


Community Health Worker Leadership In Louisiana, During and After Hurricane Katrina

 See also Kim-Farley, p. 1448, and the *AJPH* Hurricane Katrina 15 Years After section, pp. 1460–1503.

Community health workers (CHWs) have been building capacity among underresourced populations in the United States for decades by addressing health inequity and its underlying social determinants.¹ In 2005, hurricanes Katrina and Rita struck the Greater New Orleans, Louisiana area, bringing massive infrastructure damage and loss of life. A complex series of political and social issues followed, leaving close to half of the city's residents displaced a year later.² Those who returned struggled to rebuild their homes, enroll their children in a newly privatized school system,³ live in increasingly gentrified neighborhoods,⁴ navigate a fragmented health care system,⁵ and grieve the loss of entire communities. CHWs not only supported recovery from the devastation but also learned important lessons through organizing themselves into a professional association to support their growing workforce and influence policy.

INITIAL RESPONSE

After Katrina, community-based and state-funded programs immediately hired CHWs to engage in recovery efforts. CHWs labored to expand access

to health care and social services, with community-based organizations employing them to conduct Medicaid and Supplemental Nutrition Assistance Program enrollment. CHWs also navigated clients through a confusing and ever-changing web of resources for food, housing, and employment. In the absence of a functioning public hospital system and with many paper health records destroyed, CHWs employed by cancer control programs engaged in door-to-door outreach to locate patients in need of treatment. With this surge in activity, experienced CHWs often found themselves doing community outreach alongside CHWs employed by other organizations. They raised concerns with their supervisors about overlapping efforts and the possibility of overwhelming or confusing residents with contacts from multiple agencies. As gentrification changed neighborhoods, CHWs also advocated shifting their service delivery areas to better reach the populations they previously served. Ultimately, program managers began to trust CHWs' insights about where to reach vulnerable populations and the importance of coordinating efforts across agencies.

IN MENTAL HEALTH

For many New Orleanians, depression and other mental health conditions presented an ongoing challenge after Katrina. From 2008 to 2010, a community-academic partnered program aimed to bolster local health professionals' capacity to address mental health, in part by training more than 60 CHWs from a variety of agencies to provide community education and referrals for mental health services.^{6,7} Most CHW trainees previously worked exclusively on physical health (e.g., diabetes and HIV) or social issues (e.g., housing and food security), so the program offered optional monthly meetings for CHWs to discuss challenges with talking about and making referrals for mental health, voice professional frustrations, and share information about ever-evolving community resources. When the program's

funding ended, CHWs and a university-based CHW ally agreed to continue convening meetings to help CHWs cope with the ongoing emotional turmoil of providing community service and the instability of working on grant-funded positions. CHWs engaged colleagues and friends through word of mouth, and meetings grew to include CHWs working across a myriad of organizations, neighborhoods, and health issues.

UNITING

In 2011, the group formally became the Louisiana Community Health Outreach Network (LACHON). Like CHW professional networks in other states and the National Association of CHWs formed in 2019, LACHON aims to unite and champion CHWs of various job titles (e.g., community health navigator, outreach worker). Operating without full-time staff and very limited administrative funds for almost a decade, LACHON has offered ongoing CHW professional development seminars and core competency training, convened monthly membership meetings, hosted an

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annual conference highlighting Louisiana CHWs' accomplishments, and kept more than 300 community health professionals informed through an active e-mail listserv. Most importantly, LACHON has become a well-recognized voice for CHWs in Louisiana.

COLLABORATION

In 2016, the Louisiana Office of Public Health engaged LACHON to begin considering how to expand the state's CHW workforce. The Louisiana Office of Public Health readily agreed to follow national best practices in CHW policy development, many of which are process oriented and time intensive. The work became formalized in 2019 when a legislative resolution created the Louisiana CHW Workforce Study Committee, naming two of LACHON's cofounders to lead the group. Committee members included Louisiana Office of Public Health staff, researchers, and legislators, and in accordance with an American Public Health Association policy on CHW self-determination, half were CHWs. Committee coleads and their staff conducted the first-ever statewide study of Louisiana CHWs and their employers. Based on data gathered, consultation with national experts, and a review of the existing literature, the committee made policy recommendations to support and expand the CHW workforce in Louisiana. LACHON has been, and will continue to be, at the forefront of implementing these recommendations in collaboration with the state and other allies.

LESSONS LEARNED

Lessons learned from building a CHW movement in a post-disaster setting are applicable to other communities. First, the experience did not entail recovering from merely a natural disaster but also a political one. CHWs, who had limited agency in disaster response planning, were largely responsible for doing the painstaking work of reaching out to communities most affected, while also dealing with their own trauma. CHWs should be engaged in planning any disaster preparedness programs or response efforts in which they are to be involved. Their insight into the strengths and needs of marginalized populations is invaluable.

Finally, this work highlights the value of CHWs advocating for their communities and for their profession. CHWs who constructively challenged ineffective program structures after Katrina were better able to serve their communities. LACHON's founders created the organization not because they had funding, permission, institutional backing, or even knowledge of how to start an organization but because CHWs needed support. By creating their own professional association and embracing the concept of "nothing about us without us," Louisiana CHWs created a collective voice that is now driving policy decisions about their workforce. CHWs nationwide can harness their own power and ensure their needs are represented by participating in the growing number of local, state, and national CHW associations. *AJPH*

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CONFLICTS OF INTEREST

The authors have no conflicts of interest to declare.

REFERENCES

1. Community Health Worker Core Consensus Project. Resources & findings from the C3 Project. Available at: <https://www.c3project.org/resources>. Accessed April 30, 2020.
2. Sastry N, Gregory J. The location of displaced New Orleans residents in the year after Hurricane Katrina. *Demography*. 2014;51(3):753–775.
3. Haselle D. Now an all-charter district, New Orleans school experiment still faces questions. 2019. Available at: https://www.nola.com/news/education/article_30fbef6e-b476-11e9-a3b5-57480c7a30f7.html. Accessed April 28, 2020.
4. van Holm EJ, Wyczalkowski CK. Gentrification in the wake of a hurricane: New Orleans after Katrina. *Urban Stud*. 2019;56(13):2763–2778.
5. Rudowitz R, Rowland D, Shartz A. Health care in New Orleans before and after Hurricane Katrina. *Health Aff (Millwood)*. 2006;25(suppl 1):w393–w406.
6. Springgate BF, Wennerstrom A, Meyers D, et al. Building community resilience through mental health infrastructure and training in post-Katrina New Orleans. *Ethn Dis*. 2011;21(3, suppl 1): S20–29.
7. Wennerstrom A, Vannoy SD 3rd, Allen CE, et al. Community-based participatory development of a community health worker mental health outreach role to extend collaborative care in post-Katrina New Orleans. *Ethn Dis*. 2011; 21(3, suppl 1):S45–S51.