Memorandum

Date: July 23, 2014

To: Southern Nevada District Board of Health

From: **Cassius Lockett, PhD, MS,** *Director of Community Health*
Joseph P Iser, MD, DrPH, MSc, *Chief Health Officer*

Subject: Community Health Division Monthly Report

I. OFFICE OF CHRONIC DISEASE PREVENTION & HEALTH PROMOTION (OCDPHP)

1. Tobacco Control Program (TCP):

A. TCP staff is working with community partners to identify smoke-free meeting venues. Nevada Cancer Coalition staff has identified and mapped smoke-free meeting venues in Nevada, including southern Nevada, for use on the statewide Nevada Tobacco Prevention Coalition website. TCP staff worked internally to add a Smoke-free Meetings Directory page to the Get Healthy Clark County site in late May, with copy provided by the Nevada Cancer Coalition. In May, Roseman University of Health Science's Summerlin and Henderson campuses were added to the directory. Venues will be added each month, and promotion of the site will occur in the coming months. In May, 82 unique visitors viewed the Smoke-free Meetings Directory page on the Get Healthy Clark County website.

B. BreakDown, a youth program designed to educate and empower students to promote tobacco-free lifestyles, created and launched an online educational training module. The online module will be used to train hundreds of youth about the hidden dangers of electronic cigarettes and hookah. Teen users will watch online modules that include educational messages delivered by peers. After each section in the training module, there is a mini quiz. To date, 517 students have been trained as BreakDown members.

C. The TCP was awarded the maximum allowable amount of $440,000 from the Nevada Division of Public and Behavioral Health's (NDPBH) Fund for a Healthy Nevada tobacco master settlement allocation. TCP staff developed and submitted an application to NDPBH earlier this year. The award includes $390,000 for programmatic work and a $50,000 evaluation component. Staff is working with the State evaluation team to refine the project work plan.

D. The Sierra Nevada Job Corps Office asked TCP staff to provide a presentation on Other Tobacco Products, including e-cigarettes, for national Job Corps health and

wellness staff. Over 175 Job Corps sites in the US, Puerto Rico, and Guam participated in the webinar. Presentation feedback was positive.

2. **Chronic Disease Prevention Program (CDPP):**

   A. CDPP staff is a member of the Clark County School District (CCSD) wellness committee and participates in regularly scheduled committee meetings. The committee has assisted with the development of a revised Student Wellness Regulation for CCSD. The regulation, which improves student access to healthy foods and beverages and increases opportunities to be physically active, was presented to the School Board of Trustees on April 23. Staff attended the meeting representing SNHD and the local Partners for a Healthy Nevada obesity coalition and spoke in support of the proposed revisions. The revised Student Wellness Regulation was approved by the CCSD Board of Trustees on May 28. CCSD has developed training materials and resources for teachers and administrators to help support implementation of the CCSD Student Wellness Regulation. These resources will be used in the development of an online wellness course and uploaded onto an internal CCSD website. Once completed, the link will be shared with CCSD teachers, administrators, and wellness coordinators.

   B. As part of the Partnerships to Improve Community Health (PICH) grant activities, the CCSD developed and presented two professional development workshops for teachers entitled, "How Brain Breaks Affect Academic Achievement in Secondary Classrooms". The workshops are intended to provide the science behind 'brain breaks', short bursts of physical activity in the classroom, and also to provide teachers with the skills they need to implement brain breaks in the classroom. A total of 69 teachers attended the workshops.

   C. Outside Las Vegas Foundation (OLVF) is one of the community partners working with CDPP staff to increase access to opportunities to be physically active as part of the PICH grant. OLVF has expanded the Adopt a Trail program, which now includes City of Las Vegas, City of North Las Vegas, and Clark County. From January through May, 3,784 hours of volunteer time were generated on trails and in parks in Southern Nevada through the program.

3. **Injury Prevention Program (IPP):**

   A. Through the end of May, there have been a total of 18 submersion incidents with 4 of those resulting in fatal drownings. Three of the fatal drowning victims were under 4 years of age and the other was 5 years old. Fifteen submersion incidents occurred in pools, with 11 in residential pools and the other 4 in apartment pools. Race and ethnicity data was available for 10 of the incidents. Six of the victims were Caucasian (60%), two were African-American (20%), one was Hispanic (10%), and one was Asian (10%).

II. OFFICE OF EMERGENCY MEDICAL SERVICES & TRAUMA SYSTEM (OEMSTS)

1. **June Meetings:**

   A. **Drug/Device/Protocol Committee (DDP)**

   The DDP Committee assists the OEMSTS, the Medical Advisory Board (MAB), and the QI Directors Committee in researching, developing, and editing new and existing protocols. Members include volunteer representatives from permitted agencies, receiving hospitals, and individuals involved with the training of EMS professionals.

The committee reviewed the draft Hostile Mass Casualty Incident (MCI) protocol, which differs from the standard triage, treatment, and transport procedures. EMS personnel who have been appropriately trained and who are properly equipped will respond with law enforcement personnel as a force protection team to safely extricate patients from a hostile MCI-type event. The next step will be to develop educational material to support protocol implementation within the EMS system.

B. Medical Advisory Board (MAB)

The primary mission of the MAB is to support the Health Officer's role to ensure quality patient care within the EMS system by making recommendations and assisting in the ongoing design, operation, and evaluation of the EMS system from initial patient access to definitive patient care. The members include: 1) One medical director of each firefighting/franchised agency; 2) One operational director of each firefighting/franchised agency; 3) Chairman of the Regional Trauma Advisory Board; and 4) An employee of the District whose duties relate to the administration and enforcement of EMS Regulations as an ex-officio member.

It was reported that the Education Committee is going to develop a training video to address the newly created EMS field criteria for psychiatric patient transport to approved psychiatric receiving facilities. The new protocol was developed and presented to the area mental health facilities for their review. Using the strict criteria endorsed by the MAB, the new protocol will allow a small number of psychiatric patients to be taken from the field directly to a mental health facility that meets agreed-upon criteria.

A cervical stabilization training video is being produced to supplement the Cervical Stabilization protocol. The Education Committee reviewed the video and made some recommendations for edits.

A workgroup will be created to explore alternatives to transporting low acuity patients to emergency departments. The workgroup will work on arriving at parameters for EMS providers to safely make the determination not to transport.

Dr. Iser gave a brief overview of the bills that passed in the 2015 legislative session.

COMMUNITY HEALTH – OEMSTS - Fiscal Year Data

June EMS Statistics	June 2014	June 2015		FY 13-14	FY 14-15	
Total certificates issued	33	38	↑	1342	1931	↑
New licenses issued	29	22	↓	155	175	↑
Renewal licenses issued (recert only)	0	0	→	990	958	↓
Active Certifications: EMT/EMT-Basic	479	489	↑			
Active Certifications: AEMT/EMT-Intermediate	1273	1253	↓			
Active Certifications: Paramedic/EMT-Paramedic	1161	1179	↑			
Active Certifications: RN	40	44	↑			

I. OFFICE OF EPIDEMIOLOGY (OOE) PROGRAM REPORTS

1. **Pertussis in Clark County – Update:** Year-to-date, we have identified 60 cases of pertussis, 13 of which were investigated in June. Nine of the cases investigated in

June were in people who became ill in May. Four other people experienced onset of illness in June. Six of the thirteen cases (46%) were among Mesquite residents. Many of the ill persons were students at community schools: one at Virgin Valley High, one at Hughes Middle School, one at Joseph Bowler Elementary, and one at Virgin Valley Elementary. Most of the tests ordered in Mesquite are still being ordered by a single community clinician; and of the 35 pertussis tests ordered in all of Clark County in June, 50% (n=16) were ordered by Mesquite healthcare providers. We implemented our usual pertussis-response activities, including providing preventive medications to persons deemed likely to have been exposed to pertussis. No letters were sent to parents of CCSD students as the school year had ended by the time the cases were investigated.

2. Case counts by illness onset date from 2010 to present are shown below (Figure 1). Approximately 25% of reported laboratory tests ordered for pertussis since July 30, 2012 were either probable or confirmed cases. Some of these pertussis cases would not have been detected were we not performing enhanced surveillance.

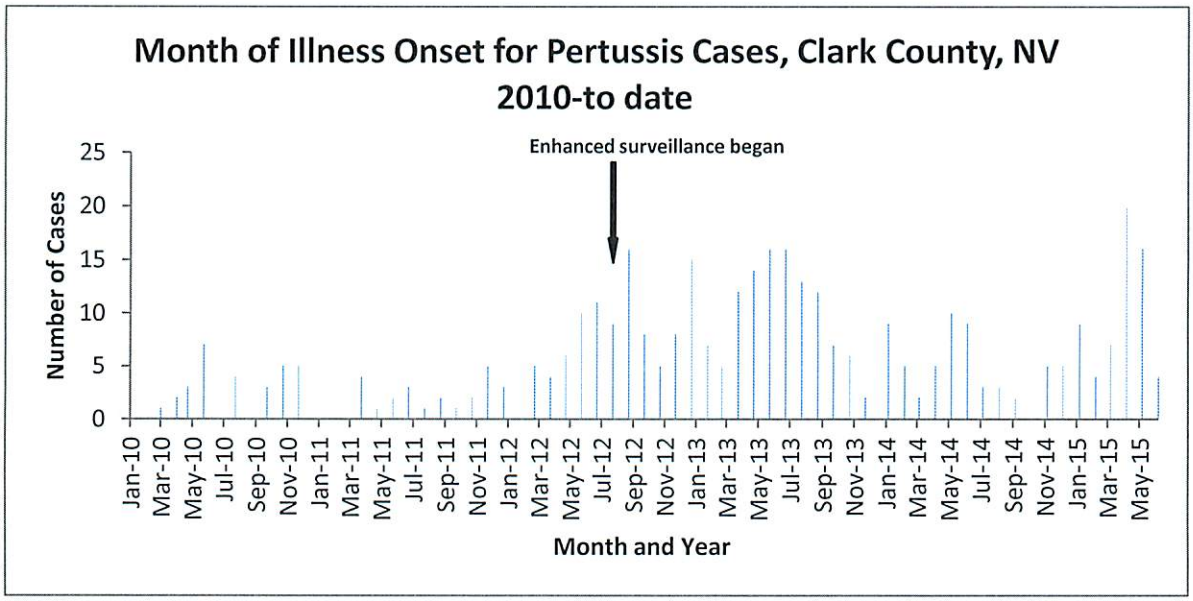

Figure 1: Onset of Illness for Pertussis Cases by Month in Clark County, Nevada–2010 to Date[1]

3. **Pediatric Early Warning Surveillance System (PEWSS)[2]:** PEWSS surveillance sentinel sites submitted a low number of respiratory test specimens to the SNPHL for testing in June. Parainfluenza virus 3 and rhinovirus/enterovirus circulated at low levels. Adenovirus was identified sporadically over the course of the month. Weekly PEWSS reports are posted online at http://www.southernnevadahealthdistrict.org/stats-reports/influenza.php.

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1 Due to the delay between pertussis symptom onset and diagnosis, most cases associated with illness onset in this month will not be identified until the following month. Enhanced surveillance (investigating potential cases when we are notified that a pertussis laboratory test has been ordered) was implemented to speed the process of detecting disease and implementing actions to prevent spread.

2 PEWSS is a year-round surveillance system developed by the SNHD to identify 16 respiratory pathogens circulating in the community. Each week, several sentinel healthcare providers submit nasal swabs collected from ill children to the Southern Nevada Public Health Laboratory (SNPHL) for testing for the following respiratory pathogens: Adenovirus, Human metapneumovirus, 4 Human parainfluenza viruses (1, 2, 3, 4), Influenza A, Influenza B, Respiratory Syncytial Virus (RSV), 4 Coronaviruses (HKU1, NL63, 229E, OC43), Rhinovirus/Enterovirus, *Chlamydophila pneumoniae*, and *Mycoplasma pneumoniae.* We use molecular methodologies to accurately identify numerous pathogens in submitted specimens, and to rapidly summarize and distribute these results to the medical and general community every week throughout the year.

4. **Disease reports and updates:**

   A. **Ebola virus:** The OOE continued monitoring of returned travelers who are at low (but not zero) risk of Ebola Virus exposure. In June, we monitored 14 returned travelers. The outbreak is considered to be over in Liberia; however, returned travelers from that country are still being monitored at this time, as are those returning from Guinea and Sierra Leone, where the outbreak continues. We also continue to update our Ebola Virus Disease (EVD) procedures and protocols as new information becomes available.

   B. **West Nile Virus**: West Nile season has begun and, to date, 17 mosquito pools have been found to be positive from eight different zip codes around the valley. No human cases have been reported.

   C. **Norovirus Outbreak Associated with a Private Party:** Office of Epidemiology staff performed an abbreviated investigation of a norovirus outbreak associated with a private event. Environmental Health contacted the retail establishment from where event food was obtained, determining that there had been no illness among employees, and that the establishment had received no illness complaints from customers. We found no evidence that the commercially prepared food was the source of norovirus. With reports of illness having ceased, no additional public-health response was needed and the investigation ended.

5. **Vital Statistics:** June 2015 showed an increase of 17% in birth certificate sales in comparison to June 2014. Death certificate sales increased by 15% for the same time frame. There was a 38% increase in the number of online orders for birth certificates and an 11% decrease in online orders of death certificates when compared with June of last year. Online orders represented 21% of total sales for birth certificates and 59% of death certificates sold for the month. Walk-in clients represented 75% of total birth certificate sales and 39% of total death certificate sales for June. SNHD received new revenues of $27,958 for birth registrations and $12,747 for death registrations for the month of June; and an additional $2882 in miscellaneous request fees. In June, VS began tracking mail order certificates separately, so that we could determine the volume of mail orders.

COMMUNITY HEALTH Vital Statistics Program - Fiscal Year Data

Vital Statistics Services	June 2014	June 2015		FY 13-14	FY 14-15	
Births Registered	1,922	2,264	↑	26,348	27,831	↑
Deaths Registered	1,216	1,339	↑	15,109	16,105	↑

COMMUNITY HEALTH Vital Statistics Program – Fiscal Year Data

Vital Statistics Services	June 2014	June 2015		FY 13-14	FY 14-15	
Birth Certificates Sold Valley View (walk-in)	3,405	3,589	↑	43,152	40,476	↓
Birth Certificates Sold Mesquite (walk-in)	16	24	↑	242	260	↑
Birth Certificates Mail Requests		129			129	
Birth Certificates Online Orders	724	996	↑	6,426	9,695	↑
Birth Certificates Billed	0	109	↑	8	1,197	↑
Birth Certificates Number of Total Sales	4,145	4,847	↑	49,828	51,757	↑
Death Certificates Sold Valley View (walk-in)	2,363	2,685	↑	38,022	33,348	↓
Death Certificates Sold Mesquite (walk-in)	4	0	↓	322	51	↓
Death Certificates Mail Requests		187			187	
Death Certificates Online Orders	3,693	4,090	↑	35,403	44,738	↑
Death Certificates Billed	3	11	↑	94	100	↑
Death Certificates Number of Total Sales	6,063	6,973	↑	73,841	78,424	↑

COMMUNITY HEALTH Vital Statistics Program - Fiscal Year Data

Vital Statistics Sales by Source	June 2014	June 2015		FY 13-14	FY 14-15	
Birth Certificates Sold Valley View (walk-in)	82.15%	74.05%	↓	86.60%	78.20%	↓
Birth Certificates Sold Mesquite (walk-in)	0.39%	.50%	↑	.49%	.50%	↑
Birth Certificates Mail Requests		2.66%			.25%	
Birth Certificates Online Orders	17.47%	20.55%	↑	12.90%	18.73%	↑
Birth Certificates Billed		2.25%	↑	.02%	2.31%	↑
Death Certificates Sold Valley View (walk-in)	38.97%	38.51%	↓	51.49%	42.52%	↓
Death Certificates Sold Mesquite (walk-in)	.07%	0%	↓	.44%	.07%	↓
Death Certificates Mail Requests		2.68%			.24%	
Death Certificates Online Orders	60.91%	58.65%	↓	47.94%	57.05%	↑
Death Certificates Billed	.05%	.16%	↑	.13%	.13%	→

COMMUNITY HEALTH Vital Statistics Program - Fiscal Year Data

Revenue	June 2014	June 2015		FY 13-14	FY 14-15	
Birth Certificates ($20)	$82,900	$96,940	↑	$996,560	$1,035,140	↑
Death Certificates ($20)	$121,260	$139,460	↑	$1,476,820	$1,568,480	↑
Births Registrations ($7)	$0	$27,958	↑	0	$300,307	↑
Deaths Registrations ($7)	$0	$12,747	↑	0	$139,657	↑
Miscellaneous	$835	$2,882	↑	$12,759	$19,911	↑
Total Vital Records Revenue	$204,995	$279,987	↑	$2,486,139	$3,063,495	↑

6. **Other:**

   A. OOE staff members were very active in preparing for and facilitating the June 18 community-partners Community Health Improvement Plan (CHIP) meeting, where they gave presentations and facilitated information exchange at poster boards. Several Board of Health members attended, joining other members of the public health community in the process of rating the seven proposed top public-health priority issues for Clark County. The goal of the meeting was to narrow the issues to two or three to be addressed by the CHIP. OOE staff members also continued the process of finalizing the Community Health Assessment (CHA) document.

   B. OOE submitted data on a number of health indicators to fulfill a request from the Big Cities Health Coalition (BCHC), areas noted in last month's report. NACCHO continues to communicate with OOE and requested additional or revised information. This project is expected to be complete (from SNHD's perspective) sometime in July, after which we expect that NACCHO will publish its findings from all of the "big cities" that contributed data.

7. **Communicable Disease Statistics:** June 2015 and Quarter 2 2015 Disease Statistics are attached.

II. OFFICE OF PUBLIC HEALTH INFORMATICS (OPHI)

Processing rules for Salmonella, AST, ALT, and Bilirubin have been added to EMSA. We are working with the Sexually Transmitted Disease (STD) group to finalize rules for Syphilis and HIV. Informatics group members attended the Council of State and Territorial Epidemiologists Annual Conference. We have brought back several new ideas for methods in disease surveillance we intend to try. Work on the firearm injury study continues. Reports were generated for HIV partner services. Enhancements were made to the Physician Input Form and further enhancements have been planned. We have been working with the Sunrise Hospital System on accepting Electronic Lab Reports (ELRs) from them in a new format. And we have been working with North Vista hospital on starting to accept ELRs from them.

III. OFFICE OF PUBLIC HEALTH PREPAREDNESS (OPHP)

1. **Planning and Preparedness:**

   A. OPHP staff attended the McCarran Triennial Airport Exercise planning meeting which included planners from McCarran airside operations, Clark County Office of Emergency Management/Homeland Security, and the SNHD. Discussion included the exercise components along with community involvement.

   B. OPHP continues to plan for the statewide full-scale exercise that will be conducted September 29 – October 1, 2015. SNHD will be testing our capability to manage a large-scale public health emergency following a release of aerosolized tularemia. SNHD plans to activate open public and closed points of dispensing (PODs) to evaluate the local capability to provide prophylaxis to the resident and visitor population of Clark County. Approximately 50 agencies are expected to participate in this exercise.

   C. OPHP continues to plan for a BioWatch Tabletop Exercise which will take place on July 29, 2015.

   D. OPHP staff continues to participate in statewide partner planning meetings and conference calls to share information and coordinate response efforts to the potential threat, screening, and identification of an Ebola Virus Disease case in

Southern Nevada. Staff continues to share information to community partners and provide briefings to various sectors of the community upon request.

E. OPHP continues to conduct the monthly Incident Command Team, Directors, Managers, and Supervisors call down. Call downs are deliverables required by CRI grants to ensure public health staff readiness to respond to a disaster.

F. OPHP Planners continue to receive Memorandums of Understanding (MOU) for Closed Points of Dispensing. These agreements allow for the facility to receive and distribute medication to their employees and their families in the event of a public health emergency.

G. OPHP staff continues to participate in the monthly Southern Nevada Healthcare Preparedness Coalition, Homeland Security Urban Area Security Initiative, Local Emergency Preparedness Committee, Southern Nevada Adult Mental Health Coalition, and individual hospital emergency management committee meetings.

2. **PHP Training And PH Workforce Development:**

   A. OPHP Education and Training: Trish Beckwith, OPHP Training Officer, continues to conduct CPR courses and a First Aid course at the Health District. Linda Newton, OPHP Training Officer, has been appointed to another term to the National Association of County and Health Officials (NACCHO) advisory group for Preparedness Planning, Outcomes, and Measurement Workgroup from July 1, 2015 through June 30, 2017.

   B. OPHP Nurse Activities: The Public Health Nurse conducted a Bloodborne Pathogens Class for 57 employees. Respirator fit testing was performed on 23 employees, nursing, and pharmacy students. .

3. **Grants and Administration:** OPHP continues to work on activities related to the three grants received for BP3. OPHP has received a five-year Ebola grant with will begin July 2015. We are currently spending down all of the BP3 funding to minimize the possibility of any carry-forward funding going into BP4. BP4 grant funds have received initial approval by the NDPBH and we are awaiting the Notice of Grant Award for the July1 start date of the grants.

4. **Medical Reserve Corps of Southern Nevada (MRC of SO NV):** MRC continues to participate in community events.

IV. SOUTHERN NEVADA PUBLIC HEALTH LABORATORY (SNPHL)

1. **Clinical Testing:** SNPHL continues to support the SNHD Nursing Division with STD testing. SNHD STD department and SNPHL cooperatively participate in the CDC Gonococcal Isolate Surveillance Project (GISP). SNPHL performs *N. gonorrhoeae* culture and submits isolates to CDC and Nursing provides the client information required by the project.

2. **Courier service:** Clinical samples for laboratory testing are transported by SNPHL courier from SNHD Health Centers or Southern Nevada hospital or commercial laboratories.

3. **Epidemiological Testing and Consultation:**

   A. SNPHL continues to support the disease investigation activities of the SNHD OOE and Nursing Division.

B. SNPHL continues to participate in the SNHD Outbreak Investigation Committee and Foodborne Illness Taskforce.

C. SNPHL continues to report results of PEWSS testing to the CDC National Respiratory and Enteric Virus Surveillance System (NREVSS).

4. **State Branch Public Health Laboratory Testing:**

A. SNPHL continues to perform reportable disease isolate testing and confirmation. Isolates submitted by local laboratories are serotyped or confirmed; stored on-site; and results reported and/or samples submitted to CDC through various national programs including Public Health Laboratory Information System (PHLIS), National Antimicrobial Resistance Monitoring System (NARMS), and Influenza Surveillance.

B. SNPHL continues to perform CDC Laboratory Response Network (LRN) testing for biological agents on clinical and unknown environmental samples.

C. SNPHL continues to perform Pulsed Field Gel Electrophoresis (PFGE) testing of *Salmonella*, *Shigella*, and Shiga toxin producing *E. coli* (STEC) isolates submitted by local clinical laboratories. SNPHL reports the PFGE data to the CDC PulseNet program and to the SNHD OOE.

5. **All-Hazards Preparedness:**

A. SNPHL continues to participate with SNHD OPHP, local First Responders and sentinel laboratories to ensure support for response to possible biological or chemical agents.

B. SNPHL staff continues to receive training on LRN protocols for biological agent confirmation.

C. SNPHL maintains sufficient technical laboratory staff competent to perform LRN testing 24 hours per day/7 days per week.

D. SNPHL continues to coordinate with First Responders including local Civil Support Team, HazMat, Federal Bureau of Investigation, and Las Vegas Metropolitan Police Department.

E. SNPHL continues to provide information to local laboratorians on packaging and shipping infectious substances and chain of custody procedures.

6. **May SNPHL Activity Highlights:**

A. At request of SNHD OOE, SNPHL staff provided sample collection and testing of multiple children potentially associated with local *Bordetella pertussis* outbreak. SNPHL staff also coordinated submission of pertussis test results performed at local reference laboratories.

B. SNPHL laboratory manager attended the Association of Public Health Laboratories (APHL) annual meeting in Indianapolis, Indiana. As a member of the APHL STD subcommittee, the manager also attended the annual in-person meeting which was held in the same location.

C. SNPHL PFGE staff assisted SNHD OOE with multiple investigations of enteric pathogen testing performed at out of state laboratories. As a CDC PulseNet certified laboratory, SNPHL staff can access additional testing information necessary for OOE staff to determine potential outbreaks.

COMMUNITY HEALTH - SNPHL – Fiscal Year Data

SNPHL Services	May 2014	May 2015		FY 13-14	FY 14-15	
Clinical Testing Services[1,2]	3,243	2,522	↓	37,822	33,032	↓
Courier Services[3]	3,331	2,416	↓	37,717	32,515	↓
Epidemiology Services[4]	1,878	1,107	↓	16,702	15,513	↓
State Branch Public Health Laboratory Services[5]	1,267	816	↓	11,011	8,960	↓
All-Hazards Preparedness Services[6]	6	18	↑	92	129	↑

CL/dm

ATT: June 2015 and Quarter 2 2015 Disease Statistics

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1 Includes N. Gonorrhoeae culture, GISP isolates, Syphilis, HIV, Gram stain testing.
2 Note: Decrease in clinical test activity due to changes in clinical test ordering algorithm instituted by SNHD nursing in October 2013.
3 Includes the number of clinical test specimens transported from facilities by SNPHL courier.
4 Includes Stool culture, EIA, Norovirus PCR, Respiratory Pathogen PCR, Epidemiological investigations or consultations.
5 Includes PFGE and LRN testing, proficiency samples, reporting to CDC, courier services, infectious substance shipments, teleconferences, trainings, presentations and inspections, samples submitted to CDC or other laboratories.
6 Includes Preparedness training, BSL-3 maintenance and repair, teleconferences, Inspections.

Clark County Disease Statistics*, JUNE 2015

Disease	2013 Jun No.	2013 YTD No.	2014 Jun No.	2014 YTD No.	2015 Jun No.	2015 YTD No.	Rate(Cases per 100,000 per month) Jun (2010-2014 aggregated)	Jun (2015)	Monthly Rate Comparison Significant change bet. current & past 5-year?~~
VACCINE PREVENTABLE									
DIPHTHERIA	0	0	0	0	0	0	0.00	0.00	
HAEMOPHILUS INFLUENZA (INVASIVE)	0	8	0	6	.	12	0.04	0.05	↑
HEPATITIS A	0	8	0	.	.	6	0.01	0.10	↑
HEPATITIS B (ACUTE)	.	13	.	12	.	5	0.11	0.05	↓
INFLUENZA**	.	509	24	502	5	444	0.43	0.24	↓
MEASLES	0	0	0	0	0	9	0.00	0.00	
MUMPS	0	0	.	.	0	0	0.01	0.00	↓
PERTUSSIS	15	69	9	40	7	63	0.43	0.34	↓
POLIOMYELITIS	0	0	0	0	0	0	0.00	0.00	
RUBELLA	0	0	0	0	0	0	0.00	0.00	
TETANUS	0	0	0	0	0	0	0.00	0.00	
SEXUALLY TRANSMITTED									
AIDS	10	106	23	115	24	85	0.85	1.16	↑
CHLAMYDIA	728	4594	814	5127	723	4739	38.37	34.94	↓
GONORRHEA	191	1052	221	1241	205	1305	9.33	9.91	↑
HIV	17	125	34	147	50	153	1.28	2.42	↑X
SYPHILIS (EARLY LATENT)	10	108	13	143	9	152	0.71	0.43	↓
SYPHILIS (PRIMARY & SECONDARY)	7	62	22	133	17	112	0.54	0.82	↑
ENTERICS									
AMEBIASIS	0	.	0	0	0	.	0.01	0.00	↓
BOTULISM-INTESTINAL (INFANT)	0	0	0	0	0	0	0.00	0.00	
CAMPYLOBACTERIOSIS	8	39	6	45	5	42	0.45	0.24	↓
CHOLERA	0	0	0	0	0	0	0.00	0.00	
CRYPTOSPORIDIOSIS	0	.	0	.	0	.	0.01	0.00	↓
GIARDIA	7	27	.	18	.	18	0.19	0.14	↓
ROTAVIRUS	7	76	11	42	.	60	0.53	0.10	↓X
SALMONELLOSIS	16	281	7	43	8	56	0.84	0.39	↓
SHIGA-TOXIN PRODUCING E. COLI#	12	23	.	8	.	10	0.27	0.05	↓
SHIGELLOSIS	.	12	.	9	0	8	0.15	0.00	↓X
TYPHOID FEVER	0	0	0	.	0	.	0.02	0.00	↓
VIBRIO (NON-CHOLERA)	0	.	0	.	0	0	0.00	0.00	
YERSINIOSIS	.	.	0	.	0	0	0.02	0.00	↓
OTHER									
ANTHRAX	0	0	0	0	0	0	0.00	0.00	
BOTULISM INTOXICATION	0	0	0	0	0	0	0.00	0.00	
BRUCELLOSIS	0	0	0	0	0	0	0.00	0.00	
COCCIDIOIDOMYCOSIS	9	37	.	37	7	34	0.39	0.34	↓
DENGUE FEVER	0	.	0	.	0	0	0.00	0.00	
ENCEPHALITIS	0	.	0	0	0	.	0.00	0.00	
HANTAVIRUS	0	0	0	0	0	0	0.00	0.00	
HEMOLYTIC UREMIC SYNDROME (HUS)	0	0	.	.	0	0	0.01	0.00	↓
HEPATITIS C (ACUTE)	0	.	0	.	.	6	0.01	0.05	↑
HEPATITIS D	0	0	0	0	0	0	0.00	0.00	
INVASIVE GROUP A STREP.##	0	0	0	0	0	0	0.00	0.00	
LEGIONELLOSIS	0	7	.	6	.	12	0.03	0.10	↑
LEPROSY (HANSEN'S DISEASE)	0	0	0	.	0	0	0.00	0.00	
LEPTOSPIROSIS	0	0	0	0	0	0	0.00	0.00	
LISTERIOSIS	0	.	.	.	0	.	0.01	0.00	↓
LYME DISEASE	.	.	.	.	0	0	0.06	0.00	↓X
MALARIA	.	.	.	.	0	0	0.02	0.00	↓
MENINGITIS, ASEPTIC/VIRAL	.	16	.	19	.	17	0.08	0.14	↑
MENINGITIS, BACTERIAL	.	5	0	6	0	11	0.04	0.00	↓
MENINGOCOCCAL DISEASE	0	0	0	.	0	0	0.01	0.00	↓
PLAGUE	0	0	0	0	0	0	0.00	0.00	
PSITTACOSIS	0	0	0	0	0	0	0.00	0.00	
Q FEVER	0	0	0	0	0	.	0.00	0.00	
RABIES (HUMAN)	0	0	0	0	0	0	0.00	0.00	
RELAPSING FEVER	0	0	0	0	0	0	0.00	0.00	
ROCKY MOUNTAIN SPOTTED FEVER	0	0	0	0	0	0	0.00	0.00	
RSV (RESPIRATORY SYNCYTIAL VIRUS)	10	1166	7	595	.	1084	0.42	0.05	↓X
STREPTOCOCCUS PNEUMONIAE, IPD###	.	32	.	49	.	65	0.19	0.14	↓
TOXIC SHOCK SYN	0	0	0	0	0	0	0.00	0.00	
TOXIC SHOCK SYN (STREPTOCOCCAL)	0	.	.	8	0	6	0.03	0.00	↓
TUBERCULOSIS	.	39	11	36	13	47	0.34	0.63	↑
TULAREMIA	0	0	0	0	0	0	0.00	0.00	
UNUSUAL ILLNESS	0	0	0	0	0	0	0.01	0.00	↓
WEST NILE VIRUS (ENCEPHALITIS)	.	.	0	0	0	0	0.04	0.00	↓
WEST NILE VIRUS (FEVER)	.	.	0	0	0	0	0.01	0.00	↓

*Due to software transition STD data since 2014 are not comparable with those in previous years. Rate denominators are interpolated population estimates/projections using demographic data under ongoing revisions by the state demographer. Use of onset date to count OOE-reported cases (since Jan-2013) causes changes in cases reported here from previously released reports. Numbers are provisional including confirmed, probable and suspect (since Feb-08) cases. HIV/AIDS case counts provided by Office of HIV/AIDS/STD; TB case counts provided by TB clinic. Data suppression denoted by '.' applies if number of cases <5. Monthly disease total reported by OOE=52(reported total=1093). Due to unavailability of current birth data, congenital syphilis rates were not calculated(reported monthly cases [suppression applied] for 2013-2015 were respectively .,0,0; YTD totals .,.,.).

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~~Confidence intervals (not shown) for the monthly disease incidence rates provided a basis for an informal statistical test to determine if the current monthly rates changed significantly from those of the previous 5 years aggregated. Text in green where rates decreased and in red where rates increased. Statistically significant changes indicated by 'X' (rate comparisons made if 5+ cases reported in the current month of this year or previous 5 years aggregated).

Clark County Disease Statistics* - Quarter2, 2015

Disease	2013 Q2 No.	2013 YTD No.	2014 Q2 No.	2014 YTD No.	2015 Q2 No.	2015 YTD No.	Rate(Cases per 100,000 per quarter) Qtr2 (2010-2014 aggregated)	Qtr2 (2015)	Quarterly Rate Comparison Significant change bet. current & past 5-year?~~
VACCINE PREVENTABLE									
DIPHTHERIA	0	0	0	0	0	0	0.00	0.00	
HAEMOPHILUS INFLUENZA (INVASIVE)	5	8	.	6	7	12	0.17	0.34	↑
HEPATITIS A	6	8	.	.	.	6	0.13	0.15	↑
HEPATITIS B (ACUTE)	5	13	8	12	.	5	0.32	0.15	↓
INFLUENZA**	54	509	118	502	61	444	3.63	2.95	↓
MEASLES	0	0	0	0	0	9	0.00	0.00	
MUMPS	0	0	.	.	0	0	0.01	0.00	↓
PERTUSSIS	43	69	24	40	43	63	1.06	2.08	↑X
POLIOMYELITIS	0	0	0	0	0	0	0.00	0.00	
RUBELLA	0	0	0	0	0	0	0.00	0.00	
TETANUS	0	0	0	0	0	0	0.00	0.00	
SEXUALLY TRANSMITTED									
AIDS	51	106	69	115	53	85	2.76	2.56	↓
CHLAMYDIA	2379	4594	2598	5127	2346	4739	115.53	113.46	↓
GONORRHEA	517	1052	675	1241	634	1305	25.56	30.66	↑X
HIV	63	125	93	147	88	153	3.39	4.26	↑
SYPHILIS (EARLY LATENT)	42	108	72	143	63	152	2.47	3.05	↑
SYPHILIS (PRIMARY & SECONDARY)	33	62	74	133	64	112	1.89	3.10	↑X
ENTERICS									
AMEBIASIS	.	.	0	0	.	.	0.11	0.10	↓
BOTULISM-INTESTINAL (INFANT)	0	0	0	0	0	0	0.00	0.00	
CAMPYLOBACTERIOSIS	24	39	19	45	23	42	1.23	1.11	↓
CHOLERA	0	0	0	0	0	0	0.00	0.00	
CRYPTOSPORIDIOSIS	0	.	.	.	0	.	0.05	0.00	↓X
GIARDIA	16	27	12	18	10	18	0.60	0.48	↓
ROTAVIRUS	38	76	35	42	23	60	1.91	1.11	↓X
SALMONELLOSIS	252	281	27	43	32	56	4.42	1.55	↓X
SHIGA-TOXIN PRODUCING E. COLI#	17	23	.	8	.	10	0.49	0.10	↓X
SHIGELLOSIS	.	12	.	9	.	8	0.30	0.15	↓
TYPHOID FEVER	0	0	0	.	.	.	0.03	0.05	↑
VIBRIO (NON-CHOLERA)	.	.	0	.	0	0	0.02	0.00	↓
YERSINIOSIS	.	.	0	.	0	0	0.02	0.00	↓
OTHER									
ANTHRAX	0	0	0	0	0	0	0.00	0.00	
BOTULISM INTOXICATION	0	0	0	0	0	0	0.00	0.00	
BRUCELLOSIS	0	0	0	0	0	0	0.00	0.00	
COCCIDIOIDOMYCOSIS	22	37	18	37	19	34	1.10	0.92	↓
DENGUE FEVER	0	.	.	.	0	0	0.01	0.00	↓
ENCEPHALITIS	.	.	0	0	0	.	0.01	0.00	↓
HANTAVIRUS	0	0	0	0	0	0	0.00	0.00	
HEMOLYTIC UREMIC SYNDROME (HUS)	0	0	.	.	0	0	0.01	0.00	↓
HEPATITIS C (ACUTE)	.	.	.	.	.	6	0.05	0.19	↑
HEPATITIS D	0	0	0	0	0	0	0.00	0.00	
INVASIVE GROUP A STREP.##	0	0	0	0	0	0	0.02	0.00	↓
LEGIONELLOSIS	.	7	5	6	.	12	0.19	0.19	
LEPROSY (HANSEN'S DISEASE)	0	0	.	.	0	0	0.01	0.00	↓
LEPTOSPIROSIS	0	0	0	0	0	0	0.00	0.00	
LISTERIOSIS	0	.	.	.	.	.	0.05	0.05	
LYME DISEASE	.	.	.	.	0	0	0.08	0.00	↓X
MALARIA	.	.	.	.	0	0	0.04	0.00	↓
MENINGITIS, ASEPTIC/VIRAL	11	16	9	19	9	17	0.33	0.44	↑
MENINGITIS, BACTERIAL	.	5	.	6	7	11	0.10	0.34	↑
MENINGOCOCCAL DISEASE	0	0	0	.	0	0	0.01	0.00	↓
PLAGUE	0	0	0	0	0	0	0.00	0.00	
PSITTACOSIS	0	0	0	0	0	0	0.00	0.00	
Q FEVER	0	0	0	0	.	.	0.00	0.05	↑
RABIES (HUMAN)	0	0	0	0	0	0	0.00	0.00	
RELAPSING FEVER	0	0	0	0	0	0	0.00	0.00	
ROCKY MOUNTAIN SPOTTED FEVER	0	0	0	0	0	0	0.00	0.00	
RSV (RESPIRATORY SYNCYTIAL VIRUS)	89	1166	93	595	52	1084	4.89	2.51	↓X
STREPTOCOCCUS PNEUMONIAE, IPD###	12	32	19	49	23	65	0.57	1.11	↑
TOXIC SHOCK SYN	0	0	0	0	0	0	0.00	0.00	
TOXIC SHOCK SYN (STREPTOCOCCAL)	.	.	.	8	.	6	0.08	0.19	↑
TUBERCULOSIS	21	39	24	36	32	47	1.21	1.55	↑
TULAREMIA	0	0	0	0	0	0	0.00	0.00	
UNUSUAL ILLNESS	0	0	0	0	0	0	0.01	0.00	↓
WEST NILE VIRUS (ENCEPHALITIS)	.	.	0	0	0	0	0.04	0.00	↓
WEST NILE VIRUS (FEVER)	.	.	0	0	0	0	0.01	0.00	↓

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