

Multidisciplinary Contributor Map

A multidisciplinary contributor map ensures that all team members involved in patient care understand their roles, responsibilities, and communication pathways. This guide provides a step-by-step approach for building and applying a contributor map in your organization.

1. Define Essential Contributors

The first step is to identify all key contributors to care coordination. These often include:

- RN Care Managers
- Behavioral Health (BH) Clinicians
- Peer Support Specialists
- Community Health Workers (CHWs)
- Primary Care Providers (PCPs)

Clearly identifying contributors ensures that the right professionals are engaged in care delivery, with recognition of the unique perspectives each discipline brings.

2. Clarify Roles to Avoid Duplication

Role clarity is critical for avoiding overlap and ensuring accountability. Develop a matrix or chart that outlines responsibilities for each contributor type. For example, RN Care Managers may focus on clinical follow-up and medication adherence, while Peer Support Specialists provide motivational support and engagement.

3. Map Communication Pathways

Establish how information will be shared across the team. Communication pathways can include electronic health records, case review meetings, team huddles, and secure messaging platforms. Mapping these pathways ensures that no information is siloed and that all contributors are aligned on patient progress.

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4. Train for Cross-Functional Understanding

Training should equip staff with a basic understanding of the roles and contributions of other disciplines. Cross-training fosters respect, reduces conflict, and encourages collaborative problem-solving. For example, clinicians may benefit from learning how community health workers address social determinants of health.

5. Use Technology-Enabled Collaboration Tools

Technology is a powerful enabler of collaboration. Use secure EHR systems, shared care plans, dashboards, and telehealth platforms to ensure real-time updates and coordinated care. Tools should be selected based on user-friendliness, compliance with regulations, and ability to integrate across systems.

Application in Practice

To apply the multidisciplinary contributor map in practice, begin by creating a visual diagram of all contributors and their roles. Facilitate a team session to validate and refine this map. Once established, use the map as a training tool for onboarding new staff and as a reference point in case reviews and team huddles.

Multidisciplinary Contributor Map – Touchpoint Workflow Example

Purpose: Ensure every member of the care team has clear points of contact and defined responsibilities at each stage of the patient journey.

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Workflow Table (Example):

Contributor	Primary Touchpoints	Communication Pathways	Frequency	KPIs / Outcomes
RN Care Manager	Medication reconciliation, chronic disease follow-up, hospital discharge follow-up	EHR care plan updates; weekly huddle notes	Weekly check-in; post-discharge within 48 hrs	90% med reconciliation within 7 days; ↓ ED visits
BH Clinician	Initial assessment, therapy sessions, crisis planning	Case review meetings; secure EHR messaging	Biweekly case review	75% clients with updated treatment plan
Peer Support Specialist	Engagement, recovery coaching, appointment reminders	Secure text / app; team huddles	2x monthly outreach	70% appointment adherence
Community Health Worker (CHW)	SDOH screening, resource referrals, follow-up on basic needs	Shared dashboard; cross-team EHR alerts	Monthly review	80% closed-loop referrals (housing/ food)
Primary Care Provider (PCP)	Annual physical, preventive screenings, med management	Direct EHR notes; quarterly case conference	Annual exam + as needed	↑ preventive screenings; ↓ hospitalizations

Process Flow Example

- 1. Referral / Intake** – RN Care Manager initiates assessment and assigns CHW for SDOH screen.
- 2. Initial Care Plan** – BH Clinician develops behavioral plan; PCP reviews physical health needs.
- 3. Ongoing Coordination** – Peer Specialist engages client; CHW tracks community referrals.
- 4. Weekly Huddles** – RN leads; each contributor reports updates and barriers.
- 5. Quarterly Case Review** – PCP, RN, and BH Clinician evaluate progress and reset SMART goals.