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CONFERENCE ABSTRACT

Understanding the sustainability of cross-sectoral care coordination: an exploration of two approaches to coordinating mental and physical health services

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Introduction: Coordinated health services are required for complex patients with comorbid mental and physical health conditions. Health Links (HL) is an initiative in Ontario, Canada promoting integration across the mental and physical health sectors. Collaborative structures in HLs were determined by local partnering organizations, resulting in various integration approaches. Therefore, HLs offers a unique opportunity to examine different approaches to mental and physical health service coordination under the umbrella of a common initiative. Our aim was to contrast two approaches to coordinating mental and physical health services, and to explore the sustainability of each approach.

Methods: This analysis was undertaken as part of an overall case study evaluation of HLs. Qualitative data collected through semi-structured interviews with HLs leaders and frontline practitioners in two HLs cases were analyzed. We conducted a descriptive content analysis of interview data to understand and contrast care coordination in each HL, and linked these to theory to explore sustainability considerations.

Results: In case 1, a multi-organizational coordination approach was used; care coordination was assigned to the most appropriate organization, which was added staff members' caseloads. Other partnering organizations were involved in care as required. Multi-organizational involvement expanded the service pool, which is vital for resource-constrained sectors. Shared organizational agendas facilitated continued commitment to integration despite staff turnover. One drawback is that processes may be too slow for timely intervention. In case 2, a primary health care coordinator was stationed at an addictions clinic to develop care plans, coordinate services and provide point-of-care physical health assessments. The coordinator diversified the scope of services at the clinic, was more likely to develop trusting relationship-based ties with other health workers, and was able to reach

traditionally hard-to-access addictions patients by establishing transitive relationships. However, case 2 is difficult to scale up and sustainability is threatened by staff turnover.

Discussion: Different coordination approaches may impact the sustainability of cross-sectoral coordination; however, the "most sustainable" approach is unclear and may be dependent on the needs of patients and the goals of integration. Sustainable collaboration has not been empirically well-explored, but institutional and social capital theories lend insight on this. Multi-organizational coordination might be sustained when resources are low and normative system drivers are pushing different sectors towards similar philosophies of patient care. Cross-sectoral point-of-care coordination may be sustained when dealing with vulnerable or marginalized patient populations, where trust is the foundation for maintaining ties.

Conclusions: We examined two approaches to cross-sectoral coordination; each approach has its strengths and limitations regarding sustainability of integration.

Lessons Learned: Policymakers and practice leaders should foster care coordination approaches that best address the needs of complex patients in local care settings, while considering sustainability.

Limitations: The current analysis only examined two approaches to coordinating care across physical and mental health sectors, and does not consider whether outcomes differ across integrated care models.

Suggestions for future research: Researchers should continue exploring sustainability considerations amongst various forms of cross-sectoral coordinated care. Moreover, understanding how the sustainment of outcomes is achieved through these various forms is valuable.

Keywords: care coordination; cross-sectoral integration; sustainability