



North End
**COMMUNITY
HEALTH CENTRE**



NECHC
ANNUAL REPORT
2025-2026

LEADERS IN COMMUNITY-DRIVEN HEALTH AND WELLNESS

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Data and statistics referenced throughout this report are drawn from the NECHC Impact Report (Wilson & Wilbur Consulting Inc., prepared for North End Community Health Centre, September 2026), unless otherwise noted.

A NOTE FROM OUR CHAIR AND CEO

The Model the Strategy Needs Already Exists

Nova Scotia is finalizing a homelessness strategy that will shape how this province cares for its most vulnerable residents for a generation. The model that strategy needs already exists here, and it works. Housing investment holds when the health infrastructure is there to make it stick.

NECHC has spent more than five decades building care around the realities of people's lives.

As the community has changed, so has the way we work. Today, we bring primary care, mobile outreach, mental health and addictions support, dental care, food access, community programs, and supportive housing together through one connected organization.

NECHC manages the majority of the province's high-acuity permanent supported housing and delivers primary care to people who would otherwise go without it. That combination is deliberate: NECHC expanded into housing because health stabilization required it, not as a departure from its mandate.

Housing instability and homelessness now shape much of the environment in which NECHC works. Many people who come to us are navigating several health and social pressures at once, so meaningful access involves more than offering an appointment or a single program. It requires time, flexibility, outreach, follow-up, and trusted relationships.

That is why NECHC's care looks different. More than 50 service types across 15 or more professions can be connected to the same person. Repeat contact and longer appointments are not exceptions to the model; they are how the model responds to complexity and helps people remain connected to care.



**Michael Sherwood, Chair,
Board of Directors**

This Annual Report allows us to see the work more clearly through the data. It shows who NECHC serves, how our programs work together, where people are finding greater stability, and where demand continues to exceed our capacity.

Across the results, three themes emerge: access, connection, and continuity.

NECHC meets people where they are, connects health care with housing and other supports that affect health, and builds relationships over time. We do more than deliver services. *We connect the pieces.*

In 2025–2026, NECHC served:



**4,199 unique patients through
40,983 visits**



**200+ people received housing
and wraparound supports**



**100+ moved from homelessness
into housing approx. 95% of housed
clients retained their tenancy**

These results show what is working. The waitlists and unmet needs identified throughout this Annual Report also show where more capacity and stronger partnerships are needed.



**Marie-France LeBlanc,
President & Chief Executive Officer**

NECHC by the Numbers

The numbers describe the community around NECHC, the complexity of the people we serve, and how primary care, outreach, housing, and other supports work together to help people remain connected and stable over time.

THE COMMUNITY AROUND US



HOMELESSNESS IN HRM

2,082

individuals and families were recorded as experiencing active homelessness

IN HRM ON SEPTEMBER 9, 2026



POINT-IN-TIME COUNT

HRM's 2025 Point-in-Time Count identified:

AT LEAST
1,150

people experiencing homelessness

AN INCREASE OF
423%

since 2018

THAT'S MORE THAN 5X THE 2018 COUNT



PRIORITY COMMUNITIES

At NECHC, we prioritize:

- Indigenous
- African Nova Scotian
- 2STGD++

communities, as they are overrepresented in the community we serve.

WHAT NECHC DELIVERED



PATIENT CARE

4,199

unique patients received care through NECHC



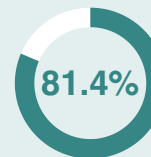
SERVICE VISITS

40,983

visits delivered across the organization



SOCIAL NEEDS



of screened patients reported at least one unmet social need



RETURNING PATIENTS

3,680

patients came to NECHC more than once during the year



CARE BY THE NUMBERS

AN AVERAGE OF
9.76

service encounters per patient

APPROXIMATELY
28

minutes per appointment on average



INTENSIVE SUPPORT

288

patients received 25 or more service encounters

NECHC by the Numbers

WHAT THE MODEL MAKES POSSIBLE



THE OVERLOOK

776
days

is the average time an Overlook tenant has called it **home**

Supportive housing for people experiencing chronic homelessness, mental health challenges and addictions.



CONNECTED CARE

MORE THAN

50

service types

ACROSS

15+

professions

can be connected to
THE SAME PERSON



HOUSING AND STABILITY

MORE THAN

200

people received housing and wraparound supports

MORE THAN

100

moved from homelessness into housing

APPROX.

95%

of housed clients retained their tenancy



OUTREACH CARE

11,679

MOSH-related activities brought care into:

Shelters

Encampments

Transitional housing

Community settings

AT THE SAME TIME

waitlists and unmet social needs show that demand continues to outpace parts of NECHC's current capacity.



WHAT IT PREVENTED



COST COMPARISON

Mobile outreach visit

APPROX.
\$160

Emergency department visit

UP TO
\$2,000

An emergency department visit can cost
UP TO 12X MORE



COSTS AVOIDED

ESTIMATED

\$75,000
TO
\$114,000

in public costs avoided
per person housed

Based on reduced reliance on **hospital** and **justice-system** responses.



SAFER SUPPLY OUTCOMES

Participants in a comparable Safer Supply program had:

31%

fewer
emergency
department visits

54%

fewer
hospital
admissions

in the year following enrolment

What We Do: Housing Is Health

“

“An average stay of 776 days is roughly more than two years — more than two years of stability, of safety and connection in someone’s life. For many of the people we serve, that means more than having a roof over their head. It means having a place to call home. It means knowing where they’re sleeping each night is safe.”

Marie-Elle Charlemagne,
Manager of Property & Supported Housing



THE PROGRAM

NECHC’s housing and stability work includes housing case management, the nine buildings NECHC owns and operates, and partnerships with community non-profit housing providers to provide 24/7 support at the Overlook and Ozanam Place.

Property Management Assistants, housing support staff, and place-based teams work together so that tenancy matters, health needs, and practical supports are not treated as separate issues.

At the Overlook, tenants have lived in their homes for an average of 776 days. That continuity matters: people have time to build relationships, connect with care, and address needs that cannot be resolved in a short stay.



What We Do: Housing Is Health

PROGRAM RESULTS



HOUSING SUPPORT

MORE THAN

200

people received housing and
wraparound supports



INTO HOUSING

MORE THAN

100

people moved directly from
homelessness into housing



TENANCY RETENTION



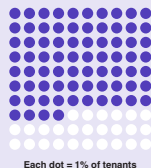
of housed clients retained
their tenancy



LONG-TERM TENANCY

74%

of Overlook tenants
had lived there for
more than one year



SUPPORTED HOUSING

89.9%

of provincially funded high-acuity
permanent supported housing
is managed by NEHC



What We Do: Mobile Outreach Street Health

“

“People know to expect us — when the van pulls up, morning or afternoon, wherever we are, there are already people standing on the sidewalk waiting to talk to us. I know folks have had pretty emotional reactions to seeing the care provided on the van, just because it looks so different from traditional healthcare.”

Martha Steeper,
Manager of Harm Reduction and MOSH



THE PROGRAM

Mobile Outreach Street Health, or MOSH, makes NECHC’s commitment to meet people where they are practical. The team brings primary health care into shelters, encampments, transitional housing, and other community settings on a rotating schedule.

MOSH care is relationship-based. The team listens and learns how people manage their health, treats immediate concerns, connects them to the right supports, and follows up over time.

PROGRAM RESULTS



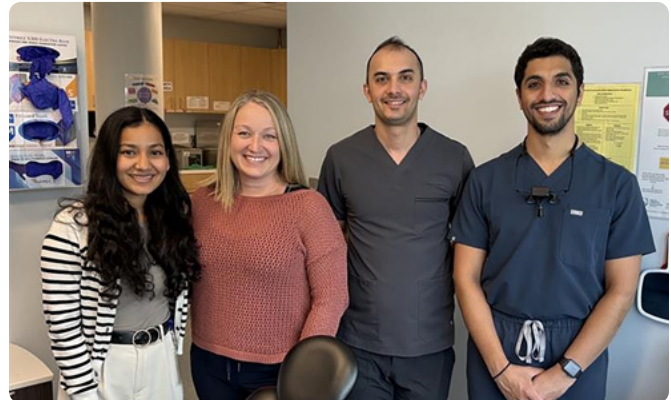
MOSH shows what access looks like in practice. If someone cannot realistically get to conventional care, the system has to reach them differently. A MOSH visit costs approximately \$160. The same person presenting at an emergency department costs the system up to \$2,000. Across 3,460 MOSH visits this year, that difference is real. But cost is not the whole of it. For many of the people MOSH reaches, this is not the cheaper version of care. It is the only version they can and will accept.

What We Do: Primary Care and Dental

“

“When people in the communities we serve aren’t able to access the healthcare they need at the time they need it, it usually exacerbates whatever condition they’re dealing with, and often rolls into other comorbidities. It’s usually not just one singular thing — it’s a puzzle.”

Francine Leach,
Manager of Primary Care and Dental



THE PROGRAM

Primary Care

The clinic provides primary care, blood work, children’s health services, and walk-in social work in a safe, familiar setting. Longer appointments, repeat visits, and follow-up allow care to proceed at the pace a person’s circumstances require.

NECHC’s interdisciplinary primary-care team includes physicians, nurse practitioners, nurses, social workers, crisis counsellors, and dietitians. Team members connect around the person rather than asking the person to navigate each service alone.

Dental Clinic

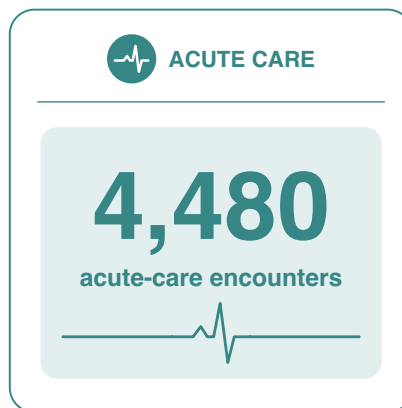
Four fully equipped suites support NECHC’s dental program, which provides preventive, restorative, and urgent care. Dalhousie Faculty of Dentistry students deliver treatment under the supervision of a licensed provider, combining community access with a teaching partnership.



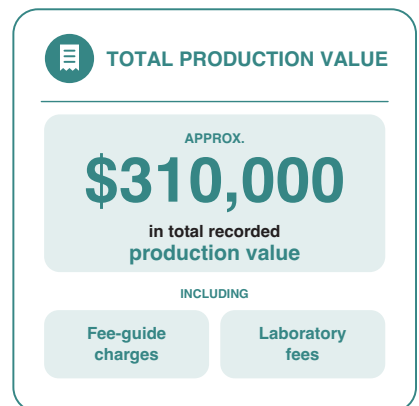
What We Do: Primary Care and Dental

PROGRAM RESULTS

Primary Care



Dental Care



What We Do: Mental Health, Food and Community



"There is no wrong door — you can come in, and we will guide you through a process to get you to the right clinician."

Lana MacLean,
Director of Community & Mental Health



THE PROGRAMS

PAUSE

- PAUSE provides immediate, community-based mental-health support through one-hour counselling appointments offered on a first-come, first-served basis. Clients do not need a health card, diagnosis, referral, or registered-patient status.
- Program Results
 - » 600 PAUSE appointment records; 101 Transcultural Psychiatry appointment records

FOOD

- NECHC's community and healthy-living programs provide practical support, trusted information, opportunities for connection, and direct access to food. Ready-to-eat food, take-home meals, and community programs help people remain engaged, stabilize, and connect with other services.
- Program Results
 - » Approximately 200 frozen meals are distributed each week
 - » Approximately 50 sandwiches and 20 breakfasts provided each day

COMMUNITY OUTREACH

This year, NECHC's outreach went beyond the usual confines of a clinic. Some of the programs included:

- Papapalooza
- Pre-school Assessment Day
- Dental Blitz
- 64+ Program
- North End Open Table
- North End Food Network
- Anchor Youth Program

What We Do: Harm Reduction and Safer Supply



"Once we address the immediate harms people are experiencing, we're able to understand what's going on beyond the clinical setting — why someone is using, why Safe Supply or the Managed Alcohol Program is the right fit when other systems can't respond."

Martha Steeper,
Manager of Harm Reduction and MOSH



THE PROGRAM

Managed Alcohol Program

The Managed Alcohol Program provides prescribed alcohol to people with Alcohol Use Disorder within a structured clinical program. It offers a safer and more consistent alternative to unmanaged alcohol use and connects participants with ongoing health and social supports. The program is relationship-based and harm-reduction focused. Care is organized around safety, stability, and continued connection rather than requiring people to resolve every issue before receiving support. Studies of comparable managed alcohol programs report 88% lower rates of withdrawal management, 47% fewer emergency department visits, and 43% fewer police contacts among participants.

Safer Supply

NECHC's Safer Supply program provides a clinical alternative to the unpredictable, unregulated drug supply. Prescribing, follow-up, and connections to other services are delivered as part of the same integrated approach.

PROGRAM RESULTS



PRESCRIPTIONS

3,777

hydromorphone
prescriptions recorded



SAFER SUPPLY OUTCOMES

Participants in a comparable
Safer Supply program had:



31%

fewer
emergency
department visits



54%

fewer
hospital
admissions

in the year following enrolment



DEMAND OUTPACING CAPACITY

APPROX.

100

people are waiting for the
Safer Supply Program



Each figure = 10 people

CHC Model of Care

The data in this Annual Report was made possible through the NECHC's partnership with Nova Scotia Association of Community Health Centers and the Province of Nova Scotia to develop a Community Health Centre Model of Care. As part of that work, we undertook a focused data project to better understand who NECHC serves, how people use care, and what becomes possible when health and social supports are connected.

The Community Health Centre (CHC) model relies on an interconnected system of support, and its value can be understood through access, connection, and continuity: reaching people where they are, bringing the right supports together around them, and staying involved long enough for trust and stability to develop.

The evidence behind the CHC model reaches far beyond NECHC and Nova Scotia. A 2020 rapid evidence synthesis found that Ontario CHC clients had 21% fewer emergency department visits than expected after accounting for patient complexity, and that CHC patients scored 69% on a standard diabetes process-of-care measure, compared with roughly 52% for other Ontario primary-care models. The same evidence shows CHCs reaching further into underserved populations than most other models: more than 30% of CHC clients lived in the lowest-income neighbourhoods studied, and CHCs consistently served more medically complex, disadvantaged patients than comparable primary care settings.

Nova Scotia's rate of hospitalization for conditions that community care can usually prevent runs 12% above the national rate, and NECHC delivers care at a fraction of the cost of emergency department care. Not every NECHC visit avoids an emergency department visit, but the direction is consistent.

The return does not show up as a single figure. NECHC is funded to deliver health and community services, but much of the value that work generates lands elsewhere: in hospitals, Emergency Health Services, the housing system, justice, and municipal budgets. Because the systems that benefit are not the ones asked to measure the result, the public value of community-based care is routinely undercounted.

That mismatch compounds over time, because community interventions tend to follow a J-curve. Previously unmet needs surface first, increasing recorded service use before stability takes hold and downstream costs fall. Canadian Housing First research shows exactly this pattern: health-care costs rise initially, then decline in later years. Evaluation built around a single year and a single sector will understate what the model delivers over a longer horizon.

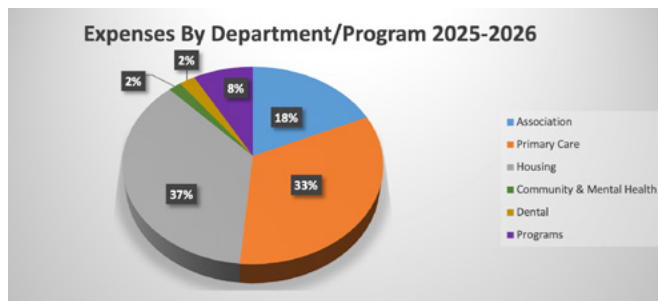
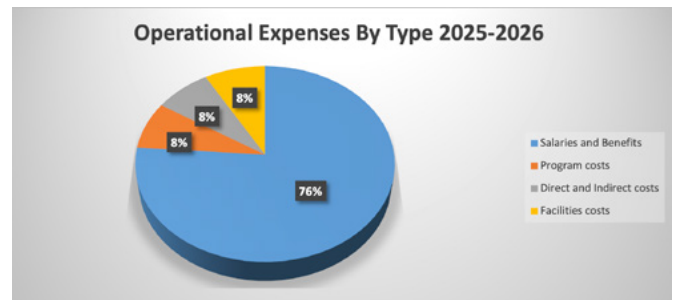
CHCs are not-for-profit, community-governed, team-based organizations that combine primary care with health promotion, social supports, and attention to the conditions that shape health.

This partnership with the province and Nova Scotia Association of Community Health Centers has created a stronger shared evidence base for understanding what the model delivers. The next step is to keep building on that work: strengthen all CHC's capacity, continue measuring outcomes across systems and over time, and use what we learn together to support the CHC model in other Nova Scotia communities.



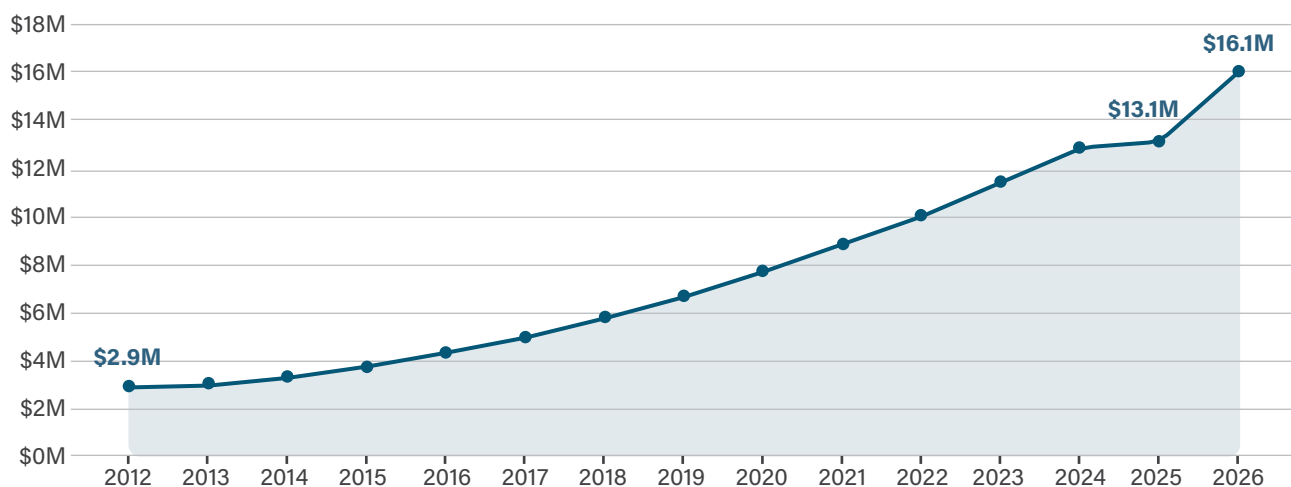
Year In Review: Financials

NECHC's finance department works to ensure the revenue and funding NECHC receives are managed with care and transparency. Strong financial stewardship makes our work possible.



Revenue has grown roughly 5.5 times since 2012, with the steepest climb in the last four years — a trajectory that tracks the scale of need in the community.

NECHC Revenue Growth, 2012-2026



As we look to the year ahead, we will continue to manage our finances responsibly and direct them toward advancing our vision as a leader in community-driven health and wellness. None of this growth would have been possible without the community behind it.

Thank you to Our Sponsors and Supporters

We gratefully acknowledge the organizations and individuals whose sponsorship and support contributed to our success this year. Your investment in North End Community Health Centre helps advance our mission, expand our reach, and create meaningful opportunities to improve health outcomes in our community.



Affordable Housing Association of Nova Scotia
Atlantica Mechanical
Bird
BrokerLink
CBRE
Citadel Investment Group
College of Physicians & Surgeons of Nova Scotia
Dalhousie University
Dalhousie University Faculty of Dentistry
Doctors Nova Scotia
Dora Construction
East Coast Credit Union
Eastlink
Estate of Sandra Darlene
Exit Metro
Halifax Assistance Fund
Halifax Visiting Dispensary
Halifax Youth Foundation
Hansen-MacDonald Family
HRM Housing & Homelessness
IWK Health Centre

J & W Murphy Foundation
Jim Kimber Construction
Kachan Physio
Killam Properties
KPMG
Margaret Casey
Nova Scotia Health
NSACHC
NSLC
Oral Science
Pink Larkin
Province of Nova Scotia
Scotia Square/Crombie
Society of Saint Vincent de Paul
TELUS Health
Tempo - Mounir
The Armour Group
The John Allen Brewing Company Limited
The ScotiaMcLeod Charitable Foundation
Ultramar (Parkland Fuel Corporation)
Upward Mobility Kitchens

We are proud to work alongside partners who share our vision of healthier, more connected communities.