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## A Current Overview of Ten University-Based Reading Clinics

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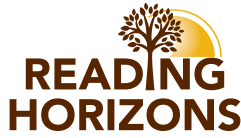
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## A Current Overview of 10 University-Based Reading Clinics

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### Abstract

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The purpose of this study was to explore the operations of a sample of university-based reading clinics in order to better understand their functions and practices and to inform the planning for the authors' own clinic. This study was carried out in two phases. In Phase I, the authors conducted Internet searches and contacted knowledgeable university faculty to create a list of currently operating clinics. They then interviewed 10 reading clinic directors about the structure and functioning of their clinics. Each interview was audio-recorded, transcribed, and focus-coded for themes related to the interview questions. Themes were then grouped into the following categories: founding and funding, student demographics, tutorial session logistics, assessment and instructional materials used, and family involvement. In Phase II, the authors conducted on-site visits to two reading clinics that they felt might best inform planning for their own. In addition to enhancing the creation of their own reading clinic, the data the authors gathered may be useful to those interested in an overview of current reading clinic organization and structure.

**Keywords:** university-based reading clinics, reading instruction, literacy clinics, reading intervention, teacher preparation

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It has been nearly a century since the conception of the university-based reading clinic. Dr. Grace Fernald created the first one in 1921 at the University of California at Los Angeles. Over the span of approximately one hundred years, reading clinics have evolved but have also received inconsistent levels of support from various stakeholders (Laster, 2013). Although support for clinics has been erratic, many researchers feel that clinics are an essential part of graduate reading education as well as an integral part of community outreach (Carr, 2003; Garrett, Pearce, Salazar, & Pate, 2006; Puryear, 2015). Currently, the educational community is under intense scrutiny. Federal and state standards are increasingly rigorous, with governments calling for greater emphasis on standardized testing. However, it has been argued that such requirements and assessments do not necessarily help teachers understand the nature of student reading difficulties. Increased diversity in student populations, a culture inclined to “fix” children’s reading deficits, and in some cases the limited use of researched teaching practices has made for rocky terrain in the field of literacy education (Ortlieb, Grandstaff-Beckers, & Cheek, 2012). This turbulent

climate has not lessened the need to provide remediation for struggling readers, however. With that in mind, what role should university-based reading clinics hold?

We structured our inquiry to learn about the daily operations, instructional materials, and methods that have been successful for established clinics by conducting phone interviews with 10 reading clinics and visiting two of those clinics in person. Our objective was to describe practices utilized by university-based reading clinics to structure activities. This study was conducted to inform the field regarding factors influencing the structure of currently operating clinics and in preparation for establishing a clinic on our campus where preservice teachers across certification areas would collaborate to provide targeted reading intervention to elementary students.

### **Research on University-Based Reading Clinics**

Although there is considerable literature available regarding such reading clinics, we were specifically interested in the history of such reading clinics in the United States, the current state of the research surrounding these clinics, and the benefits and challenges associated with clinics housed on higher education campuses.

### **History of Reading Clinics**

When the first university-based reading clinics were created in the 1920s, there was a general perception that struggling readers were lazy or incompetent. Over time, a medical model prevailed in the remediation of reading difficulties. Diagnosing the problem and working to correct it became central to clinic work. Most took the history of a student, completed diagnostic testing, made a plan for instruction, carried it out, and monitored its success (Morris, 2003).

By the 1940s, the medical model was losing steam as researchers began to understand the multiple causation factors associated with reading difficulties, recognizing that, in the case of most children, a single deficiency might be found and cured. A more student strength-based, case study approach gained momentum, resulting in establishment of a number of clinics to enhance the education of reading teachers during the 1950s (Bevans, 2004), which grew significantly during the 1960s and 1970s (Laster, 2013). In fact, during this period, the majority of graduate programs used a reading clinic or a reading practicum as a critical component of degree requirements (Ortlieb & Pearce, 2013).

The politics of education ratcheted up during the 1970s. High-stakes testing was pushing to the forefront, and as it did, increased emphasis was placed on the use of pull-out programs for students struggling with reading. Perhaps due to more school-based intervention, support for university-based reading clinics began to waiver (Bevans, 2004) and the 1980s and 1990s saw a decrease in advocacy for reading clinics. The clinics were seen as financially unviable in difficult economic times, and there was a perception that the individualized tutoring provided in clinics was incompatible with teaching large numbers of students in public schools. Further, clinics received limited federal funding and, given the strong relationship between research and funding, this possibly contributed to a continued decline in interest (Morris, 2003).

### **Founding and Funding of Reading Clinics**

Research regarding the creation and sustainability of university-based reading clinics has been intermittent. Available studies reveal that the majority of reading clinics have existed for at least 10 years (Bevans, 2004; Garrett et al., 2006). Many clinics were originally funded through the universities themselves. In order to help defray the costs,

guardians of tutees are often charged a nominal fee (usually less than \$100 per semester), with scholarship funding available for families in need of assistance (Garrett et al., 2006).

Researchers have also found that directors frequently report not having adequate resources to run their reading clinics. Common grievances have included a lack of money for funding the clinic, inadequate space for tutorials to take place, insufficient administrative support from the university, and a general lack of advocacy on the part of university faculty for the clinic's success (Bader & Wiesendanger, 1986; Bevans, 2004; Cassidy, 1992; Morris, 2003). Interestingly, Morris (2003) noted that there was still a perception that reading clinics were based on the medical model, which also led to decreased advocacy.

### **Referrals and Student Information**

Bader and Wiesendanger (1986) found that the parents/guardians of tutees made the majority (83%) of referrals to university-based reading clinics, and studies have indicated that the vast majority serve both elementary and secondary students (Bates, 1984; Irvin & Lynch-Brown, 1988). Bevans (2004) reported that students typically spend more than one semester in clinics, with two semesters being the average. Further, most students are referred to reading clinics due to deficits in decoding, vocabulary, and comprehension along with a large percentage referred for a lack of study skills (Irvin & Lynch-Brown, 1988).

### **Participants, Perceptions, and Logistics**

Bates (1984) noted that the majority of university-based reading clinics did not have a full-time director; rather there were usually multiple part-time directors. Later, Garrett et al. (2006) found that the majority had one tenure-track faculty member who also served as the full-time clinic director. Researchers agree that the majority of the clinics utilize students enrolled in reading courses as tutee evaluators (Garrett et al., 2006). Most clinics operate independently as part of one course; that is, faculty in curriculum and instruction or reading departments did not involve other university departments or had minimal collaboration with them, leading to a sense of isolation (Bader & Wiesendanger, 1986; Bates, 1984; Bevans, 2004). Methods advocated to decrease the sense of isolation and improve university-based reading clinics include requiring undergraduate and graduate students to work together via reading clinic tutoring experiences. Cassidy (1992) suggested that collaboration between these groups can occur, as can collaboration between special education and elementary education majors in order to best meet the needs of tutees.

As for the admission and tutorial session procedures, clinics are found to follow a similar general plan. Typically, the student's history is examined, diagnostic assessments are completed, an instructional plan is formulated and implemented, and student progress is assessed. Researchers suggest creating an action plan complete with a vision and mission statement, making an outline of decisions to be made and who will make them, and detailing plans for logistics, resources, instruction, and assessment (Coffey, Hubbard, Holbein, & Delacruz, 2013). Others discuss the need for a clinic framework and have suggested a daily instructional outline that includes reading easy and challenging books, writing in response to reading, and monitoring students' responses to tutoring (Mokhtari, Hutchison, & Edwards, 2010).

Assertions have been made that a reading clinic housed on a university campus is cumbersome for the faculty charged with running it (Morris, 2003). Tutee attendance has also been problematic in some cases, and in response, many directors have moved their reading clinics onto public school campuses in an effort to increase attendance (Bevans,

2004). Cuevas, Schumm, Mits-Cash, and Pilonieta (2006) confirmed this trend to move away from university-based clinics to public school-based practica.

Although logistics as well as perceptions have been obstacles for some clinics, researchers have discussed the benefits of housing reading clinics on university campuses. Pearce, Garrett, Grote-Garcia, and Schaum (2007) found that a majority of directors felt that university-based clinics were necessary to provide university students with authentic experiences to connect their learning about literacy to assessment and instruction. The depth of the knowledge gained by the tutors who participated in clinics was also cited as critically important. Morris (2003) reported that providing tutors with a university-based clinic setting creates an environment of continuous exposure to the educational needs of readers. It is through this atmosphere that adept reading teachers are created. For instance, at times, college academic settings feel far removed from the practical experiences of school teachers. When a reading clinic is held on campus, faculty may be more likely to face the realities of teaching children, as most have been removed from the K–12 setting for a number of years.

Cuevas et al. (2006) found that practicing teachers who had participated in a reading clinic or a reading practicum rated the experience highly and reported that they later used what they learned when working with youngsters in their own classrooms. Bevans (2004) discovered that stakeholders held positive perceptions of university-based reading clinics. Additionally, Puryear (2015) described how parents and tutors believe the individualized instruction in reading clinics is beneficial to tutees.

### **Instructional and Assessment Methods and Materials**

An earlier study conducted by Irvin and Lynch-Brown (1988) found many clinics assessed students using skills-based approaches, rather than approaches that encouraged using context or meaning. As recently as 2013, Ortlieb and Pearce wrote that, because of the tumultuous state of educational politics and policies, there may be a deficiency in the consistent use of best practices for reading instruction among clinic faculty. It is essential to ensure that the instructional environment in the clinic enhances students' sense of autonomy, nurtures respectful relationships, and creates self-awareness in a noncompetitive environment (Codling, 2013). The current emphasis is on the importance of data-driven instruction as well as using scientifically research-based instructional approaches. Rigorous yet motivational lessons are key (Ortlieb et al., 2012).

### **Methods**

Our qualitative inquiry into the operation of current university-based reading clinics was guided by the following research questions: (1) How do the university-based reading clinics under study structure their programs and what are their operational procedures? (2) What assessment and instruction practices exist in these reading clinics? To answer these questions, we followed a sequential method to choose the clinics we studied and collect and analyze data.

### **Data Collection Procedures**

**Internet search and recommendations.** An Internet search was conducted by typing in “university-based reading clinics” and scrolling through the first 50 hits, some of which were repetitive and some of which were not clinics. We then visited the website of each clinic and created a list of those that posted information and appeared to be operating currently. Further, we contacted university professors who were perceived to have knowledge of such clinics and chairs of the reading clinic divisions of two national

literacy organizations to ask for recommendations regarding clinics that would be ideal to interview. We also communicated with two retired professors who previously directed a clinic at our university and whose research agendas included the study of clinics, as well as a professor at another university who has published extensively on the topic. These conversations led to a narrowing of our list to 25 clinics.

**Phone interviews.** We created an interview protocol (see the Appendix) based on previous research conducted on the history of reading clinics as well as information from articles about clinics written during the past 15 years. This protocol was vetted through a phone interview with one of the retired professors described above. Following that conversation, questions were rewritten for clarity and new questions were added based on her feedback and issues that emerged during the conversation. We then contacted each of the 25 reading clinic directors on our list via email and asked if they would consent to a phone interview to discuss the operation and management of their university's clinic. We received initial responses from 15 clinic directors and conducted phone interviews with 10; we did not hear back from several when we sent out an invitation to schedule. See Table 1 for demographic information on participating universities. For the sake of time, we divided the list among the research team, and each conducted their assigned interviews independently. Interviews lasted between 29 and 57 minutes and were recorded and transcribed.

Table 1

*Demographic Information on the Reading Clinics' Universities*

University	Geographic area in U.S.	Public or private	Number of total students enrolled
University G	Mid-Atlantic	Private	51,848
University D	Southeast	Public	38,246
University B	Intermountain West	Public	31,860
University C	Southeast	Public	27,000
University H	Mid-Atlantic	Public	22,285
University E	Midwest	Public	20,015
University J	Mid-Atlantic	Public	15,401
University F	Southeast	Private	12,824
University A	Northeast	Public	11,822
University I	Midwest	Public	8,548

**Site Visits.** After transcribing and analyzing the phone interviews, we deliberated and identified four clinics for potential site visits. We eventually chose to visit two very different clinics based on (1) whether the reading clinic operated during June or July, because that is when our visits needed to occur due to funding; (2) the level of the tutors, because we preferred clinics that utilized undergraduate students; (3) whether they served students with disabilities; and (4) the clinic director's willingness to host us. We then ranked our top three and contacted each director. All invited us; however, our grant budget funded only two visits, so we chose the top two. The first two authors each visited one clinic, speaking with directors and staff and observing operations.

## Data Analysis

We independently conducted an initial focused coding (Saldaña, 2013) of phone interviews based on the interview questions. We then met to compare and resolve our codes and develop a code list. Next, we coded the interviews with the revised list and established themes (founding and funding of the literacy clinic, student information and how they are referred for reading clinic services, tutorial session logistics, assessment and instructional materials used, and family involvement). Following the site visits, we used previously established codes to conduct a focused coding and developed new codes as needed.

## Trustworthiness and Ethical Considerations

We relied on several methods to ensure rigor in our analysis. Following approval of our university's Institutional Review Board, we emailed each participant who agreed to a phone interview a consent form to sign and return. Identifying information was redacted from all transcripts, and pseudonyms were subsequently used for all university names. Within two weeks of conducting phone interviews, we emailed transcriptions to the reading clinic directors as a form of member checking. The first two authors engaged in independent coding of the same transcript prior to beginning the formal coding process. We then compared these for intercoder agreement (Saldaña, 2013). All transcripts were reviewed by the same two authors in order to compare results and create themes. Although we would have preferred to visit all clinics whose directors we interviewed, we were only able to visit two. These visits, however, added another layer of information to our phone interview results, because they gave us the opportunity to see the reading clinics in action.

## Findings

The findings gathered via phone interviews with directors of 10 clinics are presented first by theme: founding and funding, information about youngsters served, tutor information, clinic and center operation, assessment and instructional materials used, and family involvement. We then present the additional information accumulated during the two site visits.

## Phone Interviews

For clarity, we use the term *reading clinic* throughout this article, because this is the term most commonly used in conferences and journals. However, a variety of labels are used for the clinics we studied. Six used the word *reading*, and four used *literacy*. The University G clinic director discussed nomenclature:

It makes me very heartbroken and I think it's misleading that *reading* has become such a four-letter word...because when people are looking for help for their children, parents are not going to say, "Oh, let me go find a literacy clinic or let me find literacy help for my kid." So I would encourage keeping your clinic as a *reading* clinic so that people who need you the most can find you.

Eight directors called their institutions *clinics*, one used the term *center*, and one used the term *camp*. University A, the only one to use *center*, made this decision because of the medical model connotation of the word *clinic*.

**Founding and funding of the reading and literacy clinics and centers.** Most clinic directors recounted a history of their clinics during interviews, including the original founding faculty member, some of whom are well known in the field of reading education. Half of the clinics had been in existence for 45 years or more at the time of this study (two

were founded during the 1930s). Two were founded 20 years ago, and two were founded 4 to 10 years ago. The remaining directors reported not knowing when the clinic was opened or the source, if any, of original funding. Four were funded by donations and/or grants, two were initially funded by the university or college, one received college funding along with a private donation, two did not receive any initial funding other than tutee tuition, and one clinic began with funding from the state legislature and was still receiving that support at the time of this study. In order to continue providing services, eight of the clinics charge a nominal fee for each tutee (see Table 2). These clinics, however, do not turn children away if their families are unable to pay the fees, and several mentioned offering scholarships. One director (University H) shared that, even though they charge a fee, it is a very small price to pay for the services received. Another (University G), when asked about funding, replied, “There is no money. What funding is needed?” This director also said that sometimes parents see more value in the tutorial service if there is a charge: “If parents don’t pay at least something, then they are not as committed to bringing their children and you end up having more attendance problems.” This director uses the optional \$75 honorarium that some are able to pay to purchase instructional materials, usually leveled books. See Table 2 for funding information.

Table 2  
*Fees Associated With Clinics*

University	Fee	Sliding scale	What the fee pays for
University F	\$1,200	scholarships	24 sessions
University J	\$325	discounts	30 sessions
University D	\$100	Yes	15 sessions
University C	\$100	No	12 sessions
University H	\$100	Yes	10 sessions
University G	\$75	Yes	24 sessions
University E	\$5–\$40	tuition waivers	1 hour of tutoring
University B	varies	Yes	30 sessions
University A	none	N/A	N/A
University I	none	N/A	N/A

**Information about youngsters served.** Four clinic directors shared that the number of tutees they are able to serve depends on the number of undergraduate or graduate students enrolled in each course, because this number fluctuates greatly during the year. The University J director worried that enrollment of graduate students in the reading specialist program was “deteriorating” and that this would cause a dismantling of the clinic. Four clinics serve 10 to 20 tutees during each semester-long session, three serve 20 to 30, two serve up to 40, and one clinic serves upwards of a few thousand children each year both on and off the university campus (state legislature funded). Two serve children in prekindergarten through Grade 12, four serve children in kindergarten through Grade 12, two serve children in kindergarten through middle school, and two serve all ages of children as well as adults. All directors interviewed conveyed that they serve students with



identified disabilities (usually with an Individual Education Plan) and have an “inclusive environment” (University A) to cater to diverse needs. One director mentioned that an impetus for establishing their clinic was the co-director’s experience seeking reading support for her son with Down syndrome (University F). Directors specifically mentioned serving students with dyslexia and, because the parents bring the child to the clinic, most information they provide is self-reported and does not come from the child’s school. Due to the locations of the universities, all but one of the clinics reported serving tutees who are ethnically diverse. Two specifically shared that they work with many English learners, and University H offers a weeklong “intensive” program specifically for this population every other summer.

Clinic referrals were most commonly made by word of mouth. Teachers inform parents, parents inform other parents, and students enrolled in university courses inform teachers and parents about clinic services. Four directors mentioned their clinic websites and online registration and application act as a way of attracting tutees. The University G director described their “system of prioritization,” where they strive to select children who present interesting cases and who require intensive reading help from the clinic, usually as a last resort. This clinic director also makes sure that the parents commit to bringing their children for every tutoring session. The director of one of the long-established clinics stated, “We have not really advertised our clinic. We have never really needed to. We have been around so long... we have been successful with what we have done, and it’s just word of mouth” (University J).

**Tutor information.** Half of the reading clinics interviewed use graduate students as their tutors, and these are usually students seeking reading or literacy specialist certification. As part of their graduate programs, these students are required to participate in practicum hours, which involve working in the clinic. This may be situated in a reading diagnosis course, on-site reading practicum course, or reading specialist internship course.

All clinics linked tutorials to courses in the reading teacher preparation program, requiring that enrolled students tutor children. Four utilize both undergraduate and graduate student tutors. One clinic utilizes only undergraduates, primarily because their graduate program is fully online. Most of the undergraduate courses that include a tutoring component are junior- and senior-level courses, thus students have taken additional reading classes prior to enrollment. Students engaged in clinic experiences also sometimes seek other majors, including early childhood, special education, and speech and language pathology. University C utilizes the clinic to provide tutoring in children’s literature, disciplinary literacy, and ESL courses, in addition to a literacy assessment and intervention course. University F trains tutors who are majoring in areas other than education, and the clinic director said that many of these have been “incredible.” Undergraduate America Reads tutors, who are education majors, also serve as tutors in two clinics.

Six directors indicated that they require university student tutors to reflect on their work with children. Of these, five structure this process through whole-class discussions where tutors share data they have collected, their implementation of interventions, and the progress of their students. Their peers then provide specific feedback and suggestions. The University D director commented that the tutors are asked to discuss what they “see in [themselves] and in the child.” Three interviewees mentioned that the instructor conducts observations or “walk-throughs” (University E) during tutorials and provides feedback. The use of video recording was mentioned by two clinic directors, who require their tutors to video, view, and reflect on their lessons and discuss this as part of the final case study

report. One director requires tutors to observe one another and provide feedback in person after class and via a discussion blog.

**Clinic faculty.** Faculty involvement in clinic activities varies considerably by university. The majority come from reading departments or are primarily responsible for reading/literacy instruction. Some directors receive a course reassignment for facilitating the clinic, while others hold the clinic as part of one or two of the courses they teach as part of their regular load. The University F director reported that speech and language faculty are closely connected with the clinic and involved with tutees' families. The director at University A stated, "We meet with other faculty in other departments—literacy, elementary, and early childhood education. So we are all working together to be aligned with the practicum." She added that the dean and other faculty are very supportive. The University I director reported being open to the involvement of interested faculty with center research and mentioned collaborating with two other reading faculty members, a new faculty member who was developing a math component, and a faculty member in kinesiology with whom she is researching the relationship between reading and exercise. The University E director reported that "very few of the faculty have much connection to the clinic. ... I have asked them to come and do some training or research and we have gotten no response."

**Clinic and center operation.** Six reading clinics house tutorial sessions solely on the university campus. One has its own building on the campus, and the other five have a dedicated space designated only for clinic use. Two host tutorial sessions both in a university campus clinic and in local schools. The remaining clinic holds tutoring sessions only in the local schools. Four directors mentioned that their dedicated clinic spaces have rooms with two-way mirrors for viewing and instructional purposes, usually seen in Reading Recovery© program training rooms.

Six of the directors interviewed host tutorial sessions during all three semesters (fall, spring, and summer), two host sessions during fall and spring, and two hosts sessions in spring only. These offerings are based on undergraduate and graduate student enrollment as well as instructor availability. All clinics reported that tutorial sessions are scheduled for 1 hour at a time, although two clinics reported increased time (1.5–2 hours) during the summer due to the shortened semester. One director described these summer sessions as "intense" (University J). During the fall and spring, children attend one or two sessions per week. Those who offer summer clinics usually hold consecutive days of tutoring. Seven clinics offer only individualized tutoring, whereas two offer one-to-one tutoring and sessions where tutors work with two youngsters each (this varies depending on enrollment of university students and need). The remaining clinic offers only small-group instruction.

Most directors we spoke with run their clinics and centers single-handedly. Some collaborate with colleagues who teach courses with tutoring components. Only two mentioned having a graduate assistant who performs duties such as observing undergraduate tutors during lessons, grading student work, and marketing. The one exception is the largest state-funded clinic, which hires both intervention specialists and paid tutors.

**Assessment and instructional materials used.** Numerous assessment instruments and instructional strategies were mentioned by the clinic directors, so only a general overview of the most common instruments used to assess and plan targeted instruction are relayed here. Nine clinics reported that the tutors use a variation of an informal reading inventory, and the other clinic uses the Developmental Reading Assessment (DRA) to gauge students' reading levels. Two clinics use Dynamic Indicators of Basic Early Literacy

Skills (DIBELS). Seven clinics reported using some type of spelling inventory. Other, less frequently mentioned assessments were the Peabody Picture Vocabulary Test (PPVT) and running records. All 10 directors indicated that their tutors engage in progress monitoring, if not weekly, then at least midway through the semester. Tutors mostly use informal methods of assessment, such as running records, retelling, and anecdotal notes.

All clinics address reading comprehension, fluency, accuracy, phonemic and phonological awareness, and phonics during lessons, regardless of the materials used. The University G clinic director discussed how they use the “50/50 rule,” where “50% of the [tutorial] session is devoted to reading connected text and 50% is devoted to skill-driven work based on assessment data.” See Table 3 for a list of assessment materials used.

Table 3

*Assessment Materials Used by Reading Clinics*

Assessment	Number of clinics
Words Their Way Spelling Inventory	6
Observation Survey	5
Informal writing sample	3
Dynamic Indicators of Basic Early Literacy Skills (DIBELS)	2
Peabody Picture Vocabulary Test (PPVT)	2
Qualitative Reading Inventory (QRI)	2
Running records	2
Critical Reading Inventory	1
Developmental Reading Assessment (DRA)	1
Elementary Reading Attitude Survey	1
Multidimensional Fluency Scale	1
Rigby	1
Test of Word Reading Efficiency (TOWRE)	1
Woodcock-Johnson Academic Achievement Test	1

For instructional purposes, the majority of clinics (nine) use trade books and leveled books for guided reading instruction. Clinic directors procure these books from companies (Fountas & Pinnell; Capstone) and online sources (Epic; Reading A-Z). Other common supplies mentioned were magnetic letters, dry-erase boards, letter and word cards for sorting, paper for book-making, materials for specific games, and some commercial supplies. Only one clinic uses a specific tiered reading program to address student needs.

**Family involvement.** Several directors lamented that, due to the amount of time and intense planning it takes to involve families to the greatest extent possible, there is always more that they want to do. Most directors (seven) require that their tutors provide parents with a written summary or report of the child’s performance at the end of the semester. One also provides weekly reports, another provides a mid-semester report, and yet another gives parents a report every week in addition to the end-of-semester report.

Several instructors also mentioned that they encourage parents to share the report with their child's teacher. This report contains the assessment results (pre and post) as well as recommendations from the tutor. One director includes a disclaimer to parents stating that the reports are "based on limited experience with the child and are not to replace anything that the school has implemented" (University C). Two clinics provide frequent newsletters to parents in lieu of the end-of-tutorials report.

Five clinics host parent/tutor conferences, a time when the tutor shares, in person, the information that may also be included in the end-of-semester report. This is the time during which, as one director shared, the tutor provides strategies for parents to try at home (e.g., tips for reading aloud to their children) and walks parents through assessment results. One director offered a note of caution:

I have found that undergraduate students—we need to be careful when undergrad students talk to the parents because they don't always say the right thing.... It is OK for the tutors to touch base with mom and dad, but we are kind of on them about what is and is not appropriate. If the parent wants to talk about the progress of the child in the clinic, they actually talk to the instructor who is supervising that tutor. (University J)

Four clinics host end-of-semester celebrations for families, which often include light food and drinks. An activity that was mentioned included inviting the children to read part of a favorite book or read something they had written. Certificates are distributed, along with a statement about the child's successes and progress. These celebrations are, as one director said, evidence of the "beautiful relationship" that occurs between the tutor and the child in such a short amount of time (University D).

**Only three clinics offer parent workshops.** The largest clinic in our study offers frequent workshops for parents on the instructional program used by the tutors. In another, graduate reading specialist candidates lead parent workshops on relevant topics. One holds workshops on activities parents could do at home and how to read the final assessment report. Other activities mentioned by one or two clinics involve inviting families to observe lessons, hosting family literacy nights, and providing online resources for home use. In many of the clinics, the parents usually wait at the tutoring location while their child is engaged in tutoring, creating a "community of their own," as one clinic director stated (University E).

## Site Visits

**University I.** Author 1 visited University I for 2 days in July 2018. During this time, several interviews were conducted with the clinic director and informal conversations occurred with the secretary and one of the student workers. No university classes were held during the visit; however, several parents brought their children to the center for tutorial sessions. The clinic director assessed one possible center client while Author 1 was there on the first day. The secretary hosted an in-depth tour of the facility and shared her experiences related to the center.

**University information.** University I is a state university situated in a small town with a population of 17,000 in a south central state. It serves 8,276 students (7,045 undergraduate and 1,231 graduate). Of the 54 undergraduate programs, elementary education is the most popular field of study. Class sizes are small, with 84% of classes containing 30 students or fewer. Most students (91.9%) are residents of the state where the university is located. Sixty-seven percent of the students are female. The ethnic breakdown

of the university is 50.6% White, 19.3% American Indian/Alaskan native, 15.7% two or more races, 4.8% Hispanic, 4.0% African American, 2.0% Asian, and 1.7% unknown. This clinic has been in operation since 2011 and offers free tutoring for children.

**Reading center facility.** The University I Reading and Technology Center is housed in an impressive 7,800 square foot facility on the entire third floor of the Education building. The floor was added specifically for the creation of the center, made possible by a private donation by the family of a local librarian and public school teacher. A receptionist who is located in the lobby greets visitors as they enter the center, and there is comfortable seating available for parents while their children are in tutoring sessions. Off the main hallway are one classroom, several offices, a workroom that houses all assessment and instructional materials, and 21 small tutoring rooms. The initial books used by the center were donated by Feed the Children, and the university provides some support, with the clinic director writing grants as appropriate.

**Personnel.** The current director, a reading faculty member who is certified to teach students with dyslexia, has been employed at the university for six years and opened the clinic in 2012. The center employs a full-time administrative assistant and three part-time student workers. During the summer, two to three paid tutors are hired to work with students, because there are no courses offered at this time where students are required to tutor children.

**The tutors and tutees.** During the fall and spring semesters, undergraduate preservice teachers who are enrolled in two reading courses (Content Literacy Kindergarten–8 and Introduction to Reading and Writing Assessment) are required to tutor children. Undergraduate tutors employed by the America Reads program also work with students during the fall and spring semesters.

Elementary-age children make up the majority of tutees. However, the director indicated that, on occasion, tutors have worked with adolescents and adults. She described the university as being located in an area with a large Native American population, and as such, many of the children served are Native American. The clinic serves approximately 250 children per year, many of whom come from low socioeconomic status households.

**Center operations.** The center is open year-round, Monday through Friday. During fall and spring, when the two reading courses with tutoring components are offered, tutors work with children individually for 1 hour per week for approximately 16 weeks, or the entire length of the semester. Children can return to the center for tutoring as many times as needed, based on assessment data and tutor and director recommendations. If a child has made steady progress and there are no open seats for face-to-face tutoring, they may attend computer-based sessions. During these sessions, students work independently without a tutor on a computer program.

**Assessment and instructional materials.** Quite often, children attending tutorials will bring their classroom teacher's assessments, usually the computer-based Star Renaissance benchmark. Preservice teachers initially administer the Developmental Reading Assessment (DRA), Systematic Instruction in Phoneme Awareness, Phonics, and Sight Words (SIPPS), and the Words Their Way spelling inventory and reassess at the middle and end of the semester.

Instructional materials are selected based on student need, and the director requires that the programs and strategies used be from peer-reviewed journals and books for teachers that are based on research. The resource room houses picture books, chapter books, and

leveled books, some of which come from their partnership with Capstone Books. Tutors are also allowed to download books and resources from the Reading A to Z, Science A to Z, and Newsela websites. Tutors also refer to professional development resources under the center director's guidance. These include *Words Their Way* (Bear, Invernizzi, Templeton, & Johnston, 2015), *Reading Strategies* (Seravallo, 2015), and *Writing Strategies* (Seravallo, 2017). They are also working to infuse content area instruction into tutoring sessions so that students read materials related to math, science, and the arts.

**Case studies.** Undergraduate student tutors submit a case study of their work with a child at the end of the semester. Along with all assessment documents and lesson artifacts, they present detailed narrative information about their student. The center director shared what she considers to be a superb case study example. Indeed, the five single-spaced pages are so descriptive, it is obvious that the student knew her tutee well. The main sections are an introduction of the student and the tutorial setting; a description of the student's reading upon entering the tutorials; assessment procedures, observations, and interpretations; student strengths and improvement opportunities; goals for the student; instructional strategies used to address the student's needs; the student's response to the instruction; and suggestions for the parents.

**Lesson structure.** The director and course instructors require that a structured lesson be used for all face-to-face lessons. Tutors plan in-depth lessons based on the assessments they administer. On the first section of the plan, the tutor indicates the state standards that will be used to guide instruction during each component (both the standard number and full wording of the standard). The second section includes five instructional components: easy reading/familiar text, word study/working with words, guided reading, writing, and teacher read-aloud. For each component, the tutor indicates the materials that will be used, a detailed description of the activity, and a place to write a reflection after the lesson occurs. There is also a space at the bottom of the lesson for observations and anecdotal notes.

**University B.** Author 2 visited University B for a full day in June 2018. Interviews were conducted with the director, a staff member who serves as an intervention specialist and is a tutor/trainer in the Wilson Reading System, and the manager of Finance, Research, and Technology. Informal conversations occurred with several other staff members, tutors, and the person identified as the "face and voice of the organization" responsible for reception, payroll, purchasing, and scheduling. Three tutoring sessions were also observed.

**University information.** The clinic is affiliated with a large state university in the intermountain west. Located in a metropolitan area of 1.4 million, it serves 32,994 students (24,735 undergraduate and 8,251 graduate) with 72% being state residents. Among the students, 53% are male and 27% are female, with race/ethnicity reported as 67% White, 13% Hispanic/Latino, 7% Asian, 7% two or more races, 1% Black or African American, and 1% Native Hawaiian or Other Pacific Islander. Three percent of the population is identified as nonresident aliens. The student faculty ratio is 16:1. This clinic has been in operation since it was originally funded by the state legislature in 1999 and offers tutorial services on a sliding scale to participating families.

**Reading center facility.** The clinic is housed in a well-maintained suburban office building, occupying space on two floors. Visitors enter via a hallway on the first floor with a reception window and offices to the left. To the right is a large area used as classroom/tutoring space, a materials library, additional offices, and a kitchen. Upstairs are two additional spaces; one is used for small conferences, tutoring, and offices and the other is

used for small classes and distance tutoring conducted using a document camera and what was described as “simple” software.

**Personnel.** The long-serving director holds a clinical faculty position that is attached to the center rather than to a specific department. She reports working with faculty in educational psychology and special education in addition to those in the literacy field. The center employs 22 full-time intervention specialists along with paid tutors. Intervention specialists play a critical role in providing instruction and feedback to undergraduate and graduate student tutors as well as practicing teachers seeking continuing education credit. During the site visit, tutors were observed in class with one intervention specialist who modeled various word study games.

**The tutors and tutees.** Undergraduate and graduate courses are taught by clinic staff in fall, spring, and summer to fulfill practicum requirements; year-long practicum courses are also taught at both levels. Enrolled students conduct tutorial sessions along with paid tutors who are needed to serve the large number of tutees seeking assistance. The center offers assessment, basic intervention, and intensive intervention services to students in kindergarten through Grade 12. Tutors serve approximately 320 children per year on site, an additional 280 are served via distance education, and many others are impacted at schools where center staff provide professional development. The director reports serving approximately 7,000 students per year.

**Center operations.** Prior to receiving on-site tutoring, children must participate in a basic assessment appointment for which there is a \$50 fee; those needing intervention are immediately placed on the waiting list. Tutorial support is available for up to 90 sessions. Fees during fall and spring are based on a sliding scale relative to family size and gross income; a flat fee of \$75 is charged during summer. Center staff also offer professional development to educators throughout the state both at the center and in local schools.

**Assessment and instructional materials.** A variety of tools are used depending on the student’s needs and instructional level, including informal reading inventories (e.g., Pre-Reading Inventory, Early Reading Inventory, Reading Level Assessment); DIBELS, specifically the nonsense words, oral reading fluency and maze portions; a word recognition assessment based on graded word lists using a flash presentation; the word attack portion of the Woodcock Johnson Academic Achievement Test; the TOWRE (described by staff as the best dyslexia screener); and the Schlagel Spelling Assessment.

Instructional materials are selected based on the reading level and type of intervention program (e.g., basic, intensive). The center has an extensive materials collection that includes basal texts from Laidlaw, Houghton-Mifflin, and Holt, which are used with students reading at or below second-grade level. The director stressed that all basals were pre-1989 because they offer vocabulary control at the first- and second-grade levels as opposed to current anthologies that include literature and complex text, even for beginning readers. Leveled trade books are used exclusively with more advanced readers. A key component of basic intervention is systematic word study (based on the work of Ed Henderson and Darrell Morris) that is made available to all tutors. The Wilson Reading System is used for those needing intensive intervention.

**Tutoring binders.** Tutors are required to maintain tutoring binders in which they place lesson plans, observation forms completed by the reading coaches, lesson materials and lesson logs, progress monitoring information, and so on. These binders are brought to each tutoring session and must be available for intervention specialists to review on a daily basis.

**Lesson structure.** Lessons follow a highly structured and prescriptive sequence with tutors using a specific format for lesson planning. Three models are used to provide basic intervention (described as Tier II), and each was observed during the site visit.

Early Steps emphasizes the alphabet principle and learning about text (including encoding and decoding) for those at or below primer level. Next Steps serves those reading between mid-first and end-of-second-grade level, focusing on assisted reading, mastering vowel patterns in one-syllable words, and developing fluency. Higher Steps is used with tutees at early-third-grade level and above, emphasizing assisted reading, advanced phonics and spelling, and fluency. Early Steps sessions are taught during the summer to small groups of three for 30 minutes, four times per week. Next Steps and Higher Steps are taught one-to-one during 45-minute sessions. In summer, tutees receive Next Step instruction 5 days per week for 4 weeks, and Higher Steps lessons are provided a minimum of twice per week.

Instructional-level materials are used with students in all three programs. Early Steps includes rereading of a familiar book (8–10 minutes), carefully sequenced word study (8–10 minutes), writing activities (5–8 minutes), and assisted reading of a new book (5–7 minutes). The Next Steps lesson plan includes four components: word bank involving a flash presentation of high-frequency words (1 minute); assisted reading of a new text including an introduction, echo reading, solo reading by the tutee, a 100-word cold read, and comprehension activities including wh- questions, confirming predictions, retelling and/or summarizing (25 minutes); word study emphasizes mixed short vowels or vowel patterns (13 minutes); and repeated reading includes two 2-minute timed readings from previously read material (7 minutes). Similar to Next Steps, Higher Steps sessions begin with a 1-minute word bank activity. This is followed by fluency work using timed readings of previously read material followed by graphing of the number of words read correctly and the number of errors (7 minutes). Assisted reading of a new text follows, including an introduction to the book or a portion of a longer selection. Tutors engage tutees in echo and partner reading as they deem appropriate and pause frequently for tutees to answer questions, confirm predictions, and retell or summarize (15 minutes). During word study, tutors use white boards and cuing to guide students through a series of modules that include spelling practice and phonetic marking of each word (15 minutes). The final component is a second fluency session using the text from assisted reading (7 minutes).

During the visit, lessons observed in all three programs adhered to the prescribed sequence and several intervention specialists were on hand to observe each tutor using a checklist that included required lesson components. Corrective feedback was given to some tutors mid-session, and all were provided with targeted and highly specific feedback once tutees were dismissed. During Higher Steps and Next Step sessions, if a tutee was absent, the tutor was assigned to observe another tutor's lesson. The observer was told that this is standard protocol.

**Parent involvement.** Parents sign a contract regarding absences, no more than two in 20 sessions with at least 6 hours advance notification required. Parents commit to listening to their child reading and engaging in word work at home (carefully sequenced lessons are provided by the clinic). The webpage provides a video on the parent's role along with the contract.



## Discussion

Our research findings add to the literature an up-to-date account of a small sample of operational university-based reading clinics, as recent literature on this topic is slim. Several of our interviewees lamented how reading clinics have diminished and how there is declining use of the traditional clinical model where undergraduate students tutor children and are overseen by graduate students, who are then overseen by the instructor or clinic director. Because this is the case at many universities, there are graduate students who are “unprepared to work in a clinical setting” (University B). One reason for the decline is related to the decrease in graduate student enrollment at several universities we researched, although there was nothing in the previous literature that supported this. The lack of funding, however, appeared frequently in the reading clinics literature (Bader & Wiesendanger, 1986; Bevans, 2004; Garrett et al., 2006; Laster, 2013; Morris, 2003) and was consistently addressed by many of our participants when asked about funding. We discovered that most reading clinics are self-sustaining, relying on course fees paid by enrolled students and, in some instances, fees paid by tutees’ families (Bader & Wiesendanger, 1986; Cassidy, 1992; Morris, 2003), with University B’s state legislature funding being a notable exception. Clinic implementation and sustainment across the country may also depend on available space (Bader & Wiesendanger, 1986) and level of support from faculty and administration (Bader & Wiesendanger, 1986; Cassidy, 1992). The nomenclature of the reading “clinic” also emerged during our conversations with interviewees, and arguments against using the medical model are evident in the literature (Bevans, 2004) and may be yet another reason for the decline. Although meeting individual students’ needs is part of the scope for all the reading clinics discussed here, using the terminology related to medicine (e.g., diagnosis, problem) to assess and address children’s reading can be problematic because this perpetuates a deficit model approach.

Our sample of clinics has undergraduate and/or graduate students as tutors, which matches the findings of older studies. Bates (1984), Cuevas et al. (2006), and Garrett et al. (2006) commented on the importance of clinic work for graduate students, as practicing teachers learn more theory related to the reading process and gain the experience of mentoring undergraduate students while they tutor. Reading clinics help undergraduate and graduate students experience the link between assessment and instruction while working closely with children (Morris, 2003; Pearce et al., 2007). Most of the tutoring work at the reading clinics whose directors we interviewed occurs on the university campus, which aligns with the findings of the Garrett et al. study. Morris (2003) noted the importance of hosting tutoring sessions on the university campus—mainly that faculty in other areas are able to get involved.

Overall, it seems that the clinic directors interviewed use a wider variety of assessment materials than noted in previous studies. Garrett et al. (2006), for instance, discovered that most clinics they surveyed implemented formal, standardized measures. Cuevas et al. (2006), Garrett et al., and Pearce et al. (2007) reported that most or all of the clinics they studied also administered some type of informal reading inventory, similar to our findings. Ortlieb et al. (2012) recommended that tutors use assessment data to plan for instruction, regardless of the assessment used. Regarding instructional materials, the information we collected aligned with previous studies (Cuevas et al., 2006; Mokhtari et al., 2010; Pearce et al., 2007), in that the clinic directors required the use of activities related to the following components of literacy instruction: phonemic awareness, phonics, fluency, comprehension, and vocabulary. Most clinic directors mentioned the use of trade books and leveled books for guided reading instruction, aligning with the work of Mokhtari et al. (2010).

It is important to note that there is considerable variation in clinic structure, particularly as evidenced by our two site visits. Tutors at the University B clinic were coached through implementation of specific lesson components in an extremely structured format; emphasis was placed on ensuring fidelity of implementation related to those lesson components. University I also required that specific lesson components be included, but tutors were given much more leeway in terms of lesson design and implementation. Although the research questions in the current study did not include judging clinic effectiveness or approach, we did note that these structural differences are reflective of differences in the approach to reading instruction debated in the relevant literature.

## **Implications**

Although our sample was small, the information collected during the phone interviews and site visits can be utilized by clinic directors and faculty who are searching for ideas to revitalize the current state of their clinics and to inform the creation of new reading clinics.

There existed a variety of nomenclature for the tutoring initiatives we studied, which may have implications for what clinics across the country call themselves (clinic, camp, reading, literacy). Most directors interviewed served students of all ages; however, this may be a far-reaching goal for those with limited funding and a limited number of tutors. Some utilize undergraduate and graduate students, which helps to increase the number of tutors, but many universities either do not confer graduate degrees or have moved to a 100% online program at the master's level. None of the directors interviewed indicated that tutors were working across disciplines to support their tutees, which gives cause to wonder why not? Teachers are encouraged to collaborate with specialists in their schools, and this has implications for university-based clinics as they seek ways to establish these habits early at the preservice level.

Funding for clinic implementation and continuation seems to be an ever-present struggle. Some clinics get by on very little, but we wonder about the support needed to effectively monitor and provide feedback for tutors. Without funding from the university or outside donors, it is difficult to garner assistance from graduate-level students who possess the experience and proficiency needed to effectively mentor undergraduate preservice teachers.

Clinic directors mentioned a wide variety of assessments and instructional materials, including the DRA, DIBELS, several informal reading inventories, Words Their Way, and leveled texts for guided reading. Some clinic decisions are based on what students might be exposed to in the field. There are pros and cons of the various measures, and we encourage clinics to try multiple assessments to gather as much information as possible about their tutees to inform instructional decisions. They can then compare the results from these measures to evaluate their consistency and usefulness in assessing children's reading and related skills.

Most clinics seemed to provide a structured lesson plan format for tutors that included components found in a comprehensive literacy framework, with minor adjustments made to address the needs of students at various reading levels. Most plans included word study, guided reading of a new text, guided writing, and a read-aloud of a trade book or poetry. Broader implications relate to time constraints for faculty to be able to review all lesson plans prior to tutoring sessions and provide substantive feedback so that any needed revisions can be made.

We had numerous discussions about family involvement during phone interviews, which directors certainly felt were worthwhile. However, time is scarce and many find it difficult to fully and effectively implement family activities such as end-of-tutorial-session celebrations, family conferences around student work, and parent workshops. Although feedback to families was also considered important, several directors expressed concerns about novice undergraduate tutors providing feedback regarding children's reading performance and other kinds of interactions that take place between tutors and families.

### **Limitations**

Our small sample of 10 clinics whose directors agreed to phone interviews was limited due to time (both the interviewers' and interviewees') and participant interest. Although the 10 clinics are located throughout the country and operate differently, the results obtained are not generalizable and are not representative of all university-based reading clinics. The same can be said about the two site visits. These were carefully chosen and had strikingly different models; however, we were only able to conduct two visits due to time and monetary constraints, and the information obtained certainly does not embody practices at the vast array of currently operating clinics. Although similar information could have been gathered more quickly and from a larger sample via a survey, the interviews added a richness to the data and gave us personal contact with colleagues across the country with similar interests. There was limited time for interviews because we wanted to be respectful of the time commitment on the part of the interviewees. It should also be noted that even though we used the same interview protocol, some questions were asked in different ways and could have been interpreted differently by the clinic directors. Some directors were excited about certain topics, causing their answers to be deeper and lengthier than those of other clinic directors.

### **Further Research**

There has been research on various aspects of reading clinic structure, but less research emphasis has been placed on the connection between the tutoring done by university students in reading clinics and their growth as literacy educators (Morris, 2003). Although research has provided information about outside factors, practices, routines, logistics, and attitudes of stakeholders, there appears to be a lack of information regarding how university students improve their practice through reading clinic tutoring. Given the diversity in philosophy and approach of the two clinics observed, future research should focus on the effectiveness of various approaches to reading intervention on both tutees and developing educators. Learning more about how to structure reading clinics to not only benefit striving readers but also create exceptional educators is a worthy exploration. Continuing inquiry into the operations, including funding and sustainability, of reading clinics across the country also merits attention.

### **Conclusion**

Clinics require a major investment of time, human, and monetary resources. All clinic faculty interviewed for this study placed high value on the clinic setting and reported that the activities occurring in them are beneficial to children served, tutors, parents, the university, and the larger community. The findings will support the refinement of our own current clinic as we strive to provide reading support to children.

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### **Appendix: Phone Interview Protocol**

#### *Founding of the literacy clinic*

- When was the clinic created?
- What were the driving forces behind its creation?

#### *Clinic funding*

- How was the creation of the literacy clinic funded?
- Have funding sources changed over time?

#### *Student population*

- How many students are served?
- What is the age range of the students receiving services?
- How are the students served by the literacy clinic identified?
- Do any of these students have identified disabilities?
- What is the level of cultural diversity in the student population?

#### *Logistics*

- Where do the tutorial sessions take place?
- Is there a fee for students to attend? If so, who pays it?
- When during the year are students served by the literacy clinic?
- How often does an individual student attend the literacy clinic?
- How long is each session?
- Are sessions in a small group or an individual format?
- Do you hold a recognition event at the end of the tutorial sessions?

#### *Assessment and Instructional materials*

- How are students assessed upon entering the literacy clinic?
- What resources are used to assess students?
- How often are students formally assessed?
- What materials are used for tutoring and how were they selected?
- How is student progress documented? Who is privy to this documentation?

*Family Involvement*

- What parent/family involvement exists as part of the clinic?

*Tutors*

- Who are the tutors/instructors at the literacy clinic? (undergraduate/graduate)
- Is the clinic tied to a course or courses?
- Do the tutors meet as a group (with or without the supervisors) to discuss student progress? If so, how often?

*Clinic directors/instructors*

- Who directs the clinic?
- How are university faculty involved at the literacy clinic?
- How do individual faculty members collaborate?