Ending homelessness
Rebuilding lives

FY24 Neighbors First Individuals (NFI) Logic Model

Agency Strategic Goals:

- Goal #1: Strengthen and expand our services and housing programs to help end homelessness in the D.C. metro region (Goal #1 on SP)
- Goal #3: Steward and strengthen our relationships with our government partners to ensure effective service delivery, improve the services experience, and support our system's collective efforts to end homelessness.

Division/Program Goals:

- Goal 1: Provide high quality case management services to PSH participants by meeting at least 85% or higher of DHS and Medicaid billing standards on a monthly basis.
- Goal 2: Strengthen partnerships with DC government partners by attending leasing, 1:1, and provider meetings, and collaborating on contract-related challenges.
- Goal 3: Use a team approach to ensure that participant needs are met, including offering 24/7 access to an emergency on-call case manager and the Division Director.
- Goal 4: Support all NFI households in establishing and maintaining sources of income.

INPUTS/RESOURCES	ACTIVITIES	OUTPUTS	SHORT TERM OUTCOMES	INTERMEDIETE OUTCOMES	LONG TERM OUTCOMES
People • 16 FTE Case Managers • 4 FTE Managers • Up to 304 individuals referred by DHS Financial • Private Donors • Government Funding • In-Kind donations • Professional Development Funds Partnerships • DC government partners • Community Partners, such as CSA/ACT teams • Bridge housing partners Infrastructure • Computers/tablets • Cell phones • Adobe Pro licenses • Microsoft Office software • SharePoint site • Agency vehicles for staff to transport participants, if needed • Office space • HTH, Credible, HMIS • Brex • On-site notary Training • External: TCP and other required trainings • Internal: created and implemented as needed	Provide comprehensive case management services, which include but are not limited to: • Participating in warm handoffs for transferring participants • Conducting Face-to-Face engagements (e.g., home visits, visits in the community, office visits) • Conducting Non-Face-to-Face engagements (e.g., telephone calls, texts, emails, letters, video conferencing, etc.) • Making collateral contacts • Conducting visits in the community (e.g., shelters, jails, hospitals, etc.) when possible • Conducting wellness checks • Assisting with share packaging/delivery • Attending voucher briefings • Assisting with Access help line and other translation services • Advocating/supporting participants with landlords, government agencies, etc. • Monitoring mental health and substance use symptoms, conducting appropriate referrals as needed • Assisting with Medicaid and DCHA recertification • Mediating client crises, engaging emergency providers as necessary • Developing case plans, progress plans, biopsychosocial assessments, service plans • Documenting participant status and progress through DAP case notes • Addressing general participant concerns Educate participants on available resources for the following (and more) and provide referrals when possible: • Employment • IDs and vital documents • Home health aids • Food banks • Culturally-specific resources • Legal services • Financial management and budgeting • Mental health/ substance use treatment • Dental hygiene Educate clients on processes for self-sufficiency and self-efficacy as well as maintaining healthy relationships Documentation (e.g., DAP notes, UIR reports, home visit community forms, internal risk assessment forms, mortality reports, check requests, zero-income reports, etc.) Make referrals to DC agencies and other community partners Maintain communication and collaboration with DHS, DBH, DCHA as well as attend all leasing, 1:1, and monthly provider meetings Maintain emergency on-call procedure	300+ participants successfully navigate and/or maintain housing stability 300+ participants actively engage in working towards their outlined service plan goals Participant engagement rate of 90% At least 4 successful contacts, per PSH-III contract requirements, per month for at least 85% of households in the Housing Navigation phase At least 2 successful contacts, per PSH-III contract requirements, per month for at least 85% of households in the Housing Stabilization phase	At least 70% of participants demonstrate access to healthcare through the Medicaid recertification process At least 70% of participants demonstrate sufficient satisfaction with services At least 70% of participants report increased health stability, including physical and mental health At least 70% of participants have enough food resources At least 55% of participants with substance use disorders are engaged in recovery services At least 70% of participants living with mental illness have access to behavioral health providers At least 75% of participants demonstrate consistent communication and contact with service providers At least 70% of participants demonstrate consistent access to providers due to stable housing and access to phone/internet & transportation resources At least 98% of participants in the Housing Stabilization phase demonstrate housing retention and engagement with services across 12 months of service	At least 50% of participants demonstrate increased employability skills At least 80% of participants report increased health stability, including physical and mental health At least 90% of participants in the Housing Stabilization phase achieve and maintain stable, sustainable housing 75% of participants use preventive/PCP services to manage healthcare needs Maintain long term housing with at least a 85% retention rate	Decreased homelessness for high-risk individuals in DC who are assigned to Friendship Place as their housing provider Participants achieve and maintain stable housing Participants achieve their service plan goals Shorter shelter stays Continued partnership with DC government partners