What's in Scope for Interactive Health? Reflecting on the CHI 2025 Health Subcommittee Process

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Abstract

The proposal to found a Health and HCI conference brings the challenges of connecting two fields to the fore. This came to a head in CHI 2025, which introduced the option to Desk Reject papers based on lack of sufficient contextualization to the HCI literature. In this article, we reflect on our experience as Subcommittee Chairs of the Health Subcommittee for 2025, where we faced dilemmas assessing scope and contextualization for the 352 complete submissions made. Finally, we suggest three provocations for the community to grapple with the question of scope.

Keywords

CHI 2025, Health, Interactive Health

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1 Introduction

As we as a community begin to think about what knowledge contributions may be within scope for Interactive Health, we thought it might be useful to reflect on how we as a community currently define and assess that scope. We consider the Health Subcommittee of CHI to be the largest space where Interactive Health work gets consistently reviewed and published. While other venues certainly publish relevant work (e.g., ACM CSCW, IMWUT, COMPASS), the CHI Health Subcommittee offers a large sample where we believe all submissions are relevant to Interactive Health. Health has a relatively short history as a subcommittee, first occurring jointly with Accessibility & Aging at CHI in 2017 and then as a standalone subcommittee in 2019. Since then, it has grown to be one of the largest subcommittees in terms of submission volume, reviewers, and published work.

We therefore wanted to share reflections from our process of assessing submissions to the Health Subcommittee of the Papers track for CHI 2025. The CHI Papers process has two specific mechanisms for labeling submissions which are considered to be out of scope for a particular subcommittee: Desk Rejects, and Transferring submissions to a different Subcommittee [7]. The three authors were the Subcommittee Chairs (SCs) for the process this year [8]. 59 Associate Chairs (ACs) also helped assess submissions, and nominated some submissions for Desk Reject or Transfer.

We also find it important to acknowledge that we do not believe our process and scope criteria to be perfect, nor without harm. The Desk Reject process exists because our research community is massively overloaded with requests [7]. In 2025, the Health Subcommittee had the second-highest number of complete submissions (352) behind only Design (374) [4]. Reducing the review burden on the CHI-Health community, both on our ACs and reviewers external to the committee, was a major consideration in choosing to Desk Reject or transfer a submission. Nonetheless, we made hard choices that inevitably had negative consequences on individual scholars, and others in our role may not have always made the same choice about a particular submission.

2 Assessment Process in the Health Subcommittee

In terms of process, the SCs split all complete submissions roughly in three, and each SC reviewed a third, accounting for conflicts. If the SC thought a particular submission should be considered for Desk Reject or Transfer, they flagged the submission to the other non-conflicted SCs. If all non-conflicted SCs agreed, the Desk Reject or Transfer was then raised to the non-conflicted Papers Chairs, where one or more Chairs would assess and either concur or suggest the submission should be sent out for review. Transfers additionally involved engaging with the non-conflicted SCs of the other Subcommittee to ensure they felt they had appropriate expertise and bandwidth. Therefore, the bulk of Desk Rejects and Transfers that got processed were assessed by at least four individuals: all three SCs and one Paper Chair, and usually another SC or two in the case of a Transfer.

Following the paper review process, the papers were distributed to the ACs, who could then surface Desk Reject candidates [7]. These AC-recommended Desk Rejects similarly were surfaced to the Papers Chairs. AC-recommended Desk Rejects were typically for anonymity violations, which surfaced when the AC took a closer look at the submission text and supplemental materials. In a few rare cases, anonymity violations were noticed by external reviewers after assignment. These submissions were also Desk Rejected, though the authors got to see the written reviews.

In this way, 66 submissions were Desk Rejected, about 19% of the 352 complete submissions. We note that this percentage was among the highest of the Subcommittees at CHI this year[4]; we will later reflect on why we believe Health Desk Rejected at a higher rate than other Subcommittees. The CHI guidelines outline a number of reasons why a submission can be Desk Rejected, ranging from

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pragmatic (e.g., the submission must be complete, in the correct submission format) to being out of scope (e.g., the work does not engage with HCI literature).

Of particular note, the criteria of "Context" was introduced for CHI 2025: *"Lacking context in the HCI literature. This is not to say that all papers must cite other CHI papers, but papers should cite scholarly literature that relates to HCI in some way"* [7]. In total, this criteria was the most common reason for a submission to be Desk Rejected [4]. The distribution of reasons for rejection for the Health Subcommittee was fairly similar to the overall distribution of submissions[4], with most being Desk Rejected due to a lack of Context, Anonymization issues, or Template issues, with a few for Scope, being Incomplete, or Length.

It was harder to formally track exactly how many submissions we transferred in and out of the Subcommittee. Our rough estimate is that we transferred about 10 submissions out of Health, and took in a similar number from other Subcommittees. We did not see an overarching trend in what other Subcommittees we transferred submissions to/from; submissions were moved to or from at least 10 other Subcommittees (out of 18 total). That said, we observed trends in what topics we considered for moving to other Subcommittees or other Subcommittees wished to move to us.

Once a submission got past the screening process by us and ACs, it was sent out for review [7]. We also reflect some on submissions which were fully reviewed by the community, but still assessed for scope, such as conversations had during the synchronous Program Committee meeting or asynchronously with ACs on Slack.

In writing this provocation, the three of us reflected on the decisions we made during the Desk Reject and Transfer process, and looked back at the written justifications we provided and our internal conversations. We acknowledge that we did not do a systematic analysis, but this felt like a good representation of our process and a sufficient analysis for this workshop venue.

3 Categories of Out of Scope

We saw five main reasons why we considered submissions to be out of scope for the Health Subcommittee. These reasons overlap and intersect with criteria specified in the CHI review process. To protect the identity of the authors and the integrity of the process, we do not include examples from specific submissions. Instead, we aim to reflect more abstractly on the types of submissions we saw.

3.1 Lack of Engagement with HCI Literature

The most common reason for which a submission was Desk Rejected was a lack of engagement with HCI literature on the given topic. We took a fairly expansive view of what constitutes the "HCI" literature, aligned with the formal criteria (e.g., submissions need not cite other CHI papers) [7]. An approach we took was to see if the literature from any SIGCHI-sponsored conference was cited, as a significant amount of quality HCI-Health work is published in other SIGCHI venues such as CSCW, COMPASS, IMWUT, DIS and CHI Play [6]. We typically did not consider research in digital medicine or health informatics venues as directly related (e.g., JAMIA, JMIR), given that they typically do not engage with discussion of design or higher-level reflections of technology's role in health. Overall, we felt these criteria set a relatively low bar for engagement with HCI literature. We only considered submissions for Desk Rejection that cited no HCI or related literature, or when they did, the number was very small, or the authors only engaged with these papers tangentially or lightly.

We took care to consider whether the health domain or problem space of a particular submission was relatively new to HCI, which might motivate having few HCI-Health references. To do this, we further considered whether we could readily identify a history of relevant research on the topic. The Desk Rejected submissions engaged with topics core to HCI-Health, like telemedicine or patient-provider communication practices, but did so without engaging with the literature on the topic. This light engagement seemed to be exacerbated in short papers, where the authors tended to emphasize results while truncating references and discussion of those results relative to prior literature.

3.2 Challenged by Contextualization Within a Larger Project

Many health research projects are 'large', in the sense that they may have multiple research goals, some of which are formative technology-centric outcomes and others are more evaluative health-related outcomes. These projects involve multiple stakeholders, possibly including clinicians and implementation science researchers, in addition to HCI researchers. The size of the project creates multiple experimental milestones that build upon prior work, ranging from proof-of-concept evaluations of exploratory innovations, to preliminary evaluations suggesting proof-of-(medical) value, and finally to gold-standard randomized controlled trials where the interactive system is evaluated in situ.

When authors submitted to CHI from components of a large project, authors often faced tensions or encountered issues with CHI's anonymization policy. CHI requires that the authors do not identify themselves by referencing their prior work. Instead, authors should use phrases like *"As described by Epstein et. al"* rather than *"As described in our prior work"* [5]. We encountered many submissions where authors used phrases like *"our work"* to contextualize their current paper within their larger health projects. We suspect these violations occurred because authors deemed it important to fully describe how their CHI submission connected to the other parts of their project. We also expect these language choices were driven by a desire to be honest and transparent with reviewers.

We also Desk Rejected submissions for including materials that in some way de-anonymized the project or authors. This information appeared in the main text as well as supplemental materials, including (but not limited to) links to repositories, preregistration links, study materials, project names and university review boards. In our experience with large projects, these materials may be developed by other collaborators or organizations, and therefore the authors may not be aware of what is included in them. While we assume these cases were unintentional violations of CHI's anonymization policy [5], we wonder if the prevalence might be correlated with the complexity of the projects that a HCI-Health paper could be a part of.

On the flip side, submissions which were properly anonymized but not well-contextualized could face challenges during the full

review process. For example, submissions which did not articulate the novelty or contribution relative to other papers in the larger project risked being rejected. In this and other years, we have seen acceptance of submissions connected to larger health projects, including submissions connected to prior CHI papers. The current mechanism to address this is via the "related concurrent submission" declaration. This process requires the author to assess relatedness, describe the similarities and differences, and upload any concurrent submissions to allow the SCs and 1ACs to assess the overlap themselves. Overall, our observations suggest that CHI-Health authors often face an effortful task to submit papers that balance anonymity and description of their project context.

3.3 Lack of HCI Implications, Favoring Clinical Implications

A longstanding challenge with HCI-Health work has been inviting submissions to offer implications related to the design of technology rather than strictly clinical outcomes. Since 2022, the Subcommittee description has included a statement explicitly suggesting that studies associated with clinical trials, as well as systematic reviews, must additionally make HCI contributions: *"Papers must have a clear and novel contribution to HCI in terms of our understanding of people's interaction with technology in a healthcare context, or the design of health and wellness technologies. For example, systematic reviews or usability studies associated with clinical trials must also have contributions for the HCI community."* [8].

During the full review process, we observed and participated in multiple discussions about whether a submission is succeeding in making an HCI contribution [3] versus a clinical one. For example, if the stated contribution were a system or interface that claims to improve health outcomes, does the originality of the contribution lie in the technology itself, the technology's application or an improved health outcome? Which should take priority? We observed that expectations often varied between ACs, and even among us as SCs. While we did our best to standardize norms, we continue to see this distinction as hard to clarify and codify.

3.4 Minimal Implications for Health Technologies, but Potentially More for HCI

We received multiple submissions that had potential HCI contributions, but ones which we perceived to be relatively minimal for Health. For example, we received submissions proposing novel forms of interaction with technology, novel methods for detecting some human behavior, and empirical studies of human behavior. These submissions were usually proposed in some health context, such as a new interaction that could be more ergonomic or a study of an online health community. But upon further reading, we saw that the health context was less central to the contribution than the interaction or another component of the context.

In these cases, we proposed these submissions for transfer to a more appropriate Subcommittee, typically the author's backup selection. We then left it to that Subcommittee to assess the contribution. These cases were relatively rare, but we felt it was important to ensure that these submissions were evaluated based on their stronger contribution. The presence of these cases suggest potential collective misunderstanding around what constitutes "Health" within HCI, perhaps an assumption that any work which at all relates to health and well-being belongs in HCI-Health rather than another community.

3.5 Out of Format

There were a set of submissions which were Desk Rejected for using a format that was *radically* different from the one required in the submission guidelines [7]. While we took a relatively relaxed approach to formatting issues, we also needed to ensure that the papers were written and presented in a way that the reviewing community would find acceptable and digestible.

Quite commonly, submissions did not include enough information in references, such as missing the venue name or the names of authors, to the point that references were hard to understand. We Desk Rejected a small set of submissions for violating formatting rules like margins or spacing, or putting many large blocks of text in tables or figures, which could be indicative of circumventing length expectations. Overall we observed a great number of out "out of format" submissions, such as incorrect fonts or missing headings. We only considered the most egregious cases for Desk Rejection.

However, it is important to note that this happened more often if authors were observing writing practices and guidelines from other venues. We often saw this issue conflated with the clinical implications (see 3.3 and short papers issues outlined above).

Our observations suggest that HCI-Health audiences may struggle to follow the LaTeX-centered workflow of ACM publications. While Word templates exist, they have been poorly maintained in recent years, and have been known to create additional challenges with transitioning to publication (e.g., TAPS). Further, our anecdotal perspective is that many digital health venues (e.g., Journal of Internet Medical Research (JMIR), or Journal of the American Medical Informatics Association (JAMIA)) have a tradition of using large tables and figures to supplement text while adhering to strict word limits. These practices may or may not effectively transfer over to HCI-Health venues.

4 Reflecting on Scope

We believe that the high rate of Desk Rejects in the Health Subcommittee was influenced both by the nature of work submitted, but also by us as Subcommittee Chairs. One motivation to adhere strictly to Desk Reject guidelines was the sheer scale of submissions and desire on our part to reduce the reviewing load on the community, especially since we were so overloaded. But also that the inherently more disciplinary collaborations (e.g., with medical folks) in HCI-Health lend themselves to work and writing getting done by scholars who are not as well-versed with the norms and rules of CHI. Health authors may assume the health venue norms fit for CHI, but this is not always true. Health, unlike some other Subcommittees, has sister venues that are quite radically different in their idea of what a contribution is, and what is a good format, what the norms are and how to frame the topic. From our vantage point, the gulf between, say, a CHI PLAY publication and the Games and Play Subcommittee (or DIS and Design, etc.) is rather small by comparison.

Through the establishment and solidification of the Health Subcommittee, we have successfully demonstrated that there is interest

and expertise in making research contributions which are solidly at the intersection of HCI and Health. And, as a community, we have codified some norms around the shape and style of those contributions. Looking ahead, we propose three provocations for consideration in setting up Interactive Health.

4.1 Interactive Health Should Define Itself as an HCI Venue First, or a Health Venue First

The high rate of Desk Rejections in the Health subcommittee highlights a key tension: many submissions engage deeply with health, but fail to meet HCI engagement expectations. In the future, can we define Interactive Health primarily as an HCI venue that accepts health-related work, or should we redefine its scope to better embrace interdisciplinary contributions, even if they engage minimally with traditional HCI literature? To make this proposal, it is important that we consider how we might balance inclusivity with maintaining a strong HCI identity.

Taking advantage of being a different venue from CHI, the flagship HCI conference, Interactive Health could consider being open to contributions which do not fit within the norms of the CHI Health Subcommittee, such as less direct engagement with HCI literature. Additionally, this brings up the question of how that conference fits within the larger umbrella of SIGCHI. Although we see value in Interactive Health forming an identity unique from CHI-Health, we see risks with straying too far from our HCI roots.

4.2 Existing HCI-Health Norms may be hindering Interdisciplinary Collaboration

Many health-focused submissions struggle with CHI's strict anonymization and formatting guidelines, which are not the norm in other health and medical research venues. We observe that these requirements create unnecessary barriers for interdisciplinary teams, particularly those led by health researchers unfamiliar with SIGCHI norms. THis leads us to question how Interactive Health should reconsider or adapt these rules to better support cross-disciplinary participation? Interactive Health as a standalone venue has the benefit of being more approachable to a traditional Health audience. We can potentially be more flexible around format and anonymity, or at minimum we have approachable branding. But even so, we worry that our community's current norms and practices are setting up these Health authors to get beaten down by our review process. In both the Desk Reject and external review process, we frequently saw submissions from Health teams struggling to articulate their contribution to HCI.

As a result, we think it is critical that we avoid conflating *publication* with *participation* in order to be inviting to Health audiences. Fully achieving participation will require creative thinking, such as alternative publication tracks or other ways of attending. For example, many Health conferences have abstracts or panels with high acceptance rates, foregoing a rigorous review process in favor of getting more scholars conversing with one another. Having a "big tent" around what individuals or types of scholarship might be at the intersection only has upsides in terms of scholarly impact. Beyond diversifying submission format, we think this strategy will have an impact on inviting more Health scholars to engage, ultimately improving the interdisciplinary fabric of the field.

4.3 Interactive Health May Need to Reassess What Counts as a "Contribution"

Beyond diversifying submission formats, questions remain on whether we can broaden contributions to a venue such as Interactive Health, building on previous and ongoing discussions at CHI and beyond on engaging better with Health scholarship (e.g., [1, 9, 11]). The current review process often prioritizes HCI implications over clinical or health system contributions, leading to Desk Rejections or Transfers of work that may be highly impactful in the health domain. Should Interactive Health expand its definition of "contribution" to better accommodate impactful work that may not fit neatly into HCI paradigms? How might the venue create clearer guidelines that acknowledge different types of health contributions as well within an HCI framework? We feel that with Interactive Health there may be an opportunity to build a bridge fostering interdisciplinary dialogue, rather than reinforcing rigid disciplinary boundaries. Of course, there are more pragmatic barriers. The scholars behind Interactive Health are largely those from an HCI background working on intersections with Health. However, there is space to engage with researchers trained outside HCI, who engage with technology in meaningful ways and evolve the field. This may need inviting these scholars in by reassessing how we assess "engagement" with HCI in Interactive-Health to be more inclusive of digital health and medical informatics perspectives in the long run.

More immediately, we should think more about how to write our Interactive Health publications in ways which are more approachable to Health audiences. For example, maybe we embrace the notion of Structured Abstracts [2], which have been in place in medicine for 35 years [10]. Maybe we return to strict word or page limits, perhaps with larger appendices or supplemental materials, to help make our work more digestible. At least partially adapting our publication structure has the potential to increase impact.

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