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DEPARTMENT OF HUMAN SERVICES



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TECHNICAL BULLETIN

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TOPIC: Pre-Season Preparation and Surveillance Guidance for the 2026–27 Respiratory Season

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TO: Health Care Providers, Medical Facilities, Medical Laboratories, Local Health Authorities, and Surveillance Partners

Influenza, COVID-19 (SARS-CoV-2), and respiratory syncytial virus (RSV) are expected to co-circulate during the 2026–27 respiratory season, which begins with MMWR week 40 (October 4–10, 2026) and continues through MMWR week 20 of 2027 (May 16–22, 2027). Highly pathogenic avian influenza (HPAI) A(H5) continues to circulate in [wild birds, poultry, and dairy cattle](#) in the United States and remains a year-round consideration for any patient with a compatible illness and a relevant animal exposure.

Nevada's statewide approach is unchanged: rapid case ascertainment for severe outcomes and potential A(H5) exposures, sustained virologic and syndromic surveillance, and timely reporting to local health authorities (LHAs) and the Office of State Epidemiology (OSE). This bulletin is issued in advance of the season so that partners have time to complete onboarding, verify data feeds, confirm reporting pathways, and source specimen collection and personal protective equipment (PPE) supplies before activity increases.

1. PREPARE: PRE-SEASON READINESS CHECKLIST

Reporting infrastructure and surveillance system participation

- Confirm that electronic laboratory reporting (ELR) and electronic case reporting (eCR) feeds are live, complete, and passing validation. Facilities may contact informatics@health.nv.gov for assistance with ELR or eCR.
- Verify that facilities without ELR or eCR have current [Confidential Morbidity Report \(CMR\) forms](#) and the correct LHA fax and 24-hour phone numbers (Appendix A, Table 2) posted where after-hours staff can find them.
- Contact OSE's Syndromic Surveillance Coordinator to onboard for NSSP ESSENCE (HL7 ADT feed + DUA required); contact OSE's Influenza Coordinator to enroll in ILINet (~5 min/week, including zero-ILI weeks, with priority need in rural/frontier, pediatric, tribal, correctional, and student health sites).
- If your facility participates in National Healthcare Safety Network (NHSN) respiratory pathogen hospitalization reporting, confirm with your NHSN contact before the season that submissions are current and complete.

Clinical and laboratory readiness

- Confirm that your laboratory's influenza assay menu and subtyping arrangements are in place so that influenza A-positive specimens from hospitalized patients are subtyped within 24 hours of obtaining the influenza A-positive result, per CDC recommendation. This includes a written pathway for referring specimens that cannot be subtyped in-house to a public health laboratory.

Immunization

Facilities should verify [Nevada-specific guidance](#) with the Nevada State Immunization Program (NSIP, nviz@health.nv.gov) before finalizing standing orders, protocols, or patient-facing materials.

- Begin seasonal immunization planning, NSIP vaccine orders for publicly-funded vaccines, staff campaigns, and standing-order review early so that vaccination is underway before activity increases.
- Seasonal influenza vaccine does not protect against A(H5). It remains valuable because it reduces confounding seasonal illness, reduces hospital burden, and reduces the probability of simultaneous infection with seasonal and avian influenza viruses, which can lead to reassortment.

2. TEST: DIAGNOSTIC STRATEGY

Laboratory-based virologic surveillance

- Public health sentinel specimen submission: All clinical facilities — not only designated sentinel sites — are encouraged to submit respiratory specimens for public health surveillance on a biweekly basis, according to capacity. Submissions should represent a cross-section of age groups, geographic areas, and care settings when possible. If more than three surveillance specimens are received from a single facility in a given week, the public health laboratory may select a subset of those submissions for testing based on the volume of submissions received and state surveillance goals.
- SARS-CoV-2 sequencing: Retain residual SARS-CoV-2-positive specimens and submit them to the public health laboratory for sequencing. Indicate on the laboratory requisition form that the specimen is submitted for sequencing (surveillance), not for diagnostic testing.

Indications

- Test symptomatic patients who are at risk for severe disease, who are part of an outbreak or cluster evaluation, or for whom antiviral or monoclonal therapy would be considered.
 - Notify your LHA when an outbreak is suspected.
- Test symptomatic patients with a potential A(H5) exposure in the 10 days preceding symptom onset, regardless of severity.
- Test all patients admitted with a compatible respiratory illness. Obtain and document an animal and raw-dairy exposure history for every admitted patient who tests positive for influenza A, regardless of season or apparent risk.
- For intubated or critically ill patients, collect lower respiratory specimens in addition to upper respiratory specimens.

Specimens, platforms, and laboratory biosafety

- Influenza: CDC recommends collecting a nasopharyngeal (NP) swab in one tube of viral or universal transport medium (VTM/UTM) plus a nasal swab combined with an oropharyngeal (OP) swab in a second VTM/UTM tube. For patients with conjunctivitis, also collect a conjunctival swab. If these specimens cannot be collected, a single nasal swab or OP swab is acceptable.
- SARS-CoV-2 and RSV: An NP swab in VTM/UTM is preferred. Assay-authorized alternatives (nasal mid-turbinate, anterior nasal, or combined nasal-OP swabs) may be used as permitted in the test's instructions for use.

- Collect respiratory specimens using a synthetic-tip swab (e.g., Dacron or nylon) with a plastic or aluminum shaft. Cotton-tipped and wooden-shaft swabs are not recommended, and calcium alginate swabs are unacceptable.
- Molecular testing is recommended for all respiratory viruses in all patients and may be used to confirm results from rapid tests.
- Consider testing for multiple respiratory pathogens concurrently. Co-infection occurs, and a positive result for one pathogen does not exclude another.
- Store specimens refrigerated at 2–8°C and process within 72 hours of collection. If testing cannot occur within 72 hours, freeze at ≤–70°C. Store residual specimens at ≤–70°C for potential further characterization.
- Laboratory biosafety: CDC recommends that any manipulation of specimens that may generate aerosols or droplets be performed in a certified Class II biological safety cabinet (BSC). Perform a site-specific risk assessment and use appropriate personal protective equipment and other biosafety controls.

3. SUBTYPE AND CHARACTERIZE

- Influenza A: For any hospitalized patient with an influenza A-positive result, perform subtyping for seasonal influenza A(H1N1)pdm09 and A(H3N2) within 24 hours of the positive result at a public health laboratory or validated clinical laboratory. Influenza A-positive specimens not identified as seasonal A(H1N1)pdm09 or A(H3N2) should be referred promptly to a public health laboratory for novel influenza A testing, including A(H5). Where volume or resources require prioritization, prioritize the most critically ill patients, particularly those in the ICU, and those with a relevant exposure history. Establish a standing internal process rather than handling each case ad hoc.
- Influenza B: Routine influenza B lineage testing is not clinically indicated; public health laboratories may perform lineage characterization for surveillance purposes. B/Yamagata has not circulated in the United States since early 2020.
- SARS-CoV-2: Clinical management does not require variant characterization. Retain residual specimens and submit to the public health laboratory for sequencing per NS3 guidance.
- RSV: Routine A/B typing is not clinically indicated. Participate in public health typing upon request.

4. TREAT

- Influenza: Initiate neuraminidase inhibitors promptly for hospitalized patients, patients with progressive or severe disease, and high-risk outpatients. Do not delay pending test results when clinical suspicion is high. Treat empirically when A(H5) exposure is suspected.
- COVID-19: Use authorized antivirals per current [IDSA guidance](#).
- RSV: Supportive care remains the mainstay of treatment. For infant immunoprophylaxis and adult RSV vaccination, follow the [Nevada-specific guidance](#) and product labeling in effect at the time of administration.

5. REPORT

Facilities should report cases pursuant to Nevada Administrative Code (NAC) 441A.225 and as indicated in Appendix A, Table 1, to their LHA (Appendix A, Table 2). LHAs should notify OSE at dpbhepi@health.nv.gov pursuant to NAC 441A.290. Facilities not automatically transmitting case reports through ELR or eCR should complete the [Confidential Morbidity Report](#) (CMR) and notify their LHA by phone, fax, or secure email.

Minimum data set for pediatric mortality notifications

When reporting a pediatric death, document in the medical record, at minimum: demographics; residence; healthcare facility; dates (symptom onset, first positive test, admission and ICU admission, death); location of death; infancy status; underlying conditions; vaccination and immunoprophylaxis

status and dates; diagnostic test types, specimens, and results; antimicrobial and antiviral therapies and timing; imaging and major complications; autopsy status; and the cause-of-death chain.

QUESTIONS

For updated guidance, review the Division of Public and Behavioral Health [Technical Bulletin web page](#) regularly. Email dpbhepi@health.nv.gov with questions regarding respiratory virus surveillance, testing, or reporting.



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APPENDIX A: REFERENCE TABLES

Table 1: Reportability of Respiratory Viruses in Nevada, 2026–2027

Condition	Reportable	Timeframe for Reporting
Influenza	○ Hospitalizations ○ Deaths (regardless of age) ○ Known or suspected pandemic strain ○ Novel or untypeable influenza A ○ Outbreaks	Pandemic-potential strain (including H5) and outbreaks: Immediately Pediatric deaths: Within 24 hours of identification All others: Next working day
RSV	○ Positive results ○ Pediatric deaths (voluntary reporting) ○ Outbreaks	Outbreaks: Immediately Pediatric deaths: Within 24 hours of identification Positive results: Next working day
SARS-CoV-2	○ Positive results ○ Pediatric deaths ○ Outbreaks	Outbreaks: Immediately Pediatric deaths: Within 24 hours of identification Positive results: Next working day

Reporting requirements are unchanged from the 2025–26 season.

Table 2: Nevada Local Health Authorities

Local Health Authority	County(ies)	Fax & Phone Number to Report
Carson City Health and Human Services (CCHHS)	Carson City, Douglas, and Lyon	Fax: 775-887-2138 Ph: 775-887-2190
Central Nevada Health District (CNHD)	Churchill, Mineral, Eureka, and Pershing	Fax: 877-513-3442 Ph: 775-866-7535
Northern Nevada Public Health (NNPH)	Washoe	Fax: 775-328-3764 Ph: 775-328-2447
Southern Nevada Health District (SNHD)	Clark	Fax: 702-759-1414 Ph: 702-759-1300
Nevada Division of Public and Behavioral Health (DPBH) Office of State Epidemiology	All other counties	Fax: 775-684-5999 Ph: 775-400-0333

Table 3: Receiving Laboratories

Receiving Laboratory	Contact Information	Requisition Notation
Nevada State Public Health Laboratory (NSPHL)	1660 N. Virginia Street Reno, NV 89503 (775) 688-1335	“PRIORITY – suspected H5 exposure” “PRIORITY – hospitalized flu A” “PRIORITY – hospitalized flu A with suspected H5 exposure”
Southern Nevada Public Health Laboratory (SNPHL)	700 S. Martin L. King Blvd. Las Vegas, NV 89106 (702) 759-1020	As above
Commercial laboratory (e.g., Quest, LabCorp, ARUP)*	Contact contracted laboratory of choice.	Contact clinical laboratory for instructions.

**Select a commercial laboratory with influenza A subtyping capability, including A(H5). Use of a commercial laboratory does not replace immediate notification of the LHA for suspected novel influenza A, including A(H5), or other required reporting (Table 1).*

Table 4: Nevada respiratory surveillance actions contacts

If you need to...	Contact
Report suspected A(H5), novel influenza, or a suspected outbreak	Your LHA immediately (Table 2). LHAs notify OSE the same day at dpbhepi@health.nv.gov .
Report a case	Your LHA (Table 2); CMR by phone, fax, or secure email if not reporting via ELR or eCR.
Complete NSSP ESSENCE onboarding, DUAs, data quality checks, and user access	OSE — Syndromic Surveillance Coordinator afaulstich@health.nv.gov
Complete ILINet enrollment or update ILINet contacts	OSE — Influenza Coordinator afaulstich@health.nv.gov
Enroll in NREVSS (respiratory and enteric)	OSE — Influenza Coordinator afaulstich@health.nv.gov
Onboard for ELR or eCR	informatics@health.nv.gov
Ask about specimen submission, supplies, courier, and cold chain	NSPHL or SNPHL (Table 3), coordinated through your LHA
Ask general respiratory surveillance questions	dpbhepi@health.nv.gov

APPENDIX B: HIGHLY PATHOGENIC AVIAN INFLUENZA A(H5)

Current situation

A(H5) viruses continue to circulate in wild birds, commercial and backyard poultry, and dairy cattle in the United States, with sporadic spillover to humans. As of September 2026, seventy-one human A(H5) cases have been reported in the United States since early 2024, including two deaths. Nevada reported one human case in February 2025 in a Churchill County dairy worker whose only symptom was conjunctivitis. The most recent U.S. case, reported by Washington State in November 2025, was a fatal infection with A(H5N5) — the first human case of that subtype identified worldwide — in an older adult with a backyard flock and underlying immunocompromise.¹

CDC continues to assess the risk to the general public as low. Persons with occupational or recreational exposure to poultry, wild birds, dairy cattle, or other potentially infected animals are at higher risk. No human-to-human transmission has been identified in the United States. Providers should maintain a low threshold for suspicion and testing throughout the season.

Exposure history

Consider A(H5) infection in patients with acute respiratory illness and/or conjunctivitis who have had a relevant exposure within the 10 days preceding symptom onset. Document exposures explicitly in the medical record. These may include:

- Contact with sick or dead birds, poultry, livestock, or other animals, including handling, slaughtering, defeathering, butchering, or culling.
- Consumption or preparation of unpasteurized (raw) milk or raw dairy products, or handling of raw meat-based pet food.
- Direct contact with water, surfaces, or materials contaminated by fluids or excrement from potentially infected animals.
- Prolonged exposure to potentially infected birds or other animals in a confined space without using proper protective equipment.
- Contact with a confirmed, probable, or suspect human case.

Animals without clinical signs can be infected. An exposure history is relevant even when the animals involved appeared healthy.

Specimen collection when A(H5) is suspected

- Collect an NP swab and a nasal swab combined with an OP swab. The NP swab should be in its own tube of viral transport medium and the combined nasal/OP swabs should be in their own tube of sterile viral transport medium.
- If conjunctivitis is present, additionally collect one conjunctival swab per affected eye in sterile VTM. Two conjunctival swabs may be combined in one tube.
- For any patient with lower respiratory tract involvement, and for all critically ill patients, collect a lower respiratory specimen (sputum, endotracheal aspirate, or bronchoalveolar lavage) in addition to upper respiratory specimens. In the November 2025 Washington A(H5N5) case, multiple upper respiratory specimens tested negative for influenza A over the first two weeks of illness; the diagnosis was ultimately made on a bronchoalveolar lavage specimen obtained after ICU transfer, and isolation precautions were inconsistently applied in the interval. A negative upper respiratory result does not rule out A(H5).
- If clinical suspicion remains high after a negative result, repeat testing and escalate to lower respiratory sampling. Discuss additional testing with your LHA and the public health laboratory.
- Wear a NIOSH-approved N95 respirator or higher, eye protection, and gloves during specimen collection. A disposable gown is recommended.

¹ <https://www.cdc.gov/mmwr/volumes/75/wr/mm7517a2.htm>

- Place specimens immediately on refrigerant gel packs or in 2–8°C refrigeration. Use triple packaging and maintain cold chain during transport. Specimen handlers must follow safe handling practices and spill decontamination procedures.
- Label specimens and annotate the laboratory requisition form with “PRIORITY – suspected H5 exposure,” “PRIORITY – hospitalized flu A,” or “PRIORITY – hospitalized flu A with suspected H5 exposure,” as applicable.

Notification

A suspected human A(H5) case is immediately reportable to the LHA. Establish two-way communication with your LHA (Appendix A, Table 2) at the time of suspicion, before shipping specimens. The LHA will coordinate with the designated public health laboratory to ensure the specimen can be received and tested within 24 hours of collection. If a public health laboratory is unavailable, specimens may be forwarded to a clinical laboratory after confirming equivalent testing capacity. LHAs should notify OSE the same day at dpbhepi@health.nv.gov.

Management and infection control

- Initiate empiric antiviral therapy as early as possible. Do not delay treatment pending laboratory results.
- Oseltamivir post-exposure prophylaxis (standard dose is twice daily for five days), may be offered to persons with a high-risk unprotected exposure (including breaches or failures of recommended PPE) to animals confirmed or highly suspected to be infected with A(H5). Prophylaxis is ideally initiated within 48 hours of the last known exposure.
- Hospitalized patients with suspected or confirmed A(H5) should be placed in a private room under airborne and contact precautions with eye protection, in addition to standard precautions. Apply precautions at the point of suspicion, not at the point of confirmation.
- Symptomatic patients not requiring admission should isolate at home, away from household members, until at least 24 hours after symptoms have begun improving and they are fever-free (<100.4°F [$<38.0^{\circ}\text{C}$]) without antipyretics, and should avoid work or school until A(H5) has been ruled out.
- LHA to monitor exposed persons for 10 days after the last exposure, in coordination with the facility, and may have more restrictive isolation guidance than the above.