COVID-19 Morbidity and Mortality by Race, Ethnicity and Language in Washington State

Washington State Department of Health

September 30, 2020

The impacts of COVID-19 morbidity and mortality have not been felt equally by all populations in Washington State. The pandemic has exacerbated the underlying and persistent inequities among historically marginalized communities and those disproportionately impacted due to structural racism and other forms of systemic oppression. This report provides an overview of confirmed COVID-19 case, hospitalization, and death rates by race and ethnicity at state and regional levels. It also provides counts and percentages of confirmed cases and hospitalizations by primary language spoken. All rates were adjusted for age using the Washington State population distribution using the Office of Financial Management’s (OFM) April 1, 2019 population estimates by age, sex, race, and Hispanic origin. There are a number of limitations with this analysis. Analyses are limited to population groups available by OFM for the Washington State population and following Department of Health guidelines. Hispanic ethnicity is assigned first, irrespective of race, and then racial groups are identified for those identifying as non-Hispanic. Based on this, our reporting includes the following groups: Hispanic, and non-Hispanic race categorizations for White, Black, Native Hawaiian and Pacific Islander, Asian, and American Indian/Alaska Native. While this allows one to assess information by race and ethnicity groups, this categorization is incomplete and does not reflect the diversity of people and experiences across the state. Additionally, there is a significant lack of race and ethnicity reporting for COVID-19 cases and hospitalizations (about 32% missing) and for deaths (about 2% missing). Primary language spoken is missing for about 49% of cases and hospitalizations. Age information is missing for a small percentage of cases (<1%), and these cases are not included in age-adjusted rates. The lack of data limits our ability to draw firm conclusions; however, there are some concerning patterns.

Cumulative Age-adjusted COVID-19 Case, Hospitalization, and Death Rates by Race and Ethnicity per 100,000 Population

The table and figures below describe the counts and age-adjusted rates per 100,000 population in Washington by race and ethnicity for cases, hospitalizations, and deaths for the entire time period from the start of the pandemic through 2020-09-29 based on the specimen collection date. 95% confidence intervals are included in the charts. The data show that communities of color are disproportionately impacted by COVID-19 in significant ways. Native Hawaiian and Other Pacific Islander (NHOPI) and Hispanic populations have the highest age-adjusted case rates while White and Asian people have
the lowest case rates. Case rates for NHOPi and Hispanics are approximately seven times higher than case rates for Asians and Whites. Case rates for Black populations are approximately three times higher than case rates among Asian and Whites. Hospitalization rates are the highest for NHOPi and lowest for White populations. NHOPi hospitalization rates are thirteen times higher and Hispanic hospitalization rates are eight times higher compared to Whites. Hospitalization rates for black and AIAN populations are 3.5 times higher compared to Whites. White populations have the lowest death rates among all race/ethnicity groups. By contrast, NHOPi populations have death rates six times higher than Whites; AIAN and Hispanic populations have death rates four times higher than Whites, and Black populations have death rates that are about twice as high as White populations.

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Case Count</th>
<th>Age-Adjusted Case Rate per 100,000</th>
<th>Hospitalization Count</th>
<th>Age-Adjusted Hospitalization Rate per 100,000</th>
<th>Death Count</th>
<th>Age-Adjusted Death Rate per 100,000</th>
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Source: Washington Disease Reporting System (WDRS)
Includes data from 2020-01-19 to 2020-09-29
Washington Regions for Analysis

Some counties may not have sufficient case counts to analyze trends by race and ethnicity. In order to incorporate data from counties of all sizes, counties were assigned into one of 8 regions (see Map of Washington Counties and Analysis Regions below). The regions presented were developed by the Washington State Department of Health in order to better understand geographic differences in disease spread and how disease spread may be changing over time. While infection rates may not be the same within any given region, this regional grouping allows for more specific geographic analyses without excluding any counties or communities due to concerns about smaller numbers.
Missing Race Data by Region

The following table summarizes missing race/ethnicity data by region. The total number of cases, the number of cases with missing data, and the percentage of cases with missing data are shown. The Southwest, East, and North Central regions have the highest percentage of missing data and the North region has the lowest percentage of missing data.

<table>
<thead>
<tr>
<th>Region</th>
<th>Case Count</th>
<th>Cases with Unknown Race/Ethnicity</th>
<th>% Cases with Unknown Race/Ethnicity</th>
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<td>4338</td>
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<td>North</td>
<td>2809</td>
<td>353</td>
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<tr>
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<td>3286</td>
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<tr>
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<td>1528</td>
<td>230</td>
<td>15%</td>
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<tr>
<td>Puget Sound</td>
<td>37421</td>
<td>10866</td>
<td>29%</td>
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<tr>
<td>South Central</td>
<td>21470</td>
<td>5444</td>
<td>25%</td>
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Cumulative Age-adjusted Case Rates per 100,000 Population by Race, Ethnicity, and Analytic Region

The figures below describe the age-adjusted case rates by race/ethnicity and region. They were calculated using the cases with known race/ethnicity (about 68% of all reported cases). It is important to note that the numeric scale differs across regions, so use caution when comparing two or more regions, as their scale will differ. The last figure presents the results for the whole state. These data show that COVID-19 is found in significant numbers across racial and ethnic groups throughout the state, and it is not confined to certain areas, such as rural, urban, or suburban regions. Population centers in Puget Sound contribute substantially to the counts. However less populated regions, like South Central Washington, have similar differences by race/ethnicity, yet even higher rates. Further, while extreme disparities exist, people of all races and ethnicities are impacted.

<table>
<thead>
<tr>
<th>Region</th>
<th>Case Count</th>
<th>Cases with Unknown Race/Ethnicity</th>
<th>% Cases with Unknown Race/Ethnicity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Southwest</td>
<td>4068</td>
<td>2625</td>
<td>65%</td>
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<tr>
<td>West</td>
<td>2666</td>
<td>483</td>
<td>18%</td>
</tr>
<tr>
<td>Unknown</td>
<td>302</td>
<td>299</td>
<td>99%</td>
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</table>

Source: Washington Disease Reporting System (WDRS)
Includes data from 2020-01-19 to 2020-09-29
Age-adjusted Case Rates per 100,000 population by Race and Ethnicity by two-week period (March-September* 2020)

*September 2020 data include all cases with a specimen collection date through 2020-09-13 to include the most recent, complete two week period of data collection.

Monthly confirmed case rates, adjusted for age by race and ethnicity, were calculated to better understand how race- and ethnicity-specific patterns may be changing over time. Monthly race-specific counts and age-adjusted rates increased for all race/ethnicity groups through July and early August 2020, but have shown some declines since mid-August. However, case rates remain higher for NHOPI, Hispanic, Black, and AIAN populations in comparison to White, Asian, and Multiracial populations.
Race/Ethnicity

<table>
<thead>
<tr>
<th>2 Week Start Date</th>
<th>Case Count</th>
<th>Age-Adjusted Case Rate per 100,000</th>
<th>Lower 95% Confidence Interval</th>
<th>Upper 95% Confidence Interval</th>
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Hispanic

Age-adjusted Case Rates by 2 Weeks

- AIAN
- Multiracial
- NHAPI
- Black
- Asian
- White
- Hispanic
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<th>Race/Ethnicity</th>
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<th>Lower 95% Confidence Interval</th>
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<td>Age-Adjusted Case Rate per 100,000</td>
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<td>Upper 95% Confidence Interval</td>
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<td>27.3</td>
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<td>August 30</td>
<td>48</td>
<td>50.4</td>
<td>37.9</td>
<td>67.0</td>
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</tbody>
</table>

*Source: Washington Disease Reporting System (WDRS)*
*Data from 2020-03-01 to 2020-09-13*

**Cumulative Crude Case Counts and Percentages by Language Spoken**

Analysis of language spoken provides another important method to understand health disparities and communities impacted by COVID-19. Use of one method alone may mask health disparities and community-specific impacts. Almost half of reported cases are missing information on primary language. Despite missing data, there are some important observations. The following table presents counts and percentages of confirmed cases, by primary language spoken. The percentage of the Washington State population 5 years and over with limited English proficiency that speak each language are also included to provide context. The Washington State data are from the Office of Financial Management 2016 estimate of population with limited English proficiency. Findings should be interpreted with caution due to the high proportion of missing data (49%).
### Language Case Count and Hospitalization Count

<table>
<thead>
<tr>
<th>Language</th>
<th>Case Count</th>
<th>Hospitalization Count</th>
<th>% of WA Population with Limited English Proficiency*</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Cases</td>
<td>87522</td>
<td>7533</td>
<td>NA</td>
</tr>
<tr>
<td>Unknown Language</td>
<td>43300</td>
<td>49.5%</td>
<td>NA</td>
</tr>
<tr>
<td>Known Language</td>
<td>44222</td>
<td>50.5%</td>
<td>NA</td>
</tr>
<tr>
<td>English</td>
<td>31838</td>
<td>72.0*%</td>
<td>NA</td>
</tr>
<tr>
<td>Spanish</td>
<td>10376</td>
<td>23.5%</td>
<td>6.4</td>
</tr>
<tr>
<td>Marshallese</td>
<td>305</td>
<td>0.7*%</td>
<td>0.1</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>217</td>
<td>0.5*%</td>
<td>0.5</td>
</tr>
<tr>
<td>Russian</td>
<td>317</td>
<td>0.7*%</td>
<td>0.3</td>
</tr>
<tr>
<td>Chinese (all)</td>
<td>76</td>
<td>0.2*%</td>
<td>0.3</td>
</tr>
<tr>
<td>Ukrainian</td>
<td>121</td>
<td>0.3*%</td>
<td>0.2</td>
</tr>
<tr>
<td>Somali</td>
<td>131</td>
<td>0.3%</td>
<td>0.2</td>
</tr>
<tr>
<td>Tagalog</td>
<td>66</td>
<td>0.1*%</td>
<td>0.2</td>
</tr>
<tr>
<td>Amharic</td>
<td>55</td>
<td>0.1*%</td>
<td>0.1</td>
</tr>
<tr>
<td>Other</td>
<td>720</td>
<td>1.6*%</td>
<td>NA</td>
</tr>
</tbody>
</table>

*These percentages are out of the population with a known language.

### Cumulative Hospitalization Percentages by Language Spoken

The following graph presents percentages of confirmed cases with each primary language who were hospitalized. The high rates of hospitalizations among cases whose primary language was other than English or Spanish, suggests that increased exposures and/or barriers to care may contribute to more severe disease in these populations. Languages with less than 10 individuals hospitalized were removed from this analysis to protect patient confidentiality. Findings should be interpreted with caution due to the high proportion of missing data (49%).
<table>
<thead>
<tr>
<th>Language</th>
<th>Case Count</th>
<th>Hospitalization Count</th>
<th>% language specific cases hospitalized</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ukrainian</td>
<td>121</td>
<td>37</td>
<td>30.6%</td>
</tr>
<tr>
<td>Tagalog</td>
<td>66</td>
<td>19</td>
<td>28.8%</td>
</tr>
<tr>
<td>Other</td>
<td>720</td>
<td>113</td>
<td>15.7%</td>
</tr>
</tbody>
</table>

![Hospitalization by Primary Language Spoken](image-url)