

# IMPROVING SERVICE COORDINATION AND INTEGRATION THROUGH INTERAGENCY MULTIDISCIPLINARY TEAMS

## THREE MODELS OF MULTIDISCIPLINARY TEAMS

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### **Background:**

The following is a discussion of three models of multidisciplinary teams (MDT) which are designed to assist caseworkers in providing the best possible service to their client or family. Although each model shares certain characteristics with the others, they do vary based on:

- The type of relationships between members,
- The degree of coordination and integration of services the model makes available,
- The roles and responsibilities of the team members now and in the future, and
- The resource commitment that organizations with participating team members make to collaborative work.

It should be noted that the differences between models are made clearer here for the sake of discussion and that variations on these models do exist. The names given to the models were designed to differentiate them and are not necessarily the names commonly used.

Each of the following models share certain characteristics:

- The team is composed of individuals with different areas of expertise,
- The number of members may vary,
- The disciplines represented may vary,
- Each is set up to assist workers in brainstorming solutions, establishing service plans, and exploring resources,
- All of the teams usually meet on a regular basis, i.e., weekly, bi-weekly, monthly,
- Each is set up for individual caseworker to present a case for assistance; and
- Each will have a coordinator or facilitator.

The three models are presented in order of complexity and resource commitment with Model III being the most complex and providing the greatest opportunity for service coordination and integration. Illustrations are provided as to how these models might work at the Fremont Family Resource System.

### **MODEL I**

#### **Case Consultation Team**

This is the least complicated and formal of the three models. It allows caseworkers from multiple organizations to come together to seek advice and resources from each other for clients with complex problems or family issues.

**Team Composition:** Any case manager/service coordinator at the FRC who wishes to participate in the team or to present a case. Recently, eighteen organizations at the FRC providing service coordination or case management activities participated in a series of discussion related to service linkages, overlaps and gaps. In the case consultation model it is envisioned that a number of these organizations might wish to participate in a case consultation model as a means to share resources.

**Process:** In this model a case consultation team meeting is held on a regular basis (weekly, bi-weekly, monthly). Participation is voluntary on the part of agencies and therefore can vary from meeting-to-meeting depending on other agency commitments. An incentive for agency workers to participate in this process is that they may receive assistance with very complicated cases.

In this model one or more caseworkers or service coordinator's comes to the team meeting with specific questions regarding a particular case. Procedurally, the caseworker presenting a case will provide some background on the client/family and then proceed with their questions or reasons for presenting this case. There is usually little or no preparation for other team members, and they may have limited or no previous information regarding this client or family. Members of the team may provide consultation and recommendations regarding a variety of topics including but not limited to resources, method/techniques for working with a client, clarification of key issues, specific intervention strategies, other general information, etc.

**Outcome:** Generally, the members of this team are not directly involved in this case, however, they may become a member of the intervention team as a result of the consultation if deemed appropriate, they are willing and it is in the best interest of the client or family. The consultation may also result in a referral to the agency that a member may represent. At the conclusion, team members usually do not continue to have further responsibility regarding this case and follow-up does not usually occur with the exception of the primary case manager or provider who presented the case.

This model is not designed to provide a forum for coordination and integration of services. The goal is mostly consultative in nature.

**Resource Commitment:** Agencies participate in this process on a voluntary basis and caseworkers are given time to participate in team meetings where the case consultation takes place. Agencies contribute resources or promise to follow-up providing collateral support on a time/resource available basis. There is a designated facilitator with a limited role, whose job it is to help coordinate the group, set meeting dates, keep discussions on track, coordinate agency case presentation and who may coach or work with the group in order to enhance case presentation and communication among team members.

## **Model II**

### **Case Conferencing Integration Team (Designated Staff)**

**Team Composition:** In this model a "core" team such as a public health nurse, employment specialist, benefits specialist, City family service case manager or Healthy Start Parent Advocate, would meet regularly, however this team would be augmented by additional members representing different specialty areas (creating an extended team) if their expertise was a critical component of the case being presented. For example, a domestic violence specialist, a housing counselor, mental health specialist, or a drug and alcohol specialist would be added to this conference because it is believed that their expertise may be important because these issues exist with this client/family.

The exact composition of the "core" team and "extended" team will depend on the disciplines most often needed with the types of cases presented to this team and those that can be brought in as needed. Members of this team are purposefully chosen not only because of their expertise, but also because they might provide a service or act as an expeditor in accessing services for the client/family. In addition, team members may be given information regarding the case prior to the meeting. This permits members to check their records and possibly bring additional information to the meeting.

**Model Variation:** This model may be further extended beyond a "core" team and an "extended" team for the FRC, to include other (outside the FRC) already working with client or family. For example, if this client were currently involved in multiple system or organization, for example, Child Welfare, Welfare to Work, Probation, and Special Education Services, all of their service providers including their probation Officer and their teacher/school psychologist would be invited to attend and participate.

**Family Participation:** In this model the client (family) may be invited to expected to participate as part of their team. This is important because service/treatment plans need to be client driven and overtly agreed upon by the client. It is not uncommon that clients are totally intimidated by this idea. As a result, one worker, usually the primary case manager or the provider who has the best rapport with the client, will represent the client and then convey the results of the conference to be the client for their approval and commitment.

**Process:** With this model, a case is presented, and the team is asked to brainstorm regarding solutions to best assist this caseworker. However, unlike Model I, the members of this team play a more active role in developing the service plan. The team together develops a plan to assist this family, and it may include their personal involvement in a variety of forms. For example, a member might commit to conducting an assessment or to facilitating access to services from their home agency.

Usually, the provider that referred the case or the primary case manager will lead the presentation. Other members share their roles, current service/treatment plan, progress, etc. Clarification of roles and interventions often can lead to greater coordination, reducing redundancies and bringing consistency. This forum has the potential to maximize not only the coordination of components of service, but also allows for more complimentary goal setting and integrated strategies between the providers that may be involved in the same case or family. Hopefully, each person working with this client or family will integrate the goals of the others and reinforce positive behaviors as appropriate.

Ongoing communication between members of the intervention team is crucial for continued coordination and integration. This also reduces the potential of a client working one provider against the other. It is not uncommon to have a client say that what is being said by or expected from one worker is contradictory to what is being said by or expected from another provider. Some clients use this “splitting” as a way to bring confusion to their case and as a method to avoid the changes they need to make or the actions that they have agreed to accomplish.

**Outcome:** The team collaboratively develops a plan to assist this family, which includes various team member’s agency and personal commitments. For example, a member might commit to conducting an assessment of the client or to facilitating access to services from their home agency. Each person working with this client or family will integrate the goals of the others and reinforce positive behaviors as appropriate.

It is critical at the conclusion of the team meeting that the roles and responsibilities of the individual members of the team regarding the agreed upon case plan are clarified and recorded. This includes a decision as to the primary case manager for the client. The case worker that presented the case may remain as the primary case manager, the team member responsible for coordinating the components of the plan, or it may be decided that the primary case manager role is better played by another member of the team.

Follow through and follow up are an important part of this process, and therefore the same case will be presented and reviewed at a later date to assess progress in meeting agreed upon activities, goals and objectives. All team members have not only a responsibility to the client, but also to each other.

**Resource Commitment:** Policy makers from agencies providing core staff reach agreement on the service integration model, roles and relationships and procedures for information sharing. Certain staff are designated as core staff members by each core agency and priority time is provided to core team members to engage in collaborative work as part of the case consultation process. Permission and flexibility is given to core workers by their home agencies to “think out of the box” and use creative techniques in working with families. A case consultation coordinator is used to work with the team in designing protocols to work with families and to help the team develop its own process for working together thereby reducing “turf” issues.

### **Model III**

#### **Service Integration Team (Dedicated Staff)**

**Team Composition:** In this model a “core” team, such as a public health nurse, mental health specialist, employment specialist and benefits specialist would meet regularly. However, this team would be augmented by additional members representing different specialist areas (creating an extended team), if their expertise was a critical component of the case being presented. For example, a domestic violence specialist, a housing counselor, or a drug and alcohol specialist would be added to this conference because it is believed that their expertise may be important because these issues exist with this client/family.

The exact composition of the “core” team and “extended” team will depend on the disciplines most often needed with the types of cases presented to this team and those that can be brought in as needed. Members of this team are

purposefully chosen not only because of their expertise, but also because they might provide a service or act as an expeditor in accessing services for the client/family. In addition, team members may be given information regarding the case prior to the meeting. This permits members to check their recorders and possibly bring additional information to the meeting.

This model is organized in much the same way as Model II, with the exception that multidisciplinary core staff are dedicated by their parent organizations to work as part of a service integration team as their primary job function.

**Process:** Because members of this team work out of the same office, and organizations involved in service integration have dedicated staff resources to this effort, there are often greater opportunities for building a cohesive team and focusing on systems change. There are also greater opportunities for informal support and problem solving which may not be as easily developed with Model II.

Depending on the procedures of these teams, each new case may go through a multidisciplinary team conference soon after the initial assessment is completed. The goal of this would be to maximize the input from the diverse expertise of the team and to possibly coordinate on developing the intervention/service plan. Some specific issues that may be discussed might include the delineation of roles and responsibilities of team members, the assignments of a primary case manager, and the decision of what other professionals/agencies need to be involved.

**Outcome:** This model provides the greatest opportunity for service integration which can engage families in the problem solving process. The model, overtime, may also offer the best approach to expediting service delivery for families and in formulating recommendations to “parent organizations” for systems improvements.

**Resource Commitment:** A considerable investment of time is needed to work out agreements and coordination among partner organizations which are willing to pursue this service integration model. Resources are needed allow dedication of staff to this project. Additionally, staff with expertise and the willingness to work collaboratively and “think out of the box,” must be recruited for the project. Union issues regarding change of job duties may have to be resolved. Adequate support and training must be provided of the team to assist in team building and the development of common procedures and protocols for enhancing the service integration effort. In many models a team consultant or supervisor is utilized who can focus on training, team building work with partner organizations on “systems issues and resource sharing” needed to make the integration successful.

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