# Data-Driven Product Design

Analyzing use patterns and their context from the data of X-ray systems

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## **AGENDA**

- 1. Project context & research goal
- 2. Discover use patterns & detect occurrence context
- 3. Insights & conclusions
- 4. Discussion

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I am a doctor. You need to keep me and my patients <u>safe</u>.

<u>Design a system</u> that enables me to <u>effectively</u> treat my patients.







































































### THE STUDY OF USER BEHAVIOR

## **Product Design Process**

Limitations of current approaches

1 USABILITY STUDIES

Designed only on existing knowledge A limited number of specialists / scenarios

PHYSICAL PRODUCT MONITORING & FQS TOURS

Solving problem instances Scattered knowledge

3 CUSTOMER COMPLAINTS

Reported mainly for system related critical events Scattered knowledge Unknown scale of impact

#### Data-driven approach

#### **BIGGER SCALE OF IMPACT**

Perform cross-analysis:

How other users, in other hospitals, in other countries are experiencing the same/similar problem

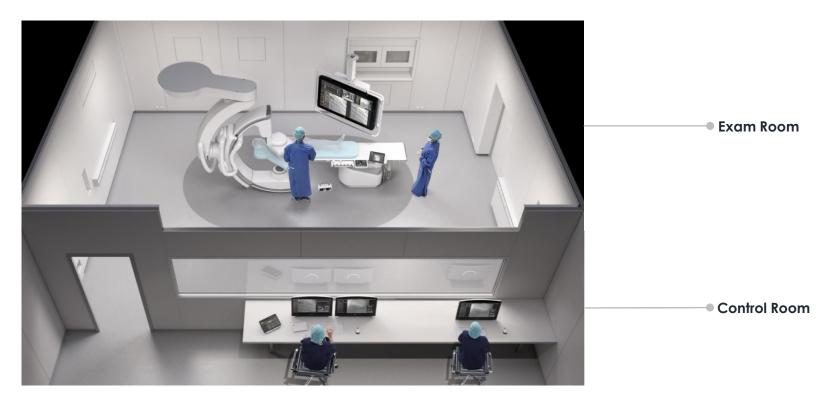
Usability Engineers
assign priorit
LOOK AT THE REASONS OF
A SPECIFIC USER BEHAVIOR

What leads to it?
In which context does it occur?



## WHICH SYSTEM ARE WE FOCUSED ON?

## Interventional X-Ray Systems (iXR): Philips Azurion







#### Why does it matter?

As humans ... Tend to forget Skipped actions Perform actions as habit Wrong actions Need to memorize & think Annoyance & frustration

So...

#### **USER EXPERIENCE**

Avoid unnecessary interactions
Reduce cognitive load (need to think & remember)
Reduce frustration and annoyance
Spend more time on meaningful things

#### **SAFETY REQUIREMENT**

Ensure Safety Requirements

By avoiding skipped /wrong actions



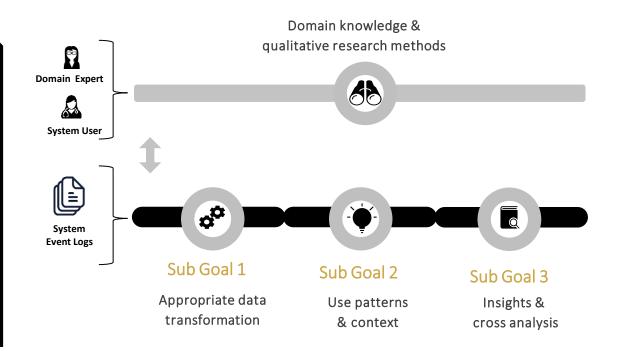


Given a system event log, how can the product design be improved by identifying user behavior which might represent a potential for automation in a specific occurrence context?





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Domain knowledge & qualitative research methods



1

Find a relevant way to transform the data, such that it allows discovering user behavior that potentially represent a need for automation and making use of contextual information.





Domain knowledge & qualitative research methods



#### Discover use patterns that might represent a potential for automation and detect the context in which a given use pattern occurs.

Pattern: expected desired use of the system

**Anti-pattern:** expected undesired use of the system





Domain knowledge & qualitative research methods



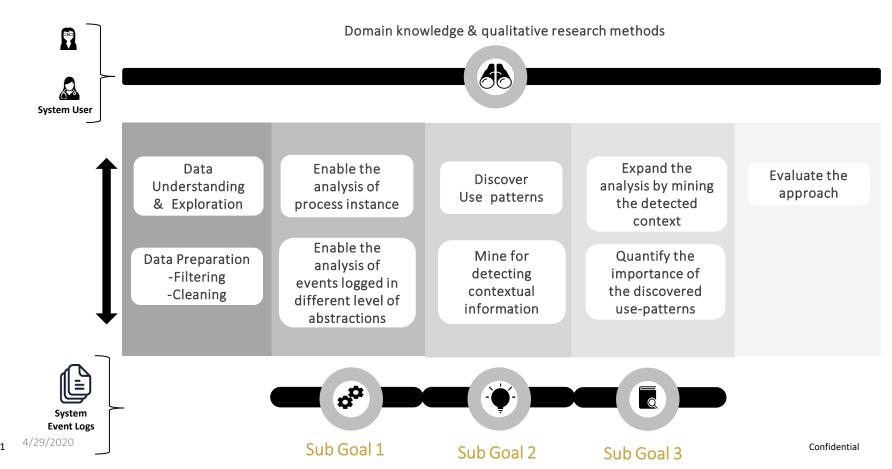
3

Analyze the identified context, detect and evaluate the occurrence of the same or similar use patterns



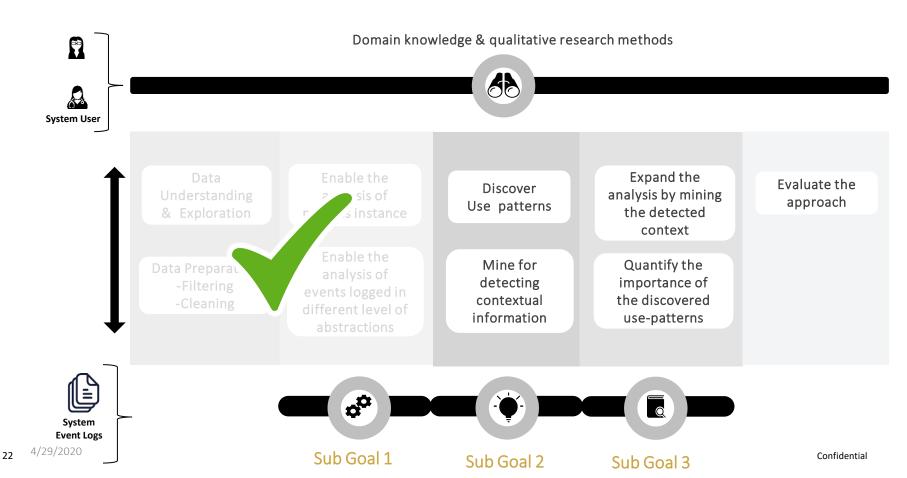
## HIGH LEVEL OVERVIEW





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## HOW DOES THE DATA LOOK LIKE?

Case process instance

Activity well defined step in the process

Event activity related to a specific case

Trace sequence of events that belong to one case

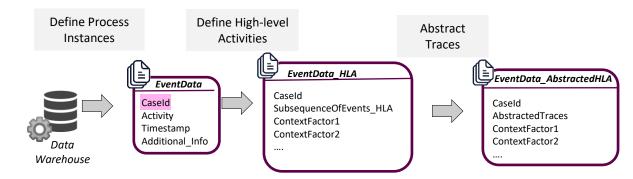
CaseID	Timestamp	Description
4226704_2018-04-06_15:12:48.169000_DLE	2018-04-0615:47:05.040	Command: StartFluoroscopy
4226704_2018-04-06_15:12:48.169000_DLE	2018-04-0615:47:05.044	Command: StartFluoroscopy
4226704_2018-04-06_15:12:48.169000_DLE	2018-04-0615:47:05.051	User output: LED on UI module is set on
4226704_2018-04-06_15:12:48.169000_DLE	2018-04-0615:47:05.062	Command: BLDisplayOrientation
4226704_2018-04-06_15:12:48.169000_DLE	2018-04-0615:47:05.062	Start prepare generator
4226704_2018-04-06_15:12:48.169000_DLE	2018-04-0615:47:05.068	Acquisition -> Prepare devices for Acquisition
4226704_2018-04-06_15:12:48.169000_DLE	2018-04-0615:47:05.145	Viewpad: UiActivity detected
4226704_2018-04-06_15:12:48.169000_DLE	2018-04-0615:47:05.154	From Generator device: Polnt: Shunt test and calibration data
4226704_2018-04-06_15:12:48.169000_DLE	2018-04-0615:47:05.156	XrayService: Prepare
4226704_2018-04-06_15:12:48.169000_DLE	2018-04-0615:47:05.202	XrayService: acquisition parameters
4226704_2018-04-06_15:12:48.169000_DLE	2018-04-0615:47:05.390	XrayService: Prepared
4226704_2018-04-06_15:12:48.169000_DLE	2018-04-0615:47:05.393	Lab: lock
4226704_2018-04-06_15:12:48.169000_DLE	2018-04-0615:47:05.406	Lab: display mandatory applications
4226704_2018-04-06_15:12:48.169000_DLE	2018-04-0615:47:05.419	Finished preparing detector
4226704_2018-04-06_15:12:48.169000_DLE	2018-04-0615:47:05.547	Finished preparing detector
4226704_2018-04-06_15:12:48.169000_DLE	2018-04-0615:47:05.555	Xray indication inside: On

## **DISCOVER USE PATTERNS**





1 Trace abstraction
Set / Bag abstraction



## **DISCOVER USE PATTERNS**



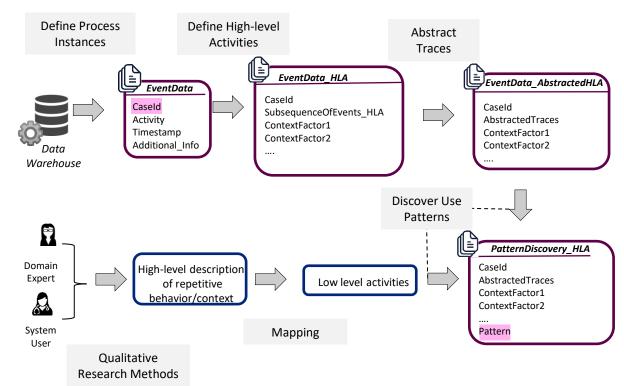


1 Trace abstraction
Set / Bag abstraction

2 Filtering activities

Check if activity occurs in the abstracted trace

SelectReceptorSize
OR
SelectReceptorCommercialSize





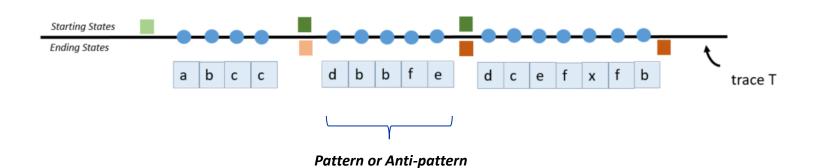
### DETECT OCCURRENCE CONTEXT



To evaluate the potential for automation

#### **CONTEXT:**

A function over the trace, which can be applied on its prefix or suffix and it is centered on the pattern occurrence i.e. system settings; time; surrounding events





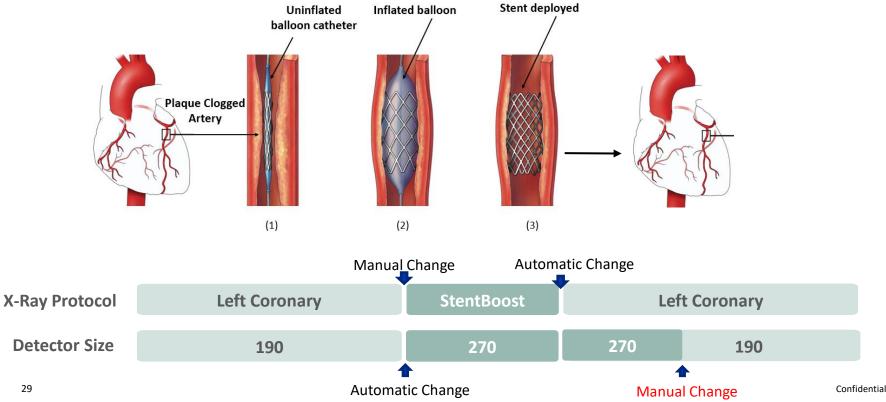
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## **CASE STUDY**

Philips Azurion systems: Manual resize of the detector after the StentBoost acquisition





## CASE STUDY

Philips Azurion systems: Manual resize of the detector after the StentBoost acquisition

### **Data Scope**

7 Azurion systems at a hospital in the Netherlands (only 3 using StentBoost)

Time Period: 8 months

Observations and interviews

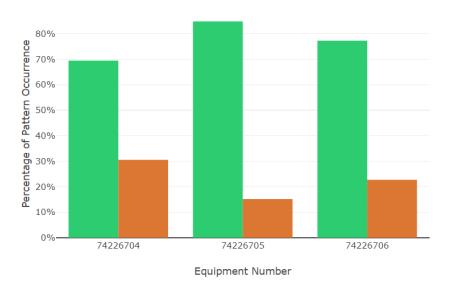






#### How often do they resize the detector manually?

Detector is manually resized (for at least 3 following acq.)Detector is NOT manually resized(for at least 3 following acq.)



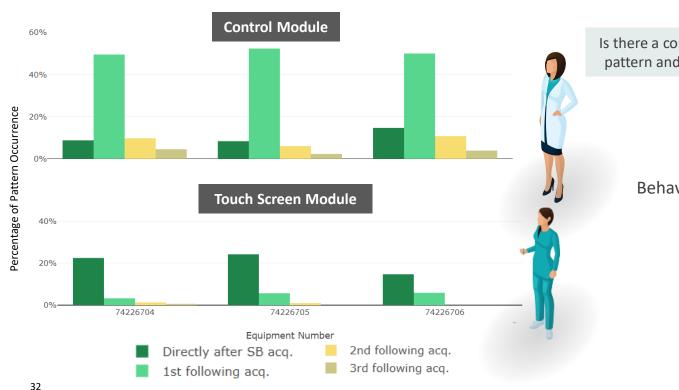
70%, 78%, 85%

of the times a SB is performed, it is followed by a manual change of the detector size, by the clinicians





#### From correlation to causality. When does the manual change occur?



Is there a correlation between severity level of the pattern and the unit used to perform the event?

Doctors **vs** Technicians

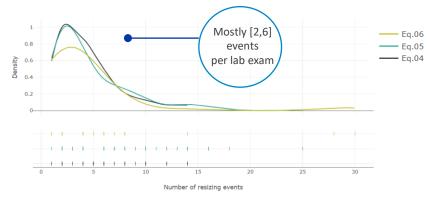
Behavior based on observations vs Learned Behavior



## QUANTIFYING THE IMPORTANCE OF THE DISCOVERED USE PATTERN

- Severity Rating
   User Experience & Problem Frequency
- Scatter Radiation
- Image Quality

What is the probability density of the number of events performed?



	Few users experiencing a problem	Many users experiencing a problem
Small impact on the user experience	Low severity	Medium severity
Large impact on the user experience	Medium Severity	High severity

#### **EVALUATION**



#### Changes are performed in the affected systems

How do the users react to changes performed in the system, initiated by our project?

Data driven evaluation

Data for evaluation: 34 days

Repeat the analysis to detect if there are still occurrence of the discovered use pattern

2 Qualitative evaluation

Observations and interviews in hospitals

### DATA-DRIVEN **EVALUATION**



### **Evaluate the reaction of users to system changes**

#### Question

Do use patterns still occur after the change in the system?

Is there a difference between learned behavior and behavior based on observation?

How fast do users get used to the system change?

Is there a benefit in terms of the number of the button clicks and exam duration?

#### **Answer**

NO, in 99% of the cases

**NO** difference

Above our expectations, immediately!
There is no error-correction period.

**Less button clicks** 

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### QUALITATIVE **EVALUATION**



### User reaction to system changes

How users **experience**, **find** and **feel** about the change.

#### Question

How do users find the interaction with the system after the change?

Is the system intuitive enough to easily understand and get used to the new configuration or they were told about it?

#### **Answer**

Perfect. They really like it.

Very intuitive.

They were not informed about the change.



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#### We proved that:

- It is possible to discover use patterns and make use of the contextual information by using the notion of high-level activities
- Traditional methods of studying user **behavior can be enhanced** with insights from a data-driven approach, contributing in this way in the product design process





#### **Technical**

1 Assuming a distinguishable start & end state of the high-level activities

2 Using trace abstraction, leads to losing the order of the events





### **Organizational**

1 If it is seen, it cannot be unseen

Legal, privacy and ethical decisions and standpoints are required to advance in the field

### FUTURE USE OF THE PROPOSED APPROACH



- 1 Extend by defining other types of high-level activities i.e. the phases of clinical workflow
- Discover other types of user behavior (not only the one representing potential for automation)
  i.e. use complaints or FQS tours as initial point
- 3 Extend to consider concurrency and parallel high-level activities
- Toward Adaptive Intelligence in Healthcare

  We suggest future work to focus more in detecting the detailed context in which specific user behavior occurs

