

## FY26 Neighbors First Individuals (NFI) Logic Model

<p><b>Agency Strategic Goals:</b></p> <ul style="list-style-type: none"> <li>• Goal #1: Strengthen and expand our services and housing programs to help end homelessness in the D.C. metro region (Goal #1 on SP)</li> <li>• 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</li> </ul>
<p><b>Division/Program Goals:</b></p> <ul style="list-style-type: none"> <li>• 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</li> <li>• Goal 2: Strengthen partnerships with DC government partners and collaborate on client and contract challenges by attending lease-ups, stabilization and navigation monitoring meetings, and DHS PSH Provider meetings</li> <li>• 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</li> <li>• Goal 4: Support all NFI households in establishing and maintaining housing, community supports, and sources of income</li> </ul>

INPUTS/RESOURCES	ACTIVITIES	OUTPUTS	SHORT TERM OUTCOMES	INTERMEDIATE OUTCOMES	LONG TERM OUTCOMES
<p><b>Staff</b></p> <ul style="list-style-type: none"> <li>• 16 FTE Case Managers</li> <li>• 2 FTE Case Manager Sups</li> <li>• 1 Division Director</li> <li>• Up to 326 participants referred by DHS</li> </ul> <p><b>Financial</b></p> <ul style="list-style-type: none"> <li>• Government Funding</li> <li>• In-Kind donations and Private Donors</li> <li>• Professional Development Funds</li> <li>• Brex cards</li> </ul> <p><b>Partnerships</b></p> <ul style="list-style-type: none"> <li>• DC government partners (e.g., DHS, DCHA, DBH, TCP, etc.)</li> <li>• Community Partners, such as CSA/ACT teams, landlords, share packages, etc.</li> <li>• Bridge housing partners</li> </ul> <p><b>Infrastructure</b></p> <ul style="list-style-type: none"> <li>• Office space and supplies</li> <li>• Computers/tablets</li> <li>• Cell phones</li> <li>• Adobe Pro licenses</li> <li>• Microsoft Office</li> <li>• SharePoint site</li> <li>• Agency vehicles for staff to transport participants, if needed</li> <li>• HTH, Credible, HMIS, CRISP</li> <li>• On-site notary</li> </ul> <p><b>Training</b></p> <ul style="list-style-type: none"> <li>• External: TCP, DHS, and other required and recommended trainings</li> <li>• Internal: created and implemented as needed</li> </ul>	<p>Provide comprehensive case management services, which include but are not limited to:</p> <ul style="list-style-type: none"> <li>• Participating in warm handoffs for transferring participants</li> <li>• Conducting Face-to-Face engagements (e.g., home visits, visits in the community, office visits)</li> <li>• Conducting Non-Face-to-Face engagements (e.g., telephone calls, texts, emails, letters, video conferencing, etc.)</li> <li>• Making collateral contacts</li> <li>• Conducting visits in the community (e.g., shelters, hospitals, rehabs/nursing homes etc.)</li> <li>• Conducting wellness checks</li> <li>• Assisting with share packaging/delivery</li> <li>• Assisting with completion of LRSP and RFTA housing applications</li> <li>• Assisting with unit inspections, as needed</li> <li>• Completing local recertification for participant not receiving Medicaid</li> <li>• Attending voucher briefings, unit viewings, and signing of leases</li> <li>• Assisting with Access help line and other translation services as needed</li> <li>• Advocating/supporting participants with landlords, government agencies, etc.</li> <li>• Monitoring mental health and substance use symptoms</li> <li>• Assisting with Medicaid and DCHA recertifications</li> <li>• Mediating client crises, engaging emergency providers as necessary</li> <li>• Developing individualized service plans (ISPs) and conducting biopsychosocial assessments (BPS)</li> <li>• Documenting participant status and progress through DAP case notes</li> <li>• Addressing general participant concerns</li> <li>• Making referrals for bridge housing, shelter placements, DC agencies, and other community partners</li> <li>• Providing and/or connecting to Utility, Emergency, and other Financial Assistance as needed and possible</li> <li>• Maintaining emergency on-call procedure</li> </ul> <p>Educate participants on the following resources (and more) and provide referrals when possible:</p> <ul style="list-style-type: none"> <li>• Mental health/substance use treatment</li> <li>• Primary care and other medical needs including dental</li> <li>• Employment</li> <li>• IDs and vital documents</li> <li>• Home health aids</li> <li>• Food banks</li> <li>• Culturally specific resources</li> <li>• Legal services</li> <li>• Financial management and budgeting</li> </ul> <p>Educate and assist clients with processes for self-sufficiency, unit cleanliness/safety, and maintaining healthy relationships</p> <p>Documentation (e.g., DAP notes, UIR reports, home visit community forms, internal risk assessment forms, mortality reports, check requests, zero-income reports, etc.)</p> <p>Maintain communication and collaboration with DHS, DBH, DCHA, 1:1 with monitoring team (DHS) and monthly provider meetings</p>	<p>Number of participants served (up to 326 participants at a time)</p> <p>Number of participants achieving or maintaining stable housing</p> <p>Number of participants maintaining stable health</p> <p>Number of participants in the Navigation phase meeting contractual engagement requirements</p> <p>Number of participants in the Stabilization phase meeting contractual engagement requirements</p> <p>Number of participants with substance use disorder referred to treatment/ACT; Number seeking treatment</p> <p>Number of participants with mental health disorders referred to treatment; Number engaged with CSA</p> <p>Number of participants receiving some form of income (e.g., employment, benefits, etc.)</p> <p>Number of participants whose ISPs and BPSs are completed in the contractually mandated timeframe</p>	<p>At least 90% participants successfully navigate and/or maintain housing stability</p> <p>At least 90% participants actively engage in working towards their identified service plan goals</p> <p>Participant engagement rate of 90% or greater (excluding incarcerated, hospitalized longer than 90 days, etc.)</p> <p>At least 80% of participants:</p> <ul style="list-style-type: none"> <li>• report increased health stability, including physical and mental health</li> <li>• have enough food resources</li> <li>• will be referred to substance use treatment when there is a known substance use need</li> <li>• will be referred to mental/behavioral health providers when there is known mental illness</li> <li>• have at least one source of income</li> </ul> <p>At least 75% of participants with substance use disorders are engaged in recovery services</p> <p>At least 75% of participants demonstrate consistent communication and contact with referral service providers due to stable housing and access to phone/internet &amp; transportation resources</p>	<p>At least 85% of eligible participants demonstrate access to healthcare (e.g., through Medicaid, DC Alliance, or other health plans)</p> <p>At least 80% of participants demonstrate sufficient satisfaction with services</p> <p>At least 65% of participants demonstrate increased employability skills</p> <p>At least 80% of participants report increased health stability, including physical and mental health</p> <p>At least 90% of participants in the Housing Stabilization phase achieve and maintain stable, sustainable housing</p> <p>80% of participants use preventive/PCP services to manage healthcare needs</p> <p>85% of monthly Medicaid and DHS billing requirements met</p> <p>80% of participants’ ISPs and BPSs are completed in the contractually mandated timeframe</p>	<p>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)</p> <p>Participants achieve and maintain stable housing</p> <p>Participants achieve their service plan goals</p> <p>Shorter shelter stays</p> <p>Participants are connected to community resources to help them maintain stable health and seek support with substance use and/or mental health disorders</p> <p>Continued partnership with DC government partners and other key community partners</p>