

Preschool Attendance: A Parental and Teacher Perspective of Barriers and Behaviors using Grounded Theory Research

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PRESCHOOL ATTENDANCE: A PARENTAL AND TEACHER PERSPECTIVE OF
BARRIERS, HEALTH BEHAVIORS AND PRACTICES USING GROUNDED THEORY
RESEARCH

by

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A dissertation submitted in partial fulfillment of the requirements
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ABSTRACT

Background: Preschool children from single-parent households with lower socioeconomic status (SES) are absent from preschool at rates higher than any other group. Some children are chronically absent, missing more than 10% of the school year. The phenomenon of preschool attendance related to behaviors, practices, and parental decision making associated with health and illness in lower SES households has not been previously studied using grounded theory methodology.

Aim: The purpose of this study was to explore decision making related to supporting attendance in a preschool of 67 children (aged 3 to 4 years) with primarily low-income, single parents and preschool teachers in South Florida. The decision making process parents and teachers face every day and the environmental supports of preschool attendance facilitated identification of factors encouraging or impeding attendance.

Results and Recommendations: Focus groups and interviews with teachers, parents and administrators were conducted, and direct observation of the school attendance process and health/attendance policies were examined. Data analysis was concurrent with data collection to allow for theoretical sampling. The data analysis revealed an underlying process of “communicating about health: benefitting children’s attendance in a preschool environment.” Supporting this theory were three themes of (a) empowerment: actions to support health, (b) trusting judgment regarding health, and (c) commitment of organization and parents to health and attendance. Recommendations for implementation of practice, policy changes, and opportunities for future research found in this unique setting were discussed to improve attendance.

ACKNOWLEDGMENTS

“The brick walls are there for a reason. They’re not there to keep us out. The brick walls are there to give us a chance to show how badly we want something” (Pausch, 2008, p. 103). Thanks to the continued love and support of my husband and children, and through sheer perseverance and determination, I was able to scale the brick wall and achieve one of my lifetime goals. My family has stood by my side through many missed occasions and events to make this dream a reality. A special thanks to Dr. Susan Chase, my dissertation chair, who became a loyal supporter from the onset of this circuitous journey to climb the wall. I have benefitted tremendously from her knowledge and leadership, especially through the learning curve of conducting qualitative research. A special thank you to my dad and Lori Aquilino who I lost along the way, but who were always my biggest cheerleaders and now cheer me on from above. Dr. Jacquie Byers was the reason I began this quest; she was a role model, friend, and student advocate. I miss her and know she is always with me in spirit. A special acknowledgement to all the participants of the study who enriched me with their sharing of their life experiences and participation—without you, this would not have been possible. Thank you to everyone who supported my climbing and scaling the wall.

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LIST OF ACRONYMS/ABBREVIATIONS

AHRQ – Agency for Healthcare Research and Quality

AAP – American Academy of Pediatrics

APHA – American Public Health Association

CDC – Centers for Disease Control and Prevention

CDF – Children’s Defense Fund

CFOC – Caring for Our Children

CPR – Cardiopulmonary Resuscitation

ELC – Early Learning Coalition

FPL – Federal Poverty Level

IOM – Institute of Medicine

NAEYC – National Association for the Education of Young Children

NCCP – National Center for Children in Poverty

NICHHD – Eunice Kennedy Shriver National Institute of Child Health & Human
Development

NIEER – National Institute for Early Education Research

ORCE – Observational Record of Caregiving Environment

SECCYD – Study of Early Child Care and Youth Development

CHAPTER 1: STATEMENT OF THE PROBLEM

Quality preschool education has been shown to have many long-term benefits including educational attainment and monetary gains into adulthood (Barnett, 2011; Reynolds, Temple, & White, 2009). Absenteeism from quality preschool programs puts children at risk for early school failure (Connolly & Olson, 2012; Ehrlich et al., 2013; Katz, Adams, & Johnson, 2015). Preschool absenteeism is a predictor of future attendance and academic performance, but despite preschool benefits, lack of attendance has been recently documented to be a growing concern. Studies have shown 25% to 50% of the preschool students in Baltimore, Chicago, and New York were absent more than 10% percent of the school year, missing the equivalent of 1 month of learning opportunity in a year (Katz et al., 2015). African American children from lower socioeconomic status (SES) have twice the rates of absenteeism in the preschool setting as any other race or ethnicity (Ehrlich et al., 2013). This chapter will discuss the impact of preschool absenteeism and vulnerable populations at risk and explore the extent to which the reasons for absenteeism are understood. The value of preschool attendance will be addressed, with the influence of state and national policies on preschool environment and attendance. The purpose of the study will be explored, and the future knowledge to be gained will be suggested.

Background of the Problem

Preschool Absenteeism

In the United States, almost half (49%) of African American children ages 3 and 4 attend preschool in a setting outside of their home (Annie E. Casey Foundation, 2014). While the literature has focused on the benefits of preschool education, these can only be realized with attendance. Absenteeism in preschool has recently begun to be evaluated due to lasting repercussions to the child and education system (Ehrlich et al., 2013; Katz et al., 2015). Research indicated absentee patterns developed in preschool persist into elementary school (Ahmad & Hamm, 2013), and chronic absenteeism places children at risk for both social and cognitive learning deficits. Families living in poverty had children with a four times higher rate of being chronically absent in kindergarten than their peers not living in poverty (Chang & Romero, 2008).

In a study conducted by Connolly and Olsen in 2012, in Baltimore city schools, over 25% of 4-year-old children attending preschool were considered chronically absent, defined as missing more than 10% of school days in an academic year (Attendance Works, 2014). Ehrlich et al. (2013) conducted a study of Chicago preschools and reported 36% of the 4-year-old children and 45% of the 3-year-old children were chronically absent. Children found to be chronically absent from preschool to second grade (four years in a row) showed lower reading scores, 72.9 versus 98.8 (109+ is above average or above the 60th percentile), on the Dynamic Indicators of Basic Early Literacy Skills (DIBELS), placing them at higher risk to fall behind in reading skills than their peers who were not chronically absent (Ehrlich et al., 2013). The combination of

chronic absence in kindergarten and poverty was predictive of lower levels of educational achievement by fifth grade (Romero & Lee 2008). There is a compounding effect of absenteeism and poverty on children's academic success, preventing their potential optimal development (Fisher, Hanson, & Raden, 2014; Romero & Lee, 2008).

Poverty and Health Risks for Preschool Aged Children

Preschool absenteeism has been shown to be the result of multiple risk factors in the child's life including level of poverty and chronic health concerns as well as access and utilization of health care resources. Children living in poverty are exposed to many variables that negatively impact their health. For example, they are more than twice as likely to live in a household with someone who smokes (Seith & Isakson, 2011).

Maternal smoking and exposure to secondhand smoke has been correlated with increased prevalence of childhood asthma, which is one of the leading causes of school absenteeism in this age group (Hollams, de Klerk, Holt, & Sly, 2014; Thacher et al., 2014). Diagnosis with asthma is more than twice as likely for a child from a low-income family than for a child from a non-low-income family (National Center for Health Statistics, 2011). In addition, children of poverty tend to live in older homes or subsidized housing with a higher incidence of lead-based paint. Children living in poverty have higher levels of lead in their blood (twice the amount) than their peers who are not living in poverty (Seith & Isakson, 2011).

Romero and Lee (2008) identified poverty as one of the key risk factors for poor health status in children. African American children living below the federal poverty level (a 200% poverty threshold for a single parent with one child was \$31,460 in 2014)

in a single-parent household typically enter kindergarten a grade level or two behind their White peers if they do not attend preschool (Ahmad & Hamm, 2013). In 2009, 36% of African American children lived below the federal poverty level (Wight, Chau, & Aratani, 2011). Children under the age of 6 living in low-income households have unique family characteristics; 88% of children who live with parents without a high school education are considered low-income, as compared with only 34% of children being considered low income if they have one parent with some college education (Jiang, Ekono, & Skinner, 2015). In the low-income families with children under 6, 68% live in rental properties as compared to 25% of their higher income peers (Jiang et al., 2015).

Health care access is another major concern for many families with lower income children and children of color. These children also have poorer health outcomes (CDF, 2014). More than 25% of children without health insurance have no usual source of health care (CDF, 2014). Black children account for over half of the total uninsured population (Addy, Engelhardt, & Skinner, 2014). In a 2009 national Kaiser Family Foundation survey of 2,073 parents, only 59% of parents who were living in poverty and were uninsured had reported their children had attended well visits, compared to 86% of parents whose children were insured (Paradise, Marks, Schwarz, & Lyons, 2009). More than 50% of the uninsured children had gone without insurance coverage for over a year, resulting in large gaps of access to health care. In addition, 25% of those same uninsured children age 1 year and older have never been insured. Children experiencing various levels of poverty endure countless challenges. The environmental

factors in neighborhoods with high poverty levels are not conducive to the physical health of the child. Health care access combined with these factors can be formidable challenges and barriers impeding school attendance.

Preschool Attendance – Why It Matters

Preschool attendance in early education programs has been shown to have long-term outcomes into adulthood (Barnett, 2011). The literature documents short-term gains in school success for children who attend preschool, especially low-income populations at risk for school failure. Children attending high-quality preschool programs in Boston, Massachusetts, and Tulsa, Oklahoma, have shown gains of between a half and a full year of additional learning in math and reading (Yoshikawa et al., 2013). Children in New Jersey attending 2 years of the Abbott preschool program (ages 3 and 4) showed gains in math, literacy, and language of nearly twice those who attended for only 1 year (Frede, Jung, Barnett, & Figueras, 2009). In addition, the authors found grade retention to be significantly ($p < .05$) higher in second grade (10.7% versus 5.3%) for children who attended preschool as compared with those who did not.

While attendance clearly supports educational gains, The National Head Start Impact study also found higher levels in some health indicators in children who attended preschool. Children participating in Head Start programs had increased access to health insurance and higher number of dental visits than their peers not participating in Head Start (United States Department of Health and Human Services, 2010). One explanation for this relationship is that preschoolers and their parents learn about health and nutrition as components of the Head Start curriculum within the preschool setting,

increasing their knowledge (Friedman-Krauss & Barnett, 2013). All of the literature addressed supports preschool attendance in a quality early education program. The preschool environment itself, however, may pose some barriers to attendance rates related to policies that discourage ill children from attending. These factors and other potential barriers to attendance have not been well studied.

Preschool Environment

National Policy

Childcare quality, including preschools, is highly variable between centers and requires standardization due to the lack of regulatory standards (American Academy of Pediatrics [AAP], 2005; Boivin & Bierman, 2014; Edie, Adams, Riley, & Roach, 2003; Finn, 2009). Licensing of childcare centers occurs at the state level. The Children's Defense Fund (CDF) (2014), the National Association for the Education of Young People (NAEYC), and the AAP (2013) have collectively advocated for federal legislation requiring adoption of national guidelines to improve regulatory standards and quality measures to ensure children's health and safety. In 1992, the AAP and American Public Health Association (APHA) released the first edition of *Caring for our children: National health and safety performance standards; Guidelines for early care and education programs*. The third edition released in 2011 stated, "These national standards represent the best evidence, expertise, and experience in the country on quality health and safety practices and policies that should be followed in today's early care and education settings" (AAP, APHA, & National Resource Center for Health and Safety in Child Care and Early Education, 2011, p. xvii).

School Environment and Policy

The policies of the school environment can play a pivotal role in supporting or inhibiting the health of the children. The AAP (2011) found lower child-to-staff ratios reduce the transmission of disease. State licensing standards are typically set below the minimum recommendations for health and safety (AAP, 2005). The state and national governing bodies also have differing priorities; the AAP is focused on health practices, and the state of Florida focuses on teaching and funding. The evidence-based recommendations regarding child to staff ratios from the Centers for Disease Control and Prevention (CDC) and the AAP is eight 4-year-old children to one adult and seven 3-year-old children to one adult (AAP, 2013). The state of Florida statute sets student-teacher ratios in the preschool setting, which are ratios of 20 4-year-old children to one adult and 15 3-year-old children to one adult (Florida Statute 402.305(2)(4)(a), 2014). The school policies or resources in place in a specific setting could play a role in parental decision making, influencing attendance.

Attendance Measurement

In 2009, the National Forum on Education Statistics published recommendations for a national attendance taxonomy and data collection for school attendance. Prior to the release of this publication, there was not a standardized methodology for data collection of school attendance in school districts between states. The lack of standardization created challenges for comparison of interstate attendance data. Formulation of practices and policies to improve attendance requires accurate data collection (Romero & Lee, 2008).

Chang and Romero (2008) issued a report for the National Center for Children in Poverty defining chronic absence as “missing 10% or more of the school year (equivalent to 18 days out of 180-day school year) regardless of whether the absences are excused or unexcused” (p. 3). The report further defined early chronic absence as occurring in grades kindergarten through third.

Attendance figures are often used as a basis for reimbursement of schools through federal or state funding, which may result in underreporting of school absences. Until recent years, measurement of preschool absenteeism and evidence on this topic have not been documented due to inconsistent methodology of data collection within school systems and/or preschool centers (Ehrlich et al., 2013; Kerr et al., 2012). The attendance data in schools have been developed to track truancy, which is defined as the number of unexcused absences. The average daily attendance, which measures the amount of students attending the school each day, is the most common data element collected, but that method does not allow for tracking individual student attendance patterns. Chronic absenteeism can be missed in a school if individual student absence is not collected. While each student is absent on different days, attendance is reported collectively every day, accounting for possibly a 90% to 95% average daily attendance rate (Attendance Works, 2014). In a classroom of 30 students over a school year, four of the students may be chronically absent and range from missing 18 to 30 days per year. One student can miss an average of only 2 days per month before he or she is considered to be chronically absent.

A policy brief, “The Attendance Imperative” (2014), published by Attendance Works, a national organization dedicated to improving policy, practice, and research around attendance, made key recommendations about chronic absenteeism at the state and federal level. These recommendations included: (a) creating a standard definition to be used statewide by each school district for consistency, (b) tracking individual student attendance in state longitudinal databases to begin in preschool, (c) sharing chronic absence reports statewide, and (d) requiring school improvement plans for chronic absenteeism and interagency collaboration. The report highlighted three key states—Indiana, Utah, and Oregon—that have adopted a common definition and used reports to raise awareness of chronic absenteeism (Attendance Works, 2014). This current study discussed the current systems for tracking preschool absenteeism with teachers to gain an understanding from their perspective and may provide unique insights to this measurement issue.

The core objective of a successful preschool attendance program is that children arrive and stay in school every day. Many factors described above have been found to be detrimental to achieving this goal. Research has consistently provided quantitative studies regarding early childhood education with some significant benefits addressed previously. Overall population figures do not offer much support in developing responses to low preschool attendance. Qualitative analysis disclosing the factors and barriers related to attendance are rare in the literature (Ehrlich et al.; 2013, Katz et al., 2015). These factors may play a role in the parent’s ability to facilitate his or her child’s attendance at preschool. This study provided insight through rare discussions with the

parents of the children regarding their decision making about why they keep their children home from school, and a review of the risk factors these parents face has not been addressed in the literature. Parents and teachers have unique knowledge about preschool attendance due to their role as the children's caretakers. Parents and teachers are the key informants to facilitate insight and discussion about the relationship of health behaviors and practices and preschool attendance. Accurate measurement of preschool attendance and discussion of factors involved in the absentee rate are also important to developing an understanding of the phenomena of preschool absence.

Purpose of the Study

The purpose of this study was as follows:

1. To explore the role of the child's health on preschool attendance
2. To explore the decision making process parents use related to preschool attendance
3. To explore the supports and policies related to attendance in a specific preschool setting.

Research Questions

1. What process do parents use when deciding whether to bring their preschool children to school?
2. What personal and family behaviors and environmental factors do the parents identify to support or prevent attendance at the preschool?
3. What role does the child's health play in decisions about school attendance?

4. How do informal and formal preschool policies and practices affect parental decision making regarding attendance?
5. How do school administrators make decisions about attendance practices?

Importance of the Study

Parents and teachers discussed their daily behaviors and practices in their home and school environments and the impact these behaviors have on preschool attendance. These participants shared unique knowledge of the preschool setting's subtle nuances that can impact a child's attendance. Quantitative research methodologies would not address the depth of inquiry into the individual's daily routines. Grounded theory research discovered the process parents face with environmental barriers and factors. It also explored the processes used by personnel in the preschool setting related to attendance. The knowledge gained can provide direction for practical interventions that might be tested to promote preschool attendance from the perspective of the key stakeholders in the process.

CHAPTER 2: LITERATURE REVIEW

A review of the literature regarding the long-term benefits of preschool education and barriers to attendance will be presented. Studies conducted on preschool absenteeism discussing the cumulative risks involved with missing school and environmental/family factors affecting attendance will be reviewed. A discussion of the gaps in the literature regarding preschool attendance and qualitative methodology related to this topic of will be addressed throughout this chapter.

Long-Term Benefits of Preschool Education

Preschool education has been rigorously evaluated in the literature and has been found to have positive gains for children across many outcome measures, including developmental, cognitive, and educational benefits, in some cases lasting many years (Barnett, 2011; Camilli, Vargas, Ryan, & Barnett, 2010; Muenning et al., 2011; Nelson, Westheus, & MacLeod, 2003). Barnett (2011) summarized the research on early education programs conducted on children 3 to 5 years old within the United States. He discussed two of the most referenced longitudinal randomized trials. The Perry Preschool program and the Abecedarian study both have shown long-term effects of preschool education into adulthood. These studies followed participants to ages 21 and 27, respectively. The High/Scope Perry preschool program began in 1962. Low-income African American children (3 or 4 years old) with IQ ranging from 70 to 85 were randomized to a pre-kindergarten education group (58) and control group (65). The two groups were matched based on family income, gender, and IQ prior to randomization. The education intervention involved 2.5 hours per day, 5 days a week, 30 weeks a year

of interactive academic instruction provided by baccalaureate- or master's-prepared teachers who had completed training in child development. Child teacher ratios were set at six children to one teacher. In addition, each family in the program/intervention group received 1.5 hours of home visits weekly. The control group started kindergarten at age 5 (Muenning, Schweinhart, Montie, & Neidell, 2009).

Schweihart et al. (2005) collected data on both groups up to age 40. The data were collected annually from ages 3 to 11 and then in subsequent years at ages 14, 15, 19, 27, and 40. Their purpose was to examine the impact of the intervention on education, economic performance, and crime prevention. The intervention group's high school graduation completion rate was 77% versus 60% for the control group. Employment at age 40 was higher in the intervention group—76% versus 62% for the control group—and this trend had continued from age 27 (69% employment for intervention group versus 56% for control group). Overall lifetime arrests were significantly fewer in the intervention group 36% versus 55% (arrested five or more times). The program group also had a significant difference in sentenced prison/jail time at age 40, at 28% versus 52% for the control group. The longitudinal study has indicated the long-term benefits related to enrolling children in a comprehensive model involving standardized curriculum with low teacher-to-child ratios and home visiting (Schweinhart et al., 2005).

The Carolina Abecedarian Project randomized 111 low-income infants to receive early education intensive training. Four cohorts of infants were enrolled beginning in 1972 and ending in 1977. The intervention groups ($n = 57$) were given age-appropriate

curricula to enhance cognition and language, and parents were offered social services support if needed. Both groups received nutritional supplements and social work services to ensure causation of cognitive development was attributed to the educational intervention and not nutrition or parental intervention (Muenning et al., 2011). The characteristics of the children who received the intervention were compared to those children who did not receive the intervention to see if there were improved health outcomes and behavioral risk factors by age 21. The data included three health measures: numbers of self-reported health problems, a depression index score, and number of hospitalizations in the past year. There were 11 measures for health risk behaviors. The questions used to assess behavioral risk factors between the two studies had some similarity, but several were different. The results indicated statistically significantly lower levels of health risk behaviors ($p = .05$) and better health outcomes for the intervention group ($p = .03$) as compared to the control group by age 21.

A federally funded, school-based preschool intervention program for urban low-income children was evaluated for long-term effectiveness to when participants reached age 28 (Reynolds, Temple, Ou, Artega, & White, 2011). The data used were from a Chicago longitudinal study tracking 1,539 low-income minority children (93% Black and 7% Hispanic) born in 1980 who completed kindergarten in 1986. From the original cohort, 989 children completed preschool and kindergarten in the 20 Child Parent Centers (CPC). The CPC provided early interventions through comprehensive center-based educational and family support services from preschool to grade 3. The children participated in half-day or full-day preschool and half-day or full-day kindergarten. The

comparison group ($n = 550$) in the nonrandomized cohort design participated in alternative early childhood programs and full-day kindergarten from five randomly selected schools (Reynolds et al., 2011). From the original sample, 900 (91%) of the birth cohort and 485 (88%) of the comparison group had follow-up data for analysis on educational attainment and socioeconomic status to age 28. The preschool group had higher rates of educational attainment: highest grade completed 12.15 versus 11.88 for the comparison group, attendance at a four-year college 14.7% versus 11.2%, and high school completion 81.5% versus 75.1% for the comparison group. The preschool groups had higher annual income in 2007, \$11,582 versus \$10,796 for the comparison group (Reynolds et al., 2011). This finding provides further evidence that preschool education has long-term benefits for children who were enrolled.

The National Institute of Child Health and Human Development (NICHD) initiated the longitudinal Study of Early Child Care and Youth Development (SECCYD) in 1991 to answer questions about childcare experiences, childcare characteristics, and their relationship to long-term developmental outcomes (National Institutes of Health [NIH], 2012). The study measured early childcare experiences (type of childcare, quantity of care, and quality of care) for a sample of 1,364 infants through grade 6, for adolescent academic and behavioral outcomes assessed at age 15. Twenty-one percent of the families had incomes lower than 200% federal poverty level, and 22% were from an ethnic minority (Vandell, Belsky, Burchinal, Steinberg, & Vandergrift, 2010). This study examined academic and behavior outcomes for 958 youth from the original cohort of the SECCYD that the researchers were able to find (Vandell et al., 2010). The childcare

had three categories; center, childcare home (any home-based childcare outside of the child's own home), or in-home care (any caregiver inside of the child's home). The study also used the Observational Record of Caregiving Environment (ORCE) using trained observers to measure childcare quality through 54 months of age. The ORCE was used for two 44-minute cycles of observation during a 2-week interval for two half-day visits at 6-36 months and one half-day visit at 54 months (NICHD, 2002). Quality of the school environment was assessed during two half-day visits scheduled within a 2-week interval. Attendance rates were assessed with 64% of children attending at least 10 hours per week. Overall, 24% of students in the cohort had attended more than one year of center care by age 4 1/2 years. The adolescent variables assessed at 15 years of age included risk-taking behaviors, impulsivity, and externalizing problems. Structural equation modeling examined direct associations between childcare experiences and adolescent outcomes at age 15. The results indicated education in a school with a high-quality ORCE score of 3.30 revealed there was an association with higher cognitive academic achievement scores (effect size, $d = .09$). No other predictor was significantly related to outcomes at age 15, so poverty or minority status alone did not predict adolescent outcomes.

In the minority population, attendance in a preschool can produce long-term benefits into later life, which can have positive lifetime consequences on income and education. One study indicated that the quality of the educational experience also played a role in predicting positive long-term outcomes. The longitudinal studies collectively have shown evidence of these long-term benefits in educational attainment,

health, and developmental outcomes over time and the positive gains of preschool attendance.

Preschool Absenteeism

In 2001-2002, 700,000 of the nation's 3- and 4-year-olds were enrolled in state-funded preschool programs (Barnett, Robin, Hustedt, & Schulman, 2003). In 2013-2014, the figure has nearly doubled to 1,347,072 (Barnett, Carolan, Squires, Clarke Brown, & Horowitz, 2015). There was also a 48% increase in state funding from \$3.47 billion to \$5.55 billion in the same decade. As a result of the increase in funding and enrollment, some school districts in Baltimore, Chicago, and New York have begun to collect preschool attendance and analyze the data (Connolly & Olsen, 2012; Ehrlich et al., 2013). The data revealed trends of high absentee rates and, within some populations, chronic absenteeism, which is defined as missing more than 10% of the school year. Chronic absenteeism has been shown to be a detriment to academic performance throughout the child's elementary and middle school years, leading to early school dropout (Balfanz, Herzog, & MacIver, 2007). Low-income and minority populations are most at risk for chronic absenteeism (Race Matters Institute, 2013).

Ehrlich et al. (2013) studied a representative sample of preschool children from four Chicago public schools programs for school years 2008-2009 and 2011-2012 to track attendance. On average, 25,000 preschool children were served annually by the programs, representing 77% of all children attending preschool in Chicago. Daily attendance logs were used to track data for patterns of absenteeism. In addition, to analyzing the reasons for absenteeism, teacher attendance logs were taken from 57

classrooms indicating a representative sample, resulting in data on 1,229 students (Ehrlich et al., 2013).

Surveys were administered to 627 parents from the 57 classrooms (representing 56% of the students). Additionally, stratified randomized sampling design was used to select 11 classrooms for parental interviews. The goal was selection of parents with children who over-represented absenteeism. The parental interviews were over representative of African American parents, high poverty, and special needs children. The students were grouped into levels of absenteeism at low, middle, and high. Two students were selected from high poverty and one from low to middle poverty. Forty parental phone interviews represented the final sample. The interviews lasted 25 to 30 minutes, and parents were asked about the child's preschool education and the types of reasons their child was absent from preschool (Ehrlich et al., 2013).

The study followed the first cohort through second grade and showed a distinct relationship between chronic absences in preschool with a five times higher rate of chronic absence in second grade for these same children. Their results discussed the patterns of absenteeism with almost half, 45%, of the 3-year-olds chronically absent from preschool. African American children were almost twice as likely to be chronically absent as other students. Chronic absenteeism patterns were also noticed in students who lived in high poverty areas. The study also showed the students who missed more preschool had lower skill levels (math, letter recognition, and social-emotional development) at the end of the year. Ehrlich et al. (2013) found when the students are chronically absent during their early years, kindergarten through second grade, their

reading scores are lower overall and required reading intervention. The data collected from teacher's logs indicated health (54%) as the primary reason children miss preschool. Logistical obstacles (18%) (transportation, family matters, and childcare) were listed second for cause of absences.

The preschool program discussed above in the Chicago Public Schools was only a half-day program requiring working parents to find childcare for the remainder of the day. There were two issues identified with the half-day schedules: logistical problems of picking up children in the middle of the day and the parental attitude that missing 2.5 hours of school did not seem to be significant. Data from both interviews and surveys identified several family characteristics associated with higher absenteeism. These were identified as: single-parent households, age of the parent (younger), parent was in poor health, living in a neighborhood with higher poverty levels, having a parent not employed or with lower educational attainment, and using the emergency room for primary care. The authors showed these factors had a cumulative effect, and children experiencing three or more of these family characteristics missed school 12.9% of the time. Recommendations encouraged better tracking of attendance at the preschool level and communication with the parents about the importance of preschool education. Ehrlich et al. (2013) identified social barriers, poverty, access to health care, transportation, and access to full-time childcare as underlying factors enabling absenteeism in the preschool population. The decision making of the parent regarding the absence was never addressed within this study. The issues surrounding access

and the feasibility of getting their children to school due to their environmental conditions were not addressed.

A study conducted by Kerr et al. (2012) placed a school nurse at elementary schools to improve chronic absenteeism by facilitating a healthier school population. Kerr et al. (2012) used a family nurse practitioner (FNP) at two elementary schools to place calls to families whose children met the criteria for chronic absenteeism. The FNP placed a call to the parent, and if he or she was willing to talk, the FNP asked about the absences. If the parent explained the absence was related to illness, the FNP offered to make a home visit or to see the child in the office at school. Each call concluded with 10 standardized sentences about the importance of school attendance. Kerr et al. (2012) found that “being sick” was used as the most common reason for absence, but there was no consensus or definition for the illness. The results showed 40% of absences reported as illness were related to transportation, family activity, or family illness. During the 2 years the intervention was in place, there was a statistically significant increase in attendance in most grades (K-3), with the exception of the Head Start program (Kerr et al., 2012).

Kerr et al. (2012) discussed several limitations with the attendance data for the Head Start program, causing the results to be unreliable. The Head Start teachers were not consistent with submitting daily attendance. The computerized software to track data within the Head Start program was pre-set to default to “present” for each child enrolled. If the student was absent, the teacher needed to go in and manually change the system to indicate an absence. The federal expectation is to have 85% attendance

within the Head Start programs. The state at the time of the study was currently operating at 92% attendance. Funding for Head Start is related to enrollment data (attendance). According to the authors, there is no incentive to change the current system (Kerr et al., 2012). The study revealed inconsistent measurement issues with absentee rates at the preschool levels, and parents acknowledging the absence related to “illness” were actually often due to other factors. This study supports the importance of accurate measurement of absentee rates and the need to discover the factors behind why children are absent from school, including those driven by policy and funding levels.

Romero and Lee (2008) examined the prevalence of cumulative risk factors and their effect on absenteeism in early schooling using the Early Childhood Longitudinal Study – Evaluating the Kindergarten Cohort 1998. The longitudinal study used a nationwide representative sample of kindergarten children ($N = 21,260$). The data used from this study had been taken at six data collection points between kindergarten and fifth grade. The design of the study required collection of data from the child, parents/guardians, teachers, and schools. Romero and Lee (2008) measured demographic variables and psychosocial risk factors and their effect on absenteeism. Poverty, being a teenaged or single parent, level of maternal education, receipt of welfare, unemployment, poor maternal health, food insecurity, and large family size (four or more children at home) were evaluated as risks for absenteeism. The most commonly encountered risks within the kindergarten cohort were living with a single mother (19%), living below the federal poverty level (18%), being in large family (14%),

and living with a mother who had not completed high school (12%). The authors pointed out the risks were more prevalent in the more vulnerable populations, poor racial/ethnic minorities, or those in poor health as indicated in Figure 1.

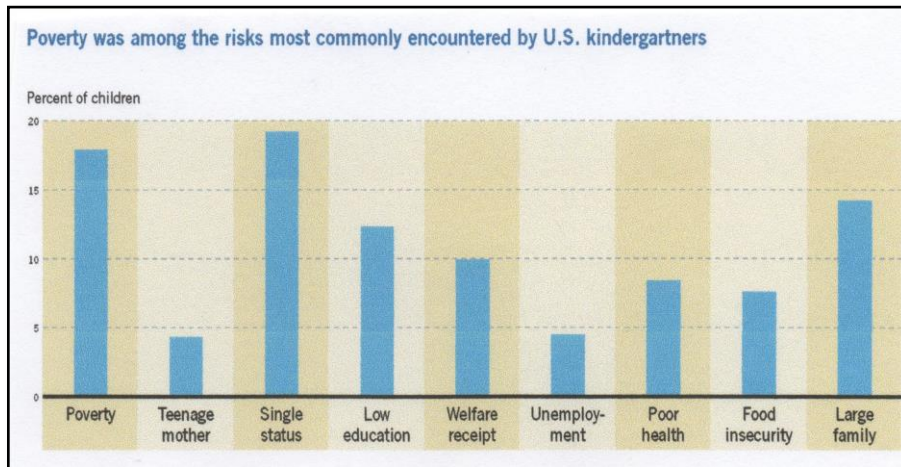


Figure 1: Poverty risks (Romero & Lee, 2008)

Children encountering individual risks had associated absence from school, but the effect sizes between each risk were small. On average, a child in kindergarten with poverty as a risk experienced four extra days of absenteeism; welfare receipt and food insecurity resulted in 2.5 days of absenteeism at this grade level. Children with any risk were more often chronically absent than their peers without any risks through grade 5. In kindergarten, 21% of the poor children were chronic absentees compared to only 8% of their non-poor peers. Children living in single-parent households (mother-only) missed one day more, on average, than children in two-parent households. The children whose mother had less than a high school degree missed on average 1.5 days more, and 22% were chronically absent as opposed to 9% of the children whose

mothers completed high school. Children whose mothers were in poor health missed almost two days of kindergarten on average and were twice as likely to be chronically absent than their peers. The authors measured cumulative risk of the children. Sixty-five percent of poor kindergarten children faced three or more risks, compared to 9% of low income, 7% of middle income, and less than 1% of their affluent peers (living 300% above the FPL). On average, Black and Hispanic children were five and four times more likely, respectively, to be exposed to three or more risks (Romero & Lee, 2008). The population of the preschool children at this study site had many of the factors described in the literature due the socioeconomic status and single parent households. This study facilitated a discussion of the parental perspective about these risks and their relationship to absenteeism.

The National Center for Children in Poverty developed a tool, the Young Child Risk Calculator, to calculate the cumulative effect of identified risk factors on academic failure, which affects attendance, and poor health when combined with economic hardship. The tool has indicated the more risk factors present in a child's life, combined with living in higher levels of poverty, will place him or her at the greatest risk for poor health status, school failure, and other maladaptive behaviors (Robbins, Stagman, & Smith, 2012). Multiple factors including environmental risk factors, lack of transportation, non-traditional work schedules, school policy on children with contagious illnesses being sent home or directed not to come, access to medical care, and parents' understanding of illness diagnosis and management may affect school attendance.

Crowley, Sangehoon, and Rosenthal (2013) assessed the prevalence of regulatory noncompliance of 676 licensed day care centers in Connecticut between January 2006 and March 2008 using results from retrospective and prospective unannounced regulatory surveys in the state of Connecticut. The 676 centers represented 41% of the state's childcare centers and 40,569 day care slots for children. The non-compliance findings revealed health and safety challenges that place the children and staff at risk for increased transmission of infectious disease and higher prevalence of injuries. The highest non-compliance category was hazardous outdoor play equipment found at 48% of the facilities. Inside the facility, the equipment was not sanitary: the diaper changing area was not clean at 32% of the centers, staff health records were incomplete at 36% of the centers, and 1 in 10 facilities did not have an individual that was cardiopulmonary resuscitation (CPR) or first-aid certified.

The authors noted on the day of inspection, only 50% of the allocated spaces for children (child/teacher ratio) at the facility were being used. This finding raised questions of utilizing the child/teacher ratio to enhance safer practices. The authors questioned the capacity, the number of students present on the day of their inspections, the relationship of number of students to infectious disease transmission, and the impact of infection rates on attendance. The inspections showed inconsistencies in compliance with regulatory mandates, which could lead to the environment at the preschool playing a role in children's absence (Crowley et al., 2013). Environmental factors will be described in this study from an observational perspective and the role in preschool absenteeism can be discussed.

Understanding the formidable dynamics parents face to explain why their children are absent can help to offer suggestions for supportive services for decision making processes. Future changes in school and funding policies to increase preschool attendance can subsequently decrease the rate of failure for the population at highest risk. Parental behaviors or decision making regarding the outcomes were not evaluated in any of the studies outlined above. A phone interview or survey data is unable to solicit the same quality of information regarding behaviors and decision making, as the primary investigator is able to elicit grounded theory methodology to uncover hidden processes and perspectives through interaction with parents and teachers.

Parental Behaviors

Factors involved in parental decision making about preschool children are multifaceted. Researchers have evaluated parental decision making about seeking health care for their children regarding different conditions and situations. The use of qualitative methodology allows the researcher to develop a clear image of the phenomenon and factors involved in their decision making.

Parental decision making with acute illness in preschoolers has been evaluated to determine when to access health care services. Winskill, Keatinge, and Hancock (2011) used an 18-item questionnaire in an emergency room in Australia with 25 parents to examine how parents respond to their child's acute illness and which factors influence and/or assist parental decision making to seek medical attention. They found parents frequently focus on deviations from normal behavior, other signs and

symptoms, and advice from their general practitioner when their children have a fever. Voigt et al. (2008) completed a cross-sectional study at a sick childcare program for mildly ill children in Rochester, Minnesota to evaluate parental decision making in seeking health care evaluation. The population of the Mayo Clinic study was employed parents with sick children at an on-site sick children's clinic provided by the Mayo Clinic with access to a healthcare provider. The study was conducted in a very unique setting, enabling the sick childcare to be provided as an employee benefit. The population was predominately White and well educated, with participants working in the health care industry. The demographics were not representative of the United States. These factors limited the ability to generalize this study to a population of low-income Black minority parents.

Difficulties a parent experiences when his or her preschooler becomes acutely ill were studied using grounded theory methodology (Kai, 1996). A group of 95 parents of disadvantaged inner city preschool children were asked to identify and explore their experiences and the information they are trying to obtain when they seek urgent care for their child. The results indicated health care professionals are able to use the encounter to empower parents by sharing more information and skills through communication and recognition of parent's difficulties (Kai, 1996).

Although the preschool attendance and parent characteristics have been studied in the past, the process of parental decision making with preschool parents and attendance has not been discussed in the literature previously. Dialogue with parents about their life experiences concerning their decision making will shed light on the

process they use to arrive at those decisions and the effect on attendance. A grounded theory methodology will facilitate eliciting this type of information and differentiate better synthesis and understanding of the core concepts.

Summary

This chapter reviewed several aspects of preschool absenteeism from longitudinal studies about preschool education and long-term outcomes in educational attainment and other developmental and social benefits. The risks and consequences of chronic absence from preschool and the relationship to low income and educational outcomes were discussed. Parental decision making and policy impact on preschool attendance were also reviewed.

CHAPTER 3: METHODS

Introduction

This chapter will include the methodology, design, and choice of setting for the study. Qualitative methods utilize inquiry of the individual and interpretation of his or her life experience as opposed to testing variables (Corbin & Strauss, 2008). Grounded theory reveals group patterns from a behavioral perspective to generate knowledge (McCallin, 2003). Grounded theory methodology was used to discover the social behaviors and processes of parents and teachers regarding their decision making related to attendance in the preschool setting. This methodological approach allows for the development of a framework to explain human behavior in context of participants' lives (Munhall, 2007). The data is richer and more informative than the current information from national surveys on preschool attendance or data on parents presenting in the emergency rooms or in situations when their children are already sick. The knowledge gained from this study elucidates key information and help facilitate development of future interventions to improve preschool attendance for this population.

Design

The substantive theory about parental decision making related to preschool attendance was developed using a grounded theory approach. This method of inquiry involved the use of focus groups and interviews with the parents and preschool teachers. Additional data sources included de-identified attendance records, school absentee logs, day care center policies, and procedures and review of federal, state, and county laws.

Study Site

A preschool program with an enrollment capacity of 80 children (aged 3 to 5 years) representing primarily low-income, single-parent households in South Florida was used as the setting. The site has four classrooms for 3- and 4-year-old children. There were eight teachers, nine administrative staff members, four volunteer grandmothers, and three kitchen staff members. One teacher has a bachelor's degree in early education, three have associate degrees in early education, and four have obtained a national certification as Child Development Associates. The preschool is nationally accredited through the National Association for the Education of Young Children (NAEYC). The school provides comprehensive parenting education and adult education classes focused on skill acquisition related to finances, employment, housing, etc. The preschool provides a food and clothing bank, tuition subsidies, and financial support when necessary. The focus of the preschool program is to care for the entire family and break the cycle of poverty.

The preschool conforms to the rules and guidelines of the accreditation process of the NAEYC. Ten standards are required to receive accreditation. These are:

1. Promote positive relationships for all children and adults.
2. Implement a curriculum that fosters all areas of child development—cognitive, emotional, language, physical, and social.
3. Use developmentally, culturally, and linguistically appropriate and effective teaching approaches.
4. Provide ongoing assessments of child progress.

5. Promote the nutrition and health of children and staff.
6. Employ and support qualified teaching staff.
7. Establish and maintain collaborative relationships with families.
8. Establish and maintain relationships and use resources of the community.
9. Provide a safe and healthy physical environment.
10. Implement strong program management policies that result in high-quality service (NAEYC, 2008).

The center director was hired within the past 2 years. She has a 25-year background in early childhood education with a strong focus on environmental issues and child health due to her background in a health care setting. Perhaps because of this influence, she instituted many changes, including implementing the environmental changes at the center to improve the overall health of the students, teachers, and staff. The center director has empowered the teachers to support the parents and their role.

Population/Participants

Parents and teachers at a preschool from primarily Black, low-income, single parent head of household families in South Florida were asked to participate in the study. Inclusion criteria for the participants were English-speaking parents with children 3 years and older enrolled at the preschool and full-time staff (at least 35 hours a week) employed at the preschool for at least 6 months. Exclusion criteria were the parent being under the age of 18, parent not living with the child or providing transportation to the school, enrolling a child at the facility less than 3 months prior to the start of data

collection for parents, and for teachers, working less than 35 hours a week at the preschool.

Eight parents participated in interviews or the one focus group in total; five of their children were 3 years old (2 boys, 3 girls), and four were 4 years old (1 boy and 3 girls). The parents were representative of the four classrooms. Two of the children had been previously diagnosed by their pediatricians with asthma. Six of the parents were single heads of household. Four parents of 3- and 4-year-old children who had been taking parenting classes were asked to review the core categories from the data for validation. They were aware of the study due to their involvement with parenting classes and had received the summary for explanation for research and chose to stay after their meeting and validate the findings of the core categories.

The teacher interviews included six out of the eight eligible teachers for the four classrooms. Two substitute teachers who frequently filled in for these classrooms were asked to validate the findings after core categories were developed. The teachers' experience ranged from 4 to 25 years within the profession. Two of the teachers had been employed over 14 years with the center.

Recruitment of Participants

Announcement of the study was made at the preschool to the teaching staff at two regularly scheduled meetings. Flyers (Appendix B) were posted for 2 weeks at the preschool in the lobby (a visible location) for all parents. Flyers were also sent home with the children from the 3- and 4-year-old classrooms on two consecutive Fridays to encourage recruitment. Sign-up for the study was conducted for 2 weeks in the lobby

by the social work intern working for the school. Participants were able to fill out an information sheet (Appendix C) indicating their interest, and return the sheet to the teacher or leave the sheet in a folder at the front desk. The principal investigator would then contact them to discuss the study and possible enrollment. Two focus groups were scheduled for the parents. Participants were reminded via phone (voice or text message) of the date and time of their focus group. A voice mail message or phone call was made initially, and text messages were sent a week prior to the focus group, and 24 hours before the focus group. One focus group was conducted in the evening in a private room with the parents at the same time as the regularly scheduled evening training classes. These training classes are provided for parents by the preschool on a variety of topics. Childcare and food are available on site during these events. The preschool also provided childcare for the children and an evening meal to the parents attending the focus groups and/or any interviews conducted during these evenings.

Additional interviews were conducted at a time prearranged with the participant and scheduled on the premises of the preschool in a private room. Both the focus group and interviews required registration prior to attendance. All focus groups and interviews were tape recorded and transcribed by principal investigator to allow accurate and complete collection of comments.

Researcher Relationship to Setting

The researcher developed a relationship with the preschool setting while conducting clinical rotations with nursing students and serving as faculty for a local university. After serving in this capacity for several semesters, it became apparent

there were some opportunities to collaborate and develop a partnership with the preschool to provide a health component as part of the quality preschool education the center desired to provide. Discussions with parents and teachers led to an inquiry about attendance and absenteeism in the preschool setting. This inquiry led to conducting a primary literature review and the development of the initial research questions of the study. When approving the study at their site, the board of directors and teacher and parent groups requested that the results be shared with them. This level of engagement has resulted in a high level of trust with the principal investigator (PI). The PI, however, is not an employee of the setting. She was supported in avoiding biased interpretation of the data by the dissertation committee chair and members.

Ethical Considerations

Risks to Participants

The study was of minimal risks to participants. Only individuals who requested to be part of the study participated. The nature of focus groups or interviews could make participants feel anxious, uncomfortable, or upset. If this was noted during a focus group, the principal investigator planned to pause the group and ask the participant to step outside. If the participant was unable to continue, he or she could leave, and the principal investigator would follow up with him or her within in a 24-hour period to determine whether the participant was comfortable and if he or she would like to participate through a private interview. If a participant became emotionally upset during an interview, the principal investigator would have stopped the interview. If the

participant was unable to continue with the interview, he or she could leave. These situations never occurred during an interview or focus group.

Participants' confidentiality was supported throughout all parts of this research. Participants were identifiable to each other in the focus group situation and were reminded that anything shared during the focus group session must not be shared outside the group. Therefore, the risk of privacy or non-confidentiality was minimized but could not be absolutely guaranteed. Every effort was made to ensure that participation was voluntary, that informed consent was obtained, and that confidentiality and privacy are ensured. Participants were offered the opportunity for individual interview if that was their choice. Participants were notified during the consenting process that if any instances of reportable events related to child endangerment were uncovered that the principal investigator was required by the state to report them. No such incidents were uncovered during the conduct of the study.

Employees were presumably vulnerable because they were being asked to participate in a research project related to their employment location. Employees were assured all information shared would remain confidential and would not be disclosed to the administrator of the preschool center except if they reported illegal or abuse activity during an interview or focus group to the principal investigator. That information was to be reported to appropriate authorities. This did not occur during the course of the study. The board of directors and administration were very supportive of the study and project. The researcher explained to the employees the support of the administration and board of the study. Employees always had a choice about study

participation; if they did not want to participate, they could refuse. Two teachers declined to participate in the interviews.

Consent Process

The Institutional Review Board of the University of Central Florida reviewed and approved the study (Appendix A). Upon agreeing to participate in the study, the participants received the summary explanation for research (Appendix F) and were given the opportunity to read the document in its entirety. Each participant provided verbal consent prior the focus group or interview. If needed or requested, the summary explanation form was explained to the participant prior to consent by the principal investigator. Each participant was alone with the principal investigator when he or she provided consent, so he or she was not coerced to consent in the presence of others.

Potential Benefits to Participants

There were no direct benefits to participants. The indirect benefits were the outcomes related to knowledge regarding the attendance in the preschool setting in the community and development of long-term interventions.

Data Sources

Initial focus group questions were developed based on the research questions for the project. The focus groups responded to open-ended questions and explored emerging issues and themes. A list of 10 questions was developed to facilitate communication with the participants during the focus group or interview (Appendices D & E). The principal investigator was free to pursue ideas raised by participants to elicit a thorough informational discussion during the focus group and interviews (Corbin &

Strauss, 2008). As is common in grounded theory methodology, focus group and interview questions changed based on emerging themes from the data already collected. The principal investigator met with the dissertation committee chair (phone or email) weekly during data collection to discuss and reflect on the focus group or interviews, and field notes were used to document any relevant comments or discussion during the focus groups and interviews.

Snowball methodology was the planned recruitment method for the study from the initial focus groups and interviews. Initially, two focus groups were planned, and the dates were set. Six parents confirmed attendance for the first focus group with only two attending. The second focus group never received any confirmed attendees. After the first focus group was over, some of the parents from the parent meeting group ending at the same time suggested setting up interviews prior to picking up their children in the afternoon for convenience. Several of these parents from the parent meeting group agreed to scheduling interviews the following week. The parents were familiar with the study due to the flyers and presentation made at their meetings. This change in recruitment and subsequent parental advisement and enlistment allowed for the theoretical sampling implicit in grounded theory arising from data analysis, resulting in successful data collection.

Ongoing data analysis and theoretical sampling guided future interviews (Corbin & Strauss, 2008). After the initial set of interviews, strategic sampling of parents who represented children with low and high attendance rates were invited to be interviewed to obtain more information about their decision making process.

Attendance records, school health absentee logs, and policy and procedure books were used as data sources pertinent to the research questions. School health absentee logs document when a child leaves school due to illness. Data were de-identified and remained anonymous on all records. Observation and examination of the attendance data collection process occurred for a 2-week period daily in the morning by the principal investigator. The principal investigator also documented all procedures currently performed at the school involving attendance data collection. These procedures included arrival of children at the facility, check-in at the front desk, and drop off and sign-in in the classroom of children with the teachers. Individual attendance records were also reviewed. The parent handbook included the use of an attendance sheet (Appendix I) and School Health form (Appendix H). These were used as other key sources of data acquisition regarding pupil attendance. In addition, observation by the principal investigator was done in the classrooms and at the center of the process and procedures related to attendance. The hygiene practices of students with teachers including identification, isolation, and notification of ill or sick students by staff to the parents and other staff was documented in field notes.

Data Management

The PI transcribed the tape recorded data from the first interview line by line for accuracy and verification. The transcription data was analyzed using Software HyperResearch[®] by ResearchWare, Inc. Software. Upon completion of the first interview and data analysis, codes were developed. Based on the codes and analysis, future interviews were transcribed line by line by the PI and coded. The PI used open

coding throughout data analysis and development of subsequent categories. The first two teacher and parent interviews were also reviewed and coded separately by the dissertation chair, another qualitative researcher, to ensure congruence using the data analysis process.

Audio files will be destroyed within 1 year. Transcription data was entered and stored electronically into a password-protected laptop in encrypted files, and only the principal investigator and dissertation chair had access to data. Data were not linked to participants' names. All paper documents will be kept for the required period of 7 years and then destroyed in accordance with the University of Central Florida's Institutional Review Board policy.

Data Analysis

Grounded theory develops a theoretical account of a core category related to the study aims through rigorous and systematic data analysis occurring concurrently with data collection (Munhall, 2007). The specific research concept or problem emerges as the analysis proceeds through constant comparison of data to allow for theory discovery. This method gleans deductive insight from the data and facilitates interpretation of the data (Teddie & Tashakkori, 2009). The PI reviewed and transcribed data within 96 hours of the interview or focus group. Ongoing analysis of data supported the ultimate goal of flexibility, allowing the data to drive the research process and collection. This type of data analysis allowed the principal investigator to analyze the concepts of interest arising out of the data within the study. Concepts emerge from the data with this type of data collection (Corbin & Strauss, 2008). Upon completion of

initial interviews and the one focus group, the theoretical sampling strategy sought participants with special knowledge of the ideas emerging from the initial data analysis. This type of sampling addressed questions arising during ongoing data analysis and supported the direction of future data collection (Corbin & Strauss, 2008). Data analysis and collection worked in unison in an effort to further elucidate the emerging categories and concepts.

Grounded theory consists of three phases of data analysis and management: open coding, axial coding, and selective coding (Figure 2). Open coding is the first phase, allowing the principal investigator and research team to identify events arising from the data as the basis for developing categories. Several codes were repeated during this phase; assessment, communication, cleanliness, and policies. This initial type of analysis was a brainstorming approach because it allowed the researcher to see all potential and possibilities within the data without any bias of filtering. The principal investigator had weekly communication (phone or via email) during the data collection phase to share information with the dissertation chair. The researcher was then able to conceptualize the data into higher and lower level concepts (Corbin & Strauss, 2008).

The codes were organized into smaller sets of themes or categories characterizing a central phenomenon of interest. The use of HyperResearch[®] and an Excel spreadsheet assisted in the organization of the codes into categories. *Cleanliness* and *hand-washing* became a category and several codes were mentioned under this category as identified in the interviews. The participants identified *illness* and *risk of infections in the preschool environment* putting their children at risk. *Decision*

making and education supported all the *hand-washing and cleanliness efforts*. This ongoing data analysis process directed further comparison and coding around the database and data collection about the phenomenon. A constant comparative method was used to look for information representing the categories found in the data (transcripts and field notes) through the use of memos.

Qualitative memos were used to document themes and categories arising from the data. The initial memo was about hand-washing in the school environment. The PI constantly compared transcription data to the arising categories and themes to document accuracy and validity. “Memos facilitate organization of data due to the elaborate and cumbersome cognitive processes involved with qualitative analysis” (Corbin & Strauss, 2008). The memos allowed the researcher to record reflections of the data and interpretations in a systematic way. Memos were used for record keeping as the categories begin to grow and conceptualize. Several memos were transcribed that became subsequent categories for the final themes. The interview and focus group questions were reworked after each transcription and coding to address the themes and categories driving the data collection. Data started to accumulate in the core categories relevant to the study and phenomenon. Another qualitative researcher (dissertation chair) reviewed the codes and procedures for data analysis to ensure confirmability of the process and ensure the principal investigator remained unbiased through weekly communication and separate coding of interview two parent and teacher interviews.

The second phase, axial coding, explored the dimensions of emerging categories and examined their relationships with each other. During this phase, a diagram was

created to support the causal relationships between the concepts and themes. A narrative regarding the data and the model began to arise, supporting the concepts and relationships about communication between the teachers and parents and how this model supports staying healthy and in school. This visual depiction of the model helped the researcher to analyze categories on the micro and macro level for theoretical analysis of each category. The diagram provided a visual display of the relationship between concepts (Corbin & Strauss, 2008).

The final phase, selective coding, concluded with constructing a narrative from the data based on the emerging model and using data from the study to support concepts and relationships. A process was proposed from the interrelated categories in the coding paradigm (Creswell, 2007). Data were collected and reviewed until a saturation and repetition of categories and themes. Data analysis was reviewed with an external qualitative researcher (dissertation chair) for oversight to ensure reliability and accuracy of the process.

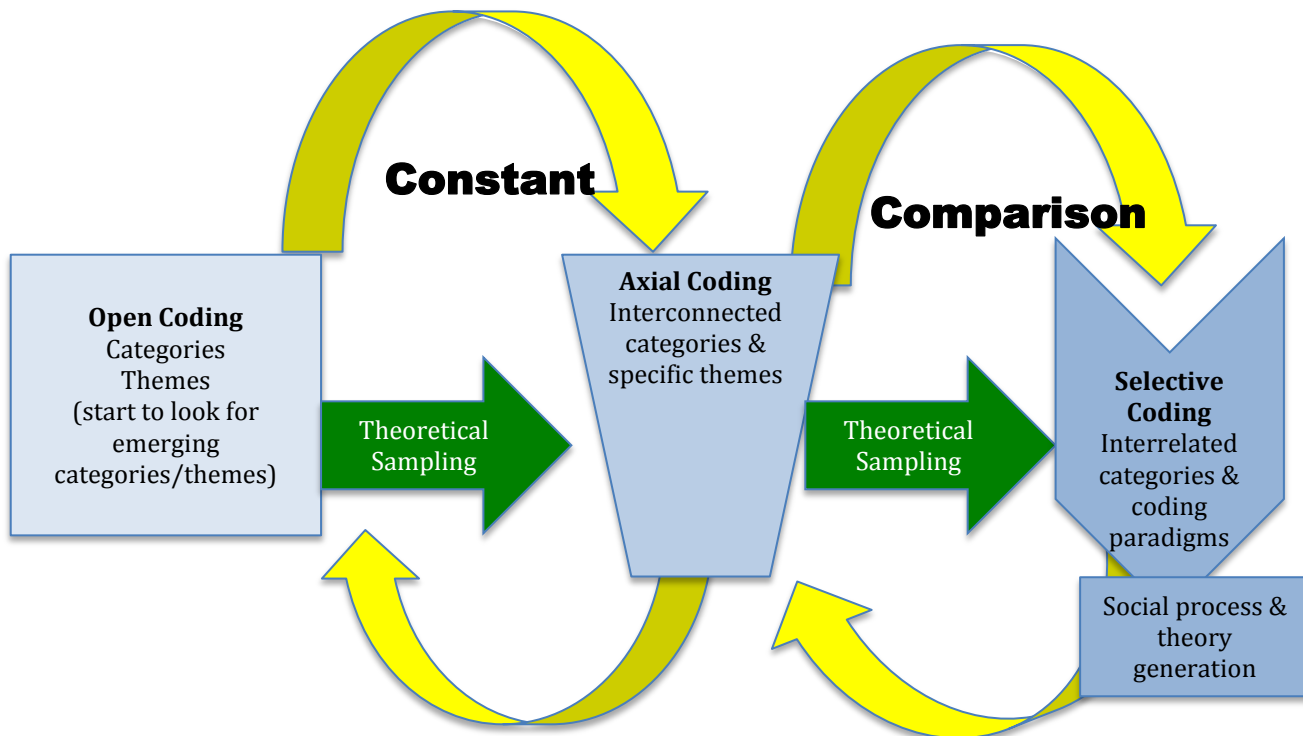


Figure 2: Grounded theory data analysis and collection process

Summary

This chapter described the design and methodology used for the study to increase knowledge regarding the phenomenon of attendance in the preschool setting. The generation of knowledge could improve understanding of behavior and development of interventions to decrease the incidence associated with chronic absenteeism. The common themes developed from the model were communication and staying healthy to stay in school; these themes are presented in Chapter Four.

CHAPTER 4: RESULTS

This chapter will present the results of a grounded theory study derived from the planned data collection and analysis for the dissertation. The purpose of this study was to explore decision making related to preschool attendance using grounded theory methodology. The parents and teachers revealed a communication process centered on promoting children to stay healthy and encouraging preschool attendance. The three themes revealed were: (a) empowerment: actions to support health, (b) trusting judgment regarding health, and (c) commitment of organization and parents to health and attendance.

The model below (Figure 3) depicts the communication process with the inter-relationship of the three themes. In the diagram, the parents and teachers are the support systems for the preschool child. Parents and teachers empower each other to make decisions about the children in the home and school environment supporting health. Relationships formed in the school environment established a trust in judgment between the parents and teachers fostering discussions about child health and attendance. The participants and preschool center identified their commitment to the school environment by adhering to the health and attendance policies implemented to support a healthy environment for their children. This collaboration between the parents and teachers reinforced the communication integral in supporting healthy children to prevent school absence. Empowerment, trust, and commitment supported parent and teacher communication about activities, children's behaviors, and health issues on a daily basis. The model below also depicts the child on a continuum moving towards

health or illness. The communication process can support the movement of the child along the continuum toward health, and a lack of a communication process could move the child toward illness. Stories from the teachers and parents as they shared their rich experiences with the children as well as direct observation by the researcher will illustrate the elements of the communication process.

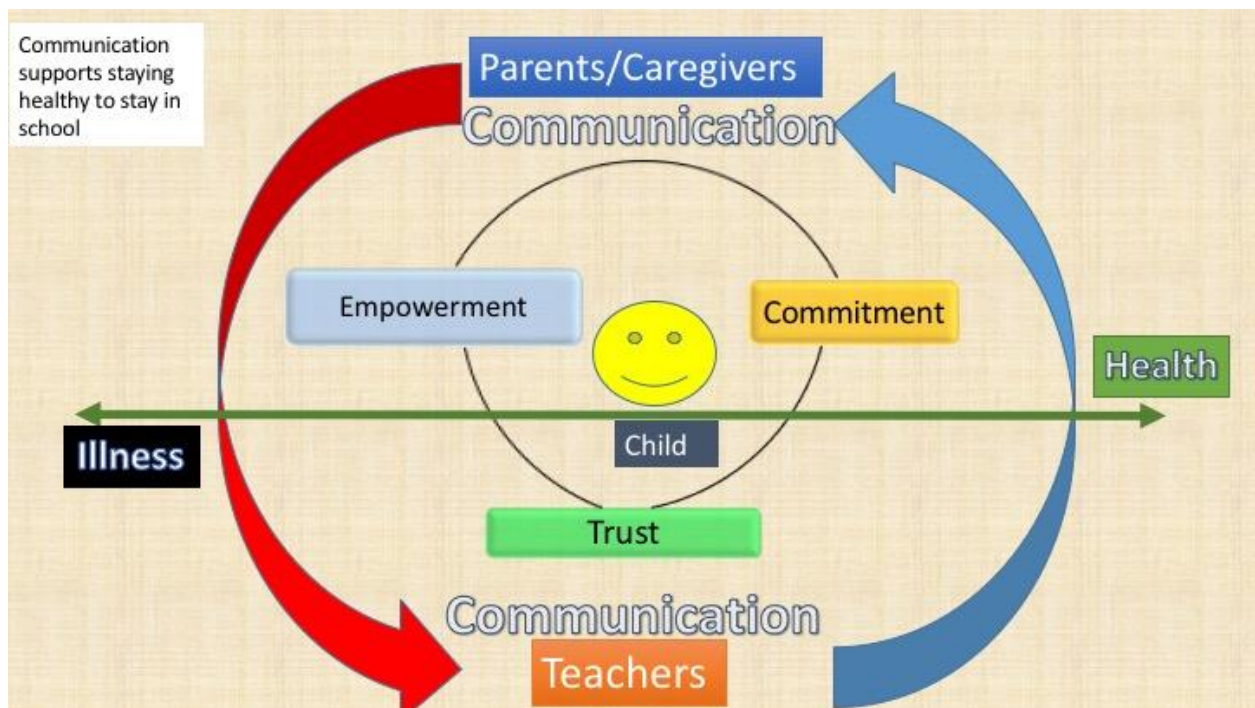


Figure 3: Grounded theory model (Meoli, 2016)

Empowerment: Actions to Support Health

Empowerment indicates the participants know there are actions they can take to keep the children healthy and engaged in school. Parents and teachers actively discussed decision making about their children's activities in the school and home environments and their actions to support health. Parents assess their children every

morning and make decisions about sending their children to school. Similarly, teachers make decisions daily about the children under their care.

Empowerment actions to support health related to communication, environmental control, hand-washing, and surveillance are interwoven because these factors are implicated in the decision making by parents and teachers to keep children healthy and decrease the spread of contagious diseases. These efforts result in children staying in school to prevent preschool absenteeism. Parent and teachers identified the structure of the school day and typical mornings, as routine procedures occurring both in the classroom and home environment to support their decisions. The teachers and parents are empowered in their environments working together to make decisions and take actions to support change. The parents and teachers identified environmental control, hand-washing, and surveillance to support a model empowering them to adopt a healthy atmosphere underlying the communication framework promoting preschool attendance.

Communication

Preschool teachers play a very important role in the life of children. More than just educators providing basic instruction on the ABCs, colors, and numbers, teachers are an integral puzzle piece to empowering the health of the preschool environment. The teachers interviewed revealed in-depth knowledge and experience about the children in their care. As a group and individually, they described several instances when children were not feeling well. The teachers discussed the times they called parents and communicated with them about health issues present in their children. The

teachers were actively involved with the children and responded based on their perceptions of the children's behaviors or actions.

Parents provided the other view of this process and their stories supported and illustrated several additional examples of how the communication process worked from their perspective. Examples were reports of conversation taking place about the events on night before, the child's behavior, or any other concern the parent or teacher shared. The teacher takes over care of the child once he or she is signed in by the parent. This information sharing was reciprocal. The teachers talk with the parents when the children arrive. They ask questions when necessary and listen to information shared by parents. The teachers talked about inquiring about the children's sleep, meals, and/or behavior from either the child or their parents to ensure an uneventful day takes place for the benefit of the child. There was an informal changing in responsibility of roles within the school environment. There is empowerment in this morning ritual of handing over the children.

Parents conveyed the importance of other forms of communication. For example, one parent stated, "If he misses school, we call them and let them know what's going on." The parents demonstrated they were empowered to keep the teachers informed about the child's health status in the home environment even when they were not in school. This process keeps the lines of communication open and increases the knowledge about the child to improve the health of the school environment to improve attendance.

The administrator had made some environmental classroom changes facilitating empowerment to improve communication. At the beginning of the last school year, computers were placed in every classroom, an addition that facilitated teachers' access to their own email. Both parents and teachers mentioned these forms of communication, including emailing using computers. The teachers are also now allowed to use phones (personal cell phones and worksite phones) in the classroom environment. This was very obvious during this study as teachers reported using their personal phones to communicate with the parents via voice or text messages.

Several times during observations and the interviews, discussions occurred about communication regarding phone calls. All classrooms beginning this school year have purchased iPads for educational purposes. The teachers are creating informational newsletters for their classrooms with pictures and giving them to the parents weekly with updates about the classroom activities and their children. In the interviews, the parents who have had their children at the center for longer than 2 years commented positively on the recent changes adopted by the teachers. One parent said she felt the teacher was easier to access now because she could call the teacher directly rather than going through the front desk. A parent indicated, "We call the teacher directly in the classroom rather than waiting for the front desk. I can call and reach her right away." Another parent noted, "they are really good about communicating, the teachers tell you about the good and the bad things." Increased access to technology in the classroom has fostered empowerment of the teachers to improve communication with the parents.

Environmental Control

One of the major reasons for absenteeism is infectious disease. Cleanliness in the preschool environment was mentioned by several parents as an important factor in helping parents decide on their choice of preschool. A parent identified the cleanliness of the environment and related it to other preschools. She was able to volunteer and work behind the scenes at this center. Several parents identified the preschool as being very clean, and when they come to pick up their children, the floors had been mopped and all the toys were put away. She stated:

I volunteered here, I was able to go behind the scenes, and it is one of the cleanest preschools; the teachers actually care about the children; they get down on the floor, and they clean the classroom while the kids sleep.

A parent stated, "It always looks and smells nice, and you can see that the teachers are always on top of everything."

Each preschool classroom is divided up into several multifunctional areas called centers. The centers represent different areas of education used for science, environment, dramatic play, library, music, and dance. Each center has specific items related to the area (sand and water table in science, books in library, costumes in dramatic play, musical instruments in music), and there are barriers between each area to serve as demarcation lines. The children eat and sleep in the classroom every day. The sleeping mats are provided by the center for the children, but the parents bring in covering for the mats to sleep (a sheet and blanket). On Friday, the teachers send home all the items the children sleep on during the week to be washed. The mats are wiped down and cleaned each Friday. Upon observation, the teachers are always

cleaning their classrooms, and the children put the toys away after playing. There is a schedule to clean toys every Friday. Teachers take ownership of their classroom, and this empowers them to keep it clean. The teachers identified a process for wiping down table surfaces after meals and playtime. Teacher D stated: “You know to keep it clean, you know and do like, while they are napping, sanitize the toys and surfaces they've been touching, like during naps, while they are napping to keep everything clean.”

The center was previously using a concentration of bleach-based products for cleaning agents, which posed potentially toxic issues for children, if they were exposed in their eyes or on their skin. A new eco-system product line of environmentally safe non-toxic antimicrobial products was introduced in the summer 2015 to be used in all classroom environments and throughout the school. There are new dispensers located in the central supply closet to facilitate ease of use and application for all staff. The teachers made positive comments during their interviews about moving away from the bleach products and the easy access to dispensing the new products. The center administration invests in equipment and resources to support the goal of cleanliness and empowering the teachers to facilitate cleanliness of their classrooms and environment.

Another investment in the preschool environment was paper towel dispensers, which were converted in all areas to motion detection to minimize the incidence of contact on surfaces. In a parent interview, the mother discussed how much her 4-year-old child talks about and enjoys this new dispensing model and waving the hands in front of the machine “to get the paper to come out.” Even the new paper towel

dispenser allows the children to feel control over their environment, facilitating the empowerment theme. The air conditioning system was upgraded to include an ionized high-efficiency particulate air (HEPA) filter to minimize the potential for harmful germs in the environment. The HEPA filtering system has been shown to decrease the incidence of asthma symptoms in some settings with the use of ventilation (Xu et al., 2010). A new environmental company was hired to clean the school after hours in addition to all the above changes.

Hand-Washing

When asked what supports attendance at preschool, hand-washing was consistently identified as an important process in both the home and school environments to prevent illnesses and decrease germs. Teachers identified hand-washing as the most important task of the day and the one event the children do most during the day. Teacher E stated:

They wash their hands during the day, at least six or seven times during the day because they do it during in the morning when they come in. We talked about that in the beginning of the school year, that even when mommy comes in because the door handles and stuff, because all that needs to be sprayed and cleaned, they're washing their hands so its pretty much all during the day more than anything else, we are cleaning and washing our hands.

Teacher B added: "We are washing hands here and when we come from outside, we wash hands; before we eat, we wash hands; after using the bathroom, we wash hands and for them to be doing the same thing at home." The parents also identified these practices. Several parents stated when they bring their children into the classroom, they are required to sign them in and the children need to go to the restroom to wash their hands prior to eating their breakfast. In observation of the classroom, the children

wash their hands and are encouraged wash by their teachers if they forget. The children wash after going outside, before lunch, if blow their nose, or any other condition warranting washing their hands. Some children will sing when washing their hands, and there are visual posters in the bathroom and classrooms about hand-washing to serve as gentle reminders. The teachers indicated the children are taught how to wash their hands by students from various nursing school programs. There are also books in the classroom to reinforce this health behavior. In both the parent and teacher interviews, the process of hand-washing was explained in detail.

Hand-washing practice follows the children home because several parents identified the children washing their hands using the same standards taught at the school. They identified the step-by-step the process the teachers indicated, even with the 3-year-old population. A parent of a 3-year-old stated:

She will tell you, turn the water on first then wet your hands, hand soap, wash your hands get a paper towel turn the water off, and what she washes her hands she sings happy birthday to you as she's washing. We wash our hands, but I don't wet them first and the same process she does, I don't do, I turn the water on so and then I wash (demonstrating with hands) like that and if she sees you do that she says my teacher says you wet your hands first, she definitely knows how to wash your hands the correct way.

Hand-washing has been shown to decrease the spread of germs and decrease the risk of infection (American Academy of Pediatrics, American Public Health Association, & National Resource Center for Health and Safety in Child Care and Early Education, 2011). For children as young as 3, learning the proper hand-washing technique is an effective precautionary step to decrease infection in this population. The communication process between the children, parents, and teachers is apparent.

Children are teaching parents how to wash their hands; several interviews had parents singing songs and visually demonstrating how to wash their hands step by step.

Children and parents are empowered by learning effective techniques to prevent illnesses and to reduce the risk for transmission of infectious diseases. The theme of empowerment is seen from the children, parents, and teachers. The groups work together to communicate about the process and cleanliness in the environment.

Surveillance

A continuity of care model was instituted at the center last year to promote secure teacher-child attachment in the preschool and infant classrooms. The children in the 3-year-old classroom will now have the same preschool teacher for 2 years, until they graduate. The continuity of care provided by the same teachers allows many benefits for the children, families, and teachers. According to Snyder (2011):

When caregivers remain with the same group of children for an extended period of time, they are more able to develop strong trusting relationships with the children in their care as well as with the parents. These consistent, trusting relationships lay the foundation for children's early explorations and learning and their successful long-term development. (p. 15)

The children in the 4-year-old age group had been with their teachers for 1 year previously. The family-teacher relationships formed were obvious in the 4-year-old parent interviews. The parents discussed the continuity of care model and how it had impacted their child and improved the knowledge the teacher had of their children. A parent said, "I love her teachers they are phenomenal, I love the staff they are great at communicating!" The teachers also expressed their excitement in watching the children change developmentally over the 2-year period, rather than having to stay consistently

with one age group over a year. The teachers have formed strong relationships with the children and parents, facilitating the empowerment leading to communication and encouraging attendance in this preschool population. The administrator's choice to build a continuity of care model supported the depth of knowledge of the individual children's patterns.

The teachers are actively involved with the decision making process at the school and have monthly lead teacher and staff meetings. The administrator has involved teachers in the parents' monthly meeting and has hosted an open house to facilitate communication. The majority of the teachers employed were at the center longer than 2 years and had established reputations prior to the new administrator making these changes. The new initiatives have facilitated improved communication and revealed the framework to enhance the attendance of the children in this environment. These new changes have resulted in teachers and parents becoming empowered in their roles to enhance the educational achievements of their children, resulting in improved attendance.

The teachers could be seen communicating continuously in both the 3- and 4-year-old classrooms. The teachers related how they assessed the children every morning from the moment they walk into the classroom visually and verbally. The teachers said they would look for scratches or marks or just a behavior change—something different for that child as compared with his or her usual appearance or manner. Their experience with these children in the classroom fostered their continued

assessment and trust in their skills and intuition. This diligent observation related to experience has a protective effect on the classroom and keeping children in school.

Empowerment was the framework to support the categories presented of environmental control, hand-washing, and surveillance; all are integral components to the functioning of the school but also the health of the children and decreasing preschool absenteeism. The teachers are empowered in their roles because of the communication and relationships established with the parents and support of the administration. Teachers and parents expressed the importance of a clean environment, and through observation and interviews, the participants were empowered to take action and control of their environments. Support of the administrative staff and recent environmental changes provide a consistent goal to improve communication and support attendance.

Trusting Judgment Regarding Health

Trust is a foundational principle to effective communication between two parties. The categories under trusting judgment regarding health were symptom recognition, decision making, and sending a child home. Teachers and parents discussed the importance of using their instincts and experience to recognize the symptomology present with children. Identification of symptoms proactively and making decisions about sending children to school prevent the entire classroom from potential exposure, resulting in more absenteeism. The teachers' experience in the preschool classroom ranged from 4 to 25 years. Parents discussed their trust in the teachers and their decision making about sending children home from school. Each of the participants

has experience in their roles and makes decisions to support a healthy preschool environment.

Symptom Recognition

These parents possess intuitive knowledge about their children and illness. Morning routines involving illness were described as atypical. Every parent knew their child was sick based on behavior-related symptoms. These symptoms in this age group were defined as cuddly, quiet, tired and without an appetite. A parent stated, "It's not hard to deal with her when she is sick; she just wants her mommy and to be cuddled and held." Other parents of more active children discussed how the activity level decreases substantially and the child is just lying around. Most parents indicated they would take the child's temperature and assess them. Based on the behavior and the symptoms, they would make a determination about taking the child to school. All parents said, if their child were sick with a fever, vomiting, diarrhea or just lying around not feeling good, they would not send them to school. This parent summarized what most parents indicated in the interviews:

sick really bad and had a bad fever, so like if he is sick and he has a bad fever and it has to play its course, I just let it play its course and take him to the doctor; he won't go to school.

In the parent interviews, they discussed identification of symptoms through behavior change and trusted their decisions about attendance.

Preschool teachers consistently communicated throughout the interviews they were aware of the health symptoms requiring exclusion of children from the group. Symptom recognition was a core category related to the trusting judgment regarding

health. Teachers were able to recognize symptoms and trust their decisions to protect the environment for all the children. The teachers identified fevers, diarrhea, vomiting, and pink eye as the most contagious illnesses most commonly seen in the children at the center requiring action. They differentiated these from other commonly seen symptoms, as a sign of a contagious disease: clear runny nose, non-productive cough, and general stomachache without nausea, vomiting, or diarrhea as examples.

During observation in the classrooms, this symptom recognition and differentiation was visible. When a boy came into school with green drainage from his nose and a deep bronchial cough, the teacher discussed the symptoms with the parent prior to admitting the child in the classroom. The child was sent to the front office, and the parent took the child home. The teacher indicated later that day, the parent had called and informed them per the pediatrician recommendation, the child would be staying home for 2 days. This communication was fostered due to the trusting relationship established with the two individuals and improves attendance by decreasing exposure to the other children in the classroom.

Preschool children not feeling well are going to have difficulty focusing in school and may be at risk for becoming ill or spreading disease within a confined environment. The teachers were aware they needed to be cognizant of the children's health status from even the subtlest of signs. This acute observation and use of detective skills from experience allowed the teachers to trust their instinct, facilitating a healthy environment at the preschool and protecting the other children in their care. Teacher B stated:

Sometimes when I feel like a child is having a bad day and I see that they are acting differently, I still automatically see if they're not feeling well by touching

them and asking, “Is something bothering you?” “Is something hurting you, what's the matter?” And a lot of times the kids are able to communicate to us that something is hurting and they don't feel good.”

Teacher E added: “You have a child that is always playing always happy, that child be crying for a long period of time you could see by the way they look, I always ask them, ‘hey are you okay?’”

Several teachers indicated they paid closer attention on Monday mornings because the children had been gone all weekend. The teacher’s assessment skills appeared to be more fine-tuned on Monday mornings. They were looking for anything unusual in part because the children had been away and may not be staying with their parents. More discussions with parents took place on Monday mornings and were visible during the observation period. The teachers would question the children more on Mondays and give them a little more time to adjust because “it was a Monday, you know,” Teacher F added.

The teachers possessed unique knowledge related to their experience in the classroom. They proactively took charge of the health and well-being of each of the children in their care and their classrooms. Teacher C explained:

You get a child who might have just missed breakfast and they're hungry and when lunch comes, they're not even thinking about their stomach anymore once they've eaten. It is just an observation, continuous observation.

The teachers put the welfare of the child as a top priority in their classroom. They care about these children as if they were their own. The parents verbalized these teachers were like surrogate parents because their children spent many hours in their care and they trusted them. The children’s interaction with the teachers was reinforced

in the parent interviews. Several parents indicated the teachers knew their children very well because they had been their teachers for 2 years, reflecting the continuity of care model.

Decision Making

The teachers make decisions about actions based on symptoms present in the classroom. When they take a temperature and find the child has a fever, they consistently stated the parents are called to come and get the children. The health form is filled out and the children are removed from the classroom to decrease exposure. The time frame to get the children was a bit unclear, but most teachers felt the parents arrived within 30 minutes to get their children or send someone. Teacher B stated:

But, like sickness, it depends, if is a fever and it is over 101, we definitely call, for them to be picked back up, because they can't be around the rest of the group, exposure. If it's vomiting, the same thing.

Teacher A added: "A fever, the parents have 30 minutes to pick up, and that child that had the fever, we don't keep this child in the classroom; we move this child from our classroom the to the office."

It is clear the teachers know the child's typical behavior pattern and notice deviations from that pattern and trust their instincts. This leads them to look for further data to investigate the health concern. They communicate with the parents about the children and their health. This conversation can occur during the day or when the parents pick up the children, depending on the degree of intensity of the illness and presentation. A parent stated:

The teacher would be like "is she okay?", and the teacher and I discussed, and the teacher noticed she wasn't herself, and I said she did not act like that last

night, and I asked if she was okay, and she said yes but the teacher noticed it and I said let me pay attention to it so when I got home, I paid attention to her. I said yes she's sleeping too much, so I knew she was going to get sick.

The teachers identified a continual process of identifying symptoms in the children due to their continued educational preparation in this field. The teachers felt prepared for this role by the education and preparation provided to them by the center. Teachers trusted their instincts and knowledge due to the education provided at the preschool. The administration organizes local agencies to work collaboratively to educate the staff on health issues regarding the children. Each summer, the teachers review the accreditation standards from the National Association for the Education of Young Children (NAEYC) and the American Academy of Pediatrics. The teachers discussed in depth the information they learned from the courses they attended during the previous summer and in-service programs offered throughout the year to prepare them to recognize symptoms and assess the children. They were able to discuss resources available to them for decision making created by the center for children who were sick. Teacher F explained, "We have a form; every classroom has a form, and on that form it states if the child has diarrhea, vomiting, a fever; it gives those indications."

The center has a health form (see Appendix H), which was mentioned in both parent and teacher interviews. The health form has been central in conveying information and serves as a communication tool as mentioned by participants. It identifies for the parents the reason and indication their children are being sent home and any stipulation for follow-up, such as 24-hour rest at home, doctor's appointment required, etc. The form is generated by the teacher when the child becomes ill. The

parent reads the form, signs the form, and is advised to follow the recommendations on the form. The form is a written communication process with a comprehensive documentation of assessment and symptom recognition and recommendations for treatment and follow-up. Parents indicated the documentation requirements by identifying the conditions prior to bringing a child back to school after being sent home by the teachers. The parents said the document would have items circled for treatment recommendations of following up with a health care practitioner, 24 hours of rest, or other indications. As stated by a parent:

It is a paper, if they have pink eye, diarrhea; the teacher checks the area so you know what the issue is; if the temp is over 100, they ask you to stay home 24-hour rest. Then the front will sign also and the teacher will sign, the parent will sign saying I recognize there is something going on, I understand I read it and I understand the symptoms. If it says a doctor note, then you have to get a doctor's note or your child can't come back without that note.

The health form provides documentation for children who leave the school early. The process as observed and described by teachers and staff is the teacher completes the form and two copies are made. One copy of the form is given to the parent when they take the child home and one copy is stored in a binder at the front desk. The original is filed in the child's folder in the administrative offices. When the parent returns to the school after the child's absence, and the recommendation was to seek medical attention. The position at the front desk is very fluid at times. There is nothing prompting the individual at the front desk to collect any paperwork from the parent. The parents stated they give the required paperwork to the teachers. The teachers then return the paperwork to the front desk, and it will get filed in the binder or in the child's folder in administration. The process as described leaves several areas for

improvement. Currently, the documentation is completed for a single episode, and the process to keep all documentation together when the child returns is not formalized. A method or process to quantify the number of children leaving the school early or the number of absences per child is not currently being tabulated.

Sending a child home. The center has a standard protocol in place, reinforced by each teacher, that specifies a response to student symptoms, which resulted in removing the children from the classroom to decrease exposure to the other children when appropriate. The protocol involves taking the child to the administrative front office to wait for the parent or other guardian to pick them up. This protocol was implemented when there was an issue with contagious diseases or unknown disease processes present in a child.

One teacher recalled a child had a fever of 101.2° and even though he was not acting lethargic when she touched him, he felt very hot. After she took his temperature in both ears, she immediately moved him from the classroom to the administrative area, completed the paperwork, and called the parents to pick him up. This story gives credence to the observation that the teachers monitor for symptoms constantly. All teachers indicated a similar process with assessment, communication, and intervention of the children.

Another day, during observations, a child was complaining of being sick to the stomach, and the teacher took the child's temperature. Even though the child was afebrile, the teacher had the child lie down, away from the other children in the room. The teacher called the parent. Another day, during a parent interview of a different

child, the parent recounted a rushed morning of leaving her child at school and receiving a phone call from her teacher about 30 minutes later. There was a questionable red mark on her daughter's forehead. During the conversation, the teacher touched the child's head and the mark came off. Apparently, the mom had kissed her daughter on the forehead resulting in the subsequent mark and phone call. The parent said, "They called me concerned, and it did not turn out to be anything, and it made me feel good." These two stories are examples of teachers calling parents and giving detailed descriptions of what is happening with their children, the time frame, a description of symptoms, the child's condition, and the teacher's impression. The decision making shows the informal communication practices between the participants and the developed relationships to support trust and judgment.

The parents and teachers used assessment individually and collectively in a shared communication process to make decisions about the children and school attendance related to health issues. The basis for the theme of trusting judgment in action was evident as many teachers highlighted the importance using their experience in assessment of the children. Teacher E stated:

I had a child with a headache and called the mom and said your son has a headache and says he is just hurting and he was crying. It gave me a signal that really something was really bothering him. She sent someone to pick him up.

Teachers' experience and the mother's trust in the communication of the assessment work together to provide the best environment for the children.

The parents and teachers both share roles in these children's lives. They are experienced and knowledgeable about their children's health and behaviors. Their

willingness to trust each other and openly share information has fostered a communication process resulting in improved health in the classroom environment promoting preschool attendance.

Trust is the foundation of communication between two individuals. Parents and teachers identified symptoms in children and their experience facilitated an environment to reduce the incidence of infectious disease by early identification to reduce absenteeism. Trust was exhibited by the parents to communicate with the teachers and make the best decision for the child and the preschool. Trusting judgment regarding health in this preschool environment has been established by a preschool administration empowering the teachers and parents by supporting decision making of the teachers. Protocols are in place to protect the children collectively to prevent the spread of infectious diseases and improve attendance. Parents and teachers respect and trust each other in their collective roles for the overall goals of the children to stay healthy and attend school.

Commitment of Organization and Parents to Health Policy

Policies and payment systems have led to specific practices and expectations in the school. One of these outcomes is a commitment to supporting health and reducing infections to ensure the children have good attendance rates. The practices were led by the administration and resulted in empowerment of teachers to expect cleanliness and to assess children for infectious illnesses to reduce transmission of infectious diseases in the preschool environment. It was visible in the way they talked about their roles, discussed the children with the parents, and most importantly engaged with the

children. The state and county has policy and funding resources available impacting attendance for this population.

Institution of Health Policy

One research question prompting the study regarded attendance policies and practices and their effect on absenteeism. How do informal and formal preschool policies and practices affect parental decision making regarding attendance? Discussions about policies and practices with the parents and teachers revealed discussions about a parental handbook followed to set child health and attendance policies.

Handbook. The handbook all parents and teachers mentioned is given to every parent upon admission to the school. The handbook was consistently discussed and referenced by all staff and parents. Teacher F said, “It is in the handbook, so that parents know about it because it is through the handbook—the parent’s handbook.” The parent handbook is comprehensive in discussing school policy, attendance, and health (see Appendix I). A parent stated, “The handbook says if your child misses more than 2 days, you have to call the school and talk to the teacher about it.” Students who have missed more than 2 days in a week are highlighted by the teachers. The parent of a 3-year-old explained: “If they don’t see him for 2 or 3 days, they will call.” The parents are called by the teachers to inquire about the absence. The handbook defines the attendance policy as missing 3 consecutive days of school and requires a doctor’s note prior to returning to school. The handbook reinforces a healthy school environment by requiring a medical note when experiencing a prolonged school absence.

Health Policies

Florida is ranked third in the nation in 4-year-old preschool enrollment. The state provides funding for 540 hours of voluntary prekindergarten (VPK) education instruction for every 4-year-old child enrolled in a program meeting criteria. Early learning coalitions were established across the state to work in collaboration with the Department of Education to facilitate coordination of services for children and families birth through 6 years old. Standards were developed for VPK education to support state funding resources with the following mission:

Every 4-year-old child in Florida shall be provided by the State a high quality prekindergarten learning opportunity in the form of an early childhood development and education program which shall be voluntary, high quality, free, and delivered according to professionally accepted standards. An early childhood development and education program means an organized program designed to address and enhance each child's ability to make age appropriate progress in an appropriate range of settings in the development of language and cognitive capabilities and emotional, social, regulatory and moral capacities through education in basic skills and such other skills as the Legislature may determine to be appropriate. (Florida Early Learning & Development Standards; Section 1(b), Article IX of the State Constitution, 2011).

According to Florida Statute 1002.71, private institutions can create their own attendance policies. In Florida, state law allows the private schools discretion in setting policy per attendance. The interviews with teachers and parents discussed a policy about missing 3 days a month. A child missing 3 days a month meets the criteria for chronic absenteeism. The 540 hours of instruction equates to 60 hours/month, 3 hours/day instruction over a 9-month school year. Missing 3 days of school in a month ($9/60 = 15\%$) would place the child in the chronic absentee criteria because he or she is missing more than 10% of the month. Neither parents or teachers when interviewed

were very specific about this policy and gave vague information about missing 3 days and being called by administration. The policy is currently being revised by the administrative team.

Attendance Policies

The center is working on its attendance policies and is in the process of setting up a new system for attendance data collection. The overhaul of the policies and system changes is related to financial accountability and improved tracking of students' attendance data. The administrator would only validate that the state will not reimburse the school for the entire month if the child is absent for more than four days. The school is able to receive reimbursement for these funds if appropriate documentation is provided to substantiate the absence (medical, emergency, etc.). The administrator indicated no child is terminated due to absence. The school is required to verify each child attending the Pre-K 4-year-old classroom because of funding with the state. This is a sheet submitted to the state education department monthly with the parent's signature and school's signature to verify attendance.

The center only provides a cash system for their families to pay for the center, but they are planning to invest in other avenues of collecting monies (credit cards, etc.). Parents are subsidized on a sliding scale based on their income levels. The current policies provide for receipt of scholarship monies upon completion of scheduled trainings offered at the center in parenting and other programs. They provide a family strengthening model for every age and engage their parents and staff. The parents

discussed favorably in the interviews these opportunities made available to them to attend classes for parenting.

The center administrator discussed attendance at the school and a specific policy regarding attendance and funding. Although the long-term goal is tracking chronic absenteeism at the individual student level, addressing current attendance policies and data sets are the focus. All of these policies—state, local, and center—work collaboratively to support the education of the preschoolers in the state. They support the theme of commitment and the communication process at the center by providing the framework of policy to dictate the structure and rules of implementation for parents and teachers.

Attendance tracking. The attendance is collected jointly by the teachers and the front desk attendant. After 10:00 a.m., the front desk attendant calls each classroom and verifies the head count of each classroom. The front desk attendant will come to the classroom and make a copy of the attendance roster for the day and compare it to sheet completed upon arrival of the child for attendance verification. This information is put into an Excel spreadsheet used to capture the attendance rates at the preschool and is monitored by the administrative staff. At the time the parents come to pick up the child, they have to sign out the child at both locations for security reasons: the classroom and front desk. The teachers discussed the absentee policy as issue because of risk of non-payment from the state rather than attendance. Teacher F explained:

If they miss more than three, we don't get paid for the month. The school won't get paid for the month. Once it goes to the third absence, it goes to an

administrator; they will intervene and make a phone call and say the child hasn't been here; if it's a sick child, parents have to bring in documentation that the child is sick, if you're just keeping your child home just to be keeping the child home, that can be cause of termination, especially in VPK because we are not getting paid as a center for VPK if that child does not show after three absences.

Several of the parents of 4-year-old students acknowledged in the interviews the importance of VPK and their child attending school. One parent stated, "It is very important with VPK, 9-12 is really enforced because that is when your child is learning." The parents knew the child's attendance was important to their education and indicated their commitment to attendance. Most parents related attendance to illness, as stated previously. If the child was ill, they were not attending school. In some instances, parents discussed keeping their children home when older siblings were out of school, for family weddings out of town and funerals. Most of these events centering around family situations. On rare occasion, parents mentioned when they were off from work, they just wanted to keep their children home. The examples were given more often from the parents of the 3-year-old children. The parents of the 4-year-old children were more focused on VPK attendance and the school policies related to funding. A parent stated, "she can't miss school unless she is sick, because they don't get paid." The parents discussed their recognition of the checking in process for their children at both the front desk and classroom to verify the attendance process and tracking.

Attendance Outcomes

Attendance rates are calculated by classroom daily and monthly using an Excel spreadsheet. The rates are collected to verify attendance and the appropriate financial compensation from the state. The attendance rates calculated for this study (total

number of student attendance days/number of school days in a month) over a 4-month period (August to November, 2015) ranged from 80% to 95% for the 32 students in the 3-year-old classrooms and 87% to 95% for the 35 students in the 4-year-old classrooms. Kerr et al. (2012) indicated at the preschool level Head Start requires an 85% attendance rate. Attendance in one of the 3-year-old classrooms was below 85% in all but 1 month so far this academic year (August through November).

The attendance data documented the number of children in the 3- and 4-year-old classrooms who were absent from school each day. The 4-month period (August through November) was also evaluated for chronic absenteeism for individual children. In the 3-year-old classrooms ($n = 32$), there were only two children identified as being chronically absent (missing more than 10% of the month) in three or more consecutive months. There were two children in the 4-year-old classrooms ($n = 35$) identified as being chronically absent for the 4 months. Over the data collection period, there were four children chronically absent for 3 or more consecutive months out of a total of 67 children (5%). The pattern for chronic absenteeism in this setting is considerably lower than what has been found in the literature. Ehrlich et al. (2013) found rates in his population with 48% of the 3-year-olds and 33% of the 4-year-olds being identified as chronically absent in Chicago. Teachers stated children in the 3-year-old classrooms missed more school than their 4-year-old counterparts. There were several possible reasons to explain the four-year old attendance rates. Teachers indicated in interviews the 4-year-old classes were established students and none had a chronic health condition. Parents of the 4-year-old children stated in the interviews that attendance

was important because VPK was to be taken seriously and their children were older and preparing for kindergarten. The 3-year-old teachers stated in the interviews some of the children in their classrooms had never attended a preschool. The immune systems of the 3-year-old children would be tested due to their lack of exposure to other children previously, placing them at a higher risk for absenteeism. Both 3-year-old classrooms included children with chronic conditions including asthma. These factors likely explain the difference in monthly attendance between the two age groups. The administrative staff in addition to developing new attendance policies is creating a tracking system for identifying individual students at risk for chronic absenteeism based on the attendance data collected.

Commitment to protecting the health and well-being of the students to reduce infection and ensure good attendance rates occurs with adoption of policies and payment systems leading to these outcomes. Parents and teachers trusted the new practices administration put in place, resulting in empowerment and improved communication. All of these efforts worked together to improve the overall health of the preschool environment through improved environmental changes, parent-teacher communication, and standardized practices in a preschool setting.

This chapter reviewed the grounded theory revealed by the data analysis regarding decision making related to preschool attendance. It is a unique communication process with complementary themes described by the parents and teachers with rich details. This center provides a model in communication between partners in education for children resulting in shared decision making to improve health.

The parents and teachers through the communication process enable and facilitate each other to improve the child's education and ability to stay in school and decrease absenteeism.

CHAPTER 5: DISCUSSION AND IMPLICATIONS

The purpose of this study was to explore decision making related to preschool attendance using grounded theory methodology. Parents and teachers from a preschool in South Florida were asked about their decision making regarding attendance and preschool absenteeism. The data revealed a school environment supporting a communication process benefitting their preschool children and their attendance. The themes of (a) empowerment actions to support health, (b) trusting judgment regarding health, and (c) commitment of organization and parents to health and attendance were illuminated by the parents and teachers by relating their lives and experiences. Implementation of the specific health-related strategies were intended to enhance preschool attendance for preschoolers. The setting provided a collaborative model of parents and teachers working together to support the process of advancing health. The participants empowered each other to facilitate a trusting relationship with a commitment to follow policy for the environment of their children to promote attendance.

Findings of this study extend the view of preschool attendance related behaviors and processes. The literature had indicated the benefits of preschool to include improved educational attainment and health for many years validated through longitudinal studies (Barnett, 2011; Reynolds et al., 2009). Qualitative studies in the preschool environment that addressed the issues of preschool attendance were rare. Ehrlich et al. (2013) and Kerr et al. (2012) completed interviews with families about school attendance. A grounded theory study in a low-income preschool environment with the single parents and teachers was not found in the literature. This study provides

examples of a communication process between parents and teachers helping to gain insight on how to support attendance in the preschool environment. A discussion of the themes will be compared to literature and contrasted to make recommendations for preschools, policy holders, and early childhood educators. The limitations of the study will be reviewed.

Themes

Empowerment promotes the action of decision making by the teachers and parents. Teachers making decisions about the children and their health revealed how empowerment supported the communication process to promote a healthy environment. Teachers and parents had formed established relationships, fostering trust and empowerment due their experience in the classroom and with each other. A similar finding was noted by Knoche, Kuhn, and Eum (2013) in their qualitative study of 21 early childhood coaches. The role of an early childhood coach was similar to that of a teacher in this setting. The early childhood coach regularly meets with parents, child care providers, and other teachers to promote competence and confidence in executing their role to the other individual and promoting the health and well-being of the children. The quality of coach-coachee relationship theme focused on communication practices and empowerment (Knoche et al. 2013). The findings supported an open communication practice between these individuals to share information and develop meaningful relationships. Empowerment was a natural occurrence due to the communication and support of parenting skills. Preschool teachers and preschool coaches described in Knoche et al. (2013) have similar roles as those found in this

study. They support parents and other teachers, which are natural outcomes. The establishment of a relationship between parents and teachers advances communication to improve the health and well-being of the child in the preschool environment.

The study site is a center offering family strengthening resources to all parents. Although these classes were not a focus of this study, parenting classes are regularly offered at this site. Educational classes are provided about child development, parenting, financial planning, employment, and many other areas to empower the parents. Class attendance is encouraged by scholarships offered or reduced tuition. Eighty-seven percent of parents participating in the focus groups and interviews have completed the parenting classes. These elements encourage parents' involvement with teachers and staff. Prior to the educational class, parents play with their children, eat dinner and mingle with teachers and other parents. The unplanned informal social hour became a routine event the parents engaged in with each other for consecutive classes which occurred over a period of 4 to 8 weeks, providing another opportunity for parents to network and socialize.

The literature has shown that preschools cultivating a culture of trust have higher attendance rates (Ehrlich et al, 2013). Trust between parents and teachers, parental involvement, committed teachers to the school environment are cultural elements that can be identified within a school to support attendance. Several cultural elements were identified at this center similar to the findings at the Chicago preschools to support attendance (Ehrlich et al, 2013). At the study site, the parents trusted the teachers to care for their children. This trust led to a culture that created communication and

discussion each day about the child's activities and progress. The trust between the parents and teachers was discussed in interviews and visible in observation visits. Parents were involved in the school through meetings and parent organizations. Teachers were frequently seen staying late and arriving early demonstrating their continued commitment to the school. These factors created a culture of trust and communication at the preschool.

Policies are the framework to running a school. Teachers and parents communicated their commitment to following the child health and absentee policies in the parent handbook. Discussions about following policy guidelines to protect the children in the environment were mentioned repeatedly in interviews. Child to staff ratios are recommended by national and state policy. The center follows the NAEYC (2014) guidelines of six 3-year-old children to one adult for a group of 12 children, nine 4-year-old children to one adult for a group of 18 children. The evidence-based recommendations regarding child to staff ratios from the Centers for Disease Control and Prevention (CDC) and the AAP is seven 3-year-old children to one adult and eight 4-year-old children to one adult (AAP, 2013). The ratios are always followed by the teachers and reinforced by administration to cover classrooms for teachers in anticipation of a teacher absence. There are two substitute teachers in addition to regular staff utilized to cover classrooms when necessary. Lower child to staff ratios are recommended to reduce disease transmission (AAP, 2013).

The themes revealed within this study were consistent with the literature. Parents' and teachers' perspectives of preschool absenteeism offer a viewpoint from

the individuals making determinations about their children. Empowered employees and parents work together to build a culture of trust to provide a healthy environment for their children. The parents and teachers are committed to this center and all aspects of communication to making the practices work.

Implications for Practice

The purpose of this study was to understand from the perspective of teachers and parents the decision making about preschool absenteeism. This study provides a voice for the parents and teachers not found in the literature previously. These individuals are the key decision makers in the children's lives, and learning from their experiences is vital for future researchers, preschool administrators, and policy makers.

Environment

Snyder (2011) identified that continuity of care in preschool programs facilitates the development of long-lasting, trusting relationships. The continuity of care model replicates an element of the home environment by providing a consistent primary caregiver for the child at the school. The parents were supportive of the model, and the teachers were initially hesitant to change from an approach that had assigned teachers to the same age group each year, but all adapted quickly. This was clearly beneficial to parents, teachers and, by extension, the children. This model enhances the relationships established during preschool between parents and teachers to form trust and empowerment underlying the communication process.

The administrator made comprehensive changes to implement this model over a period of several months. Changes included renovations to classroom technology,

creation of parent meetings, and modifications to environmental maintenance. A desktop computer and iPad tablet were put in each classroom to enhance use of technology and support curriculum guidelines. Technology use in preschool classrooms can provide increased learning opportunities, including enhancing parental participation in the classroom (Jung & McMullen, 2012). Computers in the classroom increase the dialogue between parents and teachers sharing information about appropriate software, and parents spent more time observing their children on these devices (Jung & McMullen, 2012). Parents were introduced to new technology in the classrooms during the open house in August, 2015. In this study, teachers used newly created email accounts and unrestricted phone access to expand communication with parents directly about health concerns. Instructional training classes on new software were offered to encourage classrooms to create weekly newsletters as an additional communication vehicle. Parents and teachers commented on the improved communication due to these changes.

A parent association was established in 2015 by the parents with a liaison from administration. Ehrlich et al. (2013) discussed parent engagement as a key factor in increasing preschool attendance. Communication for school wide news and upcoming events was planned and coordinated by the parents' group. The overhaul of the maintenance of the school was completed within 9 months. These changes included replacement of the contracted cleaning company, installation of a new air filtration system, and use of new cleaning products. NAEYC accreditation and the Caring for Our Children (2011) guidelines support these changes to provide a healthy environment

for the children and decrease the transmission of contagious diseases. The board of directors supported the administrator's decisions based on her rationale to improve the health of the environment for the children.

Crowley et al. (2013) found in monitoring regulatory compliance visits to preschools, staff in 10% of the facilities did not have CPR or first aid certification. Annually, an American Red Cross certified instructor is contracted by the center's administration to certify the preschool staff in CPR and first aid for those staff members requiring recertification. NAEYC accreditation guidelines require at least one staff member be certified in CPR and pediatric first aid be always present at all times (NAEYC, 2014).

The study site meets the required NAEYC accreditation guidelines and enhances the learning through a simulation exercise. One month after the staff had obtained its CPR certification, the administrator conducted a simulation of a choking child during lunchtime in a classroom coordinating with the local fire department. A child mannequin was put on the ground in the classroom and the teachers were told the child was choking. A rescue call to 911 was initiated by the teachers. These types of simulated emergencies prepare the staff for real choking incidents and review CPR skills if needed in the future. Each teacher in the school reviewed pediatric choking and CPR guidelines with the fire department staff. Improved focus on child health and safety can be achieved with monthly monitoring and unscheduled inspections from licensing agencies mandating constant diligence to regulatory standards for the health of preschoolers.

Policy

Eighty percent of all 4-year olds are enrolled in VPK education in the state of Florida, ranking it third in the United States for access to VPK (Barnett et al., 2015). The state spends \$2,238 per child enrolled in VPK. Most programs are focused on daily attendance counts, including the site of research, due to the reimbursement from the state and need for financial accountability. Attendance Works (2014) outlined in a national policy brief strategies to be implemented at the state level to improve data collection and focus on chronic absenteeism. The recommendations are to: create a standard definition for absenteeism, start tracking absenteeism at the preschool level, track individual student attendance, share information statewide, and require school improvement plans for chronic absenteeism and interagency collaboration. The report highlighted three key states—Indiana, Utah, and Oregon—that have adopted a common definition and used reports to raise awareness of chronic absenteeism (Attendance Works, 2014). A common definition to focus on absenteeism and increase awareness of chronic absenteeism has yet to be adopted by the state of Florida (Attendance Works, 2014). The preschool site for this study has the information to calculate chronic absenteeism. The study site currently collects attendance rates for both the student and classrooms and these are monitored by administration. Absentee data is not currently being evaluated at the student level across classrooms. They are in the process of developing new data collection tools of attendance measurement and will include absentee rates. The state of Florida incentivizes attendance measurement through financial reimbursement of preschools. The state reimburses each individual

school for the number of students who attend school each day. Policy drives measurement by financially reimbursing each preschool center. The current system does not systematically capture accurate data on children who are chronically absent or leave school earlier in the day. Adoption of the recommended strategies at the state level and implementation of policies for accurate measurement of chronic absenteeism tied to financial reimbursement will provide financial accountability for the \$3.8 billion annually spent on VPK. More importantly, students at risk are identified early, and interventions can be coordinated with families to circumvent future absences and prevent early school failure.

National and state policies are in place to support initiatives to identify and track chronic absenteeism. Even though the state of Florida provides VPK funding to all 4-year-olds statewide, without these chronic absenteeism policies in place, vulnerable children are at risk for failure in elementary school. The state of Florida has established 30 Early Learning Coalitions (ELC) to allocate funding and program delivery at the local level. These coalitions are comprised of community leaders and key stakeholders invested in early childhood education as consumers and advocates. The ELCs across the state can advocate for change. The Department of Education can mandate collection of absentee data for all students from preschool to grade 12. Financial accountability will follow the measurement of the data. Implementation of strategies that have been shown to be successful in other states can be used to guide policy development and practice to improve attendance into the elementary schools.

Research

This current study was envisioned by the concept of a school nurse in the preschool setting to support student health and attendance, which was suggested by parents, administrators and teachers. After a literature review was done on the issues of school nursing and preschool attendance, the result of the inquiry led to this study on preschool absenteeism. Kerr et al. (2012) had conducted a study using a Family Nurse Practitioner (FNP) in two elementary schools with Head Start classrooms to decrease early school absence. Kerr et al. (2012) was one of only two studies to report attendance issues related to health with parents and capture attendance rates in the preschool population. Attendance rates improved from year one (95.9%) to year two (96.9%) in both elementary schools. Attendance rates were much higher than reported for the school of the study being reported here. The attendance rates for the Head Start preschool program in the Kerr et al. (2012) study were also flawed because of the preset to always count the student as present. The teacher would have to manually change the record to denote the absence. The limitations section addressed several issues with integration of the FNP services at the school level, including the project was not known to families, teachers, and teacher assistants. One of the elementary schools subsequently had a new principal assigned over the summer. Even though the study used the FNP to follow up on all chronically absent children with health visits at school or in the home, there was difficulty in following through with phone calls and visits (Kerr et al., 2012).

The importance of administrative support in successful program planning and intervention has been showcased at the center of the study site reported here. It was very obvious many of the achievements and accomplishments were a result of an engaged administration. Results of an employee engagement survey taken at the study site increased from 2.5 (on a 5-point scale) in January 2015 to 4.1 in January 2016 as rated on a scale of 1 to 5 (1 being the lowest and 5 being the highest).

Kerr et al. (2012) indicated over 40% of the absences related to illness were actually not illness but were related to transportation, family activity, or family illness (Kerr et al. 2012). The parents at the center of this study reported here corroborated the above finding, indicating there were times their children missed school other than when sick, including for a family funeral out of town, transportation issues, and two parents stated they will keep their child home for a “mommy play day” when they are off from work. These events were rare and did not appear to impact attendance rates, due to their periodic occurrence. Surveys designed to further investigate this finding with parents and future development of educational interventions to prevent absenteeism are necessary.

School-based health centers (SBHC) in the preschool setting have been shown to decrease non-emergency room visits and hospitalizations (Gance-Cleveland & Yousey, 2005). A comparison of two preschool settings found the preschool with access to a SBHC benefitted by providing physical and mental health care services to a vulnerable population to reduce healthcare costs. The CDC’s Community Prevention Services Task Force recommends implementation of a SBHC in low-income

communities based on sufficient evidence completed in July 2014 (CDC, 2015). The majority of the health centers studied were in a high school setting. There were some located at the elementary and middle schools. Asthma-related outcomes showed a median decrease (70.6%) in hospitalizations in three studies and a median decrease of emergency room visits (15.8%) in four studies (CDC, 2015). Diagnosis with asthma is twice as likely for a child from a low income population (National Center for Health Statistics, 2011). Management of these children in their school setting eliminates school absenteeism and decreases health care costs.

D'Onise, Lynch, Sawyer, and McDermott (2010) completed a systematic review on preschool interventions and health outcomes for the 4-year-old population. Although the authors found limited evidence to support center-based interventions producing positive health outcomes into the future, they were able to identify a trend of beneficial health benefits related to overweight and obesity issues within the existing base of literature. They suggested the findings were related to methodological limitations of previous studies and the decreased prevalence of childhood illness (D'Onise et al., 2010). As their findings indicated, measurement of health interventions in the preschool populations has not been fully evaluated. More research is required in this area to determine the effectiveness of this type of intervention at the preschool level. Development of a SBHC for a private preschool is a costly alternative. Coordination with a local elementary school is a viable alternative to discuss strategies of implementation of a SBHC for access to local health services to the children and

families. Expansion of services to families to increase access and prevent costly hospital admissions could save long-term health care dollars.

A school nurse in a private preschool setting may be a financially cost prohibitive alternative. At this facility, the teachers and parents trust each other's judgment and management of symptom recognition. A knowledge base of infection control and prevention was demonstrated by teachers and children evidenced by hygiene practices. When a child is removed unnecessarily from the classroom, this could become a financial burden for parents missing work, especially in low-income populations. "Exclusion of children from child care accounts for almost half of work absence" (Shope, 2014, pg. 189). The teachers felt their experience and preparation help them assess children early in the classroom environment and remove them promptly. Shope (2014) made recommendations for teachers regarding excluding children from the classroom. Teachers should be knowledgeable about national exclusion guidelines in making these decisions for exclusion found in Caring for our Children, Chapter 3.6.1 (AAP, 2103). One of the guidelines clearly states fever without any symptoms does not require exclusion, yet without exception, every teacher cited fever as a reason to remove a child.

The center requires a physician's note upon return when the child is absent 3 consecutive days or more. According to Shope (2014), this practice causes undue strain on parents and the health care system, possibly forcing parents to make an unnecessary emergency room visit to comply with this policy, increasing health care costs. These have not been shown to improve the health of the environment of the

preschool or protect other children (Shope, 2014). Two parents in the interview stated if their pediatricians are closed they have to go to the “doc in the box” or a hospital emergency room to get medical documentation for the child to return. Whereas, the addition of a nurse may be cost prohibitive, a nurse can be used to circumvent many of these issues outlined above. NAEYC guidelines (2014) call for a pediatric consultant on staff to review health policies, and the nurse can serve in that capacity. Nurses view health and education as interrelated concepts and core to their practice. Nurses would be a welcome addition to the education environment because their focus is different and provides a holistic view.

Limitations

The core concepts of empowerment, trust, and commitment are based on a foundation of communication and universally evident regardless of the setting inside the school. Bias from the researcher was a potential limitation due to the previously working relationship in this environment. Minimization of this bias was made through weekly contact with the dissertation chair, ongoing memo and writing analysis, and review of data with substitute teachers and parents group. Overall, the study could have been stronger if more school settings had been included, which could have offered an examination of a variety of practices and descriptions of how preschools work to support children’s health and attendance.

The author explored parents’ and teachers’ perspectives on preschool absenteeism. The study site revealed a communication process the teachers and parents shared about the children to promote attendance. Even though the PI’s

involvement with the site had extended over a couple of years, the communication framework revealed through interviews and observations was beneath the surface of everyday operations and were new observations. The journey of inquiry with parents and teachers has led to many possible areas for research, policy, and practice. Further research with parents and teachers about absenteeism will contribute additional insight into this issue and provide more data to create tools for measurement from their perspective. Attendance policies require adoption at the state and local levels. When education and health systems currently regarded as separate entities are combined into a fused approach, the synergies have potential to improve attendance.

APPENDIX A: IRB APPROVAL LETTER



University of Central Florida Institutional Review Board
Office of Research & Commercialization
12201 Research Parkway, Suite 501
Orlando, Florida 32826-3246
Telephone: 407-823-2901 or 407-882-2276
www.research.ucf.edu/compliance/irb.html

Approval of Exempt Human Research

From: **UCF Institutional Review Board #1**
FWA00000351, IRB00001138

To: **Anne Q. Meoli**

Date: **September 30, 2015**

Dear Researcher:

On 09/30/2015, the IRB approved the following activity as human participant research that is exempt from regulation:

Type of Review: Exempt Determination
Project Title: Preschool Absence: A parental and teacher perspective of barriers and behaviors using grounded theory
Investigator: Anne Q. Meoli
IRB Number: SBE-15-11591
Funding Agency:
Grant Title:
Research ID: 15-11591

This determination applies only to the activities described in the IRB submission and does not apply should any changes be made. If changes are made and there are questions about whether these changes affect the exempt status of the human research, please contact the IRB. When you have completed your research, please submit a Study Closure request in IRIS so that IRB records will be accurate.

In the conduct of this research, you are responsible to follow the requirements of the [Investigator Manual](#).

On behalf of Sophia Dziegielewski, Ph.D., L.C.S.W., UCF IRB Chair, this letter is signed by:

Signature applied by Patricia Davis on 09/30/2015 12:06:48 PM EDT

IRB Coordinator

APPENDIX B: FLYER

**Let's talk about Preschool
Attendance
WE NEED YOUR INPUT**



**FOCUS GROUPS AND INTERVIEWS
WILL BE STARTING SOON**

**IF YOU WOULD LIKE TO TALK ABOUT YOUR CHILD'S
PRESCHOOL ATTENDANCE AND HEALTH, PLEASE
FILL OUT THE INFORMATION SHEET AND WE WILL
CONTACT YOU TO DISCUSS THE STUDY**

The purpose of this research is to describe the role of children's health on preschool absence. We will explore the decision-making process parents use related to preschool attendance and the effect of the supports and policies of a preschool setting. Parents, teachers and staff of children 3, 4, and 5 years old will be asked to participate in focus groups or individual interviews lasting from 60 to 120 minutes. The focus groups and interviews will be conducted in the evenings and there will be food and babysitting available here at the center. This study is being conducted by Anne Meoli, RN BSN, MPH from University of Central Florida, College of Nursing, 12201 Research Parkway, Suite 501, Orlando, FL 32826-3246. For further information, please contact her at (954) 288-0936.

APPENDIX C: INFORMATION SHEET



Preschool absence: a parental and teacher perspective of barriers and behaviors using ground theory

Please fill out the attached information sheet and return to the front desk to place in the marked folder. Anne Meoli from University of Central Florida will contact you with the information about participation in the study. We are interesting in speaking to parents and teachers of 3, 4 and 5 year old children. Thank you!

NAME: _____

Phone: _____(Cell)_____ (Home)

Child's Classroom: _____(Number)_____ (Teacher)

Email: _____

Best time to reach you: _____

Please circle:

Preference: Text Voice Email

The purpose of this research is to describe the role of children's health on preschool absence. We will explore the decision making process parents use related to preschool attendance and the effect of the supports and policies of a preschool setting. Parents, teachers and staff of children 3, 4, and 5 years old will be asked to participate in focus groups or individual interviews lasting from 60 to 120 minutes. The focus groups and interviews will be conducted in the evenings and there will be food and babysitting available here at the center. This study is being conducted by Anne Meoli, RN BSN, MPH from University of Central Florida, College of Nursing. 12201 Research Parkway, Suite 501, Orlando, FL 32826-3246. For further information, please contact her at (954) 288-0936.

APPENDIX D: FOCUS GROUP DISCUSSION GUIDE – PARENTS

Focus Group Discussion Guide Parents:

Introduction of facilitator: Hello my name is Anne Meoli, a doctoral nursing student from the University of Central Florida

Welcome and thank you for coming today to participate in our focus group.

I would like to explain what a focus group is and what we will be doing for those of you who have never participated in one of these types of sessions previously. The focus group is an informal discussion with a small group of individuals who have a common interest in a particular subject. We will use the focus groups to discuss absenteeism in the preschool setting and gather information about this topic. Since your children are attending this preschool, you can provide valuable insight about your children and the preschool environment. There are no right or wrong answers. You do not need to respond to every question. Everyone's input is important to discuss the issues surrounding absenteeism in the preschool setting. I am pleased you can be part of this group because I know you have important ideas to offer about this topic. Please do not hesitate to speak up when you have a point to make. As a participant, please keep things that you hear expressed in this group private. I ask that others respect your privacy as well.

I will be moderating the session and moving us along. We will be recording this focus group, so I do not have to take notes. I would like to follow what is being said and then go back and review it later so I can accurately convey your ideas and opinions. My role is to assure a productive discussion to summarize the group's feelings. I will not refer to any participant by name in the summary or research

The information will always be kept confidential to be used for my research dissertation study and to help address future families in the issues of preschool absenteeism.

1. I would like to have you tell us about your children here at the school, and how long they have attended the school?
2. Can you please describe a "typical morning" getting your child ready for school?
3. Can you please discuss times when you child may have missed school and why? Please share as many details of those details as you can. Were there things going on with other people at your home that affected decisions about attendance, (other children are sick, you are sick, that kind of thing?)
4. Can you please explain what it means for your child to be not feeling good sick or ill?
5. Please describe a specific time in the past when you kept your child home due to an illness or sickness; what were those symptoms or illnesses, did you have to see a doctor and how long did the child stay home?
6. How do you determine whether or not to take your child to school?

7. Does the school give you direction in how to determine when to keep a child home?
8. Can you please give me an example of a time you had to decide to keep your child home? Please describe the decision making process?
9. When you bring your child to school, is there anything the school can do to help you keep your children healthy?
10. In the past have you been called to come pick up a sick child? Did your child have symptoms? What were the circumstances involved with this situation?
11. Was there a time the teacher called you to discuss your child and the situation at school and what they should do or any factors related to them being sick?
12. Can you please describe the school environment in relation to your child's health and preschool absence? Can you describe any activities or environmental factors that could play a role in your child's health and preschool attendance?
13. Is there any other issue you would like to discuss that we have not addressed?

APPENDIX E: FOCUS GROUP DISCUSSION GUIDE – TEACHERS

Focus Group Discussion Guide for TEACHERS & STAFF:

Introduction of facilitator: Hello my name is Anne Meoli, a doctoral nursing student from the University of Central Florida

Welcome and thank you for coming today to participate in our focus group.

I would like to explain what a focus group is and what we will be doing for those of you who have never participated in one of these types of sessions previously. The focus group is an informal discussion with a small group of individuals who have a common interest in a particular subject. We will use the focus groups to discuss absenteeism in the preschool setting and gather information about this topic. Since your children are attending this preschool, you can provide valuable insight about your children and the preschool environment. There are no right or wrong answers. You do not need to respond to every question. Everyone's input is important to discuss the issues surrounding absenteeism in the preschool setting. I am pleased you can be part of this group because I know you have important ideas to offer about this topic. Please do not hesitate to speak up when you have a point to make. As a participant, please keep things that you hear expressed in this group private. I ask that others respect your privacy as well.

I will be moderating the session and moving us along. We will be recording this focus group, so I do not have to take notes. I would like to follow what is being said and then go back and review it later so I can accurately convey your ideas and opinions. My role is to assure a productive discussion to summarize the group's feelings. I will not refer to any participant by name in the summary or research

The information will always be kept confidential to be used for my research dissertation study and to help address future families in the issues of preschool absenteeism.

14. I would like to have you tell us about the children you teach at the school, and how long how you worked at this preschool?
15. Can you please describe a "typical morning" when the children come into school? Can you describe an "atypical morning"? Is there a process used for checking the children into the classroom?
16. Can you please explain what procedures or process you use to determine if a child is sick? Can you discuss previous examples and symptoms you have seen in children in your classroom?
17. Can you describe any recurring illnesses in the children in your classroom? Do you have any explanation about why this is happening? Any suggestions or ideas?
18. Please describe a specific time in the past when you called a parent to come and pick up a child, what illness or symptoms were involved?

19. Can you discuss the resources available to you to help you make decisions about sending children home or having them stay in school when they are sick?
20. Will you please discuss the communication you have received to prepare you on how to determine when to send a child home? Are you aware of school policies about child health or school absences?
21. Can you please describe the decision making process of sending a child home from school and the scenario involved? Give me an example of a time you had to decide to send a child home from school?
22. Can you discuss anything you can do to help you keep the children healthy?
23. Can you please describe the school environment in relation to the child's health and preschool absence? Can you describe any activities or environmental factors that could play a role in the child's health and preschool attendance?
24. Is there any other issue you would like to discuss that we have not addressed?

APPENDIX F: SUMMARY FOR EXEMPT RESEARCH



Summary Explanation for Exempt Research

EXPLANATION OF RESEARCH

Title of Project: Preschool absence: a parental and teacher perspective of barriers and behaviors using grounded theory

Principal Investigator: Anne Meoli, RN BSN, MPH

Faculty Advisor: Susan Chase, EdD, RN, FNP-BC, FNAP

You are being invited to take part in a research study. Whether you take part is up to you.

The purpose of this research is to describe the role of children's health on preschool absence. We will explore the decision making process parents use related to preschool attendance and the effect of the supports and policies of a preschool setting.

- As a participant in this study, you will be invited to participate in a focus group and/or individual interview.
- The focus group is an informal discussion with a small group of individuals who have a common interest in a particular subject.
- Focus groups could make participants feel anxious or uncomfortable.
- The interview is a private discussion with a member of the research team
- The interview and focus groups are designed to learn your perspective on preschool absence. Each will last about one hour
- Both interviews and focus groups will be audio-recorded and transcribed.
- You are free to decline participation or to decline audio recording.
- If you agree to being in a focus group or being interviewed and/or audio-recorded, you can ask to have your recording erased and your ideas removed from the analysis of the data at any time prior to the completion of the study.
- If an employee reports illegal or abuse activity during an interview or focus group to the principal investigator, this will be reported to the administrator of the preschool center.

You must be 18 years of age or older to take part in this research study.

Study contact for questions about the study or to report a problem: The person doing this research is Anne Meoli, RN, BSN, MPH from the University of Central Florida, College of Nursing. Because the researcher is a doctoral student, she is being guided by Susan Chase, EdD, FNP-BC, her UCF faculty advisor. If you have questions, concerns, or complaints, or think the research has hurt you, please contact Anne Meoli, RN, at (954) 361-6873 or meoli@knights.ucf.edu or Dr. Susan Chase, (407) 823-6274 or susan.chase@ucf.edu.

If you have questions, concerns, or complaints please call the University of Central Florida College of Nursing at (407) 823-6274.

IRB contact about your rights in the study or to report a complaint: Research at the University of Central Florida involving human participants is carried out under the oversight of the Institutional Review Board (UCF IRB). This research has been reviewed and approved by the IRB. For information about the rights of people who take part in research, please contact: Institutional Review Board, University of Central Florida, Office of Research & Commercialization, 12201 Research Parkway, Suite 501, Orlando, FL 32826-3246 or by telephone at (407) 823-2901.

APPENDIX G: HEALTH CONCERN FORM

To: _____ Child's Name: _____
 Date: _____ Room # _____
 Subject: Health Concern From: _____

We at _____ are concerned about your child's health due to behavior he/she has exhibited or symptoms we have observed: **POSSIBLE**

- Ringworm # of spots: _____ Location: _____
- Pink Eye Left Eye _____ Right Eye _____ Both _____
- Constant Cold/Flu Symptoms: _____
- Fever Degrees: Left Ear _____ Right Ear _____
- Vomiting # of times: _____
- Diarrhea # of times: _____
- Other: _____

Your child may return to school when he/she is **symptom free and** the following have been met:

24 Hour Rest Period 48 Hour Rest Period **Return on:** _____

Child Checked by Administrator Copy of Prescription Dr. Note Provided

Parent/Guardian contacted by: _____ Time: _____

Comments:

Please feel free to contact _____ if you need any assistance
 Obtaining the above information. Thank you for working with us ahead of time to keep ALL of our children safe and healthy. Please sign and print below stating that you understand the above information and will follow the above guidelines.

Signature of Parent/Guardian or Contact
(Contact person is responsible to convey message to the Parent/Guardian)

Signature of Staff Member of _____

Print Name _____

Date _____

Signature of Program Team Member _____

APPENDIX H: PARENT HANDBOOK

Meal Time

The food service at _____ is funded by the State Department of Education, Food and Nutrition Service, School Food Program in Tallahassee, Florida.

A full breakfast is served between 8:00 a.m. and 9:00 a.m. A nutritious lunch is served to the children between 11:00 a.m. and 12:00 p.m. Snack is provided after nap time. A weekly menu is posted and available to you.

Breakfast will only be served up until 9:00 a.m. If you arrive after 9:00 a. m., please be sure to have your child fed before coming to school. Food from home is not allowed.

If your child has allergies or must have a particular food eliminated from his/her diet, a Medical Statement for Children with Disabilities and Special Dietary Conditions form must be completed by your child's doctor and returned to the center. This form will be kept on file in the kitchen, in your child's classroom and in his/her file and your request will be honored. All food and allergy restrictions will only be allowed once we have the completed form and a doctor's note.

Birthday Celebrations

The Center welcomes you to share your child's birthday with us. You can bring in store bought cake or cupcakes only. Balloons and goodie bags are NOT allowed. Please schedule the celebration with your child's teacher in advance. Celebrations occur after 2:30 p.m. around snack time.

Attendance

In order for your child to receive maximum benefit from the program, daily attendance and arrival prior to 9:30 a.m. is required. If you have an appointment and will be late, please call the front desk prior to 9 a.m. If your child will be absent from school due to illness, transportation problems, etc., you must notify the Center by 10 a.m. A doctor's note is required prior to your child's return to the Center if he/she has been out of school for 3 days or more and may be required after a one or two day illness depending on the circumstance.

APPENDIX I: ENROLLMENT PAPERWORK

Enrollment Agreement - Please read and initial each section listed below, then sign and date at the bottom of the page.

Section 1: Continued

_____ **Health Concern:** I understand if my child becomes ill during the day (fever, vomiting and/or diarrhea) my child must be picked up within **one hour** of the Center contacting me. Depending on the type of illness, my child may be required to stay home for 24-48 hours and/or return to school with a doctor's note. I understand that _____ members are not permitted to administer medication to students. **May the Center consult the student's physician if parent/guardian cannot be reached?**
Yes No

_____ **Discipline Policy:** I understand that all children are treated with respect and handled in a positive, constructive and non-threatening manner. Food, rest, outdoor play or bathroom facilities are NEVER withheld as a form of punishment.

_____ **Parties:** I understand that only store bought food and beverages can be brought into the Center for parties. I also understand that balloons and goodie bags are not permitted in the Center. Classroom teachers must be advised in advance of any classroom parties. I understand that my child may consume food and/or beverages that are outside of the Child Care Food Program when participating in activities at the Center such as class parties, luncheons and/or classroom food activities. **I understand that juice boxes are not permitted in the Center. I can only provide store bought juice that can be poured into a cup.**

_____ **Services:** I understand I must participate in the Parent Enrichment Program to qualify for access to the Food/Clothing Bank and/or Emergency Assistance Fund. I also understand that I must complete a Family Assessment to maintain my child's enrollment in the Center.

_____ **Alternate Gross Motor Activities in Case of Inclement Weather:** Motor skills are carried out when the brain, nervous system, and muscles work together. According to the Florida Early Learning and Developmental Standards for Four Year Olds gross motor is the ability to use the large muscles of the arms, legs and torso (e.g., walking, running, jumping, pedaling, throwing and dancing)

During inclement weather, the following gross motor activities should be used in place of outdoor play. The following is a list of ideas that can be used. Please note that you are not limited to these ideas. Also, fine motor activities do not replace gross motor activities. The following activities are appropriate for children from ages 1-12 years old.

Intentionally Left Blank

APPENDIX J: ENROLLMENT PAPERWORK

Enrollment Agreement - Please read and initial each section listed below, then sign and date at the bottom of the page.

Section 1:

_____ **Tuition:** I understand that tuition is due every Monday morning. Tuition is due every week whether my child attends or not, as long as he/she is enrolled. **I understand that tuition will continue to be billed until I verbally terminate my child's enrollment.** Payments are due in the form of cash and/or money order made payable to _____

_____ **Drop Off/Pick up:** I understand the Center is open Monday through Friday, 6:30 am to 6:00pm. It is my obligation to arrange for pick-up and drop off during these hours. Late fees will be assessed at a flat \$10.00 fee for every 10 minute increment starting at 6:01, VPK Only late fees begins at 12:01. Late fee payment is due at the time of pick up or before the next drop off. If there are multiple late pickups care maybe terminated.

_____ **Attire:** I understand that the following items are not permitted at _____ Open toe shoes, Crocks, hair beads and backpacks. I understand that my child will not be permitted into the Center if any of the above mentioned items are present.

_____ **Naptime:** I understand that I must provide a small blanket and fitted toddler/crib sheet for nap time. Towels or ripped sheets may not be used as blankets. I must provide an extra change of clothing in the event my child needs to be changed.

_____ **Meals:** I understand that breakfast is served between 8:00 – 8:59 am. Breakfast ends promptly at 9:00am. I understand that no outside food is permitted in the Center.

_____ **Attendance:** I understand that if my child arrives after 9:30am he/she will not be permitted without a doctor's note excusing the tardiness. No child will be allowed entry into the Center after 12:00pm. A doctor's note is required prior to my child's return to the Center if he/she has been out of school for 3 days or more. Loss of contact may result in care being terminated.

_____ **Updated Contact Information:** I understand that I must maintain updated contact information at all times, failure to do so can result in care being terminated.

_____ **Changes to Authorized Pick Up:** I understand that any change to the list of Emergency Contact and Release Person can only be done by person(s) that registered the child and must be done in person. If the person being removed from the contact list is a parent/guardian, the person must be notified of their removal in the presence of a _____ **The removed person will not be allowed on _____ or any reason. Once this person is removed, I will not be able to add this person back on to the account again.**

_____ **Disruptive Behavior:** Should a parent or Emergency Contact/Release Person become disruptive or violent, using abusive language, carry a weapon, or threaten any staff member, **that person will no longer be admitted on to the Center's property. Depending on the offense, which is at the discretion of the Center, care may be terminated.**

Parent/Guardian Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

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