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Hospital Home-Bound Education: Are Teachers Prepared to Implement Transition Plans Post-Hospitalization for Student Success?

Dissertation

by

Katherine M. Kimbro-Vincent

Submitted in Partial Fulfillment of the Requirements for the Degree of

DOCTOR of EDUCATION

in

TEACHER LEADERSHIP

Bagwell College of Education
Kennesaw State University
Kennesaw, Georgia

Dr. Binyao Zheng, Chair
Dr. Belinda Edwards, Committee Member
Dr. Raynice Jean-Sigur, Committee Member

Abstract

Homebound instruction presents many challenges for teachers. Teachers are frequently not prepared to provide such services. Teachers are frustrated in recognizing that homebound services do not provide sufficient depth and intensity of instruction that some students may need. The purpose of this study was to bring awareness of what happens during the transition of a hospital homebound student post-hospitalization and their academic success. A qualitative case study allowed me to gather and analyze students' needs that addressed their medical conditions. These important aspects included not only the hospital homebound teachers, students, and staffs' behaviors/views on the overall program, but also the perceptions of those who interacted with the students, the context of the program, outside constituents, comparisons to other homebound programs, and other qualitative variables. The data-based case study was guided by looking at the needs of hospital home bound students, the needs of hospital homebound teachers, and what supports could be provided to hospital homebound teachers. All of the students that I interviewed for this study have experienced some form of significant social and emotional stress that has impaired their performance at school, as well as their physical and mental health. Current school supports do not appear to be meeting the diverse school-based needs of students with chronic illness. Hospital homebound instruction often is provided to students after regular school hours, only qualified staff members who are able to take on the extra duties of homebound instruction after their regular working day should be considered. The results revealed that this diverse group of students required multiple supports in order to be effective in their respective positions. More specifically, it was evident that teachers still feel unprepared to educate hospital homebound students and that they lack specific resources for them to be successful.

Keywords: hospital home-bound, special education, IEP, school re-entry, teacher professional development, qualitative case study

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this world, and to sprinkle this black girl magic wherever this journey takes me. Spelman, I am forever indebted to you. This doctoral journey I will never ever forget. The challenges, the celebrations, and the end result. Thanks to all of you for pouring into me. With a heart of gratitude, I give thanks.

DEDICATION

Thank you to my heavenly father for your grace. You continue to walk with me. God, thank you for your protection and shielding me in only ways you can. I dedicate this dissertation to my entire family. Everyone has had a special role in keeping me covered with prayers, kind words, and positive energy. To my mother, Patricia, you have a way of protecting your kids and ensuring that your daughters know how special, smart, and different we all are. I remember as a small child you would give me such encouraging words whenever I encountered a challenge, be it small or big, you were my number one supporter. Your support will never go unnoticed. You are not only my mother and best friend but a special light in my life that I am eternally grateful for. To my father, Dr. Dennis Kimbro, your talks have molded me into the woman I am today. I feel like I can take on the world because of you. The way you have managed to boost my self-confidence has left me with an attitude that there is nothing I cannot do. From reading you chapter after chapter, I know how proud you are of me, and I hope to continue to make you and mom proud. You are the only person in this world that encouraged me to start this journey. I am receiving my doctorate because of your hard push. Thanks dad. To my big sisters, Kelli and Kimberli. In my younger years, you have always managed to protect me, teach me, and show me the ropes with this life journey. From graduating from college to walking me down the aisle, you two are my very first friends, and I am so grateful for the special relationships we all share. To my nieces, you girls manage to keep me on my toes. You keep me youthful and make me proud to be your auntie. You girls have shining lights, and each of you is making such a positive impact in this world in such little time. You little ladies inspire me so. The world is yours so go and get it! My godmother Pauline. Thanks for being here, always. I hope I make you proud. To my friends, aunts, uncles, cousins, godchildren, thank you! You all keep me balanced and grounded.

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SPECIAL DEDICATION

To my mother, Patricia Lynn Kimbro, the strongest woman I know, thank you. Forty years ago, you almost died in childbirth with me, and we both made it. Because of God's grace, his plan was bigger. You managed to defeat the odds and the hand that you were dealt to raise me to the best of your ability. Mommy, this is for the both of us. I love you so much! Your encouragement, support, and love are all I ever needed. I got it from here! You are now resting with the angels. Thank you PLK.

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Chapter 1: Introduction

Background and Setting

The first homebound educational service began in Newton, Iowa, in 1939. The service was provided by telephone. By 1958, the Council for Exceptional Children (CEC) created the Division of Educators of Homebound/Hospitalized Children. Today, the hospital homebound service delivery model is considered the most restrictive educational setting because it segregates students from other students, both with and without disabilities. According to The Gadoe.org, (Overview of Homebound services, April 2016), hospital homebound programs are designed to provide continuity of educational services between the classroom and home or hospital for students in Georgia public schools whose medical needs do not allow them to attend school for a limited period of time.

The student's inability to attend school for medical reasons must be certified by the licensed physician who is currently treating the student for the diagnosis presented. The student must anticipate being absent from school for a minimum of 10 consecutive or intermittent school days due to a medical or psychiatric condition. The student's inability to attend school for medical or psychiatric reasons must be certified by the licensed physician who is currently treating the student for the diagnosis presented.

The provision of homebound services to students with disabilities is determined by multidisciplinary teams and documented in Individual Education Programs (IEP) or Individual Family Service Plans (IFSP). An LEA is the person representing the school district in an official capacity. The idea behind having an LEA separate from the rest of the other team (presumably, most of whom are also employed by the school district) is so that those other participants can speak freely about the child's interests rather than the district's interest. The LEA stands for

Local Education Agency. An LEA is one who represents the educational agency, typically a school district. LEA's represent the district and are responsible for ensuring that anything requested in the meeting (in terms of district resources) can be made available. This person generally consists of school administrators, special education teachers, special education directors or psychologist. They often serve dual roles in the IEP team and are responsible for providing appropriate instruction and related services that meet the legal requirements for the use of educational settings (Etscheidt, 2006).

In selecting homebound services as a delivery method, IEP and IFSP team members should consider the restrictive nature of homebound services. Because of the potential for limited interaction with peers, homebound instruction is often seen as one of the most restrictive educational settings (Patterson & Tullis, 2007). Another consideration is the assurance that students that received homebound services were able to have access to the general education curriculum (Bradley, 2007). The nature and impact of the student's disability affects the amount of time for which homebound instruction is provided.

Providing homebound services to any student is a unique and positive experience for teachers. It affords the teacher an opportunity to observe the home environment and the family dynamics within that environment. This results in greater understanding of the student's behavior. Because of the frequency of interaction and communication, it offers teachers the prospect of building stronger ties with the family. Homebound instruction may also result in greater bonds between teachers and students because of the one-on-one instruction provided and the opportunity to truly individualize instruction (Baker et al.,1999).

Homebound instruction presents many challenges for teachers. Teachers are frequently not prepared to provide such services. Few teacher-preparation programs address the issue, and

much of the available literature on homebound instruction comes from the field of early childhood special education (Klass, 1996). In addition, school districts do not have specific guidelines for their teachers on providing homebound services (Daly-Rooney & Denny, 1991). Homebound instruction presents a variety of unexpected variables with which to contend. These include disruptive siblings, a noisy environment in which to work, family conflicts, and cancellations of visits (Yell, 1998).

Teachers are frustrated in recognizing that homebound services do not provide sufficient depth and intensity of instruction that some students may need. Providing homebound instruction to students with emotional or behavioral disorders can be a particularly demanding experience. Such students can display a wide range of challenging behaviors, from apathy to defiance (Kerr & Nelson, 2002). Undesirable behaviors that are evident in school and community settings can be even more intense in the home. Teachers should plan on using their full repertoire of behavioral interventions, which could include identifying and avoiding the triggering of undesirable behaviors, the use of token economy systems, behavioral contracts, the calculated use of verbal praise, and working on tasks in small increments of time. I have developed this interest in this particular topic for both professional and personal reasons. My practical goal for conducting this research are the motivations that I have for engaging in this study, as it relates to the importance of transition planning for students that are hospital homebound and ensuring a smooth transition back to their perspective schools' post-hospitalization. I would like to change the way that Georgia's Department of Education utilizes hospital homebound programs and possibly change how it provides continuity of services for children. My intellectual goal for conducting this research is to bring awareness of the issues regarding students in the state of Georgia and ensuring a smooth transition overall. Public schools have allowed students to fail

core classes and miss credits due to their disabilities. Ask yourself, if this was your child, what would you do to support them? This is occurring in our schools at an alarming rate.

Hospital homebound services should be offered through a collaborative approach from all stakeholders including but not limited to school staff, student, parents, medical staff, educators, and administrators', however this approach does not always seem to be executed ethically (Yell, 1998). In my thirteen years of teaching students with disabilities, I have witnessed an increased number of students being left behind for medical reasons beyond their control. It is with these reasons why I propose a study that takes a closer look on a student's due process and protection for hhb instruction and ensuring that the achievement gaps with this specific population do not widen. I chose this topic because of my own family's history of challenges within this program, and to overall take a deeper look into how this program can be improved. My passion alone stems from my family's personal experiences.

Significance of the Study

Teachers must develop positive relationships with students in the home bound program to ensure student success. Transitional planning plays an important role in children. Adults can ensure that a child who is in this program can help to assist in their goals. The overall significance of this program as a whole is to help students maintain their educational performance while confined at home or the hospital. After all, this is completely out of the student's control. By working closely with school staff, families, children, and hospital staff, we could provide an overall quality of instruction for each student in this program. Results from this study will prove to be helpful for school stake holders when planning a successful homebound instructional plan.

Statement of the Problem

A fifteen-year-old boy in Pinellas County, Florida is sick with cancer and is receiving dialysis. He is falling more and more behind on his work in the hospital homebound program. His teacher stated she worked with 28 different counties and they all had different criteria for who can receive the services. The teacher then added that it sometimes took three or four months to get lessons to hospitalized children (McGrory, 2016).

Optimally, homebound instruction should be offered through a multidisciplinary team effort. Key stakeholders (e.g., parents, teachers, administrators, therapists) would systematically bring together expertise from a variety of sources and professional fields to support, serve, and monitor the student. Whether working as a member of a team or not, teachers of hhb students need to plan, implement, document, evaluate, and attempt to communicate with others. Ultimately this is important for teacher leadership, because it takes teacher leaders to step up and lead stakeholders in utilizing best practices for student support services such as hhb programs.

These motivations influence how I think about close relatives and past students of my own who have and are continually battling long term diseases. One disease that comes to mind is Sickle Cell Anemia. I have witnessed first-hand how this devastating disease has affected my family and past students. I always wondered if they were receiving full support from school staff and stake holders, including hospital staff. Seeing a few of my family members struggle in school with their health and find the strength to push through and persevere with their education was heartbreaking to watch. Two sisters each spent over a third of the school year hospitalized with multiple health challenges. I often asked them both how they were able to stay abreast on their educational studies and more importantly if they had enough credits for graduation. Their Individualized Education Plan protected them. I have witnessed first-hand the pros and cons of this program as it related to a specific past student of mine who graduated last year. I recently

serviced a student on my caseload who was diagnosed with Other Health Impairment and Deaf/Hard Hearing. This student battled with Sickle Cell disease all of her youthful life and was on the path to graduation. Unfortunately, this student was hospitalized over half of the school year and her dreams of graduating were cut short.

Conceptual Framework

Homebound instruction originated in Newton, Iowa in 1939, and the service was provided by telephone. By 1958, the Council for Exceptional Children (CEC) created the Division of Educators of Homebound/Hospitalized Children. Today, the hhb service delivery model is considered the most restrictive educational setting because it segregates students from other students, both with and without disabilities. According to The Gadoe.org, Hospital/Homebound (HHB) services are designed to provide continuity of educational services between the classroom and home or hospital for students in Georgia public schools whose medical needs, either physical or psychiatric, do not allow them to attend school for a limited period of time. HHB instruction may be used to supplement the classroom program for students with health impairments whose conditions may interfere with regular school attendance (e.g., students receiving dialysis or radiation/chemotherapy or students with other serious health conditions) (Georgia State Board of Education Rule 160-4-2-.31, 2016, para. 1).

In the hhb program in Georgia, students must be enrolled in a public school in order to receive services (Woods, 2016, p.2). HHB services are not intended to supplement regular school services and are by design temporary (Woods, 2016, p.2). The student must anticipate being absent from school for a minimum of 10 consecutive or intermittent school days due to a medical or psychiatric condition. The student’s inability to attend school for medical or psychiatric reasons must be certified by the licensed physician who is currently treating the student for the

diagnosis presented. The provision of homebound services to students with disabilities is determined by multidisciplinary teams and documented in Individual Education Programs (IEP) or Individual Family Service Plans (IFSP) (Woods, 2016, p.5). The LEA is then responsible for providing appropriate instruction and related services that meet the legal requirements for the use of educational settings (Etscheidt, 2006). In selecting hhb services as a delivery method, IEP and IFSP team members should consider the restrictive nature of homebound services. Because of the potential for limited interaction with peers, homebound instruction is often seen as one of the most restrictive educational settings (Patterson & Tullis, 2007).

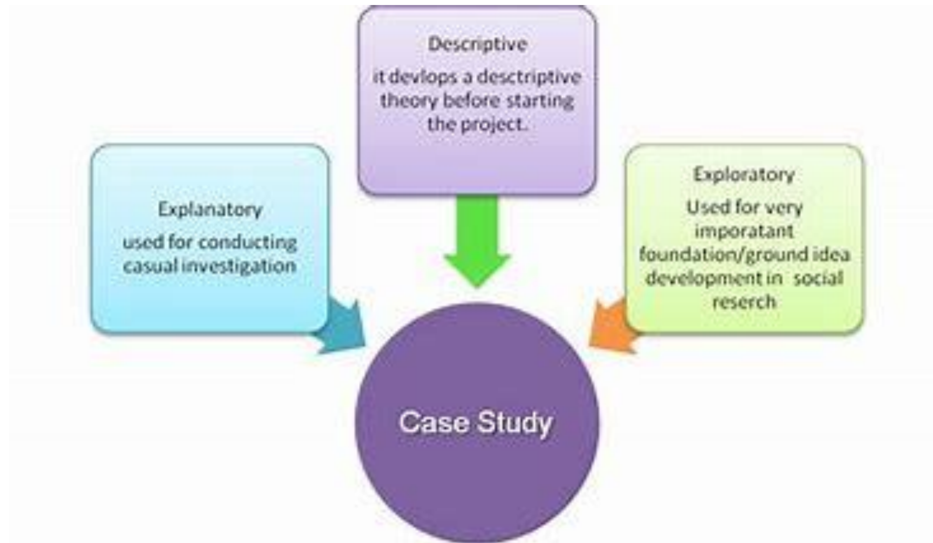
Another consideration is the assurance that students receiving homebound services have access to the general education curriculum (Bradley, 2007). The nature and impact of the student’s disability affects the amount of time for which hhb instruction is provided. Providing services to any student can be a unique and positive experience for teachers. It affords the teacher an opportunity to observe the home environment and the family dynamics within that environment; this results in greater understanding of the student's behavior. Because of the frequency of interaction and communication, it offers teachers the prospect of building stronger ties with the family. HHB instruction also results in greater bonds between teachers and students because of the one-on-one instruction provided and the opportunity to truly individualize instruction (Baker et al.,1999).

HHB instruction can also present many challenges for teachers. Teachers are frequently not prepared to provide such services. Few teacher preparation programs address the issue, and much of the available literature on homebound instruction comes from the field of early childhood special education (Klass, 1996). In addition, school districts may not have specific

guidelines for their teachers on providing homebound services (Daly-Rooney & Denny, 1991). A case study assisted me in identifying the key elements needed for this research.

Figure 1

Decision diagram for Qualitative Case Study



Purpose of the Study

The purpose of the study is to bring awareness of what happens during the transition of a hhb student during post-hospitalization and their academic success. HHB services should be offered through a collaborative approach from all stakeholders including but not limited to school staff, student, parents, medical staff, educators, and administrators'; however, this approach does not always seem to be executed ethically. There have been an increased number of students being left behind for medical issues beyond their control. It is for these reasons why I propose a study that takes a closer look at a student's due process and protection for hhb services and to ensure that the achievement gaps with this specific population do not continue. The study was guided by the following research questions:

1. What are the needs of hospital home bound students?

2. What are the needs of hospital homebound teachers?

3. What supports can be provided to hospital homebound teachers to ensure that hospital homebound students are effective academically?

Glossary of Terms

For the purpose of this study, the following definitions were adopted to clarify meaning and understanding:

Acute Illness: Medical conditions, such as injury, contagious illness, infection, or a disease with an abrupt onset (Shaw et al.,1999).

Chronic Illness: Medical conditions such as sickle cell disease, asthma, or compromised immune system that persists over a long period, affecting physical, emotional, intellectual, vocational, social, or spiritual functioning (Shaw et al., 2014).

Free Appropriate Public Education (FAPE): A key requirement of federal legislation (IDEA) which requires that special education and related services be provided to all students with disabilities. The following requirements must be met: (a) Are provided at public expense, under public supervision and direction, and without charge; (b) Meet the standards of the state board of education and the laws pertaining thereto; (c) Include preschool, kindergarten, elementary school, and secondary school education; and (d) Are provided in conformity with an individualized educational program (IEP).

General/Regular Education: The plan of instruction delivered to students in the classroom on a daily basis, following the mandated curriculum adopted by the state of Texas (TEA, 2010).

Homebound Instruction: The continuation of instruction provided at the student's home and delivered by a certified teacher employed by the local independent school district while the student is too ill to attend school (Patterson & Tullis, 2008).

IDEA of 2004: Refers to the Individuals with Disabilities Education Act (IDEA), a law ensuring services to children with disabilities throughout the nation (U.S. Department of Education, 2002a).

Individual Education Plan (IEP): An educational plan determined by a committee that encompasses an umbrella of mutually agreed upon list of services provided to assist a student in order to meet their maximum educational needs (TEA, 2010).

Multidisciplinary Team: A team of professional educators with various areas of expertise who evaluate, provide educational services for students with disabilities, and are responsible for specific program design and implementation.

Multiple Sclerosis: a chronic, typically progressive disease involving damage to the sheaths of nerve cells in the brain and spinal cord, whose symptoms may include numbness, impairment of speech and of muscular coordination, blurred vision, and severe fatigue (Merriam Webster 2019).

No Child Left Behind Act of 2001: A law which mandated schools to intensify their efforts to improve the quality of academic achievement of public schools and provision for schools that are failing to meet the requirements (No Child Left Behind Act of 2001, 2002).

Post Hospitalization: After a student gets released from the hospital.

Qualitative Case Study Design: Qualitative case study methodology provides tools for researchers to study complex phenomena within their contexts (Creswell & Clark, 2011).

Related Services: Services required for a student to benefit from special education. Related services may include transportation and supportive services such as speech, audiology, psychological services, physical and occupational therapy, and interpreters for persons with hearing impairments.

Section 504: A part of the Rehabilitation Act of 1973 that stands as the broad civil rights law designed to eliminate discrimination against any individual on the basis of his or her physical or mental impairment that substantially limits one or more major life activity or education program receiving federal financial assistance (IDEA, 2004).

Sickle Cell Disease: a chronic inherited anemia that occurs primarily in individuals of African, Mediterranean, or southwest Asian ancestry who are homozygous for the gene controlling hemoglobin S and that is characterized especially by episodic blocking of small blood vessels by sickle cells (Merriam Webster, 2019).

Special Education Services: An inclusive term under which required services are provided to students with disabilities free of charge and determined by an ARD committee (TEA, 2010).

Students with a Disability (SWD): A child who is determined by a school multidisciplinary eligibility team to have a disability according to state rules and regulations and who by reason of that disability requires special education and related services.

Transition Plan: A transition plan is the section of the Individualized Education Program (IEP) that outlines transition goals and services for the student. The transition plan is based on a high school student's individual needs, strengths, skills, and interests. Transition planning is used to identify and develop goals which need to be accomplished during the current school year to assist the student in meeting his post-high school goals (U.S. Department of Education, 2013).

Chapter 2: Review of Related Literature

A systematic review of the literature was conducted to better understand the study's major variables of interest. The literature review covers the following topics:

1) Long term illness and low graduation rates,

2) Lack of professional development,

3) Identifying improvements in the delivery of instruction,

4) Students with disabilities and their academic needs,

5) Related Issues in homebound instruction and service models,

6) Approaches addressing the needs and issues

7) IDEA, and Section 504, and 7) Summary.

In retrieving the literature, the following search engines, literature databases, and sites were utilized: EBSCO, ERIC-Education Resources Information Center, ProQuest, Google, and Google Scholar, SAGE, Clark Atlanta University, Georgia State University and Kennesaw State University Library.

Long Term Illness and Low Graduation Rates

Students with long term illnesses posted some of the lowest graduation rates. This problem has negatively impacted special education students who have transition plans, students with disabilities are more likely to experience unemployment or underemployment, lower pay, and job dissatisfaction (Dunn, 1996). Serious illnesses may cause even previously well-functioning children to have trouble returning to school. Physicians should discuss the likely

timeframe for returning at the time of diagnosis of any serious illness that requires school withdrawal. After the child returns to school, the physician should communicate with school personnel about the patient's needs and to ensure that the transition back to school is successful (Rollins, 2018). Children who frequently miss school for chronic illness reasons are at risk of low academic achievement, social problems, dropping out of school, non-enrollment in college, and related adult sequelae, such as lower income, frequent work absences, and even poorer health (Dunn, 1996). High levels of absenteeism as early as kindergarten are associated with long-term consequences, including low reading proficiency in third grade and low academic achievement in fifth grade, which correlate with lower rates of high school graduation and college enrollment. Frequent absences are associated with negative outcomes for children of all socioeconomic groups. However, absenteeism perpetuates economic and social disadvantages in children from lower socioeconomic backgrounds (Gottfried, MA 2014).

Secondary schools in today's society are faced with the challenge of increasing curricular rigor to strengthen the knowledge base of high school graduates, while at the same time increasing the proportion of all students who successfully complete a high school program. Reform advocates call for more effort devoted to linking schooling to the future, with an emphasis placed on high school graduates as skilled learners with the ability to continue their education and skills acquisition in college, technical school, or work-based programs.

High school students, who graduate in spite of having a critical illness, are less likely to enroll in community college than graduates without these health conditions and even less likely to enroll in 4-year college (Rosenbaum, 2018). Once in community college, students with health conditions were less likely to earn a credential. With few exceptions (i.e., recent hospitalization not for pregnancy, having any activity limitation that lasted more than a year), few health

conditions associated with lower educational attainments among community college students appear related to students' ability to complete coursework or attend class. Most health conditions that predicted lower educational attainments appear related to stigma and social integration, suggesting that Tinto's theory that social integration predicts college completion applies to community colleges in addition to 4-year colleges.

Lack of Professional Development

Patterson and Petit (2008) identified a lack of training designed to prepare service providers in the delivery of homebound instruction. Approximately one-fourth of the respondents indicated that districts provided them with training, while less than 20% indicated that they received training from teacher preparation programs, or from professional development opportunities such as conferences or workshops. The results indicated that the majority of these service providers delivered services without benefit of having received any form of direct training concerning homebound services. This not only jeopardized students' learning but also resulted in litigation. According to this the majority of service providers delivered services without benefit of having received any form of direct training concerning hhb services.

This publication also found that a majority of school districts do not appear to have written protocols available in the form of documented procedures, guidelines, handbooks, or manuals. Up until this point, nothing has been done to address these issues. In an effort to address these key issues, schools could provide teachers with more training in the areas of instructional delivery. The bottom-line goal of the hhb program is to help students maintain their educational performance while confined at home or the hospital. Teachers play a critical role in providing quality instruction in flexible ways to meet the individual students' needs. HHB

instruction can present many challenges for teachers. Teachers are frequently not prepared to provide such services. Few teacher preparation programs failed to address the issue, and much of the available literature on hhb instruction came from the field of early childhood special education (Klass, 1996). In addition, school districts may not have specific guidelines for their teachers on providing homebound services (Daly-Rooney & Denny, 1991). As an educator we are responsible to accommodate students who are homebound and hospitalized. Whether suffering from life-threatening illnesses or temporarily sidelined by an injury, students do not need the extra burdens of becoming “disconnected” from their academic programs.

Unfortunately, to meet the needs of students who are homebound, hospitalized or in treatment, most districts do not have the proper training this population requires. Smaller districts do not have a formal program and rely solely on itinerant teachers. By law most districts are providing only two to five-hour blocks of instruction once or twice a week.

A few hours of tutoring a week are not justifiable for 30 hours a week of instructional time. As a result, students often lose momentum and have difficulty re-engaging when they return to school. Educating middle and high school students is particularly challenging in traditional hospital and hhb programs as these students need their lessons delivered by content area teachers. As a special education teacher, I seek ways to provide a nurturing and success-focused instructional bridge for those students who must be out of the classroom for medical or related issues.

Salend and Duhaney (1995) suggested that the concept of inclusive education educating all learners together in regular classrooms under the leadership of the classroom teacher has evolved. Teachers are viewed upon as the change agents of society entrusted with the task of educating all learners, not only those who learn but also those who learn with the challenges of

being disabled. I have experienced learners who have disabilities, restricted access to the common curriculum and have witnessed their struggles amongst the disabled. This theory served what students with disabilities go through on a daily basis. Reindal (2009), stated that students experiencing disabilities were considered able to remain in regular classrooms on a full-time basis, especially if they were placed in an inclusive setting and were able to cope academically.

Professional development opportunities for teachers would help to aide in this area. One critical consideration of educating students with special needs should be identifying improvements in the delivery of instruction and related services. The transition post-hospitalization can be particularly challenging. As a result, many schools may not have access to important information from hospital stays, and may lack communication from the hospital team about utilizing best practices upon the students return to school. Many districts lack proper protocols. School districts are following different protocols and hospital providers may often wonder who the appropriate person(s) is to communicate important information. As a result, schools are becoming increasingly frustrated by HIPPA regulations (Walters, 2018). Hospitals struggle with understanding differences in educational terminology — for example, the difference between accommodations that can be provided within a classroom versus special education eligibility.

Identifying Improvements in the Delivery of Instruction

One critical consideration of educating students with special needs should be identifying improvements in the delivery of instruction and related services. HHB services are legally recognized placement alternatives; they are identified on the continuum of service options, which are addressed within the Individuals with Disabilities Education Improvement Act (IDEA) of 2004 (U.S. Department of Education, 2013). As of today, little has been done in the past by

addressing key issues that surround ensuring a successful transition post-hospitalization for hospital home bound children (Krumholz, 2013). It is important that families, facilities, and schools work together to create a transition plan for students that is supportive of both medical and emotional needs, anticipates challenges, and possibly create a path for student success. Few districts that have adopted plans for individual students and structured each plan tailored to the needs to the individual student. Over the course of my experience, I have witnessed student-patients nervous and anxious not only about integrating back into school, but also nervous about their destiny to finish high school.

To date there have been limited supportive environments that have been created to prepare staff for the student's return as well. Teachers and other support personnel have received limited training on how to handle such transitions and will require guidance on including students in lieu of their absence. Meetings have taken place for staff regarding hospital home bound students so they can have smooth transitions back to school after a hospital stay. These meetings are labeled as transition meetings. What can be done to address these issues? With proper planning and a collaborative approach, the transition from hospital to school can be supportive, encouraging, and successful, rather than overwhelming and stressful. By approaching the transition as a team, both the students and the schools can feel prepared for the tasks that may potentially lie ahead for them.

A potential area of improvement is within the rate, frequency, and duration of homebound services that are delivered. For example, if a student who has Multiple Sclerosis is only receiving 2 service hours daily, he or she may be significantly lacking quality instruction on subject areas they may need significant assistance. These areas include Math and Reading. The North Carolina Association for the Education of Chronically Ill Children (NCAECIC, 2009)

polled a list of southern states and determined that weekly instruction was frequently the requirement, but there was a wide range in the number of weekly instructional hours provided. Increasing service hours for this population could definitely positively impact this program overall.

Additionally, service providers need to hold the appropriate level of certification when it comes to teaching this special population. The state of Georgia should indicate the appropriate type of certification that is required to provide homebound instruction (Lustig, 2009). The majority of service providers are special education teachers, speech, and language pathologists, physical or occupational therapists, but any certified general education teacher can provide services as well (Patterson & Petit, 2008). Service providers may be unprepared to deliver hhb instruction.

For example, if a student is receiving instruction in the subject area of Algebra II from a speech pathologist, that teacher may have difficulty delivering the lesson effectively to the student. Service providers may not receive any direction, “Once selected, service providers may have little direction with regards to delivering or documenting instruction, collecting appropriate data and collaborating with the classroom teacher or parents” (Lustig, 2009, p.4). With the expanded criteria of IDEIA 2004 comes the potential increase in use, however, the practices concerning homebound instruction may not have experienced a change or improvement in the way they are delivered.

Approaches Addressing the Needs and Issues/Transition Plans

Flexer and Baer (2013) and Wehman (2006) recommended a number of best practices in the field of transition to improve postschool outcomes for youth with intellectual disabilities.

This particular study analyzed data from the National Longitudinal Transition Study-2 to examine whether best practices are predictive of postschool outcomes. The combination of five best practices were found to significantly predict employment, postsecondary education, and enjoyment of life outcomes after controlling for characteristics. In these analyses, parent expectations for employment and postsecondary education were some of the strongest predictors of postschool success. Although this study had several limitations, these findings suggest that best practices may be predictive of postschool success and highlight the importance of having high expectations for all youth. Transition services are the responsibility of P–12 schools with reports on plan quality submitted annually to the federal government (National Secondary Transition Technical Assistance Center, 2012a, 2012b).

The term "transition services" means a coordinated set of activities for a child with a disability that (A) is designed to be within a results-oriented process that is focused on improving the academic and functional achievement of the child with a disability to facilitate the child's movement from school to post-school activities, including post-secondary education, vocational education, integrated employment (including supported employment), continuing and adult education, adult services, independent living, or community participation; (B) is based upon the individual child's needs, taking into account the child's strengths, preferences and interests; and (C) included instruction, related services, community experiences, the development of employment and other post-school adult living objectives, and, when appropriate, acquisition of daily living skills and functional vocational evaluation (Section 602(a) [20 U.S.C. 1401(a)]).

In 1990, as a result of the growing recognition of post-high school service gaps, the Individuals with Disabilities Education Act (IDEA) required a transition plan to be developed as part of each student's IEP, beginning at age 16 or younger, if appropriate. This plan was to

identify activities and services leading to the achievement of desired outcomes for employment and post school training based on students' needs, preferences, and interests (20 U.S.C. 1401 [19]). Transition services included not only instruction but also community experiences, employment, post school objectives, daily living skills and functional vocational services.

The frequently limited experiences that students with disabilities have with occupationally relevant tasks may render standardized vocational assessments invalid, which is an important specialized needs and potential additional challenges of HHB students suggest the complexity, as well as the importance, of assembling an accurate and comprehensive transition profile. This should include information on medical history, as well as educational background and successes, career development experiences, independent living skills, and self-determination abilities (Flexer et al., 2013; Luft, 2000). Criterion and industry-standard assessments also are important in making certain that a student has the abilities to meet work expectations or to qualify for certificates and licenses.

Szymanski and Hershenson (2005) discussed standardized tests that applied to special populations and validity; however, their normative comparisons showed that confirming skill and ability levels are equally important and required in postsecondary or employment settings and ultimately, will allow students to be successful. Some standardized vocational assessments examined the match between individual skills and abilities, aptitudes, work values, and attitudes in conjunction with work demands and expectations of the employment site, which may be helpful in determining career-choice suitability.

Transition assessment should be comprehensive, addressing a broad range of domains relevant to an array of post school activities. This focus contrasts with traditional forms of

educational assessment that often address discrete skill areas (e.g., reading fluency, math computation, and social skills). For youth with Emotional Behavior Disorders and Learning Disabilities, however, secondary education has traditionally focused more narrowly on addressing social-behavioral challenges of academic needs, with less attention given to the broader spectrum of skills, knowledge, experiences, and linkages youth may need after leaving high school.

Finding accurate and disability-appropriate assessments for hhb students is extremely challenging. The academic, vocational and career choice, and living skill assessments, which so many transition plans and evaluations of their success depend on, may not be either valid or reliable for this population. Observational, ecological, functional, and situational evidence of abilities not otherwise identified on typical assessments may provide some of the more authentic and accurate transition-planning data. Transition assessments should incorporate not only work and postsecondary training environments but also apartments and neighborhood amenities, including the appropriate use of stores and services, transportation, or parking/garage services if the student has a car and a driver's license, and other related adult environments. The team needs to consider the impact of disability and appropriate accommodations in different environments, including uses that may differ from what has been successful in school-based settings.

The National Association of State Directors of Special Education (2008) recommended that educators be knowledgeable about assistive devices and appropriate technology for their students, although this can be difficult, given the rate of innovation and improvement in the past few decades. Otherwise, it should not be assumed that hhb students will leave high school knowing the supports and services they need and how to request or access them or troubleshoot related issues (Luft et al., 2009). Students also may be unaware of the different alerting devices

that allow them to live safely and independently, including alarm clocks, doorbells, and smoke detectors.

The study by Carter et al. (2009) implemented a model that was used regularly. This was known as the Transition Planning Inventory. It was used widely in schools, regularly advocated in the assessment literature with the formal tool most frequently recommended by state education agencies. The hope was to find findings that would be directly applicable to practitioners and would provide immediately useful information to study participants. As a formal, comprehensive assessment tool, the TPI can be used to gather information from multiple stakeholders about multiple domains, providing data-driven information to inform transition plan development. The TPI is a 46-item standardized assessment tool used to obtain information about students' transition-related knowledge, behavior, and skills from the perspectives of school staff, family members, and students.

HHB are legally recognized placement alternatives; they are identified on the continuum of service options, which are addressed within the Individuals with Disabilities Education Improvement Act (IDEA) of 2004 (U.S. Department of Education, 2013). The articles addressed areas for professional development opportunities for teachers that should help to aide in quality instruction and related services for students who are homebound. After reading and critiquing these articles I found that there were still missing key information on what has been done as a result of these issues listed above.

Past and current research does not show what happens when students return back into the school setting after being on homebound instruction and looking at teacher's preparedness to implement their transition plan. Transition is a process that can take place over time, and does

not happen with just student and teachers, but takes a look at medical staff as a whole to ensure that students are successful throughout so there are no gaps of instruction missed. There are gaps in teacher perspectives as it relates to training and past research touched on teacher training with homebound students. As a result, I am unsure what current trends teachers are utilizing when addressing this population. Training documents, such as written protocols, handbooks, and manuals are simply outdated.

There is a significant body of literature that described and evaluated hospital-to-school transition programs (Falvo, 2005). Most program descriptions prepared the child with chronic illness, family, peers, and school personnel for transition back to a school environment after an extended hospital stay (e.g., Bessell, 2001; Case & Matthews, 1983; Prevatt et al., 2000; Sexson & Madan-Swain, 1993; Thies, 1999). Recent trends in health care service delivery and education systems signaled a change in the approach to facilitating hospital-to-school transitions for children with chronic illnesses (Blank & Burau, 2004) and with the evolution of medical care signals that the field of education must change too. Children with chronic illness have a variety of academic requirements that they must fulfill, and they cannot do so because of their disease or condition. Their ability to successfully reintegrate into the school setting relies on careful planning of the multidisciplinary team (including medical and school personnel and the child's parents), with attention to the specific academic requirements of the child. There may be cognitive or related side effects caused by treatment of the illness (including difficulties in attention, memory, and processing speed), such as the cognitive sequelae caused from certain chemotherapy regimens and leukemia treatments (Kretz & McCabe, 2003).

ADA, IDEA and Section 504

For a student to be considered homebound simply means that the student must exhibit some type of disability that would require students to be out of school (e.g., sickness, injury, illness); thus, entitling such students to special protections under certain laws. This is regardless of whether the student is located in the general education or special education settings. Special education services under the hhb umbrella means that their disability will be protected by one or more of three specific laws, namely, the Americans with Disabilities Act of 1990 (ADA), the Individuals with Disabilities Education Act (IDEA), and Section 504 of the Rehabilitation Act of 1973 (Henderson, 2015). The ADA is a civil rights law designed to prohibit discrimination solely on the basis of a disability in employment, public service, public education, and accommodations (Henderson, 2015).

On December 3, 2004, IDEA was amended and reauthorized as the Individuals with Disabilities Education Improvement Act of 2004, which is known as IDEA 2004 (Wright 2007). IDEA is to provide federal financial assistance to state and local education agencies to guarantee special education and related services to eligible individuals between kinder and 21 years old who are determined by a multidisciplinary team to be eligible within one or more of 13 specific disability categories and who need special education services (Henderson, 2015). IDEA requires states to form and establish goals for performance of children with disabilities that are consistent with the goals and standards for nondisabled children (Individuals with Disabilities Education Improvement Act, 2004). Under this Act, all states are required to improve the graduation rates and dropout rates, and to report the progress of children with disabilities on state and district assessment.

After the reauthorization of the IDEA of 2004, Congress placed an increased focus on accountability and improved outcomes by emphasizing reading, mathematics, early intervention,

and research-based instructional techniques, requiring all special education teachers be highly qualified and meet certification requirements (Wright & Wright, 2007). The primary purpose of the Individuals with Disabilities Education Improvement Act of 2004 was to provide an education that meets child's unique needs and prepares the child for further education, employment, and independent living, followed by protecting the rights of both children with disabilities and their parents (Individuals with Disabilities Education Improvement Act, 2004). Under Special Education Homebound law, hhb students are qualified for educational services to be provided at home, hospital, or public-school setting, depending on each individual case. Under Section 504 of the Rehabilitation Act of 1973, qualified individuals are protected from discrimination based on disability (U.S. Department of Health and Human Services, 2014). To date, Section 504 addresses protections for students with disabilities and ensure students with disabilities are protected through due process.

The nondiscrimination requirements of the law apply to employers and organizations that receive financial assistance from any federal department or agency, including the U.S. Department of Health and Human Services (DHHS). Section 504 is a broad civil right law that protects the rights of individuals with disabilities in programs and activities that receive financial support from the U.S. Department of Education (U.S. Department of Education, 2014). Section 504 mandates that a team of knowledgeable participants develop an individual accommodation plan for a qualified student. Elements of an individual accommodation plan may include the provision for medical homebound instruction. There are students with disabilities that do not receive services under IDEA, but are served under Section 504 of the Rehabilitation Act of 1973. This statute does not require the federal government to provide additional funding for students identified with special needs (DeBettencourt, 2015). The major differences between IDEA and

Section 504 are in the flexibility of the procedures. For a child to be identified as eligible for services under Section 504, there are less specific procedural criteria that govern the requirements of the school personnel. Schools may offer a student less assistance and monitoring with Section 504, because there are fewer regulations by the federal government to instruct them, especially in terms of compliance.

Students who receive the general education services (educated without special education support) are also protected under the Americans with Disabilities Act. Students receiving the special education services are protected by IDEA. Individuals covered under IDEA can be viewed at as having more protection federally versus an individual who received services under 504 accommodations.

Summary of Literature

The literature review included the distinction between the two types of homebound instruction and the criteria used to assign the eligible students into the appropriate setting. This is an important piece on how students are served in the hhb setting. With the publication of low graduation rates of medically ill children showed that this population posted some of the lowest graduation rates. This problem has negatively impacted special education students who have transition plans because, compared to their non-disabled peers, students with disabilities are more likely to experience unemployment or underemployment, lower pay, and job dissatisfaction (April 4, 2017). In identifying improvements in the delivery of instruction, identifying improvements in the delivery of instruction and related services are extremely important. Homebound services are legally recognized placement alternatives; they are identified on the continuum of service options, which are addressed within the IDEA of 2004 (U.S. Department of

Education, 2013). As of today, little has been done in the past by addressing the issues that surround ensuring a successful transition post-hospitalization for hospital home bound children (Krumholz, 2013). It is important that families, facilities, and schools work together to create a plan for students that is supportive of both medical and emotional needs, anticipates challenges, and sets the student (and school) up for success.

As previously mentioned in the previous paragraph, for a student to be considered homebound simply means that the student must exhibit some type of disability that would require them to be out of school (e.g., sickness, injury, illness); thus, entitling such students to special protections under certain laws. Districts deliver traditional practices for homebound education. I addressed the changing educational shifts that occurred when responding to this populations needs. I looked to see if there were any technology devices that could be used by homebound students to help get students back on track while they were away at the hospital. There are assistive technology devices that would be able to provide homebound students. I researched how assistive technology aids in instruction. As educators we tend develop a "comfort zone" in our course structure and teaching style and consider enhancements mostly in the content area. Our students deserve better, and as practitioners, we should know how respond. This study will help educators share areas of improvements and aid in utilizing best practices for servicing this unique and overlooked population of students.

In conclusion, the review of the literature showed that homebound instruction is a key component to overall teaching and learning. It has many components that rely on one another for the program to be successful. It is up to school stakeholders to play their role(s) in ensuring that this special population will not be left behind.

Chapter 3: Methodology

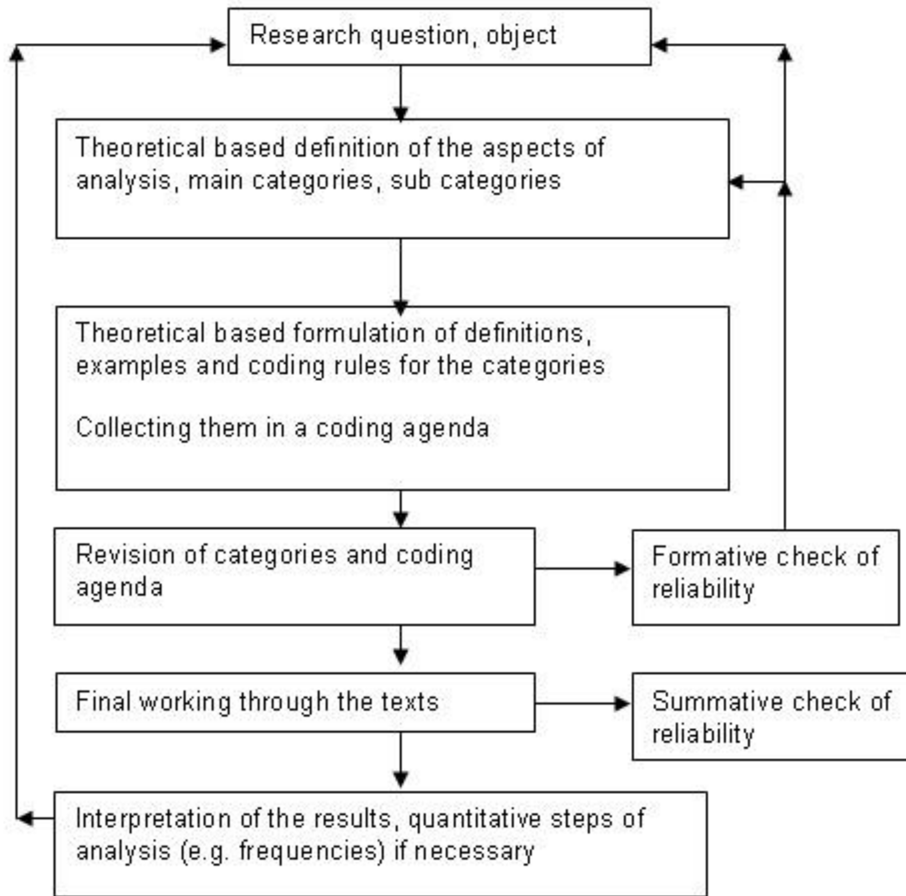
Research Design

Due to the lack of research regarding how teachers are prepared to implement transition plans post hospitalization for hospital hhb students, a qualitative case study was utilized. The qualitative case study approach is appropriate as Gaya and Smith (2016) explained that case studies are appropriate where “investigators adopt the research design to understand a real-life phenomenon under important natural conditions that are relevant to the occurrence under investigation” (p. 532). A qualitative case study allowed me to gather and analyze students’ needs that addressed their medical conditions.

The qualitative case study design is an in-depth analysis of people, events, and relationships, bounded by some unifying factor (Baxter & Jack, 2008). With my given topic, important aspects include not only the hospital homebound teachers, students, and staffs’ behaviors/views on the overall program, but also the perceptions of those who interact with this population of students, the context of the program, outside constituents, comparisons to other homebound programs, and other qualitative variables. Figure 2 illustrates the steps in a qualitative case study design model.

Figure 2

A qualitative case study design



Note: Step model of deductive category application" (Source: MAYRING, 2000a, [14]). According to MAYRING (2000a, [15]; 2001, [15]) the main idea here is to give explicit definitions, examples and coding rules for each deductive category, determining exactly under what circumstances a text passage can be coded with a category. Finally, those category definitions are put together within a coding agenda.

The primary purpose of the study was to bring awareness of what happens during the transition post-hospitalization of a hhb student and their academic success. In addition, the study was designed to take a close look into students who were in grades 9-12 and investigate to see if

their transition plans were carried out effectively post hospitalization. This chapter describes the methods that were utilized for this study. This includes the design, subject selection, instrumentation, data collection, and data analysis. The data-based study was guided by the following research questions:

1. What are the needs of hospital home bound students?

2. What are the needs of hospital homebound teachers?

3. What support can be provided to hospital homebound teachers to ensure that hospital homebound students are effective academically?

Data Collection

The participants of this study included the following individuals: 3 hospital home-bound students currently receiving services, 1 504 director over a local school district, 3 special education teachers, 1 lead teacher over special education, and 3 hospital home bound teachers. The participants were selected randomly. Majority of the participants were located from two high schools in a southeastern area of the United States. They were all invited to participate in the interview process, and all voluntarily accepted the invitations. Permission to conduct the interviews was obtained from the school district and the Institutional Review Board at Kennesaw State University. In order for the teachers to participate in the study, they were required to sign a consent form. Documents are included in Appendix A. In this study, I collected interviews, observations, and documentation.

The qualitative component of the study utilized interviews, observations, and documentations. Creswell (2007) suggested that the topics about which researchers write are emotion-laden, close to the people, and practical. Researchers ask open-ended questions, wanting

to listen to the participants they are studying and shaped the questions after they explore, and refrain from assuming the role of the expert researcher with the best questions. Interviews, observations, and documents are the backbone of qualitative research. Creswell (2007) also suggests that qualitative research is complex, involving fieldwork for prolonged periods of time, collecting words and pictures, analyzing this information inductively while focusing on participant views, and writing about the process using expressive and persuasive language. I chose this specific design so that I could engage in research and examine the different ways to explore a topic and reach audiences receptive to qualitative approaches.

I reached out to the participants via phone or email and set up the interview dates/times. Once I received the confirmation for the date and time of the interviews, I went out to the school sites prior to COVID.

After the pandemic, I set up Zoom meetings and finalized the particulars with a follow-up email. All participants were asked to sign a consent form. With their permission I asked them a total of ten questions that included information on daily responsibilities, tasks, and happenings of caring for a student with chronic illnesses. This information can be located in Appendix E. The answers from the interviews helped me to gain feedback on hhb services as it directly related to their schools. Participants could decline answers if they felt the need to. The interviews were all recorded to help aid in accurately taking notes. All names were confidential.

The information collected was from all participants listed in the study that included 11 participants. The qualitative results were made to formulate the following lead questions/statements:

1) First, I would like to know what are your thoughts that come to mind regarding hospital homebound education?

2) Can you talk about what a day is like for you when you are servicing your student(s)?

3.) How do you make decisions in terms of instruction as it relates to your students?

4.) Do you communicate with the general education teachers regularly? How do you communicate with them? Are they compliant with your requests?

5.) What would you tell other potential families about hospital home bound services regarding instruction?

6.) Does the school do a good job transitioning your student back into the schoolhouse after hospitalization? What could they do better?

7.) Do you feel that the needs and services are being met with the hospital homebound students effectively?

8.) Can you describe what a day is like for you when you are teaching your students?

9.) Are you a certified teacher? If so what areas?

I observed homebound teachers and students during lessons. I was able to look to see how teachers were engaging with their students. Student disabilities included Traumatic brain injury and Schizophrenia. I was able to look and see what materials were given, and looked for facial expressions such as frustration, verbal cues, and happiness.

Participant observation allows researchers to check definitions of terms that participants use in interviews, observe events that informants may be unable or unwilling to share when doing so would be impolitic, impolite, or insensitive, and observe situations informants have described in interviews, thereby making participants aware of distortions or inaccuracies in description provided by those informants (Marshall & Rossman, 1995). Through the use of observations, participants are allowed to develop a holistic understanding of the phenomena

under study that is as objective and accurate as possible given the limitations of the method (DeWalt &DeWalt, 2002).

The observations that I performed were kept short with participants and lasted no more than 30 minutes in total. I paid close attention to the overall detail of activity. I recorded the details and listened carefully to conversations, trying to remember as many verbatim conversations, nonverbal expressions, and gestures as possible. I created an observation record that helped to assist me in accurate data counts, and this information was categorized into themes and coded.

Participants

Table 1

Demographics of Student Participants

Name	School	Grade	Diagnosis
Jane Doe 1	Flower Child High School	10	Traumatic Brain Injury
Jane Doe 2	Hope High School	9	Would not disclose
Jane Doe 3	ABC High School	11	Schizophrenia

Table 1 shows all of the hhb students who participated in the study and their respective grade levels. Each student disclosed their disabilities with the exception of one.

Table 2

Participants Demographics

Name	Subject	Years	Highest level of education	Certification
Jane Doe 1	District Level Administrative	22	Ph.D.	L-7
Jane Doe 2	Interrelated	21	Ph.D.	L-7
Jane Doe 3	Interrelated	15	EdS	T-6
Jane Doe 4	Interrelated and English	15	EdS	T-6
Jane Doe 5	Interrelated	12	Masters	T-5
Ron Doe 6	Interrelated	5	Masters	T-5
Jane Doe 7	Interrelated	11	Bachelors	T-4

Table 2 shows all of the hhb stakeholders who participated in this study and their certification levels. Additionally, their years in the profession along with their highest degree held is shown. Please note that a T certification level reflects a renewable teaching certification and an L certification level reflects a leadership certification.

Data Analysis

At the conclusion of the interviews, the transcripts were coded, categorized, and analyzed. The interviews and observations were transcribed, coded, and categorized into identifiable themes. Theme identification is one of the most fundamental and mysterious techniques of qualitative research (Bernard, 2000). Qualitative analysis begins with coding the data, dividing the text into small units (e.g., phrases, sentences, and paragraphs), and assigning of labels to each different unit (Creswell & Clark, 2007). For the purposes of this study, I used content analysis to identify key themes in texts that allowed me to code throughout my data analysis. The themes that I implemented were the following: Teacher perspectives, Social Considerations, Emotional Considerations, and Academic Considerations. This data were then coded and organized from the scripts of the interviews. After the interviews were transcribed, data were analyzed utilizing open, axial, and selective coding. The following sections describe the data analysis.

Strauss and Corbin (1990) defined open coding as the interpretive process by which data are broken down analytically. Its purpose is to give the analyst new insights by breaking through standard ways of thinking about or interpreting phenomena reflected in the data. Data was transformed into small segments. I was able to examine and read through qualitative data (such as transcripts from interviews) and analytically break it up into discrete, bite-sized pieces of data. The data was then coded and given a descriptive label. Based on the descriptive labels, data was grouped into the same subjects with the same codes. Data were analyzed as interviews and data collection continued utilizing open coding. Once categories were formed, segments of data were reviewed and placed under the categories that best fit the description.

In axial coding categories are related to their subcategories, and the relationships tested against data (Strauss & Corbin,1990). After data was analyzed and taken apart, relationships were found through connections between codes. The axial coding strategy employed here sought to identify and make explicit the connections between concepts and categories. Strauss (1987) pioneered axial coding and suggested the strategy involving first laying out the properties of the category, mainly by explicitly or implicitly dimensionalizing it. Second, the analyst hypothesizes about and increasingly can specify varieties of conditions and consequences, interactions, strategies, and consequences that are associated with the appearance of the phenomenon referenced to by the category. Third, the latter becomes increasingly related to other categories.

Selective coding is the process by which all categories are unified around a "core" category, and categories that need further explication are filled-in with descriptive detail (Strauss & Corbin 1990). This type of coding occurs in the later phases of a study. The core category represents the central phenomenon of the study. Relationships established between

categories in selective coding are similar to axial coding. Establishing relationships was necessary in order to attain verification of categories developed in data analysis. This process increased the ability for the developing categories to be grounded in the data and increased the validity or credibility of the study.

Credibility is the equivalent of internal validity in quantitative research and is concerned with the aspect of truth-value (Korstjens & Moser, 2018). Strategies to ensure credibility are prolonged engagement, persistent observation, triangulation, and member check. The following steps were taken to ensure credibility: (a) triangulation, (b) persistent observation, and, (c) member checks. Descriptions of these strategies are provided in the following paragraphs. One step utilized was the process of triangulation. Triangulation has been defined as the utilization of various sources of data collection by the researcher to assure consistency in data received (Mertens & Laughlin, 1995; Patton, 1990). Methodological triangulation was used by gathering data by means of different data collection methods such as in-depth interviews, discussions after interviews, and documentation.

Prolonged engagement was utilized in this study. Several distinct questions were asked regarding topics related to mastery. Participants were encouraged to support their statements with examples, and the interviewer asked follow-up questions. The data was studied and compared until a theory emerged to provide them with the scope of the phenomenon under study. Over the course of an entire year, I was able to build trust with all the participants. With added trust, the participants felt more connected to me. The results produced were deemed more credible due to established relationships.

Persistent observation was utilized in the study. While the codes were being developed, the concepts and the core category helped to examine the characteristics of the data. The data

was heavily scrutinized and analyzed. In addition, the concepts were revised accordingly. If codes needed to be recoded and re-labelled, they were to provide depth of insight. The research was analyzed deep enough so that I could focus on the most relevant aspects.

All participants were allowed to check their interviews. All transcripts of the interviews were sent to the participants for feedback. Recorded interviews were utilized to check the validity of data collected in each method. This process has been referred to as peer debriefing (Mertens & Laughlin, 1995). The process of member checks also was utilized to ensure the data accurately reflect the informants' perspectives. In addition, virtual meetings were held with those who had participated in the interviews, enabling them to correct the interpretation and challenge what they perceived to be ‘wrong’ interpretations. Finally, participants were given opportunities to review transcripts of data collected for accuracy after initial interview sessions.

Transferability concerns the aspect of applicability (Korstjens & Moser, 2018). Researchers suggest that the responsibility of transferability be placed on the reader of the study (Mertens & Laughlin, 1995). To assist in increasing the transferability of the study, the researcher has enabled the reader to assess whether the findings are transferable to their own setting. Methods to confirm that data collected were dependable or reliable included providing detailed description of procedure and data collection process. For the purposes of the study, the coding process were documented as data emerges. Categories were developed based on incidents that were repeatedly presented, thus increasing the significance that the concepts presented in the theory are grounded in the data (Strauss & Corbin, 1990).

Chapter 4: Findings and Discussion

The focus of the study was to (a) examine the needs of hospital home bound students, (b) examine the needs of hospital homebound teachers, and (c) explore what supports can be provided to hospital homebound teachers to ensure that hospital homebound students are effective. While conducting my research I was able to gain a deeper understanding of what exactly students who were being serviced in this program needed. From the three interviews that I conducted, I was able to conclude that the need for support was overwhelming for this population.

Using the data from interview, observation and documentation, the three research questions were address as following:

Question 1: What are the needs of hospital home bound students?

Emotional Needs

A fifteen-year-old girl who was a part of my case study and a student at a residential facility shared with me her need for emotional stability in her life. This student is in ninth grade and only gets the chance to see her parents twice a month due to the severity of her disability. She aspires to be an artist one day. During the interview, she referenced being on two different anxiety medications to cope with her depression. Additionally, she stated she has more bad days than good days. Throughout this interview she stated that, "On a good day, I think happy thoughts," and that she is waiting on a journal to write down her thoughts.

This can serve to be true for a student like herself, having emotional instability and especially true for a student who has an IEP. An IEP can include emotional supports. This student was so disassociated with her well-being she did not even know she had an IEP. She

asked her teacher what an IEP was. IEPs typically outline emotional support and goals in a "social/emotional" section. Providing homebound instruction to students with emotional or behavioral disorders can be a particularly demanding experience. This population of students can display a wide range of challenging behaviors, from apathy to defiance (Kerr & Nelson, 2002). Undesirable behaviors that are evident in school and community settings can be even more intense in the home. Teachers should plan on using their full repertoire of behavioral interventions, which could include identifying and avoiding the triggering of undesirable behaviors, the use of token economy systems, behavioral contracts, the calculated use of verbal praise, and working on tasks in small increments of time. When I interviewed a 16-year-old male who has been in the program since he was in middle school, he shared with me that he had given up and really does not know why his mother has him in this program. He had given up on his dreams of becoming a fashion designer. With Traumatic Brain Injury, many times students are non-verbal. This student utilized the chat feature on Zoom to communicate everything. In what was supposed to be an hour-long session, ended up being a session broken up into three different sessions, due to him closing his laptop and becoming discouraged. This student is a child of seven siblings. Though his homebound teacher did a fine job of encouraging him along the way, it was not enough to keep him engaged in what seemed like a high engagement lesson. This student additionally shared with me through the chat that he has not been receiving services since last year due to COVID and was behind. He would never catch up in his eyes.

The student began to utilize the chat feature all throughout the lesson and began typing away, This program sucks!" "I ain't going to college anyway", and "I will just go on google to help me", "Nobody cares and that is on my momma!" It was heartbreaking to hear his frustrations with the program.

Parental Support

The parents of these children are experiencing a trauma of their own. All of the children interviewed had multiple siblings. This can be a lot to manage as a parent. Not to mention the healthcare plans for home-bound children. While speaking to a school counselor colleague, she mentioned that a percentage of parents are not familiar with their children's medical plan that the schools have on file. This is extremely important for a school. Parents of children with chronic illnesses experience tremendous burden when caring for their children at home. There are many challenges that are present throughout the course of chronic illnesses. Parents may struggle to manage their child's health and their own emotions, contributing to poorer health outcomes for the family. The increase in outpatient services puts enormous burdens on families. Multidisciplinary teams can help make challenging programming issues (e.g., homebound instruction) more seamless, coordinated, and less burdensome to parents.

Academic Needs

Compared with students without chronic illness, students with chronic illness have significantly greater school-based needs. Students with chronic illness are underperforming academically and missing significantly more school than students without chronic illness. Of all the students that were a part of this study, all students have missed over 20 days of school due to illness. Past research suggests that missing 10% or more of school constitutes absenteeism-related educational risk (Hancock et al., 2013). Indeed, the incidence of school refusal among children who are chronically ill is up to five times greater than the rate among the general population (Shiu, 2001). Under these circumstances, homebound instruction may be necessary until sufficient gains in academic development and/or medical treatment have transpired.

Social Needs

School psychologists have been strongly implicated in the educational care of students with chronic illness (Kaffenberger, 2006; McLoone et al., 2011). School psychologists may apply their knowledge of the health and education systems by facilitating communication between students and their family, health care team, and teachers. School psychologists may also be well equipped to inform teachers about the cognitive, social, and emotional implications of chronic illness and how they may manifest in the school environment (Barraclough & Machek, 2010). However, school psychologists may not receive adequate training nor feel equipped with the time, skills, or resources required to effectively manage the socioemotional wellbeing and cognitive needs of students with chronic illness (Kaffenberger, 2006). All of the students that I interviewed for this study have experienced some form of significant social and emotional stress that have impaired their performance at school, as well as their physical and mental health. School psychologists can offer practical support to students with chronic illness, such as by managing communication between the hospital and school, training teachers on delivering evidence-based support and monitoring students' health and wellbeing (Kaffenberger, 2006; McLoone et al., 2011; Shaw et al., 2010).

School psychologists can offer practical support to students with chronic illness, such as by managing communication between the hospital and school, training teachers on delivering evidence-based support and monitoring students' health and wellbeing (Kaffenberger 2006). Chief among these difficulties are increased behavior problems, especially internalizing problems such as depression and withdrawal (Boekaerts & Roder, 1999); impulsivity and anger control problems related to poor problem-solving skills in relationships (Clark et al., 1999) increased suicidal behavior (Tate et al., 1997); social rejection, perhaps due to misconceptions among peers regarding the illness and its contagiousness (Sexson & Madan-Swain, 1993); and

anxiety over physical changes and appearance related to the child's body image and fear of peer rejection (Sexon,1993). Poor peer relationships are associated with further stress as frequent absences disrupt friendship formations, reduce opportunity for social support, and make children with chronic illness increasingly vulnerable to other life stressors or secondary illnesses (Shiu, 2001). Peer rejection is associated with increased school absenteeism, which further complicates the problem.

Medical Needs

Children with chronic conditions are particularly vulnerable, given their extensive needs for health and related services (Davidoff et al.,2003; Szilagyi et al. 2003; Mayer et al., 2004). When needed services are not received, children and their families often suffer consequences including poor health, secondary disabilities, or unnecessary limitations in daily activities.

Current school supports do not appear to be meeting the diverse school-based needs of students with chronic illness. Commitment is needed from educators to complete training and from schools and governments to establish policies to guide the implementation of evidence-based support within schools.

Question 2: What are the needs of hospital homebound teachers?

Instructional Needs

A 20-year veteran special education teacher as well as a hhb teacher of a city in south eastern United States shared her challenges with me in this study. She claimed: "Scheduling issues are a trip, and 3 hours a week is not enough time to remediate students!" As she began to open up more about what a day looked like for her, she described it as being a hamster on a wheel. Her frustrations were felt through the Zoom interview. She is a teacher who gives her all

and really wants her students to gain knowledge of the content. Because the hours of instruction provided to hhb students usually do not match the instructional hours provided to students in traditional settings, those receiving homebound instruction are frequently given extensive homework assignments. This homework should be at the student's level, reinforce concepts and skills addressed during lessons, and be able to be completed within a reasonable period of time. In this past year, I have seen this working the complete opposite. Students are being swamped with trying to play catch up. Although the intent of hhb services is to provide services to students, and not to spy on family lifestyles, staff may witness unusual situations, such as child abuse or neglect. In such cases, they should be aware of reporting procedures.

Just like in the classroom environment, the goal for hhb students should be to personalize instruction to each individual's needs. However, the instructional needs of students receiving homebound instruction can be quite broad. HHB teachers need to be able to support students on IEPs, support students requiring AP-level instruction, and support students' social and emotional needs—as well as be able to cover a wide array of content.

Training Needs

Training needs for staff are a consistent challenge with this population of students. After an interview with the local 504 director, she enlightened me with her daily challenges as a leader in her school district. She began to speak to me with the challenges of training staff to provide services to hhb students. This participant stated, "we have an issue of non-certified staff providing services to hhb students". She also stated that her goal as a district leader was to ensure students are in the least restricted environment. In my personal experiences with being a teacher in this program, I have noticed that the number of hhb students requiring services are fluid throughout the year. I have noticed that the greatest volume of students needing services are

throughout March. This could be due to a full-time equivalent student count, also known as FTE count, that takes place in March. FTE shows accountability for students receiving services for funding purposes.

Staffing Needs

The staff assigned to provide hhb instruction should be qualified and trained to teach or provide therapy in the areas specified within the homebound service agreement (e.g., IEP or IFSP). They should be able to work well with parents and caregivers (Klass, 1996), be comfortable in teaching or providing therapy in front of others, possess good communication skills, and be well organized. Because hhb instruction often is provided to students after regular school hours, only qualified staff members who are able to take on the extra duties of hhb instruction after their regular working day should be considered. After an interview with a hhb teacher who had five years under her belt, she stated "My students' needs were being met by law only, but were these students learning, no because they were being taught by anybody". Staffing needs were such a challenge that the same teacher in this interview did not have one positive thing to say in this interview. She felt that the hhb program would be effective only if it were to be a separate program. She also stated that her experiences were difficult: "One time I got Chemistry work, and I told my student lets google this work." She stated.

Communication Needs

Communication is critical to the development of trust between school personnel and the family (Anderson & Matthews, 2001). It is important that families, facilities, and schools work together to create a transition plan for students that is supportive of both medical and emotional needs, anticipates challenges, and create a path for academic success. A lack of close

collaboration between special education teachers and other educational team members may allow the student's medical needs to interfere with his or her success in learning (Aruda et al., 2011). Ultimately, this is a disservice not only to those serving in the role of servicing this population, but also to the students for whom they are planning as well. After speaking to two different special education teachers, and hearing their concerns with communicating with other teachers, I knew that this would be a key area for improvement for the betterment of the children. One teacher described communication as, "inconsistent", while the other teacher described the communication as a "headache." It was clear that communication gaps exist still to this day with collaboration.

Scheduling Needs

There were scheduling conflicts challenges that all participants of this study brought forward were eye opening. In my fifteen years as both a special education and hhb teacher, schedules were a huge challenge that can leave teachers feeling overwhelmed and frustrated, especially when it comes to students with disabilities. One special education teacher described her school as the following: "I hate having to coordinate my schedule with 15 different teachers and their schedules, and that's not including IEP meetings. And then that schedule is frequently interrupted by students being added to my caseload. I am drowning in paperwork. Factor that with managing teaching two hhb children. Those numbers fluctuate as well. HHB seems like a revolving door with no set protocols. What seemed like a good idea, now seems like a headache I can't get rid of". Sadly, I know this feeling all too well. This system could improve on a better system in place for scheduling for all teachers.

Question 3: What supports can be provided to hospital homebound teachers to ensure that hospital homebound students are effective academically?

Teachers play an important role in children's education and their interactions with children influence multiple outcomes. Teachers have a direct influence on children's development and must be prepared to meet the diverse needs of all children in their classroom, including those with chronic illnesses. In this study, I examined special education teachers, and hhb teachers that worked directly with chronically ill children. The results revealed that this group required multiple supports in order to be effective in their respective positions.

Professional Development and Training Support

All participants revealed that they have not received any form of training as it related to servicing hospital homebound children. They stated that having only a teaching certificate was sufficient. This is a huge issue that needs to be changed. According to Olson et al. (2004), teacher preparation is an area of concern for the hospital homebound teachers as well as classroom teachers. This research supports the earlier work of Lynch et al. (1993), which specifically identifies the lack of preparation afforded teachers who educate chronically ill students. According to Clay et al. (2004), all teachers will have a child with medical needs in their classroom at some point during their career.

Instructional Support

The data in this study revealed that all participants were not given a set protocol on grading hospital home bound students. One hhb teacher who is dually certified stated the following:

"A disability does not require a physical disability. I have to mentally prepare myself for the level of instruction I am expected to deliver. My students can't seem to get a handle on the

standards. Sometimes I differentiate the instruction and sometimes I don't. I have to always get general education teachers together and play devil's advocate. The general education teachers at my school sometimes gives work and sometimes they don't. I began throwing them under the bus because grades became an issue. It is all too much these days".

Some students who qualify for special education have moderate or severe disabilities and often qualify based on diagnosed medical condition(s). Completing a traditional report card for students with significant disabilities can be especially problematic for teachers. Most consider it unfair to assign failing grades to students with moderate or severe disabilities who try hard but still are unable to demonstrate proficiency on grade-level standards. Furthermore, legal provisions require that IEPs written for children with disabilities enable them "to achieve passing marks and advance from grade to grade" (Board of Education v. Rowley, 1982, pp. 187–204). From a legal perspective, a failing grade shows that appropriate educational services were not provided. At the same time, assigning passing marks to students who have not yet met grade-level performance standards also seems inappropriate, because it inaccurately portrays such students' actual level of achievement. Lacking explicit recommendations on grading, most general education teachers make individual, informal grading adaptations for struggling learners (Polloway et al., 1994). This participant stated the following:

"There needs to be consistency overall with grading. Grading is a huge challenge, not only with special education teachers, but with general education teachers as well. There needs to be some form of consistency with the whole IEP team. Some teachers are just giving work and it is not good giving busy work for the sake of being meaningful".

While grading remains a huge challenge particularly with secondary schools, there can be a consistent protocol in place to assist teachers.

Emotional Support

The participants shared stories of the impact that this experience had on them as a result of their personal connection to the student. One teacher described teaching chronically ill children as, “doing the lord’s work”. She also stated that teaching this group requires a heightened sense of empathy. In my own experiences, this program can possess multiple challenges. The same participant that I mentioned above, also stated that teaching this group was emotionally taxing on her mental health, because there were days when she would go over and help a particular student who was suffering from sickle cell and she could tell she was having a bad day and the last thing she wanted to do was have her make test corrections to bring her grade up. “It was emotionally taxing when you see her struggling and there’s nothing you can do to, well, when it feels like there’s nothing you can do”. Teaching is not a career that only consists Teaching is not a nine to five job. Responsibilities are not confined to the workspace, and teachers are not often able to distance themselves from work or student involvement when at home. Teaching, really, is an emotionally taxing profession. For now, it is possible that the teachers' occupation stress is more likely to harm their physical and mental health, thereby degrading their teaching quality and behaviors and quality of life (Wang et al., 2015 Mearns & Cain, 2003; Doef & Maes, 2002). One participant of my study shared with me that she is currently taking two different medications for anxiety and depression. The unfortunate part of her situation is that she had to encounter challenges with Human Resources to receive 504 accommodations that would protect her at all times. She shared with me she was battling mental health challenges.

Parental Support

Parental support is a key takeaway to ensure success for any student. “If it is one thing that this pandemic has taught us is that parents and teachers must work together”! Stated a special education teacher. A hhb teacher also stated that her son missed three months of instruction because his mother did not like a certain teacher and waited until she got a new service provider. Parents and teachers must work together. This is essential for a student’s success. Parents are the experts on their children. Whereas teachers change annually, parents accumulate a wealth of knowledge about their children as learners. Teachers, on the other hand, are the experts on instruction. They know what their students need to make progress, yet the classroom setting makes it difficult to individually support every child. We must work together.

Collaborative Support

Collaboration between stakeholders in the school was identified by all study participants as an important piece in addressing the academic and emotional needs of the chronically ill student. Communication about wellness, academic, and social/emotional needs enabled teachers to modify programming to best meet expectations for students. This is consistent with research by Chesler and Barbarin (1986) that highlights the desire of the teacher to support the student without clearly established expectations agreed upon by all 89 stakeholders. Collaboration, the interaction style between school professionals, is defined as two or more equally certified or licensed professionals implementing shared teaching, decision-making, goal setting, and accountability for a diverse student body (Friend & Cook, 2009).

Collaboration between special education and general education teachers has been a challenge since I started teaching, so I know that this has been a key issue in education for a long time. Currently, considering least restrictive environment for students with disabilities in the United States requires considering students‘ full participation in the general education

curriculum delivered in the general education classroom and then considering more segregated settings only after it is determined that the student is not successful in the general education curriculum and classroom without more restrictive supports or specialized instruction (Office of Special Education Programs, 2006, sec. 614). Perspectives of collaborative behavior between teachers partially coincided with Friend and Cooks (2009) defining characteristics of collaboration: a) collaboration is based on mutual goals, b) collaboration depends on shared responsibility, c) collaborative partners share resources, and d) collaboration includes shared accountability for students (pp. 9-11).

After hearing from all the participants muttering about the same challenges with collaboration, I knew that much has not changed in the field of special education. One teacher stated that a few times she had to report a general education teacher to the hhb director for not giving her work for the student. She described her experience as a headache working with teachers. Another teacher stated that, as a special education resource teacher, she has to familiarize herself with the general education curriculum so that she can support her students and their needs. This specific teacher was responsible for teaching five different content areas. Fully understanding the needs of the chronically ill student, as well as those who support him or her, will improve transitions in and out of school and will improve social outcomes for the student (Power et al., 2003). I would recommend that there be mandatory professional development for all teachers who wish to provide services to hhb students. School districts could possibly add this as an area for Teacher Leadership for certified staff who are willing to receive the training. This would attract a more competitive talent pool. This would hold stakeholders more accountable.

Participants

Table 1

Demographics of Student Participants

Name	School	Grade	Diagnosis
Jane Doe 1	Flower Child High School	10	Traumatic Brain Injury
Jane Doe 2	Hope High School	9	Would not disclose
Jane Doe 3	ABC High School	11	Schizophrenia

Table 1 shows all of the hhb students who participated in the study and their respective grade levels. Each student disclosed their disabilities with the exception of one.

Table 2

Participants Demographics

Name	Subject	Years	Highest level of education	Certification
Jane Doe 1	District Level Administrative	22	Ph.D.	L-7
Jane Doe 2	Interrelated	21	Ph.D.	L-7
Jane Doe 3	Interrelated	15	EdS	T-6
Jane Doe 4	Interrelated and English	15	EdS	T-6
Jane Doe 5	Interrelated	12	Masters	T-5
Ron Doe 6	Interrelated	5	Masters	T-5
Jane Doe 7	Interrelated	11	Bachelors	T-4

Table 2 shows all of the hhb stakeholders who participated in this study and their certification levels. Additionally, their years in the profession along with their highest degree held is shown. Please note that a T certification level reflects a renewable teaching certification and an L certification level reflects a leadership certification.

Conclusion

The aim of this study was to better understand the experiences of secondary teachers who are responsible for educating hhb students. A better understanding of this experience could provide more insight into the classroom experience of this fragile population. This study

supported previous research about the experience of educating hhb students. More specifically, it was evident that teachers still feel unprepared to educate hospital homebound students and lack specific resources as mentioned throughout this study to become successful in doing so. Also, teacher participants discussed the importance of communication between stakeholders and how lacking content knowledge in subject areas impacted a student's overall success.

Teacher participants were able to discuss how educating this diverse group of students impacted them personally. Many of them even touched on their own emotional well-being and the need for support for themselves. Public schools, more specifically, grades 6-12, must adhere to stricter protocols on supporting their staff's emotional and physical needs. Additionally, professional development should be an ongoing support for teachers who teaches this population. Some of the essential experiences that teachers of hhb students shared will help readers understand the sensitive and critical relationship of teacher to student. In addition, teachers' understanding of their ability to support this fragile student population is an important area of research. This study can potentially lead to further research and even a software that may help students with remediation that school districts could adopt.

Significance of the Study

As stated earlier in chapter one of this study, the significance of this study comes at a high level of importance not only for hhb teachers and the students that they teach, but also all stakeholders that have a role to play in that particular student. There are so many key items that come to mind when educating this diverse student body. They are often overlooked, and a positive change must happen. As teachers we must continue to build positive relationships with students in this program to ensure student success. Teachers can ensure that a child who is in this program can help to assist in their goals. We must, help to assist in the goal planning and

instructional planning as a whole to help students maintain their educational performance while confined at home or the hospital. Through collaboration, I am confident that a positive change will come. The results from this study proved to be helpful in addressing the needs of teachers and stakeholders who work with this vulnerable population of students. There are still gaps, and I am hopeful that future research will help aid in a positive resolution and sound instructional plan overall.

Limitations of the Study

Although I tried very close to adhere to measures to promote a high level of credibility and trustworthiness in this study, areas of vulnerability and limitations emerged throughout the process. One of the primary areas of concern with this study was that most of the data analysis had to be conducted on Zoom software, due to COVID-19 and limiting the spread. COVID-19 impacted this study greatly. I had to research chronically ill subject areas, because hhb education was too broad to research. I found so much more relevant literature that is listed in the literature review when I mentioned chronically ill students instead of hospital homebound. I had one student who originally agreed to participate but had to withdraw because the students were hospitalized during the data collection period.

First, the definition of chronically ill needed to remain broad enough to be able to solicit participants who were responsible for educating this population of student. As such, the level of chronicity varied with each participant, as well as the amount of follow-up care required by each student. Another issue regarding transferability was specific to the classroom teacher and his or her certification. The experience of a core subject teacher could be different than the experience of an elective subject teacher, and this was evident in one school, as the chronically ill student was simply removed from the class. Another issue of transferability is specific to the protocols

and expectations of each school. School cultures have nuances, and the level of communication and access to resources varies from school to school.

Another potential area of vulnerability relates to privacy and confidentiality. In spite of a thorough explanation by myself and the participants of intent to protect privacy, teachers in general become hesitant overall to this study. This study was a red and gray area as one would call it. Whenever you are dealing with IEP's, medical records, many participants were hesitant discussing student medical needs. Several of the teacher participants were concerned about HIPPA regulations prior to the study and thought that sharing information was illegal. One teacher did not even disclose with me why a student was on hospital homebound because she was so scared. I stated to this participant that there was no desire to know any identifying information about the chronically ill student. Although this reassurance was made, it is impossible to know if teachers still withheld stories or modified statements in an effort to protect the identity of his or her student.

Last but not least, when I interviewed a student at a residential center, I was on a timed schedule and I felt rushed with trying my best to attain data not only from the student, but also the teacher. I went through three security checks and actually was told I was over my scheduled time. I was escorted out and had to email the residential director to allow a second visit. It was extremely frustrating and time consuming in attaining to get information for this study. I am so thankful I was able to execute effectively despite challenges and limitations.

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Table 1

Student Demographics

School	Diagnosis
Flower Child High School	Traumatic Brain Injury
Hope High School	Would not disclose
ABC High School	Schizophrenia

Student Confidentiality

The goal of this study is to understand the perspective of public high school teachers who are responsible for educating hospital homebound students, therefore, the researcher was careful with information, so as not to identify any students. When meeting with the high school administrative teams, the researcher requested from the outset that potential students who met the established parameters of chronically ill for this study, not be mentioned by name. Additionally, the researcher assured each participant during the Zoom and in person interview that the name of the hospital homebound student was not important and should not be mentioned during the interview process. No information was shared to protect confidentiality.

Table 2

Participants Demographics

Name	**Subject**	**Years**	**Highest level of education**	**Certification**
Jane Doe 1	District Level Administrative	22	Ph.D	L-7
Jane Doe 2	Interrelated	21	Ph.D.	L-7
Jane Doe 3	Interrelated	15	EdS	T-6
Jane Doe 4	Interrelated and English	15	EdS	T-6
Jane Doe 5	Interrelated	12	Masters	T-5
Ron Doe 6	Interrelated	5	Masters	T-5
Jane Doe 7	Interrelated	11	Bachelors	T-4

Participant Confidentiality

As outlined in the call for participants, the researcher clearly articulated the goal to keep information confidential. Additionally, the participants were encouraged to use pronouns or pseudonyms throughout the interview process, and the researcher has assigned pseudonyms to each school to protect confidentiality. After the transcription of the audio files was complete, the researcher deleted the original files. Prior to deletion, audio files were kept on a personal laptop computer that was locked and password protected. In addition to the audio files, all handwritten notes, documents and drafts, related to the study were kept in a locked location and will be destroyed after three years per federal regulations. The researcher will also refrain from using an identifying language, names or locations, in the written summary of this study.

Table 3

Thematic Codes and Organizational Chart of Code System

Emergent Themes	**Thematic Code**
Teacher Perspective	Teacher Perspective Empathy/Compassion Difficulty of Job Preparedness to Educate hospital homebound students
Social Considerations	Collaboration with Parents Collaboration with Peers Collaboration with Staff Challenges felt by hospital homebound students
Emotional Considerations	Personal Connection to Student Managing Peer Reaction and Needs Emotional Impact on Colleagues
Academic Considerations	Responsibilities of the Classroom Teacher Modification of Academic Program Academic Achievement

Thematic Codes
The themes and sub-codes identified in Table 3 are a result of the data analysis process of analyzing data and allowing themes to emerge. The results of this study are based upon the description of the experience of each participant as well as observations by the researcher. Each of these themes and codes are described in greater detail in chapter four.

Appendix A

Kennesaw State University IRB Research Proposal

Title of Research Study: Hospital Home-Bound Education: Are Teachers Prepared to Implement Transition Plans Post-Hospitalization for Student Success?

Researcher's Contact Information:
Katherine Vincent
404-569-7982
vkatheri@students.kennesaw.edu

Introduction

You are being invited to take part in a research study conducted by Katherine Vincent of Kennesaw State University. Before you decide to participate in this study, you should read this form and ask questions about anything that you do not understand.

Description of Project

The purpose of the study to bring awareness to the homebound program. The first homebound educational service began in Newton, Iowa, in 1939. The service was provided by telephone. By 1958, the Council for Exceptional Children (CEC) created the Division of Educators of Homebound/Hospitalized Children. Today, the hospital homebound service delivery model is considered the most restrictive educational setting because it segregates students from other students, both with and without disabilities. According to The Gadoe.org, Hospital/Homebound (HHB) services are designed to provide continuity of educational services between the classroom and home or hospital for students in Georgia public schools whose medical needs, either physical or psychiatric, do not allow them to attend school for a limited period of time.

HHB instruction may be used to supplement the classroom program for students with health impairments whose conditions may interfere with regular school attendance (e.g., students receiving dialysis or radiation/chemotherapy or students with other serious health conditions) (Georgia State Board of Education Rule 160-4-2-.31, 2016, para. 1). Hospital/Homebound (HHB) services students that must be enrolled in a public school in Georgia in order to receive HHB services (Woods, 2016, p.2). HHB services are not intended to supplement regular school services and are by design temporary (Woods, 2016, p.2). The student must anticipate being absent from school for a minimum of ten consecutive or intermittent school days due to a medical or psychiatric condition.

The student's inability to attend school for medical or psychiatric reasons must be certified by the licensed physician who is currently treating the student for the diagnosis presented. The provision of homebound services to students with disabilities is determined by multidisciplinary teams and documented in Individual Education Programs (IEP) or Individual Family Service Plans (IFSP) (Woods, 2016, p.5). The LEA is then responsible for providing appropriate instruction and related services that meet the legal requirements for the use of educational settings (Etscheidt, 2006). In selecting homebound services as a delivery method, IEP and IFSP team members should consider the restrictive nature of homebound services. Because of the potential for limited interaction with peers, homebound instruction is often seen as one of the most restrictive educational settings (Patterson & Tullis, 2007).

Another consideration is the assurance that students receiving homebound services have access to the general education curriculum (Bradley, 2007). The nature and impact of the student's disability may affect the amount of time for which homebound instruction is provided. Providing homebound services to any student can be a unique and positive experience for teachers. It affords the teacher an opportunity to observe the home environment and the family dynamics within that environment, thus resulting in greater understanding of the student's behavior. Because of the frequency of interaction and communication, it offers teachers the prospect of building stronger ties with the family.

Homebound instruction may also result in greater bonds between teachers and students because of the one-on-one instruction provided and the opportunity to truly individualize instruction (Baker, Squires, & Whiteley, 1999). Homebound instruction can also present many challenges for teachers. Teachers are frequently not prepared to provide such services. Few teacher preparation programs address the issue, and much of the available literature on homebound instruction comes from the field of early childhood special education (Klass, 1996). In addition, school districts may not have specific guidelines for their teachers on providing homebound services (Daly-Rooney & Denny, 1991). Homebound instruction can present a variety of unexpected variables with which to contend. These can include disruptive siblings, a noisy environment in which to work, family conflicts, and cancellations of visits.

Teachers may also be frustrated in recognizing that homebound services do not provide sufficient depth and intensity of instruction that some students may need. Providing homebound instruction to students with emotional or behavioral disorders can be a particularly demanding experience. Such students can display a wide range of challenging behaviors, from apathy to defiance (Kerr & Nelson, 2002). Undesirable behaviors that are evident in school and community settings can be even more intense in the home. Teachers should plan on using their full repertoire of behavioral interventions, which could include identifying and avoiding the triggering of undesirable behaviors, the use of token economy systems, behavioral contracts, the calculated use of verbal praise, and working on tasks in small increments of time.

Explanation of Procedures

The participant is being asked to participate in an interview or questionnaire to describe their experiences working with hospital homebound programs.

Time Required

30 minutes max each interview and I plan to interview only 3 participants

Risks or Discomforts

There are no risks or discomforts with this study.

Benefits

The benefits of this study are that the hospital homebound program will change the protocol, trainings, and the effectiveness of the program to increase student achievement.

Compensation

No compensation will be provided.

Confidentiality

This will be an anonymous study. Establishing trustworthiness, in regard to the concepts of validity and reliability is a crucial concern in ensuring the quality of a qualitative research. In the recent years, qualitative researches are enjoying unprecedented popularity, not only because of its richness of collected data but also because of the recent advancement in the techniques of data analysis (Rambaree, 2008). Azza (2013) stated that the utilization of ATLAS.ti 7 in aiding the process of data analysis is believed to have enormous potential in bringing more rigor and trustworthiness to qualitative inquiry of the case study. Hwang (2008) advocates the use of ATLAS.ti for its empirical benefit of enhancing credibility building by making the research processes more transparent and replicable. Yin (1994, p. 34) asserts that in case study research, “multiple sources of evidences” are used as a tactic to triangulate data to address concerns with construct validity because the multiple sources of evidence essentially provide multiple measures of the same phenomenon.

Creswell and Miller (2000) advise that in establishing trustworthiness, the researcher needs to employ a systematic process of sorting through the data to find common themes or categories by eliminating overlapping areas. By implementing ATLAS.ti, I will be able to execute the data analysis effectively at different phases of the study and confirm the data

collected through the interviews and surveys in identifying common categories or themes. Also, through the use of ATLAS.ti I will be able to increase the credibility of the study through the use of coding and recoding processes and procedures.

Inclusion Criteria for Participation

Ages 14-18 (students), 25-50 (teachers)

Signed Consent

I agree and give my consent to participate in this research project. I understand that participation is voluntary and that I may withdraw my consent at any time without penalty.

____

Signature of Participant or Authorized Representative, Date

____

Signature of Investigator, Date

PLEASE SIGN BOTH COPIES OF THIS FORM, KEEP ONE AND RETURN THE OTHER TO THE INVESTIGATOR

Research at Kennesaw State University that involves human participants is carried out under the oversight of an Institutional Review Board. Questions or problems regarding these activities should be addressed to the Institutional Review Board, Kennesaw State University, 585 Cobb Avenue, KH3417, Kennesaw, GA 30144-5591, (470) 578-6407.

Appendix B

Letter to Superintendent of Dekalb County Schools

Dear Superintendent of Dekalb County Schools

As part of my doctoral studies at Kennesaw State University, I will conduct a research study that addresses an identified problem of practice in education and contributes to the field of study. I am writing to request permission to conduct interviews with hospital home bound students, homebound teachers, special education teachers, and a district leader over student support of this program.

This letter outlines my intentions and presents the context for the study. The problem of practice that I seek to address is the complex issue of educating hospital homebound children. Current research highlights the obstacles that impede success academically, socially and emotionally for this population of students, including a void in reintegration to school after extended absence or treatment.

The need for coordination between stakeholders is evident, and these teachers needs to be heard. The aim of this study is to better understand the teacher's experience in educating hospital homebound students. Utilizing qualitative research practices, data will be collected through in-person interviews and the responses will be professionally transcribed, coded and evaluated for emergent themes. It is my contention that the research will provide insight into the classroom experience for teachers and provide voice to educators. Information from this study may create a transferable framework for professional development and administrative protocols that can be applied in a variety of school settings regardless of content or discipline. It is my hope that this study will make a positive contribution to the field of education and benefit both teachers and hospital homebound students. If you have any questions regarding this study, please contact me directly at (404) 569-7982 or via e-mail at vkatheri@students.kennesaw.edu, or my Doctoral Advisor, Dr. Binyao Zheng at bzheng@kennesaw.edu or (470) 5783495. Thank you for your continued support. I look forward to hearing from you regarding this request for permission.

Warmest Regards,

Katherine M. Kimbro-Vincent, EdS

Binyao Zheng, PhD/ Supervising professor

Appendix C

Information Cover Letter to Participants

Dear Caregiver:

You are invited to participate in a study which will examine the educational services available to families of students with medical needs. My name is Katherine M. Vincent, and I am a full-time doctoral student at Kennesaw State University, Department of Teacher Leadership. As a part of doctoral dissertation, I hope to learn how families feel about the hospital home-bound services provided to their children. With this information, I would like to help professionals such as teachers and administrators understand the needs of families and provide the best possible service to the children that they serve.

You were selected as a possible participant in this study based on your involvement in Hospital Homebound Services. If you decide to participate, I will contact you by telephone or email to arrange interviews with you in your home.

Based on your agreement to participate in the study, you will be asked questions. These interviews will help educators and professionals better understand the daily responsibilities, and tasks when caring for a child with medical needs not only in school, but hospital as well. The answers from the study will help teachers and school personnel provide homebound services that can benefit the needs of families and future families that will be a part of the program.

If you have any questions, please feel free to reach out to me. I may be reached at (404) 569-7982. My supervising professor at Kennesaw State University is Binyao Zheng, PhD and he may be reached at (470) 578-3495 at Kennesaw State University. His email is bzheng@kennesaw.edu. Thank you for your consideration.

Sincerely,

Katherine M. Vincent, EdS

Binyao Zheng, PhD/ Supervising professor

Appendix D

Student Interview Questions

Based on the consent form and your agreement to participate in the study, you will be asked questions. This interview will help educators and professionals better understand the daily responsibilities, tasks and happenings, of caring for a child on hospital homebound. The answers from the study will help teachers and school personnel provide educational services that can best fit the needs of families. Actual names and information that may identify you will be kept confidential and will not be used in the written description of interviews. You may refuse to answer any question or stop the interview at any time. Do you have any questions before we begin?

1. First, I would like to know what are your thoughts that come to mind regarding your illness and your education?
2. Can you talk about what a day is like for you?
3. How do you make decisions in terms of your education?
4. How did you first hear about hospital homebound services?
5. What would you tell other potential families about hospital homebound services regarding instruction?
6. Do you have an IEP or 504?
7. If you have an IEP, are you familiar with your transition plan?
8. When you are placed on homebound does your school do a good job with your transition back into the classroom?
9. Do you feel that your needs and services are being met in the school?
10. Can you describe what a day is like for you when you are receiving instruction from your hospital homebound teachers?
11. What do you hope to gain from the services provided to you?
12. Do you plan on going to college after high school?

Appendix E

Teacher Interview Questions

1. First, I would like to know what are your thoughts that come to mind regarding hospital homebound education?

2. Can you talk about what a day is like for you when you are servicing your student(s)?

3. How do you make decisions in terms of instruction as it relates to your students?

4. Do you communicate with the general education teachers regularly? How do you communicate with them? Are they compliant with your requests?

5. What would you tell other potential families about hospital homebound services regarding instruction?

6. Do you actively monitor your students' transition plans? Do you make your students involved in their IEP process?

7. Do you feel that the needs and services are being met with the hospital homebound students effectively?

8. Do you regularly manage your caseload? Do you actively participate in the IEP decisions regarding your students?

9. Are you a certified teacher? If yes, please list the areas that you are certified?

Appendix F

Dekalb County Schools IRB

Mrs. Ramona Tyson, Interim Superintendent

Mr. Marshall D. Orson, Board Chair
Mrs. Vickie B. Turner, Vice Chair
Mr. Stan O. Jester
Dr. Michael A. Erwin
Mrs. Allyson Gevertz
Mr. Diijon DaCosta
Dr. Joyce Morley

Office of Accountability
Research, Data, and Evaluation
1701 Mountain Industrial Boulevard
Stone Mountain, GA 30083-1027
678-676-0300

February 28, 2020
1431 Gateview Way
Marietta, GA 30062
Reference: Hospital Home-Bound Education: Are Teachers Prepared to Implement Transition Plans Post Hospitalization for Student Success (file 2019-032)

Dear Ms. K. Vincent

This letter is to inform you that your research proposal has been approved by the Department of Research, Data, and Evaluation for implementation in the DeKalb County School District (DCSD).

When you begin your research, you must secure the approval of the principal/chief site administrator(s) for all schools named in the proposal. You should provide the application with all required attachments and this district approval letter to the principal(s) to inform their decision. **Please remember the principal/chief site administrator has the final right of approval or denial of the research proposal at that site. In addition, note that teachers and others may elect not to participate in your research study, even though the district has granted permission.**

Please be reminded there is no data collection in schools between Friday, March 27, 2020 and May 29, 2020. The deadline is to protect instructional time during the assessment season and end of the year activities scheduled at individual schools. Also, meeting with teachers during their planning time is not acceptable and interviews need to be held during non-school hours. This approval is valid for one year from the date on this approval letter. Should there be any changes, addenda, design changes, or adverse events to the approved protocol, a request for these changes must also be submitted in writing/email to the DCSD Department of Research, Data, and Evaluation during this one-year approval period. Changes should not be initiated until written approval is received. Further, should there be a need to extend the time requested for the project; the researcher must submit a written request for approval at least one month prior to the anniversary date of the most recent approval. If the time for which approval is given expires, it will be necessary to resubmit the proposal for another review by the DCSD Research Review Board.

Completed results are **required** to be submitted to the Office of Accountability (Research, Data, and Evaluation). Feel free to call 678.676.1113 or 678.676.0325 if you have any questions.

Sincerely,

Dr. Linda Frazer
Interim Associate Superintendent

Dr. Joy Mordica
Director

Robert R. Freeman Administrative Complex
1701 Mountain Industrial Blvd. | Stone Mountain, GA 30083
678.676.1200 | www.dekalbschoolsga.org

Appendix G

Data Table for student participants

Topic	Student	Response	My Thoughts
Illness and Educational challenges Daily challenges Long-term decisions Services/Needs IEP/504 Needs Transitional planning Instruction Goals Post-secondary plans	Student 1—Name to remain anonymous	"I feel upset, frustrated, and upset"! "I do attempt all my work". "I have an IEP, I have OHI--ADHD. I have had it ever since middle school". "I am not familiar with any transitional plans, what is that"? "My hhb teacher makes my work easy most of the time, but sometimes we use Google for answers". "I would like to attend college one day, God willing". "My mom makes all my educational decisions for me". "I have an IEP". "Students who need HHB services should get them if they can".	This student has high ambitions. He has a great support system behind me. I do believe that his teacher does a great job communicating with all of his teachers so that his experience can be as organized as possible. I do believe that he may be lazy about wanting to push himself to do more. Many times, throughout this interview he was playing video games. He had to be redirected five times during this interview. He is a sweet kid.
Illness and Educational challenges Daily challenges Long-term decisions Services/Needs IEP/504 Needs Transitional planning Instruction Goals Post-secondary plans	Student 2--Name to remain anonymous	"My therapist helps me through everything". "My parents see me twice a week". "I am very focused on trying to break out this spot". "On a good day, I think happy thoughts". "On a bad day, I am avoiding getting hit by chairs". "This program is better than GreenLeaf". "I would recommend this program to other people; they seem like they care". "I am still waiting on a journal". "I don't know what an IEP is". "I don't want to go to college, I want to be a painter and paint canvases so I can help to financial support my family". "I am very focused in school; I want to be out of here before Christmas". "This work is so easy". "When I am thinking positive, I can do this".	I do believe that this student has great potential. She is in a residential facility homebound program for psychiatric illness. She is very bright. She sees a psychiatrist three times a week for mental illness. If she gets better and makes use of all the resources provided, she will come out to do great things. Her teacher enjoys having her in class. She is a great writer and loves to draw and journal. This is her second facility. Academically she can handle the workload. I think that with the proper care and services this residential program will be great for her.
Illness and Educational challenges Daily challenges Long-term decisions Services/Needs IEP/504 Needs Transitional planning Instruction Goals Post-secondary plans	Student 3---Name to remain anonymous	"This program sucks!" "I am very tired". "I am not going to college". "I guess my needs are met—(student shrugs shoulders)". "I have an IEP". "My mom helps me on Google to look up answers, I find everything there". "My mom makes all decisions for me". "I don't enjoy this program at all".	I struggled with this interview with this particular kid. He has so many health challenges. I had to complete this interview in two sessions. The student had to complete this interview in multiple sessions.

Appendix H

Data Table for Hospital Home-bound Director participant

Topic	504 Director	Response	My Thoughts
Overall thoughts on HHB program District level duties and responsibilities Decision making as it relates to student achievement District compliance Services/needs Daily responsibilities/task Accountability Competency	Director 1	Non-certified staff providing services to hhb students Ensuring students are in the least restricted environment Time taken away from overall job duties and responsibilities Making sure all parties are connected through Education Service Plan Effective Data Monitoring Student Grades More support for secondary HHB students Communication with 504 chairs and LTSE's Key to decision making Eligibility criteria Over 1,500 referrals weekly Staffing Issues Teacher shortage Compensatory services	I believe that a 504 coordinator's role is essential to any school district. They are to provide support, guidance and resources to school-based staff and parents regarding Section 504/ADA and HHB services. They are the glue for the county by advising district-level and school-based staff regarding the proper development of Student Section 504/ADA Educational Services Plans and HHB services for students. If a school district doesn't hire the best fit for the role, the district may find themselves in a bind. I do believe that this coordinator is doing the best job given the lack of resources provided.

Appendix I

Data Table for HHB Teacher participants

Topic	HHB Teachers	Response	My Thoughts
Daily Challenges Instructional Planning Communication Compliance Transitional Planning School Re-entry Services/Needs Daily Schedule Teacher training	Teacher 1	"Making sure students receive services that align directly to their IEP goals". "Collaboration seems hard these days, no one ever has enough time". "My kids are so low; it is a struggle these kids are way below grade level". "My caseload is unbearable".	This classroom was tough to observe. This teacher tried his best to hold things together in his classroom. Despite the many extreme behaviors that got in his way of teaching effective instruction, the teacher did well. I could not imagine going through this level of teaching different students with many severe mental illnesses.
Daily Challenges Instructional Planning Communication Compliance Transitional Planning School Re-entry	Teacher 2	"There are some challenges that I have with some students and their families". "I feel that there needs to be a better system in place for teaching content". "Instruction is based on IEP goals". "I make sure that I build positive relationships with my students". "I wish that more teachers were certified in areas to teach harder subjects".	This teacher was nothing shy of amazing! She was so incredibly organized and held her students at high regard. This teacher has over 15 years of experience and truly loves what she is called to do. Her students were engaged in learning at all times. She took time to prepare the lessons for her student. She used visuals, and actively asked them questions. She took time to contact general education teachers weekly with a google calendar. There is no wonder why her students had wonderful things to say about the program. Great teachers yield positive students who enjoy their HHB experience.
Daily Challenges Instructional Planning Communication Compliance Transitional Planning School Re-entry Services/Needs Daily Schedule Teacher training	Teacher 3	" I try and preplan everything"! "I always give my kids a mini-assessment right when I get them". "My instruction comes from my kids IE goals". "HHB is a great program if students want to receive the extra support". "I make sure I do my job and deliver the need/services for all my kiddos". "One time I had to report a general education teacher to the HHB director for not giving me work for the kid". "Communication can suck all the way around".	This teacher struggled through her lesson. Her student was totally disengaged throughout the lesson. There were many times that she had to ask him to turn his camera on, as we were on Zoom. The student turned his camera on two times during instruction and turned right back off. He complained that he did not feel like completing any work. Teacher asked questions and he shrugged shoulders multiple times. It was evident he did not care and definitely did not want to conduct any lessons that day.

Appendix J

Data Table for Special Education Teacher participants

Topic	Special Ed Teachers	Response	My Thoughts
Daily challenges Instructional planning and decision making Communication Compliance Recommendation of homebound services Transitional planning Monitoring of IEP goals Services/needs Management of caseload	Teacher 1	"Scheduling issues are a trip"! "3 hours a week is not enough time". "My overall experiences have been good". "Any teacher can modify work, not just sped teachers". "There needs to be consistency overall with grading". "Grading is a huge challenge with the whole IEP team". "Some teachers are just giving work and it is not good giving busy work for the sake of being meaningful". "Every parent should take advantage of this program; you do not work these kids getting more behind". "Teachers are my cooperative when they know why students are in HHB".	This teacher was phenomenal. Very seasoned in her ways of reaching her students needs. She was faced with many challenges with her students, but because she was seasoned, she was able to roll with the punches in terms of curriculum. She has been a special ed teacher for 16 years and apart of the HHB program for 6 years with the same school. She was able to share the pros and the cons of this program. She seemed frustrated with schedule changes at her school and wanted more organization as a whole as it came to the HHB program and meeting the needs of her students effectively.
Daily challenges Instructional planning and decision making Communication Compliance Recommendation of homebound services Transitional planning Monitoring of IEP goals Services/needs Management of caseload	Teacher 2	"Being an HHB Teacher requires a heightened sense of empathy". "A disability does not require a physical disability". "I have to mentally prepare myself for the instruction". "My students can't get a handle on the standards". "Sometimes I differentiate the instruction and sometimes I don't". "I have to always get general ed teachers together and play devil's advocate". "General ed teachers sometimes give work and sometimes they don't". "I can't effectively progress monitor anymore; it is all too much these days". "I am not conducting any data on transitional plans at this time".	I had a great interview with this teacher. We actually have known each other for a long time and have worked this program together for quite some time. I know her work ethic and it is very strong. While I observed her in action, you can tell she enjoys kids and loves teaching. Her students were engaged in her ELA lesson. She knew how to chunk the material down to where her students understood the vocabulary lesson.
Daily Challenges Instructional Planning Communication Compliance Transitional Planning School Re-entry Services/Needs Daily Schedule Teacher training	Teacher 3	" I try and preplan everything"! "I always give my kids a mini-assessment right when I get them". "My instruction comes from my kids IE goals". "HHB is a great program if students want to receive the extra support". "I make sure I do my job and deliver the need/services for all my kiddos". "One time I had to report a general education teacher to the HHB director for not giving me work for the kid". "Communication can suck all the way around".	This teacher struggled through her lesson. Her student was totally disengaged throughout the lesson. There were many times that she had to ask him to turn his camera on, as we were on Zoom. The student turned his camera on two times during instruction and turned right back off. He complained that he did not feel like completing any work. Teacher asked questions and he shrugged shoulders multiple times. It was evident he did not care and definitely did not want to conduct any lessons that day.