medicaid expansion in the remaining states that have not yet adopted it.

Priority Area 7: Prepare for Environmental Threats and Extreme Weather

Environmental hazards pose significant and growing threats to human health, as demonstrated by exposure to wildfire smoke during the January 2025 California wildfires and the ongoing health consequences stemming from the 2023 East Palestine train derailment and the September 2024 BioLab chemical fire in Conyers, Georgia. Responding to these events required state and local agencies to work with federal partners and across sectors to keep residents safe.

RECOMMENDATIONS FOR FEDERAL AND STATE GOVERNMENT:

- **Congress should increase funding for CDC's National Center for Environmental Health (NCEH) to enable nationwide protection against environmental and climate-related health threats.** NCEH safeguards the health of people across the country from environmental hazards such as lead poisoning, chemical and radiological hazards, and extreme weather, but limited funding prevents lifesaving programs from reaching all states and territories.

- **Congress should expand the capacity of the Agency for Toxic Substances and Disease Registry (ATSDR) to respond to emergencies.** Congress should provide at least $100 million in funding for ATSDR and reject efforts to remove ATSDR from CDC. ATSDR's expertise and around-the-clock response capacity have been critical in addressing chemical incidents and have strengthened environmental health capacity in state health departments, enabling them to identify how people are exposed to hazardous substances and to prevent and address those exposures.

- **Congress should increase funding to extend CDC's National Environmental Public Health Tracking Program to every state.** The network helps states collect key data on environmental health threats and target interventions to save lives. Tracking experts examine outdoor air quality, drinking water quality, and toxic substance releases, as well as their related health effects, including cancer, reproductive health outcomes, hospitalizations for asthma and cardiovascular disease, carbon monoxide poisoning, childhood lead poisoning, and developmental disabilities.

- **Congress and the administration should ensure that HHS has a dedicated office focused on addressing climate-related health impacts.** The office would coordinate and align efforts across the department to build community and health-sector resilience against environmental events, particularly in populations and geographic regions that are disproportionately affected. It would provide agency-wide leadership to integrate climate considerations into public health, healthcare delivery, biomedical research, and social service programs; align surveillance, data, and research priorities; and translate emerging climate-health evidence into consistent guidance, standards, and operational frameworks across HHS. It would also serve as a central hub for strategic coordination with other federal agencies to ensure that health impacts are systematically incorporated into national climate resilience and preparedness efforts.

- **Congress and the administration should support interagency efforts to address the health impacts of extreme heat.** Congress should sustain funding for, and the administration should strengthen, multiagency efforts to address the health impacts of extreme heat, including the National Integrated Heat Health Information System. These efforts are supported through partnerships among CDC, ATSDR, the National Oceanic and Atmospheric Administration, and the National Weather Service, which developed the Heat and Health Tracker to help guide local responses to extreme heat.

- **The White House, EPA, federal partners, and localities should take steps to improve indoor and outdoor air quality.** Poor indoor air quality is a significant environmental health risk—one that is exacerbated during emergencies such as wildfires and extreme heat events.[401] It also increases the risk of transmission of airborne and respiratory infectious diseases, particularly in poorly ventilated indoor settings. Yet indoor air quality standards remain fragmented, largely voluntary, and unevenly applied, with no comprehensive, enforceable federal guidelines for most public buildings or schools.[402] EPA, in collaboration with CDC, the National Institute for Occupational Safety and Health, and other relevant federal agencies, should establish clear, science-based federal indoor air quality guidelines for public buildings and schools and provide incentives to retrofit existing buildings to improve ventilation and filtration. The administration should also protect, enforce, and strengthen the Clean Air Act, particularly the National Ambient Air Quality Standards, which place national limits on pollutants such as particulate matter (soot) and ozone (smog). EPA should defend science-based particulate matter standards in court and continue to build on this progress to protect public health.

- **The administration should protect and strengthen the Clean Water Rule and fund CDC's Safe Water Program to safeguard clean water for all U.S. residents.** The existing rule includes measures to ensure a safe water supply, such as addressing the ongoing problem of lead, PFAS, and algal toxins in drinking water; reducing the potential for waterborne illness; and increasing protection against potential acts of terrorism affecting drinking and agricultural water systems. A proposed EPA rule would narrow federal Clean Water Act protections by redefining which bodies of water fall under federal jurisdiction, potentially reducing safeguards for water supplies in states that do not expand their own regulatory programs to fill the gap.[403] Congress should also continue to fund CDC's Safe Water Program. State, territorial, local, and tribal health officials rely on this program for specialized expertise and resources to address water contamination that routinely arises after floods, wildfires, and droughts.

- **Every state should develop a comprehensive climate vulnerability assessment and adaptation plan that integrates public health considerations in line with CDC's Building Resilience Against Climate Effects (BRACE) framework.** The BRACE framework can help jurisdictions identify likely climate-related health impacts and populations and locations at elevated risk, and develop and implement adaptation plans. State and local public health officials should also integrate environmental health considerations into their emergency operations planning and incident command systems. As interventions are implemented, continuous evaluation and quality improvement should be prioritized to ensure their effectiveness.

Year in Review: Major Public Health Developments

Convenings, Meetings, Events, Reports, and Strategies

Within the United States:

In January 2025, President Trump announced the withdrawal of the United States from the World Health Organization and the Paris Climate Agreement.[404]

A GAO report released in June 2025 reported on the results of a convening of 19 public health experts discussing how the HHS could improve the nation's infectious-disease testing efforts during health emergencies. The recommendations included:

- Develop a national testing strategy that sets clear roles and responsibilities, improves collaboration, and features a coordinating group.
- Periodically update the national diagnostic testing strategy to incorporate lessons learned from infectious-disease threats with pandemic potential, other relevant public health threats, and any related preparedness exercises.
- Either establish a national diagnostic testing forum for infectious diseases with pandemic potential or expand an existing group. The forum should include a broad representation of HHS testing experts, its component agencies, and other relevant federal agencies, jurisdictions, public and private sectors, academia, and nonprofits.
- Ensure that the national testing forum meets regularly, both before and during infectious-disease threats with pandemic potential, other relevant public health threats, and any related preparedness exercises.[405]

The U.S. Agency for International Development was dissolved by the administration, with certain functions being transferred to the U.S. Department of State, following an executive order in January that froze its operations.[406]

In July, the National Association of County and City Health Officials released its annual survey reporting on the state of the public health workforce. The 2024 Forces of Change survey found that close to 20 percent of local health departments experienced job losses in 2023. The job losses were due to layoffs and attrition and raise concerns about a shrinking public health workforce.[407]

In September, the U.S. Government Accountability Office released a report, *Disaster Assistance High-Risk Series: Federal Response Workforce Readiness*, which found "key challenges" for the federal disaster response workforce, including the concurrent nature of disasters and how reductions in the federal workforce will weaken federal agencies' capacity to respond to disasters.[408]

In September, the administration released the America First Global Health Strategy,[409] replacing the prior Global Health Security Agenda. According to the strategy announcement, it is intended to prevent infectious disease outbreaks from reaching the United States, place greater emphasis on co-investments from and the self-reliance of partner nations, and support bilateral agreements.

In December 2025, GAO released a report, *Disaster Assistance High Risk Series: State and Local Response Capabilities*, which found that state and local governments "rely extensively" on help from the Federal Emergency Management Agency and other federal agencies to prepare for and respond to disasters and that local capacity to conduct critical response activities, including restoration of water and power services, varies greatly across jurisdictions.[410]

IMPACT OF FEDERAL FUNDING CUTS/OTHER ADMINISTRATION ACTIONS

During 2025, sweeping funding claw-backs, budget cuts, workforce reductions, and program eliminations impacted federal agencies charged with protecting the public's health and the country's emergency readiness and response.

HHS lost thousands of employees.[411] Although not adopted in the final FY 2026 appropriations, the president's proposed FY 2026 budget included a 53 percent reduction for CDC and the Agency for Toxic Substances and Disease Registry, as well as the elimination of ASPR's Hospital Preparedness Program and the Prevention and Public Health Fund.[412,413] In addition, the White House Office of Pandemic Preparedness and Response was virtually shuttered.[414] Delays in the adoption of the FY 2026 appropriations bill, slow apportionment of funds to HHS, and reduction in data-collection and -sharing[415] added to the weakening of the nation's public health system.

Specific cuts in 2025 included the abrupt cancellation of more than $12 billion in federal grants for tracking infectious diseases, ensuring vaccine access, and providing mental health and addiction treatment services.[416] States that sued over the termination had nearly 80 percent of that funding restored.[417] In addition, dozens of studies researching new vaccines and drug treatments for COVID-19 and other viruses that could cause future pandemics were canceled.[418]

On the global front, during the first days of his second term, President Trump announced the withdrawal of the United States from the WHO and the Paris Climate Agreement, moves that public health experts said would undermine U.S. standing as a global health leader and make it harder to prevent and respond to future pandemics.[419] The administration announced the dissolution of USAID,[420] which has historically supported global health efforts and infrastructure. In June, the administration announced that it would no longer commit any funding to Gavi, the Vaccine Alliance.[421] Gavi immunizes children in low-income countries.[422]

2026 World Cup Will Require Extensive Public Health Planning and Coordination

The FIFA World Cup 2026 will be a premier international sporting event co-hosted by Canada, Mexico, and the United States. World Cup matches will be held from June 11 to July 19, 2026.[423] The Cup is expected to bring up to seven million international visitors to the United States.[424] U.S. host cities include Atlanta, Boston, Dallas, Houston, Kansas City, Los Angeles, Miami, New York/New Jersey, Philadelphia, San Francisco Bay Area, and Seattle.[425]

The size of the World Cup creates unique complexities and will require thorough preplanning and critical collaborations between multiple sectors, including public health, healthcare, public safety, community-based organizations, and the business community.[426]

Public health officials in the host cities and states are working in advance of the Cup events to prepare, including within the following three pillars.

1. **Preparedness.** An all-hazards planning approach and horizontal and vertical emergency response and medical services planning strategy that is based on the need to provide routine first aid given the potential for a mass-casualty event. Officials recognize the need for robust public health infrastructure and interagency coordination. They are working on interagency planning, pre-positioning of resources, and the need to communicate in multiple languages.
2. **Coordination and collaboration.** Working with partners across multiple sectors, including local governments, emergency management officials, hospital systems, police/fire/EMS, and homeland security officials.
3. **Funding.** Public health officials in host cities will need sufficient resources to adequately protect residents and visitors.

Planners have identified multiple scenarios that health departments and partners need to prepare for, including:

- Possible infectious-disease outbreaks. Contact-tracing, which is always complicated, will be made even more so by the proportion of spectators who are temporary visitors to the United States, the domestic attendees traveling from across the country who will return home after events, the sheer size of the events, and the number of languages spoken.
- Potential for impact of hot weather on spectators.
- Demands on a jurisdiction's healthcare system—for patient care as well as personal protective equipment and medical counter measures inventories.
- Food and lodging safety. Host cities will likely need to surge resources to ensure that "pop-up" food and lodging facilities meet health codes.
- Hazmat response.
- The risk of terrorism/violence.

The risk for an infectious-disease outbreak, heightened by the scope of the World Cup, the number of international travelers, and the mass gathering of domestic attendees from across the country, will require detailed prevention and response planning all rooted in surveillance, predictive analysis, and response readiness. Surveillance tools will include wastewater surveillance, including at airports, transit hubs, and event stadiums. Plans are also in place for social media monitoring and rapid information-sharing and response to rumors or false claims.

Health departments will lean into existing partnerships with community partners, including community-based organizations, and local public safety officials will resource their Medical Reserve Corps units to supplement local department staffing during Cup events as needed. However, the Medical Reserve Corps and the federal Hospital Preparedness Program, both part of ASPR, are at risk. The Medical Reserve Corps and Hospital Preparedness Program were both proposed for elimination in the president's FY 2026 budget request.[427] Congress enacted funding for both programs in the final FY 2026 appropriations law.[428]

The National Special Pathogen System held a tabletop exercise in January 2025 to discuss resource availability and response if an infectious-disease outbreak occurred during the 2026 World Cup.[429] The exercise focused on an outbreak of Middle East Respiratory Syndrome (MERS) as a possible scenario. It identified five key preparation needs:

1. In-depth planning and pre-positioning within all host cities.

2. Prompt identification and isolation of possible infections.

3. Determining and aligning responsibilities.

4. Communication, coordination, and collaboration among sectors, including public health, healthcare, emergency medical services, and public safety.

5. Ensuring hospital and laboratory surge capacity.[430]

On the world stage:

In May, the WHO's World Health Assembly adopted a "Pandemic Agreement" intended to create safeguards against future pandemics and make pandemic response more equitable.[431]

In November, the United Nations 2025 annual climate conference ("COP," or the Conference of the Parties to the U.N. Framework Convention on Climate Change) was held in Belém, Brazil. The Trump Administration did not send an official delegation, but other U.S. representatives (from states, cities, and NGOs) did attend. The conference proceedings (The Belém Political Package) included continuing to call for a transition away from fossil fuels but without specific timelines for requirements. Conference attendees called for a tripling of funding for climate adaptation worldwide.[432] During the conference, the Belém Health Action Plan, created by Brazil and the WHO was announced. The plan creates a global framework to help countries strengthen their health systems in response to the health threats of climate change, including surveillance systems and resilient health infrastructure.[433]

In December, the WHO announced a strategic plan to address coronavirus disease threats, including COVID-19, MERS, and potential new coronavirus diseases. The plan is a first-of-its-kind global plan to manage coronavirus disease threats.[434]

Food Safety

A February 2025 GAO report noted that approximately 10 million cases of foodborne illness occur in the United States on an annual basis, resulting in more than 53,000 hospitalizations and about 900 deaths. The report reiterated GAO's earlier calls for a government-wide national food safety strategy.[435]

Environmental Hazards

PFAS (per- and polyfluoroalkyl substances)

Analyses by the Environmental Working Group, drawing on EPA UCMR 5 data along with state and other sources, estimate that 176 million people in the United States are served by drinking water systems where PFAS have been detected.[436] More needs to be learned about the health effects of PFAS exposure. Evidence suggests associations between exposure to certain PFAS with increased cholesterol, changes in liver enzymes, decreased antibody response to some vaccines, developmental effects in children, some cancers, and pregnancy-induced hypertension and preeclampsia.[437] In April 2024, the Biden Administration announced the first national, legally enforceable standards for PFAS in drinking water.[438] In May 2025, the Trump Administration announced it would maintain standards for perfluorooctanoic acid (PFOA) and perfluorooctanesulfonic acid (PFOS) but extend compliance deadlines from 2029 to 2031, while also announcing its intent to rescind regulations and reconsider regulatory determinations for four other PFAS (HFPO-DA/GenX, PFHxS, PFNA, and their Hazard Index mixture with PFBS).[439]

Extreme Weather

Drought

Looking at November 2025 as a snapshot, approximately 25 percent of the contiguous United States was experiencing severe or extreme drought, and 45 percent of the contiguous United States experienced moderate to extreme drought conditions.[440]

Drought conditions have many serious impacts on communities, including threats to drinking water and the food supply, destruction of fish and wildlife habitats, risk of wildfires, respiratory illnesses related to dust, and loss of income for farmers.[441]

Floods

The summer months of 2025 experienced a significant number of extreme rain events and flooding, including in Texas, where more than 130 people died, including at least 27 people who died in flash-flooding at a summer camp near the Guadalupe River.[442] Other states impacted by severe flooding included New Mexico, West Virginia, New Jersey, New York, Oklahoma, Kansas, Vermont, and Iowa. By late July, the National Weather Service had issued more than 3,600 flash-flood warnings, close to the number it usually releases for a full year.[443]

In December, a historic level of rain and flooding in Washington state led to one death, at least 1,300 rescues, and thousands of homes being flooded.[444]

Extreme heat

As of the end of November, the year 2025 was the earth's second-warmest year-to-date on record.[445] In late July more than 200 million people across the United States experienced moderate to extreme heat risk.[446] Extreme heat is the most frequent cause of weather-related illness and deaths.[447] People at the highest risk for heat-related health impacts include children, older adults, people with pre-existing conditions, people who work outdoors or inside without air conditioning, and people who are unhoused.[448]

Hurricanes

As of December 2025, the North Atlantic had experienced 13 named storms and five hurricanes, four of which were categorized as major hurricanes.[449]

In October 2025, Hurricane Melissa, a Category 5 storm, battered the Caribbean.[450] Jamaica experienced extensive devastation across the island, including 45 deaths and estimated total damages and losses of between $8 billion and $15 billion.[451] In Haiti, a reported 43 people died due to the storm and thousands were left homeless. An estimated 6 million people were affected by the storm throughout the Caribbean.[452]

Wildfires

In January and early February 2025, the Palisades and Eaton fires in California burned more than 50,000 acres and about 16,000 structures. It forced about 180,000 people to evacuate their homes. Estimates of the economic impact of the fires range from $76 billion to over $131 billion.[453]

Infectious Diseases

Bird flu

Avian influenza A (H5) continues to circulate, but the current risk to the public's health is low, according to CDC. As of March 2026, there were a reported 71 human cases of bird flu in the United States and two deaths.[454] To date, there has been no known transmission of the bird flu virus between people. Most of the known illnesses in humans were caused by exposure to dairy herds or poultry farms and culling operations.[455]

Cases of bird flu in dairy cows have been found in more than 1,080 cattle in 19 states.[456] The outbreak also led to the culling of poultry flocks nationwide.

Cholera

According to the WHO, there were more than 565,000 cases of cholera worldwide from January to October 26, 2025, a significant increase over prior years. The majority of the cases occurred in Africa, Asia, and the Middle East.[457]

COVID-19

During 2025, the incidence and severity of COVID-19 infections were greatly reduced as compared with the height of the public health emergency. Public health officials warn that although the United States is in a much better place than it was during the public health emergency, COVID-19 is still a threat to high-risk groups, which is why vaccination is a critical tool for community-level protection against serious illness.

Research by the National Institutes of Health's Researching COVID to Enhance Recovery (RECOVER) Adult Initiative found that approximately 1 in 20 people who were previously infected by the COVID-19 virus were experiencing encephalomyelitis/chronic fatigue syndrome, compared with less than 1 percent of their uninfected counterparts.[458]

Flu

From October 1, 2025 to March 14, 2026, CDC estimated that there had been between 28 million and 49 million flu illnesses nationwide, leading to between 360,000 and 740,000 hospitalizations and between 22,000 and 74,000 deaths.[461]

Measles

During 2025, there were 2,285 confirmed measles cases reported in the United States—the highest annual total since 1991[462]—with cases reported by 45 jurisdictions as well as 25 cases reported

among international visitors.[463] Among known cases, 11 percent resulted in hospitalization, and two children and one adult died from measles during the year. Approximately 93 percent of these cases were confirmed in people who were unvaccinated or did not know their vaccination status. During the first weeks of 2026, outbreaks that began in 2025 continued, including in South Carolina, where the state had reported nearly 1,000 cases by mid-March.[464,465]

Measles was declared eliminated in the United States in 2000, meaning there was no continuous endemic transmission for at least 12 months in the presence of a well-performing surveillance system; however, elimination is not the same as eradication.[466]

In November 2025, Canada lost its official measles-elimination status after sustained transmission of measles for more than 12 months, and as a result, the Pan American Health Organization (PAHO) determined that the Region of the Americas—which had previously been verified as measles-free—no longer met the criteria for elimination. This reflects the re-establishment of endemic transmission in parts of the region after decades of interruption. Ongoing outbreaks in the United States and Mexico have raised concerns among public health authorities that the United States could also lose its measles-elimination status if endemic transmission continues without interruption for a 12-month period.[467]

VARYING COVID-19 VACCINATION RECOMMENDATIONS MAY CREATE COMPLACENCY

Public health experts have raised concerns that changes in long-standing recommendations for who should be vaccinated against COVID-19 may cause confusion and hinder vaccine access.

For the 2025–2026 respiratory virus season, CDC changed its earlier recommendation and began recommending that people ages "6 months and older get a COVID-19 vaccine based on "individual-based decision-making."[459] The earlier CDC recommendation was that all people ages 6 months and older receive the COVID-19 vaccine. However, several medical organizations, including the American Academy of Pediatrics (AAP), recommend that all children ages 6 to 23 months get the COVID-19 vaccine, along with children and teens ages 2 to 18 years who are at high risk for severe illness. AAP also advised that children and teens ages 2 to 18 years who are not at high risk for severe COVID-19 can still get vaccinated for strong protection against COVID-19. The American College of Obstetricians and Gynecologists recommends that pregnant people receive an updated COVID-19 vaccine at any point during their pregnancy, when planning to become pregnant, in the postpartum period, or when lactating. The American Academy of Family Physicians recommends that people ages 19 to 64 get one or more doses of the COVID-19 vaccine, and people ages 65 years and older get two or more doses.[460]

Vaccination Rates are Declining Nationwide: Why and What's at Stake?

Across the country, vaccination rates are declining, leaving some areas without community-level protection against numerous infectious diseases.[468] An NBC/Stanford investigation found that since 2019, 77 percent of jurisdictions in the United States have experienced declines in childhood vaccination rates. Specific to the MMR vaccine (measles-mumps-rubella), 67 percent of reporting counties and jurisdictions have immunization rates below the 95 percent needed for community-level immunity.[469]

A case in point: The largest measles outbreak in more than 30 years occurred in West Texas during winter and spring 2025. The outbreak was centered in Gaines County, where nearly one in four residents had not received the MMR vaccine. By the time the outbreak was declared over during the summer, 762 measles cases had been reported, 99 people required hospitalization, and three people died, with additional cases linked to the outbreak reported in other states.[470]

During the first weeks of 2026, outbreaks that began in 2025 continued, including in South Carolina, where the state had reported nearly 1,000 cases by mid-March.[471,472]

Numerous factors are contributing to declining vaccination rates

While a majority of Americans (63 percent) report that they are "highly confident" that childhood vaccines are effective at preventing serious illness,[473] vaccination rates are continuing to decline due to numerous factors.

- Shifting and conflicting advice about vaccines are creating confusion and in some cases inaction on the part of parents and other health consumers.[474]
- Vaccine hesitancy is growing. A national poll conducted in summer 2025 by KFF and The Washington Post found that approximately 16 percent of polled parents had skipped or delayed a vaccine for their child (besides annual COVID-19 or flu shots).[475] Respondents reported worries about possible risks associated with the shots as the most common reason for their decision to delay or skip a vaccine rather than any access issues. Skipped or delayed vaccinations were most common among families that homeschooled their children.[476]
- Vaccine exemptions for school attendance are increasing. During the 2024–2025 school year, vaccine exemption rates increased to 3.6 percent compared with 3.3 percent for the previous school year, and childhood vaccinations rates fell for the fifth consecutive year.[477]

False claims sow doubts

False claims about vaccine safety and actions by HHS that have sown doubt about the need for vaccinations made access more complicated and have created confusion about if and when to get vaccinated.

An example is CDC's change to the nation's childhood immunization schedule. The birth dose vaccine for all infants has reduced hepatitis B cases among children and adolescents by 99 percent and prevents illness and deaths in people of all ages.[478]

Vaccination exemptions are increasing

In the early 1980s, every U.S. state required that children entering school be vaccinated against vaccine-preventable diseases, but these requirements have been weakened over time and now vary widely among states. Only four states currently do not allow any nonmedical exemptions to vaccine requirements, while other states allow for exemptions on philosophical, personal, and/or religious grounds.[479] During the 2022-2023 school year, Idaho had the highest rate of kindergarten students with vaccine exemptions at 12.1 percent, followed by Oregon at 8.2 percent and Utah at 8.1 percent. The U.S. median was 3.3 percent.[480] Furthermore, high rates of vaccine hesitancy often cluster with geographic areas, which can create pockets of unprotected communities hidden by state-wide data.[481]

Vaccination rates among kindergarteners have been dropping since before the COVID-19 public health emergency, leaving many communities below the 95 percent target vaccination rate needed for community-level immunity against measles and other diseases. According to an analysis by The Washington Post of public records from 44 states and the District of Columbia, the share of counties where 95 percent or more of kindergartners were vaccinated against measles fell from 50 percent before the pandemic to 28 percent in 2024–2025, opening the door for more outbreaks.[482] Many schools have become less strict in enforcing vaccine requirements or have no policy to check for immunization status, according to the analysis. While the measles vaccine provides durable, lifetime immunity,

without herd immunity the disease can still spread among those who cannot be vaccinated due to age or medical status.

According to CDC, during the 2024–2025 school year, vaccination coverage among kindergartners for the MMR vaccine and the polio vaccine decreased nationally to 92.5 percent, lower than the 95 percent rate needed for the community or herd immunity that prevents the spread of these diseases. It is estimated that about 286,000 kindergarteners attending school nationwide during the 2024–2025 school year had no record of completing the MMR vaccine series.[483] Additional research by The Washington Post found that about 5.2 million kindergarten-age children in the United States live in communities with vaccination rates for their cohort that are below community-immunity thresholds, up from about 3.5 million before the COVID-19 pandemic.[484]

In September 2025, Florida announced a plan to phase out all vaccine requirements for school entry, the first state to do so. In addition, at least 10 states made changes to their vaccination regulations during 2025, which will likely result in more students claiming exemptions and lead to a higher risk of disease spread in those communities.[485]

The Louisiana Department of Health announced in February 2025 that it would stop promoting vaccinations to state residents, ending efforts such as promoting vaccines at health fairs, through community clinics, and in media campaigns.[486]

Some states are collaborating on multistate recommended vaccine schedules for state residents that more closely align with previous ACIP-recommended schedules and what is currently recommended by national medical organizations.[487]

Several states—including California, Colorado, Maine, and Maryland—have enacted laws reducing sole reliance on federal vaccine recommendations and allowing or requiring state vaccine policy to draw on guidance from bodies such as the American Academy of Pediatrics and the American Academy of Family Physicians. In some cases, these laws also require state-regulated insurers to cover state-endorsed vaccines.[488]

What's at risk?

In a December 2025 essay published in The New England Journal of Medicine, 12 former FDA commissioners said that recent actions by the agency "will undermine a regulatory model designed to ensure vaccine safety, effectiveness, and availability."[489]

Additionally, infectious-disease experts warn that decreasing levels of vaccination rates give diseases that were a thing of the past the opportunity to resurface. Public health officials have warned that declining childhood vaccination rates could foretell the reemergence of previously eliminated diseases in the United States as community-level immunity is lost.[490]

In discussing the 2025 Texas measles outbreak, infectious-disease specialist Dr. Peter Hotez of the Baylor College School of Medicine told KXAN, the NBC News affiliate in Austin, Texas, that the outbreak was "not hard to predict. Measles exploits low vaccination rates, and some of the counties in West Texas have the lowest vaccination rates in the state and even the country. So, guess what? That's exactly what happened."[491]

MEASLES-ELIMINATION STATUS COULD BE LOST

Measles was declared "eliminated" in the United States in 2000, but that status is at risk. A disease is determined to be eliminated if disease transmission leading to outbreaks has not occurred for at least 12 months. Between 2001 and 2011, there were 64 recorded measles outbreaks (three or more measles cases) in total.[492] In 2025, there were 48 reported outbreaks.[493]

The potential loss of measles-elimination status is due to numerous factors, including:

- Ongoing disease outbreaks across the country.
- High rates of local transmission. Between 2001 and 2011, 40 percent of measles cases came from outside the United States. In 2025, 12 percent of cases were imported, indicating a large increase in local transmission.[494]
- Declining measles vaccination rates. The MMR vaccination rate among kindergarten students in the United States was 92.5 percent during the 2024–2025 school year, down from the pre-pandemic rate of 95.2 percent.[495]

In November 2025, the Pan American Health Organization (PAHO) determined that Canada no longer met the criteria for measles-elimination status after more than 12 months of sustained transmission. As a result, the Region of the Americas—which had previously been verified as measles-free—no longer met regional elimination criteria.

As of November 2025, PAHO reported more than 12,500 confirmed measles cases across the Americas, with approximately 95 percent of cases reported in Canada, Mexico, and the United States.[496]

Mpox

Mpox is transmitted by close personal contact. It continues to be a serious public health risk in many African nations. Between January 2024 and May 2025 approximately 140,000 suspected cases of Mpox were reported in 26 African nations leading to nearly 1,800 deaths.[497] In other parts of the world, the incidence of Mpox infections is much lower but remains a risk as most of the cases have been associated with international travel.[498]

Cases of travel-associated Mpox have been reported in Africa, Asia, Europe, the Middle East, and North and South America.[499]

In the United States, 12 Mpox cases have been reported since November 2024, most were associated with international travel.[500]

Pertussis (whooping cough)

Pertussis is a serious respiratory infection that includes a severe cough that can make breathing difficult, especially in young children. Pertussis cases surged in 2024, with four times as many cases that year as compared with 2023 and reaching a peak in November 2024. Nearly 42,000 cases were reported in 2024. Cases in 2025 were lower, at almost 28,000 as of December 20, but still represent a serious health risk, including an estimated 13 U.S. deaths during the year.[501]

Polio

Progress toward the worldwide eradication of polio has been made, but during 2025 there were also concerning signs that the disease could make a comeback. Cases are occurring in Pakistan and Afghanistan, and world public health officials have voiced concerns that the elimination of USAID and its vaccination programs will lead to more cases.[502]

Rubella

Through August 2025, U.S. rubella cases provisionally numbered 11.[503] Rubella cases are highest in the 19 countries that do not use the rubella vaccine. Modeling studies have shown that using the rubella vaccine in those countries would prevent an estimated 986,000 cases of birth defects over the next 30 years.[504]

RSV

As of March 2026, respiratory syncytial virus (RSV) activity was relatively low throughout the United States for the 2025–2026 season. The lower rates of RSV activity were partially attributable to wider availability of RSV immunizations and treatment.[505]

RSV hospitalizations among babies decreased significantly after RSV-prevention products became widely used in the United States. Hospitalization rates for RSV during the 2024–2025 season were 45–52 percent lower in infants younger than 3 months old and 28–43 percent lower in infants younger than 8 months old compared with the 2018–2020 seasons.[506]

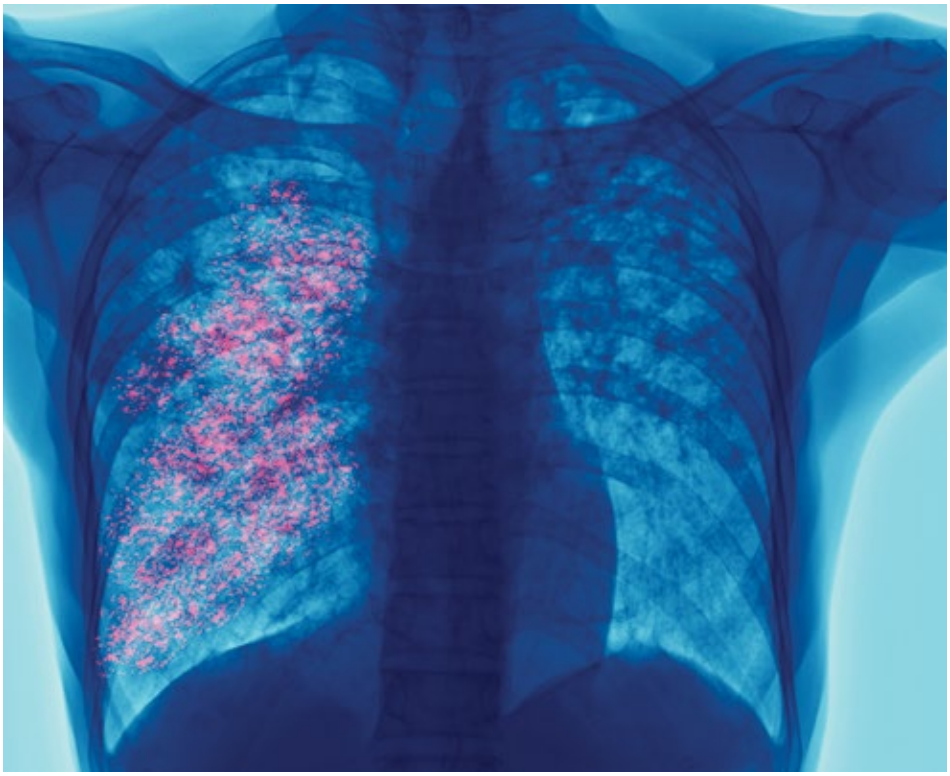
Syphilis

Syphilis is a sexually transmitted infection. The infection can also be transmitted from mother to infant during pregnancy. Syphilis cases globally have grown from approximately 6 million in 2015 to an estimated 9 million in 2025.[507] Syphilis is treatable with antibiotics.

CDC data show that U.S. cases of syphilis in newborns increased in 2024, with nearly 4,000 cases reported.[508]

Tuberculosis

Tuberculosis (TB) causes more deaths worldwide than any other infectious disease and is among the top 10 causes



of death across the globe. In 2024, 10.7 million cases of TB were estimated and lead to an estimated 1.23 million deaths.[509]

Beginning in early 2024, a TB outbreak in the Kansas City, Kansas, metropolitan area was first detected, ultimately resulting in 67 active tuberculosis cases and 79 latent TB infections, making it one of the largest tuberculosis outbreaks in the United States in recent decades.[510] After a coordinated public health response by the Kansas Department of Health and Environment, CDC, the University of Kansas Medical Center, and local health departments—and with no new active TB cases diagnosed since April 2025 and all affected individuals completing treatment—state public health officials declared the outbreak over on November 14, 2025.[511]

West Nile Virus

In 2025, 2,076 cases of West Nile Virus were reported and occurred in 47 states.[512]

Trust in Public Health Guidance and Challenges to Public Health Authorities

A national poll conducted by KFF and released in February 2026 found that Americans' confidence in federal and local health agencies continues to fall, a decline that started during the COVID-19 public health emergency. Respondents who reported a "great deal" or "fair amount" of confidence in CDC to make the right recommendations on health fell from 66 percent in June 2023 to 47 percent in the more recent polling.[513]

Since the COVID-19 pandemic, many new laws that limit the ability of public health officials to respond to public health emergencies have been adopted. The laws include restrictions on vaccine requirements, required mask-wearing, stay-at-home orders, and business closures.[514]

Methodology

Indicator Selection Criteria

Indicators are chosen based on the following criteria:

- **Significant:** Each indicator must meaningfully gauge states' readiness for public health emergencies.
- **Broad Relevance and Accessibility:** Indicators must apply to all states and the District of Columbia, with timely and accessible data. Although TFAH aims to include U.S. territories and certain federally recognized tribes, data availability constraints limit such inclusion.
- **Timeliness:** Indicators must be updated regularly.
- **Scientific Validity:** Data sources must be credible, rigorously constructed, and methodologically sound.
- **Nonpartisan:** Indicators and data must be free from political bias.

The goal is to select a range of actionable indicators that TFAH—and other stakeholders, including states—can use to track progress over time. Indicators were selected to reflect preparedness consistently across states.

Public Health Funding Data: Collection and Verification

TFAH surveyed state officials for data on state-supported public health funding. Drawing from the University of Washington's Public Health Activities and Services Tracking project, TFAH defines public health services as including:

- **Communicable Disease Control:** Epidemiology, COVID-19, hepatitis, HIV/AIDS, and related programs.
- **Chronic Disease Prevention:** Programs addressing asthma, cancer, cardiovascular disease, and similar conditions.
- **Injury Prevention:** Firearms, motor vehicles, substance use disorders, and other injury areas.
- **Environmental Public Health:** Air and water quality, food safety, and related concerns.
- **Maternal, Child, and Family Health:** Family planning, newborn screening, and related services.
- **Access to and Linkage with Clinical Care:** For example, determining beneficiary eligibility.

Insurance coverage programs and inpatient clinical facilities are excluded. State respondents guided TFAH in updating and refining the FY 2024 baseline data for improved comparability. Nearly every state and the District of Columbia verified prior funding data and provided new data for the current reporting year; Georgia, Mississippi, North Carolina, and West Virginia were the only exceptions.

Scoring and Tier Placements

TFAH grouped states into three performance tiers—high, middle, and low—based on results across 10 indicators, some of which allow for partial credit. Where data were unavailable, partial credit was assigned accordingly.

Indicators and Scoring

1. Adoption of the NLC (Nurse Licensure Compact)

- Adopted: 0.5 point
- Not adopted: 0 points

2-3. Accreditation by the Public Health Accreditation Board (PHAB) and the Emergency Management Accreditation Program (EMAP)

- Each accreditation earned: 0.5 point
- Not accredited: 0 points

4. State Public Health Funding Trends

- Increased or no change (nominal): 0.5 point
- Decreased: 0 points
- States that did not provide public health funding data were assigned 0.25 points for this indicator, reflecting missing data rather than confirmed increase/stability or decrease.

5. Community Water System Compliance (Percent of residents served by systems meeting all health-based standards)

States were scored based on how many standard deviations (SD) their percentage fell above or below the national mean:

- Within one SD above the mean (including states with 0% noncompliance): 1 point
- Within one SD below the mean: 0.75 point
- One to two SDs below the mean: 0.5 point
- Two to three SDs below the mean: 0.25 point
- More than three SDs below the mean: 0 points

6. Access to Paid Sick Leave

States were scored based on how many standard deviations (SD) their access rate fell above or below the national mean:

- More than one SD above the mean: 1 point
- Within one SD above the mean: 0.75 point
- At the mean or within one SD below: 0.5 point
- More than one SD below the mean: 0.25 point

7. Seasonal Influenza Vaccination Coverage (Ages 6 months and older)

States were scored based on how many standard deviations their coverage rate fell above or below the national mean:

- More than one SD above the mean: 1 point
- Within one SD above the mean: 0.75 point
- At the mean or within one SD below: 0.5 point
- More than one SD below the mean: 0.25 point

8. Leapfrog Hospital Safety Grade ("A" grades as a percentage of rated hospitals)

States were scored based on how many standard deviations their share of "A"-grade hospitals fell above or below the national mean:

- More than one SD above the mean: 1 point
- Within one SD above the mean: 0.75 point
- At the mean or within one SD below: 0.5 point
- Below one SD below the mean, but greater than zero: 0.25 point
- No "A"-grade hospitals: 0 points

9. Public Health Laboratory Surge Planning (Written plan for a 6- to 8-week capacity increase)

a. Has a written plan: 0.5 point

b. No plan reported: 0 points

10. Avoidable Mortality

TFAH used a min-max method to convert each state's results to a 0-to-1 scale (where higher scores indicate better outcomes) for both overall avoidable mortality and the gap between the highest and lowest racial/ethnic group rates. States with the best outcomes on overall avoidable mortality and the smallest disparities received scores closer to 1; states with worse outcomes and larger gaps received scores closer to 0. The two scores were then averaged to produce a single combined score between 0 and 1.

Points were assigned based on the combined score as follows:

- 0.76 to 1.00: 1 point
- 0.51 to 0.75: 0.75 points
- 0.26 to 0.50: 0.50 points
- 0.00 to 0.25: 0.25 points

The highest possible total score is 7.5 points.

Tier Assignments

States and the District of Columbia are assigned to tiers based on their total scores:

- High-performance tier: Top 17 scores (this year ranging from 5.75 to 7.25 points)
- Middle-performance tier: 18th to 34th states (5 to 5.5 points)
- Low-performance tier: 35th to 51st states (3.25 to 4.75 points)

Tier cutoffs are set to approximate an equal three-way distribution across jurisdictions. The number of jurisdictions in each tier may vary from year to year depending on score distributions. States with identical scores receive the same tier placement.

Assuring Data Quality

TFAH conducted multiple phases of quality assurance to strengthen the integrity of the data and deepen its understanding of state performance, particularly for outliers on specific indicators. During the state public health funding data collection process, each verified file was systematically reviewed for errors, inconsistencies, and missing data. Respondents were then contacted as needed for corrections or to complete missing entries.

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