Supporting Independent Living Through Interdisciplinary Service Learning: The Community Collaborative Model

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Abstract: *Service learning within independent living facilities may be a highly effective means to address the service gaps that challenge older adults and people who are disabled. We present a new approach to service learning by leveraging opportunities for community–university partnerships. The Community Collaborative Model (CCM) represents synergy between organized independent living and higher education at Arizona State University and led by the School of Social Work. The CCM is a unique collaborative service learning program aligned with current thinking about independent living, supportive services, and community-based service learning. We share lessons learned from the challenges of establishing this program, which included institutional hurdles, maintaining adequate physical space, student-focused planning, varying levels of preparedness, and stigma related to service use. In conclusion, we recommend means to (1) build interprofessional teams, (2) seek support and commitment of faculty partners, (3) ensure sustainability via community liaisons and clinical supervisors, and (4) create space for reflective practice.*

Keywords: *Service learning, interdisciplinary, independent living*

Service learning is a common activity for degree programs in higher education focusing on health or social services (Krout & Pogorzala, 2002; Roodin et al., 2013; Seif et al., 2014). This approach to learning allows students to gain real-world practice experience while also providing a necessary community service (Hyde & Meyer, 2004; Miller et al., 2017). The service learning model includes some common elements that are necessary to achieve the goals of improving student education and serving communities: programs and activities are developed in collaboration with communities; the services provided respond to community needs; students typically lead activities with faculty and staff oversight; and students engage in intentional reflection on their experience (Gibson et al., 2011; Oakes & Sheehan, 2014; Seif et al., 2014; Seifer, 1998). Traditional settings for service learning activities include agencies and clinics in the community or within facilities housed on a college campus (Krout & Pogorzala, 2002). With an increasing number of independent living facilities and other home- and community-based programs serving the growing older adult population (Muramatsu et al., 2010), opportunities for non-traditional

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service learning activities are more available. We present the Community Collaborative Model (CCM) as a new approach to service learning that leverages opportunities for community–university partnerships. In this paper, we describe the implementation process of the CCM and offer recommendations for practice to assist staff and faculty who may want to adopt the CCM in their own academic institutions. The purpose of this article is to apply a conceptual model for service learning and delineate its implementation. While historical data are presented, this paper should not be viewed as an empirical piece; rather, it is a starting place from which to build future research.

Independent Living

A primary component of the CCM is the independent living facility with which Arizona State University partners. The term *independent living* is a residential term usually associated with foster youth (Okpych, 2015), people who have disabilities (Nosek et al., 1992), and older adult populations (Muramatsu et al., 2010). Independent living facilities (ILs; also referred to as home or community-based services) are "sheltered" environments designed to meet the specific needs of a community (Rossen & Knafl, 2003). For older adults and adults with disabilities, the acceptance of ILs has increased due to evidence that they provide residents with a sense of agency; residents can make decisions about community activities, housing, employment, and other factors that contribute to a comfortable lifestyle (Townley et al., 2013; White et al., 2010). Studies indicate that lifestyle interventions implemented in ILs can improve health and satisfaction (Clark et al., 2012), and community-based living contributes to well-being (Xiao et al., 2016). However, ILs have been critiqued for a lack of focus on teaching people to successfully build relationships within their communities (White et al., 2010). People who have disabilities have expressed discontent with ILs due to the lack of person-centered case management, delays in access to necessary services, and barriers to accessing health care information due to low-income status (Administration for Community Living, 2018). Some studies suggest that residing in independent living is associated with declining health and quality of life and increased use of health care (Castle, 2001; Rossen & Knalf, 2007). Conversely, some studies suggest that older adults engage in increased physical activities once they relocate to an independent living facility (Castle, 2001; Rossen & Knalf, 2007). McReynolds and Rossen (2004) suggest that physical activity, nutrition, and social supports contribute to optimal aging and are key components in high quality IL settings. In IL settings with combined service learning opportunities, residents may experience positive outcomes also associated with optimal aging.

Service Learning Within Independent Living Settings

Service learning in IL settings may involve social engagement between residents and students through coordinated groups and activities. This engagement can alleviate the social isolation experienced by many older adults. Because social isolation can impact physical and mental health, the social component is an essential focus for professionals working with this population (Bonifas, 2019). According to Cacioppo and colleagues (2011), social isolation has been found to be as strong a risk factor for morbidity and

mortality as smoking, sedentary lifestyle, and high blood pressure. Additionally, lack of social engagement and relationships has a significant correlation with mortality (Holt-Lunstad et al., 2010). Older adults and those with disabilities are at higher risk for social isolation. The promotion of socialization and inclusiveness among residents is a main component of service learning in ILs. Service learning within IL facilities may be a highly effective approach to address the service gaps that challenge older adult and disabled populations. Moreover, students have found that their service learning experiences serve as a bridge from their education to direct practice with community partners (Cress et al., 2005). Service learning in these settings can improve students' attitudes and knowledge about older adults and address common stereotypes about aging (Krout et al., 2010; Oakes & Sheehan, 2014).

Growth in the older adult population and independent living facilities creates an opportunity for universities to establish new approaches to service learning that address the challenges of more traditional approaches (Krout & Pogorzala, 2002; White et al., 2010). Whereas traditional service learning approaches would require the student to venture into external community-based organizations, we present a model of service learning that integrates the community into the university setting and leverages university resources (e.g., interprofessional access to health and behavioral health specializations) to enhance the experience for service users. For the past few decades, independent living settings for older adults and for those who have disabilities have provided students with opportunities for community-based service learning activities (Krout & Pogorzala, 2002). Additionally, student-run clinics that provide care for underserved populations have existed since the 1960s but have increased over the past two decades (Seif et al., 2014).

The changes in the older adult population and increasing attention to alternative care models have led to the development of creative community solutions founded within institutions of higher education (Krout & Pogorzala, 2002). Examples of communities adding to this trend include Kendal facilities at Dartmouth in New Hampshire, Meadowood at Indiana University in Indiana, and the Pines at Davidson College in North Carolina (Krout & Pogorzala, 2002). Alternative models reduce limitations for students and community members to provide and receive services, respectively. By making independent living settings part of campuses, social work educators can address some of the limitations previously reported in traditional service learning experiences, such as delays in accessing services, establishing community relationships, and receiving education and supports to increase autonomy (Administration for Community Living, 2018; White et al., 2010). The alternative model of bringing residential communities into campuses can also address the issue of limited placements available for students, which is a common challenge in traditional community-based service learning programs (Gibson et al., 2011). The model described in subsequent sections is an alternative approach that makes the IL facility part of a university campus. The model improves upon the traditional service learning approach by increasing potential student placements, creating an environment conducive to interdisciplinary collaboration across university departments, and improving accessibility of services for IL facility residents.

Community-based Service Learning at Arizona State University

Aligned with current thinking about independent living and service learning, we describe an alternative approach to community-based service learning that we refer to as the Community Collaborative Model (CCM). The development of the CCM was strongly guided by the Arizona State University charter, which describes a vision of inclusion, of generating research that has value to the public, and—most importantly—of responsibility to the communities served. With this mission in mind, the CCM has potential to more effectively address the needs of older populations within their environment (e.g., Herbert & Molinsky, 2019) while also providing learning opportunities for more students representing multiple disciplines. The CCM brings the community members and students together in a common setting within a university. This model can decrease the burden on community members in need of services and provides learning opportunities for students in an interdisciplinary environment.

We share lessons learned from the challenges of establishing this model, including institutional barriers, maintaining adequate physical space, planning around student schedules and varying levels of preparedness, and distrust among communities' members towards universities and research. We conclude with recommendations for staff and faculty from academic institutions wishing to develop similar service learning programs. The following sections offer an overview of the activities that occurred through common stages of implementation as described by Fixsen and colleagues (2009): exploration, installation, implementation, innovation, and sustainability. We do not describe these stages sequentially, as the activities often did not advance through each stage in an ordered manner. The process of implementing this model was complex and frequently involved trials of feasibility for each activity as is typical for the implementation of any program (Fixsen et al., 2005, 2009). As challenges appeared or activities became unnecessary or no longer feasible, plans were adapted. Successfully implementing innovative practices often required a combination of multiple implementation strategies (Kirchner et al., 2020). While the implementation of this program did not necessarily follow a linear trajectory of implementation phases, we offer a description of implementation strategies that occurred over time and have continued to evolve.

Community Collaborative Model (CCM)

Exploration

The CCM is a service learning program housed within a federally subsidized independent living facility across the street from the Arizona State University downtown campus. The residents include low-income older adults (65+) and adults who have disabilities. Most residents have fixed incomes and rely on Social Security, Social Security disability, or retirement benefits as their sole source of income. Consequently, most residents fall below the poverty level and experience chronic financial and material hardship, including food insecurity. The university was able to develop a partnership with the building owners and lease part of the first floor of the building to create an office space for a research center and a clinical space for the service learning program. Through a

multitude of free onsite services (e.g., basic medical checks, case management, exercise, education), the program offers university students from a variety of disciplines (e.g., nursing, social work, recreational therapy, music, and others) service learning opportunities in a real-world environment. More importantly, this model provides residents of the facility opportunities for a variety of health and social services, including social interaction, cognitive stimulation, exercise and recreation, and case management.

Prior to developing the service program, the onsite research center conducted a comprehensive community needs assessment of the IL facility. After determining that social isolation and frequent use of emergency services (e.g., calling 911, using emergency room or urgent care) were critical issues for the residents, the research center established the "Community Collaborative" program. The program and space were strategically designed to respond to residents' perspectives and service needs. Community needs can range from mental health, physical health, transportation, advocacy, and other social services. Thus, the Collaborative offers a range of services, classes, activities, and events to residents. The flexible approach of meeting resident needs has allowed students opportunities to provide services in consideration of culture to the residents (e.g., encouraging residents to tell their origin stories in narrative psychoeducation group).

Because the CCM functions as a service learning opportunity, students are able to tailor activities to the needs of the residents. Based on individual or group needs, students have the ability to collaborate with other disciplines and modify services and activities to align with specific needs. For example, physical activity was important to residents despite having physical limitations, so students developed a chair yoga program that every resident could participate in, regardless of their physical abilities. Additionally, because residents represent many different cultures and ethnicities, students created activities for residents to attend events that allowed them to learn about different cultures. For example, students learned about residents' cultures while getting to know them, then scheduled events that allowed residents to bring food or other items that represented their culture to share with others. Overall, this collaborative method, which considers the residents' perspectives when identifying service needs that students can support, aims to improve the residents' quality of life through a holistic, integrated care approach.

Exploration Phase: Needs Assessment. In 2013, a sample of residents in the subsidized housing property completed a needs assessment to inform the planning and implementation of a long-term collaborative partnership between the university and the property. The assessment tool was created in collaboration between faculty and students from key departments in the university (i.e., social work, nursing, recreational therapy, and nutrition), and was designed to determine the needs of the residents in order to offer services that addressed those needs. The assessment was approved by the university's Institutional Review Board in 2012 and was completed using a confidential, structured clinical interview design with a convenience sample of fifty residents from a total population of 294 residents. A larger sample was not feasible due to distrust among residents toward the university and difficulty getting in touch with many residents. Participants were asked about health and behavioral health status, psychosocial status and needs (e.g., employment, socialization, education, food insecurity, financial), service utilization, and quality of life. Each interview lasted about 60 minutes, and residents were

compensated with a $10 gift card. The structured interview needs assessment measured health-related quality of life using 32 items across seven of the eight domains measured by the SF-36® Health Survey version 2: Physical Functioning, Role-Physical (role limitations due to physical health), Bodily Pain, General Health, Vitality, Social Functioning, and Mental Health (McHorney et al., 1994). Our instrument did not assess the Role-Emotional domain from the SF-36® Health Survey. However, it did include items from the UCLA Loneliness Scale (Russell et al., 1978), the Sense of Community sub-scale (Perkins et al., 1990), and modified versions of items from Lubben's (1988) Social Network Scale.

Assessment findings indicated that many residents experienced chronic illness and other health conditions—including hypertension (50%, *n*=25), high cholesterol (46%, *n*=46), diabetes (38%, *n*=19), and arthritis (25%, *n*=25)—in addition to mental illness (52%, *n*=26). One of the more commonly reported findings was a high degree of social isolation, loneliness, and feeling disconnected from the community. Nearly half (*n*=23) indicated they "often" or "sometimes" had nobody to talk to, 36% (*n*=18) reported "often" or "sometimes" feeling completely alone, and 52% (*n*=26) felt that very few of their neighbors knew them. The assessment also revealed a high use of emergency health services despite many (*n*=48) having regular access to a health care provider. Forty percent (*n*=20) of participants indicated they had called 911 and 60% (*n*=30) had used an emergency room or urgent care at least once within the previous 12 months. Priority needs were determined based on the findings of the needs assessment and the services and activities available given the departments involved. After identifying the priority needs of the residents, the key decision-makers (faculty and students from previously mentioned departments) focused on developing activities that would serve as the foundation of the CCM. Residents were not included in the decision-making beyond providing feedback through the needs assessment because the program was not yet established. However, a resident council was created for residents to voluntarily participate in program planning as the program became established.

Installation

The key findings resulted in the creation of the Community Collaborative, an interdisciplinary program tailored to address the issues of social isolation and loneliness and the management of chronic health conditions to decrease the reliance on emergency services. The physical space in the building was built in consideration of resident needs with plans for the space discussed before implementation with consideration of the potential for services. The CCM included rooms for one-on-one and small group activities, an office for students, faculty, and staff to keep records and notes, and an open space for socialization. The entry way into the space was a door connected to the lobby of the residential building for easy access. This program required the involvement of students from multiple disciplines, including social work, nursing, recreational therapy, nutrition, and music. Prior to services beginning, the interdisciplinary team planned what activities and services would occur based on the needs assessment and coordinated the schedules of students to ensure student availability was spread across semesters in order to avoid gaps in services. Under supervision from faculty and staff, students from multiple disciplines are able to translate skills from the classroom into real-world settings, practicing

interdisciplinary collaboration while meeting the specific needs of residents. Students in health-related disciplines could work with residents on lifestyle changes and the management of chronic conditions while students from other disciplines, such as social work, could focus on social activities, skill-building, and case management (e.g., assistance and referrals for food, financial, and other immediate needs). These experiences were built into policies and procedures prior to the start of the program.

Implementation and Innovation

The program began operating in the fall of 2016, and since that time, 68% (*n*=197) of residents have engaged in program services at least once. Based on daily attendance and activity tracking completed by students and staff, an average of 15 residents engage in the program daily. The most common services residents engaged in were community building activities (e.g., group socialization, attending special events), case management, and psychosocial activities (e.g., using computers, attending writing group, games, arts and crafts). Residents have been able to participate in university-sponsored and community events such as a residents' artist group made up of ten residents, six of whom exhibited and sold art in a university-hosted art show and a writing group in which one member was able to publish their first book. Between 2016 and 2019, the program offered service learning experiences to 325 students in music, nursing, nutrition, recreational therapy, and social work. Benefits to students include the opportunity to participate in cross-disciplinary teams to gain exposure to the theories and practices of other disciplines and to learn from collaborative experiences with other students and faculty. Through their service with residents, students also gain insight into the challenges faced by older adults and witness the impact of services and policies for this population.

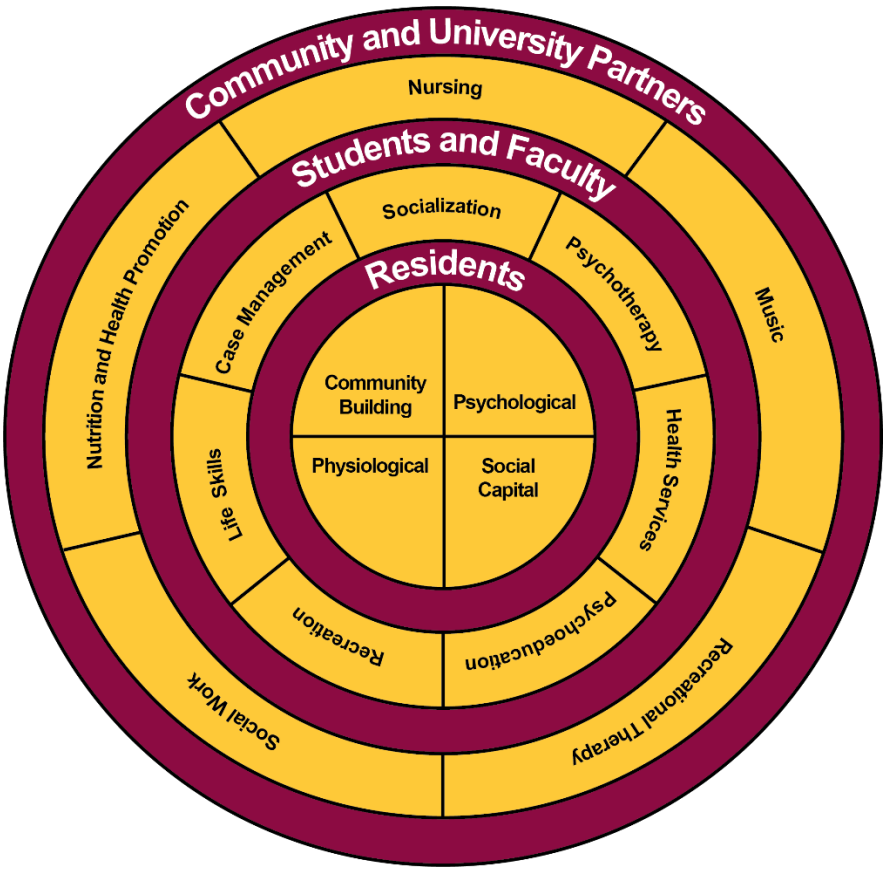
Students are integral in promoting the empowerment of residents and building a stronger sense of community. Social work students are coached in motivational interviewing as part of their field education--they use techniques to enhance motivation among residents, thus empowering them to engage with their community. As such, students benefit from seeing the positive impacts they have on the lives of residents across the course of a semester or year. Illustrating other positive outcomes, a member of the social work faculty and a student conducted a small study with the CCM and found improvements in student learning outcomes in the areas of communication and teamwork, interprofessional interactions and relationships, communication processes, and relationships (Bonifas & Garbe, 2017).

The CCM is centered around residents and students who develop a collaborative relationship based on service provision, education, and community-building. Although the program is grounded in social work, it is affiliated with multiple university departments to meet the interdisciplinary needs of residents. The social work faculty involved with developing the program were able to obtain buy-in from other departments because the CCM provides their students with service learning experiences. The program offers services addressing physical, mental, emotional, and social components of health and well-being as follows:

- **Recreational Therapy**. Students from recreational therapy provide recreational activities and leisure education, including adapted yoga and dance, guitar lessons, and creative arts and games. These students also organize community events for residents, such as a spring fling and fall festival. Decisions made related to these activities and others were made by staff, faculty, and students initially. However, a resident council was established later in the program to ensure residents had a voice in decisions being made about program activities.
- **Nutrition**. Nutrition students offer nutrition and health promotion education, including education on nutrition-related health problems, individual nutrition plans, and recommendations for healthy eating on a budget. Students also organize a food drive for residents each spring, provide a food cart at all times for residents to take items as needed, and connect residents with community agencies that address food insecurity.
- **Music Therapy**. Music therapy students facilitate group sessions of active music-making, including creating, singing, moving to, and/or listening to music. Sessions are focused on reduction of stress, community building, and inclusion through interactive musical performances and creative collaboration.
- **Nursing**. Undergraduate nursing students provide basic nursing services, such as monitoring vitals (i.e., blood pressure, pulse, and respiration rate) and blood glucose checks, wound checks, and health promotion education. Doctorate level nurse practitioner students offer more comprehensive assessment services, including home visits, health promotion, and wellness education.
- **Social Work**. Social work students provide individual counseling and biopsychosocial assessments, case management services, psychosocial education, support groups, group socialization, and community building activities.

The CCM is depicted in Figure 1. The model operates through partnerships between community and university partners comprised of fields such as social work, recreational therapy, music, nursing, and nutrition, and health promotion. Based on discussion with residents and observations of students, new partners and services are added as new needs are discovered, such as dentistry and career services. The program oversight comes from staff within the research center housed in the residential building. A program manager who is a staff member of the host research center is responsible for most of the oversight. When new needs are identified, this individual works with other departments to determine potential services and connects with new departments or outside community agencies to coordinate a partnership for services. The costs associated with the CCM are supported by donors and the college. Donor support provides for expenses such as stipends for social work students, and materials for services and events (e.g., paper, plates and cups, art supplies, gift cards, food). The college and host research center cover the salary of the program manager who provides oversight of students in collaboration with faculty from other departments. Students from disciplines outside of social work provide services for no cost and receive service learning credit through their department.

Figure 1. *The Community Collaborative Model (CCM)*



Note. The figure illustrates the interconnectedness between community and university partners, student-led services, residents (service recipients), and the center.

Sustainability

The model is sustainable due to not only the infrastructure and support provided by the university but also the ability of the research center staff to independently oversee and coordinate activities. This structure takes the burden off faculty, who are traditionally given the responsibility to oversee service learning without additional resources and time (Gibson et al., 2011). Another unique aspect of the CCM is that the program space is embedded not only into the residential building in the community but also in the university's existing infrastructure. The clinical space used by students and accessible to residents is leased by the university, and staffing is jointly supported by the university and the research center providing the oversight. Staff and faculty overseeing the program are trained through opportunities to build knowledge in areas related to field instruction and service; events are available through the School of Social Work and its various research centers. Further program faculty are evaluated yearly in a process that requires them to articulate professional improvement goals and account for previous performance as it relates to CCM

work. This creates a sustainable service learning environment that can independently function year-round (given donor contributions). The partnerships form the interdisciplinary network of students, faculty, and staff to provide key services to residents, who are at the center of the model.

The services received by residents can be categorized into four types of needs: psychological, physiological, community building, and social. The CCM brings about a mutually beneficial exchange that gives students opportunities to learn while providing valuable services to a vulnerable population. Currently, the CCM is in a state of continuous implementation and innovation. New practices are frequently implemented based on new needs that arise, and activities that are no longer needed or sustainable go away. Sustainability is always being considered and often influences changes to the program. Once the program settles into a set of standard practices, a process of evaluation will be put in place to continuously examine outcomes at the resident, student, and institutional level.

Sustainability: Challenges and considerations. Community Collaborative faculty, staff, and students generated creative solutions to a variety of challenges since the program was first implemented. When establishing the CCM that serves both students and residents, several factors must be considered prior to beginning service provision (ordered by priority): (1) physical space, (2) stigma, (3) institutional challenges, (4) student availability, and (5) perspectives and needs of students. These five themes were identified from interdisciplinary collaboration among research center staff and faculty affiliates including representatives from social work, nursing, recreational therapy, nutrition, and music. These themes are common issues that arose since the start of the program and have become regular topics for discussion among collaborators.

Physical space. Planning for a physical building space is as important as planning for time-related challenges. The CCM could not exist without the physical space existing within the residential building. This had to be developed before the program activities could be planned. Program space affects program delivery; participants may be hindered if the space is too small. There needs to be substantial, wide-open space to allow free traffic, including space for people using walkers and wheelchairs to easily maneuver among the furniture and other people. The space should have enough separate enclosures/rooms to allow for the programming being delivered (e.g., a quiet space for meditation activities, yoga, and tai chi) while group socialization is going on in a larger community space. The space should also be situated so that noise-producing program activities (e.g., music therapy and guitar lessons) can be conducted without disturbing surrounding living and office spaces. Acoustics in the space are also important when working with people with hearing impairments. In our case, we were able to separate noise-producing activities by booking space in the university's conference and event space located in the same building. An ongoing challenge related to space was that the CCM existed within a larger shared space. Within the same building, there are office spaces for staff and faculty from two separate research centers. Noise from the CCM activities occasionally disrupted work within other professional spaces. Due to how the space was built, research center employees either had to walk through the CCM (which could disrupt activities) or walk outside the building in order to get to the other side.

Stigma. We urge new programs to be mindful of stigma. This issue came up before the program was implemented. In order to determine the needs and plan for services, a needs assessment had to be conducted which required participation from residents. To increase participation in this process and beyond, trust between the university and residents is critical to dispel the beliefs residents have about being used for research purposes. In the CCM, there are two sides to the experience of stigma. The first is the resident's perceptions of institutions of higher education. When the CCM first opened, many residents expressed feelings that the university was only there to use the residents as subjects in research. Residents would speak about this during group socialization activities and in one-on-one conversations with staff and students which would be documented in program notes. During this process, we learned that it is essential to address this misconception with residents early on.

Looking back, our plans should have included time to connect with residents and discuss what research is and is not, as well as the concept of voluntary participation. We knew that there would be faculty and students interested in conducting research studies in the space with residents and with students, but this could have been introduced in a way that reduced the distrust experienced by residents who sometimes expressed feeling like research subjects, and always under scrutiny. Although the extent of the distrust towards the university was not measured, concerns by residents were often noted and discussed among staff, faculty, and students. Due to the distrust that developed around research activities, we limited the research activities initially in order to keep residents engaged in the program. A policy was eventually established requiring approval from program management. The program manager now consults with other program staff or faculty to make decisions regarding what research activities are allowable on a case-by-case basis.

The other side of the stigma issue pertains to students and staff. We made an assumption that students and staff coming from helping professions would have an understanding of the difficulties facing the older adults and people with disabilities and mental illness; however, we learned that was not the case, and education around these populations was necessary. For example, some students believe common myths about mental illness such as the misconception that people who have a mental illness are more prone to violence. Compounding the issue is the fact that students lacked a basic foundation related to mental health, and were often unfamiliar with the appropriate language to use regarding people who have mental illnesses and disabilities. These education issues with students are addressed as they come up. Ultimately, it is crucial to focus on educating students and staff on common misunderstandings related to the residential population.

Institutional challenges. Less tangible but equally critical considerations relate to the potential for distrust of institutions (i.e., the university) among disadvantaged populations. Therefore, affiliated faculty and staff must avoid overpromising and under-delivering and must be up front about what the program can offer and its limits (e.g., interns cannot provide home-based case management services). Additionally, given that the program is part of an academic institution and uses a collaborative model, approvals for changes must often go through multiple layers and disciplines. This can create delays in services for residents and difficulties in getting students needs met. While securing funding from the institution has great benefits, it is unlikely to cover all costs. Therefore, it is important to

continuously search and apply for additional funds. Efforts may be challenged because research funds would often require collecting data from residents, which brings a unique set of challenges. Trust may be impaired if faculty use the population to further research goals. In our case, we looked toward foundations that fund programs and were able to secure a small amount of funding to cover the costs of equipment and supplies. In this case, the funding came through a donor that was able to commit to continued donations each year.

Student availability. Semester and holiday breaks cause a sudden termination of services, typically for 2- to 3-week periods. The disruption to some services (e.g., counseling) can result in some residents feeling abandoned (based on observations and discussion among students and residents). As a result of this observation, it became a necessary program activity to talk openly with residents about approaching breaks. It is also necessary to create interim plans where needed and to build interest and enthusiasm for activities in the upcoming semester. Disruptions also occur when student cohorts change each semester and academic year. Student rotations create difficulties with continuity of care (Bonifas et al., 2017) and often resulted in disappointment and lack of trust from the residents. The need to repeatedly start fresh in establishing rapport between students and residents is an ongoing struggle that students, faculty, and staff attempt to mitigate wherever possible.

For other programs interested in implementing the CCM, we recommend building a staff and faculty team that can have a consistent presence. This way, even though students inevitably turn over, residents will always have a few people with whom they can develop long-term rapport. In addition to consistency in personnel, it helps to develop ongoing, consistent programming that occurs regularly. For example, in our program, we have some activities and traditions that occur regularly regardless of student availability, such as guitar lessons, music therapy, an annual bingo event, and health and nutrition fairs. The most recent challenge related to availability came about with the COVID-19 pandemic. The clinic space had to be closed, and students and staff were unable to be on campus. As a result, staff and affiliated faculty had to develop a plan to stay connected with residents as well as meet the needs of students who had educational activities to fulfill. For this situation, faculty and staff created alternative learning activities for students while still offering services to residents. Some of the activities and services included: 1) a phone line for students and staff to provide friendly and empathetic support for residents who need to talk and a help line for information and resources related to COVID-19, 2) students and staff creating a weekly newsletter (print and digital) with links to a private Facebook page for residents, positive new stories, and ideas for things to do, and 3) students hosting virtual group sessions via a video-conferencing platform.

Perspectives and needs of students. Faculty and staff have learned that mandated practicums do not always produce committed or enthusiastic students. Resident participation—and thus the Community Collaborative program—depends on students having the mindset and skills to engage vulnerable and disenfranchised populations. Students are not expected to be outgoing, but they should demonstrate qualities such as sincerity, compassion, tolerance, patience, and a real interest in learning about residents' lives and histories. Interviewing and selecting students through an application process

helped identify students who were the best fit for the program. The staff member who manages the program had the best understanding of the skills needed for the success of the program, so they conducted the interviews and selected the students. In general, the ideal student was comfortable with, and had some experience engaging with, the population being served. Level of education was less of a consideration since the program sought to attract students from all levels ranging from undergraduate to doctoral. Because students enter the program with different levels of experience, knowledge, and ability, some will need more guidance than others. All students attend an orientation on their first day to learn about program policies and procedures. Additional training may be scheduled based on needs. Program staff and faculty can meet students where they are and provide optimal instruction and support for skill development through weekly meetings with students to establish learning goals and activities and to follow-up on progress.

Recommendations for Service Learning and Community Embeddedness

The CCM created the ability to provide specialized services for residents in a subsidized housing unit near campus. Undergraduate and graduate students from multiple disciplines such as social work, nursing, recreational therapy, and music are uniquely positioned at the Community Collaborative to build on the foundation of their service education. To that end, we offer the following recommendations:

- Assemble a team of dedicated collaborative partners with a shared program vision. These partners can be identified based on their ability to fill a service need for the client population. In our case, the core partners consisted of social work, nursing, recreational therapy, nutrition, and music departments because each contributed to fulfilling a specific need of residents. As the program develops, new partners are added to address new needs. Ideally, this team should agree on a shared vision with the understanding that the program is continuously evolving to meet the needs of clients and students. The team should be able to commit ongoing time to help develop the programming and student curriculum and meet with program staff and students regularly to address concerns and brainstorm solutions. Sharing the work across several departments provides resources and increases the capacity to provide the type of programming and oversight needed for an interdisciplinary service learning program.
- Gain support and commitment from the departments and schools involved in the program to ensure allotment of time for faculty partners to play an active role in the program, especially to offer interprofessional education sessions to students. Establishing regular meetings for program partners to meet and discuss challenges and solutions, and provide training and oversight to students is critical to the success of the interdisciplinary activities.
- Consider assigning at least one long-term staff person to the Community Collaborative. This person should serve as a liaison between residents, students, the university, and other partners. The existence of this role creates continuity in care and ensures effective program management.

- Bring an independently licensed clinical social worker into the program to provide clinical oversight, guidance, and instruction to students during service delivery. Issues arise daily when working with a population in which mental health needs are high. In our program, we were able to have a part-time licensed social worker in the clinic who could be compensated as a faculty associate within the School of Social Work. This individual serves as the field instructor for social work students and is able to provide clinical supervision. Salary is determined by the School of Social Work, not the research center.
- Incorporate a weekly or at a minimum monthly interprofessional day to allow students of various disciplines to have scheduled time to work inter-professionally and engage in supervision and reflection.

Discussion

With the CCM, residents in IL settings and students from multiple disciplines (i.e., social work, nursing, recreational therapy, and music), come together to form a unique and innovative organization. The CCM, established through needs assessment and interdisciplinary experience, is a foundation on which future education, practice, and research efforts are placed.

Implications for interdisciplinary education include determining means by which students can continue to grow interprofessionally. With the CCM, service learning has involved traditional tenets of community service combined with education (e.g., Krout & Pogorzala, 2002; Roodin et al., 2013; Seif, et al., 2014). However, there is much more room to grow as creative interdisciplinary partnerships continue to flourish with the myriad programs Arizona State University has to offer. For example, initial conversations and collaborations have begun with Criminal Justice (related to security) and Emergency Management (related to disaster planning).

Educational innovation via interprofessional collaborations clearly leads to implications for practice including those we noted related to (1) physical space, (2) stigma, (3) institutional challenges, (4) student availability, and (5) perspectives and needs of students. As the CCM evolves and students, faculty, and staff become more familiar with the model, implications for practice mean increased sophistication of services offered (e.g., moving from basic case management to evidence-based interventions).

Lastly, as practice becomes more robust within the CCM, so do implications for research, which are well-aligned with the fundamentals of implementation science. Through time, we engaged in stages of exploration, installation, implementation, innovation, and sustainability (Fixsen et al, 2009), and noted the common challenges related to feasibility (Fixsen et al., 2009; Fixsen et al., 2005). As the CCM continues to evolve, we note that future research should build on the conceptual framework of the CCM, further testing its feasibility and establishing more substantial means for sustainability.

On-going data collection benefitted the program through the needs assessment being used to inform services, and daily logs of participation to understand what services were most utilized and inform outreach efforts to engage more residents. Data collection was

modified over time, which has improved the model as a result. Initially, resident participation in the Collaborative were tracked by students and staff using sign-in sheets when residents came in and a daily log of services and activities. Due to limited resources, this data was tracked on paper and had to be entered into an Excel spreadsheet to summarize the data. The process was improved by converting the daily logs into an electronic form submitted via Qualtrics (an online survey tool) which made the data more accessible daily. Additional data collection in the form of anonymous surveys and focus groups also contributed to helpful feedback to inform program activities.

In summary, we note that this paper is necessarily preliminary, as the process of creating the CCM has continued to evolve. We acknowledge the strong need for ongoing and continuous evaluation of the CCM, but we must also accept that limited resources have contributed to this shortcoming. The next step for the CCM will be to use the initial needs assessment to inform a new needs assessment and conduct an outcome evaluation to understand the benefits and barriers that exist within this model. Going forward, we suggest this work and similar endeavors require innovation to both support the CCM and contribute to the knowledge base, making both viable. As the CCM becomes fully actualized, we aim to capture data that describe our program and offer empirical support related to successful outcomes for both students and residents.

Conclusion

By highlighting lessons learned and offering practical recommendations for service learning programs based in independent living facilities, we hope faculty and staff in other universities are better prepared to engage in similar efforts. The CCM is truly an exemplar of service learning because it brings the university to where the clients are, rather than relying on people in the community to come to us. Through ongoing and supportive services, IL residents have the opportunity to gain an enhanced sense of individual agency for a longer amount of time and feel like part of their larger community. In sum, the Community Collaborative will continue to evolve and grow with the changing needs of the surrounding community. And faculty, staff, and students will continue to work on meeting the needs of those who call the community home. Over time, the CCM has and will continue to serve its purpose to educate students about strategies to integrate community service with instruction and self-reflection, and serve a vulnerable population in our community. Faculty and staff have opened the door to new and challenging learning experiences, which will ultimately strengthen the larger community in which the Community Collaborative exists.

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