صنـدوق دعــم الـبحث العلمــي
Scientific Research Support Fund

Assessment of Current Situation of Home Health Care Services in Jordan

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Amman –Jordan

July 2012

ACKNOWLEDGEMENT

We are indebted to the Scientific Research Support Fund for its generous funding of this work.

We are grateful to the Jordanian Nursing Council and its staff for their logistic support through all steps of this study. Special thanks to Eman and Gosleen for their reliable work on the tedious task of transcribing the audio tapes, and for their help in solving few administrative impasses.

Our thanks also go to both the Ministry of Health and the Ministry of Trade and Commerce for their cooperation and for facilitating access to needed information. We thank Rima Arafat for her precise work and reliable data entry. To Ayman Mansour, we extend our gratitude and admiration for his expert technical support.

We extend or appreciation to each and every home health care manager and user of home health care services who accepted to participate in the study. Without them this study could not have come to realization.

TABLE OF CONTENT

TABLES

ANNEXES

ACRONYMS

AHRQ	Agency for Healthcare Research and Quality
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CMS	Center for Medicaid and Medicare Services
ED	Emergency Department
EU	Europe Countries
HHA	Home Health Agency
HHC	Home Health Care
HHCAs	Home health care agencies
HHCS	Home Health Care Services
HHCAHPS	Home Health Consumer Assessment of Healthcare Providers and Systems
JD	Jordanian Dinar
JNC	Jordan Nursing Council
MOH	Ministry of Health
SPSS	Statistical Package for the Social Sciences
USA	United States of America

EXECUTIVE SUMMARY

1. Introduction

The healthcare system in Jordan is evolving and has to continuously respond to the changing demographic, epidemiologic and risk profile of the population. Professional home health services include medical and/or psychological assessment and intervention; wound care, medication teaching, pain management, disease education and management, physical therapy, speech therapy, and occupational therapy provided to persons in their own homes.

2. Objectives of the Study

The overall goal of the study is to describe the home health care in Jordan and perception of users' and providers of the quality of these services.

3. Methodology and Tools

This is a triangulated study of phenomenological and descriptive designs. Data were collected using a data triangulation format of data collection methods using focus groups, with managers of home healthcare agencies and health care providers (medical doctors) ,and self reports by families/users of home health care services. Data from mangers and medical doctors were collected in regards to type and level of home health care services, users profile and health conditions, staffing, staff qualifications, referrals, payment scheme, pattern of utilization and barriers to utilization, while data from families/ users were collected in regards to perception of quality of care provided by home health care agencies. Data were collected from participants using an adapted and self administered questionnaire (the Home Health "Consumer Assessment of Healthcare Providers and Systems" Survey)

The study used a convenience sample of all managers of home health care agencies who are officially registered at the Ministry of Health in Jordan, users and families of users of home care services, and medical doctors who refer to home care services and attend the care of service users.

Bivariate Analysis was applied to investigate if evaluation has been affected by demographic and personal characteristics of the users, nonparametric statistical analysis was conducted as sample size was small and distribution of samples was not normal.

4. Main Findings

4.1 Findings from the Home Health Care Agency (HHCA) Survey

The majority of home health care agencies (HHCAs) are located and providing their services in the capital city of Amman. While nurses are the main full time and part time employees working at HHCAs, some agencies employ other professionals as vocational nurses, physiotherapists, occupational therapists, and physicians. Majority of physicians providing home health care (HHC) are working independently; only 53% were satisfied of HHC services.

HHCAs use mainly media combined with visits to physician clinics to promote their services and they do not have fees schedule. The majorities of the clients of HHC services do not have health insurance and pay their fees out of pocket.

The five top clients' health problems are: older people with physical impairment, cerebrovascular accidents, cancer, heart disease and diabetic. The majority of agencies (about 78%) reported that their patients have been admitted to the hospital because patients' health care needs were beyond home health care provision or because of shortage of proper nursing/medical expertise.

4.2 Findings from Users' Perception of Home Health Care Services

The majority of users were above the age of 60 years (54.8%), while about 11% were below the age of 30 years. The majority of user were not living alone, and do not have health insurance. Regarding the quality of home health care services as perceived by clients, although 76.8% of the users reported that they will advise the institution that provides them with home health services to others, they indicated that they had some problems as not receiving the type of assistance they asked for in the same day or not provided with enough information during the follow up services.

The statistical analysis showed that although users' satisfaction level of the provided HHC services was moderate to high, it was significantly higher among those who reported their evaluation to internal sources than those who reported their evaluation to external sources. In other word, there is a possibility of social bias in reported users' evaluation.

4.3 Findings from Focus Group Discussions with Managers of Home Health Care Agencies (Qualitative Analysis)

To elicit the concerns of managers of home health care (HHC) agencies, the participants were asked the following questions: "What conditions do you think facilitate HHC provision? What conditions hinder home health care provision? The content analysis revealed eight themes discussed below. The themes indicated that the current work conditions do not facilitate HHC provision. Facilitating provision of HHC as perceived by the participants requires managing conditions that hinder effective HHC. It was believed that delivery of quality services, irrespective of other hindrances, is the only condition that facilitates effective HHC provision.

Emerging themes, conditions and challenges from the focus group discussions were: unethical practices, lack of regulation, lack of support, inappropriate referral systems, problematic female staffing, disorganized services, affordability of services, and dominance of profit making.

4.4 Findings from Focus Group Discussions with Medical Doctors (Qualitative Analysis)

To elicit the perception of medical doctors, of home health services in Jordan, the doctors who participated in the focus groups were asked the following questions? How do you perceive the quality of HHC? What facilitates and what hinders the provision of these services? The content analysis of the focus group accounts revealed four themes. Some of their perceptions paralleled the managers of HHC including the lack of organization. Their preference to using hospital nurses rather than home health care nurses confirmed the accounts made by the managers. Other concerns/ themes were, mistrust in the quality of care, and the need for medical doctors to oversee care delivered by home health care agencies, utilization and valuation of home health care, in addition to lack of organization of home health care agencies. Therefore the emerging themes were: mistrust vs. trust; low utilization of home health care; undervalued service; and, need for organization.

5. Conclusion:

In Jordan, the ability of the frail people and disabled people to choose from of a variety of cost-effective long-term care services has been limited by many factors including the lack of health insurance coverage for home care services, lack of quality home health care services available to them, and when affordable, very often these services are not accessible; this is especially true for people who live outside the capital Amman.

6. Main challenges:

This study indicated that home health care services in Jordan are facing many challenges that need proper attention as: too many agencies most of them lack proper financing, staffing, management and support systems; lack of national data base on HHCAs; fragmented home health care services that are not integrated into the health care system; absence of regulation and monitoring by health authorities; shortage of qualified personnel especially professional female nurses; lack of written policies and procedures including treatment protocols; shortage of proper supply and equipment; lack of health information system including medical records; problems of equity and financial access to poor patients ; lack of continuous quality improvement programs and periodic clients' satisfaction surveys; lack of trust and professional relations among different stakeholders; poor management practices, absence of basic governance principles and lack of effective regulation open the door for legal and ethical misconduct; and overemphasis and domination of profit making aspect on the expense of quality improvement.

7. Recommendations:

The researchers propose some recommendations and interventions to address the above challenges as: HHCAs are encouraged to develop partnerships, affiliation or even mergers in order to create strong and well organized health institutions; MOH should develop up-to-date national data base for all HHCAs; professional guidelines, practice protocols and quality indicators for home health

care services should be developed; a national service fees schedule for home health care services should be developed in partnership with all stakeholders; MOH and other concerned health organizations should perform there mandate role regarding controlling and monitoring performance of HHCAs; managers of HHCAs should create a "Caregiver-friendly" practices such as creative, flexible scheduling; fair financial incentives and continuous training programs for attracting female nurses to home health care; hospitals and home health care agencies are encouraged to develop professional partnerships and effective communication ; HHCAs should develop : written policies and procedures, health information system, medical records system, patients' education and orientation programs ,continuous quality improvement programs ,periodic clients' satisfaction surveys, continuous training programs, and proper management practices ;a code of ethics should be developed and indorsed by all home health care agencies; and Health insurance schemes should be encouraged to add home health care services to their insurance packages.

I. INTRODUCTION

The healthcare system in Jordan is evolving and has to continuously respond to the changing demographic, epidemiologic and risk profile of the population; the rising expectations of a more educated population; the fast growing private health sector; the rapid changes taking place in medical technology; and the desire among the government to expand services and achieve universal health coverage (Ajlouni, 2010).

"Home care", "home health care", "in-home care" are terms used interchangeably to mean any type of care given to a person in their own home. More recently, there is a growing movement to distinguish between "home health care" meaning skilled health care and "home care" meaning non-medical care. Home care aims supporting people with various degrees of dependency to remain at home rather than use residential, long-term, or institutional-based nursing care. Home care providers render services in the clients' own home. These services may include combined professional health care services and life assistance services. Professional home health services could include medical and/or psychological assessment and intervention; wound care, medication teaching, pain management, disease education and management, physical therapy, speech therapy, and occupational therapy (Shepperd, 1998).

Many health care treatments that were once offered only in a hospital or a doctor's office can now be done in home. Home health care is usually less expensive, more convenient, than, than and just as effective as care patients get in a hospital or skilled nursing facility. In general, the goal of home health care is to provide treatment for an illness or injury. Home health care helps patients get better, regain their independence, and become as self-sufficient as possible.

Demographic, epidemiological, social, and cultural trends in Jordan as in other countries are changing the traditional patterns of care. The next decades will see increasing rates of care-dependent older people and noncommunicable diseases as the leading cause of chronic illness and disability. The break-up of the traditional large family group and urbanization will also lead to gaps in the care of older or disabled family members. These changes in needs and social structure require a different approach to health and social sector policy and services since a disease-oriented approach, alone, is no longer appropriate. An

answer to these issues could be home care, a sustainable approach to prevent the need for unnecessary acute or long-term institutionalization and maintain individuals in their home and community as long as possible.

According to the data provided by the Ministry of health, Jordan has a total of fifty three (53) private home care agencies. Thirty six of these are in Amman, four in Irbid, three in Zarqa, two in Balqa, and one (1) in Mafraq. Other than the location of these services, nothing is detailed in relation to the structure, types or population served. There are no legislation, policies or guidelines that govern home health care services in Jordan, therefore these services are neither regulated nor monitored and their accountability to the users of the services is not defined.

Thus, there is an urgent need to explore the current status of the home health care sector in Jordan and to evaluate the patterns of utilization, barriers to utilization of this cheaper, yet more convenient alternative to long-term institutional care.

II. OBJECTIVES OF THE STUDY

The overall goal of the study is to describe the home health care in Jordan and perception of users' and providers of the quality of these services. The specific objectives are:

1. To describe the home health care service; organization, structure, staffing, staff qualifications, payment schemes, referrals, level and type of home health care services provided in Jordan.
2. To assess patterns and barriers of access and utilization of home health care in Jordan.
3. To assess users perception of quality of care provided by home health care services in Jordan.

III. LITERATURE REVIEW

Home care services have dramatically increased in many countries around the world (Van Campen &Van Gameren, 2005, Hughes, 1997, Murashima, 2002) The United States witnessed a phenomenal increase over the past several decades. Home care is the fastest growing sector of personal care expenditure (Hughes, 1991). Home health care invited and forced necessary amendments to laws, policies and insurance schemes (Delonge, et al, 2009; Hanson& Arnetz, 2007, Murashima et al, 2002) that support the service provision of this health sector.

The growth in home care services is mostly related to four basic causes: the escalating cost of inpatient care and the search for alternative services, the aging population, the increased technological capacity to provide sophisticated medical treatments at home and the preference for home care by the users (Hughes, 1997).

Home care as described in the literature has different modalities and various types of services including, domestic, physical, nursing, social, medical care, and highly sophisticated technical interventions. (Challis et al, 2001) The Netherlands have five home care services ranging from simple domestic to semi-institutional care, such as day care or night care (Van Campen &Van Gameren, 2005). Japan offers four major types of home care including: home care of the elder, high tech" care, terminal care, and psychiatric care (Murashima, 2002). Home care "modalities" in the United States has a range from simple domestic care to highly complex medical treatments. Target populations and interventions vary within and across home care modalities in the US .Home care services were erected in the US to serve special populations and meet their care needs in a cost effective manner (Hughes, 1997).

Although the literature review shows a variety of uses of home care by different populations, it is apparent that most of the home care services focus on care of the elderly. Older people live longer, have more complicated health problem that requires sophisticated technical treatments.

In countries like Canada (Denton and colleagues, 2002), and Sweden (Johansson, 2005) the care of the elderly shifted from long term institutions to community based care and private homes.

The National Cancer Institute reported that cancer patients in general prefer to be cared for at home, where they feel more comfortable and secure with their families, their friends and familiar surroundings. Palliative care is also preferred by care users to be received in a home environment (Finlay et al, 2002).

The shift of care of complex health conditions to home care demands high level of competence among care providers. In a Swedish comparative study of nursing perception on a number of variables, the study indicated that nursing staff in home care were less competent than nurses working in nursing homes. A significant number of home care nursing staff, reported insufficient knowledge in palliative care, patient transfers, oral care, nutrition, range of motion, medication and pressure ulcer Furthermore, home care was staffed by aide and practical nurses that performed delegated medical tasks on daily basis (Hasson & Arnetz, 2007).

Other studies also have shown that staff competence development was needed in mental illnesses (Roudonis et al, 2002), and dementia (Brodaty et al, 2003).

Several studies referred to the need for a link with the secondary care when caring for complex health care conditions at home (Hanson& Arnetz,2007, Fortinsky et al, 2006), Challis et al, 2001). In addition these studies also highlighted the need to perform thorough assessment of users especially of the vulnerable elderly, and to assure matching the needs of the users as measured by their level of functioning, ability to perform ADLs, and other health and social needs, with the level of service and the preparedness of the organization and the care givers.

The literature indicated that that home care is here to stay. It identified several types of home care services and pointed to the necessity to link with secondary level of care, to assess users and match them to appropriate services. It also became evident that to explore home health care, structures and processes of these services need to be addressed.

IV. METHODOLOGY AND TOOLS

1. Design

This is a triangulated study of phenomenological and descriptive designs that aims at describing home health care services in Jordan and the perception of users and health care providers of the quality of these services. Data was collected using a triangulation format of data collection methods using focus groups, with managers of home healthcare agencies and health care providers (medical doctors) ,and self reports by families/users of home health care services. Data from mangers and medical doctors was collected in regards to type and level of home health care services, users profile and health conditions, staffing, staff qualifications, referrals, payment scheme, pattern of utilization and barriers to utilization, while data from families/ users were collected in regards to perception of quality of care provided by home health care agencies.

2. Study population: The study used a convenience sample of all managers of home health care agencies who are officially registered at the Ministry of Health in Jordan, users and families of users of home care services, and medical doctors who refer to home care services and attend the care of service users.

3. Sample and sampling

3.1 For the purpose of collecting the quantitative data of the study, a convenience sample of the target population was used. According to G-Power computer program (Faul and Erdfelder, 1992) with a medium effect size of 0.30, at power of 0.80 and 0.05 two tailed level of significance for one sample t- test , a total sample of 82 subjects (family member/user) was used in the study. Inclusion criteria included those who receive/received home care services at the agency for at least one month. Other than deceased users, there was no other exclusion criteria maximized variation in data collection. Data were collected from participants using self-administered questionnaire (the adapted format of

the Home Health "Consumer Assessment of Healthcare Providers and Systems" (HHCAHPS) survey) (Annex 3)

3.2 For the purpose of qualitative data collection, a purposive sample was used for focus interviews with managers of home health care agencies and medical doctors. Interviews focused on exploring type and level of home health care services, users profile and health conditions, staffing, staff qualifications, referrals, payment scheme, pattern of utilization and barriers to utilization. All of the home health care agencies in Jordan represented by their managers were targeted. Eligibility criteria included: 1) a management/administrative position in the agency, and 2) a minimum of 6-month experience in the management/administration of the agency with proper knowledge of the agency business. The sample size for the purpose of focus group was 19 mangers (9-10 participants per group). The managers served as liaison to provide list of medical doctors who refer/care for their patients. Inclusion criteria for medical doctors included 1) those who referred/provided care for patients through home health care agencies. The sample size for the purpose of focus group was 17 medical doctors (7-10 participants per group).

4. Settings

The primary source of the data was the home health care agencies registered at the Ministry of Health who provide home health care and medical doctors who refer and collaborate with these agencies. In addition, users of home health services were targeted as part of the evaluation process of these services.

5. Procedures of data collection

The data collection procedure was as the following:

1. Approvals from the Academic Research Committee at Philadelphia University were obtained prior to data collection.
2. The Ministry of Health was contacted to provide contact list of the registered and licensed home health care agencies in Jordan.
3. The adapted and translated HHCAHPS was pilot tested using 10 users of home health care and home health care profile instrument was pilot tested using five managers of Home health care agencies.
4. The managers of all home health care agencies registered and licensed by the Ministry of Health were invited to participate in the study. They served as the liaison to facilitate the contact list of the medical consultants and users of the services who either choose the services or were referred by medical doctors, and with the medical doctors who refer or follow up.
5. The research team (Principal Investigator and Co-investigators) contacted all subjects and screened them to determine their eligibility for the study. Those who meet the inclusion criteria were invited to participate in the study and asked to sign the informed consent form.
6. Families/users of home health care services who met the inclusion criteria were informed that data were collected through self-administered questionnaire that measures their perception of quality of care provider by the home health care agencies. They were informed where to pick and return the package that included two forms; the demographic form and the Home Health Care CAHPS survey). The package also included a cover letter (annex 7) that includes information about the purpose of the study and what was expected from them and where to return the packages, and that the study is anonymous. In addition, the cover letter included contact information of the principal investigator and co-investigator for any further information and for answering the questions related to the study. The interested participants were asked to sign the cover letter in which a statement made at the end of the cover letter says explicitly that their

participation in the study was voluntarily and their decision is of their own choice without any direct or indirect influence.

7. Health care providers (mangers of home health care agencies and medical doctors) were informed that data will be collected through focus group interviews. To collect qualitative data, home health care agencies' managers who agree to participate in the study and meet the eligibility criteria were invited to participate in the group focused interviews. Time of interviews was arranged according to participant's convenience. All focus group sessions were conducted at the Jordanian Nursing Council location. Prior to the sessions, the participants were asked to sign a consent form. Prior to signing the consent forms (annex 8), the researchers explained the purpose of the study, answered participants' questions, and assured them of the confidentiality and privacy of the study. Participants were informed that they have the right to withdraw from the study at any point and that their participation is voluntary and that their decision of not participating is of their own choice without any direct or indirect influence. Each group (a total of 19 mangers and 17 medical doctors) were divided into two subgroups (7-10 in each). Each subgroup had a focus groups session of 90-120 minutes. The interviews included open discussion in regards to what facilitates and what hinders home health care. Two sessions were audio taped in full, whereas, one was partially audio taped due to the objection of one participant.

6. Protection of Human Participants

Human participants' right to confidentiality, privacy and safety were securely protected throughout the project. Files were kept in locked cabinets at the Jordanian Nursing Council. All projects' electronic versions were kept only in the primary investigator's computer. Participants were asked if they wish to take their transcribed tapes to keep or to be destroyed by the investigators. No names or any identifying information were used that may cause harm to participants at any stage of participation. An approval from the Academic Research Committee at

Philadelphia University was obtained prior to data collection at the beginning of the research project.

7. Tools/measurement

Data were collected using the triangulation format of data collection as the following:

7.1 Focus group interviews

Two focus groups that target managers of home health care agencies (9-10 persons per group) and two focus groups that target medical doctors (7-10 persons per group) were conducted. The aim of the focus groups included open discussion in regards to what facilitates and what hinders home health care, in addition to perceived solutions to improve the quality of services of home health care in Jordan (annex 1). Interviews were conducted by the researchers themselves until data saturation was achieved within the interview itself. Time for each session ranged between 90-120 minutes.

7.2 Self Report Questionnaire

A self-administered questionnaire was adapted from the Home Health Care CAHPS survey (HHCAHPS) (annex 3b). This questionnaire was translated into Arabic by a professional translator and back translated by another translator into English; discrepancies were compared and checked to assure sameness in the meanings on all items. HHCAHPS measures the perception of quality of home health care provided. The Home Health Care CAHPS Survey questionnaire includes the two types of questions contained on all CAHPS instruments—those dealing with reports of specific experiences and those asking for opinions and ratings. The Home Health Care CAHPS Survey instrument contains 34 items that cover topics such as access to care, communications, and interactions with the agency and with agency staff. There are two global items; one asks the patient to rate the care provided by the Home Health Agency (HHA), and the second asks the patient about his or her willingness to recommend the HHA to family and friends. The

survey also contains items that ask for self-reported health status and basic demographic information (race/ethnicity, education attainment level, language spoken in the home, etc. (Items 29-32 addressing race and ethnicity of users were omitted from the questionnaire for irrelevance, with remaining 31 items.) The HHCAHPS was designed to measure the experiences of people receiving home health care from Medicare-certified home health care agencies. This instrument was developed by the Agency for Healthcare Research and Quality (AHRQ) in conjunction with Center for Medicaid and Medicare Services (CMS). The tool is used globally as reference for quality assessment and measurement for health care services.

The development process for CAHPS surveys includes a public call for measures, review of existing literature, cognitive interviews, consumer focus groups, stakeholder input, public response to Federal Register notices, and field tests. The Home Health Care CAHPS Survey questionnaire includes the two types of questions contained on all CAHPS instruments—those dealing with reports of specific experiences and those asking for opinions and ratings. The Home Health Care CAHPS Survey instrument contains 34 items that cover topics such as access to care, communications, and interactions with the agency and with agency staff. There are two global items; one asks the patient to rate the care provided by the Home Health Agency (HHA), and the second asks the patient about his or her willingness to recommend the HHA to family and friends. The survey also contains items that ask for self-reported health status and basic demographic information (race/ethnicity, education attainment level, language spoken in the home, etc.). The survey is designed to meet the following three broad goals: 1)To produce comparable data on the patient's perspective that allows objective and meaningful comparisons between home health agencies on domains that are important to consumers, 2) Public reporting of survey results will create incentives for agencies to improve their quality of care, and 3) Public reporting will enhance public accountability in health care by increasing the transparency of the quality of care provided in return for public investment.

7.3. Home Health Care Profile

Home health care services was measured using an adapted 40-multidimensional item scale (Annex 4) to assess the type and level of services, years of service, users profile and health conditions, staffing, staff qualifications, health conditions of users served, capacity for service, availability of policies and procedures and user records, referrals, payment scheme, pattern of utilization and barriers to utilization. The tool has been developed using information from Ellenbecker (1995), Riccio, & Patricia (2001), and Rodriguez, & Dorothy (1982). The data has been tested for cultural convenience and appropriateness. Responses were provided was multidimensional as some question made according to a three-point Likert scale and other were dichotomous (yes versus no). The tool was pilot tested, and reliability and validity has been checked.

7.4 Potential covariates/characteristics and demographic information of participants.

For users/families: Gender, age, citizenship, medical diagnoses, length of time of use of the home health care services, type of service used, health condition ,and health insurance and method of payment. (Annex 3a).

For medical doctors: Gender, age, years of experience, area and cities served, specialization, sector, number of users referred, health conditions of referred users (annex,5).

For Home health care managers: Gender, age, education, years of experience, qualifications, type of experience, years of experience in home health care, period of employment by agency, date of registration of agency at the ministry of health, Date of initial operation of the agency, and areas (cities) served.(annex 6)

8. Data management plan

8.1 Descriptive Statistics

The computer program, SPSS Windows (version 17.0) was used to describe the variables of the study using central tendency measures (means, and medians) and the dispersion measures (standard deviation and ranges).

The estimated descriptive statistics were compared to normative samples in the literature.

8.2 Data screening and cleaning

The small estimated sample size did not allow for the proper evaluation of the reliability and validity of the survey. However, In particular, internal consistency of scales will be estimated using Cronbach's alpha. The variables will be checked for multicollinearity, singularity, and construct validity. Therefore, no subscale will be used to prevent singularity, and too highly correlated ($r \geq .90$) variables will be identified to prevent multicollinearity. Prior analysis, several techniques used to check on the quality of data. This included treating missing values, outliers, and extreme values.

8.3 Qualitative data analysis plan:

Content analysis will be used to address qualitative data available from the group session's discussions. All audio taped discussions will be transcribed verbatim and analyzed in terms of general topics of discussion and common themes of concern.

V. FINDINGS AND DISCUSSION

1. Findings from the Home Health Care Agency (HHCA) Survey

1.1 Managers' Characteristics

Nineteen managers of HHCAs participated in the survey. Table 1 indicates that 78.9% of managers (n = 15) were males and 21.1% (n = 4) were females. The age categories shows almost equal distribution as 26.3% were at age less than 30 years and 36.9% were at age 30-40 years, and 33.1% were above the age of 40 years. Only one manager (5.3%) was none Jordanian while the others were Jordanians. Most of the managers has bachelor and master degrees (42.15% and 26.35 % respectively), while 26.3%of them has less than bachelor degree and only one manager

has a PhD degree. The majority of the managers also were nurses (73.7% (n = 14) while there was one physician (5.3%) and the others (21.0%, n = 4) were from different health specialties. Regarding years of experience for managers, the table shows that the majority (about 58%, n = 11) have more than 12 years of experience, while about 15.8% have 12-15 years and about 26% of them have less than three years of experience. However, experience in home health services business showed that 50% (n = 9) of the managers were five years or less in business.

Table 1: Demographic and Personal Characteristics of Manager of Home Health Care Agencies (N = 19)

Variable		n	%
Gender	Male	15	78.9
	Female	4	21.1
Age (years)	< 30.	5	26.3
	30 – 39	7	36.8
	40 – 49	4	21.1
	50 - 59	3	15.8
Level of Education	High school	2	10.5
	Diploma	3	15.8
	Baccalaureate	8	42.1
	Master	5	26.3
	Doctorate/PhD	1	5.3
Profession	Physician	1	5.3
	Nurse	14	73.7
	Physiotherapist	3	15.8
	Laboratory technician	1	5.3

Years in business	1 – 2	5	27.8
	3 - 5	4	22.2
	6 – 8	3	16.7
	9 – 15	3	16.7
	16 – 20	2	11.1
	> 20	1	5.6
Years of experience	1 – 3	5	26.3
	8-11	3	15.8
	12- 15	5	26.3
	> 15	6	31.6
Year of agency operation	1987	1	6.7
	1993	1	6.7
	1999	1	6.7
	2001	2	13.3
	2004	1	6.7
	2008	2	13.3
	2010	2	13.3
	2011	5	33.3

1.2 Characteristics of Home Health Services

Table 2 shows that the majority of home health care agencies (HHCAs) are located and providing their services in the capital city of Amman (94.4%). Although the location of agencies was limited to Amman and Zarka, the agencies reported that they provide services to other cities such as Irbid and Jerash. Regarding type of services, all agencies (100%) reported that they provide home nursing care services, while 72.2% provide services related to medical supplies, 66.7% provide physiotherapy, and 27.8% provide occupational therapy. The

results indicate that services of HHCAs seem to be client-oriented. About half of the agencies (44.4%) reported that they have training programs to their employees.

Home health services vary across countries .As reported by Tarricone, Rosanna & Tsouros, Agis D. (2008), in almost all EU countries, home care is located at the intersection between the health care system and the social system and has its own peculiarities within each. Traditionally, the separation between health care and social systems relies on the nature of the service provided at home (health- or socially related). Home care services provided by health care systems often include:

- Rehabilitation, supportive, health-promoting or disease-preventive and technical nursing care, both for chronic and acute conditions (the latter are better known as hospital-at-home schemes), occupational therapy and physiotherapy
- home health care recipients would be mostly older people, people with complex illnesses and people with terminal illness.

Home help services, traditionally provided by the social service sector, instead, comprise: household duties, such as shopping, cooking, cleaning and administrative paperwork (such as filling in forms and paying bills), activities such as socializing or going for walks and delivering personal care (help with bathing and dressing, etc.)

Table 2: Characteristics of Home Health Care Agencies (N = 18)

Variable		n	%
Agency location	Amman	17	94.4
	Zarqa	1	5.6
Target area of services	Amman	17	94.4
	Irbid	5	27.8
	Zarqa	9	50.0
	Mafraq	0	0

	Aqaba	1	5.6
	Karak	1	5.6
	Jerash	2	11.1
	Salt	1	5.6
Type of services	Home Nursing Care	18	100
	Physiotherapy	12	66.7
	Occupational therapy	5	27.8
	Medical equipment and supplies rental	13	72.2
	Babysitting	1	5.6
	Transpiration to health care setting	1	5.6
	Geriatric care	1	5.6
	Transpiration to health care setting	1	5.6
	Geriatric care	1	5.6
	Medical supply	1	5.6
Training	Offer training programs to staff	8	44.4
Nationality of Patients	Jordanians	15	83.3
	Non-Jordanians	3	16.7

1.3 Staff Working at Home Health Care Agencies

While nurses (registered and associate) are the main full time and part time employees working at HHCAs (Table 3), some agencies have also reported that they employ other professionals as vocational nurses, physiotherapists, occupational therapists, and physicians. More than half of the agencies do employ full time staff. This could be influenced by the health and social benefits provided to their staff as only 38.9% of the agencies provide social and health care benefits to their staff.

Table 3: Staff Categories Working at Home Health Care Agencies

Variable	**Profession**	**Distribution of HHCAs according to no. of staff in each category (N = 18)**							
		> 10		**6 – 10**		**1 – 5**		**0**	
		n	**%**	**n**	**%**	**n**	**%**	**n**	**%**
Full time job	Registered nurses	0	0	5	25	4	25	9	50
	Associate nurse	0	0	2	11.1	3	16.7	13	72.2
	Vocational nurse	0	0	0	0	1	5.6	17	94.4
	Physiotherapist	0	0	0	0	4	22.2	14	77.8
	Occupational therapist	0	0	0	0	3	16.7	15	83.3
	Physician	0	0	0	0	2	11.1	16	88.9
Part time job	Registered nurses	2	11.1	4	22.2	3	16.7	8	44.4
	Associate nurse	2	11.1	3	16.47	2	11.1	10	55.6
	Vocational nurse	0	0	1	5.6	1	5.6	16	88.9
	Physiotherapist	0	0	0	0	5	27.8	13	72.2
	Occupational therapist	0	0	0	0	2	11.1	16	88.9
	Physician	0	0	0	0	1	5.6	17	94.4

1.4 Demographic and Personal Characteristics of Physicians Providing Care at Home Health Care Agencies

Regarding physicians, Table 5 shows that 88.2% (n = 15) were males, while 12.7% (n = 2) were females. The majority of them were of age 50 years or above (58.8%, n = 10), while only one physician was at the age of 30 years or less and the others were at the age between 30-49 years (29.6%, n = 5). Only one physician (5.9%) was non-Jordanian, while all other physicians were Jordanian. According to physicians, 58.8% (n =10) of them see 1-5 home care patients per month, while 16.7% (n = 3) and 11.8% (n = 2) see 6-10 patients and 16-30 patients per month, respectively. 35.3%, of the physicians are cardiologists (n = 6), 17.6% are internists (n = 3) and 17.6%, are urologists (n = 3). Only two physicians (11.8%) work as full time at home health care agency, while the other physicians are working independently. While 52.9% (n = 9) of them have knowledge about the home health services, only 17.6% (n = 3) had received training in Home health care services. Regarding satisfaction with home health care services, 52.9% (n = 9) were satisfied compared to 47.1% (n = 8) were not satisfied.

Table 4: Demographic and Personal Characteristics of Physicians Providing Care at Home Health Care Agencies (N = 17)

Variable		n	%
Gender	Male	15	88.2
	Female	2	12.7
Age (years)	< 30	1	5.9
	30 – 39	2	11.8
	40 – 49	3	17.6
	50 - 59	7	41.2
	> 60	3	17.6
Specialty (could be more	General practitioner	1	5.9

than one area of specialty)	Internal medicine	3	17.6
	Cardiologist	6	35.3
	Oncologist	1	5.9
	Urologist	3	17.6
	Neurologist	1	5.9
	Pulmonary	1	5.9
	Others	4	23.5
Average number of home care patients per month	1 – 5 patients	10	58.8
	6 – 10 patients	3	17.6
	> 10 patients	2	17.6
Satisfaction with HHC services	Completely unsatisfied	2	11.8
	Somehow satisfied	5	29.4
	Satisfied	6	35.3
	Completely satisfied	3	17.6
Working with Agency	Yes	2	11.8
	No	15	88.2
Knowledge of HHC services	Yes	9	52.9
	No	6	35.3
Training in HHC	Yes	3	18.8
	No	13	81.2

1.5 Service Fees and Service Promotion at Home Health Care Agencies

As indicated in Table 5, most of the agencies reported that they charge their clients per visit (61.1%), per day (50.0 %) and per procedure (50.0%), although 61.1% of the agencies reported that they do not have service fees schedule. In addition, agencies reported that they decide the charging fees most of the time (66.7%), and this actually, has not caused the agency any problem as 77.8% (n = 14) of the agencies reported that they never or rarely encounter financial problems related to fees payment. Regarding clients' promotion, the table showed that the majority (61.1%) of HHC agencies use media combined with visits to physician clinics to promote their services.

Some countries have both "not-for-profit" and "for-profit" home health agencies. Beth Han et al (2007) found that for-profit and not-for-profit home health agencies behaved similarly with regard to length of service among patients within differently structured payment systems.

Table 5: Service Fees, Service Promotion and Payment Issues at Home Health Care Agencies

Variable		Number of HHCAs	%
Services fees	Per hour	6	33.3
	Per visit	11	61.1
	Per procedure	9	50.0
	Per day	9	50.0
	Per case	5	27.8
	Per month	1	5.6
	Shift. Monthly	1	5.6
	Per medical supplies	1	5.6
Do you have services fees	Yes	7	38.9

schedule	No	11	61.1
Who determine the fees	Agency	12	66.7
	Agency and government	1	5.6
	None	5	27.8
Do you provide your staff with full-benefits package including social security, health assurance, transportation, etc	Yes	7	38.9
	No	10	55.6
Service promotion	Media	2	11.1
	Direct visit to physicians clinics	3	16.7
	Media and Direct visit to physicians clinics	11	61.1
	Physicians	2	11.1
	Brochures	1	5.6
	Other clients	1	5.6

Variable	**All the time**		**Very often**		**Rarely**		**Never**	
	n	**%**	**n**	**%**	**n**	**%**	**n**	**%**
How often do you encounter financial problems related to payment of service fees (delay of payment, partial payment, denying payment, etc.	1	5.6	3	16.7	7	38.9	7	38.9

1.6 Type of Payment and Patients' Contact Hours at Home Health Care Agencies

Table 6 below shows that the majority of the clients of HHC services do not have health insurance (94.4%) and most of the patients have other sources of payment coverage that may include self, family, relatives or charity. Most agencies reported that service fees are paid out of pocket either by the clients themselves (61.1%) or by their families (72.1%). This raises an important issue of financial accessibility and equity regarding home health care services in Jordan. Poor patients can't receive these services, and thus we can conclude that home care services in Jordan are apparently confined to patients who can pay the fees of services.

Table 6: Type of Payment Service and Patients' Contact Hours at Home Health Care Agencies (N=18)

			%
Type of payment	Health insurance	1	5.6
	Self	11	61.1
	Family	13	72.2
	Relatives	2	11.1
	Charity	3	16.7
Hours of patients' contact	< 8 hrs./week	9	50.0
	8 – 12 hrs./week	14	77.8
	24 hrs. / week	15	83.3

Many studies investigated the influence of income and health insurance on use of home care. Fleishman (1997) reported that a higher income was associated with use of a home help in people who were HIV positive. In contrast, Riemsma et al

(1998) found that patients with rheumatoid arthritis who had a low income made more use of professional home care.

Regarding patients' contact hours, agencies reported that they vary between 8 hours per week to 24 per week. This limited number of service hours is likely associated with the lack of health insurance coverage for home care. It also raises questions about the quality, continuity and effectiveness of care provided to home health care patients.

1.7 Clients' Health Problems

As shown in Table 7, the five top clients' health problems as perceived by the managers of HHCAs were: older people with physical impairment (83.3 % of the agencies), cerebrovascular accidents (77.8%), cancer (62.1%), heart disease and diabetic (55.6% for each). Mental illness, dementia and respiratory problems were reported by 40% of the agencies. While other health problems like paraplegia, quadriplegia, renal problems, children with disabilities and hearing/ visual impairment were reported by less than 50% of the agencies.

The clients' health problems as perceived by the managers of HHCAs are on line with the general picture of morbidity in Jordan. Jordan, like other middle income countries, is witnessing an epidemiological transition, which is characterized by an increase of non- communicable diseases, particularly cardiovascular diseases, cancer, diabetes and chronic respiratory conditions. The major cardiovascular diseases are hypertension, coronary heart disease and stroke. Among the factors contributing to a high prevalence of noncommunicable diseases are the increasing elderly in the population as well as the lifestyle changes including unhealthy food consumption pattern, smoking and residential life lacking manual work and physical exercise (Ajlouni, 2011).

In Saudi Arabia for example home care patients suffer from similar health problems .As reported by the Saudi Society for Home Care of Patients with Chronic Diseases (Shefa, 2011), 90% of cases cared for at home were for patients suffering from diabetes mellitus (36%), hypertension (28%), and cerebral vascular accidents (26%). The study reported that 98% of patients were satisfied from the home care services.

Algera, Marco et al. (2004) studied home care needs of patients with long-term conditions based on literature review of 13 studies related to this topic.

They found that there is a dearth of publications on factors influencing the match between care need and actual use of professional home care among people with long-term conditions. Most of the 13 publications reviewed concerned determinants of professional home care use, rather than the match between patients' felt needs and the home care delivered. From these studies, a profile of people with long-term conditions who used home care emerged. In general, older, non-white women, with multiple chronic diseases and impairments, and who had recently had inpatient care, tended to make more use of professional home care.

Table 7: Clients' Health Problems and Health Status as Perceived by HHCAs Managers (N=18)

Health Problem	Number of HHCAs	%
Mental illness	9	50.0
Cancer	11	62.1
Dementia	9	50.0
Diabetes	10	55.6
Heart Disease	10	55.6
Hearing/ visual impairment	2	11.1
Cerebrovascular accidents	14	77.8
Paraplegia	7	38.9
Quadriplegia	7	38.9
Respiratory problems	9	50.0
Renal problems	7	38.9
Children with Disabilities	7	38.9
Other chronic conditions	5	27.8
Older people with physical impairments	15	83.3

1.8 Referral of Patients and Reasons for Hospital Admissions

Table 8 indicates that the majority of agencies (about 78%) reported that their patients have been admitted to the hospital because patients' health care needs were beyond home health care provision or because of shortage of proper nursing/medical expertise. This indicates that home health care agencies may not have enough qualified health professionals to provide the appropriate home health care. Another possible explanation is the lack of training as reported before, as the agencies reported that more that 50% of the time their do not train their health professional to home health care services and that home health care might be limited to general health care rather than specialized one.

Shortage of proper medical equipment to care for patients at home was perceived by 22% of the agencies as another reason for admitting patients to hospitals. Thus, recruiting more qualified staff to deliver home care, providing them with appropriate training and providing agencies and patients with needed equipment and supplies could minimize the barriers for home health care provision and reduce the rate of admissions to hospitals.

Regarding referral patterns to hospitals, patients' self referral was perceived by about 84% of the agencies followed by health practitioners' referrals and agency referrals. Since self referrals may not always reflect actual needs of patients for hospitalization, the perception of patients and their families about the quality of services and the availability ,appropriateness and accessibility of home care services may minimize unnecessary self referrals to hospitals.

A study conducted for the Alliance for Home Health Quality and Innovation in the USA cost effectiveness of home care (Avalere Health, 2009), found that patients with at least one chronic disease who used home health care after hospitalization saved Medicare $1.7 billion over a two-year period; and they had 24,000 fewer rehospitalizations during the 2005-2006 study periods.

(Shepperd ,Sasha et.al. 2009) used randomized controlled trials to assess the difference in mortality rates between patients receiving hospital care and patients receiving home care found that :there was no significant difference in mortality at 3 months for patients who received hospital care at home; admissions to hospital were greater, but not significantly so, for patients

receiving hospital care at home; and patients receiving hospital care at home reported greater satisfaction than those receiving inpatient care.

Another study by De Haan et al. (1993), Kenney (1993) studied the influence of health care system characteristics on use of home care by people with long-term conditions. De Haan et al. found that if a general practitioner was notified about a stroke patient's discharge from hospital, the chance of home care use increased. Kenney () described the influence of many health care system characteristics on use of home care by patients with chronic obstructive pulmonary disease, chronic heart failure or stroke, and found that the chance of using it increased when there were fewer nursing home beds or more home health staff available. In addition, use of home care was greater if there were fewer hospitals based long-term care arrangements or more hospital-owned home health agencies.

A study on the impact of home care on hospital days (Huges S.L.,et. Al 1997) concluded that home care has a significant impact on reducing hospital days.

Table: 8 Reasons for Admission and Hospital Referrals as Perceived by HHCAs Managers (N=18)

Variable		**Number of HHCAs**	**%**
Reason for admission:	Seeking proper nursing/medical expertise	5	27.8
	Seeking proper medical equipment/supplies	4	22.2
	Patient care needs were beyond the home care provision	9	50.0
Patients referred by*:	Health Practitioner	11	62.1
	Self-referral	15	84.3
	The agency	9	50.0

*Numbers and percentages do not sum up because of overlapping

1.9 Quality of Care Provided By HHC Agencies

One important aspect of quality of care is the availability of written policies and internal and external monitoring system (see table 9). The results showed that only 44.4% of the home health care agencies (n = 8) have written policies and procedures manual and 27.8% have professional mentoring. In addition, agencies are not fully-equipped to provide home health care services. 50% of them reported that they own the equipment they use, while 50% of them stated that they either buy or rent the equipment for the patients. This indicates that home health care agencies in Jordan are providing situation –oriented services and are not well prepared to provide comprehensive home services within a systematic approach of care. However, agencies reported that they have immediate response (24 hrs calling service) to their staff in emergency situation (88.9%, n = 16). One question would be how do agencies provide a quality of home health care, while they are not well equipped and neither have the appropriate staff. In another word, what type of care do agencies provide in emergencies if they have shortage of personnel and supply? One possible explanation would be inferred from the percentage of clients terminated or not accepted. The analysis showed that the majority of the agencies (72.2%, n = 13) do terminate or not accept clients due to lack of staff or equipment, while 27.8 % only (n = 5) of them terminate patients for financial reasons or inability to pay fees. Another issue is related to type of services provided; most agencies (83.4%) reported that they do not provide non-personal care. This is not unexpected as most of the patients who need home care live with their families and families usually provide them with non-personal care as housekeeping, catering laundry, etc.

Third of home health care agencies (33.3%, n = 6) do not keep medical records for patients and 44.5% of them do not provide their clients with written information about the type of care provided.

As reported by managers of HHCAs themselves, it is evident that home health care services in Jordan are facing many quality challenges that need proper attention as: lack of written policies and procedures including treatment protocols, shortage of qualified personnel, shortage of proper supply and

equipment, lack of health information system including medical records and lack of systematic monitoring and control. Terminating patients for financial reasons as clearly stated by the managers, is another issue that has quality and equity dimensions and need to be addressed by health policy makers in Jordan.

A study that examines the factors that affect quality of health services provided at home (Henrksen, Kern et al 2009) found that the sensory, physical ,and cognitive limitations of patients and their caregivers play a key role in the ability of patients to manage home health care needs. Other major components affecting successful home health care management are the nature of health care tasks undertaken, the physical environment, the medical devices and technologies used, the social and community environments and relevant external factors that that shape the context of health care.

Table 9: Indicators of Quality of Care Provided By HHC Agencies (N=18)

Indicator	Answers	Number of HHCAs(n)	%
Source of medical equipment	Owned by the agency	9	50.0
	Buying or renting equipment for patients	9	50.0
Availability of written policies and procedures manual	Yes	8	44.4
	No	10	55.6
Professional monitoring	Yes	5	27.8
	No	13	72.2
Agency of professional monitoring	Jordan Nursing and Midwifery Council (JNMC)	4	22.2
	MOH	1	5.6
Availability of a 24 hour	Yes	16	88.8

phone number to call in case of emergency	No	2	11.2
Reason for termination	Lack of payment	5	27.8
	Lack of staff	8	44.4
	Lack of equipment/supplies	5	27.8

Indicator	**Answers**							
	All the time		**Very often**		**Rarely**		**Never**	
	n	**%**	**n**	**%**	**n**	**%**	**n**	**%**
Provision of non-personal care to patients (housekeeping, catering laundry, etc.)	0	0	3	16.7	3	16.7	12	66.7
Keeping medical records	10	55.6	1	5.6	6	33.3	0	0
Providing patient and family with written information	5	27.8	5	27.8	5	27.8	3	16.7

2. Users' Perception of Home Health Care Services

Regarding the users' perception of home health care services, the survey have addressed several areas of services and that include service information, service providers, caring aspects, quality of services, and general evaluation of home health care services.

2.1 Users' Characteristics

A total of 82 users completed and returned the questionnaire. The majority of users (see table 10) were above the age of 60 years (54.8%, n = 44), while about 11% (n = 9) were below the age of 30 years. 51.2% of them (n = 42) were males, and 48.8% (n = 40) were females. About 46% (n = 38) have bachelor and graduate level of education, while 23.2% (n = 19) have high school level of education. Most of the users were Jordanian citizens about 76%, n = 62), while the non-Jordanians were 24% (n = 20). The majority of user were not living alone (86.6% (n = 71), and do not have health insurance. More than 90% of the users were diagnosed with heart problems, lung problem, and diabetes. Their use of the home health services vary from 1 week to more than 8 years; however, the highest reported period was more than six months and less than one year (18.3%), and the lowest was less than one week (1.2%, n = 1). Most of the users sought home health services for nursing care (61.0%, n = 50) and specialized health care services (25.6%, n = 21).

In the United States as reported by Jones, Adrienne et al (2012), men aged 65 years and over used home health care at a lower rate than women. Among home health care patients 65 years and over, women were more likely to be 85 years and over while men were more likely to be married and receive home health care as post-acute care. Women 65 years and over who received home health care were less likely than males to receive wound care and physical therapy, and more likely to receive homemaking services. Among home health care patients who were 65 years and over, cancer was more prevalent among men, and essential hypertension was more common among women.

Table 10: Demographic and personal characteristics of users of home health care services (N = 82)

Variable		n	%
Gender	Male	42	51.2
	Female	40	48.8
Age (years)	< 20.	3	3.7
	20 – 29	6	7.3
	30 – 39	3	3.7
	40 – 49	8	9.8
	50 - 59	17	20.7
	> 60.	44	54.8
Level of education	Eighth class or less	11	13.3
	High school	19	23.2
	Diploma	14	17.2
	Baccalaureate	28	34.1
	Graduate level	10	12.2
Citizenship	Jordanian	62	75.6
	Non-Jordanian	20	24.4
Do you live alone	Yes	11	13.4
	No	71	86.6
Medical diagnosis*	Heart	34	41.5
	Lung	17	20.7
	Diabetes	24	29.3
	Tumors	4	4.9
	Bones fractures	14	17.1

	OBGYN	1	1.2
	Psychiatric	5	6.1
	Dementia	11	13.4
	Cancer	7	8.5
Length of using home health services	1 Week or less.	1	1.2
	2 Weeks.	1	1.2
	1 Month	5	6.1
	2 Months	9	11
	3 Months	10	12.2
	4 Months	7	8.5
	6 Months	10	12.2
	6 Months - 1 year	15	18.3
	1 - 3 Years	3	3.7
	4 - 7 Years	3	3.7
	> 8 Years	1	1.2
	No Answer	17	20.7
Type of HHC services*	Specialized	21	25.6
	Nursing Care	50	61.0
	Domestic Care	10	12.2
	Companionship	9	11.0
Health insurance	Yes	11	13.4
	No	71	86.6
Percentage of insurance coverage (n = 11)	Complete	4	36.4
	Partial	7	63.6
Source for none insured	Out of pocket	67	94.4

(n = 71)	Charity	4	5.6

*Numbers and percentages do not sum up because of overlapping

2.2 Users' Perception about Information Provided by Home Health Care Agencies

In relation to information, the results (table 11) showed that users have reported high level of satisfaction about the type of introductory information that had been provided to them when they started their treatment courses with the institution; 72.0% to 81.7% of users reported that the institution provided them with such information and appropriate education. However, users had lower satisfaction about the follow up information. Users reported that they had low to fair agreement responses that their home health care service institution educated them about the goal of treatment (53.7%), medication time (53.7%), pain information (62.2), and side effects of their medication (46.3%). In general, the users reported that although they felt moderately satisfied about the information received at the beginning of treatment course, they had low satisfaction about health information provided to them during the follow up services.

2.3 Users' Satisfaction of the Interpersonal Aspects of Care Provided at Home Health Care Agencies

The interpersonal aspects of care, such as caring, respect, kindness and listening, are characterized as the "human side" of provider-patient relationships.

Literature supports that satisfaction with care enhances patient outcomes. Donabedian (2003) stated that "achieving and producing health and satisfaction, as defined for its individual members by a particular society or subculture is the ultimate validation of the quality of care." He believed that the patient's greatest contribution to evaluating health care quality is assessing the interpersonal aspects of care. Wickizer, et al (2004) found that satisfaction with interpersonal aspects of care was strongly associated with the overall treatment experience.

Table 11 Users' Perception of Type of Information Services Provided By Home Health Care Services Institutions (N = 82)

Variable	Yes		No		Don't know	
	n	%	n	%	n	%
When you started receiving health care in this institution, has anyone from the institution educate you about the care and the services you will receive?	67	81.7	7	8.5	8	9.8
When you started receiving health care in this institution, has someone from the institution talked to you about the amendments you should make in the home environment to be able to move safely?	59	72.0	14	17.1	8	9.8
When you started receiving health care in this institution, has someone from the institution talked to you about the prescriptions and medications you have been taking?	63	76.8	12	14.6	7	8.5
When you started receiving health care in this institution, has someone from the institution asked you to check and review the prescriptions and medications you have been taking?	66	80.5	9	11.0	7	8.5
During the last two months of care, have a care provider from this institution talked to you about pain?	55	67.1	25	30.5		

Variable	Yes		No		No changes of treatment	
	n	%	n	%	n	%
During the last two months of care, has any care provider from this institution educated you about the goal of giving you a new treatment or the goal of changing treatment	44	53.7	11	13.4	27	32.9
During the last two months of care, has any care provider from this institution educated you about the new medication time?	44	53.7	11	13.4	27	32.9
During the last two months of care, has any care provider from this institution educated you about the side effects of these new medications?	38	46.4	17	20.7	27	32.9

The "usually" and "always" agreement responses of clients for items related to Interpersonal Aspects of care (see table 12) ranged from 73.1% "Care providers are aware and knowledgeable of recent developments in home care" to 85.2% "Care providers respect clients."

Although most response rates seem satisfactory, the rates might be considered debatable as the aspects such as respect, listening, insight and awareness, notification, explanation and clarification are the core elements of quality of health care services that should be maximized to the utmost levels. Moreover, 12.2% (n = 10) of users reported that they have never received any explanation from the health care providers about their health care services. Such figure indicates that home health care agencies should develop training programs to train care providers on communication skills .This will improve their ability to

convey messages and information, especially to old patients, in a manner easy to understand.

Inadequate licensing and resource systems for caregivers were reported as the main reasons for dissatisfaction of home care clients as reported by Rodriguez, Dorothy (1982) in her study to assess child home day care services in Pittsburgh, USA as perceived by care providers and parent consumers.

Table 12: Users' Perception of the Interpersonal Aspects of Care Provided At Home Health Care Agencies (N = 82)

Variable	Never		Somewhat		Usually		Always	
	n	%	n	%	n	%	n	%
Care providers are aware and knowledgeable of recent developments in home care	8	9.8	14	17.1	15	18.3	45	54.8
Care providers notify clients about their arrival time to his home	6	7.3	12	14.6	15	18.3	49	59.8
Care providers treat clients so kindly	4	4.9	7	8.5	18	22.0	53	64.6
Care providers explain things to clients in a manner easy to understand	10	12.2	12	14.8	14	17.1	45	54.9
Care providers listen to clients carefully and with proper attention	8	9.8	9	11.0	11	13.4	54	65.8
Care providers respect clients	4	4.9	8	9.9	12	14.6	58	70.6

2.4 Users' perception of quality of home health care services

Regarding the quality of home health care services as perceived by clients, the results (table 13) indicate that users had some problems related to the quality of care received from home health care agencies. Users agreement responses ranged from 30.5% "During the last two months of care, had you faced any problems in the care that was provided to you from this institution" to 69.5% "During the last two months of care, have you taken a new treatment, or has been there any change in any of your treatments you are receiving." Although 76.8% (n = 63) of the users reported that they will advise the institution that provides them with home health services to others, only 64.2% (n = 43) of them reported that they have received the type of assistance they asked for in the same day and 33.8% (n = 24) of them reported that they did not.

The contradictory repots of quality of services required review for the users perception of the concepts and norms of quality of care. The general evaluation reports have supported this claim as 48.8% (n = 40) of the users reported that their evaluation for their health is "Possibly bad" to "surely bad", while only 13.4% (n = 11) reported that their health is excellent. Particularly, 44.5% (n = 37) of the users reported that their emotional status is possible too bad and 15.8% (n = 13) of them reported that emotional status as excellent.

Therefore, HHCAs should develop continuous quality improvement programs to raise the standard of care provided to clients and increase their level of satisfaction. Also, it is recommended that these agencies perform periodic clients' satisfaction surveys to identify dissatisfaction areas and develop proper interventions to minimize them.

Many studies were performed to assess the quality of home care. Patricia(2001) assessed the quality as perceived by patients, physicians, and nurses; she found that as overall, patients and physicians rated their satisfaction with nursing care identically (20% were satisfied, 71% were undecided, 9% were dissatisfied), while 70 percent of the nurses were satisfied, 20 percent were undecided, and 10 percent were dissatisfied with their nursing care. Both physicians and patients were most satisfied with professional aspects .of nursing care; nurses were most satisfied with teaching aspects. Patients and physicians were most dissatisfied

with teaching; nurses were equally dissatisfied with technical skills and communication/psychosocial aspects of nursing care.

Fadyl, Joanna et al. (2011) studied the themes of quality of home care as perceived by people who experience disability. Three main themes were identified by the respondents as main quality drivers: (1) technical competence of care service and professionals; (2) a 'human' approach to service provision; and (3) context-appropriate response to needs.

Table 13: Users' Perception of Quality of Services Provided By Home Health Care Agencies (N = 82)

Variable	Yes		No	
	n	%	n	%
During the last two months, had you called the institution office asking for assistance or advice?	66	67.1	26	31.7
During the last two months of care, when you called the home health care institution office did you receive the assistance or the advice you asked for?(N=66)	46	69.7	20	30.3
During the last two months of care, have you received the type of assistance you asked for in the same day?(N=67)	43	64.2%	24	33.8%
, have you taken a new treatment, or has been there any change in any of your treatments you are receiving?	57	69.5	25	30.5
During the last two months of care, had you faced any problems in the care that was provided to you from this institution?	25	30.5	57	69.5

Variable	Surely No		Mostly No		Surely Yes		Mostly Yes	
	n	%	n	%	n	%	n	%
Will you advise your family and friends to deal with this institution?	11	13.4	7	8.5	15	18.3	48	58.5

Variable	Excellent		Very good		Good		Possibly bad		Surely bad	
	n	%	n	%	n	%	n	%	n	%
In general, how do you evaluate your physical health?	11	13.4	13	15.8	18	22.0	25	30.5	15	18.3
In general, how do you evaluate your psychological and emotional status?	13	15.8	13	15.8	17	20.8	26	31.8	13	15.8

2.5 Bivariate Relationships

The second and third research questions are attempting to investigate the quality of home health care services (HHCS) provided by the agencies and barriers to home health care utilization. This required first examining users' evaluation of HHCS and their evaluation of their health status physically and psychologically. The analysis shows (Table 14) that the mean score of users' evaluation of HHCS was 7.60 (SD = 2.90). About 25% of the users had a score of 6.0 or below and 25% of them had a score of 10.0 or above. This means that 50% of the users

had a score between 6.0 and 10.0 and this would be considered moderate to high level of general satisfaction of HHCS provided by agencies. To investigate whether users' evaluation has been affected by demographic and personal characteristics of the users, nonparametric statistical analysis is conducted as sample size was small and distribution of samples was not normal. The analysis (see table 14) shows that there was no significant difference in users evaluation of health care provision in regards to gender (U = 728.5, p .78), citizenship (U = 438.0, p = .096), and whether they live alone or not (U = 241.5, p = .900); while there is significant difference in regards to source of information (U = 310.5, >.001). In addition, the analysis shows that there is no significant difference in users' evaluation of health care provided between those who recommend agencies and those who do not (U =25.0, p = .245), while there was a significant difference between those who have health insurance and those who do not (U = 213.0, p = .033).

Table 14: Differences in users' evaluation of health care provided by agency in relation to selected demographic and personal characteristics (N = 82).

Variable		**M**	**SD**	**Statistical Test**	
				Man Whitney U test	**p-value**
Gender	Male	7.74	2.76	728.5	.777
	Female	7.53	2.91		
Citizenship	Jordanian	7.66	3.10	438.0	.096
	Non-Jordanian	7.15	2.50		
Living alone	Yes	7.29	3.20	241.5	.900
	No	7.59	2.93		
Source of information	Internal	9.20	1.25	310.5	>.001
	External	5.98	3.185		

Recommending agency to others	Yes	2.55	2.38	25.0	.245
	No	3.71	1.11		
Health insurance	Yes	5.40	3.81	213.0	.033
	No	7.89	2.64		

Using Kruskal Wallis test to investigate differences in users' evaluation of health care provided in regards to users' age group and evaluation to their health physically and psychologically; the analysis (see table 15) shows no significant difference in regards to age groups and general users' evaluation to their psychological health; while there was significant difference in regards to users' evaluation to their physical health (chi square = 10.89, p = .028).

Moreover, difference in users' evaluation to health care provided by HHC agencies has been investigated in regards to users' health problems and health status. The analysis shows there was no significant difference in users' evaluation to health care provided by HHC agencies in regards to their type of health problem they sought care for or to their current evaluation of their health status ($p > .05$). On the other hand, the analysis shows that there is a significant difference in regards to source of information between those who recommended HHC agencies and those who did not (chi-square = 23.50, $p < .001$), while there were no significant differences in regards to levels of users' physical health evaluation (chi-square = 8.34, p = .074) and levels of users' psychological health evaluation (chi-square = 7.41, $p> .05$).

The results indicate that differences in users' evaluation to provided health care at HHC agencies are related to factors as source of information (internal versus external resources) and health insurance status. All other variables were statistically non-significant although there were significant differences between the subgroups of variables. For example males mean score was higher than females, those who are not living alone have higher mean score than those who live alone, and those who will not advise the agency had higher mean score than those who will. The mean differences have impression that all these factors have a role in deciding the quality of care provided and may serve as indicators for quality of care provided by HHC agencies. In addition, patients' health problems

and the current health status of the patients that serve as reasons to seek HHC did not show any effect on the users' evaluation for HHCS or their evaluation for their health. In conclusion, although users' satisfaction level of the provided HHC services was moderate to high, it was significantly higher among those who reported their evaluation to internal sources than those who reported their evaluation to external sources. In other word, there is a possibility of social bias in reported users' evaluation.

Table 15: Differences in Users' Evaluation of Health Care Provided by Agency in Relation to Selected Demographic and Personal Characteristics (N = 82).

Variable		M	SD	Statistical Test	
				Kruskal-Wallis	p-value
Age group	< 20	7.67	1.53	6.377	.271
	20 - 29	7.83	4.02		
	30 – 39	6.00	3.61		
	40 – 49	7.88	2.36		
	50 - 59	8.94	1.39		
	> 60	7.14	3.21		
Length of HHCS utilization	1 Week or less	9.00	1.27	10.76	.293
	2 Weeks	10.00	1.87		
	1 Month	8.20	3.03		
	2 Months	8.22	1.39		
	3 Months	8.10	1.91		
	4 Months	6.57	4.16		
	6 Months	8.31	2.50		

	> 6 Months, less than 1 year	8.60	3.10		
	1 - 3 Years	6.00	3.32		
	4 - 7 Years	5.33	4.04		
	> 8 Years	2.00	1.12		
Physical health evaluation	Excellent	8.36	2.11		
	Very good	8.77	2.28		
	Good	8.61	1.85	10.90	.028
	Possible	7.24	2.92		
	Bad	5.46	3.93		
Psychological/emotional health evaluation	Excellent	9.15	1.14		
	Very good	7.62	2.66		
	Good	8.41	2.09	5.56	.161
	Possible	6.96	3.06		
	Bad	6.92	3.75		
Level of education	8th level or less	6.30	3.37		
	High school	6.30	3.37		
	Diploma	8.86	1.70	9.94	.077
	Undergraduate	8.25	2.50		
	Graduate level	6.20	3.39		

3. Focus Group Discussions with Managers of Home Health Care Agencies (Qualitative Analysis)

3.1 Introduction

To elicit the concerns of managers of home health care (HHC) agencies, the participants were asked the following questions: "What conditions do you think facilitate HHC provision? What conditions hinder home health care provision? The content analysis revealed seven themes discussed below. The themes indicate that the current work conditions do not facilitate HHC provision. Facilitating provision of HHC as perceived by the participants requires managing conditions that hinder effective HHC. One participant however, believed that delivery of quality services, irrespective of other hindrances, is the only condition that facilitates effective HHC provision.

Emerging themes, conditions and challenges from the focus group discussions were: unethical practices, lack of regulation, referral systems, problematic female staffing, disorganized services, affordability of services, and profit making.

3.2 Unethical Practices and Moral Hazards

The managers reported repeated unethical practices that included hiring of unqualified workers to care for patients with complex problems as evidenced in the following statements:

"I would not send a 'companion' to care for a patient with serious problem..... A patient who is on intravenous therapy for example, not like many others."

"The problem for home health care is the bad practices of some of the agencies; they undermine our work and our reputation."

Another concern that invited a heated discussion, among the participants, was the request for commission by colleagues, physicians and other workers, as evidenced and validated in the following accounts:

"Hospital staff asks for commission on patients referred (informally) to us. They ask for high commission. These hospital hustlers and nurse brokers cannot be controlled by their administration."

"My relationship is with physicians, however, I never ignore the nurses, even when I find a case through a doctor I have to acknowledge the nurses, for them (nurses) the patient is a commercial good…they need to benefit, if they don't…?!"

"Not only nurses ask for commission cleaning workers expect it too!"

"What are you talking about; I once had a doctor who called me, to tell me he has a case for me to sell!!"

"A physician saw me in the hospital, he stopped me saying 'I have a patient for you, fifty- fifty!"

Few participants supported giving a percentage to the referring nurse for example:

"If he is your friend and he sends you a case then you have to give him something, otherwise he will send the case to someone who pays him."

Managers reported that other agencies may entice and lure clients and persuade them to leave their services for a discounted rate. One participant bitterly reported the following:

" On the third day of admission of a bed ridden patient to our services, I went to send needed medical equipment, and there, I found a nurse from another agency …, the manager of this agency, whom I know vey well, called me laughingly and said 'I stole your patient."

Further concern expressed by the participants was related to families supporting unethical practices as follows:

"Families' behavior, at times, is manipulative and dishonest. In trying to save money, families feed into dishonest practices."

"Families need our nurses, but they do not want to pay the agency's administrative fees, after we send them our nurses, they try to contract them independently! There is nothing I can do, it is not only the nurses that are dishonest, and the families are difficult too."

Discussion

Unethical practices in healthcare are a serious problem that face health care systems in all countries and not confined to home health care industry or specific country. Professor Bernard Lown (1999), Nobel Peace laureate and outstanding cardiologist, has described Unethical practices in his book titled "The Lost Art of Healing" by saying: "We are sometimes baffled by the competing demands of apposite medical practices, personal biases, moral hazard (i.e. conflict of interest decision making) and the pervasive market-driven consumerism, so much so that we have subsumed our nobler instincts, and have lost our humane compassionate touch."

In USA, physician leaders in hospitals, large group practices and academic health centers are deeply concerned about ethical violations and unethical business practices impacting U.S. health care, according to results of a published survey Conducted by the American College of Physician Executives in 2005. The survey found high percentages of physician leaders are either "very concerned" or "moderately concerned" about: physicians refusing to accept calls on patients who don't have insurance (79%); influence exerted by medical device manufacturers (79%); over-treating patients to boost income (78%); influence by pharmaceutical companies (76%);and board members with conflicts of interest (66%).One of the most startling findings: nearly 54 percent of the survey respondents said there was a health care organization in their community that they believed to be involved in unethical business practices (APCA,2005).

Lauxen, O (2009) performed a qualitative ethnographic study to explore moral problems in the daily practice of nurses at home health care in Germany. The results showed that the ethical principle of beneficence was the core concept for the participants. Moral problems arise when nurses cannot act in accordance to this principle or when they cannot determine the good in a situation. In particular, there were four types of moral problems: "beneficence vs. autonomy", "beneficence vs. justice", "beneficence vs. loyalty" and "The good cannot be determined". Some participants lack ethical competencies. Furthermore,

appropriate support services for dealing with moral problems have to be designed.

Hogue, Elizabeth E (2003) in her book "Discontinuation of Home Health Care Services: Making Ethical Decisions" emphasized that it is important to thorough examine the ethical dimensions during initiation, provision and termination of home care services. These dimensions as presented in this book include: autonomy of patients, justice and beneficence/non-beneficence.

Miller, Ivan (1998) mentioned eleven unethical home care practices with emphasis on mental health care. They include: disregarding personal and medical privacy, using deceptive language violating traditional scientific ethics, practicing outside of a professional's area of competence, creating and intensifying conflicts of interest, keeping secrets about financial conflicts of interest, violating informed consent procedures, using" fee splitting" or "kickbacks", squandering money entrusted to their care, and disregarding information about harm to patients.

However, to minimize unethical practices and moral hazards in home health practice in Jordan, it is recommended that a code of ethics should be developed and indorsed by all home health care agencies, also MOH and other health professional associations should activate their role in monitoring and controlling health care practices in the country including home care.

3.3 Referral System

Most of the participants in the focus group reported concern over the lack of referral systems from hospitals, despite individualized informal referrals by hospital staff who have friends, or by those who expect financial returns. Two participants, however, reported receiving referrals from physicians and from hospitals. One actually has contracts with a number of hospitals.

The participants reported the reasons for lack of referral as expressed in the following:

"We tried to contact hospitals and establish a referral system with them. The supervisors, however refused because they choose to please their nurses… may be they benefit too!"

"If our services get to be known to users, hospital rates will go down."

'Hospitals will continue to block our work, they are afraid of the threat of home health care on their profit."

"Of course we compete; I just received a patient who was discharged with a bill of JD75.000! What do you think people will do when the bill is down to 25% when we provide the services?"

The difficulty in establishing referral agreements with the hospitals and with physicians can be related to the perceived capabilities of the agencies; most of the participating agencies did not have full time staff, they usually hire per Diem staff and according to the patient load. Reliable services as evident in two accounts of the participants, succeeded in establishing referrals and or referral agreements with the hospitals. These two participants had well-established services, and had adequate numbers of full time registered nurses. The following expressed their view on the subject:

"*Reputable agencies who deliver quality develop trusting relationships with physicians who consistently refer patients. I have a good relationship with doctors, mostly specialists, and with nurse administrators. You said (addressing other participants) that you do not receive hospital referrals, but we (agency) do, we have contracts with hospitals."*

Discussion

Appropriate and efficient provision of services at home requires more than skilled personnel; effective communication between the hospitals and home health care agencies is an often overlooked but essential tool for maintaining the patient's health in the community. A method was developed in some hospitals in the USA to create home care orders that guides the physician through the order writing process, uploads data from the electronic medical record, and creates a legible, complete order set that can be faxed quickly to the agency (Siegler ,Eugenia L. 2007).

Castro, Juianna M et al. (1998) performed a study to assess the need for home health care referral screening for elderly patients after emergency department (ED) discharge. They concluded that "If home care referral screenings of elderly

ED patients are performed and appropriate referrals are made before ED discharge, a seamless delivery system of health care is provided. A home care visit resulting from a referral may be all that is needed for the maintenance of a patient's condition. To improve the quality and continuity of patient care, home care screening should be integrated into the routine discharge ED activities."

Prescott, Patricia A et al (2007) performed an exploratory study to determine the degree to which patients with identifiable levels of need for services were referred for home health care and if selected clinical and functional status measures are useful in distinguishing need for service. Data were collected on physical function, dependency at discharge, perceived helpfulness of others, social support, readiness for self-care, and planned adherence to treatment as well as demographic and medical variables for convenience sample of 145 patients ready for hospital discharge. They found that patients in need of service but not referred by their physicians were found to differ significantly from patients not in need of care on all dimensions.

Since proper home care has a significant impact on reducing hospital days, containing health costs and improving the quality and continuity of patient care as discussed before, hospitals and home health care agencies are encouraged to develop effective professional partnerships to refer patients from hospitals to agencies and vice versa.

3.4 Need for Regulation

The lack of governance of HHC services and the need for regulation was a theme that was highlighted by all the participants. The participants yearned for The Ministry of Health involvement as expressed in the following statement:

"Only if the ministry (MOH) would be involved, we feel all alone fighting the many issues that challenge our work… 'Ya Ami' most of the agencies hire unqualified workers… unqualified workers, whether they work for agencies or independently, undermine our work and the trust in our services. The families also do not know who to report to when they have problems."

"The Ministry gives us a piece of paper (license); it is one visit to the Ministry that is it. I never saw them again."

They shared a number of concerns as shown in the following:

"Monitoring visits were limited to one visit, and they asked us about number of nurses and whether we sell medical equipment or not. (Implying that monitoring is not effective)"

"Sometimes the owners of the agencies do not have professional degrees; I know one who is a Tawjihi graduate. Is not he breaking the law?"

"I do not know where to go if I have a problem."

"If we were supported by an official body, then we do not get fooled by nurses or by families, then we will know that our contracts are honored."

"Many of the agencies that are not allowed to sell equipment do, this is against the law. When we apply for license we are asked to specify 'the purpose' of the business. Some agencies have one purpose; nursing home care, and not medical equipment sales. They only specify one purpose to avoid paying the fees and the taxes. These agencies break the law, but who follows up? Nobody does!"

The participants raised issues related to requirements and guidelines, which reflected their incomplete knowledge of the governing laws and bylaws. Participants however, knew that they were not allowed to sell medical equipment under the home care nursing licensure, but chose to do so as expressed in the following:

"we opt to sell and rent medical equipment… profit does not come from nursing care, we need to supplement our income through commission from rentals or income from sale of basic medical supplies, wheel chairs, beds, and sometimes medical equipment can include monitors, ventilators and sophisticated equipment necessary for specialized care."

Discussion

The Health Professions and Institutions Licensing Directorate at the MOH is the regulatory body of services rendered in the private sector including home health care services. This directorate holds a listing of licensed home health care agencies. However, its regulatory processes is limited to issuing of licensure to services according to a set criteria that requires that the applicant (owner-to be) of the agency is a registered nurse with five years of experience.

The managers of HHCAs expressed the need for a governing body as if it did not exist. Their accounts reflect the lack of implementation of regulatory process, their knowledge of the role of the administration was sketchy at best. Analysis also revealed that it is unusual for agencies to have contact with the administration, to be visited or monitored.

The lack of governance of home health care agencies that operate in the absence of standards , guidelines and mechanisms for monitoring and follow up , invites a whole array of legal and ethical misconduct, disorganization and a loose system that is not, and cannot be held accountable to service users or any other stakeholder.

3.5 Need for Organization

The participants perceived disorganization as one of the hindrances in their work, they felt that the lack active governance was the main reason of this disorganization, and expressed the need for collaboration among each other to support one another and to set the rules for working together and for clean competition. The participants complained about the lack of information and reports that facilitate the planning and the management of their work, they did not know how many licensed agencies are available; they have many unanswered questions related to logistics of their work. The lack of information available to consumers deprives them of making choices and also keeps home health care services unknown and underutilized. They felt that their work is hindered by the fluid system that has loose boundaries, and gaps that do not define the work of nurses especially those who are free-lance and work on there own. They perceived lack of support and did not know who to communicate with, and how, if and when they had problems or grievances to report.

Some of these concerns are supported by the following statements:

"Walla, our work is so chaotic how we hunt for patients, how we relate to other agencies, how we end services and discharge patients is a mess."

"Give me a way to advertise for myself where patients are available/ I do not know how to find patients."

"Taxi drivers bring in customers… who will organize the work? Is this allowed or not allowed?"

"We have no status anywhere; we were never contacted or invited to a meeting. You (JNC) are the first to remember us."

"I am a licensed man, no one validates my existence."

"We do not know who to go to…"

"I do not know how to transport my staff, or my patients, I want a permit to do this, and I do not know how to do this or where to go."

"The nurses who work on their own do not report to anybody, who will support them if they face problems? Besides, they work without offices, they do not pay taxes. We pay taxes and they get the patients."

"Owners of agencies are respectful people, but there are some individuals who intruded on our business. They can be easily identified by us, but not to others."

"Name me an office to report to, and I am willing to report all bad and illegal activities. I guarantee you; we will clean up the mess in a month."

"We were visited by the nurse director of one of the governorates, who walked in and asked us if we had a microwave! I do not think that is what she meant. I do not think she was from relevant office."

Discussion

Competent leadership and effective management systems are critical components of any health organization especially home health care organizations which are facing complex challenges and pressure to produce quality and sustainable results. Good governance is acknowledged to be essential for the success of any organization. Siddiqi et al (2008) reported that good governance involves 10 principles: strategic vision, participation and consensus orientation, rule of law, transparency, responsiveness, equity and inclusiveness, effectiveness and efficiency, accountability, intelligence and information, and ethics.

The managers of HHCAs raised many important issues that reflect poor management practices and absence of basic governance principles.

Home health care services require a different set of competencies related to running a business and managing staff, in addition to the complex demands of managing customers, and more importantly providing quality services and protecting the users of the services. The difficulties encountered by these agencies may be compounded by the non-challenging requirements of setting up this type of business that attracts young nurses who do not have the experience and the understanding of the complexity of their venture.

3.6 Problematic Female Staffing

The shortage of female nurses poses problems to some of the agency managers represented who were all males with one exception. The following are quotations of two of the managers:

"Shortage of female nurses causes problems for us not only in terms of covering patients, it also results in recruiting workers without references, which put us in trouble in the past."

"We have problems with self-respect. We have problems also with driving female nurses to the homes of our customers, especially during the evening shift; we get stopped by the police and questioned about...' (Implying indecent behavior).

"I am trying to recruit female nurses from the Philippine; at least, I will know my staff."

Discussion

Shortage of female nurses in Jordan is a known problem for all sectors and at all levels of care (Ajlouni 2009). This problem is compounded by cultural norms of limiting their working hours to daytime and to contained work environment in hospitals. Working in unpredictable home environments of users is viewed as unacceptable and unsafe for females.

Shortage of female nurses especially in home care is not confined to Jordan; it is a world wide problem. Ellenbecker CH and Cushman MJ (2001) performed a study about the nurse shortage from a home care agency perspective. They

found that certified home care agencies are challenged to meet an increasing demand for services in USA while faced with a predicted severe nursing shortage. Meeting this demand will depend on an agency's ability to recruit and retain a qualified nursing staff. Knowledge of the extent of the nursing shortage, along with information of administrators' perceptions of the problem and activities they have implemented to alleviate a shortage will provide information to meet this new challenge.

Chenoweth L et al (2010) conducted a study to find factors that attract and retain nurses in aged and dementia care. They found that a family-friendly, learning environment that values and nurtures its nursing staff, in the same way as nurses are expected to value and care for their patients and residents, is critical in ensuring their retention in dementia and aged care.

Rosenfeld, P (2007) reported that "Caregiver-friendly" practices such as creative, flexible scheduling; access to social workers; financial and legal services; and increased awareness among managers about caregiver strains were important factors for retaining nurses in home eldercare.

Letvac, S (2001) stated that the different roles assigned to women in today's society are burdensome, particularly for nurses who deal with the stress of managed care, downsizing, the nursing shortage, caring for increasingly ill patients, long and irregular hours, and daily crises. These issues should be addressed by homecare mangers to help female nurses cope with the rigors of the workplace.

Ellenbecker CH, Byleckie JJ. (2005) concluded that the greatest amount of variability in satisfaction for home healthcare nurses are salary and benefits, stress and workload, and organizational factors, that is, factors over which organizations and management have the most control.

Solutions to female nurse staffing problems in Jordan require careful study and strategic planning at the state and agency levels. Strategies are needed to motivate young women to enroll in nursing faculties to meet the shortage of female nurses like providing more scholarships and improving work conditions for female nurses. Also, managers of HHCAs should create a "Caregiver-friendly" practices such as creative, flexible scheduling; fair financial incentives and continuous training programs for attracting female nurses to home health care.

3.7 Affordability of Services

The analysis revealed that home health care is not covered by insurance and that most of service users pay out of pocket. This fact limits the services to those who can afford it who are mostly residents of Western Amman. The Agencies registered to serve other governorates also serve in Amman because clients of areas other than Amman who can pay the fees are very few. Sometimes agencies accept patients from the public sectors.

It was clear that the payment schemes even within each agency varied according to the complexity and also the hours covered. The daily fees reported by the agencies ranged between JD 15-25 per shift for Jordanians, while independent nurses charge JD50. Agencies give up to 87%.

The data revealed that the participants consistently compared the cost of hospitalization to that of home health care, and advocated for the coverage of this service by health insurance.

Discussion

Welfare states and wealthy countries either provide home health care services (HHCS) directly to patients through not-for profit state agencies or subsidy these services through social health insurance or social security programs. In England HHCS are provided by the state free of charge under the National Health Services (Klein R, 1995).

In the USA these services are provided by for profit agencies and the fees are reimbursed by the government under the Medicaid and Medicare health insurance programs. There is no out-of-pocket deductible or co-payment for the beneficiary except for medical equipment items (Marziano, Michele et al 1998).

Some government hospitals in Saudi Arabia have special programs for home health care. Abdul-Aziz University Hospital, as an example, provides home visits for patients with disability and chronic illness; including those with terminal illness .These services are provided free of charges for Saudi citizens. (KAUH - Home Health Care, 2011).

As discussed in section 1.6 before, the results of this study raise an important issue of financial accessibility and equity regarding home health care services in

Jordan. Poor and less advantaged patients can't receive these services.Therfore, financial barriers should be addressed by health policy makers to make home health services in Jordan more equitable and accessible to all irrespective of their ability to pay.

3.8 Profit Making

The focus on business was over emphasized by the participants to the extent that care concerns were not mentioned except when used to defend issues such as why hospital nurses should not care for patients at home after long working hours and that these nurses compromise the quality of care .

They also added that "hospital nurses block any attempts by families to call agencies, because they want the business for themselves."

"Nurses who work independently, without agencies have no reference and when they (families) face trouble they come back to us. Some of these nurses are public employees and are not allowed to work independently, it is the law."

Discussion

Since home health care industry, traditionally an industry of non-profit organizations, has increasingly become, as has the rest of the health care industry, invaded by for-profit organizations, many researchers have been involved in studying the impact of profit making on the quality of home care outcomes. Ellenbecker CH (1995) studied the differences in behaviors and industry outcomes generated by non-profit and for-profit organizations in Massachusetts, USA. Results suggest that while profit and non-profit agencies behave similarly in many areas, there are areas of difference, with significant differences found in the amount of service delivered and the rates charged.

In USA, an inquiry by the Senate Finance Committee in 2011(Martin Vince 2011) has found that the nation's three largest home-health companies tailored the care they provided to Medicare patients to maximize their reimbursements and profits from the federal program. Strategies used at these companies included the designation of an "A-Team" tasked with developing programs to target the most profitable Medicare therapy treatment patterns and maximize Medicare

reimbursements, and increasing the number of therapy visits to increase mix and trigger bonus payments.

It is evident from the discussions in the focus group with representatives of HHCAs that profit making was an overarching concern that overshadowed all emerging themes. Revisits of all the statements that support the themes indicate that the business side was evident in many of these statements. Concerns over ethical conduct focused on money related matters as commission, competition, luring cases, and families escaping administrative fees and contracting the nurses directly. Themes of regulation were also colored with financial concerns related to workers competing over the business that hindered money making for the agencies. Referral concerns were also issues related to the hospitals denying them the access to patients and to potential business shares. This clearly indicates that home health care industry in Jordan is not well organized and controlled, it also lacks basic standards and codes for professional practice.

4. Focus Group Discussions with Medical Doctors (Qualitative Analysis)

4.1 Introduction

To elicit the perception of medical doctors, of home health services in Jordan, the doctors who participated in the focus groups were asked the following questions? How do you perceive the quality of HHC? What facilitates and what hinders the provision of these services? The content analysis of the focus group accounts revealed *four themes*. Some of their perceptions paralleled the managers of HHC including the lack of organization. Their preference to using hospital nurses rather than home health care nurses confirmed the accounts made by the managers. Other concerns/ themes were, mistrust in the quality of care, and the need for medical doctors to oversee care delivered by home health care agencies, utilization and valuation of home health care, in addition to lack of organization of home health care agencies. Therefore the emerging themes were: Mistrust vs. Trust; Low Utilization of Home Health Care; Undervalued Service; and Need for organization.

4.2 "Mistrust vs. Trust"

With the exception of three participants, medical doctors agreed that home health care services were of compromised quality, and that they had negative experiences with these services. These doctors reported that agencies do not monitor the work of their employees and that they see many patients in the hospitals with complications related to "bad care" they received by agency nurses.

Reasons behind mistrust are further demonstrated in the following accounts:

"I had very bad experiences with them (HHC agencies). I personally dealt with five agencies, (participant gave locations of the agencies), and I would not use them again... Once, I became aware that the care giver was a worker who used to be a cleaner in an obstetrics department in a hospital outside Jordan."

"They use old fashioned nurses. The agencies I know recruit unqualified workers… "

"How can I trust these nurses? Once, a nurse gave me his business card. I asked him about the location of the agency he worked for; he told me he had none! How does he expect me to send anybody to him?"

"When we interview new nurses for hire at the hospital, we find that their knowledge base is very weak, how can they work independently?"

"Many of the agency nurses are new graduates, without experience, may be they were never in a hospital before. Hospital nurses are good, even the practical nurses from the hospital are good".

Analysis showed that medical doctors only reach out to nurses they worked with in hospitals to care for their patients at home They felt that the nurses cannot work on their own and that they need to work under doctors' supervision or with the hospitals' support. This preference is evidenced in the following:

" *The nurse I take from the hospital has the' back up' from his seniors and the support of the hospital."*

"Whoever delivers health care should be able to make decisions, must be a specialist.'

"We should be their team, the patient needs assessment and needs a clinical eye."

Trust in home health care by a small group of doctors was related to good experiences with few of the agencies who were reliable and thorough in their work. These mentioned agencies were trusted to care for seriously ill patients of all ages. The doctors' satisfaction in the care is expressed in the following:

"There is (name) and (name) that I would trust with very challenging conditions. I know they have highly professional services like a hospital ICU. (Name) diagnosed a patient and called me immediately, he was right… he saved the patient. I would trust this man with any of my patients."

Discussion

Medical doctors, who trusted home health care, worked closely with the agencies and reported absolute trust in the nurses and the managers. Interestingly, the trusted agencies in this focus group were the same agencies that reported having referral relationships with doctors and hospitals in the other focus group run for HHC managers.

The findings indicate that medical doctors are willing to trust, when they have assurances that these agencies and nurses are qualified and prepared to provide quality care to the users of the services. Quality of care as perceived by the doctors ranged from bad to excellent. Medical doctors did not and would not utilize the services of agencies they did not trust for the various reasons above mentioned. Assurances regarding quality and safe practices cannot rely on chance; monitoring, evaluation and reporting of these services is of utmost significance and importance. Direct experience and proper communication enhance the trust of and the collaboration between Home health care providers and medical doctors, however, this is secondary condition to that of professional and government regulation; regulatory processes, that draw boundaries, define the scope and the roles of the agency nurses are overdue.

4.3 Low Home health Care Utilization

Utilization of home health care in general appears to be very low despite the participants' acknowledgment of the many benefits of home health care including infection control and money saving. The reported number of referrals was between 2-5 cases every month, with the exception of one physician who believed very strongly that home health care is best choice for care of his pediatric patients, and he used these services, with close monitoring, for acutely ill children in addition to the chronically ill. He believed that home environment is necessary for the recovery of children, in addition to the well-known other reasons. He reported referring 10-15 patients per month to one agency he trusted. The pattern of low utilization as shown in the discussion was not related to the lack of trust voiced, but more to the lack of interest in the use of unneeded services iterated by some as follows: " I do not need the services," and, " I do not to refer to others unless the family asks.".

Discussion

Health care services in Jordan are mostly delivered at the tertiary level of care in hospital settings and by specialized, and or subspecialized medical doctors. Medical doctors in Jordan are hesitant to abandon the paternalistic model of care; they continue to view themselves as responsible for the health and health outcomes of "medical care". Medical doctors are also reluctant to work within the interdisciplinary team, never mind releasing their" patients" to the care of "other than doctor" health providers. Under the current situation of home health care services that lack definition and accountability, underutilization of these services is not surprising.

The changing demographics of the population and that of the epidemiologic profile of Jordan, with increased aging population and chronic illnesses, will, sooner or later, invite a reform in the system of health care and a shift toward affordable models, therefore increased utilization of home health care. (Ajlouni, 2010).

Medical doctors verbalized the need to directly supervise the care given to their patients, and in the absence of that especially to the "unknown" would be completely unacceptable.

The findings indicated that medical doctors need to be informed and better informed about the nature and the quality of home health care. Better advocacy, advertising, clear definitions and descriptions of these services are needed, to entice medical doctors to use home health care more often. They need to trust that home health care can often be an alternate to hospitalization. Medical doctors lacked the interest in these services, and therefore they need to be motivated to change their stand and their attitude. Incentives that will invite doctors involvement need to be explored, including establishing inter- provider partnerships and introducing multidisciplinary team approach to home health care. Government inclusion of home health care models of services within the public health system may also bring to light the nature of these services and support better utilization their importance to enhance the health of citizens and to save the health system considerable amounts of money. The literature provides solid examples of most developed countries in viewing home health care services, as irreplaceable and more sustainable alternatives with many viable benefits (The UK National Health Services, The US department of Health and Human services).

4.4 Undervalued Services

Eight of the medical doctors underestimated the value the work delivered by home health care, in addition to what they reported on the inadequate quality, they thought that home health care nurses charge a large amount of money, that rates and fees should be controlled and monitored, but they also believed that the nature of the agencies' work is mostly "housekeeping". The following further demonstrates these perceptions:

"They ask for enormous amounts of money, over 1000 Jordanian dinar / month"

"They ask for 25 dinars per 8 hours!"

"The amount of money they make should be limited and monitored by Nurses and Midwives Council".

Discussion

Underestimating the value of home health care, as verbalized by the participants, was spirited by advocacy for the users. The lack of trust, lack of knowledge and familiarity with these services certainly contributed to the undervaluing. Home health care in other countries is acknowledged as important and legitimate health care services that are reimbursed by public insurance. Organized home health care through strong association is highly respected by all stakeholders. The need is evident here for forming an accountable, national formal body that is able to lobby with relevant government agencies, legislative bodies and private organizations that better introduces these services and communicates their scope and their capacities as health care service entities. Monitoring and evaluation of these agencies would establish accountability to the public and enhance valuing of these services by all stakeholders; a government responsibility that need not be ignored nor overlooked in Jordan.

4.5 Need for organization

The medical doctors perceived home health care services as disorganized. They believed that there is no system and no organizing body for these services. This is expressed in the following;

"Where are the nurses' association and council that oversee these agencies?"

The lack of information on the scope of their work, quality of services and credibility are not known to doctors or to families. One alarmed participant questioned as follows:

"How do we work with them? Who are they? Are they nurse or unqualified workers? What is it they are qualified to do? Which one is good and measured by what standards?" addressing the researcher the medical doctor continued: "if you want to help them organize them."

Discussion

Home health care in Jordan is, undoubtedly, an undefined service and is not integrated into the health care system, despite its availability since the late eighties and its survival today. The HHC agencies do not have a formal representation in any system; each of these functions independently and is run as a business without any attempt for organization, or representation by a formal or informal body, they are certainly not regulation. The lack of reference to these services is alarming and definitely renders these services of little, if any, use for the users and for support of other services and other health providers.

Home health care in many countries is an integral service of the health care system. The United States, Canada, Australia are among these countries. Home health care agencies form professional associations -at the national and state /provincial levels- of members who are involved in home health care, example of these is the Home Healthcare Nurses Association (HHNA), a US national professional that provides leadership and a unified voice for home care and hospice nurses. The American Association for Homecare is yet another body that lobbies the congress, the White House, the Centers for Medicare and Medicaid Services, and other agencies to strengthen federal policy for homecare.(The American Association for Health Care).

The Ontario Home health care Association members are key stakeholders in health care delivery in Ontario; they play an important role to play in the on-going reform of Ontario's health care system. They are contracted by all three levels of government, Community Care Access Centers, insurance companies, institutions, corporations and private individuals. The strengths of these associations indicate that unified action of strong professional bodies are highly recognized and respected.

Home health care agencies in Jordan, need to redefine who they are, form a body that represent them, while professional and government agencies like the Jordanian Council and the Ministry of Health need to offer needed support in developing professional standards and guidelines, to hold these accountable, and introduce mechanisms that assures their delivery of safe and quality services to all citizens.

The underlying issue of regulation is a cross cutting issue in all presenting themes that emerged in the focus group with representatives of medical doctors. Lack of trust, underutilization and undervalued services were very likely due to lack of accountability from the organizations and from relevant professional and government authorities ;a shared concern with the focus groups with the representatives of home health care managers.

VI. CONCLUSION (Challenges and Recommendations)

In Jordan, the ability of the frail people and disabled people to choose from of a variety of cost-effective long-term care services has been limited by many factors including the lack of health insurance coverage for home care services, lack of quality home health care services available to them, and when affordable, very often these services are not accessible; this is especially true for people who live outside the capital Amman.

The quantitative and qualitatative analysis uncovered many challenges and problems that hinder the performance of home health care industry in Jordan and affect negatively on the effectiveness, efficiency and quality of services delivered to patients. This section of the study highlights these challenges and suggests interventions to deal with them.

1. Challenges

- The industry has more than fifty small competing agencies; most of them lack proper financing, staffing, management and support systems.
- Home health care services are fragmented services and are not integrated into the health care system.
- Absence of professional guidelines practice protocols and quality indicators.
- Lack of national data base on HHCAs.
- Lack of control and monitoring by health authorities.
- Most agencies do not have full time staff; they usually hire per Diem staff according to the patient load.

- Shortage of professional female nurses.
- Lack of discharge planning and referral system from hospitals to HHCAs and vice versa.
- Lack of national service fees schedule.
- Home health care services (HHCS) are not covered by most public and private health insurance schemes.
- Problems of equity and financial access to poor patients. Terminating patients for financial reasons as clearly stated by the managers, is an issue that has quality and equity dimensions and need to be addressed by health policy makers in Jordan.
- Demographic and morbidity transition (more aged people with long-term conditions) in Jordan and increasing demand on HHCS.
- Inadequate licensing and resource systems for caregivers and lack of training programs.
- Shortage of proper medical equipment to care for patients at home and the rising costs of this equipment.
- Shortage of written policies and procedures.
- Most agencies are providing situation –oriented services and are not well prepared to provide comprehensive home services within a systematic approach of care.
- Lack of health information system including medical records keeping.
- Lack of patients' education and orientation programs.
- Weak communication skills.
- Lack of continuous quality improvement programs and periodic clients' satisfaction surveys.
- Prevalence of some unethical practices that included: hiring of unqualified workers, commission and "split fees", enticing and luring clients, providing unnecessary services, etc.

- Lack of trust and professional relations among different stakeholders (agency managers, nurses, physicians, hospitals, MOH officials, patients and families).
- Poor management practices, absence of basic governance principles and lack of effective regulation open the door for legal and ethical misconduct.
- Overemphasis and domination of profit making aspect on the expense of quality improvement.

2. Recommendations

- HHCAs are encouraged to develop partnerships, affiliation or even mergers in order to create strong and well organized health institutions to meet the growing challenges and demands for home health care services in Jordan. The Government can play an important role by providing incentives and official support to such initiatives.
- The MOH should develop a comprehensive and up-to-date national data base for all HHCAs in the country.
- HHCAs ,MOH, Higher Nursing Council, Nursing Association and other health and medical associations should work together to develop professional guidelines ,practice protocols and quality indicators for home health care services.
- MOH and other concerned health organizations should perform there mandate role regarding controlling and monitoring performance of HHCAs.
- A national service fees schedule for home health care services should be developed in partnership with all stakeholders.
- HHCAs should develop : written policies and procedures; health information system; medical records system, patients' education and orientation programs, continuous quality improvement programs ; periodic clients' satisfaction surveys; continuous training programs; and proper management practices to raise the standard of care provided to clients and increase their level of satisfaction.

- Recruiting more qualified staff to deliver home care, providing them with appropriate training and providing agencies and patients with needed equipment and supplies could minimize the barriers for home health care provision and reduce the rate of admissions to hospitals.
- Home health care agencies should develop training programs to train care providers on communication skills .This will improve their ability to convey messages and information, especially to old patients, in a manner easy to understand.
- To minimize unethical practices and moral hazards in home health practice in Jordan, it is recommended that a code of ethics should be developed and indorsed by all home health care agencies.
- Hospitals and home health care agencies are encouraged to develop effective professional partnerships and effective communication to refer patients from hospitals to agencies and vice versa.
- Strategies are needed to motivate young women to enroll in nursing faculties to meet the shortage of female nurses like providing more scholarships and improving work conditions for female nurses. Also, managers of HHCAs should create a "Caregiver-friendly" practices such as creative, flexible scheduling; fair financial incentives and continuous training programs for attracting female nurses to home health care.
- Financial barriers to home health care should be addressed by health policy makers to make home health services in Jordan more equitable and accessible to all irrespective of their ability to pay. Health insures schemes should be encouraged to include home health care services to their insurance package.

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Annex (1)

Home Care Needs Assessment Tool

Please respond to all of the following questions.

1. Your agency is located in _____ city.
2. Your agency provides services to patients in the following cities/towns:
    1. _____
    2. _____
    3. _____
    4. _____
    5. _____
    6. _____
    7. _____

3. Check all kinds of services usually provided by your home care agency:

    ____Home Nursing Care

    ____Physiotherapy

    ____Occupational therapy

    ____Medical equipment and supplies rental

    ____Other services (Please specify)

    _____

4. How many years have you been in business? Years
5. Who owns your agency?

    A. Individual (one person) B. Partners C. Company
6. If owned by one person or partners please specify the professions of the owner(s)

.....

7. How many of your staff is employed as full-time staff?

Registered Nurses (RNs)_____

Licensed Practical Nurses (LPNs)_____

Vocational Nurses (less than 18 months of formal education after Tawjihi)_____

Physiotherapists_____

Occupational Therapists_____

Physicians_____

8. How many of your staff are employed as part-time staff?

   Registered Nurses (RNs)_____

   Licensed Practical Nurses (LPNs)_____

   Vocational Nurses (less than 18 months of formal education after Tawjihi)_____

   Physiotherapists_____

   Occupational Therapists_____

   Physicians_____

9. Do you provide or organize any training programs for your staff? Yes No

10. If your answer to question 9 above is Yes, please specify the training programs you usually provide:

11. In the last year, what are the percentages of your patients whom their home care fees were paid by:

    Insurance (%)

    Self (%)

    Family/Relatives (%)

    Relatives (%)

    Charity (%)

12. In the last year, your agency has provided home care for patients with the following health conditions (please indicate percentages):

    Mental illness (%)
    Cancer (%)
    Dementia (%)
    Diabetes (%)
    Heart Disease (%)
    Hearing/visual impairment (%)
    Cerebrovascular accidents (%)
    Paraplegia (%)
    Quadriplegia (%)
    Respiratory problems (%)
    Renal problems (%)
    Children with Disabilities (%)
    Other chronic conditions (%)
    Older people with physical impairments (%)

13. Among the patients you have served in the last year, what was the percentage of patients you contracted for:

    Less than 8 hours/week (%)
    Less than 8 hours/day (%)
    8 - 12 hours/day (%)
    24 hours/day (%)

14. On what bases you calculate your service fees? (Check all that apply to you)

_____Per hour
_____Per visit
_____Per procedure
_____Per day

_____Per case

_____Other (specify)

15. Do you have service fees schedule/list? _____Yes

    _____No

16. If your answer to question 15 was yes, then who determines your services fees?

    A. Your agency

    B. Your agency and a governmental agency

    C. A governmental agency

17. How often do you encounter financial problems related to payment of service fees (delay of payment, partial payment, denying payment, etc.)?

    A. All the time B. Very often C. Rarely D. Never

18. How often does your agency provide non-personal (housekeeping, catering, laundry, etc.) care to patients?

    A. All the time B. Very often C. Rarely D. Never

19. Where do you get the medical equipment/supplies that your patients need?

    _____Buy them for the patient

    _____Have our own

    _____Rent them from other agencies

20. What was the percentage of your patients admitted to the hospitals in the last year because your agency could not provide them with proper nursing/medical expertise? _____%

21. What was the percentage of your patients admitted to the hospitals in the last year because your agency could not provide them with proper medical equipment/supplies? _____%

22. What was the percentage of your patients admitted to the hospitals in the last year because their care needs were beyond the home care provision? _____%
23. Do you maintain a written policy and procedure manual that direct or help your staff in their work? Yes NO
24. What was the percentage of your patients who were referred to you by:

A. Hospitals % B. Individual doctors or health practitioners %

C. Clients %

D. Your staff % E. Others (specify): %

25. In the last year, what was the percentage of your patients who are not Jordanians? _____%
26. Do you keep medical records for your patients?

A. All the time B. Very often C. Rarely D. Never

27. Is there any organization which performs professional monitoring or control on your services?

Yes NO

28. If the answer for question 26 above was "Yes", please indicate the organization(s) which does this:

_____

_____

29. In the last year, what was the percentages of your patients who were:

Mobile, conscious and alert _____%

Bed ridden & conscious _____%

Bed ridden & unconscious _____%

On oxygen therapy _____%

Ventilator dependent_____%

On enteral (NG, gastrostomy, or jejunostomy) feeding_____%

Permanently having a Foley catheter_____%

Permanently having a stoma (e.g., colostomy) _____%

30. Please indicate the percentage of your last year patients who needed the following services:

_____% needed assistance with their personal hygiene (e.g., bathing, dressing, incontinence, etc.)

_____% needed assistance with home making (e.g., shopping, cooking, laundry, etc.)

_____% needed companionship (e.g., baby-sitting)

_____% needed assistance with their elimination needs (e.g., frequent enemas, stoma care, etc.)

_____% needed sophisticated nursing/medical procedures (e.g., wound dressings, frequent suctioning, parenteral therapies, ambulatory mechanical ventilation, etc.)

31. Please indicate the percentages of your last year patients who:

_____% were not on any medications

_____% were on oral medications

_____% were on continuous intravenous therapies

_____% were on intermittent intravenous therapies

32. Do you provide your patients and their families with written information (e.g., booklets, pamphlets, etc.) about their health conditions and their management?

A. All the time B. Very often C. Rarely D. Never

33. In the last year, how many patients did you have to turn down (not accept) or terminate care because of lack of payment? _____

34. In the last year, how many patients did you have to turn down (not accept) or terminate care because of lack of staff? _____

35. In the last year, how many patients did you have to turn down (not accept) or terminate care because of lack of equipment/supplies? _____

36. How do you promote your services?

A-Through advertising in the media B- Through direct visits to hospitals and doctors' clinics C-Both A & B

D-Through other means (specify).....

37. Do your patients or your staff have a 24-hours phone number to call in case they needed some assistance or support at home? _____Yes _____No

38. Do you provide your full-time staff with a full-benefits package including social security, health assurance, transportation, etc.? _____Yes _____No

39. Please write down the positions, numbers, and qualifications of your administrative/supportive staff:

_____

_____

_____

_____

_____

Please list all the barriers to effective home care utilization in Jordan:

_____

_____

_____

_____

Annex (2)

Semi Structured Interview with Medical Consultants

1. Institution:

   .....

2. Area of Practice: .....

3. Do you refer your patients/user to home care services:
   □ Yes □ No
   If yes, how often did you use services in the past twelve (12) months?

   .....

   .....

   .....

   .....

4. What were the medical conditions that you used the services? list

5. Were you satisfied with the services?
   □ Yes □ No

   If Yes, describe, if No list reasons:

6. Did you need a service (home care) that were not available
   □ Yes □ No

   If Yes, what were the services needed:

7. What were the obstacles for utilization? list
8. What are your suggestions for improving these services? List
9. Any other comments?

Annex (3/A)

البيانات الشخصية
مستخدمي خدمات الرعاية المنزلية

1) الجنس
   أ. ذكر
   ب. أنثى

2) العمر:
   أ. أقل من 20
   ب. 20 – 29
   ج. 30 – 39
   د. 40 – 49
   ه. 50 – 59
   و. أكثر من 60

3) الجنسية:
   أ. أردني
   ب. غير أردني

4) التشخيص الطبي:
   أ. قلب
   ب. رئة
   ج. سكري
   د. أورام
   ه. عظام
   و. نسائية
   ز. نفسية
   ح. خرف
   ط. سرطان
   ي. أخرى، أذكر

5) المشكلة الصحية:
   أ. قلب
   ب. رئة
   ج. سكري
   د. أورام
   ه. عظام
   و. نسائية
   ز. نفسية
   ح. خرف
   ط. سرطان

ي. أخرى، أذكر

6) الفترة الزمنية في استخدام الخدمات المنزلية:
---

7) نوع الخدمات:
أ. رعاية صحية متخصصة
ب. رعاية تمريضية
ج. خدمات منزلية
د. مرافق

8) تغطية نفقات الخدمة:
أ. هل لديك تأمين صحي:
1. نعم
2. لا

ب. نسبة التأمين للخدمات المنزلية:
1. كاملة
2. جزئية

إذا كانت جزئية اذكر النسبة: ----------

ج- في حال عدم وجود تأمين صحي، كيف يتم تغطية النفقات:

Annex (3/B)

Home Health Care CAHPS® Survey

September 1, 2010

Vey Instructions

- Answer all the questions by checking the box to the left of your answer.
- You are sometimes told to skip over some questions in this survey. When this happens you will see an arrow with a note that tells you what question to answer next, like this:

☑ Yes ➔ If Yes, go to Q1 on Page 1.

☐ No

Your Home Health Care

1. According to our records, you got care from the home health agency, [AGENCY NAME]. Is that right?

As you answer the questions in this survey, think only about your experience with this agency.

1 ☐ Yes

2 ☐ No ➔ If No, please stop and return the survey in the envelope provided.

2. When you first started getting home health care from this agency, did someone from the agency tell you what care and services you would get?

1 ☐ Yes

2 ☐ No

3 ☐ Do not remember

3. When you first started getting home health care from this agency, did someone from the agency talk with you about how to set up your home so you can move around safely?

1 ☐ Yes

2 ☐ No

3 ☐ Do not remember

4. When you started getting home health care from this agency, did someone from the agency talk with you about all the prescription and over-the-counter medicines you were taking?

1 ☐ Yes

2 ☐ No

3 ☐ Do not remember

5. When you started getting home health care from this agency, did someone from the agency ask to see all the prescription and over-the-counter medicines you were taking?

1 ☐ Yes

2 ☐ No

3 ☐ Do not remember

Your Care from Home Health Providers in the Last 2 Months

These next questions are about all the different staff from [AGENCY NAME] who gave you care in the last 2 months. Do not include care you got from staff from another home health care agency. Do not include care you got from family or friends.

6. In the last 2 months of care, was one of your home health providers from this agency a nurse?

1 ☐ Yes

2 ☐ No

7. In the last 2 months of care, was one of your home health providers from this agency a physical, occupational, or speech therapist?

1 ☐ Yes

2 ☐ No

8. In the last 2 months of care, was one of your home health providers from this agency a home health or personal care aide?

1 ☐ Yes

2 ☐ No

9. In the last 2 months of care, how often did home health providers from this agency seem informed and up-to-date about all the care or treatment you got at home?

1 ☐ Never

2 ☐ Sometimes

3 ☐ Usually

4 ☐ Always

5 ☐ I only had one provider in the last 2 months of care

10. In the last 2 months of care, did you and a home health provider from this agency talk about pain?

1 ☐ Yes

2 ☐ No

11. In the last 2 months of care, did you take any new prescription medicine or change any of the medicines you were taking?

1 ☐ Yes

2 ☐ No ➔ If No, go to Q15.

12. In the last 2 months of care, did home health providers from this agency talk with you about the purpose for taking your new or changed prescription medicines?

1 ☐ Yes

2 ☐ No

3 ☐ I did not take any new prescription medicines or change any medicines

13. In the last 2 months of care, did home health providers from this agency talk with you about when to take these medicines?

1 ☐ Yes

2 ☐ No

3 ☐ I did not take any new prescription medicines or change any medicines

14. In the last 2 months of care, did home health providers from this agency talk with you about the side effects of these medicines?

1 ☐ Yes

2 ☐ No

3 ☐ I did not take any new prescription medicines or change any medicines

15. In the last 2 months of care, how often did home health providers from this agency keep you informed about when they would arrive at your home?

1 ☐ Never

2 ☐ Sometimes

3 ☐ Usually

4 ☐ Always

16. In the last 2 months of care, how often did home health providers from this agency treat you as gently as possible?

1 ☐ Never

2 ☐ Sometimes

3 ☐ Usually

4 ☐ Always

17. In the last 2 months of care, how often did home health providers from this agency explain things in a way that was easy to understand?

1 ☐ Never

2 ☐ Sometimes

3 ☐ Usually

4 ☐ Always

18. In the last 2 months of care, how often did home health providers from this agency listen carefully to you?

1 ☐ Never

2 ☐ Sometimes

3 ☐ Usually

4 ☐ Always

19. In the last 2 months of care, how often did home health providers from this agency treat you with courtesy and respect?

1 ☐ Never

2 ☐ Sometimes

3 ☐ Usually

4 ☐ Always

20. We want to know your rating of your care from this agency's home health providers.

Using any number from 0 to 10, where 0 is the worst home health care possible and 10 is the best home health care possible, what number would you use to rate your care from this agency's home health providers?

☐ 0 Worst home health care possible

☐ 1

☐ 2

☐ 3

☐ 4

☐ 5

☐ 6

☐ 7

☐ 8

☐ 9

☐ 10 Best home health care possible

Your Home Health Agency

The next questions are about the office of [AGENCY NAME].

21. In the last 2 months of care, did you contact this agency's office to get help or advice?

1 ☐ Yes

2 ☐ No ➔ If No, go to Q24.

22. In the last 2 months of care, when you contacted this agency's office did you get the help or advice you needed?

1 ☐ Yes

2 ☐ No ➔ If No, go to Q24.

3 ☐ I did not contact this agency

23. When you contacted this agency's office, how long did it take for you to get the help or advice you needed?

1 ☐ Same day

2 ☐ 1 to 5 days

3 ☐ 6 to 14 days

4 ☐ More than 14 days

5 ☐ I did not contact this agency

24. In the last 2 months of care, did you have any problems with the care you got through this agency?

1 ☐ Yes

2 ☐ No

25. Would you recommend this agency to your family or friends if they needed home health care?

1 ☐ Definitely no

2 ☐ Probably no

3 ☐ Probably yes

4 ☐ Definitely yes

About You

26. In general, how would you rate your overall health?

1 ☐ Excellent
2 ☐ Very good
3 ☐ Good
4 ☐ Fair
5 ☐ Poor

27. In general, how would you rate your overall mental or emotional health?

1 ☐ Excellent
2 ☐ Very good
3 ☐ Good
4 ☐ Fair
5 ☐ Poor

28. Do you live alone?

1 ☐ Yes
2 ☐ No

29. What is the highest grade or level of school that you have completed?

1 ☐ 8th grade or less
2 ☐ Some high school, but did not graduate
3 ☐ High school graduate or GED
4 ☐ Some college or 2-year degree
5 ☐ 4-year college graduate
6 ☐ More than 4-year college degree

30. Are you Hispanic or Latino/Latina?

1 ☐ Yes
2 ☐ No

31. What is your race? Please select one or more.

1 ☐ White

2 ☐ Black or African-American

3 ☐ Asian

4 ☐ Native Hawaiian or other Pacific Islander

5 ☐ American Indian or Alaska Native

32. What language do you mainly speak at home?

1 ☐ English

2 ☐ Spanish

3 ☐ Some other language:

_____

(Please print.)

33. Did someone help you complete this survey?

1 ☐ Yes

2 ☐ No ➔ If No, please return the completed survey in the postage-paid envelope.

34. How did that person help you? Check all that apply.

1 ☐ Read the questions to me

2 ☐ Wrote down the answers I gave

3 ☐ Answered the questions for me

4 ☐ Translated the questions into my language

5 ☐ Helped in some other way:

_____

(Please print.)

6 ☐ No one helped me complete this survey

Participant

Date: ----------

Location: ----------

Annex (4)

Home Health Care Agency Profile

Please respond to all of the following questions.

1. Your agency is located in _____ city.
2. Your agency provides services to patients in the following cities/towns:
    1. _____
    2. _____
    3. _____
    4. _____
    5. _____
    6. _____
    7. _____

3. Check all kinds of services usually provided by your home care agency:

    ____Home Nursing Care

    ____Physiotherapy

    ____Occupational therapy

    ____Medical equipment and supplies rental

    ____Other services (Please specify)

    _____

4. How many years have you been in business? Years
5. Who owns your agency?

A. Individual (one person) B. Partners C. Company

6. If owned by one person or partners please specify the professions of the owner(s)

.....

7. How many of your staff are employed as full-time staff?

   Registered Nurses (RNs)_____

   Licensed Practical Nurses (LPNs)_____

   Vocational Nurses (less than 18 months of formal education after Tawjihi)_____

   Physiotherapists_____

   Occupational Therapists_____

   Physicians_____

8. How many of your staff are employed as part-time staff?

   Registered Nurses (RNs)_____

   Licensed Practical Nurses (LPNs)_____

   Vocational Nurses (less than 18 months of formal education after Tawjihi)_____

   Physiotherapists_____

   Occupational Therapists_____

   Physicians_____

9. Do you provide or organize any training programs for your staff?

   Yes No

10. If your answer to question 9 above is Yes, please specify the training programs you usually provide:

11. In the last year, what are the percentages of your patients whom their home care fees were paid by:

    Insurance (%)

    Self (%)

    Family (%)

    Relatives (%)

    Charity (%)

12. In the last year, your agency has provided home care for patients with the following health conditions (please indicate percentages):

    Mental illness (%)

    Cancer (%)

    Dementia (%)

    Diabetes (%)

    Heart Disease (%)

    Hearing/visual impairment (%)

    Cerebrovascular accidents (%)

    Paraplegia (%)

    Quadriplegia (%)

    Respiratory problems (%)

    Renal problems (%)

    Children with Disabilities (%)

    Other chronic conditions (%)

    Older people with physical impairments (%)

13. Among the patients you have served in the last year, what was the percentage of patients you contracted for:

    Less than 8 hours/week (%)

    Less than 8 hours/day (%)

    8 - 12 hours/day (%)

    24 hours/day (%)

14. On what bases you calculate your service fees? (Check all that apply to you)

_____Per hour

_____Per visit

_____Per procedure

_____Per day

_____Per case

_____Other (specify)

15. Do you have service fees schedule/list? _____Yes

    _____No

16. If your answer to question 15 was yes, then who determines your services fees?

    A. Your agency

    B. Your agency and a governmental agency

    C. A governmental agency

17. How often do you encounter financial problems related to payment of service fees (delay of payment, partial payment, denying payment, etc.)?

    A. All the time B. Very often C. Rarely D. Never

18. How often does your agency provide non-personal (housekeeping, catering, laundry, etc) care to patients?

    A. All the time B. Very often C. Rarely D. Never

19. Where do you get the medical equipment/supplies that your patients need?

    _____Buy them for the patient

    _____Have our own

    _____Rent them from other agencies

20. What was the percentage of your patients admitted to the hospitals in the last year because your agency could not provide them with proper nursing/medical expertise? _____%

21. What was the percentage of your patients admitted to the hospitals in the last year because your agency could not provide them with proper medical equipment/supplies? _____%

22. What was the percentage of your patients admitted to the hospitals in the last year because their care needs were beyond the home care provision? _____%

23. Do you maintain a written policy and procedure manual that direct or help your staff in their work? Yes NO

24. What was the percentage of your patients who were referred to you by:

    A. Hospitals %

    B. Individual doctors or health practitioners' %

    C. Clients %

    D. Your staff %

    E. Others (specify): %

25. In the last year, what was the percentage of your patients who are not Jordanians? _____%

26. Do you keep medical records for your patients?

    A. All the time B. Very often C. Rarely D. Never

27. Is there any organization which performs professional monitoring or control on your services?

    Yes NO

28. If the answer for question 26 above was "Yes", please indicate the organization(s) which does this:

_____

_____

29. In the last year, what was the percentages of your patients who were:

    Mobile, conscious and alert _____%

    Bed ridden & conscious _____%

    Bed ridden & unconscious _____%

    On oxygen therapy _____%

    Ventilator dependent_____%

    On enteral (NG, gastrostomy, or jejunostomy) feeding_____%

    Permanently having a Foley catheter_____%

    Permanently having a stoma (e.g., colostomy) _____%

30. Please indicate the percentage of your last year patients who needed the following services:

    _____% needed assistance with their personal hygiene (e.g., bathing, dressing, incontinence, etc.)

    _____% needed assistance with home making (e.g., shopping, cooking, laundry, etc.)

    _____% needed companionship (e.g., baby sitting)

    _____% needed assistance with their elimination needs (e.g., frequent enemas, stoma care, etc.)

    _____% needed sophisticated nursing/medical procedures (e.g., wound dressings, frequent suctioning, parenteral therapies, ambulatory mechanical ventilation, etc.)

31. Please indicate the percentages of your last year patients who:

_____% were not on any medications

_____% were on oral medications

_____% were on continuous intravenous therapies

_____% were on intermittent intravenous therapies

32. Do you provide your patients and their families with written information (e.g., booklets, pamphlets, etc.) about their health conditions and their management?

A. All the time B. Very often C. Rarely D. Never

33. In the last year, how many patients did you have to turn down (not accept) or terminate care because of lack of payment? _____

34. In the last year, how many patients did you have to turn down (not accept) or terminate care because of lack of staff? _____

35. In the last year, how many patients did you have to turn down (not accept) or terminate care because of lack of equipment/supplies?

_____

36. How do you promote your services?

A-Through advertising in the media

B- Through direct visits to hospitals and doctors' clinics

C-Both A & B

D-Through other means (specify).....

37. Do your patients or your staff have a 24-hours phone number to call in case they needed some assistance or support at home? _____Yes

_____No

38. Do you provide your full-time staff with a full-benefits package including social security, health assurance, transportation, etc.?

_____Yes _____No

39. Please write down the positions, numbers, and qualifications of your administrative/supportive staff:

_____

_____

_____

_____

_____

_____

_____

_____

_____

40. Please list all the barriers to effective home care utilization in Jordan:

_____

_____

_____

_____

Annex (5)

البيانات الشخصيـــة

(الأطباء)

1. الجنس ذكر❑ أنثى❑

2. العمر: _____

3. التخصص:

1. طبيب عام
2. طبيب أسرة
3. أخصائي باطني
4. أخصائي قلب
5. أخصائي عظام
6. أورام
7. كلى ومسالك بولية
8. الجهاز الهضمي
9. أنف وأذن وحنجرة
10. جلدية
11. نسائية وتوليد
12. أعصاب
13. الأمراض التنفسية
14. نفسية
15. تخصص اخر: حدد: .....

4. معدل عدد المرضى الذين يتم تحويلهم شهريا: .....

5. جنسية المرضى المحولين:

غير العرب (جنسيات غير عربية) ❑ عرب ❑ اردنيين ❑

6. هل تعمل مع المؤسسة التي تحول لها ؟

نعم❑ لا❑

7. مستوى الرضى عن اداء مؤسسات الرعاية الصحية المنزلية؟

راض جدا ❑ راض الى حد ما ❑ غير راض الى حد ما ❑ غير راض تماما ❑

8. هل لديك اطلاع مباشر عن نوعية الخدمة المقدمة من قبل مؤسسات الرعاية الصحية المنزلية ؟

لا ❑ نعم ❑

9. هل حصلت على دورة متخصصة في مجال الرعاية الصحية المنزلية ؟

لا❑ نعم ❑

10. الفئة التي تقدم تقدم لها الرعاية:

العسكريين❑ القطاع الخاص ❑لقطاع الحكومي ❑

جهات دولية (مثل الانروا و اليونيسف) ❑ الاعفاء (حكومي او غير ذلك) ❑

Annex (6)

البيانات الشخصية
مدير/ خدمات الرعاية المنزلية

1) الجنس
   أ. ذكر
   ب. أنثى

2) العمر:
   أ. أقل من 30
   ب. 30 – 39
   ج. 40 – 49
   د. 50 – 59
   ه. أكثر من 60

3) الجنسية:
   أ. أردني
   ب. غير أردني

4) المؤهلات العلمية:
   أ. ثانوية عامة
   ب. دبلوم
   ج. بكالوريوس
   د. ماجستير
   ه. دكتوراة

5) الدورات: إذكر:

---

6) المهنة:
   أ. طبيب
   ب. ممرض
   ج. غير ذلك

7) عدد سنين الخبرة:
   أ. 1 – 3

ب. 4 – 7
ج. 8 – 11
د. 12 – 15
ه. أكثر من 15 سنة

8) عدد سنوات العمل في المؤسسة التي تعمل بها حاليا:
أ. 6 – 11 شهرا
ب. 1 – 3 سنوات
ج. 4 – 7 سنوات
د. 8 – 11 سنة
ه. 12 – 15 سنة
و. أكثر من 15 سنة

9) سنة تسجيل مؤسسة الرعاية التي تعمل بها في وزارة الصحة
---

10)تاريخ تشغيل المؤسسة؟

Annex (7)

عزيزي المشارك/ المشاركة
شكراً لاهتمامكم ورغبتكم المشاركة في هذه الدراسة بعنوان:

تقييم الوضع الحالي لخدمات الرعاية الصحية المنزلية في الاردن من وجهة نظر مقدمي الخدمة والمستفيدين من هذه الخدمات

والتي تهدف الى تسليط الضوء على خدمات الرعاية الصحية المنزلية في الأردن من حيث نوعية الخدمة المقدمة ، واحتياجات طالبي الخدمة وتوقعاتهم منها، وذلك للإفادة من هذه الدراسة في رسم السياسات ووضع التشريعات الناظمة لها.
جميع المعلومات والبيانات ستعامل بسرية تامة ، ولا يحق لأي شخص الإطلاع على هذه المعلوات سوى الباحثين العاملين بها، وستحفظ الوثائق الخاصة بالدراسة في أماكن خاصة لا يصل اليها إلا الباحثون .
لا يتطلب الإشتراك في هذه الدراسة ذكر الإسم او ما يدل علية ومهما كانت اجابة أو رأي المشارك فإناه لن تؤثر وبأي شكل على وضع المؤسسات أو الأشخاص المشاركين وللك الحق في المشاركة أو الإعتذار عن المشاركة في الدراسة،فالمشاركة في هذه الدراسة طوعية وبحض اخيارك وهي مشاركة غير مدفوعة،كما يحق للمشارك الإنسحاب منها في أي وقت إن كان ذلك مناسباً له.
حصلت هذه الدراسة على موافقة صندوق دعم البحث العلمي في وزارة التعليم العالي ،بيحيث يسمح للباحث القيام بجمع البيانات من المشاركين حسب اختيارهم .
يستغرق مليء الإستبانات حوالي 40 دقيقة كحد اعلى ،ويحق للمشارك في البحث سؤال الباحثين عن أي أمر يتعلق بالبحث ،كما يحق له الحصول على نتائج الدراسة عند الإنتهاء منها.

الباحث الرئيس :
د. هانية دواني
مدير الشؤون الفنية /المجلس التمريضي الاردني
Email: Dr Hania @ gmail.com
Tel: o777699000

Annex (8)

عزيزي المشارك / المشاركة

شكرا" لاهتمامكم ورغبتكم بالمشاركة في هذا البحث العلمي.

تهدف هذه الدراسة " تقييم الوضع الحالي لخدمات الرعاية الصحية المنزلية في الأردن من وجهة نظر مقدمي الخدمة والمستفيدين من هذه الخدمات" الى التعرف على الخدمات الصحية المنزلية التي تقدمها مؤسسات الرعاية الصحية المنزلية على وجهة نظر المستفيدين ومقدمي الخدمة لنوعية الخدمات التي تقدمها هذه المؤسسات.

ستعامل جميع المعلومات بسرية تامه ، ولا يحق لاي شخص الاطلاع على هذه المعلومات باستثناء الباحثين. وستحفظ البيانات في اماكن خاصة لا يصل اليها الا الباحثون .

سيتم تسجيل المقابلات صوتيا في الجلسة التي ستشاركون بها إلا أنه سيتم إتلاف جميع الأشرطة المسجلة بعد الانتهاء من تدوين محتواها.

لا تتطلب المشاركة في البحث ذكر الاسم او ما يدل عليه ومهما كانت الإجابة فان هذه الاجابات والآراء لن تؤثر بأي شكل كان على وضعك و لك الحق بالاشتراك او رفض الاشتراك في البحث .
المشاركة في البحث طوعية وبمحض اختيارك وهي مشاركة غير مدفوعة .

حصلت هذه الدراسة على موافقة المؤسسة التي ينتمي إليها الباحث الرئيس وعلى دعم من صندوق البحث العلمي التابع لوزارة التعليم العالي والبحث العلمي.

تستغرق الجلسات لغايات جمع المعلومات حوالي 90 دقيقة كحد أعلى.
يحق للمشارك في البحث سؤال الباحثين عن أي أمر يتعلق بالبحث وكذلك يحق له الحصول على نتائج البحث عند الانتهاء منه .

الباحث الرئيس :-
د. هانيا دواني
مدير الشؤون الفنية / المجلس التمريضي الاردني
E-mail: drhaniad@gmail.com
موبايل: 0777699000