Title: Centering Community Expertise in Designing for Digital Health Equity

Background

Clinical program design, implementation, and evaluation are often done without meaningful input from communities most impacted by systemic oppression and health inequities (e.g., Black, Indigenous, and other people of color [BIPOC]). COVID-19 further exacerbated inequities created by unjust structures. New healthcare systems should be co-designed with communities most harmed by these structures. In recognition of the need to minimize the harmful impacts of power differentials, we began by surfacing professional healthcare norms that perpetuate harmful power dynamics, creating braver spaces to deconstruct these norms, and re-building core values that will carry forth into partnership with community-based organization (CBO) liaisons. Our work is grounded in anti-oppression values, including redistributing power, developing authentic relationships, and mutual accountability.

Project

The Community Organization Led Equity by Design (CO-LED) program will center on communities exposed to systematic harm to co-design digital health, which is the intersection of technology and healthcare. The program has three goals: 1) Create bi-directional communication and collaborative, continuous improvement; 2) Identify and address structural factors that contribute to health inequity (e.g., racism, sexism, classism); and 3) Address racial and ethnic inequities by integrating the ideas and perspectives of systematically harmed communities. We will connect with eight CBO liaisons, who will be partners contributing their ideas for how digital health could improve their health and well-being, using human-centered design as a process framework.

Evaluation

We will evaluate the impact of the program by describing group dynamics of the collaboration among health system leaders and CBO liaisons using both qualitative (meeting minutes and in-depth interviews) and quantitative (surveys and electronic health record [EHR] data) assessments. In-depth interviews will be conducted at the conclusion of the program to elicit additional beliefs about how the experience felt to team members through a lens of collaboration (i.e., how well did we work together?), power (i.e., how well did we narrow socially constructed power differentials?), and impact (i.e., how well did we do what we sought to?). Data extracted from the EHR will be used to assess changes to disparities in utilization of digital health tools based on the implemented project(s).

Key words

Digital healthcare; health equity; community-based organizations