Ending homelessness
Rebuilding lives

FY 25 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 monthly
- 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 housing, community supports, and sources of income

INPUTS/RESOURCES	ACTIVITIES	OUTPUTS	SHORT TERM OUTCOMES	INTERMEDIETE OUTCOMES	LONG TERM OUTCOMES
Staff • 17 FTE Case Managers • 2 FTE Case Manager Sups • 1 Division Director • Up to 326 participants referred by DHS Financial • Government Funding • In-Kind donations and Private Donors • Professional Development Funds • Brex cards Partnerships • DC government partners • Community Partners, such as CSA/ACT teams • Bridge housing partners Infrastructure • Computers/tablets • Cell phones • Adobe Pro licenses • Microsoft Office • SharePoint site • Agency vehicles for staff to transport participants, if needed • Office space and supplies • HTH, Credible, HMIS • On-site notary Training • External: DHS, 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, hospitals, rehabs/nursing homes etc.) • Conducting wellness checks • Assisting with share packaging/delivery • Assisting with completion of LRSP and RFTA housing applications • Completing local recertification for participant not receiving Medicaid • Attending voucher briefings, unit viewings, and signing of leases • 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 (BPS), service plans (ISP) • Documenting participant status and progress through DAP case notes • Addressing general participant concerns • Making referrals for Bridge Housing, shelter placements, DC agencies, and other community partners • Maintaining emergency on-call procedure Educate participants on the following resources (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 and assist clients with processes for self-sufficiency and 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.) Maintain communication and collaboration with DHS, DBH, DCHA, 1:1 with monitoring team (DHS) and monthly provider meetings	Number of participants served (up to 326 participants at a time) Number of participants achieving or maintaining stable housing Number of participants maintaining stable health Number of participants in the Navigation phase meeting contractual engagement requirements Number of participants in the Stabilization phase meeting contractual engagement requirements Number of participants with substance use disorder referred to treatment/ACT; Number seeking treatment Number of participants with mental health disorders referred to treatment; Number engaged with CSA Number of participants receiving some form of income (e.g., employment, benefits, etc.) Number of participants progressing towards their ISP goals	At least 90% participants successfully navigate and/or maintain housing stability At least 90% participants actively engage in working towards their identified service plan goals Participant engagement rate of 90% or greater At least 80% of participants report increased health stability, including physical and mental health At least 80% of participants have enough food resources At least 80% of participants will be referred to substance use treatment when there is a known substance use need At least 75% of participants with substance use disorders are engaged in recovery services At least 80% 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 75% of participants demonstrate consistent access to providers due to stable housing and access to phone/internet & transportation resources At least 80% of participants will have at least one source of income	At least 85% of participants demonstrate access to healthcare through the Medicaid recertification process At least 80% of participants demonstrate sufficient satisfaction with services At least 65% 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 80% of participants use preventive/PCP services to manage healthcare needs 82% of monthly Medicaid and DHS billing requirements met	Decreased homelessness and increased quality of life for high-risk individuals in DC who are assigned to Friendship Place as their PSH services provider (identified by self-report) Participants achieve and maintain stable housing Participants achieve their service plan goals Shorter shelter stays Participants are connected to community resources to help them maintain stable health and seek support with substance use and/or mental health disorders Continued partnership with DC government partners