

## Digital Inclusion Informed By the History of Redlining



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As we head into a new year, a growing number of hospitals are launching digital navigator programs to ensure that patients can use telehealth and other digital health tools. Based on my experience working with leading hospitals across the country, I've learned that efforts to promote [digital health equity](#) must begin by understanding the historical and root causes of digital inequity in the local community. Often, these will include the uncomfortable topic of racism.

Endorsements of digital inclusion as a “[super social determinant of health](#)” reflect a growing awareness of this dynamic as a public health issue, but more attention is needed on the structural and institutional factors that got us to where we are today.

### Mapping Digital Inequity

In mid-2017, I was training Cuyahoga County Community College community health worker students in Cleveland, Ohio to perform what is now called [digital navigation](#). Back then, Cleveland had yet to be named “[the worst connected city in the country](#),” and my students were most struck by maps showing the stark differences in household internet subscriptions for suburban versus urban households in our county.

According to the [National Digital Inclusion Alliance](#), **digital navigators** are “trusted guides who assist community members in internet adoption and the use of computing devices.”

My digital navigator students were further shocked by the marked similarity of this pattern to maps showing intense pockets of segregation, poverty, and low life expectancy. Yet, what struck them most of all was when I showed a historic [redlined map](#) of Cleveland, Ohio.

**For decades—beginning in the 1930s—redlined maps were used by lenders to deny credit for neighborhoods with a large or growing share of residents who were Black, Jewish, or “undesirable” immigrants.**

The geographic pattern of the contemporary maps was almost indistinguishable from the historic map.

“**Digital redlining**” is a term that is now used for a [phenomenon found across the country](#) to describe the systematic exclusion of low-income neighborhoods from broadband service. Poor residents are often charged the same rate for sub-standard, low-speed home internet as wealthier neighbors pay for much faster service.

My students were among the first to learn that they were personally affected by digital redlining, but it took me a bit longer to figure it out.

## **Building an Army of Digital Justice Warriors**

In my next class, I asked my students to launch or download the [MyChart patient portal app](#) on their personal phones. A buzz went around the room until one student explained that they didn’t all have phones that could (1) access the internet and/or (2) know how to download an app.

Things started to click, and these abstract digital equity concepts suddenly became visceral.

**My students realized that the absence of on-ramps to the “information superhighway” in their own neighborhoods replicated and reinforced the impact of historic and pervasive structural and institutional racism.**

Even though I’d spent two decades conducting clinical and prevention studies with a particular focus on health equity, I had to check my privileged assumption that all of my students had connected devices and some digital literacy skills. Click, again.

In those moments, as my students realized why they lacked the internet and understood the impact of that gap on their lives, an army of digital justice warriors was born.

## **Patient Portal Disparities**

Early in the pandemic, digital access disparities were identified as [drivers of telehealth adoption disparities](#). This echoed a pattern of [patient portal use disparities](#) seen with growing frequency in the decade prior to the pandemic: portals were used most often by those who stood to benefit the least.

**Low patient portal adoption—a byproduct of digital discrimination—is still concentrated among [specific populations](#) that already experience worsening health outcomes than others.**

Portals became the primary way patients scheduled COVID-19 vaccine appointments, checked COVID-19 test results, and had telehealth visits. But, [reliance](#) on them for COVID-19 prevention and care likely amplified disparities in both telehealth use and health outcomes, as noted in [AHIMA Foundation’s 2022 digital accessibility research](#).

## **A Digital Inclusion Call To Action**

Well-meaning encouragement of patients to make appointments or view test results in the portal will likely be ineffective for those living in [neighborhoods](#) that have been systematically deprived of access to affordable, high-speed internet.

It took decades for healthcare professionals to realize recommendations to “eat healthy” had little impact on those living in food deserts. Now, many [health systems have begun to facilitate access to healthy foods](#). A similar [upstream approach](#) is needed regarding digital access.

Understanding demographic and geographic patterns of internet access and adoption is an essential starting point. Finding and partnering with [digital inclusion professionals and organizations](#) in your community is a crucial next step.

***Let 2023 be the year that hospitals and health systems become leading champions of digital equity and inclusion.***

### ***About the Author***

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*Amy Sheon, Ph.D., MPH, is a nationally recognized thought leader around digital health equity and inclusion with 30+ years of experience in government, academia, and the non-profit sectors. Since 2017, she has led Public Health Innovators, LLC where she consults with health systems, governments, non-profit, philanthropic, and medical professional organizations, and the tech industry to develop strategies to ensure equitable, meaningful, and impactful adoption of digital health technologies. From 2011-2021, Dr. Sheon served as the founding Executive Director for the Case Western Reserve University School of Medicine’s Urban Health Initiative and completed a Senior Fellowship with the National Digital Inclusion Alliance. She earned an MPH at the University of Michigan and a Ph.D. in public health policy from the Johns Hopkins Bloomberg School of Public Health.*