

Understanding COPD patients in the hospital system via administrative data

Henry Wilde, Vincent Knight, Jonathan Gillard

Abstract

This work presents an analysis of how patients with chronic obstructive pulmonary disorder (COPD) interact with the hospital system in South Wales.

1 Introduction

This introduction will briefly summarise the literature review for studying a patient corpus via clustering. Following this, a condensed data analysis is presented highlighting the main conclusions of the clustering and the overall benefits compared with traditional condition-treatment segmentation.

2 Constructing the queuing model

The simplest queuing model using the data available is an $M|M|c$ queue with multiple classes. In this model, the following assumptions are made:

1. Inter-arrival and service times of patients are each exponential with some mean.
2. There are c servers available to arriving patients at a single node representing the overall resource availability at the hospital.
3. There is no queue or system capacity.
4. A first-in first-out service policy is implemented.

Each group of patients has its own arrival distribution. The parameter of this distribution is taken to be the reciprocal of the mean inter-arrival times for that group.

Like arrivals, each group of patients has its own service time distribution. The parameter of this distribution is approximated via the length of a patient's stay, i.e. the total time spent in the system. Without full details of the process order or idle periods during a spell, some assumption must be made about the true 'service' time in relation to the time spent in hospital. This work considers the mean service time, $\frac{1}{\mu}$, to be directly proportional to the mean total system time, $\frac{1}{\phi}$, such that:

$$\mu = p\phi \tag{1}$$

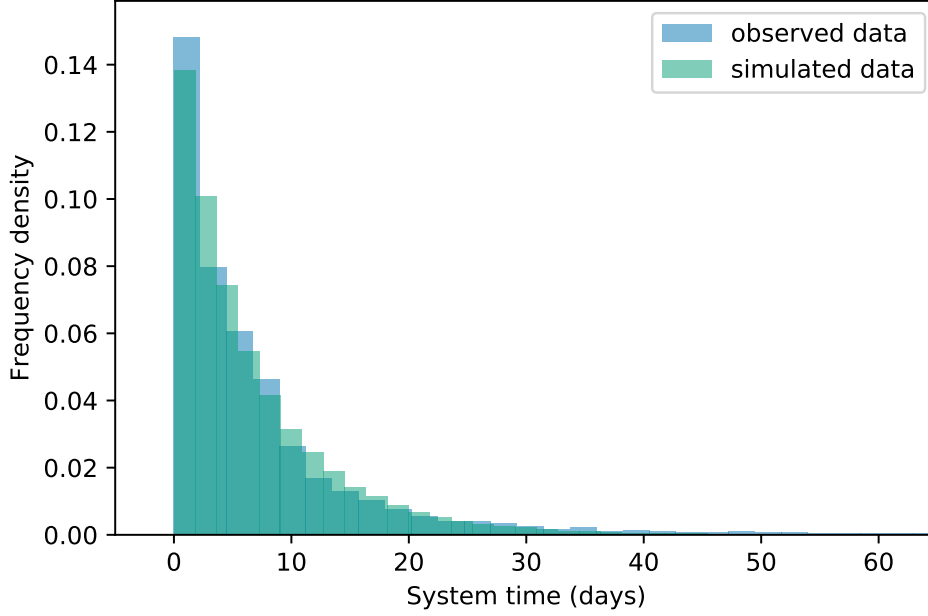


Figure 1: A histogram of the simulated and observed length of stay data for the best parameter set.

where $p \in (0, 1]$ is some parameter to be determined for each group, denoted by p_i for group i .

As the full details of how the patients move through the hospital system, and the details of the system itself, are unknown, an appropriate number of servers c must be found as well as each p_i . Finding the optimal resource capacity, represented by c , for the system is often a difficult problem solved using simulation models as in [3, 2]

In order to evaluate appropriate values of each p_i and the value of c , the system is simulated across of parameter space. Then, for each set of parameters, the total time distribution is compared with that in the available data via the (first) Wasserstein distance. This distance measures the approximate ‘minimal work’ required to move between two probability distributions where ‘work’ can be loosely defined as the product of how much of the distribution’s mass must be to be moved with the distance it must be moved by. More formally, the Wasserstein distance between two probability distributions U and V is defined as:

$$W(U, V) = \int_0^1 |F^{-1}(t) - G^{-1}(t)| dt \quad (2)$$

where F and G are the cumulative density functions of U and V respectively. A proof of (2) is presented in [1]. The parameter set with the smallest maximum distance over a number of runs is then taken to be the most appropriate.

The results of this parameter estimation can be summarised in Figures 1 and 2. Each figure shows a comparison between the observed lengths of stay across all groups with the newly simulated data with the best and worst parameter sets respectively. Indeed, it can be seen that, in the best case, a very close fit has

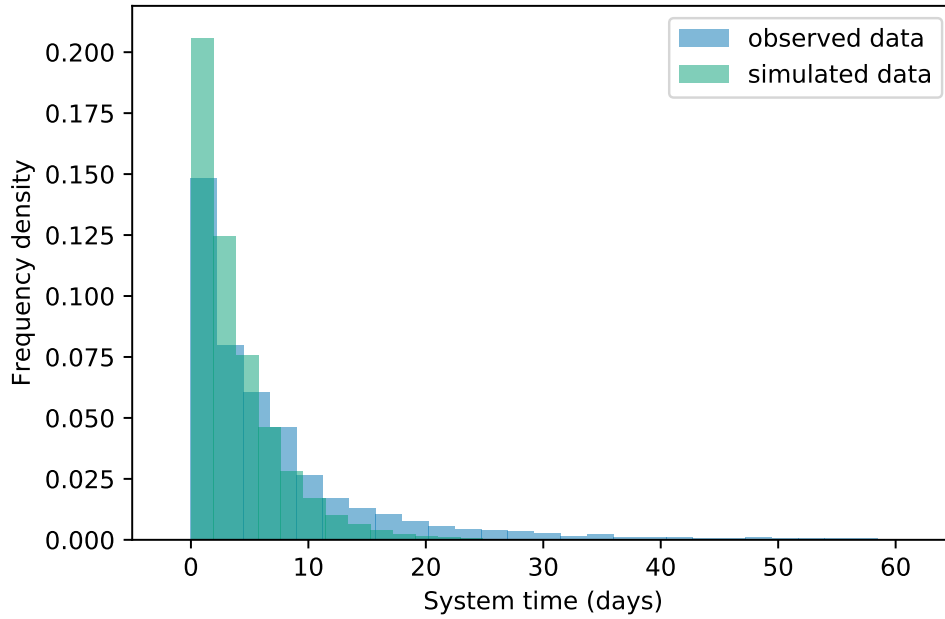


Figure 2: A histogram of the simulated and observed length of stay data for the worst parameter set.

been found. Meanwhile, Figure 2 highlights the importance of good parameter estimation under this model since the likelihood of short-stay patient arrivals has been inflated disproportionately.

3 Adjusting the queuing model

Body of the writing and plots come here. What can we see in the what-if scenarios? The main scenarios are:

- How would server utilisation (i.e. resource consumption) be affected by an increase in overall patient arrivals?
- How is the system affected by certain types of patients (e.g. short-stay, low-impact) arriving less frequently?
- What are the sensitivities of mean system times and server utilisation based on a change in c ?

4 Conclusion

Summarise the findings and novelty of the paper: sensitivity analysis and queuing models are within reach despite a lack of data. The chosen modelling discipline for service times is very simplistic but can return good results (refer back to best-case parameter plot).

References

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