2015

An Appreciative Inquiry of an Exemplary Hospice Interdisciplinary Group Caring for Individuals With Alzheimer's Disease

Patricia Ozzie Dixon
Nova Southeastern University, dpatrici@mynsu.nova.edu

NSUWorks Citation
Patricia Ozzie Dixon. 2015. *An Appreciative Inquiry of an Exemplary Hospice Interdisciplinary Group Caring for Individuals With Alzheimer's Disease.* Doctoral dissertation. Nova Southeastern University. Retrieved from NSUWorks, College of Arts, Humanities and Social Sciences – Department of Family Therapy. (41)
https://nsuworks.nova.edu/shss_dft_etd/41.

An Appreciative Inquiry of an Exemplary Hospice Interdisciplinary Group Caring for Individuals with Alzheimer's disease

By

Patricia Ozzie Dixon

A Dissertation submitted to the
Graduate School of Humanities and Social Sciences of Nova Southeastern University
in Partial Fulfillment of the Requirements for the Degree of
Doctor of Philosophy

Nova Southeastern University

2015

Nova Southeastern University

Graduate School of Humanities and Social Sciences

This dissertation was submitted by Patricia 0. Dixon under the direction of the persons listed below. It was submitted to the Graduate School of Humanities and Social Sciences and approved in partial fulfillment of the requirements for the Degree of Doctor of Philosophy at Nova Southeastern University.

Approved:

5/11/2015
Date of Proposal

Anne H. Rambo, PhD

Christopher Burnett, PsyD

Robin Cooper
Robin Cooper, PhD

Anne H. Rambo, PhD
Chair

9/30/2015
Date of Final Approval

Acknowledgments

First and foremost, I give praises to my God, to whom all things are possible; without his help, it would have been impossible for me to have accomplished this enormous undertaking. Secondly, I thank everyone who has helped to contribute to the production of this dissertation. I would never have been able to finish without the guidance of my committee members, help from friends, and the support of my family and husband. I owe them a depth of gratitude one that I will cherish forever.

I would like to express my deepest appreciation to my chair, Dr. Anne Rambo. I have been amazingly fortunate to have a chair who gave me the push to explore on my own and, at the same time, the direction to get better when my steps weakened. I am thankful to her for reading and commenting on revisions of this dissertation. Her patience and constant support and prompt feedback helped me to finish this program. May God continue to bless her. It is my hope that one day I would be able to assist other students in some way as Dr. Anne Rambo has shown me her kindness and support.

I would like to thank Dr. Christopher Burnett, who has always been there to listen and encourage me to think on my own by asking me, “So what is the next best question?” I am deeply grateful to him for giving me respect to use my brains rather than giving me advice. I would also like to thank Dr. Robin Cooper for her insightful comments and constructive feedbacks at different stages of my dissertation. Her willingness to help and giving her best suggestions helped me tremendously to ease some of the stress that accompanied the task of completing a dissertation.

My friends prayed with me, supported me, and gave me encouragement during those times I felt like giving up would be easier. In times when I felt discouraged in completing this dissertation, my friend, Dr. Jacqueline Clarke who would say to me, “Let me reframe this for you: A dissertation is like a long journey to the top of a hill; when you reach the top, what a beautiful view looking down.” I am indebted to her for her continuous encouragement and prayers.

I am also indebted to all my professors and my classmates who have encouraged me throughout my class work, clinical, and examinations. I would like to acknowledge Dr. Arlene Gordon, Dr. Ron Chenail, Dr. Martha Marquez, and Dr. James Hibel, who always have encouraging words to help me to go another step further.

Many friends have helped me stay sane through these difficult years. Their support and care helped me to overcome setbacks and stay focused on my graduate study. I greatly value their friendships and I deeply appreciate their belief in my potential.

Most importantly, none of this would have been possible without the love and patience of my family, especially my husband, Calden, who supported and comforted me through challenging times. My mother Eileen McDonald Hynes and my sister Audrey Hynes Cammock to whom this dissertation is dedicated. Audrey has been a constant source of love, concern, support, and strength all these years to my mother and me. I would like to express my heartfelt gratitude to everyone.

Table of Contents

List of Tables

List of Figures

Abstract

Alzheimer's disease is a debilitating illness that is the 6th leading cause of death among the elderly. The treatment of Alzheimer's requires multiple interventions due to the complexity of the disease. The interdisciplinary group (IDG) model of care is considered a best practice for patients' medical management (Molyneux, 2001). The IDG focuses on a holistic approach, which includes both patients and their caregivers. The IDG in hospice consist of professionals from different clinical disciplines whose collaborative knowledge and skills assist in caring for patients and their families. This study focused on what works well in an exemplary IDG, using appreciative inquiry as the method of inquiry. Data were collected from 6 participants of an exemplary IDG caring for patients diagnosed with Alzheimer's disease. The data were analyzed using the appreciative inquiry 4-D cycle: Discovery, Dream, Design, and Destiny. In the Discovery phase, 10 themes emerged, showing connection to the Dream phase. The Dream phase led into the Design phase, focusing on *provocative propositions*, which bridge the best of *what is* with *what might be*. This then connected with the Destiny phase, bringing the dreams of the future to the present. I found that what works well with this exemplary IDG is the connection to other members of the team and the larger system; dedication; commitment; and valuing of team members, their patients, and patients' families. The findings suggested the need for increased training of marriage and family therapists for IDG settings as the systemic thinking of marriage and family therapy appears to be a good fit for the IDG.

CHAPTER I: INTRODUCTION

Background of the Problem

My experiences, beliefs, and values have consistently led me in the direction of caring for individuals who encountered challenges in their daily lives. Some of these challenges are related to physical, mental, emotional, or spiritual well-being. When faced with such circumstances, I am never too busy to help resolve the issues. Throughout my 30 years of nursing and as a family therapist in training, I have developed a sense of responsibility towards my patients/clients. For example, I watched a husband, who was married to one of my elderly patient for 60 years, anticipating her death from Alzheimer's disease. Daily, he watched his wife's deterioration from the progressive debilitating effects of Alzheimer's disease. He would sit at her bedside during his daily visits and cried. As I observed his tears and downhearted demeanor, I felt a sense of empathy, knowing that she was at her end of life. His attempts to communicate with her by tenderly stroking her hair and body while whispering into her ear seemed pointless because she was unable to respond. He showed his love and care towards his wife while coping with his own circumstances. In instances like these, I find myself combining both my nursing and family therapy training to assist individuals to process, accept, and resolve their challenges. In addressing patients/clients, I am curious about how to best integrate hospice nursing with marriage and family therapy interventions.

My curiosity about incorporating both nursing and family therapy interventions is not only professional but also personal. Eleven years ago, my mother was diagnosed with Alzheimer's disease. Since her diagnosis, my siblings and I have become the caregivers. Our collaboration with her care helped us to cope with her progressive deterioration. In the earlier stages, she had good and bad days. When she was lucid, those days were difficult days, because she would verbalize, “I am losing it.” In those times, she became terrified of losing her memory and independence. Her biggest fear was being institutionalized: One day, she said to me, “I want my children to promise me that if I can no longer take care of myself not to place me in an institution.” Her children honored her wishes. As time passed, I became more aware of the effects of Alzheimer’s disease on the mental processes within an individual. With my mother’s deteriorating health, she confided in me that on some days, she felt lost and just wanted to go home to her mother, not realizing that her mother had died over 30 years ago. To have gained insight of what she was experiencing, my heart often sank into my chest as I tried to imagine her feelings of loss. The worsening of her memories was also accompanied by behavioral changes. For example, at times she became very argumentative and aggressive. The doctors informed us that Alzheimer’s disease is incurable and debilitating changes are inevitable. Although I am a nurse, working with the Alzheimer’s disease patients, I am finding difficulties accepting the changes personally.

Over the past 11 years, there has been a decline in not only my mother’s health but also my health. As an offspring of the Baby Boomer era with the societal expectation that children assume caregiving responsibilities of their elderly parents, I have often felt burdened keeping up with the role as a caregiver. Additionally, maintaining full-time employment, school, taking care of my spouse and children caused me at times to feel overwhelmed. My mother has had multiple hospitalizations and with my own family, school and work responsibilities increasing demands have been placed on my entire family system. With all these challenges my spouse, children, and siblings experienced, we continue to feel blessed that our mother is physically here.

My experiences with caring for individuals with Alzheimer's disease place me in the position to hear other people's stories that have loved ones with this illness. Some of the stories have similarities to my family's experiences. These stories are sometimes filled with feelings of gratitude and accomplishments whereas others are filled with challenges and resentments. In dealing with varied perspectives, I became an advocate for individuals living with Alzheimer's disease. My advocacy also allows me to manage the caregiving responsibilities of my mother. Through, advocacy and facing my personal experiences, my beliefs have been reinforced that people do the best they can in the situation presented. Hence, accepting such guided beliefs I am becoming more aware that patients/clients and caregivers can be assisted from a position of hopelessness to one with different outcomes through reframing their problem stories. These stories include finding treasures such as humor and joy in precious memories experienced. By engaging in conversations of treasured memories, caregivers come to understand that enjoying the presence with the person living with Alzheimer's disease can be joyful, peaceful, meaningful, and fulfilling, that allow for the expansion of stories.

The Prevalence of Alzheimer's disease in the United States

Alzheimer's disease is of growing concern in the United States. The disease is recognized as a terminal illness and is prevalent among the elderly. Although, aging is not the cause of Alzheimer's, the elderly population is the most vulnerable predisposed to this debilitating brain disease (Khachaturian & Radebaugh, 1996). The rapid growth of the disease affects not only societal dynamics but also the family structure (Neal & Hammer, 2007). The disease is a gradual deteriorating process that includes loss of cognitive abilities, fine motor skills, eventually resulting in total loss of body functions (Jivanjee, 1995).

Currently, there are 5.1 million individuals living in the United States who have been diagnosed with Alzheimer's disease (Alzheimer's Association' 2013). Prior to the 5.1 million affected by this ailment, there were 15.4 million caregivers who provided more than 17.5 billion hours of unpaid care. Overall, it was estimated that care for individuals with Alzheimer's disease was valued at $216 billion. It is also customary that these family members that provided care assumed responsibilities without monetary compensation (Alzheimer's Association, 2013; Fradkin & Heath, 1992). With the enormous amount of caregiving responsibilities, caregivers are impacted psychologically, physically, and financially (Grumbach & Bodenheimer, 2004). The sources of stress vary according to the caregiver's own situational stressors, such as the caregiver's illness, physical or financial well-being, or problem with conflicting responsibilities of work or children (Light & Lebowitz, 1990). Thus, caregivers are faced with all the challenges that accompany the individual diagnosed with Alzheimer's disease, although they each have different experiences.

These overwhelming challenges on caregivers can overtly be manifested in verbal abuse that challenges both patients and other caregivers (Amirkhanyan & Wolf, 2003; Post, 2005; Schulz & Martire, 2004). In an effort to understand these challenges experienced caring for a family member with Alzheimer's disease, it is important to know that reactions to the anticipatory loss are displayed in varying ways. Many receive the diagnosis with reactions of shock, disbelief, and feelings of loss, and others receive the diagnosis as part of the aging process. Caregivers may therefore display trauma, feelings of loss, and a sense of responsibility or obligation as their parents/family members become dependent on others for their daily basic needs. Thus, these newly diagnosed families are in need of guidance, support, and education with which they can begin to incorporate the care of the individual with Alzheimer's disease into their family systems.

Some families invest their time, energy, and resources in looking for information to manage their situations and others just want the situation to go away. Many caregivers do not understand the progression of the disease and wonder what will happen should they die before the individual with Alzheimer's disease dies. These thoughts foster feelings of fear, loneliness, helplessness, resentments, doubts, and betrayals, which cause them to think no one understands their pain. In contrast, caregivers who have poor relationships with the care recipients and have to deal with signs of dementia become angry, frustrated, and stressful in their roles as caregivers (McAllister, Perry, & Parcel, 2008). In general, caring for individuals with Alzheimer's disease is an ongoing adjustment process within the family structure.

Role Change Within the Family Structure

From a systemic perspective, individuals diagnosed with Alzheimer's disease strongly impact the structure in family dynamics, challenging family members to adjust to new roles. Challenges may include role reversal when a child assumes the responsibility caring for a parent, which at times evolved into caregivers', desiring to rid themselves from the burden of care. Personally, I had an experience conversing with a daughter who felt burdened and anger about caring for her mother. She expressed, "Why isn't she dead yet? Can't you just give her some morphine and end it? She wasn't a good mother, anyway." In another case, a son who was the caregiver displayed anger by removing himself from his mother's care. He instructed the nurses, "Do not call me under any circumstance unless it is death."

On the other hand, there are caregivers who display unrealistic expectations. In one case, a daughter displayed a gamut of emotions, namely powerlessness and guilt. She felt powerless as her father's condition deteriorated cognitively and physically. Her father lost the ability to speak, smile, or walk. Over time, he deteriorated beyond the point at which he was unable to sit up without support. She expressed her guilt by saying, "I am so fat and he is just fading away." In actuality, she was not obese but felt helpless to stop the progression of her father's decline. Her father earlier made a living will declaring his wishes not to be kept alive by artificial means. Therefore, I could reframe her troublesome feelings to help her become aware of the thoughtfulness of her father relieving her of the burden to make his health care decisions. As a result, her feelings of guilt and helplessness were alleviated, as her perceptions shifted to new meanings.

By being empathetic to patients/clients' voices, my compassion and curiosity assist in shifting them to different perspectives fostering new meanings. By assisting them to generate brand new meanings, I gain more understanding that professionals and/or family caregivers, approach caregiving responsibilities in varying ways (Martire, Lustig, Schulz, Miller, & Helgeson, 2004). Thus, the success of providing care for individuals with Alzheimer's disease relies on the collective efforts and less on the fragmentation in health care services. As Alzheimer's disease is a growing concern in U.S. society, it is necessary that health care providers become more aware of how their collaborative efforts impact health care systems.

Purpose of the Study

Interdisciplinary model of care is outlined by the Medicare Condition of Participation. This is a universal phenomenon of the postmodern era that allows for the collaboration of health care agencies such as hospices. These agencies integrate patients' rights, comprehensive assessments, interdisciplinary groups (IDGs), care planning, and coordination of services, which include family care and external agencies involvements to achieve quality assurance in health care (Edmondson, 2003; Manser, 2009; Reese & Sontag, 2001; Thomas, Sexton, & Helmreich, 2003; Wittenberg-Lyles & Oliver, 2007). From my experience as a nurse, I have seen IDGs' interactions and collaboration have been practiced in a variety of settings other than hospice. Manser (2009) noted that group collaboration explored several aspects of IDGs, which include the nature of group interaction, discourse among group members, leadership style, and group effectiveness. However, the study indicates that there is a lack of research on what works well among the IDG members in hospice care (McCallin, 2001). The purpose of this study was to address the gap in the literature by allowing the voices of an exemplary IDG to be heard in accordance with what works well among them caring for individuals with Alzheimer's disease in hospice care setting.

Focus of Chapters

Chapter I provided a brief overview of my interest and experiences with the Alzheimer’s disease population in hospice care. It discussed the prevalence of Alzheimer’s disease in the U.S. population. Additionally, it showed the importance of collaboration about health care staff, external agencies and family members. Chapter II reviews the literature regarding the historical overview of Alzheimer’s disease; the significant problems of Alzheimer’s in the elderly population, and the impact of Alzheimer’ disease on society and caregivers. Additionally, it explores literature about caregiver’s distress and the necessity of developing strategies for dealing withcaregivers’ emotional burden, such as depressive disorder’s prevention and self-management through social support and involvement in support group activities. It also describes characteristics of the IDG in treating individuals with Alzheimer’s disease. The chapter identifies the scarcity in the literature in relation to the limitation of research carry out on the voices of the IDG members in hospice setting. Chapter III describes the research methodology used in investigating what works well with exemplary IDGs’ caring for individuals with Alzheimer’s disease. It provides information about the methodology, role of the researcher, participants’ selection, procedures, data collection, and data analysis, as well as data validation.

In Chapter IV, I present the analysis from six face-to-face interviews. The data were analyzed using a qualitative appreciative inquiry. The transcripts of the six participants interviewed along with my observations in the field were coded and categorized by themes to identify what works well with exemplary IDGs caring for individuals with Alzheimer’s disease. Simultaneously, as I analyzed the data, I refer to the literature discussed in Chapter II to determine how the findings from this study provided additionally information to existing research of IDGs in hospice and the collaborative process between patients and caregivers with Alzheimer’s disease.

In Chapter V, I present the significance of the study and relevance to the population. Additionally, I provide some implications for prospective research, practice, and training, for clinical professionals such as marriage and family therapists, in a hospice care setting. Also, I examine the limitations of the study through analyzing the voices of the members of exemplary IDGs.

CHAPTER II: REVIEW OF THE LITERATURE

Alzheimer’s disease has become a national concern due to the growing elderly population in the United States. Although the disease is not age related, it occurs more frequently among the elderly (Khachaturian & Radebaugh, 1996). The improvements in standard of living and medical advancement have contributed to reduce mortality and increase in the aging population. Consequently, the growing elderly population has seen the prevalence of Alzheimer’s disease in the society, which has impacted the health care and family systems in the United States. The prevalence of the disease in the society has served to inform health care professionals in examining alternative practices to maximize care for individuals with Alzheimer’s disease (Demiris, Washington, Oliver, & Wittenberg-Lyles, 2008). Simultaneously, family members caring for individuals with Alzheimer’s disease explore avenues to manage stressful situations; leading them to discovering the benefits from sharing their feelings with mental health professionals experienced in the area of dementia (Neal & Hammer, 2007). As a result, there has emerged an acceptance for interdisciplinary groups (IDGs) to care for individuals with Alzheimer’s disease and their family members.

This paper focuses on what works best for IDGs. The chapter discusses and defines the stages of Alzheimer’s disease, and its debilitating effects upon the individual. It shows literature review on Alzheimer’s disease treatment and its effects on society and on the Baby Boomers who usually take over the role of caregivers. Additionally, the chapter evaluates psychological challenges caregivers’ experience, and the benefits of caregivers’ support group. In addition, the definition of IDG, clinical professionals, best practices, the collaborative process, effectiveness, and challenges of the team caring for individuals on hospice with Alzheimer’s disease are discussed. The chapter ends with discussing the relevance of marriage and family therapy to IDG teams in enhancing training and competence in both fields. Although Alzheimer’s disease is an incurable disease, there are treatment options available to improve the quality of life. However, when all treatment modalities are exhausted, individuals who battle with this terminal illness are usually referred to hospice services for end-of-life care. The term *hospice* was originally applied to specialized treatment for chronically ill dying individuals (Saunders, 2000). In 1948, physician Cicely Saunders began the first hospice house named St. Christopher Hospice in London, England. Saunders eventually went on to create the initial modern hospice comprising of different disciplines. In 1963, Saunders introduced through lecture sessions this specialized care for the dying when she visited Yale University in the United States. She lectured medical students, nurses, social workers, and chaplains on topics of the dying patients and the idea of holistic care for the dying (National Hospice & Palliative Care Organization, 2013). As a result, the philosophy of holistic care in hospice was later adopted in the United States.

Holistic approach involves caring for terminally ill patients physically, mentally, emotionally, and spiritually using different disciplines within hospice services. Health care providers’ implemented strategies to integrate all disciplines into patients’ care. The integration of these disciplines was intended to promote success in providing quality health care rather than fragmented services. Thus, the Medicare Condition of Participation was developed as a foundation to guide hospices on what was necessary to maintain patients’ rights through the collaboration of IDGs. The IDG idea extended to multiple types of terminal illnesses, which include cardiovascular disease, cancer, cerebrovascular accident, renal failure, and Alzheimer's disease.

According to the Alzheimer's Association (2013), Alzheimer's disease is the seventh major cause of death amongst the elderly. The difference between Alzheimer's disease and other chronic illnesses is that after diagnosis, the individual can live for over 13 years (Alzheimer's Association, 2013). However, the quality of life decreases as the disease progresses. The progression is mainly seen in the brain, as acetylcholine neurotransmitters is diminished, causing damage to the central nervous system. The losses within the central nervous system are related to the severity of symptoms that individuals with Alzheimer's disease experience. Therefore, the progression of Alzheimer's disease is seen in stages.

Stages of Alzheimer's Disease

Alzheimer's disease progresses through seven stages. At each stage, the individual become more debilitated. However, not everyone will experience the same symptoms of progression.

Stage 1

This is the earliest stage of the disease, in which no impairments are noticeable so memory problems may not be apparent. However, memory problems are typically the first warning signs (Alzheimer's Association, 2013).

Therefore, an interview with a medical professional may show some symptoms associated with dementia.

Stage 2

This stage shows mild cognitive decline as seen in early signs and symptoms of Alzheimer’s disease, although these could also be age related. Symptoms associated with this stage usually manifest into memory lapses—forgetting familiar words or the location of everyday objects. At this stage, the physician may place individuals on a regimen of medications to slow the progression of the disease. Medications prescribed may increase concentrations of acetylcholine, leading to increased communication between the nerve cells. This may temporarily slow or stabilize the progression of the symptoms of Alzheimer’s disease (Alzheimer’s Association, 2013).

Stage 3

At this stage, Alzheimer’s disease can be diagnosed in some individuals, but not everyone exhibits symptoms of increase cognitive decline. During a detailed medical interview, physicians may be able to detect a problem in memory or concentration. The most common difficulties noticeable are recalling recent events. For instance, a person at this stage usually has trouble remembering newly introduced persons or events and increasing difficulties with daily routines, planning, or organizing (Alzheimer’s Association, 2013).

Stage 4

At Stage 4, moderate cognitive decline is noticeable. A thorough medical interview can more easily detect symptoms of forgetfulness of recent events. Individuals show impaired abilities to perform challenging mental arithmetic, such as counting backward from 100 by 7s. In addition complex tasks, such as planning dinner for guests, paying bills, or managing finances becomes more difficult. Individuals also show forgetfulness about personal history. In some situations, they become moody or withdrawn, especially in socially or mentally challenging situations (Alzheimer's Association, 2013).

Stage 5

At this stage of Alzheimer's disease, moderate to severe cognitive decline is noticeable. More attention is given to assisting those at this stage with day-to-day activities as they experience gaps in their memory. However, no assistance is needed with eating or using the toilet. Also, individuals at this stage may be unable to recall their own addresses or telephone numbers. They become more confused—less oriented to place and time. However, they remember significant events about themselves and their family (Alzheimer's Association, 2013).

Stage 6

Extreme cognitive decline is noticeable. Individuals' memories at this stage continue to worsen. They exhibit personality changes and require extensive help with daily activities. With progression of the disease, they sometimes remember their own names but have problems remembering their personal history.

Stage 7

In this stage of the disease, increases in severity of cognitive declines are noticeable. For example, the inability to respond to their environment is lost. Atrophy (shrinking) of the brain occurs and verbal communication becomes incoherent. Individuals in this final stage will need help with much of their personal care, including eating or using the toilet. They lose the ability to smile, sit without support, and hold their heads up. Their reflexes become abnormal, muscles grow rigid, and swallowing is impaired. They regress to a state with infant-like symptoms. They are completely dependent on others for care. When nearing the end of life, a person may be in bed most or all the time as the body shuts down (Alzheimer’s Association, 2013). No more treatment options are available as the progression of the disease follows the natural process, resulting in death.

Treatment for Alzheimer’s disease

At present, there is no cure for Alzheimer’s disease. On average, about 50% of those who take medications prescribed for Alzheimer’s show a reduced progression of the disease process (Alzheimer’s Association, 2013). Currently, the U.S. Food and Drug Administration have approved five drugs that temporarily slow the worsening of symptoms for about 6 to 12 months. These drugs are categorized into two forms of drug therapies; however, each drug works differently (Alzheimer’s Association, 2013). There are cholinesterase and memantine inhibitors. Medications such as Aricept, Exelon, Razadyne, and Cognex are used in the therapy as cholinesterase inhibitors, which address cognitive symptoms of memory loss, confusion, problems with thinking, and reasoning. The memantine inhibitor therapy is Namenda, used in the latter stage as the disease progresses. Unfortunately, as the disease reaches the final stage, all medications are discontinued and the disease follows the natural progression until death (Alzheimer’s Association, 2013).

Alzheimer's and Its Effect on Society

In the United States, the average life expectancy is 80 years (Khachaturian & Radebaugh, 1996). Khachaturian and Radebaugh (1996) estimated that over a period of 20 years, individuals with Alzheimer's disease would double as the population gets older. One of the contributing factors of the population getting older has to do with the advancement of medical technology, resulting in better medical management for the elderly (Khachaturian & Radebaugh, 1996). Consequently, more people will die from progressive chronic conditions rather than severe medical complications. Therefore, the phenomenon of people living longer will place tremendous increase on the needs for long-term caregivers, such as those caring for individuals with Alzheimer's disease. Presently, the Alzheimer's Association (2013) estimated that 5.3 million of all ages have Alzheimer's disease. Current statistics shows that 5.1 million people ages 65 and older develop the disease. The Alzheimer's Association estimated further that another 500,000 younger than 65 years old are diagnosed with Alzheimer's and other dementias. Of these individuals, approximately 40% are estimated with Alzheimer's disease (Alzheimer's Association, 2013).

More women than men have Alzheimer's disease because women live longer than men (Alzheimer's Association, 2013). Such longevity of women contributes to the factor of gender discrepancies (Alzheimer's Association, 2013). This disparity and the rapid aging of the population due to longevity influences society, with skyrocketing health care costs plus shorter hospitalization leaving families and other informal caregivers to substitute for formal health care. Consequently, caregivers find themselves in a position that requires readjustment of their lives, social relationships, and their finances to meet their new demands (Casarett, Crowley, & Hirschman, 2004). Neal and Hammer (2007) indicated that the majority of the caregivers' roles fall mainly on the child or children of the individual with Alzheimer's disease. Thus, the rapid growth of Alzheimer's disease affects the dynamics of not only the family structure but also society.

Alzheimer's and Its Effects on Baby Boomer Caregivers

Neal and Hammer (2007) noted that because of the high cost in caring for terminally ill individuals, there is increasing reliance on family members taking on the roles as caregivers. The roles of family caregivers, specifically caring for the individual with Alzheimer's disease, are multifaceted and require many services. Services may include receiving adult social services, home day care services provided by doctors and nurses, as well as hospice's service (Neal & Hammer, 2007). Generally, individuals with Alzheimer's disease have multiple challenges that are interrelated. Among significant challenges is that most physicians are less likely to spend time on cognitive problems, deemed untreatable (Grumbach & Bodenheimer, 2004). In addition, primary care physicians avoid being too involved with interventions about behavioral symptoms due to the long-term nature of and lack of information relating to managing patients with Alzheimer's disease (Grumbach & Bodenheimer, 2004).

The typical individual diagnosed with Alzheimer's disease need 24-hour, round-the-clock care. Thus, families may choose different types of care for their loved ones. For instance, some families choose institutionalization as the best care whereas others prefer and are capable of caring for their relatives at home. Neither of these prevents caregivers' burdens or stressors. Caregivers solely responsible for relatives at home are faced with daily tasks of rendering care. On the other hand, those who place relatives in institutions may shift caregiving, but are faced with the responsibilities of visiting their relatives in nursing homes, dealing with health care staff, and doctors as they seek assurance for the best possible care (Szinovacz & Davey, 2008).

A large number of the elderly population has become a legacy for Baby Boomer family caregivers. Most of these caregivers are middle-aged daughters and sons. These caregivers find themselves taking care of their elderly family members with Alzheimer's disease for greater than 46 hours per week. Moreover, due to the demands for the care recipient, over 50% of these caregivers reported feeling that they were on duty for 24 hours daily (Arno, Levine, & Memmott, 1999). Many of these Baby Boomers had to end their employment due to the demands of caregiving. They also experience high levels of depressive symptoms while providing care for their relatives with late-stage Alzheimer's disease (Schulz et al., 2003).

When a child assumes caregiving responsibilities for a parent with Alzheimer's disease, the relationships between family members as well as the family roles may be altered. The role of caregiver is generally assumed by a daughter, but as the elderly population increases, sons are seen to be getting more involved in their parents' care (Briggs, 1998; Campbell, 2010). As a result, there is significant interference with the leisure patterns of the family system. Consequently, caregivers find themselves in positions requiring readjustments in their social relationships, finances, and other life issues (Casarett et al., 2004). Additionally, with the advance progress in medical science, nutrition, and lifestyle changes, multigenerational relationships within families have become more widespread (Delgado & Tennstedt, 1997). This may intensify role expectations within families, resulting in stressors or conflicts.

As the stages of Alzheimer's disease progress, increasing levels of care are required (Cohen, 2000). With the length of time, caring for a family member from diagnosis to the late stage of the disease, caregivers encountered stressful demands in behavioral problems, which include dementia associated with the progression of the disease (Cohen, 2000). In the past decade, caregiving has been intensely studied, but with the exception of a few studies, little attention has been paid to the impact on caregivers providing end-of-life care to family members whose illness progress to dementia (Schulz et al., 2003). The literature also indicated limited research on the impact of bereavement on caregivers (Schulz et al., 2003). Schulz et al. (2003) conducted a study with 1,222 pairs of caregivers and recipients enrolled in the Resources for Enhancing Alzheimer's Caregiver Health. This study tested the feasibility of numerous psychosocial interventions and their impact on the health and well-being of caregivers caring for persons with Alzheimer's disease (Schulz et al., 2003). The results showed that 90% of caregivers believed that death came as relief to the patient and 72% believed that death of the patient was a relief to themselves (Schulz et al., 2003). Most of the caregivers (68.5%) stated they were prepared for the patient's death and 21.4% used bereavement-related services after the patient's death (Schulz et al., 2003).

Schulz et al. (2003) noted that illnesses and disabilities can cause emotional distress, impaired self-care, and biological vulnerability in caregivers. Health issues experienced by caregivers can be attributed to caring for recipients, suffering from physical disabilities, cognitive impairments, and behavioral problems (Schulz & Martire, 2004). In support of these challenges, published studies concluded that the illnesses of the care recipients have a negative effect on the emotional well-being of caregivers (Amirkhanyan & Wolf, 2003; Post, 2005; Schulz & Martire, 2004). However, Schulz and Martire (2004) pointed out that there are considerable inconsistencies in the literature in relation to caregivers' illness-related challenges.

Caregivers' Psychological Experiences

Caregivers often experience psychological distress due to the severity of the cognitive and behavioral challenges of care recipients with Alzheimer's disease (Robinson, Adkisson, & Weinrich, 2001). As the disease progresses, caregivers may be faced with several years of caregiving, based on the stage of the disease. The way caregivers handle these cognitive and behavioral challenges will determine their psychological well-being. If the disease progression happens over a number of years, caregivers may be exposed to physical and mental stresses. Some of these mental stressors include depression, anger, agitation, paranoia, and delusional ideations. However, caregivers are also faced with emotional stressors in having to carry out daily activities for care recipients, such as bathing, feeding, toileting, financial, and other legal obligations (Robinson et al., 2001).

These mental and emotional stressors are sometimes manifested in psychological and psychosomatic illnesses among family caregivers (Robinson et al., 2001). In a quantitative study, Robinson et al. (2001) used the Revised Memory and Behavior

Problem Checklist to examine the relationship between specific type of problematic behaviors and the total impact experienced from caregiving. The researchers discovered significant correlation with caregivers' well-being in relation to their reactions to the problem behaviors towards individuals with Alzheimer's. Additionally, it was discovered that both male and female caregivers reported similar frequencies of problem behaviors caring for individuals with Alzheimer's disease; however, female caregivers react with greater levels of sensitivity towards disruptive and depressive behaviors than male caregivers (Robinson et al., 2001). Overall, the researchers proposed that caregivers, especially women, need to receive specific individualized education and training to manage their psychological well-being while caring for individuals with Alzheimer's disease (Robinson et al., 2001).

Caregiver Support Groups

Steffen and Mangum (2012) noted that caregivers support groups that lack social support have been linked to major depression in caregivers of individuals with Alzheimer's disease. Through a self-reported longitudinal study involving two interviews conducted over a 6-month period, Steffen and Mangum examined the predictors of dementia family caregivers who attended support group's meetings. Attendees were assessed for perceptions of similarity between themselves and other members, depressive symptoms, perceptions of social support, support group facilitator, and other members. The study concluded that caregivers who attended support group meeting at least twice per month, benefited from group interaction, developed problem-solving skills from group members with similar issues in managing the care of their family members with

Alzheimer’s disease; which led to decrease depressive symptoms (Steffen & Mangum, 2012). However, the study showed that those who attended one meeting showed a higher level of depressive symptoms. Support groups therefore shown to be important to the well-being of caregivers (Steffen & Mangum, 2012).

Additionally, Alzheimer’s support group providers’ assist families with support as well as instrumental in supporting individuals at early stages of the disease. Snyder, Jenkins, and Joosten (2007) proposed that support groups provides a forum for socialization and learning for individuals with mild to moderate Alzheimer’s disease as well as support to caregivers. Individuals attending these support groups discuss everything, from life stories to new medication available to treat the disease. Moreover, support groups do not necessarily focus on the manifestations of the disease but rather how to overcome the emotional toll on caregivers. Thus, these support groups enhance the family’s well-being and reduce stressors in assuming caregiving responsibilities (Snyder et al., 2007).

Mittleman, Roth, Coon, and Haley (2004) noted that support group interventions were also paramount to alleviating psychological distress caregivers experienced during caring for an individual with Alzheimer’s disease. Furthermore, these researchers noted that sometimes the psychological distress of caregivers persist after the death of the care recipient (Mittleman et al., 2004). Mittleman et al. studied 406 spouse caregivers of Alzheimer’s disease patients who lived at home to determine the long-term effects of counseling and support on symptoms of depression. The participants were divided into two equal groups: Two hundred and three caregivers received enhanced counseling and support treatment and the other group received no treatment. Caregivers that were assigned to the support groups received six sessions of individual and family therapy and agreed to attend support group for 4 months after their enrollment. The Geriatric Depression Scale was administered at baseline and at follow-up periods for as long as the caregivers continue to participate in the study. In the 1st year, caregivers who received supportive treatment showed a gradual decrease with depressive symptoms and the controlled group that did not receive any support group treatment showed a gradual increase of depressive symptoms.

According to Kim, Chang, Rose, and Kim (2012), burdens that caregivers experience are defined as a multiple dimensional response to the negative appraisal and perceived stress resulting from taking care of individual with Alzheimer's disease. These negative appraisal and perceptions threaten caregivers' physical, psychological, and emotional well-being (Kim et al., 2012). Kim et al. argued that several caregiving-related factors were associated with caregivers' burden, such as the types of tasks performed and the level of support available. Thus, caregivers who have little or no access to supportive resources show greater risk to their physical, psychological, and emotional well-being (Kim et al., 2012). Consequently, the systemic impact Alzheimer's disease poses to the entire family necessitates the holistic approach of an IDG.

The Interdisciplinary Group

Alzheimer's disease has a negative impact on care recipients and caregivers. Molyneux (2001) suggested that the best practice to treat chronic illnesses is through collaboration of an interdisciplinary group (IDG). Shortell et al. (2004) argued that coordination of care for the chronically ill individual requires effective communication among the medical members providing care. Strong team leadership and an appreciation of the role among multiple disciplines allow for productive interactions between informed patients and better prepared health care professionals (Shortell et al., 2004). When patients and their caregivers are more informed about their treatment plan, the IDG's delivery of care will be more effective (Martire et al., 2004). Notwithstanding, the complexity of medical management and/or poor IDG collaboration can negatively affect the delivery of health services and patient care. Thus, IDG interventions must address their strengths and challenges in order to improve professional practice and health care outcomes (Zwarenstein, Goldman, & Reeves, 2009).

The Medicare Hospice Benefit Act mandated the use of IDGs to manage complex issues of chronically ill individuals namely those with Alzheimer's disease. The act provided specific federal guidelines that required hospice agencies to adopt an interdisciplinary approach to patient care. According to federal guidelines, patient care must be coordinated and consist of at least four core disciplines: a physician, nurse, social worker, and chaplain (Demiris, Oliver, & Wittenberg-Lyles, 2009). The interdisciplinary collaboration, therefore, became an important component in the delivery of care, which was standardized in hospice services (Demiris et al., 2008). Standardization of care required the IDG holding weekly meetings to discuss treatment plans and case management (Demiris et al., 2008). Although, the IDG is an important component in hospice care, there are limited studies pertaining to how clinical professionals use their expertise to derive the best possible outcomes through collaboration (Manser, 2009).

Arnold et al. (2011) noted that collaboration between registered nurses and physicians have shown to reduce morbidity and mortality rates. Besides the reduction in morbidity and mortality rates, collaboration, also reduces the cost of care, medical errors, and job satisfaction (Arnold et al., 2011). Collaboration also provides patients and their family in managing changes. As change occurs, patients and families desire to be kept informed and actively involved in medical decision making (Abramson & Mizrahi, 1996; Davidson et al., 2007). Such medical decision making generates social and economic changes which impact interdisciplinary teamwork and collaboration in health care. Abramson and Mizrahi (1996) noted that the viability of health care relies on effective collaboration of the IDG. Currently, IDGs are implemented in emergency rooms and on surgical and critical care teams in which health care providers have a clear understanding of treating patients holistically. The concept of treating patients holistically incorporates patients' cultural, bio-psychosocial, and spiritual beliefs in their care plans (Davidson et al., 2007).

In addressing the complexity of chronically ill individuals such as those with Alzheimer's disease, Connor, Egan, Kwilosz, Larson, and Reese (2002) believed that consideration of the whole person in the social context should factor in their treatment plan. As such, addressing their bio-psychosocial and spiritual beliefs offer tremendous benefits to their end-of-life care. Therefore, one may proffer the argument that the IDG of professionals fit well in drawing from each domain of their expertise. The IDG being an essential aspect of today's organizational culture operates within a resource-rich environment of multiple cultural orientations. This allows for their expertise to be a complementary contribution with the environment of patient-focused care (McCallin, 2001). Within the organization of hospice, the ability to share resources plays a vital role in the care planning process and the coordination of resources to other members of the group.

The expertise of different medical professional contributes to the well-being of patients' health reforms. These reforms include standards of practice, equal access to free delivery of care within an integrative organizational culture (McCallin, 2001). In addition, weekly meetings with the IDG collaborates the care planning for each patient and family. These meetings are so critical that the Medicare Conditions of Participation mandated not only the frequency but also the composition of the team (Oliver, Demiris, Wittenberg-Lyles, Porock, & Collier, 2010). Team members gather in the hospice office for 4 to 5 hours weekly discussing each patient's care plan (Oliver et al., 2010). Wagner (2000) contended that chronically ill patients would benefit from a care team, which includes clinicians and educators. These professionals should possess self-management and organizational skills with an understanding of team functions as well as public health principles and approaches. Such understanding of team functions would facilitate the maximization of best practices among IDGs (Wagner, 2000).

Best Practice in Caring for Chronically Ill Patients

Best-practice care for chronically ill patients encompasses treatment that enhances comfort and improves the quality of care for patients during the last phase of life. When quantity of life is known to be limited, quality of life becomes a primary goal of care (Kinzbrunner & Policzer, 2011). Quality of life focuses on comfort measures rather than curative measures. Thus, best practice in the clinical arena falls under clinical governance, which examines the entire patient and caregiver's experience. This governance covers all aspects of health, which ranges from hand washing technique, pain management, psychosocial challenges, and spiritual issues (Grol & Grimshaw, 2003). Best practice also allows patients to be involved in the decision-making process that is crucial to meeting their needs. These needs encompass concerns or complaints that must be attended to immediately (Grol & Grimshaw, 2003). Thus, one may argue that best practice is a continuous quest for improvements, involving research and practices to find out what works best in caring for patients with chronically illnesses.

There is no specific therapy excluded from consideration. However, the complete care of the patient lies in the agreement between the individual's primary physician, the hospice IDG, and primary caregivers. The expected outcome is designed not to focus on curative measures but rather to meet the patient's and family's goals in relieving distressing symptoms of pain while enhancing the quality of life. The patient is of paramount importance, and the patient's choices and decisions regarding care are also vital and must be followed (Kinzbrunner & Policzer, 2011; National Hospice and Palliative Care Organization, 2013).

The Medicare Hospice Benefit Condition of Participation was established in 1983 to provide Medicare beneficiaries with access to be high quality end-of-life care. Therefore, the Medicare Hospice Benefit Condition of Participation is considered the model of quality care for people facing a life-limiting illness. Hospice is a patient centered, cost-effective system of care that utilizes an interdisciplinary team of health care professionals to provide compassionate care. This also includes expert medical care, pain management, emotional, and spiritual, especially tailored to the patient’s needs and wishes. It is the hospice philosophy that each person has the right to die pain free, with dignity, and that families will receive the necessary support through the anticipatory grieving process. Thus, the interdisciplinary team of professionals is responsible for the care of each hospice patient and their loved ones (Kinzbrunner, & Policzer, 2011; National Hospice and Palliative Care Organization, 2013).

An IDG team ensures that critical elements of care are addressed by all members, as well as collaboration with a patient’s primary physician, who may not have the training or time to competently perform end-of-life issues. These issues include population management; protocol-based regulation of medication, self-management support, and intensive follow-up (Wagner, 2000). Thus, health-related quality-of-life best practices are designed to assess the impact of illness or treatment of the patient’s well-being (Kinzbrunner & Policzer, 2011).

Mickan and Rodger (2000) proposed that teams are viewed as a three-stage system, in which members pass on information (input), maintain internal processes (throughput), and produce specific results (output). Additionally, Mickan and Rodger noted that the characteristics of an effective team consist of three levels: individual, organizational, and team functions. Therefore, it is important that optimal individual function, supported by organizational function contributes to an environment that promotes effective teamwork. Teamwork requires a clear purpose within the context of health care incorporating specific groups of clinical professionals that are knowledgeable about all aspects of patient care. Furthermore, Ferrell (2004) proposed that in order to advance the science of end-of-life care, it is necessary for clinicians to have a foundation of clear domains and variables to enhance research and clinical practice (Ferrell, 2004). In order to facilitate the purpose of clear domains, it becomes essential to have ongoing dialogue and education. When there is clarity and consistency among the team and clear organizational goals, the team becomes more integrated, supported, and resourced (Mickan & Rodger, 2000).

In support of these domains, the National Hospice and Palliative Organization implemented a pathway for clinical guidelines to ensure best practice for chronically ill patients receiving end-of-life care (Kinzbrunner & Policzer, 2011). These guidelines are appropriated to the patient’s treatment plan, which promotes quality, consistency, and reliability of services within hospice organizations. These include three important end-result outcomes for chronically ill patients and their families: safe and comfortable dying, self-determined life closure, and effective grieving (Kinzbrunner & Policzer, 2011).

To further expand these guidelines, the National Consensus Project for Quality Palliative Care (n.d.) released the Clinical Practice Guidelines for Quality Palliative Care, which serves as a foundation for creating new care programs. The guidelines describe elements of best practices for eight domains: (a) structure and processes of care, which emphasizes the IDG engagement and collaboration; (b) physical aspect of care, which ensures the individual’s assessment and treatment plan is implemented; (c) psychological and psychiatric aspects, which focus on the collaborative assessment process of cognitive concerns and psychiatric diagnoses; (d) social aspects of care, which place greater emphasis on interdisciplinary engagement and collaboration with patient and families; (e) spiritual, religious, and existential aspects of care, which collaborate in attending to the spiritual concerns throughout the individual's illness; (f) cultural aspects of care, which emphasize culture as a source of resilience and strength for the patient and family; (g) care of the patient at the end of life, which ensures that documentation of signs and symptoms of the dying process is included in the circle of care; and (h) ethical and legal aspects of care, which deal with advance care planning, documentation, acknowledgment, and affirmation of the complexity of moral issues in hospice.

Although there are national guidelines for palliative care, there are gaps in research about this. According to Grol and Grimshaw (2003), one of the most consistent findings in research on health care services is the gap between evidence and practice. In a systematic review of 235 assessments of guidelines conducted by Grol and Grimshaw, the researchers used an analytical approach to derive a single-effect size of a specific proportion of patients receiving appropriate treatment. The range of effects and median effects across studies of each intervention summarize approaches to improve one of the best-practice guidelines (hand washing) in the hospital setting. The researchers discovered that although thousands of guidelines were available, not all were adhered to in practice. Some of the reasons given for the differences included health care teams being more cautious in acute care settings and tending to have a higher degree of no adherence in chronic care settings.

Additionally, Grol and Grimshaw (2003) noted that quality care guidelines could be improved if applied criteria for the best practice were described in published work.

Moreover, Grol and Grimshaw pointed out that the Appraisal of Guidelines for Research and Evaluation could provide validated criteria to optimize guidelines internationally. Grol and Grimshaw further noted that changes are partially within doctors' control; however, the prevailing professional and organizational culture determines the outcome to a large extent. Therefore, best practice should aim at enhancing proficiency, using educational material or didactic policies through continuing medical education. These strategies may also be effective with changing practices that include interactive and continuous education that allows for feedback on performance by peers (Grol & Grimshaw, 2003). In addition, measures and action at the level of teams or organizations are frequently needed when developing plans for change in clinical practice (Grol & Grimshaw, 2003).

Collaboration within Interdisciplinary Groups

Historically, Interprofessional interactions were authoritarian and dominated by physicians (McCallin, 2001). In the 1980s, when primary nurses and the nurses' process were introduced, interactions between nurses and physicians gradually changed (McCallin, 2001). As nurses became more visible in patients' care, physicians' control was challenged by nurses' decision making in the nursing process. Nurses' challenges threatened the Interprofessional interaction (McCallin, 2001). Subsequently, the emphasis of teamwork forced health care professionals to recognize the need for interdisciplinary group (IDG) contribution to patients' management (McCallin, 2001). Thus, IDGs teamwork became a strategy for change. This concept of interdisciplinary team collaboration toward patient care has been in existence since the early 1900s.

A group of physicians, Richard Cabot, Martin Cherkasky, H. K. and Silver, proposed that collaboration of different health care disciplines would best facilitate better outcomes and patients' satisfaction (Bronstein, Kurzejeski, & Parker-Oliver, 2005; Cooper & Fishman, 2003). These physicians proposed that social workers, doctors, and educators worked together on patients' challenges. Such collaborative effort would eliminate the potential of fragmentation of services and allows for a more comprehensive management of patients' care. Thus, collaboration of the social workers, nurses, and physicians in patient's plan of care assists physicians in gaining broader perspectives on the entire patient care (Bronstein et al., 2005).

In support of physicians' proposal of teamwork, Cicely Saunders, the founder of the modern hospice movement, served as a role model for interdisciplinary work because she was trained as a social worker, nurse, and physician (Bronstein et al., 2005). Being educated in all three disciplines, Saunders identified how critical teamwork serviced and facilitated the management of the entire person. Saunders's commitment to hospice patients resulted in a social model of care that advocates a systemic approach. This perspective reflected social work values and standards toward a holistic approach of patients' management, thus making social workers a vital component of hospice care (Bronstein et al., 2005). Saunders's approach of managing the hospice patient as a whole person and not part of a person fit well within her philosophical framework that advocated for collaborative management of the chronically ill, which requires attention to the physical, spiritual, financial, and psychosocial needs of both patients and families (Bronstein et al., 2005). Saunders, equipped with the experience of a social worker, envisioned the social worker’s role as an integral part of IDG. However, the integrated role of social workers has encountered problems in the IDG framework, as competition between social workers, nurses, and chaplains in various practice settings have usually been present (Bronstein et al., 2005).

The IDG’s relationship, however, has not been limited to the members from different clinical disciplines but rather is expanded to the entire organizational structure working towards one common goal. Additionally, the IDG consciously tries to integrate knowledge from distinct disciplines to assist the intellectual processing of information available to the group. Intellectual processing by members of the IDG has been very important since group members came to understand the goals within the group (Bronstein et al., 2005). Additionally, as the goals within the group were identified, group members’ strategies to achieve the goals became paramount. These strategies of the IDG included professional skills, communication, problem solving, and goal setting, which enhance the collaborative nature of the group.

Roles within Interdisciplinary Groups

The composition of a typical interdisciplinary group (IDG; as depicted in Figure 1) may consist of up to 17 or more members; these include an attending physician, a hospice physician, a social worker, a chaplain, six hospice aides, six primary hospice nurses, a group manager, other caregivers, and a volunteer. The main focus of the IDG is on patient and family. Although, a typical group consists of interdisciplinary practitioners, family members, patient, other caregivers, and volunteers, according to state law, only the core members of the IDG are necessary during the weekly care-planning meetings. These members are a physician, nurse, social worker, and chaplain; without these members, the care-planning meeting cannot be held.

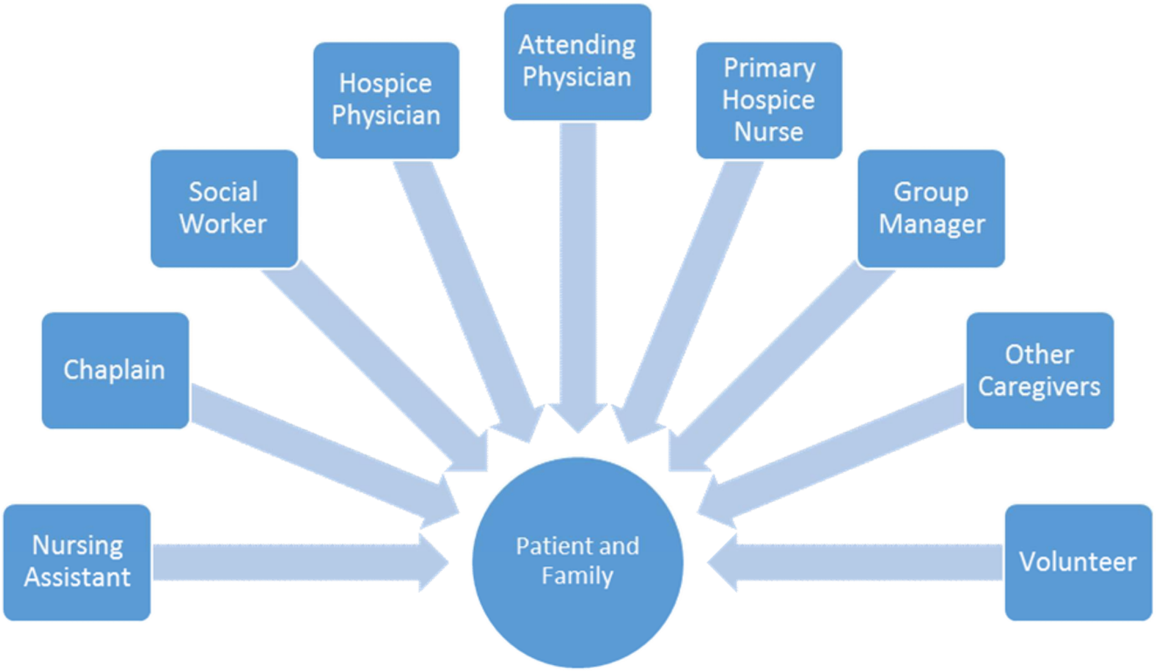

Figure 1. Structure for hospice interdisciplinary groups

These disciplines aid in accessing care to patients and providing information to caregivers for individuals diagnosed with Alzheimer's disease. The ability of the IDG members in meeting both care recipients and caregivers' needs while maintaining their quality of life is an accomplishment of the group. The IDG members also have moments when roles become blurred, and if not fully understood by all members, may create feelings of failure and under appreciation of other members' expertise (Johanson & Johanson, 1999).

Blurring of roles. This is a necessary function in the context of the IDG, although there are possibilities that role blurring is not fully understood by all members of the group. However, resistance and confusion associated with redefining roles in the IDG are often present among members of the team. Therefore, it becomes necessary that certain nonclinical skills, such as group cohesion, communication, and conflict resolution skills, be learned by the IDG. These would assist each professional to become primarily orientated to others cultural, beliefs, intellectual abilities, and expertise (Hall & Weaver, 2001). When IDG members have overlapping competencies and shared responsibilities, according to the model of varying practices, benefits accrue to the team, patient recipient, caregivers, and the organization (Brown, Crawford, & Darongkamas, 2002).

Thus, interdisciplinary membership groups operate as interactional feedback loops that allow members to support each other while providing optimal care to patients and their caregivers. Systemically, the IDG members will impact team members, the care recipient families' caregivers, and community personnel. Additionally, IDGs engage in discussions, which are less focused on stress and more on the best practices for individuals with Alzheimer's disease. Thus, all members of the IDG are seen as equally important in the outcome of the plan of care (Grumbach & Bodenheimer, 2004).

On the other hand, deficiency in the understanding of each member's unique contribution may cause anxiety, conflict, and ineffectiveness in teamwork (Hall & Weaver, 2001). This may be manifested in some members lacking abilities to recognize the values of other members, thus undermining their proficiency and contributions. As a result, when role blurring is misunderstood, problems emerge among the IDG members, may lead to disengagement and feelings of resentment. Additionally, team members may lose some level of efficiency within their field of expertise (Brown et al., 2000). For instance, role blurring may cause some nurses to have deficiency in being a clinical nurse specialists and assuming roles of physicians (Hall & Weaver, 2001).

The Group manager. The group manager is a registered nurse who is the leader of the entire team. The manager is the facilitator of the weekly group meetings and care planning process. Daily activities among group members are supervised by the group manager. The manager provides support for challenges encountered by group members such as the medical practitioner, outside customers, and caregivers. The manager is also considered as the central resource system for the group, patients, families, and other customers (Johanson & Johanson, 1999).

Physician. In managing the Alzheimer's patient, the hospice physician is an integral member of the IDG. Physicians are responsible for managing medication regimens and therapies for care recipients. They also participate in continuing education processes for the entire team (Johanson & Johanson, 1999). As a result a holistic approach, which includes the primary nurse, chaplain, social worker, and nurse assistant, is incorporated in addressing different areas of patients' treatment plans.

Registered nurses. The primary care managers are registered nurses, who provide more hands-on help in establishing a coordinated plan of care with the group's physician to reduce symptoms in patients. Nurses see Alzheimer's patients on an intermittent basis. Nurses services may include assessment, teaching, supervisory activities, evaluation of the disease progression, suggestion on nutrition, psychosocial issue, emotional support, bereavement assessment, and working with volunteers to meet patients' needs (Johanson & Johanson, 1999).

Nurse’s assistants. Nurse’s assistants are frequently in the patients’ home and therefore play a vital role in the care of the chronically ill hospice patients. The nurse’s assistants provide intermittent care under the direction of registered nurses and are usually exposed to the home situations most intensely. Their services include assistance with the activities of daily living such as bathing, dressing, feeding, grooming and other daily routines. The nurse assistants’ services are based on need, as outlined in the plan of care. The nurse assistant is not a sitter or a housekeeper, but is usually the one who spends the most time with the patients (Johanson & Johanson, 1999).

Social worker. The philosophy of social workers principally includes the values embraced in the hospice setting. The social worker is responsible for identification and referral of resources to the patient recipient and family members or caregivers. Social workers provide emotional support, psychosocial and financial counseling to patient and family. The social worker is also available for home visits or serves as a contact person on the telephone (Johanson & Johanson, 1999).

Chaplain. The chaplain provides spiritual needs to patients, their caregivers, their families and the interdisciplinary team. The chaplain elicits and responds to questions of meanings, guilt, disappointments, loss, and fear about future outcomes (Johanson & Johanson, 1999). The chaplain is nondenominational and assists in finding clergy of specific faith. The chaplains usually visit in the home of patients or consult on the telephone. They usually carry out a 12-month follow-up care, which include post bereavement to caregivers and family members (Johanson & Johanson, 1999).

The Collaborative Process of Interdisciplinary Groups

The interdisciplinary group (IDG) focuses on a holistic approach, addressing the collaboration of the IDG team, the implementation of the individual with Alzheimer’s disease treatment plan and caregivers’ distresses or burdens. These interventions focus on the care recipient’s behavior, as well as address issues that reduce caregivers’ burdens associated with caring for the patient recipient (Grumbach & Bodenheimer, 2004). The collaborative teamwork of the IDG members is the important components of professional hospice care services. Such collaborative interventions include training and education programmes, information-technology-based support, specialized computer, telephone networks, and formal approaches to planning care, which takes into account the specific needs of caring for individuals with Alzheimer’s disease (Grumbach & Bodenheimer, 2004).

The collaborative approach allows expert in different disciplines to evaluate and provide feedback from the recipient’s care plan process. This approach not only ensures a complete care for clients’ satisfaction but also facilitates cohesiveness and close interpersonal relationship among IDG members (Grumbach & Bodenheimer, 2004). As a result, members of the IDG hold weekly meetings to collaborate on the care recipient’s treatment plan. These meetings facilitate the coordination and provision of the hospice services, and provide a platform for team members to share responsibilities and goals (Grumbach & Bodenheimer, 2004).

The IDG collaborative interventions target the care recipient’s dependency and disruptive behavior that places enormous stressors on caregivers. These stressors include feelings of anxiety, depression, and loss of self-esteem. By addressing these behaviors and dependency, the primary stressors impinging on caregivers are positively altered. Likewise, the active participation of caregivers in the IDG meetings increases their knowledge on caregiving and the availability of information on social support and other community resources (Grumbach & Bodenheimer, 2004).

Effectiveness of Interdisciplinary Groups

Wittenberg-Lyles, Oliver, Demiris, and Regehr (2009), in an exploratory study, examined hospice interdisciplinary group (IDG) members' use of relational communication controls in their attempts to share information and contribute to decision making in team meetings. These researchers discovered that participants from different health care background consisting of physicians, nurses, social workers, chaplains, bereavement counselors, and volunteer coordinators during IDG meetings fostered one-up messages (Wittenberg-Lyles et al., 2009). These one-up messages in team meetings usually result in gaining control of information exchange. Overtime, such one-up messages tend to dominate the dimension of interpersonal collaboration among team members (Wittenberg-Lyles et al., 2009). Consequently, one-up messages were considered as the struggle for control within the relational exchange in the IDG communication during meetings.

Thus, in the IDG meetings nonmedical information such as the patient's spiritual or psychosocial well-being was minimized in the sharing of information. However, there tended to be over reporting of information between primary nurses and physicians in relation to patients' physical well-being (Wittenberg-Lyles et al., 2009). Although the

IDG meetings were specifically geared toward sharing patients' information, interpersonal communication in team meetings was influenced by the organizational context (Wittenberg-Lyles et al., 2009). As such, the formal relationships developed between team members impacted the outcomes of the IDG meetings (Wittenberg-Lyles et al., 2009).

Thomas et al. (2003), in a quantitative study, measured and compared critical care physicians and nurses' attitude about teamwork. Research participants were asked to describe the quality of collaboration and communication they experienced. Collaboration and communication among 73% of physicians with nurses were rated very high, at 70% to 71%, whereas collaboration and communication among 33% of the nurses with the physicians were rated very high, at 70% to 71% (Thomas et al., 2003). The differences in the statistical results suggested that global rating of teamwork may be attributable to several specific issues, which included the challenges nurses faced in speaking up, unresolved disagreements between physicians and nurses, and lack of nurses input in decision-making process (Thomas et al., 2003). This research showed challenges that physicians and nurses faced working together but the IDG team was not examined on what worked best.

Wittenberg-Lyles and Oliver (2007), through a mixed methodology study using qualitative observation and quantitative information to assess validity of the use of theoretical model collaboration and corresponding scale, identified collaborative communication encompassing the theoretical framework of IDG collaboration in hospice setting. By comparing and contrasting observed collaboration communication with team members' perceived collaboration differences of the theoretical framework, the study showed that interdisciplinary collaboration among IDG members were sustained through one of four types of collaborative communication: (a) interdependence and flexibility of job, (b) newly created professional activities, (c) collective ownership of goals, and (d) reflective process (Wittenberg-Lyles & Oliver, 2007). Although this study examined the IDG, it focused on collaborative communication for the team rather than a range of factors that worked best.

A study conducted by Reese and Sontag (2001) highlighted that to facilitate respect of other trained disciplines, group leader should establish an atmosphere of team respect toward others' knowledge. Within such an atmosphere, the sharing of qualified knowledge among team members would be encouraged, creating a cohesive team. Additionally, orientation to the role of each member was important in promoting competence and appreciation regarding how relative factors may determine one's own role (Reese & Sontag, 2001). Schofield and Amodeeo (1999) also discovered that if the roles of team members were clearly defined and delegated in their roles to manage overall patients' needs, improved outcomes would be inevitable at all levels for the IDG and the organization. These two studies identified internal and external factors as critical contributors to the success of the IDG.

Additionally, Shortell et al. (2004) identified four characteristics of perceived team effectiveness that relate to improved teamwork: (a) overall team effectiveness, involving the extent to which the team felt it had the necessary information, authority autonomy and related items to do its work; (b) team's skills, reflecting its ability to make changes, which also serve as the source of team cohesion; (c) the participation and goal agreement, reflecting the unity of the team behind super ordinate goals and its respect for individuals' contributions; and (d) organizational support, reflecting the team's ability to obtain resources and the suitability of a rewards structure that encourages it to work (p. 1041). Also, a group culture that encourages goal attainment, achievement, and participation of all disciplines tends to facilitate team decision making, which promotes team effectiveness (Shortell et al., 2004). Overall, team effectiveness was fostered by members' commitment to organizational super ordinate goals, such as total quality care management or continuous improvement toward quality care (Shortell et al., 2004).

Notwithstanding, Simons and Peterson (2000) noted groups that experience tasks conflict tend to make best judgments because such disagreements inspire best intellectual understanding of the issues being presented. Other factors that influence successful interventions in chronic disease management involve the delegation of responsibility to team members who will ensure that patients receive appropriate clinical and self-management support services. In addition, IDG programs that manage individuals with chronic illnesses, such as Alzheimer's disease, tend to exploit the varied skills of the team by using strategies, which include but are not limited to population-based care, treatment planning, evidence-based clinical management, and self-management support growth (Simons & Peterson, 2000). In general, existing literature seemed to illustrate the internal and external factors necessary for the functioning of interdisciplinary teams. These teams tend to involve multiple professional caregivers focused on a specific population, treatment plan, clinical management, and support growth for treating individuals diagnosed with Alzheimer's disease (Abeles, Gift, & Ory, 1994; Abramson & Mizrahi, 1996; Wagner, 2000).

Kuziemsky et al. (2009) noted that interdisciplinary teams are a significant component of modern organizational work and an important factor in achieving positive, cost-effective outcomes in various organizational arenas. Furthermore, an effective IDG communication leads to improve patients and family outcome, as well as improve the diagnostic and prognostic abilities of health care professionals (Kuziemsky et al., 2009). In an effort to provide the best practice for patients and alleviate challenges involving multiple caregivers, family members and health care providers, it was recommended by the federal government in 1983 that a team approach would be best suited to manage such patients (Demiris et al., 2009).

Consequently, hospice organizations were mandated through the Medicare Hospice Benefit Act to use IDGs to manage complex issues of the chronically ill individuals namely those with Alzheimer's disease. The act provided specific federal guidelines that required hospice agencies to adopt an interdisciplinary approach to patient care (Demiris et al., 2009). Therefore, the interdisciplinary collaboration became an important component in the delivery of care in hospice services (Demiris et al., 2008).

Challenges Within Interdisciplinary Groups

According to De Dreu and Weingart (2003), teamwork in organizations poses several challenges in working effectively with teams. Challenges include conflict between team members because of their perceived differences (De Dreu & Weingart, 2003). A qualitative research of hospice social workers' experiences on an interdisciplinary group (IDG) discovered that challenges to collaboration included personality and team conflict (Parker-Oliver & Peck, 2006). These conflicts may include but are not limited to relationship conflicts consisting of individual tastes, political differences, personal values, and interpersonal styles (De Dreu, 2003; Parker-Oliver & Peck, 2006).

Other common challenges of the IDG include interpersonal conflicts wherein team members become protective of their professions, expertise, and contributions to the team (Larson, 2003). Additionally, research indicated that competitions also exist in the IDG meetings for many years between nurses and social workers (Reese & Sontag, 2001). The lack of understanding across disciplines suggested that role competition, role confusion, and role definition have been contributing factors leading to disagreements within the team as well as isolation of members (Connor et al., 2002). Such conflicts disrupt interdisciplinary collaboration and systemic plan of care (Connor et al., 2002). Thus, a dysfunctional IDG meeting can leave members with feelings of failure (Sabur, 2003).

In addition, De Dreu and Weingart (2003) indicated the emergence of task conflicts associated with distribution of resources, policies, procedures, and interpretations of facts. There can also be professional disciplines conflicts. For example, social workers are viewed in hospice as ancillary members, lacking training and sensitivity about other professionals' expertise (Reese & Sontag, 2001). Thus, conflicting interpersonal communication may create challenges with interpersonal collaborations (Wittenberg-Lyles et al., 2009). Such interpersonal and task conflicts can foster disruptive operations among IDG members by affecting performance, reducing satisfaction, and team productivity. De Dreu and Weingart (2003) noted that in the past decade, there has been a growing tendency in the literature that relationship conflict hurt team effectiveness, but under certain situations, task conflicts can be beneficial to team effectiveness.

Other factors identified as detrimental to the effectiveness of teamwork include the organization's culture, its commitment to quality improvement, and a strong leader who is a passionate advocate for its work (De Dreu & Weingart, 2003). In general, the overall support the team receives from the organization and support for total quality improvement approach will have an impact upon the effectiveness of Interdisciplinary team building. Additionally, on the concept of multidisciplinary teams, Brown et al. (2000) cited professional identity emerging as precedence over teamwork, thus producing isolation of members from different departments and professional groups. Such isolation is detrimental to the effective performance of IDG members, as it increases animosity, reduces support and prevents cohesiveness. More specifically, on IDG team, social workers are believed to experience the greatest sense of isolation, because of distance from their own department, and engagement in an environment dominated by other disciplines (Brown et al., 2000). Consequently, social workers and nurses are at times seen as opposing each other, making it difficult for these two disciplines to enhance team collaboration (Brown et al., 2000). In resolving such oppositions, it is recommended that members aim at nonhierarchical positions rather than focusing on territorial control (Brown et al., 2000). By not focusing on territorial control, the IDG becomes more efficient and stronger to carry out effective communication and leaderships among members.

Once the team has developed clear structure, the team needs to maintain clear processes through agreed and formal systems of communication and coordination to maintain quality care (Mickan & Rodger, 2000). Mickan and Rodger (2000) proposed that when all members of the IDG are interconnected and take decisions jointly and manage conflict effectively, the team is more productive with the planning process. Thus, patients' care can ultimately be enhanced through the coordinated efforts of effective health care teams (Mickan & Rodger, 2000).

The literature highlighted challenges among IDG teams including task conflicts, interpersonal communication, professional isolation, and territorial control. However there is a gap in the literature on what works well with IDG caring for individuals with Alzheimer's disease. Investigating what works well with IDG, would be relevant for enhancing teamwork performance. With the growing trends of an aging population and increasing diagnosis of individuals with Alzheimer's disease, awareness of what works with IDGs become relevant to the field of marriage and family therapy.

Relevance of Marriage and Family Therapy to Interdisciplinary Groups

The systemic approach of marriage and family therapy is similar to the holistic approach used within the interdisciplinary group (IDG), which involves systems such as patients/clients, families, team members, organization, and external customers. The holistic approach is fragmented within IDGs; however, improvements can be made to include a systemic marriage and family therapy approach that will serve in connecting the patients'/clients' care planning processes. Presently, marriage and family therapy is not a clinical profession integrated into hospice IDGs. However, based on the similarities of both fields, marriage and family therapy can be an added discipline to the IDG of health care organization such as hospice. Marriage and family therapy could focus on care recipients, caregivers, and family members coping with stressors and psychological problems experience with end-of-life challenges.

In 2001, the Institute of Medicine recommended that a patient-centered approach rather than a clinician- or disease-centered approach best fits patients' needs in different clinical settings (Rolland &Walsh, 2005). This led to a growing interest in the development of specialized training in family system approaches to health care. However, as health care systems tried to integrate biomedical and psychosocial, it became apparent that health and mental health professionals encountered challenges because of lack of sufficient knowledge and skills to work effectively with family-related challenges (Rolland &Walsh, 2005). As a result, a demand for training in family systems in relations to health care for chronically ill individuals should be included in marriage and family therapy master's and doctoral programs. Marriage and family therapists receiving training in psychotherapy and family medical system would enhance working within IDGs alongside families in crisis (Rolland & Walsh, 2005).

Summary

Chapter II presented the literature review about the collaboration of multiple clinical disciplines working in health care environment to provide best-practice health care for individuals with chronic disease, such as Alzheimer's disease. Alzheimer's disease is a significant health problem among the elderly population and caregivers' involvements continue to be of high priority in providing care while maintaining personal and family life. The collaboration of an IDG of clinical professionals decreased the fragmentation of health care services; allowing for patients' physical, spiritual, emotional, and psychological needs to be met.

Current hospice care under the Medicare Condition of Participation endorses the use of mandated IDGs in hospice services. The literature indicated IDGs as beneficial to patients and families. However, the literature implied scarcity of research on what works well among IDG members. Therefore, this researcher allowed the voices of individuals of an exemplary IDG team in providing their perceptions on what works well among them. Thus, this study adds to previous research in analyzing IDG members' views of ways their collaborative work in caring for individuals with Alzheimer's disease foster best practices.

Moreover, marriage and family therapy and the IDG condition of participation have similarities in relation to the individual's mind, body, and spirit, and organizational internal and external systems. As such, marriage and family therapy can enhance IDGs team and vice versa, which adds to the relevance of this research in the analysis of exploring what works best among IDGs. As a result, both IDGs and marriage and family therapy can enhance teamwork in developing competence in training professionals to effectively work in medical settings. For by allowing IDGs' members to voice what works well among them, this study provided empowerment, which could enable IDGs and/or marriage and family therapy professionals to enhance competence and training opportunities that may further broaden both fields.

CHAPTER III: METHODOLOGY

Qualitative Research

A qualitative approach was selected for this research study due to the nature of the research objectives, which explore the subjective understandings of members of an exemplary interdisciplinary group (IDG) caring for individuals diagnosed with Alzheimer's disease regarding what works well in their teamwork. According to Burman (1994), a qualitative approach allows the researcher to explore issues that may not be well suited for exploration through quantitative means. The qualitative paradigm focuses on how individuals ascribe meaning to their experiences; unlike quantitative research that involves statistical analysis (Creswell, 1998; Neuman, 2000). Qualitative research uses a naturalistic approach that seeks to understand phenomena in a context-specific setting, involving the real world. The researcher does not attempt to manipulate the phenomenon interest but remains natural and strives to stay free from any presumptions of the phenomenon being studied (Patton, 2002). Moreover, in qualitative paradigm, the researcher produces findings that are not arrived by statistical procedures or other means of quantification. The research focuses on people's lives, their experiences, behaviors, emotions, and even social movements or organizational functioning (Strauss & Corbin, 1998). Drawing upon a particular tradition within qualitative inquiry, this study used appreciative inquiry (AI) as the qualitative methodology. AI was applicable for this study because it allowed for the evaluation of ways people or organizations optimized operations in examining accomplishments and achievements.

Appreciative Inquiry as a Research Method

Appreciative inquiry (AI) methodology examined the research question, what works well with an exemplary IDG caring for individuals diagnosed with Alzheimer's disease? The methodology utilized semi structured interview questions to inquire from participants who were members of an IDG, what works well as a team caring for individuals diagnosed with Alzheimer's disease. The inquiry into this research question can be relevant to the marriage and family therapy field in providing additional information that seeks to examine the achievements and accomplishments of clinical teamwork among IDG members caring for individuals with Alzheimer's disease.

AI was relevant to this study because it placed emphasis on the achievements, hopes, and dreams and shifted the research to focus on what can be appreciative within organizations. The AI was developed by David Cooperrider, Diana Whitney, and other researchers at Case Western Reserve University in the 1990s. It was intended as a tool for organizational change (Cooperrider, 1990). The AI process was also designed to help organizations to create images of the future as well as a sense of commitment and hope to change for the better (Michael, 2005). The use of AI allows researchers to focus on the inquiry of the positive core of the organizations or individuals (Cooperrider, Whitney, & Stavros, 2003). Its approach to change is based on discovering people's inner strength as a base for improvement and growth. The inner strength is derived from the word appreciative, which is the act of recognizing the best in people or validating their past and present strengths and potentials (Barrett & Fry, 2005). Thus, the use of AI allowed participants to tell their stories. By telling their stories, they were allowed to bring the best from the past into their current reality and projected it into their imagined future (Stratton-Berkessel, 2010).

Primarily, through interviewing and evaluating participants' stories; the best from the past is discovered that set the stage for effective imagination of what could be (Barrett & Fry, 2005). Therefore, AI searches for the best of what is to provide the basis for imagining what might be. It brings a group of people together to discover and create that which is healthy, successful, and positive in organizational life. It is inclusive in that it invites a widening circle of voices in creating opportunities and forums for servicing inspirational stories (Barrett & Fry, 2005).

Moreover, contrary to experimental research investigation, qualitative AI does not seek to address research gap; nor is it a singular methodology based on a firmly established way of proceeding. However, it is improvisation, a metaphor, which begins with a clear purpose, but the most remarkable outcomes are unexpected (Whitney & Trosten-Bloom, 2010, p. 13). Additionally, this qualitative AI methodology allowed for the emergence of natural categories and themes from the data analysis. This method provided an in-depth understanding of the IDG's ability to identify factors that contributed to their accomplishments and achievements as caregivers.

Appreciative Inquiry Theoretical Research Perspective

Appreciative inquiry (AI) is rooted and grounded on the theory of social constructionism, which answers the question of how do people know what they know. AI describes the power of the idea of language as the creator of people's realities (Watkins, Mohr, & Kelly, 2010). In essence, AI is a collaborative and highly participative, systemwide approach to seeking, identifying and enhancing the “life-giving forces” (Watkins et al., 2010, p. 22) that are present when a system is performing optimally in individual and organizational terms. It is about times during which, profound knowledge about the system at its moments of when miracles are uncovered and used to co-construct the best and the future of that system. Therefore, *appreciative* emphasizes the idea that something increases in value and *inquiry* is the process of seeking to understand through asking questions. Thus, AI focuses on the ability to multiply the life-giving forces within the system in things the system wants to increase (Watkins et al., 2010).

AI can be viewed as a genetic DNA process of research (see Figure 2). This AI’s genetic process is through constructive conversation which allows for trusted experience to be shared. Additionally, new possibilities are imagined and brand new relationships are created to bring forth a preferred future (Watkins et al., 2010). By implementing varying assumptions people’s questions have a direction, and those directions often depend on the hidden assumptions in those questions. In other words, the questions are circular and interactional. Therefore the composition of the AI methodology can be seen as the DNA, consisting of building blocks of constructionist, simultaneity, anticipatory, poetic, wholeness, and positive inquiries (Watkins et al., 2010).

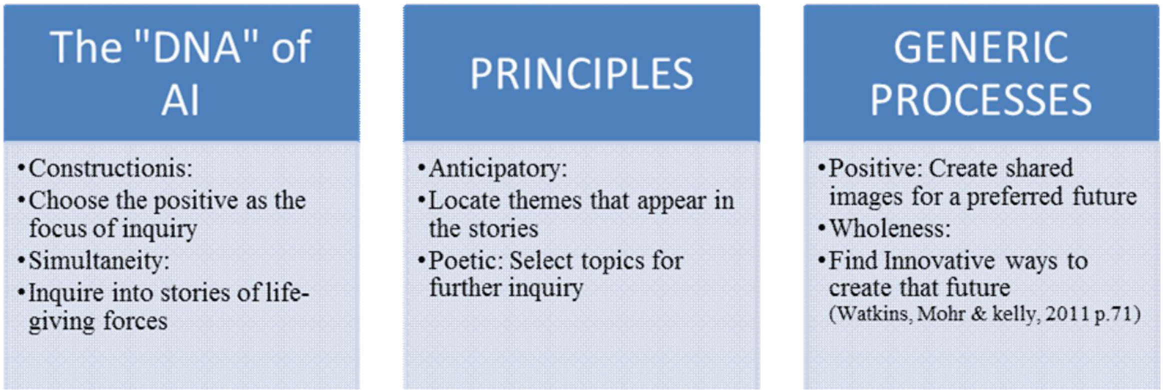

Figure 2. The DNA of appreciative inquiry, principles, and generic processes (Watkins, Mohr, & Kelly, 2010)

The constructionist principle is related to the social constructionist theory that one’s thoughts about the world are developed through interpretation and construction rather than merely simple recording of the phenomena (Reed, 2007). Thus, one is able to view conversations as a means of generating innovative future possibilities. Overtime, the constructionist views choose the positive as the focus of inquiry. The simultaneous principle noted that inquiry and change are simultaneous; so they are not separate and sequential stages in development (Reed, 2007). Thus, the future can be deliberately changed by visualizing what is desired. Anticipatory principle is the way people think about the future, which will shape the way they move towards the future. Whereas poetic principle emphasizes the way that people author their world, choosing the part of their stories, which they are most interested in and experimenting with different “plotlines” (Reed, 2007, p. 26). The wholeness principle proposes that whatever people believe is strong and positive lead to a new manner of thinking. The positive principle focuses on asking positive questions, engaging people more deeply, and for a longer time. Thereby, capturing people's interest is an effective way of getting them involved in change (Reed, 2007).

According to Michael (2005), to conduct this type of AI, the process is aimed at research rather than one of organizational change. Therefore, every question asked during this process has a direction, and an outcome based on shared understanding. Thus, it is necessary to ask questions to which the researcher does not know the answer and is in an anticipatory state to learn something interesting and important (Michael, 2005).

Appreciative Inquiry Processes

Watkins et al. (2010) cited five generic processes of appreciative inquiry (AI), in which it is imperative for the research to become cognizant of what questions build pathways into people's shared understanding and facilitates new ways of connecting to their preferred future. Therefore, the researcher should be mindful in understanding that questions have a moral impact on people's lives. With AI methodology, the researcher seeks to ask questions that inspire, intrigue, delight, clarify, and build stronger connections (Cooperrider et al., 2003). To build these connections of what has been possible and worthwhile in the participants' lives; my questions will attempt to bring their most valued experiences into their consciousness by applying the processes of AI. Watkins et al. cited five generic processes or phases of AI, which are illustrated in Figure 3.

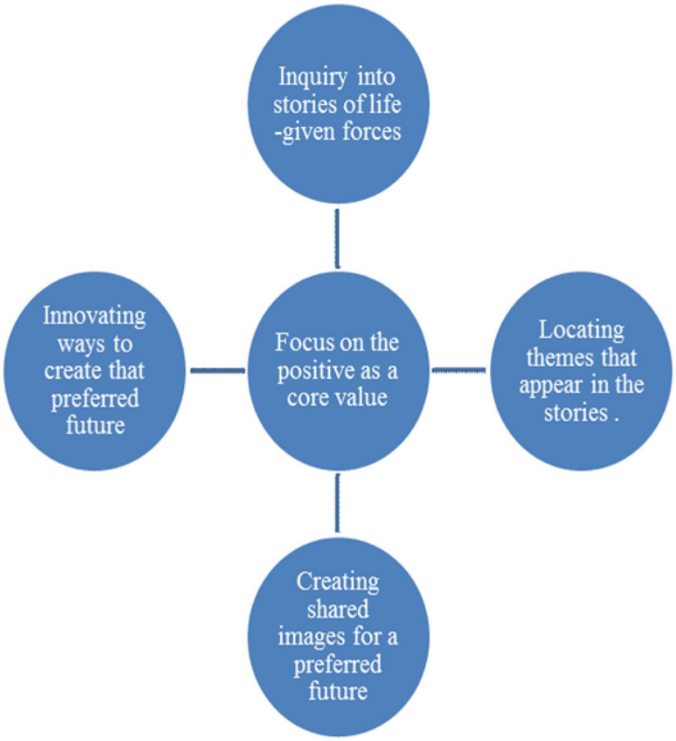

Figure 3. Watkins et al.'s (2010) five generic processes or phases of appreciative inquiry practice. In appreciative inquiry, I seek information into the stories of life-giving forces, which focus on positive core value, revolving around the innovations of a preferred future, new themes, and evolving into new possibilities

These five generic processes of AI are interrelated in a 4-D cycle (see Figure 4). This 4-D cycle revolves around the positive core of AI, which is interrelated to four phases: Discovery, Dream, Design, and Destiny (Watkins et al., 2010). The Discovery phase is appreciating the best of what is, focusing on the moments of each IDG member working as a team in meeting the treatment goals of the individual with Alzheimer's disease (Watkins et al., 2010) Additionally, in the Dream phase, questions focus on people's accomplishments; such as what is sustaining their dedication.

The Design phase looks at what could have been better, which allows for reflection on past successes or what stood out as being exceptionally well due to the individual's commitment. In the Destiny phase, questions focus on what small change would encourage more individuals to become engage in positive outcomes (Watkins et al., 2010).

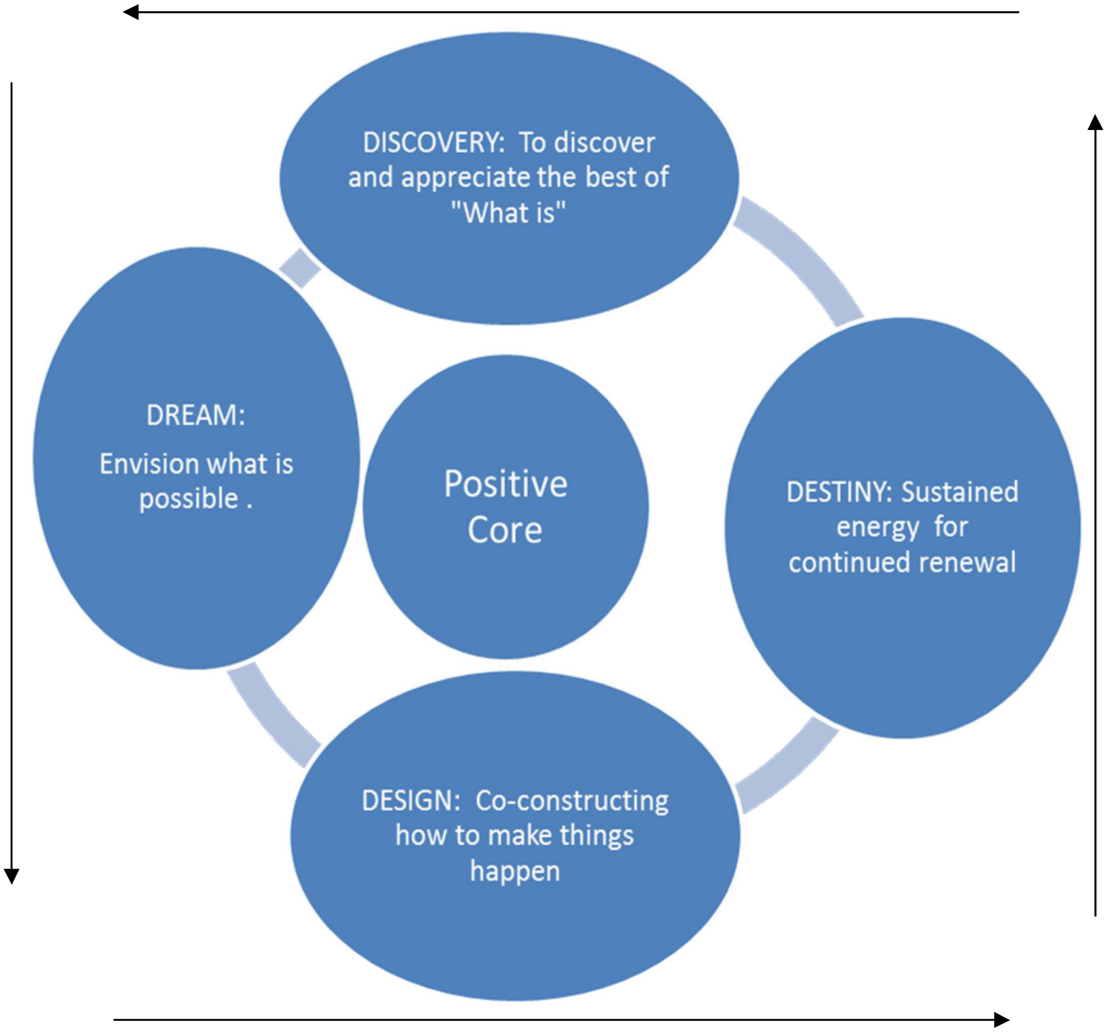

Figure 4. Appreciative inquiry 4-D cycle illustrates the interconnectedness of the 4-D cycle of AI positive core being connected to (viewing counterclockwise) discovery, dream, design, and destiny (Whitney & Cooperrider, 2000).

Furthermore, AI suggests that these exceptional times could be found among the most difficult and most challenging organizations and relationships (Michael, 2005). The

AI also makes extensive use of storytelling as a method of discovery and in the traditional appreciation environment. The AI works best when used in an environment in which narrative rich communication is created (Whitney & Cooperrider, 2000). Therefore, this study incorporated exemplary IDG team members' stories as part of the inquiry process to ascertain what works well collaboratively within their group.

Research Design

The nature of AI allowed me to examine the experiences of the IDG team and evaluated what has been working positively in treating individuals with Alzheimer's disease. The AI method allowed me to get an in-depth understanding from the perspective of those who created, implemented, and reviewed the treatment plans for individuals with Alzheimer's in hospice care. Research data were obtained through semi-structured interviews from each member representing different disciplines of the IDG team. I explored to what extent the postmodern approach accentuated the IDG members' inner potentials and achievements (Reed, 2007). To do this, I framed the interview questions as ways in exploring people's accomplishments and achievements in order to explore the positive core values from their perspectives and projected into the future through the format of Solution-Focuses Brief Therapy questions (Watkins et al., 2010; Whitney & Trosten-Bloom, 2010).

Role of the Researcher in Appreciative Inquiry

As the primary investigator, I maintained a reflective attitude. Willig (2001) noted that reflexivity is the ability of the researcher to reflect or think critically, sensitively, sincerely, and candidly about the research experience and process (Willig, 2001).

Reflexivity recognizes how the meanings the researcher acquired from the data analysis are influenced by interpretation. In the application of appreciative inquiry (AI) methodology this researcher attempted to focus on the achievements and accomplishments of the participants, which was done through analyzing the participants' dialogue and transcripts (Willig, 2001).

The participants' experiences are also dependent upon the researcher's interpretation of the phenomena. Therefore, as the researcher, I worked closely with the participants and became aware of the danger of biases through my own experiences and unknown preconceived notions that could influenced the data collection and data analysis. The research integrity was maintained by being aware of personal constructive realities to the phenomena. Concurrently, this researcher accepted that participants' interview data were shaped by the conversation between each participant and the researcher.

Researcher's Self-Reflection

According to the qualitative research paradigm, the researcher is central in the construction of knowledge, which leads qualitative researchers to highlight the reflexive aspects of the research process. Reflexivity has many meanings; however, the researcher commitment to reflexivity suggests that the research topic, design, and process together with the researcher's personal experience of doing the research are reflected on and critically evaluated through the data analysis (Merrick, 1999). A reflexive approach to the qualitative research process is paramount in the use of qualitative methodological design. As the researcher, I avoided personal agendas and unconscious biases that could have influenced the collection and the analysis of the data through my personal ongoing self-reflection. Harrison, MacGibbon, and Morton (2001) noted that self-reflection of the researcher allows for a clear description of the researcher's own experiences, values, and positions of privilege. This is due to the notion that researchers choose their research base on their interests, which may influence their research data and findings (Harrison et al., 2001).

Therefore, I was cognizant of my own experience and personal interests in relation to ways I could have biased this research. In my reflective stance, I observed participants, with the understanding that my aim in providing data regarding the emotional and social world of each participant. I also, reminded myself that as the observer, I partially shared participants' experiences, so in the research, I was the observer as well as the observed. As a result, I was observing participants, but I was also observing my responses and experiences throughout the research process.

In the interviewing process, I maintained a stance of non-reactivity in order to increase the reliability of the participants' responses. This was achieved through being cautious with how I ask questions, so my tone or the context in which the questions were asked did not influence participants' responses (Glensne & Peshkin, 1992). In addition, I paid attention to my own prejudgment by using a journal to record questions that emerged from participants and my responses to such questions. I also, recorded field notes that corresponded with the context and observations during the process of my research. I then incorporated my journal notes in my data analysis, which assisted in identifying my attitude and position of the topic of my research, thus reducing biases that could have influenced the outcome.

Data Collection

In this research, my sampling was geared toward an exemplary IDG team caring for individuals with Alzheimer’s disease in a hospice setting. Qualitative research identifies participants and sites based on places and people that help others to understand the central phenomenon within that context (Merriam, 2002). I attempted to understand this phenomenon through the perspective of an exemplary IDG working within hospice caring for individuals with Alzheimer’s disease. The use of descriptive coding will allow for the understanding of the phenomenon in question (Saldaña, 2009).

Participants were recruited through professional referrals, letters and flyers. Permission was secured from the gatekeeper of the bulletin boards within hospice organization in recruiting participants. This researcher also used social media, personal contacts inviting participants for the study. In addition, individuals with relevant authority were asked to pass flyers onto other exemplary IDGs located throughout Miami, Broward, and Palm Beach, Florida. IDGs within hospice organization usually consists of 17 members or greater. I identified IDGs in which all the members were agreeable to participate in the study. Groups in which majorities of the members were opposed to participating were eliminated. Three exemplary IDG teams agreed to participate in the study. I then randomly selected from these three groups using a numeric system to select the group that participated in the study. No member within the selected

IDG elected to withdraw from the study, therefore the study was carried out with the first selected IDG team.

The data collection processes entailed four steps: (a) soliciting participants using a flyer, recruitment letter, and permission letter (see Appendices A, B, and C); (b) obtaining participants' agreement through signing an informed consent (see Appendix D); (c) obtaining informed consent from each participant; and (d) interviewing participants utilizing semi-structured interview questions (see Appendix E).

Participant Selection

The study included interviews with individuals who were members of an exemplary IDG in a hospice setting. In order to exclude gender bias, no gender restriction was imposed in this study. Participants were not limited to any specific ethnic groups and consisted of six members from IDGs team. The participants comprised of the team's physician, licensed social worker, chaplain, a registered nurse, a nurse's assistant, and the team manager, who all participate in weekly team meetings. The participants did not have any age specification but were all members of the selected team. They all were fluent in English and lived in the South Florida area. Additionally, the IDG participants were able to meet with me for approximately 60 to 90 minutes in a personal interview. Individuals who were under the supervision of my IDG were not allowed to participate in this research.

Procedures

The approval from Nova Southeastern University's Institutional Review Board for Research with Human Subjects was the first step necessary in the data collection process. Collection of the data included participants from an IDG who were working with individuals with Alzheimer's disease in a hospice setting. Data collection focused on each discipline of the IDG caring for individuals with Alzheimer's disease. The data collection consisted of four processes: (a) soliciting participants through the use of personal contacts, social media, newsletters, and bulletin boards within various hospice settings throughout Miami, Broward, and Palm Beach, Florida, (b) obtaining permission from relevant personnel to post the recruitment flyers and/or recruitment letter on electronic sites or printed media (e.g., hospice centers' e-mails, newsletters, magazine, and/or bulletin boards); (c) obtaining informed consent from each participant; and (d) interviewing participants by using semi-structured questions (refer to Appendices A, B, and C). The interview took approximately 60–90 minutes, in a location that mutually agreed upon by the participant and researcher. Participants were interviewed during their personal time. Therefore, it was not necessary to obtain authorization from the Institutional Review Board for Research with Human Subjects to obtain permission for participants to get time off from supervisors.

At the time of the interview, participants were given an informed consent form to identify information related to the research (see Appendix D). Participants read the consent form and verbalized their understanding to me before signing the form. Participants were informed that the research was voluntary and were educated about their rights to withdraw from the research at any time without penalty. Participants were given a signed copy of the informed consent for their record and another copy was kept in a secure locked cabinet at my home office.

Approximately 2 to 4 weeks after the interview, participants were e-mailed an encrypted code document of their transcript that allowed them to review the synthesis of their interview data. Each participant reviewed and provided feedback to me as to whether the interpretation of their interview data represented the experiences transcribed in the interview data. After participants received and reviewed the word document, each was asked to note any corrections or confirmed summary of their interview interpretation without corrections. If there were changes, participants contacted me by phone or e-mail.

The aim of the study was to get an in-depth understanding into what works well with an exemplary IDG caring for individuals with Alzheimer's disease. As a result, of the foundation of the interview, which was constructed in language allowing guided, open-ended conversations that allowed me to gain in-depth understanding of the participants' attitudes, perceptions, and viewpoints on the topic (Bogdan & Biklen, 2003; Patton, 2002). The interviews were taped, recorded, and transcribed by the researcher. I transcribed the recordings within a week after the interviews are conducted. This was to ensure that everything that was captured in the interview remained as accurately as reported.

Confidentiality

To ensure confidentiality, consent forms were filed and locked in a cabinet at my home office. There was minimal risk to confidentiality due to the nature of the data which was collected. However, measures were used to maintain anonymity for participants and organization used. I secured all electronic recordings devices, written notes, and transcriptions in a locked cabinet at my home office. In addition, I secured all electronic data in a password-protected computer available only to me. The recording and transcripts were only accessible to my dissertation chair, personnel from the Institutional Review Board office, and me. The data will be destroyed 36 months after the study ends.

Interview Questions

The interview questions were structured to incorporate all four phases of the AI process, which consisted of 10 questions in totality.

Discovery Phase I.

1. What do you love most about working with this interdisciplinary group? What first drew you to this group and what has most encouraged you to stay with this group?
2. As an interdisciplinary group member, there are inevitably high points and low points, successes and frustrations. What stands out for you as a high point when you felt most accomplished within the group?
3. Hospice uses interdisciplinary groups to manage patients' care. What do you value most caring for hospice patients with Alzheimer's disease? What do you most hope you can contribute to these individuals with Alzheimer's disease?

Dream Phase II.

4. Imagine a time in the future when other interdisciplinary groups look to your group as an example, as your group continues to grow as an exemplary group in which all members excel in their field of expertise, what would be happening differently and who else would notice the difference?
5. What are you most proud of having helped the group accomplish?

Design Phase III.

6. What are the areas in which you feel group members' participation could have the most impact on improving the quality of care for the chronically ill individuals such as Alzheimer's disease?
7. As you reflect on successful ways your group currently implements strategies to improve group collaboration and cohesiveness, what strategy stands out as being exceptionally promising? What can your organization do to assist the group to become more a leader within the organization?
8. What do you consider indicators that you are doing an excellent job within your group, patients and families and the organization as a whole?

Destiny Phase IV.

9. What small changes could your group make right now that would really encourage other teams to get to engage in improving their group?
10. What specific ways would you like to contribute to realize this dream?

Additionally, in conducting the interview, from the questions, I sought to gain the participants' personal stories, perceptions, and experiences regarding their involvement as a team.

Data Analysis

This study on what works well with an exemplary IDG caring for individuals with Alzheimer's disease was conducted through an AI approach. This approach is based on the descriptive (qualitative) research design—a fact-finding activity generally undertaken to assess the opinions, behaviors, or characteristic of a specific group, community, or population and to detail the account of the prevailing situations (Saldaña, 2009). However, descriptive method does not essentially seek to test hypothesis or make predictions of the research, but provides an accurate description on the variables. Thus, the analysis is data driven, although the researcher's theoretical and epistemological commitments may influence the analysis because data are not coded in an epistemological vacuum (Braun & Clarke, 2006). A code in qualitative inquiry is most often a word or short phase that symbolically assigns a summative, salient, essence capturing, and/or evocative attribute for a portion of language-based or visual data. The data can consist of interview transcripts, participants' observations, field notes, and other documents (Saldaña, 2009, p. 3).

Therefore, the use of the essentialist or realists approach allows the researcher to speculate motivations, experiences, and meanings in a straightforward way because a simple unidirectional relationship is assumed between meanings, experiences, and language. Yet, a method of conducting the analysis would be evidenced to prove the study's validity (Braun & Clarke, 2006). In qualitative data analysis, researchers must "organize and prepare the data for analysis, review the data thoroughly, and analyze the data with a coding process" (Creswell, 2003, pp. 191-192). Thus, the data analysis process was code guided (Creswell, 2003), which began with my gathering and organizing all the data that was collected from the interviews. Copies of each participant's interview transcript were kept in individual files containing all pertinent documents. This was due to creating digital files for each participant to store the participants' digital interview recordings and digital transcripts as a backup. I conducted the data analysis process with a thorough review of hard copies of each interview transcript while listening to the digital recordings. This process allowed me to make any necessary corrections that had occurred during the transcription and to gain a comprehensive understanding of the interview data (Creswell, 2007).

In this study, I assigned descriptive code to the data in the margin of the interviewee's transcript. The use of descriptive coding to conduct first cycle coding, has been involved in identifying and labeling portions of the data that describe aspects of the 4-D cycle: Discovery, Dreaming, Designing, and Destiny (Cooperrider, Whitney, & Stavros, 2008; Saldaña, 2009). Additionally, the use of pattern coding was used to identify patterns within the descriptions themes that emerged. The themes and patterns categorized the data within the backdrop of the 4-D cycle. When I was satisfied that the coding process was well established with the related description, I further reduced and interpreted the meaning and, through dialogue, to confirm that these were the interviewees' meanings (Cooperrider et al., 2008; Saldaña, 2009). Finally, with the use of the 4-D cycle backdrop, I transferred "coherent synthesis of the data corpus" (Saldaña, 2009, p. 149) transcripts, which incorporated focusing on the stories extracted from the participants' transcripts leading into the theoretical framework. In developing the theoretical framework, excerpts from the participants' supported the explorations of meanings and definitions.

The theoretical base analysis was written in a Word document report, which was submitted to this researcher's committee members who reviewed and provided feedbacks on the report. The reviewed report was then cleaned up to reflect the committee members' feedbacks, and a final Word document was created that identified what works well with an exemplary IDG team caring for individuals with Alzheimer's disease.

Standards and Verification

To ensure reliability for the study, trustworthiness was critical while establishing the quality for research (Golafshani, 2003). This was connected to credibility, which referred to the degree to which the findings were realistic and valid. In this research, I used several measures to ensure quality of the research. I maintained rigorous reviews of the theoretical framework which emerged from the main categories of the 4-D cycle. Upon satisfaction that the analysis captured the essence of the theoretical base analysis, reflecting the everyday actions of the IDG, the irrelevant data were discarded. At this point, the information gathered was used to develop the final analysis, which captured the meanings of what works well with an exemplary IDG team caring for individuals with Alzheimer's disease (Riessman, 2008). Furthermore, in continuing the process of the quality of the research, the analysis was deeply rooted under the four phases of AI. Not only did this researcher maintain the 4-D cycle format of the questions but also the analysis was integrated in the four phases. The researcher's dissertation committee members reviewed and offered their feedback.

As the researcher, I maintained a reflective position and awareness of my biases. My goal was to avoid attaching my own interpretation to participants' narratives of their experiences regarding the phenomena. I documented my personal observations and triangulated my research experience with the interviews and the literature (Lincoln & Guba, 1985). Therefore, the themes and categories were generated using the 4-D cycle rather than from my presuppositions. The data analysis generated information that described how the interdisciplinary team assessed their experiences and accomplishments as they interacted with Alzheimer’s disease individuals and their caregivers.

Transferability

Transferability refers to how findings from the research can be applied in other contexts and with other studies (Graneheim & Lundam, 2004). To facilitate transferability, I became aware of each IDG member distinct description of culture, context, selection, and characteristic in transcribing their interviews during the data analysis while ensuring that a rich and in-depth understanding of the findings were transferred (Graneheim & Lundam, 2004). I considered all findings in the research as trustworthy as I adhered to the data collection procedure to generate findings of what works well with exemplary IDG professionals caring for individuals with Alzheimer’s disease.

Summary

This study aimed to fulfill the requirements for a research that analyzed and discovered what works well with an exemplary IDG of hospice professionals caring for individuals diagnosed with Alzheimer’s disease. The qualitative AI design was chosen in order to uncover and bring forth existing strengths, achievements, accomplishment of the IDG members in relation to the expectations of the phenomenon being studied. The study added to the knowledge of organizational research with IDG professionals collaborating with patients’ well-being. The study is relevant to the marriage and family therapy field as the literature review indication that there is paucity of research in examining the positives of clinical collaborative teams such as the IDG caring for individuals diagnosed with Alzheimer's disease.

At present, the marriage and family therapy profession has not being utilized in the IDG serving hospice patients. Mental health issues and challenging family dynamics are usually addressed by social workers from a non-systemic perspective whereas marriage and family therapy incorporates the entire system. Thus, Marriage and family therapists' systemic viewpoint could facilitate information to advance research on how to effectively manage mental health illness with chronically ill patients and their families dealing with end-of-life challenges. Similarly, this will also provide an opportunity for additional information by the schools of marriage and family therapy to increase training and development of competent therapists with medical background with the focus on patients and their families in a hospice setting. This integration will also benefit members of the IDG team with their own personal challenges.

Additionally, the data collection procedures using the semi-structured interview questions was formatted to include the 4-D cycle of AI, which aided in gleaning past and present strengths, successes, resources, and potentials among the team. Following the transcriptions of the interviews with participants, data analysis categorized themes embedded in the AI 4-D cycle format of dream, design, destiny, and discovery. This cycle was interactional with varied feedback loops, which aided to generate a final report, reflecting discoveries from the study.

CHAPTER IV: RESEARCH FINDINGS

This research was a qualitative appreciative inquiry (AI) augmented in a descriptive framework. The data analysis examined the perceptions and experiences of the hospice interdisciplinary group (IDG) through collecting and analyzing data to discover what works well. The data were drawn from 10 semi-structured interview questions with six participants. The analysis addressed findings by detailing participants' responses to the interview questions constructed to reflect an AI 4-D cycle: Discovery, Dream, Design, and Destiny. These focus on asking unconditional positive questions to ignite transformative dialogue and action within human systems by asking unconditional positive questions about caring as the positive core surrounded by 10 major themes, which revolved around the positive core.

The positive core provided the participants the opportunity to elaborate on their experience in working on an IDG. Although this study was not done in a focus group, as intended by most AI studies, I decided that the goal of my study was to ascertain the combined voices of the IDG. Therefore, I allowed the voices of the IDG to reflect themes that were analyzed using descriptive analysis to conceptualize the AI 4-D cycle: Discovery, Dream, Design, and Destiny. This assisted in co-constructing new ideas that generated new possibilities to strengthen what have been working well within the IDG. As ideas were co-constructed through the stories gleaned from the voices of participants, I interpreted, analyzed, summarized, and categorized using descriptive coding analysis.

Descriptive Analysis

Descriptive analysis was applied to the data gained from the six participants in my study who were members of a hospice exemplary IDG comprising professional disciplines. This descriptive analysis led to findings related to how participants spoke about their accomplishments and what they most valued in working with individuals with Alzheimer's disease. In analyzing qualitative data collected through AI interviews, there is no prescribed method of analysis. In this study, to capture detailed descriptions of experiences and perceptions of participants, I selected a descriptive analysis approach. In addition, in using AI, I focused on a systemic approach, analyzing the data presented by participants that highlighted their stories as a system functioning at its optimal level (Whitney & Trosten-Bloom, 2003).

The following presentation of findings is organized to reflect these two approaches to the data analysis. The results related to each of the four stages of the AI process are presented in sequence. Within each of these sections, the results related to each stage are presented in terms of major themes pertaining to that part of the AI process. The chapter concludes with a discussion of the three overarching themes that were found to apply to all four stages of the AI process: Communication, Appreciative Attitude, and Relational Bonding.

Before presenting the results, I briefly summarize the participants from whom the data were collected. I categorize the demographics profiles of the participants using attribute coding (Saldaña, 2009). These profiles are represented in Table 1.

Participants Demographic Profiles

Table 1 depicts the demographics of members representing IDG interviewed. The members are typical of IDGs within hospice settings.

Table 1

Participant Demographic Profiles

Interdisciplinary group position	Gender	Hospice experience (in years)	Age range (in years)	Educational background	National origin
Chaplain	Male	14	60–70	MDiv	United States
Group leader	Female	14	40–50	RN, BSN	Jamaica, West Indies
Nurse’s assistant	Male	9	50–60	HSDG	Jamaica, West Indies
Physician	Female	13	40–50	MD	Puerto Rico
Registered nurse	Female	9	40–50	RN, AS	United States
Social worker	Female	3	50–60	LSW, MS	United States

Table 1 indicates that the participants were of diverse background, as is typically reflected in an IDG. The education background of the participants varied as required by the IDG; there were no specifications on cultural diversity. The six participants’ ages ranged from 40 to 60 years old; four were female and two were male. Two were born in Jamaica, one in Puerto Rico, and three in the United States. The mean average work experience of participants was over 10 years, with only one participant reporting fewer than 5 years. This participant actually worked at hospice for only 3 years, but had been a social worker for 32 years. Additionally, the education level of participants varied; a physician with training in medicine, specializing in gerontology, and two registered nurses, one with a bachelor of science degree and the other with an associate science degree in nursing. Two other participants each had a master’s degree, one in social work and the other in divinity. The participant with certification as a nursing assistant had a high school diploma. After reviewing the participants' demography, I used first-cycle descriptive coding and second-cycle pattern coding methods to highlight the themes that emerged from each participant's data, in accordance with the AI 4-D cycle (Saldaña, 2009). These methods of coding are typical of descriptive analysis.

Data Analysis

According to Saldaña (2009), descriptive coding identifies the themes and are not abbreviations of the content but focus on the method of analysis. This method assisted in data reduction and stored information describing the attributes of the interviewees. With this, I was able to provide descriptions of what the participants were saying, as well as categorize, summarize, analyze, and interpret the data (Saldaña, 2009). In addition, these 10 themes, which revolved around the positive core, depicted an exemplary IDG according to the participants' experiences. As the descriptive coding identified the themes and the positive core, the AI 4-D cycle (Discovery, Dream, Design, and Destiny) evolved in relation to analyzing what works well for IDG in hospice working with patients with Alzheimer's disease.

This type of descriptive coding correlates with the goals of the Discovery phase that represented the vision of the dream, the delivery, and the bridging of the future (Saldaña, 2009; Whitney & Cooperrider, 2000). After the emergence of the Discovery phase, I continued to manually analyze the data by categorizing it into the identified 10 themes, allowing for the other three phases of the AI 4-D cycle to evolve.

Discovery Phase

In the data analysis process of the Discovery phase there were three main interview questions with sub questions that were specifically designed to discover the participants' perspectives of what works well with the IDG: (a) what do you love most about working with this group? What first drew you to hospice and what has most encouraged you to stay with this group? (b) As a group member, there are inevitably high points and low points, success and frustrations. What stands out for you as a high point when you felt most accomplished within the team? and (c) What do you value most caring for hospice patients with Alzheimer's disease? What do you most hope you can contribute to these individuals? After collecting the data I applied first cycle descriptive and second cycle pattern coding to identify the themes of the Discovery phase.

From the analysis of participants' transcripts the prominent themes were (a) Relational Bonding, (b) Teamwork and Collaboration, (c) Personal and Professional Satisfaction, (d) Empathy, (e) Communication, (f) Employee Recognition and Achievement, (g) Appreciative Attitude, (h) Leadership, (i) Commitment, and (j) Organization Awareness, which circled the positive core of caring. This positive core is embedded throughout the 10 prominent themes of the data analysis.

Discovery phase Theme 1: Relational Bonding. The first theme pertaining to the Discovery phase is Relational Bonding. This theme refers to how participants identify conditions and situations in which, they supported each other while dealing with other challenges and providing quality care to patients and their caregivers. Relational bonding within the IDG group was frequently mentioned as one of the determining characteristic to maintain an effective group. Participants identify and discover the natural conditions necessary for them to enter into and maintain a relational system that fosters support and respect for each group member's input, embracing trust and strong group leadership, and having a nonjudgmental atmosphere. Various members of the team referred to relational bonding as respecting the contributions of members to the team and the difference the team provides to patients and their families:

- Chaplain: "I do believe our home health aides are doing a wonderful job. . . . They really don't get the fame and chunk of affections they deserve. I would really like to see them have a more reasonable compensation........They are our representatives ....They do all the dirty work. This is a high-stress job. In order to lower group members' stress level, so that they can go out and perform again, I make sure.......during the week I would call them and say, 'How are you doing?.......Let's meet for lunch or a cup of coffee, or would you like to talk on the phone?'"
- Physician: "To help the family, significant others, and friends through the dying process is very difficult........The group accurately brings you the opportunity to know everybody who actually works for the group. You get information from the patients and from different sources, not only the nurses but the chaplain, the social worker, and especially the nursing assistant. In hospice, you are making sure patients are comfortable; you are helping patients not only medically. You are making sure that you are helping the patient with everything else that you put in this job."

- Nurse's assistant: "When you do all you can for a patient and the patient is satisfied, it is really encouraging. I enjoyed my work . . . I know I cause a change, when you can see the result that the patient is satisfied……..To deal with Alzheimer's disease, you use . . . touch and explain…….several times what you are about to do……..When you make a difference with a patient, it works for everybody in the team."

The chaplain, physician, and nurse's assistant indicated that relational bonding makes a difference with the IDG. In this theme, IDG members acknowledged their interconnectedness to each other, patients, and family members, which contributed to managing stressful environmental situations and relying on shared resources while fostering comfort to patients and their families. Relational bonding not only involves the connectivity of IDG members, patients, and their family members but also is recursive with the second theme of the Discovery phase: Teamwork and Collaboration.

Discovery phase Theme 2: Teamwork and Collaboration. The second theme relating to the Discovery phase is Teamwork and Collaboration. Teamwork and collaboration entail members making conscientious efforts that encompass giving back to the team, performing at their best, embracing diversities in people, differences in professional roles, accepting members orientations and belief system, and acknowledging the value each member perform in the group. The Teamwork and Collaboration theme in the IDG were emphasized by the nurse's assistant, social worker, and group leader in their transcripts as follow:

- Nurse's assistant: "Teamwork is an effort........We give back to our team, we help each other, and we take care of each other.......knowing that you have done your best on a day-to-day basis."
- Social worker: "Working with a diversity of people with unique background, idea, orientation and beliefs system, is what I love most........Things I never thought about in my psychosocial mind, a medical person would say something different. "
- Group leader: "All of our roles.......are interchangeable and are interconnected [,] ......the nurse's aide, doctor, chaplain, primary nurse, and the social worker."

Participants such as the nurse's assistant, social worker, and group leader work collaboratively as a team in making a difference to the IDG. For them, the theme of Teamwork and Collaboration depicted a sense of purpose that harmonizes the team's efforts. As team members make efforts in performing their roles, they co-construct team success, which is harnessed in the Discovery phase third theme: Personal and Professional Satisfaction.

Discovery phase Theme 3: Personal and Professional Satisfaction. Collectively, the participants described the Discovery phase third theme, Personal and Professional Satisfaction. This theme allows for flexibility, times spent with family, a sense of altruism, transcendentalism, pride, motivation, challenge, growth, opportunity for higher levels of learning, and camaraderie. The participants indicated ways their passions in caring for the well-being of patients in hospice promote personal and professional satisfaction among the IDG team. The physician, social worker, chaplain, and registered nurse described this theme in varying ways:

> **Physician:** "Hospice . . . allows me more time with my family and my son, who has special needs. Hospice is more flexible . . . to do what I know and like. ....I have family time for my kids and my husband who is also a physician. I started hospice, 10 years ago and ......this is what I really wanted to do because there is such a need. Hospice is very fulfilling........You have the opportunity to do what you have been trained to do, but also.......fulfilling because we live in a world in which everybody wants to live forever. Hospice is a little more relaxed where you are making sure patients are comfortable, and you are making sure you are helping the patient not only medically, but with everything else you put into this job........When you are helping somebody through one of the most difficult times of dying, I cannot imagine someone with the option to be in hospice is not.......when that difficult time comes."

- Social worker: "In the cases of Alzheimer's and dementia [,].......opportunities to help are greater than anything I have ever done in my life. My role is to provide the right resources for the patient and convince families they need more care.......and able to do it where they don't feel we [are] the opposition."
- Chaplain: "[Alzheimer's disease] patients cannot express their feelings, so I try to create a common space for them........This is very special for me to be able to let them feel that space. It is so satisfying helping people make the transition from life to death, being with them in their heart and their soul and being with the family who are suffering in their heart and soul."

- Registered nurse: “When I see a difference with patient’s care . . . and I received feedback from the family or the patient, that I have made some kind of difference through whatever dynamics they were going through [,] . . . that’s a high point.”

The physician, social worker, chaplain, and registered nurse reflected their roles in the IDG as providing medical, psychosocial, spiritual, and emotional care through their roles personal and professional satisfaction were evident. This theme of personal and professional satisfaction was embedded in their interpersonal relationships with their families, colleagues, patients, and the patients’ families. As a result, the participants demonstrated that as they provided care to patients diagnosed with Alzheimer’s disease, they become aware of making differences in people’s lives, which formed the basis for their personal and professional satisfaction. The theme of Personal and Professional Satisfaction is connected to the roles of IDG members and depicts their ability to be empathic in caring for patients diagnosed with Alzheimer’s disease and their families.

Discovery phase Theme 4: Empathy. The fourth theme in the Discovery phase is Empathy. *Empathy* refers to the sensitivity and emotional reactiveness that IDG member’s exhibit towards their patients and their family members, yet it is extended to team members. It is personable and varied from individuals to individuals. Empathy is contextual to experiences and in accordance with the roles of the IDG members. For the chaplain, physician, nurse’s assistant, and registered nurse, empathy involves going into deeper space, allowing someone to feel, making patients comfortable, dedicating one’s entire being, touching, becoming attached, plus feeling patients' and family members' emotions. These descriptions of empathy were depicted in the following excerpts:

- Chaplain: "People ask how . . . I do this. . . . My answer [is]. . . 'How can I not?' . . . I get to a deeper space by sticking with the team........It is very special for me to be able to let [patients] feel."
- Physician: "In hospice, you are making sure patients are comfortable; you are helping patients not only medically. You are making sure that you are helping the patient not only medically, but with everything else that you put in this job........What we do is very difficult. We put our heart and soul and mind and spirit, and sometimes we feel so overwhelmed."
- Nurse's assistant: "Patient is bed bound.......The family/caregiver wants the patient out of bed. You explain.......reasons a patient cannot get out of bed but they insist. . . . To deal with Alzheimer's disease, you use.......touch and explain . . . what you are about to do........Brief moment of clarity when I am finished taking care of them.......The patient might say thank you."
- Registered nurse: "It is sad when they come and go ....Sadder when I have had the patient for a time and they make a difference in my life. When I become attached and they become attached to me [,].......I become a part of their family."

From these excerpts, empathy was viewed from a spiritual, medical, helping, and relational perspective. Each perspective suggested IDG members bonding in caring for patients and their family members that make the difference in the dying transitions and the lives of others.

Discovery phase Theme 5: Communication. The fifth theme relating to the Discovery phase is Communication. This theme refers to as the heartbeat of the IDG. Various members of the IDG referred to communication as having the ability to initiate and maintain dialogue that express their thoughts, patients and families concerns in a clear and concise manner, which contributed to decision making of the IDG. The following quotes from participants' transcripts depicted the themes:

- Physician: "Communication is important. When the team is on the same page with the patient's plan of care . . . and everybody is telling you that the patient is . . . eating better [,] . . . the patient is more alert and smiling, and that is wonderful. When we are talking with the nurse's assistants, nurses, social worker, chaplain, and everybody involved in the patients' care for what we want for that patient best interest, that's a high point."
- Group leader: "When we have everything in place, being proactive, the families are, 'Wow [,] . . . if you weren't here, we couldn't have done this.' . . . It's nice to get phone calls from them saying, 'I am just calling to say thank you........We have a great communication and we need that simply because we are.......the families' sole source of medical care, managing symptoms [and] psychosocial, spiritual, and basic needs. We cannot be presumptuous. We cannot stereotype a particular family. Even within culture, there are different dynamics. That's something we have to learn."

Communication facilitates the interconnectedness of the team, the patients, their families, and the organization. It helps in disseminating information necessary for patients care plans and sharing pertinent information to the team. Communication is also important in providing clarity for team members as well as family members making contact with the organization.

Discovery phase Theme 6: Employee Recognition and Achievement. The sixth theme relating to the Discovery phase is Employee Recognition and Achievement. This theme refers to the value that is placed on each member's contribution to the IDG. Collectively, the participants felt that employees' recognition build and nurture stronger organizational atmosphere. The organization giving recognition and acknowledgment to their individual performance or group give them a sense of pride and the feeling of appreciation. These attributes also encouraged the repetition of positive behaviors, increased morale, loyalty, and enhanced team building. Employee recognition and achievement include tangible rewards or accolades such as a pat on the back or letting members know how special they are in carrying out their duties or celebrating special days. The following quote from the group leader's transcript depicted this theme:

> We implemented on the IDG celebrating birthdays by getting a cake and a gift for the birthday person. . . . We really just acknowledge each other........I think that just open up the window for people to hear publicly how their teammates feel about them ....I came into this team not knowing how people really interacted with each other........I think it really open up more doors for people to feel more comfortable to say, "Wow, I am really an important part of this team."

As expressed by the group leader of the IDG, employee recognition and achievement allows for the team to commend each other, foster personal comfort and open up space for people to know that they are appreciated. As the team feels appreciated, interaction among the group increases, which fosters the self-worth of each member.

Discovery phase Theme 7: Appreciative Attitude. The seventh theme relating to the Discovery phase is Appreciative Attitude. This theme refers to gratitude shown to IDG members from team members, managers, colleagues, and patients and their families. Appreciative attitude allows employees to feel valued for their work, because they are noticed and acknowledged for the work performed on behalf of the organization. Appreciative attitude is displayed when group leaders/managers' report the successes of the team members to upper management and employees are recognized monetarily or by words of thanks and/or by rewards. Additionally, appreciative attitude is demonstrated to employees from colleagues, patients and their families with expressions of gratitude through thankfulness or positive feedbacks.

The participants collectively agree that being supportive, respected, and considerate; help them to achieve their patients' goals. Thus information shared that generate positive feedbacks from customers or colleagues facilitate appreciative attitude. Additionally the group leader supports the IDG's successful accomplishments, which is circulated among the team by the group leader and other group members. The following quotes from nurse's assistants and registered nurse's transcripts depicted this theme:

- Nurse's assistant: "I think that . . . the team manager would be the person to notice what is happening........She is the top report of the success to the general manager. . . . People are compensated for doing a good job[,] . . . sometimes receiving awards such as nurse of the year........That['s] a good way for the feedback of that."
- Registered nurse: "Indicators of doing an excellent job comes in feedback from patients and families through thank you cards, appreciation card saying [,].......'Thank you for helping me to go through this,' 'Thank you for taking care of my husband/wife.' The indicators are definitely in the feedback which let me know that we are doing a good job."

Appreciative attitude promotes harmony within the organization and among IDG members yet suggests to employees that their work is valued by their patients and families. It reinforces to employees that their managers noticed and acknowledged their services and take keen measures to report successful efforts to the general manager. Appreciative attitude, therefore, connects to strong leadership, which is the eighth theme in the Discovery phase.

Discovery phase Theme 8: Leadership. The eight themes relating to the Discovery phase is Leadership. This theme refers to the characteristic of the IDG's group leader. Various members of the IDG referred to the group leader as one who is knowledgeable and who reacts positively to assist all the members in meeting their objectives. She possesses good communication skills and passes on information accurately to the IDG that inspire and motivate the members to bring out their best efforts to meet organizational goals through mutual cooperation and cohesive behaviour. The positive behavior she displays fosters respect for her and her IDG team. This theme was portrayed in transcripts of the physician and social worker:

- Physician: “To be honest with you, I think we have a wonderful team........The team manager helps with organizing all the team members........If you ask me what do I want to complain about the team, I would have to say, ‘Nothing.’?”
- Social worker: “There are not enough team managers. The manager position is so hard........When we are out there in the field, it’s like being in a vacuum; it is really scary. If my team manager is there, everything is fine but when she is not there, it’s very scary.”

Supportive leadership in the IDG assists with team organization, eliminate complaints, and promote a sense of security in the field. Leadership is, thus, viewed as reliable, dependable, and supportive within the team and in the field. As a result, leadership assists in co-constructing commitment of members in the IDG.

Discovery phase Theme 9: Commitment. The ninth theme relating to the Discovery phase is Commitment: This theme refers to members possessing a sense of dedication that remove restriction in offering care in the best well-being of the patients and their family members. Commitment evokes a strong sense of intention and focus from self to team, customers (patients and families), and the organization. The participants’ passion about the time and energy they put into their job reflected the positive co-construction of their experiences. The participants’ willingness to care for their patients becomes an internal sense of obligation and commitment to care for patients, their families, and IDG members. Thus, commitment is depicted in the devotion of their time and energy related to their job and personal responsibilities. The following quotes from the chaplain's transcripts depicted this theme:

> First of all, contrary to the organization objectives, I give every patient and their families my cell number. They can call me 24/7 on weekends and whenever they want........This is not a 40-hour job; this is a job where people need you. You can't tell anybody when to die; you can't tell anybody when to be stressful........People have to talk. If my phone rings at 9:30 or 10 p.m. at night [,].......that's okay.

Discovery phase Theme 10: Organization Awareness. The 10th theme relating to the Discovery phase is Organization Awareness. This theme refers to participants' social and professional interactions within the organization climate. Various members of the IDG referred to organization awareness as knowing the expectations of the organization management and their subordinate. They know who makes the decisions and who are able to influence them in getting things done. They are aware of how their actions and behaviors are affected by the values and culture of the organization. The participants collectively understood the internal workings of their company, knew how to get their work accomplished by utilizing and respecting each IDG member input. Their reliance upon each other and the relational bonding that existed throughout the group is what make the IDG successful. The following quotes from participants' transcripts depicted this theme:

- Group leader: "I think if we are allotted more time according to what is going on with the patient [,]. . . . We would be able to shine more........Being more proactive, for example........Having more time allotted. I can anticipate more things and be better prepared........I can sit with the family longer and explain in more detail what is going on with their loved one."

- Chaplain: "When I am with an Alzheimer's patient, depending on how advanced their Alzheimer's is, sometimes, they will look at me and open their eyes.......I will recite a familiar Jewish prayer and I can tell by their facial expression that it has gone into their mind. If they are Christian, Catholic, I will recite the Lord's Prayer and if they are Muslim, I have Muslim prayers. . . . Most people with Alzheimer's disease are seniors, so I don't go to the modern prayers.......The old prayers they would recognize and from their eyes and their kinesis and their body expressions, I know that they have heard me."

Organization awareness is a product of self-awareness in which IDG members evaluate contextual issues and appropriate the required responses for the benefit of all involved. So even when time is limited they maximize outcome by operating within the ambit of what is available from organizational procedures. Thus, organization awareness eliminates mediocrity and foster conscientious evaluations that allows for actions that make a difference for patients and their families. As a result, the team and the organization benefits when all members possess organization awareness. This 10th theme indicated the importance of care that is necessary within hospice settings. Therefore, caring is seen as the positive core of the Discovery phase.

Discovery phase: Positive core caring. In the data analysis, the positive core of caring was highlighted within all the themes of the Discovery phase. Care was seen as a sense of purpose depicting compassion for the overall well-being and safety of patients, their families, and the IDG's members. The positive core provided the participants the opportunity to elaborate on their experiences in working on an IDG. Each participant's perspective suggested that bonding and caring for patients and their family members made a difference in the dying, transitions, and the lives of others.

Caring is connected to the compassions and unselfishness of the IDG for patients diagnosed with Alzheimer's disease. Seemingly from the nurse's assistant perceptions, the positive core of caring revolved around caring for the team and caring for the patient. The social worker positive core of caring resolved around meeting patients,' IDG members', and caregivers' psychological and emotional needs. The physician's perspective of caring was making every effort to keep her patients' symptoms under control. The team leader in general caring involved the patients their families, the IDG, and the organizational goals and objectives. The relational systems cycle in Figure 5 illustrates the 10 themes of the Discovery phase with caring as the positive core.

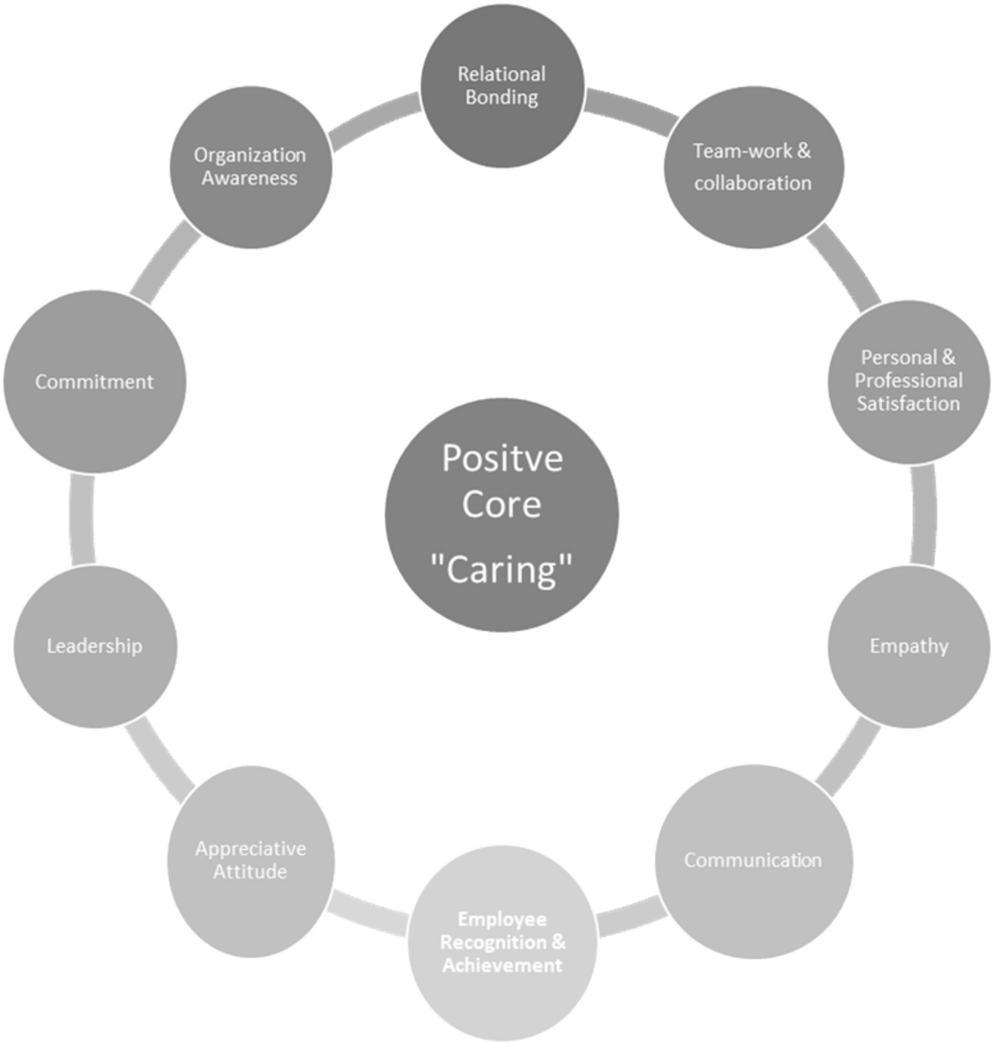

Figure 5. Relational systems of the Discovery phase of an exemplary interdisciplinary group showing what works well in hospice setting with Alzheimer’s disease patients. Ten themes emerged from the data analysis Discovery phase, with caring seen as the positive core.

Dream Phase

The Dream phase was analyzed using descriptive second cycle pattern coding to develop a more condensed interpretation of participants’ experiences. According to Saldaña (2009), descriptive coding is the process that enables the researcher to move from multiple codes in the first cycle of coding to a few major themes, categories, or at least one theory or narrative in the second cycle. Combining the Dream phase descriptive coding with AI, people are asked to rediscover the best of what is in order to dream boldly and initiate what could be (Whitney & Trosten-Bloom, 2003). In my analysis of the Dream phase, responses from the participants indicated what worked well with the IDG, and provided their dreams of what could be better for IDGs in a well-run organization. The participants' interview data of the Dream phase fell into two themes: Overall Changes in the Health Care System, and Well-Run Organizations. Theme 1 contains three subthemes: (a) Supportive Environment; (b) Consistency in Patient Care; and (c) Manageable Delegation of Workload. These subthemes would support the accomplishment of the second Dream phase theme, which is to create well-run organizations in hospice settings caring for patients diagnosed with Alzheimer's disease. The two themes and three subthemes of the Dream phase are illustrated in Figure 6.

Each participant was allowed a reasonable amount of time to visualize their dreams. A few of the participants took a longer period of time with their responses to the dream questions whereas others were readily available to visualize their dreams. Each participant shared dream aspirations, desiring an overall change in the health care system, which would foster strategies to encourage a supportive environment, consistency in patient care, and manageable delegation in work load. These strategies would promote better possibilities for a well-run organization. The participants' descriptions of what they envisioned for a future exemplary IDG were portrayed in the participants' analysis of new possibilities.

Dream phase Theme 1: Changes in the Health Care System. Figure 6 below shows conditions necessary to create changes in the health care system would result in a well-run organization, thereby generating favorable exemplary IDGs. Participants envisioned that changes in the health care systems would comprise of three dreams needed to represent exemplary IDGs in well-run hospice care settings: a supportive work environment, consistency in patient care, and manageable delegation of workload.

Supportive work environment. The participants shared the consensus that the organization, supervisors, and group members foster a supportive environment. From the organization perspective, it is necessary that the organization not only support the daily operations of the company but also promote a supportive environment for the group leaders as well as the IDG members and all other employees. This would include supervisors consistently supporting the IDG members through difficult or challenging situations involving patients or personal issues. Equally, supervisors encouraged a positive environment by validating members on jobs well done. Additionally, the group supervisors could further enhance the IDG by being better equipped as the resource persons, assisting in gathering and disseminating information that would enable employees to maximize productivity on a more consistent basis at all times.

Likewise, the participants identified their support and appreciation of each other, but extended their dream to include such support and appreciation to be exemplified in all IDGs. Thus, the participants of this study emphasized that all IDG members become more cognizant of the importance in supporting and appreciating each other as each member contributes uniquely to the team’s effective functioning.

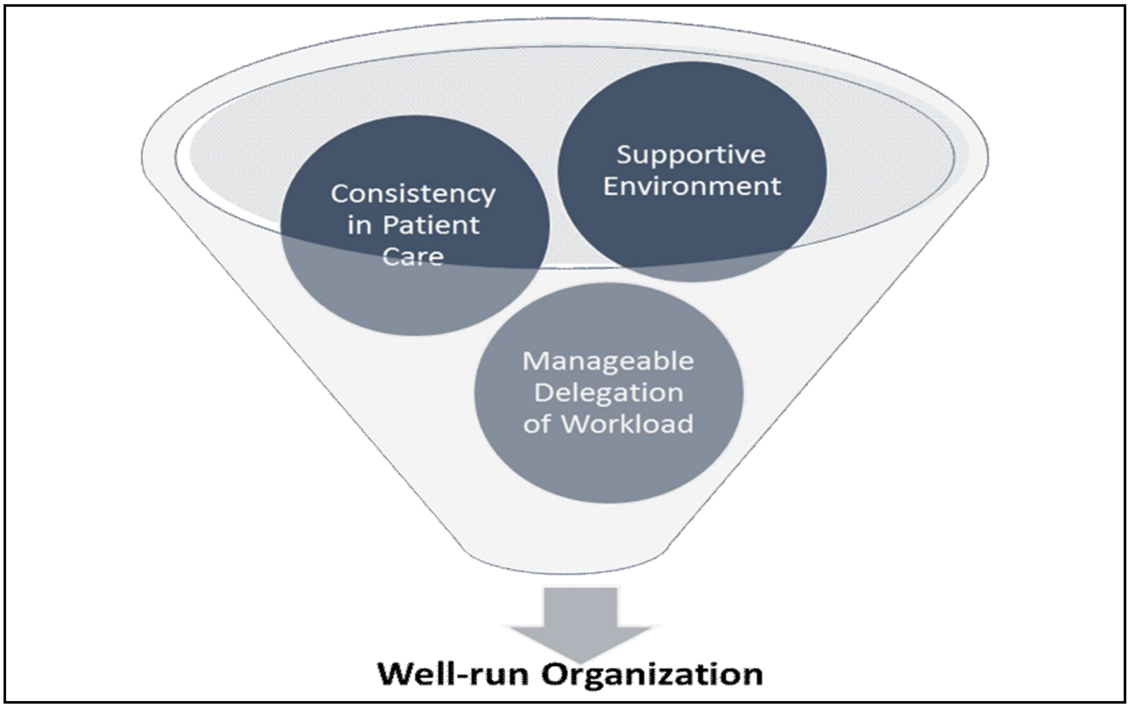

Figure 6. The Dream phase of exemplary interdisciplinary group, new possibilities of a well-run hospice organization, which emerged from data analysis.

Appreciation of IDG members involves group members having a sense of being comfortable with their group leaders, the organization, and accepting each role as valuable for the group's success. The chaplain and physician viewed the value of the group's success to include the organization reviewing the compensation and/or encouragement of members who work hands-on with patients and family. The chaplain said,

> I would really like to see the nurse's aides have a more reasonable compensation. . . . They are our representative with these families, and they do all the dirty work.

> I help them to feel in their hearts enough compassion to do their jobs . . . This is a high-stress job.

The chaplain's support for the IDG takes on a tone that would contribute to his dream of making things better in future IDGs. In his view, the dream of the IDG progressive success is to reevaluate the individuals who do all the dirty work with appropriate compensation commensurate to the job they perform. The chaplain to the group encouraged the nurse's aides to maintain compassion for their job. As a result, he hoped that with appropriate compensation, he dreamed that his encouragement would continue to help other people embrace their successes with the IDG.

Similar to the chaplain, the physician reiterated,

> Sometimes, you feel like you need that pep talk, you are doing a good job. I feel like nobody tells me that . . . I know other people feel that way. To say, "You're doing a great job, a wonderful job"—that's where the organization needs to do better.

The physician and the chaplain both felt that complimenting the members on their contributions to the IDG would lead to new possibilities for the organization. For them, valuing members by letting them realize their contributions to the successes of the IDG is what the organization can improve on to have more exemplary IDGs.

Consistency in patients' care. Participants, especially the social worker, dreamt of having consistency in patients' care, which would contribute to better quality care for patients and families. Consistency in patients' care would perpetuate quality and enhance the IDG as well as the organization's successes. Thus, the responses to the dream statements envision a better quality of patients' care include medical management running more smoothly by allowing other members to access more accurate information. The social worker said,

> The inconsistencies of nurses are really uncomfortable for patients. Our nurses, in particular, have too much paperwork. There is not enough consideration taken for the type of work they do. When you have patients who are extremely ill [,] . . . it just requires more time........I think the nurses are really getting worn out. We are not looking at the most critical issues, which are the need for more staff, especially nurses, to be consistent with patients' care; we are just looking at numbers.

The social worker's dream was for greater level of consistency and providing patients' comfort as a priority of nurses' duty rather than the focus on paperwork. In other words, the consistency in patients' care should become the nurse's primary focus, whereby they are less task oriented and more relationally connected to patients and families dealing with end-of-life issues. Additionally, the organization should become concerned about nurses' burnout and assess delegating manageable workloads.

Delegation of manageable workload. The ability to effectively delegate a manageable workload is an essential skill for group managers and nurses. The participants envisioned in their dreams for a more improved IDG having an appropriate allocation of work. The participants believed that the ability to implement a practical work load is essential for teamwork that lets individuals share responsibilities. Success in teamwork generates a strong sense of collaboration, pride, and accomplishment within the team. Thus, the ability to effectively delegate is an essential skill to foster new possibilities. Usually delegation falls under the responsibilities of the group leader. If done poorly, there could likely be conflict, low productivity, and dissatisfaction among group members. These lead to disharmony and high attrition in an organization.

In dreaming about workload appropriation, the group leader cited the importance of quality time in providing quality care:

> I would like to see where we could have more time to spend with the patients. I don't think that we have the capability to provide care . . . up and beyond to really shine to other colleagues. I think that we need more time and body to do that. So being that we have standards of how many patients we have to see........There are times that we need more time than is allotted to be able to shine more.

The group leader envisions an adequately staff IDG with reasonable time allocated to provide quality care. She felt that her group, if given that help, would be able to better "shine." For her, the standard of care would be enhanced with the organization recognizing the importance of quality care in accordance to time and staff allocation of tasks.

The physician, on the other hand, emphasized empowerment, dedication for her patients, and support from other members within the health care system to foster change as well as enhance IDGs. The physician cited that

> The nurses need to know their patients........Physicians need answers to determine patients' appropriateness for hospice. The chaplain, social worker, and physician [address] patients and families social, economic, and spiritual issues. My concern

> is with the patients and the patients' families. If the organization . . . can find ways to lessen the paperwork, we can . . . actually have more patients contact.

In essence, the physician envisions her dream of an IDG providing quality care as one that spends less focus on paperwork and is more focused on patients' and families' psychosocial, spiritual, and physical well-being, being mindful of the threats of lawsuits to the organization and professional responsibilities.

Dream phase Theme 2: Well-Run Organizations

As society ages and more seniors are being diagnosed with terminal illnesses such as Alzheimer's disease, the health care teams, including physicians, nurses, group leaders, and other health professionals in hospice settings will be required to focus on more efficient and effective ways of providing quality health care. This will involve the prioritization of medical models being more systemic in their approach to coordinating care, reducing costs, disseminating roles, and improving care to patients and their families. These are the dreams of the participants in working towards having well-run organizations for hospice care.

Therefore, the participants envisioned that a well-run organization should first entail implementation of strategies to assist in the elimination of the nursing crisis. This will mean the organization becoming more acquainted with the issues that nurses face in hospice settings and taking steps in improving IDGs to operate at their optimal levels. Secondly, it will be imperative for organizations to adapt new approaches to ease the workload of the IDG members, which will require ongoing acquisition of knowledge to care for Alzheimer's patients. However, knowledge does not become the sole role of the organization's management, but also all health care providers improving knowledge and putting their hearts into the work. As was emphasized by the physician, a well-run organization should reflect more than knowledge, adding commitment of the heart for one's work:

> Health care providers need more than knowledge to care for Alzheimer's patients. They need to put their heart in their work—not only for a paycheck but for the goodwill of the patients. Once there isn't any resistance and patients' needs are met [,] . . . things will be very good. We are a very good team and we welcomed and supported the facilities where our patients reside. Caring for Alzheimer's patients, I think the best case scenario is that our team takes care of . . . this type of disease in a nursing home or assisted living facility. However, I am old schooled. I would love to see these patients living at home . . . but with our crazy schedule, the Baby Boomers, work, marriage, and young children, it is difficult. The perfect scenario is to have them live at home with help.

The physician envisioned IDGs having more knowledge to care for patients with Alzheimer's disease, as well as a heart for what they do. Moreover, she would prefer for patients to remain at home and be cared for, but recognized the challenges such a dream would have on family members. Therefore, she envisioned hospice settings having exemplary IDGs to provide care as alternative avenues in which family caretakers depend on the role of hospice teams. The IDGs' roles thus become tantamount to operating a well-run organization.

Similar to the physician, the group leader advocated for IDG educational growth but from a different perspective:

> Our organization . . . had a group of college recruitment officers who lectured on employees furthering their education. . . . I was very thrilled........I shared the information with my group........It was encouraging seeing that they understood that education is power, knowledge, and wisdom. I also shared that furthering education was not just about medical field. They had the opportunity to go back to school for a master's in business administration, medicine, or information technology. Being able to encourage them and to see them embraced the information was a wonderful thing.

The group was cognizant of the role advance education will have in enhancing a well-run organization. Her dream was for members of the IDGs to embrace professional diversification as opportunities for growth and expansion within a hospice setting. The group leader and the physician envision the impact knowledge will have on enhancing a well-run hospice organization, though both spoke about knowledge differently. The registered nurse envisioned continuing support for her group as the dominant criterion in achieving favorable outcomes:

> By supporting each other, we can get more done because we don't look at each other as "You are this" and "You are that." We work together in an effort to reach our goals by getting whatever it is that our patients need, their families need, and where they are comfortable.

The Dream phase for the registered nurse depicts the need for organizational support for group members, which will contribute to the elimination of roles being blurred because members working in unison will be for the ultimate good of the patients and their families. As a result, group members' togetherness becomes paramount in achieving the goals for each member, the group, patients, their families, and the organization. As members' togetherness promotes unity with all the systems involved, a well-run organization evolves for all.

Summary. Overall, each participant's dream statement was for the betterment of the IDG operation. Their dream statements would foster camaraderie that promote and acknowledge the uniqueness and importance that each member brings to the group. The participants' narratives identify their feelings of self-worth, as they saw themselves as the best group of nurses, nurse's aide, physician, social worker, and group leader who want to have a positive influence on other IDGs by sharing their knowledge of what it takes to be an exemplary IDG. An exemplary IDG included allowances for nurses to spend more time with patients, providing quality care that is less cumbersome with paperwork, better compensation for nurse's assistants, advance education involving knowledge of Alzheimer's disease, and diversification into fields that will add to organizational development, leading to enhancing support within IDGs, thus fostering unity and achieving goals for all. With unity and achievement of goals, participants dreamed of improved hospice organizations, which fueled the emergence of the Design phase. The Design phase embarked on new beginnings, bridging the best of what is with new ideas about what might challenge the current situation to offer new possibilities for positive change (Whitney & Cooperrider, 2000).

The Design Phase: Engaging Vision

The Design phase of my AI evolved from the Dream phase by further analysis of the data using descriptive coding. Thus, descriptive coding for the Design phase concentrated on developing a thicker description of participants' experiences. In this phase, people were asked to envision their dreams as if they already existed. Thus, the Design phase illustrates the proposal for change through trajectories of dreams coming alive, but taking into account the reality of the context in which it would be applied (Whitney & Cooperrider, 2000). Accordingly, the design statement for this study considered factors that affect the design process and environment of IDGs, such as the need for processes that are exclusively appropriate for the unique contexts and requirements of an IDG.

The Design phase evolving from the Dream phase of characteristics for change in health care systems involving supportive environment, consistency in patients' care, and manageable delegation in workloads could promote a well-run organization by describing the major themes of the participants' best stories. In other words, the Design phase of the interviews led to *provocative propositions,* which bridge the best of what is with what might be (Hammond & Royal, 1998). As a result, six provocative propositions emerged as the themes that fundamentally reflect exemplary IDGs' views for organizational changes. Six themes that emerged from the design questions with the interviewees: (a) Taking Care of Each Other, (b) Giving Recognition in a Timely Manner, (c) Constructive and Receptive Feedback, (d) Respecting and Receiving Group Members' Contributions and Opinions, (e) Valuing Openness, and (f) Daily Fulfilling the Commitment to the Team.

Design Phase Theme 1: Taking Care of Each Other

The participants working on the hospice IDG possess a strong relational paradigm, which is interconnected, to patients, patients' families, IDG members and the organization on a whole. Consequently, group members' actions do not occur in isolation but are related to one another and members mutually depend on each other to facilitate their role. As such, participants viewed that taking care of each other was essential to enhance the operation of an exemplary IDG. The physician and nurse's assistant cited ways taking care of each other affects the team:

- Physician: "The chaplain, especially, on the team, he is wonderful. He brings the spiritual support not only for the patients and the families but for the entire team."
- Nurse's assistant: "We support the organization's value. We take care of each other's. All our values are very important........It is very important that we make a difference because when you make a difference with patients, it works for everybody in the team."

From the physician, the way the chaplain extends spiritual support to patients, their families, and the entire team seemingly impacts the positive core of the IDG, whereas the nurse's assistant cited the entire organization and group members working as interrelational systems, which take care of each other and being the "difference which makes the difference" (Bateson, 1972, p. 459). Care for others in the Design phase thus builds on the positive core of care from the Discovery phase. Caring, therefore, is connected to a supportive environment in the Dream phase, which is necessary to operate a well-run organization in a hospice setting. Concurrently, participants collectively believed that another custom of generating members caring for each other in a well-run organization is to give recognition in a timely manner.

Design Phase Theme 2: Giving Recognition in a Timely Manner

Recognition cultivates a sense of organizational support and self-satisfaction. These senses of support foster effective organizational commitment and enable employees to receive support from the employer. The chaplain highlighted the necessity for recognition in hospice work:

> Recognition especially for the nurses and nurse's assistants, whom have a very difficult job, is necessary........I believe some kind of recognition for them, if there is nothing in the way of money.......then it can be a pat on the back, saying, "You are doing a great job. Thank you." That goes a long way in showing appreciation.

The chaplain emphasized that the task of caring for patients diagnosed with Alzheimer's disease is difficult for members of the team. However, tangible or intangible recognition is vital in maintaining motivation of IDG members within the organization. When members feel appreciated, productivity, creativity, and commitment become overarching tenets within a well-run organization. The need for a well-run organization is not only the outcome of the Dream phase but also becomes linked to the Design phase of the organization for recognizing and appreciating IDG members. Recognition and appreciation are correlated to constructive and receptive feedback, which facilitates professionalism as well as personal development within organizations.

Design Phase Theme 3: Constructive and Receptive Feedback

In the Design phase, participants indicated that constructive and receptive feedback embodies symmetrical and complementary interactions (Keeney, 1983) within organizations having IDGs. These interactions are generated in the Dream phase as possibilities for changes in the health care system, which, through descriptive coding, becomes evident in the Design phase as practical steps within IDGs to foster what might be. Thus, constructive and receptive feedback is a recursive practice from employers, supervisors, patients, family members, and group members that promote exemplary practices of IDGs. The registered nurse and social worker pointed out the following:

- Registered nurse: “I get feedback from my manager always; she says, ‘You are doing a good job out there.’ I also receive feedback from patients and families through thank-you cards, appreciation cards saying, ‘Thank you for helping me to go through this,’ . . . ‘Thank you for taking care of my husband/wife.’ The indicators that I am doing an excellent job are definitely in the feedback.”
- Social worker: “The way the family and patients respond to us is through those surveys sent out for quality assurance. Families are very vocal. They tell us what we are doing well and what we have not done well........Our team manager called and asked, ‘How is it going? Are you getting what you need?’”

The registered nurse and the social worker expressed that feedback is a necessity to enhance employees' behaviors. Feedback is given by the manager as commendations, and patients and family members give gratitude as feedback. Gratitude as feedback serves as an indicator that particular group members have done an excellent job. The organization harnesses such feedback by implementing collection of surveys which are used for quality assurance. The social worker highlighted that such surveys inform the organization what is being done well, yet caring inquiries from team managers are clues to members that they are doing well.

On the other hand, the group leader monitors the operations, especially after-hours reports, ensuring that there are no breaks in patients' plan of care. She also emphasized that feedback is given by family members expressing thanks or sending donations to the organization:

> Good indicators are looking at the after-hours reports . . . and see that patients' medications are filled........Sometimes, the day gets altered, things shifted, but patients still need to have their medication. The mile marker that we are doing a good job is seeing what is on the after-hours report; I think this is a good indicator when I don't have these things [missed medication or a break in the plan of care] on that report. As for patients and families, it's nice to get phone calls.......saying, "I am just calling to say thanks." When families call and say that we are doing a great job that means a lot. The organization knows about these phone calls, when we receive thank-you cards and donations from patients and families.

The group leader indicated that after-hour reports, which are standardized procedures of the organization, as well as communication with patients' families, serve as constructive feedback to provide quality assurance. As a result, what the team does well and what may improve in designing changes are identified. Thus, members become aware of ways they continually contribute to the team's optimal operations and the organization's goals. As such, respecting group members' contributions and opinions becomes evident among the IDGs as well as the organization.

Design Phase Theme 4: Respecting and Receiving Group Members' Contributions and Opinions

When group members know that their contributions and opinions are received, they feel respected. Feeling respected motivates members internally to strive to give their best and to share new ideas. When group members are allowed to voice their ideas, they get the opportunity to evaluate what may be best for patients in varying situations. This further communicates support for each other and assists the team to face challenges together. The registered nurse stated that

> We support each other. We help each other! If somebody commented on something, it helps, and somebody else commented we as a group put it all together to come to one common goal ....Group efforts help to get through the challenges........It works because I may have an idea and didn't think that there is something else that could work and somebody may come up with something else.

From the registered nurse's perspective, respect between group members provides feelings of admiration, which promotes personal self-worth. When IDGs members feel personal self-worth, there is a sense of group-oriented focus for the team. Consequently, group members act collectively, relationally, and cohesively, with all group members profiting from such contributions. When members acknowledge each other's unique contributions, the team promotes openness within the IDG.

Design Phase Theme 5: Valuing Openness

Participants indicated that valuing openness among IDGs enhances the communication and provides continuity in patients' plan of care. For example, the physician believed that communication is vital to the openness of the group:

> The way I do this is through communication with the phone or text messages. Communication is number one . . . Everybody knows what's going on . . . When there is a lack of communication [,] . . . everything is disrupted. I need to know if the patient has any social economic issues that the physician is on board talking with that family. I need the social worker and the chaplain's involvement. When there is depression with the patient or family member, I need the chaplain to help me with the spiritual support.

Valuing openness through communication allows for the appreciation of role diversity, both professionally and culturally within IDGs. The IDG members performing their roles transmit valuable information to other members in the group, resulting in better job performance and patients' care. With better job performance and enhanced patients' care, group members demonstrate their commitment on a daily basis to the IDG.

Design Phase Theme 6: Daily Fulfilling the Commitment of the Team

Members of the IDGs are cognizant that their commitment to each other assists in fulfilling the daily commitment of the team. Therefore, they work with the zeal that they are contributing to the success of the team despite their emotional feelings of frustration. In achieving the success of the team, there are challenges faced by varying members, such as feeling overloaded with paperwork. The physician cited that requirements of documentation by the organization take away time spent with the patients:

> At times, I feel the frustration of a lot of work........To describe it in one word, it would be *paperwork*. I see the frustration on the paperwork that the company needs to be filled out. Unfortunately, in this world, everything is a lawsuit and everybody who practices my kind of medicine or any kind of medicine does so with a question mark. Unfortunately, we live in a world that we need to document everything and it's so far exaggerated........My concern is with the patient and the patient's family, so I think the organization may actually try to find ways not to have some paperwork so they can actually have more patient contact than filling paperwork.

Although the physician recognized the importance of documentation due to legal implications, it was felt that the organization might implement measures to reduce the time spent on paperwork. This would allow for more quality time in caring for the patients.

Comparatively, the social worker explained that the organization needs be more considerate of the chronicity of the patients served and delegate workload to nurses accordingly. The social worker stated,

> I think that often times our nurses in particular have too much work to do. Their workloads are just too high; it's just too high. I don't think that there is enough

> consideration taken for the type of work that you are doing when you have patients in the community, when you have patients that are acutely ill.

Whereas the physician and the social worker indicated the high workload demands among the medical staff, the group manager described the overlapping roles of the nurses, resulting in even greater demands on their time. The group manager pointed out that nurses sometimes find themselves having to resolve psychosocial, spiritual, or mental challenges the patient or the family is experiencing:

> Sometimes, the nurses drifted into the psychosocial or spiritual role but are very quick to make that phone call letting me know what is going on . . . I don't just want them to have tunnel vision. I think that is a great way to grow. However, I have to be careful because there is a fine line between going outside the scope of one's practice and one's actual profession. But in the same token, I want everybody to be involved.

The group leader is cognizant that each discipline should maintain their professional boundaries; nevertheless, she recognizes the value of members' overarching roles. The overarching roles provide group members with the opportunity to be aware of patients' challenges from all perspectives.

The participants' transcripts highlighted that commitment to the IDG and the organization fosters a sense of a positive employee's proficiency, which helps to fulfill the requirements of group members to meet their daily goals. In general, the Design phase brought out that members, in their commitment to their daily operations, are able to take care of each other, harness constructive and receptive feedbacks, and respect and receive group members' contributions and opinions, thereby valuing openness, which promotes the organizational goals. As a result, through such mutuality in their roles, the participant portrayed the proposal for change that is typical of the Design phase. The Design phase moves to the final phase of the AI 4-D cycle, the Destiny phase. This phase delivers the dream and the new design of what will be. According to Barrett (1998), the Destiny phase is one of experimentation and improvisation, sometimes described as *organizational jazz*. This jazz is likened to building and learning on what is already known until it becomes a part of a repertoire to facilitate transformation (Barrett, 1998).

Destiny Phase: What Will Be

The fourth phase of AI is Destiny, which delivers on the new images of the future and is sustained by nurturing a collective sense of purpose and movement (Cooperrider et al., 2008). It is a time of continuous learning, adjustment, and improvisation—all in the service of shared ideals. The momentum and potential for innovation and implementation are extremely high. By this stage in the process, everyone is invited to align their interactions in co-creating the future (Cooperrider et al., 2008), thereby fostering a shared positive image of the future. In analyzing the data to reach the Destiny phase, an interactional cycle depicting the appreciative inquiry 4-D cycle evolved. This portrayed the entire processing of the 4-D cycle as circular and recursive in nature. The Destiny phase provocative proposition is seen as a bold statement that brings the participants' dream to life. As a result, the Destiny phase interacts with the Dream phase, bridging the dream to the Design phase, the Discovery phase, and then to the Destiny phase.

Subsequently, as all phases are actualized, the cycle recalibrates to any of the phases—Discovery, Dream, Design, or Destiny.

In this study, the two questions for the Destiny phase focused on small changes of the IDG. Specifically, it focuses on what members need to make right to engage in improving their group, thus contributing to realize their dreams. With these questions, I asked participants to think of creative ways in bringing their dream to actualization by reflecting upon their previous responses of the interview questions. Therefore, they were asked to recall best practices of their IDG and integrate the responses into the Destiny phase, inspiring them to bring their dreams alive. Such responses were aligned to their provocative proposition for the future; that indicated a collective sense of purpose and movement to enhance an exemplary IDG.

Provocative proposition: Shared ideals. The *provocative proposition* is a bold statement that brings a dream to life. It is the statements that bridge the best of what is with the organization's vision of what might be. It becomes the written expression of the organization's desired future that is written in the present tense to guide the planning and operations in the future. It is also known as the *vision statement* and must be a positive statement about what is desired.

In asking the questions related to the provocative proposition, participants varied with their responses. Four participants projected what might be in the future in the Destiny phase whereas two participants saw the IDG already at its best, indicating that they were presently living their ideal. The physician presented a provocative proposition statement that projected into the future her dream of what it might be to achieve an ideal in the Destiny phase. The physician conceptualized her provocative proposition statement

> All my grandparents had Alzheimer’s so it’s always on the back of my mind that I have a high incidence and strong possibility to suffer in the future. I try not to think about it, but I would love to find a cure or at least an effective treatment for Alzheimer’s disease. I would love to see more patients being taken care of at home........Families need to care for those patients. Patients who do not have the blessing to stay at home with the support of their families, friends—or community-based centers, then hospice, just to be in good places. Good places . . . that are clean and safe and take good care of patients, medically, psychosocially, spiritually, and emotionally. So what do I need to do? I need to find the best place for them, to make sure they are getting the care, the assistance, supervision, and safety. That would be my dreams come true.

The physician’s ability to positively posit her provocative statement of finding a cure for Alzheimer’s disease was based on her personal experience with Alzheimer’s disease, her background as a researcher in gerontology, and working with the geriatric population in hospice, as was described earlier. These attributes seemingly contributed to her demonstrating proficiency in continuous learning, adjusting, and collaborating with IDG members in finding innovations that bridge her dream to the future. Hence, through her work in hospice with her IDG, she dreams for best care, assistance, supervision, and safety for patients. Her Destiny phase is augmented in progressive research as well as working with her IDG members to facilitate best practices for patients with Alzheimer’s disease on a continuous basis. The physician presenting her provocative proposition statement implies that her vision may become possible through reliance on research and the participation of others in her dream. Her achieving her stated ideal bridged the operation of the IDG with how other members perceive their roles.

Comparatively, the registered nurse's Destiny phase was illustrated with her conceptualization of being a mentor to new nurses, depicting her reliance on transmitting knowledge and mentoring others:

> I contributed to the profession by helping new nurses. I love to teach........I like to impart my knowledge. . . . I like to give them what I know so that they can learn. . . . They may change and do better than I did—that what is I would like to do.

The registered nurse viewed her role not only as imparting knowledge but also teaching others, believing they will do better and even advance to higher levels of learning that will facilitate change. Her Destiny phase is the continuation of knowledge through teaching and mentoring that allows others to attain advanced levels of learning to promote change.

Change is therefore constant in the Destiny phase and bridges the best of the organization with what might be when all segments of a hospice organization become acquainted with the operation and the mission statement reflects a three-pronged design of care: care for patients and families, care for each other, and organization showing care. This three-pronged Design phase was depicted in the chaplain's provocative proposition:

> I believe that every single person in.......senior management and corporate should spend a week or two in the field to see what.......is needed for the other teams to

> look at things differently. I would like to see on the back of our badge, patients and families come first and we take care of each other. The patients coming first, I really believe the organization should introduce an electronic group for caregivers' grief psychotherapy so more people can attend. My legacy is to find more ways to help people.

The chaplain envisioned administrators having hands-on patient care experience to be more appreciative of the work the staff does caring for patients. Gaining hands-on knowledge by interacting with IDGs in the field (caring for patients) might expand the vision mission statement of the organization to reflect the positive core of caring. Within this positive core of care, the chaplain envisioned adding electronic psychotherapy grief groups for caregivers, thereby reflecting the organization becoming innovative in caring for all systems involved in hospice.

A system of care requires leaders striving to connect all elements of hospice's operations in reaching the best of what is. This is the role of the group leader. For the group leader interviewed in this study, her vision of what might be is to strive for positivity through connectedness. She said, "What I am seeing is connection [with other IDGs] because if you care more and you are feeling good, it is going to trickle in every aspect of your life."

The Design phase for the group leader envisioned caring more and allowing what is done in one exemplary IDG to trickle down to other groups that become reflected in among team members and in their lives. Thus, connectivity of the best in one IDG to the best in others bridges the future operation of the organization, which is a vision of the what might be when all IDG members envision each other as connected to the common goal of caring. Consequently, caring is not only an ideal of the Destiny phase but also recursive with the positive core in the Discovery phase.

Although two participants did not provide a provocative proposition, they view groups already operating at their best. For instance, the nurse's assistant and the social worker view the IDG as functioning in providing what was needed. Therefore, they were unable to envision what might be for the organization in the future. The nurse's assistant said, "I am not certain about that because it seems all the groups are doing great"; the social worker said, "I don't know if that can be really changed. . . . People feel needy. . . . Families really want the nurses there. I don't know if that can be changed."

The *provocative proposition* is a shared concept that is interrelated with all members of the group. There were participants such as the physician, registered nurse, chaplain, and group leader who envisioned the best of the group and projected a vision for what might be in the future based on their experiences or perceptions with research, patient care, training, mentorship, social and organizational adjustments of mission, as well as leadership promoting interconnections. Indirectly, two participants implied the best of the present, which can serve as a means to inform the future. Thus, their roles in guiding the planning and operations for the future were not in their provocative proposition statement. Therefore, the Design phase of the study illustrated that shared ideals were connected to what participants view as already achieved and visions others have in enhancing the operations of the IDGs.

Collective Overview of Participants Interviewed

My reflection on the participants' interview data led me to believe that the sense of security and support the group creates encouraged participants to take more initiative in applying themselves. In situations in which an IDG member felt alone when working in the field with patients and families, the member found encouragement and inspiration from other team members. This was specifically stated by the social worker as follows: "Sometimes when we are out there, I hear my nurses say this, too........If my manager is there, everything is fine but when she is not, it's scary." This expression implied that the support the members received from their group leader, coworkers, and the organization builds commonality reliance and a focus to achieve their shared goals. Such encouragements and assistance help to boost their confidence to be successful achievers. Altogether, the support of the group environment helps to increase productivity and help employees become more motivated at work.

Collectively, the total value created by the IDG was based on the effectiveness of their group effort. In one instance, the physician felt that her group functioned well because the team has gained the members' trust to be nonjudgmental, saying,

> The good thing about our team is that.......everybody is real. There is no masquerade. Everybody is open to talk and we have the trust. When we are talking, we are talking what we really think without any fear of what anybody else is going to think.......because we have been together for so long. When I open my mouth, I honestly don't think you're going to judge me ....I feel comfortable. I

> feel that I can actually speak my mind........That is trust, being able to open up without that fear of being judged.

The participants each bring their own sets of unique values to the IDG with a certain set of relevant skills and knowledge. Some of those experience areas overlap and others are distinct to one or two employees. In their weekly group meeting, everyone gets the opportunity of shared knowledge and experience. Pooling their resources makes it easier to handle challenging situations by drawing from expertise of other group members.

All the participants described the 10 themes but in varying level of intensity. For instance, the physician, registered nurse, nurse's assistant, and chaplain were more focused on Communication, Appreciative Attitude, Relational Bonding, Teamwork and Collaboration, and Empathy whereas the group leader and the social worker focused on these themes but Empathy was less dominant and Personal and Professional Satisfaction, Employee Recognition and Achievement, and Organization Awareness were more highlighted. These focuses of members of the IDG seemed to exemplify their direct involvement with the physical, relational, and spiritual management of patients and/or family. However, the themes universally emphasized by all six participants were Communication, Appreciative Attitude, and Relational Bonding.

Summary of Findings

Following are the research findings in response to the research question on what works well with an exemplary IDG caring for patients with Alzheimer's disease. The study consisted of AI interviews of six participants in a hospice setting. Participants volunteered and were chosen using a purposive method, requiring at least 1 year of hospice experience, which resulted in a diverse group of medical personnel, with a diverse set of experiences, who care for patients with Alzheimer's disease and other end-of-life issues. To maintain confidentiality, pseudonyms were used in the interviews with a physician, group leader, social worker, chaplain, registered nurse, and a nurse's assistant.

Data collection occurred over 3 months via face-to-face interviews that were recorded and transcribed. The initial finding in the Discovery phase of the AI 4-D cycle—Discovery, Dream, Design and Destiny—were presented according to each interview question. Major categories were presented according to an AI format and analyzed using descriptive coding to initially reveal 10 categories that encapsulated caring as the positive core.

Findings show IDG' members in hospice valued as components necessary for an exemplary IDG. The IDG members used communication and collaboration as an intricate functioning of the IDG's operation. Through communication and collaboration, IDG members are able to gather information to facilitate patients', families', and external and internal customers' goals.

Kuziemsky et al. (2009) illustrated in previous research that communication played a major role in the group collaborative process. This research data also identified communication as an inherent component of a successful IDG. The IDG members performing their roles transmit valuable information to other members in the group, resulting in better job performance and patients' care. In essence, the IDG's effective communication helped to bring quality care to the patients and allowed the openness for each member's voice to be heard. Valuing openness through communication allows for the appreciation of role diversity, both professionally and culturally within IDGs. Additionally, the collaborative process supports IDGs collectively taking responsibility for the group outcome in which each member feels a sense of accomplishment because goals are met communally. One of the significant benefits of asking AI questions allows the participants to become engaged with rich story telling of their experiences working in an IDG. The participants talked about their dedication to their patients, families, and coworkers. They discussed the relationships they build with their patients, their families, and coworkers, as well as their personal experience of having a loved one dying from Alzheimer's disease. The physician reflected on her grandparents, what it was like losing them to Alzheimer's disease, and how such experience impacted her life.

> All my grandparents suffered from Alzheimer's disease, so I am very familiar . . . with Alzheimer's disease, even before I decided to become a doctor. It is a huge, responsibility. It's an economic burden........I've seen so many terrible things from divorces to many conflicts. It's so stressful because it's difficult; it is not easy.

The physician's experience allows her to be empathic to patients, families, and IDG group members working in a hospice environment. She became more cognizant of her vulnerability to Alzheimer's disease and hoped to find a cure.

The Dream phase findings were consolidated into four major categories: Overall Changes in the Health Care System; Supportive Environment; Consistency in Patient Care; and Manageable Delegation of Workload. These categories would enhance IDGs in a well-run organization. In the Design phase, findings fell into six categories, resulting in six provocative propositions emerging as the themes that fundamentally reflect exemplary IDGs' views for organizational changes. These themes from the design questions from the interviewees were Taking Care of Each Other, Giving Recognition in a Timely Manner, Constructive and Receptive Feedbacks, Respecting and Receiving Group Members' Contributions and Opinions, Valuing Openness, and Daily Fulfilling the Commitment to the Team. In the fourth stage of the AI cycle, the Destiny findings supported bringing the dreams of the future to the present.

CHAPTER V: DISCUSSION AND IMPLICATIONS OF THE STUDY

This study was designed to describe participants' taking part in the appreciative inquiry (AI) process to discover their positive core hospice-related experiences and how they use their experiences to develop a captivating vision of what works well with an exemplary interdisciplinary group (IDG) caring for current and future patients dealing with Alzheimer's disease.

In this chapter, I discuss the implications of the findings of the three universal themes of the study—communication, appreciative attitude, and relational bonding. Also, I examine ways the findings can be maximized in hospice organizations, steps family therapists can take to facilitate the implementations of the three universal themes in hospice, possibilities for training professionals in the mental health field, implications for future research, implications for self-care of the therapist, and the relevance of the study to the marriage and family therapy field. Additionally, I discuss limitations of the study, identifying challenges and future considerations. I conclude with my reflections as the researcher.

Implications of Findings: The Three Universal Themes

The analysis of the study identified 10 themes from the participants' transcripts. The prominent themes were (a) Relational Bonding, (b) Teamwork and Collaboration, (c) Personal and Professional Satisfaction, (d) Empathy, (e) Communication, (f) Employee Recognition and Achievement, (g) Appreciative Attitude, (h) Leadership, (i) Commitment, and (j) Organization Awareness. From the 10 themes, three universal themes—communication, appreciative attitude, and relational bonding—were identified. These three universal themes underscored the participants' experiences, dreams, collaboration, teamwork, appreciation, expectations, and accomplishments, all of which made up the success of an exemplary IDG caring for patients with Alzheimer's disease.

Communication

The universal theme Communication was seen as essential in the operation of the exemplary IDG, because each member depended on communication to effectively function in their roles. Communication comprises of the dissemination of vital information throughout the IDG via e-mails, texts messages, telephone conversations, and/or face-to-face meetings, which served to ensure patients' safety and their families' satisfaction. For example, the physician stated that communication is the "heartbeat of the team, making sure everyone is on the same page." Thus, communication was depicted as the tool that ensured the effective operation of the IDG as everyone received the same information.

Additionally, communication permits feedback and encourages questions promoting the sharing of ideas and best practices to benefit all group members. Communication allows the entire organization to function effectively through the dissemination of information, because if communication is not carried out then the safety of patients' care may be compromised resulting in medical errors, injuries, and/or death. Therefore, lack of communication could potentially cause legal implications for group members and ultimately to the organization. Communication therefore is seen as a critical skill in the organization's environment ensuring the success of the IDG efforts. In other words, communication promotes good team interactions, cultural diversities, tolerance, understanding, and enhances camaraderie among team members working within a multidisciplinary team environment.

Appreciative Attitude

The second universal theme, Appreciative Attitude, implied that team members relied on each other for the sharing of information to perform their roles. This collaborative process encourages members to learn and grow professionally within the group. As a result, group members' appreciation towards each other nurture healthy competition within the team and facilitate mutual respect as well as camaraderie among group members.

Additionally, appreciative attitude implied that patients and family showed their appreciations in the form of recognition through letters, phone calls, and surveys. In turn, employers demonstrated their appreciation through employees' acknowledgment and/or recognition awards. For example, complimenting employees with "a pat on the back by saying good job or well done" or doing other ceremonial planned events that present awards. Thus appreciative attitude fosters team building spirit, strengthens group members' relationships, enhance trust, promotes transparency, and create reciprocity of information among the interdisciplinary group.

Relational Bonding

This third universal theme from the study illustrated that empathy, caring, collaboration, and respect were shared among IDG members, patients, and patients' families. Therefore, relational bonding was seen where IDG members created a supportive environment allowing members to participate in the organizational goals and objectives. As a result, relational bonding fostered openness, allowing each member to feel a sense of comfort in bringing something different to the group and ultimately the organization. Thus, the team worked together to create a successful IDG atmosphere, which allowed the IDG's members to be exemplary in their roles.

In general, the study depicted that Communication, Appreciative Attitude, and Relational Bonding were the universal themes that incorporate the essential functions of an exemplary IDG. These themes allowed for information sharing, appreciation of roles, openness, and collaboration within hospice organizations, which use interdisciplinary groups.

Maximizing the Universal Themes in Organizations With Interdisciplinary Groups

The three universal themes Communication, Appreciative Attitude, and Relational Bonding are interrelated and have the potential of maximizing services within hospice and other organizations such as, hospitals, universities, and community centers. As the study brought out, communication was seen as a critical skill in the dissemination of information for IDGs to function successfully in the daily operations in the organization. Additionally, communication and appreciative attitude work systematically in building trusting relationships and commitment within the IDG. Along with appreciative attitude, relational bonding has a very strong connection with communication, because it facilitates the collaborative process, allowing member to effectively carry out their roles within the IDG.

As member within IDGs carry out their roles, they foster partnership with internal and external customers that could potentially increase productivity. Increased productivity will allow greater profitability for organizations which create expansion of services. The expansion of services will allow organizations to harvest a competitive market that strive on best practices, thereby allowing employees to focus on services that meet customers' satisfaction. Customers' satisfaction will require employees' dedication, motivation, and commitment, which in turn position organizations to develop new innovations to compete in the market place. Altogether, communication, appreciative attitude, and relational bonding can serve as a catalyst in maximizing innovative services, in which employees are dedicated, motivated and committed in increasing productivity.

The Universal Themes and Family Therapists

The universal themes Communication, Appreciative Attitude, and Relational Bonding are integrative and are embedded in relationships. Through relationships, members of the IDGs are able to operate effectively implementing these three themes. However, hospice IDG philosophy is primarily linear, focusing on cause and effect and attributing to a holistic approach. Although, members work as a team their roles are individualistic, so service are at times fragmented. Fragmentation of services is viewed as one of the challenges of organizations with IDGs; hence, a goal of IDGs is connecting systems to optimize services. Optimizing services will best be achieved with the practices of developing relationships that link patients, their family members, IDG members, the organization, and the community together.

Furthermore, optimizing services construct relationships in context, therefore allowing opportunities for IDGs to extend practices through extension of meanings augmented in relationships. In contrast, family therapists primarily focus on relationships, and ultimately work in connecting systems of families, organizations, and communities. Family therapists aim at connecting relationships through exploring meanings with language. Through language, family therapists seek to strengthen communication and relational bonding. When communication and relational bonding are achieved, there is a higher level of appreciative attitude, which demonstrates the integration of the three universal themes established in this research. Therefore, in organizations such as hospice, family therapists can facilitate the implementation of the three universal themes Communication, Appreciative Attitude, and Relational Bonding by exploring meanings through language that contextualize and challenge existing fragmented systems.

Possibilities for Training Professionals in the Mental Health Field

With the aging population, it is suggested that people 65 and older are the fastest growing segment of the U.S. population. By 2030, older adults will account for 20% of the nation’s population, up from 13% in 2008 (American Psychological Association Office on Aging, 2011). Based on this percentage, mental health professionals will become valuable resources for this population, as there are growing rates of suicide, depression, stressors relating to loss of loved ones, relocation, health conditions, caregivers demands, change in employment status, and economic instability affecting this group. As a result, the mental health field will progressively require health care professionals trained in meeting the needs of the aging population.

Although there are increasing training programs offered in the mental health field such as geropsychology and geriatrics, there is still need for research and special courses developed for the ageing across the mental health disciplines (American Psychological Association Office on Aging, 2011). As the research from this study indicated, not only individuals with Alzheimer's disease experience depression and behavioral issues relating to mental health; family members and/or caregivers are affected. Therefore, training across mental health discipline is greatly recommended to work with the increasing demand of the aging population.

The Relevance of the Study to the Marriage and Family Therapy Field

The increasing population of Alzheimer's disease care recipients has placed demands on various sectors of society, forcing their families to choose different directions in providing them with care. An option of choice is the use of hospice IDGs to manage the medical, psychosocial, emotional, and spiritual needs of these individuals. Unfortunately, not only the medical, psychosocial, emotional, and spiritual needs of the care recipients are at risk but also the well-being of family members and/or caregivers. Neal and Hammer (2007) noted family members caring for individuals with Alzheimer's disease explored avenues to manage stressful situations, leading them to discover the benefits of sharing their feelings with mental health professionals experienced in the area of dementia.

Therefore, it is recommended based on the findings from this study that consideration be given in increasing training in family systems to marriage and family therapy graduate students in relation to therapeutic intervention with chronically ill individuals, such as those diagnosed with Alzheimer's disease. Rolland and Walsh (2005) highlighted that marriage and family therapists receiving training in psychotherapy and family medical system will provide opportunities within IDGs to manage families in crisis. Furthermore, in 2001, the Institute of Medicine recommended the standard of medical practice integrating a patient-centered approach rather than a clinician- or disease-centered approach to best fit patients' needs as an integrative patient-centered approach will focus on relational aspects of the patient and their families, and/or caregivers. Additionally, the Institute of Medicine proposal indicated that an integrative patient-centered approach will eliminate medical management fragmentation of care. Marriage and family therapists tend to focus on a client centered systemic approach; therefore, the American Association for Marriage and Family Therapy has the potential to conduct further research that will strengthen political advocacy in integrating marriage and family therapists as a core member of the IDGs.

Implications for Self-Care of the Therapist

The work of the practicing therapist can be demanding, challenging, and emotionally demanding. Therefore, therapists' failure to adequately attend to their own psychological wellness and self-care can place them at risk for impaired professional functioning. Hence, there is always the need for an ongoing focus on self-care for the prevention of burnout and for maintaining one's own psychological wellness. As practicing therapists, there are a number of challenges and stressors that place them at risk over time for experiencing distress, burnout, trauma, and—eventually—impaired professional competence. As a result, therapists must engage in active attempts to effectively manage these challenges and demands through ongoing self-care efforts. Failure to do so may result in harm to their clients, profession, and relationships. Malinowski (2014) noted in a study of 1,000 counseling psychologists, 62% were found to be depressed and 42% experienced thoughts related to suicidal ideation. According to Malinowski, the motivation for success, professionalism, and personal satisfaction are good intentions yet the repercussion of self-care deficit can be detrimental to the therapists' health and well-being (Malinowski, 2014). Thus, self-awareness is a vital tool for therapists to recognize their mental impairments, inability to manage personal stressors, and/or burnout and seek the necessary help.

Implications for Future Research

The improvements in standard of living and medical advancement have contributed to reduce mortality and increase the aging population. Yet, there is a scarcity of studies on the significance of IDGs' relationships with patients, and their families. As the literature review indicated, research focuses on families' dynamics, anticipatory grieving, and end-of-life issues. However, the literature fails to capitalize on the power of relationships as a positive solution to the concerns relevant in hospice. Future research can therefore, include the power of relationships using the AI 4-D cycle to examine the influence of families, caregivers, and the IDGs working with individuals in hospice.

Additionally, scarcity of research exists on the relationships children have while caring for their parent/s diagnosed with Alzheimer's disease and working with the IDG. Adult children who take on the responsibility to care for their parent/s diagnosed with Alzheimer's disease are usually taking care of their own family issues. There are time that emotional and financial emerged and create additional challenges in such family relationships. Yet, limited research focus on how relationships in such families are affected and the role IDGs can play in facilitating coping mechanisms. Future research can therefore explored the lived experiences of adult children who are caregivers to their parent/s diagnosed with Alzheimer's disease and ways the IDGs involvement help them to face challenges arising from their parent's condition.

Also, more research can be done to investigate the impact of a spouse working with the IDG group caring for a spouse diagnosed with Alzheimer's disease. Such research can focus on comparative analysis of the relationships the couple had prior to the diagnosis and how relational dynamics determine working with the IDGs.

Further, action research integrating marriage and family therapy within IDGs can be conducted on a larger scale to determine what works well with multiple IDGs involving a focus on family systems. Presently, marriage and family therapists are not primary members of IDGs. However, with the increasing aging population and healthcare changes consideration can be made to include marriage and family therapists on IDGs.

This study used qualitative AI design that addresses the members of the IDG, yet the gap exists in the literature regarding investigating IDGs members in a focus group. A focus group would provide information on roles of IDGs and their impact on patients as well as their family members. There is also limited research that focuses on individual members of the IDGs and their concerns about what works well with patients and their families or caregivers. For example, within the research, the physician indicated that her relationship with the group was very comfortable as she has been able to speak her mind without the fear of being judged. Therefore, it is suggested that future research utilizing all four phases of the AI 4-D cycle would be best supported in a focus group allowing participants more time for self-reflection needed in the Destiny phase to allow ideas to come alive, because some participants had difficulties bringing their dreams to reality.

Another topic of future inquiry could focus on exploring how IDG can influence other organizations; such a research can examine the positive and/or negative effects of all shareholders in the system. Also, researching the influence of organizations can examine the collaborative effects of interventions, structures, protocols, uniqueness, and preexisting affective conditions on the effectiveness in capitalizing on the expertise of IDGs (Manser, 2009).

In general, there is a paucity of study on what works well with the IDGs. Additionally, examining IDGs relationship with patients, family members, and/or caregivers will expand research about IDGs in organizations such as hospice. Also, research can serve to provide information on ways to incorporate principles of the IDGs when working with a spouse caring for a diagnosed spouse or children caring for a diagnosed parent. Such research can generate further studies for organizations to examine IDGs as systems of operation which capitalize on the expertise of members.

Limitations of the Study

This study examined the experiences of six members of a hospice interdisciplinary group of one of the largest hospices located in South Florida. Although this number of in-depth interviews provided a large data source, it did not permit overview of the larger population of hospice employees. The IDG members are part of the hospice group and do not represent the diversity that is found in most hospices nor do they represent the experiences of others who are employed in hospice organizations. Besides the generalizability of the study, another limitation of this study was the inability of all IDG members to construct the future (the Design phase) and realize the dream (the Destiny phase). Thus, some participants found it challenging to bring the dream to the future. It was very possible that if the participants were allowed to dream collectively, they may have been inspired by their group member to co-construct and put into action what was one dominant dream. Therefore it was difficult to know what might have been overlooked collectively, dreaming individually.

Another limitation was the inability of one researcher to process the enormous amount of data comparing one exemplary IDG experiences to another IDG working in hospice caring for patients with Alzheimer's disease. As Cooperrider et al. (2008) brought out, the use of AI research only sought to reveal the best of what exists and offer suggestions and potential of what can be. It was very possible that participants fromother hospices' exemplary IDG may have had similar experiences or have been more engaged in the roles of IDG members than the researcher was led to believe. Due to specificity of the design of interview questions to address the phases of the AI 4-D cycle, there were potential biases presented in participants' responses; in view of these biases, similar studies could be done using different methodology to collect the participants' experiences.

Researcher's Reflections

I was challenged as I considered how this study could be free from biases. Thus, in making sense of the study, I engaged in ongoing reflections, seeing myself as observer and observed, utilizing the semi structured questions as techniques to remain focused. These aided in the reduction of biases to the extent possible I focused on the participants' experiences, allowing mine to lie dormant. My biases were not the only challenges I experience with this research. This research was physically and emotionally challenging but as I undertook this journey, I focused on the AI positive principle. Keeping in mind AI allows language to create realities, I was determined to have successes in completing this research. AI philosophy assisted me to remain motivated and away from any prejudgment or negative conclusion of the IDGs members.

My personal experiences as a practicing family therapist, nurse, daughter, and caregiver of a mother with Alzheimer's disease inspired me to select this topic and population for this study. As a nurse manager working with a hospice IDG, I have often wondered what drives the IDGs members to stay committed and dedicated to their job responsibilities, because so often the voices of the IDG members go unheard. IDG member may observe steps that would lead to improvement of their responsibilities to patients, families, and team members but voicing such opinions often go unheard at the organizational level. This has been indicated in the following excerpt by the chaplain:

> I would like to see the organization have caregivers groups only for caregivers not for patients. . . . I have been after this for a while even just to have it online . . . to be facilitated by a chaplain or social worker........I have suggested this at least a

> half a dozen times over the years. I guess the organization does not okay it.........I even outlined it to the point with different bereavement managers that people would have to sign [a] confidentiality statement.

This participant indicated that not validating a person's voice can be stressful. As suggested in Chapter IV of this study, this participant and others remains positive for the sake of patients, their families, and the IDG. Instead of drawing any conclusions, I learned much from the participants—specifically, that positive attitudes are as contagious as negative ones. Several other comments were made by the participants in the interest of having the best of what could be for patients and their caregivers. These comments were not a hindrance to the participants' doing their jobs or telling their stories of the *wow* moments working on an exemplary IDG. Whatever obstacle the IDG encountered, the members remained dedicated, committed, and loyal to their patients, their patients' families, and the organization. I was amazed at the synchronization of the IDG members' responses to the interview questions even though they had no knowledge of each other's interview responses.

Through these participants' narrative, I understood the meaning of dedication and commitment as well as the continuous efforts to create change to get better. With this understanding, I hope this study inspires others to find ways of allowing the voices of others to be heard. Because there are several factors that contribute to an IDG's successfully working with patients with Alzheimer's disease, getting firsthand information from IDG members' observations and experiences can assist in optimizing the operations of organizations with IDGs such as hospice.

This study presents some steps that marriage and family therapists can become aware of when working in organizations comprising of IDGs. Furthermore, as marriage and family therapists infiltrate the medical arena who may struggle with holistic and linear epistemology, they can influence increasing systemic perspective in such arenas. As a solution-focused brief therapist grounded in social constructionism, my main approach is to explain the processes by which people come to describe, clarify, or otherwise account for the world in which they live (Gergen, 1985). From the study, I learned that the way participants articulate their understanding of their experiences hinges on their views of existence, which emerged from their convictions, hopes, values, and dreams.

Summary

This study allowed me to reflect on my experiences as a registered nurse, group leader, and a caretaker of a mother diagnosed with Alzheimer's disease for almost 13 years, and a training marriage and family therapist. I was able to hear the voices of individuals who have been dedicated and committed as members of the IDG and their relationships to the team, patients, and their families. I therefore, became cognizant of the recursive nature of my findings as "partial arcs" (Keeney, 1983, p. 58) that approximate my experiences, training, and this research. Using AI as my methodology, I was able to incorporating the lineal and systemic perspectives in identifying the 10 themes of the Discovery phase, which led into a relational system cycle depicting caring as the positive core.

The findings also brought out that a well-run organization comprising of IDGs would have a supportive environment, encourage changes in the health care system consistent with patient care, and manage the workload of the IDGs. Yet, such well-run organizations would be embedded in the provocative propositions of members caring for each other, having recognition in a timely manner, encouraging constructive and receptive feedback, respecting and receiving group members contributions and opinions, valuing openness, and promoting the daily fulfillment of the team. These provocative propositions were connected to the group's shared ideals that assisted the IDG in bringing dreams to reality. The findings of this study, thus encompasses all 4-D phases of AI methodology, which highlighted the interactional patterns of the researcher, the participants, and the processes of the organization. The study depicts that what works well with an exemplary IDG was their interconnection to their roles, dedication, commitment, and valuing of team members, their patients, and patients' families. In analyzing my findings, I am encouraged of the benefits that can be gained incorporating marriage and family therapists as members of the IDGs. As such, it is my hope that training of marriage and family therapists will increase in focusing on the medical aspect of patients and caregivers.

References

Abeles, R. P., Gift, H., & Ory, M. G. (1994). *Aging and quality of life.* New York, NY: Springer.

Abramson, J. S., & Mizrahi, T. (1996). When social workers and physicians collaborate: Positive and negative interdisciplinary experiences. *Social Work, 41*(3), 270–281. Retrieved from SocINDEX with Full Text database.

Alzheimer's Association. (2013). 2013 Alzheimer's disease facts and figures. *Alzheimer's & Dementia, 9*(2). Retrieved from http://www.alz.org/downloads/facts_figures_2013.pdf

American Psychological Association Office on Aging. (2011). Discover the answers . . . Be a part of the solution. Retrieved from http://www.apa.org/pi/aging/geropsychology.pdf

Amirkhanyan, A. A., & Wolf, D. A. (2003). Caregiver stress and non-caregiver stress: Exploring the pathways of psychiatric morbidity. *The Gerontologist, 43*(6), 817–827. doi:10.1093/geront/43.6.817

Arno, P. S., Levine, C., & Memmott, M. M. (1999). The economic value of informal caregiving. *Health Affairs, 18*(2), 182–188. doi:10.1377/hlthaff.18.2.182

Arnold, J. J., Dozois, E. J., Holubar, S. D., Klipfel, J. M., Maxson, P. M., Overman Dube, J. A., & Wrobleski, D. M. (2011). Enhancing nurse and physician collaboration in clinical decision making through high-fidelity interdisciplinary simulation training. *Mayo Clinic Proceedings, 86*(1), 31–36. doi: 10.4065/mcp.2010.0282

Barrett, F. J. (1998). Coda—creativity and improvisation in jazz and organizations: Implications for organizational learning. *Organization Science, 9*(5), 605–622. doi:10.1287/orsc.9.5.605

Barrett, F. J., & Fry, R. E. (2005). *Appreciative inquiry: A positive approach to building cooperative capacity.* Chagrin Falls, OH: Taos Institute.

Bateson, G. (1972). *Steps to ecology of mind.* IL: University of Chicago Press.

Bogdan, R. C., & Biklen, S. K. (2003). *Qualitative research for education: An introduction to theories and methods* (4th ed.). Boston, MA: Allyn & Bacon.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77–101. doi: 10.1191/1478088706qp063oa

Briggs, R. (1998). *Caregiving daughters: Accepting the roles of caregiver for elderly parents.* New York, NY: Garland.

Bronstein, L, R., Kurzejeski, L., & Parker-Oliver, D. (2005). Examining variables related to successful collaboration of the hospice team. *Health and Social Work*, *30*(4), 279–286. doi:10.1093/hsw/30.4.279

Brown, B., Crawford, P., & Darongkamas (2002). Blurred roles and permeable boundaries: The experience of multidisciplinary working in community mental health. *Health and Social Care in the Community*, *8*(6), 425–435. doi: 10.1046/j. 1365-2524.2000.00268.x

Burman, E. (1994). Interviewing. In P. Banister, E. Burman, I. Parker, M. Taylor, & C. Tindall (Eds.), *Qualitative methods in psychology: A research guide* (pp. 49–71). Philadelphia, PA: Open University Press.

Campbell, L. (2010). Sons who care: Examining the experience and meaning of filial caregiving for married and never-married sons. *Canadian Journal on Aging, 29*(1), 73–84. doi: 10.1017/s071498080999033x

Casarett, D. J., Crowley, R. L., & Hirschman, K, B. (2004). How should clinicians describe hospice to patients and families? *American Geriatrics Society*, *52*(11), 1923–1928. doi:10.1111/j.1532-5415.2004.52520.x

Cohen, D. (2000). Caregivers for persons with Alzheimer's disease. *Psychiatry Report, 2*(1), 32–39. doi: 10.1007/s11920-000-0039-x

Connor, S. R., Egan, K. A., Kwilosz, D. M., Larson, D. G., & Reese, D. J. (2002). Interdisciplinary approaches to assisting with end-of-life care and decision making. *American Behavioral Scientist, 46*(3), 340–356. doi: 10.1177/ 000276402237768

Cooper, B. S., & Fishman, E. (2003). *The interdisciplinary team in the management of chronic conditions: Has its time come?* Retrieved from http://www.partnershipforsolutions.org/DMS/files/TEAMSFINAL3_1_.pdf

Cooperrider, D. L. (1990). Positive image; positive action: The affirmative basis of organizing. In S. Srivastva, & D. L. Cooperrider, (Eds.), *Appreciative management and leadership (pp. 91-125)* San Francisco, CA: Jossey-Bass.

Cooperrider, D. L., Whitney, D., & Stavros, J. (2003). *Appreciative Inquiry Handbook: The first in a series of AI workbooks for leaders of change*. Bedford Heights, OH: Lakeshore.

Cooperrider, D. L., & Whitney, D. (2005). *Appreciative inquiry: A positive revolution in change*. San Francisco, CA: Barrett-Koehler.

Cooperrider, D., Whitney, D., & Stavros, J. (2008). *Appreciative inquiry handbook: For leaders of change.* Brunswick, OH: Crown.

Creswell, J. W. (1998). *Qualitative inquiry and research design: Choosing among five traditions*. Thousand Oaks, CA: Sage.

Creswell, J. W. (2003). *Research design: Qualitative, quantitative, and mixed methods approaches* (2nd ed.). Thousand Oaks, CA: Sage.

Creswell, J. W. (2007). *Qualitative inquiry and research design: Choosing among five approaches*. Thousand Oaks, CA: Sage.

Davidson, J. E., Powers, K., Hedayat, K. M., Tieszen, M., Kon, A. A., Shepard, E., & Armstrong, D. (2007). Clinical practice guidelines for support of the family in the patient-centered intensive care unit: American College of Critical Care Medicine Task Force 2004-2005. *Critical Care Medicine*, *35*(2), 605–622. doi: 10.1097/01. ccm.0000254067.14607.eb

De Dreu, C. K. W., & Weingart, L. R. (2003). Task versus relationship conflict, team performance, and team member satisfaction: A meta-analysis. *Journal of Applied Psychology, 88*(4), 741–749. doi:10.1037/0021-9010.88.4.741

Delgado, M., & Tennstedt, S. (1997). Puerto Rican sons as primary caregivers of elderly parents. *Social Work, 42*(2), 125–134. doi:10.1093/sw/42.2.125

Demiris, G., Oliver, D. P., & Wittenberg-Lyles, E. (2009). Assessing caregivers for team interventions (ACT): A new paradigm for comprehensive hospice quality care. *American Journal of Hospital Palliative Care, 26*(2), 128–134. doi: 10.1177/ 1049909108328697

Demiris, G., Washington, K., Oliver, D. P., & Wittenberg-Lyles, E. (2008). A study of information flow in hospice interdisciplinary team meetings. *Journal of Interprofessional Care, 22*(6), 621–629. doi: 10.1080/13561820802380027

Edmondson, A. C. (2003). Speaking up in the operating room: How team leaders promote learning in interdisciplinary action teams. *Journal of Management Studies, 40*(6), 1419–1452. doi:10.1111/1467-6486.00386

Ferrell, B. R. (2004). Overview of the domains of variables relevant to end-of-life care. In National Institutes of Health, *National Institutes of Health State-of-the-Science Conference on Improving End-of-Life Care* (pp. 29–31). Bethesda, MD

Ferrell, B. R., Connor, S. R., Cordes, A., Dahlin, C. M., Fine, P. G., Hutton, N........& Zuroski, K. (2007). The national agenda for quality palliative care: The National Consensus Project and the National Quality Forum. *Journal of Pain & Symptom Management*, *33*(6), 737–744. doi:10.1016/j.jpainsymman.2007.02.024

Fradkin, L. G., & Heath, A. (1992). *Caregiving of older adults*. Santa Barbara, CA: ABC-CLIO.

Gergen, K. J. (1985). The social constructionist movement in modern psychology. *American Psychologist*, *40*(3), 266–275. doi:10.1037/0003-066x.40.3.266

Gergen, K. J. (1994). *Toward transformation in social knowledge* (2nd ed.). Thousand Oaks, CA: Sage.

Glensne, C., & Peshkin, A. (1992). *Becoming qualitative researchers: An introduction*. New York, NY: Longman.

Golafshani, N. (2003). Understanding reliability and validity in qualitative research. *The Qualitative Report, 8*(4), 597–607. Retrieved from http://nova.edu/ssss/QR/QR8-4/golafshani.pdf

Graneheim, U. H., & Lundman, B. (2004). Qualitative content analysis in nursing research: Concepts, procedures and measures to achieve trustworthiness .*Nursing Education Today , 24*(2),105–112. doi:10.1016/j.nedt.2003.10.001

Grol, R., & Grimshaw, J. (2003). From best evidence to best practice: Effective implementation of change in patients' care. *The Lancet*, *362*(9391), 1225–1230. doi: 10.1016/s0140-6736(03)14546-1

Grumbach, K., & Bodenheimer, T. (2004). Can health care teams improve primary care practice? *Journal of the American Medical Association, 291*(10), 1246–1251. doi:10.1001/jama.291.10.1246

Guidelines for psychological practice with older adults. (2014). *American Psychologist, 69*(1), 34–65. doi:10.1037/a0035063

Hall, P., & Weaver, L. (2001). Interdisciplinary education and teamwork: A long and winding road. *Medical Education, 35*(9), 867–875. doi:10.1046/j.1365-2923. 2001.00919. x

Hammond, S., & Royal, C. (Eds.). (1998). *Lessons from the field: Applying appreciative inquiry.* Plano, TX: Practical Press.

Harrison, J., MacGibbon, L., & Morton, M. (2001). Regimes of trustworthiness in qualitative research: The rigors of reciprocity. *Qualitative Inquiry, 7*(3), 323–345. doi: 10.1177/107780040100700305

Jivanjee, P. (1995). *Caregiving to family members with Alzheimer's disease.* New York, NY: Garland.

Johanson, G. A., & Johanson, I. V. (1999). The core team. In D. C. Sheehan & W. B. Forman, *Hospice and palliative care concepts and practice* (pp. 31–39). Sudbury, MA: Jones & Bartlett.

Keeney, B. P. (1983). *Aesthetic of change*. New York, NY: The Guilford Press.

Khachaturian, S. Z., & Radebaugh, S. T. (1996). *Alzheimer's disease: Cause(s), diagnosis, treatment, and care.* New York, NY: CRC Press.

Kim, H., Chang, M., Rose, K., & Kim, S. (2012). Predictors of caregiver burden in caregivers of individuals with dementia. *Journal of Advanced Nursing, 68*(4), 846–855. doi: 10.1111/j.1365-2648.2011.05787

Kinzbrunner, B. M., & Policzer, J. S. (2011). *End-of-life care: A practical guide* (2nd ed.). New York, NY: McGraw-Hill.

Kuziemsky, C. E., Borycki, E. M., Purkis, M. E., Black, F., Boyle, M., Cloutier-Fisher, D., . . .Wong, H. (2009). An interdisciplinary team communication framework and its application to healthcare 'e-teams' systems design. *[BioMed Central] BMC Medical Informatics & Decision Making*, *9*(1), 43–57. doi:10.1186/1472-6947-9-43

Larson, D. (2003). Exploring the nature of the Interdisciplinary team: An excerpt from *The Helper's Journey*. *Hospice Palliative Insights* (4), 6–8.

Light, E., & Lebowitz, B. D. (1990). *Alzheimer's disease treatment and family stress: Directions for research*. Washington, DC: Hemisphere.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Beverly Hills, CA: Sage.

Malinowski, A. J. (2014). *Self-care for the mental health practitioner: The theory research and practice of preventing and addressing the occupational hazards of the profession*. London, England: Jessica Kingsley.

Manser, T. (2009). Teamwork and patient safety in dynamic domains of healthcare: A review of the literature. *Acta Anaesthesioligica Scandanavica, 53*(2), 143–151. doi:10.1111/j.1399-6576.2008.01717.x

Martire, L. M., Lustig, A. P., Schulz, R., Miller, G. E., & Helgeson, V. S. (2004). Is it beneficial to involve a family member? A meta-analysis of psychosocial interventions for chronic illness. *Health Psychology, 23*(6), 599–611. doi:10.1037/0278-6133.23.6.599

McAllister, A. L., Perry, C. L., & Parcel, G. S. (2008). How individuals, environments, and health behaviors interact: Social cognitive theory. In K. Glanz, B. K. Rimer, & K. Viswanath, *Health behavior and health education: Theory, research and practice* (4th ed., pp. 178–208). San Francisco, CA: Jossey-Bass.

McCallin, A. (2001). Interdisciplinary practice – A matter of teamwork: An integrated literature review. *Journal of Clinical Nursing, 10*(4), 419–428. doi: 10.1046/j. 1365-2702.2001.00495.x

Merriam, S. B. (2002). Assessing and evaluating qualitative research. In S. B. Merriam & Associates (Eds.), *Qualitative research in practice* (pp. 18–33). San Francisco, CA: Jossey-Bass.

Merrick, E. (1999). An exploration of quality in qualitative research: Are “reliability” and “validity” relevant? In M. Kopola & A. L. Suzuki, *Using qualitative methods in psychology* (pp. 25–36). London, England: Sage.

Michael, S. (2005). The promise of appreciative inquiry as an interview tool for field research. *Development in Practice, 15*(2), 222–230. doi: 10.1080/ 09614520500042094

Mickan, S, & Rodger, S. (2000). Characteristics of effective teams: A literature review. *Australian Health Review*, *23*(3), 201–208. doi: 10.1071/ah000201

Mittleman, M. S., Roth, D. L., Coon, D. W., & Haley, W. E. (2004). Sustained benefit of supportive intervention for depressive symptoms in Alzheimer’s caregivers. *American Journal of Psychiatry, 161*(5), 850–856. doi:10.1176/appi.ajp.161.5.850

Molyneux, J. (2001). Interprofessional team working: What makes teams work well? *Journal of Interprofessional Care, 15*(1), 29–35. doi: 10.1080/ 13561820020022855

National Consensus Project for Quality Palliative Care. (n.d.). [Home page]. Retrieved from http://www.nationalconsensusproject.org/

National Hospice and Palliative Care Organization. (2013). *Standards of practice for hospice programs.* Alexandria, VA: Author.

Neal, M. B., & Hammer, L. B. (2007). *Working couples caring for children and aging parents: Effect on work and well-being.* Mahwah, NJ: Erlbaum.

Neuman, W. L. (2000). *Social research methods: Qualitative and quantitative approaches* (4th ed.). Boston, MA: Allyn & Bacon.

Oliver, D. P., Demiris, G., Wittenberg-Lyles, E., Porock, D., & Collier, J. (2010). Caregiver participation in hospice interdisciplinary team meetings via videophone technology: A pilot study to improve pain management. *American Journal Hospice Palliative Care, 27*(7), 465–473. doi: 10.1177/1049909110362402

Parker-Oliver, D., & Peck, M. (2006). Inside the interdisciplinary team experiences of hospice social workers. *Journal of Social Works in End-of-Life and Palliative Care, 2*(3), 7–21. doi: 10.1300/j457v02n03_03

Patton, M. Q. (2002). *Qualitative research and evaluation methods* (3rd ed.). Los Angeles, CA: Sage.

Post, S. G. (2005). Altruism, happiness, and health: It's good to be good. *International Journal of Behavioral Medicine*, *12*(2), 66–77. doi: 10.1207/ s15327558ijbm1202_4

Reed, J. (2007). *Appreciative inquiry: Research for change.* Thousand Oaks, CA: Sage.

Reese, D. J., & Sontag, M. A. (2001). Successful Interprofessional collaboration on the hospice team. *Health & Social Work, 26*(3), 167–175. doi:10.1093/hsw/26.3.167

Riessman, C. K. (2008). *Narrative methods for the human sciences*. Thousand Oaks, CA: Sage.

Robinson, K. M., Adkisson, P., & Weinrich, S. (2001). Problem behavior, caregiver reactions, and impact among caregivers of persons with Alzheimer's disease. *Journal of Advanced Nursing, 36*(4), 573–582. doi:10.1046/j.1365-2648.2001. 02010.x

Rolland, J. S., & Walsh, F. (2005). Systemic training of healthcare professionals: The Chicago Center for Family Health Approach. *Family Process, 44*(3), 283–301. doi:10.1111/j.1545-5300.2005.00060.x

Sabur, S. (2003). Creating an optimal culture and structure for the IDT. *Hospice Palliative Insights,* 4, 22-23. doi: 10.3928/00989134-20090527-04

Saldaña, J. (2009). *The coding manual for qualitative researchers.* London, England: Sage.

Saunders, C. (2000). The evolution of palliative care: *Patient Education and Counseling,* 4, 17-13

Schofield, R. F., & Amodeeo, M. (1999). Interdisciplinary teams in health care and human services settings: Are they effective? *Health & Social Work, 24*(3), 210–219. doi:10.1093/hsw/24.3.210

Schulz, R., & Martire, L. M. (2004). Family caregiving of persons with dementia: Prevalence, health effects, and support strategies. *American Journal for Geriatric Psychiatr*y, *12*(3), 240–249. doi: 10.1097/00019442-200405000-00002

Schulz, R., Mendelsohn, A. B., Haley, W. E., Mahoney, D., Allen, R. S., Zhang, S., . . . Belle, S. H. (2003). End-of-life care and the effects of bereavement on family caregivers of persons with dementia. *The New England Journal of Medicine*, *349*(20), 1936–1942. doi:10.1056/nejmsa035373

Shortell, S. M., Marsteller, J. A., Lin, M., Pearson, M. L., Wu, S.-Y., Mendel, P., . . . Rosen, M. (2004). The role of perceived team effectiveness in improving chronic illness care. *Medical Care, 42*(11), 1040–1048. doi:10.1097/00005650-200411000-00002

Simons, T., & Peterson, R. (2000). Task conflict and relationship conflict in top management teams: The pivotal role of intragroup trust. *Journal of Applied Psychology, 85*(1), 102–111. doi:10.1037//0021-9010.85.1.102

Snyder, L., Jenkins, C., & Joosten, L. (2007). Effectiveness of support groups for people with mild to moderate Alzheimer's disease: An evaluative survey. *American Journal of Alzheimer's disease and Other Dementias, 22*(1), 14–19. doi:10.1177/1533317506295857

Steffen, A, M., & Mangum K. R. (2012). Predicting attendance at dementia family support groups. *American Journal of Alzheimer's Disease and Other Dementias*, *27*(8), 633–639. doi:10.1177/1533317512465677

Stratton-Berkessel, R. (2010). *Appreciative inquiry for collaborative solutions: 21 strength-based workshops.* San Francisco, CA: Pfeiffer.

Strauss, A. L., & Corbin, J. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory.* Thousand Oaks, CA: Sage.

Szinovacz, E. M., & Davey, A. (2008). *Caregiving contexts: Cultural, familial, and societal implications.* New York, NY: Springer.

Thomas, E. J., Sexton, J. B., & Helmreich, R. L. (2003). Discrepant attitudes about teamwork among critical care nurses and physicians. *Critical Care Medicine, 31*(3), 956–959. doi:10.1097/01.ccm.0000056183.89175.76

Van Gaalen, R. I., & Dykstra, P. A. (2006). Solidarity and conflict between adult children and parents: A latent class analysis. *Journal of Marriage and Family*, *68*(4), 947–960. doi:10.1111/j.1741-3737.2006.00306.x

Wagner, H. E. (2000). The role of patient care teams in chronic disease management. *British Medical Journal*, *320*(7234), 569–572. doi:10.1136/bmj.320.7234.569

Watkins, M. J., Mohr, B., & Kelly, R. (2010). *Appreciative inquiry: Change at the speed of imagination* (2nd ed.). San Francisco, CA: Wiley.

Whitney, D., & Cooperrider. (2000). The appreciative inquiry summit: An emerging methodology for whole system positive change. *OD Practitioner, 32*(1), 13–26. https://appreciativeinquiry.case.edu/intro/classics.cfm?coid=647

Whitney, D., & Trosten-Bloom, A. (2003). *The power of appreciative inquiry: A practical guide to positive change.* San Francisco, CA: Berrett-Koehler.

Whitney, D., & Trosten-Bloom, A. (2010). *The power of appreciative inquiry: A practical guide to positive change* (2nd ed.). San Francisco, CA:Berrett-Koehler.

Wiecha, J., & Pollard, T. (2004). The interdisciplinary ehealth team: Chronic care for the future. *Journal of Medical Internet Research, 6*(3), e22. doi:10.2196/jmir.6.3.e22

Willig, C. (2001). *Introducing qualitative research in psychology: Adventures in theory and method.* Philadelphia, PA: Open University Press.

Wittenberg-Lyles, E. M., & Oliver, D. P. (2007). The power of interdisciplinary collaboration in hospice. *Progress in Palliative Care, 15*(1), 6–12. doi:10.1179/ 096992607x177764

Wittenberg-Lyles, E. M., Oliver, D. P., Demiris, G., & Regehr, K. (2009). Exploring interpersonal communication in hospice interdisciplinary team meetings. *Journal Gerontology Nursing, 35*(7), 35–45. doi:10.3928/00989134-20090527-04

Zwarenstein, M., Goldman, J., & Reeves, S. (2009). Interprofessional collaboration: Effects of practice-based interventions on professional practice and healthcare outcomes. *Cochrane Database of Systematic Reviews*, 3, Art. CD000072. doi:10.1002/14651858.CD000072.pub2

Appendices

Appendix A: Participant Recruitment Flyer

Nova Southeastern University

RESEARCH PARTICIPANTS NEEDED

Do you work with an interdisciplinary group in hospice caring for individuals with Alzheimer's disease?

Do you work with a hospice interdisciplinary group?

Are you 18 years or older

Are you available for a 2-hour interview?

Are you available for 1 hour to review the interpretation of your interview?

Do you speak English?

Do you live in South Florida?

Are you currently employed in hospice?

THEN YOU ARE INVITED TO PARTICIPATE IN THIS RESEARCH STUDY

The research study will be used in the education of marriage and family therapists and any organizations with clinical professionals working in hospice caring and chronically ill patients.

Participation is voluntary, with no penalty for withdrawal.

Please contact Patricia O. Dixon, MS, MIBA, BS, RN,
CRNI
@
[redacted] **or E-mail** [redacted]

Appendix B: Recruitment Letter

Date

Dear Potential Participant:

My name is Patricia O. Dixon; I am a doctoral candidate in the Marriage and Family Therapy program at Nova Southeastern University. I am conducting research under the direction of my Dissertation Chair, Anne Rambo, PhD. The study is entitled—*An Appreciative Inquiry of an Exemplary Hospice Interdisciplinary Group Caring for Individuals With Alzheimer's Disease.*

The aim of the research is to add new perspectives to existing research into what works well with an exemplary interdisciplinary group. The goal of the research is to uncover and bring forth existing strength, achievements, accomplishment of the participants and the expectations of the phenomenon being studied. In addition, the proposed study seeks to add to the literature, allowing the voices of an exemplary interdisciplinary group to be heard about what works well among them caring for individuals with Alzheimer's disease. Participation in this study involves eight hospice caregivers from different clinical disciplines sharing their views of what works well within an exemplary hospice interdisciplinary group.

The accompanied flyer invites participants to the study. Furthermore, the flyer lists the criteria for participation. An interested person/s may contact the researcher Patricia O. Dixon at: [redacted] or by e-mail listed below. If there are any questions or concerns about this study an interested person/s may also contact Dr. Anne Rambo at [redacted] for further information.

Participation in the research is solely voluntary. Anyone who wishes to withdraw from the study may do so at any time without penalty. The Institutional Review Board with Human Participants at Nova Southeastern University (NSU) has approved this study. Any interested person/s with queries about their research rights in relation to this study can contact the NSU Institutional Review Board at (954) 262-5369 or by e-mail at: IRB@nsu.nova.edu.

Thank you for taking the time to read this letter about the research study. I hope to hear from you soon.

Sincerely,

Patricia O. Dixon, MFT, MIBA, BSN, CRNI	Anne Rambo, PhD,
Researcher	Chair, Dissertation Committee
3301 College Avenue	Department of Family Therapy
Davie, Florida 33314-7796	Graduate School of Humanities
Nova Southeastern University	& Social Sciences
[redacted]	3301 College Avenue
	Davie, Florida 33314-7796

Appendix C: Permission for Posting Authorization Letter

____
Name of Organization
____
Address
____

Date

Human Research Oversight Board (Institutional Review Board)
Nova Southeastern University) NSU)
3301 College Avenue
Ft. Lauderdale, FL 33314

(954) 262-5369/Toll Free: 866-499-0790

IRB@nsu.nova.edu

Please note that Patricia O. Dixon, PhD Candidate, has the permission of

____ to post the notice of her

research entitled: An Appreciative Inquiry of an Exemplary Hospice Interdisciplinary

Group Caring for Individuals With Alzheimer's Disease

____

If there are any questions, please contact my office.

Signed, ___________________________________

Authorizing Representative

Appendix D: Consent Form for Participation in the Study

An Appreciative Inquiry of an Exemplary Hospice Interdisciplinary Group Caring for Individuals With Alzheimer's Disease

Funding Source: None.
IRB protocol #:

Patricia O. Dixon, M.B.A., M.S.	Anne Rambo, Ph.D.
Nova Southeastern University	Nova Southeastern University
3301 College Avenue	3301 College Avenue
Fort Lauderdale, Fl.33314	Fort Lauderdale, Fl.33314
[redacted]	[redacted]

For questions/concerns about your research rights, contact:
Human Research Oversight Board (Institutional Review Board, or IRB)
Nova Southeastern University
Office of Grants and Contracts
954-262-5369/Toll Free: 866-499-0790
IRB@nsu.nova.edu

What is the study about?
You are invited to participate in a research study. The purpose of this study is to understand the experiences of an exemplary interdisciplinary group in a hospice care setting working with individuals with Alzheimer's disease. The proposed study seeks to add to the literature, allowing the voices of exemplary interdisciplinary groups to be heard about what works well among them caring for individuals with Alzheimer's disease.

Why are you asking me?
You have been invited to participate in this study because you are a member of an exemplary interdisciplinary group in hospice care setting, you are currently employed by hospice, you are over 18 years old and speak English, and you live in South Florida area. There will be approximately 8 participants in this study.

What will I be doing if I agree to be in the study?
Your participation in this study will involve about two hours of your personal time in face-to-face interview with Mrs. Dixon. The interview location will be private and mutually agreed upon. You will be asked about your experience of working within the interdisciplinary group. You will be asked to describe the group's accomplishments and achievements working collaboratively. You will also be asked to reflect on your own contribution and influences within the group.

Your participation in this study will also involve one follow-up phone interview with Mrs. Dixon about the synthesis of your interviewed data as interpreted from the data analysis. Mrs. Dixon will call you 2 days within receipt of the e-mail of the synthesis of your interviewed data for your feedback. This phone call will last approximately 1 hour to discuss your reviews regarding how the data analysis captured your experiences. If any changes are requested, Mrs. Dixon will perform suggested revisions immediately after follow-up phone contact. Mrs. Dixon may also terminate your interview at any time if she observes that you are in danger or do not meet inclusion criteria.

Is there any audio or video recording?

This research project will use a zoom H4N handy portable digital voice recorder to record the participant's semistructured interview questions. The recording will be conducted in a private location convenient to the participant. Mrs. Dixon will transcribe the digital voice recording of the interview using headphones in a private location at Mrs. Dixon's home office. The audio recording of the interview will be available to be heard by this researcher, and co-investigator, Dr. Anne Rambo, and other personnel from the IRB. The recording will be kept securely in a locked cabinet located in the researcher home office. The recording will be kept for 3 years (36 months) from the end of the study and will be magnetically deleted after that time by Mrs. Dixon. Because your voice will be potentially identifiable by anyone who hears the recording, your confidentiality for things you say on the recording cannot be guaranteed although the researcher will try to limit access to the recording as described in this paragraph.

What are the dangers to me?

This research represents a minimal risk to you. The risks are no greater than other risks you might experience from participation in an interview. You will use approximately two hours for the interview and approximately 1 hour to review the data synthesis analysis for feedback and/or agreement via telephone. There is the possibility that mild to moderate discomforts may arise from sharing your experiences. If this happens, Mrs. Dixon will have available referral sources of three mental health professionals, however, you will have to pay for such services.

There may be a loss of confidentiality, because in the voice recording, there is a possibility that your voice could be identified. However, to insure confidentiality, for each study participant, Mrs. Dixon will transcribe each interview in a private location at her home office and use headphones to ensure privacy and confidentiality. Pseudonyms will be used so that participants' identities are protected during the interviews and any name will be de-identified in transcription process. If you have any concerns about the risks or benefits of participating in this study, you can contact Patricia O. Dixon at [redacted] [redacted] or the university's Human Research Oversight Board (the Institutional Review Board or IRB) at the number listed above

Are there any benefits for taking part in this research study?

There are no direct benefits to you for participating in this research.

Will I get paid for being in the study? Will it cost me anything?
There are no costs to you or payments or incentives for participating in this study.

How will you keep my information private?
To protect privacy the PI will meet the participants in a private and agreed upon location. The PI will inform participants that "all information obtained in this study is strictly confidential unless disclosure is required by law." All data will be kept securely in a locked cabinet located in the PI's home office for 36 month from the conclusion of the study, after that time, data containing identifiable information such as the original consent form hard copies of transcripts, written notes will be destroyed by shredding. Digital voice recordings will be magnetically deleted. Electronically stored data will be deleted in entirety from the PI personal computer. The PI will destroy all data as described. The IRB, regulatory agencies, or Dr. Anne Rambo, may review research records.

What if I do not want to participate or I want to leave the study?
You have the right to leave this study at any time or refuse to participate. If you do decide to leave, or you decide not to participate, you will not experience any penalty or loss of services you have a right to receive. If you choose to withdraw, any information collected about you **before** the date you leave the study will be kept in the research records for 36 months from the conclusion of the study and may be used as a part of the research.

Other Considerations:
If significant new information relating to the study becomes available, which may relate to your willingness to continue to participate, this information will be provided to you by the investigators.

Voluntary Consent by Participant:
By signing below, you indicate that.

- This study has been explained to you.
- You have read this document, or it has been read to you.
- Your questions about this research study have been answered.
- You have been told that you may ask the researchers any study-related questions in the future or contact them in the event of a research-related injury.
- You have been told that you may ask Institutional Review Board (IRB) personnel questions about your study rights.
- You are entitled to a copy of this form after you have read and signed it.
- You voluntarily agree to participate in the study entitled *An Appreciative Inquiry of an Exemplary Hospice Interdisciplinary Group Caring for Individuals With Alzheimer's Disease*

Participant’s Signature:____________________________ Date: ________________

Participant’s Name:_______________________________Date: _________________

Signature of Person Obtaining Consent:______________Date:_________________

Initials:______Date:________ Page 4 of 4

Appendix E: Semistructured Interview Questions

Discovery Phase I

1. What do you love most about working with this group? What first drew you to hospice and what has most encouraged you to stay with this group?
2. As a group member, there are inevitably high points and low points, successes, and frustrations. What stands out for you as a high point when you felt most accomplished within the team?
3. What do you value most caring for hospice patients with Alzheimer's disease? What do you most hope you can contribute to these individuals?

Dream Phase II

4. Imagine a time in the future when other groups look to your group as your group continues as an exemplary group in which all group members excel in their field of expertise. What would be happening differently and who would notice the difference?
5. What are you most proud of having helped the group accomplish?

Design Phase III

6. What are the areas in which you feel group members' participation could have the most impact on improving the quality of care for the chronically ill individuals, such as those with Alzheimer's disease?
7. As you reflect on successful ways your group currently implements strategies to improve group collaboration and cohesiveness, what strategy stands out as being

exceptionally promising? What can your organization do to assist the group to become more a leader within the organization?

8. What do you consider indicators that you are doing an excellent job within your group, patients, and families and the organization as a whole?

Destiny Phase IV

9. What small changes could your group make right now that would really encourage other teams to get to engage in improving their group?
10. What specific ways would you like to contribute to realize this dream?

Biographical Sketch

Patricia O. Dixon was born in Jamaica, West Indies; lived in Paterson, New Jersey, for 16 years; and subsequently moved to Pembroke Pines, Florida, in 1987. She attended Passaic County College in Paterson, New Jersey, in 1980 and graduated as a registered nurse in 1983. In 1977, she married Calden Dixon. Dixon came from a large Cuban/Jamaican family. Her father and his six siblings were born in Cuba and migrated to Jamaica and the United States in the 1950s. Dixon and her husband have four daughters and a son—Kelinda, Tiffany, Sasha, Jamie, and Christopher, and five grandchildren. In her spare time, she like reading, cooking, and traveling around the world to exotic countries.

Dixon has been working in the field of nursing since 1983 and presently works with a hospice organization, where she has been since 2001. She has extensive nursing experience, which includes being a nursing director and a nursing administrator for a high technology pediatric infusion company, and is currently a nurse manager in a hospice organization. Dixon earned a bachelor's degree in legal studies, master's degree in international business, and master's degree in health science at Nova Southeastern University.

While working as a nurse in hospice organization, Dixon recognized the need to work with individuals and families to better aid the therapeutic process of terminally ill patients and their caregivers. With this awareness and dream, she pursued her doctoral studies in marriage and family therapy at Nova Southeastern University. Dixon's dream is to incorporate marriage and family therapy in the hospice interdisciplinary group.