COVID-19 Data FAQs

Last updated 8/6/20

What's the difference between the weekly "epi curve" graph and the weekly cumulative case count graph?

- An epi curve (epidemiological curve) shows the number of confirmed cases based on when symptoms started. If someone was tested on a Friday, but symptoms started on a Wednesday, that case would be included in Wednesday's numbers in our epi curve.
- A cumulative case count shows the number of confirmed cases as they are reported to us. If someone was tested on a Friday, but symptoms started on a Wednesday, that case would be included in Friday's numbers in our case count graph. Because of the differences between when a person starts experiencing symptoms, and when that person gets tested, the numbers on these two graphs will not match.

Where does our Whatcom County case data come from?

Whatcom County receives its data from the Washington Disease Reporting System, which is the database that different health care groups such as clinics, hospitals and health departments receive, enter and track disease-related data. It's a system that we regularly use to track many diseases of public health concern.

Why do we use rates when talking about case numbers in our county?

We use rates (ex: cases per 100,000 residents) to report some data because a rate factors in different population sizes and demographics. Rates let us compare groups that have different sizes, and we use rates often in our public health data.

For instance, 100 cases in a county with 10,000 people looks very different than 100 cases in a county with 100,000 people. One out of every hundred people in the county with 10,000 people has a confirmed case, while one out of every thousand people in the county with 100,000 people has a confirmed case.

Some of our data shows the rate of newly confirmed cases over a two week period. The two week timeframe was chosen to match the Washington State Risk Assessment Dashboard and because new infections may take up to two weeks before being diagnosed. The two week rate of newly confirmed cases allows us to better understand and respond to active infections by showing only those cases that have been diagnosed over the previous two weeks.

Why do you use school district boundaries when showing the location of cases around the county rather than zip codes?

When looking at data by sub-county location, we often use public school districts to define community boundaries. We do this because many people tend to identify their community in connection to schools and school districts. We don't use some other boundaries like zip codes or census tracts because:

- Zip codes cut through cities and towns, so they don't align well with the way many of us identify where we live.

- Census tracts are much smaller boundaries that are more like neighborhoods. If we were to use census tracts in our data analysis, we couldn't share a lot of the data publicly. That's because we have to follow small numbers guidelines that protect the privacy and confidentiality of protected health information, and help us share reliable and accurate data.

Why aren't you sharing recovery data?

We are unable to share recovery data for a few reasons. First, for quite a while, there was not a good, official definition of what recovery meant in relation to COVID-19. We also don't have the ability to track and contact people with confirmed cases and ask them for updates about their symptoms on a regular basis. Recovery is often a spectrum, and doesn't happen the same way for everyone. A person typically doesn't wake up one day and feel totally back to normal, it's a gradual process that happens at different rates for different people. There may also be some who have had an antibody test that suggests they've had the virus, but who never had preliminary testing when they were having symptoms. Others were close contacts, or even roommates of people who had confirmed cases, but were not tested. These are some of the factors that have made tracking recoveries difficult.

Are antibody tests reported?

As of right now, we are not reporting antibody testing numbers or information. There are dozens of antibody tests being marketed in the United States that haven't been fully validated yet. Some tests are more accurate than others, and some can't be compared to each other. We simply don't know at this point that those tests are giving valid information.

Also, there isn't yet enough scientific information to tell us how long immunity lasts in people who have been infected. With many diseases, immunity can wane over time for various reasons. We need to study this more before we can say that an antibody test proves immunity to COVID-19 in the long run.

Why are there some data that you don't share?

Federal laws protect your health information so that it's kept private. We only share protected health information if it's legally required. We also do not share some data that aren't specifically addressed as protected health information when we have a reasonable concern that sharing the data, or a combination of data, could allow an individual person to be identified. For example, we don't share the sex, age and city of residence for cases of disease, because it's possible that in small communities, that could be enough information for someone to identify the specific person who is sick.

We follow the Washington State Department of Health (DOH) Small Numbers Standards. Based on these standards, we do not share numbers less than 10 except when the value to the public is critical. For example, we reported first cases of COVID-19 in the county, even though the total case count in our community was less than 10.

To be meaningful, our data sets must be 80% complete to conduct analyses or provide information about sub-sets of the data. If the data aren't complete, we risk sharing inaccurate and unreliable data. For example, early on in the COVID-19 outbreak, we did not have race or ethnicity data for many confirmed cases. Once we had race and ethnicity data for at least 80% of confirmed cases, we were able to share a breakdown of confirmed cases by race or ethnicity.

Why don't you share details about outbreaks or clusters?

We do not share specifics about disease clusters, or industry- or employer-specific data at this time. There are several reasons for this. We need to ensure that industries, employers, employees, and groups are willing to cooperate with us during disease investigations. Releasing information about a business, employer, or gathering can hinder the trust and cooperation needed for our investigations to be effective. Maintaining trust is essential to our work. Secondly, consistent with the expectation of privacy provided by HIPAA, we do not release any details that might make it possible to specifically identify anyone's medical condition.

We provide the following stratified sub-population data:

- Age by decade
- Sex at birth
- By sub-geography
- Race and ethnicity

We update these data at a level of frequency that assures timely, reliable, and meaningful use and ensures completeness and accuracy of the data.