Southern Nevada Health District

Influenza Season Wrap-Up Report
Season 2025-2026

Final Report
Division of Disease Surveillance & Control
Office of Epidemiology
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Overview

In the United States, Influenza activity often begins to increase during the fall and winter months of each year. Although influenza viruses circulate throughout the year, influenza typically peaks between December and February and may continue through May. This annual time frame is commonly referred to as “flu season.”

During each flu season, the Southern Nevada Health District (SNHD) compiles data from multiple sources to provide a weekly snapshot of influenza activity within Clark County, Nevada. For the 2025–2026 season, data were collected between September 28, 2025, and May 17, 2026. These dates correspond to the Centers for Disease Control and Prevention (CDC) Morbidity and Mortality Weekly Report (MMWR) from Week 40 of 2025 through Week 20 of 2026. This report summarizes influenza (flu) surveillance findings for Clark County, NV, during the 2025-2026 flu season.

Case Definitions

Influenza confirmed case definition:

A case with laboratory-confirmed influenza who was hospitalized for a least 24 hours or who died.

Unless otherwise specified, “confirmed cases” in this report refers to cases meeting this surveillance definition.

Influenza-associated hospitalization case definition:

- An individual who was admitted into a hospital within 14 days after a positive influenza test, or
- An individual who was admitted to the hospital within three days before a positive influenza test and had a hospital length stay greater than 24 hours.

Laboratory criteria:

A positive influenza test by polymerase chain reaction (PCR), culture, direct or indirect immunofluorescent antibody staining, immunohistochemistry (IHC) antigen staining, or a rapid influenza diagnostic test (RIDT).

Influenza-associated death case definition:

A case who was tested positive for influenza by an appropriate laboratory test and died in the following two scenarios:

- Case died directly or indirectly from a clinically compatible influenza illness or the cause of death is listed as pneumonia on the death certificate, and death happened within 30 days from the date of specimen collection.
- Cause of death is listed as influenza on the death certificate regardless of the time interval between the date of death and the date of specimen collection.

Key Influenza Statistics

During the 2025–2026 influenza season, SNHD reported a total of 1,458 confirmed influenza cases in Clark County (**Table 1**). Among these cases, there were 1,438 hospitalizations and 61 deaths. Using the finalized 2024–2025 data, this represents 580 fewer reported cases (28.5%), 569 fewer hospitalizations (28.4%), and 53 fewer influenza-associated deaths (46.5%). Pediatric influenza-associated deaths also decreased from two to one. These findings indicate a substantial reduction in reported influenza-associated morbidity and mortality compared with the previous season.

Among the 1,438 influenza-associated hospitalizations reported during the 2025–2026 season, adults aged 65 years and older accounted for nearly half (47.8%) of all hospitalized cases. Adults aged 50–64 years and 25–49 years represented the next largest age groups, accounting for 17.3% and 16.9% of all hospitalized cases, respectively **(Table 2)**. Collectively, adults aged 50 years and older accounted for 65.2% of influenza-associated hospitalizations, underscoring the continued disproportionate burden of severe influenza outcomes among older adults. Although the proportion of hospitalized individuals aged 65 years and older decreased compared with the previous season (52.4%), this age group continued to account for the largest share of hospitalizations.

As shown in **Figure 1**, influenza activity during the 2025–2026 season followed a more prolonged pattern than the previous two seasons. Confirmed cases increased gradually during the fall before peaking in MMWR week 52. Although weekly confirmed cases remained lower than those observed during the 2024–2025 season, flu activity persisted later into the surveillance period, with cases continuing through the spring months. Notably, the peak in MMWR week 52 was consistent with the timing of the previous season's peak, although the magnitude of weekly confirmed cases was lower during 2025-2026. The continued detection of cases into the spring suggests a more extended period of influenza activity despite the overall reduction in reported cases and severe outcomes.

Influenza Vaccination

Vaccination against influenza remains an important public health strategy for reducing illness and preventing severe outcomes. To assess trends in documented influenza vaccination among Clark County residents, SNHD calculated the percentage of individuals with a recorded influenza vaccine dose within the state immunization information system (NVWebIZ) during the past five influenza seasons (2021–2022 through 2025–2026) (**Table 3**).

During the 2025-2026 influenza season, documented influenza vaccination coverage varied by age group, with the highest percentage observed among individuals aged 65 years and older (43.1%). Despite having the highest coverage, fewer than half of individuals in this age group had a documented influenza vaccination. Compared with the 2021–2022 season, documented influenza vaccination coverage declined across all age groups. The largest decreases were observed among children aged 0–4 years (10.9 percentage points) and 5–11 years (7.3 percentage points). Overall documented vaccination coverage declined from 21.1% in 2021-2022 to 16.4% in 2025-2026, representing an approximately 22% relative decrease. These findings demonstrate a sustained downward trend in documented influenza vaccination across Clark County's population, including age groups at increased risk for influenza-associated complications.

To further evaluate the vaccination status among individuals experiencing severe influenza outcomes, SNHD assessed documented influenza vaccination status among confirmed influenza-associated hospitalizations during the 2025–2026 season. Vaccination status was determined through deterministic matching with influenza vaccination records in NVWebIZ (**Table 4**).

Among hospitalized cases, 17.5% were vaccinated at least 14 days before symptom onset, while 2.5% received influenza vaccination within 14 days before symptom onset. The majority of hospitalized cases (80%) did not have documented influenza vaccination records identified in NVWebIZ. Therefore, only 17.5% of hospitalized cases had a documented vaccination at least 14 days before symptom onset, while the vaccination status of the remaining 82.5% could not be

classified as having been vaccinated at least 14 days before symptom onset. Because the absence of documentation does not necessarily indicate that an individual was unvaccinated, these findings should be interpreted with caution. Additionally, these data describe vaccination documentation among hospitalized individuals and should not be interpreted as an estimate of vaccine effectiveness or evidence that vaccination status caused the observed hospitalization outcomes.

Table 1. Seasonal influenza comparison*

Clark County, NV

Metric	2024-2025**	2025-2026
Total Cases	2,038	1,458
Total Hospitalizations	2,007	1,438
Total Deaths	114	61
Pediatric Deaths	2	1
Dominant Strain	Influenza A (not sub-typed)	Influenza A (not sub-typed)

** Influenza season defined as MMWR weeks 40–20.*

*** Provisional data published in the 2024–2025 Influenza Season Wrap-Up Report have since been updated. Reported totals increased from 1,904 to 2,038 cases, 1,874 to 2,007 hospitalizations, and 109 to 114 deaths.*

Table 2. Influenza-associated hospitalizations by age group

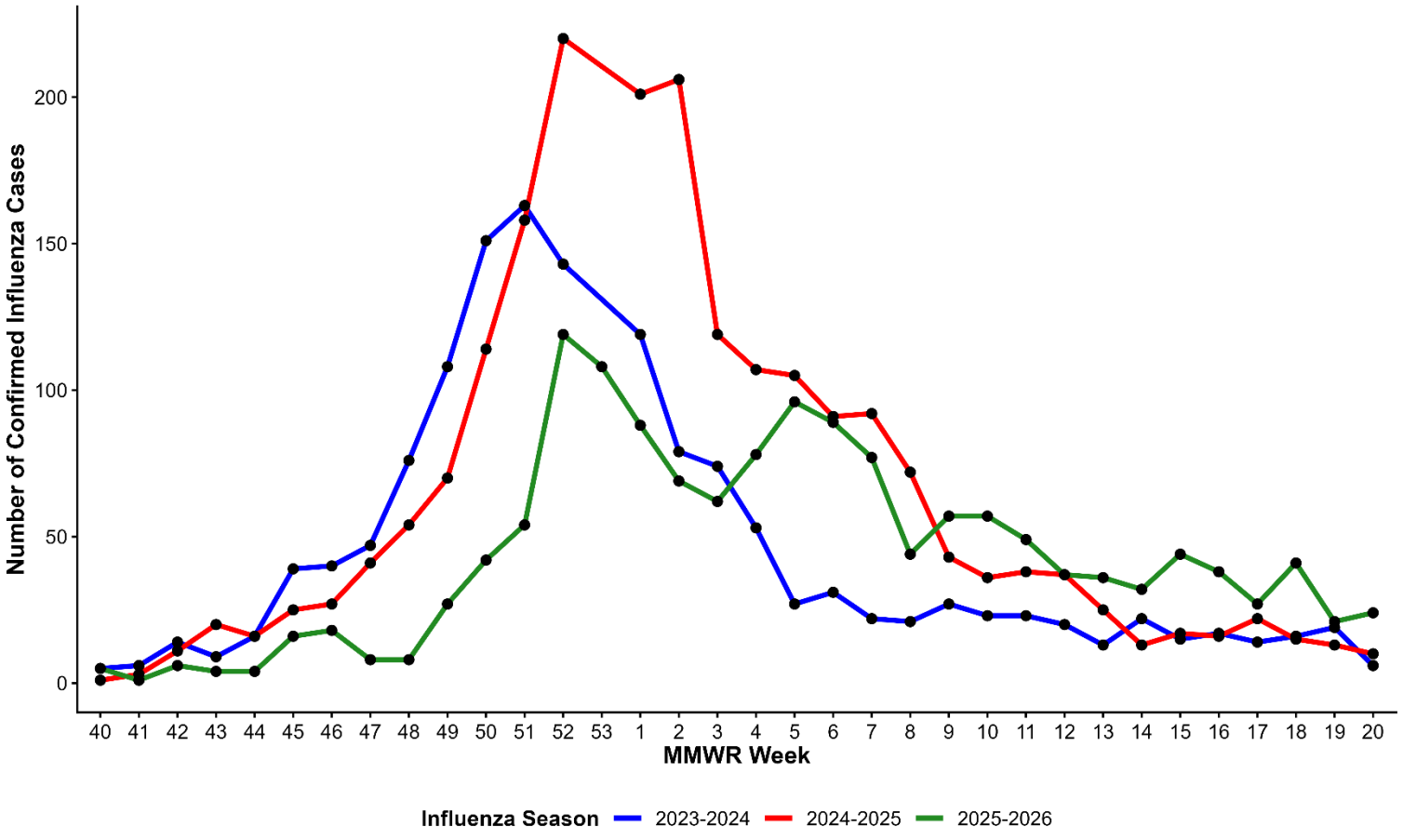
Clark County, NV

Age Group	Hospitalizations	Percentage (%)**
0-4	79	5.5
5-17	121	8.4
18-24	58	4.0
25-49	243	16.9
50-64	249	17.3
65+	688	47.8
Total	**1,438**	**100.0**

Source: SNHD EpiTrax Warehouse

***Percentages may not total 100% due to rounding.*

Figure 1. Seasonal trend of confirmed influenza cases by MMWR week
Clark County, NV



Source: SNHD EpiTrax Warehouse

Table 3. Distribution of influenza vaccine percentage coverage*

Clark County, NV by age group and season

Age Group	2021-2022	2022-2023	2023-2024	2024-2025	2025-2026	Overall Change in Percent Vaccinated
0-4	26.0	22.3	19.9	17.5	15.1	-10.9
5-11	19.1	17.0	15.2	13.7	11.8	-7.3
12-17	15.4	14.4	13.1	12.2	10.6	-4.8
18-24	8.4	7.7	6.8	6.7	6.4	-2.1
25-49	12.9	12.3	11.0	10.6	9.8	-3.1
50-64	24.2	24.5	21.4	19.2	17.7	-6.5
65+	47.7	50.2	47.6	44.6	43.1	-4.6
Total	**21.1**	**20.8**	**18.9**	**17.6**	**16.4**	**-4.6**

** Vaccination percentage is derived from the number of single doses administered to individuals between MMWR weeks 26–20.*
Vaccine Data Source: NVWebIZ
Population Data Source: NV Demographer Office, Vintage 2023, Projection Years 2022–2026.

Table 4. Vaccination status of influenza-associated hospitalizations*

Clark County, NV

Vaccination Status	Number of Cases	Percentage (%)
Vaccinated ≥14 days before onset	252	17.5
Vaccinated <14 days before onset	36	2.5
No documentation	1,150	80.0
Total	**1,438**	**100.0**

** Vaccination status was determined through deterministic matching with NVWebIZ influenza vaccination records.*

Definitions:
Vaccinated ≥14 days: Influenza vaccine received ≥14 days before symptom onset.
Vaccinated <14 days: Influenza vaccine received <14 days before symptom onset.
No documentation: No influenza vaccination record was identified in NVWebIZ. This does not necessarily indicate the individual was unvaccinated.

Source: *NVWebIZ.*

SNHD Laboratory Based Surveillance

The Southern Nevada Public Health Laboratory (SNPHL), commercial laboratories, and healthcare providers reported laboratory-confirmed influenza infections among patients who tested positive by one of the following methods: viral culture, immunofluorescence antibody testing, serology, Rapid Influenza Diagnostic Tests (RIDTs), Reverse-Transcriptase Polymerase Chain Reaction (RT-PCR), or an unspecified positive influenza test documented in the patient's medical record. Hospitalizations and deaths among individuals with laboratory-confirmed influenza were identified through surveillance investigations, medical record review, and coroner records.

In addition to influenza type, surveillance data may also include subtype information for type A specimens. During the 2025–2026 season, the predominant influenza virus identified among laboratory-confirmed cases was Influenza A (IAV), accounting for 81.4% of all cases (**Table 5**). Among influenza A specimens, 88.6% were not subtyped. Of the 133 IAV specimens that were subtyped, 69.2% were identified as seasonal A(H3), while 30.8% were identified as seasonal A(H1N1).

The predominance of seasonal A(H3) among subtyped specimens was consistent with national surveillance data from this season, which indicated that most subtyped IAV samples (86.5%) were A(H3N2).[1] Compared with the previous season,[2] the percentage of reported influenza B virus (IBV) specimens also increased (18.6% vs. 8.0%). The increased co-circulation of IAV and IBV may have contributed to the prolonged influenza season observed in Clark County (**Figure 1**), consistent with findings reported in previous studies.[3]

Table 5. Influenza-associated hospitalizations by viral type*

Clark County, NV

Influenza Virus		**Test Type**			
Type	Subtype	Non-RIDT	RIDT	Total	Percentage** (%)
A	H1N1	41	0	41	2.9
A	H3	92	0	92	6.4
A	Not subtyped	778	259	1,037	72.1
B	Not subtyped	147	121	268	18.6
Total		**1,058**	**380**	**1,438**	**100.0**

Source: SNHD EpiTrax Warehouse
RIDT: Rapid Influenza Diagnostic Test

** Influenza virus classification was based on the highest priority laboratory result available for each hospitalized case.*
***Percentages may not total 100% due to rounding.*

Severity Indicators and Underlying Conditions

Among hospitalized patients, 188 (13.1%) were admitted to an intensive care unit (ICU), and 59 (4.1%) required mechanical ventilation **(Table 6)**, indicating that a subset of hospitalized patients experienced severe influenza-associated illness requiring advanced supportive care. Overall, 95.8% had at least one documented underlying medical condition. The high prevalence of underlying medical conditions among hospitalized patients highlights the disproportionate impact of influenza among individuals with conditions that may increase the risk of severe illness. Diabetes (17.5%) was the most frequently reported condition, followed by chronic lung disease (15.2%) and asthma (11.9%). Figure 2 summarizes the five most frequently reported underlying medical conditions.

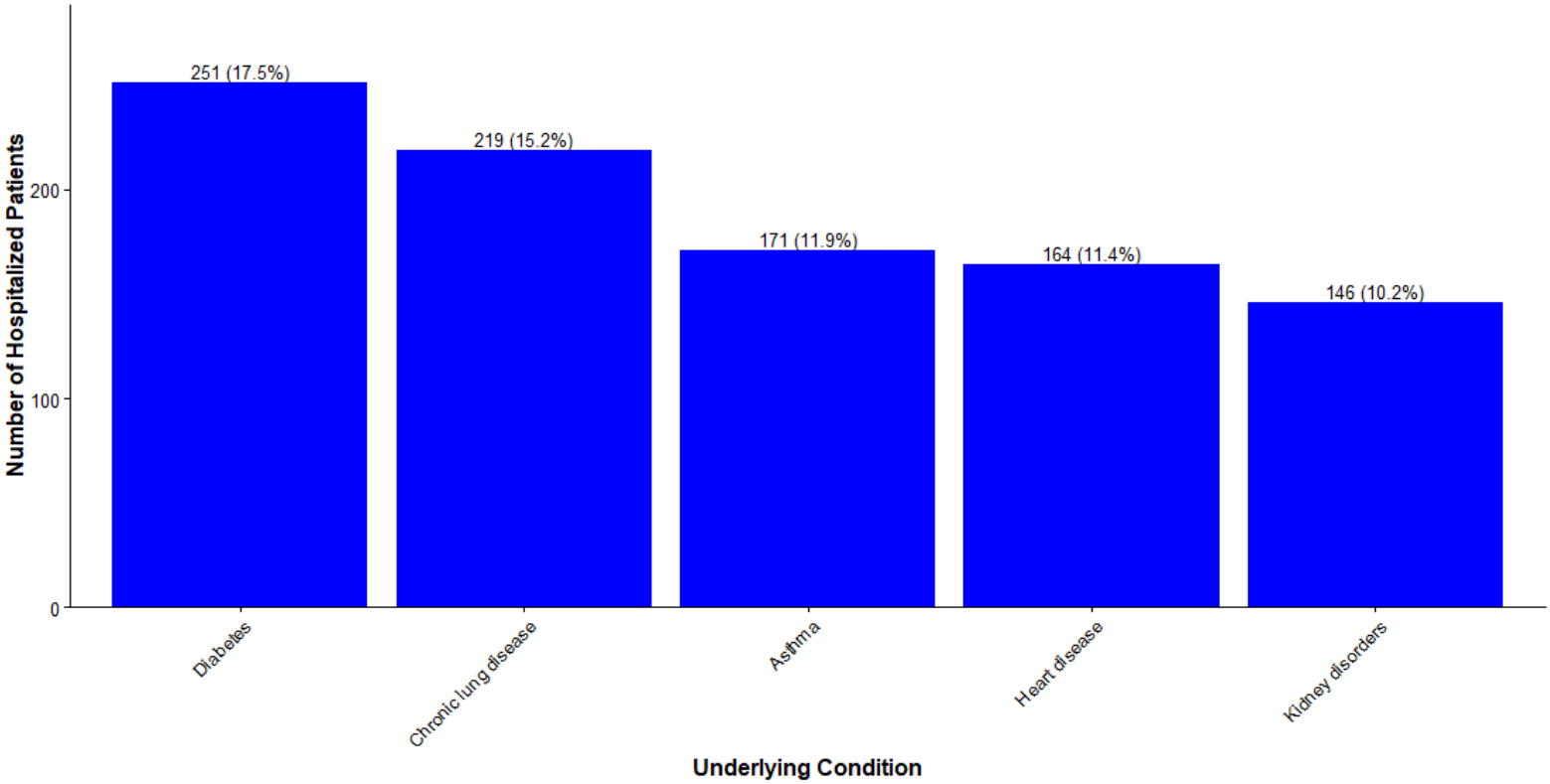
Table 6. Influenza severity indicators among hospitalized cases

Clark County, NV

Severity Indicator	Number of Patients	Percentage (%)
Hospitalized for more than 24 hours	1,438	100.0
Ventilator Use	59	4.1
Admitted to Intensive Care Units (ICU)	188	13.1
Underlying medical conditions	1,377	95.8

Source: SNHD EpiTrax Warehouse
Individuals may report more than one severity indicator

Figure 2. Frequency of select underlying conditions among hospitalized patients with influenza (n = 1,438)*
Clark County, NV



*Percentages represent the proportion of hospitalized influenza patients with each documented underlying condition; patients may have more than one condition.
Source: SNHD EpiTrax Warehouse

Influenza-associated mortality

Influenza-associated mortality includes all deaths resulting from a clinically compatible illness that was confirmed to be influenza by an appropriate laboratory or rapid diagnostic test, with no complete recovery between illness onset and death. SNHD conducts retrospective reviews of medical and vital records for up to 30 days following the date of death to identify influenza diagnosis after notification by laboratories or partner agencies.

As shown in Table 7, a total of 61 influenza-associated deaths were reported during the 2025-2026 flu season. Among the 61 influenza-associated deaths, 44 (72.1%) occurred among individuals aged 65 years and older, followed by individuals aged 50–64 years (n=12, 19.7%). There was 1 death reported among individuals aged 0-24 years (1.6%). This represents a slight decrease compared with the previous influenza season, where 1.8% of all influenza-associated deaths occurred among individuals in this age group.[2]

Further evaluation of influenza-associated mortality by viral type found that 52 (85.2%) of the 61 deaths were associated with IAV, while 9 (14.8%) were associated with IBV (**Table 8**). Among IAV-associated deaths, 36 (59.0%) were not subtyped, including cases identified by RIDT. Seasonal A(H3) accounted for 11 deaths (18.0%), followed by seasonal A(H1N1) with 5 deaths (8.2%).

Table 7. Influenza-associated mortality by age group
Clark County, NV

Age Group	Deaths	Percentage (%)
0-4	1	1.6
5-17	0	0.0
18-24	0	0.0
25-49	4	6.6
50-64	12	19.7
65+	44	72.1
Total	**61**	**100.0**

Source: SNHD EpiTrax Warehouse

Table 8. Influenza-associated mortality by viral type*
Clark County, NV

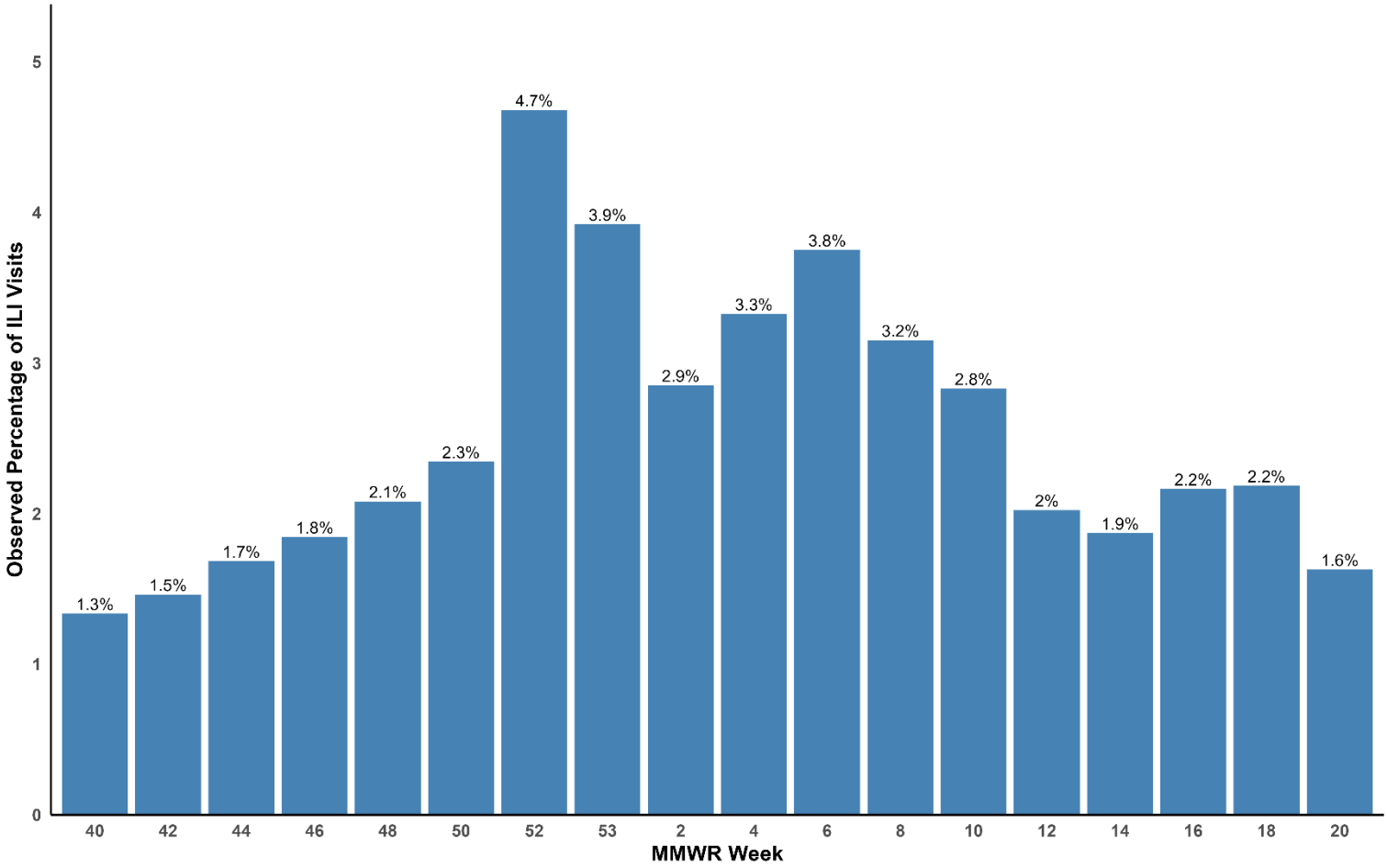
Influenza Type	Deaths	Percentage (%)**
Influenza A (H1N1)	5	8.2
Influenza A (seasonal H3)	11	18.0
Influenza A (not sub-typed)	29	47.5
Influenza A (RIDT)	7	11.5
Influenza B (non-RIDT)	4	6.6
Influenza B (RIDT)	5	8.2
Total	**61**	**100.0**

Source: SNHD EpiTrax Warehouse
RIDT: Rapid Influenza Diagnostic Test.
** Influenza virus classification was based on the highest priority laboratory result available for each case.*
***Percentages may not total 100% due to rounding.*

SNHD Syndromic Surveillance

SNHD also uses the CDC's Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE) to conduct syndromic surveillance for Influenza. When observing the bi-weekly percentage of Emergency Department visits for Influenza-like-Illness (ILI) for the prior season (**Figure 3),** an increase in the percentage of ED visits was observed between weeks 50-52, which showed an increase from 2.3% - 4.7%. While fluctuations in the percentage of ILI were observed in the proceeding weeks of the season, the overall percentage ILI was found not to exceed the 4.7% observed in week 52. The correlation between ED visits and reported hospitalizations for Influenza (Figure 1), reflects the complementary nature of these surveillance tools.

Figure 3. Biweekly percentage of emergency department visits for influenza-like illness by MMWR week Clark County, NV



Source: Centers for Disease Control and Prevention. National Syndromic Surveillance Program, ESSENCE.

Influenza antiviral medication use

Influenza antiviral drugs are prescription medications used to treat influenza infection.[4] Antiviral medications are most effective when initiated within 1-2 days of symptom onset. However, delayed treatment may still provide clinical benefit when started later, especially among those at increased risk of influenza-related complications.[5] Currently there are four antiviral medications recommended for the treatment of influenza: oseltamivir, zanamivir, peramivir, and baloxavir.

According to the CDC, there are certain population groups that would benefit from the use of these medications.[4] These groups include those hospitalized with influenza, individuals who are extremely sick with influenza but do not need to be hospitalized, and those at increased risk of serious influenza complications based on their age or underlying health conditions.

Among the 1,458 confirmed influenza cases reported during the 2025–2026 season, antiviral treatment within 48 hours of symptom onset was documented for 794 (54.5%) cases **(Table 9)**. There were an additional 239 (16.4%) cases with documented antiviral treatment that were initiated more than 48 hours after symptom onset. The remaining 425 (29.1%) cases could not be classified by treatment timing based on available surveillance data. Among the 1,033 cases with a valid treatment interval, 76.9% received treatment within the recommended 48 hours of symptom onset **(Figure 4)**.

When evaluating Figure 4, the cumulative proportion of treated influenza cases increased rapidly during the first few days after symptom onset, with. Among the 1,033 cases with documented treatment information, it was found that 76.9% of cases received treatment within 48 hours and that 92.8% had treatment initiated within 5 days of symptom onset **(Figure 4).**

To assess differences in hospitalization duration by antiviral treatment timing, median length of hospital stay was compared among hospitalized cases in each treatment group. Median length of hospital stay was 3 days among those who received antiviral treatment within 48 hours of symptom onset, 3 days among those treated more than 48 hours after symptom onset, and 2 days among those for whom treatment timing could not be determined. No, statistically significant difference in length of stay was observed among the three treatment-timing groups (Kruskal-Wallis p=0.067).

These findings should be interpreted with caution because treatment timing could not be determined for 425 cases. This included cases without documented antiviral treatment information, cases with treatment information but no documented treatment date, and cases in which the recorded treatment date preceded the reported symptom-onset date. Therefore, the 425 cases should not be interpreted as cases that did not receive antiviral treatment. Additionally, other factors that may influence the median length of hospital stay were not evaluated in the analysis.

Table 9. Antiviral treatment timing among confirmed influenza cases*

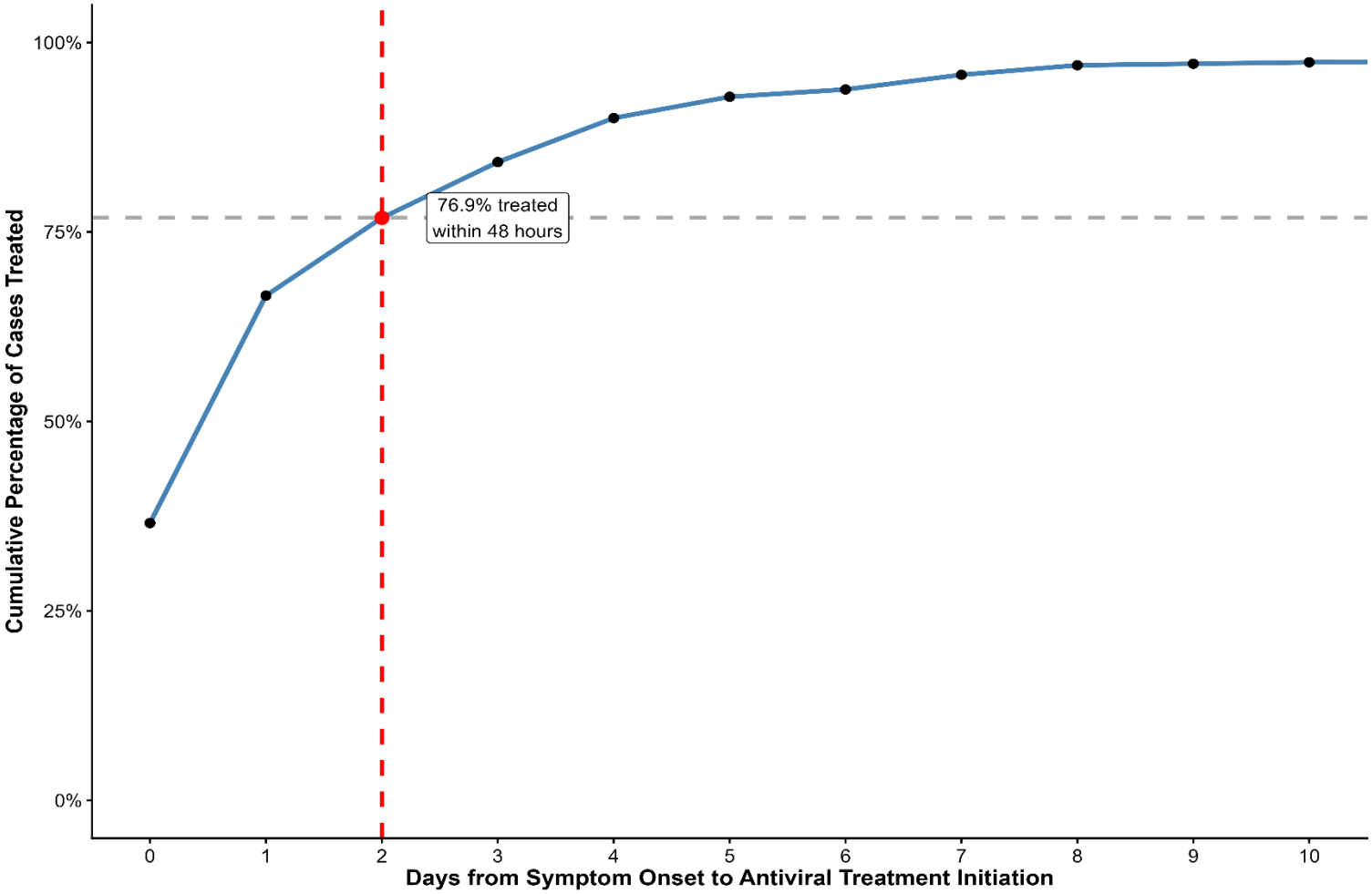
Clark County, NV, 2025–2026 Influenza Season

Treatment Timing	Number of Cases	Percentage (%)
Timely Treatment (within 48 hours)	794	54.5
Treatment after 48 hours	239	16.4
Treatment timing unable to be determined	425	29.1
Total	**1,458**	**100.0**

** Timely antiviral treatment was defined as antiviral initiation within 48 hours of symptom onset.*
Source: SNHD EpiTrax Warehouse.

Figure 4. Cumulative proportion of confirmed influenza cases receiving antiviral treatment*

Among cases with documented treatment dates (n=1033), Clark County, NV.



* Timely antiviral treatment was defined as antiviral initiation within 48 hours of symptom onset.

Source: SNHD EpiTrax Warehouse.

Influenza wastewater surveillance

SNHD monitors wastewater surveillance at the Flamingo Water Resource Center in Clark County, Nevada, serving approximately 2.4 million residents. Samples are collected three days a week and analyzed by the WastewaterSCAN project.[6] Since the onset of the COVID-19 pandemic, WastewaterSCAN has analyzed pathogen concentrations in solid wastewater matrices.[7] The use of solid-phase wastewater samples may be particularly useful for influenza surveillance, as previous studies have demonstrated that IAV viral RNA concentrations can be several orders of magnitude higher in solid wastewater samples than in the liquid fraction.[8]

During the 2025-2026 influenza season, wastewater surveillance data demonstrated distinct temporal patterns. In the case of IAV, the PMMoV-normalized wastewater signal concentrations increased sharply beginning in MMWR week 50 **(Figure 5),** with peak concentration seen in late 2025. Wastewater concentration levels for IAV fluctuated slightly in the subsequent weeks showing a second smaller peak with average concentrations levels approaching 100 copies/g in MMWR weeks 2 of 2026, until steadily declining for the remainder of the season. In contrast, wastewater concentrations for IBV did not show steady increases until MMWR week 5 of 2026 **(Figure 6)**. During the latter portion of this season, IBV showed fluctuating activity with peak activity being observed in MMWR week 14. Of note, a second larger peak in IBV concentration occurred in MMWR weeks 21 and 22 of 2026, immediately following the defined influenza season. The continued elevation of IBV concentrations following the defined influenza season indicates that detectable community-level IBV activity persisted beyond the traditional influenza season.

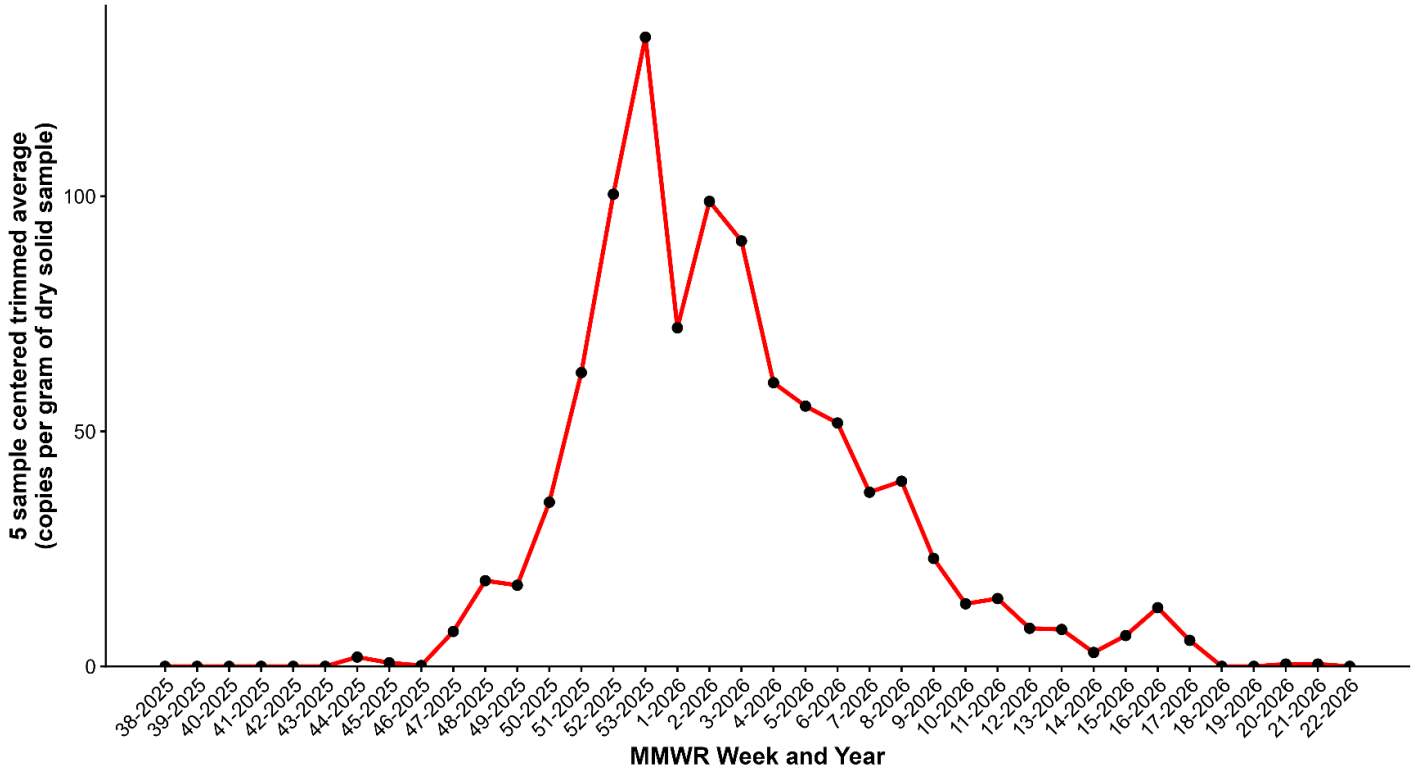
The varying fluctuations observed in wastewater concentrations for IAV and IBV were found to have similarities observed in the trend of both ILI and confirmed case activity during the 2025-2026 season **(Figure 1 and Figure 3**). For instance, peak activity in both confirmed cases and ILI activity were observed during MMWR week 52, coinciding with the highest reported IAV normalized concentration of the season. The convergence of these signals during MMWR week 52 provides evidence that this period represented the peak of influenza activity observed during the 2025-2026 season. Moreover, these findings lend support to the complementary role of wastewater surveillance in influenza surveillance, providing an additional measure of community-level influenza activity.

Influenza A virus subtypes are commonly characterized by their surface glycoproteins, hemagglutinin (H) and neuraminidase (N).[9] Monitoring of subtypes for influenza is essential for understanding circulating strains, seasonal activity, and tracking subtypes of importance such as Influenza H5 that was monitored during the last season.[10] Along with clinical data, wastewater surveillance can provide an early population-level indicator of subtypes that are circulating in the community.

Using available data from WastewaterScan, subtype data for IAV was monitored at the Flamingo Water Resource Center during this last influenza season **(Figure 7)**. While normalized concentration levels for H5 were not detected, a pronounced increase in A(H3) was detected after MMWR week 48 of 2025. This increase was found to peak for the season in MMWR Week 52 and was then followed by a second peak of lower normalized concentrations found in MMWR week 3 of 2026. H3 remained intermittently elevated through MMWR week 7 before declining substantially for the remainder of the season. In contrast, influenza A(H1) detections were sporadic and remained comparatively low, with small increases observed during late 2025 and early 2026.

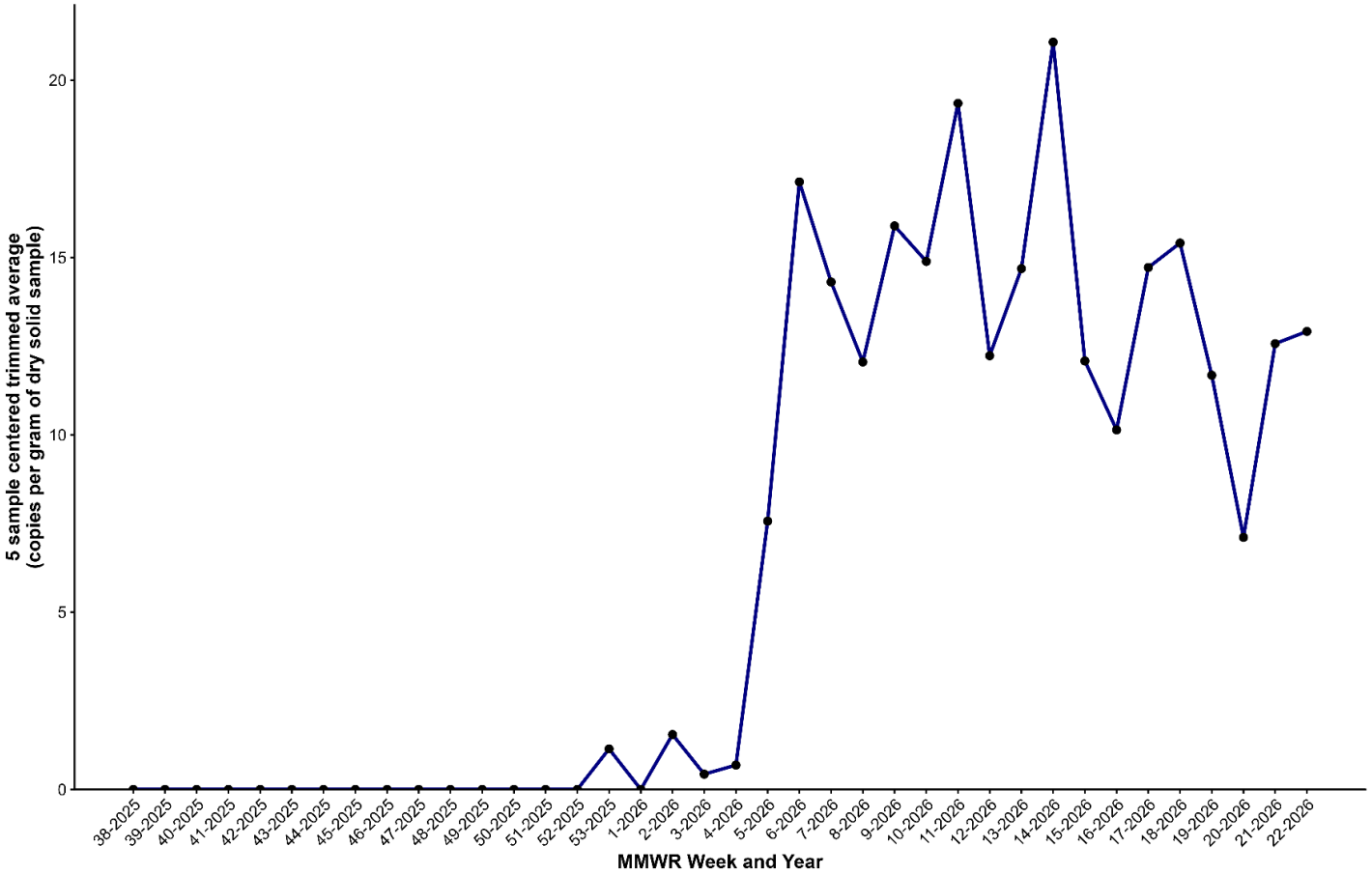
Together, these findings indicate that IAV activity in wastewater was predominantly associated with H3 detections, with H1 contributing only intermittent and low-level detections. The predominance of H3 detected through wastewater surveillance was consistent with clinical and laboratory surveillance findings at the local and national levels (**Table 5**),[1] which showed a predominance of H3 among hospitalized cases and laboratory samples where subtyping was performed.

Figure 5. Influenza A Virus Wastewater Trend
Influenza Season (2025-2026)



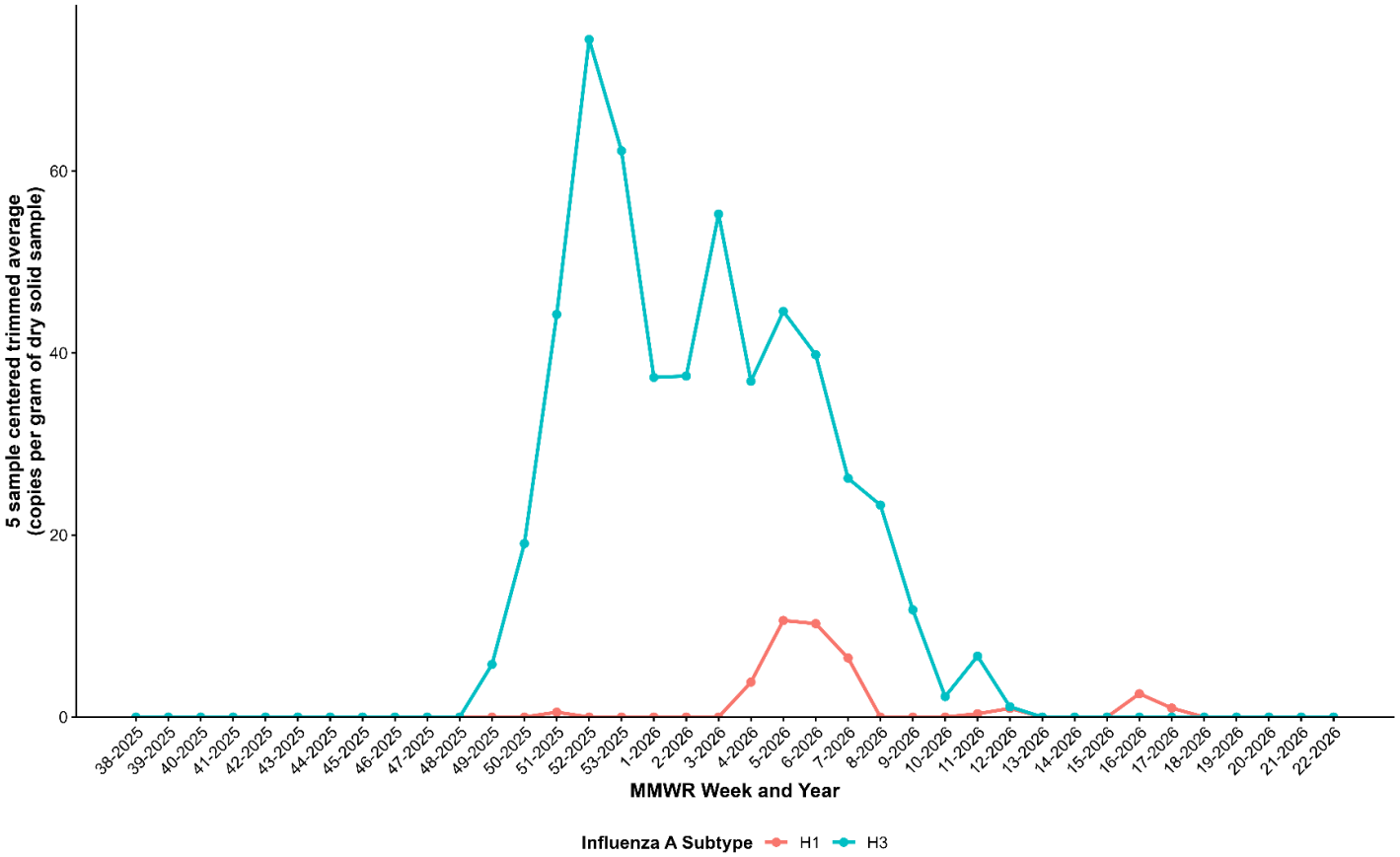
Source: WastewaterScan.org
Sampling Location: Clark County Water Reclamation District, Flamingo Water Resource Center
Note: The sampling period was extended two weeks before and after the typical influenza season to capture potential changes in community influenza activity.

Figure 6. Influenza B Virus Wastewater Trend
Influenza Season (2025-2026)



Source: WastewaterScan.org
Sampling Location: Clark County Water Reclamation District, Flamingo Water Resource Center
Note: The sampling period was extended two weeks before and after the typical influenza season to capture potential changes in community influenza activity.

Figure 7. Influenza A Subtype Wastewater Trends
Influenza Season (2025-2026)



Source: WastewaterScan.org
Sampling Location: Clark County Water Reclamation District, Flamingo Water Resource Center
Note: The sampling period was extended two weeks before and after the typical influenza season to capture potential changes in community influenza activity.
Influenza Subtype H5 was not detected throughout the sampling period.

Conclusion and future recommendations

The data presented in this annual report highlights the findings and existing challenges observed during the 2025-2026 season within Clark County, Nevada. While the data from this past season indicated a less severe season for influenza, it is important for public health officials and individuals to remain vigilant regarding respiratory diseases. As such, the following recommendations aim to strengthen influenza control efforts, improve early detection, and reduce community-level transmission in future seasons.

1) Continue to promote annual influenza vaccination among all eligible individuals

The decreased rate of influenza vaccination across all age groups during the prior five seasons reflects a concerning trend within the community, particularly given the continued circulation and evolution of influenza viruses. Although there is no universally established vaccination coverage threshold for achieving community immunity against seasonal influenza, the Healthy People 2030 initiative has established a target of 70% influenza vaccination coverage among individuals aged 6 months and older as a national benchmark for influenza vaccination coverage.[11]

To improve overall vaccine uptake within the community moving forward, a better understanding of the attitudes and drivers of vaccine hesitancy is needed. As noted in a recent 2025 survey of 1,015 adults from the National Foundation for Infectious Diseases,[12] some of the most frequently reported barriers to influenza vaccination included concerns about side effects (16%), saying they never get sick (13%), doubts about vaccine efficacy (12%), and concerns about getting sick from the vaccine (12%).

To strengthen influenza vaccine uptake moving forward, SNHD could consider exploring two key strategies:

a) Evaluate local viewpoints towards influenza and influenza vaccination

While national data may provide valuable context, the decision to vaccinate is multifactorial and shaped by local beliefs and experiences. Therefore, caution should be taken when trying to apply national viewpoints to a local population. Local surveys should be conducted to help SNHD understand specific concerns or misconceptions surrounding the influenza vaccine. The results of these surveys could help guide the development of future interventions within the community.

b) Leveraging existing data to guide future vaccine education and events

SNHD should use existing data sources (both internal and external) to help guide current and future vaccine educational campaigns and events within Clark County. By leveraging systems such as the state Immunization Information System (NV WebIZ), the SNHD disease surveillance system (EpiTrax), and demographic and geographical population data, SNHD could identify populations and geographic areas with lower vaccination coverage and greater potential need for targeted intervention. This could result in future outreach events and educational campaigns being more strategically targeted.

2) Promote preventative strategies to limit community transmission

While vaccination remains the bedrock of influenza prevention, it should be paired with other non-pharmaceutical interventions to help reduce transmission and by extension influenza-associated hospitalizations and mortality during influenza seasons. Continued promotion of everyday preventative behaviors can help limit the spread of the disease and protect vulnerable populations. Strategies to emphasize include:

a) Staying home when symptomatic or ill
b) Practicing proper respiratory hygiene (e.g., covering coughs and sneezes)
c) Frequent handwashing or use of hand sanitizers
d) Use of face masks, particularly in crowded or high-risk settings (e.g., healthcare facilities, long-term care facilities, public transit)

Public messaging from local health jurisdictions should normalize and reinforce these behaviors, particularly during periods when multiple respiratory viruses are circulating (e.g., influenza, RSV, and COVID-19). Embedding these practices into workplace, school, and community settings can help reduce both influenza and other respiratory pathogen morbidity and mortality.

3) Expand and Enhance Influenza Surveillance and Data Collection

Innovations such as wastewater surveillance offer promising opportunities to detect and monitor respiratory pathogens, including influenza, at the community level. For jurisdictions such as SNHD, wastewater surveillance represents a novel layer of early warning that can complement traditional case, hospitalization, and syndromic surveillance. As SNHD continues to develop its wastewater surveillance, continued evaluation will be important to determine how data can best be incorporated into routine influenza surveillance and public health response.

Due to the relative novelty of wastewater surveillance and differences in laboratory testing and normalization methods, several key areas should be prioritized:

a) Strengthening epidemiological correlations

Additional work is needed to evaluate the relationship between wastewater influenza signals and traditional measures of disease activity, including diagnosed influenza cases, emergency department visits, hospitalizations, and other indicators of community transmission. Evaluating these relationships across multiple influenza seasons and using consistent analytical approaches will help determine how wastewater data can best inform influenza surveillance and public health decision-making.

b) Enhancing public and stakeholder communication

As wastewater surveillance data become more visible to the public through platforms such as wastewater dashboards, it will be important to develop effective communication strategies that explain what wastewater signals represent, their limitations, and how they should be interpreted in conjunction with other traditional surveillance data. Clear communication will be essential for building trust among stakeholders and within the community to ensure the continued use and sustainability of wastewater surveillance as a public health tool.

c) Encourage antiviral treatment into routine surveillance

Moving forward, continued collection of antiviral treatment data should be maintained as part of routine influenza surveillance. While antiviral treatment status was routinely captured for reported cases, the date of treatment administration was not consistently available. During this prior season, 76.8% of cases with a valid treatment interval received antiviral treatment within 48 hours of symptom onset, demonstrating the potential value of these data for assessing the timeliness of treatment. Healthcare provider reporting of antiviral treatment-date could allow SNHD to more consistently evaluate timely antiviral treatment, particularly among hospitalized patients and individuals at increased risk for severe influenza.

d) Encourage influenza virus subtyping when feasible

Improving the availability of influenza subtype information should be considered an important component of enhanced influenza surveillance. When feasible, influenza A specimens should be subtyped to better characterize circulating viruses and identify changes in the distribution of influenza subtypes over time. During the 2025–2026 season, 72.1% of reported influenza A cases were not subtyped, limiting the ability to fully characterize circulating influenza subtypes within Clark County. Increasing the proportion of influenza A cases with available subtype information would strengthen local surveillance and improve the ability to compare clinical, laboratory, and wastewater surveillance findings.

References

1. Centers for Disease Control and Prevention. *Weekly US Influenza Surveillance Report: Week 20, ending May 23, 2026.* FluView. Published May 29, 2026. Accessed August 5, 2026. https://www.cdc.gov/fluview/surveillance/2026-week-20.html
2. Southern Nevada Health District. *Annual Influenza Summary Report: Season 2024–2025.* Office of Epidemiology; August 2025. Accessed August 5, 2026. Annual Flu Wrap-Up Report (Season 2024–2025)
3. Caini S, Huang QS, Ciblak MA, et al. Epidemiological and virological characteristics of influenza B: results of the Global Influenza B Study. *PLoS One.* 2016;11(3):e0152310. doi:10.1371/journal.pone.0152310
4. Centers for Disease Control and Prevention. Treating flu with antiviral drugs. June 26, 2026. Accessed August 9, 2026. https://www.cdc.gov/flu/treatment/antiviral-drugs.html
5. Centers for Disease Control and Prevention. *Treating influenza (flu): Information for people at high risk for serious flu complications*. Published September 10, 2022. Accessed August 9, 2026. CDC PDF: Treating Influenza (Flu)
6. These data were collected as part of the WastewaterSCAN/SCAN project, a partnership between Stanford University, Emory University, and Verily. Accessed on August 10, 2026.
7. WastewaterSCAN. Publications. WastewaterSCAN. Accessed August 15, 2026. https://data.wastewaterscan.org/publications/
8. Roldan-Hernandez L, Van Oost C, Boehm AB. Solid-liquid partitioning of dengue, West Nile, Zika, hepatitis A, influenza A, and SARS-CoV-2 viruses in wastewater from across the USA. *Environ Sci Water Res Technol.* 2025;11(1):88-99. doi:10.1039/D4EW00225C.
9. Centers for Disease Control and Prevention. Types of influenza viruses. Published September 26, 2025. Accessed August 17, 2026. https://www.cdc.gov/flu/about/viruses-types.html
10. Washington State Department of Health. Health advisory: subtyping of influenza A recommended for hospitalized patients. Published January 21, 2025. Accessed August 17, 2026. https://doh.wa.gov/public-health-provider-resources/washington-health-alert-network/health-advisory-subtyping-influenza-recommended-hospitalized-patients
11. Office of Disease Prevention and Health Promotion. Increase the proportion of people who get the flu vaccine every year—IID-09. Healthy People 2030. Accessed August 17, 2026. Healthy People 2030 objective IID-09
12. National Foundation for Infectious Diseases. 2025 NFID National Survey on Respiratory Diseases. National Foundation for Infectious Diseases. Published December 3, 2025. Accessed August 17, 2026.