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Viewpoint

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ABSTRACT

Purpose: This viewpoint discusses a plausible framework to educate future speech-language pathologists (SLPs) as socially responsive practitioners who serve and advocate for the burgeoning vulnerable ethnogeriatric populations with neurogenic communication disorders.
Method: We provide an overview of the demographic, epidemiological, and biopsychosocial context that supports the implementation of equity-based, population-grounded educational approaches for speech-language pathology services in ethnogeriatric neurorehabilitation caseloads and discuss a plausible perspective based on the educational social determinants of health (SDOH) framework by the National Academies of Sciences, Engineering, and Medicine.
Results: The NASEM's three-domain SDOH educational perspective integrates education, community, and organization to create a self-reinforcing pedagogical coproduction that, grounded in the synergized partnerships of educational institutions, engaged communities, and organizational leadership, aims to address systemic drivers of health perpetuating ethnoracial disparities in health, care, and outcomes.
Conclusion: Exponentially growing vulnerable ethnogeriatric populations with age-related neurogenic communication disorders warrant the implementation of health equity education strategies to train technically prepared, socially conscious SLPs as service providers and advocates.

National public health has been compelled into urgent self-assessment by the confluence of persisting health care inequities in underserved ethnoracial groups, highlighted by the ongoing COVID pandemic, and persisting social injustice, strongly exemplified by multiple cases of police brutality (De Salvo et al., 2021; Devakumar et al., 2020). Steadily growing ethnoracial diversity in the United States critically requires a major socially responsive transformation of the health care system into an equitable and antiracist multisectoral process that can drastically minimize the disproportionate health, care, and outcome disparities in Black, Indigenous, and People of Color (BIPOC) communities, which include the heterogenous Black, American Indian, Alaska Native, Asian, Latino/a or Hispanic, and Native Hawaiian and Other Pacific Islander groups in the country (Hopper et al., 2020; Tsai et al., 2021).

Speech-language pathologists (SLPs), like all health care professionals, can be powerful catalysts in the

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transformative multisectoral overhaul of the health care system to minimize inequities in BIPOC communities (Berwick, 2020; Centeno et al., 2020; National Academies of Sciences, Engineering, and Medicine [NASEM], 2016). Because health is a social phenomenon deeply linked to social justice and health equity (Solar & Irwin, 2010), SLPs, trained with the professional knowledge, cultural competence, and health equity principles to advance health care with justice (American Speech-Language-Hearing Association [ASHA], 2021a; Landry, 2021), can be both expert providers and strong advocates for change (Bailey et al., 2017; Berwick, 2020; Centeno et al., 2020). Critically, in addition to scientific, clinical, and cultural foundations, exponential ethnoracial growth in the country requires professional education in speech-language pathology to instill the knowledge and lifelong consciousness on the life realities of BIPOC groups and the impact of multiple converging inequities on the health profile, services, and outcomes in marginalized communities, including older minoritized BIPOC individuals (Bridges et al., 2017; Hardeman et al., 2018; Khamis-Dakwar & Randazzo, 2021; Penn et al., 2017; Samra & Hankivsky, 2021).

As the country progressively experiences a sharp migration-driven growth in ethnoracial heterogeneity with a profound impact on both child and adult clinical populations (ASHA, 2021b; NASEM, 2021; Vespa et al., 2020), services to expanding ethnogeriatric populations with neurogenic communication disorders provide a powerful illustration of the priority clinical scenarios that require transforming in order to provide effective and equitable clinical management of increasing vulnerable multiethnic caseloads in the country. While the unique health challenges of older populations, especially minoritized geriatric groups, have been an ongoing public health priority (Agency for Healthcare Research and Quality, 2021; *The Lancet Healthy Longevity*, 2021b; Qualls, 2012), there are major current gaps in professional training, clinical resources, and research with critical care implications in ethnogeriatric contexts that diversity-focused professional strategies have not been able to remediate (Centeno, 2015; Ellis et al., 2021; Khamis-Dakwar & Randazzo, 2021; Kleinman & Benson, 2006; Wallace, 2017).

Disparities in the health, care, and recovery in minoritized populations, including older adults, call for community-informed interventions that address upstream macrolevel structural (systemic or institutional) determinants of health (e.g., institutional policies, official laws, and educational perspectives) with deleterious downstream impact on more proximal microlevel individual and community drivers of health (e.g., diet, physical activity, air quality; NASEM, 2016; Sharma et al., 2018; Williams et al., 2019). As employment in speech-language pathology extensively grows in response to the service demands from the rapidly expanding geriatric populations with aging-related chronic communication and swallowing complications (ASHA, 2021b; Bureau of Labor Statistics, 2021; Yorkston et al., 2010), there is a critical need for sizeable numbers of competently trained SLPs to optimally meet the clinical needs of larger ethnogeriatric caseloads in adult neurorehabilitation programs (Centeno & Harris, 2021; Cummings-Vaughn, 2017; *The Lancet Healthy Longevity*, 2021b; Qualls, 2012).

This article presents a viewpoint to discuss the needs and plausible framework for the socially responsive, equity-grounded education of SLPs to serve communicatively disabled ethnogeriatric groups in neurorehabilitation across the country. Guiding the framework is the premise that, interwoven among the sociocultural and environmental drivers of health in ethnogeriatric groups, there are systemic culturally incongruent racist forces in health care that adversely influence life-course factors in ethnogeriatric communities with an impact on the aging process, including brain health (*The Lancet*, 2021; *The Lancet Healthy Longevity*, 2021b; Williams et al., 2019). By starting with an overview of ongoing demographic transitions and related epidemiological and biopsychosocial scenarios in ethnogeriatric populations in the United States, we highlight the needs for a transformative training framework to prepare technically competent, socially conscious SLPs to work with communicatively disordered ethnogeriatric neurorehabilitation caseloads in the country.

Demographic Factors

Consistent with much of the world (Dwolatzky et al., 2017; Kristiansen et al., 2016), ethnogeriatric groups in the United States are anticipated to continuously grow as the population steadily ages and becomes more ethnoracially diverse from increasing international immigration (Centeno & Harris, 2021; Mizoguchi et al., 2019; Vespa et al., 2020; Yeo, 2009). The year 2030 in particular is estimated to be a demographic turning point in the country as the ≥ 65-year-old population will sharply increase when all baby boomers (those individuals born between 1946 and 1964) are over the age of 65 years and immigration, in an environment of declining birth rates and high mortality in the older non-Hispanic White population, becomes the main driver of population growth (Vespa et al., 2020). The number of people who are ≥ 65 years old, expected to grow by ~18 million between 2020 and 2030, is projected to reach ~98 million by 2060, including a triple growth in the ≥ 85-year-old cohort to ~18.2 million (Mather et al., 2015; Ortman et al., 2014).

In parallel to the rapid aging of the population, BIPOC groups in the United States, currently constituting

about 39% of the total population, are predicted to reach close to 44% by 2030, driven by international migration (Vespa et al., 2020). The number of immigrants arriving in the country has more than quadrupled since 1965, constituting 13.7% of the population today (Budiman, 2020). Propelled by the ≥ 65-year-old immigrant population more than doubling from 3.3 million in 2000 to 7.5 million in 2019 (Camarota & Zeigler, 2021), U.S. BIPOC individuals are projected to comprise ~50% of the ≥ 65-year-old population by 2060 (Mather et al., 2015). By this time, the older population in the country is estimated to be 55% non-Hispanic White, 12% non-Hispanic Black, and 9% non-Hispanic Asian. Hispanics will be 22% (Federal Interagency Forum on Aging-Related Statistics, 2016; Mizoguchi et al., 2019).

Extensive ethnoracial diversity translates into major linguistic and cultural heterogeneity. The composition of today's geriatric social environments in the United States, like their younger counterparts, consists of numerous coexisting BIPOC groups that represent a complex variety of intersecting linguistic profiles (i.e., monolingual and bilingual/multilingual speakers of minority languages, and users of dialectal varieties of English and other languages) and life trajectories (i.e., regions and countries of origin, health profiles, sociocultural histories, socioeconomic circumstances, and educational experiences; Cummings-Vaughn, 2017; Gerst-Emerson & Burr, 2014; Penn et al., 2017).

Epidemiological Factors

The COVID-19 pandemic heightened our attention to the alarming unpreparedness of health care systems to effectively respond to the disproportionate health vulnerability in disadvantaged ethnogeriatric populations (*The Lancet Healthy Longevity*, 2021a; Yeonjung, 2020). With marked population aging, extensive demands in long-term care are estimated from increasing geriatric caseloads with age-related chronic neurological disabilities, prominently including communicatively disordered individuals with stroke or dementia complications, particularly members of minoritized groups (Chen & Zissimopoulos, 2018; Obviagele et al., 2013; Uomoto & Loughlin, 2016). While an additional 3.4 million stroke survivors are projected by 2030 (Obviagele et al., 2013) and approximately 14 million individuals with Alzheimer's disease and related dementia are anticipated by 2060 (Matthews et al., 2019), older members from BIPOC groups will be extensively represented in stroke and dementia caseloads. Older individuals from BIPOC ethnoracial communities are especially vulnerable to age-related neurological complications from multiple intersecting drivers of health, care, and outcomes operating in marginalized, underserved communities (Fleming & Harris, 2017; Harris & Fleming, 2009; Hilal & Brayne, 2022; *The Lancet Healthy Longevity*, 2021b; Uomoto & Loughlin, 2016).

Regarding stroke, a cluster of key interacting variables (e.g., age, sex, race/ethnicity, level of education, geographic location, discrimination, and access to specialty care) has been implicated in ethnoracial disparities in stroke prevalence. Specifically, groups of older adults, African Americans, American Indians/Alaska Natives, persons with lower levels of education, and persons living in the southeastern United States with limited access to cardiovascular services care and exposed to chronic racial discrimination have been reported to have higher stroke prevalence (Bailey et al., 2017; Centeno & Harris, 2021; Labovitz, 2020). Similarly, in terms of dementia, while the pathophysiological course of dementia and other related neurocognitive disorders is similar across ethnoracial populations, converging socioeconomic, care, and lifestyle factors (e.g., wealth, quality and extent of medical coverage, educational attainment, physical activity), biological variables (e.g., genetics), and systemic culturally inadequate White-normative care policies and practices have been highlighted in the disproportionate prevalence of dementia risk factors in African Americans, Hispanics, and American Indian/Alaska Native communities (e.g., hypertension, diabetes, and cardiovascular health; Alzheimer's Association & Centers for Disease Control and Prevention, 2019; Bailey et al., 2017; Chen & Zissimopoulos, 2018; Chin et al., 2011; Harris & Fleming, 2009).

Biopsychosocial Factors

Environments that support care, independence, and social connectedness to home and community are optimal living contexts to promote well-being for all geriatric groups (O'Sullivan et al., 2020). Although aging in place, the ability to remain in one's home or community as one ages (O'Sullivan et al., 2020), depends on a variety of factors (e.g., family structure, financial support, health profile, ethnoracial status, caregiving situation, and societal attitudes to aging), many individuals in the growing ethnoracially diverse older groups in the country have numerous challenges that are amplified by living with chronic disabilities, including communication disorders (McCallion, 2014; Mikton et al., 2021; Qualls, 2012).

Because older BIPOC groups in our high-migration social environment differ across many factors, special attention must be given to the varying life circumstances, such as individual health histories, experiential trajectories, and socioeconomic circumstances, of the different geriatric ethnic profiles coexisting in the country, including Indigenous

populations living alongside recent immigrants, refugees, and settled minority groups (Alzheimer's Association & Centers for Disease Control and Prevention, 2019; Cummings-Vaughn, 2017). Individual circumstances, such as economic disadvantage, language barriers, limited connectedness to the U.S. culture, chronic stress, and neighborhood characteristics, interact with the limitations in care from White-normative and xenophobic attitudes and policies toward BIPOC groups within the health care system (Minsky-Kelly & Hornung, 2022; Paradies et al., 2015; Penn et al., 2017). These conditions impose serious challenges on the living environments, health promotion, and service quality in minoritized geriatric environments with critical consequences on the quality of the aging process (Dahlgren & Whitehead, 2007; Ferraro et al., 2017; McCallion, 2014).

The cumulative biopsychosocial effects of chronic life stress in vulnerable, marginalized ethnogeriatric groups, particularly the impact of societal and structural racism, can have severe somatized consequences that result in physical and mental deterioration with an impact on health profiles and brain health (Ferraro et al., 2017; Forrester et al., 2019; Hilal & Brayne, 2022; *The Lancet Healthy Longevity*, 2021b). For older BIPOC individuals with chronic communication disabilities from stroke or dementia and other neuropathologies, as in other vulnerable and stigmatized older communities in neurorehabilitation, such as lesbian, gay, bisexual, transgender, queer or questioning (LGBTQ) and rural groups (Boggs et al., 2017; Inungu & Minelli, 2022), chronic challenges from stressful living conditions and complex health histories, including comorbidity profiles, can amplify the psychoemotional difficulties from the neurogenic disabilities (Harris & Fleming, 2009; Saldivar et al., 2016; Shehata et al., 2015).

A Framework for Socially Responsive Professional Education for Ethnogeriatric Neurorehabilitation Services

Growing research evidence, underscoring that health inequities in BIPOC populations are not fully explained by downstream health determinants (e.g., socioeconomic circumstances, educational level, community environment), has highlighted structural racism and its multiple manifestations as a fundamental driver of health (Bailey et al., 2017; Gee & Ford, 2011; Williams et al., 2019). Discussing the broad impact of life-course structural racism and racialized social structures on the mental and physical well-being of ethnoracial groups is beyond the scope of this article (Forrester et al., 2019; Paradies et al., 2015; Williams et al., 2019). Regarding ethnogeriatric populations, the preceding discussion highlighted that lifelong exposure to racism, xenophobia, and discrimination, while resulting in chronic stressful living conditions with deleterious effects on overall health, similarly impacts access, extent, and quality in the care of minoritized populations with repercussions on healthy aging, including neurological health (Forrester et al., 2019; Hilal & Brayne, 2022; *The Lancet Healthy Longevity*, 2021b; Williams et al., 2019).

Consistent with calls for transformative interventions targeting the ripple effect of upstream social determinants of health (SDOH) on the socio-ecologic framework driving healthy living (Gee & Ford, 2011; Thornton et al., 2016), using comprehensive approaches to address the complex upstream–downstream interconnections of SDOH is imperative, especially to target the macrolevel role of structural racism in adverse health inequities (Bailey et al., 2017; Gee & Ford, 2011; Williams et al., 2019). While international and local policies (Solar & Irwin, 2010; United Nations, 2015; United States Department of Health and Human Services, 2001, 2021) have resulted in valuable socially responsive and culturally relevant educational strategies aligned with health equity principles and professional requirements (ASHA, 2021a; Ford & Airhihenbuwa, 2018), there is minimal evidence that these policies have strengthened deeper understandings about the role of culture on health or have mitigated the downstream impact of structural racism (Gee & Ford, 2011; Kleinman & Benson, 2006; Williams et al., 2019).

The aims advanced by official policies can be meaningfully integrated into a transformative educational approach that consolidates complementary ethnomedicine, social medicine, and health equity principles for ethnogeriatric care (Bailey et al., 2017; Frenk et al., 2010; *The Lancet Healthy Longevity*, 2021b; Yeo, 2009). In this integrated framework, professional training goes beyond cultural competence to instill the knowledge and consciousness about the interconnections among culturally shaped biopsychosocial health drivers and public health critical race praxis, specifically employing approaches to examine life-course upstream–downstream interactions in health outcomes (Bailey et al., 2017; Hankivsky et al., 2017; *The Lancet*, 2021; Sharma et al., 2018; Thornton et al., 2016). This framework acknowledges individual sociocultural and biopsychosocial life trajectories while simultaneously heightening awareness of the possible power hierarchies perpetuating marginalization, vulnerability, and inequities in health science and services (Dahlgren & Whitehead, 2007; Edberg, 2023; Ford & Airhihenbuwa, 2018; Hankivsky et al., 2017; Hardeman et al., 2018; Jacobs et al., 2021).

Cultural competence in health care, traditionally interpreted within linguistic and sociocultural terms, must additionally encompass deeper ethnomedical knowledge

about the role of culture in health promotion (Edberg, 2023). Culture, in its original anthropological interpretation, directly links personal social worlds, beliefs, behaviors, and lived experiences to each individual's life profile, including health outcomes, disposition to care, and meaning of illness and disability (Kleinman & Benson, 2006; Periyakoil, 2019). Culture impacts individual social, cognitive, behavioral, and biological factors, thus driving health outcomes in combination with environmental, societal, and systemic determinants (Barr, 2015; Edberg, 2023). In multiethnic health care contexts, individual extent of acculturation to the American culture varies greatly among the different ethnoracial groups and its members (Periyakoil, 2019). Thus, to address health disparities, the ways that culture intersects with individual socioeconomic, environmental, and systemic determinants of health must be acknowledged (Barr, 2015; Edberg, 2023).

In addition, because eliminating structural racism is central to address health inequities (Devakumar et al., 2020; Ford & Airhihenbuwa, 2010, 2018; Gee & Ford, 2011), critical race theory (CRT) provides important guidance to identify, assess, and undo the root causes of racialized social structures in health care research and practice (Bridges et al., 2017). Particularly, intersectionality, a central CRT principle (Crenshaw, 1989), directs the attention of health science researchers and practitioners to the multiple intersecting axes of inequality that interact with race and ethnicity in individual and population health (e.g., race/ethnicity, gender, sexual orientation, citizenship status, occupation, spirituality/religion, and age: African, woman, lesbian, immigrant, factory worker, Catholic, and older adult). Intersectionality powerfully compels the health care community to focus on the nuanced multifactorial entwinements shaping hierarchies of social advantage, power, and privilege that perpetuate discrimination, marginalization, vulnerability to illness, and, in turn, disparities (Hankivsky et al., 2017; Samra & Hankivsky, 2021; Solar & Irwin, 2010).

The NASEM Educational SDOH Framework

Compared to other health care professions (e.g., Kern et al., 1998; Phillips et al., 2015), speech-language pathology cannot presently rely on a rich scholarship record in professional education for health care services, especially for individuals who will be working with multiethnic groups (e.g., Horton-Ikard et al., 2009; Hyter & Salas-Provance, 2023; Johnson & Jacobson, 2017). Much of the instructional material to cover diversity content is provided by general professional guidelines and policies and the limited literature available (ASHA, 2022a, 2022b; Hyter & Salas-Provance, 2023). In this article, we adapt NASEM (2016) educational SDOH framework to propose socially attuned ethnogeriatric educational strategies grounded in the multilevel interconnections between upstream systemic and downstream individual and community drivers of well-being and health (Solar & Irwin, 2010; World Health Organization [WHO], 2008). The NASEM SDOH framework, used for curricular health equity planning in health care professions (e.g., Denizard-Thompson et al., 2021), is an instructional plan informed by multidisciplinary expert knowledge on health care education and SDOH policies to educate practitioners as change agents cognizant of the interrelated upstream macrolevel–downstream microlevel connections in health care environments (Frenk et al., 2010; Solar & Irwin, 2010; WHO, 2008).

The NASEM SDOH educational perspective synergizes three domains, education, community, and organization, in a dynamic coproduction process for transformative community-informed experiential learning (NASEM, 2016; Solar & Irwin, 2010). Community engagement for the collection of community-identified needs is essential in the NASEM framework. While the education domain operates as the institutional driver that shapes the overall framework through academic and clinical curricular goals created in close collaboration with community partners, a supportive organizational culture generates complementary institutional policies for a sound community-shaped educational process. For the purpose of this article, in contrast to the original NASEM (2016) focus on a learning continuum from foundational to professional development, our adapted NASEM SDOH framework, summarized in Table 1, applies the framework to foundational professional preparation in speech-language pathology.

Education Domain

Curriculum. Using an infusion approach, coupled with an intersectional perspective, allows the inclusion of the multiprofessional health equity content throughout the coursework that integrates public health and medical information to discuss SDOH vulnerability as shaped by macrolevel–microlevel interactions. For example, in the aphasia course, information about ethnoracial disparities in stroke prevalence can be included to highlight the role of a cluster of key variables, including age, sex, race/ethnicity, level of education, geographic location, and racist, White-centered service to account for the disproportionate prevalence of stroke in older adults, the various Black ethnicities, American Indians/Alaska Natives, persons with lower levels of education, and persons living in vulnerable regions of the country (Inungu & Minelli, 2022; Labovitz, 2020; Landry, 2021; Minsky-Kelly & Hornung, 2022). Also, in the research course, discussing the methodological limitations in adult research in speech-language pathology can especially examine gaps in BIPOC participant recruitment and evidence generalizability to

Table 1. Strategies for a socially responsive educational framework to serve ethnogeriatric neurorehabilitation caseloads.

Domain and goals	**Education** Learners • To acquire knowledge on the role of social determinants of health (SDOH) and their intersectionality in shaping health, services, and outcomes of ethnogeriatric individuals, communities, and populations • To apply an SDOH-grounded approach to clinical care for ethnogeriatric caseloads Faculty • To deliver equity-based instructional content on the role of SDOH and their intersectionality in shaping health, services, and outcomes of ethnogeriatric individuals, communities, and populations • To provide knowledge on client engagement to address SDOH in ethnogeriatric clinical care		
	Focus area	**Key content**	**Suggested readings[a]**
	Curriculum	Infusion approach coupled with an intersectionality perspective	Dahlgren and Whitehead (2007) Ellis et al. (2021) Hardeman et al. (2018) Landry (2021) Williams et al. (2019)
	Coursework	Specialized coursework in geriatric care, especially in ethnoracially diverse older groups in neurorehabilitation	Centeno and Harris (2021) Ferraro et al. (2017) Hilal and Brayne (2022) Saldivar et al. (2016) Uomoto and Loughlin (2016)
	Clinical training	Clinical experiences in transdisciplinary collaborative environments involving multiethnic older caseloads	Alzheimer's Association and Centers for Disease Control and Prevention (2019) Cartwright et al. (2015) Edberg (2023) Frenk et al. (2010) NASEM (2016)
	Reflexivity	Cultural assessment instruments for faculty and student self-evaluation in cultural competence and social awareness	Campinha-Bacote (2003) Matteliano and Stone (2010) Minsky-Kelly and Hornung (2022)
Domain and goals	**Community** • To develop the educational process as a coproduction of academic leaders and community representatives to identify care priorities and authentic care facilitators • To engage an interprofessional community in collaborative and coeducational learning experiences		
	Focus area	**Key activities**	**Suggested readings[a]**
	Outreach and partnerships	A network of university–community partnerships in community centers and/or clinical settings with vulnerable older populations	NASEM (2016) Price et al. (2021)
		Engagement of client, community residents, and practitioners from other professions	Edberg (2023) NASEM (2016) Price et al. (2021) Rust and Speights (2018)
Domain and goals	**Organization** • To engage administrative, academic, and community organizations in the coproduction of the educational process by creating the synergies that support academic and clinical experiences		
	Focus area	**Key activities**	**Suggested readings[a]**
	Leadership	Program and curricular development by administrative and academic leadership in collaborations with community partners	Frenk et al. (2010) Landry (2021) NASEM (2016)
		Policy-making by partner health care and community organizations	Decker et al. (2017) Denizard-Thompson et al. (2021) NASEM (2016) Rust and Speights (2018)

[a]Full bibliographical references of the suggested readings are available in the references section of this article.

highlight the problems with evidence validity and implications in the care given to BIPOC patient groups (Ellis, 2009; Ellis et al., 2021; Landry, 2021).

Coursework. Specialized coursework in geriatric care must be included in the curriculum, particularly having key information on the growing ethnoracially diverse older groups. Most notably, ethnogeriatric content should highlight the demographic, epidemiological, and group-specific biopsychosocial interactions operating in health promotion, care, and outcomes in ethnogeriatric groups, particularly in communicatively disordered older BIPOC individuals in neurorehabilitation (Ferraro et al., 2017; Harris & Fleming, 2009; Qualls, 2012; Saldivar et al., 2016). Course content should also promote the CRT assessment of care policies and procedures and discuss

health promotion and service provision as the products of intersecting drivers of health, specifically examining how upstream policies might not acknowledge the special life circumstances of BIPOC populations and their health vulnerability (Dahlgren & Whitehead, 2007; Hilal & Brayne, 2022; *The Lancet Healthy Longevity*, 2021a, 2021b).

Clinical training. Clinical experiences in health care settings will consolidate course content and deepen the comprehension of clinical evidence focusing on collaborative interprofessional work, multiethnic caseloads, expert knowledge from different health professions, and skills to assess and manage complex health and social needs within a specified population group (Ju et al., 2022; Sharma et al., 2018). Importantly, population groups recognized as ethnoracially mixed older individuals, diagnosed with determinants affecting their health, will be populations of interest as part of clinical training and experience (Cartwright et al., 2015; *The Lancet Healthy Longevity*, 2021a; Phillips et al., 2015). These clinical experiences will also expose students to community-informed knowledge that can shape care and outcomes in older ethnoracially mixed environments (e.g., acculturation, language barriers, educational limitations, health literacy gaps; Periyakoil, 2019), the engagement approaches to collect individual culturally shaped illness narratives and to determine dispositions to intervention (Edberg, 2023; Kleinman & Benson, 2006), and the available culturally attuned and linguistically appropriate clinical procedures that can best serve ethnogeriatric populations in neurorehabilitation (Centeno et al., 2020; Fleming & Harris, 2017; Harris & Fleming, 2009; Wallace, 2017).

Reflexivity. Self-assessment instruments of cultural competence and social awareness will allow faculty and students to engage in self-reflection regarding their individual strengths and any gaps in need of remediation to improve the academic and/or clinical components of the equity training program (Campinha-Bacote, 2003; Decker et al., 2017; Matteliano & Stone, 2010).

Community Domain

Outreach and partnerships. Embedding coproduction and coeducation in a community-driven curricular process is a fundamental strategy for improving cultural competency, interprofessional learning, and value-based care for marginalized populations (Price et al., 2021). Coproduction and coeducation with both community and other practitioners as partners, while reinforcing the importance of an inclusive curriculum incorporating both knowledge in social justice and cross-professional intervention principles, particularly engage community residents to teach us their realities, lived histories, and their perspective to shape the clinical process and enhance its outcomes (Alzheimer's Association & Centers for Disease Control and Prevention, 2019; NASEM, 2016; Rust & Speights, 2018).

Organizational Domain

Leadership. Inclusion of health equity in the nonclinical and clinical components of health care education requires commitment from the academic leadership running the program, accreditation agencies issuing professional standards, and institutional administrators in charge of community experiences (Frenk et al., 2010; NASEM, 2016). Notably, the local leadership at the training school, including both administrators and faculty, is crucial to generate the equity clinical and nonclinical curricular experiences with community collaborators that will facilitate the conceptual bases and lifelong societal consciousness in the students (Decker et al., 2017; Frenk et al., 2010; Landry, 2021).

Conclusions

As the U.S. population rapidly ages and becomes more diverse, a social landscape of tremendous health disparities and social injustice sharpens our attention on the urgency to expedite educational strategies for socially attuned service and advocacy in ethnogeriatric neurorehabilitation care. This viewpoint has highlighted the rationale and plausible educational framework to closely align speech-language pathology education with the much-needed health equity principles warranted by increases in vulnerable older BIPOC populations. These educational strategies, albeit critically dependent on decisive administrative and academic support from professional programs, require vigorous policies and mandates from professional organizations for the wide implementation of socially grounded antiracist education that provides the knowledge and creates the consciousness to minimize disparities in ethnogeriatric neurorehabilitation caseloads with communication disorders. Because the growing geriatric population includes such other vulnerable groups as well (e.g., LGBTQ and rural communities; Boggs et al., 2017; Inungu & Minelli, 2022), the socially responsive educational principles highlighted in this article can be adapted to encompass the special circumstances of other underserved marginalized older individuals with neurogenic communication disorders in the country.

Author Contributions

José G. Centeno: Conceptualization (Lead), Investigation (Lead), Writing – original draft (Lead), Writing – review & editing (Lead). **Loraine K. Obler:** Conceptualization (Supporting), Investigation (Supporting), Writing – original draft (Supporting), Writing – review & editing (Supporting). **Linda Collins:** Conceptualization (Supporting), Investigation (Supporting), Writing – original draft (Supporting), Writing – review & editing (Supporting).

Gloriajean Wallace: Writing – original draft (Supporting), Writing – review & editing (Supporting). **Valarie B. Fleming:** Writing – original draft (Supporting), Writing – review & editing (Supporting). **Jacqueline Guendouzi:** Writing – original draft (Supporting), Writing – review & editing (Supporting).

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