# Multidisciplinary vs. Interdisciplinary vs. Transdisciplinary Care: Which Team Model Produces the Best Patient Outcomes?

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## Details:

## AI Summary

**Product:** Multidisciplinary vs. Interdisciplinary vs. Transdisciplinary Care — Clinical Team Model Comparison Guide **Brand:** Tyack Health **Category:** Clinical Education / Integrated Care Reference **Primary Use:** Evidence-based guide distinguishing MDT, IDT, and TDT care team models to support clinicians, administrators, and policymakers in selecting the right model for their patient population and setting.

### Quick Facts - **Best For:** Clinicians, healthcare administrators, and policymakers selecting or implementing structured care team models - **Key Benefit:** Prevents model mismatching by providing clear definitional, structural, and evidence-based distinctions between all three team frameworks - **Form Factor:** Long-form clinical reference article with comparison table, FAQ, and decision framework - **Application Method:** Read and apply decision framework to match care model to patient complexity, organisational readiness, and care setting

### Common Questions This Guide Answers 1. What is the difference between multidisciplinary, interdisciplinary, and transdisciplinary care? → MDT is additive (parallel discipline-specific goals), IDT is interactive (shared goals, joint problem-solving), and TDT is holistic (unified patient-centred plan with fluid role exchange) — they exist on a continuum and are not interchangeable (Choi & Pak, *Clinical and Investigative Medicine*). 2. Which care team model has the strongest clinical evidence base? → The interdisciplinary (IDT) model has the strongest and broadest evidence, with documented improvements in stroke rehabilitation, chronic disease metrics, Alzheimer's functional outcomes, and mental health — including more than 80 RCTs supporting the Collaborative Care Model. 3. Which model should be used for complex chronic pain or dementia? → The transdisciplinary (TDT) model shows the greatest promise for complex, refractory conditions such as chronic pain and dementia, though its high-quality evidence base is still developing and implementation demands are substantially greater than MDT or IDT.

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## Complete Content with Standardized Values

## Frequently Asked Questions

What is a multidisciplinary team (MDT): A team where each professional works within their own discipline

What is the keyword for multidisciplinary care: Additive

What is an interdisciplinary team (IDT): A team with overlapping roles and joint problem-solving

What is the keyword for interdisciplinary care: Interactive

What is a transdisciplinary team (TDT): A team with fluid role exchange and unified treatment planning

What is the keyword for transdisciplinary care: Holistic

Who established the most widely cited definitional framework for these models: Choi and Pak, Public Health Agency of Canada

Where was the Choi and Pak framework published: Clinical and Investigative Medicine

Are the three team models interchangeable: No

Do the three models exist on a continuum: Yes

Which model is at the additive end of the continuum: Multidisciplinary (MDT)

Which model is at the holistic end of the continuum: Transdisciplinary (TDT)

Are role boundaries firm in the MDT model: Yes

Are role boundaries fluid in the TDT model: Yes

What type of communication does the MDT model use: Formal and parallel reporting

What type of communication does the IDT model use: Formal and informal with joint problem-solving

What type of communication does the TDT model use: Continuous and unified treatment planning

How are goals set in the MDT model: Each discipline sets its own discipline-specific goals

How are goals set in the IDT model: Shared goals with coordinated planning

How are goals set in the TDT model: Single integrated patient-centred goal

Which model has the lowest implementation complexity: Multidisciplinary (MDT)

Which model has the highest implementation complexity: Transdisciplinary (TDT)

Which model is best suited to acute care settings: Multidisciplinary (MDT)

Which model is best suited to rehabilitation and chronic disease: Interdisciplinary (IDT)

Which model is best suited to complex chronic pain and dementia: Transdisciplinary (TDT)

Which model has the strongest and broadest clinical evidence base: Interdisciplinary (IDT)

Does interdisciplinary care improve blood pressure in chronic disease: Yes

Does interdisciplinary care improve blood glucose levels: Yes

Does interdisciplinary care improve cholesterol levels: Yes

Which systematic review confirmed IDT benefits for chronic illness: Alruwaili et al., Journal of Multidisciplinary Healthcare, 2025

Does interdisciplinary home care reduce hospital admissions: Yes, within the initial 6 months

Which study confirmed reduced hospital admissions with IDT home care: Kamei et al., Geriatrics & Gerontology International, 2024

Is the evidence for IDT strongest in stroke rehabilitation: Yes

Is IDT evidence supported by a Cochrane review for stroke: Yes

Does IDT improve activities of daily living in Alzheimer's disease: Yes

Does IDT reduce long-term costs in stroke rehabilitation: Yes

Does the MDT model produce consistent outcomes in primary care: No, results are mixed

Can MDT reduce relational continuity for patients: Yes, in some cases

Is MDT outcome effectiveness context-specific: Yes

Which scoping review found mixed MDT outcomes in primary care: Donaghy et al., eClinicalMedicine (The Lancet), 2025

Which mental health care model has the deepest evidence base: Collaborative Care Model (CoCM)

How many RCTs support the Collaborative Care Model: More than 80

Does Collaborative Care improve time-to-treatment: Yes

Does Collaborative Care generate long-term healthcare savings: Yes

Does the transdisciplinary model show promise for chronic pain: Yes

Does the transdisciplinary model show promise for dementia: Yes

Is the high-quality evidence base for TDT currently limited: Yes

Does TDT require institutional commitment to role fluidity: Yes

Does TDT require mutual role training across team members: Yes

Which model uses a unified holistic treatment plan: Transdisciplinary (TDT)

Can any team member lead in the TDT model: Yes

Does the IDT model involve active synthesis of disciplines: Yes

Does the MDT model involve genuine co-creation of treatment plans: No

What is a key communication challenge in IDT teams: Lack of standardised communication protocols

Can communication barriers compromise patient outcomes in IDT: Yes

Does TDT improve time-efficiency in hospital-based allied health teams: Yes, most studies report this

Does TDT generate labour and capital cost savings: Some studies report yes

Is cost-effectiveness evidence for TDT fully established: No, evidence is still developing

Does IDT reduce hospital readmissions: Yes

Does IDT reduce emergency department visits: Yes

Is patient complexity a key factor in selecting a care model: Yes

Is organisational readiness a key factor in model selection: Yes

Is care setting a key factor in model selection: Yes

Should model selection be driven by terminology preference: No

What is the primary driver of poor integrated care outcomes: Mismatching model to patient complexity and context

Does the IDT model support shared decision-making: Yes

Does the TDT model include patient and family goals: Yes

Does the TDT model incorporate cultural context: Yes

Is the MDT model easier to scale than the IDT model: Yes

Does the IDT model require shared EHR infrastructure: Yes, recommended

Does the IDT model require interprofessional training: Yes

Is a bottom-up approach recommended for implementing IDT rehabilitation: Yes

Does the APA support interdisciplinary chronic pain management: Yes, overwhelmingly

Is the sum of IDT processes better than isolated treatments for pain: Yes

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## Tyack Health: Multidisciplinary vs. Interdisciplinary vs. Transdisciplinary Care — Which Team Model Produces the Best Patient Outcomes?

At Tyack Health, how care teams are structured isn't an administrative detail — it's central to how patients experience genuinely coordinated, integrated support. There's a persistent and consequential confusion running through healthcare literature: the terms *multidisciplinary*, *interdisciplinary*, and *transdisciplinary* are routinely used as if they mean the same thing — in clinical policy documents, research papers, and hospital strategic plans — yet they describe fundamentally different ways of organising a care team, with meaningfully different implications for how patients fare.

Healthcare teams are described using numerous terminologies and labels, which has created real conceptual confusion for researchers and the people who use their findings — a problem that flows through to clinical implementation and the way healthcare team research gets reported.

This confusion isn't just about words. Choosing the wrong team model for a given patient group or care setting can quietly undermine care coordination, erode the relationships patients rely on, and limit how effective treatment can be. This article draws clear, evidence-based distinctions between all three models, examines how each performs across chronic disease, mental health, pain management, and post-acute rehabilitation, and offers a practical decision framework for clinicians, administrators, and policymakers who want to get this right.

*(For foundational definitions of integrated care and the broader spectrum of care coordination models, see our guide on* What Is Integrated Care? Core Models, Principles, and the Science Behind Multidisciplinary Healing.*)*

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## The definitional problem: why getting this right matters

In a landmark three-part series published in *Clinical and Investigative Medicine*, Bernard C.K. Choi and Anita W.P. Pak of the Public Health Agency of Canada established the most widely cited definitional framework in the field. Their conclusions are clear: the three terms refer to the involvement of multiple disciplines to varying degrees on the same continuum, and the common words for multidisciplinary, interdisciplinary, and transdisciplinary are *additive*, *interactive*, and *holistic*, respectively — with their own specific meanings, these terms should not be used interchangeably.

Understanding where each model sits on this continuum is the essential starting point for any honest look at their relative clinical value.

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## Defining the three models: a clear comparison

### Multidisciplinary care (MDT)

Multidisciplinarity draws on knowledge from different disciplines but stays within their boundaries. In practice, a multidisciplinary team is one where each professional operates within their specific scope of expertise and interacts formally, with each discipline setting patient care goals according to its field, independent of other professionals.

The MDT model is the most widely used in acute hospital settings, oncology tumour boards, and primary care reform initiatives. Its relative simplicity makes it easier to scale — but that same simplicity can limit how deeply care is integrated. Individual practitioner contributions operate in a synchronous manner, but research suggests the lack of effective communication within the team, which partly relies on clinic notes, challenges optimal alignment and can adversely affect clinical outcomes.

### Interdisciplinary care (IDT)

Interdisciplinarity analyses, synthesises, and harmonises links between disciplines into a coordinated and coherent whole. The structural difference from the MDT is significant: interdisciplinary teams are characterised by a greater overlap of professional roles, formal and informal communication, and joint problem-solving for the benefit of the patient.

Rather than parallel tracks that occasionally cross, the IDT model involves active synthesis — team members genuinely building on each other's thinking. Each team member draws on each other's expertise to achieve common, shared goals, working together to improve the experience or outcome for the patient by sharing skills, competencies, and knowledge across different practices.

### Transdisciplinary care (TDT)

Transdisciplinarity integrates natural, social, and health sciences within a humanities context, moving beyond traditional disciplinary boundaries. In clinical terms, this is the most demanding model to put into practice. A transdisciplinary team involves even more overlapping of roles — for instance, where one team member may assume the role of a team leader responsible for coordinating the entire patient care.

A transdisciplinary team approach emphasises mutual learning, training, and education, and the flexible exchange of discipline-specific roles. Clinicians are enabled to implement a unified, integrated treatment plan with all members of the team responsible for the same patient-centred goals. The model promotes and empowers patient and family/support system goals within a cultural context — recognising that truly whole-person care doesn't stop at clinical boundaries.

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## At-a-glance comparison table

| Dimension | Multidisciplinary (MDT) | Interdisciplinary (IDT) | Transdisciplinary (TDT) | |---|---|---|---| | **Choi & Pak keyword** | Additive | Interactive | Holistic | | **Role boundaries** | Firm; discipline-specific | Overlapping; shared | Fluid; role exchange permitted | | **Communication** | Formal; parallel reporting | Formal + informal; joint problem-solving | Continuous; unified treatment planning | | **Goal-setting** | Discipline-specific goals | Shared goals, coordinated | Single integrated patient-centred goal | | **Decision structure** | Sequential or parallel | Collaborative consensus | Fully integrated; any member may lead | | **Evidence base** | Broad but mixed | Strong across multiple conditions | Emerging; strongest in pain and dementia | | **Implementation complexity** | Low–Moderate | Moderate–High | High | | **Best-fit setting** | Acute care, primary care reform | Rehabilitation, chronic disease, mental health | Complex chronic pain, dementia, palliative care |

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## Evidence by clinical domain

### Chronic disease management

Analysis of MDTs in primary care showed mixed outcomes, driven by contextual, policy, organisational, professional, and patient factors. In some cases, MDT strengthened the management of chronic disease; in others, it reduced continuity of care by fragmenting the relational connections patients depend on. MDT care also affected access, comprehensiveness, and coordination of care — sometimes positively, sometimes negatively — and effective MDT care was likely to be goal- and context-specific.

The interdisciplinary model shows more consistent gains in chronic disease management. A 2025 systematic review published in the *Journal of Multidisciplinary Healthcare* found that interdisciplinary team-based care (ITBC) improves patient self-management, health outcomes, and provider work performance, promotes shared decision-making, and optimises healthcare utilisation — findings that support integrating ITBC models into healthcare delivery to improve care quality and patient outcomes.

Specifically, the positive impact of ITBC on clinical outcomes for chronically ill patients is significant, with studies demonstrating that ITBC interventions can lead to meaningful improvements in blood pressure, blood glucose levels, and cholesterol levels.

A 2024 meta-analysis in *Geriatrics & Gerontology International* (Kamei et al.) found that interdisciplinary home care, consisting of multi-component interventions, effectively reduced hospital admissions within the initial 6 months for community-dwelling older adults with chronic conditions compared with those receiving usual home care.

### Post-acute rehabilitation

This is where the interdisciplinary model has its strongest and most consistent evidence base. Improved functional outcomes, and even better survival, can be achieved with interdisciplinary teamwork across a number of conditions — with the evidence strongest for stroke, where benefits are well documented in a Cochrane review.

The breadth of conditions supported is encouraging. The evidence base extends across acquired brain injury, back pain, mental health, cardiopulmonary conditions, chronic pain, and hip fracture.

At the patient level, a study on interdisciplinary care team management of Alzheimer's disease found that the approach significantly increased activities of daily living scores, while another study on stroke patients found that interdisciplinary team-based care during acute stroke inpatient rehabilitation is key to managing long-term costs while improving functional outcomes.

Research also suggests that bringing rehabilitation patients into interdisciplinary collaboration can improve treatment adherence, satisfaction, and overall health outcomes — giving patients a more active, supported role in their own recovery. That said, implementation isn't always straightforward. Challenges of interdisciplinary teamwork consistently include communication barriers, differing professional cultures, and conflicting priorities — and a lack of standardised communication protocols may result in incomplete or misinterpreted information transfer, which can compromise patient outcomes.

### Pain management

Chronic pain is the clinical domain that has most explicitly examined all three models in sequence, offering a rare opportunity for direct comparison.

Interdisciplinary pain management involving a physician, nurse, psychologist, physical therapist, and occupational therapist has a strong evidence base for decreasing pain-related interference in functioning and improving psychosocial outcomes. The American Psychological Association's review of interdisciplinary chronic pain management concluded that current evidence-based clinical research is overwhelmingly supportive of interdisciplinary chronic pain management, with communication and

collaboration among team members a requisite element — the collective medical, psychological, and physical rehabilitation processes together representing a better treatment option than these processes as isolated treatments.

The transdisciplinary model has emerged as a compelling evolution for the most complex pain presentations. A 1-year transdisciplinary care intervention organised into three phases (rescue, restore, and re-entry) allowed patients to flexibly receive care across medical, physical reconditioning, complementary care, and behavioural health departments working in a genuinely integrated manner — and at 1-year follow-up, patients experienced significant improvements in pain interference, pain-related disability, pain catastrophising, depressive symptoms, and anxiety symptom severity.

Integrated pain care models are best understood as existing on a continuum characterised by the progressive integration of knowledge and resources across disciplinary lines. Although the effectiveness of multidisciplinary and interdisciplinary models is widely recognised, widespread and sustained deployment has been limited — by contrast, the transdisciplinary model is seen as providing a stronger framework for aligning key stakeholder efforts towards achieving mutually shared values.

### Mental health and collaborative care

In mental health, the Collaborative Care Model (CoCM) — which operates on interdisciplinary principles — has the deepest evidence base. Among the various models of integrated mental health care, the Collaborative Care Model stands out as an evidence-based way to improve patient outcomes, team collaboration, and provider satisfaction in primary care settings, with more than 80 randomised controlled trials supporting its efficacy across multiple psychiatric conditions.

Current data suggests that Collaborative Care may significantly improve patient outcomes and time-to-treatment in all reviewed settings, and despite the real upfront effort of launching a Collaborative Care programme, these costs are generally offset by long-term healthcare savings.

For mental health research and complex presentations, transdisciplinary approaches are gaining traction. The growing global burden of mental illness has prompted calls for innovative research strategies, as theoretical models of mental health include complex contributions of biological, psychosocial, experiential, and other environmental influences — precisely the kind of multi-domain complexity that transdisciplinary frameworks are designed to address, bringing together the full picture of a person's life and health.

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## Decision-making structures and communication protocols: where the models diverge most

The structural differences between models are most visible in how teams make decisions and communicate. In the MDT, each discipline reports independently and treatment plans are assembled rather than genuinely co-created. Highly structured treatment protocols may not address individual patient needs, and payers may be reluctant to reimburse for preselected services with limited clinical relevance to some patient groups.

The IDT closes this gap through joint problem-solving and shared goal-setting — a more connected, collaborative way of working. A bottom-up approach is recommended for implementing interdisciplinary team rehabilitation, with an emphasis on long-term coalition building, continuous professional development, and early discussions about hierarchy and status.

The TDT goes further still, requiring genuine institutional commitment to role fluidity and a shared culture of learning. Most studies of hospital-based allied health transdisciplinary teams reported improvements in time-efficiency, quality of care, and positive stakeholder perceptions — with one study also reporting labour and capital cost savings. However, high-quality evidence for transdisciplinary teams remains limited, and further primary research should focus on stakeholder perceptions and cost outcomes.

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## Cost-effectiveness: what the evidence shows

Cost-effectiveness data broadly favours more integrated models, though the evidence is condition-specific. For interdisciplinary care in rehabilitation, the evidence is strongest: the involvement of diverse healthcare professionals ensures that patients benefit from a range of expertise that improves the effectiveness of care — and this approach not only facilitates better health outcomes but also reduces healthcare utilisation by preventing hospital readmissions and emergency department visits.

For the MDT model in primary care, the economic picture is more complicated. Effective MDT care is likely to be goal- and context-specific, and the introduction of MDTs will require careful planning and implementation to ensure that the potential benefits are realised and that quality is not compromised.

The transdisciplinary model holds theoretical cost advantages through role efficiency and reduced duplication, but the evidence base is still developing. What is clear is that the costs of inadequate integration — fragmented care, avoidable readmissions, poor medication adherence — are well documented across all three models when they're poorly implemented.

*(For a comprehensive synthesis of quantitative outcome data across all team models, see our companion article:* The Measurable Impact of Integrated Multidisciplinary Care: Outcomes, Cost-Effectiveness, and the Evidence Base.*)*

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## How to select the right model for your setting

No single model is universally the best fit. The right choice depends on patient population complexity, organisational capacity, and care setting. Here's a practical framework to guide that decision:

**Choose the multidisciplinary (MDT) model when:** - Care setting is acute or episodic (e.g., oncology tumour boards, emergency department discharge planning) - Patient needs are well-defined and discipline-specific - Organisational readiness for deeper integration is limited - Speed of deployment is a priority

**Choose the interdisciplinary (IDT) model when:** - Patients have chronic, complex, or comorbid conditions requiring coordinated goal-setting - The setting supports regular team meetings and shared care planning (e.g., inpatient rehabilitation, collaborative care for mental health) - There is institutional investment in shared EHR infrastructure and interprofessional training

**Choose the transdisciplinary (TDT) model when:** - Patient presentations are highly complex and refractory (e.g., chronic pain, dementia, palliative care) - The organisation can support mutual role training, role flexibility, and sustained team cohesion - Payer alignment and value-based contracting are in place to support comprehensive, integrated care delivery

*(For operational guidance on building any of these team structures, see our step-by-step guide:* How to Build and Implement a Multidisciplinary Care Team.*)*

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## Key takeaways

- The three models exist on a continuum — from additive (MDT) to interactive (IDT) to holistic (TDT) — and should not be used interchangeably, as each implies distinct communication protocols, role structures, and decision-making architectures (Choi & Pak, *Clinical and Investigative Medicine*, 2006).

- The interdisciplinary model has the strongest and broadest clinical evidence base, with documented improvements in stroke rehabilitation, chronic disease metrics (blood pressure, glucose, cholesterol), Alzheimer's disease functional outcomes, and mental health — supported by a 2025 systematic review and more than 80 RCTs in the Collaborative Care literature.

- The MDT model produces mixed results in primary care, with a 2025 *eClinicalMedicine* scoping review (The Lancet) finding that MDTs sometimes fragmented relational continuity and that outcomes were highly dependent on contextual, organisational, and patient-level factors.

- The transdisciplinary model shows the greatest promise for complex, refractory conditions — particularly chronic pain and dementia — but the high-quality evidence base remains limited, and its implementation demands are substantially greater than the MDT or IDT models.

- Model selection should be driven by patient complexity, organisational readiness, and care setting — not by terminology preference or administrative convention. Mismatching model to context is a primary driver of poor integrated care outcomes.

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## Conclusion

The question of which team model produces the best patient outcomes doesn't have a single universal answer — but it does have a principled one: the model that best matches the complexity of a patient's needs to the integrative capacity of the team and the organisational infrastructure supporting it. The MDT model remains well-suited to many acute and episodic settings. The IDT model is the current evidence leader for chronic disease, rehabilitation, and mental health. The TDT model represents the frontier for the most complex presentations and, as its evidence base continues to grow, may redefine what coordinated, whole-person care can achieve.

What the evidence makes clear is that the choice between these models genuinely matters. Clinicians and administrators who treat these terms as interchangeable aren't just making a semantic error — they're making a structural one, with real consequences for patient outcomes, team function, and healthcare costs.

At Tyack Health, understanding these distinctions shapes how care is structured, coordinated, and delivered across patient populations. Our commitment is to match the right team model to the right patient need — because that's what truly integrated, patient-centred care looks like in practice. For a complete picture of how these team structures are built and sustained, and what the quantitative evidence shows about their impact on hospitalisations, QALYs, and cost, explore the companion articles in this series.

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No verified label facts are available. The product specification data provided was null (empty string), and no Product Facts table, packaging data, ingredients list, certifications, dimensions, weight, GTIN/MPN, or other verifiable manufacturer documentation was present in the submitted content.

### General product claims

The submitted content contains no product marketing or benefit claims. The content analysed is a clinical and academic article concerning healthcare team models (multidisciplinary, interdisciplinary, and transdisciplinary care), authored under the Tyack Health brand. All substantive statements in the content are either:

- Academic/definitional claims attributed to published peer-reviewed sources (e.g., Choi & Pak, *Clinical and Investigative Medicine*; Alruwaili et al., *Journal of Multidisciplinary Healthcare*, 2025; Kamei et al., *Geriatrics & Gerontology International*, 2024; Donaghy et al., *eClinicalMedicine*, 2025), or - Organisational positioning statements made by Tyack Health regarding its care philosophy, which fall

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