HOUSING is HEALTHCARE

COMING HOME OF MIDDLESEX COUNTY

2019 ANNUAL REPORT

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ALL ABOUT Coming Home

OUR MISSION

Coming Home's mission is to create a true system to end homelessness in the County by collecting and analyzing data; identifying needs and gaps in resources; developing needed programs; fostering collaborative strategies and public-private partnerships among all stakeholders to rehouse individuals and families as quickly as possible, and to facilitate connections to community resources to provide them the choices and opportunities to pursue healthy lifestyles.

OUR VISION

We envision an environment where:

- The stigma of homelessness in Middlesex County is dispelled, encouraging anyone at risk of homelessness to know of, and to access, resources to prevent their homelessness;
- Anyone who becomes homeless knows how to efficiently access resources to regain self-sufficiency and permanent housing, and;
- Where resources are adequate to meet the need.

OUR VALUES

- A person's right to self-determination
- Personal dignity
- Diversity
- An integrated society

2019 Highlights

- In the first year of our partnership with our local cute-care hospitals to address the social determinants of health of the highest utilizers of the hospitals' emergency rooms, we were able to enroll 40 of the hardest to reach and serve into the Social & Health Services Integration (SHI program) and to permanently house 10 Participants, with 3 more in the housing search process.

- Working collectively with our system of homeless service providers, we reduced the number of Chronically Homeless (i.e., long-term with a disability) persons by 66 persons or 25%.

- Our community-based case managers served 197 "households" in 2019 and were able to secure permanent housing for 46% of these clients.

- We engaged 15 new landlords who agree to rent to our system's clients, bringing the total number of landlords in our network to 68.

- We held three successful fundraising events: a golf outing; a day at the races; and a full-fledged masquerade ball.

- We participated in the Rutgers' Bridging the Gap program, hosting two very impressive graduate students, one from the Medical School and the other from the School of Public Health.

A WORD FROM

The Chairman & Executive Director

As a provider of social services, Coming Home of Middlesex County recognized from the outset that a person's health is affected by much more than the medical care they receive in a clinician's office or a health care facility. We hold our medical professionals in the highest esteem and respect and rely on their care and expertise. However, a person cannot adhere to a specified healthy diet without access to food and a kitchen in which to prepare whole foods; cannot get their children all the relevant vaccinations without transportation to the health center; cannot follow the treatment regimen and medication requirements of the mental health program without the social supports of friends and family; and certainly cannot avoid stress and generally take care of themselves when their night's sleep is on a bench at the train station.

In the last couple of years, health care providers have likewise turned their attention to the Social Determinants of Health (SDoH) such as food, housing, transportation and the support of a social network and we welcome their attention and enthusiasm. In 2016, we convened a cross-sector collaborative of social and healthcare providers, the work of which resulted in the launch this year of our SHI program, whereby the area acute-care hospitals finance the work of two Coming Home case managers to address the social needs of the highest utilizers of their emergency departments (EDs). The initial incentive for participation of the hospitals was a reduction in the unnecessary and often unreimbursed costs of inappropriate use of the EDs. While important and still a goal, after a year of hard work together, we and the hospitals are much more impressed by the compelling stories and hard-earned success of the program participants that we have helped and housed.

All of Coming Home's work - data analysis, coordinated assessment, community-based case management and certainly the creation of affordable homes - is geared towards achieving sustainable, permanent housing for its clients. To do so, we address the SDoH of socioeconomic status, education, employment, physical environment and social support networks each and every day that serve as barriers to housing for our clients. With the help of all of our cross-sector stakeholders, and hopeful changes in public policies and programs concerning the reimbursement of social service work, we hope to continue positively affecting the well-being of Middlesex County residents.

Brad Caruso
Coming Home Chairperson

Eileen O'Donnell
Executive Director

A LOOK AT *Our Programs*

SOCIAL AND HEALTH SERVICE INTEGRATION (SHI)

We completed our first year of this program whereby our case managers reach out to the highest utilizers of the emergency departments of our area acute-care hospitals to address such social determinants of health as housing and food insecurity, and breakdown of social networks. With vouchers provided by the State Department of Community Affairs, we are able to provide permanent housing to persons who have long lived without.

HOMES FOR HOMELESS (H4H)

Recognizing the paucity of affordable housing in Middlesex County, we developed and run a program to catalyze the creation of housing specifically for persons without, working in conjunction with the County, affordable housing developers, municipalities and social service providers.

LANDLORD ENGAGEMENT

Homeless persons need homes and building more, while essential, can take so long. We developed an initiative to encourage our area landlords to rent to the clients of our collective by sharing information and meeting the landlords' needs as business persons.

COORDINATED ASSESSMENT AND USE OF DATA

If you've met one homeless person, you've met one homeless person. Anyone can become homeless through no fault of their own and for a myriad of reasons; therefore, no one solution fits all. Ending homelessness requires a systematic approach informed by objective data. Through our coordinated assessment system, we uniformly assess persons who are homeless and prioritize them for resources based on severity of needs. We collect data to understand all of a person's barriers to stable housing and to regularly measure the success of initiatives designed to address those barriers.

HOMELESS HOTLINE CASE MANAGEMENT

Coming Home assists persons who are homeless and not eligible for other homeless assistance programs, safely stay in the community and address particular barriers to stable housing by providing connections to community services, budgeting instruction and locating permanent housing.

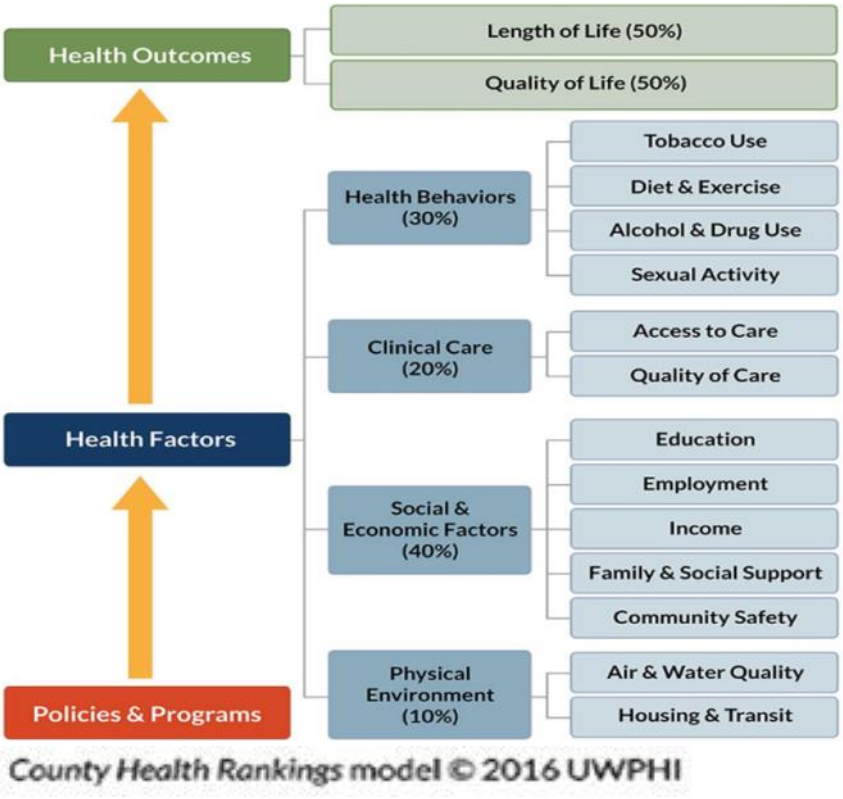
"Unicorn Housing." We got Creative - Housed 26 chronically homeless in 8 weeks (28% reduction in CH)!

Coming Home

Social & Health Service Integration (SHI)

It is widely acknowledged that medical care is estimated to account for only 10-20 % of the modifiable contributors to a person's healthy outcomes. The other 80 to 90 % are broadly called the Social Determinants of Health (SDoH): health-related behaviors, socioeconomic factors, and environmental factors. The states of homelessness and health are engaged in a constant volley of cause and effect spiraling ever downward.

INTERACTION BETWEEN HEALTH OUTCOMES, THE SDoH, AND POLICIES AND PROGRAMS



In this paradigm, housing is listed as contributing to 10% of a person's health outcomes; however, homelessness does not exist in a vacuum. It is often caused by loss of employment, reduction in income, break-down of family & social supports, untreated mental and physical illnesses and struggles with substance abuse. Therefore, the SDoH with which we deal contribute to more like 70-80% of a person's health status. Coming Home case managers are trained and skilled in addressing all of these causes of homeless-ness and barriers to permanent housing with which their clients present. It is for this reason that area health care facilities recognized us as their natural partner to address the life needs of patients and fami-lies outside the confines of their facilities.

This year was our first full year partnering with Barnabas Health's Robert Wood Johnson University Hospital and Saint Peter's University Hospital to address the SDoH of housing, food insecurity and social supports for the highest utilizers of the emergency departments (ED) of the acute-care hospitals. The partnership is called the SHI program for social and healthcare services integration. Each hospital funded one case manager at Coming Home and provided us a list of their highest ED utilizers for the past 18 months. Coming Home conducted extensive outreach to subsequently locate the identified persons (no simple task for those who were street homeless), screened them for the SDoH and sought to enroll them as Participants in the SHI program. The NJ State Department of Community Affairs dedicated 25 rental assistance vouchers to Program Participants; Rutgers University Behavioral Health offered enhanced assistance to Participants needing behavioral health treatment, and WellCare Health Plans of New Jersey assists with data collection for the program.

Over the course of 2019, Coming Home conducted 755 discrete outreach activities to 86 unique patients and was able to enroll 40 of the ED high utilizer patients as Participants. The needs the Participants presented with most frequently were for food, shelter, permanent housing, mental health and/or substance abuse treatment and welfare benefits. Immediate needs for food and, most often, shelter can be met quickly. We address the other needs at the Participant's pace: once engaged, our case managers develop an individualized plan with the Participants according to their personal goals.

The case managers supply guidance and apply progressive engagement techniques to help the Participants reach their optimal level of self-sufficiency; ultimately, however, the Participants retain their right to self-determination. Nonetheless, we are happy to report that, to date, we were able to successfully permanently house, with the assistance of vouchers, 10 Participants and 3 more are in the housing search process.

In order to improve our health outcomes, which are among the lowest for developed countries despite our significant spending on medical care, we must continue to form and operate cross-sector partnerships like SHI to address the upstream SDoH. Personal responsibility plays an important role in getting and staying healthy. But too many people do not have access to an equal measure of choices and opportunities to pursue healthy lifestyles. The community-based case management of the SHI program is a necessary, but not sufficient, tool to provide the most vulnerable among us with the opportunity to be healthy. This tool needs the assistance of social policies and programs that increase the resources available, such as affordable housing, and the development of new healthcare payment models that include reimbursement for the provision of the social services that contribute greatly to a person's state of health. Coming Home is committed to partnering with all sectors to continue to build a culture of health in Middlesex County.

CB's Story

CB was referred to the SHI program as a high utilizer of the ED at St. Peter's hospital. In 2018, she visited the hospital ED 47 times. Most of these visits occurred over the weekend when her primary care physician was unavailable. CB has mental and physical illnesses that can be managed with treatment. In our initial meeting, she stated, "the hospital is like my second home."

CB was quite guarded the first few times she met with us. After meeting with her multiple times and developing a rapport, we were able to identify services she needed to optimize her overall wellbeing. She had previously been introduced to an Adult Medical Day Program; however, she had poor attendance due to her unmanaged mental health symptoms. CB was linked to mental health treatment through the local community health center but reported feeling uncomfortable in a group setting. We collaborated with CB's HMO and were able to link her to an individual therapist, allowing her to engage in treatment and manage her symptoms.

The combination of attending a day program consistently and having a form of mental health treatment that best met CB's needs, resulted in a significant reduction in CB's ED visits, and she no longer uses the hospital as a "second home." CB can socialize with peers again and enjoy activities in the community. By taking a holistic approach and addressing CB's social needs, we reduced the number of visits to the hospital ED, thus realizing a cost savings to the hospital and improved well-being for CB.

More SHI Stories

DEMETRIC BROWN

Demetric was referred to our SHI case managers as a high emergency department (ED) utilizer who had been living on the streets and panhandling for well over a year. We first engaged with him while he was on a bench in downtown New Brunswick, hunched over in the cold, panhandling and asking for food. We worked to build a relationship with him, with the goal of addressing his mental illness and homelessness. Through the County welfare agency, we got him emergency assistance benefits and a hotel placement. Through June 2019, we assisted him in continuing his mental health treatment. Due to his homelessness, however, attendance was sporadic, and his medication compliance was limited. We also worked with him to resolve a multitude of outstanding minor homeless legal issues, such as trespassing.

In July, he was involved in an altercation at an Edison hotel and was arrested and jailed for a couple of weeks. After his release in mid-July, he remained homeless, either in a paid hotel placement or on the streets. Due to his police involvement, he was sanctioned by the welfare agency, resulting in the loss of his hotel placement. The Edison hotel incident also resulted in criminal charges in Superior Court, where Coming Home acted as his advocate and got the charges suspended while he was assessed for competency.

Without a stable location from which he could arrange transportation to attend his program, Demetric fell out of compliance with his treatment, experiencing a significant decline in his mental health, and causing him to become a risk to himself and others as his depression and paranoia increased. Coming Home collaborated with his mental health provider and local law enforcement to have Demetirc hospitalized briefly in November in order to stabilize his mental health. Upon discharge, Demetric was able to stay briefly with a relative, instead of on the street, while Coming Home worked to locate a landlord who would rent to him. We were ultimately successful, a full year after opening his case.

Throughout the year, Coming Home observed that when taking his medications and able to attend his partial care program, Demetric's mood and behaviors were positive, he was generally compliant with his mental health treatment and legal requirements, and was able to actively participate in his own care. Demetric has reported that he enjoys attending the day program and now that he is housed, with access to adequate nutrition, rest, and transportation, he attends consistently. After beginning to work with Coming Home, Demetric's usage of the hospital ED decreased dramatically.

We will continue to assist Demetric as he sets, and strives to meet, his new life goals. Today, Demetirc is not sitting on a bench; rather, he walks down the street with a new stride, carrying himself tall and with purpose. He expresses sincere gratitude for the assistance Coming Home has offered him in gaining housing.

TERRENCE DAVIS

Coming Home case managers met with Terrence on 1/7/19. He is 35 years old and suffers from a serious mental illness, anger management issues, a history of substance abuse, chronic health issues and a traumatic brain injury (TBI). He was homeless, a frequent user of the hospital emergency department and was well known to law enforcement. At our first encounter, Terrence was very angry and upset due to his current living situation on the streets. He was distrustful of everyone and reported a constant sense of dread, "not knowing what was going to happen, just waiting, and just feeling helpless too often."

Coming Home advocated for Terrence to be accepted into the men's shelter and provided support for him while he resided there. During his shelter stay, he experienced a mental health crisis and was hospitalized. We visited him in the hospital and advocated for his return to the shelter upon discharge. From there, we assisted Terrence with his application for a rental assistance voucher, engagement in mental health services, and compliance with treatment recommendations. We helped him move into permanent housing on 7/1/19, and obtain food stamps. Also, after missing a rent payment Terrence acknowledged his challenges in fiscal responsibility and accepted a "representative payee" for his disability benefits, in order to ensure that he does not lose his housing. Terrence has not visited the ED since his mental health hospitalization.

Today, Terrence demonstrates a sense of optimism, positive energy and pride. He voluntarily attends his mental health appointments and the Community Wellness Center, a peer-led support center for individuals living with mental illness, where he uses the computer and works on skill development. Terrence has repeatedly thanked his case manager for not giving up on him. He continues to struggle with his symptoms and TBI, but is engaged in appropriate services and calls his case manager to ask for advice when he is having a difficult time. Terrence is beginning to learn to trust again and continues to work on his impulse control and interpersonal skills. We are happy to have been able to affect his life so positively .

The 2019 Team

BOARD OF DIRECTORS

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Sarah Clark, *DEVCO - Vice Chair*
Sharon Grice, *Consultant - Vice Chair*
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Michael Nulty, *Matthew & Nulty Inc.*
Patricia McKenna, *Transparent Title & Settlements, LLC*
Ronald Rios, *Middlesex County, Freeholder Director*
Wilda Diaz, *City of Perth Amboy, Mayor*

MANAGEMENT TEAM

Eileen O'Donnell, *Executive Director*

Meriam Shenoda, *Executive Assistant & Accountant*

Bobbin Paskell, *Assistant Director, Systems & Chief Operating Officer*

Frances O'Toole, *Assistant Director, Programs*

Cassandra Jones, *Case Manager, Coordinated Assessment*

Christiana Osawe, *Case Manager, Social Service Navigator*

Fiorela Tejeda, *Case Manager, Social Service Navigator*

Ciara Tamburello, *Case Manager, SHI Social Service Navigator*

Courtland Cobb, *Case Manager, SHI Social Service Navigator*


Fundraising Committee


CHM TEAM

Get Involved

Support our Mission
Visit our website, www.cominghomemiddlesex.org; Email us, mshenoda@cominghomemiddlesex.org; or Call us, 732-296-7954

Join the conversation!
facebook.com/ComingHomeMC & Twitter.com/cominghomemc

Participate as a volunteer or join our Board
Connect with us directly through the website or by email.

BOARD COMMITTEES

Accessibility Committee: meets every quarter to give advice and guidance on how to produce more affordable housing units for homeless persons in Middlesex County. This includes the identification of potential properties for development and careful analysis of project costs based on past experiences.

Members: *Melissa Bellamy, Keith Jones, Brian Matula, Arp Trivedi, Patricia McKenna, Jim Zarra, Yvette Molina, Glenn Patterson, Louis Delucia and Susan Kramer-Mills. Frances O'Toole is the designated staff member.*

Sustainability Committee: focuses on developing measures to assist homeless and formerly homeless persons grow in their ability to be self-sufficient, notably working with the County Workforce Development and NJ Employment Services, as well as others, to identify employment opportunities and assist homeless persons in securing good-paying jobs.

Members: *Jamie Schleck, Gloria Aftanski, Jean Holtz, Nicole Fernandez and Kevin Kurdziel. Bobbin Paskell and Chris Osawe are the designated staff members.*

Fundraising Committee: is the source of energy, ideas and work to help Coming Home meet the goals and objectives of its Resource Development Plan and to help the Board raise funds to support the work of Coming Home. In 2019, this committee held a successful golf-outing; a Day at the Races and, in October, its first full-fledged Gala - a masquerade ball!

Members: *Sharon Grice, Bridget Kennedy, Kathleen Gwozdz, Liz Schullstrom and Patricia McKenna. Eileen O'Donnell and Meriam Shenoda are the designated staff members.*

OUR PARTNERS

* Barnabas Health, Inc.
* Bergen County United Way/Madeline Partners
* Central Jersey Legal Services
* Middlesex County Government
* Middlesex County Housing Continuum of Care Committee
* Middlesex County Office of the Public Defender
* Monarch Housing Associates
* NJ 211
* NJ Department of Community Affairs
* Puerto Rican Action Board
* Raritan Bay Area YMCA
* Reformed Church of Highland Park Affordable Housing Corp.
* ReVireo, Inc.
* Robert Wood Johnson University Hospital
* Rutgers Eric B. Chandler Health Center
* Rutgers Mason Gross School of the Arts
* Rutgers University Behavioral Health Care
* Rutgers University RWJ Medical School
* St. Peter's University Hospital
* Town Clock Community Development Corp.
* United Way of Central Jersey
* WellCare Health Plans of NJ
* WellCare Innovations
* Windels Marx Lane & Mittendorf, LLP

Homes for Homeless

(H4H)

In pertinent part, Article 25 of the Universal Declaration of Human Rights (UDHR) states:

> "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control."

These words, along with the rest of the document, were carefully written after a full reconciling of the mass atrocities committed during WW II by a committee of nine people, chaired by Eleanor Roosevelt. With 50 countries contributing to the final document, the UDHR became a cornerstone of Human Rights International Law, and a global commitment to recognize the dignity of each individual person.

The UDHR was adopted by the General Assembly at the United Nations on December 10, 1948, and almost 72 years later we are still battling to realize Article 25. It is not purely coincidental that housing and medical care are consecutively listed in a document proclaiming 30 articles of inalienable human rights. It is a long-held belief that the two are intrinsically linked and cannot be separated.

Coming Home agrees that well-being and good health can only be achieved in concert with a safe, clean, and decent place to call home. We, as a society, have fallen far short of reaching this commitment, globally and locally.

Rest and relaxation are customary orders from a doctor when recovering from any episode of poor health. Whether chronic or acute, bed rest is essential to a speedy recovery. People experiencing homelessness are often released back to the street after a hospitalization, often causing a longer recovery time, or exacerbation of the initial medical complaint.

Having no fixed or permanent address can also prevent people from managing episodic and chronic health problems by seeing their physicians for check-ups and lab tests, causing unnecessary hospitalizations in the first place. Sick and vulnerable persons can become homeless, and homeless persons can become sicker and more vulnerable.

Coupling the high cost of health insurance and medical expenses with the high cost of living in Middlesex County, a person of average income is highly vulnerable to financial devastation after experiencing a moderate to severe health condition. An academic study published in 2019 indicates that the unaffordability of medical expenses is the most frequent cause of personal bankruptcy. Therefore, if a person of average means is vulnerable, a person of low and very-low means will be in a highly critical position.

As we report in the data section of this document there were 430 homeless "households" on the night of the 2019 PIT, including 158 children. This number does not include 194 "precariously housed" families and individuals who are at high risk of imminently losing their housing. Recognizing that there is a finite amount of resources and an affordable housing crisis nationwide, Coming Home seeks to catalyze the creation of affordable housing through its Homes for Homeless program.

COMING HOME'S 2019 H4H PROJECTS

408-410 ALPINE STREET, PERTH AMBOY

This is our third and latest development venture with the Perth Amboy YMCA. Alpine Street is partly funded by a large grant awarded to Coming Home, by the New Jersey Department of Community Affairs (DCA), and a second large grant from the County's Housing First Capital Fund. This three-unit residential property is undergoing a substantial renovation and will house three families with young children. We expect the property to be fully occupied by Fall 2020.

187-189 HANDY STREET, NEW BRUNSWICK

As a recipient of a second National Housing Trust Fund grant, administered by the DCA, Coming Home is partnering with BCUW/Madeline Housing to build a four-unit, multi-bedroom residence in New Brunswick. We are the grateful recipient of a donation of a small vacant lot that we were able to combine with the purchase of the contiguous small lot to permit the multi-family dwelling.

293 TOWNSEND STREET, NEW BRUNSWICK

We are also under contract to purchase a four family house in town in need of much renovation for which we again will partner with BCUW/Madeline Housing to reconstruct at least 4 units of housing for persons who are homeless.

MIDDLESEX COUNTY HOUSING FIRST CAPITAL FUND

Coming Home receives and reviews applications from affordable home developers for funds from the County's Housing First Capital Fund (HFCF), one million dollars ($1,000,000) of annual funding from the Freeholders, specifically for the creation of affordable housing for those who are homeless. Coming Home makes recommendations to the County on the merits of the application, similar to an underwriter reviewing an application for traditional financing. Coming Home's Accessibility and Executive committees review the applications as to cost-effectiveness and fulfillment of the needs of homeless persons in the County and verify that each project will provide social service supports and be conveniently located to transportation and amenities.

In 2019, Coming Home received and approved five applications to the HFCF, three of which also applied for Low-Income Housing Tax Credit (LIHTC) funding from the State. Of the three LIHTC projects approved for HFCF investment, only one project scheduled for South Brunswick was approved by the State to move forward. The two non-LIHTC projects are smaller developments in New Brunswick and Highland Park and are expected to be completed and occupied by the end of 2020.

Landlord Engagement

Maslow's Hierarchy of Needs is a motivational tool used in psychology to describe the patterns through which human motivations generally move and to denote the importance of the foundation of basic human needs. At the bottom of the pyramid are the physiological needs including water, food, shelter, sleep, and clothing. This means that in order for motivation to arise at the next stage, this stage must be satisfied within the individual. Each stage sets the foundation for the next stage, meaning that you cannot properly live in a place of true self-actualization, where you are aiming to be a better version of yourself daily, without having satisfied more basic components of life. Can you imagine life without any of the foundational factors? No wonder there is such a strong correlation between homelessness & food insecurity and poor health outcomes & chronic isolation. Maslow places the need for health one step higher than the need for shelter; therefore, satisfying the need for shelter must come first.

Housing First, the prevailing model nationally for ending homelessness, echoes Maslow's pyramid, and aims to quickly and successfully connect individuals and families experiencing homelessness to permanent housing. Case managers get them "housing ready" and offer supportive services even after they are housed to maximize housing stability and prevent returns to homelessness. Evidence supports that people are able to make improvements to their lives, especially in the areas of health, mental health, and employment, once housed.

With this in mind, Coming Home and Middlesex County have been spearheading the **Landlord Engagement** Initiative as a response to the ever-increasing need for stable and healthy housing. Our committee is comprised of social service providers, landlords, property managers, real estate agents and active community members who are passionate about creating change surrounding housing those most in need.

People experiencing homelessness often feel stuck, and many are struggling to have their basic physiological needs met daily. Our landlords are helping us battle the stigma of homelessness and give a second chance to our clients who might have an eviction or nonviolent criminal history. Our landlords are instrumental in meeting the clients' needs for shelter and sleep and, by doing so, they help our clients have hope for a fulfilled life after a fall.

Landlord Engagement Committee: meets bimonthly to address the participating landlords' interest in community service, their business needs and the coordination with social service providers to assist with tenant issues.

Case Manager Collaborative

Acknowledging that cross-sector and in-sector collaboration is needed to end homelessness, Coming Home established the Case Manager's Collaborative which convenes monthly. The Collaborative is comprised of case managers from various social service and health care providers throughout Middlesex County dealing with homelessness, and its aim is to discuss clients' needs, share resources, and develop best practices. The Collaborative has grown greatly over the years and consistently works to strategize and explore all options available to assist clients on the road to permanent housing and self-sufficiency. The Collaborative has invited different organizations, such as Central Jersey Legal Services, which provided the group helpful information on the process for expungement of criminal records and landlord/tenant rights; and the RWJUH Peer Recovery Program and the Addiction Recovery (STAR) program to discuss available services for persons dealing with addictions.

Easter Celebration at Zebra Way

Thanks to the exuberance and kindness of youth from the EduCare Foundation, we were able to deliver new backpacks to our client's children for a new start to the school year

Coordinated Assessment and Use of Data

Implemented in November 2015, the Coordinated Assessment process creates a single point of entry for persons homeless or at risk of homelessness in Middlesex County. It is comprised of three steps: Access, Assessment, and Prioritization/Referral, and provides for (i) standardized access to the homeless service system, (ii) uniform assessment of homeless persons and application of agreed upon prioritization criteria and (iii) referral for available housing resources. Generally, we prioritize based on length of homelessness and severity of needs. Accordingly, Chronically Homeless (CH) (i.e., long term with a disability) persons are prioritized for permanent housing as quickly as possible. Individuals who are chronically homeless typically struggle with significant mental health and/or addiction issues, as well as multiple chronic health problems; often use the hospitals for primary care, and have extreme difficulty in following through with treatment recommendations due to their homelessness.

Point in time 2019

As federally required, we conduct a Point in Time (PIT) survey each year in January. Typically, the data reflects the information that we already know since we collect and monitor data on our homeless population regularly.

On the 2019 PIT night:

- 430 homeless households comprised of 620 individuals, including 158 children, were in Middlesex County.
- 78% of the homeless households were in Emergency Shelter, Transitional Housing, or Hotel Placement.
- 22% (135 individuals) were Unsheltered.
- 3.9% increase in overall homelessness between 2018 and 2019 in Middlesex County, which is the smallest increase since 2016 when Coordinated Assessment was fully implemented.

With the implementation of Coordinated Assessment, we enhanced our outreach efforts which can account for subsequent increase in numbers. The smaller increase between 2018-2019 could reflect that our housing placement and prevention work is again keeping pace with our outreach efforts.

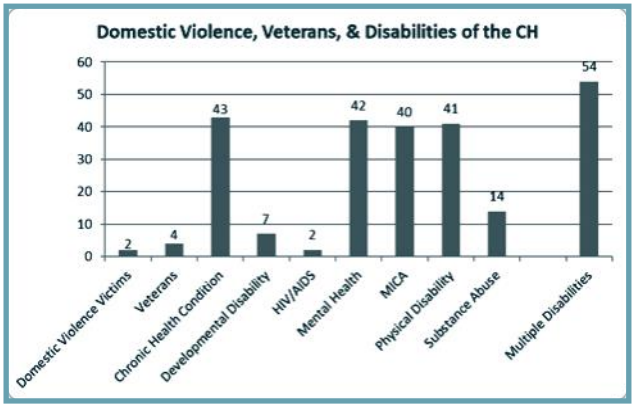
CHRONIC HOMELESSNESS:

A "snapshot" of the chronic homeless population on the night of the 2019 PIT:

- 109 households (25.3% of all homeless households) were chronically homeless.
- 101 households without children / 8 families with children.

In line with our data mining throughout the year, the PIT showed that:

- 48% of all CH adults (54) have multiple disabilities.
- 72.6% (82) of the CH population have a mental health diagnosis.
- 40 persons with mental health diagnoses reported a substance abuse disorder.



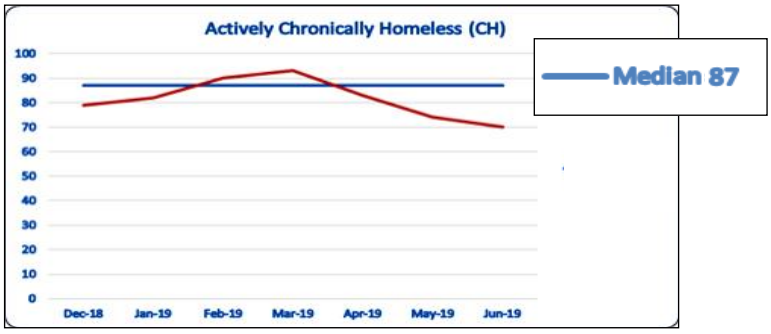
2019 PIT - Chronic Homeless Detail

Homeless service providers in Middlesex County, especially our outreach projects, are actively working with the vast majority of the CH population, who, through the Coordinated Assessment process, are prioritized for permanent supportive housing. We anticipate that the 2020 PIT numbers will show a decrease, since we have been focusing on reducing CH in our community through case conferencing and data analyses.

Built for Zero

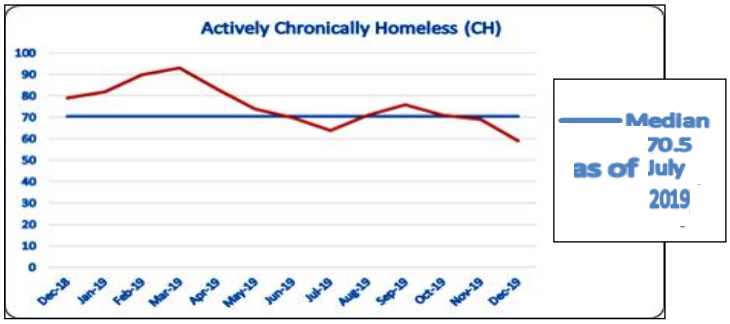
While Coordinated Assessment provides a process to triage and assist individuals in moving through the system, our continued participation with the Built for Zero (BFZ) initiative of the national nonprofit agency Community Solutions, provided us with tools and ideas to further develop that process, using real time data as the primary driver in our quest to end homelessness in our community.

In April 2019, Coming Home invited our BFZ coaches to lead a "Local Learning Session" with Emergency Shelter and Outreach staff and system leadership to assist us in collectively setting new goals and strategies to reduce our CH number and measure progress – short term - to meet our goals. This "Improvement Team" committed to reducing the CH number by 28% in 6 weeks. Through close monitoring of our data, as well as the addition of case conferencing among agencies to discuss targeted clients, our team exceeded its goal.



6 Week Challenge (Apr-June 2019)

After the 6 week challenge, we reviewed lessons learned, analyzed the data, and set new goals. We entered into our "Summer Stretch Challenge" (July – September), to continue to reduce our CH number. We successfully housed an additional 19 chronically homeless individuals during this time, which was our goal for housing placement. Our data showed, however, that the influx of CH into the system increased as well. To address this issue, we included in our case conferencing, the discussion of homeless individuals on our By Name Homeless List who were at risk of "aging into" a chronic homeless status to reduce our inflow number, while continuing our success with housing placement. Again, we had success in that we reached an all-time low point in our CH number in December 2019. During the course of 2019, we reduced the number of Chronically Homeless persons in Middlesex County by 66 or 25%. We will continue to use the data to drive our decisions to further improve our system.



Run Chart through Dec. 2019

Homeless Hotline Case Management

Coming Home continues to provide community-based, case management services for homeless individuals and families. Due to high volume with the success of the Coordinated Assessment program, we began triaging our case management referrals, offering more intensive case management to those who needed it, and offering a problem-solving oriented service to those able to navigate needed services with less active involvement of staff. Coming Home case managers also use email and text to communicate with clients, which allows more flexibility for clients who are not able to attend appointments during work hours.

The outcomes demonstrate the effectiveness of these changes, with:

- **20% increase this year in clients moving to permanent housing.**
- **29% decrease in loss of contact/voluntarily dropping out of services.**

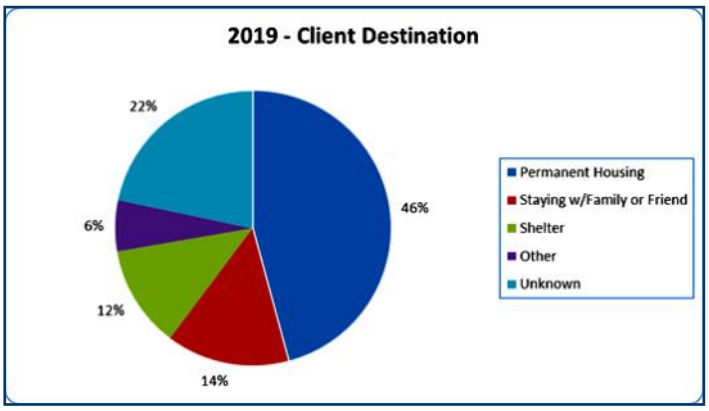
While the majority of cases referred by NJ 211 for assistance are families with children (58%), we have observed an increase in the number of elderly who are presenting with a housing crisis. Elderly individuals on fixed income who experience a housing crisis are at higher risk for health problems, or having to choose between paying their rent or taking care of their health. Coming Home will monitor this data in 2020; seek affordable housing opportunities where possible for these individuals; and partner with our local healthcare providers to ensure that seniors are receiving the medical assistance they require.

In addition to case management assistance, Coming Home assists individuals with 1.5 months' rental assistance to secure their apartments, using funds from an annual grant from the NJ Division of Family Development. In this manner, Coming Home was able to directly assist *55* clients in 2019 who would not have been eligible for any other rental assistance.

Case manager rock stars!

Coming Home served 197 cases in 2019, of which 158 were closed by the end of the year:

- 46% of all clients moved into their own housing (20% increase from 2018)
- 14% left to stay with friends or family, at least temporarily
- 12% of Coming Home's clients transitioned into a shelter, where they received ongoing case management assistance from the agency providing shelter
- 22% of households voluntarily discontinued services without providing a destination (a decrease from 2018, demonstrating improved ability to keep clients engaged in services)
- 7% went to other destinations.



Client Testemonial

My name is Stacy, and I am 53 years old and became homeless due to emergency surgery I had on my aorta. My family came to Maryland and brought me back to New Jersey to stay with my daughter and son-in-law, but that didn't work out. I have a service dog -- my son-in-law did not want any dogs, plus their house was partly under construction. Everyone was forced to stay in a hotel because the house needed a new boiler. I have limited funds with SSD from Social security, and I wasn't eligible for services from the Middlesex County Board of Social Services. I also ended up in the hotel at my own expense. I was forced to give my dog up for adoption, and I stayed at a bus station and at a church for a while, and then in a hotel for three days at Coming Home's expense when I ran out of money. Finally, I was able to use a voucher I had transferred to here from Maryland, and Coming Home helped me with my security deposit to move in. I am thankful for Coming Home.

Financial Reporting 2019

STATEMENT OF ACTIVITIES
YEAR ENDED DECEMBER 31, 2019/2018

	Unaudited 2019	Audited 2018
Support and Revenues		
Government grants	$ 552,000	$ 522,899
Program income	52,740	77,617
Corporate & Foundation	271,126	321,820
Special events	37.523	10,562
In-kind donations	60,497	67,496
Individual Contribution	16,770	6304
Other Income	4,890	2,113
	$ 995,546	**$ 1,008,811**
Expenses		
Program Services	$ 430,615	$ 396,752
Management and General	263,907	201,267
Fundraising	74,435	42,027
	$ 768,957	**$ 640,046**
Income from investment in JV		65,212
Changes in net assets	**$ 226,589**	**$ 433,977**
Net Asset, Beginning of the Year	963,180	529,203
Net Asset, End of the Year	**$ 1,189,769**	**$ 963,180**

STATEMENT OF FINANCIAL POSITION
DECEMBER 31, 2019/2018

	Unaudited 2019	Audited 2018
Assets		
Cash	$ 397,885	$ 200,546
Grants receivable	604,760	593,330
Other current assets	824	
Other assets	2,287	
Investment in JV	188,903	188,903
	$ 1,194,659	**$ 982,779**
Liabilities and Net Assets		
Accounts Payable	$ 4,890	$ 19,599
Net Assets - Unrestricted		963,180
	$ 1,194,659	**$ 982,779**

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Fundraising

Coming Home's Fundraising Committee was on fire this year with new ideas and renewed fervor. We held a successful golf outing in May at the Glenwood Country Club in Old Bridge and a Day at the Races at the Monmouth Park Racetrack in Oceanport, NJ. We raised some funds and, as importantly, grew our network of friends and supporters. We ended the year with our first full-fledged Gala, honoring retiring Freeholder Blanquita Valenti: it was a very popular masquerade ball in October, held at the Hyatt in New Brunswick and it brought in much needed funds to support our programs and operations.

Coming Home Fall Gala—Masquerade Ball Nightcap

A Day at the Races

Spring Golf Outing

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Ending Homelessness in Middlesex County

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