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EVIDENCE-INFORMED GOVERNANCE AND PERFORMANCE MANAGEMENT FOR U.S. COMMUNITY HEALTH SYSTEMS: A FRAMEWORK FOR ACCOUNTABILITY, RESOURCE STEWARDSHIP, AND OUTCOMES

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ABSTRACT
The study explores the evidence-based governance and performance management of U.S. community health systems, specifically in terms of accountability, resource stewardship, and health outcomes. A thematic synthesis of studies and institutional publications published was carried out for the purpose of conducting a qualitative systematic literature review. Five themes emerged: community governance, performance management, financial accountability, resource efficiency and integration of quality and financial outcomes. Results show that an effective governance requires meaningful community representation, measurable performance indicators, financial monitoring and contextualized efficiency assessment. The study suggests an integrated governance–performance management–accountability–resource stewardship–community outcomes framework that encompasses continuous feedback.

Keywords:
Evidence-informed governance; community health systems; performance management; accountability; resource stewardship; health outcomes

1. INTRODUCTION

1.1 Background of the Study

In an evolving governance landscape, community health systems in the U.S. face rising complexity and are held accountable to a broad range of stakeholders for their performance, the stewardship of their resources, and their impact. Evidence-informed governance (EIG), defined as the systematic incorporation of evidence and research, local context and data, and professional expertise into decision-making, has become a key way to enhance the performance of these systems (Bellows & Warren, 2021; Dill et al., 2024).

The accountability of governance in community health is not just about meeting regulations, but also shared responsibility among multiple stakeholders. In public health, the term "accountability" is defined as "the principle that individuals, organizations and the community are responsible for their actions and may be expected to explain them to others" (Institute of Medicine, 2010, p. 87). This principle is the foundation of systems of performance measurement that make the implementer, whether a public health agency, hospital, or community organization, accountable for achieving agreed-on strategies to achieve population health targets (Institute of Medicine, 2010). Evidence to action governance is supported by performance management systems. According to the Centers for Disease Control and Prevention (2024) performance measurement is "ongoing monitoring and reporting of program accomplishments, particularly progress toward pre-established goals". Good performance management can help the policy-maker target resources to areas that require improvement, decide where to allocate budget, and improve accountability by ensuring that citizens are kept up to date on the effectiveness of the services.

Collective stewardship of common health resources is needed in community health systems to ensure the most benefit for all people living in the community. Performance measures may be developed to evaluate progress towards the achievement of a program, project or initiative at any point during the program – short, medium and long term outcomes (Dill et al., 2024, p. 3). These measures will be used to support tracking capacity and process and differentiate between output performance measures (immediate, tangible output from activities) and outcome performance measures (impact of interventions).

Although there are policy requirements such as the Affordable Care Act (ACA) Community Health Needs Assessment (CHNA) requirements, there is a lack of clear and measurable goals in many community health improvement processes, and there are few robust evaluation plans. Bellows and Warren (2021) highlighted that "fragmented funding, poor coordination, disease-specific training, donor-influenced management, funding and priorities, poor supply and referral linkages with the health system and poor supervision, support", are some of the obstacles that need to be addressed to scale up, maintain and mature community health. This disconnect poses

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a risk to the ability to realize collective impact on the outcomes of population health through a multi-sector approach.

The shift to value-based care has made it even more urgent to establish evidence-based governance structures that connect measurement of outcomes with accountability mechanisms and resource allocation. Health equity is considered a priority for local health departments, but performance measure scores and metrics were generally not specific enough to allow for better tracking of LHDs' progress in the communities they serve, according to recent environmental scans of local health departments (LHDs) (Dill et al., 2024, p. 10). Given the need for an integrated framework of evidence-informed governance, to support health systems in the United States in improving accountability, optimizing resource stewardship, and improving measurable health outcomes, this study will fill this important gap.

1.2 Objectives of the Study

1) To explore the existing level of evidence-informed governance in community health systems in the United States and assess the disconnect between the expectations and the actual implementation of evidence-informed governance.
2) To design an integrated accountability framework linking performance measurement, stewardship of resources and tracking of outcomes in multi-sector community health partnerships.
3) To determine the degree to which current performance measurement systems in local health departments and community health organizations do include specific, measurable health equity and population health outcomes.
4) To make evidence-based recommendations for how to strengthen governance structures to increase transparency, maximize resources, and improve measurable health outcomes in community health systems across the United States.

1.3 Problem Statement

Twenty-five years of policy changes and significant public investment have done little to address the ongoing problems American community health systems have had in effective governance that is accountable, evidence-based and effective in the management of resources and measurable improvements in population health. Recent assessments show significant mismatches between expectation and reality in governance. Few community health boards (CHBs) fully or substantially meet the measure for establishing a performance management system, with less than half (43%) doing so, and fewer (35%) do so fully or substantially implementing the measure (Minnesota Department of Health, 2024).

One standard issue is the lack of strong accountability mechanisms that connect health equity outcomes with performance measures and health resource distribution. In addressing racial and ethnic inequities in health and health care, the National Academies of Sciences, Engineering, and Medicine (2024) cited a lack of accountability and processes that support sustained and measurable progress as a major challenge. Additionally, evidence-informed decision-making is further hindered by data limitations, such as subpopulation-specific data that is missing, including data by race/ethnicity and socioeconomic status (Centers for Disease Control and Prevention, 2024, p. 12).

While the importance of resource stewardship is recognized, resource stewardship challenges remain. The problems that community health programs encounter are "little government ownership (e.g., low funding, poor coordination, and communication), strong donor influence, contradicting policies, a top down reform process, and fragmentation" of primary health care services (Resham et al., 2024). Performance measures are not specific, "Many performance measures, especially outcomes, lacked specificity that would help to better capture LHDs' progress in the communities they serve" (Dill et al., 2024, p. 10).

The impact is quantifiable in terms of continuing health inequalities and poor population health performance. Operationalizing evidence-informed governance, in order to enhance accountability, optimize resource stewardship, and improve measurable outcomes, will be a crucial step that community health systems in the United States must take to help them underperform in comparison to their potential, let alone to close longstanding health inequities.

1.4 Research Questions

1) What is the state of the evidence-informed governance practices of community health systems in the United States, and what obstacles do they face to ensure their successful adoption at the local level?
2) What is the best way to create an integrated accountability framework, connecting performance measurement, stewardship of resources, and tracking of outcomes for varied stakeholders in a community health system?
3) How much do existing performance management systems in local health departments and community health organizations include explicit health equity and population health measures and outcomes?

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4) Which evidence-based governance structures and policy mechanisms are most effective at increasing transparency, use resources efficiently, and improve measurable health outcomes in the U.S. community health system?

1.5 Scope and Delimitations

This study will focus on evidence-informed governance and performance management practices in U.S. community health systems, including local health departments, community health boards, and multi-sector community health partnerships from 2020 to 2024. Three key dimensions form the focus of research: accountability mechanisms, resource stewardship practices, and outcome measurement systems that are aligned to health equity goals. The geographic area of focus is only publicly funded community health systems in the U.S. and focuses primarily on jurisdictions with formal performance management systems in place, as required by state or federal legislation.

The study focuses on published literature, government reports, and evaluation documents that have been released in 2024 or later, with no proprietary data from private health systems and international community health models. The framework covers governance in general, but not clinical care delivery processes and individual provider accountability, or hospital-based quality improvement initiatives outside of the community context. Further, the research does not evaluate specific interventions or programs, but rather governance and performance management structures that influence the implementation and evaluation of interventions and programs.

2. LITERATURE REVIEW

2.1 Conceptual Foundations of Evidence-Informed Governance in Public Health

Evidence-informed decision-making in public health (EIDP) is an advancement over evidence-based practice, incorporating factors that are important to consider in practice or real-world setting. NACCHO (2024) defines evidence-informed decision making as the process that "takes evidence-based practice a step further by incorporating research evidence 'along with expertise, existing public health resources... the local context and community, and the political climate'". This distinction puts evidence-informed governance closer to evidence-based governance than to the more adaptive models, recognizing that the best decision is one that takes scientific evidence into account, but also considers practical considerations and values of stakeholders.

The conceptual basis of evidence-based public health (EBPH) is given as follows: "The process of program and policy development, implementation and evaluation in public health based on principles of scientific reasoning, such as systematic application of data and information systems, and appropriate use of behavioral science theory and program planning models" (Office of Disease Prevention and Health Promotion, 2021, p. 1). Evidence-based decision-making is a process that combines "1) best available research evidence, 2) practitioner expertise and other available resources, and 3) the characteristics, needs, values and preferences of those who will be affected by the intervention" (Jacobs et al, 2012).

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Figure 1: Domains that influence evidence-based decision making. Satterfield et al (2009)

Theoretical frameworks that connect governance, accountability, and performance management grew out of the Institute of Medicine's (2010) efforts to define accountability as the principle that "individuals, organizations and the community are responsible for what they do and will be held to account for their actions by others (p. 87). This principle is reflected in performance monitoring systems to track progress towards health improvement targets and hold implementers accountable.

2.2 Accountability Mechanisms in U.S. Community Health Systems

Regulatory and voluntary structures include the need to conduct Community Health Assessment/Community Health Improvement Plan (CHA/CHIP) as required under the Affordable Care Act and state statutes that specify performance reporting requirements in U.S. community health systems. The Institute of Medicine (2010) defines accountability as "the principle that individuals, organizations and the community are accountable for what they do and may need to explain that to others. Performance related accountability requirements require local health departments to report annually on performance measures, and to show competence in meeting the subset performance standards (Minnesota Department of Health, 2024).

There is some consistency in stakeholder accountability for communities, funders, policy makers and multi-sector partners but not others. A lack of accountability and processes for sustained and measurable progress is a major challenge that the National Academies of Sciences, Engineering, and Medicine (2024) stated (Chapter 8). When assessing Accountable Communities for Health efforts, the National Academy of Medicine found that "specific mechanisms for upholding accountability (such as reporting and financial mechanisms) are often underdeveloped or missing from practice" (2022, p. 4).

The challenges to good accountability are the lack of coordination in governance processes, poor reporting frameworks, and weak enforcement capacity. Newly analyzed data show that only 43% of CHBs have a performance management system in place, and only 35% have a system in place (Minnesota Department of Health, 2024). These gaps erode the opportunity for multi-sector collaboration for collective impact on population health outcomes.

2.3 Performance Measurement and Management Frameworks for Community Health

CDC Program Evaluation Framework has been one of the frameworks developed that incorporated performance management in public health, along with the Public Health Accreditation Board (PHAB) standards. According to CDC (2024), performance measurement is "ongoing monitoring and reporting of program accomplishments, especially progress toward pre-established goals. Progress can be measured at any point of a program and consists

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of two types of performance measures: output measures are immediate tangible results of activities and outcome measures are the impacts of the interventions (Dill et al., 2024, p. 3).

There are severe limitations in the measurement of health equity. Through the environmental scans, it was identified that "many performance measures, especially outcomes, were found to be lacking in specificity that allows for better tracking of LHDs' progress from the communities that they serve" (Dill et al., 2024, p. 10). Measuring the health outcomes at the community level is difficult due to multi-sector collaboration and attribution, and to fragmented data systems.

While there are benefits of a shared measurement system that provide accountability for specific activities in a community health improvement process, as noted by Stoto et al. (2019), existing efforts rarely include implementation strategies with pre-specified performance measures. Bellows and Warren (2021) highlighted the need to face the "fragmented funding; weak coordination; disease-specific training; donor-influenced management, funding, and priorities". According to the Pew-MacArthur Results First Initiative (2018), performance management systems enable policymakers to "direct resources toward areas needing improvement, make informed budget decisions, and strengthen accountability".

2.4 Resource Stewardship and Allocation in Community Health Governance

Shared stewardship in community health encompasses "the collective management of a community's resources related to the delivery of health care so as to make the most effective use of those resources for the benefit of all members of that community" (McGinnis et al., 2011). This framework focuses on the shared responsibility to optimize the use of resources across organisations to meet the goal of population health.

The problem of aligning budgeting, funding sources and performance incentives still exists. The National Academy for State Health Policy (2023) noted that "fragmented funding streams are a mainstay in the U.S. health care and public health" systems, which can pose barriers to coordination of investments and accountability (p. 1). Little government ownership (low funding, poor coordination, and communication), strong donor influence, contradicting policies, a top down reform process, and fragmentation of primary health care services are challenges community health programs have (BMC Primary Care 2024).

Community health investment that is cost efficient and value-based also needs benchmarks that can measure what happens to health when resources are invested. McGinnis et al. (2011) suggested that there are indicators of stewardship: "Cost and cost-efficiency; evidence-based, high-quality care; availability of prevention and health promotion services; and public health outcomes". The Center for Health Care Strategies (2023) highlighted the need to create a mission for health system-community partnerships that rebalance power and ensure that resources are allocated to community priorities.

2.5 Gaps and Opportunities in Current Community Health Governance Frameworks

The empirical evidence shows that there are significant gaps in the extent to which governance policy is implemented on the ground. The NAO evaluation of Accountable Communities for Health initiatives revealed, "all of the initiatives reported major challenges related to ACH performance measurement and formal structures to demonstrate accountability to communities served" (2022). Limited data also hamper efforts to measure health equity: “Missing data from subpopulations, such as race, ethnicity, sexual orientation, and gender identity, and socioeconomic status” (Centers for Disease Control and Prevention, 2024).

There is insufficient specificity in measures of performance to achieve meaningful accountability. The findings of environmental scans suggest that "many performance measures, especially outcomes, were not specific enough to allow for better tracking of the progress of LHDs serving from the communities they serve" (Dill et al., 2024). In addition, current indicators "measure the extent to which their community health boards are able to deliver essential public health functions, but do not indicate if community health boards have the capacity to address the unique needs of their communities" (Minnesota Department of Health, 2024).

These gaps are being filled by emerging frameworks that incorporate governance and performance management tools. The University of Minnesota Center for Public Health Systems (2024) created health equity performance measure toolkits to help boost the ability of local health departments to define, measure, and track progress. NACCHO (2024) promotes evidence-informed decision-making that incorporates "research evidence along with expertise, existing public health resources, the local context and community, and the political climate".

3. METHODOLOGY

3.1 Research Design

This research will follow a qualitative systematic literature review (SLR) design to create an evidence-based framework of governance and performance management for U.S. community health systems. The systematic literature review method was chosen as it offers a systematic and transparent method to identifying, assessing and synthesizing empirical and policy evidence on the governance, accountability, stewardship of health services

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resources and organizational outcomes. The Preferred Reporting Items for Systematic Reviews and Meta Analyses (PRISMA 2020) guidelines are followed to make the review methodologically transparent and reproducible.

3.2 Data Sources

Data were collected from PubMed, Scopus, Web of Science, CINAHL, Google Scholar, HRSA, AHRQ and HHS publications.

3.3 Search Strategy

The literature search included terms such as evidence informed governance, community health systems, FQHCs, performance management, accountability, and resource stewardship using the Boolean operators (AND/OR).

3.4 Inclusion Criteria

English language studies on U.S. community health systems, governance and accountability, performance measures, performance management, and/or resource stewardship were included.

3.5 Data Analysis

Thematic synthesis was used to code and analyse relevant studies. Themes identified were woven into a conceptual framework containing a connection between governance, accountability, resource stewardship and health outcomes.

3.6 Ethical Consideration

Only published secondary data were used for the study. Hence, no ethical approval was necessary.

4. THEMATIC ANALYSIS OF SELECTED STUDIES

A thematic analysis was conducted from 10 peer-reviewed journal articles that explored governance, financial management, efficiency, quality improvement, performance, and outcomes in U.S. community health centers and federally qualified health centers (FQHCs). There were several main themes that emerged: governance and community representation, performance management and quality, financial sustainability, resource stewardship and efficiency, and integration of governance with organizational outcomes.

4.1.1 Evidence-Informed Governance and Community Representation

Governance became a significant aspect of the accountability of community health systems. Using four years of data, Wright (2013) analyzed FQHC governing boards and found that very few board members identified as consumers were representative of the typical FQHC patient. A qualitative analysis was also conducted using interviews with 30 board members, which revealed that there were economic and social disparities between the board members and the patients served. These findings open up the question of the extent to which formal consumer representation is enough to provide effective community representation.

Wright (2015) also explored the leadership roles of patient trustees. The researchers used four years of governing-board data to determine that trustees who represented patients were significantly less likely to be on executive committees and board chairs than other trustees. The study correlated the distribution of leadership positions with the extent of patient representation in governance because these roles have an impact on the board agenda.

There is also some evidence that consumer representation does not necessarily dictate resource allocation. The percentages of consumers on FQHC governing boards was not associated with the percentage of federal grant funds spent on uncompensated care, according to Wright and Ricketts (2013). Rather, the percentage not insured was linked to the provision of uncompensated care. These results, when considered together, indicate that an evidence-informed governance model needs to evaluate representation as well as the real power that governing boards have over organizational decisions.

4.1.2 Performance Management and Quality Outcomes

It is evident from the literature that systematic performance measurement is an effective tool for measuring community health center performance. Analyzing 1,039 community health centers, Shi et al. (2012) analyzed 2009 data from the Uniform Data System and looked at six clinical quality measures. Health centres overall performed at levels similar to national averages in clinical care and outcome. For instance, 63% of people with high blood pressure had their blood pressure under control, as opposed to 48% of the nation.

However, Shi et al. (2017) studied the association between patient-centered medical home recognition and clinical performance. The authors identified better performance among recognized health centers in a number of measures using data from the 2012 UDS and medical home recognition. Once the factors that affected patient, provider and practice performance were accounted for, recognized centers performed significantly better in the following areas: asthma-related pharmacologic therapy, diabetes control, pap testing, prenatal care and tobacco cessation intervention.

The results indicate that measurable clinical indicators should be incorporated into performance management systems. They also demonstrate the importance of evaluating, rather than measuring, the performance of the

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organizations in relation to clearly defined measures and not just by general assessment of the quality of services provided.

4.1.3 Financial Accountability and Sustainability

Another theme that is repeated is financial stewardship. McAlearney (2002) investigated the financial performance of community health centers from 1996 to 1999, and found that over half of the CHCs had operating deficits in 1997, 1998 and 1999. The study also revealed that centers with more uninsured users and centers that were part of Medicaid managed care were negatively impacted.

Cheung et al. (2008) surveyed 100 community health center CEOs about perceived financial impacts of Health Disparities Collaboratives. Almost three-quarters of respondents felt that their financial costs overall were higher because of patients and nearly three-quarters said their financial costs of patient care were higher. The authors also discovered a relationship between perceived financial harm and the percentage of patients who are uninsured.

Huang et al. (2008) studied the financial impact of a diabetes quality improvement program in 74 health centers and five case-study health centers. The financial impact on CEOs was mixed. The initiative cost an extra $6 to $22 per patient, with no regular revenue associated with it in the first year. These results suggest that financial monitoring is needed for performance improvement programs, in addition to clinical monitoring.

4.1.4 Resource Stewardship and Organizational Efficiency

Research on efficiency shows the need for the connection between resources and measurable outputs. Marathe et. al (2007) investigated technical and cost efficiency of CHCs based on panel data, data envelopment analysis and latent growth curve modelling. The authors discovered that the contextual factors were more influential on efficiency than the structural factors of the organization. They also discovered that the increase in technical efficiency was positively related to the increase in cost efficiency.

Using UDS data from 2005 to 2007, Amico et al. (2014) analyzed 644 U.S. FQHCs to determine how FQHC grant revenue is related to technical efficiency. They conclude that their results suggest that external funding and organizational features should be explored when studying efficiency.

McGarvey et al. (2019) analyzed FQHC operating environment and quality data using data envelopment analysis and latent class analyses to understand the efficiency of FQHCs. They found that the efficiency measures varied based on the type of health center and the model used. This discovery was very important because it indicates that the contextualization of performance measures when assessing resource stewardship is warranted.

4.1.5 Integration of Quality, Finance, and Outcomes

The facts suggest that there is a need to look at the financial and clinical performance side by side. Davlyatov et al. (2019) analyzed 992 community health centers to determine that there was a relationship between the quality of care and financial performance. In particular, for every 1% rise in controlled hypertension, financial performance rose by 0.023%.

The multiple studies reviewed suggest that governance, performance measurement, financial management and resource efficiency are interdependent factors of the performance of the community health system. The evidence also demonstrates that contextual factors, patient mix, funding models, governance and organizational features impact performance. Thus a governance structure that is evidence-informed should include these dimensions not as separate aspects but in conjunction with one another: community representation, measurable quality indicators, financial monitoring, efficiency measures and outcome assessment.

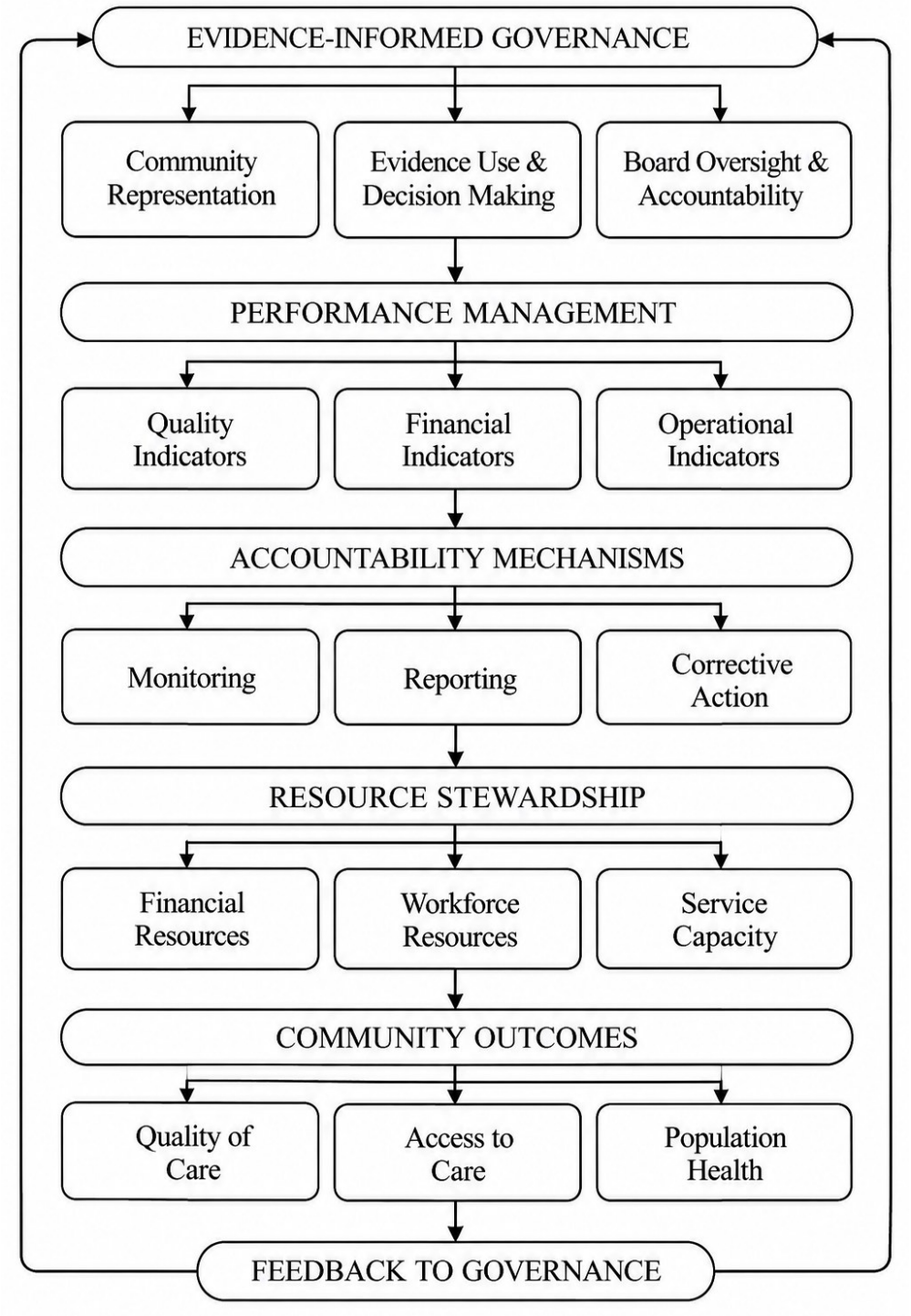
4.2 Proposed Evidence-Informed Governance and Performance Management Framework

This study suggests the Evidence-Informed Governance and Performance Management Framework for U.S. Community Health Systems based on the five themes identified from the literature reviewed. The framework connects governance arrangements and evidence use with performance management, accountability, and resource stewardship and outcomes.

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Figure 1: Proposed Evidence-Informed Governance and Performance Management Framework



4.2.1 Evidence-Informed Governance

The framework starts with evidence-based governance. This element includes community representation, oversight by the board and systematic application of organizational and population information to decision-making. Wright 2013, 2015 demonstrated that formal involvement of patients on FQHC boards does not necessarily translate into equitable patient leadership on the board. For this reason, the framework takes into

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account representation and meaningful participation. Evidence should be used to make decisions on service priorities, organizational performance, financial conditions, and community needs.

4.2.2 Performance Management

Governance decisions should be expressed in terms of measurable objectives for performance. The second part of the framework is performance management.

The following three groups of indicators are suggested:

1. Quality measures (e.g. control of hypertension, preventive care).
2. Financial indicators including operating performance and sustainability of revenue.
3. Operational indicators including efficiency, service capacity, etc.

Shi et al. (2012, 2017) have shown that measurable clinical measures can be useful in evaluating the performance of community health centers. McGarvey et al. (2019) further showed the importance of considering quality and operating environments when evaluating efficiency.

4.2.3 Accountability Mechanisms

Performance information should go straight to accountability, not be just reported back to the board as a separate item. Performance reports should provide information to boards and management to track progress, identify issues and make informed decisions about actions to take to address the issues. The framework thus links monitoring, reporting and corrective action. Accountability is not a reporting exercise but a process.

4.2.4 Resource Stewardship

Allocate resources based on accountability findings. Resource stewardship is responsible management of financial resources, personnel and service capacity. McAlearney (2002) found financial issues were one of the problems with community health centers, and Marathe et al. (2007) and McGarvey et al. (2019) showed that efficiency is important when evaluating a health center's performance. These findings support linking financial and operational information to governance decisions.

4.2.5 Community and Organizational Outcomes

The final one is about results. The framework is centered on three general outcome areas – quality of care, access to care, and population health. Clinical quality and financial performance studies at community health centers support the relationship between performance and outcomes. A study of Davlyatov et al., 2019, found an association between hypertension control and financial performance, for instance.

4.2.6 Feedback Loop

The framework is not a linear process but a continuous one. Outcome data is fed back to governance and used to drive further decisions. This feedback process enables governing boards and managers to review priorities, adjust the provision of resources and set new performance measures. The proposed framework thus builds links among the five themes as shown below:

Evidence-informed governance → Performance management → Accountability → Resource stewardship → Community and organizational outcomes → Governance feedback.

This framework allows for a population-level analysis of resource use and organizational performance and preserves community health outcomes as the ultimate measure of performance, with governance decisions as the driver of the resource use and organizational performance.

5. SUMMARY OF FINDINGS

The study explored evidence related to governance, performance management, accountability, resource stewardship, and outcomes in U.S. community health systems, focusing especially on populations that are underserved. The results indicate that there are strong associations between effective governance and the use of evidence, engagement with patients and communities, performance monitoring and resource allocation within community health systems.

First, the literature suggests community representation is an essential part of governance of health centers. Research conducted at federally qualified health centers (FQHCs) revealed consumer representatives have varying levels of involvement and impact on board meetings. While representation from patients is necessary, it has been found that there may be some differences in the extent to which consumer representatives and the broader patient community are represented in patient boards, depending on the socioeconomic characteristics of that patient community.

Second, performance management became a significant way of turning governance decisions into measurable quality enhancements in care. Analysis of the U.S. health centers revealed some differences in clinical performance among centers, and recognition as a patient-centered medical home was correlated with better performance on some measures of clinical quality. These findings reinforce the need for using clinical measures and operational measures that are clearly defined in decisions for governance and management.

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Third, there is a relationship between financial accountability and sustainability of the community health system. The studies reviewed cited financial factors of uninsured patients, payment of Medicaid, quality improvement efforts and increased overhead. The results suggest that quality and financial management do not be regarded as two independent organizational activities.

Fourth, resource stewardship impacts organisational effectiveness. Research based on the efficiency models revealed that financial resources, grant revenues and organizational conditions and external operating conditions have influence on health center efficiency. The evidence also suggests that the environment of where a community health center operates should be taken into consideration when evaluating efficiency, and not just performance comparisons between the clinic and other clinics.

Last, there is some literature that indicates that a connection exists between quality, financial outcome and community outcomes. There is some evidence that certain quality measures can be linked to financial performance, but this does not mean that there is a direct causal link. Overall, the results indicate that governance, performance measurement, accountability and resource allocation are interrelated and should be approached as an integrated framework.

The findings from this study lead to a five-stage continuum of evidence-informed governance, performance management, accountability mechanisms, resource stewardship, and community and organizational outcomes. The framework includes an ongoing feedback mechanism that enables the evidence of outcomes to guide future governance decisions, priorities, resource allocations, and performance targets.

5.1 Conclusion

Community health systems are vital to meeting the needs of underserved populations in the United States. The success they can have in achieving this role is not only dependent on clinical service delivery, but also on the quality of governance, performance management, accountability and resource stewardship.

The evidence reviewed is consistent with these functions being interrelated. Community representation augments the foundations of governance decision making, and evidence-based performance management offers organisations tangible data to help them evaluate their performance and progress. Mechanisms of accountability assist boards and managers in detecting lapses in performance and then take steps to rectify the situation. Good resource stewardship then links performance data to financial, human resources and service level decisions.

The results also reveal that community health systems are situated in different financial, demographic and organizational contexts. So, performance measures should integrate standardized measures with context data. Restricting attention to individual quality or financial metrics can miss the larger impact of community health systems on access, population health and community well-being.

The concept of Evidence-Informed Governance and Performance Management Framework (EIGPM) outlines the conceptualization of integration of these functions. The framework does not present a validated causal model. Instead, it combines the knowledge gained from the literature reviewed and develops a unified governance and performance management strategy. Further empirical studies are needed to validate the framework with other types of community health systems in the United States and to assess how increased governance, accountability, stewardship, and performance management is related to better organizational and community results.

5.2 Recommendations

The recommendations of the study based on the findings are as follows:

1) Expand robust community representation: Have active consumer members of governing boards that represent the communities served.
2) Apply evidence to governance: Draw on dependable clinical, financial, operational and community data for decision making and resource allocation.
3) Establish holistic performance systems: Monitor quality, financial, operational, access and population-health indicators.
4) Enhance accountability: Develop systems to track performance, track results, define problems and implement corrective action.
5) Relate resources to performance evidence: Allocate funding, workforce and services based on evidence of need and local context.
6) When making efficiency assessments, take context into account: Take into account factors such as population, funding, geography and operating conditions when assessing performance.
7) Link quality: Review the cost of improving quality, and ensure sustainable funding and administrative support are in place.
8) Create feedback loops: Prioritize and allocate resources according to quality, access, financial and population health outcomes regularly.

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