Integrating healthcare into housing: a preliminary look at the impact of embedded nursing on well-being and care coordination

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OHSU Office of Rural Health Forum on Rural Population Health

Thursday, May 15, 2026, 10:10a-11:10a

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Objectives:

- **At the close of this session, attendees should be able to:**
  - Identify innovative roles for faith community nursing in a nurse led health resource center operating from a senior/disabled apartment complex
  - Summarize the preliminary results of a pilot project placing a faith community nurse (FCN) in a non-traditional rural community setting
  - Discuss real-life stories of individuals impacted by engaging in a nurse-led health resource center services

Background

- Faith Community Health Network (FCHN) formalized non-profit status in 2021 to increase nursing presence in the community, specifically in faith communities
- 2024 idea to put a faith community nurse in a subsidized housing was inspired by serving a Veteran in HUD-VASH apartment in Lebanon, OR
- FCHN applied for a 2-year pilot grant through Intercommunity Health Network Coordinated Care Organization to create a nurse-led health resource center in one subsized disabled/senior housing location
- Launched early January, 2025
- Currently all FCHN–affiliated nurses are actively licensed volunteers: UNPAID professionals

Pilot Title:
Improving Senior/Disabled Access to Care

Pilot summary:

"Nurse-led health resource center (HRC) to serve as a community-based healthcare access point to for faith community nurses or other RNs to equip and empower chronic disease self-management and provide spiritual and social support to residents, many of whom are elderly, medically frail, and/or disabled."

Grant period: 1/2025 – 12/2026

GardenView Apartments

GardenView is designed with natural gathering spaces inside and out.

GardenView Apartments

The building has an elevator and a large community room with a functional kitchen.

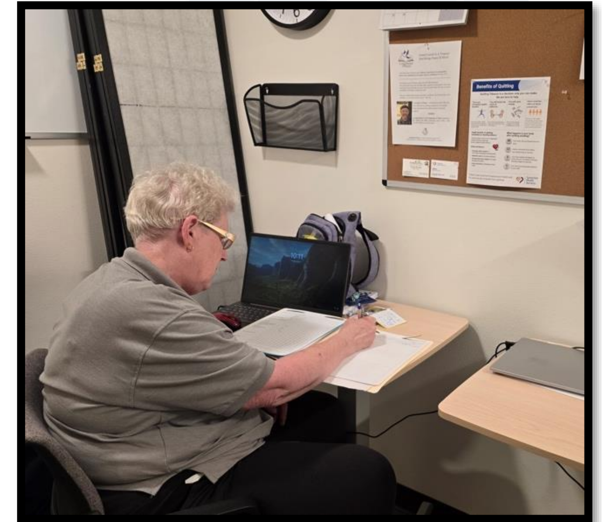
Need had already been identified!

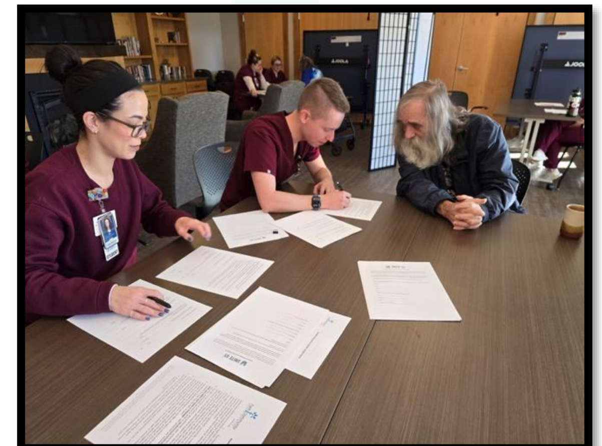
- GardenView had a small room available, equipped with a sink and small waiting area. The room was originally designed for the local health system to staff with a medical provider or nurse, but the pandemic staffing crisis thwarted those plans indefinitely.
- Pilot funds allowed FCHN to convert the room into a Health Resource Center to help fulfill the need.

Health Resource Center Scope & Partners

The HRC is not a clinic or primary care substitute and HRC personnel are not "on-call."

- Partnerships for success:
  - Unpaid FCNs volunteer time and expertise serving autonomously under their RN license for two hours twice a month
  - FCHN used pilot funds to purchase screening equipment, locking filing cabinet, laptop, printer
  - GardenView/Linn-Benton Housing Authority provided private space
  - Linn-Benton Community College Nursing Program coordinated 2nd year nursing students to do intakes as part of community clinical experience





Examples of RN activities

- Baseline and mid-term survey
- Assess & refer for SDoH & health needs
- Arrange for/provide spiritual resources/supports as needed
- Provide healthcare navigation/ referral for health insurance enrollment/assistance
- Advocate with clinic care coordinator/ primary care provider
- Refer to health system's Financial Assistance Program
- Coordinate on-site health services (foot care, dental, behavioral health, basic care van)
- Respond to questions related to chronic or acute medical conditions; provide education and refer as needed

Examples of service collaborations

- Residents living in subsidized apartments (48)
- Faith community nurses
- Nursing students/instructors
- Medical students/instructors – "Dinner Tonight"
- Foot care (vouchers)
- Dental care providers
- Local congregation members
- Older Adult Behavioral Health Initiative staff
- Senior Health Insurance Benefit Assistance Program
- Health System Basic Care Mobile Van staff
- Spiritual care providers
- Local health system
- Local fire district

GardenView Management Feedback

Gmail   Faith Community Health Network <faithcommunityhealthnetwork@gmail.com>

RE: Mid-term comments - would you please provide input no later than July 8?
1 message

GV Manager <GVManager@l-bha.org>   Mon, Jul 7, 2025 at 11:48 AM
To: Faith Community Health Network <faithcommunityhealthnetwork@gmail.com>
Cc: Jonathan Baker <Jonathan@l-bha.org>, Donna Holt <donna@l-bha.org>

Hello,

I wanted to share that the on-site supportive health team has been making meaningful progress with tenants here at Garden View.

Several tenants have shared how the Health Network helped them access financial assistance through their pharmacy, allowing them to take their prescribed medications consistently. These programs have long existed, but many of our senior residents have not known how to navigate them—this support has been a critical bridge.

While attendance at the offered group sessions has been limited, those who do participate have expressed appreciation and found them helpful.

That said, there has been a recent setback with the foot clinic—some residents were unexpectedly billed or experienced care that was not beneficial. This has understandably caused concern.

As with any new program, building trust takes time—especially in communities like ours. I believe that, with patience and continued positive engagement, the program will continue to grow and provide real value to our tenants.

To support these efforts, I was thinking it might be helpful if your team created an introductory flyer or welcome letter about your services. I could include it in the leasing packet for new tenants as part of their move-in orientation.

Keep up the good work and thank you for your continued support of our community.

Best regards,

Sheila Brooks
Garden View Apartments / Resident Manager
3011 S Main Rd
Lebanon, OR 97355
P: 458-233-4124
F: 541-570-1187

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Keep up the good work and thank you for your continued support of our community.

Mid-term survey comments – what services were most commonly accessed?

- Checking my blood pressure
- Arranging foot care
- Getting answers to questions about my health condition
- Helping me know what to ask at an upcoming medical appointment
- Connecting me with resources for transportation and food

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2025 encounters – touched several goals

Category	# of encounters
Consent to participate, UniteUs, and intake assessment	10
Refer for Medicare or Medicaid enrollment assistance	1
Connect to housing assistance and follow-up	3
Connect to Meals on Wheels	1
Footcare Vouchers	8
Referral to PCP or Urgent Care	4
Accompanied to medical appointment (in FCN's congregation)	4
Total encounters	**31**

"...the number of encounters has not been as critical to success as the nature of those encounters... preventing unnecessary burden on the healthcare system as well as preserving quality of life for the resident..."

Advocacy & Referral

"I am so grateful you told me to call my doctor when I came in and told you I felt funny on my new medicine. I didn't want to bother them, but I told the office that you told me to call. It turns out that my new medication was two times the dose the doctor wanted me to take! He changed the prescription and I feel great now."

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Connection to Community Resources

"Thank you … for telling me about our local health system's financial assistance program's medication benefit! I was taking my heart medicines only every other day because I haven't been able to afford them."

Spiritual Care

"I was so very much in need of encouragement. Thank you for taking time to listen and to pray with me. You are such a blessing!"

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Public Domain Photo by Nashua Volquez-Young: https://www.pexels.com/photo/woman-wearing-red-hat-and-sunglasses-1729931/

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Advocacy, Health Education & Referral

“Thank you for encouraging me to ask my doctor for a referral to Pulmonary Rehab. I can now walk all the way to the end of the sidewalk without stopping and I am much less wobbly on my feet! I haven’t fallen since!”

Chronic Disease Self-Management

"I had been going to the emergency department almost every month. You explained the importance of hydration… and helped me find a way to make sure I get enough fluid each day. I haven't been to the Emergency Department in over EIGHT MONTHS!"

AI-generated image

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Spiritual Care, Advocacy & Referral

"I was homeless before I moved in to GardenView. My toenails were so long that they curled under and were cutting the bottoms of my feet. I am so thankful for my professional footcare voucher!"

Connections to Transportation Support

"I didn't know how I was going to manage getting to my appointments in Corvallis. Thank you for telling me about RideLine and Crossroads Communities!"

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Advocacy and Connection to Transportation Support

"I would not be able to afford the monthly treatment plan with my doctor in Seattle, but you connected me with Angel Flight West and they are going to fly me to my appointments at no charge! It is a miracle, and I would never have known about that if you weren't here. You are a blessing to us!"

AI-generated image

AI-generated image

Health Education, Referral, & Chronic Disease Self-Management

“I had no idea my blood pressure was high! I am so thankful you were there to check it for me and tell me what the numbers meant. I am seeing my doctor this afternoon.“

EMS impact – reduction was a project goal

Facility Name	# of Apts	EMS Calls 2022	EMS Calls 2023	EMS Calls 2024	EMS Calls 2025
Garden View Apartments	48	23	38	45	49
			65%* ↑	18%* ↑	8.9%* ↑
	* Percentage Change: (New Value – Old Value) / Old Value x 100			Informal RN presence in building	FCHN Health Resource Center Launched in January 2025

The number of calls has continued to go up annually, but at a much slower pace in these past 18 months…

Pilot learning for sustainability: Identifying community-based HRC requirements:

- Space requirements (handwashing facilities, wifi, private, secure)
- Types of medical and office equipment needed
- Documentation forms for various types of encounters; locking file
- Strategies for communicating with participants
- Professional boundary setting (e.g., set hours, dedicated phone and email, etc.)
- Affiliation agreements with nurses, nursing school, housing entity

Pilot learning for sustainability: Scalable; easy replication

- This model is easily replicated with a small investment:
  - Apartment buildings
  - Houses of worship
  - Senior centers
  - Where community members gather
- Mobile RN or fixed HRC

Photo by RDNE Stock project: https://www.pexels.com/photo/woman-in-blue-polo-shirt-sitting-on-brown-woven-armchair-6148913/

FCNs in any setting don't just deliver services. They improve access and directly impact healthcare cost drivers.

Pilot learning for sustainability: Potential for rewarding & autonomous work in the community – paid or unpaid

- Faith Community Nurses
- Nurse Entrepreneurs
- One RN position could support TEN HRCs!

Recent passage of House Bill 2789 will allow RNs to bill Medicaid for nursing services on a limited basis.

Rulemaking is underway:

OAR 410-130-0800 - Care management services

“Establishes registered nurses as an enrolled provider type for care management services.”

Pilot learning for sustainability - Partners in care

- Providers are appreciative of the “boots-on-the-ground” triage assistance in the community as partners in care.
- FCNs can triage and screen in the community to:
  - Explain dangerous symptoms
  - Encourage & facilitate referrals
  - Prevent unnecessary clinic, urgent care and emergency department visits through education and consultation

“Thank you for saving his life.”

Learning for sustainability: Opportunities for learning

- Pilot replication could provide many opportunities for practical community health learning
  - 2nd year RN students
  - Medical students
  - Physical therapy students
  - Allied health students

Tremendous community health awareness and learning potential for all student health career disciplines

Learning for sustainability: Logic model guides our work

- IHN-CCO connected us with Oregon State University researchers to help us guide data collection and synthesis
- Captures preliminary assumptions and allows us to test those, along with the more formal goals
- Guides progress over the short, medium, and longer time frames of the work – even beyond the grant period
- Provides a framework for reporting
- Captures salient points needed for professional journal publication and/or professional presentation
- Creates a historical snapshot of the project
- Captures external factors and unexpected consequences
- ***See separate handout***

LOGIC MODEL FOR Improving Senior and Disabled Access to Care - GardenView Apartments – Part 1

SITUATION
Residents of Garden View Apartments experience barriers to accessing routine healthcare & services to address SDoH needs

INPUTS	PROCESS	
What we invest	Activities – What we do	Participation – Who we engage
Faith, passion, dedication, volunteerism, professionalism, ethics Annual Foundations of Faith Community Nursing Course (FFCN) Nationwide forum for sharing best practices and resources LBCC, FCN & Linn-Benton Housing Authority Affiliation Agreements DST Pilot grant funds HRSN Capacity Building grant funds Time: FCHN leadership & affiliates Volunteer affiliate nursing students recruited by FCHN as part of their community clinical experience Partnership investment: community based organizations, educational entities, healthcare organizations, local faith communities, other state/national entities	RN volunteers at GV Health Resource Center (2x/month) to: • Assess & refer for SDoH & health needs; arrange for educational & spiritual resources as needed • Provide healthcare navigation/ referral for health insurance enrollment/assistance • Coordinate on-site health services (foot care, dental, behavioral health, basic care van) • Refer residents for SHS Financial Assistance Program • Respond to questions related to chronic or acute medical conditions; provide education and refer as needed	Low-income senior/disabled GV residents GardenView and LBHA leadership Faith Community Nurses Nursing students Medical students – "Dinner Tonight" Local congregation members Local service providers (examples) • Older Adult Behavioral Health Initiative Age Café • Senior Health Insurance Benefit Assistance • Samaritan Health Basic Care Van • Toes by Pros (Vouchers) • Spiritual care (Bible studies, prayer, presence, encouragement)

Grant period: 1/2025 – 12/2026

PRELIMINARY ASSUMPTIONS

- We will be able to effectively communicate hours/events with residents
- Residents know their insurance status and benefits offered by their plan
- If we have an event, they will come
- Residents have many questions about health and medication that can be answered by an RN
- Residents have many unmet health-related social needs
- Residents are not socially connected
- Residents are not comfortable contacting providers with issues
- Residents know if they are enrolled in SHS financial assistance and are aware of Rx benefit

LOGIC MODEL FOR Improving Senior and Disabled Access to Care - Part 2 – EARLY OUTCOMES

SITUATION
Residents of Garden View Apartments experience barriers to accessing routine healthcare & services to address SDoH needs

SHORT TERM (1-8 MO)	MEDIUM TERM OUTCOMES (8-16 MO)
Early impacts and learning – shifts in attitude & perspective, skills gained, motivations	Observable behavior, practice and/or policy change

Communication privacy concerns
• Event sign-up lists converted to confidential drop box with registration forms
Increase trust between GV residents & FCN affiliates and FCHN staff & other volunteers
• Unexpected payment required by services we hosted – we increased communication clarity and sought alternative providers
Increase access to health care and resources for GV residents
• Nursing students (2nd year) well-equipped to identify problems and effectively navigate intake process
• RNs were able to resolve significant healthcare literacy issues that would affect outcomes
Increase residents' knowledge of SHS Financial Assistance
• Advised residents of health system Co-Pay/Rx benefits
Gathered data early and frequently to help us identify missing documentation
	Goals set at grant outset:
	• Increase resident follow-up on HRSN referrals
	  • Identified limited need in this population
	  • Referral process established to partner CBO if need arises
	• Increase resident use of PCP for routine healthcare
	  • Unable to effectively measure; self-reports suggest movement toward this goal
	  • Triage/assist/encourage residents to utilize appropriate healthcare resources
	  • Unwilling to "bother" provider; lack of digital literacy contributes to care-seeking hesitancy
	• Increase number of insured GV residents
	  • Residents do not understand their coverage/benefits contributing to hesitancy in seeking care
	  • Unable to navigate electronic portals for many reasons
	• Reduce non-emergent EMS calls
	  • Consistent RN presence 2 hours, twice per month reveal preventive intervention successful for those served - health information, gift of presence/spiritual care, advocacy
	  • Consistent (monthly) Samaritan Basic Care Van on-site
	  • Collaborate with Fire District to standardize tracking by year by address (in progress)

Grant period: 1/2025 – 12/2026

EXTERNAL FACTORS/DISCOVERIES

- Many do not have insurance identification cards or know insurance status/plans
- Resident with conspiratorial mindset negatively influenced early participation
- Service/payment issues by community partner reflected poorly on FCHN
- EMS calls currently by address, but were not currently separated by year – changed tracking method to assist in our measurement process
- Lack of central communication mechanism hampered information sharing early on
- GV building layout promotes community and social connectivity
- Perceived "busyness" of PCP translates to unapproachability by residents
- Residents show up for a quick question but decline intake assessment
- HRSN benefit on hold to GV residents who are otherwise HRSN eligible due to risk of losing housing subsidy

LOGIC MODEL FOR Improving Senior and Disabled Access to Care - Part 3 – LONG TERM OUTCOMES

SITUATION
Residents of Garden View Apartments experience barriers to accessing routine healthcare & services to address SDoH needs

LONG TERM OUTCOMES (17-24 MO

Social, economic, civic conditions or population health impact over time

Goals set at grant outset:

- Decrease number of resident self-identified SDoH health needs – in progress
  - Most needs are already met through wrap-around supports through LBHA/GV management and Community Services Consortium
  - Referrals to health system financial assistance and SHIBA - ongoing as identified
- Decrease residents' use of the ED – in progress
  - Consulting with healthcare business expert to help assess how each prevented EMS transfer translates into dollars saved
  - Model for assessing cost avoidance and return on investment
- Next steps considered
  - Proposal to healthcare system to invest in staffing RN-led health resource centers in low-income and senior housing across the county
  - Formalize HRSN referral tracking to partner CBOs
  - Consider building layout when identifying health resource center services going forward
    - Report discovery of social and connectivity benefit of GV layout to LBHA
    - Recommend Health Resource Room availability in new construction
  - Collaborate with other FCN organizations for tools to capture quick encounters and other reporting and documentation tools
  - Continue to seek affordable and appropriate electronic health record

Grant period: 1/2025 – 12/2026

UNINTENDED CONSEQUENCES/EXTERNAL FACTORS/DISCOVERIES

- Minimal hours of RN time are needed to provide resident health resource support (2 hours, 2x month). Model is scalable; one full time RN or two part time RNs could potentially serve ten low-income apartments each month. Potential "pressure-relief valve" for entire regional health system
- Identified as "model" community clinical site for 2026 Linn-Benton Community College Nursing Program Accreditation Visit
- Extensive research failed to identify a sustainable electronic health record
- RN reimbursement rules may make replication more feasible

- Anecdotal case stories support potential for cost avoidance
  - EMS/first responders
  - Non-emergent ED visits
- FCHN legitimized locally and nationally (publications, leadership participation/recognition at national level)
- Drew attention to need for compensation mechanism for autonomous nursing practice in the community; rule-making in progress, community health RN definition submitted to NUCC)

Summary of lessons lessons learned thus far

- Consistency is critical – same nurse, same times, posted times
- Being nimble - meeting the unique needs of the community served
- Social connection may not be a need in all settings
- Innovation involves risk and thinking outside the box
- Incentives don't have to be fancy… unique to the population!
- We don't have to do it all – bring in the experts!
- One communication mistake can impact the entire project
- Collect plenty of data and look at it in different ways
- Nursing school involvement results in impressive tacit learning

Lessons learned thus far

- Coordinated Care Organization support and encouragement has been golden
- Project managers are key to collaborating with partners, identifying resources, getting the word out
- External resources like health system mobile units are not "free"… pursue clarity in collaboration and then communicate clearly to avoid negative impact to the entire project
- Simultaneous Health-Related Social Needs capacity-building grant added challenges and complexity that stretched us beyond capacity
- Sometimes old school is the feasible solution … paper charts
- Logic model is a indispensable tool for guiding and reporting

An untapped community resource

Scalability and replicability is the ultimate win!

- Registered Nurses are autonomous
  - Our brain is our main tool! Professional clinical judgement, assessment, and triage
  - Nursing process in the community is the same:
    - Assessment
    - Nursing Diagnosis
    - Planning
    - Implementation
    - Evaluation
- Nimble! Reimbursement options may increase feasibility

Bottom line

ONE *faith community nurse or community health nurse or two part-time RNs could support* ***TEN*** *HRCs each month!*

This model has ***PRESSURE RELIEF VALVE*** *potential for an entire health system*

- FCHN has delivered the Foundations of Faith Community Nursing Course annually since 2019; enrollment has increased each year
- Oregon:
  - 35 FCNs across nine counties
  - 17 HM across six counties
- US (excluding Oregon):
  - 21 FCNs in seven states outside Oregon
  - 3 Health Ministers in three states

As of April, 2026...

Faith Community Nurses & Health Ministers trained by the Faith Community Health Network

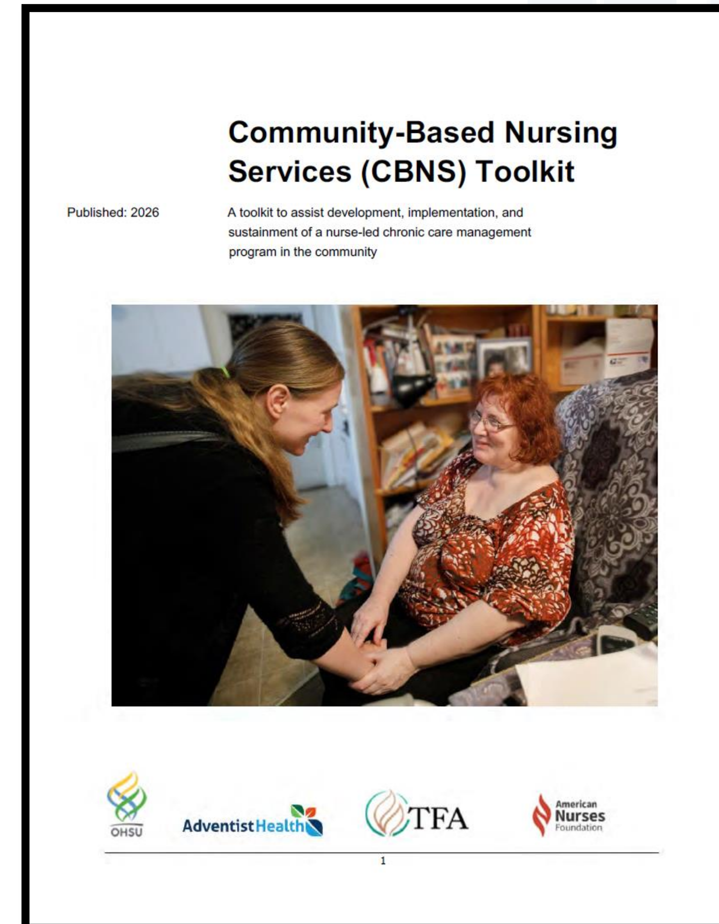
\# Faith Community Nurses

\# Health Ministers

American Nurses Foundation Study has been published and we are reviewing…

- Toolkit created based on the materials developed and lessons learned from the project.
- They are hoping the toolkit will assist organizations to accelerate their process to develop financially sustainable RN-led programs.
- Article published to outline key points of the toolkit

  Izumi et al. BMC Health Services Research (2025) 25:1542 https://doi.org/10.1186/s12913-025-13788-1



Toolkit publicly available at: https://www.ohsu.edu/sites/default/files/2026-01/cbns-toolkit_accessible.pdf

Thank you to the Intercommunity Health Network Coordinated Care Organization’s Delivery Systems Transformation Team for the opportunity to pilot this concept!

Please check us out

- Visit our website
- Follow us on social media
- Spread the word – we host an annual Foundations of Faith Community Nursing Course to train more nurses about spiritual care and serving in their faith communities and beyond