

April 2024

Faith Community Nursing Case Study: SHARE Grant Procurement during the Covid-19 Epidemic

Deborah J. Ziebarth
Mary Baldwin University

Deborah Fell-Carlson
Faith Community Health Network

Marcy Shanks
Faith Community Health Network

Follow this and additional works at: <https://digitalcommons.wku.edu/ijfcn>



Part of the [Public Health and Community Nursing Commons](#)

Recommended Citation

Ziebarth, Deborah J.; Fell-Carlson, Deborah; and Shanks, Marcy (2024) "Faith Community Nursing Case Study: SHARE Grant Procurement during the Covid-19 Epidemic," *International Journal of Faith Community Nursing*: Vol. 9: Iss. 1, Article 5.

Available at: <https://digitalcommons.wku.edu/ijfcn/vol9/iss1/5>

This Article is brought to you for free and open access by TopSCHOLAR®. It has been accepted for inclusion in International Journal of Faith Community Nursing by an authorized administrator of TopSCHOLAR®. For more information, please contact topscholar@wku.edu.

Faith Community Nursing Case Study: SHARE Grant Procurement during the COVID-19 Pandemic

Introduction

A handful of faith community nurses (FCNs) in rural Oregon joined together in early 2019 to form the Faith Community Health Network (FCHN). The FCHN applied for and received a *Supporting Health for All through Reinvestment* (SHARE) grant (Oregon Health Authority, 2023) to equip local FCNs and to launch new faith community nursing practices within Linn County. Faith Community Nursing is a specialty recognized by the American Nurses Association. This nursing specialty is unique in that FCNs work in or with a faith community to provide whole-person care interventions. FCNs are licensed registered nurses with additional education to provide healthcare coordination and spiritual care interventions in a community setting (Ziebarth, 2014).

This case study presents the story of the FCHN's journey from coalition to non-profit status and the procurement of the SHARE grant, "*Rebuilding the Bridge Between Healthcare and Faith Communities*" during the COVID-19 pandemic. The FCHN received the SHARE grant from the Intercommunity Health Network Coordinated Care Organization (IHN-CCO). The grant supported the FCNs to expand their network, document electronically, and provide both care coordination and other faith community nursing interventions to the vulnerable.

Demographics

Lebanon has a population of 18,945 and is the largest community in the rural eastern half of Linn County. Samaritan Health Services is the regional healthcare provider and published a recent assessment (Samaritan Health Services, 2023). Lebanon has higher rates of poverty and homelessness than Linn County at large. Approximately 92% of the residents are white. There is a strong agricultural base with farming important to their way of life. Ten percent are Hispanic or Latino, likely underreported. Median household income for the white population is \$56,200 with 12.7% below the poverty level. Median household income for the area's Hispanic/Latino population is \$53,500, with 16.6% of this population below poverty level.

The *2022 Annual Homelessness Assessment Report* to Congress reports that Oregon has the sixth highest homeless rate in the US and homelessness increased 22.5% between 2020-2022. Over 60% of these homeless Oregonians are completely unsheltered. This problem is magnified in Lebanon. Approximately 14% of the adult-working-age population are uninsured and having difficulty accessing healthcare, largely due to lack of transportation (Mulder et al., 2000; Samaritan Health Services, 2023). They suffer from chronic disease at higher rates than the average Oregonian, including heart disease, arthritis, asthma, cancer, cardiovascular disease, chronic obstructive pulmonary disease, depression, diabetes, heart attack, and stroke. Disability prevalence in working age adults (18-64 years of age) is 13.6%; 3-5% higher than the state average (Samaritan Health Services, 2023; US Census Bureau, 2022). Nearly 20% of Linn County's residents are over 65 years of age. It is not surprising, given this community health profile, that Oregon's first outbreak of COVID-19 was in Lebanon.

Food insecurity is a community-wide issue. Such a large percentage of children qualify for the National School Lunch Program in the Lebanon Community School District that the school district has implemented the Community Eligibility Provision (USDA Food and Nutrition Services, 2023) allowing school districts to provide breakfast and lunch to all children in the district without requiring families to apply (Lebanon Community School District, 2023). The Lebanon Community School District graduation rate ranks 127th of 235 Oregon high schools (U.S. News, 2023).

Despite the demonstrated need, the faith community nursing practice specialty had been declining in Oregon for about a decade. FCNs were not present at the policymaking table when Oregon Healthcare Reform passed in 2009, thus, FCNs were omitted as a valued community health provider. Oregon FCNs, who were once considered indispensable partners in the continuum of care, gradually left the specialty because there was no place for them within Oregon's new Coordinated Care Organization (CCO) model. Yet, the need for FCNs is evident, especially given the rising rates of homelessness and significant healthcare access challenges.

The Oregon Health Plan is Oregon's Medicaid provider; the plan administrator for Linn, Benton, and Lincoln Counties is the Intercommunity Health Network Coordinated Care Organization (IHN-CCO). There were significant care gaps identified that could be filled by FCNs, given the nursing specialties' fluidity between community and health care institution settings (Ziebarth, 2014). Unfortunately, FCNs were no longer part of the healthcare continuum, and most Oregon stakeholders and influencers were unaware of the specialty.

Methodology

The purpose of this case study is to present a community problem and a community response within a naturalistic understanding of variables. A case study is a focus on a phenomenon within its real-life context where the number of variables of interest are unmeasurable (Yin, 1999). It is an empirical inquiry that investigates a contemporary phenomenon in depth and within its real-life context, especially when the boundaries between phenomenon and context and variables are not clear (Yin, 2009). A case study is both the process of learning about and the product of our learning from the case. The authors hope that the lessons learned will empower other FCNs to formalize their networks and seek grant funding to initiate, stabilize, and expand their reach.

Case Study

Pre-pandemic – a fledgling start

In the fall of 2018 Faith Community Nursing – Health Ministries Northwest, a Portland, OR-based non-profit, hosted the Westberg Institute for Faith Community Nursing Foundations of Faith Community Nursing Course (FFCN) in Linn County. The course graduated nine students, including three FCNs and one health minister from Linn County. These four met monthly throughout 2019, developing partnerships with other community coalitions and organizations. Upon learning that the Portland non-profit disbanded, the Lebanon-based network approached their local community college's *Extended Learning Department* with an offer. One FCN would deliver the Westberg FFCN if the college would pay the initial fee to become a Westberg

Institute Educational Partner. A deal was struck and the in-person FFCN was scheduled for April 2020, but COVID-19 pandemic changed these plans.

Lebanon, Oregon – Oregon’s COVID-19 Epicenter

Two residents of the Oregon Veterans’ Home (OVH) located in Lebanon tested positive for COVID-19 on March 11, 2020, and were among the first cases in the state. The virus spread rapidly among the elderly residents, and OVH soon became the first COVID-19 hotspot in Oregon. Lebanon was dubbed Oregon’s coronavirus “epicenter” (Zarkhin, 2020) just weeks before the FFCN scheduled start date and restrictions were rapidly implemented county-wide. The FFCN was delivered by Zoom in October 2020. This course graduated 17 participants from across the country, including six local FCNs. Five of the local graduates chose to affiliate with the Lebanon-based network, essentially doubling the size to eight. Changing the name to the Faith Community Health Network (FCHN), they continued to meet virtually each month and invited other community stakeholders.

FCN Survey

FCHN leaders conducted a survey with area FCNs about barriers to practice. The survey results suggested that there were concerns about compliance with the Oregon Nurse Practice Act, especially related to secure documentation. They were undeterred by COVID-19 restrictions, per se, but needed electronic devices to participate in virtual meetings and to assist faith community members with telemedicine appointments. The FCNs saw that digital healthcare access had created a significant barrier to care. Healthcare consumers, especially the elderly, are often fearful of using electronics, have little knowledge of their use, and are limited by the physical challenges of poor dexterity and visual acuity so common among the elderly and disenfranchised (Marimuthu, et al., 2022).

SHARE Grant

The IHN-CCO Delivery Systems Transformation (DST) committee was an early FCHN partner. The DST convenes representatives from over 70 community-based organizations, including housing authorities, shelter leaders, homeless advocates, school districts, health equity advocates, the FCHN, and others serving *Oregon Health Plan* members. The DST’s main purpose is to identify solutions to bridge gaps in care by funding small pilot projects submitted by community partners that represent new and innovative health initiatives. To be considered, projects must contribute to the DST’s Quadruple Aim of improving health; increasing quality, reliability, and availability of care; lowering or containing the cost of care; and improving health equity (IHN-CCO, 2022). Still in COVID-19 lockdown, the FCHN submitted a DST SHARE grant proposal. The proposal, entitled *Rebuilding the Bridge Between Healthcare and Faith Communities*, outlined the importance of supporting the re-emergence of FCN practice in Linn County. The goal was to equip and sustain a network of coordinated care for IHN-CCO members using trained FCNs in local faith communities, thus bringing FCNs back into the continuum of care. This required several strategic steps: 1) recruit and train additional faith community nurses, 2) equip FCNs with computers, software, and training to encourage documentation and data sharing, and 3) engage IHN-CCO members within their respective faith communities in health information exchanges, healthcare coordination, and advocacy for qualified services. These services included

accessing Oregon Lifeline phone service, connection to resources using the UniteUs platform (ConnectOregon), assistance to help community members obtain stable housing, transitional care (especially upon discharge from hospital or emergency room), consistent and appropriate Medical Home connection, and health literacy support.

Post-pandemic re-opening launches new beginnings – and challenges

In late-August of 2021, just weeks after Oregon was officially re-opened for business after COVID-19, and about 10 weeks before the 2021 Foundations of Faith Community Nursing Course was due to commence, the FCHN received news that they were awarded the SHARE grant. With minimal knowledge of non-profit organizational structure or requirements, the FCHN sought legal counsel to form a non-profit, secured an account for the FCHN at a financial institution to receive the funds, began developing the necessary non-profit infrastructure, and created systems to manage the incoming grant funds – all while preparing for the 2021 FFCN. They were awarded 501(c)(3) non-profit status as a 509(a)(2) public charity in mid-December 2021, effective retroactively to September 13, 2021. As such, they could receive tax deductible donations, apply for other funding, and become a Westberg Educational Partner. The FCHN team busied themselves getting bids and procuring computers, coordinating computer and software training, mentoring, and formalizing essential processes throughout the first half of the grant period.

The outreach to recruit additional FCNs and health ministers and to educate the public about faith community nursing backfired. Although COVID-19 restrictions had been lifted, people were still hurting. The recruiting message was lost. Phone calls poured into the FCHN from individuals and social service agencies seeking support for community members suffering from loneliness and isolation, neglected health needs, housing insecurity, and more. The FCHN team served many of these individuals informally but were quickly overwhelmed. Not wanting to generate additional referrals they could not support, the FCHN pulled back on their outreach.

Additionally, it became apparent that their chosen documentation software would not meet the team's needs. It would not aggregate data from other users and required annual purchase of an expensive Microsoft Office package for each user. There was no way to securely share client information within a team. Most importantly, the team found the system difficult to use, and knowledge gained in the team training had faded. Most FCNs opted to track encounters manually instead.

Although pandemic restrictions had been lifted, it was the first summer families and friends could be together. About half of the FCNs on the FCHN team were focused on nurturing previously neglected family relationships and participating in long-postponed events. The other half, mostly the FCHN Board of Directors, were focused on developing the necessary non-profit infrastructure. With FCN attention channeled elsewhere, the FCHN experienced a lag in the implementation rollout within faith communities at the end of the grant period.

SHARE Grant Results

Board Structure and Operations	Educate nurses and faith leaders to support recruiting FCNs and health ministers	Equip and train FCNs and health ministers	Engage IHN-CCO members
Formed non-profit, elected Board leadership; drafted bylaws, policies, defined organizational structure, etc.	Precepted CAPSTONE projects for two local Baccalaureate Degree nursing students.	Graduated nine local nurses/health ministers from the Foundations of Faith Community Nursing Course.	Regular FCN presence at faith-based homeless outreach center serving 50+ individuals.
Separated Network activities from Board functions and created a Board meeting schedule.	Guest lecturer to associate degree nursing students on social determinants of health and community health nursing (faith community nursing).	Coordinated and executed monthly nursing education/networking meetings for the entire FCHN team.	Served 70+ individuals with unknown insurance, some 20+ times, in advance of the planned launch. Note: the FCNs tracked these encounters manually.
	Individual FCNs spoke with Faith Community leaders in person, on phone, and by zoom.	Procured 11 laptops and one Chromebook; distributed to local FCNs and health ministers.	Successfully secured stable housing for a unstably-housed Veteran and a homeless gentleman with fragile health conditions.
	The FCHN hosted an educational session with the Oregon State Board of Nursing (OSBN) Executive Director and spoke at an OSBN public meeting.	Trained 17 FCNs/health ministers on Windows 11, the fundamentals of the Microsoft Office package, and the Pittsburgh Mercy Electronic Documentation System.	Assisted three community members with housing applications and empowered them to complete the application process independently.
	FCHN members wrote an article published in the OSBN Sentinel entitled "Faith Community Nursing – Is it right for you?" (Fell-Carlson & Shanks, 2022).	Coordinated Connect Oregon registration for all FCHN members.	
	Stories published in a variety of media intended to recruit nurses.		

Two Exemplars

- RS is a recently widowed elderly gentleman who is a member of a service-oriented faith community. While engaged in a service activity with another faith community member, RS spontaneously pulled up his pantleg to expose large weeping ulcers on both legs. The faith community member immediately suggested RS be assessed by the FCN. The*

FCN visited RS at his “home” which was an old motor home without heat or running water. RS consistently arrived to worship clean and did not complain, so the faith community was unaware of this living situation. Upon assessment, the FCN learned that RS was diabetic and had not been feeling well for some time. He was weak and could walk only short distances without resting. He hauled small amounts of water for drinking and washing and hauled out his waste, which he dumped nearby and covered with soil. He was cold and although he picked up food boxes regularly, he was struggling to get enough fruits and vegetables in his diet. Legally blind and computer illiterate, he was at a loss to identify and access resources available to him. He had an old glucometer but did not know how to use it. The FCN prayed with RS, and with his permission, they formulated a plan of care together.

The FCN accompanied RS to his primary care provider (PCP). The FCN explained his living situation and advocated for diabetes education, wound care, and other necessary ancillary services to address his many health issues. She assisted RS with completing an application for subsidized housing and worked with his PCP to document his fragile medical condition, which moved him to the top of the housing list. The FCN accompanied him to most of his “first” appointments for the various ancillary services and taught him how to use the calendar on his smartphone to keep track of his appointments.

Within one year of that first encounter, RS is in his own subsidized studio apartment, augments his food box with fruits and vegetables he gets with his food stamps and from the faith community, and climbs the three flights of stairs to his apartment with ease. He sees his PCP regularly and the FCN stays in touch and attends appointments with him when there is a need. He now serves others in the faith community and is a regular volunteer at the local food bank.

- 2. BC is an elderly Veteran who was in fragile health and too ill to leave his home when a health minister in a local faith community offered to pick up groceries for him. He lost his driver’s license when he fell ill a year or so prior. In passing, he mentioned to the health minister that his sister living in another state had sold his home of 69 years and he had 30 days to vacate the property. BC had lived in his home his entire life. His home leaked profusely; there was one small area in the home that stayed dry, and BC had his recliner in that spot. His home had visible mold and moss growing inside and large cracks in the walls and around the doors let in muted light and cold air from the outdoors. He was on continuous oxygen and heated his home with a wood stove that was in serious disrepair. Recognizing the gravity of the situation, with his permission and in collaboration with the FCN, the health minister reached out to Veterans’ Services and advocated to get BC into subsidized housing. He moved into his apartment with his two large companion dogs within 6 weeks of learning of his eviction. The FCN met him for an assessment and with his permission, the health minister and FCN collaborated in partnership with his VA social worker to establish and implement a plan of care.*

Eighteen months later, BC is established in his apartment in a friendly independent senior housing community. He has many friends and enjoys the social events planned by the residents. He uses the local bus system independently and is studying to re-take the test to regain his driver’s license. He enjoys Bible studies with a few of the men in the faith community, although he is still not well enough to attend services on a regular basis. He is established with a Primary Care Physician who, in partnership with the FCN, helps him manage his chronic conditions. In his clean environment away from mold, he needs his oxygen only at night. He states that the eviction and assistance of the faith community’s health ministry team likely saved his life.

Logic Model

The FCHN struggled to track their metrics during the grant period. Although they were able to capture some trackable metrics, they did not have a good system for capturing qualitative data. They shared these challenges in their final report to the DST at the end of the grant period. The DST partnered with Oregon State University to provide research consultation support and FCHN leaders were introduced to the “logic model” as a tool to help capture and organize both quantitative and qualitative data while simultaneously creating a framework for publishing results (Kellogg, 2004; Taylor-Powell & Henert, 2008). The completed logic model created for the grant period can be found in Figure 1a and 1b below.

Figure 1a

PROJECT DEVELOPMENT AND PUBLISHING GUIDE – LOGIC MODEL FOR Rebuilding the Bridge Between Healthcare and Faith Communities – Part 1		
	INPUTS	PROCESS
<p>SITUATION Increased need for nursing assessment and decision-making in the community</p> <p>PRIORITIES Recruit, train and equip nurses; serve clients</p> <p>Grant period: 9/2021 – 9/2022</p>	<p>What we invested before and during the project</p> <p>Faith, passion, dedication</p> <p>Annual Foundations of Faith Community Nursing Course (FFCN)</p> <p>Literature review</p> <p>Internal practice survey of local faith community nurses (FCNs)/health ministers</p> <p>Time to write grant application, fiduciary accountability</p> <p>Time spent learning non-profit management</p> <p>Monthly professional education, mentoring, and networking via Faith Community Health Network (FCHN)</p> <p>Partnerships: community based organizations, educational entities, healthcare organizations, local faith communities, other state/national entities</p>	<p>Activities – What we did during the project</p> <p>Outputs – Results of our activities and who we reached with our project</p> <p>Quickly formed a non-profit and all work that goes with that</p> <p>Served those in need</p> <p>Quoted and distributed technology</p> <p>Purchased and trained on Microsoft software and electronic documentation system (EDS) software (Pittsburgh-Mercy)</p> <p>Tracked metrics</p> <p>Held monthly networking and educational meetings and quarterly board meetings</p> <p>Continued to provide 5+ hours of community health content via lecture at local ADN nursing program</p> <p>Precepted two BSN students</p> <p>Many referrals from community based organizations</p> <p>9 local nurses/health ministers FFCN trained during project</p> <p>Board leadership elected; reated bylaws, policies, defined organizational structure, processes</p> <p>Separated Network from Board functions</p> <p>11 laptops, 1 chromebook in hands of local FCNs and health ministers</p> <p>12 FCNs/health ministers Windows, Office, EDS trained</p> <p>70+ people served – some 20 or more times</p> <p>Approximately 100 ADN nurse graduates more aware of community health (and faith community specifically) as a specialty practice</p>
	<p>PRELIMINARY ASSUMPTIONS</p> <ul style="list-style-type: none"> If they have ways to document, all FCNs will start their autonomous practice Outreach efforts will reach nurses (instead of clients) We need to measure all of what we set out to do Faith community member healthcare coverage demographics mirrors local community (insured/Medicaid, etc.) FCN trainings will result in desired learning/skill development and will result in use of new skills/knowledge Increasing general community awareness of faith community nursing will recruit more FCNs Pastoral leadership with good understanding will adopt FCN practice 	

Figure 1b

PROJECT DEVELOPMENT AND PUBLISHING GUIDE – LOGIC MODEL FOR Rebuilding the Bridge Between Healthcare and Faith Communities – Part 2		
OUTCOMES		
Short Term (1-4 mo) - early impacts and learning – shifts in attitude & perspective, skills gained, motivations	Medium Term (4-8 mo) – observable behavior, practice and/or policy change	Long Term (9-12 mo) – social, economic, civic conditions or population health impact over time
<p>SITUATION Increased need for nursing assessment and decision-making in the community</p> <p>PRIORITIES Recruit, train and equip nurses; serve clients</p> <p>Grant period: 9/2021 – 9/2022</p>	<p>Researched technical specifications and solicited technology quotes; selected vendor</p> <p>Learned to develop non-profit organizational structure and lead non-profit</p> <p>Reevaluated initial board assignments and matched skill sets and giftings with Board leadership positions and held elections</p> <p>Realized Board functions and network functions are separate</p> <p>Some starting to serve. FCNs began talking to faith leaders resulting in varying levels of leadership support</p>	<p>FCNs and health ministers acquire technology, including EDS</p> <p>Software training completed (Windows 11, Office, and EDS)</p> <p>Monthly network meetings and check-ins with coaching result in increased collaboration</p> <p>Quarterly board meetings improve structure and reporting processes</p> <p>Outreach efforts to local civic organizations and networking result in increased collaboration and FCN referrals but no increase in FCNs.</p> <p>Service delivery expands across team in and out of faith communities - well ahead of scheduled launch</p> <p>Measurement challenges discovered and conveyed in mid-term report/presentation to funder; chose two to measure out of our list of many</p> <p>Partnerships emerge, resulting in recognition by Oregon Health Authority and Oregon State Board of Nursing (OSBN), local Coordinated Care Organization</p>
<p>EXTERNAL FACTORS</p> <ul style="list-style-type: none"> Time requirement to set up and create infrastructure for non-profit Lack of RN technology competency/digital hesitancy ADN faith community nurses - lack of community assessment skills and confidence for autonomous practice Lack of awareness – faith community leadership, members, and nurses Behaviors related to emergence from COVID Lack of awareness of local nurses and faith leaders Recognition of FCN value among state and local leaders Pittsburgh Mercy Electronic Documentation System shortcomings 		

Incorrect Assumptions and Lessons Learned

Assumption	Reality	Lessons Learned
FCNs will adopt the documentation system and become competent.	The overall level of computer literacy was lower than anticipated and extensive training was required in basic computer use before documentation software could be introduced.	Evaluate basic computer skills.
The Pittsburgh Mercy Electronic Documentation System will serve the FCN documentation needs.	It was not adopted. It was cumbersome to update and maintain and required expensive software.	Research “best practice” methods of documentation in Faith Community Nursing.
FCNs make practice a priority and designate time commitment.	Instead, post pandemic, FCNs reunited with family and friends and this (unpaid) opportunity was set aside.	Unavoidable. Be clear in expectations.
Faith Leaders are familiar with Faith Community Nursing.	Most faith leaders in East Linn County were unfamiliar with the practice and could not grasp why they would need it. Many were concerned that their faith community would be at increased liability risk.	Survey surrounding faith community leaders and have an informational session.

Basic nursing education equips an RN to be an FCN.	Few nurses with associate degrees are equipped and confident for autonomous community practice without physician oversight.	Partnered with local community college to infuse community health into local associate degree nursing curriculum.
FCNs will remain actively licensed after leaving paid work.	Two FCNs opted to let their RN license lapse because they needed a break and didn't see another option.	Educate RNs about options to retain active licensure after leaving paid work.
Becoming a grant recipient is unlikely.	Grant was awarded. Team was unprepared without necessary non-profit structure for fiduciary accountability. Creating that structure on a short timeline added stressful workload at the same time the team was implementing the grant deliverables and learning grant management.	It is ideal to have the non-profit structure in place before adding the grant management workload.
Media exposure of good work will draw the attention of future FCNs and result in more FCNs eager to serve.	The FCHN's success stories without an intentional recruiting message led the public to believe the team was fully staffed and operational when the intent was to recruit more FCNs. The team was ethically challenged when many of the service requests and agency referrals that came in as a result of this media exposure had to be passed along to other community-based organizations because the many needs were for the community-at-large and were beyond the capacity of the small FCHN team.	<p>Focused recruiting outreach is needed for FCNs, perhaps at the regional denomination level. Be strategic in messaging to fit the specific purpose and audience.</p> <p>Establish realistic service "boundaries" and include in messaging.</p> <p>Note: The FCHN applied for and received a subsequent grant intended to support professional outreach, education, and team recruitment and to support a website for the FCHN.</p>
It is important to measure many aspects of the work to show value.	<p>The FCHN set too many outcomes to measure and unrealistic grant metrics, for example, citing a metric for reduced hospitalization when the FCHN would not have sufficient time to measure this, they did not have access to data related to hospitalizations, and lacked the expertise to tease out the impact if that data were available.</p> <p>The data collection tool used was lacking insurance status and other key information that was needed for measurement.</p>	Use the logic model from the beginning to critically assess what can realistically be measured during the grant period. Choose only two or three important outcomes directly related to the goal of the project to track and be sure the desired information is in the data collection tool.

Conclusion

Receiving this grant created efforts in three areas: 1) Sustaining the existing FCHN Network, 2) Grant management, and 3) Non-profit infrastructure development, leadership, and management. The FCHN was unprepared for grant management and non-profit work, but moved

forward in faith and took steps to equip their leadership team. Also, forming the non-profit was critical to sustainability. The non-profit status created instant credibility and eligibility for resources that were unavailable to the FCHN as a coalition and provided a platform to engage with other entities on an equal basis.

The FCHN success has been in their team leadership model. They have an executive director who is responsible for keeping things on track, but the team divides the work based on skill set and interest which keeps the team engaged, assures everything gets done, and is essential to sustainability. The network recently applied for their third grant.

Community networking and partnerships are key. Getting involved in community health improvement efforts can reveal much need or bring much needed awareness. For example, a volunteer grant-writer with strategic planning experience was drawn to this work and has recently joined the team as an advisor.

Maintaining the current FCHN meeting structure and providing stimulating educational topics throughout the pandemic and beyond was essential to sustaining the engagement of those FCNs and health ministers involved with the FCHN. It also elevated recruitment of FCNs and health ministers. Most FCHN educational meetings are offered at no charge via Zoom and are open to everyone; networking meetings are open except during confidential staffing meetings.

This SHARE grant moved faith community nursing forward in Linn County – and beyond - in many ways while exposing unexpected gaps and challenges. The FCHN is grateful to the Community Advisory Council, the IHN-CCO Board of Directors, the Delivery Systems Transformation staff and committee, and others who made it possible to lay the foundation for a regional community health service that will be a resource likely to grow over time and serve the vulnerable in this rural region for years to come. The FCHN Board is committed to continue to build on this foundation to bridge the gap between faith and health, expanding access in Linn, Benton, and Lincoln Counties in the future.

References

- Fell-Carlson, D. & Shanks, M. (2022). "Faith community nursing – is it right for you?" *The Sentinel*, 41(3), 22-24.
https://www.oregon.gov/osbn/Documents/Sentinel_2022_August.pdf
- Intercommunity Health Network Coordinated Care Organization. (2022). *Delivery System Transformation Committee (DST) 2022 Strategic Plan*. In 2022 Minutes & Presentations, March 31, 2022. <https://ihntogether.org/how-we-serve/delivery-system-transformation-committee/meeting-resources/>
- Kellogg, W. (2004, January). Using Logic Models to Bring Together Planning, Evaluation, and Action: Logic Model Development Guide.
https://www.naccho.org/uploads/downloadable-resources/Programs/Public-Health-Infrastructure/KelloggLogicModelGuide_161122_162808.pdf
- Lebanon Community School District (2023). *Nutrition*.
<https://www.lebanon.k12.or.us/departments/nutrition>.
- Marimuthu, R., Gupta, S., Stapleton, L., Duncan, D., & Pasik-Duncan, B. (2022). Challenging the digital divide: Factors affecting the availability, adoption, and acceptance of future technology in elderly user communities. *Computer*, 55(7), 56-66.
<https://doi.org/10.1109/MC.2022.3172026>
- Mulder, P. L., Kenkel, M. B., Shellenberger, S., Constantine, M. G., Streiegel, R., Sears, S. F., Jumper-Thurman, P., Kalodner, M., Danda, C.E., & Hager, A. (2000). The behavioral health care needs of rural women. Washington, DC: American Psychological Association, Committee on Rural Health. <https://www.apa.org/pubs/reports/rural-women.pdf>
- Oregon Health Authority. (2023, December 26). Supporting Health for All through Reinvestment: the SHARE Initiative.
<https://www.oregon.gov/oha/hpa/dsi-tc/pages/share.aspx>
- Samaritan Health Services. (2023). Community Health Needs Assessments 2023-2026 – Samaritan Lebanon Community Hospital.
<https://www.samhealth.org/about-samaritan/community-benefit-initiatives/community-benefit-and-grants/community-benefit-health-assessments>
- Taylor-Powell, E. & Henert, E. (2008). Developing a logic model: Teaching and training guide. University of Wisconsin-Extension Cooperative Extension.
<https://fyi.extension.wisc.edu/programdevelopment/files/2016/03/lmguidcomplete.pdf>
- U.S. Census Bureau. (2022, July 1.). *Quick Facts*. Linn County, Oregon.
<https://www.census.gov/quickfacts/fact/table/linncountyoregon/PST045222>

- U.S. Department of Housing and Urban Development. (2022). The 2022 annual homelessness assessment report (AHAR) to congress.
<https://www.huduser.gov/portal/sites/default/files/pdf/2022-ahar-part-1.pdf>
- U.S.D.A. Food and Nutrition Service. (2023, December 21). Community eligibility provision,
<https://www.fns.usda.gov/cn/community-eligibility-provision>
- U.S. News. (2023, December 21). *Education*.
<https://www.usnews.com/education/best-high-schools/oregon/districts/lebanon-community-school-district-9/lebanon-high-school-16534>.
- Yin, R. K. (1999). Enhancing the quality of case studies in health services research. *Health services research*, 34(5 Pt 2), 1209.
- Yin, R. K. (2009). How to do better case studies, In Bickman, L. & Rog, D.J. (Eds.), *The SAGE handbook of applied social research methods*, (2nd. ed., pp. 254-282). Sage Publications.
- Zarkhin, F. (2020, March 13). Oregon veterans' home awaits coronavirus test results but getting help as 'epicenter' of state outbreak. *The Oregonian*.
<https://www.oregonlive.com/coronavirus/2020/03/oregon-veterans-home-getting-help-as-epicenter-of-state-coronavirus-outbreak.html>
- Ziebarth, D. (2014). Evolutionary conceptual analysis: Faith community nursing. *Journal of Religion and Health*, 53(6), 1817-1835.