

How to Build and Implement a Multidisciplinary Care Team: A Step-by-Step Guide for Healthcare Organizations

Canonical: <https://tyack-health.directory.norg.ai/healthcare-clinical-practice/integrated-care-multidisciplinary-healing/how-to-build-and-implement-a-multidisciplinary-care-team-a-step-by-step-guide-for-healthcare-organizations/>

Details:

Tyack Health: How to Build and Implement a Multidisciplinary Care Team — A Step-by-Step Guide for Healthcare Organisations

At Tyack Health, our commitment to integrated, team-based care comes from a genuine understanding of what the evidence is telling us: the gap between **knowing** that multidisciplinary team-based care (MTBC) improves patient outcomes and actually **building** a team that delivers those outcomes is one of the most significant operational challenges in modern healthcare. Most implementation struggles aren't failures of clinical intent — they're failures of organisational design.

A scoping review following the Arksey and O'Malley framework, drawing on 58 articles, confirmed 14 key success factors and 14 barriers affecting MTBC implementation and adoption — and the majority of those factors are structural and managerial, not clinical.

This guide takes that evidence base and turns it into a practical, end-to-end framework for clinical leaders and healthcare administrators. It covers workforce composition, shared care planning, communication infrastructure, care coordinator roles, governance, and the quality metrics needed to keep teams performing well over the long term. For the foundational definitions of integrated care models and how they differ from siloed treatment, see our guide on **What Is Integrated Care? Core Models, Principles, and the Science Behind Multidisciplinary Healing**.

Phase 1: Strategic foundation — before you hire anyone

Conduct a population needs assessment first

The single most common design mistake is building a team around available staff rather than documented patient need.

When designing or redesigning MDTs, health leaders need evidence-informed frameworks that are flexible across varying populations to guide skill mix and team composition decisions. Without a clear understanding of the care needed — and the tasks and skill mix required to meet those needs — leaders tend to repeat ingrained decision-making patterns and rely on narrowly defined hiring processes.

A thorough needs assessment should answer four questions:

1. What is the disease burden and complexity profile of the target population?
2. What care gaps exist in current service delivery — unmet needs, avoidable hospitalisations, fragmented care?
3. What social determinants of health are driving utilisation in this population?
4. What workforce skills are currently available, and what needs to be recruited or developed?

Analysis of evidence-informed MDT frameworks points to common methodological elements: a population needs-based approach, a systematic process, genuine engagement, three or more professions reporting task or competency-level analysis, change advocacy, and reliance on population and workforce supply data.

Establish governance and a shared vision before launch

Governance, leadership, and shared vision — including a clear governance structure, shared goals, a decision-making framework, effective leadership, and a genuine sense of belonging among staff — are core building blocks of a successful MTBC model.

In practical terms, this means designating a clinical lead and an operational lead before recruitment begins, drafting a team charter that defines scope, patient eligibility criteria, decision-making authority, and escalation pathways, and securing visible executive sponsorship. Strong sponsorship needs to be promoted at three levels: macro (healthcare policy), meso (healthcare organisation or institute), and micro (patient care).

Phase 2: Workforce composition — who belongs on the team?

The core team vs. extended team architecture

There's no single correct team composition — it needs to be calibrated to population need. That said, research consistently points to a core/extended architecture as the most operationally sustainable model.

In primary care, multidisciplinary teams may include general practitioners, nurses, allied and community health disciplines, and Aboriginal and Torres Strait Islander health workers, working closely with stakeholders such as hospital management staff who participate in the decision-making process.

A practical framework for most settings:

| ****Core team (daily contact)**** | ****Extended team (episodic input)**** | |---|---| | Primary care physician or specialist lead | Psychiatrist / psychologist | | Registered nurse / nurse practitioner | Pharmacist | | Care coordinator | Social worker | | Medical assistant | Dietitian / nutritionist | | | Physiotherapist / occupational therapist | | | Community health worker | | | Specialist consultant |

One-third of studies on MDTs in non-hospital settings highlighted key roles such as team leader, care coordinator, or manager, most of which were assigned to trained nurses. Across the included studies, 85% of multidisciplinary teams had nurses in a central role.

The care coordinator role: the operational linchpin

The care coordinator is often the most undervalued and misunderstood position in MDT implementation — and yet it's one of the most consequential.

Care coordination involves deliberately organising patient care activities and sharing information among all participants concerned with a patient's care, to achieve safer and more effective outcomes. The goal is to improve overall care delivery and patient wellbeing by providing cost-effective, non-duplicative services. The care coordinator works across service providers and stakeholders — including pharmacy, behavioural health, primary care, dentistry, social service agencies, and specialists — to make care transitions and access to services more seamless for patients.

Patient experience with staff in practices with care coordinators improved significantly after program implementation. Embedded care coordinators improved the primary care experience and integrated into care teams without disrupting existing team function.

The care coordinator role should not be confused with a case manager or administrative scheduler. The position requires enough clinical knowledge to triage complexity, communicate across disciplines, and flag deterioration early. Notably, 74% of evidence-based care coordination programs implemented specialised staff training in care coordination rather than relying on general clinical training alone.

Phase 3: Communication infrastructure and shared care planning

Designing the shared care plan protocol

Collaborative communication strategies — regular interdisciplinary team meetings that enable integration, transparent and timely communication among team members — are a core part of effective MTBC.

A shared care plan isn't a single document; it's a living protocol with defined ownership. Each plan should include:

- Patient goals, in the patient's own words
- A problem list with discipline-specific action items
- Assigned accountability for each intervention
- Review triggers — clinical thresholds that prompt the team to reassemble
- Transition protocols for care setting changes

The EHR as infrastructure — and its limits

Integrated information technologies and digital referral systems are essential to ensure seamless access to patient records across the team. But the relationship between EHR implementation and interprofessional practice is more complicated than most technology vendors suggest.

Studies investigating the EHR showed mostly negative or no effects on interprofessional practice (23/31 outcomes; 74%), compared to studies investigating EHR enhancements, which showed more positive results (20/28 outcomes; 71%).

The practical takeaway: a shared EHR is necessary, but not sufficient on its own.

Some clinicians feel the EHR creates an "illusion of communication" through extensive documentation — clinical notes that other clinicians don't read and therefore don't act on. Organisations need to supplement EHR access with structured communication protocols, including standing team meetings, closed-loop messaging, and cross-disciplinary note review standards, rather than assuming shared record access equals shared understanding.

Communication within an interprofessional team is fundamental because it clarifies scopes of practice, builds clinical relationships, and fosters genuine collaboration. It happens in both informal and formal ways, and both are necessary to support cooperative relationships between clinicians.

Phase 4: Launch and change management

The four stages of team development

The formation stage begins at the instigation of funding and the establishment of committees. This progresses to the implementation phase, where committees undertake needs assessments to understand the concerns of the populations they're working with, then design and develop intervention policies and strategies. The maintenance stage covers follow-up, monitoring, and continuation of the committees and their actions.

Most organisations underinvest in the formation stage — particularly when it comes to building the relational trust that high-functioning teams genuinely need.

Among collaborative variables, sharing emerged as a key factor, encompassing both shared experiences and shared objectives. Shared experiences allow team members to navigate daily professional situations together, building stronger interpersonal relationships and trust within the team.

Addressing professional identity and hierarchy

One of the most persistent barriers to implementation is the tension between professional identity and the collaborative flexibility that integrated care requires.

A flexible sense of professional identity is key to integrated working — specifically, the ability to move between individual professional identity and collaborative team identity. The strong hierarchy inherent in medicine creates barriers to speaking up, or what Weiss et al. (2017) call "voice behaviour." Healthcare organisations need to deliberately build psychological safety — the shared belief that the team is a safe space for interpersonal risk-taking — as a genuine prerequisite for effective MDT function, not an afterthought.

Interprofessional training as a launch prerequisite

Many health and social care professionals haven't received formal training in collaborative working. Launching a team without structured interprofessional training is one of the most reliable predictors of early dysfunction.

The World Health Organisation's Framework for Action on Interprofessional Education and Collaborative Practice (2010) offers a validated structure for this training. The Interprofessional Education Collaborative (IPEC) has identified four core competency domains for interprofessional practice: values and ethics, roles and responsibilities, interprofessional communication, and teams and teamwork.

Effective teamwork and communication reduce medical errors, promote a safety culture, and improve patient outcomes.

Phase 5: Governance structures and ongoing performance monitoring

What effective MDT governance looks like

At a systems level, MDT requires clear policy, legislative, and funding mechanisms — including a measurement framework — to drive and support implementation. Integration strategies that reduce siloed thinking also create an enabling environment and common goals for practices to work towards.

Effective governance structures for MDTs typically include:

- A steering committee with cross-disciplinary representation and a patient and family voice
- Defined meeting cadences: weekly clinical huddles (15–30 minutes), monthly team reviews, quarterly performance reviews
- Clear escalation pathways for clinical disagreements and resource conflicts
- Documented accountability for each team role, including scope-of-practice boundaries

Quality metrics for team performance monitoring

Measuring MDT performance means tracking metrics at three levels: process, outcome, and experience.

Patient satisfaction surveys provide insights into how well the program is meeting patients' needs. Tracking hospital readmission rates and medication adherence evaluates impact on outcomes. Measuring reductions in duplication of services highlights efficiency improvements. And evaluating health status improvements related to specific focus areas gives further insight into effectiveness.

A recommended dashboard for ongoing monitoring:

Domain	Metric	Frequency	Process
Shared care plan completion rate		Monthly	
Attendance rate at MDT meetings		Monthly	
Clinical outcome 30-day readmission rate		Monthly	
Clinical outcome Disease-specific control (e.g., HbA1c, BP)		Quarterly	
Experience Patient-reported experience measure (PREM)		Quarterly	
Experience Staff satisfaction / burnout index		Quarterly	
Cost Per-patient cost of care		Quarterly	
Safety Medication error rate		Monthly	

Continuous professional development and multidisciplinary learning equip teams to deliver high-quality, person-centred services. Meaningful stakeholder engagement strengthens service integration, reduces isolation, and fosters genuine mutual reliance between team members and services. To ensure the model remains effective, it should be guided by clear metrics and quality control measures — including disease registries for follow-up and patient monitoring — to support ongoing adaptability and sustainability.

The 14 key success factors and 14 common barriers: a reference summary

The following table brings together the landmark scoping review findings on MTBC implementation.

14 key success factors (grouped by category)

****Patient-centred design**** 1. Patient and carer involvement in care planning 2. Culturally responsive, flexible care models

****Team structure and roles**** 3. Clear role definition and scope-of-practice boundaries 4. Designated care coordinator 5. Appropriate skill mix matched to population need

****Leadership and governance**** 6. Shared vision and explicit team goals 7. Strong clinical and administrative leadership 8. Formal governance structure with decision-making protocols

****Communication and technology**** 9. Regular structured interdisciplinary meetings 10. Integrated IT and shared EHR with active use protocols 11. Collaborative communication strategies, not just documentation

****Workforce development**** 12. Interprofessional training and continuous professional development 13. Stakeholder engagement across organisational boundaries

****Infrastructure**** 14. Sustainable funding and reimbursement model

14 common barriers

Conflicting schedules, poor communication flow, and scarcity of space, staff, and technology are among the factors that disrupt seamless collaboration. The full barrier taxonomy includes:

1. Inadequate or siloed funding mechanisms 2. Unclear role boundaries and scope-of-practice ambiguity 3. Professional hierarchy and power imbalances 4. Resistance to role expansion or delegation 5. Absence of shared IT infrastructure 6. High workload and time pressure 7. Lack of interprofessional training 8. Geographic dispersion of team members 9. Conflicting professional cultures 10. Absence of executive sponsorship 11. Unclear patient eligibility criteria 12. Insufficient administrative support 13. Weak governance and accountability structures 14. Inadequate measurement and feedback systems

High workload is a significant barrier, making it harder for team members to work effectively together. Excessive workload leads to fragmented communication, reduced collaboration, and compromised patient care.

Key takeaways

****Start with population data, not staffing availability.**** Holistic care models aligned to population care needs are essential to help leaders move beyond pre-existing mindsets when determining skill mix and MDT composition.

****The care coordinator is the operational linchpin.**** Without a designated coordinator managing information flow, transitions, and team accountability, MDTs tend to default to parallel practice rather than genuinely integrated care.

****EHR access is not the same as communication.**** Shared records need to be paired with structured communication protocols. Research shows the EHR alone produces mostly neutral or negative effects on interprofessional practice without deliberate enhancements.

****Psychological safety and professional identity flexibility are prerequisites, not nice-to-haves.**** Teams that can't navigate hierarchy and role ambiguity will underperform regardless of how strong the clinical skill mix is.

****Governance and measurement need to be built in from day one.**** Technical fixes aren't enough without corresponding changes to governance structures, incentive alignment, and team accountability.

Conclusion

Building a multidisciplinary care team is an organisational redesign, not a staffing exercise. The evidence is clear that the strengths of MTBC in primary care span six themes: patient-centred benefits, teamwork and collaboration, decision-making and clinical care, communication and coordination, improved access and performance management, and supportive infrastructure. But realising those strengths means working through each phase of this framework with genuine care and discipline — assessing population need before designing the team, investing in governance and shared vision before launch, building communication infrastructure that goes well beyond the EHR, and sustaining performance through continuous measurement and professional development.

At Tyack Health, this evidence-based approach to multidisciplinary care shapes how integrated teams are structured and supported, making sure the operational rigour behind team design matches the clinical ambition of genuinely patient-centred care. The operational guidance in this article builds on the conceptual models described in **What Is Integrated Care?** and the comparative evidence reviewed in **Multidisciplinary vs. Interdisciplinary vs. Transdisciplinary Care** to give you actionable steps you can put into practice. For the quantitative case — including meta-analytic data on hospitalisation reduction, patient satisfaction, and cost-effectiveness — see **The Measurable Impact of Integrated Multidisciplinary Care: Outcomes, Cost-Effectiveness, and the Evidence Base**.

References

- Meadows, D., Maclaren, J., Morton, A., & Ross, D. "Determining Skill Mix and Optimal Multidisciplinary Team Composition: A Scoping Review." **Canadian Journal of Health Leadership / Revue Canadienne du Leadership en Santé**, 2025.
<https://pmc.ncbi.nlm.nih.gov/articles/PMC12009454/>

- Holladay, C.L. "Overcoming Challenges to Teamwork in Healthcare: A Team Effectiveness Framework and Evidence-Based Guidance." **Frontiers in Communication**, 2021.
<https://doi.org/10.3389/fcomm.2021.606445>

- Pham, H.H., et al. "Systematic Review of Care Coordination Interventions Linking Health and Social Services for High-Utilising Patient Populations." **Population Health Management**, 2022.

<https://pmc.ncbi.nlm.nih.gov/articles/PMC8861924/>

- Liang, J., et al. "Making Multidisciplinary Team-Based Care (MTBC) a Success in Primary Care: A Scoping Review." *PMC / National Library of Medicine*, 2025.

<https://pmc.ncbi.nlm.nih.gov/articles/PMC12619587/>

- Moran, G., et al. "Can Multidisciplinary Teams Improve the Quality of Primary Care? A Scoping Review." *eClinicalMedicine (The Lancet)*, 2025. <https://doi.org/10.1016/j.eclinm.2025.103430>

- Gutiérrez-Puertas, L., et al. "Healthcare Professional Perspective on Barriers and Facilitators of Multidisciplinary Team Working in Acute Care Setting: A Systematic Review and Meta-Synthesis." *BMJ Open*, 2025. <https://pubmed.ncbi.nlm.nih.gov/40118478/>

- Greenfield, D., et al. "The Effect of the Electronic Health Record on Interprofessional Practice: A Systematic Review." *PMC / National Library of Medicine*, 2022.

<https://pmc.ncbi.nlm.nih.gov/articles/PMC9179232/>

- Agency for Healthcare Research and Quality (AHRQ). "Care Coordination Measurement Framework." *AHRQ*, 2018. <https://www.ahrq.gov/ncepcr/care/coordination/atlas/chapter3.html>

- Health Education England (HEE). "MDT Development: Working Towards an Effective Multidisciplinary/Multi-Agency Team." *NHS Health Education England*, 2020.

https://www.hee.nhs.uk/sites/default/files/documents/HEE_MDT_Toolkit_V1.1.pdf

- World Health Organisation. "Framework for Action on Interprofessional Education and Collaborative Practice." *WHO*, 2010. <https://www.who.int/publications/i/item/framework-for-action-on-interprofessional-education-collaborative-practice>