Harbor & Table
COLLECTIVE
Building bridges to wellness, one neighbor at a time

Harbor & Table Collective — FY2024 Impact Summary

(Fictional / For storytelling & marketing use only — not an audited report or official evaluation)

Topline Impact (FY2024)

- **People served (unique individuals): 142,500**
- **Behavioral health counseling sessions provided: 28,400**
- **Housing placements (emergency & permanent supportive): 3,850**
- **Total meals served (hot meals & grocery packs): 1,020,000**
- **Transportation trips provided: 89,200 trips** (~23 full-time equivalent drivers)
- **Active care coordination clients (IDD & seniors): 2,800**
- **Service sites operating (average concurrent): 12 sites**
- **Volunteer hours contributed: 48,300 hours** (~23 full-time equivalent years)
- **Community partnerships & collaborative referrals: 156 organizations**

Reach & Efficiency Metrics

- **Cost per person served (all programs, net): $63** (Total program expenses divided by unique individuals served)
- **Cost per behavioral health session: $95** (Direct clinical costs + supervision)
- **Cost per housing placement: $1,560** (Includes case management, deposits, move-in support)
- **Cost per meal (cash outlay, excluding in-kind): $2.75**
- **Cost per transportation trip: $18.50** (Vehicle operations, fuel, maintenance)
- **Volunteer leverage ratio:** For every $1 of program cash spent, volunteers contributed $3.80 in time/in-kind value.
- **Client retention in integrated services:** 82% of clients receiving 2+ services remained engaged for 6+ months.

Program-Level Outcomes

Behavioral Health Services

- **Counseling sessions provided:** 28,400 individual and group therapy sessions
- **Unique clients served:** 3,240 individuals received behavioral health services

- **Crisis interventions:** 1,850 crisis contacts with same-day response
- **Substance use disorder (SUD) support:** 680 clients in recovery programs

Key outcome: *Client-reported symptom improvement —* **73%** *of clients reported reduced symptoms (PHQ-9/GAD-7 scores) after 3+ months of services. Client satisfaction rate:* **85%** *(rated services as 'good' or 'excellent').*

Housing Solutions

- **Total housing placements:** 3,850 individuals (emergency shelter, transitional, permanent supportive)
- **Emergency shelter nights:** 42,600 bed-nights provided
- **Permanent supportive housing placements:** 1,240 individuals
- **Rapid rehousing assistance:** 2,610 individuals with rental assistance & case management
- **Average time from intake to placement:** 18 days

Key outcome: *Housing stability rate —* **78%** *of placed individuals remained stably housed at 12-month follow-up. Returns to homelessness within 24 months:* **22%**.

Food & Nutrition Programs

- **Meals produced:** 820,000 hot meals (includes community meals and meal delivery)
- **Food pantry distributions:** 200,000 grocery pack equivalents (950,000 lbs food distributed)
- **Households receiving pantry support:** 22,400 households (average 4.9 visits per household)
- **Congregate meal sites operating:** 8 community kitchens (average 875 meals per site per week)
- **Local procurement rate:** 42% of food spending sourced from local/regional producers

Key outcome: *Food insecurity reduction — Households reporting 'often' or 'sometimes' lacking food decreased from* **31% (baseline) to 19%** *among program participants at 12-month follow-up. 63% of pantry users reported improved ability to meet monthly food needs within 3 months.*

Transportation Services

- **Total trips provided:** 89,200 one-way trips
- **Unique riders served:** 8,450 individuals
- **Active fleet vehicles:** 18 vehicles (12 accessible, 6 standard)
- **Trip purposes:** Medical appointments (54%), social services (28%), employment (12%), other essential needs (6%)

- **Average response time:** 92% of scheduled trips completed on time (within 15-minute window)

Key outcome: *Appointment attendance — Transportation recipients showed* **68% improvement** *in medical appointment attendance compared to pre-enrollment baseline. 89% of riders rated service quality as 'excellent' or 'good'.*

Care Coordination Services (IDD & Seniors)

- **Active care coordination clients:** 2,800 individuals (1,680 seniors, 1,120 individuals with IDD)
- **Average case load per coordinator:** 1:35 ratio
- **Service referrals facilitated:** 14,200 warm referrals to partner agencies
- **Person-centered plans developed:** 2,640 comprehensive care plans (94% of active clients)
- **Crisis prevention interventions:** 920 proactive interventions preventing hospitalizations or facility placements

Key outcome: *Community tenure & quality of life —* **87%** *of care coordination clients remained living independently in community settings. Client/family satisfaction with care coordination:* **91%***.*

Equity & Access

- **% of services delivered in high-need census tracts:** 68%
- **Languages supported by program materials / staff:** 7 (English, Spanish, Mandarin, Arabic, Haitian Creole, Portuguese, Somali)
- **Sliding-scale / zero-barrier services:** 100% of core services available on sliding fee scale; no one turned away for inability to pay
- **Medicaid acceptance rate:** 100% (all billable services accept Medicaid)
- **ADA-accessible facilities & vehicles:** 100% of service sites and 67% of transportation fleet (12 of 18 vehicles)

Year-over-Year (YoY) Trends (FY2023 → FY2024) — Fictional

- Unique individuals served: **+22%** (117,000 → 142,500)
- Behavioral health sessions: **+35%** (21,000 → 28,400)
- Housing placements: **+48%** (2,600 → 3,850)
- Meals served: **+30%** (785,000 → 1,020,000)
- Transportation trips: **+42%** (62,800 → 89,200)
- Care coordination clients: **+27%** (2,200 → 2,800)
- Volunteer hours: **+12%** (43,100 → 48,300)

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- Client satisfaction (weighted average): **+3%** (82% → 85%)
- Cost efficiency (cost per person served): **−7%** (improved efficiency)

Anonymized Client Stories (Copy-Ready)

Story 1 — Integrated Care Journey:

"After losing stable housing due to a mental health crisis, 'James' connected with our crisis intervention team. Within 72 hours, he was placed in emergency shelter and enrolled in weekly counseling. Our care coordinator helped him access disability benefits, and our transportation service ensured he made it to every appointment. Six months later, James moved into permanent supportive housing and continues behavioral health services. He recently started volunteering at our community kitchen."

Story 2 — Senior Care Coordination:

"'Maria,' an 82-year-old widow, was struggling to manage multiple chronic conditions and missing medical appointments due to lack of transportation. Our care coordinator developed a comprehensive plan connecting her to our transportation service, meal delivery, and home health partners. Maria now attends all her medical appointments, receives three meals per week, and reports feeling 'less alone and more supported than I have in years.'"

(Use pseudonyms and anonymize identifying details for real-world privacy protection.)

Methodology & Measurement Notes (Be Transparent)

- **Sources:** Clinical records, intake assessments, housing placement logs, meal service records, transportation dispatch logs, care coordination case notes, and client satisfaction surveys. All metrics above are fictional and intended for illustrative purposes.
- **Counting rules:** 'Unique individuals served' is unduplicated across all service lines using encrypted identifiers. Clients receiving multiple services counted once in total but reflected in individual service line metrics.
- **Clinical outcomes:** Behavioral health symptom improvement measured using standardized tools (PHQ-9, GAD-7) at intake and 3-month intervals. Housing stability tracked through quarterly follow-up contacts.
- **Survey timing & sample:** Satisfaction surveys conducted with approximately 15% of service recipients (stratified random sample). Follow-up outcome data reflects clients with 6+ months of engagement.

- **Attribution caveat:** Outcomes reflect association with Harbor & Table services; causal claims are not made without controlled evaluation. Many clients receive services from multiple community partners.

Suggested Visualizations for Social / Web

- Five-card social carousel: (1) Topline impact (142,500 people, 5 service lines); (2) Behavioral health & housing outcomes; (3) Food & transportation services; (4) Care coordination spotlight; (5) Client story + CTA.
- Animated pie chart showing service distribution: Behavioral Health 30%, Housing 20%, Food/Nutrition 20%, Transportation 15%, Care Coordination 10%, Other Support 5%.
- Map graphic with 12 service sites (dots) and 68% of services in high-need census tracts highlighted.
- Infographic showing integrated care journey: One client accessing behavioral health → housing → transportation → ongoing care coordination.

Short Copy Snippets (Social-Ready)

Instagram / Facebook (single post):

"In FY2024 Harbor & Table Collective served 142,500 neighbors across five service lines — from behavioral health counseling to safe housing, nutritious meals, reliable transportation, and care coordination. Here's how your support created pathways to wellness last year. [link] #IntegratedCare #CommunityWellness"

LinkedIn (professional):

"FY2024 snapshot: Our integrated care model delivered 28,400 behavioral health sessions, placed 3,850 individuals in stable housing, and coordinated comprehensive support for 2,800 seniors and individuals with disabilities. Proud of this progress in addressing whole-person wellness — more to do."

Twitter/X (thread opener):

"FY2024 impact: 142.5K people served. 28.4K counseling sessions. 3,850 housing placements. 1M+ meals. 89K transportation trips. Integrated care = comprehensive wellness. 🧵👇"

Data Transparency & Suggested Disclaimer (Copy to Paste)

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Impact metrics above are fictional and created for storytelling and marketing purposes for the Harbor & Table Collective campaign. They are not audited and should not be used as official program evaluations or legal documents. Any resemblance to real outcomes or organizations is coincidental.