Implementing Strength-Based Dialogue to Reframe Clinical Education and Community Engagement

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Abstract

Purpose: Healthcare professionals want to solve problems. When health disparities are observed, the solution often rests on expanding access to clinical services. But what are the varied paths that persons with communication disorders might take to access speech, language, and hearing care? Where are these paths successful and where does a well-intended initiative have an absent or limited effect in altering disparities? Multiple, complex factors affect access to healthcare in underserved communities. However, current practice tends to frame the goals and metrics of outreach programs in terms of access to healthcare services, which risks privileging the perspective of the providers who want to increase the volume of services accessed over the voices of the community members for whom access to healthcare is only part of the larger course of their lives. Solutions that do not reflect those community strengths outside the service provision framework likely yield minimal impact on quality of life, since the community members are less likely to fully embrace the solution.

Method: In this clinical forum, we describe a community-informed strengths-based framework for clinicians and clinical researchers whose work is designed to reach underserved communities by employing mutual trust, empathy, active listening, and patient-centered care planning. Through case scenarios we exemplify key tenets of the framework.

Conclusion: The community-informed strengths-based framework detailed in this clinical forum supports a paradigm shift from a biomedically-informed strengths-based framework to a model of healthcare service provision that focuses on individual or community strengths. Eliciting guidance from those receiving care and framing the totality of encounters in terms of the process of responding to community strengths can build a collaborative and sustainable path forward toward achieving health goals.

Keywords: strengths-based service delivery, health outcomes, developmental language disorder, cognitive decline, community health workers, clinical education

Introduction

Clinical education forms the foundation for professional development for graduate students in the fields of speech-language pathology and audiology. Effective clinical education "ensures that new clinicians are well prepared and that individuals with communication disorders receive quality services" (ASHA, n.d.). Clinical educators help graduate students "develop professional behaviors, including the ability to work with individuals and their families" within the context of interprofessional education and practice (ASHA, n.d.). One of the most widely-used methods of clinical education is the case-based learning scenario (ASHA, n.d.). Analyzing and discussing client cases provides a functional context for graduate students to learn about clinical decision-making with a person-centered approach (Santana et al. 2018). Case studies foster learning that will generalize outside of the classroom to clinical work in the community (O'Fallon & Garcia, 2023). By reflecting on the specific needs of individual clients, students can learn about the impact of healthcare and educational policy and infrastructure on clinical service provision, as well as systemic inequities within healthcare.

Clinical education is incomplete without a focus on community health. In recent years, evaluation and treatment in speech-language pathology (SLP) has become increasingly focused on person-centered care. However, the individual strengths of a client and their family are often measured without acknowledging a person's surrounding community. Although community health initiatives are within the scope of practice for speech-language pathologists (SLPs; ASHA, 2016), there is limited guidance about how to implement community considerations in care planning, clinical research, and clinical education. It is becoming clear to clinicians, clinical educators, administration, and leadership that we are not optimizing health outcomes (Wilson Beer, 2019; Di Sante & Potvin, 2022). Clinicians have recognized the need to move beyond

cultural competence toward cultural humility (Hall & Johnson, 2020; Gregory, 2020). Yet, we are working within the constraints of our respective systems. Nevertheless, we need to move toward community engagement and dialogue (Gray, 2022). Reframing clinical education curriculum to include strength-based dialogue has the potential to position community engagement at the center of clinical work for the future.

Community health is traditionally framed by a strengths-based biomedical model in which individual community members take responsibility for their health by accessing healthcare experts as the need arises. Healthcare professionals, educated within the same model, then see themselves as servicing people with needs. There is an increasing awareness of the missed opportunity to embrace client strengths necessary to achieve health outcomes, such as patient activation scores, which measure a client's engagement with their own health outcomes (Hibbard et al., 2004; Koh et al., 2013; Pekonen et al., 2020). Unfortunately, viewing clients as either needy or empowered runs the risk of reinforcing the biomedical frame that privileges the clinicians' activities against the community framing in terms of broader strengths. A focus on authentic dialogues between clients and clinicians, in which communication partners say and do what they genuinely believe, builds mutual trust necessary for optimizing health outcomes and forefronts the relationship between them, instead of highlighting the point of interaction where the service is exchanged (and "access" is realized). This clinical forum proposes a strengths-based frame, situated in the social determinants of health, in which individuals partner with healthcare agents to leverage their shared capacity for enhancing behavioral change through mutual trust. The innovation of a community-informed strengths-based framing is to understand the capacity as *shared* and co-created in the context of authentic relations among interested parties and evolving dialogues between client and clinician. Put another way, strength is shared

more equally between client and clinician within a community-informed strengths-based model of healthcare. Table 1 illustrates key differences between a biomedically-informed strengths-based model and a community-informed strengths-based model of health. We explain the two frameworks in the sections that follow.

Insert Table 1

From the Biomedical Model to the Social Determinants of Health

The biomedical model has been criticized for creating a sense of the body as a mechanism where disease is represented as an external aberration best treated by medical intervention, which devalues the individual's agency and the holistic functioning of the body (Engel, 1960). Later criticisms turned to the systemic manifestations of the biomedical model and to the ways in which the neoliberal ideal of individual responsibility prevented researchers from seeing the holistic functioning of the socio-ecological context (Krieger, 1994). The slip in the criticism of the biomedical model is important for understanding how talk about the social determinants of health can remain tied to parts of a reductionist and disempowering model: If the final determination of health or illness is situated in the individual's body, then the strengths-based approach is only about supporting the individual client's capacity. Even when taken as a whole and as "determined" by social forces, the many ways in which the strengths of a community can shape the experience of health – e.g., support or shame, accommodation or exclusion, trust or disengagement – are obscured by an approach that situates the responsibility for health in the individual client's separate strength (Metzl & Hansen, 2014). A shared dialogue begins from a place of connection and not from an analytic separation. The tools associated with the biomedical model can be brought to bear *within* that shared dialogue, and the healthcare professional can support a shared sense of strength that acknowledges the community's role

without obscuring the embodied experience of the individual. The social determinants of health are then considered as part of the context for an effective shared dialogue – the clinician must understand what obstacles, goals, and strengths the client has – and not as an expert-driven explanation for the poor health outcomes of disempowered groups (Weinstein, et al., 2017).

In some ways, this movement from a biomedical model to a shared-dialogue view of the social determinants of health represents a subtle change in emphasis in the way that one engages with clients, and yet it also explains why so many of the assessment protocols tend to perpetuate status quo or dominant epistemologies given that "a priori" assumptions are made without input from the tested population. The "nothing about us without us" movement is a call to take seriously the experiences and perspectives of our clients and research participants (Charlton, 1998). The commitment to a community-engaged and strengths-based dialogue shows us how to begin that process by critically appraising the biomedical model and the analytic tools that biomedical research has provided (Xie et al., 2021).

Competence: From Cultural to Structural

Clinicians and their clients participate in structures and systems that facilitate or block progress to health and wellbeing. Cultural competence models assume that if we fix the clinician, then we would move toward meaningful, authentic, honest dialogue that builds mutual trust for a strengths-based problem-solving approach. Adjusting our lens so that we appreciate cultural difference and its impact on human behavior is important: We do not want cultural incompetence. Yet, cultural competence models miss everything that happens to the client outside of the clinical space, as the client navigates their own self-efficacy and their capacity to adhere to clinical recommendations while traversing complex healthcare systems. Professionals are more effective when they embrace cultural humility, which appreciates individual differences

within and across cultural groups, as the intersectionality of one's identity to provide a step toward a community-informed strengths-based model (Crenshaw, 1989; Tervalon et al., 1998). The culturally humble clinician and client would be less prone to stereotype or essentialize others. Yet, cultural humility may miss the impact of structural gaps and barriers on our ability to be healthy and well. For example, a client seeking nutritional advice for managing diabetes from a culturally-humble clinician who provides a safe environment will still experience challenges of transportation to a place to exercise, residing in a food desert, and a limited budget to purchase healthy foods. A structural competence model would solve this problem by bringing community strengths explicitly into the shared dialogue developed between clinician and client. That is, the clinician in this case might with appropriate cultural humility recommend that the client with diabetes gather with others in their community to walk for 30 minutes each evening. However, the successful clinician has moved beyond cultural competence and humility into active problem solving with the client that marshals their situated knowledge—when she knows, for example, that there is a social worker creating a new support group to help navigate structural gaps or barriers in a shared context.

Recruiting Representative Communities to Programming Embedded in Representative Communities

Clinical researchers who view participants as "subjects" may only reach out to or engage in dialogue with community members when it is time to recruit them into research projects. They take a transactional approach with community members that defies trust building. This practice aligns with a biomedical strengths-based model in that it focuses on a part rather than a whole. That is, research participants are simply a part of the clinical researcher's agenda, rather than a co-driver of the entire research enterprise. As implementation science becomes central to how

research studies are carried out, clinical researchers are beginning to align more with a community-informed strengths-based model by creating community advisory boards that provide opportunities for ongoing dialogue (McGaffigan, 2011). There is a need to move from consulting with community members and clients to posing questions together and involving them in everything from co-curricular course design to research design.

Learning: From Initiation-Response-Evaluation to Project-based

The two models of health are akin to differences in how teachers interact with their students. Teachers often pose a question or explain a concept, allow students to respond, and then evaluate student's responses within the Initiation-Response-Evaluation (IRE) mode of questioning (Sinclair et al., 1975). The IRE default is also enacted by clinicians seeking to check that what they have said to clients has been understood. Indeed, knowing the steps one needs to take to complete evaluation or treatment is important and does offer strength to the student or client. However, the IRE model of questioning fails to leverage the strengths, ideas, and strategies that students and clients can offer. For example, teachers who engage their students in project-based learning follow the student's interests as they scaffold students into higher levels of discourse about the topic of interest (Helm & Katz, 2016). Likewise, clinicians who deploy ethnographic interviewing (Westby et al., 2003) to find out how their clients experience the world may be more likely to discover resources that the client possesses to exert strength and resolve their communication needs than are clinicians who complete traditional medical intake forms. Clinicians who engage in in-depth interviewing will obtain a dynamic rather than static portrait of the client's life.

Communicating: Jargon to Plain Language to Dialogue

Moving toward a community-informed strengths-based model of healthcare requires switching from jargon to plain language in our spoken and written interactions with clients. Jargon refers to specialized vocabulary within a content area or profession (Swann, 2019). Jargon is part of the cultural milieu for the clinician. However, the client may leave the interaction without comprehension after listening to a clinician explain in jargon. To improve how well clinical messages are conveyed, clinicians must reduce jargon and increase plain language (Stableford & Mettger, 2007). Plain language refers to "grammatically correct language that includes complete sentence structure and accurate word usage" (NIH, 2010). Plain language allows the clinician's message to be better understood by clients. Yet, plain language fails to address the structural barriers. For example, a client who reads a housing brochure may be overwhelmed and confused by the legalese and detailed application process. They can connect with someone who explains the form in plain language. Now, the client understands what they need to do, but they are held back because of a structural barrier, such as transportation needs or difficulty obtaining required financial documentation, to complete the application.

Only in dialogue do clinicians learn of the limiting structural barriers. A clinician's well-intended treatment recommendations may be clearly articulated and explained, but impossible for the client to implement. For example, clinicians regularly invite clients to "come back next week" for a follow-up visit. This practice is easier said than done for many clients who face structural barriers, such as needing to take multiple city busses to visit a provider's office or being unable to easily leave their own place of (self) employment for a midday appointment. Finding childcare to attend multiple clinical visits is also a very real structural challenge for persons across the socioeconomic spectrum.

Solving Problems: Teach-back Method to Active Listening & Solution Focused Brief Therapy Philosophy

The teach-back method is designed to ensure understanding of healthcare instructions and recommendations for follow through after discharge from the inpatient setting or an outpatient appointment (Talevski et al., 2021). This client education model was designed to ensure accurate understanding and communication in a healthcare setting and there is emerging evidence to show the efficacy of this strategy (Ha Dinh et al., 2016). Consistent with the biomedical-informed strengths-based model, this method focuses on accurate delivery and reception of information but does not explicitly include listening to a client/caregiver and identifying goals of care that elevate the strengths of the person and their community. In a community-informed strengths-based approach, the client is seen as partner in care planning and a member of the health team and a plan of care first starts with deep, active listening (Luterman, 2017). After active listening, a provider can personalize a care plan that incorporates the strengths of the individual client and opportunities for support within their community network. In a solution-focused brief therapy approach, the clinician and client design goals collaboratively with a focus on person-centered solutions to achieve increased quality of life. The clinician provides positive reinforcement by identifying specific examples of success where the client leveraged their strengths together with the strengths from their community.

Summary

Each of the movements described above from a biomedical strengths-based model toward a community-informed strengths-based model allow for regular, ongoing dialogue between healthcare professionals and clients, which can establish and maintain mutual trust. Clinical educators play a key role in shaping how graduate students help clients navigate structural

barriers that prevent optimal health outcomes. We now turn to a pragmatic exploration of practical strategies for that transition with an emphasis on incorporating these concepts into clinical education.

Case Scenarios

Case scenarios have been the foundation of clinical education for implementing evidence-based practice. They provide an important point of discussion and critical thinking (O'Fallon & Garcia, 2023). We present three clinical scenarios that illustrate the opportunities for dialogue that encourages strength at various points of clinical engagement in the field of communication sciences and disorders. Each is based on plausible interactions from actual field experiences, but no real identities are being described or disclosed. In the first, we present a case of child language assessment in which outcomes vary as a function of having established mutual trust and shared expectations. The second scenario describes a preventative intervention program to minimize cognitive decline among underserved older adults through social engagement and cognitive stimulation. Lastly, we present a model of the community health worker as a potential advocate for productive dialogue between clients and clinicians. In each clinical scenario, there are multiple opportunities to exert mutual strength to meet communicative needs. We begin each case scenario with a list of the most salient model features to be drawn from the account.

Case 1: Mobile Screening for Communication Disorders in Children

- Social determinants of health
- Programming embedded in representative communities
- Project-based learning
- Dialogue
- Active Listening & Solution Focused Brief Therapy Philosophy

A professor of communication sciences and disorders and her undergraduate students are conducting free hearing and language screenings on their department's mobile unit at a back-to-school fair held each year by the city's mayor. Annabelle, a chiropractor who is concerned about her son's communication, is also at the fair to provide free spinal screenings. She thought about calling her husband to advise him to bring their son to the fair for the language screenings because she is concerned that his language may be delayed: her son is approaching the age of five and is having difficulty answering complex questions. Despite his apparent delays in communication, Annabelle feels her son is bright and worries that if she brings her concern to daycare personnel, they will "label him" and "hold him back" academically. She reads a New York Times article (McWhorter, 2022) opining on how widely used tests of language tend to stigmatize Black children like her son who sometimes speaks "Ebonics" (see also Ball & Bernhardt, 2008; Pearce & Williams, 2013). She is also aware that implicit- and racial bias were significantly related to "patient–provider interactions, treatment decisions, treatment adherence, and patient health outcomes" (Hall et al., 2015, p. e60).

When she went home from the fair and talked things over with her husband, he empathized, but worried more about not getting their son the help he needed and suggested that they contact his pediatrician for advice. The pediatrician agrees with Annabelle's observation and writes a referral for SLP services. Annabelle insists that the pediatrician provide them with a list of SLPs, preferably African American. Her husband called everyone on the list but, due to the covid-19 pandemic, was placed on several waiting lists. The SLP who was available and willing to come to their home for testing was an energetic young blonde woman with two years of experience. Annabelle was dubious, but her husband insisted that they move ahead with scheduling testing.

The SLP arrived a bit early so that she could create a RIOT. The RIOT assessment process entails Reviewing, Interviewing, Observing, and Testing (Langdon, 2002). She *r*eviewed the child's medical history before the meeting and noticed that he was born within a geriatric pregnancy. She *i*nterviewed the parents to learn more about the language practices and routines in their home and about the child's interests. The SLP's concerns about her son's interests and in trying to understand when and how he communicates left a positive impression with Annabelle that continued as the SLP *o*bserved her son playing with his toys, intermittently sprinkling in comments (e.g., "that's a neat puzzle!; I wonder what piece goes there."). Annabelle was relieved that the SLP interacted with her son very easily and naturally, as if they were old friends. The SLP then joined the child at his child-sized table for *t*esting. She started with a hearing screening, which the child passed. She moved on to a test of intelligence so that she could rule out developmental disability; the child performs within normal limits. The SLP then administered the Diagnostic Evaluation of Language Variation-Screening Test (Seymour et al., 2003), which determined that the child presented with some variation from mainstream American English (he was bidialectal) and was classified at the highest risk for language impairment. Finally, she audio-recorded Annabelle and her son engaging in free play with his toys to transcribe and analyze later. Before she leaves, the SLP has coffee with the parents to offer some preliminary results that align with Annabelle's observations, schedule a follow-up visit for additional testing, and to plan for intervention goals, with input from the parents.

Case 2: Minimizing Cognitive Decline in an Older Adult who Experienced Unstable Housing

- Social determinants of health
- Project-based learning

- Programming embedded in representative communities
- Active Listening and Solution Focused Brief Therapy

Jane is a 60-year-old woman with a chronic heart condition. She spent her adult years living paycheck-to-paycheck while raising her children, who are now grown and live several hours away. During a recent hospital admission followed by an extended inpatient rehabilitation stay, Jane missed several weeks of work and was then laid off. When she returned to her apartment, she was behind on rent, utilities, credit card payments, and several other bills. In the months that followed, Jane attempted to find a new job, but her health was not stable, and it was difficult to find employment that would work around her medical appointments. Her job search was ultimately not successful. She missed several months of rent and was evicted from her apartment. Like many older adults in the Boston area, she had difficulty finding an affordable apartment (City of Boston, 2022). Unfortunately, she did not have family or friends with room for her to stay or resources to support her financially. She also needed affordable housing that would be accessible with her wheelchair, and this further limited her housing options (Brown et al., 2017). Jane lived in transitional housing for several months. A few months ago, she was offered permanent housing through a local non-profit organization. Since moving into permanent housing, she has attended medical appointments consistently and received assistance from staff for mail-order delivery of her medications.

Since being laid off from work Jane lacked vocational fulfillment. She missed her daily interactions with new, young employees at work, where she would “teach them about life.” These interactions made her feel “important.” The program manager at her new residence recommended she join the *Intergenerational Dialogue and Collaboration for Cognitive Wellness* group (CogWell) that met weekly in her building’s dining room. She was initially reluctant,

stating, “I don’t want to work on my memory right now.” She also felt her memory “hadn’t been the same” since the hospitalization, but she was reluctant to attend a group with memory drills where she might experience failure. She also felt lonely. The previous year of her life had been stressful, and she felt isolated without contact from her former coworkers and neighbors, as is often the case for unhoused persons (Levasseur et al., 2010; Cornwell et al., 2009). After learning that her new neighbor was attending CogWell, she decided to try the program.

Upon entering the dining room, Jane was given a name tag and welcomed by a SLP graduate student, who invited her to sit at an open table. The graduate student participated in two orientation sessions prior to starting this clinical experience. In these meetings, she and her classmates read articles about the high prevalence of cognitive impairment among people who are unhoused or experience homelessness (Stone & Cameron, 2019). They also read and discussed articles about implicit biases and homelessness in the US (Terui & Hsieh, 2016; Slayton, 2021). Prior to meeting the older adults in CogWell, students acknowledged their own implicit biases about homelessness and reflected on the potential effect of these biases during clinical work. Students aim to reshape implicit biases across the course of the semester through weekly conversations with faculty and classmates.

Although feeling vulnerable in her new role as clinician, the graduate student was prepared to engage with older adults in this supervised clinical experience. After sharing a bit about herself and the purpose of the program, the graduate student asked Jane about her favorite pastime activities. With hesitation, Jane shared that she had been extremely tired recently, so she spent most of her time watching television. The more time she spent alone, the harder it felt to initiate interactions with others. With support from her clinical supervisor, the graduate student acknowledged Jane’s feelings of loneliness, validated her courage to try group today, and then

asked her about her favorite television show. Jane listed some of her favorite sitcoms from the past few decades. Unfamiliar with these titles, the graduate student found clips on YouTube and watched them with Jane. With enthusiasm, Jane described the context and drama among the characters. After the two reminisced about Jane's favorite episodes, the graduate student engaged Jane in a conversation about her hopes and goals for the future using solution-focused brief therapy (Burns, 2006; BRIEF, 2016). Through a series of open-ended questions, Jane explained that, although she dreamed about going back to her old job, she would feel successful and accomplished if she could find a way to "feel like a leader again". Jane explained that taking on a leadership role would make her valuable to her new community. Jane and the graduate clinician planned to take a turn leading the CogWell group in a subsequent week by eliciting favorite shows from the larger group and watching YouTube clips at the suggestion of the other residents and graduate students. Jane and the graduate student successfully facilitated a dynamic group conversation with rich, reminiscing memories and laughter. Feeling a sense of purpose, Jane became a regular member of CogWell and invited other residents to join.

In the subsequent weeks Jane shared with the other residents and graduate clinicians that the instability in her life was fueled by losing her job and then her housing. Moving into stable housing, having a case manager, and joining the CogWell group all improved Jane's outlook on the future, her access to health, and her feelings of connectedness. It did not, however, resolve all her challenges. In addition to cognitive decline and loneliness during her time of housing instability, she also experienced physical decline. She told the CogWell group that she was "supposed to be exercising more". When a graduate student asked a follow up question, Jane responded, "Oh we don't really need to talk about it; that's all I wanted to say for now." This interaction highlights the importance of ongoing case management to support Jane's complex

medical needs. Stable housing alone or access to one medical provider is not sufficient to help most older adults like Jane. However, stable housing and communicating with providers, who are guided by a case manager can change the trajectory of Jane's health and her quality of life.

Case 3: Optimizing Wellness Outcomes through Community Health Workers

- Social determinants of health
- Structural competence
- Programming embedded in representative communities
- Dialogue

The work of Community Health Workers (CHWs) has recently been broadly celebrated as a key element in integrating vulnerable populations into their own care (Kim et al., 2021; Zulu & Perry, 2021). CHWs have found a wide range of roles in healthcare, including providing coordination, navigation, psychosocial support, chronic disease management, and a wide variety of health education and outreach. The fundamental idea at the University of Houston Community Health Workers Initiative is to approach care coordination as individual health advocacy oriented by a shared sense that the healthcare and social service systems are failing, and not the individuals who are having difficulty accessing appropriate care. The CHWs work with the individuals to create plans that navigate the difficulties with the system and allow them to optimize their moments of contact with the health system and to achieve their personal health goals.

For example, a CHW recently made first contact with a family at a local food distribution site and had a series of care coordination meetings with Cai, the mother of the family. The CHW's role in food distribution was to ensure that every client of the food distribution non-profit had optimal access to the broader healthcare system, based in an understanding of the

family's own goals and barriers faced. It soon became clear that Cai was not able to thrive because childcare was so difficult to secure. Childcare is difficult for many people in her community, and she had resigned herself to not being able to address the issues. However, as the CHWs entered into deeper dialogue with the family, it became clear that the most difficult child to care for had signs of a developmental language disorder which Cai had seen but not felt equipped to address. She was simply too overwhelmed with other priorities and fatalistic about the situation. How could she spend even more time on one child, when access to childcare was already such a burden? The CHW working with Cai, however, had training in resource utilization for families and in the types of health resources available at the university. She understood that appropriate engagement with the university's speech and hearing clinic could actually reduce the overall burden. Because of the connection back to the university's expertise, the CHW was able to arrange appropriate screening for the child and to begin the application process for extra social service support for the child. Although the process is ongoing, that support should then make other goals achievable for the family, including the childcare arrangements for the family as a whole. Finally, the successful health advocacy makes it more likely for Cai to trust the CHW on other health messaging and reinforces the sense that she and her family are a source of strength and self-determination in the process, with the appropriate help from the social service sectors and the healthcare professionals. The fatalism about the situation can be replaced with a measured optimism and resilient sense of long-term engagement with appropriate experts in a responsive healthcare system.

Although some CHWs are employed as front-office staff or play the role of case manager for clients and families, the CHW in this case scenario was not employed by the university's speech and hearing clinic and was not directly involved in the delivery of speech-language

pathology services for the child. The CHW engagement with Cai and her family points to a different role, parallel to the difference between interventions focused on cultural competencies and those that address structural determinants of access. The CHW in the clinic makes it easier and more comfortable to be in the clinic and to succeed in those interactions. The CHW that is fully embedded in the community ensures that the clinic is an option. In Cai's case, the CHW was able to make concrete recommendations for creating better overall outcomes because the training in available services included SLPs in the university clinic.

In this case, the relationship is established as a partnership through the dialogue between the CHW and Cai, as oriented by the developing understanding of the paths that Cai is already on and the ways that they can better navigate the available services. For SLPs, the relationship with clients is always mediated by the referral process, but that fact does not preclude the opportunity to enter into authentic and meaningful dialogue with clients and with the CHWs who are helping them navigate the healthcare system. CHWs can serve guest lecturers in graduate courses to provide clinical educators and graduate students with authentic accounts of structural barriers to successful care and the importance of listening to complete and nuanced accounts of the community context for care. CHWs can help create better conditions for dialogues between individual clients and SLPs by grounding both sides of the conversation in concrete experiences of long-term goals, specific barriers, and the variety of strategies required to navigate the structural challenges faced by both clients and clinicians.

Conclusions

Clinical education should advance solutions to healthcare problems. To solve healthcare problems, healthcare professionals must go further than cultural competence. Indeed, there has already been a shift in much of the healthcare community from cultural competence to cultural

humility, but this shift is only a precondition to authentic shared dialogue. Recent calls have been made to increase cultural responsivity in SLP practice to mitigate against reproducing inequality and bias on the basis of dialect in the United States (Farrugia-Bernard, 2018). Although the critical move beyond cultural competence to cultural humility is underway (humility is better than hubris), a yet further step is to move into authentic dialogue with clients to assess and address cooperatively the structural barriers that confront clients from all walks of life and that beset healthcare providers. As evidenced in case scenario #2, authentic and meaningful dialogue does not immediately resolve all health disparities. Rather, dialogue establishes a sure space to progress toward wellness.

Policy change is important but insufficient to address structural barriers. There is a gap between what policy documents say and the actual practices within the health profession (Pascoe et al., 2018). In no way are we suggesting that policy changes are unimportant. Yet, we recognize that to make a meaningful impact on structural gaps and barriers, an open dialogue in identifying and leveraging community strengths is critical for immediate change. This task is easier for frontline professionals such as physicians and community health workers. For professionals such as SLPs and audiologists, who are not in frontline contact with the community, it is more complicated to see the structures that hinder authentic dialogue and to respond to structural gaps and barriers with their clients: SLPs and audiologists must unwrap "patients" who are referred to them by teachers and physicians, to see them as persons.

Moreover, the expectation that university clinics must serve as a revenue source may prevent them from serving as a resource to support the solutions arrived at through authentic dialogue. This entrepreneurial model also forces university researchers to decide to focus their time, talents, and resources into winning grants rather than building community relationships

required to mend structural gaps and barriers. The move to structural understanding allows SLPs to see themselves as working with clients and other professionals, such as CHWs, to address the broader range of challenges faced by the clients and to ensure the best outcomes for the process.

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[1] *Hearth, Inc. is a non-profit organization in Boston dedicated to the elimination of homelessness among the elderly. In 1991 seven women formed the Committee to End Elder Homelessness (now Hearth, Inc.) providing housing for nine individuals. Today, Hearth, Inc. has seven buildings which provides 228 units of housing.

References

American Speech-Language-Hearing Association. (n.d.). *Clinical Education and Supervision.* (Practice Portal). Retrieved May 19, 2023 from www.asha.org/Practice-Portal/Professional-Issues/Clinical-Education-and-Supervision/.

American Speech-Language-Hearing Association. (2016). *Scope of practice in speech-language pathology* [Scope of Practice]. Available from www.asha.org/policy/.

Ball, J., & Bernhardt, B. M. (2008). First Nations English dialects in Canada: Implications for speech-language pathology. *Clinical linguistics & phonetics*, *22*(8), 570-588. http://dx.doi.org/10.1080/02699200802221620

Burns, K. (2006). *Focus on Solutions: A Health Professional's Guide*. Germany: Wiley.

BRIEF (2016). *The language of solution focused brief therapy*. The Centre for Solution Focused Practice. Retrieved January 13, 2023, from https://www.brief.org.uk/resources/brief-practice-notes/the-language-of-solution-focused-brief-therapy

Brown, R. T., Hemati, K., Riley, E. D., Lee, C. T., Ponath, C., Tieu, L., Guzman, D., & Kushel, M. B. (2017). Geriatric Conditions in a Population-Based Sample of Older Homeless Adults. *The Gerontologist*, 57(4), 757–766. http://dx.doi.org/10.1093/geront/gnw011

Charlton, J. I. (1998). Nothing about us without us. Berkeley, CA: University of California Press.

City of Boston (2022). *42nd Annual Homeless Census*. Mayor's Office of Housing. https://www.boston.gov/departments/housing/annual-homeless-census

Conrad, & Blackman, S. (2018). Crenshaw, K. (1989). Demarginalizing the intersection of race and sex: A Black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. University of Chicago Legal Forum, 1(8), 139–167. In Responding to Learner Diversity and Learning Difficulties. Information Age Publishing, Incorporated.

Cornwell, E. Y., Waite, L. J. (2009). Social disconnectedness, perceived isolation, and health among older adults. *Journal of Health and Social Behavior,* 50, 31–48. http://dx.doi.org/10.1177/002214650905000103

Di Sante, M. & Potvin, L. (2022). We Need to Talk About Social Inequalities in Language Development, *American Journal of Speech-Language Pathology*, 31(*4*), 1894-1897. https://doi.org/10.1044/2022_AJSLP-21-00326

Engel. (1960). A Unified Concept of Health and Disease. *Perspectives in Biology and Medicine*, *3(4),* 459–485. https://doi.org/10.1353/pbm.1960.0020

Farrugia-Bernard, A. M. (2018). Speech-language pathologists as determiners of the human right to diversity in communication for school children in the US. *International Journal of Speech-Language Pathology*, *20*(1), 170-173. http://dx.doi.org/10.1080/17549507.2018.1406002

Gray, J. D. (2022). ASHA Voices: The critical but unseen social determinants of health. *ASHA LeaderLive*, *Healthcare*, February 18, 2022. https://leader.pubs.asha.org/do/10.1044/2022-0217-podcast-social-determinants-pediatric-feeding/full/

Gregory, K. (2020). For My Perspective/Opinion: Moving forward as a profession in a time of uncertainty. *ASHA LeaderLive*, *Career Management*, August 4, 2020. https://leader.pubs.asha.org/do/10.1044/leader.fmp.25082020.8/full/

Ha Dinh, T. T., Bonner, A., Clark, R., Ramsbotham, J., & Hines, S. (2016). The effectiveness of the teach-back method on adherence and self-management in health education for people with chronic disease: A systematic review. *JBI database of systematic reviews and implementation reports, 14(1*), 210–247. https://doi.org/10.11124/jbisrir-2016-2296

Hall & Johnson (2020). The Three CCCs of Dysphagia Management: Culturally Competent Care. *Perspectives of the ASHA Special Interest Groups*, 5(*4*), 1000-1005. https://doi.org/10.1044/2020_PERSP-19-00112

Hall, W. J., Chapman, M. V., Lee, K. M., Merino, Y. M., Thomas, T. W., Payne, B. K., ... & Coyne-Beasley, T. (2015). Implicit racial/ethnic bias among health care professionals and its influence on health care outcomes: A systematic review. *American Journal of Public Health*, *105*(12), e60-e76. http://dx.doi.org/10.2105/AJPH.2015.302903a

Helm, J. H., & Katz, L. G. (2016). *Young investigators: The project approach in the early years*. Teachers College Press.

Hibbard, J.H., Stockard, J., Mahoney, E.R., & Tusler, M. (2004). Development of the Patient Activation Measure (PAM): Conceptualizing and measuring activation in patients and consumers. Health Services Research, 39, 1005-1026. http://dx.doi.org/10.1111/j.1475-6773.2004.00269.x

Kim, K., Choi, J.S., Choi, E., Nieman, C.L., Joo, J.H., Lin, F.R., Gitlin, L.N., Han, H.R. Effects of Community-Based Health Worker Interventions to Improve Chronic Disease Management and Care Among Vulnerable Populations: A Systematic Review. *American Journal of Public Health, 106,* e3-e28. http://dx.doi.org/10.2105/AJPH.2015.302987

Koh, H.K., Brach, C., Harris, L.M., Parchman, M.L. (2013). A proposed 'health literate care model' would constitute a systems approach to improving patients' engagement in care. Health Affairs, 32, 357-367.http://dx.doi.org/10.1377/hlthaff.2012.1205

Krieger. (1994). Epidemiology and the web of causation: Has anyone seen the spider? *Social Science & Medicine*, *39*, 887–903. https://doi.org/10.1016/0277-9536(94)90202-X

569 Langdon, H. W. (2002). *Interpreters and translators in communication disorders: A*
570 *practitioner's handbook.* Thinking Publications.
571 Levasseur M., Richard L., Gauvin L., & Raymond, E. (2010) Inventory and analysis of
572 definitions of social participation found in the aging literature: proposed taxonomy of
573 social activities. *Social Science & Medicine, 71*, 2141–2149. doi:
574 10.1016/j.socscimed.2010.09.041
575 Luterman, D. M. (2017). *Counseling persons with communication disorders and their families*.
576 PRO-ED, Inc. 8700 Shoal Creek Boulevard, Austin, TX 78757-6897.
577 McGaffigan, E. (2011). *It's not so simple: Understanding participant involvement in the design,*
578 *implementation, and improvement of Cash & Counseling programs* [Doctoral thesis,
579 University of Massachusetts Boston].
580 https://www.proquest.com/docview/916613799?pq-origsite=primo
581 McWhorter, J. (2022, October 10). A language test that stigmatizes Black children. *The New*
582 *York Times*. https://www.nytimes.com/2022/10/07/opinion/black-english-testing.html
583 Metzl, J.M., & Hansen, H. (2014). Structural competency: theorizing a new medical engagement
584 with stigma and inequality. *Social Science & Medicine,103,* 126-133.
585 http://dx.doi.org/10.1016/j.socscimed.2013.06.032
586 O'Fallon, M. & Garcia F. (2023). Using activing learning strategies to strengthen cultural and
587 linguistic diversity training in communication sciences and disorders program.
588 *Perspectives of the ASHA Special Interest Groups, SIG 10 Issues in Higher Education*, 1-
589 14. https://doi.org/10.1044/2022_PERSP-22-00033
590 Pascoe, M., Klop, D., Mdlalo, T., & Ndhambi, M. (2018). Beyond lip service: Towards human
591 rights-driven guidelines for South African speech-language pathologists. *International*

Journal of Speech-Language Pathology, *20*, 67-74. http://dx.doi.org/10.1080/17549507.2018.1397745

Pearce, W. M., & Williams, C. (2013). The cultural appropriateness and diagnostic usefulness of standardized language assessments for indigenous Australian children. *International Journal of Speech-Language Pathology, 15*, 429–440. https://doi.org/10.3109/17549507.2012.762043

Pekonen, A., Eloranta, S., Stolt, M., Virolainen, P., & Leino-Kilpi, H. (2020). Measuring patient empowerment–A systematic review. *Patient education and counseling*, *103*(4), 777-787. http://dx.doi.org/10.1016/j.pec.2019.10.019

National Institutes of Health (2010). Plain Language at NIH. https://www.nih.gov/institutes-nih/nih-office-director/office-communications-public-liaison/clear-communication/plain-language

Santana, M. J., Manalili, K., Jolley, R. J., Zelinsky, S., Quan, H., & Lu, M. (2018). How to practice person-centred care: A conceptual framework. *Health Expectations : An International Journal of Public Participation in Health Care and Health Policy*, 21(*2*), 429–440. https://doi.org/10.1111/hex.12640

Seymour, H. N., Roeper, T. W., de Villiers, J. (2003). *Diagnostic Evaluation of Language Variation—Screening Test.* Ventris Learning.

Sinclair, J. M., Sinclair, J. M., & Coulthard, M. (1975). *Towards an analysis of discourse: The English used by teachers and pupils*. Oxford University Press, USA.

Slayton, N. (2021). Time to Retire the Word ‘Homeless’ and Opt for ‘Houseless’ or ‘Unhoused’ Instead? Architectural Digest. https://www.architecturaldigest.com/story/homeless-unhoused

615 Stone, B., Dowling, S., Cameron, A. (2019). Cognitive impairment and homelessness: A scoping
616 review. *Health & Social Care in the Community*, 27(*4*), e125–e142.
617 https://doi.org/10.1111/hsc.12682
618 Swann, J. (2019). *Dictionary of Sociolinguistics*. Edinburgh University Press.
619 Talevski, J., Wong Shee, A., Rasmussen, B., Kemp, G., & Beauchamp, A. (2020). Teach-back:
620 A systematic review of implementation and impacts. PloS one, 15(4), e0231350.
621 https://doi.org/10.1371/journal.pone.0231350
622 Tervalon, M., & Murray-Garcia, J. (1998). Cultural humility versus cultural competence: A
623 critical distinction in defining physician training outcomes in multicultural education.
624 *Journal of health care for the poor and underserved*, *9*(2), 117-125.
625 http://dx.doi.org/10.1353/hpu.2010.0233
626 Terui, S. & Hsieh, E. (2016). "Not Homeless Yet. I'm Kind of Couch Surfing": Finding
627 Identities for People at a Homeless Shelter. *Social Work in Public Health*, 31(*7*), 688–
628 699. https://doi.org/10.1080/19371918.2016.1188739
629 Weinstein, J. N., Geller, A., Negussie, Y., Baciu, A., & National Academies of Sciences,
630 Engineering, and Medicine. (2017). Committee on community-based solutions to
631 promote health equity in the United States. *Communities in action: pathways to health*
632 *equity. Washington, DC: National Academies Press*, 57-97.
633 Tervalon, M., & Murray-García, J. (1998). Cultural humility versus cultural competence: A
634 critical distinction in defining physician training outcomes in multicultural education.
635 *Journal of Health Care for the Poor and Underserved 9(2)*, 117-125.
636 doi:10.1353/hpu.2010.0233

637 Westby, C., Burda, A., & Mehta, Z. (2003). Asking the right questions in the right ways:
638 Strategies for ethnographic interviewing. *The ASHA leader*, *8*(8), 4-17.
639 https://doi.org/10.1044/leader.FTR3.08082003.4
640 Wilson Beer, M. (2019). Simple ways to boost healthcare access for people with communication
641 disorders. *ASHA LeaderLive*, *Healthcare*, March 25, 2019.
642 https://leader.pubs.asha.org/do/10.1044/simple-ways-you-can-improve-health-care-
643 access-for-people-with-communication-disorders/full/
644 Xie, R.Z., Malik, E.d., Linthicum, M.T., & Bright, J. Putting stakeholder engagement at the
645 center of health economic modeling for health technology assessment in the United
646 States. *PharmacoEconomics, 39,* 631–638 (2021). https://doi.org/10.1007/s40273-021-
647 01036-3
648 Zulu, J.M., & Perry, H.B. Community health workers at the dawn of a new era. *Health Research*
649 *Policy and Systems, 19*, 1-5. http://dx.doi.org/10.1186/s12961-021-00761-7