

**Dean’s Lecture Series – “Conceptualizing Radical Healing Through The  
Voices of Teens and Their Parents**

Date: Wednesday, October 9th, 2024

Presenters: Dr. Maria Veronica Svetaz and Dr. Bryana French

**Abstract:** The Psychology of Radical Healing Framework (French et al., 2020) is a model for healing from racial trauma created by BIPOC scholars, activists, and practitioners. Advancing beyond individual-level approaches to coping with racial trauma, the model calls for multisystemic healing that involves critical consciousness, radical hope, strength and resistance, cultural authenticity and self-knowledge, and collectivism. Through using this framework, we present initial findings from listening sessions with Immigrant African and Latine youth and families to inform radical healing interventions.

**Q&A Questions & Responses:**

1. How will we move to action after listening at Hennepin Health Care?

We need to clarify a critical piece of our listening sessions that we might not have clarified enough: The Listening Session **participants came from the community**; they were linked in some way or another with the different community organizations that work with us. They used **different healthcare systems in the Twin Cities, but not necessarily Hennepin Healthcare**. We tried various recruitment methods and finally decided to use this method, as we needed more than flyers or on-site invitations. It did not matter as we wanted to recap the collective experiences with Healthcare. **I want everyone to understand that this is more than just Hennepin Healthcare**. We were eager to collect opinions from the communities we serve, not so much about us but about health and healthcare in general.

We plan to do different presentations at Hennepin Healthcare and use our participant's voices to elevate the care we provide in our organization.

What we have been hearing here is very similar to what we heard from Hennepin Health’s Community Listening Sessions, and this amplifies and solidifies those findings. The thirst to be able to be “seen” as a whole, the thirst to be “listened to actively” and to have systems cater to their preferences and values (the “one-stop” care for all) has found (in my opinion) “saturation levels”: when we ask, we keep hearing the same message repeatedly. It is essential to continue to advocate for the healthcare system to transform its design to cater to this need (e.g., think about templates, billing, and reimbursement in primary care). Dr Vero used a grant in 2001 (EHDI-Eliminating Health Disparities Initiative MDH) to create team-based care, which allowed me to do that. Several models are out there to help make this Team-based care emphasizing Integrative Care. And please, let’s continue to advocate for strengths-based ICD Codes. For example, try to find an ICD code that reflects that someone is a Gifted Learner somewhere. And continue to advocate for codes that do not perpetuate stigmatization. After our talk for the first time in my clinic, I noticed this code: “Immigrant with language difficulty”, and thought: the

patient does NOT have a language difficulty: he speaks a different language. The term signals a deficit, and he does not have one. He was born in a place where our language was not used. How about: “Immigrants fluent in a different language than English.” We tried to make an access point, but language matters, and they go to the patient’s chart. I changed how the diagnosis was “displayed” (Yes, one more click!).

2. Dr. French mentions “movement to action with efficacy” to foster reflexivity and help create critical consciousness. What is our path, as a community, to “start doing something about it,” as Dr. Svetaz advocates? How do we measure our efficacy and hold ourselves accountable as a medical school?

This is a great question, and I would love for our U of MN Medical School leaders to be able to respond to it. In Health Equity, Education helps to some extent. Still, the most significant changes come from solid policies and procedures that create different benchmarks and a system that monitors those benchmarks continuously. That is the accountability part. I like this document that tackles this for all kinds of organizations in general: <https://equityinthecenter.org/aww/> / and here is another document that might be useful in moving towards antiracist organizational change: [https://cwdb.ca.gov/wp-content/uploads/sites/43/2021/05/Handout-Anti-Racist-Org-Development-Continuum\\_ACCESSIBLE.pdf](https://cwdb.ca.gov/wp-content/uploads/sites/43/2021/05/Handout-Anti-Racist-Org-Development-Continuum_ACCESSIBLE.pdf)

3. As a follow-up to Dr. Nunez’s question, in your analysis so far, did you identify any ways to affirm the community strengths in healthcare settings? I come from a different institution, and one of the things we did was to have flexible visitor policies to allow for more community in care settings, and allowing more personal items in patient rooms that helped the care teams see their identity beyond MRNs, diagnosis, and pathologies.

Great questions! In Hennepin Healthcare, the DEI Department started delivering curly hair products in Maternity Care and other areas where patients are hospitalized. We are now increasing the availability of hijab options in all hospital units, treating these and other culturally responsive supplies with the same priority as other medical necessities. The other part is having posters and signs in the languages your patients speak and having displays with posters with images of people coming from the same communities as them. Another is having food that caters to different groups, which we have at Hennepin Healthcare.

Critical evaluations of healthcare providers are also needed to assess for and respond to microaggressions and bias enacted. What is the consequence when a patient or family member complains about maltreatment? Are providers required to engage in DEIB education regularly and be held accountable for that learning? Are there benchmarks about how their patients perceive them by race/ethnicity?

One of the most important initiatives is having culturally concordant team care that reduces barriers.

4. Is it not impossible for us to arrange for "patient ERG's" just like we do for cancer patients, craniofacial patients in the community, where they can share stories that we as practitioners can benefit from? This can make up for the "lack of time" we have created in zeal to see more patients.

ERG: Employee Resource Groups, also known as “Affinity Groups”. I feel that Group Care is the answer for some cases, mainly as it brings the “community” and honor to the “group lens” our patients of color have. This idea of having community advisory groups could be beneficial if the organization is held accountable for the feedback.

However, the main answer is how to create “Relationship-based care,” where you know that building trust is the most essential element in your patient-clinician equation. Patients of color prefer a whole-person approach and this model. Our healthcare model, on the other hand, is compartmentalized and expertise-based and is not friendly towards this type of care.