NEVADA STATE HEALTH DIVISION

Acquired Immuno-Deficiency Syndrome (AIDS)

And

Human Immuno-Deficiency Virus (HIV)

In Nevada

Epidemiological Profile (2004)

Bureau of Community Health

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The Bureau of Community Health website is currently under development. Once this process has been complete this Epidemiological Profile will be posted on the HIV/AIDS/TB/ Program portion of the website. Access information will be published as soon as it becomes available.

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Executive Summary

Demographic and healthcare issues pose unique challenges in addressing HIV/AIDS in Nevada. Nevada has been the fastest growing state in the nation for 18 consecutive years, with 4.1 percent average annual population growth. The state's population continues to diversify. Between 1999 and 2003, the Hispanic and Asian/Pacific Islander populations grew 36 percent and 34 percent respectively. By 2008, one-in-four Nevada residents will be Hispanic and seven percent of the population will be Asian/Pacific Islander. In addition, about 19 percent of Nevada's population lacks health insurance, giving the state one of the highest percentages of uninsured in the nation. Finally, the United Health Foundation ranked the overall health of Nevada residents 37th in the nation, in part because of high overall mortality, cancer deaths, and inadequate prenatal care.

Although Nevada has the 35th largest population in the nation, the state's AIDS rates are disproportionately high. In 2003, for cases per 100,000 population, Nevada ranked 14th in the nation for the rate of adolescents and adults living with AIDS, 18th in the nation for the annual AIDS case rate, and 20th in the nation for the number of new HIV cases. Nevada had the second highest AIDS case rate in the western United States, second only to California and higher than all of the rest of its neighboring states.

During 2003, 462 people were newly diagnosed with HIV/AIDS in Nevada. Of those, 45 percent were diagnosed with HIV and 55 percent were diagnosed with AIDS. In addition, 4,786 people were living with HIV/AIDS, of whom 50 percent were living with HIV and 50 percent with AIDS.

HIV/AIDS cases were diagnosed in 16 of Nevada's 17 counties in 2003. The majority (87 percent) of cases were in the state's most populous area, Clark County, which has 71 percent of the state's population. HIV/AIDS increasingly concentrated in Clark County between 1999 and 2003: the number of AIDS cases increased from 210 to 230, representing 82 percent of the state's total in 1999 and almost 91 percent in 2003. Clark County was also home to almost 80 percent of persons living with HIV/AIDS in the state.

In Nevada, the overwhelming majority of people diagnosed with HIV/AIDS were male. During 2003, 85 percent of new HIV/AIDS cases and 83 percent of persons living with HIV/AIDS were male. HIV/AIDS cases also affected more males and fewer females during the past five years. The drop in female cases was reflective of the decrease in Clark County numbers. The number of female cases in the rest of the state actually rose. Of note, females diagnosed with both HIV and AIDS were younger than their male counterparts: on average, females diagnosed with HIV were two years younger than males, while females diagnosed with AIDS were four years younger.

About 71 percent of new HIV/AIDS cases occurred in people age 25 to 44, and HIV infection was the 7th leading cause of death among adults in this age group. The past five

years showed a disturbing trend; the number of HIV/AIDS cases in 13 to 24 year olds doubled.
Nevada's HIV/AIDS population became more racially/ethnically diverse in the past five years, with growth in Hispanic and Asian/Pacific Islander cases. The state's Black population was highly overrepresented in the HIV/AIDS population – Blacks represented 27 percent of the new HIV/AIDS cases and 22 percent of persons living with HIV/AIDS, yet only 7 percent of the population. In 2003, the HIV/AIDS incidence rate among Nevada's Black residents was six times that for Whites. Whites were underrepresented in the state's HIV/AIDS population. Whites comprised about 64 percent of the state's population but only about 47 percent of total HIV/AIDS cases. The number of new White cases also decreased 14 percent in the last five years.

The largest at-risk group in Nevada is men who have sex with other men (MSM). During 1999, about 56 percent of people newly diagnosed with HIV/AIDS had been exposed through MSM, increasing to almost 70 percent in 2003. At the same time, exposure through other modes decreased across the board, down 39 percent for injection drug use (IDU), 28 percent for MSM and IDU, 17 percent for Heterosexual contact, 67 percent through a mother with/at risk for HIV, and 35 percent for unknown/other sources.

Nevada's other high risk populations include its substance abusing population, those with sexually transmitted diseases, and the state's prison population. Among substance abusers, injection drug use decreased, contributing to the lower exposure rates to HIV/AIDS by IDU. The White population showed the highest numbers of sexually transmitted diseases in the state, with the Hispanic population second. Chlamydia was the most prevalent among people between the ages of 13 and 24, while Gonorrhea was prevalent in the 13 to 24 and 25 to 44 year old age groups. The number of cases of Syphilis was low, and was concentrated in males. In Nevada's incarcerated population, rates of persons living with HIV/AIDS were 5.2 times higher than the general population. Nevada's HIV/AIDS rates in the incarcerated population were lower than the nation's, although Nevada's small female prisoner population had over four times the national female rate of living with HIV.

Nevada has 54 Counseling, Testing, and Referral Services (CTR) sites located throughout the state. In the past five years, 131,262 people received HIV tests and 1,244 were diagnosed with HIV infection at one of the CTR sites.

The state's two primary care facilities for HIV/AIDS are Northern Nevada HIV Outpatient Program, Education and Services (NNHOPES) in Reno, and The University Medical Center/HIV Wellness Center (UMC) in Las Vegas. Approximately 31 percent of persons living with HIV received medications through the AIDS Drug Assistance Program (ADAP). Of the persons living with HIV/AIDS in Nevada who were receiving care through the Ryan White program, 550 (33 percent) obtained services at NNHOPES and 1,125 (67 percent) obtained them at UMC. Of those patients, 79 percent were male and 21 percent female. The majority were White (55 percent) and between the ages of 25 and 44 (62 percent). Males, non-Hispanic Black persons, and those exposed to

HIV/AIDS through Other/Unknown sources and IDU use were overrepresented among those persons living with HIV/AIDS that did not receive services at Nevada's clinics.

Between 557 and 717 hospitalizations for HIV/AIDS occurred in Nevada each year during the past five years. Of those, 93 percent resided in Nevada and 7 percent lived in one of 28 other states, located throughout the United States. About 80 percent of patients were male, 60 percent were age 25 to 44, and about 70 percent were single. During the past five years, the average length of stay ranged from 9.5 to 10.9 days and the median length of stay from 5.0 and 7.0 days. The top diagnoses were infectious or parasitic diseases (30 percent of total), respiratory diseases (15 percent), digestive diseases (between 7 and 11 percent, depending on the year), and circulatory diseases (4 to 8 percent). Approximately half underwent surgical, therapeutic or diagnostic procedures. About 70 percent of these patients were discharged home. Finally, one-third had Medicaid insurance, one-quarter were covered by Medicare, one-in-five had commercial/negotiated discount insurance, between 5 and 9 percent had HMO coverage, and between 4 and 9 percent had no insurance.

Introduction

Profile Description

This epidemiologic profile presents specific information regarding the most current data on HIV/AIDS. In detail this profile will describe the general population, people who live with HIV/AIDS, and those who are at risk for HIV infection in Nevada.

The purpose of this profile is to serve as a resource for prevention and care efforts, to demonstrate the need for funding for the implementation of prevention and care services, and to serve as an evaluation tool for justifying the current programs and policies in Nevada. Epidemiological information is crucial to prioritizing targeted populations and to the entire planning process.

Funding for Nevada's HIV Prevention Program comes from a cooperative agreement between the Centers for Disease Control and Prevention (CDC) and the Nevada State Health Division. CDC requires that the Nevada HIV Prevention Community Planning Groups (CPGs) utilize the most up-to-date and accurate epidemiological data available in setting priorities, and in the development of goals and objectives to guide and coordinate future HIV prevention efforts.

The profile addresses the following five questions:

1. **What are the socioeconomic and demographic characteristics of the general population in Nevada?**
2. **What is the scope of HIV/AIDS in Nevada?**
3. **What are the indicators of risk for HIV infection and AIDS in the population covered by Nevada?**
4. **What are the patterns of utilization of HIV services in persons in Nevada?**
5. **What are the number and characteristics of persons who know they are HIV-positive, but who are not receiving HIV primary medical care?**

Background

Acquired Immuno-Deficiency Syndrome (AIDS) is the most severe manifestation of Human Immunodeficiency Virus (HIV) infection. AIDS was first recognized in 1981 by the Centers for Disease Control and Prevention. Statewide surveillance for AIDS in Nevada began in 1982. Because the cause for AIDS was unknown at that time, the surveillance case definition included many opportunistic infections and tumors. Persons with AIDS were noted to have abnormalities in their immune systems that left them susceptible to certain infections. As more information became available, the AIDS surveillance case definition was modified.

In 1984, HIV was determined to be the cause of AIDS. HIV infects a specific cell of the immune system, the T-lymphocyte, and kills the cell. Very often, HIV infection is without symptoms and people do not know they are infected. However, they carry the

virus in their blood and other body fluids and can infect other persons exposed to these fluids.

In 1992, Nevada initiated mandatory reporting of HIV infection by name. The purpose was to find persons with early HIV infection and ensure that they were educated about their disease and referred to appropriate treatment. Therefore, Nevada has a surveillance system for both HIV infection and AIDS.

AIDS cases in this report are cases where an HIV-infected person has developed the disease called AIDS. HIV cases in this report are cases where an HIV-infected person has not yet developed the disease called AIDS. Once an HIV case becomes an AIDS case, the HIV and AIDS surveillance system is updated to reflect that occurrence. This report provides data on both HIV and AIDS as defined above.

The purpose of this profile is to establish the true scope of HIV/AIDS in the state of Nevada. By preparing this profile to represent Nevada's communities, it will serve as an essential tool for the work of HIV/AIDS prevention and care planning teams.

The purpose of reporting names was to insure that infected individuals could be located and provided with the necessary education, assure appropriate treatment, and allow assistance with partner identification and notification. It also helps to assure an unduplicated count of HIV cases. This arrangement has allowed Nevada to maintain its HIV and AIDS surveillance system. The overall goal is to increase HIV testing, maintain education and prevention efforts, and reduce the number of infection due to HIV. This Epidemiological Profile was made possible with data from those surveillance systems.

Data Sources

1. HIV/AIDS Reporting System (HARS)

The HIV/AIDS Reporting System (HARS) is a national reporting system developed by the Centers for Disease Control and Prevention (CDC) to track the AIDS epidemic. The CDC's Division of HIV/AIDS Prevention developed HARS to simplify the management and analysis of HIV and AIDS surveillance data. Nevada has a mandatory reporting law that requires any individual who has tested positive for HIV or who is diagnosed with AIDS to be reported to the Health Authority having jurisdiction where they reside.

2. Supplemental HIV/AIDS Surveillance Projects

- **HIV in Prisons, 2001:** The U.S. Department of Justice's Bureau of Justice Statistics (BJS) collected data on the number of HIV-positive and active AIDS cases among prisoners held in each state and the Federal prison system at year-end 2001. BJS provided this annual report, published in January 2004, which outlined detailed HIV/AIDS prison information, including the number of AIDS-related deaths, a breakdown for women and men with AIDS, and comparisons to AIDS rates in the general population. The data from this report were used in the Incarceration section of the document.

3. Behavioral Surveys

- **Behavioral Risk Factor Surveillance Survey (BRFSS):** Nevada has participated in the Behavior Risk Factor Surveillance Survey (BRFSS) since 1992. The Nevada BRFSS telephone survey tracks health risks in Nevada. Information from the survey is used to improve the health of the Nevada people. Respondents are asked if they have ever been tested for HIV, whether they would encourage their sexually active teens to use condoms, and what they estimate their chances of getting AIDS are.

4. HIV Counseling, Testing, and Referral Services (CTR)

HIV Counseling,Testing, and Referral Services (CTR) was first developed in 1988. Its purpose is to provide a venue for HIV testing along with appropriate counseling and referral for other HIV-related services. The data collected in this process are useful in assisting HIV prevention service areas. CTR was developed by the CDC, the National Center for HIV, STD, and TB Prevention (NCHSTP), and the Division of HIV/AIDS Prevention (DHAP). HIV Counseling and Testing became a standard clinical practice in HIV prevention efforts. The CDC recommended that HIV counseling and testing be provided in a variety of settings to persons seeking testing or at risk of HIV infection. Data collected at Nevada's 54 CTR sites were used in the Ryan White section of this report.

5. Substance Abuse Data

The Nevada State Health Division's Bureau of Alcohol and Drug Abuse (BADA) funds 27 agencies to provide substance abuse treatment services at 51 sites throughout Nevada. As part of BADA's goal of reducing the amount of substance abuse in Nevada, the Bureau collects a variety of data about people who have sought out substance abuse treatment at those sites. Data included in this report are primarily from the state fiscal year 2004, which contains total admissions from July 1, 2003 through June 30, 2004.

6. Vital Statistics Data

Among its many functions, the Nevada State Health Division's Bureau of Health Planning and Statistics maintains the Nevada Interactive Health Database System, which provides information on low birth weight, prenatal care visit, fertility, teen birth, BFRSS, cancer, death, population, hospital discharge, YRBS, and most frequently requested statistics. This document utilized the mortality module of the Interactive Database System for information on HIV/AIDS deaths.

7. Population Data

- **U.S. Bureau of the Census:** In addition to taking a census of the population every 10 years, the Census Bureau conducts a census of economic activity of state and local governments every five years. Every year the Census Bureau conducts

more than 100 other surveys. The Census Bureau's site (http://www.census.gov) includes data on the demographic characteristics (including age, gender, and race/ethnicity) of the population, family structure, educational attainment, socioeconomic status, and housing status. The Census Bureau provides annual reports on changes in these areas, as well as updates on state and county-specific information. Census Bureau data on socioeconomic indicators and educational attainment were used in this report.

- **The Nevada State Demographer:** The Nevada State Demographer's office is responsible for conducting annual population estimates for Nevada's counties, cities, and towns. The office also estimates population by age, sex, race, and ethnic origin of Nevada's counties. Population projections are produced on an annual basis as well. Their annual publications include the Annual Estimates; 2000 Projections; Age and Race Estimates; and Portraits of Nevada's Population. The Nevada State Demographer also produces a file of population estimates and projections, from 1990 through 2022. The State Demographer's 2003 population estimates were used in the demographic section of this report.

8. Hospital Discharge Data

The Center for Health Information Analysis (CHIA) serves the community by making specific Nevada hospital related data available to both the private and public sectors. They are contracted with the University of Nevada and work in conjunction with the Division of Health Care Financing and Policy of the Department of Health and Human Resources for the state of Nevada. Their goal is to provide meaningful data to help research organizations in developing utilization patterns, health status and related issues. CHIA provided data on all people discharged from Nevada hospitals between 1999 and 2003 who had a diagnosis of HIV/AIDS.

Profile Strengths and Limitations

Strengths:

- Nevada is the 7th largest state in the nation in total square miles. Yet is has a relatively small population, with population centers concentrated in areas around the state, from the highly populated cities of Las Vegas and Henderson in Clark County to the frontier communities in Nevada's rural counties. Nevada has two local health authorities and one state health authority: Clark County Health District, with central offices in Las Vegas; Washoe County District Health Department, with central offices in Reno; and the Nevada State Health Division, with central offices in Carson City, which is the health authority in all of the counties other than Clark and Washoe. Because of Nevada's unique population distribution, these authorities maintain an ongoing dialogue.

- The Nevada State Health Division has also prided itself in maintaining excellent relations between Bureaus in the Division. The Bureau of Community Health received tremendous technical support from other Bureaus in the Division, especially from the Bureau of Health Planning and Statistics and the Bureau of

Alcohol and Drug Abuse. This cooperation speaks to Nevada's united commitment to public health in the state.

- Persons with unrecognized and untreated HIV infection may not have symptoms for years. The average time from untreated HIV infection to AIDS is eight to ten years. Many drugs are now available to treat HIV infection. The usual regimen is a combination of drugs that are taken daily. The goal of treatment is to reduce the amount of virus in the blood to "undetectable" levels by laboratory methods, and to maintain a level of T-lymphocytes that keeps the immune system function intact. When a person with HIV infection stays on an effective treatment regimen they may never reach the AIDS stage. Therefore, AIDS surveillance will not be a true indicator of the burden of HIV disease in our communities. HIV cases in this report are cases where the person has the virus but has not yet developed AIDS, while AIDS cases are cases where the person with HIV developed an opportunistic infection. The AIDS and HIV surveillance system is updated to reflect that occurrence. This report provides the results of both types of cases.

Limitations:

- The numbers of persons reported do not reflect the total burden of HIV disease in Nevada. Many persons are infected but do not know it because they have not been tested and therefore are not reported to health authorities. In the U.S., it is estimated that one-quarter to one-third of people infected with HIV are unaware of their status.

- We do not have an estimate of persons in Nevada who carry the virus but do not know it. One of the main goals of the state HIV/AIDS program is to increase HIV testing in persons who have high risk behaviors for infection, identify those infected, and refer them for treatment and prevention services, thus reducing the number of HIV infected persons who do not know they are infected and thereby reduce HIV transmission.

- Nevada is one of the top vacation destinations in the country. During 2003, almost 49 million people visited the silver state, averaging about 4 million visitors per month. Visitors include persons who work temporarily in the state's entertainment industry. Through 2003, 873 of those temporary workers sought treatment for HIV and AIDS at clinics, hospitals, and physicians' offices throughout the state. None of those people were included in Nevada's statistics, as they were initially diagnosed in another state. In addition, the state received no funding for their treatment.

- The analysis of data from the Rural Counties in Nevada is limited by the relatively small size of their populations and low numbers of cases.

- The last census conducted by the U.S. Bureau of the Census was in 2000. The 2003 population numbers used in this report are estimates, and have not been confirmed.

Profile Preparation

This profile was prepared by the HIV/AIDS Surveillance Program in the Nevada State Health Division's Bureau of Community Health. The profile was created in close collaboration with the Nevada Ryan White CARE Act and HIV Prevention programs and the Centers for Disease Control and Prevention.

This report used the following statistical methods to measure the effect of HIV/AIDS on specific populations, adjust for delays in reporting, and account for cases with missing risk information:

- HIV prevalence estimates were calculated using a method recommended by the CDC. This method takes into account the reporting delay for HIV (not yet AIDS) and AIDS cases and divides the number of persons diagnosed with HIV/AIDS by the estimated range of persons diagnosed with HIV infection.
- For ease of reading, HIV infection that has not yet developed into AIDS, or HIV (not yet AIDS), was shortened to read "HIV."
- Case rates were calculated for the 12-month period per 100,000 population. For these rates, denominators were derived from the Nevada State Demographer's 2003 population estimates. The numerator is the number of reported cases that were diagnosed during the 12-month period.
- When HIV/AIDS data are presented as annual trends, it may appear that the most recent year has fewer cases. This is an artifact of reporting delay. Reporting delay refers to the time between the diagnosis of a case and receipt of the report by the health department. Cases recently diagnosed may not yet have been reported.
- Regarding "missing risk information," the cases that have been diagnosed recently are more likely to be reported without a specified risk (exposure). To provide data on the reclassification of risk over time, the cases with missing risk information have been assigned to the "Other or Unknown" risk category.
- The Bureau of the Census, in compliance with the Office of Management and Budget Directive 15 (OMB 15), expanded race/ethnicity reporting in 2000. The expanded questionnaire allowed respondents to select one or more races to indicate their racial identity. However, for comparisons with HIV/AIDS data for which information on only one race and Hispanic identity is collected, the race/ethnicity data obtained from the Nevada State Demographer were combined into five categories: White; Black; Hispanic; Asian/ Pacific Islander; and American Indian/Alaskan Native. For analysis involving small numbers of cases in some racial/ethnic groups, those cases have been grouped in a category. For ease in reading, two of the race categories have been abbreviated. White, not Hispanic will be shortened to White and Black, not Hispanic to Black.

Organization of the Profile

Section 1: Core Epidemiologic Questions

Question 1: What are the socioeconomic and demographic characteristics of the general population in Nevada?

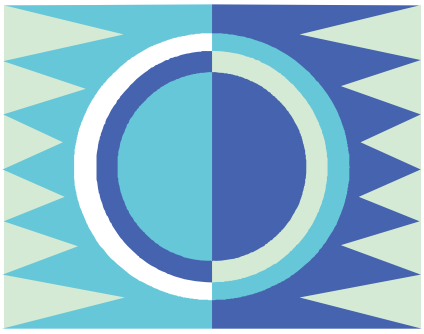
Question 2: What is the scope of HIV/AIDS in Nevada?

Question 3: What are the indicators of risk for HIV/AIDS infection in Nevada?

Section 2: Ryan White HIV/AIDS CARE Act Special Questions

Question 1: What are the patterns of utilization of HIV services by persons in Nevada?

Question 2: What are the number and characteristics of persons who know they are HIV-positive, but who are not receiving HIV primary medical care?



Section 1

Core Epidemiologic Questions

Question 1: What are the socioeconomic and demographic characteristics of the general population in Nevada?

Question 2: What is the scope of HIV/AIDS in Nevada?

Question 3: What are the indicators of risk for HIV/AIDS infection in Nevada?

Question 1

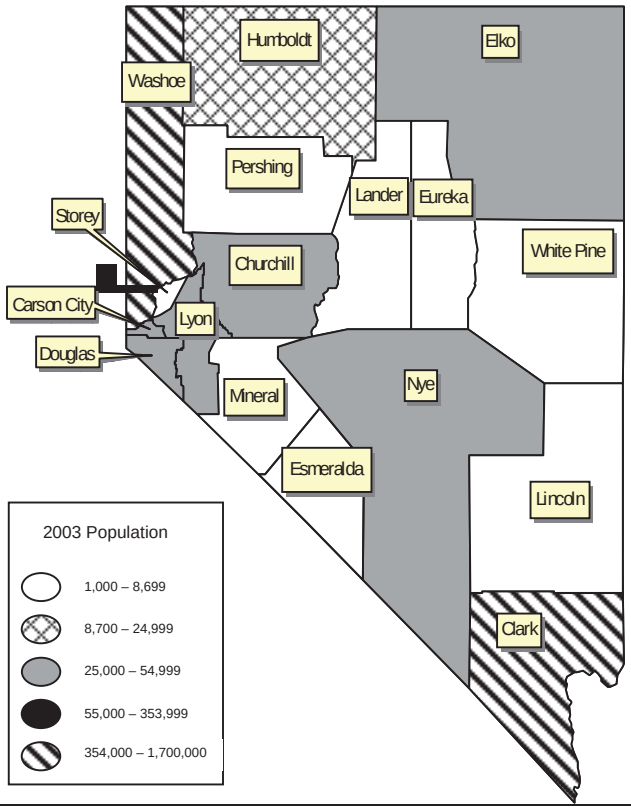
- **What are the socioeconomic and demographic characteristics of the general population in Nevada?**

SUMMARY HIGHLIGHTS

Population: In size, Nevada is the seventh largest state in the union. By population, Nevada was the 35th largest in 2003, with a total estimated population of 2,292,258 persons. Nevada has 17 counties that cover 110,540 square miles. About 83 percent of the state is federally owned, leading to vast sparsely populated areas in rural Nevada combined with large population centers in Clark and Washoe Counties. Clark and Washoe Counties contain 87 percent of the state's population, 71 percent and 16 percent respectively. The most populous cities are concentrated in the two large population centers. Las Vegas and Henderson, the two most populous cities, are located in Clark County along with other large cities such as North Las Vegas and Boulder City. Reno, the third most populous city, is located in Washoe County along with its sister city, Sparks.

Figure 1

2003 Nevada Population by County



Demographic Composition: According to 2003 population estimates, the racial/ ethnic composition of the state was 64 percent White, 22 percent Hispanic, 7 percent Black, 6 percent Asian/Pacific Islander and 1 percent American Indian/Alaska Native. Hispanics and Asian/Pacific Islanders are the fastest growing racial/ethnic groups in the state. Between 1999 and 2003, the number of Hispanic residents grew 36 percent while the Asian/Pacific Islander population increased 34 percent. By 2008, the number of Hispanic residents is projected to increase 30 percent, and one-in-four Nevadans will be Hispanic. The Asian/Pacific Islander population is projected to grow 26 percent, and will comprise 7 percent of the population.

Age and Gender: In 2003, the median age of Nevada residents was 36 years. Almost one-third of the population in Nevada was between the ages of 25 and 44 (30 percent), and one-quarter of the population was 45 to 64 years old (24 percent). About 17 percent of the population was between the ages of 13 and 24, 15 percent was 2 to 12 years old, 11 percent were age 65 and Older, and 3 percent were Less than 2 years old. The proportion of males was slightly higher in the overall population compared with females (51 percent vs. 49 percent respectively).

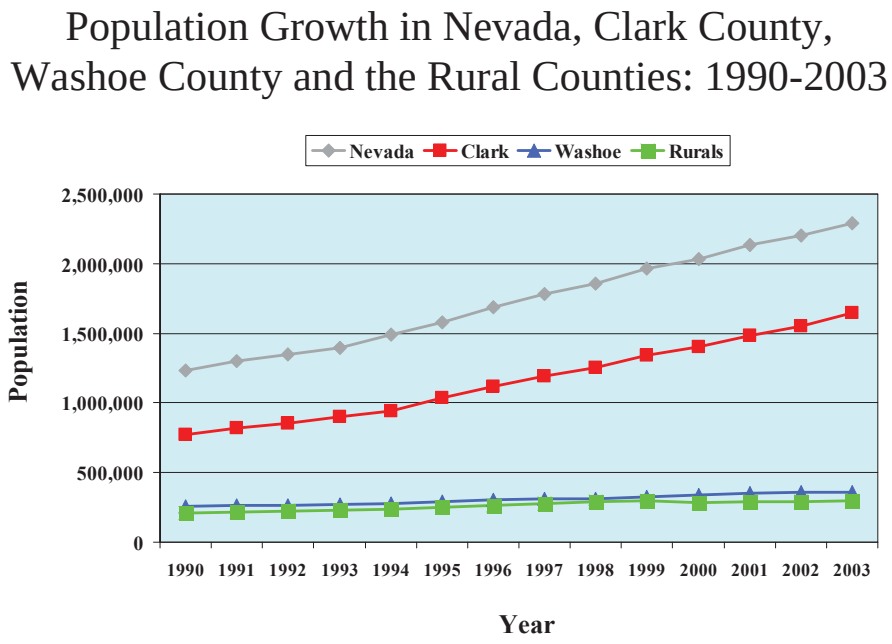
Poverty, Income and Education: According to the U.S. Census Bureau, between 2002 and 2003 the median household income for Nevada residents increased less than 1 percent, from $44,958 to $45,184. In 2003, Nevada ranked 15th among states for per capita income. In 1999 (the latest year for which data are available), about 11 percent of the population in Nevada lived under or below the poverty level. Educationally, 81 percent of Nevada's population had a high school diploma, and about 18 percent had a bachelor's degree or higher.

Health Indicators: In 2004, the United Health Foundation ranked Nevada 37th in the nation based on 19 health indicators. Theses indicators determined the healthiest (1st) to least healthy (50th) states in the nation. According to the report, Nevada's strengths (ranking higher than 20th in the nation) included its low occupational fatalities rate (4.6 deaths per 100,000 workers), its low infant mortality rate (6.1 deaths per 1,000 live births), and a moderate prevalence of obesity (21.2 percent of the population). United Health identified six indicators as areas for improvement for the state. They included three mortality indicators: total mortality (934.4 deaths per 100,000 population), rate of cancer deaths (215.3 deaths per 100,000 population), and motor vehicle deaths (2.0 per 100,000 miles driven), for which Nevada ranked 42nd, 41st and 41st respectively. The state also ranked low on access to care indicators, ranking 44th in the nation for the rate of uninsured population (18.9 percent of the population) and 44th in the nation for access to adequate prenatal care (only 69.7 percent of pregnant women received adequate prenatal care). In addition, the state ranked 44th in the nation on the rate of violent crime (638 offenses per 100,000 population). United showed that Nevada had two other risk areas as well, prevalence of smoking and premature death, both of which were ranked 38th.

DEMOGRAPHICS, BASED ON 2003 POPULATION ESTIMATES FROM THE NEVADA STATE DEMOGRAPHER'S OFFICE

Nevada has been the fastest growing state in the country for the past 18 years, averaging 4.1 percent annual growth. Between 1990 and 2000, Nevada's population increased almost 65 percent, from 1,236,130 to 2,034,050 people. The state's population increased another 12 percent to 2,292,258 people between 2000 and 2003. In the last 13 years, the state's population increasingly concentrated in Clark County. Between 1990 and 2003, Clark County's population grew about 122 percent, from 741,459 to 1,643,633 people. During that time, the county's population rose from about 62 percent to almost 72 percent of the state's total population.

Figure 2



In 2003, the largest age group for both genders was 25 to 44 year olds, with 30 percent of the population, followed by 45 to 64 year olds, with 24 percent. Nevada had the highest ratio of males to females among states in the country, with 103.0 males for every 100.0 females. Males outnumbered females in every age group up until the age of 45, at which point the trend reversed (Table 1).

Table 1
Distribution of the general population in Nevada, by age group for each gender: 2003

	Percentage of Population		
Age Group	Males (n=1,164,107)	Females (n=1,128,851)	Total (n=2,292,958)
<2	3.0%	2.9%	3.0%
2-12	15.5%	15.2%	15.3%
13-24	17.0%	16.3%	16.7%
25-44	30.8%	29.2%	30.0%
45-64	23.5%	24.2%	23.8%
65+	10.3%	12.1%	11.2%
Total*	**100%**	**100%**	**100%**

* = Totals may not equal 100% exactly as a result of rounding

During 2003, almost two-thirds of people living in Nevada were White (64 percent), while about 22 percent were Hispanic, 7 percent were Black, 6 percent Asian/Pacific Islanders, and 1 percent American Indian or Alaska Natives. Whites were the largest racial group for both genders (63 percent and 64 percent respectively). Males had a larger percentage among Hispanics versus females, while females made up the larger percentage of Asian/Pacific Islanders (Table 2).

Table 2
Percentage distribution of the general population in Nevada, by race/ethnicity for each gender: 2003

	Percentage of Population		
Race/Ethnicity	Male (n=1,164,107)	Female (n=1,128,851)	Total (n=2,292,958)
White	63.4%	64.2%	63.8%
Hispanic	23.0%	20.9%	21.9%
Black	6.9%	7.0%	6.9%
Asian/Pacific Islander	5.4%	6.5%	6.0%
American Indian or Alaska Native	1.3%	1.4%	1.3%
Total*	**100%**	**100%**	**100%**

* = Totals may not equal 100% exactly as a result of rounding

Of the counties in the state, Clark County was the most racially diverse. In 2003, only 59 percent of its population was White, compared to 72 percent in Washoe County and 81 percent in the rural counties. Clark County also had the highest percentage of Hispanic and Black residents: 24 percent and 9 percent respectively, compared to 19 percent and 2 percent in Washoe County, and 13 percent and 1 percent in the Rural Counties (Table 3).

Table 3
Distribution of the population, by race/ethnicity and county of residence: 2003

	Percentage of Population			
Race/Ethnicity	Clark County (n=1,643,633)	Washoe County (n=362,458)	Rural Counties (n=295,866)	Nevada (n=2,292,958)
White	58.9%	72.0%	80.9%	63.8%
Hispanic	24.3%	18.5%	13.2%	21.9%
Black	9.1%	2.2%	0.9%	6.9%
Asian/Pacific Islander	6.9%	5.4%	1.6%	6.0%
American Indian or Alaska Native	0.8%	1.9%	3.5%	1.4%
Total*	**100%**	**100%**	**100%**	**100%**

* = Totals may not equal 100% exactly as a result of rounding

SOCIOECONOMIC STATUS

In 1999, about 11 percent of Nevada residents lived in poverty. By county, the lowest percentage of individuals living in poverty was in Storey County (5.8 percent) and the highest was in Lincoln County (16.5 percent). About 10.8 percent of residents in Clark County and 10.0 percent of residents in Washoe County lived in poverty.

Nevada's 1999 median household income was $44,581. By county, median household income ranged from $32,891 in Mineral County to $51,849 in Douglas County. The majority (22 percent) of households in Nevada earned between $50,000 and $75,000 per year, while about 18 percent earned between $35,000 and $50,000. About 12 percent earned less than $15,000 per year and only 4 percent earned more than $150,000. In general, Nevada had higher percentages of middle-income residents and lower percentages of residents at both the lower and upper ends of the household income scale than the nation as a whole.

In 2003, almost 19 percent of Nevada's residents lacked health insurance for the entire year. Among residents under age 65 who were not yet eligible for Medicare insurance, about one-in-five was uninsured in 2002 and 2003. Between 2001 and 2002, the percentage of uninsured in Nevada jumped by over 90,000 people, bringing Nevada's uninsured rate from 16 percent to 20 percent. Between 2002 and 2003, the number of uninsured decreased by 500 people, a 1 percent drop.

Table 4
Percent of Nevada residents without health insurance by age group, 2000-2003

	Percentage of Population			
Age Group	2000 (n=2,023,378)	2001 (n=2,132,498)	2002 (n=2,206,022)	2003 (n=2,296,566)*
<18 years	14.9%	14.2%	19.7%	17.4%
<65 years	17.6%	17.9%	22.3%	21.2%
65+ years	1.0%	1.1%	0.6%	1.0%
Nevada Average	**15.5%**	**16.1%**	**19.7%**	**18.9%**

Source: U.S. Bureau of the Census, "Income, Poverty and Health Insurance Coverage in the United States," 2000, 2001, 2002, 2003. *U.S. Census Bureau population estimate for 2003 does not match Nevada State Demographer 2003 estimate.

By race/ethnicity, Hispanics were more than twice as likely as Whites to be uninsured. Blacks were also more likely to be uninsured; 23 percent of the Black population lacked insurance, compared to 17 percent of the White population.

Table 5
Percentage of adults (aged 19-64) without health insurance in Nevada, by race/ethnicity: 2000

Race/ethnicity	Percentage of Population
White	17%
Black	23%
Hispanic	36%
Other, not Hispanic	17%

Source: Health Coverage and Uninsured, Kaiser Family Foundation. Available at http://www.statehealthfacts.kff.org.

Between 80 percent and 84 percent of people in the state who were at least 25 years old had a high school diploma or higher in 2000. Washoe County residents were more educated than those in the rest of the state, with higher percentages of residents with both high school diplomas and bachelor's degrees.

Table 6
Percentage of population 25 years and older, with high school diploma or bachelor's degree or higher: 2000

	Percentage of Population	
Area	High school diploma or higher	Bachelor's degree or higher
Clark County	79.5%	17.3%
Washoe County	83.9%	23.7%
Rural Counties	82.6%	15.5%
Nevada	**80.7%**	**18.2%**

Source: Census 2000 Summary File 3 (SF 3) - Sample Data. http://factfinder.census.gov.

Question 2

- **What is the scope of HIV/AIDS in Nevada?**

HIV and AIDS has all affected population groups within Nevada. However, it occurred at varying degrees in different age, racial/ethnic, gender, and risk group. This section evaluates the characteristics of persons infected with HIV who do not yet have AIDS and those persons who have been diagnosed with AIDS.

Highlights

- Nevada was disproportionately represented in the nation's AIDS population, especially among adult/adolescent AIDS cases. Nevada ranked 11th, 12th and 6th in the nation for White, Black, and Asian/Pacific Islander adolescent/adult cases rates per 100,000 people compared to the rest of the nation. These rates represented a five-year average (1999 through 2003) adolescent/adult AIDS case rate per 100,000.

- Nevada had larger percentages of male AIDS cases than the nation in 2003. Nevada also had higher percentages of Black AIDS cases and cases among 25 to 44 year olds. Nevada had far higher percentages of people exposed to AIDS through men having sex with men, and lower percentages of people exposed through injection drug use and heterosexual contact.

- Sixteen of Nevada's seventeen counties reported HIV/AIDS cases in 2003, yet the majority of the cases were confined to the two major metropolitan areas in the state: Clark and Washoe Counties.

- Clark County led the state in the number of both HIV and AIDS cases during 2003. The county reported over 80 percent of the HIV cases in the state each year between 1999 and 2003 while AIDS cases were increasingly concentrated in the county. Clark County reported almost 91 percent of the state's AIDS cases in 2003, up from 82 percent in 1999. In addition, 81 percent of persons living with HIV/AIDS lived in Clark County.

- Between 1999 and 2003, the number of newly diagnosed HIV/AIDS cases in Nevada ranged between 436 and 481 per year, with 462 cases in 2003.

- About 85 percent of new HIV/AIDS cases diagnosed in 2003 were among males and 15 percent were among females. Between 1999 and 2003, the number of new HIV/AIDS cases among males increased 2 percent while the number of cases among females dropped 12 percent. The decrease in cases among females was driven by 20 percent decrease in new female AIDS cases.

- The Black HIV/AIDS population was disproportionately large in Nevada. Although 7 percent of Nevada's population was Black in 2003, the Black population represented 27 percent of new HIV/AIDS cases, and 23 percent of people living with HIV/AIDS. The rate of Black AIDS cases was more than six times higher than that for Whites.

- By race/ethnicity and gender, the highest HIV incidence rates were in Black males, followed by Hispanic males, Black females, and White males. The highest AIDS incidence rates were in Black males, followed by Black females, Hispanic males and White males.

- The number of people living with HIV in Nevada increased 50 percent between 1999 and 2003, while the number of people living with AIDS increased 52 percent.

- About seven-in-ten people diagnosed with HIV/AIDS in Nevada were between the ages of 25 and 44. This statistic was true from 1999 through 2003. In that five-year span though, the number of cases for people age 13 to 24 doubled, and 13 to 24 year olds overtook 45 to 64 year olds as the second highest age group for new diagnoses of HIV cases.

- The largest risk category for HIV/AIDS in Nevada was men having sex with men (MSM). Between 1999 and 2003, the number of people exposed through MSM increased 24 percent while exposure from all other sources decreased.

I. Overall HIV/AIDS Trends in Nevada

NEVADA COMPARED TO THE NATION

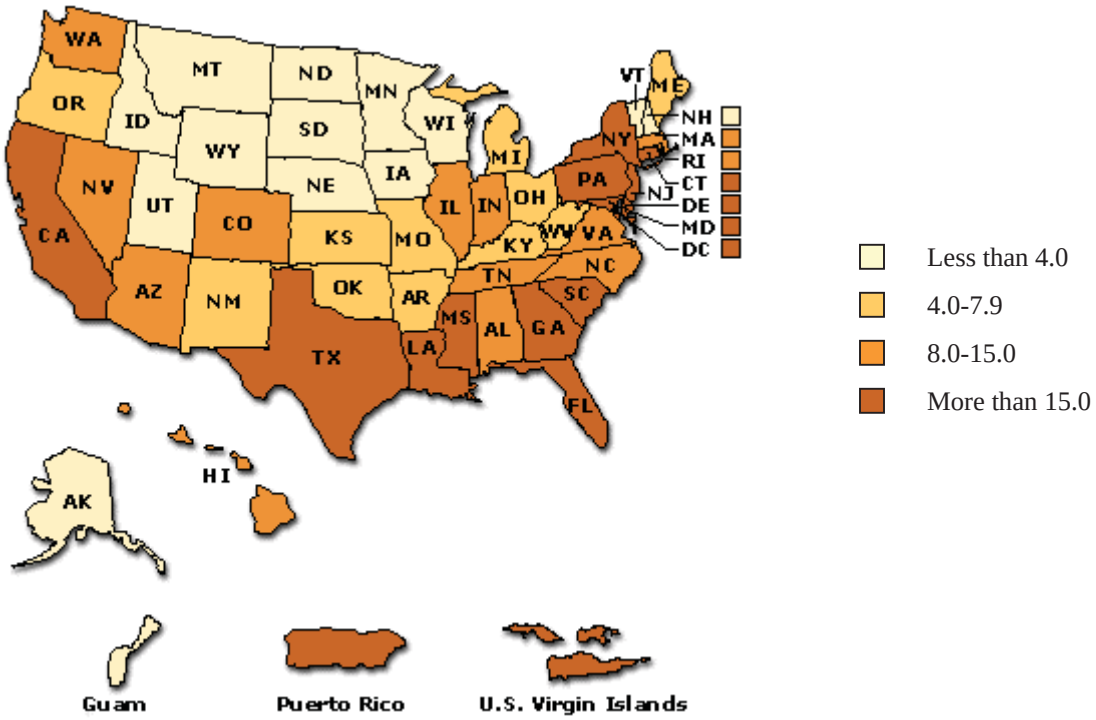
Nevada had one of the smaller populations in the nation during 2003, with the 35th largest total population. Yet, the incidence of AIDS in the state was disproportionately high. The Henry J. Kaiser Family Foundation[1] ranked Nevada 14th highest in the nation in cases per 100,000 persons for the rate of adolescents and adults living with AIDS, and ranked 18th for the annual AIDS case rate. In addition, they ranked Nevada 19th in the nation on the death rate for HIV/AIDS and 20th on the number of HIV cases.

The adult/adolescent AIDS case rate was especially high for three racial groups/ethnicities: Asian/Pacific Islanders – 6th highest in the nation, Whites – 11th highest, and Blacks – 12th in the nation (Table 7).

Compared to other states in the western U.S., Nevada's annual AIDS case rate was second only to California's. Nevada's rate was 12.4 per 100,000 compared to California's rate of 16.6. Annual AIDS case rates per 100,000 for Nevada's neighbors were 11.0 for Arizona, 6.8 for Oregon, 3.1 for Utah, and 1.9 for Idaho.

[1] Note: The Kaiser Family Foundation uses numbers that reflect a five-year average, from 1999-2003.

Figure 3
AIDS Case Rate per 100,000 Population in 2003



Source: The Henry J. Kaiser Family Foundation

Table 7
Selected HIV/AIDS statistics, United States versus Nevada in 2003: rates/100,000 population, overall numbers, and Nevada's national rank (1 = highest rate, 50 = lowest rate)

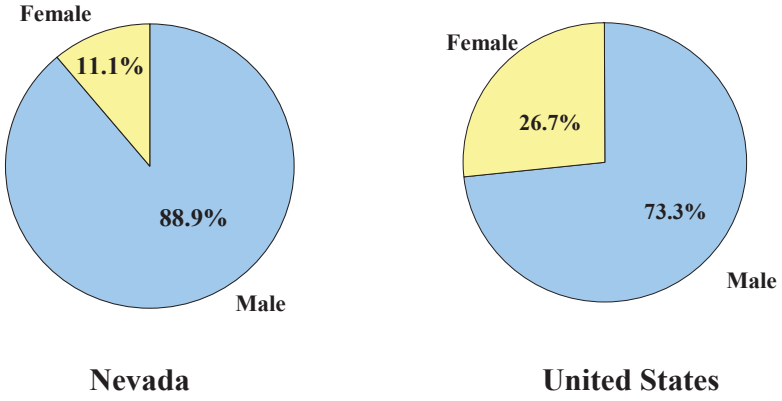
	U.S.	Nevada	Nevada Rank
Rate of adolescents/adults living with AIDS	167.3	146.7	14
Annual AIDS case rate, all ages	15.2	12.4	18
Adult/adolescent AIDS case rate, by race/ethnicity			
Whites	8.1	10.3	11
Blacks	73.9	75.5	12
Asian/Pacific Islanders	5.2	7.0	6
Adult/adolescent AIDS case rate, by gender			
Males	28.2	25.4	17
Females	9.3	4.8	22
HIV/AIDS death rate	4.9	3.5	19 (3-way tie)
Annual number of HIV cases	33,301	221	20
Number of new AIDS cases	44,963	277	27
Number of persons living with AIDS	405,926	2,654	27
Cumulative AIDS cases	902,233	5,237	28

Source: Kaiser statehealthfacts.org

Compared to the rest of the nation, Nevada had a higher proportion of AIDS cases among males. In 2003, 89 percent of AIDS cases diagnosed occurred in males, compared to 73 percent nationally.

Figure 4

AIDS cases diagnosed in 2003 by gender, Nevada versus the U.S.



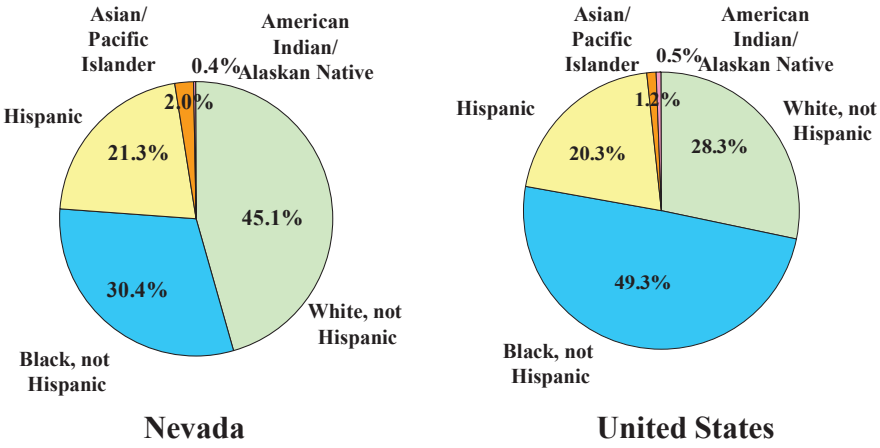
Sources: HARS database; CDC HIV/AIDS Surveillance Report, Cases of HIV Infection and AIDS in the United States, 2003

By race/ethnicity, Nevada had a smaller percentage of Black cases, 30 percent in Nevada versus 49 percent nationally. This smaller number reflects the smaller percentage of Black residents in the state (7 percent) compared to the nation (12 percent)[2]. Nevada had a larger percentage of White cases as well. Nevertheless, as noted previously, Blacks are overrepresented among HIV/AIDS cases, accounting for 27 percent of total cases while only representing 7 percent of the population.

[2] U.S. Census Bureau, USA QuickFacts

Figure 5

AIDS cases diagnosed in 2003 by race/ethnicity, Nevada versus the U.S.

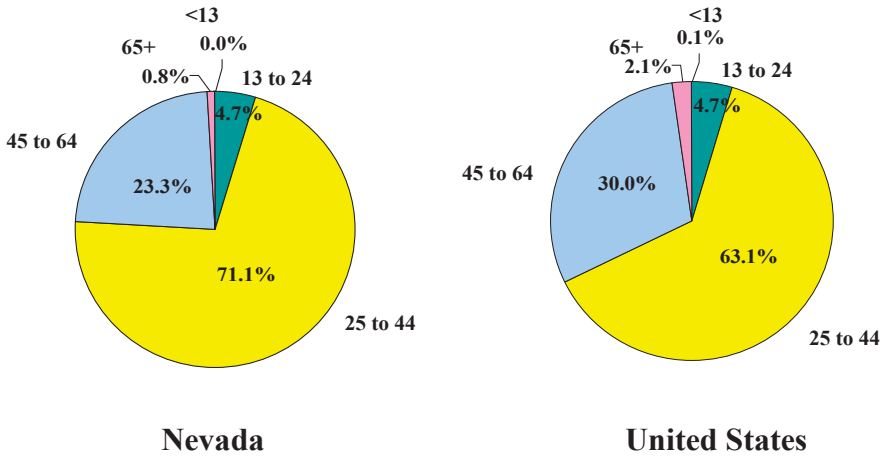


Sources: HARS database; CDC HIV/AIDS Surveillance Report, Cases of HIV Infection and AIDS in the United States, 2003

By age group, the people diagnosed with AIDS in Nevada were younger than in the nation as a whole. About 71 percent of people diagnosed with AIDS in Nevada were 25 to 44 years old, compared to 63 percent nationally.

Figure 6

AIDS cases diagnosed in 2003 by age group, Nevada versus the U.S.

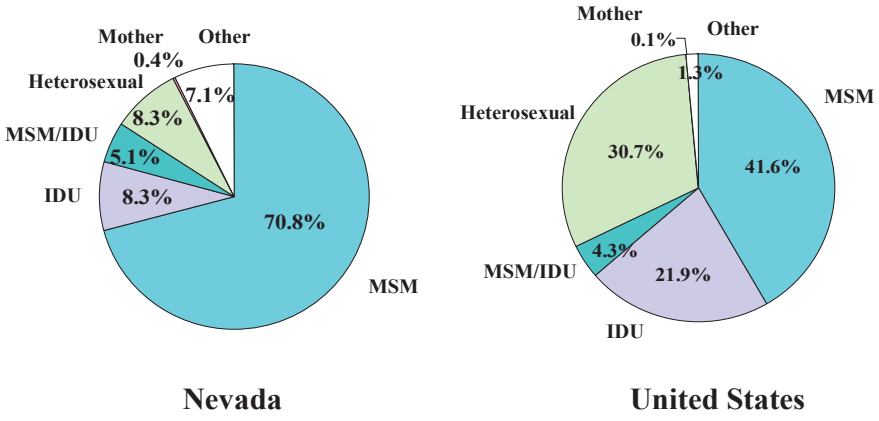


Sources: HARS database; CDC HIV/AIDS Surveillance Report, Cases of HIV Infection and AIDS in the United States, 2003

The proportion of men diagnosed with AIDS that had been exposed to the disease through sex with other men (MSM) was much higher in Nevada versus the U.S., 71 percent compared to 42 percent. Nevada also had a much lower percentage of people exposed to AIDS through heterosexual contact and injection drug use (IDU).

Figure 7

AIDS cases diagnosed in 2003 by mode of exposure, Nevada versus the U.S.



Sources: HARS database; CDC HIV/AIDS Surveillance Report, Cases of HIV Infection and AIDS in the United States, 2003

THE BURDEN OF DISEASE: HIV/AIDS IN NEVADA

In 2003, 462 Nevada residents were newly diagnosed with HIV/AIDS, a rate of 20.1 cases per 100,000 persons. In addition, 4,786 people were living with HIV/AIDS in Nevada, a rate of 208.7 per 100,000 persons.

About 85 percent of people newly diagnosed with HIV/AIDS and 83 percent of persons living with HIV/AIDS were male. The rate of new HIV/AIDS cases in males was almost six times as high as that for females: 547.2 per 100,000 versus 97.7 per 100,000.

By race/ethnicity, White residents comprised almost half of new cases and about 57 percent of persons living with HIV/AIDS. A disproportionate number of Black residents had HIV/AIDS. Although fewer than 7 percent of Nevada residents were Black in 2003, 27 percent of new cases and 23 percent of persons living with HIV/AIDS were Black. The rate of persons living with HIV/AIDS among Black residents was almost four times the rate of that among Whites.

HIV/AIDS hit young adults in Nevada hardest. Almost 70 percent of new cases and 74 percent of people living with HIV/AIDS were among people in the 25 to 44 age group.

Almost 70 percent of people newly diagnosed with HIV/AIDS and 57 percent of those living with the disease had been exposed to the infection through male-to-male sex.

About 12 percent of those living with HIV/AIDS had been exposed through intravenous drug use (IDU), yet 7 percent of those newly diagnosed had been exposed through this route).

Table 8
HIV/AIDS cases and rates (per 100,000) in Nevada, by gender, race/ethnicity, age group, and exposure category: 2003

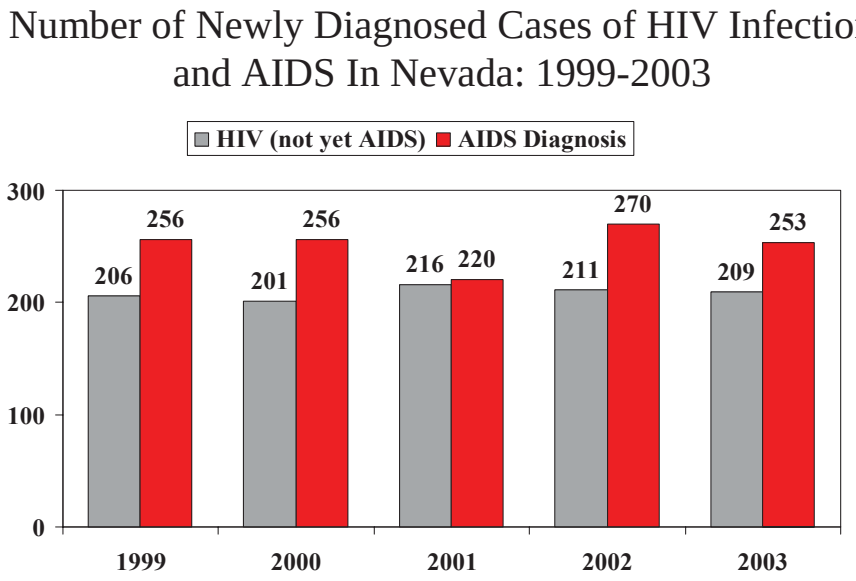
	New HIV/AIDS Cases			Persons Living with HIV/AIDS		
	No.	**%**	**Rate**	**No.**	**%**	**Rate**
Gender						
Male	395	85%	33.9	3,995	83%	343.2
Female	67	15%	5.9	791	17%	70.1
Race/Ethnicity						
White	219	47%	15.0	2,750	57%	188.0
Black	124	27%	77.9	1,112	23%	698.9
Hispanic	104	23%	20.7	790	17%	157.1
Asian/Pacific Islander	8	2%	5.8	82	2%	59.8
American Indian /Alaska Native	3	1%	9.7	43	1%	138.9
Unknown/Multiple Race	4	1%	-	9	0%	-
Age Group						
<2	0	0%	0.0	13	0%	19.1
2-12	0	0%	0.0	14	0%	4.0
13-24	52	11%	13.6	417	9%	109.1
25-44	322	70%	46.8	3,541	74%	514.8
45-64	86	19%	15.7	761	16%	139.2
65+	2	0%	0.8	40	1%	15.6
Exposure Category						
Men having sex with men (MSM)	319	69%	-	2,733	57%	-
Injection drug use (IDU)	33	7%	-	588	12%	-
Male to male sex & IDU	26	6%	-	314	7%	-
Heterosexual contact	49	11%	-	535	11%	-
Mother with/at risk for HIV	1	0%	-	29	1%	-
Other/Unknown	34	7%	-	587	12%	-
Total	**462**	**100%**	**20.1**	**4,786**	**100%**	**208.7**

Source: HARS database

Of the 462 people newly diagnosed with HIV/AIDS in Nevada during 2003, 209 (45 percent) were diagnosed with HIV. In 2003, 253 people were diagnosed with AIDS. These numbers reflects persons who were diagnosed in 2003 and who were reported to the health department.

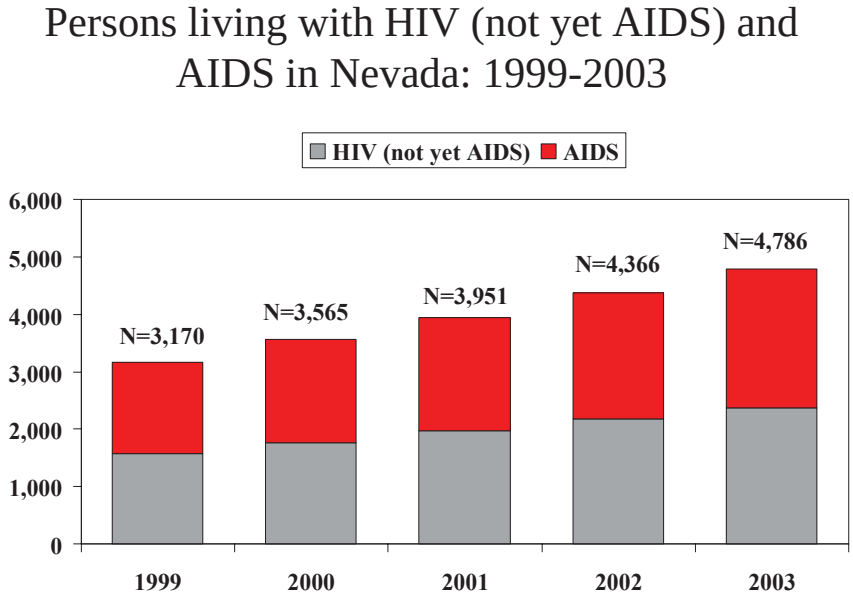
Between 1999 and 2003, the number of newly diagnosed HIV/AIDS cases in Nevada fluctuated between 436 and 481 per year, with the lowest number in 2001 and the highest in 2002. Between 1999 and 2003, AIDS cases comprised anywhere from 50 percent to 56 percent of total new cases – in 2003, 55 percent of total new cases (Figure 8).

Figure 8



Between 1999 and 2003, the number of people living with HIV/AIDS in Nevada increased 51 percent, from 3,170 to 4,786. These numbers represented an average increase of over 10 percent per year. This increase was equally driven by the increase in people living with HIV (up 50 percent) and the people living with AIDS (up 51 percent). These increases also illustrate the effects of the highly active antiretroviral therapy (HAART) in prolonging people's lives.

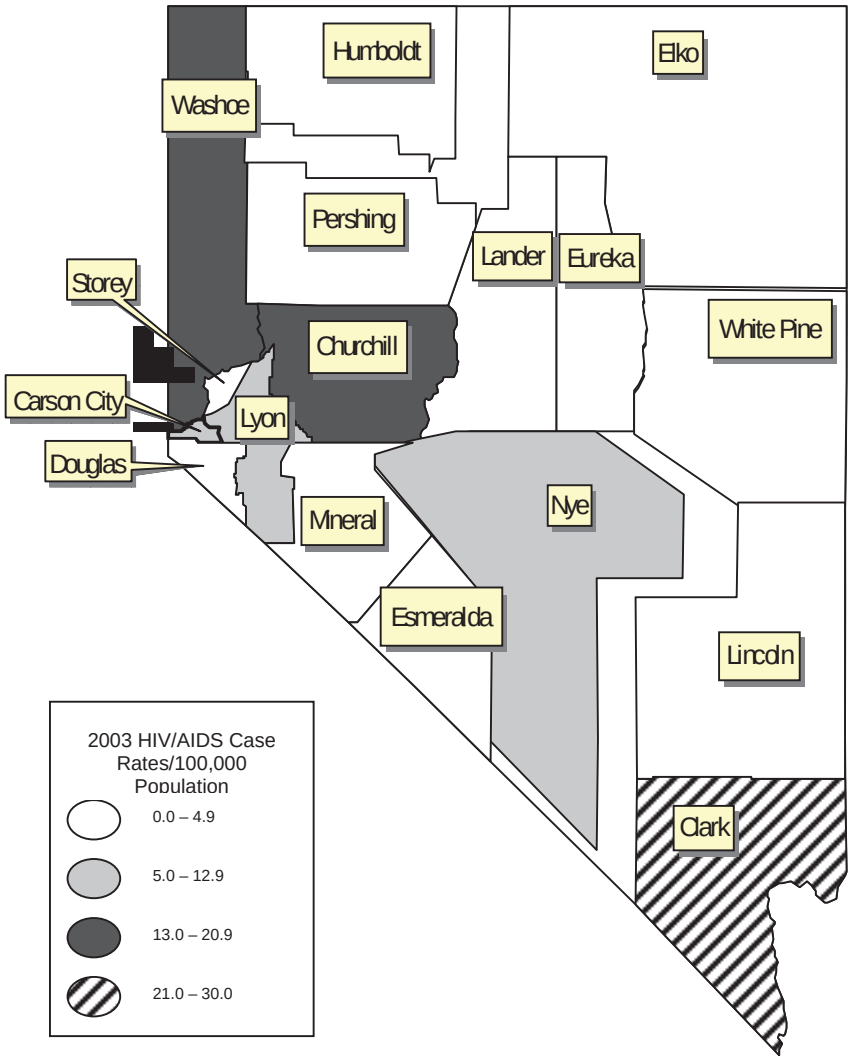
Figure 9



In 2003, Clark County had the highest HIV/AIDS case rate, 24.5 per 100,000 persons (Figure 11). Two other counties, Washoe and Churchill Counties, had HIV/AIDS case rates of between 13.0 and 20.9 infected persons per 100,000. Three counties, Carson City, Nye County, and Lyon County, each had HIV/AIDS case rates of 5.0 to 12.9 persons per 100,000. All the rest of the counties had rates of 0.0 to 4.9 persons per 100,000.

Figure 10

Nevada newly diagnosed HIV/AIDS case rates per 100,000 population by county, 2003



II. HIV and AIDS: Gender Differences

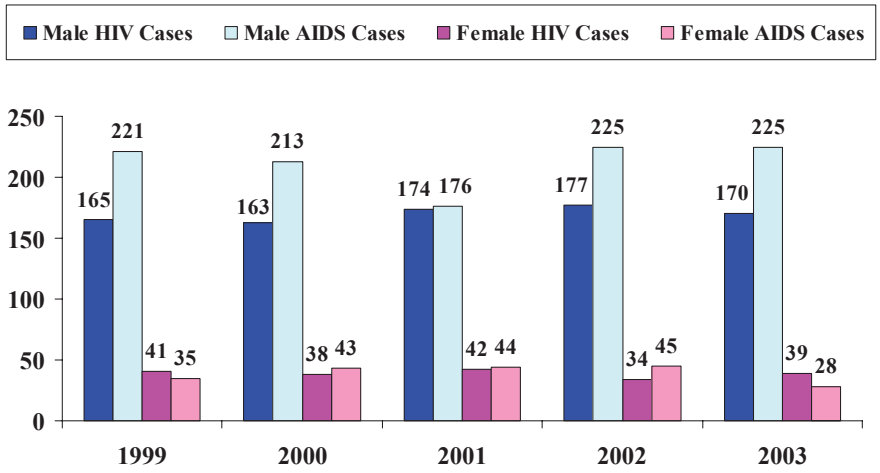
Newly Diagnosed Cases

In 2003, about 81 percent of HIV cases and 89 percent of AIDS cases were among males. The HIV rate for males (15/100,000) was nearly four times higher than that for females (4/100,000), and males were diagnosed with AIDS six times more often than females (19/100,000 and 3/100,000 respectively).

Between 1999 and 2003, the number of male HIV and AIDS cases fluctuated, and the overall 3 percent and 2 percent increases in cases were not statistically significant. At the same time, the number of female HIV cases decreased 5 percent while AIDS cases dropped 20 percent.

Figure 11

Number of HIV (not yet AIDS) and AIDS cases in Nevada, 1999-2003: Males versus Females



Source: HARS database

By gender and race/ethnicity, the highest incidence rates of HIV cases occurred in Nevada's minority groups. In order, the highest rates for HIV infection were for Black males (44/100,000), followed by Hispanic males (17/100,000), Black females (15/100,000), and White males (12/100,000). The racial/ethnic breakdown was similar for the rates of AIDS cases: Black males (74/100,000), Black females (23/100,000), Hispanic males (19/100,000) and White males (15/100,000).

Among females, both the percentage of Black females newly diagnosed with AIDS and the rate of AIDS was highly disproportionate to the population. Black females made up 31 percent of the newly diagnosed female HIV cases and 64 percent of the newly diagnosed female AIDS cases but only 7 percent of the female population. In addition,

Black females had over five times the HIV rate of White females, and 32 times the AIDS rate.

Table 9

HIV versus AIDS cases and rates (per 100,000 population) in Nevada during 2003, by gender and race/ethnicity

	Males						Females					
	HIV			AIDS			HIV			AIDS		
Race/ethnicity	No.	%	Rate	No.	%	Rate	No.	%	Rate	No.	%	Rate
White	85	50%	11.5	109	48%	14.8	20	51%	2.8	5	18%	0.7
Black	35	21%	43.9	59	26%	74.0	12	31%	15.1	18	64%	22.7
Hispanic	44	26%	16.5	50	22%	18.7	6	15%	2.5	4	14%	1.7
Asian/Pacific Islander	3	2%	4.7	4	2%	6.3	0	0%	0.0	1	4%	1.4
American Indian or Alaskan Native	1	1%	6.6	1	0%	6.6	1	3%	6.3	0	0%	0.0
Unknown/Multiple Race	2	1%	-	2	1%	-	0	0%	-	0	0%	-

Source: HARS database

More than two-thirds of the males (68 percent) and females (67 percent) diagnosed with HIV in 2003 were between the ages of 25 to 44. Overall, females who were diagnosed with HIV were younger than their male counterparts. The average age of females diagnosed with HIV was 32.41 years, compared with 34.29 years for males.

Females diagnosed with AIDS were also younger than their male counterparts. The average age of females diagnosed with AIDS was 35.69 years, compared to 39.29 years for males. About 75 percent of women with AIDS were between the ages of 25 and 44, while 18 percent were 45 to 64, and 7 percent were 13 to 24. For males, 71 percent were age 25 to 44, 24 percent were 45 to 64 and 4 percent were 13 to 24.

Table 10

HIV versus AIDS cases in Nevada during 2003, by gender and age at diagnosis

	Males				Females			
	HIV		AIDS		HIV		AIDS	
Age	No.	%	No.	%	No.	%	No.	%
<2	0	0%	0	0%	0	0%	0	0%
2-12	0	0%	0	0%	0	0%	0	0%
13-24	30	18%	10	4%	10	26%	2	7%
25-44	116	68%	159	71%	26	67%	21	75%
45-64	24	14%	54	24%	3	8%	5	18%
65+	0	0%	2	1%	0	0%	0	0%
Average Age	**34.29**		**39.64**		**32.41**		**35.69**	

Source: HARS database

The largest risk category for men diagnosed with HIV and AIDS in Nevada was men having sex with men (MSM). About 80 percent of males diagnosed with HIV and AIDS were exposed through MSM. Two-thirds (67 percent to 68 percent) of females were

exposed through heterosexual contact, although more than 20 percent either did not know how they were exposed to the virus or weren't asked about exposure.

Table 11

HIV versus AIDS cases and rates (per 100,000 population) in Nevada during 2003, by gender and mode of exposure

	Males				Females			
	HIV		AIDS		HIV		AIDS	
Exposure Category	No.	%	No.	%	No.	%	No.	%
Men having sex with men	140	82%	179	80%	0	0%	0	0%
Injection drug use (IDU)	7	4%	19	8%	5	13%	2	7%
MSM and IDU	13	8%	13	6%	0	0%	0	0%
Heterosexual contact	2	1%	2	1%	26	67%	19	68%
Mother with/at risk for HIV	0	0%	0	0%	0	0%	1	4%
Other/Unknown	8	5%	12	5%	8	21%	6	21%

"Other/Unknown" risk category includes hemophilia, blood transfusion, perinatal, and risk not reported or not identified; Source: HARS database

Persons Living with HIV and AIDS

Among persons living with HIV in 2003, 82 percent were male and 18 percent were female. Between 1999 and 2003, the number of males living with HIV increased 51 percent versus 49 percent for females.

About 85 percent of persons living with AIDS were male in 2003. Between 1999 and 2003, the number of females living with AIDS increased at a faster rate. Over the five-year period there was a 58 percent increase in the number of females living with AIDS whereas males experienced a 51 percent increase during the same period of time. As a result, the percent of males living with AIDS decreased from 86 percent to 85 percent.

Table 12

Number of persons living with HIV and AIDS in Nevada, by gender: 1999-2003

	HIV					AIDS				
	1999	**2000**	**2001**	**2002**	**2003**	**1999**	**2000**	**2001**	**2002**	**2003**
Males	1,281	1,437	1,603	1,772	1,936	1,367	1,537	1,684	1,865	2,059
Females	299	333	372	403	439	223	258	292	326	352
Total	**1,580**	**1,770**	**1,975**	**2,175**	**2,375**	**1,590**	**1,795**	**1,976**	**2,191**	**2,411**

Source: HARS database

III. HIV and AIDS: Racial Group/Ethnicity

Newly Diagnosed Cases

In Nevada, White residents were underrepresented in the HIV and AIDS populations. The White population comprised 64 percent of the total population, but only about 50 percent of the HIV cases and 48 percent of AIDS cases. In comparison, the Black population was overrepresented: the Black population was 7 percent of Nevada's total population, yet comprised 22 percent of the HIV and 30 percent of the AIDS population. In 2003, Blacks had the highest rates of both HIV and AIDS cases: 30/100,000 for HIV and 48/100,000 for AIDS cases. The rate of AIDS cases among Blacks was more than six times higher than that for Whites and almost five times as high as the rate for Hispanic residents. Hispanics were somewhat overrepresented in the HIV population, making up 22 percent of the total population and 24 percent of HIV cases.

Table 13
HIV and AIDS cases and rates (per 100,000 population) in Nevada by race/ethnicity: 2003

	HIV			AIDS			Total Population
Race/Ethnicity	**No.**	**Percent**	**Rate**	**No.**	**Percent**	**Rate**	**Percent**
White	105	50%	7.2	114	45%	7.8	64%
Black	47	22%	29.5	77	30%	48.4	7%
Hispanic	50	24%	9.9	54	21%	10.7	22%
Asian/Pacific Islander	3	1%	2.2	5	2%	3.6	6%
American Indian/Alaskan Native	2	1%	6.5	1	0%	3.2	1%
Unknown/Multiple Race	2	1%	-	2	1%	-	-
Total	**209**	**100%**	**9.1**	**253**	**100%**	**11.0**	**100%**

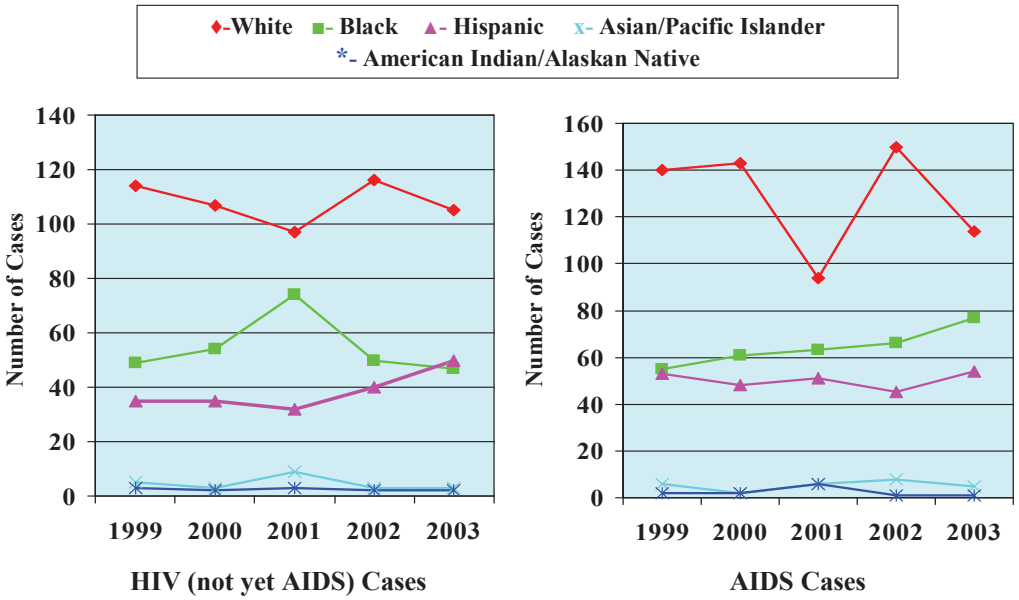
Source: HARS database

During the past five years, the Hispanic population experienced a 43 percent increase in the number of HIV cases, mirroring the growth in Nevada's Hispanic population. Between 1999 and 2003, the number of Black cases remained unchanged and Whites cases decreased 8 percent. Cases among Asian/Pacific Islander and American Indian/Alaska Native populations fluctuated but were low and steady between 1999 and 2003.

Between 1999 and 2003 the number of Black AIDS cases increased 40 percent. At the same time, the number of White cases decreased 19 percent. Cases among Hispanic, Asian/Pacific Islander and American Indian/Alaska Native populations fluctuated but were steady between 1999 and 2003 (see Figure 12).

Figure 12

HIV (not yet AIDS) and AIDS cases among persons in Nevada, by year of diagnosis and race/ethnicity: 1999-2003



Source: HARS database

MSM was the highest exposure category for each race/ethnicity during 2003. About 46 percent of White HIV cases resulted from MSM, compared to 55 percent of Black, 78 percent of Hispanic, 100 percent of Asian/Pacific Islander, and 50 percent of American Indians/Alaska Native cases. The next largest exposure category, occurring primarily among females, was Other/Unknown. About 21 percent of Black HIV cases and 50 percent of American Indian/Alaskan Native cases resulted from unknown modes of exposure. Exposure to HIV from heterosexual contact comprised 17 percent of Black, 14 percent of White, and 10 percent of Hispanic HIV cases. Injection drug use (IDU) and IDU/MSM exposure to HIV was most common in the White population, where each category represented 9 percent of cases.

As with HIV cases, the mode of exposure for the highest number of AIDS cases in 2003 was MSM. By race/ethnicity, about 77 percent of the White cases, 80 percent of the Hispanic and Asian/Pacific Islander cases, 100 percent of the American Indian/Alaskan Native cases, and 55 percent of the Black cases resulted from exposure through MSM. About 8 percent of people diagnosed with AIDS in 2003 had been exposed through IDU, 8 percent through Heterosexual contact, and 7 percent through a Mother with/at risk for HIV. The highest number of IDU cases was among Whites (11 percent of White cases), and the highest number of Heterosexual contact cases was among Blacks, although Heterosexual contact represented 20 percent of Asian/Pacific Islander cases (see Table 14).

Table 14
Number of HIV and AIDS Cases in Nevada, by race/ethnicity and exposure category: 2003

	HIV Cases					AIDS Cases				
Risk Category	**White**	**Black**	**Hispanic**	**Asian**	**American Indian**	**White**	**Black**	**Hispanic**	**Asian**	**American Indian**
MSM	69	26	39	3	1	88	42	43	4	1
IDU	9	2	1	0	0	13	7	1	0	0
MSM/IDU	9	1	3	0	0	5	6	1	0	0
Heterosexual	15	8	5	0	0	3	13	4	1	0
Mother w/ at risk for HIV	0	0	0	0	0	5	8	5	0	0
Other/Unknown	3	10	2	0	1	0	1	0	0	0
Total	**105**	**47**	**50**	**3**	**2**	**114**	**77**	**54**	**5**	**1**

"Other/Unknown" risk category includes hemophilia, blood transfusion, perinatal, and risk not reported or not identified; Source: HARS database

Persons Living with HIV and AIDS

In 2003, about 57 percent of people living with HIV were White, while 25 percent were Black, 15 percent were Hispanic and 2 percent were Asian/Pacific Islander. A higher percentage of people living with AIDS were White (58 percent), compared to the Black (22 percent), Hispanic (18 percent), and Asian/Pacific Islander (2 percent) populations.

The number of people living with HIV rose for every racial/ethnic group between 1999 and 2003. The largest numeric increase (+400) occurred within the White population. The largest percentage increases occurred within the smaller Unknown, Asian/Pacific Islander, Hispanic, and American Indian HIV populations, with 133 percent, 82 percent, 70 percent, and 69 percent increases respectively (see Figure 13).

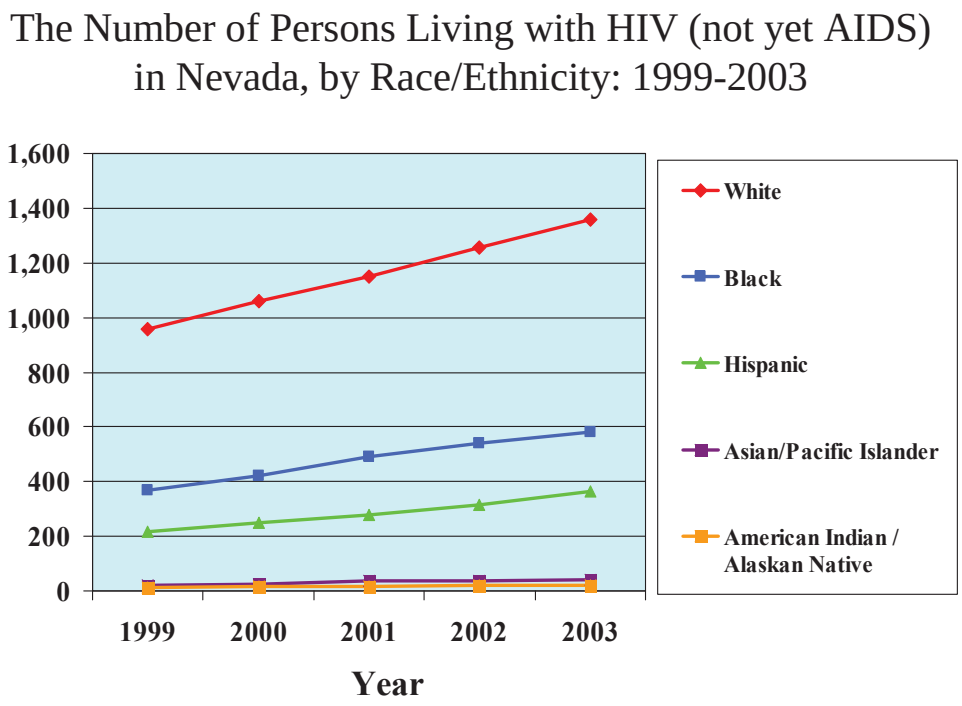
All race/ethnicity groups saw increases in the number of persons living with AIDS between 1999 and 2003. As with persons living with HIV, the largest increase in AIDS cases occurred in the White population, but the largest percentage increases occurred within the Asian/Pacific Islander and Black populations (75 percent and 68 percent).

Table 15
Number of persons living with HIV and AIDS in Nevada, by year & race/ethnicity: 1999-2003

	Living with HIV					Living with AIDS				
Race/Ethnicity	**1999**	**2000**	**2001**	**2002**	**2003**	**1999**	**2000**	**2001**	**2002**	**2003**
White	957	1,059	1,149	1,258	1,357	981	1,096	1,179	1,295	1,393
Black	370	420	491	539	583	314	361	410	461	529
Hispanic	215	248	278	316	366	258	298	338	378	424
Asian/Pacific Islander	22	25	35	37	40	24	25	30	37	42
American Indian/ Alaskan Native	13	15	18	20	22	13	15	19	20	21
Unknown/Multiple Race	3	3	4	5	7	0	0	0	0	2
Total	**1,580**	**1,770**	**1,975**	**2,175**	**2,375**	**1,590**	**1,795**	**1,976**	**2,191**	**2,411**

Source: HARS database

Figure 13


The Number of Persons Living with HIV (not yet AIDS) in Nevada, by Race/Ethnicity: 1999-2003
1,600
1,400
1,200
1,000
800
600
400
200
0
1999
2000
2001
2002
2003
Year
White
Black
Hispanic
Asian/Pacific Islander
American Indian / Alaskan Native

IV. HIV and AIDS: Age Group

Newly Diagnosed Cases

In 2003, more than two-thirds of the HIV (68 percent) and AIDS (71 percent) diagnoses were among persons age 25 to 44. HIV cases were also prevalent in two other age groups: 13 to 24 (19 percent) and 45 to 64 (13 percent) year olds. About one-quarter (23 percent) of AIDS cases were in persons between the ages of 45 and 64.

Table 16
HIV and AIDS cases in Nevada, by age group at diagnosis: 2003

	HIV Cases		AIDS Cases	
Age Group	Number	Percent	Number	Percent
<2	0	0%	0	0%
2-12	0	0%	0	0%
13-24	40	19%	12	5%
25-44	142	68%	180	71%
45-64	27	13%	59	23%
65+	0	0%	2	1%
Total	**209**	**100%**	**253**	**100%**

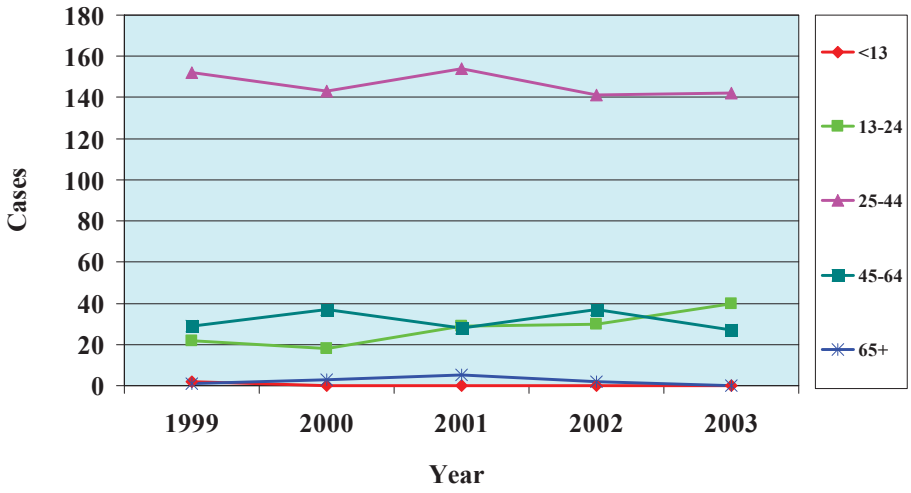
Source: HARS database

About 73 percent of total HIV cases through 2003 occurred in persons between the ages of 25 and 44 (1,684). The number of HIV cases within that age group dropped 7 percent between 1999 and 2003, from 152 to 142. Among 45 to 64 year olds, the number of HIV cases fluctuated but remained stable. However, the number of cases for people age 13 to 24 increased 82 percent, from 22 to 40, and this age group moved into the second spot in 2003, after 25 to 44 year olds. The HIV rate among 13 to 24 year olds increased 53 percent between 1999 and 2003, from 6.84 to 10.46 cases per 100,000 population.

The majority (89 percent) of cases in the 13 to 24 year old group occurred in persons between the ages of 19 and 24. Only 15 cases (11 percent) occurred in 13 to 18 year olds, and over half of those cases occurred in 18 year olds. Since the increase in the use of antiretroviral therapy during pregnancy and labor, Nevada saw fewer cases of HIV in children under the age of 13. No reports of new cases in children age 12 and younger occurred in 2003 (see Table 17 and Figure 14).

Figure 14

The Number of HIV (not yet AIDS) Cases in Nevada, by Year and Age at Diagnosis: 1999-2003



The majority (72 percent) of persons who were diagnosed with AIDS in Nevada was also between the ages of 25 and 44. Within that age group, the number of cases rose 6 percent between 1999 and 2003. The number of cases in the second largest age group, 45 to 64 year olds, fluctuated up and down by as much as 20 cases in that five-year period. The number of AIDS cases among 13 to 24 year olds remained small, but tripled between 1999 and 2003, from 4 to 12 cases. As with HIV cases though, 93 percent of AIDS cases in the 13 to 24 year old age group occurred in 19 to 24 year olds.

Table 17
Number of HIV and AIDS cases among persons in Nevada, by year and age at diagnosis: 1999-2003

	HIV Cases						AIDS Cases					
Age	1999	2000	2001	2002	2003	Total Cases	1999	2000	2001	2002	2003	Total Cases
<2	0	0	0	1	0	6	1	0	0	0	0	12
2-12	2	0	0	0	0	6	0	2	0	0	0	14
13-24	22	18	29	30	40	282	4	12	9	6	12	168
25-44	152	143	154	141	142	1,684	170	171	156	183	180	3,542
45-64	29	37	28	37	27	306	73	66	52	75	59	1,076
≥65	1	3	5	2	0	25	8	5	3	6	2	83

Source: HARS database

The average age of persons diagnosed with HIV decreased 3 percent between 1999 and 2003, from 35.33 to 34.12 years. The average age of persons diagnosed with AIDS was older, but also dropped 3 percent, from 40.33 to 39.32 years. For both groups, average age fluctuated within those five years and differences were not statistically significant.

Table 18
Average age of persons diagnosed with HIV and AIDS in Nevada: 1999-2003

HIV					AIDS				
1999	**2000**	**2001**	**2002**	**2003**	**1999**	**2000**	**2001**	**2002**	**2003**
35.33	36.96	35.13	35.66	34.12	40.33	39.45	39.12	43.90	39.32

Source: HARS database

Persons Living with HIV and AIDS

Between 1999 and 2003, the number of persons living with HIV age 25 to 44 increased by 559 persons, from 1,183 to 1,742. The largest percentage increase of persons living with HIV occurred within the 45 to 64 age group (68 percent), although the 13 to 24 year old and 65 and older groups experienced large increases as well (57 and 54 percent respectively).

The number of people living with AIDS in the <2 year old age group remained consistently low each year between 1999 and 2003. All other age groups experienced increases: cases in persons age 65 and older increased at the fastest rate (82 percent), but 45 to 64 year old cases increased 66 percent, and cases in 13 to 24 year olds increased 56 percent.

Table 19
Number of persons living with HIV and AIDS in Nevada, by year and age at diagnosis: 1999-2003

	Persons Living with HIV					Persons Living with AIDS				
Age Group	1999	2000	2001	2002	2003	1999	2000	2001	2002	2003
<2	9	9	9	10	10	3	3	3	3	3
2-12	6	6	6	6	6	6	8	8	8	8
13-24	202	222	250	277	317	64	74	82	89	100
25-44	1,183	1,318	1,467	1,604	1,742	1,216	1,356	1,489	1,640	1,799
45-64	167	200	225	258	280	290	340	379	432	481
≤65	13	15	18	20	20	11	14	15	19	20

Source: HARS database

Perinatal Infection

Since HIV surveillance began in 1992, 72 children were reported as being -infected by birth or in utero because of the HIV status of the mother. More female children were born with HIV (53 percent) than male children (47 percent).

V. HIV and AIDS: Mode of Exposure

Newly Diagnosed Cases

Overall the highest risk category for HIV in Nevada was men having sex with men (MSM), with 67 percent of cases. The largest proportion of AIDS diagnoses in 2003 was also attributed to MSM, with 71 percent of cases.

Table 20
HIV and AIDS cases in Nevada, by mode of exposure: 2003

	HIV Cases		AIDS Cases	
	Number	**Percent**	**Number**	**Percent**
Men having sex with men	140	67%	179	71%
Injection drug use (IDU)	12	6%	21	8%
MSM and IDU	13	6%	13	5%
Heterosexual contact	28	13%	21	8%
Mother with/at risk for HIV	0	0%	1	0%
Other/Unknown	16	8%	18	7%
Total	**209**	**100%**	**253**	**100%**

"Other/Unknown" risk category includes hemophilia, blood transfusion, perinatal, and risk not reported or not identified; Source: HARS database; Source: HARS database

Between 1999 and 2003, the number of HIV cases in the largest exposure group, MSM, increased 32 percent. The number of cases in most other exposure groups decreased: exposure from injection drug use (IDU) dropped 40 percent, MSM and IDU decreased 24 percent, and other/unknown exposure decreased 52 percent. The number of people exposed through heterosexual contract was unchanged – 28 cases in 1999 and in 2003.

The number of people diagnosed with AIDS who were exposed through MSM increased 18 percent over the last five years. The number of cases in the other major exposure groups all decreased between 1999 and 2003: IDU was down 38 percent, MSM/IDU was down 32 percent, heterosexual contact decreased 32 percent, and other/unknown exposure went down 5 percent.

Table 21
Number of HIV and AIDS cases in Nevada, by year of diagnosis and exposure category: 1999-2003

	HIV Cases					AIDS Cases				
	1999	**2000**	**2001**	**2002**	**2003**	**1999**	**2000**	**2001**	**2002**	**2003**
MSM	106	111	117	128	140	152	156	121	161	179
Injection drug use (IDU)	20	16	19	17	12	34	39	22	32	21
MSM and IDU	17	12	11	12	13	19	10	11	17	13
Heterosexual contact	28	22	23	32	28	31	32	33	36	21
Mother with/at risk for HIV	2	0	0	1	0	1	2	0	0	1
Other/Unknown	33	40	46	21	16	19	17	33	24	18
Total	**206**	**201**	**216**	**211**	**209**	**256**	**256**	**220**	**270**	**253**

"Other/Unknown" risk category includes hemophilia, blood transfusion, perinatal, and risk not reported or not identified; Source: HARS database

Persons Living with HIV and AIDS

Between 1999 and 2003, people living with HIV had been exposed to the disease through all of the major risk factors, and the number of people exposed through each mode of exposure increased. The largest increase was in exposure from MSM, which had both the largest numeric increase (476 cases) and the fastest rate of increase (62 percent).

For people living with AIDS, most of the increases in cases between 1999 and 2003 came from exposure through MSM (up 514 cases). By exposure type, the sharpest rises in cases came through other/unknown and heterosexual contact, which increased 104 percent and 63 percent respectively.

Table 22

Number of persons living with HIV and AIDS in Nevada, by exposure category: 1999-2003

	Living with HIV					Living with AIDS				
	1999	**2000**	**2001**	**2002**	**2003**	**1999**	**2000**	**2001**	**2002**	**2003**
MSM	764	871	982	1,104	1,240	979	1,106	1,208	1,337	1,493
Injection drug use (IDU)	187	201	220	236	247	248	277	298	323	341
MSM and IDU	103	115	126	137	149	127	134	141	155	165
Heterosexual contact	182	201	222	251	277	158	183	210	239	258
Mother with/at risk for HIV	15	15	15	16	16	9	11	11	12	13
Other/Unknown	329	367	410	431	446	69	84	108	125	141
Total	**1,580**	**1,770**	**1,975**	**2,175**	**2,375**	**1,590**	**1,795**	**1,976**	**2,191**	**2,411**

Note: "Other/Unknown" risk category includes hemophilia, blood transfusion, perinatal, and risk not reported or not identified; Source: HARS database

VI. HIV and AIDS: County Differences

Newly Diagnosed Cases

The following tables cover HIV and AIDS cases within the following Nevada counties:

- **Clark County**
- **Washoe County**
- **The Rural Counties**: Carson City, Churchill, Douglas, Elko, Esmeralda, Eureka, Humboldt, Lander, Lincoln, Lyon, Mineral, Nye, Pershing, Storey, and White Pine Counties

The tables list the number of cases within each geographic region, the case rate (when available), and the cumulative number of cases. The cumulative number represents all recorded cases between 1982 and 2003 for AIDS, and between 1992 and 2003 for HIV.

Between 1999 and 2003, the number of new HIV cases in Clark County ranged between 165 to 172 each year, representing about 80 percent of the total number of HIV cases in Nevada. The number of new HIV cases in Washoe County ranged between 26 and 37 each year, representing 13 percent to 17 percent of the state's total. Only 2 percent to 5 percent of Nevada's HIV cases were in the Rural Counties (between 4 and 10 cases per year).

The proportion of the state's new AIDS cases in Clark County increased from about 82 percent of the total in 1999 to almost 91 percent in 2003. Washoe County AIDS cases decreased from 14 percent to 7 percent of the state's total. In the Rural Counties, the percentage of AIDS cases decreased from 4 to 2 percent.

Table 23
HIV and AIDS cases in Nevada, by year of diagnosis and county: 1999-2003

	HIV					AIDS				
County	**1999**	**2000**	**2001**	**2002**	**2003**	**1999**	**2000**	**2001**	**2002**	**2003**
Clark	176	165	169	177	172	210	214	190	238	230
Washoe	26	29	37	24	30	35	32	21	28	18
Rural Counties	4	7	10	10	7	11	10	9	4	5
Nevada	**206**	**201**	**216**	**211**	**209**	**256**	**256**	**220**	**270**	**253**

Source: HARS database

By gender, Clark County reported the highest, and growing, percentage of male HIV and AIDS cases. Males comprised a larger percentage of HIV (82 percent) and AIDS (89 percent) cases in 2003 versus cumulatively (81 percent HIV and 86 percent AIDS). In contrast, the 2003 percentages for males were smaller in both Washoe and the Rural Counties than the cumulative percentages, showing an increasing female HIV and AIDS population (Table 24).

Table 24

HIV, and AIDS cases and rates (per 100,000 population) in Clark, Washoe and Rural Counties in Nevada, by gender: 2003 and cumulative Cases

	HIV, not yet AIDS			AIDS		
	No.	Rate	Cumulative	No.	Rate	Cumulative
Clark County	**172**	**10.5**	**1,859**	**230**	**14.1**	**3,903**
Male	141	17.0	1,502	205	24.7	3,365
Female	31	3.9	357	25	3.1	538
Washoe County	**30**	**8.3**	**340**	**18**	**5.0**	**728**
Male	24	13.1	283	15	8.2	684
Female	6	3.3	57	3	1.7	44
Rural Counties	**7**	**2.4**	**106**	**5**	**1.7**	**264**
Male	5	3.3	88	5	3.3	219
Female	2	1.4	18	0	0.0	45

Source: HARS database

Clark County had the most racially diverse HIV population (and the most racially diverse general population). During 2003, only 47 percent of the people diagnosed with HIV in Clark County were White, while 25 percent were Black, and 26 percent were Hispanic. In contrast, 70 percent and 57 percent of people diagnosed with HIV in Washoe and the Rural Counties were White. About 13 percent of people diagnosed with HIV in Washoe County were Black and 13 percent were Hispanic (4 cases each). In the Rural Counties though, almost a third of the people diagnosed were Hispanic.

Clark County's AIDS population was even more diverse than its HIV population: 44 percent of people diagnosed with AIDS in 2003 were White, while 32 percent were Black, and 21 percent were Hispanic. The same was true for Washoe County: Whites made up about 50 percent of AIDS cases, while Blacks represented 28 percent and Hispanics 17 percent. In the Rural Counties, four out of the five people diagnosed with AIDS were White while the fifth was Hispanic.

In both Clark and Washoe Counties, Blacks had far higher rates of the disease than people of other races/ethnicities. The rates of HIV and AIDS cases in Clark County's Black population were two-and-a-half and four times higher than the rate for Hispanics, respectively. In Washoe County, the rates of HIV and AIDS cases in the Black population were six and two-and-a-half times higher than the next highest races/ethnicities respectively (see Table 25).

Table 25
HIV, and AIDS cases and rates (per 100,000 population) in Clark, Washoe and Rural Counties in Nevada, by race/ethnicity: 2003 and cumulative cases

	HIV			AIDS		
	No.	Rate	Cumulative	No.	Rate	Cumulative
Clark County						
White	80	8.3	989	101	10.5	2,313
Black	43	29.0	521	74	49.8	932
Hispanic	44	11.1	294	48	12.1	576
Asian/Pacific Islander	3	2.7	38	5	4.4	57
American Indian or Alaskan Native	1	7.2	16	0	0.0	23
Unknown/Multiple Race	1	-	1	2	-	2
Washoe County						
White	21	8.0	238	9	3.4	580
Black	4	50.1	47	3	37.5	53
Hispanic	4	6.0	45	5	7.5	84
Asian/Pacific Islander	0	0.0	2	0	0.0	5
American Indian or Alaskan Native	0	0.0	5	1	14.6	6
Unknown/Multiple Race	1	-	3	0	-	0
Rural Counties						
White	4	0.9	71	4	0.9	207
Black	0	0.0	16	0	0.0	39
Hispanic	2	2.0	14	1	1.0	11
Asian/Pacific Islander	0	0.0	1	0	0.0	3
American Indian or Alaskan Native	1	6.2	2	0	0.0	4
Unknown/Multiple Race	0	-	2	0	-	0

Source: HARS database

During 2003, the majority of Nevadans diagnosed with HIV and AIDS were young adults between the ages of 25 and 44. In Clark and Washoe Counties, a growing number of the newly diagnosed were in the 13 to 24 year old age group, especially those diagnosed with HIV. In 2003, about 20 percent of residents diagnosed with HIV in both counties were between the ages of 13 and 24, compared to 12 percent of Clark and 13 percent of Washoe County residents cumulatively.

In the Rural Counties, 100 percent of new HIV cases and 80 percent of new AIDS cases were diagnosed in people between the ages of 25 and 44 during 2003. In contrast, cumulatively, only 69 percent of HIV and 74 percent of AIDS cases were diagnosed in persons age 25 to 44 (Table 26).

Table 26

HIV, and HIV cases and rates (per 100,000 population) in Clark, Washoe and Rural Counties in Nevada, by age at diagnosis: 2003 and cumulative cases

	HIV, not yet AIDS			AIDS		
	No.	Rate	Cumulative	No.	Rate	Cumulative
Clark County						
<2	0	0.0	5	0	0.0	11
2 to 12	0	0.0	6	0	0.0	14
13 to 24	34	12.3	223	10	3.6	129
25 to 44	115	22.9	1,360	164	32.7	2,849
45 to 64	23	6.2	243	54	14.5	838
≥65	0	0.0	22	2	1.1	62
Washoe County						
<2	0	0.0	0	0	0.0	1
2 to 12	0	0.0	0	0	0.0	0
13 to 24	6	10.8	43	2	3.6	26
25 to 44	20	18.0	247	12	10.8	497
45 to 64	4	4.3	49	4	4.3	187
≥65	0	0.0	1	0	0.0	17
Rural Counties						
<2	0	0.0	1	0	0.0	0
2 to 12	0	0.0	0	0	0.0	0
13 to 24	0	0.0	16	0	0.0	13
25 to 44	7	8.9	73	4	5.1	196
45 to 64	0	0.0	14	1	1.1	51
≥65	0	0.0	2	0	0.0	4

Source: HARS database

The statewide increase in number of men exposed to HIV and AIDS through sex with other men (MSM) was noticeable at a county level, in all counties. In Clark County, about 70 percent of HIV and 72 percent of AIDS cases resulted from MSM in 2003, compared to 55 percent of HIV and 62 percent of AIDS cases cumulatively. In Washoe County, 53 percent of HIV cases resulted from MSM in 2003, compared to 46 percent cumulatively. In the Rural Counties, 43 percent of people diagnosed with HIV and 60 percent diagnosed with AIDS had been exposed through MSM, compared to 30 percent of HIV and 41 percent of AIDS cases cumulatively.

Exposure to HIV and AIDS through heterosexual contact was on the rise in Washoe and the Rural Counties. In 2003, 13 percent of people newly diagnosed with HIV and 6 percent of those diagnosed with AIDS in Washoe County had been exposed through heterosexual contact, versus 10 percent of HIV and 4 percent of AIDS cases cumulatively. In the Rural Counties, 20 percent of people had been exposed to AIDS through heterosexual contact in 2003, versus 9 percent cumulatively. In Clark County, 2003 percentages of people exposed through heterosexual contact were similar to the cumulative (see Table 27).

Table 27
HIV, and AIDS cases and rates (per 100,000 population) in Clark, Washoe and Rural Counties in Nevada, by mode of exposure: 2003 and cumulative cases

	HIV		AIDS	
	No.	Cumulative	No.	Cumulative
Clark County				
MSM	121	1,031	166	2,431
IDU	9	185	19	652
MSM & IDU	8	106	13	316
Hemophiliac	0	1	0	4
Heterosexual Contact	23	233	19	354
Transfusion/Transplant	0	3	1	20
Other/Risk not specified	11	289	12	101
Mom w/ HIV or HIV Risk	0	11	0	23
Pediatric Transfusion	0	0	0	2
Washoe County				
MSM	16	158	10	505
IDU	2	37	2	64
MSM & IDU	4	34	0	52
Hemophiliac	0	0	0	2
Heterosexual Contact	4	35	1	31
Transfusion/Transplant	0	1	0	11
Other/Risk not specified	4	75	4	61
Mom w/ HIV or HIV Risk	0	0	1	2
Pediatric Transfusion	0	0	0	0
Rural Counties				
MSM	3	32	3	107
IDU	1	23	0	75
MSM & IDU	1	17	0	23
Hemophiliac	0	0	0	3
Heterosexual Contact	1	15	1	25
Transfusion/Transplant	0	1	0	10
Other/Risk not specified	1	17	1	21
Mom w/ HIV or HIV Risk	0	1	0	0
Pediatric Transfusion	0	0	0	0

"Other/Unknown" risk category includes hemophilia, blood transfusion, perinatal, and risk not reported or not identified; Source: HARS database

Persons Living with HIV and AIDS

During 2003, 80 percent of Nevadans living with HIV resided in Clark County, while 15 percent lived in Washoe County, and 5 percent lived in the Rural Counties. About 82 percent of persons living with AIDS lived in Clark County, 13 percent lived in Washoe County, and 5 percent lived in one of the Rural Counties.

The sharpest increase in numbers of people living with HIV/AIDS occurred in Clark County: 52 percent and 58 percent increases for those living with HIV and AIDS respectively. The number of people living with HIV in Washoe County increased 46 percent and the number living with AIDS rose 33 percent. The Rural Counties saw a 42

percent increase in persons living with HIV and a 19 percent increase in those living with AIDS.

Table 28
Persons living with HIV and AIDS in Nevada, by county: 1999-2003

	Living with HIV					Living with AIDS				
County	1999	2000	2001	2002	2003	1999	2000	2001	2002	2003
Clark	1,252	1,407	1,568	1,735	1,900	1,249	1,421	1,577	1,770	1,972
Washoe	247	275	309	332	360	232	257	274	293	309
Rural	81	88	98	108	115	109	117	125	128	130
Nevada	**1,580**	**1,770**	**1,975**	**2,175**	**2,375**	**1,590**	**1,795**	**1,976**	**2,191**	**2,411**

Source: HARS database

VII. HIV and AIDS: Deaths in Nevada

HIV disease was the seventh leading cause of death among persons 25 to 44 years old in Nevada, and was the primary cause of death for 41 people, or 3.4 percent of all deaths in the age group, during 2003.

Table 29

Top ten leading causes of death among 25-44 year olds in Nevada: 2003

Cause of Death	Number	% of Total	Rate per 100,000
1. Diseases of the heart	195	16.3%	26.8
2. Nontransport accidents	170	14.2%	15.9
3. Intentional self-harm (suicide)	137	11.5%	11.2
4. Transport accidents	122	10.2%	
5. Malignant neoplasms (cancer)	121	10.1%	9.1
6. Assault (homicide)	83	6.9%	7.6
7. HIV disease	**41**	**3.4%**	**3.3**
8. Symptoms, signs, not elsewhere classified	37	3.1%	2.6
9. Septicemia	31	2.6%	2.5
9. Chronic liver disease and cirrhosis	31	2.6%	2.3
10. Cerebrovascular diseases (stroke)	27	2.3%	1.5
Total number of deaths in 2003	**1,196**	**100.0%**	**82.8**

Source: Nevada Interactive Health Database System, Mortality Module, 1990-2003

Overall, HIV disease was the primary cause of death for 76 people in all age groups during 2003. By gender, males accounted for 87 percent of HIV disease deaths, and the rate of death from HIV disease (5.68 per 100,000) for males was 16 times higher than that of females. By race/ethnicity, Blacks accounted for 20 percent of deaths, and the death rate for Blacks from HIV disease (10.13/100,000) was more than three times that of Whites. By age group, over half (54 percent) of all deaths from HIV disease were in 25 to 44 year olds, and almost 40 percent were among people between the ages of 45 and 64. By county of residence, almost nine-out-of-ten deaths from HIV disease (86 percent) occurred for persons living in Clark County (Table 30).

Table 30
Deaths due to HIV infection and AIDS in Nevada: 2003

	Number	Percent of total	Death rate per 100,000
Sex			
Male	66	87%	5.68
Female	10	13%	0.90
Race/ethnicity			
White	43	57%	2.86
Black	15	20%	10.13
Hispanic	16	21%	4.19
Asian/Pacific Islander	0	0%	-
American Indian/Alaska Native	2	3%	a
Age Group			
<2	0	0%	-
2-12	0	0%	-
13-24	0	0%	-
25-44	41	54%	1.86
45-64	30	39%	1.27
65+	5	7%	0.22
County of residence			
Clark	65	86%	4.07
Washoe	7	9%	1.83
Rural Counties	4	5%	a
Total	**76**	**100%**	**3.34**

"a" = not applicable, due to small sample size; Source: HARS database

By race/ethnicity and gender, the highest death rates were for Black males (18/100,000) and Black females (10/100,000).

Table 31
Numbers and rates (per 100,000 population) of deaths among persons with AIDS in Nevada, by gender and race/ethnicity: 2003

	Males			Females			Total		
Race/Ethnicity	**No.**	**%**	**Rate**	**No.**	**%**	**Rate**	**No.**	**%**	**Rate**
White	45	58%	6.1	7	44%	1.0	52	56%	3.6
Black	14	18%	17.5	8	50%	10.1	22	24%	13.8
Hispanic	17	22%	6.4	1	6%	0.4	18	19%	3.6
Asian/Pacific Islander	0	0%	0.0	0	0%	0.0	0	0%	0.0
American Indian/Alaskan Native	1	1%	6.6	0	0%	0.0	1	1%	3.2
Unknown/Multiple Race	0	0%	-	0	0%	-	0	0%	-
Total	**77**	**100%**	**6.6**	**16**	**100%**	**1.4**	**93**	**100%**	**4.1**

Source: HARS database

About 89 percent of cumulative AIDS deaths in Nevada were among males and 11 percent were among females. Between 1999 and 2003, an increasing number of females, from 15 percent to 17 percent, died from AIDS. Throughout the five-year period, the numbers of deaths among males and females decreased 22 percent, although the last two years saw increasing numbers (Table 32).

Table 32
Number of deaths among persons with AIDS in Nevada, by year of death and gender: 1999-2003

	1999	2000	2001	2002	2003	Cumulative deaths through 2003
Males	101	78	60	73	77	2,182
Females	18	16	11	14	16	268
Total	**119**	**94**	**71**	**87**	**93**	**2,450**

Source: HARS database

VIII. AIDS Comorbidities: Tuberculosis

In 2003, 27 people, or 11 percent of the AIDS population, had a comorbidity of tuberculosis. By gender, 25 males and 2 females who had AIDS were also diagnosed as a confirmed case of tuberculosis.

Table 33
AIDS cases among persons in Nevada, by gender and tuberculosis comorbidity: 2003

	Males		Females		Total	
TB Diagnosis	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**
Not Diagnosed	61	70%	11	85%	72	72%
Confirmed case	25	29%	2	15%	27	27%
Presumptive case	1	1%	0	0%	1	1%
Total	**87**	**100%**	**13**	**100%**	**100**	**100%**

Source: HARS database

Question 3

- **What are other indicators of risk for HIV infection and AIDS in Nevada's population?**

Substance Abuse

The 2001 National Household Survey on Drug Abuse (NHSDA) found that about 17 percent of young adults (ages 18 to 25), 9 percent of adolescents age 12 to 17, and 5 percent of adults (age 26+) in Nevada were estimated as having substance abuse or dependence problems. In addition, NHSDA found that 7.3 percent of Nevada residents age 12 and older had used illicit drugs in the past 30 days, translating to about 113,000 individuals. According to Morgan Quitno Press's "Health Care State Rankings 2004," Nevada had the nation's fifth highest binge drinking rate in 2003.

Injection drug use (IDU) leads to an increased risk of contracting HIV because of the practice of sharing contaminated needles. Between 1999 and 2003, the number of people exposed to HIV/AIDS through IDU dropped 39 percent and, the percent of people exposed to HIV/AIDS through IDU dropped from 14 to 7 percent. Yet exposure through IDU remains one of the primary risk factors for HIV and AIDS in Nevada.

IDU as a risk indicator is tracked through data collected by the Nevada State Health Division's Bureau of Alcohol and Drug Abuse (BADA). BADA's goal is to reduce the amount of substance abuse in Nevada. Substance abuse is defined as excessive use of a mood-altering substance, such as alcohol (beer, wine and/or hard alcohol) and/or various drugs, including crack cocaine, heroin/ morphine, marijuana/hashish, methamphetamine, other amphetamines and other non-specified drugs. BADA works to achieve its goal through prevention, early intervention and treatment programs. In the last year, BADA funded 27 agencies to provide substance abuse treatment services at 51 sites throughout Nevada.

The following substance abuse data were collected at those sites. These data were pulled primarily from state fiscal year 2004 (SFY 04), which contains total admissions from July 1, 2003 to June 30, 2004. The statistics were drawn from the 11,942 admissions for SFY 2004. Of those, 4,778 were alcohol-related, 3,493 were for methamphetamines, 1,515 were for marijuana, 739 were for crack/cocaine, 667 were for heroin/morphine, 382 were for other types of cocaine, and 368 were for other non-specified drugs.

In SFY 2004, 10,503 non-injection drug users and 1,439 injection drug users were admitted for treatment. The following characteristics were observed about the injection drug users in the state:

- Methamphetamines (53 percent) and heroin/morphine (41 percent) were the drugs of choice for injection drug users. In contrast, among general substance abuse patients, alcohol was the largest presenting problem; 40 percent of admissions

involved alcohol, while 27 percent involved methamphetamines, 13 percent marijuana/hashish, 6 percent crack/cocaine, and 6 percent other non-specified substances.

- Males had a higher prevalence of injection drug abuse (59 percent of IDU admissions) while more females were admitted more often for treatment of overall abuse (64 percent of total).

Table 34
Substance abuse admissions in Nevada during SFY 2004: total admissions versus admissions for injection drug use (IDU), by gender

	Percent of Admissions	
Gender	**Total Admissions**	**Admissions for IDU**
Males	36%	59%
Females	64%	41%

- Injection drug users were slightly older than non-injection drug users. The average age of people admitted for treatment of injection drug use was 35 compared to the average age of 33 for all people admitted for treatment.
- The White population was admitted most frequently for treatment of injection drug use (81 percent of total). The next largest admission groups for IDU were the Hispanic (9 percent) and the Black (5 percent) populations.

Table 35
Substance abuse admissions in Nevada during SFY 2004: total admissions versus admissions for injection drug use (IDU), by race/ethnicity

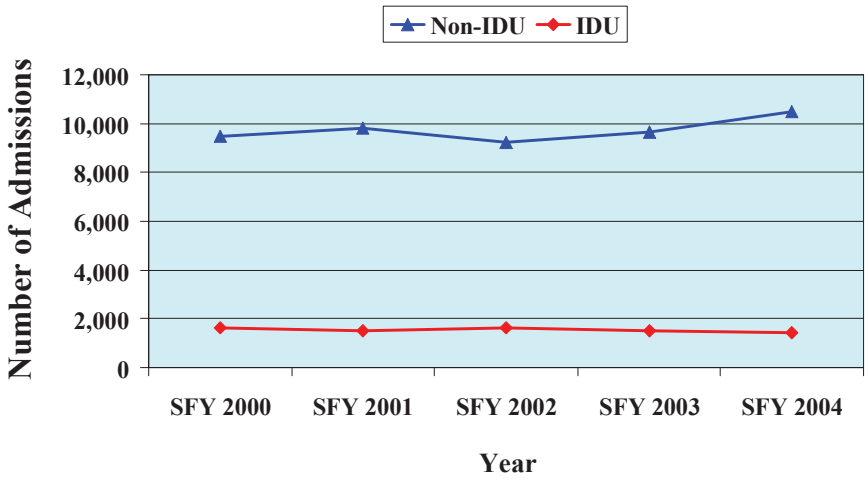
	Percent of Admissions	
Race/Ethnicity	**Total Admissions**	**Admissions for IDU**
White	68%	81%
Black	11%	5%
Hispanic	13%	9%
Asian/Pacific Islander	1%	1%
American Indian/ Alaskan Native	5%	4%
Other	2%	1%

- Most of the injection drug users were not working. Half (50 percent) of the injection drug users were unemployed, 30 percent were not in the labor force, 16 percent were working full-time and 4 percent were working part-time. In contrast, among total admissions, 43 percent were unemployed, 31 percent were not in the labor force, 21 percent worked full-time, and 5 percent worked part-time.
- In the five-year SFY period, SFY 2000-2004, 14 percent (7,711) of the 56,400 people admitted for substance abuse treatment were admitted for injection drug use (IDU) and 86 percent (48,689) were admitted for non-IDU. The admissions for treatment among injection drug users decreased 12 percent in the past two years while admissions among non-injection drug users rose 14 percent. Between

SFY 2000 and 2004, IDU admissions dropped from 15 percent to 12 percent of total admissions.

Figure 15

Trends in patients admitted for substance abuse treatment in Nevada: state fiscal year (SFY) 2000-2004



Sexually Transmitted Diseases

Individuals who have been infected with a sexually transmitted disease (STD) are at least "two to five times more likely than uninfected individuals to acquire HIV if they are exposed to the virus through sexual contact." In addition, if an individual who is HIV positive is also infected with another STD, there is a higher probability that the person can transmit HIV through sexual contact than other HIV-infected persons.[3] Because various STDs can cause lesions or skin sores, an increased susceptibility to contracting other STDs and HIV via these damaged areas exists.

According to Morgan Quitno Press, Nevada ranked 26th in the nation for its sexually transmitted disease rate. Table 36 presents information on the three most common reportable STDs in Nevada: Chlamydia, Gonorrhea and Syphilis, which require mandatory reporting to the Nevada State Health Division by all health departments, physicians, and laboratories.

Chlamydia: In 2003, a higher percentage of females (73 percent) had Chlamydia compared with males (26 percent). This gender difference may be an artifact of clinical practice. Often male partners of female Chlamydia cases are epidemiologically treated without a definitive diagnosis. Due to various intake methods, race/ethnicity data were frequently unknown. For Chlamydia, the largest proportion of cases with known race/ethnicity were White. Whites had the highest incidence of Chlamydia (39 percent of total), compared to Hispanics (30 percent), Blacks (25 percent), Asian/Pacific Islanders (5 percent), and American Indian/Alaskan Natives (2 percent). The age group most affected by Chlamydia was 13 to 24 year olds (71 percent), and the next largest was 25 to 44 year olds (26 percent).

Gonorrhea: In 2003, males and females contracted Gonorrhea in similar proportions (52 percent vs. 48 percent respectively). Of those patients with known race/ethnicity, the largest affected group was the Black population (47 percent). White patients comprised 33 percent of cases while Hispanic populations had 17 percent.

Syphilis (Primary & Secondary): By gender, males (75 percent) were more likely to be reported with Syphilis than females (25 percent). Of those with known race/ethnicity, 70 percent of cases were among White persons compared to Black (10 percent), Hispanic (10 percent), and American Indian/Alaska Native (10 percent) persons. Unlike Chlamydia and Gonorrhea, the age group that was most affected was 25 to 44 year olds. The remaining age groups were split among 13 to 24 (17 percent) and 45 to 64 (17 percent) year olds.

[3] Fleming DT, Wasserheit JN. 1999. From epidemiological synergy to public health policy and practice: The contribution of other sexually transmitted diseases to sexual transmission of HIV infection. Sexually Transmitted Infections 75:3-17

Table 36

Number of STD cases in Nevada by gender, race/ethnicity, and age group: 2003

	Chlamydia	Gonorrhea	Syphilis (Primary & Secondary)
Gender			
Males	1,535	1,149	9
Females	4,262	1,058	3
Unknown	1	1	0
Race/Ethnicity			
White	1,361	482	7
Black	861	686	1
Hispanic	1,056	251	1
Asian/Pacific Islander	163	22	0
American Indian/Alaskan Native	79	11	1
Unknown/Other	2,278	756	2
Age (yrs.)			
<2	9	2	0
2-12	7	4	0
13-24	4,144	1,119	2
25-44	1,510	943	8
45-64	67	130	2
≥ 65	9	4	0
Unknown	52	6	0
Total	**5,798**	**2,208**	**12**

Data Source: Nevada State Health Division, Communicable Disease Program, STD*MIS database

Incarceration

In 2002, Nevada's incarceration rate was 499 per 100,000 people, compared to the national rate of 686 per 100,000. Nevada had eight public prisons and one privately operated prison. These prisons held 10,426 inmates, of which 839 were female. A disproportionate number of those prisoners were Black (27 percent).[4]

The rates of HIV infection are 5 to 10 times higher inside correctional institutions than in general society. The most recent data available on incarcerated populations with HIV are available from the Bureau of Justice Statistics. This information was based on a report written on HIV in prisons using 2001 data. For the purposes of this profile, comparisons will be conducted on incarcerated populations living with HIV/AIDS in Nevada and the United States.

The national rate of incarcerated inmates living with HIV slowly decreased over a three-year period, from 210 to 190 infected per 10,000 persons. In comparison, the rate of inmates living with HIV in Nevada was lower, fluctuating between 140 and 160 infected per 10,000 (Table 37).

[4] Bureau of Justice Statistics, Prison & Jail Inmates at Midyear 2002; The Prison Index: Taking the Pulse of the Crime Control Industry

Table 37
Number of incarcerated inmates living with HIV and rate per 10,000 population: United States versus Nevada, 1999-2001

	1999		2000		2001	
	No.	Rate	No.	Rate	No.	Rate
United States	25,807	210	25,333	200	24,147	190
Nevada	125	140	151	160	127	140

Note: These rates pertain to the incarcerated population within the category. For example, 210 persons out of 10,000 persons in the prison population are HIV positive nationally.
Source: Bureau of Justice Statistics, HIV in Prisons, 2001

In both 2001 and 2002, the national rate of incarcerated inmates living with AIDS was 50 per 10,000 persons. In Nevada, the rate was lower, 30 per 10,000 persons.

Table 38
Number of incarcerated inmates living with AIDS and rate per 10,000 population: United States versus Nevada, 1999-2001

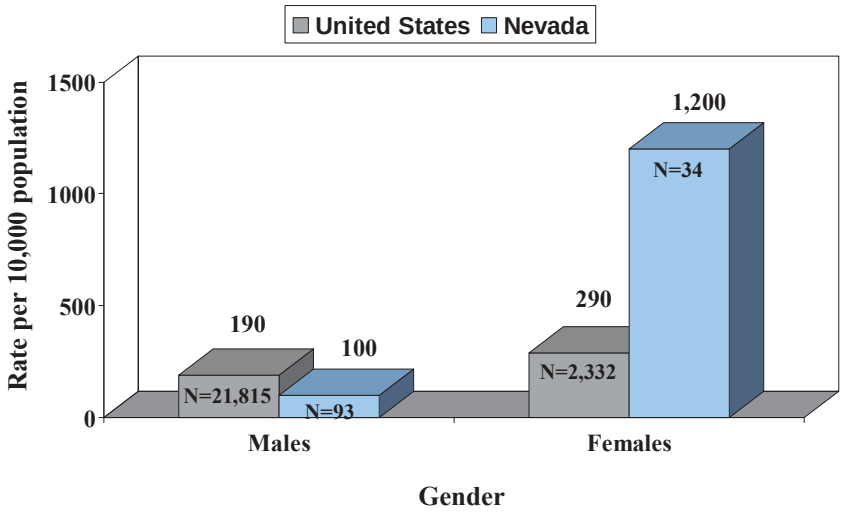
	2000		2001	
	No.	Rate	No.	Rate
United States	5,696	50	256	50
Nevada	28	30	24	30

Source: Bureau of Justice Statistics, HIV in Prisons, 2001

By gender, a disproportionate number of incarcerated females were infected with HIV, both nationally and in Nevada. The rate of incarcerated female inmates living with HIV in Nevada was four times the national rate: 1,200 per 10,000 persons in Nevada versus 290 per 10,000 in the United States (Figure 16).

Figure 16

Incarcerated Inmates Living with HIV in the United States and Nevada, Rate per 10,000 by Gender: 2001



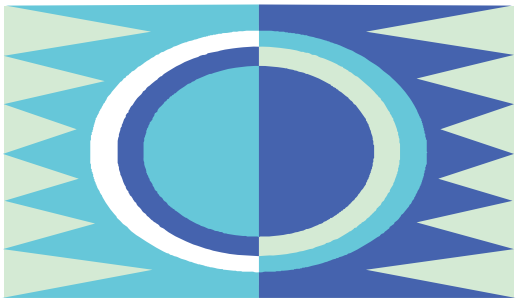
The national death rate recorded for inmates who died from AIDS-related illnesses rose from 15 to 20 per 100,000 persons between 2000 and 2001. In Nevada, no deaths were recorded for 2000 and one was recorded in 2001 (10 per 100,000 persons).

Table 39

Number of AIDS-related deaths among incarcerated inmates living with AIDS and rate per 100,000 population, United States versus Nevada: 2001-2002

	2000		2001	
	No.	**Rate**	**No.**	**Rate**
United States	185	15	256	20
Nevada	0	0	1	10

Note: Due to the small numbers, the populations were figured by rate per 100,000 populations.
Source: Bureau of Justice Statistics, HIV in Prisons, 2001



Section 2

Ryan White HIV/AIDS Care Act Questions and Considerations

Question 1: What are the patterns of utilization of HIV services by persons in Nevada?

Question 2: What are the number and characteristics of persons who know they are HIV-positive, but who are not receiving HIV primary medical care?

Question 1

- **What are the patterns of utilization of HIV services by persons in Nevada?**

HIV Counseling, Testing and Referral Services (CTR)

The purpose of the HIV Counseling, Testing and Referral Services (CTR) is to provide an opportunity for high-risk individuals to receive counseling regarding HIV and how to prevent its transmission as well as testing and referral for other services as needed. The data collected in the process include demographics, exposure risk, and health insurance information. Nevada has 54 HIV CTR sites located throughout the state, of which 34 are in Clark County, three are in Washoe County, and 17 are in the Rural Counties.

The gender distribution of people who were tested at a Nevada CTR site was 54 percent male and 46 percent female. Of the general population who were tested, less than 1 percent tested positive for HIV. A disproportionate number of positive tests were male compared to female (79 percent versus 21 percent respectively).

The race/ethnicity of the general population who were tested at Nevada CTR sites was predominately White (53 percent). About 22 percent of the population was Black, 20 percent was Hispanic, 3 percent was Asian, 1 percent was American Indian, and 1 percent was Other or Unknown. Of those who tested positive, 45 percent were White (45 percent), 30 percent Black, and 21 percent Hispanic.

By age distribution, the majority of the CTR site-tested population was in the combined age groups of 20 to 29 and 30 to 39 (63 percent). The 13 to 19 (15 percent) and 40 to 49 year old age groups (15 percent) made up 30 percent of the tested population. Less than 7 percent were in the combined age groups of Less than 5, 5 to 12, 50 and Older, and Unknown. The highest number of people to test positive for HIV was in the 30 to 39 year old age group (40 percent), compared to the 20 to 29 (26 percent), 40 to 49 (24 percent), 50 and over (8 percent) and 13 to 19 (3 percent) year old age groups. The remaining age groups of Less than 5, 5 to 12, and Unknown combined comprised less than 1 percent of the total.

While only 8 percent of the total number of tests were among men who had sex with men (MSM), almost half (47 percent) of the positive tests were in this exposure category. About 14 percent of the positive tests were among those who had a sexual partner at risk, 10 percent were among heterosexual IDUs, and almost 10 percent were for heterosexuals (Table 40).

Overall, these data suggest a need to improve outreach to the MSM and minority populations within Nevada. Doing so would decrease the cost per case identified through the CTR services.

Table 40
Counseling, Testing & Referral Services data for Nevada, by gender, race/ethnicity, age group, and exposure category: 1999-2003

	Total Tests		Positive Tests	
	Number	**Percent**	**Number**	**Percent**
Gender				
Male	71,179	54.2	981	78.9
Female	60,081	45.8	263	21.1
Unknown	2	0.0	0	0.0
Race/Ethnicity				
White	69,451	52.9	554	44.5
Black	29,000	22.1	370	29.7
Hispanic	25,803	19.7	261	21.0
Asian/Pacific Islander	4,408	3.4	28	2.3
American Indian/Alaskan Native	1,335	1.0	13	1.0
Other	1,137	0.9	17	1.4
Unknown/Undetermined	128	0.1	1	0.1
Age Group				
<5	37	0.0	0	0.0
5 to 12	220	0.2	3	0.2
13 to 19	20,164	15.4	35	2.8
20 to 29	49,108	37.4	323	26.0
30 to 39	33,367	25.4	491	39.5
40 to 49	19,900	15.2	298	24.0
≥ 50	8,128	6.2	93	7.5
Unknown	338	0.3	1	0.1
Exposure Category				
MSM & IDU	883	0.7	54	4.3
MSM	9,848	7.5	586	47.1
Heterosexual IDU	12,213	9.3	128	10.3
Sex Partner at Risk	18,392	14.0	178	14.3
Child of HIV+ Woman	51	0.0	3	0.2
STD Diagnosis	11,623	8.9	52	4.2
Sex for Drugs/Money	7,266	5.5	10	0.8
Sex while using drugs	16,940	12.9	40	3.2
Hemophilia/Transfusion/Transplant	791	0.6	6	0.5
Victim Sexual Assault	1,717	1.3	3	0.2
Health Care Exposure	1,021	0.8	4	0.3
No acknowledged risk	17,574	13.4	53	4.3
Heterosexual, no other risk	31,398	23.9	118	9.5
Other	940	0.7	3	0.2
Not Specified	605	0.5	6	0.5
Total	**131,262**	**100.0**	**1,244**	**100.0**

Source: Clark County Health District

The Ryan White CARE Act

Congress enacted the Ryan White CARE Act, a federal law, in 1990. In 1996 and 2000, Congress amended and reauthorized the Act and imposed new requirements on this law, which supported the division of four Titles. Currently the CARE Act provides federal funding to states, territories, and Eligible Metropolitan Areas (EMAs). These funds are used to develop systems of care, as well as to cover medical and social support services for persons living with HIV disease who lack health insurance and financial resources. The following CARE Act titles are explained below as they apply to Nevada:

Title I – Local Areas. Title I provides emergency relief assistance to 51 EMAs that are affected by the HIV/AIDS epidemic. These EMAs must have a population of at least 500,000 people, and have had more than 2,000 cumulative AIDS cases within a five year period. In Nevada, only the Las Vegas area, which includes Clark County, part of Nye County, and Mohave County in Arizona, qualifies as an EMA.

Title II – States. Title II offers funding to states to improve access to primary care, as well as to support services that enhance access to and retention in primary care. Nevada has two primary facilities that receive Title II funding for AIDS Drug Assistance Programs (ADAP):

- The Northern Nevada HIV Outpatient Program, Education and Services (NNHOPES): Located in Reno, NNHOPES is a non-profit clinic that provides outpatient medical care, support services, education and other various programs for individuals living with HIV/AIDS in northern Nevada.
- The University Medical Center/ HIV Wellness Center (UMC): UMC in Las Vegas provides primary care and home health services to individuals with HIV/AIDS and their families in southern Nevada.

Other areas for which Title II funding are used:

1. Support services through regional HIV care consortia and/or local health departments. NNHOPES' consortium services, and Clark County Health District's social work and nursing case management receive this funding. In addition, a special subgrant funds minority outreach services through AIDS Community Cultural Education Program and Training (ACCEPT) in northern Nevada, and Clark County Health District in southern Nevada.
2. Services provided directly by the state, and directly contracted services. Nevada receives CARE funding for people with both mental health problems and HIV/AIDS.
3. Health insurance coverage, such as the Health Insurance Continuation Program (HICP). NNHOPES receives this funding as it provides coverage for persons living at 200 percent or less of the poverty level. This program also helps patients to extend existing insurance (through COBRA) and to purchase private insurance.
4. Housing Opportunities for Persons with AIDS (HOPWA) funding. In Nevada, both NNHOPES and Aid for AIDS in Nevada (AFAN) receive HOPWA funding.

Although HOPWA funds come from the Department of Housing and Urban Development (HUD), it provides related HIV/AIDS services.

Title III – Community-Based Programs. Title III provides funding to primary care service providers who offer outpatient HIV early intervention services (EIS), primary care to people with low income, and care to the medically underserved. In addition, Title III provides HIV planning and capacity building funds that are given to public and private non-profit organizations. This funding assists non-profits to plan a comprehensive continuum of outpatient HIV early intervention/ primary care services for their communities, and to enhance or develop HIV capacity for primary care services. In Nevada, both NNHOPES and UMC Wellness Center receive Title III funding.

Title IV – Children, Youth, and Women with HIV Disease and Their Families. Title IV provides funding to increase access to health care and clinical research for HIV infected and affected children, youth, women, and their families. In Nevada, only NNHOPES receives Title IV funding.

Primary Medical Care

In 2003, Nevada providers granted services to a total of 1,675 people who were living with HIV/AIDS. By gender, males obtained services almost four times more than females did (1,332 vs. 341 respectively). Of those who sought services, 550 individuals were assisted in northern Nevada (33 percent), and 1,125 were seen in southern Nevada (67 percent).

By race/ethnicity, the majority of patients were White (55 percent), compared to Black (24 percent), Hispanic (14 percent), Asian/Pacific Islander (3 percent), American Indian/Alaska Native (1 percent) and Unknown/Multiple Race (3 percent).

Among the 1,675 individuals who were provided services, the largest age group was 25 to 44 year olds (62 percent). The second largest age group was 45 to 64 year olds (33 percent) and the remaining combined age groups of Less than 2, 2 to 12, 13 to 24, and 65 and Over made up 6 percent of the population.

Almost half of the individuals living with HIV who sought services in Nevada were exposed to HIV through male-to-male sex (47 percent). The next largest exposure factors were unknown or unreported (16 percent), heterosexual contact (16 percent), and injection drug use (14 percent) (Table 41).

Table 41

HIV primary medical care, by gender, race/ethnicity, age group, and exposure category: 2003*

	Total CARE	
	Number	**Percent**
Gender		
Male	1,332	80%
Female	341	20%
Transgender	2	0%
Unknown	0	0%
Race/Ethnicity		
White	926	55%
Black	399	24%
Hispanic	236	14%
Asian/Pacific Islander	47	3%
American Indian/Alaskan Native	24	1%
Unknown/Multiple Race	43	3%
Age Group		
< 2	4	0%
2-12	12	1%
13-24	46	3%
25-44	1,040	62%
45-64	554	33%
≥ 65	19	1%
Exposure Category		
Men having sex with men (MSM)	781	47%
Injection drug use (IDU)	227	14%
MSM and IDU	107	6%
Hemophilia/coagulation disorder	1	0%
Heterosexual contact	263	16%
Receipt of transfusion of blood, blood components, or tissue	5	0%
Mother with/at risk for HIV	6	0%
Other/Unknown	285	17%
Total	**1,675**	**100%**

* Patients reported are patients who are HIV positive only; Source: CARE Act Data Reporting (CADR)

Among those people who received services for HIV treatment, 32 percent also had TB skin tests performed. Overall, 2 percent of the total TB tests came back positive, and treatment was started. In addition to TB testing, Hepatitis C testing was also made available. Twelve percent of the overall clients were screened for Hepatitis C, and 5 percent of those came back positive.

Table 42

HIV primary medical care by Tuberculosis (TB) and Hepatitis C status: 2003	
TB skin test (PPD Mantoux)	534
Treatment due to Positive TB skin test	13
Screening/Testing for Hepatitis C	200
Treatment for Hepatitis C	10

Comparison of CARE Act Clients to Total Persons Living with HIV/AIDS

In 2003, 63 percent (3,003) of the reported people living with HIV/AIDS in Nevada were receiving services from CARE Act providers. By gender, 59 percent of men and 79 percent of women living with HIV/AIDS received CARE Act services. Compared to the total number of persons living with HIV/AIDS in 2003, American Indian/Alaskan Natives, Asian/Pacific Islanders, and Blacks were most likely to receive care: respectively, about 81, 78, and 74 percent of the total became clients. In contrast, only 50 percent of Hispanics and 56 percent of Whites with HIV/AIDS became CARE Act clients.

Table 43

Comparison of persons with HIV/AIDS in Nevada and Persons receiving services through CARE Act Providers

	Persons living with HIV/AIDS in 2003		CARE Act Provider Clients	
	Number	% of Total	Number	% of Total
Gender				
Male	3,995	83.4%	2,373	79.0%
Female	791	16.5%	624	20.8%
Transgender	0	0.0%	6	0.2%
Unknown	0	0.0%	0	0.0%
Race/Ethnicity				
White	2,750	57.4%	1,574	52.4%
Black	1,112	23.2%	818	27.2%
Hispanic	790	16.5%	398	13.3%
Asian/Pacific Islander	82	1.7%	64	2.1%
American Indian or Alaska Native	43	0.9%	35	1.2%
Unknown/Multiple Race	9	0.2%	114	3.8%
Age Group				
< 2	13	0.3%	5	0.2%
2-12	14	0.3%	18	0.6%
13-24	417	8.7%	120	4.0%
25-44	3,541	74.0%	1,934	64.4%
45-64	761	15.9%	900	30.0%
≥ 65	40	0.8%	26	0.9%
Total	**4,786**	**100.0%**	**3,003***	**100.0%**

Sources: HARS database and CADR

* = The number of patients in care exceeds the total recorded number of people in Nevada living with HIV/AIDS for several categories. This discrepancy reflects those individuals diagnosed out of state, and as such were not included in the HARS database, yet received care in Nevada.

Support Services

The Clark County Health District (CCHD), located in southern Nevada provides support services such as community prevention, counseling, outreach and educational programs for people living with HIV in southern Nevada. CCHD also provides services for those who are affected by another person living with HIV such as family members, children and close friends. In the Care Act Data Report (CADR), the Clark County Health District had the only available information in Nevada regarding HIV support services.

In 2003, 1,328 people who were HIV positive and 146 affected persons received support services from the Clark County Health District. Among those served, 76 percent were male and 23 percent were female. More than half of those individuals were White (51 percent), 32 percent were Black, 13 percent were Hispanic, 1 percent were Asian/Pacific Islander, 1 percent were American Indian/Alaska Native, 2 percent were of Multiple Race, and 3 percent were of Unknown Race. The majority of support services were accessed by those in the 25 to 44 year old age group (68 percent), compared to other age groups such as 45 to 64 (25 percent), 13 to 24 (6 percent), 65 and over (1 percent) and under 12 (1 percent).

Table 44

HIV support services provided by CCHD, by gender, race/ethnicity, and age group: 2003

	HIV Positive	HIV Affected
Gender		
Male	1,041	83
Female	283	63
Transgender	4	0
Unknown	0	0
Race/Ethnicity		
White	648	61
Black	419	57
Hispanic	162	27
Asian/Pacific Islander	17	0
American Indian or Alaska Native	11	0
Multiple Race	26	1
Unknown	45	0
Age Group		
< 2	1	0
2-12	6	0
13-24	74	13
25-44	894	113
45-64	346	19
≥ 65	7	1
Unknown	0	0
Total	**1,328**	**146**

Source: CADR

AIDS Drug Assistance Program (ADAP)

ADAP, the state administered program that is authorized under Title II of the Care Act, provides FDA-approved medication to individuals living with HIV who have low income, are underinsured, or are uninsured. Both UMC Wellness Center in Las Vegas and Northern Nevada HOPES in Reno provide ADAP coverage.

Nationally, about 30 percent of people living with HIV/AIDS who are receiving care are enrolled in ADAP. In Nevada, about 27 percent of those receiving CARE services are enrolled in ADAP.

In Nevada, 82 percent of ADAP enrollees were male, and 18 percent were female, transgender or unknown. Of the 813 ADAP enrollees, the largest racial/ethnic group was White (55 percent), followed by the Hispanic (22 percent), Black (20 percent), Asian/Pacific Islander (2 percent), American Indian/Alaska Native (1 percent) and Unknown/Multiple Race (1 percent) racial/ethnic groups. The highest percentage of individuals receiving ADAP was in the 25 to 44 year old age group (62 percent). The second highest percentage was among 45 to 64 year olds (33 percent). All other combined age groups totaled 5 percent of total ADAP enrollees.

Table 45

Nevada ADAP active enrollees, by gender, race/ethnicity, and age group: 2003

	Number	Percent of Total
Gender		
Male	666	82%
Female	144	18%
Transgender	3	<1%
Unknown	0	0%
Race/Ethnicity		
White	442	54%
Black	166	20%
Hispanic	175	22%
Asian/Pacific Islander	17	2%
American Indian or Alaska Native	5	1%
Unknown/Multiple Race	8	1%
Age Group		
<2	1	<1%
2-12	6	1%
13-24	20	3%
25-44	501	62%
45-64	270	33
>=65	15	2%
Total	**813**	**100%**

Source: Nevada State Health Division ADAP database

Hospital Discharge Data

Between 1999 and 2003, the number of hospital discharges in Nevada among people living with HIV or AIDS ranged from 557 in 2001 to 717 in 2003. To the extent that these numbers may represent an unduplicated count, it would suggest that the hospitalizations represented between 14 percent and 15 percent of the people living with HIV/AIDS in the state. Of those who were hospitalized, about 80 percent were male and 20 percent were female. Around 60 percent of patients were between the ages of 25 and 44 while about one-third fell between the ages of 45 and 64. The majority (about 70 percent) of patients was single, and around one in ten were married.

The total number of hospital days for HIV/AIDS patients ranged between 5,414 in 2001 and 6,981 in 2003. The average length of stay was between 9.50 and 10.89 days, and the median length of stay ranged between 5.0 and 7.0 days.

Table 46
Demographic characteristics of HIV/AIDS hospitalizations in Nevada, 1999-2003

	1999	2000	2001	2002	2003
Gender					
Male	550	502	440	491	582
Female	135	125	117	128	135
Age					
<13	16	9	5	3	0
13-24	9	6	6	9	17
25-44	428	368	344	392	454
45-64	212	218	183	208	234
65+	20	26	19	7	12
Marital Status					
Single	514	427	409	449	556
Married	87	76	47	88	75
Legally Separated	5	4	10	6	2
Divorced	53	82	64	51	15
Widowed	12	23	9	17	38
Unknown	14	15	18	7	20
Life Partner	0	0	0	1	11
Length of Stay					
Mean	9.50	9.73	9.72	10.89	9.74
Median	5.5	6.0	5.0	6.0	7.0
Total Days	6,509	6,101	5,414	6,743	6,981
Total	**685**	**627**	**557**	**619**	**717**

Source: University of Nevada, Las Vegas, Center for Health Information Analysis (CHIA)

About 93 percent of HIV/AIDS hospitalizations in Nevada between 1999 and 2003 were among residents of Nevada and about 7 percent among residents of one of 28 other states.

About half of those out-of-state patients lived in the neighboring states of California and Arizona, and about half lived elsewhere, from all regions of the United States.

The majority of patients who resided in Nevada lived in Clark County, a percentage that increased over time, from 83 percent in 2000 to 88 percent in 2003. At the same time, the number of patients who resided in Washoe County decreased over time. Washoe County residents made up 13 percent of Nevada's HIV/AIDS hospital patients in 2000, but only 8 percent in 2003. HIV/AIDS hospital patients from the Rural Counties comprised between 2 percent and 3 percent of the total.

Table 47
Residence of HIV/AIDS patients hospitalized in Nevada, 1999-2003

County of residence	1999	2000	2001	2002	2003
Clark County	543	487	434	491	597
Washoe County	86	85	74	63	59
Rural Counties	14	14	12	21	20
Total Nevada	**643**	**586**	**520**	**575**	**676**
California/Arizona	21	27	21	24	19
All other states	21	14	16	20	22
Total out of state	**42**	**41**	**37**	**44**	**41**
Total admissions	**685**	**627**	**557**	**619**	**717**

Source: Center for Health Information Analysis (CHIA)

Over the past five years, the number of HIV/AIDS patients who were emergency admissions increased, from 69 percent of the total in 1999 to 76 percent in 2003. At the same time, the number of elective admissions dropped from 18 percent of the total in 1999 to 12 percent in 2003.

Table 48
Admission type of HIV/AIDS patients hospitalized in Nevada, 1999-2003

Admission Type	1999	2000	2001	2002	2003
Emergency	470	445	392	464	548
Urgent	88	51	62	61	84
Elective	126	130	103	93	84
Newborn	1	1	0	1	0
Trauma	0	0	0	0	0
Unknown	0	0	0	0	1
Total	**685**	**627**	**557**	**619**	**717**

Source: Center for Health Information Analysis (CHIA)

The majority of HIV/AIDS patients who were admitted to the hospital came through the emergency room. In 1999, 72 percent of these patients came through this route, up to 79 percent by 2003. About a quarter of the patients were referred for admission by their physicians.

Table 49
Source of admission for HIV/AIDS patients hospitalized in Nevada, 1999-2003

Admission Source	1999	2000	2001	2002	2003
MD referral	161	157	132	153	130
Clinic referrral	5	11	10	5	3
HMO referral	7	1	0	4	1
Transfer from a hospital	7	3	5	2	11
Transfer from a SNF	2	1	0	1	0
Transfer from another health care facility	6	2	6	1	7
Emergency Room	493	445	401	451	565
Court/Law enforcement	0	2	0	1	0
Unknown	4	5	3	1	0
Total	**685**	**627**	**557**	**619**	**717**

Source: Center for Health Information Analysis (CHIA)

HIV/AIDS patients in Nevada were hospitalized for a wide variety of illnesses and injuries. About 30 percent of hospitalizations were for treatment of infectious and parasitic diseases (ICD-9 codes 001-139). Of those diseases, the majority (64 percent to 71 percent) were for Pneumocystosis (between 70 and 104 cases per year), Candidiasis (25 to 50 cases per year), and Septicemia (13 to 21 cases per year). Between 14 percent and 17 percent were for respiratory diseases, of which about 80 percent were types of pneumonia (62 to 90 cases per year). Digestive diseases made up between 7 percent and 11 percent of total diagnoses, of which over half were diseases of the liver and the pancreas, or were gastroenteritis/colitis. In addition, Cellulitis (codes 681 and 682) comprised between 2 percent and 4 percent of diagnoses, and diseases of the circulatory system comprised 4 percent to 8 percent of total diagnoses (between 27 and 44 cases per year) (Table 50).

Table 50
Diagnoses for hospitalized HIV/AIDS patients, 1999-2003*

Diagnosis	1999	2000	2001	2002	2003
Infectious and parasitic diseases	227	174	181	195	224
Neoplasms (malignant to benign)	20	25	17	17	28
Endocrine, nutritional, metabolic diseases, & immunity disorders	31	37	21	38	29
Diseases of the blood and blood-forming organs	17	15	13	21	16
Mental disorders	11	18	17	13	13
Diseases of the nervous system and sense organs	23	15	21	12	20
Diseases of the circulatory system	34	41	45	27	44
Diseases of the respiratory system	115	105	81	86	127
Diseases of the digestive system	59	60	40	50	78
Diseases of the genitourinary system	15	19	19	28	17
Complications of pregnancy, childbirth, and the puerperium	8	5	5	10	8
Diseases of the skin and subcutaneous tissue	24	16	19	27	31
Diseases of the musculoskeletal system and connective tissue	13	13	10	10	11
Signs, symptoms, and ill-defined conditions	45	45	27	43	34
Injury and poisoning	26	31	27	24	26
Factors influencing health status and contact with health services	13	4	5	8	6
External causes of injury and poisoning	3	0	0	2	0
Congenital anomalies	1	0	0	0	0
Total	**685**	**623**	**548**	**611**	**712**

Source: Center for Health Information Analysis (CHIA). *=Diagnoses represent both primary diagnoses, and secondary diagnoses where primary is HIV (042), and some diagnoses were missing.

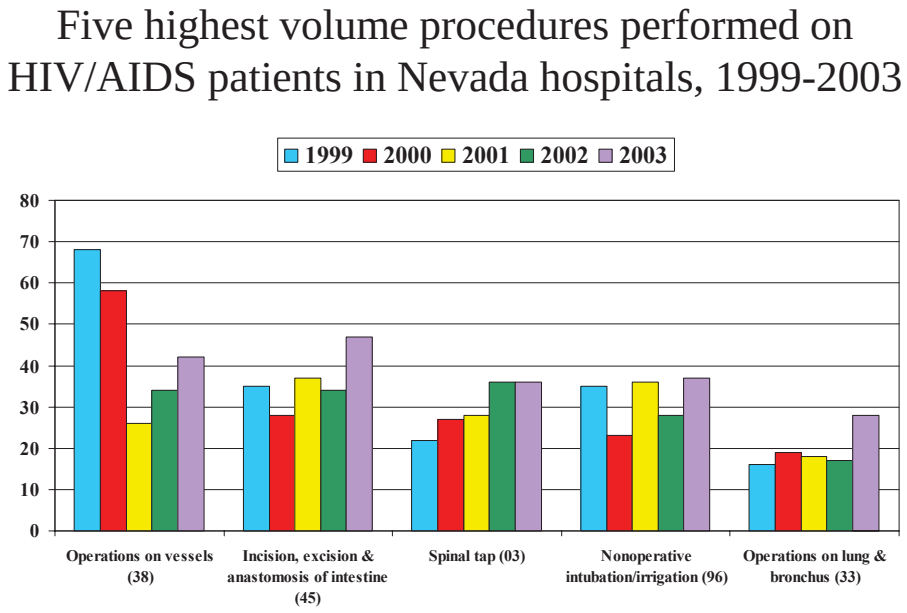
About half of HIV/AIDS patients hospitalized in Nevada facilities underwent surgical, therapeutic or diagnostic procedures. The highest volume procedures were operations on vessels; the incision, excision, and anastomosis of intestines; spinal taps; non-operative intubations and irrigations, operations on the lung and bronchus; other non-operative procedures; and incisions of the skin and subcutaneous tissue (Table 51 and Figure 17).

Table 51
Procedures performed on hospitalized HIV/AIDS patients, 1999-2003

Primary Procedures	1999	2000	2001	2002	2003
Procedures & interventions not elsewhere classified	0	0	0	1	1
Operations on nervous system	29	32	32	44	39
Operations on endocrine system	1	0	0	1	0
Operations on eye	0	1	1	0	0
Operations on ear	0	1	0	0	0
Operations on nose, mouth & pharynx	2	2	2	4	4
Operations on respiratory system	22	38	29	27	40
Operations on circulatory system	81	74	47	52	63
Operations of hemic & lymphatic systems	7	10	8	12	5
Operations on digestive system	71	60	62	59	84
Operations on urinary system	5	4	3	4	8
Operations on male genital organs	0	2	0	2	1
Operations on female genital organs	2	5	8	1	2
Obstetrical procedures	6	3	5	6	4
Operations on musculoskeletal system	13	19	16	12	11
Operations on integumentary system	17	18	14	19	16
Miscellaneous diagnostic & therapeutic procedures	74	60	57	59	69
Total procedures	**330**	**329**	**284**	**303**	**347**

Source: Center for Health Information Analysis (CHIA)

Figure 17



Between 1999 and 2003, about 70 percent of hospitalizations among HIV/AIDS patients resulted in a discharge to home or self care each year. Another 6 percent to 9 percent went home where they received home health care, home IV, or hospice services. Between 8 percent and 10 percent were discharged or transferred to other institutions,

from short-term care hospitals to a skilled nursing/long-term care facilities. Another 8 percent to 10 percent died in the hospital.

Table 52
Discharge status for hospitalized HIV/AIDS patients, 1999-2003

Discharge Status	1999	2000	2001	2002	2003
Routine - discharge to home or self care	482	425	386	438	495
Discharged/transferred home under care of Organized Home Health Service Organization	45	53	34	31	37
Discharged/transferred to home under care of a home IV provider	0	3	2	4	9
Hospice - Home	0	1	2	3	3
Discharged/transferred to another short term general hospital	6	16	4	1	10
Discharged to intermediate care facility	0	0	0	1	1
Discharged/transferred to another type of institution	29	20	30	20	19
Discharged to inpatient rehab facility	0	0	0	5	13
Discharged/transferred to a skilled nursing/Medicare long-term care facility	22	24	18	20	32
Hospice - Medical Facility	0	0	3	2	5
Still patient	2	0	0	0	1
Left against medical advice	26	33	35	39	35
Expired	73	52	43	55	57
Total	**685**	**627**	**557**	**619**	**717**

Source: Center for Health Information Analysis (CHIA)

A third or more of HIV/AIDS hospitalizations were paid for by Medicaid insurance, both Nevada Medicaid and other Medicaid. Another quarter of the admissions had Medicare coverage and about one-in-five had negotiated discount/commercial insurance coverage. Between 5 percent and 9 percent of admissions had HMO coverage, and 4 percent to 9 percent did not have health insurance. Of those without insurance, less than half qualified for county indigent coverage.

Table 53
Payer sources for hospitalized HIV/AIDS patients, 1999-2003

Payer Source	1999	2000	2001	2002	2003
Nevada Medicaid	238	191	183	219	252
Other Medicaid	5	7	0	7	5
Medicare	170	188	141	175	172
Negotiated Discount/Commercial Insurer	158	128	120	124	127
HMO	40	29	49	33	68
Self Pay	29	35	21	22	20
Miscellaneous/SIIS Coverage	34	25	26	23	39
County Indigent	8	20	14	11	10
CHAMPUS/CHAMPVA	3	4	2	7	19
Charity	0	0	1	1	1
Unknown	0	0	0	1	4
Total	**685**	**627**	**557**	**619**	**717**

Question 2

- **What are the number and characteristics of persons who know they are HIV-positive but who are not receiving HIV primary medical care?**

Individuals who are not receiving care for HIV/AIDS are classified as having an unmet need. This unmet need occurs when, during a 12-month period, no evidence of HIV primary medical care existed in the following areas: viral load testing, CD4 count, or provision of antiretroviral therapy.

Of the population living with HIV, nearly six-out-of-ten people (57 percent) were receiving primary medical care. However, 43 percent of people living with HIV were not receiving any medical care. In addition, almost half (46 percent) of those who were out of care had a diagnosis of AIDS.

Table 54
Patients in care versus out of care in Nevada: HIV and AIDS

	HIV	AIDS	Total	
	No.	No.	No.	Percent
Total in care	1,675	1,808	3,483	56.7%
Total out of care	1,448	1,211	2,659	43.3%
Total records*	**3,123**	**3,019**	**6,142**	**100.0%**

Source: HARS database
* = The total number of patients in and out of care exceeds the total recorded number of people in Nevada living with HIV/AIDS. This discrepancy reflects those individuals diagnosed out of state, and as such were not included in the HARS database, yet received care in Nevada.

Among those persons living with HIV/AIDS that did not receive services at Nevada's clinics, males, Black persons, and those exposed to HIV/AIDS through Other/Unknown and IDU sources were overrepresented, compared to the total number of persons living with HIV/AIDS.

Overall, four-out-of-five persons out of care were male (82 percent). The majority of patients who did not receive care were White (63 percent), compared with Black (24 percent), Hispanic (12 percent), Asian/Pacific Islander, and American Indian/Alaska Native populations (1 percent). By age group, the majority of individuals were between the ages of 30 to 39 years (42 percent), and more than a quarter were 20 to 29 years old (29 percent). The largest exposure category among out of care patients was men having sex with other men (46 percent). IV drug use and unknown exposures were the second and third highest categories (17 percent and 16 percent respectively).

Table 55

Patients out of care in Nevada, by gender, race/ethnicity, age group, and exposure category: 2003

	HIV, not yet AIDS	AIDS	Total	Percent of Total
Gender				
Male	1,158	1,019	2,177	81.9%
Female	290	192	482	18.1%
Race/Ethnicity				
White	905	760	1,665	62.6%
Black	373	262	635	23.9%
Hispanic	149	161	310	11.7%
Asian/Pacific Islander	8	16	24	0.9%
American Indian or Alaska Native	9	12	21	0.8%
Unknown/Multiple Race	4	0	4	0.2%
Age Group				
<13	20	8	28	1.1%
13-19	20	3	23	0.9%
20-29	550	212	762	28.7%
30-39	542	573	1,115	41.9%
40-49	194	323	517	19.4%
>49	49	92	141	5.3%
Unknown	73	0	73	2.7%
Exposure Category				
MSM	525	684	1,209	45.5%
IDU	218	231	449	16.9%
MSM & IDU	100	122	222	8.3%
Hemophiliac	1	2	3	0.1%
Heterosexual Contact	110	128	238	9.0%
Transfusion/Transplant	1	4	5	0.2%
Other/Risk not specified	400	32	432	16.2%
Mom w/ HIV or HIV Risk	93	8	101	3.8%
Total	**1,448**	**1,211**	**2,659**	**100.0%**

Source: HARS database

LAS VEGAS ELIGIBLE METROPOLITAN AREA (EMA)

EPIDEMIOLOGIC PROFILE

Update through 2003

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Table of Contents

INTRODUCTION

I. Snapshot of the Epidemic

This document reflects HIV/AIDS epidemic information within the Las Vegas Eligible Metropolitan Area (EMA) and fundamental information for the state of Nevada for the periods 1999 through and including 2003. Its formation is based on the Epidemiologic Profile previously prepared up to and including 2000 and the previous EPI updates prepared for 2001 and 2002 respectively. This information, unless otherwise noted, is primarily based on the HIV/AIDS Reporting System (HARS) and reports both HIV and AIDS data.

II. Format of the Epidemiological Review

Abbreviations

EMA	Eligible Metropolitan Area
IDU	Injecting Drug User
MSM	Men Who Have Sex with Men
PLWA	Person(s) living with AIDS
PLWH	Person(s) living with HIV
MSM/IDU	Men Who Have Sex with Men and are Injecting Drug Users

Race/Ethnicity Breakdowns

Hispanic	A person of Mexican, Puerto Rican, Cuban, Central or South American or other Spanish culture or origin, regardless of race.
Caucasian	A person having origins in any of the original peoples of Europe, North Africa, or the Middle East. White, not Hispanic
African American	A person having origins in any of the black racial groups of Africa. Black, Not Hispanic
American Indian / Alaskan Native	A person having origins in any of the original peoples of North America, and who maintains cultural identification through tribal affiliations or community recognition.
Asian/Pacific Islander	A person having origins in any of the original peoples of the Far East, Southeast Asia, the Indian subcontinent, or the Pacific Islands, including, for example, Cambodia, China, Guam, Hawaii, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Samoa, Thailand, and Vietnam.

Key Terms, Definitions and Calculations

Case: A condition such as HIV (e.g., an HIV case) or AIDS (e.g., an AIDS case), according to a standard case definition.

Confidence interval (CI): A range of values for a measure that is believed to contain the true value at a specified level of statistical certainty (e.g., 95%).

Cumulative case: The total number of cases of a disease reported or diagnosed during a specified time. Cumulative cases can include cases in people who have already died.

> ***Example:*** Assume that 8,000 AIDS cases had been diagnosed in a state from the beginning of the epidemic through the year 2001. Among the 8,000 person with AIDS, 3,000 had died. The cumulative number of AIDS cases diagnosed in that state through 2001 would be 8,000.

Cumulative incidence rate: The total number of cases during a specified time period, among all people at risk for the disease.

A cumulative incidence rate is calculated by dividing cumulative incidence for a specified time period by the population in which cases occurred during the time period. A multiplier is used to convert the resulting fraction to a number (numerator) over a common denominator, often 100,000.

$$\frac{\text{Number of new cases in specified period}}{\text{Population at risk in specified period}} \times 100{,}000$$

> ***Example:*** Assume that from 1990 through 2001, 18,000 AIDS cases occurred in a state. During the same time 1,800,000 people lived in the state.

$$\text{Cumulative Incidence Rate} = \frac{18{,}000}{1{,}800{,}000} \times 100{,}000 = 1{,}000 \text{ AIDS cases per } 100{,}000 \text{ persons}$$

Estimate: When accurate data are not available, an estimate may be based on the data that are available and an understanding of how they can be generalized to larger populations. In some instances, national or state data may be statistically adjusted to estimate local conditions. Estimates should be accompanied by statistical estimates of error (a confidence interval), which describes the uncertainty associated with the estimate.

> ***Example:*** The estimated HIV incidence in state X was 2.1% per year (95% CI, 1.4 – 2.6)

Incidence: The number of new cases in a defined population in a certain time period, often 1 year, which can be used to measure disease frequency. It is important to understand the difference between HIV incidence and reported HIV diagnoses. HIV incidence refers to all persons infected with HIV during a specified period of time (usually 1 year). However, new diagnoses include cases in persons who have been infected for longer periods; they do not include cases in persons who were tested anonymously. Because anonymous test results are not included, HIV surveillance data may not represent incident cases.

> ***Example:*** During the year 2001, a total of 1,100 AIDS cases were diagnosed in a given state. This is the incidence of AIDS for 2001 in that state.

Incidence rate: The number of new cases in a specific area during a specific time period among those at risk in the same area and time period.

Incidence rate provides a measure of the effect of illness relative to the size of the population. Incidence rate is calculated by dividing incidence in the specified period by the population in which cases occurred. A multiplier is used to convert the resulting fraction to a number over a common denominator, often 100,000.

$$\frac{\text{Number of new cases in specified period}}{\text{Population at risk in specified period}} \times 100{,}000$$

> ***Example:*** Assume that during the year 2001, a total of 1,100 AIDS cases were diagnosed in a given state. This is the incidence of AIDS for 2001 in that state. The population in the state was 2,200,000 in 2001.

$$\text{The Incidence Rate} = \frac{1{,}100}{2{,}200{,}000} \times 100{,}000 = 5 \text{ per } 100{,}000 \text{ persons in the state}$$

Interpretation: The explanation of the meaning of available data. An example is examining a trend, such as the number of HIV cases diagnosed during the 5-year period. Interpreting a trend enables a planning group to assess whether the number of events is increasing or decreasing. However, groups should use caution in interpreting trends that are based on small increases or decreases.

Mean: The sum of individual scores in a data set divided by the total number of scores. The mean is what many people refer to as an average.

> ***Example:*** Assume that people in a given service area in 2001 are the following ages at diagnoses of HIV; 18, 18, 19, 20, 22, 23, 26, 31, 41. The total of the 9 ages = 218 years.

$$\frac{218 \text{ years}}{9} = 24.2 \text{ years is the mean age}$$

Median: The middle value in a data set. Usually, approximately half the values will be higher and half will be lower. The median is useful when a data set contains a few unusually high or unusually low values, which can affect the mean. It is also useful when data are skewed, meaning that most of the values are at one extreme or the other.

> ***Example:*** Assume the following ages at diagnosis of HIV in the year 2001 data for a given service area: 18, 18, 19, 20, 22, 23, 26, 31, 99. Although the mean age is 30.7, the median age is 22. In this instance, the median age better reflects the central value for age in the population.

No identified risk (NIR): Cases for which epidemiologic follow-up has been conducted, sources of data have been reviewed – which may include an interview with the patient or provider – and no mode of exposure has been identified. Any case that continues to have no reported risk 12 or more months after the report date is considered NIR.

No reported risk (NRR): Cases in which risk information is absent from the initial case report because the information had not been reported by the reporting source, had not been sought, or had not been found by the time the case was reported. Cases may remain NRR until epidemiologic follow up has been completed and potential risks (exposures) have been identified. If risk has not been identified within 12 months of being reported as NRR, the case may be considered NIR.

Prevalence: The total number of cases of a disease in persons not known to have died in a given population at a particular time.

> ***Example:*** By the end of 2001, if the cumulative number of persons with AIDS in state X is 1,900 and 1,000 have died, then the prevalence of AIDS in state X is 900 (1,900 persons who have ever had an AIDS diagnosis minus 1,000 who have died).

Rate: A measure of the frequency of an event or a disease compared to the number of persons at risk for the event or disease. Usually, when rates are being calculated for an epidemiologic profile, the general population, rather than the population potentially exposed to HIV infection by various high-risk behaviors, is used as the denominator. The size of the general population is known from census data, whereas the size of the high-risk population is usually not known.

** Definitions taken from Integrated Guidelines for Developing Epidemiologic Profiles, Department of Health & Human Services, Centers for Disease Control & Prevention*

III. Historical Perspective of the Epidemic within the EMA

Both the Las Vegas EMA and the state of Nevada as a whole continued to experience fluctuation in the number of new HIV cases between 1993 and 1996. For example, between 1993 and 1994, the number of cases in the EMA rose 31 percent, only to drop 26 percent between 1994 and 1995. Between 1997 and 2003, the number of new HIV cases remained steady. Overall, the Las Vegas EMA saw a 17 percent increase in the number of new HIV cases between 1993 and 2003 (Table 1 and Figure 1).

Clark County represented the vast majority of HIV cases in both the EMA and in Nevada. In 2003, Clark County had 97 percent of the Las Vegas EMA's new HIV cases and 82 percent of Nevada's new cases.

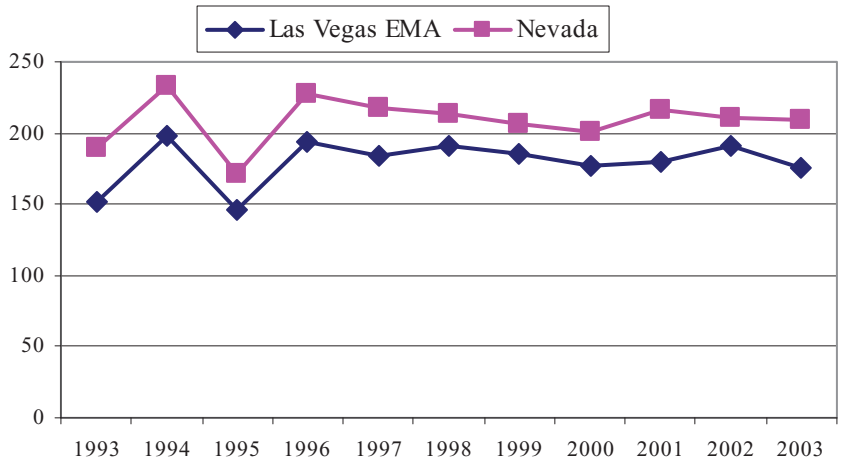
Table 1

Number of new HIV cases in the Las Vegas EMA, 1993 - 2003

	Clark (NV)	Nye (NV) and Mohave (AZ)	Las Vegas EMA	Nevada
1993	137	14	**151**	190
1994	185	13	**198**	233
1995	131	15	**146**	171
1996	182	12	**194**	228
1997	178	6	**184**	218
1998	179	12	**191**	213
1999	176	9	**185**	206
2000	165	12	**177**	201
2001	169	11	**180**	216
2002	177	14	**191**	211
2003	172	4	**176**	209

Sources: Nevada State Health Division, HIV/AIDS Reporting System (HARS); Arizona Health Department

Figure 1: Number of new HIV (not combined with AIDS) cases in the Las Vegas EMA, 1993 - 2003



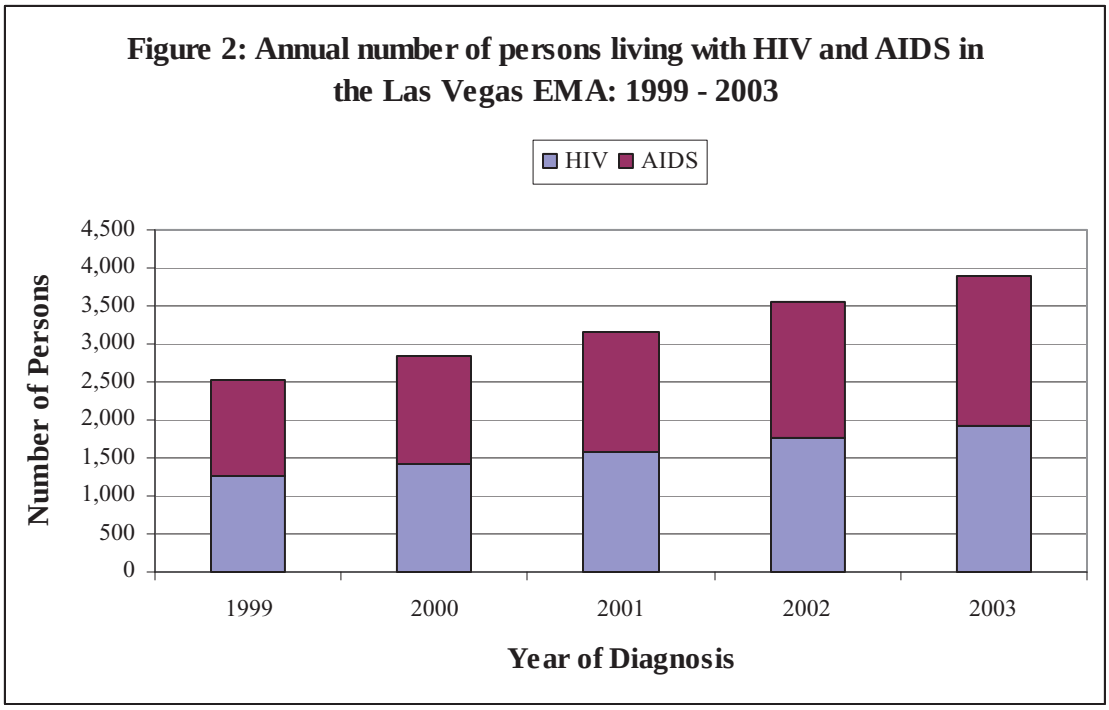
The number of persons living with HIV infection and AIDS in the Las Vegas EMA increased steadily over time. As of December 2003, an estimated 1,912 persons were living with HIV infection and 1,984 were living with AIDS. Almost all (99 percent+) of the people living with HIV/AIDS in the Las Vegas EMA lived in Clark County.

Table 2

Annual number of persons with HIV infection and AIDS in the Las Vegas EMA, 1999 - 2003

	Clark County		Nye and Mohave Counties		Total EMA	
	HIV	AIDS	HIV	AIDS	HIV	AIDS
1999	1,252	1,249	10	11	**1,262**	**1,259**
2000	1,407	1,421	10	17	**1,417**	**1,431**
2001	1,568	1,577	9	18	**1,577**	**1,586**
2002	1,735	1,770	18	16	**1,753**	**1,788**
2003	1,900	1,972	12	16	**1,912**	**1,984**

Source: Nevada State Health Division, HIV/AIDS Reporting System (HARS)



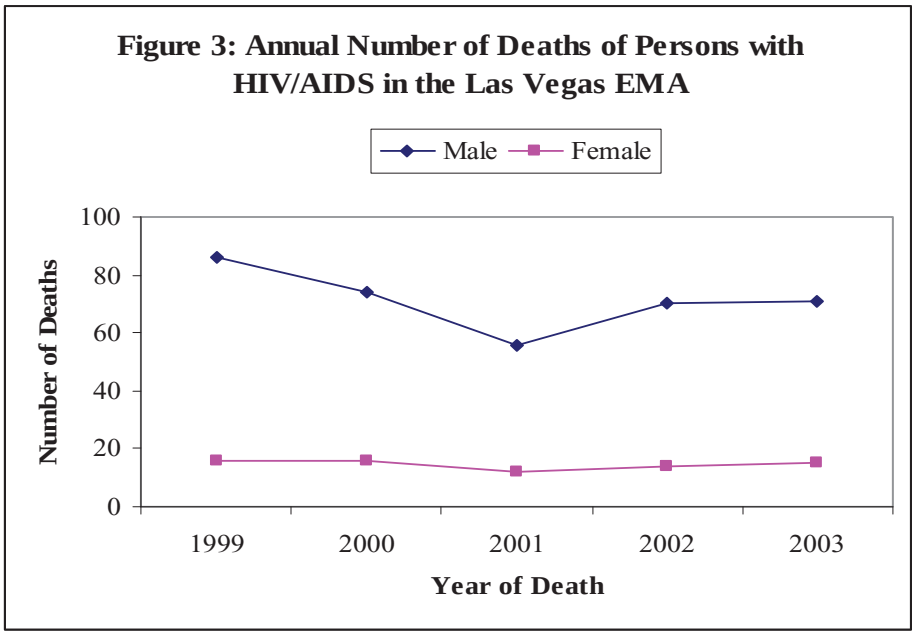
From 1999 to 2003, the number of deaths of persons with HIV infection or AIDS decreased 16 percent overall, from 102 in 1999 to 86 in 2003, with a dip to 68 in 2001. Within the five-year period, the number of deaths per year among females remained fairly constant, ranging from 12 deaths in 2001 to 16 in 1999. The number of deaths among males decreased 17 percent, from 86 deaths in 1999 to 71 deaths in 2003. When noted with the number of persons living with infection or disease respectively, the EMA reflected on the increased life expectancy supported by client inclusion in primary medical care.

Table 3

Annual number of deaths of persons with HIV/AIDS in the Las Vegas EMA, 1999 - 2003

	Clark County		Nye & Mohave Counties		Total EMA		
	Male	Female	Male	Female	Male	Female	Total
1999	85	16	1	0	**86**	**16**	**102**
2000	64	13	10	3	**74**	**16**	**90**
2001	51	10	5	2	**56**	**12**	**68**
2002	59	14	11	0	**70**	**14**	**84**
2003	65	14	6	1	**71**	**15**	**86**
Total	**324**	**67**	**33**	**6**	**357**	**73**	**430**

Source: Nevada State Health Division, HIV/AIDS Reporting System (HARS)



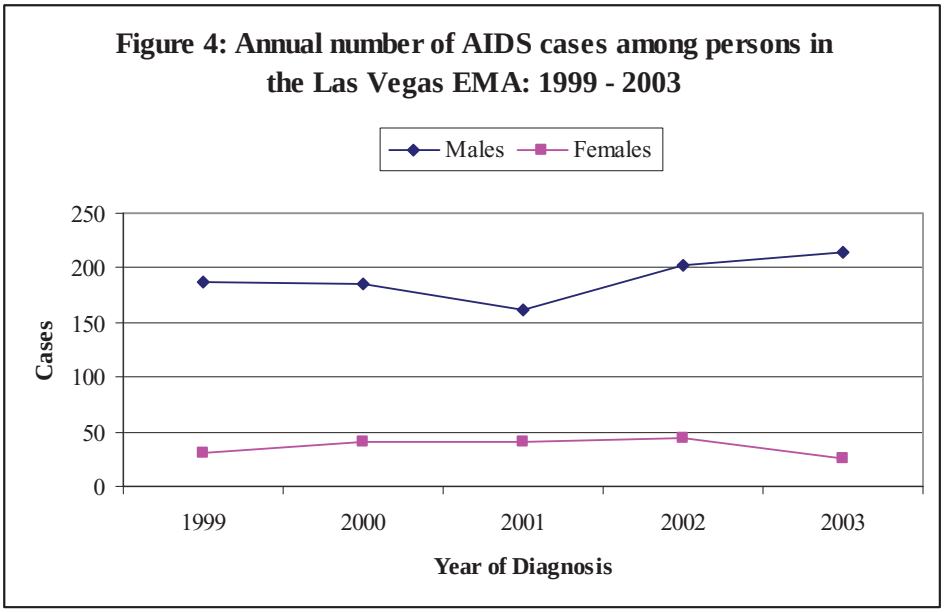
From 1999 to 2003, the number of newly diagnosed AIDS cases in the EMA increased 10 percent, from 218 in 1999 to 239 in 2003. In that time period, the number of male cases increased 14 percent, and grew from 86 percent to 90 percent of total cases. The number of female cases decreased from 31 to 25, but stayed above 40 cases per year between 2000 and 2002.

Table 4

Annual AIDS cases among persons in the Las Vegas EMA, 1999 - 2003

	Males		Females		Total
	No.	% of Total	No.	% of Total	No.
1999	187	85.8%	31	14.2%	218
2000	185	82.2%	40	17.8%	225
2001	161	79.7%	41	20.3%	202
2002	203	82.2%	44	17.8%	247
2003	214	89.5%	25	10.5%	239

Source: Nevada State Health Division, HIV/AIDS Reporting System (HARS); Arizona Health Division, HIV/AIDS Surveillance



IV. General Information on the Las Vegas EMA and its Associated State Authorities

The Las Vegas Eligible Metropolitan Area (EMA) is comprised of Clark and Nye counties in the state of Nevada, as well as Mohave County in the state of Arizona. Data on HIV/AIDS are collected and analyzed within each county and reported to their respective State Health Authorities. Due to the large proportion of both HIV and AIDS-related cases continuing to be identified with the Clark County region as well as allocation for the Ryan White Title I funding, the Clark County Health District retains the responsibility for overall accounting and reporting of data pertaining to the EMA.

For males and females combined, 35 percent of the overall population within the EMA was under the age of 25, 30 percent were between the ages of 25 to 44 years old, 23 percent were between the ages of 45 and 64, and approximately 12 percent were over the age of 65.

Table 5

Distribution of the general population in the Las Vegas EMA by age group and gender, 2003

Age (yrs)	Est. %	Males (50.7%)	Females (49.3%)	Total
< 5	7.2%	68,291	65,132	133,423
5 – 9	7.0%	66,343	63,354	129,696
10 - 14	7.0%	66,135	62,133	128,268
15 – 24	13.9%	132,501	123,491	255,992
25 – 44	29.7%	285,334	262,431	547,764
45 – 64	23.3%	213,247	215,811	429,058
≥ 65	11.9%	103,025	115,951	218,976
Total	**100.0%**	**934,876**	**908,302**	**1,843,178**

Source: Nevada State Demographer, 2003 population projections; US Census Bureau/Arizona State Demographer

Whites comprised the largest proportion of the population within the EMA, approximated at 62 percent (1,138,482), while Hispanics accounted for 23 percent (419,479), Blacks comprised 8 percent (149,852), and Asians made up 6 percent (114,741) of the population.

Table 6

Percentage distribution of the population within the Las Vegas EMA by race/ethnicity and gender, 2003

	Males (n = 934,876)		Females (n = 906,051)		Total (N = 1,843,178)	
Race/Ethnicity	**No.**	**%**	**No.**	**%**	**No.**	**%**
White, not Hispanic	574,465	61.4%	564,017	62.1%	1,138,482	61.8%
Black, not Hispanic	74,675	8.0%	75,177	8.3%	149,852	8.1%
Hispanic	222,690	23.8%	196,789	21.7%	419,479	22.8%
American Indian or Alaskan Native	9,210	1.0%	9,504	1.0%	18,714	1.0%
Asian/Pacific Islander	5,913	5.7%	6,828	6.8%	114,741	6.2%
Some other race	923	0.1%	987	0.1%	1,910	0.1%
Total	**934,876**	**50.7%**	**908,302**	**49.3%**	**1,843,178**	**100%**

Source: Nevada State Demographer, 2003 population projections; US Census Bureau/Arizona State Demographer

Clark County contributed the largest portion 89 percent (1,634,633) of the EMA population, followed by Mohave County with 9 percent (171,367) and Nye County supporting 2 percent (37,178).

Table 7

Percentage distribution of the population within the Las Vegas EMA by race/ethnicity and county of residence, 2003

	Clark (NV) (n = 1,634,633)		Nye (NV) (n = 37,178)		Mohave (AZ) (n = 171,367)		Las Vegas EMA (N = 1,783,625)	
Race/Ethnicity	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
White, not Hispanic	962,757	58.9%	32,138	86.4%	143,587	83.8%	1,138,482	61.8%
Black, not Hispanic	148,475	9.1%	461	1.2%	916	0.5%	149,852	8.1%
Hispanic	396,798	24.3%	3,158	8.5%	19,523	11.4%	419,479	22.8%
American Indian or Alaskan Native	13,871	0.8%	900	2.4%	3,943	2.3%	18,714	1.0%
Asian/Pacific Islander	112,732	6.9%	521	1.4%	1,488	0.9%	114,741	6.3%
Some other race	-	-	-	-	1,910	1.1%	1,910	0.1%
Total	**1,634,633**	**89%**	**37,178**	**2%**	**171,367**	**9%**	**1,843,178**	**100%**

Source: Nevada State Demographer, 2003 population projections; US Census Bureau/Arizona State Demographer's office

Each of the counties within the EMA supported poverty levels exceeding 10 percent of the populations.

Table 8

Percentage of population under the poverty level in counties comprising the Las Vegas EMA, 1999

County	Percent at or below federal poverty level
Clark, NV	10.8%
Nye, NV	10.7%
Mohave, AZ	13.9%

Source: US Census Bureau: State & County Quick Facts, 2003 Population Estimates

The proportion of the population at least 25 years old with a high school diploma or higher was similar among counties within the EMA. The proportion of the population with at least a bachelor's degree was higher in Clark County than in the other counties.

Table 9

Percentage of population 25 years and older, with high school diploma or higher or with bachelor's degree or higher, 2000

Las Vegas EMA	Percent with High school diploma or higher	Percent with Bachelor's degree or higher
Clark, Nevada	79.5%	17.3%
Nye, Nevada	79.2%	10.1%
Mohave, Arizona	77.5%	9.9%

Source: US Census Bureau: State & County Quick Facts, 2003 Population Estimates

Within both Nevada and Arizona, Hispanic residents were more likely to lack health insurance than White residents. Nevada residents had higher rates of uninsured than Arizona residents for both White and Hispanic persons.

Table 10

Adults (aged 19-64) without health insurance in Nevada and Arizona, rate by race/ethnicity, 2000 - 2003

	Nevada		**Arizona**	
Race/Ethnicity	No.	Rate (Percent)	No.	Rate (Percent)
White, not Hispanic	190,200	17%	345,430	12%
Black, not Hispanic	28,100	23%	NSD	NSD
Hispanic	167,790	36%	477,510	31%
Other	33,870	17%	80,050	28%
Total	419,960	NA	931,340	NA

NSD: Not Sufficient Data; NA = not available
Source: Health Coverage and Underinsured, Kaiser Family Foundation (http://statehealthfacts.kff.org)

V. Facts on Newly Diagnosed HIV infections

By gender and known race/ethnicity, Black males had the highest rate of HIV infection in the Las Vegas EMA, followed by American Indian/Alaskan Native males, Hispanic males, Black females, and White males. The HIV rate among Black males was twice as high as the HIV rate among the next highest group.

Table 11

New HIV cases, and rates per 100,000 people in the Las Vegas EMA by race/ethnicity and gender, 2003

	Males			Females			Total		
Race/Ethnicity	**No.**	**Pop.**	**Rate**	**No.**	**Pop.**	**Rate**	**No.**	**Pop.**	**Rate**
White, not Hispanic	65	574,465	11.3	15	564,017	2.7	80	1,138.482	7.0
Black, not Hispanic	33	74,675	44.2	9	75,177	12.0	42	149,852	28.0
Hispanic	39	222,690	17.5	5	196,789	2.5	44	419,479	10.5
Asian/Pacific Islander	3	52,913	5.7	0	61,828	0.0	3	114,741	2.6
American Indian/ Alaskan Native	2	9,210	21.7	0	9,504	0.0	2	18,714	10.7
Unknown/Multiple Race	1	923	108.3	0	987	0.0	1	1,910	52.4
Total	143	934,876	15.3	29	908,302	3.2	172	1,843,178	9.3

Source: HIV/AIDS Reporting System (HARS); Arizona Health Department, HIV/AIDS Surveillance

By risk exposure category, 123 (72 percent) of the new HIV cases in 2003 were classified as infected through men having sex with men (MSM), 22 (13 percent) through heterosexual contact, 11 (6 percent) by other/unknown mode of exposure, 8 (5 percent) through injection drug use (IDU), and 8 (5 percent) by MSM and IDU. Among the 143 males with HIV infection, the predominant mode of exposure was MSM (86 percent), followed by MSM combined with IDU (6 percent) and the other/unknown method of exposure (4 percent). Among the 29 females with HIV infection, the predominant mode of exposure was heterosexual contact (72 percent), followed by other/unknown (17 percent) exposure and by IDU (10 percent).

Table 12

New HIV cases and rates per 100,000 people in the Las Vegas EMA by mode of exposure and gender, 2003

	Males		Females		Total	
Exposure Category	**No.**	**%**	**No.**	**%**	**No.**	**%**
MSM	123	86%	0	0%	123	72%
IDU	5	3%	3	10%	8	5%
MSM and IDU	8	6%	0	0%	8	5%
Heterosexual contact	1	1%	21	72%	22	13%
Mother with/at risk for HIV	0	0%	0	0%	0	0%
Other/Unknown	6	4%	5	17%	11	6%
Total	143	100%	29	100%	172	100%

Source: HIV/AIDS Reporting System (HARS); Arizona Health Department, HIV/AIDS Surveillance

The distribution of risk differed by race/ethnicity. MSM contact reflected the highest instance of HIV infection presenting 29 (76 percent) new infections amongst Hispanics and 66 (74 percent)

infections within the White populace. Heterosexual and IDU contact ranked as the next highest risk categories within defined racial groups.

Table 13

HIV cases in the Las Vegas EMA by exposure category and race/ethnicity, 2003

Exposure Category	White, not Hispanic		Black, not Hispanic		Hispanic		Asian/ Pacific Islander		American Indian/ Alaskan Native		Unknown/ Multiple Race		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
MSM	82	79%	43	57%	40	83%	4	80%	1	0%	1	50%	171	73%
IDU	12	12%	6	8%	1	2%	0	0%	0	0%	0	0%	19	8%
MSM and IDU	5	5%	6	8%	1	2%	0	0%	0	0%	1	50%	13	6%
Heterosexual	2	2%	13	17%	3	6%	1	20%	0	0%	0	0%	19	8%
Mother with/ at risk for HIV	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
Other/ Unknown	3	3%	7	9%	3	6%	0	0%	0	0%	0	0%	13	6%
Total	104	100%	75	100%	48	100%	5	100%	1	100%	2	100%	235	100%

Sources: HIV/AIDS Reporting System (HARS); Arizona Health Department, HIV/AIDS Surveillance

The majority of people (84 percent) who died from HIV/AIDS in the Las Vegas EMA were male, while 16 percent were female. About 55 percent of people who died from HIV/AIDS were White while 26 percent were Black and 20 percent were Hispanic. As with the HIV infection rate, the death rate among Blacks was much higher than those among other race/ethnicities. For Black males, the death rate was more than twice as high as the rate among White males. The death rate among Black females was more than ten times higher than for White females.

Table 14

Number of deaths of persons with HIV infection or AIDS and the death rates per 100,000 populations in the Las Vegas EMA by race/ethnicity and gender, 2003

	Males			Females			Total		
Race/Ethnicity	No.	Pop.	Rate	No.	Pop.	Rate	No.	Pop.	Rate
White, not Hispanic	42	574,465	7.3	5	564,017	0.9	47	1,138,482	4.1
Black, not Hispanic	14	74,675	18.7	8	75,177	10.6	22	149,852	14.7
Hispanic	16	222,690	7.2	1	196,789	0.5	17	419,479	4.1
Asian/Pacific Islander	0	52,913	0.0	0	61,828	0.0	0	114,741	0.0
American Indian/Alaskan Native	0	9,210	0.0	0	9,504	0.0	0	18,714	0.0
Unknown/Multiple Race	0	923	0.0	0	987	0.0	0	1,910	0.0
Total	72	934,876	7.7	14	908,302	1.5	86	1,843,178	4.7

Sources: HIV/AIDS Reporting System (HARS); Arizona Health Department, HIV/AIDS Surveillance

In the Las Vegas EMA, HIV disease was the sixth leading cause of death among people between the ages of 25 and 44. During 2003, 35 young adults died from HIV disease, 4 percent of all deaths in the 25 to 44 year old age group.

Table 15

Ranking of 10 leading underlying causes of death among persons 25-44* years of age in the Las Vegas EMA, 2003

Cause	Ranking	Deaths	Total deaths, % (N = 1,023)
Unintentional Injury	1	250	25%
Heart disease	2	172	17%
Malignant neoplasms	3	107	10%
Suicide	4	107	10%
Homicide	5	77	8%
HIV disease	**6**	39	**4%**
Septicemia	7	27	3%
Chronic liver disease	8	24	2%
Cerebrovascular disease	9	20	2%
Diabetes mellitus	10	17	2%

Source: Nevada State Health Division, Interactive Health Database: Mortality Module, 1990-2003; Arizona Health Status and Vital Statistics 2003

VI. Facts on Newly Diagnosed AIDS Cases

The Las Vegas EMA as a whole observed fluctuation in newly diagnosed AIDS cases in the last three years. As noted below, the lion's share of cases existed within the Clark County locale. The number of AIDS cases within the state of Nevada shifted from 230 in 2001 to 278 in 2002 to 253 in 2003. In the Las Vegas EMA, the number of cases moved from 202 in 2001 to 247 in 2002 to 239 in 2003.

Males continued to represent the largest number of AIDS cases within the EMA at 86 percent while females reflected a considerably lower proportion at 14 percent.

Table 16

AIDS cases among persons in the Las Vegas EMA, by gender and age at diagnosis, 2003

	Males			Females			Total		
Age	**No.**	**Pop.**	**Rate**	**No.**	**Pop.**	**Rate**	**No.**	**Pop.**	**Rate**
<5	0	68,291	0.0	0	65,132	0.0	0	133,423	0.0
5-9	0	66,343	0.0	0	63,354	0.0	0	129,696	0.0
10-14	0	66,135	0.0	0	62,133	0.0	0	128,268	0.0
15-24	10	132,501	7.5	1	123,491	0.8	11	255,992	4.3
25-44	150	285,334	52.6	21	262,431	8.0	171	547,764	31.2
45-64	52	213,247	24.4	3	215,811	1.4	55	429,058	12.8
>= 65	2	103,025	1.9	0	115,951	0.0	2	218,976	0.9
Total	214	934,876	22.9	25	908,303	2.8	239	1,843,148	13.0

Sources: HIV/AIDS Reporting System (HARS, Arizona HIV/AIDS Surveillance.

MSM contact consistently reflected the largest number of AIDS cases (72 percent) as compared to IDU (9 percent) and heterosexual contact (8 percent).

Table 17

AIDS cases in the Las Vegas EMA by exposure category and gender, 2003

	Males		Females		Total	
Exposure Category	**No.**	**%**	**No.**	**%**	**No.**	**%**
MSM	172	80%	0	0%	172	72%
IDU	19	9%	2	8%	21	9%
MSM and IDU	13	6%	0	0%	13	5%
Heterosexual contact	2	1%	18	72%	20	8%
Mother with/at risk for HIV	0	0%	0	0%	0	0%
Other/Unknown	8	4%	5	20%	13	5%
Total	214	100%	25	100%	239	100%

Source: Clark County Health District, HIV/AIDS Reporting System (HARS), Arizona Health Division

By race/ethnicity and mode of exposure, MSM was the primary risk factor for all identified race/ethnicities in the Las Vegas EMA. Heterosexual contact was the second largest exposure group for Blacks, Asian/Pacific Islanders, and Hispanics while IDU was the next largest exposure group for Whites.

Table 18

AIDS cases in the Las Vegas EMA by exposure category and race/ethnicity, 2003

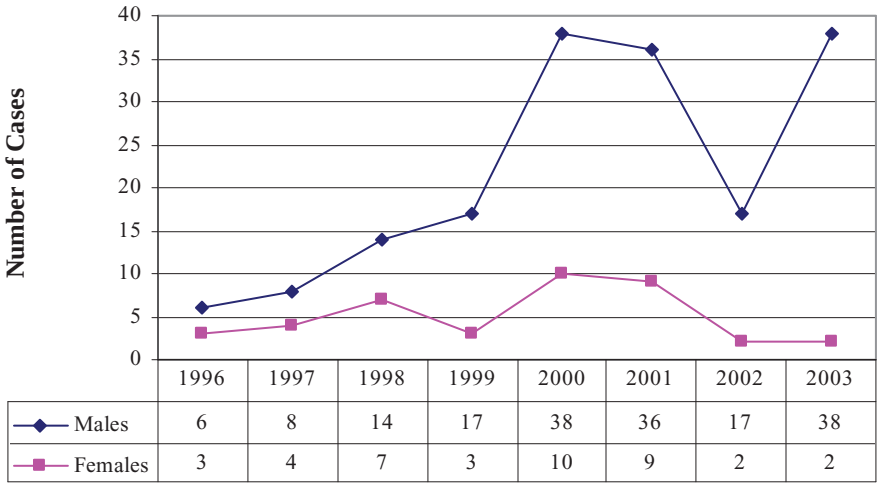
	White, not Hispanic		Black, not Hispanic		Hispanic		Asian/ Pacific Islander		American Indian/ Alaskan Native		Unknown/ Multiple Race		Total	
Exposure Category	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
MSM	82	79%	43	57%	40	83%	4	80%	1	0%	1	50%	171	73%
IDU	12	12%	6	8%	1	2%	0	0%	0	0%	0	0%	19	8%
MSM and IDU	5	5%	6	8%	1	2%	0	0%	0	0%	1	50%	13	6%
Heterosexual	2	2%	13	17%	3	6%	1	20%	0	0%	0	0%	19	8%
Mother with/at risk for HIV	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
Other/Unknown	3	3%	7	9%	3	6%	0	0%	0	0%	0	0%	13	6%
Total	104	100%	75	100%	48	100%	5	100%	1	100%	2	100%	235	100%

Source: Nevada State Health Division, HIV/AIDS Reporting System (HARS).

VII. Out of State HIV cases in Clark County by Gender

In 1996, the Clark County Health District began data collection on the increasing number of out of state cases moving into the Clark County area. Figure 5 on page 94 reflects the number of HIV case reports from other states now residing in Clark County and receiving care.

Figure 5: Out of State HIV (not yet AIDS) Cases by Date of Report in Clark County



	1996	1997	1998	1999	2000	2001	2002	2003
Males	6	8	14	17	38	36	17	38
Females	3	4	7	3	10	9	2	2

Whites continued to account for the majority of Out of State HIV reports; however the rates decreased in this population from 76 percent in 2001 to 68 percent in 2002 to 52 percent in 2003 as the rates for other racial/ethnic groups increased. The "other" racial category was inclusive of individuals of Asian, Pacific Islander, American Indian and Alaskan Native populations which collectively did not experience a significant change in the Out of State reporting criteria.

MSM contact offered the largest number of Out of State cases noted within Clark County, while IDU ranked second comprising 5 of the 40 cases reported in 2003 as noted in Table 19 below.

Table 19
Out of State HIV cases by exposure category supported by date of report in Clark County, NV: 1996 - 2003

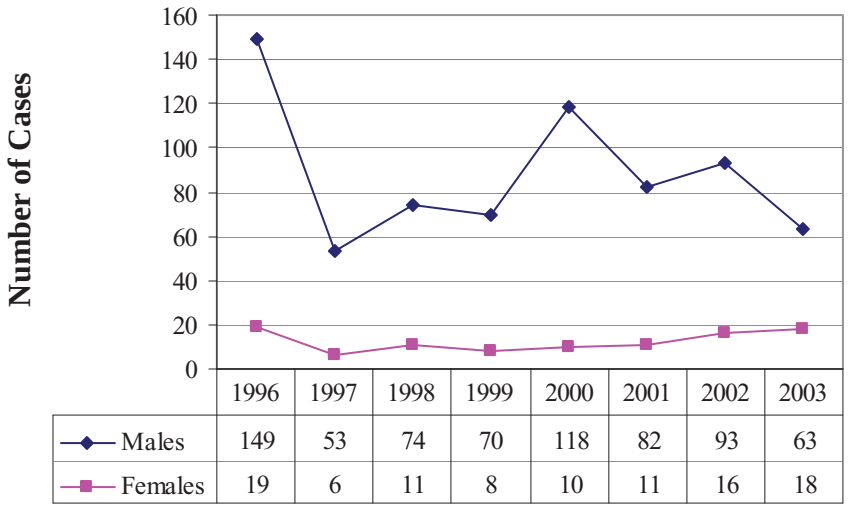
Exposure	1996 No.	1997 No.	1998 No.	1999 No.	2000 No.	2001 No.	2002 No.	2003 No.
MSM	3	4	4	11	23	16	12	**34**
IDU	2	2	5	1	9	8	3	**5**
MSM and IDU	0	1	1	3	4	6	0	**1**
Heterosexual	1	3	5	1	7	10	3	**0**
Mother with/at risk for HIV infection								
Other/unknown	3	2	6	4	5	5	1	**0**
Total	9	12	21	20	48	45	19	40

Source: Clark County Health District, HIV/AIDS Reporting System (HARS)

VIII. Out of State AIDS Reports

Figure 6 reflects the number of AIDS case reports from other states by sex, now residing in Las Vegas and receiving care. In 1996 data collection began on the increasing number of Out of State AIDS cases relocating to the Clark County area. As noted a continual prominence of 63 males comprised 78 percent of the Out of State AIDS cases noted within the county.

Figure 6: Out of State AIDS Cases by Gender



	1996	1997	1998	1999	2000	2001	2002	2003
Males	149	53	74	70	118	82	93	63
Females	19	6	11	8	10	11	16	18

Whites continued to account for the majority of the Out of State AIDS reports with the highest representation being noted in 1996. Transition to Clark County amongst Blacks significantly decreased (50 percent) from 27 in 2002 to 13 in 2003, while a slight increase amongst the Hispanic and other communities of color occurred.

As noted in Table 20 below, MSM contact consistently served as the greatest risk exposure category while fluctuation between IDU and heterosexual contact remained significantly noted.

Table 20

Out of State AIDS cases by exposure category supported by date of report in Clark County, NV

	1996	1997	1998	1999	2000	2001	2002	2003
MSM	96	27	41	41	80	54	64	**56**
IDU	15	6	20	14	15	13	26	**9**
MSM and IDU	12	10	10	12	19	10	7	**2**
Heterosexual	16	3	6	8	5	12	9	**13**
Mother with/at risk for HIV	0	0	0	0	0	0	0	**0**
Other/unknown	0	0	0	0	0	0	0	**1**
Total	**139**	**46**	**77**	**75**	**119**	**89**	**106**	**81**

IX. Unmet Need Estimate

The Clark County Health District Office of AIDS, HIV Surveillance Project undertook estimating the unmet need for the previous Ryan White Title I application. An assessment of quality and level of reporting in Nevada and Arizona was done. At least 95 percent or more of testing performed was reported to local and/or state health authorities. The state reporting guidelines are as follows:

- Arizona and Nevada have named-reporting of HIV and AIDS.
- Nevada has named-reporting of detectable viral load and t-cell reporting <500 CD-4.
- Arizona has named-reporting of detectable viral load.

For the estimate of unmet need, the Project investigated these data sources:

- All HIV reports to local and state HIV Reporting Systems detailing any report without laboratory data for 12 months, specifically HIV viral loads, T-cells, and any other laboratory-based evidence of infection or monitoring.
- Missing/updated information in Vital Records death certificates.
  - The search turned up 23 previously unknown deaths.
- National data purchased from Social Security, for death update information.
- Related in-house databases, for co-infections reports.
- Early Intervention/Evaluation Clinic files, checked for non-laboratory visits.
- The CQM Special Project Report, reviewed for the assessment of those new to care in 2002.
- An in-house copy of the DMV database for Nevada, for possible People Living with HIV/AIDS (PLWH/A) matches of persons still living in Nevada and Clark County during 2003.
  - This database was updated throughout the year as cases were recognized to be falling into the out-of-care criteria established.
  - The DMV database was used to establish current address and state residence on 948 clients falling out-of-care during the last year.
- The Ryan White Title I data system, WebCIM, for any laboratory or primary care information – sorting out those who were only registered.
  - The EMA funded community service providers to establish criteria and search for clients receiving services at their agencies. These providers utilized WebCIM for clients that were falling "out-of-services" and potentially could fall "out-of-care" if left unchecked.
  - The in-house "out-of-care" project workgroup regularly queried activity in WebCIM to match medical/laboratory evidence reports to cross-check for care activities.
- Local laboratory compliance (investigated via site visits).

The reporting form for communicable disease was also revised, to assist providers in reporting.

In addition, the updated HARS database/registry was reported to the Nevada State Health Division, HIV Surveillance program on a monthly basis with reflected updates. The HIV Surveillance program cross-checked all ADAP applications with reports in the registry to confirm their reported status in Nevada. The program also cross-matched Vital Records deaths with the registry – similar to what the Health District performed on a local level. The HIV Surveillance program developed the following extraction for Clark County Health District. A

total of 7,090 records for the jurisdiction were reviewed, removing all known deceased. In addition, 4,872 records were extracted for the time period with 2,003 (40.1 percent) meeting the "out-of-care" criteria – 1,068 infected with HIV and 935 diagnosed with AIDS.

Those individuals "out-of-care" number 2,003 and constitute the Las Vegas EMA's estimate of "unmet need." This constitutes 40 percent of the individuals who know their HIV status.

The following data were extracted for all patient records in HARS with no reported deaths and an AIDS or HIV diagnosis before May 1, 2004. Total Out of Care was computed from a SAS-based program provided by the CDC and is based on all patients in HARS who received no treatments or blood tests during the period 05/01/2003 through 04/30/2004.

Table 21

Patients In or Out of Care in Clark and Nye Counties

	HIV	AIDS	Total	Percent
Total Records	2,645	2,247	4,872	100.0%
Total Out of Care	1,068	935	2,003	40.1%
Total In Care	1,557	1,312	2,869	58.9%

Table 22

Patients Out of Care in Clark and Nye Counties – By Age Group

Age Group	HIV	AIDS	Total	Percent
Unknown/NR	73	0	73	3.6%
<13	16	8	24	1.2%
13 – 19	15	3	18	0.9%
20 – 29	395	156	551	27.5%
30 – 39	391	450	841	42.0%
40 – 49	139	253	392	19.6%
>49	39	65	104	5.2%
Total Out of Care	1,068	935	2,003	100.0%

Table 23

Patients Out of Care in Clark and Nye Counties – By Gender

Gender	HIV	AIDS	Total	Percent
Males	844	775	1,619	80.8%
Females	224	160	384	19.2%
Total Out of Care	1,068	935	2,003	100.0%

Table 24

Patients Out of Care in Clark and Nye Counties – By Mode of Exposure

Mode of Exposure	HIV	AIDS	Total	Percent
MSM	383	533	916	45.7%
IDU	123	177	300	15.0%
MSM and IDU	61	98	159	8.0%
Adult Hemophil.	1	0	1	<0.1%
Heterosexual	79	102	181	9.0%
Transfusion	0	2	2	0.1%
Not Specified	332	15	347	17.3%
Mother	89	8	97	4.8%
Total Out of Care	1,068	935	2,003	100.0%

Table 25

Patients Out of Care in Clark and Nye Counties – Race/Ethnicity

Race/Ethnicity	HIV	AIDS	Total	Percent
White	648	546	1,194	59.6%
Black	297	236	533	26.6%
Hispanic	109	132	241	12.0%
Asian/P.I.	7	13	20	1.0%
Amer. Indian/ Alaskan Native	5	8	13	0.6%
Multiple Race	1	0	1	<0.1%
Unknown/NR	1	0	1	<0.1%
Total Out of Care	1,068	935	2,003	100.0%

The Clark County Health District reduced the overall percent "out-of-care" from 63 percent (of 4,629) to 40 percent (of 4,872) total combined HIV/AIDS cases in the last 12 months. This was the result of an intense program by the "out-of-care" project work group. The current framework is after a case is established to be "out-of-care," which involves a thorough review of records and data sources, the program staff contacts the last known provider of medical/laboratory services. In cases where physicians consider the individual an active patient, permission is sought for specially trained staff from either the Prevention or Ryan White title I Care Projects to visit the client(s) and offer referrals, counseling, and updated laboratory services. Clients without current known providers are scheduled visits directly. Nevada views HIV infections as lifelong diseases requiring updated reporting when any specimen is analyzed. Additionally, Nevada regulation allows for follow-up on individuals to ensure proper treatment is offered. Any client can refuse entry into services; however, they will be periodically contacted to ensure it is the client's wish not to enter care. Besides active work, a passive public information effort was undertaken utilizing existing forums and venues to get information circulating about "returning to care." These activities assisted in contributing to the drop within the EMA of the unmet need numbers. Illustrating the current work load of this project, at the beginning of July 2003 the "out-of-care" project work group was reviewing and finding as follows:

- 948 individuals were assigned for review
    - 497 were in services but not in primary care

- 174 were out of services and not in primary care
- 177 were never in care after their diagnoses
- 77 from the priority follow-up in 2003 were out of care cases
- 23 were discovered to be deceased

This number adjusts each month. It is the number being reviewed and has not reached the assignment for field action level yet. At any point approximately 20 to 25 individuals are being followed at that level.