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Can Coaching Help Community Partnerships Promote Health Equity, Community Engagement, and Policy, Systems, and Environmental Changes? Results From an Evaluation

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Keywords: *Community coalition, community partnership, evaluation, health equity, community engagement, coaching, technical assistance*

Introduction

Communities have increasingly formed multisector partnerships to address the social determinants of health and promote health equity (Erickson et al., 2017; Hogg & Varda, 2016; Mattessich & Rausch, 2014; Mays, Mamaril, & Timsina, 2016; Zahner, Oliver, & Siemering, 2014). Because no single sector can address all the factors that influence health, multisector partnerships have the potential to tackle challenging health issues by increasing collaboration across a range of stakeholders (Woulfe, Oliver, Zahner, & Siemering, 2010). Partnerships may use a variety of strategies to improve the health of their communities, from increasing availability of direct services to pursuing policy changes. Some evidence suggests that partnerships can have positive effects on health outcomes and health equity (Mays et al., 2016; McAfee, Blackwell, & Bell, 2015).

Truly collaborative work of partnerships is not easy; many struggle to build the capacities necessary for diverse stakeholders to pursue shared goals (Siegel, Erickson, Milstein, & Pritchard, 2018; Wolff, 2016; Woulfe et al., 2010). For example, partnerships require strong internal processes and structures, along with the skills, knowledge, and capacity needed to pursue health promotion activities (Roussos & Fawcett, 2000). In addition, partnerships require specialized skills in order to address longstanding health

Key Points

- Foundations and other entities have increasingly funded coaching and technical assistance to support multisector community partnerships to promote health and health equity. However, much remains to be learned about how coaching can best support these partnerships.
- As part of its efforts to build a culture in which everyone in the United States has a fair opportunity to be healthy, the Robert Wood Johnson Foundation partnered with the University of Wisconsin Population Health Institute to provide structured coaching to strengthen the capacities of community partnerships. The foundation contracted with Mathematica to evaluate the coaching program, focusing on whether it had an effect on strengthening the capacity of partnerships to prioritize policy, systems, and environmental changes; promote health equity; and increase community engagement.
- The evaluation found that the coaching program provided valuable support to many partnerships, helping some focus on policy, systems, and environmental changes. Integrating health equity and community engagement into a general health-promotion coaching model might be best suited for

(continued on next page)

Key Points (continued)

partnerships just beginning to develop a strategy to improve health equity. Partnerships that already have a strong understanding of health equity might benefit most from intensive, specialized technical assistance to address inequities. Some partnerships reported that coaching shifted their thinking around community engagement, but none reported increasing engagement as a result of coaching.

- To advance health equity and engage communities, we propose that funders consider investing in partnerships that already prioritize leadership of community members most affected by inequities. Specialized technical assistance may help leaders not affected by inequities to think critically about their community's history and structures of power, ongoing racial and power dynamics, and their own personal stories and levels of privilege.

inequities (Fawcett, Schultz, Watson-Thompson, Fox, & Bremby, 2010). Some practitioners argue that if partnerships are to make an impact on health inequities, they must explicitly address issues of social and economic injustice and structural racism; meaningfully engage community members most impacted by health inequities (hereafter, "community members") by giving them equal power in shaping the partnership's agenda and activities; and focus on promoting policy, systems, and environmental (PSE) changes rather than programmatic activities (McAfee et al., 2015; Wolff et al., 2016). Many partnerships struggle in these areas, including with their ability to integrate community members in partnership initiatives (Motes & Hess, 2007; Roussos & Fawcett, 2000; Siegel et al., 2018).

Foundations, government agencies, and other entities often use technical assistance to increase the ability of partnerships to improve health and health equity. Technical assistance strategies include coaching, facilitation, and didactic and experiential learning, and can be delivered through multiple formats (e.g., written products; webinars; in-person, video, and telephone meetings) and in varying levels of intensity and duration (Le, Anthony, Bronheim, Holland, & Perry, 2016; Lyons, Hoag, Orfield, & Streeter, 2016). Further, the content of technical assistance varies depending on whether its funders or recipients, or a combination, are driving the curriculum (Lyons et al., 2016; Mitchell, Florin, & Stevenson, 2002).

Coaching draws on empowerment theory, organizational change theory, and adult learning theory to build capacity among individuals, organizations, and community partnerships to bring about change (Motes & Hess, 2007). A coach acts as intermediary to facilitate action, offering guidance and support to leaders as they negotiate the challenges of community-based initiatives (Brown, Pitt, & Hirota, 1999). Rather than giving specific guidance on what to do or providing tangible support directly, a coach helps leaders figure out how to identify appropriate solutions and take action on their own (Hubbell & Emery, 2009; Smathers & Lobb, 2014). A coach's role in helping leaders develop cultural knowledge, examine their own individual and organizational culture, identify diversity, and strengthen efforts to engage community residents (Motes & Hess, 2007) are particularly relevant to promoting health equity and community engagement. For example, a coach can facilitate discussions around cultural awareness and diversity, encourage the use of self-assessment tools, identify resources, and provide training to build capacity in cultural competence. A coach can also advise partnerships on how to support the participation of community residents with tips on scheduling meetings and budgeting incentives for meeting participation.

Modest evidence suggests that varied types of technical assistance can help partnerships improve internal structures, processes, and communication, and can enhance skills in planning, implementing, and evaluating health promotion programs (Butterfoss, 2004; Chiappone et al., 2018; Hunter et al., 2009; Riggs, Nakawatse, & Pentz, 2008; Woods, Watson-Thompson, Schober, Markt, & Fawcett, 2014). Less is known about the effectiveness of coaching to

strengthen the ability of multisector partnerships to prioritize PSE strategies, health equity, and engagement of community members (hereafter, "community engagement").

As part of its efforts to build a culture in which everyone in the United States has a fair opportunity to be healthy, the Robert Wood Johnson Foundation partnered with the University of Wisconsin Population Health Institute and launched the County Health Rankings & Roadmaps Program (CHR&R) in 2010. CHR&R offered technical assistance through online resources and coaching to help communities build capacity to promote health and health equity. From 2014 to 2018, CHR&R offered a coaching program to individual community leaders seeking to form a new partnership and to teams of leaders representing existing partnerships.

The foundation contracted with Mathematica to evaluate the coaching program, focusing on whether it had an effect on strengthening the capacity of partnerships to prioritize policy, systems, and environmental (PSE) changes; promote health equity; and increase community engagement. This article summarizes the results and discusses ways in which coaching may have affected the ability of partnerships to incorporate these elements into their work; identifies lessons learned; and shares recommendations for funders interested in pursuing similar strategies.

The County Health Rankings & Roadmaps Coaching Program

The coaching program, one component of CHR&R, shared the larger program's broad goals of increasing awareness of the multiple factors (especially social and economic) that shape health and engaging and supporting multisector partnerships to help them improve health in their communities. (See Figure 1.)

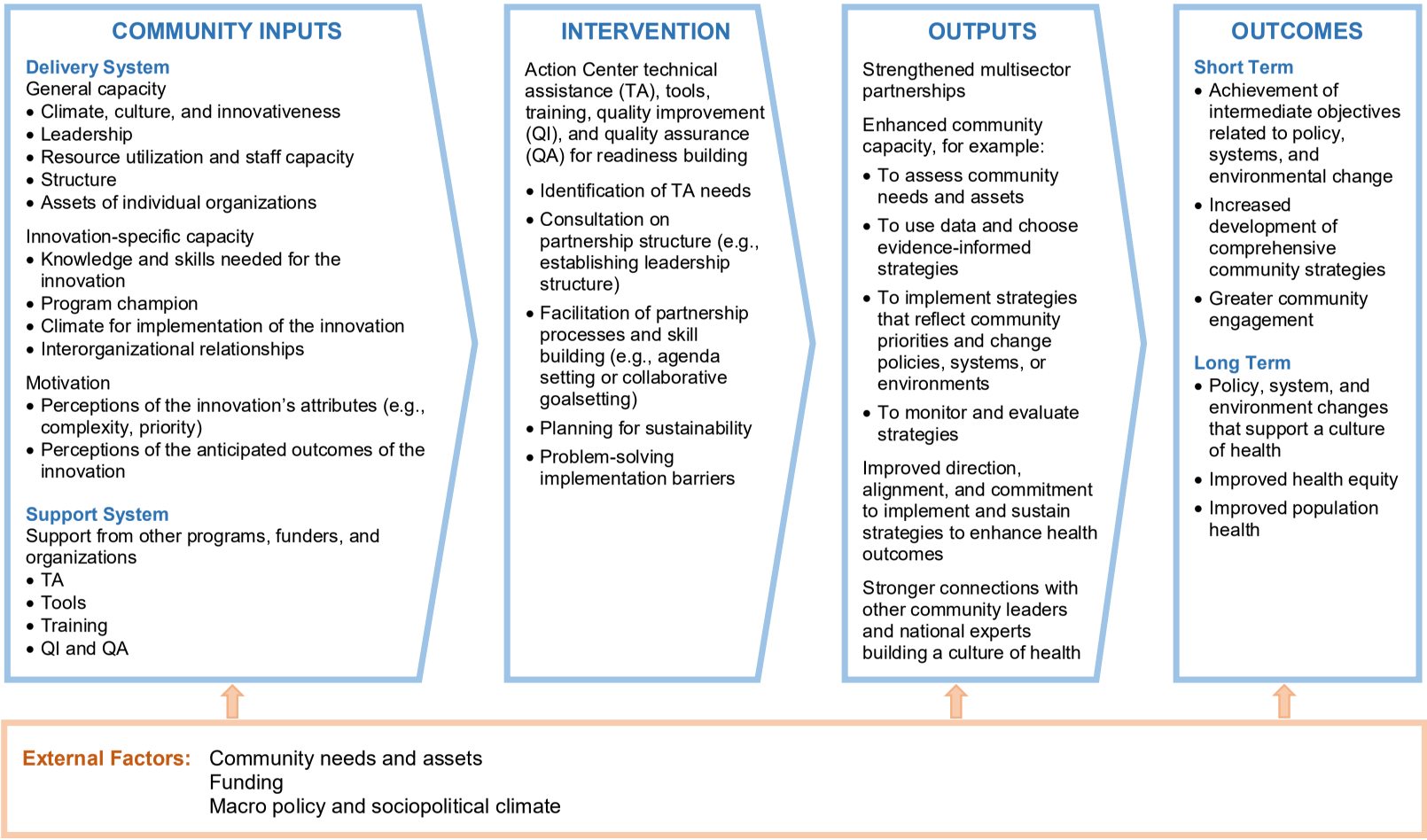
Community leaders learned about the coaching program through CHR&R, the Population Health Institute or foundation staff, or their other professional networks. To participate, community leaders submitted an application with information about their partnership, its goals, and a team of three to seven members who would participate in coaching. A range of informal, newly formed, and well-established partnerships applied. Coaching was intended for small teams representing a multisector partnership, with the intention that the team would then apply the coaching principles to its work with the broader partnership. However, individual leaders could also apply and participate. Hereafter, we refer to both coaching teams and individual leaders as "coaching teams." CHR&R program staff matched each team with a coach based on the partnership's goals and the coach's area of expertise and geographic location.

A coach's role in helping leaders develop cultural knowledge, examine their own individual and organizational culture, identify diversity, and strengthen efforts to engage community residents are particularly relevant to promoting health equity and community engagement.

Structure and Evolution

The general format for coaching involved three elements. (See Figure 2.) First, each team identified specific goals that members hoped to achieve during coaching, such as prioritizing partnership goals, incorporating community input into a strategic plan, or identifying ways to measure progress. Coaches then met with each team for 60 to 90 minutes once a month via tele- or videoconference. During each meeting, the coach briefly reviewed the team's coaching goal and action steps identified from the previous meeting, and then discussed the current issue or challenge identified by the team.

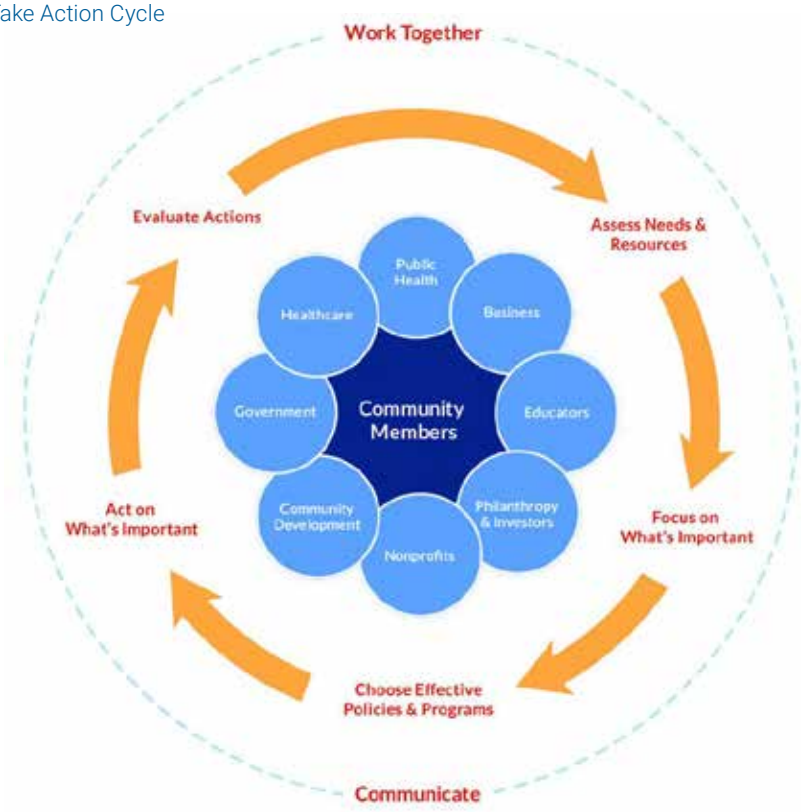
FIGURE 1 Conceptual Framework at the Start of the Coaching Program



Note: The community partnership is the primary delivery system change agent, which interacts with its existing support system. The inputs were informed by the Interactive Systems Framework for Dissemination and Implementation (Scaccia et al., 2015; Wandersman, Chien, & Katz, 2012; Wandersman et al., 2008). The outputs were derived from CHR&R, *Roadmaps to Health Coaching Program.* Available at http://www.countyhealthrankings.org/roadmaps/roadmaps-to-health-coaching.

FIGURE 2 Coaching Format

FIGURE 3 Take Action Cycle



Reprinted from University of Wisconsin Population Health Institute: https://www.countyhealthrankings.org/take-action-cycle

Coaches used the online tools and resources available on the CHR&R website to facilitate discussions and guide partnerships through steps of the Take Action Cycle and build partnership capacity. (See Figure 3.) For example, coaches used a tool called Team Blueprint to help the team clarify its partnership's goals, members' roles, and processes. Over the three- to 11-month coaching engagement, each team met with its coach for a total of three to 11 times and communicated by email in between meetings. Coaches also conducted one in-person site visit to each partnership to facilitate learning and capacity building. For example, a coach facilitated workshops for one partnership toward the end of the coaching period to help the community shift toward a systems-change approach. Although the program offered flexibility around the

timing of the site visit, most site visits during this period took place toward the end of the coaching engagement to allow enough time for the coaches to assess the team's skills and how to best use the site visit as a skills-building opportunity.

The original goal of coaching was to help multisector partnerships work together to improve health, and coaching covered many topics. During the coaching program, the priorities of the Population Health Institute and the foundation shifted to include an increasing emphasis in three areas:

- **PSE.** Coaching aimed to help partnerships shift from delivering more services or better programs toward a focus on PSE to create widespread community change. For example, a coach might encourage a partnership to consider promoting healthy school-lunch policies rather than introduce cooking classes in schools. Two tools that coaches frequently used to facilitate these discussions were the Intervention Planning Matrix guide, which helps partnerships identify which strategies are a program, systems change, environmental change, or policy; and the Policy Advocacy Choice Tool, which helps the partnership select a policy or systems change with the greatest likelihood of successful adoption.

- **Health equity.** Coaches sought to increase partnerships' understanding of health disparities and equity, strengthen their capacity to focus on equity, and/or help identify actions partnerships could take to promote health equity. Coaches tailored discussions based on each leader and team's understanding and comfort with equity. The County Health Rankings model provided coaches with a starting point for discussions about equity because, as one coach described it, the model helps illustrate that "where you live matters to your health." Coaches asked teams questions about their community's gaps in health or facilitated awareness activities to understand whether equity is an area of focus. Coaches also identified ways to connect equity to current issues of the partnership, such as building capacity for storytelling or addressing challenges connecting with community residents.

- **Community engagement.** Coaches tailored their support to help partnerships understand why community engagement was important, find ways to build trust with community members, and include community members in partnership planning and decision-making. Coaches approached community engagement by discussing partnership representation: who is at the table and whose voices are missing. Coaches encouraged teams to consider whether they truly engage people most affected by inequities or whether their activities focus on gathering input from community residents without providing an equal space for them to drive the conversation and decision-making.

Meeting Partnerships Where They Are

Coaches worked with teams representing partnerships at various stages of development, including individual leaders only beginning to develop relationships with potential partners, as well as partnerships that had collaborated for years. Teams also had varying levels of understanding of the concept of health equity and of experience with community engagement. Therefore, although coaches used the Take Action Cycle, they tailored coaching according to the starting place and needs of each team.

Coaches sought to strike a balance between helping teams pursue their self-identified goals, and encouraging progress toward PSE and an increased focus on equity and community engagement. For example, even if the coaching team had not identified community engagement as a goal, coaches might raise the issue proactively.

Coaches were recruited for their range of experience and expertise. As the program expanded, newer coaches, often people of color, spurred a more explicit emphasis on promoting equity and community engagement. Although CHR&R

TABLE 1 Partnership Characteristics

	Number of Teams	Number of Individuals	Total Number of Teams
Number of coaching teams	44	7	51
Teams with at least one completed interview	42	7	49
Duration of coaching[a]			
3 months	10	-	-
4 to 5 months	9	-	-
6 to 7 months	6	-	-
8 to 9 months	13	-	-
10 to 11 months	6	-	-
Total	44	-	-
Type of organization leading the partnership			
Health care system or medical center	6	0	6
Community coalition or partnership	6	0	6
County or municipal government department or agency (e.g., health department or city government agency)	12	3	15
Public school or university	4	0	4
State or regional service organization or foundation	16	4	20
Total	44	7	51
Geographic region			
Midwest (IA, IL, IN, KS, MI, MO, OH, WI)	15	0	15
Northeast (CT, MA, NH, NJ, NY, PA, VT)	12	1	13
South[b] (AL, FL, KY, MS, NC, TN, TX, VA)	13	0	13
West (CA, CO, OR, UT, WA)	4	6	10
Total	44	7	51

Source: Mathematica analysis of contact information provided by CHR&R.

[a] Information about the duration of coaching was not available for individual leaders.

[b] One partnership covered two states in the Midwest and South regions; for the purposes of this table, we included this partnership in the state in the South region in which respondents described conducting their activities.

staff actively sought ways to train all coaches to incorporate a focus on equity and community engagement, program leaders reported that coaches had varying levels of familiarity and comfort with these topics, depending on their training and experiences.

The Evaluation

Although coaches sought to improve many aspects of partnership structure and processes, the qualitative evaluation focused on understanding whether and how coaching helped strengthen partnerships' capacity in three areas: prioritizing PSE changes, promoting health equity, and strengthening community engagement. Because no two coaching interventions were the same, the evaluation, instead of attempting to measure progress toward a predetermined, universal goal, sought to understand whether teams made self-reported progress in any of these areas.

From September 2015 to August 2016, 51 coaching teams located in 28 states participated in the formal coaching program. (See Table 1.) CHR&R provided a list of 231 participants representing

the 51 coaching teams. Each coaching team included from one to nine members. We requested individual interviews with all participants, with the goal of interviewing two or three members of each coaching team.

Interviews

We interviewed one to four members of each coaching team, for a total of 105 participants representing 42 teams and seven individual leaders. We were unable to reach any participants from two teams. The majority of the 126 participants not interviewed did not respond to our outreach; 23 declined the interview (some said they lacked time or did not participate in enough coaching sessions), and 10 had non-working email or telephone numbers, changed organizations, or retired. We also interviewed all four CHR&R staff leaders responsible for the coaching program and seven of the eight coaches who provided coaching to the teams during the period of study.

To understand how coaching might have affected a partnership's work over the long term, we conducted 60-minute telephone interviews about 12 months after the coaching engagement ended. Semistructured interviews with coaching participants focused on the partnership's self-reported accomplishments, whether they prioritized PSE changes, the extent to which they understood the concept of health equity and sought to promote it, and ways in which they engaged community members in their planning and decision-making.

To understand the perspectives of coaches and staff leaders, we also conducted 60-minute semi-structured telephone interviews with 11 coaches and staff leaders. Topics included coaching content and strategies, barriers and facilitators to communities' ability to incorporate principles from coaching into their work, and whether and how coaches helped communities plan strategies to address health inequities and increase community engagement.

Analysis

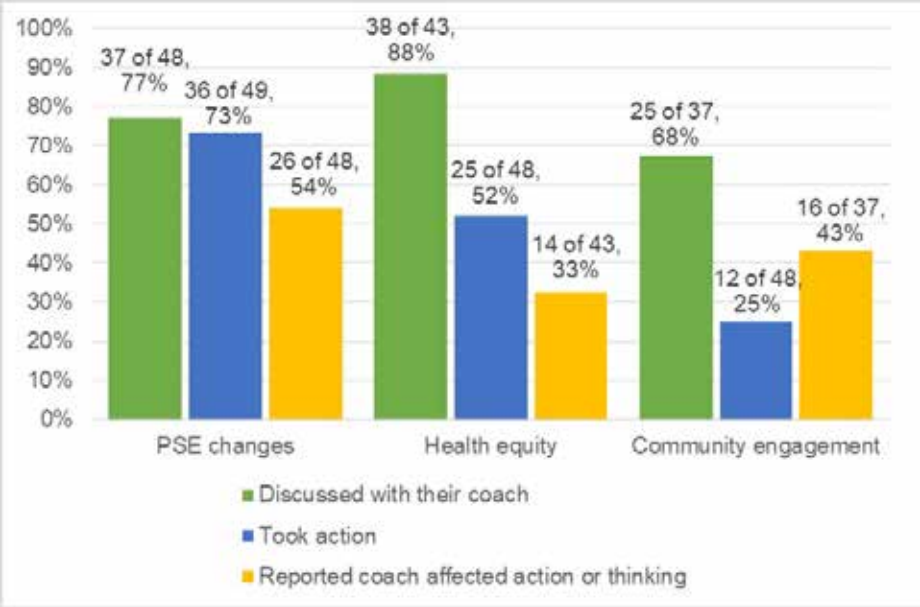
One of three evaluation team members read all the interviews from a single coaching team and summarized findings at the partnership level. A second evaluation team member reviewed the findings and confirmed information in the transcript as needed. In cases where there was disagreement, a third team member was brought in to review and discuss until consensus was reached. The evaluation team members analyzed interview transcripts using a grounded theory approach, whereby the team looked for emerging patterns in the data to identify themes. The team used an Excel database to document findings and conduct the analysis.

For each of the three areas of focus (PSE, health equity, and community engagement), we counted a team if at least one respondent said they discussed the issue with their coach, took action, or that coaching affected their partnership's action or thinking. To assess progress toward at least one PSE goal, we asked respondents to describe the kinds of actions the partnership had been taking to address the health issue on which their coaching team focused and the partnership's main accomplishment. We coded each initiative as PSE or non-PSE and whether the respondent reported progress. We asked respondents whether coaching played a role in the partnership's reported actions or accomplishments. As happens during qualitative interviews, some respondents did not answer specific questions (or answered in a way that did not address the question directly), and some interviews might not have covered a specific question. Thus, the total number of coaching teams in the denominator varies slightly by question. Teams whose respondents could not remember discussing an issue with their coach were included in the denominator.

Limitations

The evaluation offers important insights about the use of coaching, but has several limitations. First, we did not speak with all members of a coaching team. Those who did not respond to or declined our interview requests might have had

FIGURE 4 Summary of Findings



experiences different from those who agreed to an interview.

Second, our analysis of partnership progress relies on self-reports by coaching teams; we did not verify accomplishments. However, most respondents who reported progress were able to describe it in detail. Respondents were also frank about when they could not remember discussions with their coach or were unsure whether coaching contributed to their partnership's progress. We also did not attempt to track change over time. Rather, we conducted interviews after coaching concluded and asked participants to reflect on whether and how coaching affected their work.

Third, to give partnerships time to implement some work, we interviewed participants one year after coaching ended. However, some respondents had difficulty remembering aspects of coaching, including whether they had discussed certain topics with their coach. Finally, because partnerships are exposed to many potential influences, it is difficult to attribute changes in behavior solely to coaching.

Despite these limitations, we believe that our findings can help inform funders' strategies to support the work of community partnerships to promote PSE, health equity, and community engagement.

Results

Across the three areas of focus (PSE, health equity, and community engagement), more coaching teams reported progress with their partnership's efforts toward PSE than with their efforts to promote health equity or community engagement. (See Figure 4.) Respondents from over half the 49 coaching teams reported that the coaching program affected their partnership's approach to PSE; a third reported that coaching affected their partnership's approach to health equity, and less than half reported that effect on their approach to community engagement.

Given the range of developmental stages and goals with which the partnerships began the program, the light-touch coaching intervention, and the complexity of the potential topics addressed during coaching, one might expect the program to affect capacity differently for each partnership

[O]ne respondent observed, "Members of our executive committee that were part of coaching were the ones that drove hard to incorporate racial equity statements in our charter documents for the coalition. That would probably be the biggest, really concrete change that we made relative to [coaching]."

across the areas of PSE, health equity, and community engagement.

Policy, Systems, and Environmental Changes

Coaches connected teams to tools and resources to help them develop or deepen the skills and knowledge needed to select and implement PSE changes. We hypothesized that this could have led partnerships that did not already have a focus on PSE to consider, select, or implement it instead of only programmatic interventions.

Respondents from 73% of coaching teams (36 of 49) reported that their partnership made progress toward at least one PSE goal during coaching or since coaching ended. Most commonly, PSE changes focused on changing health behaviors or the environment to support healthy behaviors, for example, creating walking paths or safe places for physical activity, improving access to healthy food, or passing policies to reduce tobacco use or exposure.

Over half (54%) of the teams (26 of 48) said that coaching helped them pursue those changes (22 teams) or affected their approach (four teams). Of those that made progress toward PSE changes:

- Ten said that coaching helped identify potential local policies (as most teams felt federal policy approaches were unattainable), identify politically feasible PSE approaches, or narrow their focus to a potential PSE change that felt achievable.
- Eight said coaching helped with partnership processes, membership, and leadership, which equipped them to advocate for policy changes.
- Eleven noted that although coaching did not play a direct role in their decision to pursue PSE, it helped formalize ideas, build soft skills (such as partnering), or coalesce others around a shared goal, which strengthened the partnership as it sought PSE changes.

Four teams said that coaching affected their approach, but did not report progress toward PSE. Seven other teams focused on programmatic goals or activities not aimed at PSE changes (such as supporting community gardens or offering nutrition education or cooking classes), and partnerships for five teams disbanded (and thus did not make progress) or did not work on collaborative projects.

Six teams described several challenges when trying to shift the partnership's focus from programming to PSE. A few perceived that PSE changes would be similar to policy advocacy, which their funder(s) would not allow, or would require involvement in politics, with which they had little experience. Others said they lacked the appropriate stakeholders to address PSE effectively. In addition, teams from well-developed partnerships noted the need for specialized support, for example, to help them plan PSE changes in inner cities or related to living wages or effects of incarceration on families.

Incorporating Health Equity

As some coaches began to incorporate health equity into more discussions, we hypothesized that partnerships could have changed various aspects of the partnership's structure or work to reflect a greater emphasis on health equity.

Over half (52%) of the coaching teams (25 of 48) described implementing initiatives to promote health equity during or after coaching. Many (21 of 48) took steps to address specific inequities in their communities, such as engaging in system-wide coordination or planning to advance equity or in developing targeted programs with marginalized populations. For example, one partnership provided assistance to low-income families of color as a way to improve kindergarten readiness, an area of disparity. Ten partnerships sought to raise awareness about health equity by writing reports or white papers, conducting trainings, or convening educational events to increase their communities' focus on equity. One of these partnerships developed an infographic to share with policymakers on health inequities within a local neighborhood. Ten partnerships incorporated health equity into their governance structures: they included a focus on equity in their mission statements or goals, or set up work groups dedicated to equity. For example, one respondent observed,

> Members of our executive committee that were part of coaching were the ones that drove hard to incorporate racial equity statements in our charter documents for the coalition. That would probably be the biggest, really concrete change that we made relative to [coaching].

Respondents from 88% of the teams (38 of 43) said they discussed health equity with their coaches. Of these 38, 14 said that their coaches affected their approach to health equity, and most said that coaches helped increase understanding of or capacity to address health equity. For example, a few teams said that coaching helped them shift their focus to identifying and targeting services to specific populations and away from the health of the general population. Coaching also helped draw attention to the importance of health equity; during a site visit, one coach gave a presentation on health equity to partnership members and the wider community.

Some teams made the link between health equity and community engagement and indicated that coaches helped them diversify partnership membership and understand how differences in experience between the coaching team and community members could affect the team's approach to health equity.

[O]ne respondent said that coaching "played a role in influencing how we develop our goal around health equity. [Health equity] is something that gets talked about a good bit, but we were kind of struggling, understanding how [to] go beyond educating people."

Coaching helped a few partnerships go beyond raising awareness about equity to actively promoting it. This included learning how to use data to target those most affected by inequities and thinking about how to engage elected officials on issues related to health equity. For example, one respondent said that coaching

> played a role in influencing how we develop our goal around health equity. [Health equity] is something that gets talked about a good bit, but we were kind of struggling, understanding how [to] go beyond educating people. Part of our conversation with [our coach] was thinking about our goal, to get people to take some type of action [and] take ownership … to give individuals and organizations the tools they need to make changes within their sphere of influence. The best way to do that, we thought, is this training on equity … and providing ongoing assistance on addressing health equity. Thinking through how to do it came out of conversations with [our coach] and others on our team.

About half (23 of 43) of the teams said the discussions with their coach about health equity did not affect their work. Most of these teams said that their partnership was already focused on improving health equity.

One respondent observed, "We are not that racially or ethnically diverse, but we certainly face the issue of poverty. And we don't always do a great job … to pull in someone that is living in poverty to the same table as decision-makers."

Respondents from 28 teams described at least one challenge addressing health equity. A few noted that some members of their partnership or wider community did not understand health equity or did not agree it should be a focus of their work. For example, one partnership advocated for building greenways in lower-income neighborhoods, but some argued that those in such communities could drive to greenways in other neighborhoods. Another community thought it was addressing health equity by offering free summer camps to all, but acknowledged that lower-income people did not attend because the partnership lacked a "formal communication link with that group of folks."

In terms of challenges to incorporating health equity into their work, coaching teams cited difficulty engaging community members. A few cited the national, state, or local political climates. Others struggled to identify or select clear, evidence-based actions they could take.

Seven teams, mostly in rural areas, responded to the evaluation questions about equity by stating that their entire community faced challenges with poverty, and that they sought economic equity for their community relative to other nonrural communities, rather than attending to inequities that might exist within their own communities (e.g., along racial lines). Some specifically noted that because their communities were mostly white, they did not address racial or other inequities. But one respondent from a majority-white community reported that the partnership's lack of knowledge of potential racial inequities in their community was an issue they hoped to address.

Community Engagement

As coaches began to incorporate community engagement into more discussions, we hypothesized that partnerships could have shifted their focus to reflect a greater emphasis on it.

One quarter (25%) of teams (12 of 48) reported that their partnerships included community members in planning and decision-making (seven teams) or had made some progress (five teams) during or after coaching. Two partnerships required that 50% of the membership of all their work groups needed to be people directly affected by the groups' issues. A third partnership ensured that all its work groups included at least one community member; it also developed leadership programs to prepare predominantly Spanish-speaking residents and youth to take part in the partnership and advocate for policy changes. Another partnership described building deep relationships with community-based organizations led by members of groups most impacted by inequities. One respondent described their partnership's community engagement efforts in this way: "Everything we've done has been from the place of reaching out to the community first and building their voice in — building their leadership capacity within the conversation, not just creating practitioner spaces."

Most teams (36 of 48), however, did not report engaging community members in planning and decision-making during or after coaching. Respondents from 27 teams said they included professionals who worked at service agencies but no community members served by those agencies. Some respondents understood the distinction and said they wanted to engage community members; 16 seemed to equate the inclusion of service providers with community engagement, or said that service providers could speak for the community members most affected by inequities. One respondent observed,

> We are not that racially or ethnically diverse, but we certainly face the issue of poverty. And we don't always do a great job … to pull in someone that is living in poverty to the same table as decision-makers. Rather, organizations that work directly with [people living poverty are] more likely to have a seat at those discussions, and that's something we've recognized we need to change, but sometimes change is easy to talk about and harder to make.

Respondents from 18 teams (including those representing partnerships with a strong focus on health equity) said their partnerships collected data from community members without including them in making decisions.

Coaches sought to help partnerships improve their understanding of community engagement and identify ways to better engage community members. Respondents from 68% of teams (25 of 37) said they discussed community engagement with their coach, and 43% (16 of 37) said coaching affected their approach. Teams reported that coaching helped increase their understanding of meaningful community engagement, encouraged them to invite community members to join their teams, helped identify strategies for building trust with community members, and helped them consider ways to change their structures and approaches to better incorporate community members into their partnerships. One respondent said,

> Our coach talked about the importance of not just throwing community members in there, but making sure that we gave them a voice, that they were a full part of what was happening and had decision-making power and weren't just tokens.

Of the 16 teams reporting that coaching had affected how they thought about or approached community engagement, 11 still had little engagement after coaching ended. Of the five partnerships rated as having strong engagement after coaching, most said they had prioritized community engagement before coaching began.

Respondents from 31 teams described at least one challenge with community engagement. Some teams reported that their coach encouraged

One respondent said, "Our coach talked about the importance of not just throwing community members in there, but making sure that we gave them a voice, that they were a full part of what was happening and had decision-making power and weren't just tokens."

them to improve community engagement, but that they had not succeeded. Some did not agree with or chose not to implement the coach's suggestions. Others said they could not figure out how to put the suggestions into action or did not receive specific enough guidance. A few respondents reported that "life challenges" made it difficult for community members to commit to the partnership or take a leadership role (e.g., community members were unable to take time off work to attend partnership meetings consistently); notably, the systemic inequities that partnerships tried to address often contributed to these challenges.

Some coaches offered their perspectives and reflections on why some partnerships had difficulty engaging community members. A few noted that many partnerships were composed primarily of professionals who were not affected by inequities or did not have direct connections to the communities they sought to engage, which created several challenges:

- Discomfort or lack of interest in examining dynamics related to power and race within partnerships and communities. For example, one coach described that when partnerships do not give the voices of community members the same weight as those

Our findings suggest that integrating health equity and community engagement into general community-improvement coaching might be best suited for partnerships just beginning to develop a strategy to improve health equity.

of the professionals, they create a "virtual kids' table" for community members.

- An inability or unwillingness to schedule meetings so that working community members could attend or to compensate community members for attending, even though professionals in the partnership are paid for their time.

- Unfamiliarity, discomfort, or a lack of trust with working across socioeconomic, racial, ethnic, or age divides, and uncertainty about how to build trust.

Discussion

Coaches provided support on a broad range of topics to build partnership capacity. Our evaluation found that the coaching program helped some partnerships pursue PSE changes. These findings are consistent with literature demonstrating that technical assistance more broadly can help partnerships build the skills needed to plan, implement, and evaluate health-promotion programs. Although coaches attempted to incorporate a focus on health equity and community engagement, our results suggest that coaching was less effective in helping partnerships make progress in these areas.

Our findings suggest that integrating health equity and community engagement into general community-improvement coaching might be best suited for partnerships just beginning to develop a strategy to improve health equity. Multiple teams cited ways in which their coach helped them understand, raise awareness, or incorporate health equity into the partnership's structure or governance. A limited number of teams indicated that coaching helped their partnerships move from an understanding of equity to an ability to take concrete action to address inequities in their communities, suggesting that coaching may be less effective for partnerships that already have a strong understanding of health equity and might require intensive, specialized technical assistance to address inequities. Similarly, although some teams reported that their coach helped them understand the importance of community engagement or think about how to increase engagement, none reported increasing engagement as a result of coaching.

These findings are unsurprising, as progress toward reducing health inequities nationwide has been elusive (Bleich, Jarlenski, Bell, & LaVeist, 2012; Fawcett et al., 2010), and community engagement is a long-standing and well-documented challenge for public health partnerships (Roussos & Fawcett, 2000). Coaching practitioners have noted that these concepts are linked; without meaningful engagement of community members, community change interventions are less likely to be effective or sustainable (Kahl, Emery, & Holmes, 2016). The leadership of community partnerships largely by traditional institutions, rather than grassroots groups, is one key reason for this struggle (Cheadle et al., 2008; Erickson et al., 2017; Himmelman, 2001). Public health, health care, and nonprofit institutions are often dominated by professionals who do not have personal experience of inequities or direct connections to communities most impacted by inequities (hereafter "professionals").[1]

[1] We acknowledge that every person has intersectional identities, whereby some aspects of their identity afford them privilege (e.g., possessing a high level of education) and others result in personal experiences of inequities (e.g., being a person of color). At the same time, we acknowledge the observations from coaches and findings from the broader literature describing the divide that often exists between professionals (as defined here) and communities who, as a whole, have historically had less power and privilege, and have experienced the impacts of forces such as systemic racism and lack of access to economic opportunities.

This poses several challenges. First, professionals often bring a hierarchical perspective to leadership, in which public health officials or health care executives control agenda-setting, budgets, and timelines, and value professional expertise over personal experience with inequities (Nelson, Prilleltensky, & MacGillivary, 2001; Roussos & Fawcett, 2000). For example, some professionals have spent years using epidemiological data and tend to prioritize the use of these data over the knowledge and ideas from community residents. Further, they often establish partnership meeting times and locations that are most comfortable and convenient for professionals, rather than for community residents.

In addition, the culture and unspoken rules of a partnership dominated by professionals are likely to be uncomfortable or intimidating and to discourage involvement of community members and leaders (Nelson et al., 2001; Roussos & Fawcett, 2000). Finally, lead agencies for partnerships often do not prioritize or do not have the mechanisms to compensate community residents for their time, despite the fact that professionals are paid for their own involvement. Having dedicated resources to compensate community members—for travel or child care expenses, for example—might help to reduce some of these barriers to participation.

CHR&R coaches and staff described similar challenges in their efforts to promote community engagement with coaching teams:

- Many partnerships lacked relationships with community members, and many lacked the skills, authority, or willingness to deviate from the partnership's standard processes and structures to engage community members.

- Conversations about the partnership's approaches to health equity and community engagement often touched on sensitive issues related to race and power, which were challenging to hold in a virtual setting and during once-a-month calls.

- Coaches had different life experiences from one another and from the coaching participants. Fewer partnerships reported discussing community engagement with their coaches, as compared to health equity. This could indicate that coaches' varied backgrounds affected the content of coaching, or that coaches did not think some teams were ready to discuss community engagement.

For successful community engagement, partnerships and the agencies leading them need to acknowledge differences in power between professionals and community residents and be willing to share and redistribute power. Multisector partnerships have garnered support from institutions and entities with power for advancing a community's health agenda. Prioritizing partnership membership by the community's power brokers, such as CEOs and elected officials, is likely to magnify differences in power and perpetuate the development of initiatives misaligned with the needs of marginalized communities. A study of local multisector health partnerships, nominated by outside observers for being well developed, found that few of these partnerships "developed mechanisms to ensure that residents have both voice and power in the work" (Siegel et al., 2018, p. 33).

Conclusion

The coaching program provided valuable support to many partnerships, helping some of them change their approach to focus on PSE. Coaching also affected some partnerships' thinking around and approach to health equity, albeit to a lesser extent than for PSE. Although some teams reported that coaching shifted their thinking around community engagement, coaching did not appear to affect their ability to take action within the follow-up period of this evaluation.

As funders and practitioners consider strategies for supporting community partnerships that seek to advance health equity and engage communities, we propose two considerations.

One is to invest in partnerships that already prioritize leadership of community members most

[T]o fundamentally shift their approach to community engagement, partnerships may need a more intensive technical assistance approach to help leaders think critically about their community's history and structures of power, ongoing racial and power dynamics, and their own personal stories and levels of privilege.

affected by inequities. Funders interested in promoting community efforts to advance equity and engage communities may consider which organizations are best positioned to pursue these goals. CHR&R coaches reported that formal institutions (such as public health departments), made up of professionals, led most partnerships they coached. These partnerships often faced challenges when trying to engage the community. Grassroots groups, in contrast, already have strong community ties (Erickson et al., 2017; Himmelman, 2001).

If the goal is health equity, then supporting partnerships that are already led by community members and/or are structured to prioritize community engagement (for example, by requiring that at least 50% of work group members are directly affected by the issues the group seeks to address) has the potential to be more effective than trying to steer partnerships led by professionals toward community engagement. Partnerships led by community members may still benefit from coaching to help them improve partnership processes and structures; gain technical, topic-specific expertise; and create action plans. Recruiting grassroots groups into a coaching program may, however, require different or more intensive strategies, as these groups may have fewer connections with major foundations or national health initiatives, and less likely to reach out proactively for assistance.

Another strategy worth consideration is investing in intensive, specialized technical assistance to help partnerships led by professionals engage communities and take action to promote equity. As many multisector partnerships are likely to continue to be led by professionals who may not be directly impacted by health inequities or have few direct connections to communities who are directly impacted, funders might also consider other assistance that might be better suited to helping these partnerships promote health equity and engage communities. Including these topics in a coaching program appears to have affected some partnerships' thinking about health equity and community engagement, which suggests that coaching could play a role in planting seeds for future efforts.

However, to fundamentally shift their approach to community engagement, partnerships may need a more intensive technical assistance approach to help leaders think critically about their community's history and structures of power, ongoing racial and power dynamics, and their own personal stories and levels of privilege. Increased in-person and more frequent interactions may be necessary to build the trust necessary to tackle sensitive issues related to race and power dynamics. In addition, hiring, training, and dedicating specific technical assistance providers to address these challenging topics would provide partnerships with more specialized support. Finally, this approach might require dedicating resources to partnerships that are ready and willing to address equity and community engagement, and need assistance identifying or implementing steps for how to do so. Issuing a specific call for applications could help attract these types of partnerships.

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