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Section I. Project Summary

Purpose of the Manual

The Generational Opportunities to Achieve Long-Term Success program (GOALS), takes a multi-generational approach to improve the overall wellbeing for families experiencing homelessness by developing skills through residential based, whole family services (parent, child and family). This manual was created with two purposes:

- 1) To provide comprehensive guidance on the GOALS program model, including implementation and intervention delivery; ;
- 2) To inform and guide other programs interested in adapting a residential-based program to disrupt multi-generational poverty cycles.

Program Overview

GOALS is a collaborative effort in Colorado led by Family Tree and Arapahoe County Human Services, in partnership with diverse government and community-based service providers. GOALS is supported in part by Arapahoe County Human Services. Family Tree operates the Oxford Vista residence and coordinates services for families. Family Tree provides GOALS intervention services and coordinates with on and off-site service providers. Services will be provided, primarily on-site, by local organizations including CWEE, AD/Works, Early Childhood Education programs, Arapahoe County Human Services, Mental and Physical Health Services. A formative evaluation (Phase I) and impact evaluation (Phase II) of the GOALS program is being conducted by Center for Policy Research (CPR).

GOALS was developed and is being tested as an effective approach to addressing multi-generational poverty among families experiencing homelessness. The intent of the program is to disrupt the cycle of poverty by directing services to parents, children and the whole family unit, while providing safe, temporary housing. Through a plan co-created by families and service providers, parents work to overcome barriers and develop skills to financially support the family, children get high-quality early childhood education/education and other services that set them up for success now and in the future, and the family gets support to improve its overall well-being and puts them on a path to economic stability. Throughout the process, the experience and perspective of families informs future program development.

Program Model/Components

GOALS is located on the Oxford Vista campus at 15001 E. Oxford Ave. in Aurora, Colorado. Approximately 15 families at a time will be housed for stays of approximately four to nine months. Families have access to diverse services, including:

- **Individualized case management**
- **Employment services**
- **Early childhood education and support for academic achievement**
- **Mental and physical health services**
- **Social network development**
- **Parenting and family function education**
- **Collaborating partners**



Section II. Development of the GOALS Intervention

Identifying the Problem, Populations and Interventions

An episode of homelessness can be caused by a myriad of personal or systemic circumstances; because of the compounding negative impacts of living in poverty, many impoverished families are at risk of housing instability and homelessness. A family without secure housing, reliable transportation, or food, while also being exposed to the stresses of poverty such as untreated health issues, has few resources to become financially self-sufficient. Homelessness and poverty have particularly dire impacts on children, causing potential delays in language, literacy, social and emotional development that lead to cascading life-long negative conditions. This complex, multi-generational problem demands an equally multifaceted solution that incorporates the voice of families to achieve results.

Target Population

GOALS serves families primarily from the City of Aurora and Arapahoe County, Colorado, who are eligible for or currently receiving public assistance and who are currently experiencing homelessness or at-risk of becoming homeless. Families are considered eligible if they can receive public benefits, make less than \$75,000 annual household income, and have at least one child under the age of 18 living with them or who have no children but are expecting. Families selected to participate in GOALS may also be selected by other criteria within the screening assessment (see the Screening section for more details).

Family Voice Framework

A key component to developing the intervention was the incorporation of family voice and choice. According to Ascend at the Aspen Institute, best practices for developing a framework for two-generational (Two-Gen) approaches to addressing poverty suggest that including Family Voice should be a key component in any service model and that interventions are most successful when they reflect the needs of the community it is intended to serve. The Center for Policy Research (CPR) developed the Family Voice framework to be incorporated into the GOALS program design through a review of relevant literature, guidance from Ascend at the Aspen Institute, and discussions with and review of documents from the Jefferson Prosperity Project (JPP) - a model 2Gen program located in Jefferson County, Colorado.

Additionally, in order to gain feedback from the families who would be served by the GOALS program, the CPR conducted three focus groups with fifteen parents who received benefits and/or services from Arapahoe County who had a history of housing instability. The focus groups asked parents to reflect upon intervention goals, necessary on-site services, and previous experiences with communal living situations. The focus groups also asked parents about their experiences with supportive professionals, including the qualities of good case managers and essential traits that encouraged them towards progress in a program. Feedback from these focus groups helped to inform the hiring of program staff, identify key community partnerships, and create rules, expectations, and policies around communal living.

A core component of the Family Voice model is that the right to self-determination for individuals and families should remain central to all service provision. Client-centered, individualized case-management serves as a primary tool for clients exercising their personal agency and providing ongoing feedback. As an economic stability program, GOALS should provide supportive services to clients in making their own plans, solving their own problems and creating their own paths. For more information on Family Voice, read [CPR's Research Brief here](#).



Program Model

The GOALS Program Model consists of an over-arching program goal of achieving two-generational economic security for families experiencing homelessness. The goal is achieved by focusing on three discreet objectives achieved by providing services for parents, children, and the family as a whole. The program model was developed to provide insight as to which program elements are essential components of each of the objectives, as well as which services work to achieve those goals and go into each component. The Goals Program Model is detailed through the Theory of Change shown in Figure 1 below.

Figure 1: GOALS Program Model

Program Goal	Achieve Two Generational Economic Security for Families Experiencing Homelessness		
Objective	Family is Healthy and Functional	Parent(s) Earn a Livable Wage	Support Children's Development of Potential
Preconditions	<ul style="list-style-type: none"> ✓ Family's basic needs are met ✓ Family is cohesive and mutually supportive 	<ul style="list-style-type: none"> ✓ Parent has the ability and skills to secure and maintain employment ✓ Parent overcomes barriers to securing and maintaining employment 	<ul style="list-style-type: none"> ✓ Children participate and succeed in P-12 and post-secondary education ✓ Children avoid engaging in risky behaviors
Services to Meet Objectives	<ul style="list-style-type: none"> ✓ Safe, stable congregate housing and meals ✓ Parenting education & support ✓ Recreation ✓ Economic stability planning case management ✓ Social capital development ✓ Enrollment in eligibility benefits ✓ Family counseling 	<ul style="list-style-type: none"> ✓ Employment services and training ✓ Post-secondary education ✓ Health and mental health treatment ✓ Financial literacy training ✓ Work supports ✓ Child care ✓ Support for overcoming barriers to employment 	<ul style="list-style-type: none"> ✓ Early childhood education ✓ Tutoring ✓ Developmental screening and intervention ✓ Social/emotional development ✓ Recreation ✓ Health & mental health treatment ✓ School-based services ✓ Enrichment programs

Logic Model

The GOALS logic model provides a more in-depth and detailed look at the activities provided by the GOALS program. It is organized by children, parents, and families and details the following:

- ✓ **Inputs:** Service organizations responsible for providing the intervention and resources
- ✓ **Activities:** What services are actually provided to families, parents, and children
- ✓ **Outputs:** What the families, parents, and children in GOALS are responsible for within the program – this describes the intervention services
- ✓ **Short-Term Outcomes:** Immediate outcomes and results of GOALS participation while residential services.
- ✓ **Medium-Term Outcomes:** Continued results of GOALS achieved from program exit up to 12 months post GOALS enrollment.
- ✓ **Long-Term Outcomes:** The ultimate program result and lasting impact. This outcome spans multiple generations to break the cycle of poverty and homelessness.



Generational Opportunities to Achieve Long-Term Success (GOALS)

GOALS Intervention Manual

GOALS: A Comprehensive Two-Gen Case Management & Residential Services Approach with Long-Term Follow-up

Logic Model

INPUTS	ACTIVITIES	OUTPUTS	SHORT-TERM OUTCOMES	MEDIUM-TERM OUTCOMES	LONG-TERM OUTCOMES
<ul style="list-style-type: none"> *Arapahoe County Human Services * Family Tree * Ability Connects Head Start /Child care provider * Aurora Mental Health; Health Care Providers 	Families <ul style="list-style-type: none"> ⇒ Congregate housing and meals ⇒ Family cohesion training ⇒ Social capital development ⇒ Safety planning for DV ⇒ Recreation ⇒ Access to health insurance/ benefits ⇒ Post-residential economic planning case management 	<ul style="list-style-type: none"> ◇ House 15 families 4-9 mo's ◇ Individualized parent, child, family goals related to economic stability ◇ Family safety plan ◇ Targeted assistance to prevent homelessness ◇ Plan for economic security and activities 	<ul style="list-style-type: none"> *Prevent family violence *Decrease individual and family stress and hardship & improve protective factors *Provide safe and secure residential and meal services 	<ul style="list-style-type: none"> *Improve well-being and social capital *No homeless episodes post-exit *Family economic stability *Facilitate transition to stable housing 	Increase family economic stability and break the cycle of poverty for families across generations
<ul style="list-style-type: none"> *Arapahoe Douglas Works and CWEE * Center for Policy Research * Parenting Class Facilitators * School-age service providers * Financial literacy Workshop Facilitator 	Parents <ul style="list-style-type: none"> ⇒ Employment program: adult education, job training and skill development ⇒ Post-secondary education ⇒ Health and mental health treatment ⇒ Financial literacy training ⇒ Work supports ⇒ On-site childcare ⇒ Overcoming barriers to employment 	<ul style="list-style-type: none"> ◇ Participation in parenting classes, early childhood education, services/ programs ◇ Childcare ◇ Receive mental and physical health services ◇ Improved financial skills and creation of a plan for financial future 	<ul style="list-style-type: none"> *Participation, parenting classes *Develop employment goals and reduce barriers to employment *Participation, employment services and/or training *Improvements in mental and physical health issues *Participation in services *Progress towards goals *Attends financial literacy classes and workshops 	<ul style="list-style-type: none"> *Decrease toxic stress *Progress towards goals *Secure employment that meets income needs *Increased enrollment in post-secondary education or vocational / trade schools *Better banked and have financial plans 	
<ul style="list-style-type: none"> * Aurora Public Schools * Cherry Creek Schools * Tri-County Health 	Children <ul style="list-style-type: none"> ⇒ Early childhood education ⇒ After-school & summer tutoring ⇒ Developmental screening and intervention ⇒ Social/emotional development ⇒ Recreation, school-based services, and enrichment programs 	<ul style="list-style-type: none"> ◇ Participation in recreation ◇ Participation in after-school and summer school tutoring 	<ul style="list-style-type: none"> *Participation in services *Progress towards goals *Improved academic performance & attendance, decrease in disciplinary action 	<ul style="list-style-type: none"> *Improved school readiness, *Enhanced protective factors *Improved social-emotional skills 	



Evaluation Plan

The Center for Policy Research (CPR) is conducting a two-phase evaluation of the GOALS program to assess the needs of parents and child(ren) in homeless or at-risk families, and report on the impacts of the intervention in a Two-Generation framework. Phase I is a formative evaluation and Phase II is an impact evaluation.

Phase I, Formative Evaluation: The formative evaluation will last approximately 18 months and take place from approximately January 2019 through June 2020. During the formative evaluation, CPR is assisting with the development of the intervention, documenting the implementation, piloting survey instruments, and creating an online management information system for case management and data collection purposes. CPR is also providing on-going technical assistance including participating on the project management team, conducting regular site visits and training to gather feedback from staff on the intervention and make changes to the model as needed. Lastly, CPR will report on the lessons learned through the formative evaluation, which will lead to refinements to the intervention and service delivery model.

Phase 2, Impact Evaluation: Beginning with the opening of additional residential units at the Oxford Vista Campus and completion of the formative evaluation, CPR will begin Phase II of the evaluation. In Phase II, CPR will conduct the impact evaluation using a random assignment evaluation design to test the impacts of the GOALS intervention against a comparison group. The impact evaluation will assess and compare outcomes of GOALS families compared to a control group of similarly-eligible families – outcomes will be assessed using tools developed during the formative evaluation, follow up telephone surveys and administrative data. The purpose of the evaluations will be assess if the GOALS model was implemented as intended, and if families served by the program saw improvement in the areas of economic stability, housing, employment, health and well-being, compared to the families in the control group receiving “business as usual” services.

Evaluation of the GOALS program includes:

- (1) Working with program staff and partners to refine program design and to implement and test a means for tracking participation and outcomes for GOALS families;
- (2) Documenting if the GOALS intervention is being implemented as intended, and providing staff with feedback for continuous quality improvement;
- (3) Collecting data to determine if the goals of housing, early childhood education, health and well-being, and economic assets are being met for families being served by the program;
- (4) Sharing collected information with program staff to correct problems and refine and revise the model to ensure intended outcomes are being achieved;
- (5) Producing a strong assessment of final outcomes related to housing, early childhood education, health and well-being, and economic assets for families enrolled in GOALS;
- (6) Producing a final report, appropriate presentations and a program manual for replication, including dissemination of the results of the evaluation to researchers, service providers, and program funders.



Section III. The GOALS Intervention

Roles and Responsibilities of Staff

There are two types of staff for the GOALS program: Navigators and overnight staff. Navigators are case managers who work closely with families to encourage their participation and are primarily responsible for encouraging families to develop and set goals and to work on a plan for goal completion. They are also responsible for administering surveys and tools and recording information in the GOALS online management information system. Overnight staff are primarily responsible for ensuring that the site is running smoothly, monitoring the comings and goings of residents, and diffusing situations. The majority of this section will describe the qualifications and training of Navigators.

Roles and Required Qualifications

When hiring for a Navigator position, the program director and site supervisor will decide how to post and recruit potential Navigators and oversee the hiring process – a sample Job Posting for the Navigator position can be found in Appendix A. Focus groups with the target population were used to determine the qualities that are critical for Navigators and site staff to have. Overall, families articulated that quality support staff were empathetic, non-judgmental, and resourceful; ultimately their stories indicated that relationship-building and trust were important to them, and that Navigators relate to them as more than a case-load or a file.

Ideal Qualities for Navigators

- ✓ Knowledge and interest in working with individuals experiencing housing instability
- ✓ Empathetic and non-judgmental
- ✓ Resourceful
- ✓ Good listeners
- ✓ Flexibility
- ✓ Case management experience

Other qualities that are considered important for Navigators to have are: flexibility, organization, collaborative, prior case management experience, and a positive outlook on helping people who are experiencing homelessness and an overall understanding of this population. Additional skills include knowledge of and experience with trauma-informed care and being connected to community resource providers. All staff must pass a criminal background check.

Training and Onboarding

Facility-specific training for all staff is provided by the site supervisor, who will go over site specific policies depending on the staff's role. All staff, including overnight staff and management must attend trainings on the topics of 2-Gen Approaches and motivational interviewing. Navigators also receive additional ongoing training and technical assistance in the form of: weekly staff meetings to provide peer support and discuss ongoing cases; evaluation support for proper documentation and navigation of the GOALS CONNECT system. Lastly, as part of a coordinated effort to address resident needs, all service partners for the GOALS program are trained in 2-Gen Approaches and participate in collaborative meetings

Training for the GOALS project and administering the intervention was provided by the Family Tree. Family Tree's training curriculum is designed to teach how to work with families experiencing the effects of poverty for working with unstably housed individuals, and focuses on empathy, strengths-based, and solutions-focused.



Continued Technical Assistance

The Center for Policy Research will continue providing continued technical assistance to Navigators to provide training on the GOALS Connect data entry system. Technical assistance is provided monthly on-site with Navigators to review data entry procedures and formalize how the intervention will be documented within the GOALS Connect system. Feedback from Navigators and staff will also inform any necessary adjustments to the model intervention.

Meeting	Topic	Frequency	Attendees
GOALS MIS training/TA	Continued technical assistance with entering and refining the GOALS Connect system	Monthly and as needed	Navigators and Evaluation Team
Project Management Meeting	Review and discuss ongoing project management issues and concerns, trainings, and activities	Monthly	Project director, project manager, site supervisor, evaluation team
GOALS Staff meeting	Discuss with all staff current issues, areas for support	Weekly	Site supervisor, Navigators, overnight staff

Identification and Enrollment of Target Population (Families)

This section outlines the process for identifying, screening, and referring and enrolling families in the GOALS program. As shown below, enrollment in GOALS begins with identification of potentially eligible families by referral partners; once the family has been referred to GOALS, the program director is responsible for outreach to families for an invitation to enroll.

- Referral partners identify eligible families: eligible families qualify for benefits in Arapahoe County, are homeless or unstably housed, pregnant or have at least one youth under 18;
- ↳ Referral sites introduce the GOALS program with a script and administer the screening tool, which determines eligibility;
- ↳ Referral site sends the screenings of eligible families to the GOALS program director
- ↳ Program director enters screenings into the GOALS CONNECT system and holds screening until space available for enrollment
- ↳ Program director reaches out to families and provides description of the GOALS program and offers tour of facility and enrollment (as space is available).
- ↳ Families that are eligible and interested in participating in GOALS complete informed consent, release of information and are enrolled.

Referral Screening

Families who are eligible for referrals to GOALS should be either homeless or unstably housed and either have at least one child under age 18 living in the household or be pregnant/expecting. Any service provider or individual who is trained in the use of the screening tool may administer and refer the family to the GOALS program manager (listed in the contacts section of this manual). Before making the referral, the referring organization or individual should tell the family that the GOALS program is designed to provide families with four to nine months of residential services, food case management, health and mental health treatment, and facilitation of connection to childcare.



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The referring service provider should complete the screening and referral form and refer eligible families to the GOALS program manager. The family should then be told to expect a call from a GOALS staff member to tell them more about the program and to assess their eligibility.

When a family is presented as potentially-eligible for the GOALS project, their screening and referral form will be entered into the GOALS CONNECT system by the program manager and the system will hold the screening form until space is available and the family is offered enrollment in the program. As space is available, the program manager will reach out to the families and ask if they are willing to participate in the GOALS programming, agree to abide by Policies and Procedures. If yes, they are offered a tour of the facility and a move in date.

Enrollment

Eligible families must complete the enrollment process which includes 1) attaining informed consent to participate 2) acquiring demographic information for all family members and 3) completing the Baseline assessment, which includes education and employment information. **Intake and Enrollment may take 1-2 hours to complete.**

Informed Consent

In order to participate in GOALS, families must be presented with information about the project and then have the opportunity to consent to receive services and be a part of the program's research study. Enrolled families are expected to have read the informed consent information sheet and sign that they acknowledge the risks and responsibilities of enrolling in GOALS. The study has no known risks to participating; residents must acknowledge that they agree to community living expectations and standards and that they will follow the facility's rules and guidelines.

Intake: Basic Information and Baseline

Once an eligible family has completed informed consent, they will need to fill out some basic information about each of the family members in the household, such as demographics. Basic information should be collected at enrollment.

The Baseline Survey is an important part of the intake process and serves as a measure of how the family is doing upon entry to GOALS. The Baseline Survey should be collected within the first week of the family enrolling in GOALS and should be collected with the entire family present, since the basic information asks about housing and employment history, education, and other characteristics. The Baseline Survey should be completed all at once and may take up to an hour to complete. More detailed information about the Baseline Survey can be found on page 12.

Intervention Framework: Family Voice

A core component in the design and implementation of the GOALS intervention is the incorporation of the Family Voice Framework. This framework asserts that the rights of the individuals and families being served is a key resource in determining how to treat and work with families in need. All services should be client-centered, meaning that individualized case-management serves as a primary tool for clients exercising their personal agency and providing ongoing feedback. This framework is central to the intervention and all components of the model should reflect this core tenant. Below are some examples of how the Family Voice Framework is used within the intervention:



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- GOALS should provide supportive services to clients for making their own plans, solving their own problems, and creating their own paths.
- While there are rules and standards of behavior that are necessary within a communal living environment like GOALS, residents should be involved in the creation of policy whenever possible and to avoid unnecessary restrictions.
- Family voice will be most effectively expressed within a context of supportive community among the residents and a shared sense of ownership of the program. GOALS should intentionally support the creation of community and ownership among residents for the day-to-day activities at GOALS, such as:
 - Orientation and mentorship of new residents
 - Group recreational activities
 - Weekly, resident-led meetings to address issues related to communal living
 - Celebrating milestones and successes (birthdays, job interviews, good grades, etc.)
 - Supporting one another through childcare or meal preparations.
 - Creating opportunities for residents to “give back” to the GOALS community through service activities such as establishing a community garden, facility improvements, planning recreational activities, etc.
- GOALS staff should request and incorporate formal feedback from residents on program practices and solicit suggestions for improvement.
- GOALS should create and support a resident Advisory Board that offers authentic and meaningful guidance on program administration.
- GOALS could encourage and support leadership development among residents to enhance confidence and ability to fully engage with family voice. For example, if the resident meetings are routinely led by residents, rotate this responsibility and establish, with the residents, basic protocol and facilitation expectations for leading the meeting.
- Take advantage of program graduates lived experience as program ambassadors with GOALS partners, funders, and the community at large.

GOALS Connect (GOALS Management Information System)

GOALS Connect is a secure, online database that collects information on families enrolled in the Generation Opportunities to Achieve Long-Term Success (GOALS) project. This system was designed by the Center for Policy Research (CPR) and developed by CiviCore specifically for the GOALS project to aid in the tracking of various program components. The GOALS Management Information System (GOALS Connect) was designed to support the Generational Opportunities to Achieve Long-Term Success program by providing secure, real-time documentation of the intervention. While Navigators provide case management and connections to services and referrals, they are able to document these activities within the GOALS Connect system.

By measuring the intervention in a secure database, the Center for Policy Research (CPR) can provide support and analytics for solidifying the intervention and be able to report on the intensity and effectiveness of these services. Within the system are various tools designed to measure family well-being, which will allow the program to report on the outcomes of the GOALS program. Using an online data management system is also important for monitoring the intervention and ensuring that families are receiving the services specified in the intervention while they are at GOALS.



Operationalized Intervention

The GOALS intervention is designed to break the cycle of two-generation poverty (2Gen) and informed using a family voice framework. GOALS is designed to provide concrete services and case management to families while respecting their rights to choice and autonomy. The intervention takes a 2Gen approach by serving the parents, children, and family as three interconnected parts and aims at improving outcomes for each in the four key areas of housing, education, employment, and health and well-being. Within this framework, the GOALS program provides several on and off-site services, referrals, workshops, and case management.

Providing Safe and Stable Congregate Housing and Food

Families housed at GOALS will be given their own room within the facility and will have groceries provided for them for the purposes of preparing their own food. Families living at GOALS must agree to congregate housing, to live on a drug-free campus, to follow the facility's rules and policies, participate in a chore schedule, and to participate in the weekly Community meeting and should be engaging with the Navigator on a regular basis.

Case Management Using Motivational Interviewing

Case management is an essential part of the GOALS approach. While at GOALS, families and individuals are expected to meet with Navigators on site to keep them updated on their progress, workshop attendance, and goals. When providing case management, Navigators should ensure that they are using strength-based approaches and motivational interviewing or asking reflective questions to build trust with the family and to develop a case management plan that works for the family. Remember, all services and case management provided by GOALS consider the family voice framework and take a trauma informed approach.

Case management notes can be tracked within the GOALS Connect system; these records are important for the evaluation to track how often Navigators are meeting with families to discuss their goals, go over tools, and talk about progress within the intervention. Anytime you need to document contact with either the family as a whole, or with an individual, you will need to make a case management record; these should be added each time a family or family member formally meets with a Navigator to discuss an issue or challenge.

Establishing and Tracking Goals

Navigators work with families and individuals to set personalized goals for their case management. Goals should be specific to the individual or family making the goals and should relate to the outcome areas of housing, employment, education, or health and wellbeing. Navigators should set goals with families within the first month of their residency at GOALS and check in on the progress of goals on an ongoing basis. Setting goals is an important tool that Navigators can use to help keep families on track.

Goals can be created for individuals or families. It is important to note that goals are an important part of how we track certain measure of progress through the intervention. For example if a school-aged child is not enrolled in school at the time of his enrollment into the GOALS program, Navigators must set a goal with that family about how they will make sure that the child enters and maintains attendance at school. This goal should be tracked within case management records and should be updated periodically to reflect the goal's progress.



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Intervention Service Delivery

Families living at GOALS will have a variety of on-site services provided to them, such as recreation, education, health screenings, childcare, and others. These services are provided for the family as a whole, as well as for parents and children individually. On- and off-site services are provided by community partners, such as local workforce programs including AD Works and CWEE, Aurora Mental Health, and other public and private agencies.

<i>GOALS Intervention Services and Workshops</i>			
Location	Families	Parents	Children
<i>On-Site</i>	<ul style="list-style-type: none"> ✓ Parenting education & support ✓ Homeless case management ✓ Social capital development ✓ Enrollment in eligibility benefits ✓ Family counseling ✓ Assistance connecting to childcare ✓ Health & mental health treatment ✓ Clothing, services, food, toiletries 	<ul style="list-style-type: none"> ✓ Financial literacy ✓ Employment services and training, coaching, resume writing ✓ Health and mental health treatment ✓ Financial literacy training ✓ Work supports 	<ul style="list-style-type: none"> ✓ Tutoring ✓ Books, supplies, meal programs for students ✓ Enrollment in early childhood education ✓ Developmental screening and intervention ✓ Recreation ✓ Enrichment programs
<i>Off-Site</i>	<ul style="list-style-type: none"> ✓ Transportation assistance ✓ Family counseling, health and mental health treatment 	<ul style="list-style-type: none"> ✓ Credit recovery ✓ Childcare ✓ Support for overcoming barriers to employment 	<ul style="list-style-type: none"> ✓ Literacy programs ✓ Transportation to school ✓ Tutoring, afterschool and summer programs

On-site Service Delivery: Workshops and Activities

Families at GOALS should participate in at least one on-site activity per week, as available. Services or activities work towards improving the focus areas of housing, employment, education, and health and well-being. Activities are usually provided one on one with families or individuals. These services are generally provided by service providers, who may come to the site to do wellness visits with families, provide direct support for job searches to parents, or oversee recreational activities for families and children. On-site service providers include the Center for Work Education and Employment (CWEE), Arapahoe/Douglas Works! (AD Works), Summit Education, and others.

Another on-site support utilized by the GOALS intervention are workshops. Workshops are a series of ongoing meetings or activities that may have a different focus each time. Workshops can be educational, such as for the purposes of teaching a cooking class or job search skills, or they can be peer-lead groups. The key distinction between workshops and services is that workshops are part of an ongoing series that the family members are expected to participate in with some regularity. For example, adult family members might participate in a job search skills workshop, which contains four classes participants complete in series. Another important workshop for families to regularly participate in is the weekly GOALS Family Voice meeting, in which families get together to discuss successes or challenges at the facility and work together with the Navigators to provide feedback about GOALS services, case management, and other in-house issues. Regular participation in these meetings and other workshops is a GOALS program requirement.

Off-Site Services and Referrals

In addition to the on-site services provided for GOALS families, participating families will also have access to off-site services and referrals. Off-site service providers work in partnership with GOALS to ensure a wide range of supportive services to families by providing access to supportive services like transportation,



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education, and activities. Some off-site service partners include Tri-County Health, Community College of Aurora, Cherry Creek Schools, Aurora Public Schools, public/private childcare providers, and others.

When a family or individual is in need of or could benefit from additional services outside of those provided by GOALS or a partnering organization. Navigators should be tapped into a wide referral network of partners working in the human services field. When families have a problem or goal, a primary responsibility of the Navigator is to help the family find solutions and refer them to the appropriate agency. Families referred to GOALS typically have prior referrals and service providers they are working with. If there is a gap in needs, Navigators connect families to those services they need. All GOALS service partners are also trained in 2Gen approaches and collaborate with each other and GOALS project management to ensure that they are making coordinated efforts to address the residents' needs.

Assessment Tools

Throughout the intervention Navigators and case managers will periodically administer tools and measures designed to assess the wellbeing and progress of an individual or family. The following table lists the various program measures, including a brief description and when they are to be completed.

Tool	Frequency & Completion Time	Description
Screening	1x before enrollment in the GOALS program	Assess eligibility for enrollment in the GOALS program
Baseline	1x at program intake or within the first week of GOALS residency	Surveys about housing history, education, employment, and measures of optimism, economic stability, and family cohesion.
2Gen Index	Required to be entered into GOALS Connect <u>2x:</u> 1) Within the first week of enrollment 2) When the family exits the facility	Measures family well-being, resources, barriers to employment, and assets
Strengths & Challenges	1x – Within the first week of enrollment	Asks adult household members to think critically about their strengths and challenges – aids in goal setting and areas for improvement
Exit Survey	1x – Upon program exit or transition to moving out	Brief survey about where the family is exiting to and how their circumstances changed as a result of GOALS
Follow-Up Survey	2x – at 12 and 24 months post program exit	Surveys about housing history, education, employment, and measures of optimism, economic stability, and family cohesion. Measures post-intervention progress.

Baseline Survey

The Baseline Survey contains questions about the whole household, including information about benefits, education, employment, and attitudes of optimism and family inclusion. This survey should be conducted immediately after the family decides to enroll in GOALS and completed family information. The Baseline Survey may take 20-40 minutes and will only need to be completed once.

Because this survey asks questions related to the income and educational attainment of all family members, all adults in the household should be present for the completion of the Baseline Survey (the Baseline Survey may also be completed by the Head of Household alone, provided they are able to answer questions about family income and past employment and housing and feel they can speak for their household on matters of economic stability, inclusion, and optimism).



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2Gen Index

The GOALS 2Gen Index is a short questionnaire that asks families (usually the Head of Household) about measures related to family well-being, child-rearing, and barriers to livable wages. The full form uses a modified stoplight measurement that asks families to rate the target area on a scale of 1-4 based on the severity of need (see below).

1	2	3	4
Area of Immediate Concern	Needs Attention	Stable, could Improve	Doing Well

Using the modified stoplight scale above, families are asked to rate their needs in response to the questions. **The final section of the 2Gen Index asks the Navigator to calculate the average across each of the categories.** 2Gen Indexes should be completed monthly to track family progress towards their goals and ultimately safe and stable housing and long-term economic stability.

Strengths and Challenges

The Strengths and Challenges tool is designed to help families focus on their areas of need, while also acknowledging the strengths that will help them achieve their goals. The Strengths and Challenges measure is a short questionnaire that asks adult family members about their perceived strengths and barriers. This measure should be completed with a Navigator once per month. Firstly, the family should be asked to identify **at least three strengths** and then proceed to challenges. Finally, the client should identify **three things** that s/he/they would like help working on. These may be the challenges listed above, be unrelated, or just more specific.

Exit Survey

When a family is ready to transition out of the GOALS facility, they will need to complete an exit survey. Exit surveys are to be completed with Navigators. The exit survey is brief and primarily asks about the services they received and their perceived helpfulness. Exit Surveys are to be administered by the program supervisor and should be conducted as soon as site staff is made aware of the family's intent to transition.

Follow-Up Survey

Families who have exited the GOALS program will continue to receive ongoing contact and support from Navigators periodically. As part of this follow-up care plan, follow-up surveys will be administered 12 and 24 months after program exit. These surveys will be conducted by phone and will duplicate many of the same questions from the Baseline around current housing, employment, and education status, in order to measure outcomes after program exit.

Program Completion

Transitioning out of the GOALS facility can happen in a variety of different ways and will be determined by the family and Navigator collaboratively. If a family knows where they will be transitioning to and has a plan in place for moving into stable housing, this should be addressed in the regular community meeting or in 1on1 support with a Navigator. Once site staff has been made aware that a family is working on transitioning out of GOALS, they should work with the family to close out or make sure there is action plan for any outstanding goals the family has set. An Exit Survey should be conducted with the family within the last few weeks of their residency, or soon after program exit, and the family should have a meeting with a Navigator and site supervisor to talk about a plan for ongoing support after program exit and what aftercare services or communication will look like. GOALS staff and community partners should be engaged in working with the family to support their move by ensuring transfer of services and/or assisting with transportation and moving expenses.

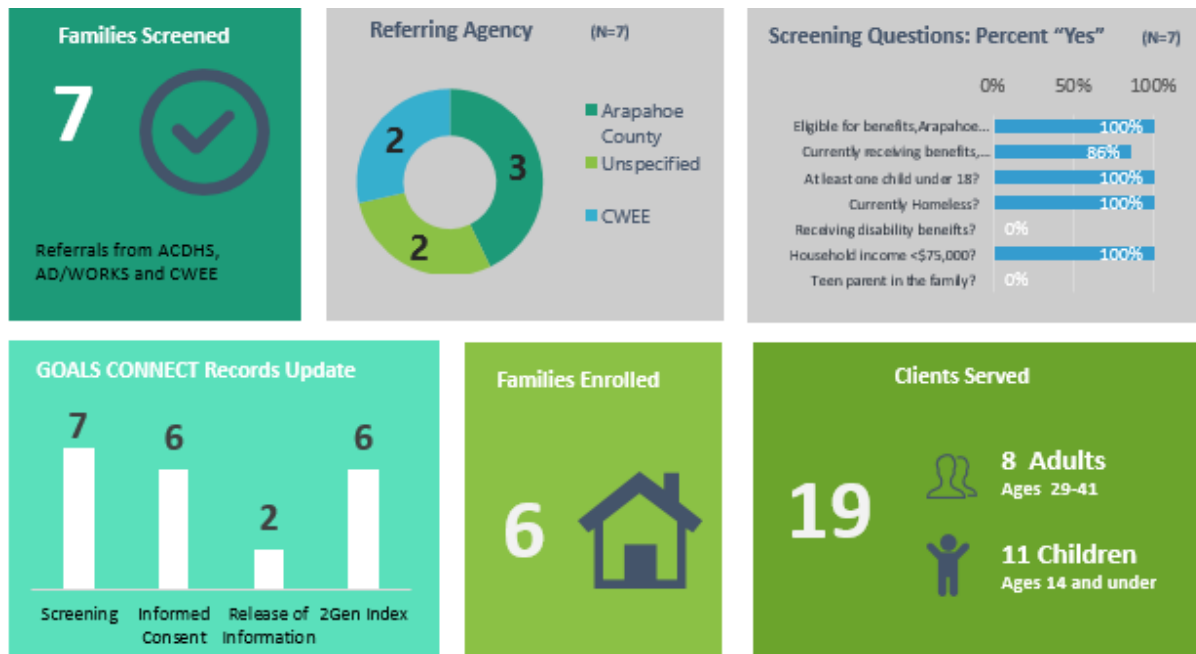


Follow-Up Phase

Families who received services at GOALS will continue to receive communication with Navigators post-program exit. Once a family is ready to exit, they should form a plan with their Navigator about how they will transition out of the program and their expectations for follow-up. During the follow-up phase, Navigators should, at a minimum, attempt to follow up with families once a month by phone to check in and address any additional needs or services the family may have. Many times when families have established a new place of residence or are just starting out after a period of transition, they will need some continued case management, referrals, or services to help them establish and solidify healthy patterns and connections to additional resources.

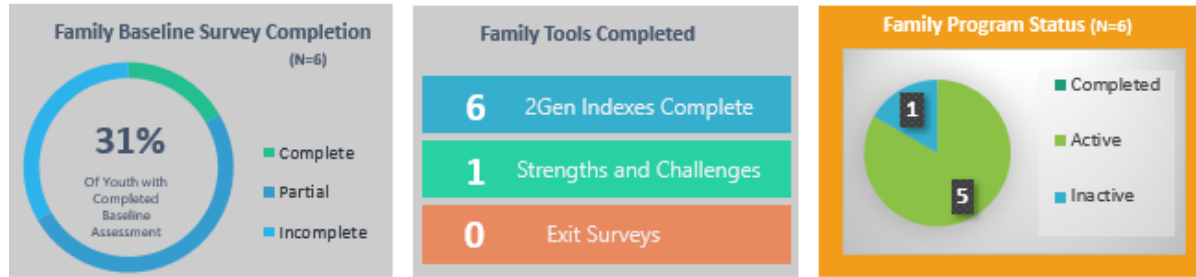
Ensuring Program Fidelity and Continuous Quality Improvement (CQI)

In order to ensure that the GOALS program is functioning as designed to achieve 2Gen outcomes outlined in the program model, key aspects of the intervention will be routinely monitored and reported on by CPR throughout the evaluation phase through a CQI process. The CQI process monitors through the GOALS-CONNECT system, key data performance measures. This information is analyzed and reported to the project management team each month. The evaluator will produce monthly reports on the status of enrollment and case management within the GOALS program. These reports will be given to all Navigators and project management as part of an ongoing discussion about data entry and accountability. All data collection and reporting issues will be brought up as part of the TA meetings with Navigators. Below is an example of a monthly CQI report based on the GOALS-CONNECT dashboard.





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Meetings and Technical Assistance

As part of a plan to make sure that the intervention is being implemented as intended, the site supervisor and program director will be engaged in ongoing monthly meetings with the evaluator (CPR) to discuss what is going on at the site, plans for onboarding new staff, and what training or technical assistance is being provided to ensure quality data entry. Additionally, the site supervisor and program director will meet with staff and Navigators weekly to discuss any site-specific issues and to have ongoing communication between project management issues and direct support to program staff. Lastly, all Navigators and direct program staff will have ongoing technical assistance meetings with the evaluator to discuss data collection and site-specific issues in order to gather feedback for project management on the development of the data collection system or the program development in general. The table for ongoing TA and meetings is located in the Continued Technical Assistance part of Section II on page 7.

Program Requirements (Fidelity)

While the GOALS program has several policies and procedures specific to administering the intervention, only certain measures are considered requirements for the evaluation. The following checklist demonstrates what needs to be recorded in order to show that the model is being implemented:

- Screenings:** All screened or potentially-eligible families have an eligibility screening form uploaded
- Intake:** All enrolled families complete the intake process, which includes:
 - Informed Consent and Release of Information
 - Basic Information for all family members housed at GOALS
 - Baseline Survey for all families housed at GOALS
- Case Management:** Families meet with Navigators to establish and work towards goals
 - 1x case management record per week
 - Families set 2 goals with Navigators 2-4 weeks after enrollment
- Services and Workshops**
 - Weekly community meetings
 - Parents and children participate in 2x on or off-site workshops or activities per week
 - Receiving on-site services regularly (mental health, childcare, employment, benefits)
- Outcomes and Measures**
 - 2Gen Index (2x: Once upon enrollment, once at program exit)
 - Exit Survey (at program exit)
 - 12 and 24-month Follow-Up Surveys



Appendix



Appendix A: Navigator Job Description



Position: Family Navigator, GOALS Program

Supervisor: GOALS Program Supervisor

Position Status: Part Time (32 hours)- may include weekends, hourly, non-exempt

Position Summary: Provide Case Management for families in the Goals Program

Navigator Qualifications: Bachelor's degree in a human services related field plus three years of experience working with homeless families or a comparable mix of education/experience working with oppressed populations required. Must be committed to utilizing a 2 Generational or multigenerational approach that focuses on parenting support, education, employment and child development. Building relationships with at-risk families. Knowledge of community resources. Establish and maintain working relationships with various community providers. Must have a valid Colorado driver's license, car insurance, and acceptable motor vehicle record. Must clear background checks with Colorado Bureau of Investigation (CBI). Proficient oral and written skills.

Family Navigator Responsibilities:

1. Support Family Tree mission and model Family Tree values of commitment, integrity, accountability, inclusiveness, collaboration and advocacy.
2. Responsible for supporting families in achieving their stated goals to successfully achieve success in safe, stable housing, employment and family stability.
3. Provide and document case management according to specific program(s) guidelines.
4. Develop, monitor and revise housing stabilization plan with program participants.
5. Engage both children and their caregivers in meaningful activities.
6. Understand and adhere to Case Management best practices
7. Participate in monthly Supervision.
8. Work collaboratively with fellow team members and community partners.
9. Promptly enter documentation and information into Client files and HMIS, as required
10. Attend weekly staff meetings, supervision meetings, on-site and off-site trainings, and other meetings as requested.
11. Adhere to all Family Tree, Inc. established policies and procedures, including those regarding timely reporting of suspected child abuse or neglect and confidentiality of client information.
12. Ensure a safe work environment and follow all safety procedures.
13. Other duties as assigned.

Physical Requirements: This position also requires the ability to meet the physical demands associated with essential functions: talking, hearing (ordinary conversation), and seeing (read paperwork, computer work), manual dexterity sufficient to operate a computer, calculator and telephone. Lastly, must be able to physically exert force of 10-15 lbs.

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