

## Big Data in a Pandemic

## Internet of living things – big data can save lives and economies

Over the past few years we have been researching the use of big data in investing (see our primer on big data and machine learning here). Companies often utilize big data to monitor consumer spending patterns or assess corporate or economic activity in real time. With the outbreak of the COVID-19 pandemic, investors used big data to track air pollution, traffic congestion and shipping activity in China. In retrospect, big data should have been urgently mobilized in the more important tasks of saving lives and protecting economies. In this note we will propose a potential big data solution - 'internet of living things' - that can be employed to fight a pandemic and help in re-opening economies in its aftermath.

A leading authority in epidemics recently stated: "If you think you are in line with the outbreak, you are already three weeks behind." In the age of big data, machine learning and internet of things, this could be different, as technologies exist to have a real-time picture of a pandemic. Real-time assessment would allow authorities to be ahead of the virus, to optimize the response and resources, and to assess the effectiveness of measures taken. Why are traditional data always lagging the virus? When the first symptoms of an illness appears, most people wait some time to confirm the symptoms or wait in hope that initially mild symptoms go away. After several days they may seek medical help, but appointments or tests may not be immediately available. When virus tests are obtained, results may take several additional days to arrive. In all, from the first onset of symptoms to a confirmation of a disease, it may take 1 or 2 weeks, often even longer. If there is a pandemic outbreak, 1 or 2 weeks may mean that the virus is already spread out of control, before it even shows in official statistics.

Big data revolution came largely as a result of widespread use of internet-enabled smart phones and ability to process large quantities of structured and unstructured data in real time. There is no reason why anonymized, aggregate information about onset of disease symptoms could not be available and tracked by artificial intelligence in real time. Output of such a system would be used to prevent and contain pandemics, as well as manage re-opening of economies in the aftermath. In an analogy to the internet of things, we can call this system the 'internet of living things.' Below we roughly outline possible components of an 'internet of living things' – big data/AI system to prevent and mitigate global pandemics.

Of course, great care will need to be taken to ensure data is protected, anonymized and used only in aggregate, to prevent personal data from being stolen or manipulated by a malicious actor.

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Global pandemic 'daily roll call': similar to how many employers conduct daily roll calls of employees and track their health status, one could have a daily smartphone-based survey of the broad population. For instance, the survey could be administered via required landing page on iOS/Android smart phone devices, or via text messages (similar to emergency alerts). Each user would need to input their status regarding disease symptoms (e.g., temperature reading and other symptoms for individual and/or household members). A minute of time would be a small ask during a pandemic, but would provide likely the most comprehensive real-time picture of illness and its dynamics. Individual countries could also require the smart phone roll call by mandating it (similar to census), or tying it to specific government incentives (e.g., mobile payments to survey participants, consumption vouchers, health care credits, etc.).

**Broad distribution of free diagnostic smart-devices**: by providing free devices such as smart thermometers or other internet connected diagnostic tools (e.g., smart watch sensors, etc.), countries could create their own 'internet of living things' networks. From these networks, health authorities could obtain a real-time picture and be able to prevent and manage seasonal outbreaks, region-specific illnesses, or global pandemics. The internet of living things could be an ongoing system with its own economics, or it could be an emergency response system activated as a response to an epidemic.

Establishing of big data pandemic war rooms: either on a global, regional, or country level, these centers would be needed to process and analyze large volumes of complex data obtained from the 'internet of living things.' Once the data are processed, these war rooms of data scientists and health professionals would coordinate the response with appropriate authorities. Insights obtained from surveys or smart devices would allow governments to act during initial stages of an outbreak, manage containment measures, and later optimize reopening the economy (region by region, and in different phases), while managing and monitoring risks of creating secondary outbreaks in real time.

Make available all pandemic-relevant data to allow for crowdsourcing solutions: Many big data and AI challenges over the past years were solved with a method of crowdsourcing. A dataset is posted on a website, open for anyone to tackle it and find

a solution (usually there is an award for a person who first solves the problem). Millions of talented scholars and data scientists across the developed and developing world would be available to seek and find a solution. Following this template, all the data relevant for the pandemic and remedies should be available on a central website in real time. Problems such as forecasting outbreaks, assessing prevention measures, assessing success rate of various treatments, etc., would likely be solved quicker and better via crowdsourcing. For example – recently there has been a lot of discussions on the effectiveness of malaria drug Hydroxycholorquine in the treatment of COVID-19. There are several inconclusive and incompatible studies about the efficacy of this drug (e.g., there are 2 papers from French authors, 2 from Chinese, 1 from Korean, various other data points from governments, hospitals and even individuals, and a number of ongoing official trials). If these data were available in real time, there would likely be a machine learning/AI-driven model that could combine the different datasets to produce a probability model for success of this drug (e.g., integration of traditional and unstructured data, partial and ongoing trial results, etc.). Such a machine learning /AI algorithm would allow medical professionals to make potentially life-saving decisions (be it to use or not to use) ahead of slower traditional statistical studies that are employed during 'peace time.' Finally, one could



make available data such as 3D scans of all parts for various equipment such as masks, ventilators, etc., to allow for a distributed 3D printing supply chain.

Individualized AI assessment to re-enter economy: All of the 'internet of living things' data (e.g., specific to individual's health risk, immunity status, region specific risks to contract or spread disease in a particular region, etc.) could be processed by AI to recommend to an individual potential restrictions (or removal of restrictions) of travelling to certain areas, re-entering the workforce, etc. The recommendations would be produced based on an individual's as well as comprehensive 'internet of living things' real time data, and could reduce risk for the individual, for others, and could optimize re-starting of economy case by case, in different geographic regions and stages of pandemic.

# We believe the creation of an 'internet of living things' to address pandemic risk should be an immediate and an ongoing priority.

In our last note, we featured one real-time big/alternative dataset that reports the occurrence of influenza like illness coming from kinsa thermometers (see <a href="here">here</a> and further below in this note). As we mentioned before, we believe this dataset is very useful in tracking real-time outbreaks of atypical influenza-like illnesses across the country. We believe this dataset correctly pointed to COVID-19 outbreaks ahead of these outbreaks being reported in the media or being documented in official data releases. We also believe that this dataset provides useful insights on the efficacy of measures put in place to restrict the spread of all iLIs, which include COVID-19. As with any big/alternative dataset, answers are not readily available and there are various biases and limitations on what can and cannot be extracted from such a dataset.

To illustrate further our thinking process and explore the limitations of models, we have analyzed NYC iLI data in conjunction with various COVID-19 datasets made available by state authorities and hospitals. In this study, we are not trying to forecast an absolute number of cases, but rather provide an example of incorporating big/alternative data into model projections, illustrate modelling challenges (e.g., model design and how various assumptions impact the output), and gain insights on the timing of a potential hospitalization case inflection point.

Our first assumption is that that the atypical increase of iLI in March is largely driven by COVID-19 cases, and that the decline of iLI is largely driven by implemented restrictions. However, one cannot infer how much of the iLI decline is due to a decline in cold/flu and how much is due to a decline in COVID-19. At one extreme (optimistic), all of the decline is due to a COVID-19 decline, and at the other extreme (pessimistic) none of decline is due to COVID-19 (note, however, cold/flu decline is also important as it frees up hospital capacity). The truth is likely somewhere in between, so we averaged the two scenarios. The second important assumption is on the recovery rate and timeline for COVID-19 cases. Here we took the available information on the average recovery time of ~2 weeks (for milder cases), and ~4 weeks recovery for severe cases, and fitted a smooth recovery curve for each day of atypical iLI. This approach can give us the model number of the total COVID-19 positive cases each day. This number is of course much larger than the number of test-confirmed cases (e.g., many COVID-19 cases won't be tested due to mild symptoms or being asymptomatic, self-isolation/home care, early recovery, unwillingness or inability to obtain a test, etc.). We believe that the number of tests confirmed is not the most relevant metric (e.g., in the 2017/2018 flu season there were ~45M flu cases, the vast majority of which weren't confirmed by testing), but

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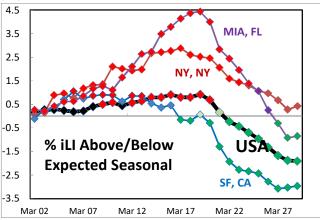
rather the important metric is hospital admissions/loads that create risk of a health care system breakdown.

Inflection in hospital admissions is a function of actual number of cases, as well as the timeline of progression of cases from mild to severe, and hospitalization rates (currently averaging ~20% of confirmed cases). Hospitalization rates however lag the number of actual cases. As we argued initially, after the first onset of symptoms, there could be 1-2 weeks before a person is potentially hospitalized. In that time period, a significant fraction of mild cases will actually get better, eliminating the need for hospitalization. Hospitalization rates are themselves self-reflexive: the longer a person does not recover from COVID-19, the higher the likelihood of hospitalization. So we modeled hospitalization rates iteratively in conjunction with recovery rates. In other words, as the number of true cases declines (due to recovery of mild cases), % hospitalization of cases increases as they did not recover and are becoming severe/critical. Modeling recovery and hospitalization curves introduce additional uncertainty in our model. Our model indicates that the number of NYC infections peaked already (model indicates approximately 8 days ago) at a much larger number than current confirmed cases of 33,474. Due to the lag in recovery and hospitalization rate curves, our model shows peak hospitalization occurring this past weekend, with some ~17,000 cases. We don't rely on the total number of hospitalizations in our model as accurate, as it needs to be scaled with the total number of cases (which will likely never be fully known due to mild and asymptomatic cases). In fact we know our model is over-estimating the number of hospitalizations as the current actual number is only 7,410. We do have more confidence in the potential inflection in hospitalizations that our model indicates is happening now. Data from Sunday's press conference held by Gov. Cuomo show a meaningful slowdown in hospitalizations over the past 3 days, as well as a faster increase in hospital discharges than hospital admissions, both of which are roughly consistent with our model.

Figure 1 shows the % iLI above/below expected seasonal – an update of the chart from our last report (<a href="here">here</a>). One can see a continued decline in atypical iLI nationally. In SF county, restrictive measures appear to be very successful and suppressed virtually all iLIs. In NY, iLI declined but is still significantly higher than the national level – as expected given how severe the NY outbreak is.

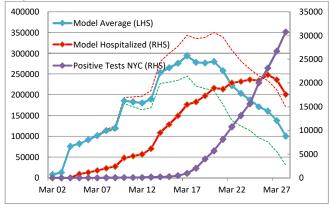
Figure 2 shows a model of NYC COVID-19 cases and hospitalization rates based on atypical iLI data, model recovery and hospitalization rates. Modeling steps/assumptions introduce uncertainty for absolute number estimates. However, the main features indicate that the number of active cases likely peaked already (model indicates ~8 days ago), and that hospitalization rates are possibly peaking now.

Figure 1: Incidence of atypical influenza-like illness by location over time



Source: kinsa, J.P. Morgan QDS.

Figure 2: Illustrative model of NYC COVID-19 cases and hospitalizations



Source: J.P. Morgan QDS.



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