Care coordination is one of those things in medicine that makes so much sense that whenever I explain it to non-medical people they shake their heads and say “duh.” At its core lies good communication: 15 minutes on a phone here, 20 minutes writing e-mails there, and somewhere in between dealing with faxes, follow-up appointments, meetings, and paperwork all in the name of good patient care. It is something that physicians are perfectly adept at doing. We are taught these skills in medical school and residency! How many follow-up appointments did I make as a third-year student? How many specialist notes and consults did I hunt down as an intern? It’s nice that trainees learn how to do this type of work, but once residency is over, this idyllic way of practicing medicine abruptly stops—and many days, practicing clinicians seeing four patients an hour fly by the seat of their pants to keep from getting behind. Comprehensive management of complex patients becomes impossible as assessments and plans read “Problem A: managed by cardiology, follow with them. Problem B: managed by nephrology, follow with them. Problem C: dermatology appointment in two weeks. Problem D: LDL not at goal, increase statin and see in six weeks for recheck.”

It is not that primary care physicians do not enjoy managing A, B, and C—many just don’t have time. And this assumes they get notes, records, and reports for all tests, labs, and specialty visits to be able to do it! So referral rates and costs increase while patients receive comprehensive yet fractured care that lacks cohesion. If a physician cannot coordinate this, how can we expect our patients to do it?

Enter care coordination: the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient’s care to facilitate the appropriate delivery of health care services. Organizing care involves the marshaling of personnel and other resources needed to carry out all required patient care activities, and is often managed by the exchange of information among participants responsible for different aspects of care. Instead, we think about it as a trained, committed, and licensed nurse or other health care provider who works with the patient, primary care physician, and specialists at all care sites, including the patient’s home, to coordinate care.

Care coordination achieves the “triple aim”—improved health of the population, enhanced patient experience of care (including quality, access, and reliability), and reduced or controlled cost. Patients really, really like it, too!

That care coordination is not a routine part of everyday US medical care is unfortunate—and all the more so for patients who receive care in the safety net. Our most vulnerable patients are a special population and would likely benefit most from coordinated care.

A first step to knowing how to do this in the safety net is a set of best practices: Although there is likely not one way of coordinating care for all safety net clinics across the country, we have some excellently detailed leads. A very well-written report from California showing how five counties integrate and coordinate care demonstrated last year that there are many ways to do this right. Ku and colleagues from George Washington University have shown in great comparative detail how a diverse group of six communities across the United States (Austin, TX; Brooklyn, NY; Indianapolis, IN; Marshfield, WI; San Francisco, CA; and St. Louis, MO) coordinates care successfully.

Care coordination for patients in the safety net is a hard, time-consuming, and high-stakes proposition. Why? Safety net patients face many barriers that other patients do not: Cultural, linguistic, financial, literacy, educational, and access barriers all underlie the complexity. These underlie the care of all the medical and mental health needs that are getting coordinated. When these barriers complicate care, it takes longer. Anyone who has ever seen a trapeze artist fall into a safety net knows what happens when the net breaks. We cannot let our patients hit the floor!

In piecemeal fashion, many safety net clinics and systems have long recognized the need to carefully shepherd these patients through the system. We now call this care coordination. Navigators, care coordinators, and social workers are already an integral part of making the successful care for this patient population a reality. With the advent of the full implementation of the Affordable Care Act, the prospects of making care coordination a vast safety net across the country—using the same evidence-based methodology that continues to improve other aspects of care—is becoming a near-realized hope. As we improve a patient’s experience, reduce costs, and increase efficiency, let us remember that...
munication is tough to measure and not commonly reimbursed, but it often saves and improves lives.

References