Week 3: Evaluating Models

Dr. Rachel Sippy
University of Cambridge

Week 3 Overview

- Monday, August 9:
  - ~~Guest lecture & R session by Megan O'Driscoll~~
  - ~~Stochastic models~~
  - ~~Guided practice in R~~
- ~~Tuesday, August 10:~~
  - ~~Step-by-step model building~~
  - ~~Building a COVID-19 model~~
  - ~~Guided practice in R~~
- Wednesday, August 11:
  - Guest lecture: COVID-19 in Bangladesh by Kate Hampson
  - Comparing models to data & evaluating models
  - Guided practice in R

Post Questions in the Chat!

(or ask over microphone)

Workshop Schedule

Time	Topics
2:00—2:10 pm	~~Greetings~~
2:10—3:00 pm	COVID-19 in Bangladesh – Dr. Kate Hampson
3:00—3:10 pm	Break
3:10—3:20 pm	Sensitivity Analysis
3:20—3:50 pm	Assessing Models
3:50—4:00 pm	Break
4:00—5:00 pm	Review & Questions

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Sensitivity Analysis

Terminology

Parameterization	Selecting values for the parameters in the model (taking from literature, best guess, fitting to data)
Fitting (calibration)	Parameterizing the model by finding a model with the “best” fit to some data (using a statistical goodness of fit metric)
Validation	Comparing the results of a parameterized model to data to see if the results are “valid” (are the results reasonable or using some statistical test)
Sensitivity analysis	Changing the values of parameters to see how this affects the results (one-way or multi-way)

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  - see how the model performs under range of conditions
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- How does parameter uncertainty affect results?
  - how big is the uncertainty around each parameter
  - how important is the parameter

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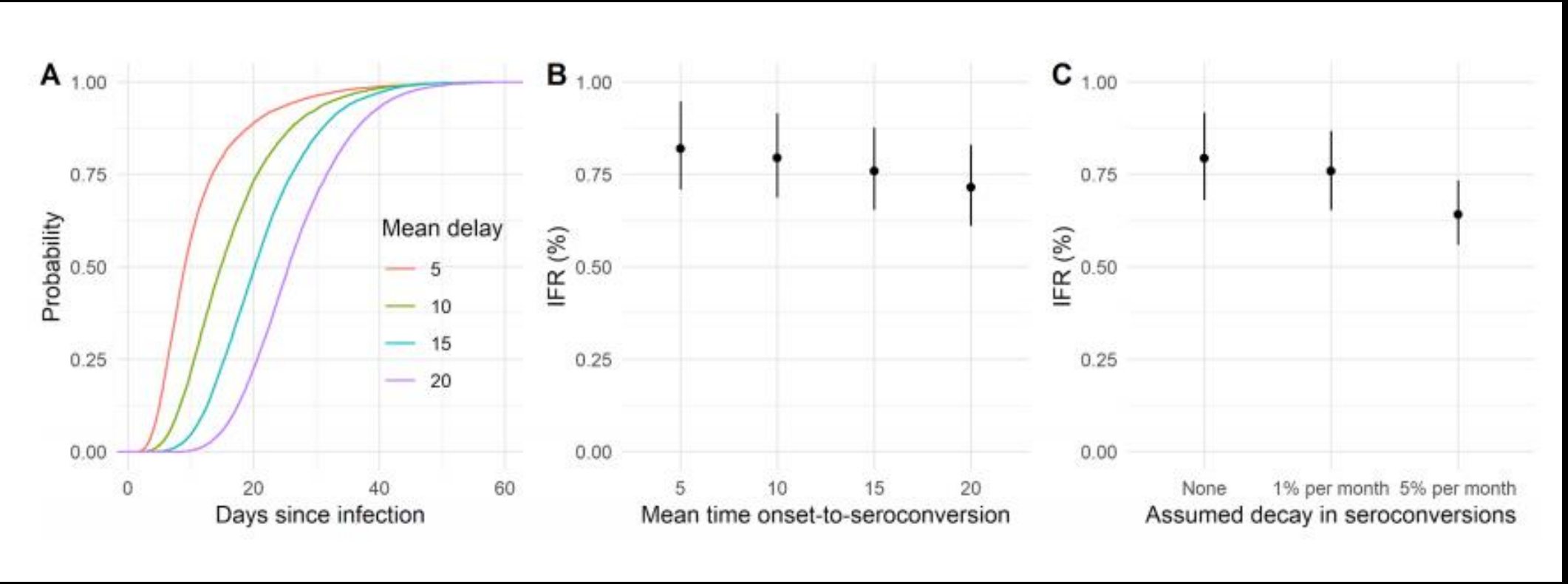
these allow you to calculate confidence intervals

Sensitivity Analysis



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Model Evaluation & Assessment

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     - Models are only one source of information!
     - We cannot make models for every question

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- Reasonable, useful & relevant!

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  - consider the model assumptions and if they are appropriate for the question
- How is uncertainty incorporated into the model?
  - has uncertainty been added to any model parameters?
  - look for confidence/prediction intervals for model estimates
  - was a sensitivity analysis performed?

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  - more than one model can help with decision-making
- How wide are the confidence intervals surrounding the estimates?
  - do not be over-confident when interpreting models
  - uncertainty will increase for long-term projections

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  - similar population? similar geopolitical setting?
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  - is the model intended to be generalizable?

comment

The importance of local context in COVID-19 models

COVID-19 models have been extensively used to inform public health officials about potential interventions. Nevertheless, careful attention must be taken when extrapolating projections and parameters across different regions, as there is no one-size-fits-all model for the pandemic.

Rosalind M. Eggo, Jeanette Dawa, Adam J. Kucharski and Zulma M. Cucunuba

Infectious disease models are an integral part of public health decision making, and have been crucial tools throughout the COVID-19 pandemic. In early 2020, models estimated the extent of COVID-19 in Wuhan and regional patterns of importations, made projections of potential epidemics and healthcare needs, and provided short-term predictions of case numbers in newly unfolding outbreaks. As countries considered control and mitigation measures, models helped assess likely effects of proposed interventions and determine 'counterfactuals', that is, expected epidemic trajectories if an intervention was not implemented. However, it is important to stress that the quality of such projections depends on within- and between-country variation in transmission, control and burden.

Transmission

The dynamics of directly transmitted respiratory infections depend on multiple factors, including population demography: variation in age and spatial distribution; size and composition of households, schools, and workplaces; and population behavior, often measured as contact rates between

that each sub-community has a separate epidemic[3], caused by structure within a city[4], geographics[5] or other factors. National or regional differences in extent or type of community structure may impact projections, and multi-peaked epidemics can also result from interventions. These effects are especially difficult to predict for new pathogens.

Another factor is the frequency and characteristics of different settings that drive transmission[6]. For COVID-19, information has emerged about high-risk settings, such as households, hospitals, congregate settings including long-term care facilities, and overcrowded communities. However, incorporating this level of complexity into transmission models before this information becomes available is challenging. As a result, the dynamics of very detailed models are likely to reflect strong underlying assumptions rather than genuine patterns in (as yet unknown) data.

Severity and impact

To project the extent and impact of COVID-19 in other countries, estimates of severity (for example, age-specific hospitalization and mortality rates) were

Excess mortality data can be useful to better understand deaths and pandemic impacts[10]. However, when using excess or all-cause mortality data, care is needed to understand the context, because interventions such as social distancing and stay-at-home orders could have decreased prevalence of other infectious diseases and thus decreased mortality, and could also have reduced deaths due to other causes (for example, road traffic accidents). Conversely, large epidemics or intensive interventions can disrupt care for non-COVID-19 causes, leading to increased morbidity and mortality that can lag the epidemic or interventions by a considerable period of time, as with deaths from diseases like cancer.

Control

Early responses to SARS-CoV-2 outbreaks varied globally, with many countries implementing lockdown-type interventions, including varying levels of school, work and business closures, stay-at-home orders, curfews and quarantines. In addition, test–trace–isolate strategies and individual-level measures like hand-washing and mask-wearing were promoted to varying

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Eggo 2021

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- What are the limitations?
  - limitations can come from the data being used and the model
  - are the limitations well-articulated?
  - be realistic about what models can and cannot do!

Wrong but Useful — What Covid-19 Epidemiologic Models Can and Cannot Tell Us

Inga Holmdahl, S.M., and Caroline Buckee, D.Phil.

Amid enormous uncertainty about the future of the Covid-19 pandemic, epidemiologic models are critical planning tools for policymakers, clinicians, and public health practitioners. Some models with apparently conflicting conclusions have received substantial press coverage, giving the impression that mathematical models are in general unreliable or inherently flawed. But infectious disease modeling is an expansive field with a long history, encompassing a range of methods and assumptions that are not necessarily directly comparable, or even designed for the same purpose (see box).

Covid-19 modeling studies generally follow one of two general approaches that we will refer to here as forecasting models and mechanistic models. Although there are hybrid approaches, these two model types tend to address different questions on different time scales, and they deal differently with uncertainty.

Forecasting models are often statistical in nature, fitting a line or curve to data and extrapolating from there — like seeing a pattern in a sequence of numbers and guessing what comes next. These models yield quantitative projections that policymakers may need in the short term to allocate resources or plan interventions.

The original versions of the controversial model from the Institute for Health Metrics and Evaluation (IHME) fell into this category, approximating the shape of the epidemic curve from outbreaks in China and Italy and applying it elsewhere (see table). Since purely statistical approaches don't account for how transmission occurs, they are generally not well suited for long-term predictions about epidemiologic dynamics (such as when the peak will occur and whether resurgence will happen) or for inference about intervention efficacy.[1] Several forecasting models therefore limit their projections to one week or a few weeks ahead.

Mechanistic models, like the Susceptible–Exposed–Infectious–Recovered frameworks, mimic the way SARS-CoV-2 spreads and can be used to forecast or simulate future transmission scenarios under various assumptions about parameters governing transmission, disease, and immunity. Unlike purely statistical models, mechanistic approaches include important nonlinear feedback — the more people become infected, the faster disease spreads. Because these models reflect the underlying transmission process, the disease-specific parameters driving it can be modified to test how the pandemic may change under various assumptions about the disease and implementation of control measures.

Mechanistic modeling is one of the only ways to explore possible long-term epidemiologic outcomes. For example, the model

Five Questions to Ask about Model Results.

1. What is the purpose and time frame of this model? For example, is it a purely statistical model intended to provide short-term forecasts or a mechanistic model investigating future scenarios? These two types of models have different limitations.
2. What are the basic model assumptions? What is being assumed about immunity and asymptomatic transmission, for example? How are contact parameters included?
3. How is uncertainty being displayed? For statistical models, how are confidence

nterest?

re applicable to your

odel

Holmdahl 2020

Assessing Models

- Is more information needed from the model?
  - model results may lead to additional questions!
  - could the model be improved or expanded?

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  - could the model be improved or expanded?
- Has the model been validated?
  - comparison of model predictions/projections to real-life data
  - fitting the model to these data and assessing model error

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16 March 2020 *Imperial College COVID-19 Response Team*

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Summary

The global impact of COVID-19 has been profound, and the public health threat it represents is the most serious seen in a respiratory virus since the 1918 H1N1 influenza pandemic. Here we present the results of epidemiological modelling which has informed policymaking in the UK and other countries in recent weeks. In the absence of a COVID-19 vaccine, we assess the potential role of a number of public health measures – so-called non-pharmaceutical interventions (NPIs) – aimed at reducing contact rates in the population and thereby reducing transmission of the virus. In the results presented here, we apply a previously published microsimulation model to two countries: the UK (Great Britain specifically) and the US. We conclude that the effectiveness of any one intervention in isolation is likely to be limited, requiring multiple interventions to be combined to have a substantial impact on transmission.

Two fundamental strategies are possible: (a) mitigation, which focuses on slowing but not necessarily

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Methods

Transmission Model

We modified an individual-based simulation model developed to support pandemic influenza planning[5,6] to explore scenarios for COVID-19 in GB. The basic structure of the model remains as previously published. In brief, individuals reside in areas defined by high-resolution population density data. Contacts with other individuals in the population are made within the household, at school, in the workplace and in the wider community. Census data were used to define the age and household distribution size. Data on average class sizes and staff-student ratios were used to generate a synthetic population of schools distributed proportional to local population density. Data on the distribution of workplace size was used to generate workplaces with commuting distance data used to locate workplaces appropriately across the population. Individuals are assigned to each of these locations at the start of the simulation.

Transmission events occur through contacts made between susceptible and infectious individuals in either the household, workplace, school or randomly in the community, with the latter depending on spatial distance between contacts. Per-capita contacts within schools were assumed to be double those elsewhere in order to reproduce the attack rates in children observed in past influenza pandemics[7]. With the parameterisation above, approximately one third of transmission occurs in the household, one third in schools and workplaces and the remaining third in the community. These contact patterns reproduce those reported in social mixing surveys[8].

We assumed an incubation period of 5.1 days[9,10]. Infectiousness is assumed to occur from 12 hours prior to the onset of symptoms for those that are symptomatic and from 4.6 days after infection in those that are asymptomatic with an infectiousness profile over time that results in a 6.5-day mean generation time. Based on fits to the early growth-rate of the epidemic in Wuhan[10,11], we make a baseline assumption that R_0=2.4 but examine values between 2.0 and 2.6. We assume that symptomatic individuals are 50% more infectious than asymptomatic individuals. Individual infectiousness is assumed to be variable, described by a gamma distribution with mean 1 and shape parameter α=0.25. On recovery from infection, individuals are assumed to be immune to re-infection in the short term. Evidence from the Flu Watch cohort study suggests that re-infection with the same strain of seasonal circulating coronavirus is highly unlikely in the same or following season (Prof Andrew Hayward, personal communication).

Infection was assumed to be seeded in each country at an exponentially growing rate (with a doubling time of 5 days) from early January 2020, with the rate of seeding being calibrated to give local epidemics which reproduced the observed cumulative number of deaths in GB or the US seen by 14th

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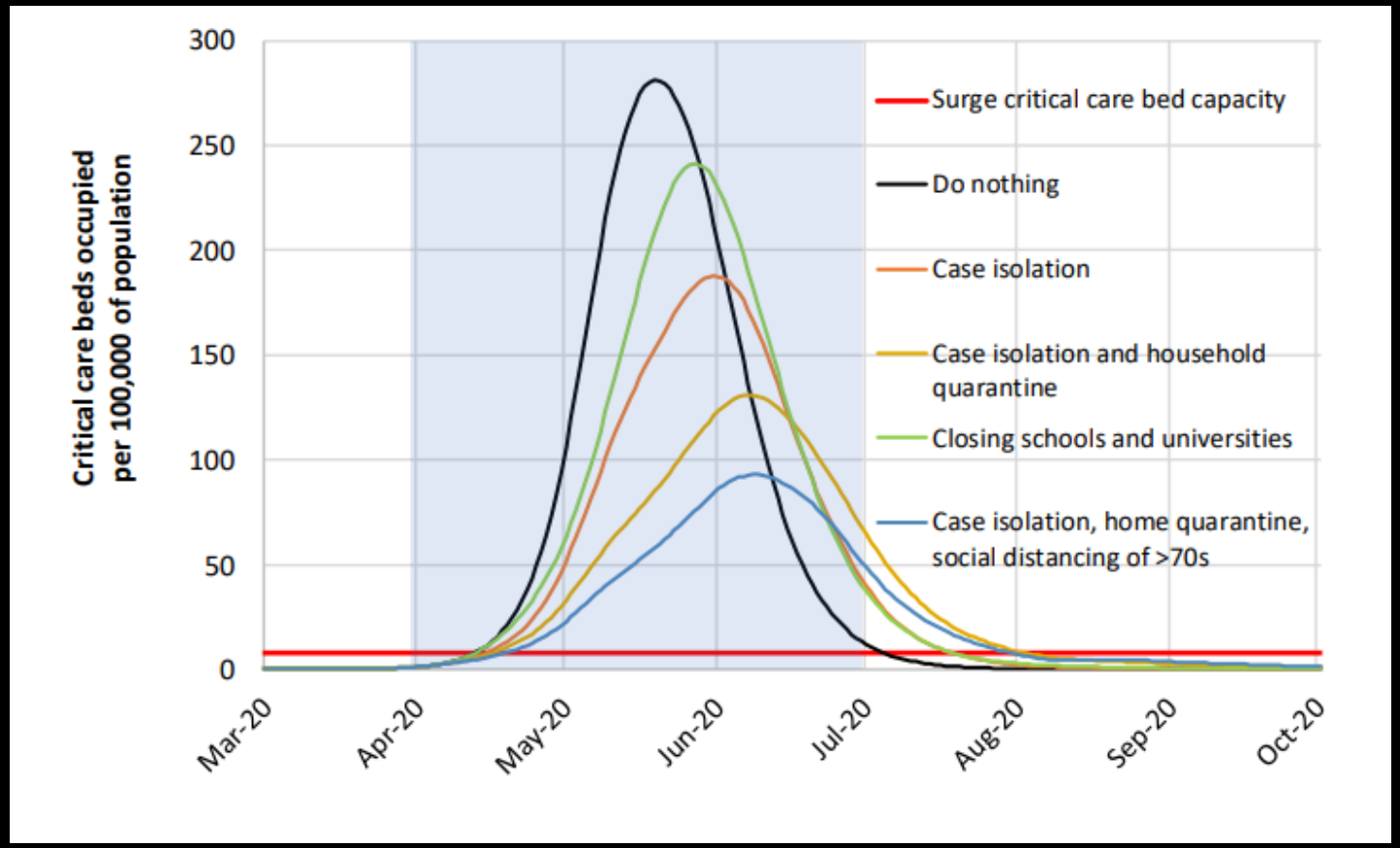

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R_0	On Trigger	Total deaths: Do nothing	CI_HQ_SD	PC_CI_SD	PC_CI_HQ_SD
2	60	410,000	47,000	6,400	5,600
	100	410,000	47,000	9,900	8,300
	200	410,000	46,000	17,000	14,000
	300	410,000	45,000	24,000	21,000
	400	410,000	44,000	30,000	26,000
2.2	60	460,000	62,000	9,700	6,900
	100	460,000	61,000	13,000	10,000
	200	460,000	64,000	23,000	17,000
	300	460,000	65,000	32,000	26,000
	400	460,000	68,000	39,000	31,000
2.4	60	510,000	85,000	12,000	8,700
	100	510,000	87,000	19,000	13,000
	200	510,000	90,000	30,000	24,000
	300	510,000	94,000	43,000	34,000
	400	510,000	98,000	53,000	39,000
2.6	60	550,000	110,000	20,000	12,000
	100	550,000	110,000	26,000	16,000
	200	550,000	120,000	39,000	30,000
	300	550,000	120,000	56,000	40,000
	400	550,000	120,000	71,000	48,000

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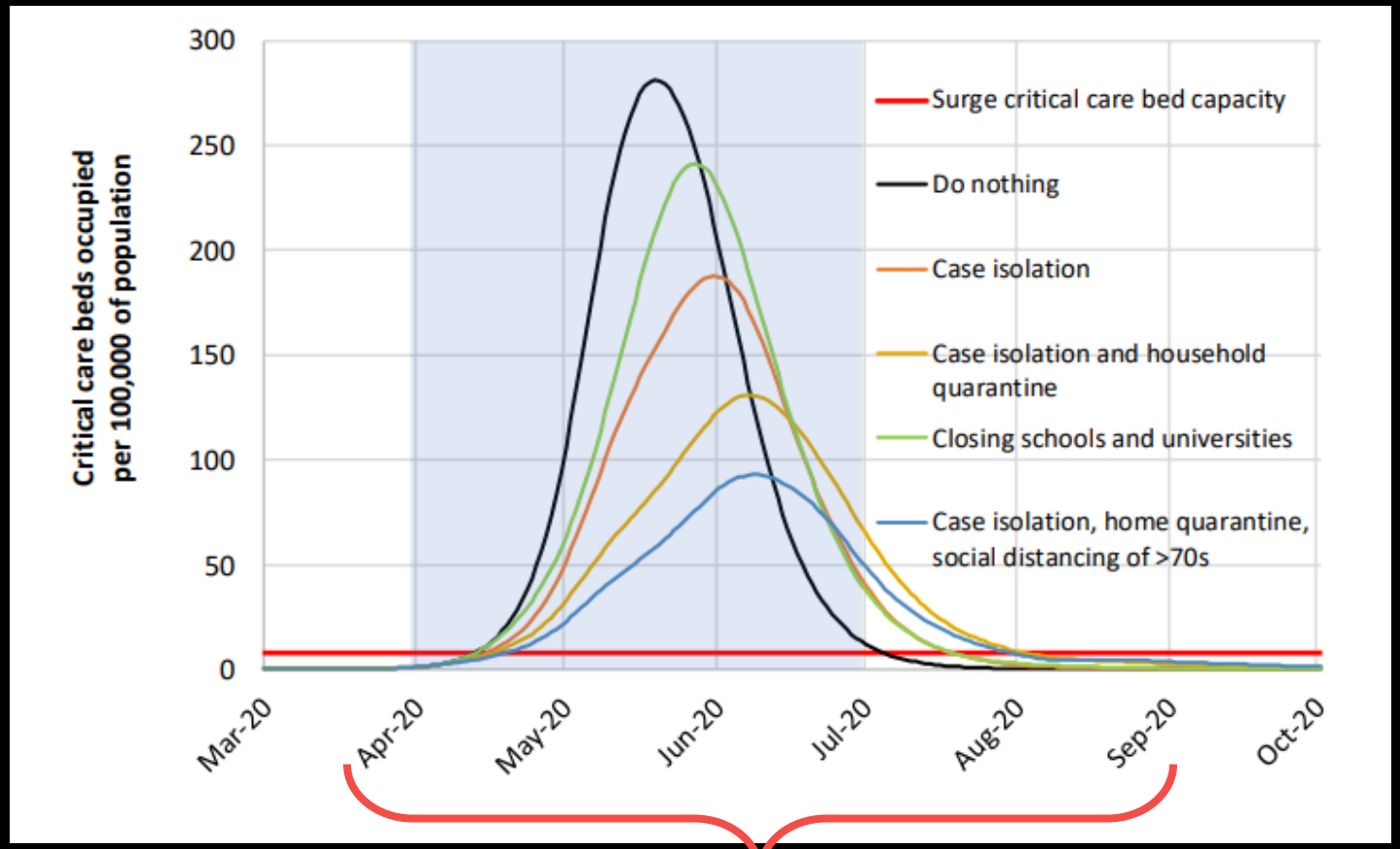
3. Are there multiple models to consider?
4. How wide are the confidence intervals?
5. Does the model represent your population/scenario?
6. What are the limitations?
7. Is more information needed from the model?
8. Has the model been validated?



6 months, start of pandemic

Assessing a Model

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To avoid a rebound in transmission, these policies will need to be maintained until large stocks of vaccine are available to immunise the population – which could be 18 months or more. Adaptive hospital surveillance-based triggers for switching on and off population-wide social distancing and school closure offer greater robustness to uncertainty than fixed duration interventions and can be adapted for regional use (e.g. at the state level in the US). Given local epidemics are not perfectly synchronised, local policies are also more efficient and can achieve comparable levels of suppression to national policies while being in force for a slightly smaller proportion of the time. However, we estimate that for a national GB policy, social distancing would need to be in force for at least 2/3 of the time (for R_0=2.4, see Table 4) until a vaccine was available.

However, there are very large uncertainties around the transmission of this virus, the likely effectiveness of different policies and the extent to which the population spontaneously adopts risk reducing behaviours. This means it is difficult to be definitive about the likely initial duration of measures which will be required, except that it will be several months. Future decisions on when and for how long to relax policies will need to be informed by ongoing surveillance.

The measures used to achieve suppression might also evolve over time. As case numbers fall, it becomes more feasible to adopt intensive testing, contact tracing and quarantine measures akin to the strategies being employed in South Korea today. Technology – such as mobile phone apps that track an individual's interactions with other people in society – might allow such a policy to be more effective and scalable if the associated privacy concerns can be overcome. However, if intensive NPI packages aimed at suppression are not maintained, our analysis suggests that transmission will rapidly rebound, potentially producing an epidemic comparable in scale to what would have been seen had no interventions been adopted.

Long-term suppression may not be a feasible policy option in many countries. Our results show that the alternative relatively short-term (3-month) mitigation policy option might reduce deaths seen in the epidemic by up to half, and peak healthcare demand by two-thirds. The combination of case isolation, household quarantine and social distancing of those at higher risk of severe outcomes (older individuals and those with other underlying health conditions) are the most effective policy combination for epidemic mitigation. Both case isolation and household quarantine are core epidemiological interventions for infectious disease mitigation and act by reducing the potential for onward transmission through reducing the contact rates of those that are known to be infectious (cases) or may be harbouring infection (household contacts). The WHO China Joint Mission Report suggested that 80% of transmission occurred in the household[16], although this was in a context where interpersonal contacts were drastically reduced by the interventions put in place. Social distancing of high-risk groups is predicted to be particularly effective at reducing severe outcomes given the strong

Assessing a Model

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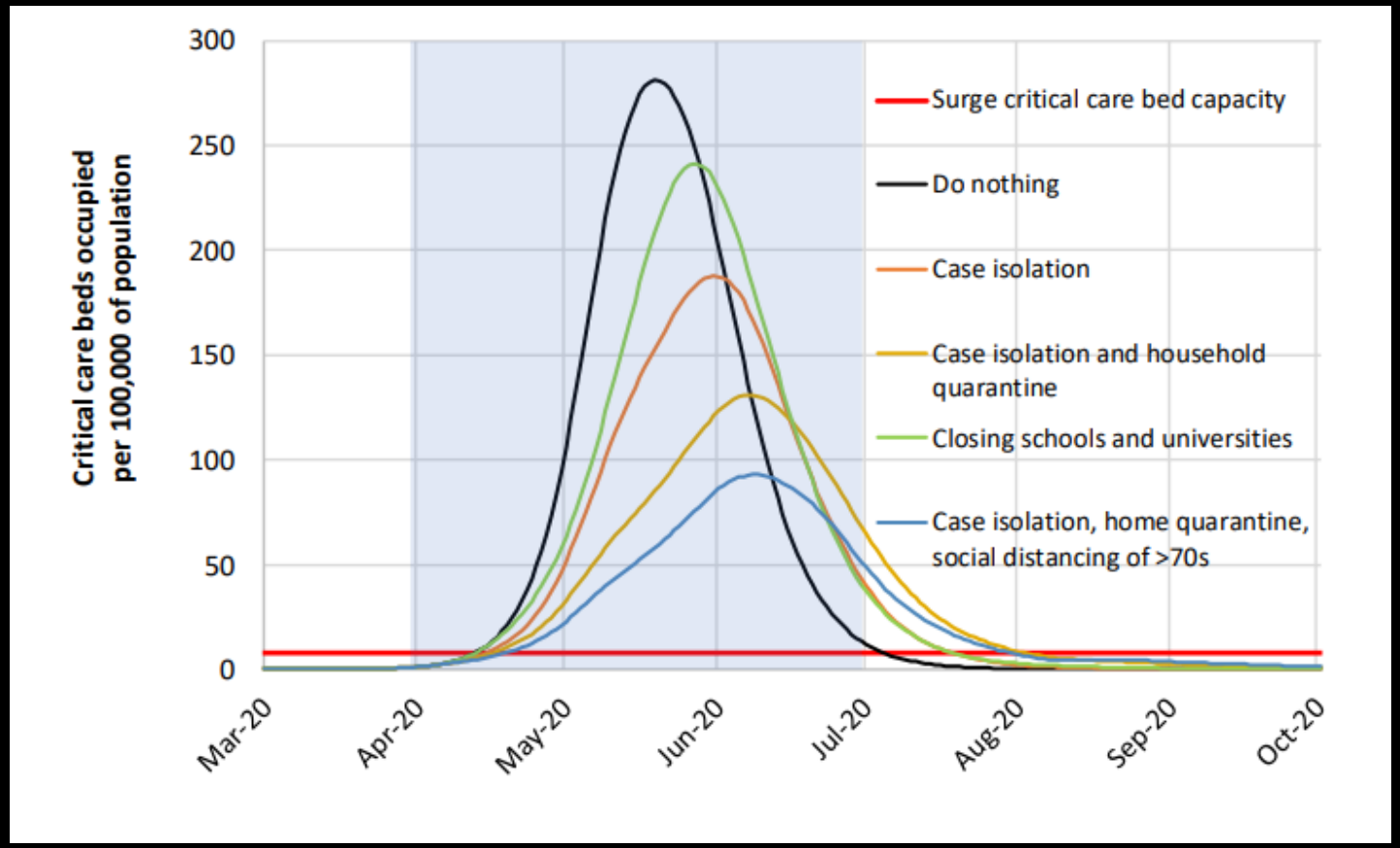

Assessing a Model

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Questions?

10 minute break

Workshop Schedule

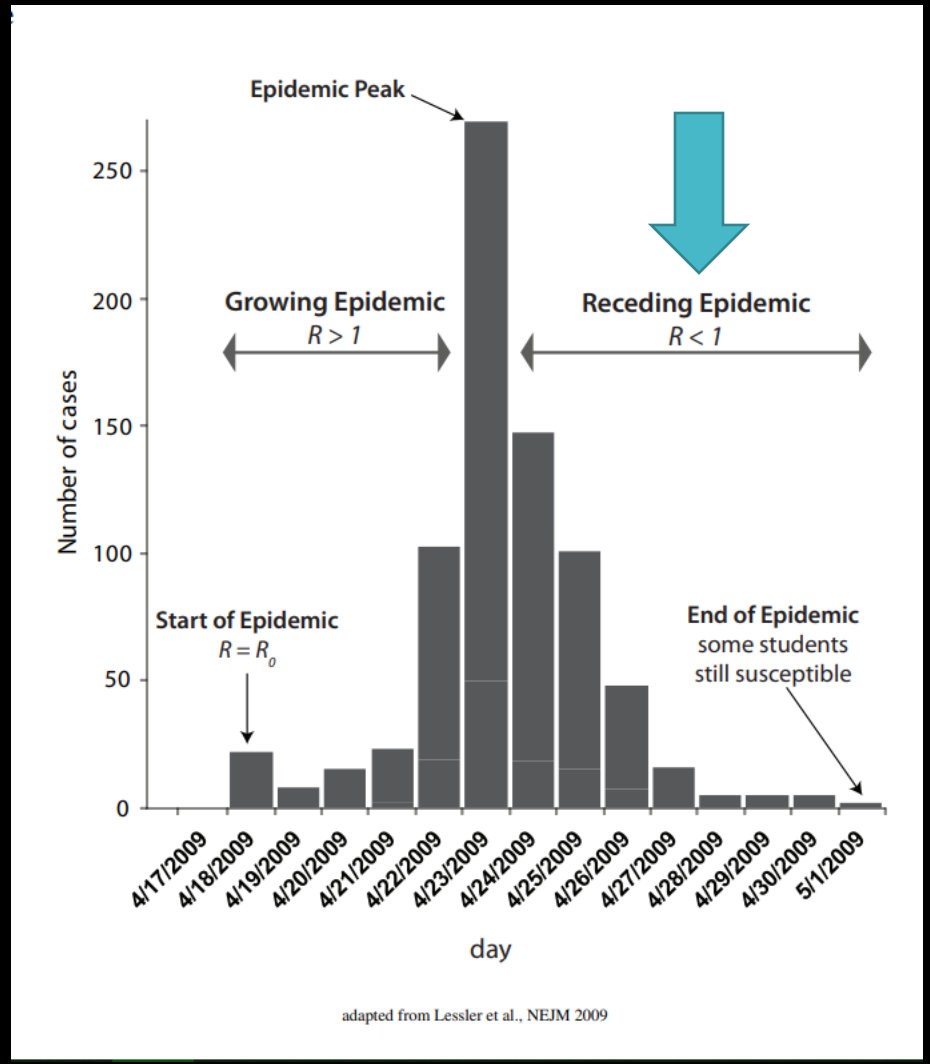
Time	Topics
2:00–2:10 pm	~~Greetings~~
2:10–3:00 pm	~~COVID-19 in Bangladesh - Dr. Kate Hampson~~
3:00–3:10 pm	~~Break~~
3:10–3:20 pm	~~Sensitivity Analysis~~
3:20–3:50 pm	~~Assessing Models~~
3:50–4:00 pm	Break
4:00–5:00 pm	Review & Questions

Review Slides

(& practice questions)

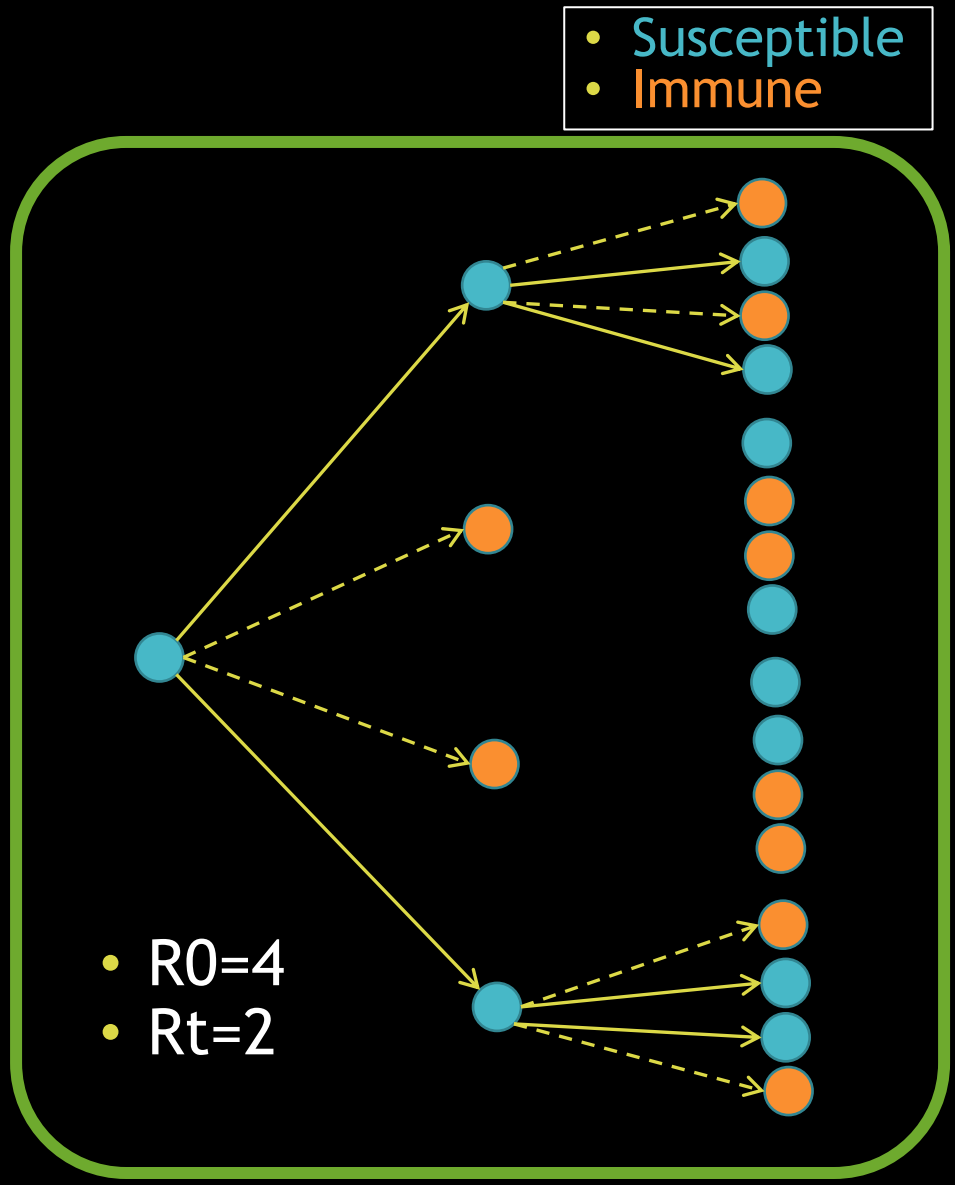
Reproductive Numbers & Epidemic Curve

- Reproductive numbers change throughout an epidemic
  - as the epidemic continues, there will be fewer susceptible people and the reproductive number will decrease unless:
    - more susceptibles are added
    - something changes to increase transmission
  - if Rt=1, transmission will be stable
  - as soon as Rt<1, the epidemic will start to fade



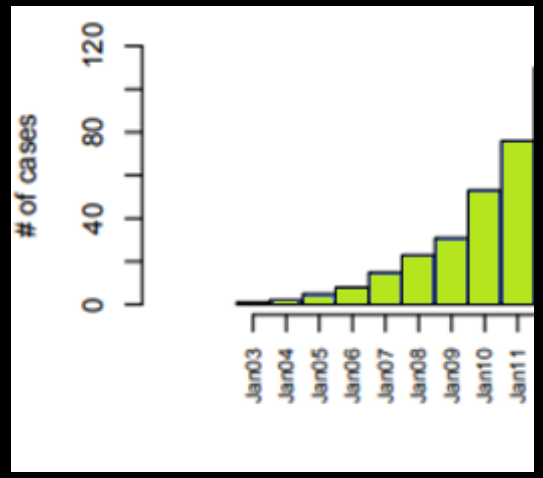
Reproductive Number & Herd Immunity

- Herd immunity
  - recall that the number of new cases depends on the presence of infected persons (to cause infection) but also the presence of susceptible persons (to become infected)
  - $R_t = R_0 s_t$
  - if half of the population is immune, the reproductive number is cut in half
  - if there are enough immunes, we can control transmission

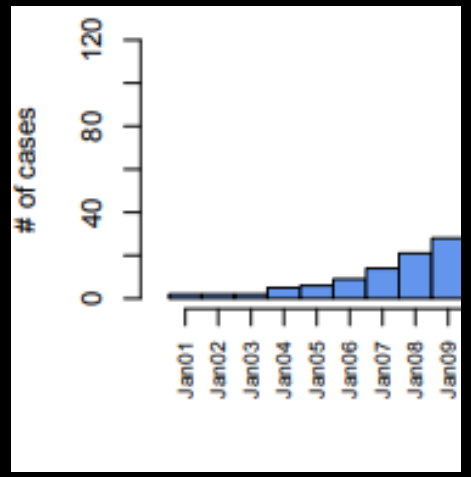


Reproductive Number & Final Size

- We have this equation:
  - $r(\infty) = e^{-R_0 r(\infty)}$
- Which can be arranged as:
  - $R_0 = -\frac{\ln(1-r(\infty))}{r(\infty)}$
- final epidemic size and basic reproductive number can be used to calculate each other if we already know one
- Without going through the derivation, there is another equation for calculating R0 from final size
  - $R_0 = \frac{N}{N-S(0)-R(\infty)} ln \frac{N-R(\infty)}{S(0)}$



- Epidemic A
  - Y(t)=218
  - t=8
  - γ=1.5
  - R0=2.01
  - Y(t)=31
  - t=4
  - γ=1.5
  - R0=2.29



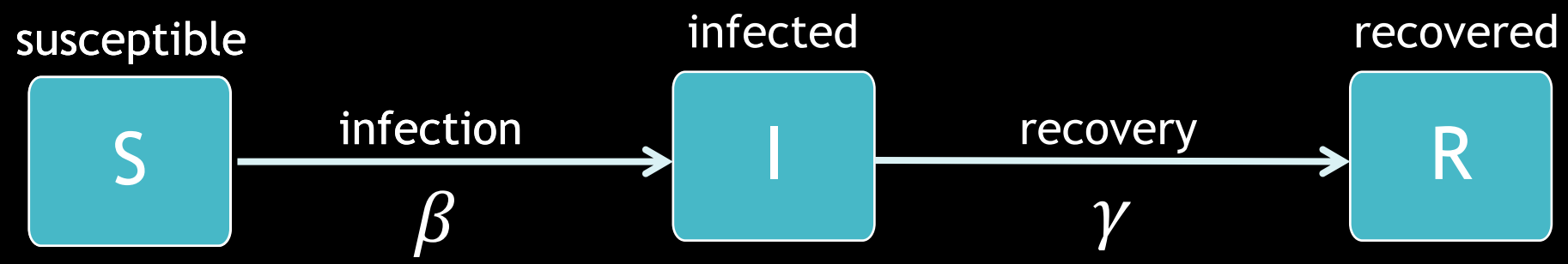
- Epidemic B
  - Y(t)=89
  - t=8
  - γ=1.5
  - R0=1.84
  - Y(t)=17
  - t=4
  - γ=1.5
  - R0=2.06

Method	Epidemic A R0	Epidemic B R0
Final epidemic size	2.04	1.91
Exponential at t=8	2.01	1.84
Exponential at t=4	2.29	2.06

Reproductive Number & Early Size

- We can also use the cumulative number of cases early in an epidemic by fitting an exponential curve to the outbreak
- $R_0 = 1 + \frac{\ln(Y(t))/t}{\gamma}$
- Y(t)=cumulative number of cases at time t

SIR Model: Kermack & McKendrick

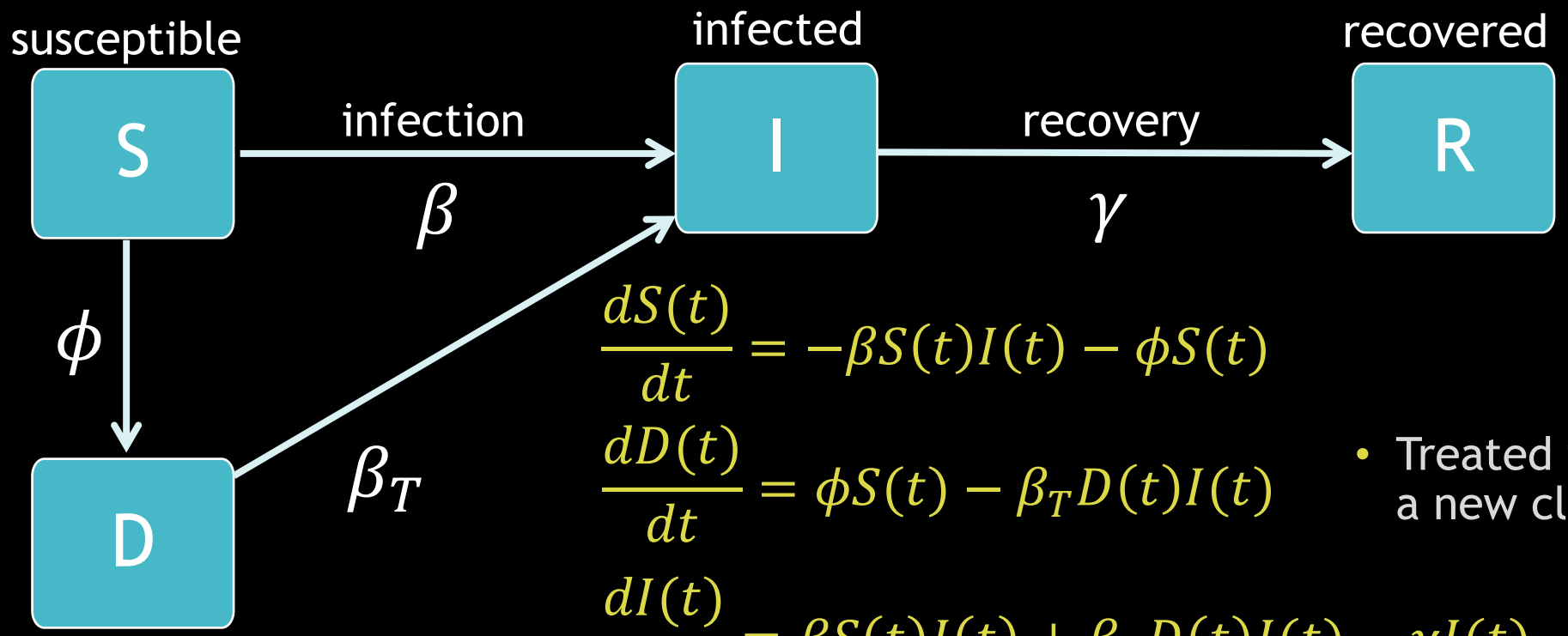


$$\frac{dS(t)}{dt} = -\beta S(t) I(t)$$

$$\frac{dI(t)}{dt} = \beta S(t) I(t) - \gamma I(t)$$

$$\frac{dR(t)}{dt} = \gamma I(t)$$

Treatment Provides Partial Protection



$$\frac{dS(t)}{dt} = -\beta S(t)I(t) - \phi S(t)$$

$$\frac{dD(t)}{dt} = \phi S(t) - \beta_T D(t)I(t)$$

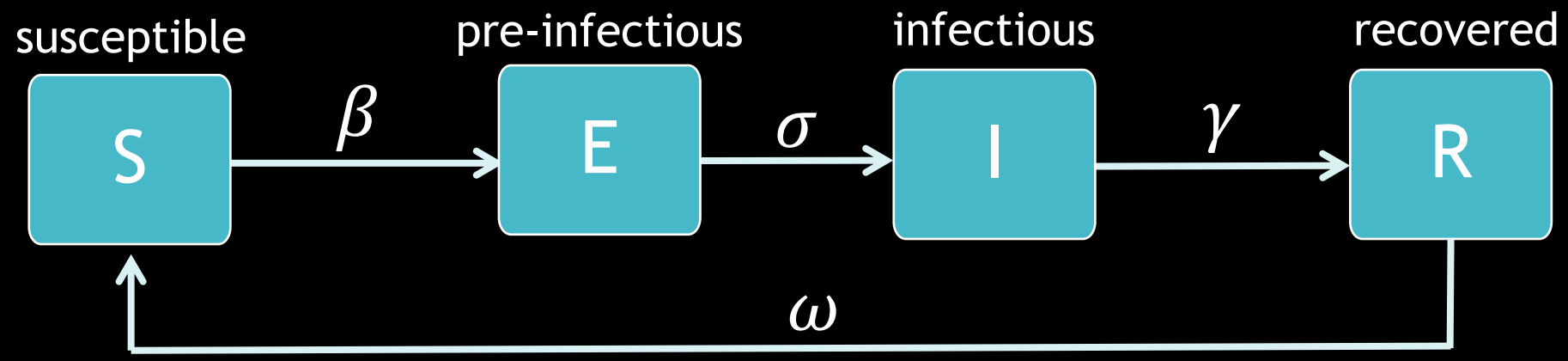
$$\frac{dI(t)}{dt} = \beta S(t)I(t) + \beta_T D(t)I(t) - \gamma I(t)$$

$$\frac{dR(t)}{dt} = \gamma I(t)$$

- β: transmission coefficient
- γ: recovery rate
- ϕ: rate of providing treatment
- β_T: transmission coefficient for treated individuals

- Treated individuals are in a new class

Knowledge Test



This is a diagram for transmission of *Mycoplasma pneumoniae*. Which of the following statement(s) is/are correct? (may be more than one!)

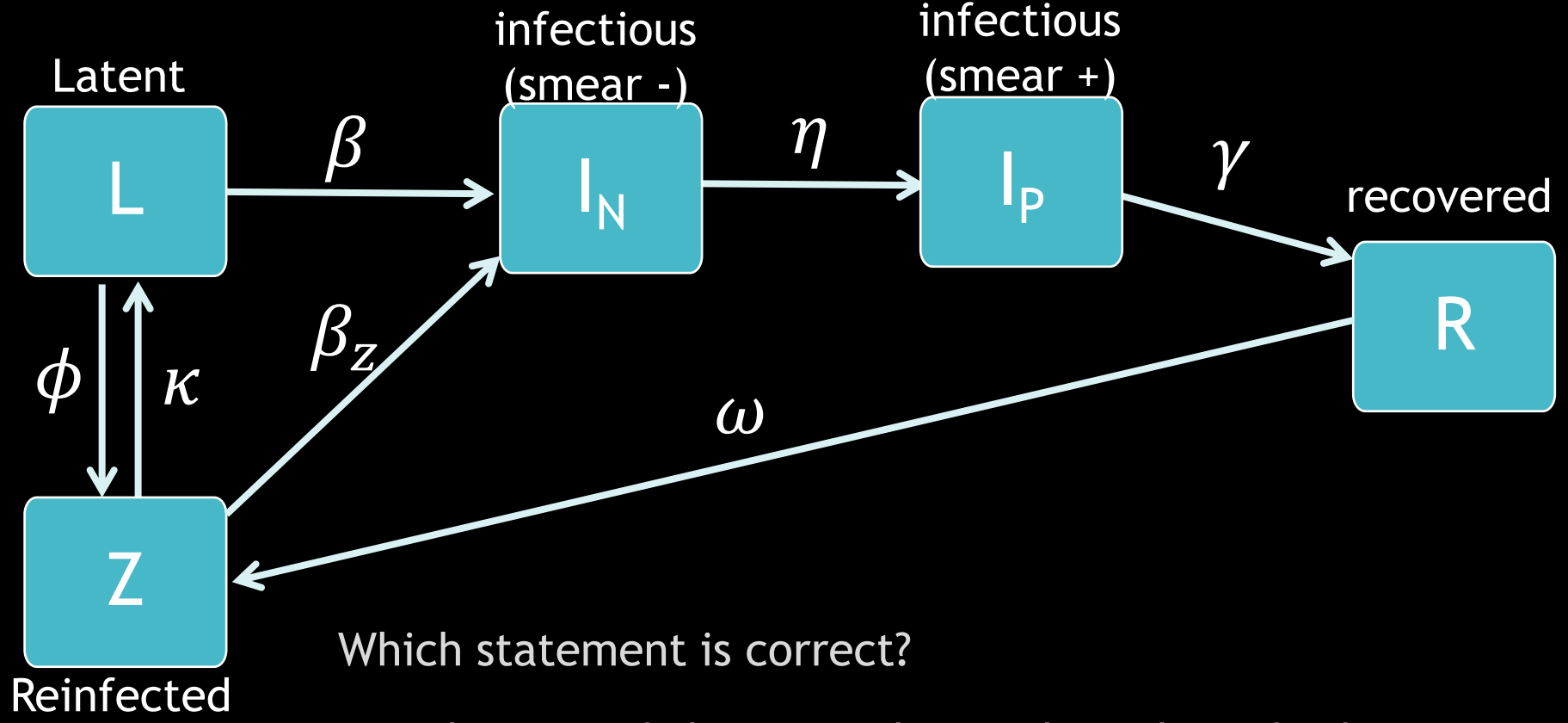
A. The model will predict that the total population will decrease over time

B. The model will predict that the total population will increase over time

C. The model will predict that the total population size will stay the same

D. The rate of change in the number of immune individuals is given by: $\frac{dR(t)}{dt} = \gamma - \omega$

E. The rate of change in the number of immune individuals is given by: $\frac{dR(t)}{dt} = \gamma I(t) - \omega R(t)$



This is a simplified diagram for TB in a high-transmission setting. Smear- and smear+ people are both infectious, but smear- are 25% less infectious

Which statement is correct?

A. The rate of change in the total number of infectious people ($I(t)=I_N(t)+I_P(t)$) is given by:

$$\frac{dI(t)}{dt} = \beta L(t) + \beta_Z Z(t) - \gamma I_P(t)$$

B. The rate of change in the total number of infectious people ($I(t)=I_N(t)+I_P(t)$) is given by:

$$\frac{dI(t)}{dt} = \beta L(t) + \beta_Z Z(t) - \eta I_N(t) - \gamma I_P(t)$$

Questions?