



Date: May 19, 2025

To: Nevada State Board of Health

Through: Richard Whitley, MS, Director DHHS
Cody Phinney, MPH, Administrator, DPBH

From: Ihsan Azzam, PhD, MD, MPH, Chief Medical Officer

Re: Report to the Board of Health for May 06, 2025

Expected Impact of Federal Funding Reduction on the State Public Health System

The United States (US) Department of Health and Human Services rescinded more than twelve billion dollars in pandemic-era funding, impacting vaccination efforts, infection prevention, and mental health services across the states. These cuts have led to halted projects, staff layoffs, and reduced capacity in state and local health departments. In response to these challenges, Nevada leadership have endorsed continued state funding for public health programs to mitigate the effects of federal cuts. However, given that approximately 27.7% of Nevada's state budget relies on federal funding, the state may face significant challenges in maintaining essential health services without such federal support. Overall, the federal funding cuts could place considerable strain on Nevada's public health system, threatening the accessibility to- and quality of healthcare services for Nevada residents.

Additionally, the 2025 federal funding cuts may significantly affect Medicaid eligibility, enrollment and expansion; the availability and accessibility of mental health services, and other essential public health infrastructure. Nevada can be faced with a potential loss of nearly \$1.9 billion in federal Medicaid funding over the next two years. This is due to proposed reductions in the federal reimbursement rate for Medicaid expansion from 90% to 60%, potentially affecting tens of thousands of Nevada residents who gained coverage under the Affordable Care Act expansion. Subsequently, the state may need to reduce benefits, limit enrollment, or find alternative funding sources to cover these shortfalls. Furthermore, federal funding cuts have led to the closure of mental health facilities and the elimination of essential mental and behavioral health programs in Nevada. Notably, Renown Health's Crisis Care Center in Reno closed just two months after opening due to the termination of its federal grant. Additionally, more than \$600,000 in grants intended for mental health services for the homeless youth, affecting programs administered by the University of Nevada Las Vegas (UNLV) Practice Clinic were rescinded.

COVID Update

The US Department of Health and Human Services canceled around \$12 billion in federal grants

to states that were allocated during the COVID-19 pandemic. These grants were being used to track, prevent and control infectious diseases, including measles and the highly pathogenic H5N1 avian influenza, as well as track mental health services and fund addiction treatment. However, more than five years since COVID was declared a pandemic, the nation and the world is still facing the regular emergence of new variants of the virus, SARS-CoV-2. The latest variant on the rise is LP.8.1. It's increasing in Australia, making up close to one in five COVID cases in New South Wales, and at least three in five cases in the United Kingdom. LP.8.1 was first detected in July 2024. It's a descendant of Omicron, specifically of KP.1.1.3, which is descended from JN.1, a subvariant that caused large waves of COVID infections around the world in late 2023 and early 2024.

The World Health Organization (WHO) designated LP.8.1 as a variant under monitoring in January 2025. This was in response to its significant growth globally and reflects that it has genetic changes which may allow the virus to spread more easily and pose a greater risk to human health. Specifically, LP.8.1 has mutations at six locations in its spike protein, the protein which allows SARS-CoV-2 to attach to human cells. One of these mutations, V445R, is thought to allow this variant to spread more easily relative to other circulating variants. V445R has been shown to increase binding to human lung cells in laboratory studies.

As the symptoms of LP.8.1 do not appear to be more severe than other circulating viral strains, the WHO classified its risk to the global public health to be low. However, the LP.8.1 remains a variant under monitoring, rather than a variant of interest or major concern. The WHO is describing the changes to the virus observed with the LP.8.1 as not likely to make a significant difference to the trajectory of the pandemic.

On the other hand, COVID infections continue to constitute major national and international health concerns, continuing to cause tens of thousands of infections, hospitalizations and deaths. And, because many people are no longer testing or reporting their infections, the real number of cases is probably far higher. Continued vigilance and vaccination, particularly for medically vulnerable groups, is essential in minimizing the impact of the disease. Current COVID vaccines are still expected to offer good protection against symptomatic and severe disease with LP.8.1.

Measles National Outbreak Update

The national measles situation has escalated significantly with the CDC reporting 1,024 confirmed cases across 31 jurisdictions as of May 15, 2025. The largest outbreak remains centered in Texas and New Mexico, where cases have dramatically increased accounting for almost 90% of cases, with most cases involving unvaccinated children and adults or those with inadequate vaccination status. Three measles-related deaths have occurred so far including one unvaccinated adult in New Mexico and two unvaccinated school-aged children in Texas with no underlying conditions. There have been 14 outbreaks (an outbreak is defined as 3 or more related cases) reported in 2025, with at least 92% of all confirmed cases (947 of 1,024) are outbreak-associated. For comparison purposes, 16 outbreaks were reported during 2024 with only 69% of cases (198 of 285) were outbreak-associated.

As this measles outbreak started to infect too young children to be fully vaccinated, local health officials in some jurisdictions in Texas decided to adjust the age-related recommendations, advising first vaccine doses at 6 months instead of 12-15 months for very young children,

additionally, Texas health officials also recommended to accelerate the second dose to shorten the interval between doses for those with only one shot.

Because of vaccination, the probability of encountering measles, rubella, or polio in the US is low since widespread vaccination has built protective barriers in the US. But as/if vaccinations decline, these diseases can rapidly resurface, as in the currently expanding measles national outbreak. Vaccines protect not only those who receive them but also the most vulnerable members of society including infants too young to get the vaccines and highly vulnerable people who are immunocompromised. By getting vaccinated, children and adults contribute to a community-wide barrier that prevents the spread of pathogens.

Population immunity, also known as *herd immunity*, occurs when a community is protected from an infectious disease because enough people in the community are immune. Immunity to measles can result from vaccination or from having had the infection previously.

The safety and effectiveness of vaccines are best understood by comparing the risks of the diseases they prevent versus the risks associated with the vaccines themselves. Because vaccines are administered to large numbers of healthy people to prevent infections, they are subjected to especially rigorous oversight. The FDA performs a rigorous review of laboratory, preclinical (animal testing), and clinical data to ensure the safety, efficacy, purity, and potency of vaccines. After they are approved for marketing, vaccines are also required to undergo additional studies, as vaccine safety is monitored through several systems that allow patients and/or healthcare providers to report side effects and enable researchers to study medical records should any potential safety concerns arise. A deluge of misinformation has led to unwarranted fears about vaccines, but the data overwhelmingly support their safety and effectiveness. The risks of vaccine-preventable diseases far outweigh the minimal risks associated with vaccination. Moreover, rigorous monitoring of side effects ensures that vaccines remain among the safest medical interventions available.

By maintaining high vaccination rates, we not only safeguard individual health but also preserve the collective health of our communities, ensuring that preventable infectious diseases remain a thing of the past. Almost all recent and historical state, national and international studies demonstrated that the difference in risk between contracting a disease and receiving a vaccine is dramatic. The complications of preventable infectious diseases can be severe or even fatal, while serious side effects from the vaccines are extremely rare.

In 2023, the US vaccination coverage rate for two doses of the measles, mumps, and rubella (MMR) vaccine among kindergarteners was 92.7%. This indicates a high level of protection against measles, though it's slightly below the 95% target rate set by the CDC. While most children in the US are vaccinated, there are pockets of communities with lower or very low vaccination rates. While the CDC does not have specific Nevada numbers, the general trend suggests that Nevada's vaccination rates are likely below the 95% target rate.

It is estimated that in the 2018/19 school year, 95% of kindergarten students in Nevada were vaccinated against measles. By 2023/24, the vaccination rate had fallen to 91.8%. Nationally, the vaccination rate during that time period dropped from 94.7% to 92.7%. Those drops in vaccination rates correspond with an increase in the number of parents filing religious exemptions.

In 2018/19, an estimated 3.2% of Nevada kindergarteners had a religious exemption. By the 2023/24 school year, 5.6% did. Nationally, 3.1% of kindergarten students had a religious exemption. The percentage of children with medical exemptions has remained steady at .2% in Nevada and nationally.

The measles, mumps, and rubella (MMR) vaccination rates in Nevada vary by county, from 83% in White Pine County to 95.8% in Storey County. In Clark County, the largest county in the state, 91.5% of students were vaccinated, while 94.8% in Washoe County were. According to the National Institute of Health *measles elimination* hinges on vaccination coverage remaining above 95% to retain sufficient community protection. The observed recent declines in routine measles vaccination due to the COVID-19 pandemic a serious cause for concern.

If the measles outbreak continues to rapidly expand and gets worse, there is a potential for increased hospitalizations, vaccine demand spikes, and delays of non-measles care. The DPBH continue to monitor and forecast supply needs, strengthen and highlight vaccination distribution plans, and enhance infection control protocols for hospital workers and at-risk populations as this situation with the measles outbreaks persists. The Division also continues to encourage all parents to follow established vaccination guidelines to help protect their children and the community.

So far, no cases of measles were detected in Nevada. However, an increased case spread is anticipated. The Nevada DPBH already released several updates and detailed guidance for healthcare providers emphasizing that more than 13% of this year's measles cases have required hospitalization. The State advisory highlighted three critical actions for suspected measles cases 1) Immediate Isolation in airborne infection isolation rooms (AIIR), 2) Prompt Notification of the local/state health authorities, and 3) Proper Specimen Collection including nasopharyngeal/throat swabs and blood samples for confirmatory testing. The guidance also addressed post-exposure prophylaxis options, noting that susceptible individuals and those with no documented vaccination may receive MMR vaccine within 72 hours or immunoglobulin within 6 days of exposure. Additional guidance was issued for the those planning to travel to impacted areas.

Influenza Update

As of mid-May 2025, influenza activity in Nevada has decreased, aligning with national trends indicating a decline in flu cases. The percentage of outpatient visits for influenza-like illness (ILI) has fallen below the national baseline of 3.0%, indicating minimal flu activity in the state. So far about 133 influenza associated deaths were reported in Nevada this season. Most hospitalizations and deaths have occurred among individuals aged 65 and older. The predominant circulating strains include Influenza A (H1N1) and A (H3N2).

In early 2025, a new strain of the highly pathogenic avian influenza (H5N1 D1.1 genotype) was detected in Nevada dairy cattle. This strain had previously been identified primarily in wild birds. A Nevada dairy worker contracted this strain, marking the first human case of H5N1 D1.1 in the U.S. The individual experienced mild illness and has since recovered. The DPBH is monitoring the situation closely, emphasizing that while the general public's risk remains low, those working with birds, poultry, or cattle should exercise caution.