The Impact of Policy on the Status of Accessible Learning Opportunities for Students with Chronic Health Conditions

Making Action Possible in Southern Arizona (MAP Dashboard)
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The information and data provided from this report is not intended to be and is not legal advice. All information and data available are for general information purposes only and reflects only publicly available information related to state statutes and Department of Education regulations as of June 1, 2024. Authors do not have a legal background and identify as professionals in the fields of education and psychology, specifically school psychology. For those seeking further guidance, options include contacting the Department of Education or an Education attorney within their state.

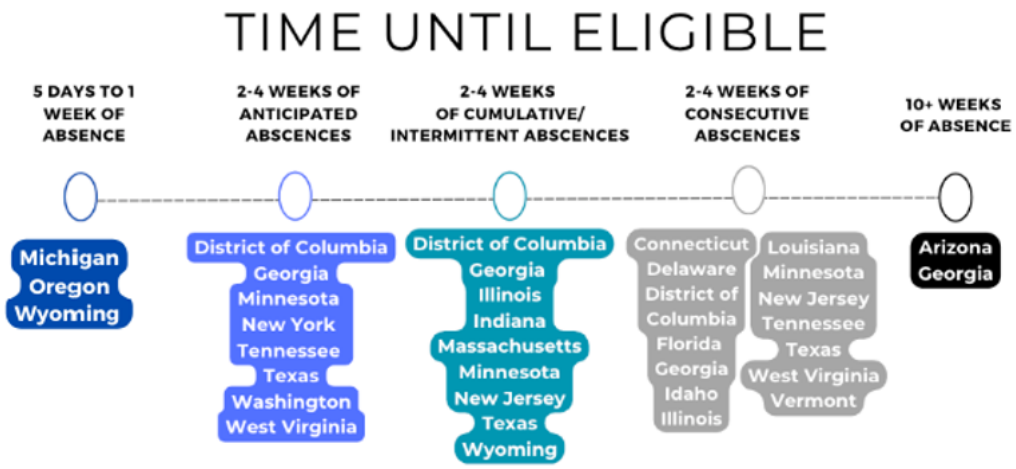
Executive Summary

Between 20-45% of school-age children receive ongoing medical care for chronic health conditions (James et al., 2022; Stille et al., 2022; U.S. Department of Health and Human Services, Office of Population Affairs, 2016). An estimated 13-27% of youth have a chronic physical illness or physical health-related condition (Wijlaars et al., 2016).

This study examines the policies and practices related to homebound instruction for students with chronic health conditions across the United States, with a particular focus on Arizona. The research encompasses three main aims: analyzing state policies and regulations, investigating Southern Arizona school districts' homebound instructional practices, and exploring a case study of hospital-based instruction in Southern Arizona.

Key findings from the state policy analysis revealed that 40 out of 51 jurisdictions (including DC) have active statutes and regulations relevant to homebound instruction, with significant variations in eligibility criteria, instructional time requirements, and implementation timelines across states (Figure 1). Notably, Arizona's policy has several critical gaps, including a lengthy eligibility time frame, limited healthcare provider options, and a lack of clear implementation guidelines. The analysis of Southern Arizona school districts shows that 84.4% of analyzed districts have both homebound and chronic illness policies in place, but most adopt verbatim language from state guidelines without customization, potentially leading to inconsistent application. These policies often lack clear definitions for "timely" provision of materials and neglect critical considerations for assessments.

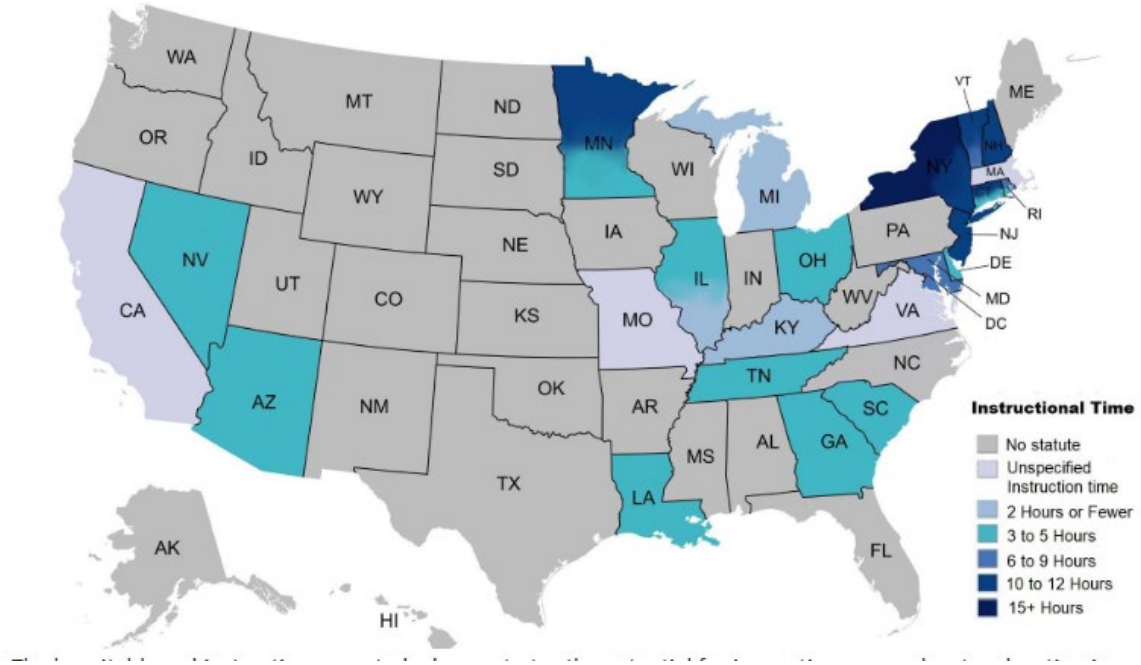
Figure 1: Coded United States Department of Education



Disclosure: The criteria for eligibility based on time missed can vary between states and may depend on whether the absence is anticipated, consecutive, intermittent, or cumulative. The following map shows where states require a specific duration of absence for eligibility; however, the interpretation can differ based on the terminology used. For example, in Arizona, a student must have three school months of absences, but this can include the cumulative total of intermittent absences.

Regarding Instructional time (i.e., hours or amount of time a student who is homebound/hospitalized is entitled to), 26 states (51% overall; 65% of coded states/DC) addressed the requirements for instructional time. Requirements were coded as two or fewer hours per week (3 states) to 10 to 12 hours per week (6 states, 1 with fewer for elementary, 1 with more for secondary, and 1 based on the number of days needing service). The majority of states required between three and five hours of instruction weekly (12 states, 2 with more for secondary; 1 with less if technology is utilized). States employed different methods to calculate instructional time, including minimum hours per day, average hours per day, or a specific number of hours per week. Several states differentiated instructional time based on grade level. Four states did not specify an instructional time minimum, but rather indicated based on students' needs or as indicated in a plan developed by the teacher, school, or the Local Educational Agencies (LEA). Eleven states also explicitly deferred the specific hours based on need or the student's Individual Educational Plan (IEP). Arizona indicates a minimum of four hours of instruction.

Figure 2: Minimum Instructional Time Requirements for Homebound Students



The hospital-based instruction case study demonstrates the potential for innovative approaches to education in medical settings, offering personalized education plans for hospitalized children while facing challenges in balancing education with medical needs, school collaboration, and maintaining student engagement. Based on these findings,

Key recommendations include:

- Reducing eligibility timeframes
- Expanding acceptable healthcare providers
- Establishing clear timelines for eligibility determination and service implementation

- Increasing minimum instructional time
- Developing reintegration support guidelines
- Addressing attendance tracking and curriculum requirements more explicitly
- Requiring professional development for educators
- Merging guidance on chronic health and homebound statutes.

These changes would align Arizona's homebound instruction policy more closely with best practices seen in other jurisdictions, potentially improving educational access and outcomes for students requiring these services. By implementing these recommendations, policymakers and educators can better support the unique needs of students with chronic health conditions, ensuring they receive high-quality education despite health-related challenges.

Definition of Terms

Accident
"An unexpected and medically important bodily event especially when injurious" (Merriam-Webster, n.d.a)

Americans with Disabilities Act
A comprehensive federal civil rights law that prohibits discrimination against individuals with disabilities in various areas of public life, including jobs, schools, transportation, and all public and private places open to the general public (U.S. Department of Justice, n.d.)

Chronic illness
A chronic illness is a condition in which one may need ongoing treatment for an illness or disability that has lasted for an extended period of time (American Psychological Association, n.d.)

Curriculum
The planned sequence of instruction, including the learning objectives, standards, teaching methods, materials, and assessments used to guide student learning in a specific educational program or course (The Glossary of Education Reform, n.d.)

Department of Education
The Department of Education (DOE) works federally to oversee and integrate policies meant to regulate and improve education within the nation. Each state typically has a DOE, though it may be called something else, with the most common alternatives being Department of Publication Instruction or Department of Elementary and Secondary Education. In Arizona, it's called the Arizona Department of Education (ADE) (U.S. Department of Education, n.d.)

Disability
"a person who has a physical or mental impairment that substantially limits one or more major life activities, a person who has a history or record of such an impairment, or a person who is perceived by others as having such an impairment" (U.S. Department of Justice, n.d.)

Homebound instruction
Educational services provided outside the traditional classroom setting, typically in a student's home, to ensure continuity of education for those unable to attend school due to medical or other qualifying conditions (Shaw et al., 2014)

Hospital school
An educational program within a hospital setting that caters to those with chronic illness or disability, inhibiting them from being present in the traditional classroom (Caggiano et al., 2021)

Illness
Includes a disease or other condition affecting the health of an individual, including mental and physical health (38 USC § 1171(b)(1), 2012; Legal Information Institute, n.d.)

Injury
Physical harm or damage to someone's body caused by an accident or an attack (Cambridge, n.d.)

Intermittent
Occurring at irregular intervals in an educational context, referring to students who alternate between regular school attendance and periods of home or hospital-based instruction due to medical or other qualifying conditions (Merriam-Webster, n.d.b)

Jurisdiction
The legal authority or range of authority in educational matters, which may include the school of origin, school of hospitalization, contracting third-party providers, and dual enrollment arrangements (Law Insider, n.d.; Merriam-Webster, n.d.c)

Medically complex
An individual with multiple significant chronic health conditions that impact two or more body systems, requiring high utilization of healthcare services, and potentially needing technological assistance or dependence for daily functioning (Burns et al., 2021; Kuo et al., 2016)

Re-integration/transition
Processes and plans for each student following home/hospital school that are tailored to individual needs and circumstances to successfully place them back into school without the student being behind on curriculum and support a sense of normalcy. It's important to consider what kind of ongoing care management the student will need (Burns et al., 2021)

Remote Instruction
Virtual or telephonic delivery that may be synchronous (live instruction) or asynchronous (pre-recorded sessions or independent work). "Online instruction can also take many different formats, but most instruction typically involves electronic engagement between a teacher, student, and course materials (e.g., audio, video, text, or other course materials located in a learning management system" (Black et al., 2022, p. 2). Some instructional models are hybrid, with some in-person attendance and other portions of the week when the student is ill moving to online.

Special education
A tailored educational approach designed to meet the unique learning needs of students with disabilities or specific health conditions, while aiming to integrate with the traditional curriculum as much as possible (Benitez Ojeda & Carugno, 2022)

Special healthcare need
A special healthcare need requires additional treatment in the area of an individual's physical, mental, behavioral, emotional, or developmental domains (Centers for Disease Control, 2024)

Statute
Statute can be defined as a law, regulation, or rule, made by a government body (Merriam-

Webster, n.d.d)

Introduction

Between 20-45% of school-age children receive ongoing medical care for chronic health conditions (James et al., 2022; Stille et al., 2022; U.S. Department of Health and Human Services, Office of Population Affairs, 2016). An estimated 13-27% of youth have a chronic physical illness or health-related condition (Wijlaars et al., 2016). In the educational sphere, chronic health conditions may be referenced as special healthcare needs, which encompass "have or are at increased risk for chronic physical, developmental, behavioral or emotional conditions and also require health and related services of a type or amount beyond that required by children generally" (Stille et al., 2022, p. S1). Chronic illness can prevent children from attending school, leading to missed assignments, academic struggles, social isolation, psychological stress, and significant learning barriers (Perfect & Moore, 2019). Lum et al. (2019) also revealed significant educational disparities for chronically ill students, with these students facing a substantially higher likelihood of grade repetition, parent-reported academic struggles, and recent illness-related absences compared to students without chronic health conditions. Additionally, nearly 8,000 per 100,000 children are hospitalized annually in the United States (Steinke et al., 2016), further disrupting their education. Even short-term illnesses or intermittent flares of their condition may result in significant disruptions in school functioning that make it challenging for students to reintegrate into the school milieu (Schuster et al., 2011). In a seminal publication addressing the educational-medical gap, Thies (1999) articulated

> Who is responsible for managing the education of an adolescent with [a chronic illness] who misses six weeks of algebra and biology – two to four days at a time? This question highlights the challenges to schools posed by children and adolescents with chronic illness. Unlike other disabilities, the course of illness presents a roller coaster of changing needs, moving between acute and medical crises and long-term management of health. Some move in and out of the special education system depending on their health status, a system whose policies, practices, and expectations are not necessarily a good fit (p. 396).

Over 25 years after this publication, the advent of better technologies and clinical practices for treatment and the introduction of new medicines have contributed to increased survival rates.

In contrast to the optimism afforded by advances in pediatric medicine, the educational circumstances surrounding students with chronic and critical illnesses are dispiriting (Irwin & Elam, 2017). We propose that four critical factors perpetuate the inaccessibility of many students with chronic medical conditions. First, no universal federal policy provides explicit provisions for *how* educational systems address the accessibility of students with chronic medical conditions. Second, wide variability exists across state statutes and policies with regard to timing, method of instruction, and best practices for the education of students with chronic medical conditions who cannot regularly participate in their classes. Critically, several states are void of legal mandates governing the education of these students. Third, policies established for education systems are created separately from those that govern healthcare facilities, and professionals in either setting are not necessarily obliged to adhere to the other institutions'

policies. Finally, without adequate laws, regulations, or guidelines, schools are often left to their own vices. Students who are hospitalized or homebound become siloed physically, socially, and academically due to insufficient legal protections, disunited educational and hospital practices, and the absence of research-based evidence guiding service delivery.

Although Arizona (AZ) has a homebound education law under title 15 (AZ Stat § 15-901, 2022), it is unclear how it fits in the continuum of educational accessibility relative to the rest of the United States (U.S.) and the District of Columbia (DC). Therefore, this White Paper will provide findings of a systematic analysis of state statutes and Department of Education regulations that address the provision of instruction and educational services for youth with chronic medical conditions. Further, the White Paper includes information gathered from Southern Arizona school districts regarding the implementation of Arizona's homebound instruction policy. Finally, this paper includes the perspective of a hospital school program's teacher regarding educational access, barriers to learning, and suggestions for those serving the educational needs of students with chronic medical conditions.

History of Homebound and Hospital-Based Instruction

Services for students unable to attend school due to their medical condition or while hospitalized have varied over the past century. Sikorski et al. (1993) documented Chicago's centralized process for approving educational services outside the traditional school setting. The process required physician documentation, a board review, and an assigned teacher. However, this process often took a month before the student received educational services. Initially, one or two teachers were assigned to the hospital units; however, they discontinued designated hospital locations in response to more children remaining at home rather than in hospitals. However, this shift increased the costs and time associated with in-home instruction. The model of service delivery shifted in 1990 following complaints of violation against Section 504 of the Rehabilitation Act. Although Chicago retained a group of centralized teachers to provide services in hospitals and those without an assigned teacher, the policy shifted responsibility for instruction to local teachers from the student's school of origin. Sikorski et al. (1993) noted that shifting responsibility to teachers from school of origin incurred half the cost as the centralized system. This illustration reflects two critical concepts. First, practices (i.e., the responsibility of the education for these students) may be influenced by both advocacy (e.g., raising complaints) and educational policy (e.g., moving from centralized to local districts). Second, it is important to reflect on current practices to develop more efficient and cost-effective services.

Currently, public schools serve many students with chronic medical conditions; a portion of instruction may be provided by a public school even when they cannot attend school. However, not all states require a district to provide education to students when they are not in school. Moreover, for states that do mandate some form of education when a child has a chronic medical condition that precludes them from attending school, the responsibility to provide instruction may fall on the school of origin, the school where the student is residing (home or hospital) during the time absent or may not be specified.

When students are hospitalized, they are typically augmented or temporarily shifted to school programming within hospitals (Perry et al., 2014; Steinke et al., 2016). Hospital School

Programs (HSPs) are defined as educational services offered in a hospital at the bedside, in a small classroom, or in a hybrid format by a state-certified teacher. In addition, to direct educational services, most HSPs offer family support services, such as information on special education, social work services, as well as education re-entry support post hospitalization, provided free-of-charge (Rodriguez et al., 2023). Students typically remain enrolled in their school of origin while attending a HSP as their attendance, with their attendance and academic progress reflected on their school records. However, some laws require students to disenroll if they participate in an HSP. Educational instruction encompasses all academic subjects and is generally aligned with state curriculum requirements. Prior to participation in HSPs, medical and educational staff assess the student's hospital placement (e.g., intensive care unit, medical floor), and stability of their health (Rodriguez et al., 2023). In most cases, hospital school teachers coordinate services through the schools and provide direct instruction and educational services to address missed learning opportunities (Kuo et al., 2018).

Policies Governing the Education of Students with Chronic Medical Conditions

Policies have been shown to create a culture of service delivery that upholds the expectation of supporting those in need and ensuring their access to care. Policies include statutes and regulations. Statutes are laws passed by the legislature. On the other hand, regulations are developed by designated agencies (e.g., Department of Education). Both statutes and regulations are binding.

Federal Regulations

At the federal level, students with chronic medical conditions may receive accommodations through Section 504 of the Rehabilitation Act of 1973, as any medical condition is eligible as long as it "causes a substantial limitation on the student's ability to learn or [to complete] another major life activity." The Americans with Disabilities Act (ADA), first enacted in 1990 to forbid discrimination for individuals with disabilities, applies both in and outside the school setting. The ADA Amendments Act of 2008, effective January 1, 2009, included an amendment to the Rehabilitation Act of 1973, clarifying the meaning of disability in Section 504. In the Amendments Act, Congress provided additional examples of general activities that are to be considered 'major life activities,' including "eating, sleeping, standing, lifting, bending, reading, concentrating, thinking, and communicating." Most chronic medical conditions result in difficulties in one or more of these areas (ADA 42 U.S.C. § 12101 et seq, 2008).

Further, enacted in 1975, the Individuals with Disabilities Act provides youth with disabilities the right to a Free and Appropriate Education (FAPE). This means that all schools must provide access and instruction to students K-12. Students with medical conditions who need specially designed instruction may be eligible for a special education classification under Other Health Impairment (OHI). Among one of 13 school-age categories under the Individuals with Education Improvement Act (IDEIA, 2004), verbatim text for OHI references the potential impact of some of the most prevalent conditions, "limited strength, vitality, or alertness due to chronic or acute health problems, such as heart conditions, tuberculosis, rheumatic fever, nephritis, asthma, sickle cell anemia, hemophilia, epilepsy, lead poisoning, leukemia or diabetes which adversely affects a child's educational performance" (U.S. Department of Education, n.d.). This list is certainly not fully inclusive of the various medical conditions that students may

experience, but they do represent the most commonly diagnosed. Even though FAPE guarantees these children a suitable and individualized education, it is often misrepresented by school and court systems, which frequently dictate the level at which public schools provide special educational support (Scanlon et al., 2021).

Notably, "public education in America has not historically addressed the needs of students unable to attend school due to medical conditions, but [that] federal policy changes since the 1960s have made some progress in defining the responsibility of school systems to the student population of chronically ill children" (Wilson-Hyde, 2009, p. 48). However, since states often oversee educational practices, it is critical to evaluate the current statutes and regulations that govern the education of students with chronic medical conditions.

State Policies

As noted, the federal guidelines reference hospital/home instruction as an alternative placement for the provision of instruction and other related services. However, they do not mandate that these educational services be readily provided for those eligible for OHI to ensure FAPE. Consequently, the availability of homebound instruction for students with chronic medical conditions varies between states and often from district to district (Tseng & Pluta, 2016). The vague and inconsistent policies across states and the absence of federal regulations have led to inequitable homebound services. Generally, literature has suggested the nature of educational access for children with chronic illness include: the typical model in the U.S. is to provide students who become eligible for hospital/homebound with one hour of tutoring per week per core subject they are enrolled in, resulting in a modal value of four or five hours of tutoring per week (Irwin & Elam, 2017; Shaw et al., 2014) as compared to the 25 hours of instruction per week healthy children receive (Hull & Newport, 2011). Further, anecdotally, educators hired to provide hospital/homebound services are often not required to be certified teachers, and instruction may be provided in various formats, including via telephone or telepresence. Fiscal responsibility and oversight also vary across states, with some not providing additional resources, some indicating the school of origin should provide the service, and some requiring disenrollment from their school and enrollment in the school where the hospital resides to be able to receive school services. The latter poses challenges as the student must enroll in a school in which they do not have peer connections or familiarity. There is also inconsistency in the time to determination and time before eligibility (Shaw et al., 2014). Moreover, some students are absent intermittently, either missing several days per week or significant portions of days (e.g., dialysis patients and patients requiring frequent blood transfusions; Irwin & Elam, 2017).

Evidence has suggested that the structure of homebound education has invoked a sense of complacency. The lack of clarity or even the existence of legal mandates has created a domino effect of federal, state, and local education agencies failing to provide FAPE to students who cannot attend school due to their chronic health conditions. To provide up-to-date information and recommendations to the general public, educators, and families, this project analyzed state laws and regulations (Aim 1) as well as gathered Southern Arizona's school districts' homebound or hospital-based instructional practices (Aim 2). Finally, we used a case study approach to feature a hospital school program in Southern Arizona to explore its unique challenges, successes, and potential as a model for addressing the educational needs of hospitalized children (Aim 3).

Method

The approach taken was consistent with several previously published educational policy analysis studies (Briesch et al., 2017; Maki et al., 2015; MacFarlane et al., 2009; McNicholas et al., 2017; Pennington et al., 2014; Perfect et al., 2013). There were multiple sources of information to address our aims: state policies, Southern Arizona School District's policies and practices related to the provision of homebound instruction, and preliminary input from educators. For Aim 1, researchers conducted an internet search to retrieve laws, statutes, and regulations related to education for children with chronic health conditions. In conjunction with the state name, the following keywords were searched "*special healthcare needs," "chronic illness," "chronic medical condition," "chronic illness" "homebound laws/statutes," "hospital instruction"* (i.e., [State Name] homebound laws for children with chronic medical conditions). All 50 states and the District of Columbia were included in the analysis, with attempts made to verify and retrieve laws that could be located online by contacting state Departments of Education. The timeframe for extracting the statutes and regulations was between January to May 2024. Some laws, statutes, and regulations not gathered during initial retrieval were deemed unavailable or non-existent. Any changes beyond that data range are not reflected in the coding unless serendipitously discovered. The primary goal was identifying and obtaining the original law or policy. As another step, we reviewed websites and documents that detail state policies established by the state's Departments of Education. When statutes or regulations were not available for retrieval, we contacted representatives from the state department of education for policies regarding youth with special healthcare needs. Prior to coding compiled laws, each research team member underwent training on homebound education background and a 3-hour code training session. Appendix 1 includes the full list of regulations that were coded as not all of these were specifically cited in the narrative of this white paper.

Once policies were compiled, researchers developed a two-cycle coding scheme using Taguette software for qualitative analysis. Two lead researchers and two undergraduate research assistants served as coders. To reduce coding inaccuracies due to coder drift, states and the four coders were entered into a random generator and assigned 26 jurisdictions, each varying with whom each team member was paired. The initial cycle used 25 evaluation codes across five categories including *Eligibility* (conditions, documentation requirements for confirmation of condition, days until eligible, time to determination; renewal/re-eligibility, intermittent or continuous absences); *Instruction* (who, what, when, where, and how); *Caregiver Involvement; Management/coordination* (oversight; reviews; dispute resolution; jurisdiction; billable service; dollars allocated; funding sources); and *Other considerations* relevant to the provision of educational services (related services, tracking progress, special educational eligibility, 504 status). With regard to the instructional categories, codes included qualifications of instructor, affiliation of instructor, the nature of the content (e.g., standards-based), how many hours per week, documentation of contact hours, scheduling and location of services, and modalities (online, in-person). To that end, we examined the existing state statutes and Department of Education regulations that are relevant to the education of youth with chronic medical conditions.

A secondary coding cycle was implemented after each state was double-coded and reconciled to determine intercoder and intra-coder reliability. The secondary cycle involved 120

subcodes to identify more specific patterns and themes. This cycle encompassed more focused subcodes under the single primary (parent) code. A total of 120 subcodes were developed to identify more specific patterns and themes. The same coding software was utilized for secondary coding. Coding documents whether the domain and its subparts within the statutes, regulations, or guidelines are present, unspecified (mentioned but vague), or restricted (i.e., specifically noted as not required). After the double-coding process was complete, the first author met with each pair of coders to examine, discuss, and resolve discrepancies through consensus judgments. This process resulted in refining coding criteria to address inconsistency in ratings (McNicholas et al., 2017).

For Aim 2, the research team contacted public school districts across the Southwestern Arizona counties of Pima, Santa Cruz, and Cochise; Charter schools were not included. A total of 17 districts for Pima, 20 districts for Cochise, and 8 for Santa Cruz were contacted via email or phone call by the research team. Out of the 45 districts that were contacted, 10 of them provided information regarding their district policies on homebound, enrollment status, and procedures. Additional information was extracted from publicly available websites or published handbooks from the Arizona School Board Association.

Aim 3 utilized a case study approach given that there was only one hospital school program in Southern Arizona. A descriptive case study aims to provide a detailed account of an intervention or phenomenon within its authentic setting. This approach allows researchers to paint a comprehensive picture of the subject, capturing its components as they exist in authentic settings, highlighting the program's unique features, and documenting challenges (Crowe et al., 2011; Hyett et al., 2014). This case study employed a combination of publicly available information (e.g., newspaper articles, website, press releases, etc.; Available upon request) about the hospital school program and an interview with the current hospital school teacher. The 45-minute interview was conducted via Zoom, which included the facilitator, co-facilitator, and the hospital school program teacher. The interview protocol for the hospital school teacher aimed to gather comprehensive insights into the role, experiences, and challenges associated with providing education in a medical setting. It started by exploring the teacher's background and experience, seeking to understand their path to becoming a hospital school teacher and the relevant training or preparation they had received. The protocol then delved into daily operations and responsibilities, exploring the typical activities and the types of patients served. A significant focus was placed on the educational approach, examining how teaching methods were tailored to meet diverse needs and the difficulties encountered in this unique environment. Collaboration and communication were explored, with questions about interactions with caregivers and schools of origin regarding curriculum, special education, and accommodations. Challenges and solutions were covered to understand common problems and innovative strategies. Professional development was another key area, investigating training opportunities and connections with other hospital school teachers. Finally, future directions were discussed, inviting the teacher to share their vision for improvements and enhancements to the hospital school experience, concluding with advice for aspiring hospital school teachers and any additional insights they wished to share. As part of the coding and interpretation process, qualitative indicators of reliability and validity included member checking (participant reviews transcript and approves the data; McKim, 2023), team debriefing, triangulation, and credibility (Korstjens & Moser, 2017).

Results

Aim 1. Analysis of State Policies (Statutes and Regulations) Related to Homebound Instruction for Students with Chronic Health Conditions

Among the state laws and Department of Education regulations that were reviewed for the 50 states and the District of Columbia, 40 had active policies relevant for inclusion of homebound instruction. Table 1 provides a summary of the primary codes, secondary codes, and States that were coded as being present for that category.

Table 1. Primary Codes, Secondary Code Log and States Analyzed

Primary Codes	Secondary Codes	States Analyzed
Caregiver Involvement	Caregiver Supervision Caregiver Notification/Consent	California, Florida, Georgia, Iowa, Maryland, Missouri, New Hampshire, New Jersey, Pennsylvania, Tennessee, Washington, West Virginia, Wisconsin
Condition Specificity	Chronic Illness Disability Injury/Accident Pregnancy Other	Arizona, California, Delaware, Florida, Georgia, Indiana, Maryland, Massachusetts, Minnesota, New Jersey, Pennsylvania, Tennessee, Texas, West Virginia, Vermont, Louisiana, New York, Rhode Island, Idaho, South Carolina, District of Columbia, Connecticut, Wyoming, Oklahoma
Curriculum Requirement	Individual Education Plan (IEP) Make Progress Written Education Plan Required Materials State-Approved Curriculum Primary Teacher Involvement	Connecticut, Delaware, District of Columbia, Georgia, Indiana, Iowa, Kentucky, Louisiana, Maryland, Missouri, New Hampshire, New Jersey, New York, Oregon, Rhode Island, Tennessee, Vermont, Virginia,, West Virginia, Wisconsin
Dispute Resolution	Appeal Allowable Due Process Decision Final	Connecticut, District of Columbia, Maryland, Minnesota, Missouri, New Hampshire, New York, Oregon, Pennsylvania, and Wisconsin
Educator Qualifications	Non-specified Special Education Certified State-certified or Licensed Qualified Agency	Georgia, Iowa, Idaho, Illinois, Indiana, Kentucky, Maryland, Michigan, Minnesota, New York, North Carolina, Nevada, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Virginia, and West Virginia
Eligibility	Educational Benefit/Progress/Medically-Able Least Restrictive Environment	Alaska, Arizona, California, Connecticut, District of Columbia, Delaware, Florida, Georgia, Idaho, Illinois, Indiana, Kentucky, Louisiana, Massachusetts, Maryland,

	Attendance/Instruction Healthcare Provider MD Mental Health Provider Nurse Practitioners Physician Physician Assistant School Psychologist	Michigan, Minnesota, Missouri, North Carolina, New Jersey, New York, Ohio, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, Vermont, Virginia, Washington, Wisconsin, and West Virginia
Instructional Modality	Home Hospital Hybrid Online Other (e.g., library) Treatment Center	Alaska, California, Connecticut, Delaware, District of Columbia, Florida, Georgia, Idaho, Illinois, Iowa, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Nevada, New Jersey, New York, North Carolina, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Virginia, Vermont, West Virginia, and Wyoming
Instructional Time	2 or fewer hours 3-5 hours 6-9 hours 10-12 hours 15+ hours	Arizona, California, Connecticut, Delaware, District of Columbia, Georgia, Illinois, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Nevada, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, Tennessee, Virginia, and Vermont
Jurisdiction	Contracted Third-Party Providers Department of Ed-Operated/Approved Hospital School Program Dual Enrollment/Return Access Per agreement/contract School of Hospitalization School of Origin/District Non-Specified	Alaska, Arizona, California, Connecticut, District of Columbia, Florida, Iowa, Maryland, Massachusetts, Michigan, Minnesota, Nevada, New Hampshire, New York, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, Tennessee, Texas, West Virginia, and Wyoming
Last Updated	Within Past Year 1-3 Years 4-5 years 6-9 Years 10-19 years 20+ Years	California, Connecticut, District of Columbia, Delaware, Florida, Georgia, Idaho, Illinois, Iowa, Kentucky, Maryland, Michigan, Minnesota, New Hampshire, New Jersey, Nevada, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, Virginia, Vermont, Washington, West Virginia, Wisconsin, and Wyoming

Monitoring	Record of Instructional Activities Reporting Progress Screening for Need	Minnesota, Missouri, New Jersey, New York, Oregon, Rhode Island, South Carolina, and West Virginia.
Non-Traditional School Year	No Alternative, Summer Break, Evening, Weekend, Make-Up.	Delaware, Georgia, Illinois, Indiana, Minnesota, Missouri, New York, Rhode Island, and South Carolina
Oversight of Implementation	School Staff School District Homebound Teacher Special Education State Department Third Party Contract	District of Columbia, Florida, Illinois, Kentucky, Maryland, Massachusetts, New Hampshire, New Jersey, New York, North Carolina, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, Virginia, and West Virginia
Recording of Attendance	Calculation of Average Daily Attendance, Hours to Day Conversion, Make-Up, Maximum Allowable, Minimum Allowable, Non-Specified, Other Numerical Sum of Enrollment	Alaska, Arizona, California, District of Columbia, Florida, Georgia, Idaho, Indiana, Kentucky, Louisiana, Maryland, Michigan, Minnesota, Missouri, Nevada, New Hampshire, New York, Ohio, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, Washington, and West Virginia
Reintegration or Transition	Allowed Transition Options, Reintegration Planning, Not Permitted	California, Delaware, District of Columbia, Florida, Georgia, New Hampshire, Tennessee, and West Virginia
Renewal Requirements	Annually Periodically No Requirement 20-30 days 46-60 days 61-90 days 90 days-6 months	Delaware, District of Columbia, Florida, Indiana, Iowa, Kentucky, Maryland, New Jersey, North Carolina, Pennsylvania, Tennessee, and West Virginia
Special Education	Eligible Outside of Special Education Must follow IEP/504 Not the Same as Special Education Special Education Required	Alaska, Connecticut, Delaware, District of Columbia, Florida, Illinois, Indiana, Iowa, Kentucky, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Nevada, New Hampshire, New Jersey, New York, North Carolina, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Vermont, Virginia, Washington, West Virginia

Time Until Determination	Non-specified Within 5 days 10-15 days 30+ days	California, District of Columbia, Georgia, Maryland, Massachusetts, Missouri, New Jersey, New York, and Wisconsin
Time Until Eligible	Within 5 days 6-9 days 10-15 days 16-29 days 30+ days	Arizona, Connecticut, Delaware, District of Columbia, Florida, Florida, Georgia, Idaho, Illinois, Indiana, Louisiana, Massachusetts, Michigan, Minnesota, New Jersey, Oregon, Tennessee, Texas, Vermont, Washington, West Virginia, and Wyoming
Time Until Implementation	Immediately Medical Clearance Within 5 days 10-15 days	California, Connecticut, Delaware, District of Columbia, Illinois, Louisiana, Massachusetts, Michigan, Minnesota, New Jersey, New York, and Oregon

There were several subcodes related to *Eligibility*: condition specificity, educational considerations (inability to attend school or potential educational benefit), enrollment requirements, healthcare provider qualifications, and duration of condition.

Only 24 jurisdictions (47% overall; 60% of coded states/DC) included specific conditions that meet eligibility criteria for homebound instruction. Chronic illness was coded for 16 states. Some states simply mentioned chronic illness or physical conditions; others listed specific conditions. For instance, the Massachusetts Department of Elementary and Secondary Education (2022), 603 CMR 28.02 included "asthma, attention-deficit hyperactivity disorder, diabetes, epilepsy, a heart condition, hemophilia, lead poisoning, leukemia, nephritis, rheumatic fever, and sickle cell anemia**"** whereas Code of Maryland Regulations, Title 13A, Subtitle 03, Chapter 05 (2023) outlines, "These conditions include, but are not limited to, kidney failure, cancer, asthma, cystic fibrosis, sickle cell anemia, depression, and bipolar disorder. including drug and alcohol dependency." Delaware specifies "sudden physical or mental illness; Accident; Episodic flare up of a chronic physical or mental health condition; Injury; or Pregnancy, childbirth or related medical condition" (DE Code § 930, 2019). The specific conditions mentioned for Arizona include only "illness, disease, accident, or other health condition" (AZ Stat § 15-901(B)(16), 2022).

Thirty-one (61% overall; 78% of coded states/DC) states addressed eligibility related to educational considerations, enrollment requirements, and/or healthcare provider qualifications. Nineteen states required students to be prevented from, unable to, or confined to home or hospital. Nine states referenced documenting the ability to benefit from or potential to make progress. Arizona statute mentioned the latter; that is, students needed to demonstrate that they can profit from homebound instruction. Two states restricted students from receiving homebound instructional services if they were enrolled in a nonpublic or virtual school, whereas three states specified enrollment in a public school as a condition to be eligible for homebound. Arizona did not indicate enrollment requirements.

Regarding Healthcare Provider Qualifications, 21 (41% overall; 53% of coded states/DC) states specified a medical doctor/licensed physician, and six states indicated a nurse practitioner.

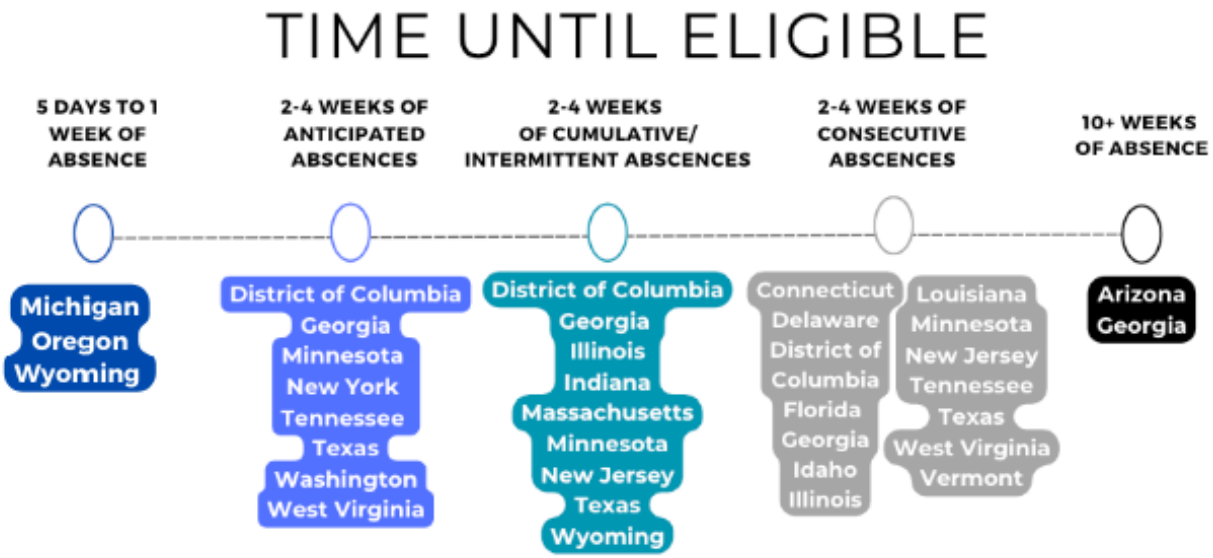
Seven states allowed a mental health provider to authorize homebound instruction. Maryland and Pennsylvania both permitted a school psychologist to authorize homebound instruction. Some jurisdictions, such as the District of Columbia, permitted various providers to provide documentation regarding the medical condition. Accordingly, DC's statute includes "licensed physician, licensed nurse practitioner, licensed clinical psychologist, licensed mental health counselor or therapist, or physician assistant" (D.C. Code § 38-251.01, 2020). For Arizona, eligibility is only considered if the student is "examined by a competent medical doctor and who is certified by that doctor" (AZ Stat § 15-901, 2022).

Four primary codes related to *Timing*: Eligibility, Determination, Implementation, and Instructional Time.

Twenty-three (45% overall; 58% of coded states/DC) states explicitly outlined eligibility criteria by providing a timeframe for missed school days to become eligible for homebound services. Michigan, Oregon, and Wyoming stood out for eligibility, ranging from students missing more than 5 days to a week. Fourteen of these states required an absence of 10 to 15 consecutive, cumulative, or intermittent days to qualify for homebound instruction. A smaller group of states (three) established longer eligibility periods ranging from 16 to 29 days, though these were often cumulative or aggregate absences. Illinois was unique in that it clarified not only the total number of days, but also when services were expected if a child were to miss school on an "ongoing intermittent basis." The statute defined this to mean "that the child's medical condition is of such a nature or severity that it is anticipated that the child will be absent from school due to the medical condition for periods of at least 2 days at a time" (IL Stat § 14-13.01, 2018). Washington D.C. encompasses many avenues for coverage such as '"home and hospital instruction program" means a program that provides instruction and support to students who have been or are anticipated to be absent, on a continuous, partial, or intermittent basis, from their school of enrollment for 10 or more consecutive or cumulative school days during a school year due to a health condition' (D.C. Code § 38–251.01, 2020).

Other states, such as Georgia, Minnesota, and Tennessee, introduced variations with short-term and long-term eligibility thresholds. As depicted in Figure 1, Georgia falls into nearly every time until eligible category because of multiple distinctions. For Georgia's temporary homebound service, the statute indicates the student would qualify for less than nine weeks and have a minimum of 10 consecutive (actual or anticipated) days of absence. However, similar to Illinois, it also had a caveat related to intermittent absences, for which the student may receive homebound service if they have an anticipated minimum of 10 days, provided they miss "at least 3 consecutive days for each occurrence" (GA Code §160-4-2-.31, 2009). Georgia's long-term homebound service is indicated when the student has a "medically diagnosed chronic health condition which may cause the student to be absent from school for more than nine consecutive weeks per year or equivalent on a modified calendar" (GA Code §160-4-2-.31, 2009). At the farther end of the spectrum, two states (TX and WA) required four weeks or a month of "estimated" or "expected" absences, while Arizona mandated a substantial absence of either 90 days or intermittent periods totaling three school months, though both could be anticipated or actual. Figure 1 includes a timeline listing the states based on their Time to Eligibility as well as whether their statute includes terminology for anticipated, consecutive, or intermittent.

Figure 1. Coded United States Department of Education



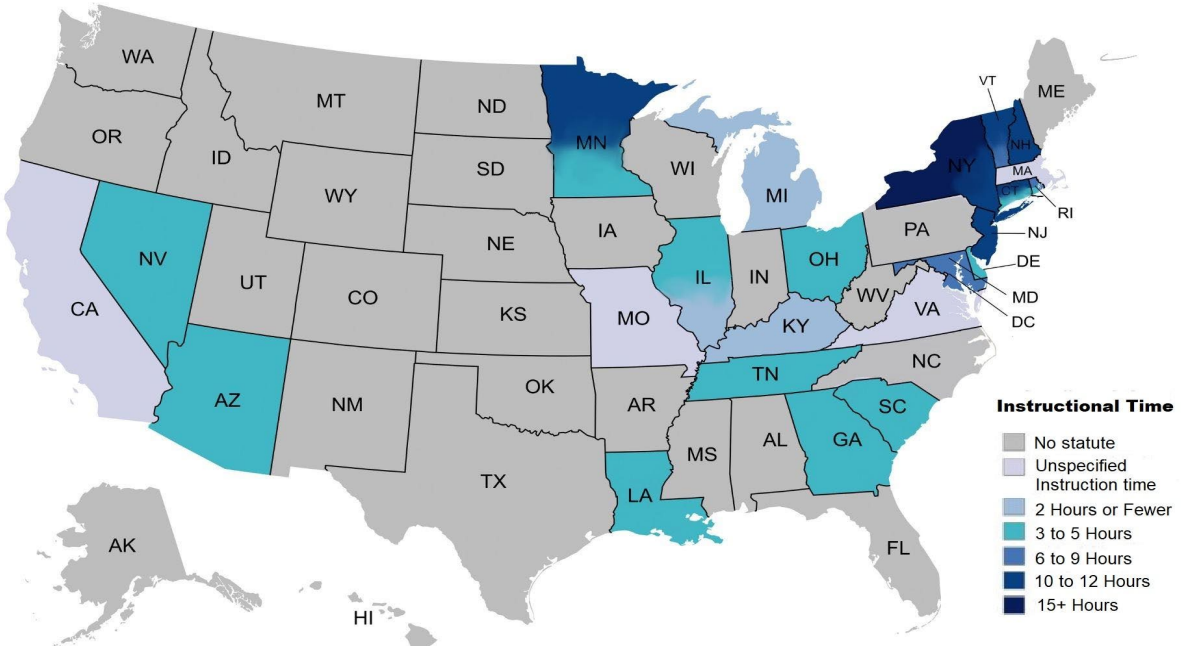
Disclosure: The criteria for eligibility based on time missed can vary between states and may depend on whether the absence is anticipated, consecutive, intermittent, or cumulative. The following map shows where states require a specific duration of absence for eligibility; however, the interpretation can differ based on the terminology used. For example, in Arizona, a student must have three school months of absences, but this can include the cumulative total of intermittent absences.

Nine (18% overall; 23% of coded states/DC) states' policies referenced a maximum Time to Determination for when a decision must be made regarding approval or denial of homebound instruction. Five states specified a determination within five days. Two states were coded as requiring a determination within 10 and 15 days. Although Missouri did not outline the timeline for determination, it does require time procedures for notification of services by specifying, "If the building level administrative team determines homebound services are not needed, the building principal or his/her designee will notify the requesting party within 5 school days of the decision" (MO Stat § PR 6275, 2013). Wisconsin had the longest time for determination by stating, "The school board shall render its decision, in writing, within 90 days of a request" (WI Stat § 118.15(1)(d), 2024). Nine (18% overall; 23% of coded states/DC) states were also coded for time until Implementation of homebound services as "immediately" or between three to five days, while three states indicated instruction needed to begin within 10 to 15 days. Four states included the added requirement that medical clearance is required in addition to the timeframe. An example of this caveat was Oregon, which only specified parameters around implementation in state-operated hospitals, "educational services in state operated hospitals must commence if a patient's hospital stay is expected to last five schools' days or longer and the hospital staff has determined the patient is medically able to receive educational services" (Oregon Administrative Rule [OAR] § 581-015-2580, 2021). For both determination and implementation, when present in state statutes, these policies include phrasing such as "immediately," "within," "no later than," [number] "day of absence," or "by" [number of days]. Arizona was silent on how long districts

have to make a determination regarding eligibility for homebound instruction, and it does not address a required timeline for implementation.

Regarding Instructional Time (i.e., hours or amount of time a student who is homebound/hospitalized is entitled to), 26 (51% overall; 65% of coded states/DC) states addressed the requirements for instructional time. Three states were coded as two or fewer hours per week, and six states mandated 10 to 12 hours per week (1 with fewer for elementary, 1 with more for secondary, and 1 based on the number of days needing service). The majority of states required between three and five hours of instruction weekly (12 states, 2 with more for secondary; 1 with less if technology is utilized). States employed different methods to calculate instructional time, including minimum hours per day, average hours per day, or a specific number of hours per week. Several states differentiated instructional time based on grade level such as: Connecticut (5 hours versus 10 hours), Delaware (3 hours for elementary versus 5 hours for secondary), New York (10 hours for elementary versus 15 hours for secondary), Rhode Island (5 versus 6), Vermont (6 versus 2 hours per core course for secondary; CT Stat §10-76d-15, 2013; DE Code § 930, 2019; NY Code 8 § 175.21. 2021; RI Code 200-RICR-20-30-6, 2018; VT Stat § 1252, 2013). Four states did not specify a minimum instructional time, but rather indicated based on students' needs or as indicated in a plan developed by the teacher, school, or the Local Educational Agency (LEA). Eleven states also explicitly deferred the specific hours based on need or the student's Individual Educational Plan (IEP). Arizona indicates a minimum of four hours of instruction.

Figure 2. Minimum Instructional Time Requirements for Homebound Students



Thirty-two (63% overall; 80% of coded states/DC) states included information about requirements or options for instructional modality. Twenty-three states mentioned that instruction could be delivered in the home, whereas 22 specifically mentioned hospital settings for the provision of instructional services. Twenty were coded for both home and hospital. Twenty-three included other examples such as libraries, rehabilitation centers, healthcare treatment facilities/centers, or "anywhere as appropriate." The most commonly referenced setting

amongst these alternatives was a treatment facility or center. For instance, Michigan did not specifically mention services at home, other than calling it 'homebound' but did include "district or intermediate school district is required to provide instructional services under subsection (1) to a pupil placed in a hospital, treatment center, or other treatment facility" (MI Stat § 388.1709, 2017). Fifteen states described online, virtual, remote, or electronic means as acceptable modes of delivering instruction. Three states did not provide parameters regarding requirements as to location, but instead expected the decision to be made by the IEP team or those responsible for providing homebound instruction. Although Arizona does not specifically address instructional modality, it does refer to "homebound" or "hospitalized" students within the statute.

Renewal requirements were coded for 11 (22% overall; 28% of coded states/DC) states. Three states required reviews for continued eligibility every 30 days, six states mandated reevaluation every 60 days, two required three months or 90 days, and four indicated annual recertification. Without providing a specific review timeline, Iowa's regulation indicates, "The provision of services in a home or hospital setting shall satisfy the following: a. The service and the location of the service shall be specified in the individual's IEP. b. The status of these individuals shall be periodically reviewed to substantiate the continuing need for and the appropriateness of the service" (IA Code § 281-41.410, 2024). Arizona does not directly address renewal requirements, but it appears that in order to be eligible each academic year, new documentation must be provided.

Twenty-one (41% overall; 53% of coded states/DC) states specified Educator Qualifications. Eighteen of those states indicated instruction must be provided by a certified teacher. Additionally, nine states explicitly acknowledged that homebound instruction for students who also qualify as having a disability must be provided by a certified special education teacher. Four states mentioned provisions for contracting with third-party agencies that have qualified staff to provide the instruction. A few states referred specifically to instruction delivered in hospital school programs. For instance, Rhode Island included the requirement, "All teachers employed in hospital programs shall be trained and certified to provide special education in the area of basic disability for which the hospital program is established" (RI Code § 200-RICR-20-30-6, 2018). Although Arizona's statute does not appear to specifically indicate qualifications of the instructor and therefore was not coded as being present in this category, a supplemental document issued by the state department of education notes instruction is to be provided "by teachers with the same certification as the regular classroom teacher" (Arizona Department of Education, 2023).

Twenty (39% overall; 50% of coded states/DC) states addressed Curriculum requirements. Four states establish the expectations that homebound instruction will be coordinated or under the supervision of the classroom teacher. Five states required a written education plan. Five states included the requirement that the school provides the student with all necessary supplies, textbooks, and/or other instructional materials. Eight states mentioned the requirements of an IEP for students with disability or eligibility under special education. Six states specify the curriculum requirements to provide instruction necessary to make progress. Although 37% of states have some reference to curriculum requirements, Connecticut had a statute that was subcoded in nearly every category (e.g., Special Education, Make Progress, Required Material, State-Approved Curriculum).

> Instruction provided pursuant to the provisions of this section shall maintain the continuity of the child's general education program and, in the case of a child with a disability, shall be provided so as to enable the child to continue to participate in the general education curriculum and to progress towards meeting the goals and objectives in the child's IEP. For purposes of this section, "maintaining the continuity of the child's general education program" means the child shall receive instruction in core academic subjects required by the board of education for such child or an interdistrict magnet school or charter school in which such child is enrolled for promotion or graduation. Such interdistrict magnet school or charter school shall cooperate with the board in planning homebound instruction and shall provide instructional materials to enable the board to provide appropriate instruction to the child (CT Stat § 10-76d-15, 2015).

Arizona does not mention curriculum requirements or allowances regarding adaptations for homebound students.

Eight (17% overall; 20% of coded states/DC) states included provisions for tracking student progress (*Monitoring*), including grades, competencies, standards, or exam results, as well as timing and type of educational services. However, only five states required that progress reports be submitted. Additionally, six states mandated documentation of instructional activities, such as when and what services were provided, but did not specify reporting timelines. Minnesota was the only state coded for including a requirement for conducting a needs assessment (i.e., "A screening must be conducted by education staff to determine the student's academic, social, and behavioral needs") for homebound students (MN Stat § 3525.2325, 2007).

Seventeen (33% overall; 43% of coded states/DC) unique states provided information about Oversight of Implementation. Six states required school districts to be the responsible party for the provision of homebound or instruction services. Four statutes stated school staff (e.g., superintendent, principa, classroom teacher) are responsible. Seven states specified that the Special Education team is responsible. Massachusetts specifies "the principal shall arrange for provision of educational service" and "The principal shall coordinate such services with the Administrator of Special Education for eligible students" (MA Stat § 603 CMR 28.03, 2022). Oregon and Kentucky were coded as their states' Department of Education having the authority to oversee provision of instruction. Oregon and Florida allowed for third-party contracting specifically related to educational programming in hospital settings. Although nearly one-third of states specifically addressed oversight of implementation of instruction for homebound students, Arizona is not one of them.

Fourteen (27% overall; 35% of coded states/DC) states were coded for Caregiver Involvement. Eleven states specifically mentioned that a caregiver must provide notification to the school or consent for homebound instruction. For the most part, the eight states that were coded as Caregiver Supervision/Consultation mentioned that an adult 21 years or older, or the legal guardian, must be present during instruction. Missouri was additionally coded as "Other" for their unique description of caregiver involvement, "For a nondisabled student, the building level administrative team will make a decision with respect to the need for homebound services. The parents, guardian or eligible or emancipated student are not required participants in this

process, but the administrative team has the discretion, on a case-by-case basis, to decide if their participation would be helpful" (MO Stat § PR 6275, 2013). Caregiver role or involvement is not clarified in Arizona's statute or regulations.

Nine (18% overall; 23% of coded states/DC) states were coded under the Non-Traditional School year. Missouri is one of those states that specified homebound services should only occur during the regular school calendar. Whereas Illinois also had the expectation that homebound should only occur during school hours, it allowed for the option for all parties involved to agree to an alternative. About 12% (n = 6) of the states permitted instruction during the Summer. South Carolina indicated that "if the school district delays the start of services for any reason, the student is still entitled to the instructional services, and the school district must make up the missed instructional periods even if the regular school year has ended and services are provided without the benefit of state funding" (SC Code § 43-241, 2019). South Carolina further allows make-up sessions in the evenings or weekends. Georgia is the only other state that mentioned make-up sessions, in this case, if the child is unable to receive instruction during a regular school day due to their health. Arizona's current policies do not have requirements regarding when instruction occurs, what to do when sessions are missed or delayed, or whether summer sessions are permitted.

Seven (14% overall; 17% of coded states/DC) states were coded for Reintegration or Transition. Three of these states (i.e., California, Delaware, and Florida) allowed for partial return, meaning students were entitled to either a hybrid of homebound and in-school instruction or shortened on-site days. California specified that a student may receive instruction for part of the week by the school where the student is residing when ill, as well as at their school of origin when they are well enough to attend school. Additionally, once a student is able to return to school, they are permitted to return to their school of origin:

> A pupil receiving individual instruction who is well enough to return to a school shall be allowed to return to the school, including a charter school, that he or she attended immediately before receiving individual instruction, if the pupil returns during the school year in which the individual instruction was initiated. A pupil who attends a school operated by a school district or a charter school, who is subsequently enrolled in individual instruction in a hospital or other residential health facility for a partial week, shall be entitled to attend school in his or her school district of residence, or receive individual instruction provided by the school district of residence in the pupil's home, on days in which he or she is not receiving individual instruction in a hospital or other residential health facility, if he or she is well enough to do so (CA Code § 48207.3, 2019).

Tennessee, Georgia, New Hampshire, and DC required a transition or reintegration plan to support the student's return to school after homebound instruction. For example, New Hampshire stipulated the following regarding transition for homebound students "Develop a written plan for the transition of the child into a less restrictive environment which shall include the following: a. Objective criteria for determining when the student will no longer require a home-based program and will receive special education services in a school-based program; b. Specific activities for

each phase of the transition; and c. The specific time frame for each phase of the transition process" (NH Code § Ed 1111.05, 2017). Arizona does mention of reintegration or transition.

Twenty-four (47% overall; 60% of coded states/DC) unique states were coded for Recording of Attendance. Thirteen states were coded for mentioning the need to calculate average daily attendance; six of those, along with an additional six, indicated that students receiving homebound instruction or in a hospital could be counted as present. Example wording is found with Michigan that specified "from either the district the pupil is enrolled in or the intermediate school district in a non-special education homebound program may be counted in membership" (MI Stat § 388.1709, 2017).

Five states, including Arizona, outlined hours-to-day conversion, such that a certain number of hours per week/day of instruction were deemed equivalent to a full school day. For instance, Nevada describes "More than 1 day of attendance may be accumulated during a single instructional session of more than 1 hour, but the number of days of attendance reported for the pupil for that school year may not exceed the minimum number of days of free school required" (NV Code § 387.286, 2023). Arizona notes "a full day of attendance may be counted for each day during a week in which the student receives at least four hours of instruction" (AZ Stat § 15-901, 2022). Accordingly, a full day of attendance is counted for at least 4 hours of instruction. Georgia is the only state coded that students can make-up lost instruction and once a make-up session is completed it can be counted retroactively towards attendance. Four states were coded for having conditions regarding the maximum allowable instruction hours per week.

A total of twenty-two (43% overall; 55% of coded states/DC) states were coded for Jurisdiction. Only three were coded for allowing schools to contract with third parties to provide homebound instruction. Furthermore, eight states allow schools to establish cooperative agreements or contracts with agencies and hospitals. Seven states specified that the school where the student resides or is hospitalized is responsible for their education. Twelve states were coded for mentioning that the school of origin is responsible for the student's education.

As mentioned under transition/reintegration, California allows for dual enrollment, meaning students are entitled to remain enrolled in and return to their school of origin while also being enrolled in a hospital school. However, regarding jurisdiction, the statute specified, "either individual instruction at home provided by the school district in which the pupil is deemed to reside, or individual instruction in a hospital or other residential health facility, excluding state hospitals, provided by the school district in which the hospital or other residential health facility is located" (CA Stat § 48206.3, 2019). Additionally, six states referenced that the Department of Education or state-approved Hospital School Program may oversee responsibility for the student's education. Arizona's statute does not address the jurisdiction that should oversee/provide the homebound instruction.

A total of nine states (18% overall; 23% of coded states) were coded for Dispute Resolution. Five states referred to parents being able to appeal regarding home or hospital instruction or placement. Two states were coded that the school administration decision regarding placement is final. Three states referenced parental rights for due process. Arizona does not include options for appeal. D.C. stood out for its detailed description of the appeal

process for homebound instruction; some elements of related text regarding this appeal contained within the statute is as follows:

> A parent may appeal an LEA's decision to approve or deny a request for home or hospital instruction by submitting a written request for an appeal to OSSE. An appeal to OSSE shall be submitted within ten (10) calendar days of receipt by the parent of the LEA's written decision . . . Upon receipt of the parent's request for appeal, OSSE shall provide mediation between the parent and the LEA" (D.C. Code § 23-204, 2021).

If mediation does not resolve the dispute within 8 days, the statute mandates that the OSSE must convene a three-member panel. It appears that the parent, who has the right to orally present their argument, has the burden of proof for the documented need for homebound or hospital instruction. However, DC stipulated "There shall be a presumption in favor of the medical opinion set forth in the medical certification of need submitted in support of the request for home or hospital instruction" (D.C. Code § 23-204, 2021). The appeal panel decision must be rendered within 10 days and implemented within 5 days.

Thirty-one (61% overall; 78% of coded states/DC) states were coded for having a year in which at least one aspect of the policies had been Last Updated; these were the ones for which a date was apparent in the policy we extracted. Four states contained some aspects of their statute updated within the past year. One of the 31 states was coded to not have updated a part of its statute in nearly 20 years. Six states updated some parts of their statute that were last updated 10-19 years ago. For the remaining states, they had partial updates to their laws between 1-9 years. Arizona has renewed the statute, however, there does not appear to have been any updates. Arizona State Legislature's (n.d.a) website specified, "The Arizona Revised Statutes have been updated to include the revised sections from the 56th Legislature, 1st Regular Session. Please note that the next update of this compilation will not take place until after the conclusion of the 56th Legislature, 2nd Regular Session, which convenes in January 2024." We could not locate any historical information that reflected when the statute was first enacted, nor that the statute has ever been modified since its inception.

Twenty-nine (57% overall; 73% of coded states/DC) states made some reference to Special Education. Eight states specified in their regulations that homebound is available to general education and special education students and require schools to follow the special education plan (IEP or 504) if being placed or currently in special education. Sixteen additional states explain that delivery of homebound instruction for students with disabilities must follow their IEP or 504 Plan. Coding reflected that five states exclusively referenced homebound in the context of special education. Arizona was not among the states coded, but it appears that homebound or hospital-based instruction is not tied to special education, and that it is distinct from a placement decision made by the special education team as part of the student's IEP.

Table 2 provides a summary of coding results after reviewing Arizona's statute related to homebound instruction. Although this policy is binding for these students and included in the results related to the systematic review of state policies as planned for Aim 1, there are two additional sources that provide further information regarding the education of students with chronic medical conditions in the state. First, regarding homebound, the Arizona Department of

Education's (2023) document entitled, *Homebound Instruction* reiterates the requirements related to healthcare provider qualifications and time until eligible. Accordingly, the student's need for homebound or hospitalized instruction must be based on factors related to health conditions or accidents that have been verified by a doctor, who also confirms that regular schooling cannot be attended given the individual's health status, intermittently, for a total of three school months.

In addition to the previously explained definition of homebound instruction, the Arizona Department of Education distinguishes homebound from homeschooled and home-based modes of instruction. In home-based instruction, a child's IEP will determine the least restrictive environment for them to be placed in while still maintaining a FAPE. Thus, although not specified in the actual statute, this document clarifies that students who are homebound do not need to be classified under special education, and that placement under special education is distinct from homebound due to a chronic condition. Further, unlike the homebound statute, this document outlines correct documentation for this type of instruction including the child's name, the time a child has been estimated to be absent from school (consecutive or intermittent), and a doctor's signature. Annual review and determination are recommended, providing clarification of Renewal Requirements not provided in Arizona's statute.

Another Arizona statute, 15-346. *Policies and procedures concerning pupils with chronic health problems*, is specific for "Pupils who are not homebound, but who are unable to attend regular classes for intermittent periods of one or more consecutive days because of illness, disease, pregnancy complications or accident" as well as "pupils who suffer from a condition requiring management on a long-term basis" (AZ Stat § 15-346, n.d). Thus, eligibility requirements of Condition Specificity are also indicated in this policy. Additionally, it denotes that the statute is relevant for those who may be absent for only one to an undetermined number of days, over multiple instances. Moreover, although limited in scope, 15-346 also states "Homework availability to ensure that pupils with chronic health problems have the opportunity to keep up with assignments and avoid losing credit because of their absence from school." There is greater flexibility regarding healthcare provider qualifications in this policy including licensed health professionals (Podiatry, Chiropractic, Medicine and Surgery, Naturopathic Medicine, Osteopathic Physicians and Surgeons, and Physician Assistants) or a registered nurse practitioner. The caveat with this policy is that it directs "the governing board" (i.e., each school district governing board) to adopt policies in this regard. Additional clarification from the *AZ Department of Education School Finance Manual [G] Defining Excused Absences* document that "Even though school districts and charter districts no longer need to apply to the Department of Education for chronic health problem exceptions, documentation pertaining to chronic health problems should be retained" (Arizona Department of Education, 2021).

Table 2. Arizona's Policy Code Comparison

Category	Arizona's Policy	Notes
Attendance Recording	Full day counted if a minimum 4 hours of instruction in a week	Flexible attendance calculation: Leaves unclear for attendance counting for intermittent students
Caregiver Involvement	Not clarified	No defined role
Condition Specificity	Illness, disease, accident, or other health conditions	Broad, non-specific language but allows flexibility
Curriculum Requirements	Not mentioned	No specific adaptations or requirements
Dispute Resolution	Not included	No appeal process mentioned
Educational Considerations	Students must demonstrate ability to profit from instruction	Requires potential educational benefit
Educator Qualifications	Not specified	No requirement on qualifications of the homebound educator
Healthcare Provider	Only medical doctors can certify	Restrictive compared to other states
Instructional Modality	Refers to "homebound" or "hospitalized" students	Not specifically detailed
Instructional Time	Minimum 4 hours per week	On the lower end of state requirements
Jurisdiction	Not mentioned	Unclear who has jurisdiction of homebound instruction
Monitoring	Not specified	No tracking provisions
Non-Traditional School Year	Not addressed	No provisions for summer or make-up sessions
Oversight of Implementation	Not specified	No clear responsible party
Reintegration/Transition	Not mentioned	No plan for returning to traditional schooling
Renewal Requirements	Not mentioned	Unclear when parents should renew their child for homebound services
Special Education	Not mentioned or required to be eligible	Both general education and special education qualify
Time to Eligibility	Three school months or intermittent periods totaling three school months	Has the longest time to eligibility in the U.S; Vague interpretation of intermittent
Time Until Determination	Not specified	No mandated decision-making timeframe
Time Until Implementation	Not specified	No required implementation schedule

Aim 2: Southern Arizona's School Districts' Homebound or Hospital-Based Instructional Practices

The policy analysis of 45 school districts revealed that 38 (84.4%) have both homebound and chronic illness policies in place. Only 3 districts (6.7%) did not have a handbook available that included homebound or chronic illness policies, while 4 (8.9%) districts had incomplete or unclear information. Common policy elements across districts included certification requirements, homework availability, teacher collaboration, and annual review and recertification processes. For the references to homebound in the handbooks and/or websites, 31 out of 45 (68.9%) districts explicitly stated that classroom teachers were expected to work with homebound teachers concerning materials to be covered. The same statement appeared in these school policy documents, specifying that the goal is to ensure that "each homebound student may rejoin the class upon return to school." Thirty (66.7%) out of 45 districts had policies that indicated the homebound teacher must have the same certification as the regular classroom teacher. Most districts included a notation regarding the minimum of four hours per week of homebound instruction. Some districts, like Tucson Unified School District (TUSD), publicized via their website multiple delivery methods specifically with regard to homebound students: (1) Traditional homebound instruction (Pre-K to 5th grade), (2) Video conference instruction (6th grade and above), and (3) Combination instruction (mix of in-home and video conference). Naco Elementary USD and Willcox USD provide more detailed processes for developing instructional plans in their policy manuals available through their websites, including: (1) Considering the nature of the health condition, (2) Assessing the student's academic capacity, (3) Determining appropriate service delivery methods, and (4) Maintaining integration with the regular education program, when possible. There is limited explicit mention of caregiver involvement or input in the homebound instruction process. One district policy stated: "Student home visits are supervised by a parent or caregiver 18 years of age or older." Two policies mentioned, "The teacher(s) and parent/legal guardian shall meet promptly following return of the chronic health condition certification to develop an instructional plan." Several districts mentioned that parents must call in each absence.

Related to students with chronic health problems (versus homebound), 24 (53.33%) included mental or behavioral health care providers with a psychologist listed; this qualification is not among the list of licensed professionals in *Policies and procedures concerning pupils with chronic health problems* (AZ Stat § 15-346, n.d). The phrase "The assigned teacher(s) shall have the responsibility to provide, in a timely manner" appears in 31 out of the 45 district policies. Regarding oversight of the chronic illness policy, 9 districts mentioned that "The Superintendent shall develop regulations for meeting the requirements of this policy," 3 districts indicate that "The District Administrator shall develop regulations for meeting the requirements of this policy," and 1 district mentioned that "The Head Teacher shall develop regulations for meeting the requirements of this policy." Overall, most districts kept these policies separate, though two seemed to place them on a continuum of options for students with chronic medical conditions to address their needs.

The subset of responding districts provided additional insights into policy implementation (n = 10). The number of students receiving homebound services varied widely, ranging from 0 to 30 students per district. Most districts reported using the state attendance system to track

homebound instructional hours. The process for initiating homebound services typically involves families contacting the school nurse or special education department, followed by the completion of medical certification forms. Districts generally reported flexibility in scheduling homebound instruction based on teacher and family availability.

Aim 3: Hospital-Based Instruction in Southern Arizona

Background

HSPs have been a part of the Southern Arizona pediatric hospital network for over a decade. Children's Hospital 1 and Children's Hospital 2 both implemented HSPs to address the educational needs of hospitalized children. These programs aimed to alleviate stress related to missing school and help students maintain academic progress during their medical treatment (Eaton, 2012). Eaton (2012) described the inception of Children's Hospital 1, which merged from a collaborative vision between the hospital and a local public school. The school district took the first step by providing a half-time teacher, challenging Children's Hospital 1 to match this commitment. This call was answered through the engagement of an insurance company whose employees embraced the cause and initiated a life insurance promotion that generated funds to support teacher salaries. The combined efforts of all listed parties and other community partners sustained the HSP. Eventually, the school district was not able to sustain the cost of the teacher. The hospital continued to contract teachers and secure volunteers to provide individualized educational support to prevent children from falling behind academically during hospital stays. By facilitating an on-site classroom or bedside teaching, and assisting with seamless re-entry to regular schools, the HSP exemplified a comprehensive community approach to addressing the educational needs of hospitalized children. Children's Hospital 3 in a Southern Arizona city launched in Fall 2016. This HSP was initially a partnership between Children's Hospital 3 and the local university, addressing the critical need for educational continuity during hospitalization. It is currently the only hospital in Southern Arizona with a dedicated hospital school program.

Program Structure

` The HSP in Southern Arizona program is staffed by a single full-time education specialist with over 30 years of teaching experience, who has been in this role for 6.5 years. This teacher (pseudonym: Teacher X) was interviewed to ascertain their perspective on HSPs and servicing students with chronic medical conditions that resulted in hospitalization or intensive outpatient treatments. The teacher serves the entire pediatric population, primarily working with oncology, hematology, eating disorders, dialysis, and some behavioral health patients. The HSP is operated in a Child Life Specialist department, so supervision is not conducted by someone with educator credentials.

Key Features and Challenges

Balancing Education and Medical Needs. One of the biggest challenges is maintaining routine around instruction due to medical procedures, treatments, and varying energy levels of patients. Teacher X explained, "I think one of my biggest challenges is consistency in schooling. I can meet with them (as in the student), but oftentimes, there are so many barriers." Therefore, the teacher must be flexible and adapt to each student's situation. A health barrier may be, as Teacher X stated, "Then there's the will of the student, and I can't force them. They're sick. I

can't force them. We've got lack of motivation, we've got the medical barriers, and school barriers." Conflicting schedules may occur when planning to do school as can be seen when the teacher asks, "What time do you want to do school today?" or I will say, "I have time at 1:00.'Well, we have a procedure today at 1:00, so we can't do school.'" An example of a school or learning barrier is "Some schools say 'Just have them get online and go to their class profile and do the assignments.' After so much time, if there's no instruction, they can't do the assignments. Then we're at a standstill there."

School Collaboration. Coordinating with schools of origin can be challenging. Some schools are more responsive than others in providing work packets or offering online resources. "Most schools aren't giving a lot of paper, pencil now. With younger children, I reach out to the school and I ask the teachers to send me some of their work. Some schools are better than others." Consequently, the teacher often must create materials based on state standards when school-provided work is unavailable. Additionally, Teacher X noted other staff that assist with homebound advocacy, "School district nurses and school nurses are very helpful in advocating for our medically fragile patients."

Caregiver Roles and Involvement. Family values around education may vary, particularly when the caregivers are so concerned about the students' life or health.

> Sometimes that's half the battle with school too is a family that believes in education and thinks education's important. Because we get a lot of families that education's not important in their family. They've never gone to college or none of their children have graduated or whatever. It's just not important to them. If that's the case, then it's not important to the child a lot of times. Those children really stand out that really want to do school all through this journey.

Consequently, parents may not set as many parameters or assist the student in transitioning. Teacher X explained how she navigates this type of situation. "I might go into a child's room to try to see what is going on for school that day and they are playing on their video game and the parents don't encourage them to get off. I will say, "What time do you want to do school today? or I will say, 'I have time at 1:00.' (as an example)."

Student Engagement. Building a rapport with students is crucial but can be difficult due to their health conditions. "There's a lot of challenges. I think part of the process is building rapport with a student so that they will be willing to work with me and with other students. It's hard to break in and build rapport because they don't feel well, so they don't want to engage with you." The teacher uses various strategies, including educational games, to make learning more appealing to children who have ongoing medical issues and may be resistant to traditional schoolwork. For instance, the teacher explained, "I have one patient right now, she's seven, and she just refuses to do any school. I can't make her do worksheets because she thinks that's school, so we do educational games."

Space and Resources. Recently, the program gained access to a "play zone" including a dedicated classroom space. "Now I have this big classroom. I'm just learning how to manage my time and this space because it's really far away from the units." However, this has created new challenges in managing time and space efficiently, as the classroom is located far from patient units.

Funding and Support. The program is funded through the hospital foundation and donors for the HSP. The teacher must meet productivity metrics and maintain detailed logs of student interactions.

Unique Aspects of Hospital-Based Teaching

Advocacy Role. The teacher serves as a liaison between families, schools, and medical staff, providing advocacy and education for parents navigating special education systems.

Emotional Support. The program offers a sense of normalcy and achievement for hospitalized children, which is particularly important for those facing serious illnesses.

Flexible Delivery Methods. The teacher adapts instruction methods based on student needs and medical constraints, offering bedside teaching, classroom instruction, and educational games.

Challenges and Areas for Improvement

Professional Development. Given the lack of other educator colleagues, Teacher X gained her networking and consultation needs through an organization known as Hospital Educator and Academic Liaison (HEAL). There is a need for more consistent training and professional development opportunities specific to hospital education and special education.

Additional Staffing and Educational Expertise. Given the new classroom space and the program's demands, hiring another teacher could be beneficial in the future.

Technology Integration. While technology can be helpful, it's not always the answer. The program needs to balance online resources with traditional teaching methods to meet diverse student needs.

Discussion

The complex interplay between chronic health conditions and education requires schools to develop comprehensive, flexible systems to support affected students. This includes individualized health planning, improved communication between medical and educational professionals, and adaptive teaching strategies to ensure these students can achieve their full academic potential despite health-related challenges. Homebound instruction policies vary significantly across the United States, reflecting diverse approaches to supporting students unable to attend traditional school settings. Analysis for Aim 1 examined key aspects of these policies, including eligibility criteria, instructional modality, implementation timelines, and instructional time requirements.

For Aim 1, although Arizona's Statute § 15-901 (2022) is specifically available for children requiring homebound instruction, there are critical gaps in the statute that need to be addressed as it creates significant barriers for those students and families requiring non-traditional instruction due to the student's health condition. AZ Statute § 15-901 (2022) covers students with illness, disease, accident or other health conditions. Although not detailed in the specific medical conditions, this could be viewed as allowing latitude in diagnoses. Nonetheless, certain states were less ambiguous in outlining the conditions that may warrant homebound instruction. For example, as shown in the Results, states such as Massachusetts and Maryland expand the scope by providing examples of various conditions. Similarly, Delaware also

incorporates unforeseen as well as ongoing conditions and clarifies that emotional-behavioral conditions are health-related. Further, the wording allows for a flexible interpretation by the healthcare provider, whereas a more restrictive set of conditions could be limiting. Regarding the healthcare provider required to certify the students' health condition, AZ only accepts documentation from a medical doctor. This means that other healthcare providers who are otherwise licensed or certified in the state to practice independently would not be acceptable certifiers of the student's condition for homebound eligibility purposes. Although AZ's pupils with chronic illness statute includes more healthcare providers, noticeably missing from both are mental health providers such as psychologists. A more expansive list of suitable providers who may determine eligibility is contained in other states' regulations, such as in Washington D.C.'s policy (D.C. Code § 38–251.01, 2020), as presented in the Results.

As can be seen in Figure 2, regarding Time until Eligible, AZ's number of days for eligibility is a considerable and concerning outlier, requiring a "period of not less than three school months" or "intermittent periods of time totaling three school months" (AZ Stat § 15-901, 2022). For the latter, it does not provide parameters, nor does it describe how homebound services should be delivered in an intermittent manner. For instance, if a student is present in school for a half-day, but is absent the rest of the week, would a school district determine they have met the minimum number of hours and not provide further instruction for that week. Additionally, it is uncertain what triggers homebound instruction when it is unclear whether a student will attend school during a given week. In contrast, we feature Illinois because it not only specifies eligibility occurs after a period of two weeks or more, but also clarifies what intermittent means, "ongoing intermittent basis" means that the child's medical condition is of such a nature or severity that it is anticipated that the child will be absent from school due to the medical condition for periods of at least 2 days at a time" (IL Stat § 5/14-13.01, 2018).

Furthermore, as noted in the Results section, AZ does not mandate a timeline for Determination or Implementation. Although many states also do not address determination and implementation, the majority of the ones that do, require a decision, notification, or implementation within five days; between 10 and 15 days was the second most common timeframe. Due to absence of such criteria, this may cause impositions on Arizona families because it provides exposure of risk as some schools may delay, postpone, or neglect a family's request for homebound or once approved for homebound, impact the implementation of actual instruction.

Instructional time requirements ranged from under two hours up to 15 hours per week. As depicted in Figure 1, the map reflects that Arizona is on the lower end of the minimum number of hours required (i.e., 4 hours). New York had one of the most robust statutes, recently updating the number of hours of instruction for elementary and middle school students to 10 hours per week and high schoolers to 15 hours per week. Once again, a point of confusion is that since Arizona does include intermittent in its statute, there is no guidance for schools' obligation to provide homebound instruction for students who attend for at least one at least half day, meeting the four-hour minimum, but still being absent as part of the 90 or more days total.

In addition to the above, Arizona's Homebound statute does not provide provisions for Curriculum Requirements, Monitoring, Oversight of Implementation, Caregiver Involvement,

Non-Traditional School Year, Reintegration/Transition, Educator Qualifications, Renewal Requirements, Jurisdiction, and Dispute Resolution. Therefore, there is ambiguity related to scheduling, accountability, tracking progress, ensuring smooth transitions, appeals, instructor credentials, and parental input and/or presence. Although some of these domains are addressed in the supplemental documents issued by the Arizona Department of Education and/or the alternative chronic illness policy, they are not specifically mandated for the provision of homebound instruction. This leaves many unaddressed issues related to awareness, accessibility, and enforceability of the document.

Research Aim 2

The analysis of Southern Arizona school district policies reveals a widespread recognition of the need to support students facing health-related educational barriers through homebound and chronic illness instruction. However, significant concerns arise regarding the practical implementation of these policies. Most districts adopt verbatim language from state guidelines without customizing or detailing concrete steps, leading to potential inconsistencies in application. While many policies reference educational qualifications for instructors, this crucial detail is often absent, potentially affecting the quality of instruction. On the other hand, it is noteworthy that most school district policies noted the expectation that homebound instructors would collaborate with classroom teachers, which is not statutorily mandated. Chronic illness policies also exhibit shortcomings, lacking clear definitions of "timely" provision of materials and neglecting critical considerations for assessments, which may place an undue burden on teachers and create assessment challenges that put the student at risk. Although only a couple districts integrate homebound and chronic illness policies to delineate the specific use cases, for both interventions, variations in policy comprehensiveness and implementation practices highlight the need for greater standardization. Despite the reported flexibility in scheduling and delivery, this can jeopardize the consistency and quality of instruction. Further investigation is warranted to ensure equitable access to these resources. Taken together, these considerations call for the development of more comprehensive, detailed, and tailored policies to address the practical challenges of implementing homebound and chronic illness instruction, ensuring all students can receive a high-quality education.

Research Aim 3

This case study of the only hospital school program in Southern Arizona highlights the innovative approach of the Children's Hospital School Program 3 in addressing the educational needs of hospitalized children. By combining dedicated staffing, university partnership, and a holistic approach to education, the program aims to mitigate the academic and social impacts of extended hospital stays on young patients. Understanding of education, policies, and the school experience beyond learning support may vary based on leadership in HSPs, particularly if supervisors do not have educational backgrounds. Moreover, very few states establish parameters of oversight for HSPs.

Limitations

Our research methodology encompasses several critical limitations that require careful consideration. The data extraction window between February and May 2024 potentially excludes

subsequent updates. This temporal constraint suggests potential changes that may have occurred since the review, and may impact homebound instruction in certain states. Policy updates within our research should be carefully distinguished from simple renewals, recognizing there may be no changes even with a recent date or that modifications are not necessarily comprehensive changes, but rather represent minor, non-essential adjustments.

Information accessibility presented another significant limitation, as not all relevant details were consistently visible across source documents. This variability necessitates a cautious approach to interpretation, acknowledging that some critical contextual elements may have been overlooked in the coding. Researchers must remain cognizant of these procedural constraints to ensure accurate and responsible understanding of policies and procedures.

Regarding Aim 2, the bulk of the data collection occurred during the summer months with some follow-up during the Fall 2024. Therefore, not all districts were able to be reached. Additionally, identifying the appropriate point of contact proved quite difficult. If messages were left, very few school personnel returned the calls. It is uncertain whether this reflected their busy schedules, reluctance to share this information, and/or team members not reaching the appropriate person. Just because policies were in writing does not mean they were being implemented. This is particularly the case since most of the policies do not specify concrete practice and implementation practices may vary across districts even if the language in the handbooks is the same. Furthermore, despite limited content, it's possible certain districts may offer more innovative approaches and comprehensive service delivery.

Regarding Aim 3, the case study method, while providing in-depth insights, has inherent limitations. It often lacks generalizability due to its focus on a single or small number of cases. The subjective nature of data collection and analysis can introduce researcher bias. That being said, there was only one hospital school program in Southern Arizona, so the approach taken was driven by this fact. Future research should examine perspectives of educators from different hospital school programs and traditional school settings across various jurisdictions, students, and caregivers.

Recommendations

The following recommendations aim towards improving Arizona's (and many other states) policy:

1. **Reduce the eligibility time frame** to align more closely with other states (e.g., maximum of 10-15 consecutive days).
2. **Establish parameters for educational services** for those who may miss school on a partial, ongoing, or intermittent basis.
3. **Clarify procedures for intermittent homebound services,** including how to calculate eligibility and how instruction should be provided in these situations.
4. **Expand acceptable healthcare providers** to include nurse practitioners and mental health professionals (e.g., school psychologist).
5. **Expand the health conditions that are eligible for homebound services** to include mental health conditions, pregnancy, and other rare genetic disorders. This may help educators identify students who might be eligible.

6. **Establish clear timelines for Time to Determination** (e.g., within 5 school days) and service implementation (e.g., immediately or after approval), allowing only for exceptions related to the students' health.
7. **Consider increasing minimum instructional time,** especially for secondary students. The inclusion of the word "minimum" means that most districts likely impose the minimum even when the courses or curriculum is more rigorous, or the students themselves require more instructional time.
8. **Address the ambiguity in wording for converting hours to minutes**, which lies in whether the "four hours of instruction" applies to the week as a whole or to each individual day. Consider rephrasing this component of the policy to something such as: "A student may be counted as present for all five days of a school week if they receive a total of at least four hours of instruction during that week, regardless of how those hours are distributed across the days."
9. **Develop guidelines for transition and reintegration support** when students return to regular school. Reintegration supports or plans should meet the transitional needs of each individual student, incorporate the student's health care plan, and any other necessary accommodations to achieve a successful reentry. As a preventative measure, consider essential auxiliary services such as counseling or behavioral interventions to reduce resistance to returning to school and address mental health challenges.
10. **Include attendance tracking, curriculum requirements, and progress monitoring** more explicitly in the policy.
11. **Require professional development** geared toward chronic health conditions, behavioral supports, and family-school collaborations.
12. **Merge or establish guidance on how to leverage both statutes for chronic health and homebound** to allow for accessibility for graded assignments, assessments at home, real-time grade updates, and flexibility in due dates, so the student's grades are not impacted and transparency in progress is maintained.
13. **Develop guidance when involving third-party contractors.** Encourage consulting with hospital school programs to facilitate consistency in communication and implementation of services. School districts should collaborate with their nearest hospital school program to develop guidelines when working with their students in order to achieve successful implementation of homebound services.
14. **Ensure that parents are well-informed about homebound instruction,** a service designed to support students who cannot attend school due to medical or other qualifying conditions. Additionally, under the Child Find law, school psychologists and special education staff have a responsibility to actively identify students who may benefit from homebound instruction. They should proactively reach out to parents, providing clear and accessible information about the available services and how to access them.
15. **Strengthen and broaden hospital school programs** through collaboration with state education departments, integration of comprehensive psychoeducational services (e.g., school psychology, counseling), and seamless home-hospital-school transitions. Foster partnerships with local universities that have relevant training programs and research-to-practice initiatives to benefit both institutions and bridge the health-education divide.

By implementing these changes, it can be assumed that more students would be served through homebound instruction to reduce significant instructional gaps. These students would

likely receive more targeted and individualized instruction. State mandated instructional time should be considered minimums, especially if the requirements are on the lower end of the range (e.g., 2-4 hours). As a result, educational outcomes would likely improve due to increased instructional time and better-tailored services. Greater consistency in policy implementation across school districts would reduce disparities in service provision, and students with chronic health conditions or disabilities would have improved access to a free and appropriate public education in the least restrictive environment. Smoother transitions between homebound instruction and regular school attendance would support better continuity of education, while better-informed parents and caregivers would lead to more effective advocacy for their children's educational needs. Ultimately, program evaluation and research efforts would allow for systematic monitoring of the effectiveness of current and revised practices. These findings could be used to inform future policy and program development.

Implications

Although Arizona's statute recognizes the unique circumstances of homebound and hospitalized students by allowing a flexible approach to counting attendance, it falls short in several areas. The focus on ensuring students receive a minimum amount of instruction (4 hours) rather than adhering to a strict daily schedule is positive. However, the statute's limitations are evident, and school districts often follow suit, potentially compromising the quality and consistency of education for homebound students. Addressing these shortcomings could significantly improve educational outcomes and support for students with chronic health conditions in southern Arizona.

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