ABORIGINAL HEALTH & WELLNESS CENTRE OF WINNIPEG

MOBILE HEALTHCARE CLINIC ANNUAL REPORT

2025/2026

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INTRODUCTION

Director's Note

It is with deep gratitude and reflection that I present the 2025-2026 Annual Report for the Aboriginal Health and Wellness Centre of Winnipeg's (AHWC) Mobile Healthcare and Wellness Clinic (MHC). This reporting period has been defined by both extraordinary impact, on-going learning, and overwhelming demand. Every day, our team has witnessed firsthand the urgent and growing need for equitable, accessible, and culturally grounded healthcare services within Winnipeg's most vulnerable communities.

Street medicine in Winnipeg has proven to be not only relevant, but essential in AHWC's continued efforts to provide quality and meaningful services to all the constituents we serve. MHC continues to respond to the ongoing healthcare crisis—one that disproportionately affects those who have been historically underserved and systematically excluded for far too long. MHC exists to serve constituents who have been lost within, or denied access to, the traditional healthcare system. Through our decolonized outreach model, we are meeting people exactly where they are at, reducing barriers, and restoring pathways to the care they rightfully deserve.

MHC's work is grounded in a holistic, Indigenous-led approach that places constituents at the centre of the care model. All roles within our non-hierarchical care team; physicians, nurses, crisis counsellors, Indigenous social planner, peer mentors, support workers, hold equal value and importance. The constituents' needs and voices are validated and honoured at all times throughout the care plan.

Relationship-building remains the foundation of our success. Trust is not assumed—it is earned through consistency, respect, and the recognition of each individual's dignity and lived experience. The provision of food, hygiene supplies, harm reduction materials, smudge kits, clothing, transportation, essential household items, and any other need that is identified as crucial to the improvement or their overall health and well-being is not supplementary to our care—it is integral. While these approaches may fall outside of conventional or colonial frameworks, they are critical to achieving meaningful and lasting outcomes.

The undeniable demand in the community this year has pushed MHC's resources to their limits. The scale of need continues to exceed our current capacity, making it clear that additional and sustained investment is required. Despite these constraints, our small but mighty team has demonstrated unwavering dedication, compassion, and resilience. Their work has not only improved access to care but has also in some cases contributed to the diversion of individuals from emergency departments, alleviating pressure on an already strained healthcare system.

The recognition of MHC's successes and impact had afforded us the honour of having been invited to present on the international stage at the World Indigenous Peoples Conference on Education in Auckland, New Zealand. This opportunity reflects the strength and signifi-

-cance of our model, and the growing recognition of Indigenous-led, community-based solutions in addressing complex health challenges.

As you read through this report that outlines both quantitative and qualitative data, we invite you to acknowledge the progress made in the short time since MHC's inception and more importantly the work ahead that still remains. The success of MHC is a testament to what is possible when care is decolonized and is rooted in culture, community, and connection. With additional and continued support, we can and will expand our reach, deepen our impact, and ensure that those most in need are no longer left behind.

Miigwetch to our team, our partners, our funders, and most importantly, to the constituents who trust us with their care.

Sincerely,

Laiza Pacheco

Director of the Mobile Healthcare and Wellness Clinic

Overview

Since its launch in July 2024, the AHWC Mobile Healthcare Clinic (MHC) has been key in addressing critical community needs and gaps in healthcare access for individuals experiencing homelessness and extreme poverty in Winnipeg. Operating within a holistic framework, the clinic focuses on physical, mental, emotional, and spiritual health, and providing care directly within homes, encampments, shelters, and community hubs.

AHWC prioritizes Winnipeg's First Nations, Métis, Inuit and Two Spirit, LGBTQ+ Peoples, while also caring for non-Indigenous relatives, and refers to individuals and families accessing services as **constituents** – a term that recognizes their right to have a voice in the care they receive. From inception, the agency has continuously evolved its programming based on the priorities identified by these constituents.
While the clinic operates as a mobile service, the importance of having a consistent, welcoming landing space became increasingly clear overtime. This need emerged organically as constituents began seeking out the team outside of outreach hours, looking for a familiar and safe place to connect. In response, the clinic established a home base at The Salvation Army Weetamah (324 Logan Avenue) in June 2025, renting space to support both service delivery and operations.

Having this dedicated location has only strengthened relationships and continuity of care by providing a more reliable, accessible space where constituents are finding us for follow-up visits, and ongoing engagement. It also supports essential operational needs, including storage of medical supplies, coordination of outreach activities, and a central point for team members to connect.

Guiding Principles

MHC operates under a decolonial, harm-reduction framework, offering care to all people regardless of race, gender, sexual orientation, health coverage, substance use, mental health status, or behaviour. This approach dismantles social, logistical, and cultural barriers that often prevent access to care.

Foundational to this model is the philosophy of meeting people where they are, in location and connection. Services are delivered in spaces where constituents feel most comfortable, strengthening trust and affirming lived experiences. Through this hands-on, relationship-centered approach, MHC has empowered many to engage with healthcare proactively and consistently.

MHC creates an environment where constituents feel safe and comfortable to address their healthcare needs, acknowledging that a holistic approach is imperative and cannot solely be a medical intervention. MHC focuses on the entire well-being of the constituent and recognizes that factors such as food security, spirituality, housing, and trauma must be addressed to aid in the building of the necessary connection constituents require in receiving care.

Goal

Through MHC's targeted partnerships and regular community presence, the clinic aims to maximize accessibility, built community trust, and is committed to delivering equitable, culturally safe, and trauma-informed care that responds directly to the needs and priorities voiced by its constituents.

Community Partners

The work of MHC is made possible through the ongoing collaboration and support of a wide network of community partners. These partnerships are foundational to delivering accessible, responsive, and culturally safe care, particularly for our constituents experiencing complex health and social challenges. Community organizations, shelters, outreach programs, and service providers play a critical role in connecting our constituents to care, supporting follow-up, and helping address broader determinants of health such as housing, income, and social support.

Through these partnerships, MHC is able to extend its reach beyond traditional healthcare settings and integrate services within spaces that are familiar and trusted by the community. Our partners not only provide physical locations and logistical support, but also invaluable knowledge of community needs, relationships with clients, and continuity of care across systems.

Through strong partnerships, MHC is able to deliver accessible and responsive care across the community. We are grateful to the following organizations and individuals for their contributions:

- N'Dinawemak
- North End Women's Resource Centre (NEWC)
- Community Outreach Signal App
- Ka Ni Kanichihk Inc.
    - Velma's House Safe Space
- Sunshine House
- Resource Assistance for Youth (RaY)
- AHWC's Rapid Access to Addictions Medicine (RAAM) Clinic, Program to Access Treatment for HIV and Support (PATHS)
- Siloam Mission
- Health Outreach and Community Support (HOCS)
- Health Sexuality & Harm Reduction (HSHR)
- WRHA Home Care Downtown District
- The Link
- Dr. Jill Wiwcharuk, BC SMMD
- Chef Sam at SNA, MERC
- University of Manitoba
- The Salvation Army
- Downtown Community Safety Partnership (DCSP)
- Klinic
- Winnipeg Fire Paramedic Service (WFPS)
- Street Connections
- Thunderbirds
- AHWC Housing & Housing Supports

Source: MHC Data Library; MHC Work Tracker Document

Building Care Through Community Connections

MHC plays a vital role in coordinating care and bridging systems gaps. Since April 1st, 2025, MHC has continued to develop strong and evolving connections with partner organizations in striving to provide comprehensive care for their constituents by establishing **14 new partnerships this year,** for a **total of 23 community partnerships**.

Velma's House Safe Space: MHC has developed a strong relationship with the team and participants at Velma's House, operated by Ka Ni Kanichihk where in most recent few months there has been an extremely high medical acuity and high social need at Velma's . The team at Velma's is remarkably resilient and hardworking, persistently providing care much outside of their scope and capacity. Acknowledging that NCMC sets up with a small medical staff and physician approximately 2 times per month, MHC's site medical lead, has started a conversation with providers around partnering together to support frequently and regularly inside of Velma's. MHC and NCMC have been discussing and are in the early phases of setting up a clinic room in the back area of the new Velma's location, equipped with a vaccine fridge and clinical supplies. MHC has been utilizing the space for very sensitive situations but primarily providing care directly in the bed space or out on our mobile units. Velma's team is very eager to formalize this partnership and are working to coordinate a time that their management team can meet with MHC.

N'Dinawemak (190, 145 Powers, 357 Kennedy, Weetamah): While MHC team has an established partnership with set up days at 190, through connection and meeting with the director, the MHC team has formed a long standing and reciprocal relationship with N'dinawemak across their sites, and personal portfolio of accessibilities. Victor has been able to secure housing, emergency sheltering, and provide other wrap-around supports that have been difficult to access through other avenues of process for constituents. The director holds integrity to push against systems of injustice for MHC clients and works back and forth with the MHC team to meet needs and assist each constituent episodically week after week. N'dinawemak has also been an integral player in case management and support for many MHC constituents, often taking over when there has been no previous connection in respective housing units, or previous supports have not been adequate for need.

NEWC (North End Women's Centre): MHC continues to maintain a strong and consistent relationship with NEWC through regular service delivery every other Friday outside of NEWC with the physician. This location has become a reliable and trusted access point for care serving not only for NEWC, but also for those three blocks of Selkirk Avenue, where we typically see constituents during set ups.

Community Outreach (Signal App Group): MHC maintains strong connections with community outreach partners, MSP and DCSP, through shared communication in Signal. This network supports real-time coordination of care through shared "be on the lookout's" (BOLOs), and alerts/requests for support within our respective scopes of practice and care.

Ka Ni Kanichihk: MHC has formed strong bonds with all levels of team players within Kankanichihk. Partnerships occur at both the organizational and provider level, including nurse-to-nurse with Go Ask Auntie, which supports ongoing shared care for constituents, especially collaborating to meet long outstanding needs for clients. MHC regularly attends the Sexual Wellness Lodge and Velma's House weekly, often multiple times per week.

Sunshine House: While winter months have shifted to a more flexible model of service delivery, MHC continues to provide harm reduction supplies and other outreach items weekly to Mobile Overdose Prevention Site (MOPS) and maintains ongoing support for the Sunshine House team. Regular MOPs set up days are expected to resume as the spring begins. MHC remains in strong partnership with Kelly's Corner, Winnipeg's safe haven for 2SLGBTQ+ and currently has constituents in their medical and social portfolios that are provided care at this location. This site is also key in MHC's partnerships with public health nursing and Health Sexuality & Harm Reduction (HSHR) when reconnecting clients that have been lost to care or have outstanding STBBI concerns. Sunshine House is also a key partner in connection for MHC's 2S, trans, non-binary community, with liaison Lucas checking in regularly with MHC nurses.

RAY (Resource Assistance for Youth): MHC's partnership with RAY is currently connected by outreach teams to support shared constituents who may be difficult to locate or have disengaged from care. While RAY's medical team has their established relationships in community, and function mostly adjacent to MHC there is ongoing communication and periodic collaboration to support continuity of care for overlapping populations.

AHWC (RAAM, HIV PATHs): The MHC team has leaned into its partnership with internal AHWC programs, including RAAM and HIV PATHs. As part of Manitoba's broader provincial HIV network, the PATHS program provides outreach-based, client-centred care and intensive case management for people living with HIV who are not connected or are precariously linked to HIV care. Collaboration with PATHs supports access to lab work for HIV-related care, particularly when specimen transport is challenging in outreach settings. MHC's relationship with RAAM is also strengthened by sharing a counsellor.

Siloam Mission: MHC has established a longstanding relationship with Siloam through a regular clinic set up every other Saturday within their clinic space during the colder months. This partnership has been highly effective, and yields appointment numbers of 16-24 on average on those Saturdays. The reception from constituents has also been positive, with many seen during these times who are now part of the regular portfolio of care in the community during regular hours.

HOCs (Housing and Outreach Case Supports): MHC has developed strong relationships with the team members with HOCS, particularly in supporting shared constituents in areas of case management. This partnership has been integral partner in providing more intensive supports in the community. HOCs has also been responsive and had a key role in providing referrals to constituents to MHC and are responsive in assisting MHC when additional support is needed by enlisting their full team on board to ensure high quality and wraparound care.

HSHR (Health Sexuality & Harm Reduction, Public Health): The MHC nurse has formed strong and consistent relationships with many of the nurses with HSHR and public health. This includes regular communication to reconnect constituents that have been lost to care, or requiring follow ups, diagnostics, and outstanding treatments. Through this partnership, successful full-course treatments have been administered, and long-term relationships have been built with upwards of 35 MHC constituents. It has become a monthly occurrence for a phone call between nurses to discuss portfolio of constituents who are lost to care, and both teams collaborate in plans of action to locate and connect with respective constituents.

WRHA Home Care Downtown District: MHC has begun establishing relationships with Winnipeg Regional Health Authority (WRHA) Home Care to support constituents with complex needs. Through ongoing collaborations, both teams are working to bridge gaps in services for constituents who face barriers but require WRHA services. Through these relationships, home care teams have been more informed on how to best support MHC constituents, and have been able to work in collaboration with MHC to ensure adequate, flexible care.

The Link: The Link has taken on case management for two select high-needs youth constituents within the MHC portfolio, providing the necessary additional support and coordination for complex cases.

Dr. Jill Wiwcharuk: Dr. Jill is a street medicine doctor in BC, who is currently doing the same work. This connection supports the exchange of best practices across jurisdictions, strengthening MHC's approach by learning alongside parallel programs.

Chef Sam at SNA (Spence Neighborhood Association), MERC (Magnus Eliason Recreation Centre): MHC receives regular weekly bread donations that support the provision of food to constituents, which plays an important role in meeting immediate basic needs, especially for those experiencing food insecurity.

Source: MHC data library, MHC Work Tracker Document

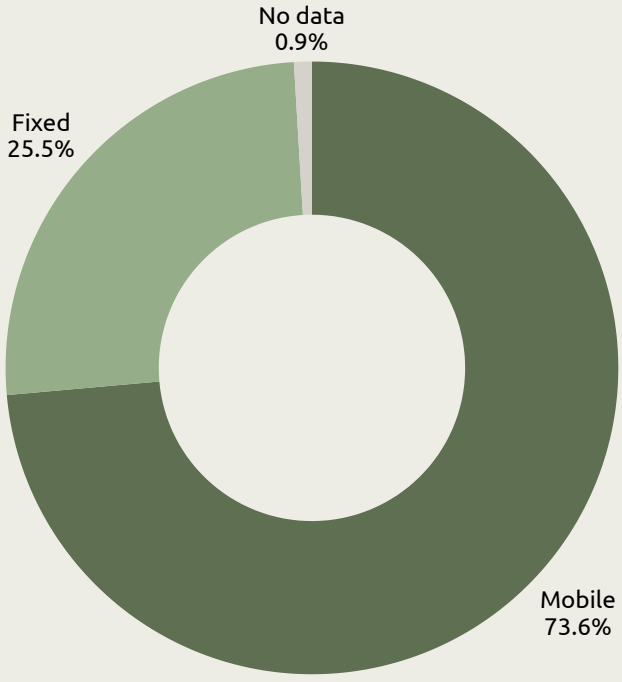
Service Locations & Days

The clinic delivers essential care to mobile locations where individuals experiencing homelessness or extreme poverty can seek shelter and community, including encampments, bridges, and other community hubs located throughout downtown Winnipeg and its adjacent neighborhoods, including Point Douglas, and Elmwood/East Kildonan . Services are provided on Tuesdays, Wednesdays, and Thursdays, at over 80 different locations.

The clinic also coordinates fixed service delivery days alongside other community-based organizations who have also identified primary healthcare as a critical, unmet need among their constituents. On Fridays, MHC is primarily located at NEWC, while also attending some Fridays at N'Dinawemak. Additionally, one Friday this year was operated out of Siloam Mission, Sunshine House's MOPS, Kennedy Street, and the annual Austin Street Festival in August.

Saturdays alternate between Sunshine House's MOPS and Siloam Mission. Additionally, one Saturday this year operated out of Velma's House, NEWC, and Kennedy Street. This year also saw two fixed location days on Tuesdays at St. John's Park and Velma's House, 10 fixed location days on Wednesdays at Sunshine House's MOPS, Velma's house and St. John's Park, and as two fixed location days on Thursdays at Velma's House and Dollarama on Main Street.

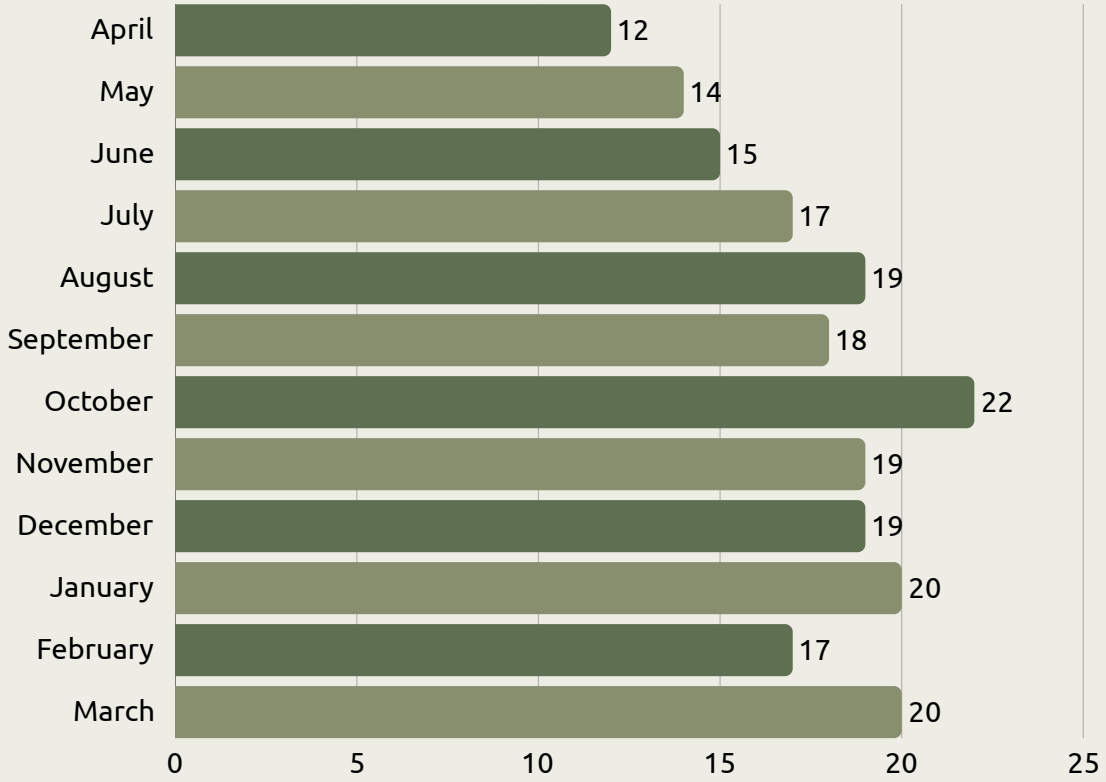
Mobile vs Fixed Location Days



The majority of service days (73.6%; 156 of 212) took place at mobile locations, emphasizing MHC's focus on delivering services directly within the community, and reaching constituents in locations where they are most accessible. In comparison, 25.5% (54 of 212) of service days occurred at fixed locations, which provide stable access points of care for constituents.

Source: MHC Data Library; Registration and Daily Tracking Document, n=212.

Service Days by Month



Source: MHC Data Library; Registration and Daily Tracking Document, n=212.

Service days start lower in the spring, gradually rising to a peak in October 2025, and then remain relatively stable through the colder months of November 2025 to March 2026, with only minor fluctuations.

Access Points

Fixed Locations

- North End Women's Centre (NEWC)
- N'Dinawemak (190 Disraeli)
- Siloam Mission (300 Princess Street)
- Sunshine House, MOPS (646 Logan Avenue)
- 357 Kennedy Street
- Austin Street Festival
- Velma's House (455 McDermot Avenue)
- Dollarama (1114 Main Street)

Mobile Locations

- St. John's Park (510 Main Street)
- 145 Powers Street
- Velma's House (455 McDermot Avenue)
- Sunshine House, Kelly's Corner (646 Logan Avenue)
- Furby Street Housing
- Bell Tower (470 Selkirk Avenue)
- Burrows Avenue
- Dollarama (1114 Main Street)
- The Salvation Army Weetamah (324 Logan Avenue)
- The Salvation Army (180 Henry)

These top 10 mobile locations represent the most frequently visited sites for MHC service delivery among a total of 80 different mobile locations. These locations account for a significant proportion of outreach activity, which indicates where there is the highest and most consistent demand for services.

Several of these top mobile sites also overlap with fixed service locations, which highlights the importance of these locations as key access points for constituents, where consistent presence supports ongoing engagement and continuity of care.

Team

The clinic is supported by a dedicated and diverse team that brings together a range of skills, experiences, and perspectives. This team includes physicians, nurses, mental health crisis counsellors, an Indigenous social planner, a medical office assistant, and a peer support worker.

Within this model, team members often wear many hats. On any given day, they may provide clinical/medical care, offer emotional and crisis support, help with navigating services, assist with paperwork, or connect constituents to resources.

We are grateful for the dedicated individuals who make up MHC's team. Their commitment, compassion, and flexibility are at the heart of the care we provide.

Zachary Potskin	Medical Office Assistant
Connor Keeper	Indigenous Social Planner
Deanna Garand	Registered Nurse
Jowell Richardson	Mental Health Crisis Counsellor
Crystal Hughes	Mental Health Crisis Counsellor
Wesley Overwater	Peer Support Worker
Paula Wurtz	Registered Nurse, Casual
Karis Klassen	Registered Nurse, Casual
Michaela Miller	Registered Nurse, Casual
Lauren Ferguson	Mental Health Crisis Counsellor *(until May 2025)*
Dr. Camisha Mayes	Medical Director
Dr. Kathy Kisil	Site Medical Lead (2026 to present)
Dr. Iris McKeown	Site Medical Lead (2025)
Dr. Christine Buchel	Physician
Dr. Al Buchel	Physician
Dr. Michael Zhanel	Physician
Dr. Samreen Rizwan	Physician
Dr. Jennifer Campbell	Physician
Dr. Jacky Anand	Physician
Dr. Fernando Villasenor	*(until September 2025)*
Laiza Pacheco	Mobile Healthcare and Wellness Clinic, Director

APPROACH & METHODOLOGY

This report is grounded in decolonial methodologies and approaches, from MHC's decolonial healthcare model, to the data extraction processes, analysis, and writing of this report.

Decolonial methodologies call on us to challenge Eurocentric systems and structures, paradigms, processes, and practices that undermine Indigenous and local knowledge, worldviews, and lived experience (Chilisa, 2019; Denzin et al., 2008; Smith 2012) and to center Indigenous epistemologies (Smith, 2012). These methodologies bring to the forefront the need to locate, critically analyze and dismantle colonial systems of power (Arvin et al., 2013), recognizing that awareness of colonizing praxis is vital (Kovach, 2009; Touch & Yang, 2012). Furthermore, this lens brings to our attention that monoculture within healthcare has excluded Indigenous knowledge/ways of knowing (Smith, 2012), and the importance of contextualizing to aid in understanding this greater story (Smith 2012). A decolonial approach seeks actions needed to make room for non-Eurocentric knowledge systems (Chilisa, 2012; Tuck & Yang, 2012), and to increase capacity building in communities to control health discourses and actions (Smith, 2012). By decentering colonial formalized healthcare practices and data extraction procedures, challenging ideologies can be set into praxis, making space to re-insert Indigenous ways of providing healthcare and changing the way community relatives experience healthcare.

The western biomedical system is rooted in colonial practices, including epistemic dominance (Coones Long et al., 2025; San-tos et al., 2026), and corresponding data extraction/reporting practices such as:

- Focus on certain measurements for impact/quality of care that do not align with cultural and context specific aspects, these measurements often inadequately engage with the systemic roots of health inequities (Yanful et al., 2023).
- Focus on illness and a reductionist approach that does not consider, and actively dismisses, Indigenous views on interconnected health such as environment, community, relationships, culture and spirituality, resulting in significant gaps in the mainstream systems for effectively addressing the needs of Indigenous communities (Santos et al., 2025; Sehgal et al., 2025).
- Is predominately reactive (Franklin, 2019), where decolonial & Indigenous models of healthcare are ontologically proactive and address barriers to care/health.
- Focus on 'standardization' as the protocol of operation (Accad 2016, p. 145), where decolonial practices emphasize flexible care and delivery (Corso, 2022; Clare, 2026).

Moreover, the dominant monoculture of extracting data for health reports often perpe-tuates colonial healthcare structures by ignoring cultural knowledge/practices that do not abide by the dominant discourses of health (Chambers et al., 2018). An example includes the lack of measurements for capturing data beyond 'outcomes' to 'processes', such as the guiding principles of relational and relational accountability (Smith 2012, Wil-

-son, 2008), that Eurocentric formal standards of measurement do not capture or illustrate (Yanful et al. 2013). Another example includes the lack of capturing services dedicated to the wider determinates of health in standardized healthcare reporting, including integrating advocacy efforts to break down barriers such as systemic racism and housing needs within healthcare.

The praxis application of decolonial methodologies in the context of extracting and writing this report means we actively seek to step outside of conventional impact measurements to capture how MHC is redefining models of healthcare, challenging and pushing past 'normative', dominant discourses of what healthcare should involve. This includes capturing the wider approaches and supports/services that MHC provides, incorporating important epistemological aspects such as repairing trust, building strong relationships, focusing on community, and other aspects of relationality (Smith, 2012; Wilson, 2008), as well as capturing decolonial healthcare elements such as colonization-informed care, holistic care, and storytelling (Santos et al., 2026). It also means moving away from only capturing the formality standards for services, to capturing the fluidness and flexibility that the MHC healthcare model provides in working to meet the wider needs of the community through their holistic care.

A decolonial praxis approach also means illustrating ways in which MHC actively seeks to undo and dismantle colonial privilege (Kovach, 2009; Smith, 2012) by breaking down barriers for those that exist outside of colonial restrictions to care (such as providing care to those without the formalities of a health card). This also means highlighting how MHC services reduce wider systemic barriers including capturing things such as systems navigation and advocacy; point-of-care treatment (acute, chronic and over the counter medication that are provided from MHC stock) that work to reduce transpor-

-tation and financial barriers; transportation arrangements and rides for their constituents; as well as the wound care supplies that MHC provides for constituents to take home, and the provision of other essential supplies – all dislodging western formality structures that exists in colonial healthcare practice. Furthermore, this means that the data extracted and the way the report is written aims to de-emphasize the formalities of time and service limitations, and actively re-position the report so that it uncovers these wider decolonial impacts. These include illustrating aspects such as the breath of all services provided instead of one 'reason' metrics and shifting away from normative 'outcome' only reporting to 'process' reporting (Yanful et al., 2013). In this, we seek to illustrate the broader scope of services provided beyond just the numbers that are presented while also providing contextualization to the wider impact that is emerging from MHC's decolonial services and care.

METHODS

Data Sources

There were multiple data sources used in the compilation of this report including a manual extraction of EMR data through Accuro, the MHC Data Library where raw datasets were already compiled by the MHC staff, as well secondary source reports that MHC produced.

AccuroEMR

A manual extraction of data recorded in AccuroEMR, a Canadian electronic medical record platform used to manage patient records and clinical workflows, was undertaken to produce the primary raw dataset for this report. Details of the data extracted from the EMR are outlined in the data extraction section below.

There are two main reasons why a manual extraction approach was implemented rather than generating a standard electronic report directly from Accuro:

(1) Limitations in Accuracy of Systematically Extracted EMR Data
Systematically extracted datasets from the Accuro database are not always accurately reflected due to:

- When a reason for the visit in the Billing and Appointment details is not entered, these are captured as 'blanks' in the 'reasons' statistics in the Accuro-generated reports. Through manual review, the encounter notes often document the reason for the visit, removing false 'blank' entries and only capture the true 'blank' entries. True 'blanks', through the manual review occur only when there is no reason indicated in the Billing and Appointment information and there is no encounter note. Manual extraction improves data accuracy by decreasing the number of 'blank' entries through locating and providing the reasons for visit through providers' encounter notes.
- In some cases, the 'reason' in the Billing and Appointment details may be pre-selected or entered incorrectly and may not reflect the actual services provided. When running the electronic statistics dataset through Accuro-generated reports that rely on these fields and may therefore misrepresent the true reason and services provided in the visit. A manual extraction addresses these discrepancies, and reduces these errors, by aligning recorded reasons/services with providers' encounter notes.
- In some cases, a patient may be registered in the system and marked as "seen" in the Billing and Appointment details; however, the providers' encounter notes indicate that the patient had left without being seen (LWBS). This data quality discrepancy can lead to overestimation of the number of patients seen and visits recorded. Manual extraction helps address this issue through verification of providers' encounter notes, resulting in more accurate counts of encounters and visits actually occurred.

2) Incomplete Capture of Services in System-Generated EMR Data
An EMR dataset produced systematically through standard Accuro reporting functions is limited in its functions as the user is restricted to one presenting 'reason' for the encoun-

-ter/visit and does not reflect the full range of services addressed within an encounter/visit. As MHC uses a decolonial model of care, manual extraction is required to capture the full scope of services provided. Capturing all reasons is essential to accurately represent the breath, depth, and impact of care provided. This also includes services beyond conventional clinical care such as systems navigation, transportation coordination for appointments, point-of-care treatments and medications provided directly from MHC stock, and provision of take-home wound care supplies.

Manual data collection is timely, energy intensive, and costly, while not ideal, it is the chosen method due to the limitations of the EMR health repository. These limitations represent a need for a systems level overhaul if health providers and decision makers are to understand the true complexity of the patient populations.

MHC Data Library

The MHC Data Library holds seven raw datasets that have been produced by MHC care team throughout the year.

Registration and Daily Tracking Documents: The MHC team recorded daily counts for a range of service-related measures throughout the year. This dataset was used to triangulate and validate the counts for patients registered with the AccuroEMR data. It was also used for days open for services, number of teams per service day, mobile location visit counts, fixed location visit counts, locations where services were provided, number of patients turned away at closing, and Indigenous Social Planner activities.

New Patient Questionnaire Responses: The MHC team produced this dataset through an optional questionnaire offered to new constituents at the time of registration. As participation was voluntary, this dataset does not represent all unique constituents who received services from MHC, but only those who chose to answer some or all of the questions when registering as a new patient. Full numbers on how many individuals answered each question will be outlined in the report through "*n=*".

This raw dataset was used for Indigenous Identity; Status; Gender Identify; Sexual Orientation; Emergency/Urgent care deferrals based on MHC services; and Awareness of MHC.

Stories and Quotes Document: This document consists of stories of constituents' journeys with MHC over the course of the year, as documented by the team's full-time nurse, crisis counsellor, and the site medical lead. All stories provided use fictitious names to keep the constituents anonymous and share de-identified data through stories. It also includes anonymous quotes from constituents and partner agencies, collected by MHC staff for the report. These narratives provide a qualitive component that speaks to the impact of the services provided and complements the descriptive statistics and are integrated throughout the report.

MHC Work Tracker Document: This dataset, produced by the full-time nurse, is used in the report to capture information on systems meetings, community partner list and interactions, and triangulation with the providers' encounter notes in Accuro on Manitoba Housing forms.

Crisis Counsellor Notes and Updates Document: This document contains details on the Crisis Counsellor's ongoing services with 24 unique constituents with a large focus on documenting patients who are receiving ongoing counselling, systems navigation, and assistance with forms. This document is used in the report to provide context to the Systems Navigation & Advocacy section.

Medical Student Learners Document: This document provides details about the Medical Student Learners program with MHC, as well as data from pre/post surveys focused on the impact of street medicine exposure. This document is used for the Medical Student Learner Impact section.

Cost for MHC Visit and Recommendations Document: This document from the MHC Director provided us with the estimated cost per MHC visit that was used as a key metric in our cost analysis. It also provided the recommendations for increased funding and infrastructure support to expand MHC's impact, in the recommendations section.

Secondary Sources

AHWC Mobile Healthcare Clinic Report: This report was produced in the 2024-2025 fiscal year by the MHC staff and provided information for the overview section, guiding principles section, and goal section.

Monthly Clinic Board Reports: These are monthly reports that were produced by the MHC staff in the 2024-2025 fiscal year and were used for providing some context in the Introduction Section of the report.

Data Extraction

Healthcare data extraction refers to the process of collecting and transforming raw data (Kang & Cairns, 2022). The aims of data extraction are to obtain information about who is receiving care through MHC and what characteristics/observations are surrounding the care/services they receive, for data to be analyzed and illustrated through descriptive statistics.

Two experienced researchers carried out all data extraction and analysis for investigator triangulation. Investigator triangulation is a research strategy involving more than one researcher to collect and/or analyze the data to increase the concurrent credibility, validity, reliability, and accuracy of the research findings (Cohen et al., 2000; Noble & Heale, 2019). As each researcher has their own perspectives and paradigmatic biases, utilizing two or more investigators to cross-check evidence ensures that fundamental biases that can arise from the use of a single investigator are overcome (Cohen et al., 2000; Noble & Heale, 2019).

The steps for the data extraction include the development of the data extraction template, the protocol for data extraction, the piloting of the data extraction template, and the processes used to carry out the data extraction.

Development of Data Extraction Forms

An AccuroEMR data capturing form outlining the data currently recorded in the system was provided by MHC. Based on these existing categories, two researcher data extractors developed a data extraction template (Appendix A). Additional data points were also incorporated to capture reasons/services not reflected in the original form provided by MHC (e.g., Point-of-Care Treatment for Acute Health Concerns; Non-Prescription Medications). These added data points were reviewed and agreed upon by both researchers.

The data extraction template captures the follow data points: 'Code' (a unique anonymous identifier code for each constituent); date and day of each encounter; Health Card Coverage (whether the constituent has a provincial health card, or no health card); Sex;

Age Category; Service Type; Duration of Encounter; Duration of Visit; Care Team; Services Provided (reasons/services categories outlined in Appendix B), along with 'Notes for services provided'. It also includes all referral categories Appendix C), and corresponding Referral Notes; as well as Non-Patients Seen.

The accompanying service and referral notes allowed the extractors to break down these data points even more, such as distinguishing housing referrals to report (e.g., Housing First, St Boniface Street Links, the provincial Your Way Home Housing Strategy , N'Dinawemak, Salvation Army, Kelly's Corner, Manitoba Housing, West Central Women's Resource Centre) and breaking down the "other" category (e.g., number of transportation services arranged and provided; number of wound care supplies provided to patient etc.).

Protocol, Processes, and Piloting

Protocol

A protocol is required to ensure the consistency of data extraction so that the risk of unsystematic data collection is reduced by providing a guide for the extraction of essential data in a systematic, transparent, and reproducible manner to facilitate the development of an accurate dataset (Kang & Cairns, 2022). Without proper operational rules, the health data may not be extracted consistently, creating a risk of biasing the analysis (Kang & Cairns, 2022).

The two researcher extractors developed a standardized protocol for data extraction as outlined below:

- Clear definitions were established for each reason/service and each referral category from MHC (see Scope of Services section for detailed definitions and parameters).
- Reasons/services were recorded when patients were directly seen during an encounter. Services provided without a direct interaction, such as systems navigation on the constituent's behalf, chart or lab review, or outreach/follow-up attempts, were recorded as Visit Type "Other". These were excluded from encounter or visit counts, but included in the total service counts and related analysis.
- Encounter notes documented by providers were used as the primary source for identifying reasons/services provided and referrals. If no encounter note was available, data for reasons/services was extracted from the Billing and Appointment details (accessed via the F4 function).
- If the encounter note documented the appointment as "LWBS", the encounter was excluded from the dataset.
- If there was an appointment scheduled (e.g., home visit) and the encounter note identified that the constituent was not there, the encounter was marked as a "No Show: Yes" and was excluded from the dataset.
- If there was no encounter note and the Billing and Appointment details indicated "No Show: Yes", the encounter was excluded from the dataset.
- If there is no encounter note and the Billing and Appointment details indicated "No Show: NO", the encounter was included in the dataset. If a reason/service was listed in the Billing and Appointment detail, that reason/service was included in the data extraction. If there was no reason/service identified in the Billings and Appointment details OR the reason/service had a question mark "?" and could not be confirmed with an encounter note, these were included in the data extraction and classified as 'true blank'.

- A “true blank” classification required all of the following conditions to be met:

  (1) The Billing and Appointment details indicated “No Show: No” (i.e., the patient was not a “no-show” and was seen);
  (2) There was no encounter note to document the reasons/services provided;
  (3) There was no reason/service identified in the Billing and Appointment details, or the note the entry was unclear (e.g., contained a question mark “?”) and could not be confirmed with providers’ encounter notes.
- If there was no encounter note and no reasons/services provided in the Billing and Appointment details, but the “No Show” status was masked or unavailable, the encounter was extracted as an “Unidentified Blank”, as it could not be determined whether it represented “No Show: Yes” (LWBS) or a “True Blank”.
- If an encounter was captured only through a provider’s encounter note without corresponding Billing and Appointment details indicating the length of the appointment, a default duration of 15 minutes was allocated for the encounter.

Processes Prior to Piloting

All unique patients, and their encounter dates, were extracted by the researchers in a dual extraction process, going day by day using the Accuro Scheduler tab and cross referencing it with the Accuro Day Sheets, to reduce extraction errors and ensure greater accuracy (Mathes et al., 2017)., All unique patients were provided a unique anonymous identifier code which was then included in the data extraction template. Following this step, the data extraction template was piloted.

Piloting

The data extraction tool was piloted by both the researchers, extracting the data for five encounters with unique patient identifier codes. This was done to validate the data extraction tool by checking the replicability of the data extraction and to clarify the extraction tool (Kang & Cairns, 2022) prior to full data extraction. Any unclear items were resolved as a team by both researchers to ensure consistency and reliability of data and clarified in the extraction protocol. This process is also useful to pinpoint where any subjectivity may arise in the data extraction (Kang & Cairns, 2022) and set parameters in the protocol. Once the piloting was done, the data extraction protocol and processes were finalized, and full data extraction commenced.

Processes Following Piloting

Once the piloting of the data was completed, the unique identifier codes (n=568) were split in half for each independent researcher to perform singular extraction. Dual data extraction of all data by two extractors is not always necessary as the basic principle of reduced extraction methods is if the focus is on extracting characteristics vs extracting outcome data (Mathes et al., 2017). As this extraction is focused on characteristic data points, dual extraction is not mandated as necessary for accuracy (Mathes et al., 2017). However, upon full completion of data extraction, all extracted data was double reviewed by the independent researcher to ensure accuracy and reliability of the raw data.

Data Analysis

The extracted data was analyzed quantitatively through descriptive statistics, a method used for understanding data through collating, summarizing and presenting raw data effectively (Marshall & Jonker, 2010; Warner, 2013), allowing for a thorough examination of factors (Maxwell et al., 2017). Descriptive statistics are used to summarize and illustrate key characteristics of a group of observations (the raw data) in a logical, clear, and understandable format ((Marshall & Jonker, 2010). Counts, pro-

-portions, measures of central tendency (e.g., mean, mode, medium), measures of dispersion (e.g., range), and measures of distribution (e.g., frequency) are utilized in this report to illustrate the characteristics (Marshal & Jonker, 2010), as well as identifying, displaying, and providing insights into the patterns and trends located in the dataset (Alabi & Bukola, 2023; Cooksey, 2020).

For this data, both numerical procedures/summaries and visually/graphical techniques (i.e., bar charts, graphs, pie charts) are incorporated to provide visual measures of characteristics (Marshal & Jonker, 2010), as visualization aids in discerning data patterns and trends, describing essential features within the dataset, and facilitating quick insights and a general depiction (Alabi & Bukola, 2023; Cooksey, 2020).

Qualitative data that was pulled from the encounter notes was only used to provide context to the descriptive statistics, and not analyzed on its own, such as referrals to types of health specialists (e.g., Plastic Surgeon, Orthopedics, Diagnostic imaging etc.), and stories to provide context through de-identified data.

Qualitative data that was provided through the MHC Data Library: Stories and Quotes Document was not included in any analysis. Rather, this de-identified data was only used to provide a qualitative component that speaks to the descriptive statistics presented and to provide context to the real-life impact for the constituents.

Cost Savings Analysis was performed using ChatGPT with the following key metrics: annual visits, unique constituents, cost per MHC visit, MHC emergency room diversion data, average emergency room visit cost, homelessness-related hospital admission cost, and ambulance utilization cost.

SCOPE OF SERVICES

MHC offers 57 unique, integrated services to meet the complex and intersecting health needs of its constituents. These specific services are also referred to as reasons" for constituent encounters and visits in the EMR and used to capture the care provided during each patient encounter. These 57 services are grouped into 10 key service categories that reflect both clinical and social care priorities.

Primary Care

Includes a wide range of comprehensive, frontline health services that address the majority of constituents' immediate and ongoing health needs. These services encompass general health assessments, prevention, diagnosis, treatment, and coordination of care across a wide spectrum of conditions.

Health Promotion and Education: Providing information, guidance, and support to help constituents make informed decisions about their health and wellbeing. Services may involve education on topics such as disease prevention, medication use, harm reduction, safer sex practices, hygiene, nutrition, and management of chronic or acute conditions.

Immunization: Assessment, administration, and documentation of vaccines to protect against preventable diseases. Services may involve reviewing immunization history, providing recommended vaccines (e.g. Tdap, Twinrix, Engerix-B, Pneumo and Prevnar 20), educating constituents about vaccine benefits and potential side effects, and monitoring for immediate reactions following administration.

Minor Procedure: Low risk, on-site medical interventions that do not require hospitalization or advanced surgical facilities. These services may involve wound closure (e.g., suturing/stitching), drainage of wounds or abscesses, removal of sutures or staples, insertion or removal of devices (e.g., IUD), removal of skin lesions (e.g., mole removal), and skin biopsies.

Regular Check-Up: General assessment and the evaluation and management of common, non-complex health concerns. Services may include routine check-ups, vital signs monitoring, and assessment of minor or acute conditions such as sinus infections (e.g. bronchitis), headaches, gastrointestinal issues, urinary tract infections, musculoskeletal pain (joint or muscle), eye concerns, allergies, lice, etc.

Treatment for Minor Injury: Assessment and management of non-life-threatening injuries such as bruises, sprains, and minor trauma. Services may involve physical assessment, pain management, and functional evaluation of the affected area. This also includes screening to rule out more serious injuries (e.g. fractures or significant soft tissue damage) and determining whether further investigation or referral is required.

Wound Care: Assessment, treatment, and management of acute and chronic wounds. Services may involve cleaning and dressing wounds, monitoring signs of infection, providing treatment, and supporting healing through follow-up care and education. This can include care for cuts, abrasions, ulcers, abscesses, burns, frostbite-related wounds, and injection-related wounds.

***Referrals to* Emergency Department (General):** Coordination of referrals to hospital emergency departments for further assessment, investigation, or treatment that cannot be safely managed within MHC. This involves advising constituents to present to the emergency department, directly communicating with emergency department staff to facilitate care, and providing information and documentation to support continuity of care.

***Referrals to* Indigenous Community Health Provider:** Referrals to Indigenous-led or Indigenous-based health services that provide culturally appropriate, holistic care.

***Referrals to* Medical Specialists & External Providers:** Coordination and facilitation of referrals to external healthcare providers beyond the scope of services provided by MHC. This includes medical specialists in plastic surgery, physiotherapy, minor injury clinics, immunology, dermatology, cardiology, ophthalmology, gynecology, orthopedics, and psychiatry, as well as other health specialists such as Sport for Life.

***Referrals to* Outpatient Services & Allied Health:** Referrals to non-emergency, scheduled healthcare services provided in outpatient settings where constituents receive care without being admitted to the hospital. These include hospital-based or affiliated outpatient clinics and allied health (occupational therapy, foot care, dental).

***Referrals to* Emergency Department (911/EMS):** Emergency situations where immediate medical attention is required and EMS are called to assess and transport a constituent to the emergency department. These involve urgent or life-threatening conditions (e.g., altered level of consciousness, suspected sepsis, head injury, or other acute medical emergencies) that cannot be safely managed within MHC. This also includes handover of the constituents to paramedics, and communication of information to support continuity of care during transport to the hospital.

***Referrals to* Primary Care Provider:** Referrals and connections to a primary care provider (family doctor or nurse practitioner) to support continuity of care beyond MHC by connecting constituents to their regular provider for management of chronic conditions, follow-ups, preventive care, medication/prescription management, and coordination of additional services.

***Referrals to* Spiritual Healthcare Provider or Supports:** Referrals to spiritual care providers and supports that address the spiritual and emotional wellbeing of constituents. These services may include access to Elders, traditional knowledge keepers, chaplain services, faith-based supports, or other spiritual care providers beyond the scope the Indigenous Social Planner is able to provide.

***Referrals to* Urgent Care:** Referrals to urgent care for timely assessment and treatment of non-life-threatening conditions that require prompt medical attention. This may involve advising constituents to seek care at urgent care centres, or specialized urgent care services (e.g., eye care), particularly for concerns such as worsening symptoms (increasing pain, fever, redness, or signs of infection).

Chronic Condition Management & Acute Care

Includes the assessment, treatment, and ongoing care of both long-term (chronic) conditions and short-term (acute) health concerns.

Chronic Disease or Condition Management: Ongoing assessment and monitoring of symptoms and progression of long-term health conditions that require continuous care. This includes managing conditions such as diabetes, hypertension, asthma, chronic obstructive pulmonary disease (COPD), arthritis, and mental health conditions.

Diabetes Testing: Screening used to identify or assess diabetes and blood glucose. This involves point of care blood glucose testing, HbA1c testing, and assessment of related symptoms.

Diabetes Treatment and Management: Clinical management of diabetes to maintain safe blood glucose levels and prevent complications. This may include initiating or adjusting medications, providing education on medication use and blood glucose monitoring.

Point-of-Care Treatment for Acute Health Concerns: Treatment of short-term or urgent health concerns provided directly at the point-of-care by MHC providers from MHC stock.

Point-of-Care Treatment for Chronic Disease or Condition: Treatment for long-term, chronic health concerns provided directly at the point-of-care by MHC Providers from MHC stock.

Medications & Prescriptions

Includes services that support constituents in accessing necessary medications for both acute and chronic conditions. It encompasses the clinical assessment, prescribing, and provision of medications to ensure timely and appropriate treatment.

New Prescription: Clinical assessment and authorization of medications by an MHC provider to treat or manage acute or chronic health conditions. This involves issuing new prescriptions and providing guidance on appropriate use.

Non-Prescription Medication: Provision or administration of non-prescription medications directly at the point of care to address acute symptoms or support ongoing treatment. Medications may include analgesics (acetaminophen, ibuprofen), antihistamines, topical treatments, pediculicides, cold and flu remedies, and other commonly used over-the-counter products.

Prescription Refill: Clinical review and renewal of an existing medication to support continuity of care for ongoing treatment. This may involves assessing the constituent's current health status and determining the ongoing appropriateness of the prescription.

Sexual & Reproductive Health

Includes services that support constituents in accessing necessary medications for both acute and chronic conditions. It encompasses the clinical assessment, prescribing, and provision of medications to ensure timely and appropriate treatment.

Contraceptives: Provision and management of contraceptive methods to support pregnancy prevention and reproductive health. This involves providing or prescribing contraceptives (oral contraceptive pills or condoms), administering injectable contraceptives (Depo-Provera), and insertion of long-acting reversible contraceptives (IUDs).

HIV Management: Ongoing clinical care and support of individuals living with HIV. This involves monitoring health status, prescribing and managing antiretroviral therapy, supporting medication adherence and addressing side effects of complications.

HIV Point-of-Care Testing: Rapid, point-of-care screening for HIV using test kits that provide results during the same visit.

Pap Test Examinations: Collection of sample of cells from the cervix for lab analysis.

Pregnancy Testing: Assessment and administration of urine-based point-of-care testing to determine the presence of pregnancy hormone (hCG).

PrEP (Pre-Exposure Prophylaxis for HIV Prevention): Provision of PrEP to support the prevention of HIV for individuals at risk of HIV exposure.

STBBI Testing: Screening and diagnostic services for sexually transmitted and blood-borne infections, such as HIV, hepatitis B and C, syphilis, gonorrhea, and chlamydia. Testing may be done on-site or through laboratory requisitions for blood, urine, or swab samples.

STBBI Treatment: Clinical management of sexually transmitted and blood-borne infections such as HIV, hepatitis B and C, syphilis, gonorrhea, and chlamydia. This may involve prescribing and administering appropriate medications (e.g., azithromycin, cefixime, bicillin), managing symptoms, and monitoring response to treatment.

***Referrals to* Manitoba HIV Program:** Referrals and connections to the Manitoba HIV Program (Nine Circles, HSC, Brandon) for specialized, comprehensive care for constituents living with or at risk of HIV. This may involve completing referral documentation, coordinating appointments, and supporting constituents in navigating and engaging with the program to ensure continuity of care.

Substance Use Support

Includes a range of supports for those navigating substance use, grounded in principles of harm reduction, and non-judgmental care. These services meet people where they are in their journey with substance use without requiring abstinence or crisis to access support.

Detoxification Program Clearance Forms: Clinical assessment and documentation completed to determine a constituent's medical suitability for admission to a detoxification or withdrawal management program. This may involve reviewing medical history, current substance use, vital signs, and any acute or chronic conditions that could impact safe participation in detox.

Drug Screening Test: Point-of-care or lab-based tests to detect presence of substances in the body, typically through urine samples.

Harm Reduction Supplies: Distribution of harm reduction supplies to reduce risk of infection, injury, and other health-related harms associated with substance use. Supplies may include sterile injection equipment (needles, syringes), naloxone kits, and other protective materials.

Opioid Agonist Therapy (OAT): Clinical management of opioid use disorder through the use of prescribed medications such as methadone or suboxone, which help reduce withdrawal symptoms, cravings, and the risk of overdose, to support stabilization and recovery. This involves assessment and initiation of OAT, ongoing medication management, monitoring of treatment response, and support for adherence.

Substance Use Support: Includes assessment, counselling, education, and connection to resources (e.g., available treatment and support options) for constituents experiencing substance use.

***Referrals to* RAAM:** Referrals to the AHWC Rapid Access to Addictions Medicine (RAAM) clinic or services which provides low-barrier access to assessment and treatment for substance use disorders.

***Referrals to* Withdrawal Management Services:** Referrals to detoxification services that provide supervised support for those undergoing withdrawal from substances such as alcohol, opioids, or other drugs.

Mental Health Support

Includes emotional support, counseling, and crisis intervention for individuals experiencing mental health challenges (e.g., stress, anxiety, depression, trauma, and grief).

Counselling: Supportive interactions that address constituents' mental, emotional, and psychosocial needs. This may involve crisis intervention, emotional support, brief therapeutic counselling, and discussions related to mental health, trauma, and life stressors.

Mental Health Supports: Mental health support provided outside of counselling services and referrals. These supports are provided by the nurses and physicians, and involve mental health discussions when the constituents present with concerns such as anxiety or depression, follow-up for mental health needs, mental health resources, situations where ASIST protocol was enacted, and completion of Forms 4's for psychiatric assessment.

***Referrals to* Mental Health Services:** Referrals and connections to community mental health services for assessment, treatment, and ongoing support (AHWC, DCSP, Klinic, CRC, Mental Health Crisis).

Systems Navigation

Services that includes services that support constituents patients in accessing and navigating complex health and social systems. This may involve assisting individuals in accessing housing, income support, and other resources beyond clinical care.

Forms: Services that support constituents with the completion, submission, and follow-up of various applications and forms related to health and social supports (income assistance (EIA), housing, disability assessment forms, treatment forms, tax credit forms). This may involve completing forms on constituents' behalf with consent, submitting or dropping off documentation, and providing updates on the status of applications to help reduce administrative barriers.

Systems Navigation: Services that support constituents in accessing and navigating healthcare, social, and community-based systems. This may involve coordinating appointments, facilitating referrals, and connecting constituents to external services such as housing programs, EIA, Family Doctor Finder, and other community resources.

Referrals to **Domestic or Intimate Partner Violence Supports:** Referrals and connections to services that support constituents experiencing domestic or intimate partner violence.

Referrals to **General Housing Services and Supports:** Referrals and connections to a range of housing-related services that support constituents in securing, maintaining, or improving their housing situation.

Referrals to **Housing (Emergency Shelter)**: Referrals and connections to emergency shelter services that provide immediate, short-term accommodation for constituents experiencing homelessness or housing crisis.

Referrals to **Housing (Transitional):** Referrals and connections to transitional housing programs that provide supportive housing for constituents who are experiencing homelessness or housing instability.

Diagnostics

Includes services that provides laboratory testing and screening for accurate diagnosis and informed treatment planning.

Lab Services: Collection and coordination of laboratory tests to support assessment, diagnosis, and monitoring of health conditions through point-of-care testing (when available), including point-of-care blood work, urine analysis, swabs, and other diagnostic tests.

Requisitions: Ordering and provision of laboratory test requests to support assessment, diagnosis, and monitoring of health conditions. This involves completing and issuing requisition forms for tests such as bloodwork, urine testing, as well as imaging such as ultrasound, CT scans, and mammography.

Relational Care

Essential supports that fall outside of conventional healthcare/clinical models, but that are essential to meeting the holistic needs of constituents, and to capture/show wider decolonial services provided in this healthcare model.

Appointment Reminders: Providing reminders to constituents about upcoming appointments to support attendance and continuity of care. These reminders may be delivered in person or by phone, depending on what is most accessible and appropriate for the constituent.

Building Rapport: As many constituents have experienced discrimination and trauma within the healthcare system, some may be cautious about trusting healthcare providers. The MHC team dedicates time working to create safe and supportive environments to strengthen relationships and trust to encourage engagement with the health supports constituents need.

Medication Support: Assisting constituents with medication access and management, including supporting travel to the pharmacy, picking up prescriptions for those who are unable to do so, and locating constituents to deliver, and sometimes administered on-the-spot needed medication.

Provision of Basic Needs: Distribution of essential items such as water, snacks, clothing, and seasonal gear (e.g., winter jackets, gloves, hats, socks) to support the immediate health, safety, and comfort of constituents.

Transportation Support: Supporting constituents in accessing transportation to attend medical appointments, obtain medications, or connect with other essential services. This may involve coordinating transportation with partner organizations, providing bus tickets, or directly transporting constituents by MHC providers.

Indirect Care

Services that support the delivery of care without direct, face-to-face encounters or interactions with constituents.

Care Coordination: Communication and collaboration with external healthcare providers, community organizations, and social services to support continuity and integration of care. This involves sharing relevant information to ensure constituents receive appropriate and timely services and care.

Documentation: Recording, review, and updating of clinical and service-related information to support safe, accurate, and continuous care. This involves charting encounter details, reviewing existing records, and updating documentation to reflect changes in a constituent's health status, care plan, or service needs.

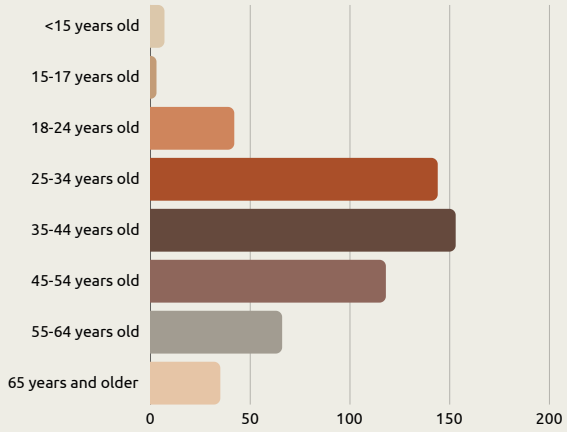
Follow-Up and Outreach Activities: Proactive efforts by providers to maintain connection with constituents outside of direct clinical encounters. This involves follow-up attempts in-person or by phone, general wellness check-ins, status updates, and efforts to locate or reconnect with constituents after missed visits/appointments.

DEMOGRAPHICS

Age Category

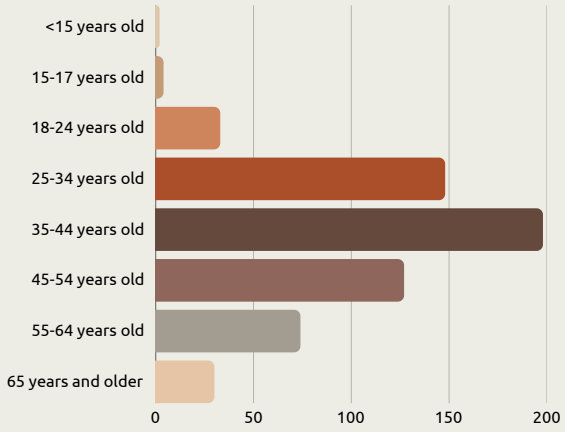
Age distribution provides insights on MHC's reach across various life stages.

2025-2026



Source: AccuroEMR, n = 568.

2024-2025



Source: AccuroEMR, n = 616.

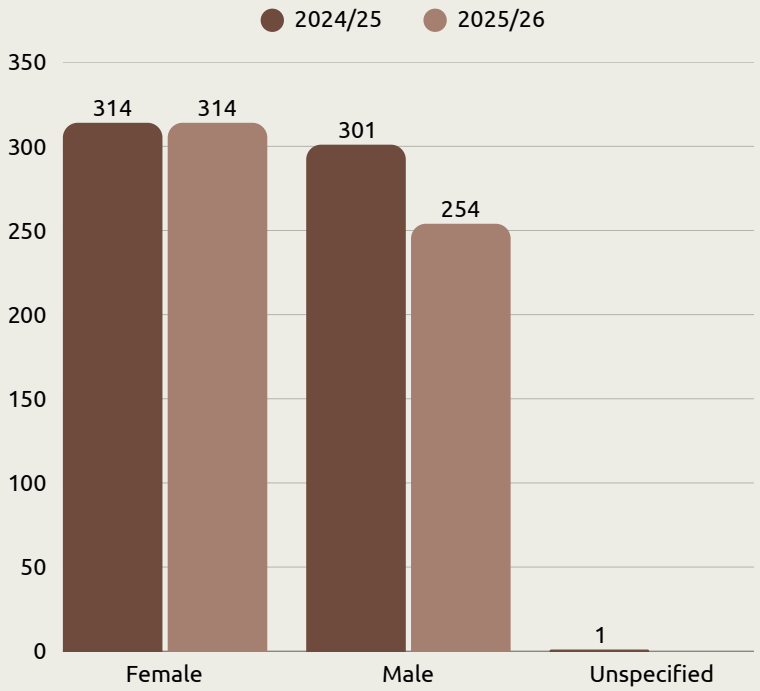
MHC primarily serves middle-aged adults (25-54 years), who account for over 70% of all constituents. The highest utilization is among constituents aged 35-44, followed closely by those aged 25-34. The low utilization among children and adolescents (under 18), who make up less than 2% of total constituents. Young adults (18-24) and seniors (65+) represent a modest portion of constituents, while patients aged 55 and older account for nearly 18%.

Both years show a consistent pattern of clinic utilization dominated by middle-aged adults (25-54 years). However, there are subtle shifts in which specific age groups are most represented and how strongly each group contributes to total encounters and visits.

Compared to last year, MHC utilization reflects a more evenly distributed age profile within the adult population, with less concentration in the 35-44 age category while still maintaining middle-aged adults as the primary users of services. There is a gradual increase in engagement among both younger adults (18-24) and seniors (65+), indicating a slow but broadening of the constituent base.

Biological Sex

AccuroEMR captures data with options limited to ‘Female’ and ‘Male’, or otherwise ‘Unspecified’ when information is not provided. It is important to note that while this data is used to provide insight into the biological, sex-specific health of the population, the clinic maintains a broader and more inclusive understanding of sex.



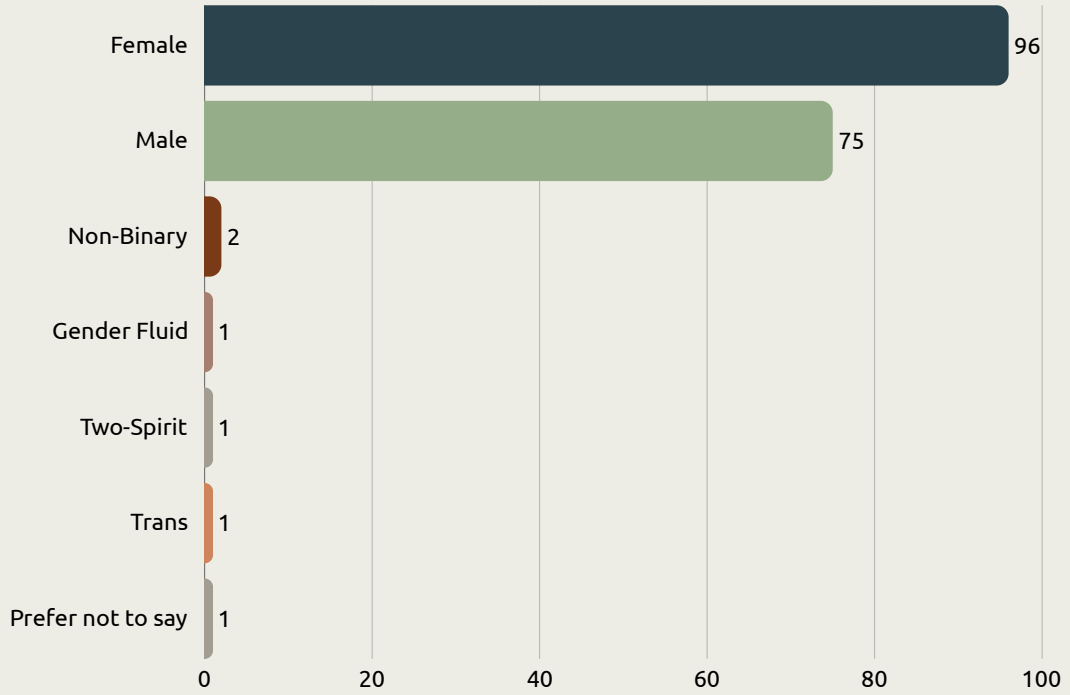
Source: AccuroEMR, n = 616 (2024/25); n = 568 (2025/26)

The data shows the distribution of constituents by biological sex among a total of 568 individuals. Of these 314 constituents (55.3%) are female and 254 constituents (44.7%) are male, indicating that females make up a modest majority of those accessing MHC, and suggesting a slightly higher level of engagement with clinic services among female patients compared to male patients.

When compared to last year’s data, where 51% (314 constituents) were female, and 0.2% (1 constituent) was unspecified, several shifts are evident. While the number of female constituents remains the same (314), their proportion has increased due to a decrease in male constituents. The male population declined from 301 to 254, resulting in a wider gap between female and male patients this year. Overall, the data may indicate a growing gender gap in MHC utilization, with female patients representing an increasing share of service users.

Self-Identified Gender

Understanding and respecting gender identity is essential to decolonizing healthcare practices and providing an inclusive and affirming healthcare space. Recognizing that gender identity is distinct from biological sex, MHC aims to move beyond the limitations of binary sex categories (female/male) typically used in EMR systems. Instead, gender identity is captured through the MHC Data Library as a more inclusive and accurate reflection of the constituents served and can ensure services are better provided to meet any unique needs outside of the male/female binary.



Source: MHC Data Library; Registration and Daily Tracking Document, n=177

*This data does not include responses from new patients registered in November.

The majority of respondents identified as female, followed by male. A small number of individuals identify outside of binary categories, including non-binary, gender fluid, Two-Spirit, and trans. Additionally, one individual chose not to disclose their gender identify.

Note: *This was an open-ended field, allowing constituents to describe their identities in their own words.*

Jamie's Story

Jamie's story highlights the importance of this MHC's inclusive approach. Living with chronic transcience, substance use challenges, and identifying as trans/non-binary, Jamie faced significant barriers to safety and care. In shelter systems that are often divided strictly into male or female spaces, individuals who do not conform to these categories can experience heightened risk, discomfort, and isolation. These structural limitations made it difficult for Jamie to access safe and dignified support.

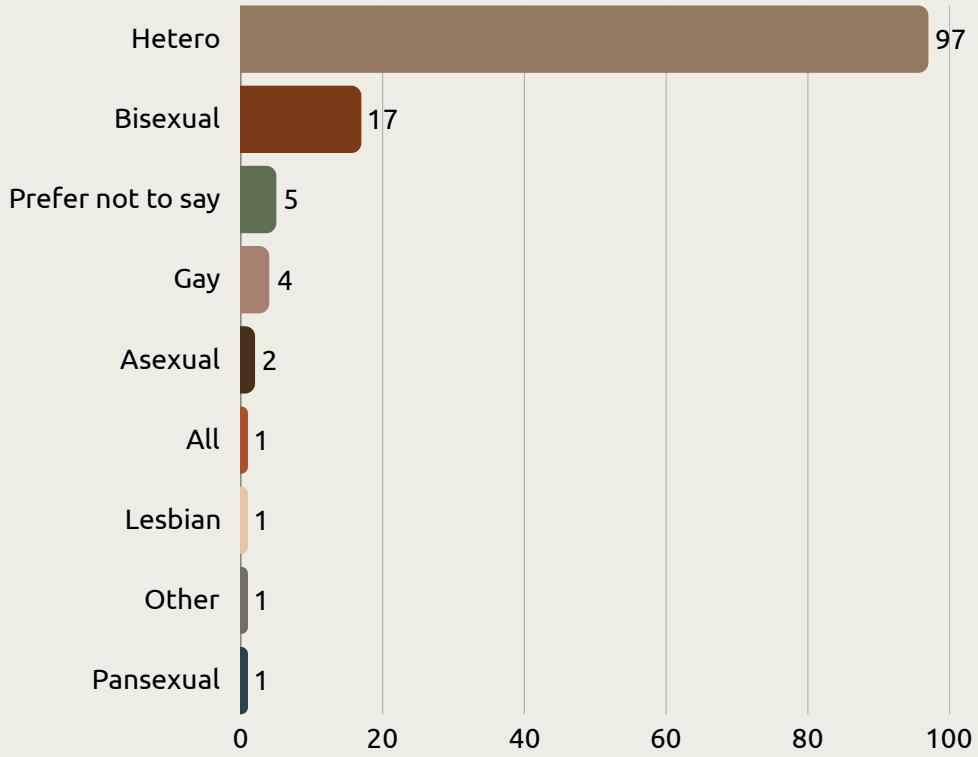
Through a slow and consistent relationship built at Velma's House, MHC was able to create a safe and affirming space for Jamie to engage in care. Jamie shared their goal of pursuing gender-affirming medical care and beginning a sobriety journey, and with the support from MHC, Jaime was able to initiate their medical transition. This milestone was acknowledged and celebrated by the team with their favourite cake on the mobile vehicle.

More recently, the team has supported Jamie through coordinated systems navigation, including a warm hand-off to Sunshine House services to connect them to more relevant support at their current chapter of life.

Source: MHC Data Library; Stories and Quotes Document

Sexual Orientation

Understanding the diversity of sexual orientations among constituents is essential for designing and implementing inclusive and affirming healthcare spaces that are sensitive to the specific needs of all community members. Awareness of who is accessing care helps ensure that services are appropriate and free of assumptions based on heteronormativity.



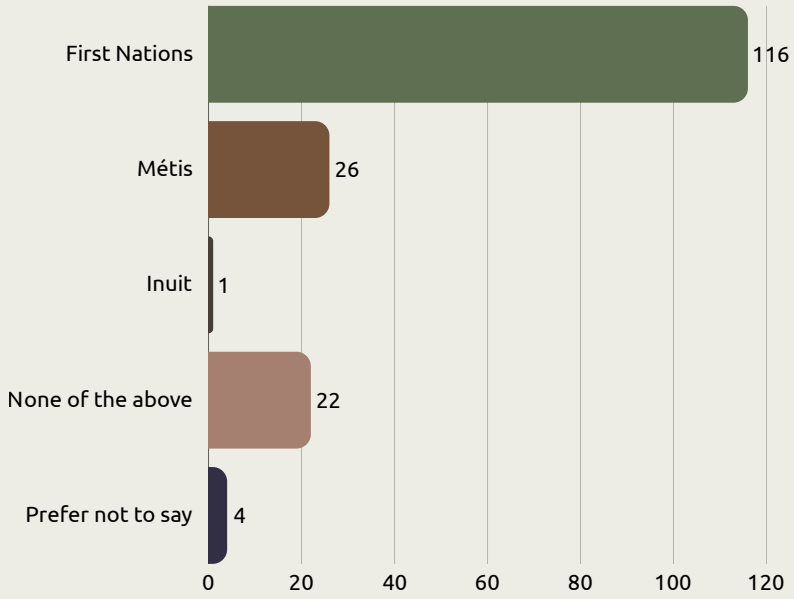
Source: MHC Data Library; Registration and Daily Tracking Document, n=129
*This data does not include responses from new patients registered in November.

The majority of respondents identified as heterosexual, representing the largest proportion by a significant margin. The next most commonly reported orientation was bisexual, followed by smaller numbers of individuals who preferred not to say and gay. A small number of constituents identified as asexual, while lesbian, pansexual and “all” and other categories were each reported by one individual.

Note: *This was an open-ended field, allowing constituents to describe their sexual orientation in their own words.*

Indigenous Self-Identification

Understanding how constituents self-identify is not only a way to capture who is using MHC services, but also a way of highlighting the need for services that respect and actively incorporate Indigenous perspectives and values into its service delivery.



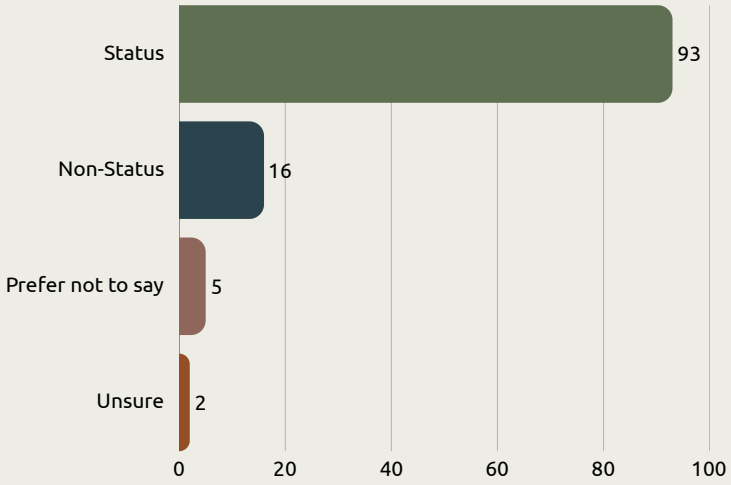
Source: MHC Data Library; Registration and Daily Tracking Document, n=169.

*This data does not include responses from new patients registered in November.

The majority of respondents identified as First Nations, representing the largest group. A smaller number identified as Métis, while one respondent identified as Inuit. Additionally, 22 respondents identified as "none of the above", and 4 respondents preferred not to disclose.

Status

Of the 116 who indicated they were First Nations, the majority of reported having Status, representing the largest group. A smaller number identified as Non-Status. Additionally, 5 respondents preferred not to disclose, and 2 respondents were unsure.



Source: MHC Data Library; Registration and Daily Tracking Document, n=116.

*This data does not include responses from new patients registered in November.

PERFORMANCE MEASUREMENTS

Unique Constituents: Individuals recorded in the EMR as distinct (non-duplicate) constituents who received at least one service from MHC.

New Constituents: Individuals recorded in the EMR as unique constituents who received services from MHC, whose initial visit occurred during this reporting year.

Returning Constituents: Unique constituents whose initial visit occurred prior to this reporting year and continue to receive services during this reporting year.

Visit: A period of time where constituents were seen, and services were provided, consisting of one or more encounters.

Encounter: A constituent's distinct interaction with one or more MHC providers within a visit. Multiple encounters can occur within a single visit. For example, a constituent may have one encounter with a physician and a separate encounter with a counsellor during the same visit.

Service Days: Days between April 1, 2025 to March 31, 2026 on which MHC was open for constituents to receive services and care.

Services Provided: While EMR data captures a main presenting reason for each encounter, the manual count includes all services provided during each encounter and visit. In many cases, constituents received care for multiple reasons within a single encounter or visit. The number reflects the total number of reasons/services provided, capturing the full scope of care provided rather than a main presenting reason.

Indirect Care: Services that support the delivery of care without direct, face-to-face encounters or interactions with constituents.

Follow-Up Visit: Any subsequent visit that occurs after a constituent’s initial visit.

Non-patient / Family Members Seen: Constituents who were provided services without registering, who came into the visit with the registered constituent and received services alongside the registered constituent.

Constituents Registered but Not Seen/Left Before Being Seen: Individuals who were registered for services during clinic hours but were not seen by an MHC provider. Registration occurs throughout clinic hours to maximize access to healthcare. However, wait time for each registered constituent can vary due to factors such as type and complexity of services required, as well as the clinic’s flexible, patient-centered model, which allows the time needed to share their concerns without time limits. As a result, some registered constituents may choose to leave before being seen.

Blanks: Any encounter that does not provide a reason for the services provided. This category is only checked off if there was no reason in the Billing and Appointment details or the encounter note.

Impact Indicators

Measures the reach, scope, and frequency of service delivery. These indicators are critical for understanding clinic utilization, identifying patterns in patient engagement, assessing how well the clinic is responding to the community's health needs over time.

Snapshot of Care

568
Unique Constituents

458
New Constituents

110
Returning Constituents

1,162
Visits to MHC

1,847
Encounters with Constituents

212
Service Days

3,420
Services Provided

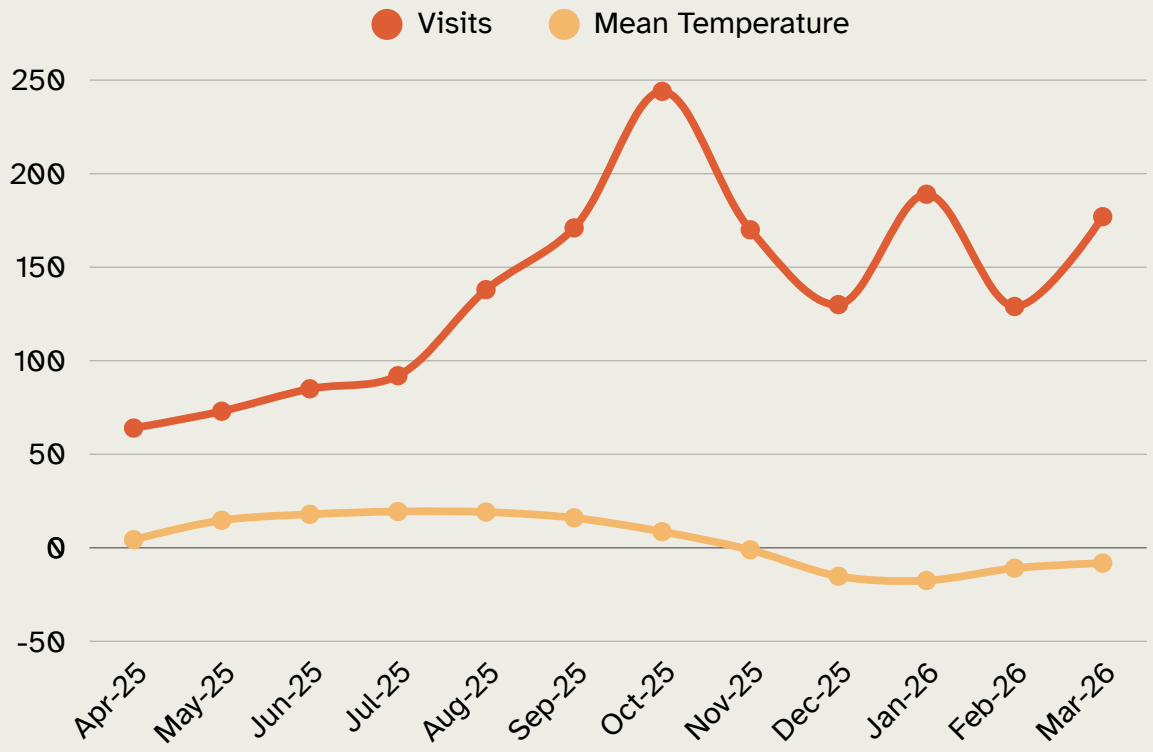
180
Indirect Care Services

Source: AccuroEMR

Trends in Service Utilization

Visits and Seasonal Temperature by Month

Visits at MHC in relation to average temperature from April 1, 2025 to March 31, 2026 .



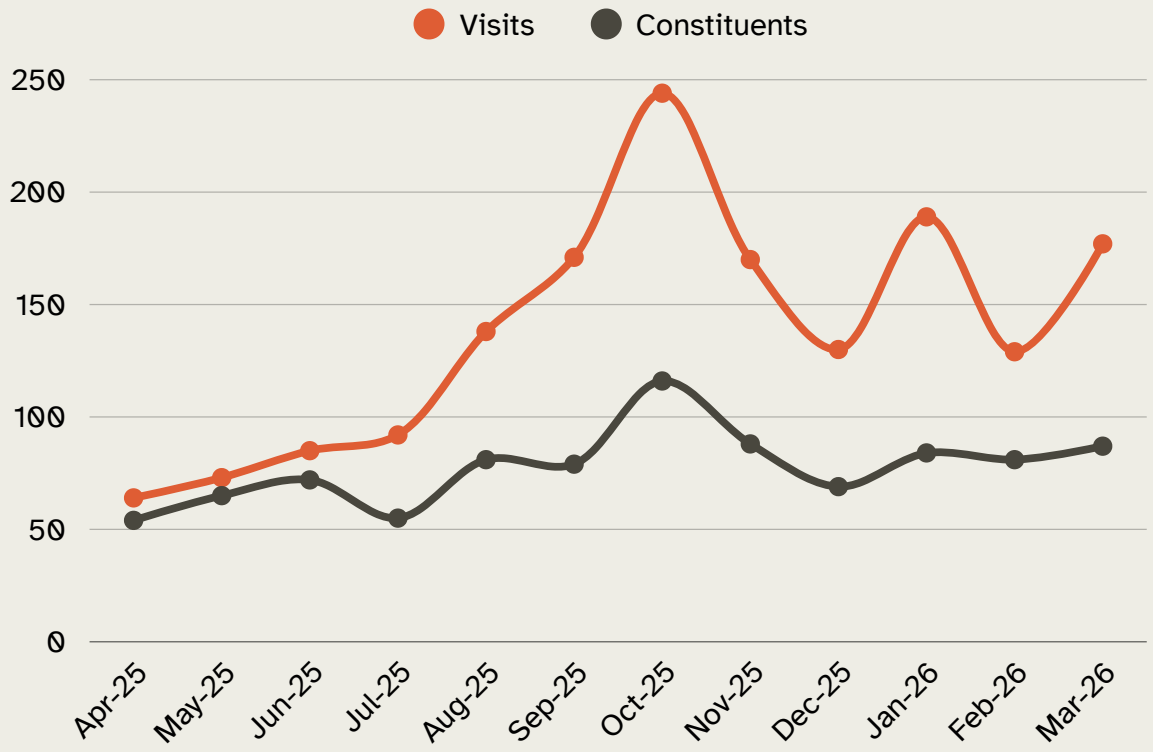
Source: AccuroEMR; Weather Dashboard for Winnipeg

This data demonstrates an inverse relationship with mean temperature over the course of the year.

During the warmer months (April to August), as temperatures rise from 4.3° to a peak of 19.4°C, the number of visits increases gradually from 64 to 138. From September onward, as mean temperatures drop from 16.0°C to below freezing in November (-1.1°C) and continue to fall through the winter months, the number of visits increases substantially, peaking at 244 visits in October, and remaining elevated throughout the colder months (170 in November; 130 in December; and 189 in January).

Visits and Constituents by Month

Visits at MHC in relation to average temperature from April 1, 2025 to March 31, 2026 .



Source: AccuroEMR

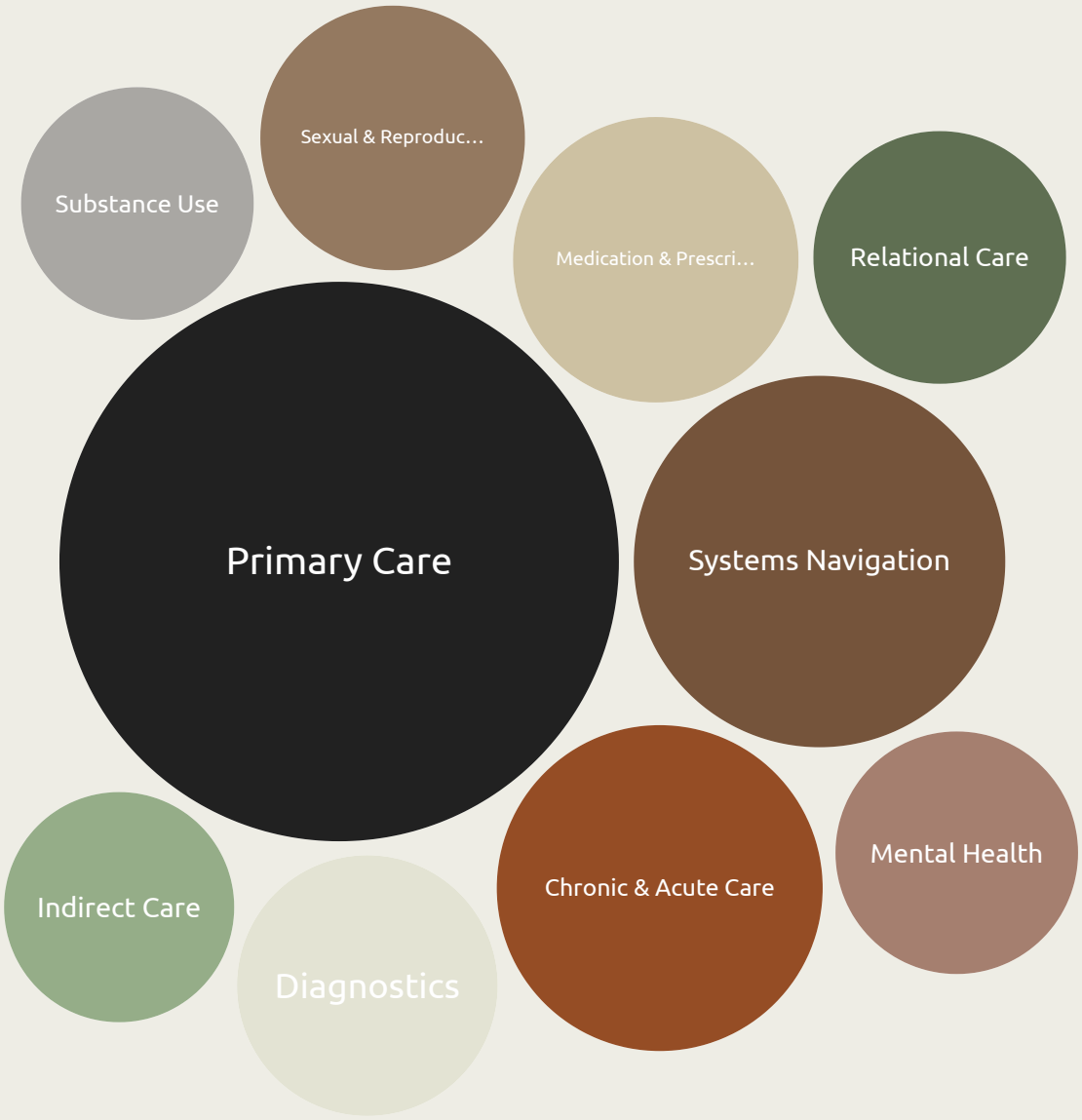
The number of visits and constituents both show a general increasing trend over the year. From April to June, both visits (64 and 85) and constituents (54 and 72) increase steadily. In July, visits continue to increase to 92 while the number of constituents drops (55), which indicates that a smaller group of constituents accessing services more frequently.

This pattern becomes more pronounced in August and September where visits increase sharply (138 to 171), while the number of constituents slightly decreases (81 to 79). The gap between visits and constituents continues to widen into the fall, peaking in October with 244 visits and 116 constituents, which shows a higher use of services by the same individuals.

While the number of constituents increases overtime, the number of visits grow at a faster rate, which may indicate increased frequency of care per constituent, especially during the fall and winter months.

Service Categories

Service Utilization by Service Category



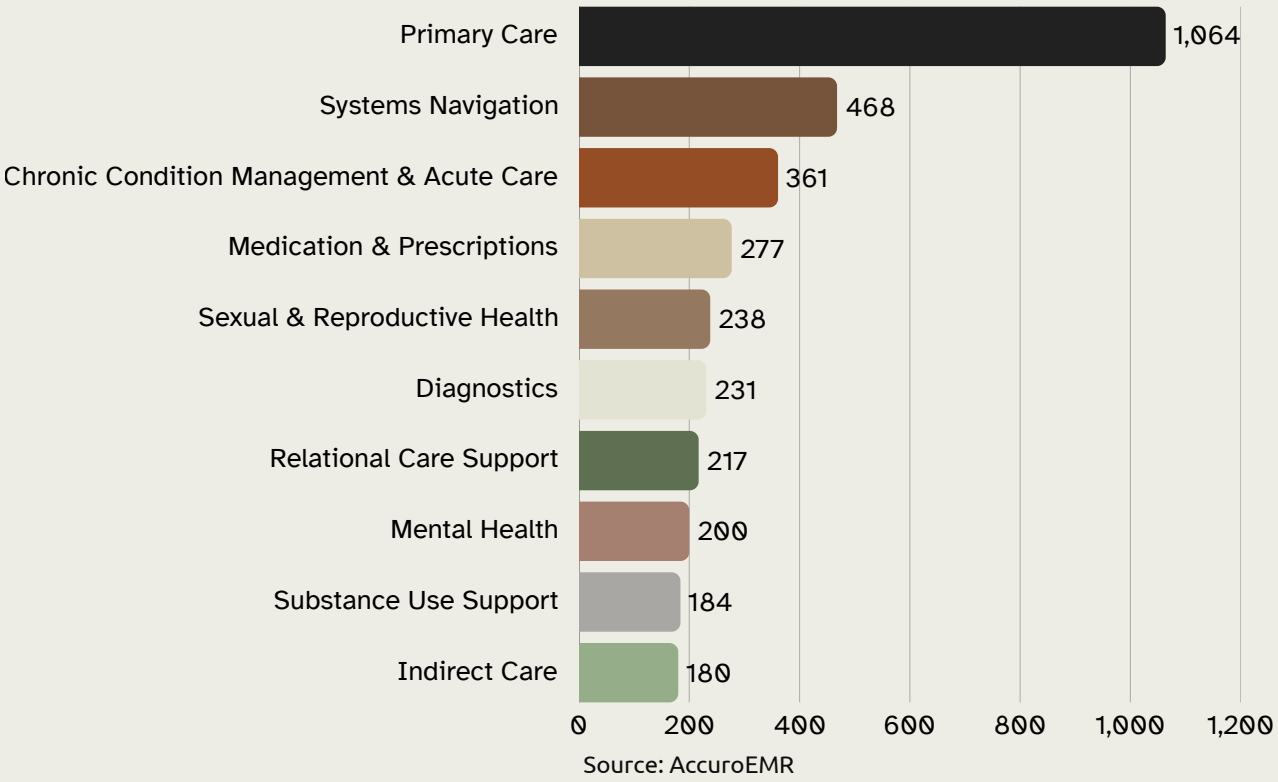
Source: AccuroEMR

This bubble chart visually represents the relative volume of services provided across the different service categories, with the largest bubble indicating higher levels of service use.

Primary Care is the most prominent category, indicating that the majority of services delivered fall within clinical care. Systems Navigation is the second largest service utilized, followed by Chronic Condition Management & Acute Care.

Service Categories

Service Utilization by Service Category



Source: AccuroEMR

This bar graph allows for clearer comparison between categories and highlights clear differences in service distribution.

A **total of 3,420 services** were provided during the reporting period. The circles visually represent the distribution of patient encounters across 11 key service categories.
Primary Care dominates service utilization, accounting for 31.1% (1,064) of services provided. Systems Navigation is the second largest category, accounting for 13.7% (468).

Chronic Condition Management & Acute Care (10.6%; 361) and Medication & Prescriptions (8.1%; 277), Sexual & Reproductive Health (7.0%; 238), and Diagnostics (6.8%; 231) also represent significant portions of services provided, as well as Mental Health Support (5.8%; 200) and Substance Use Support (5.4%; 184).

Relational Care Supports (6.3%; 217) and Indirect Care (5.3%; 180), also represent important components of the MHC model, as they highlight the importance of relationship-building and behind-the-scenes activities that support access to care.

Decolonial Dimensions of Impact Indicators

This section redefines how healthcare services are understood and measured by moving beyond the conventional biomedical models and actively challenging colonial assumptions about what healthcare should involve. It intentionally steps outside of conventional healthcare evaluation methods and presents a more holistic account of impact that affirms Indigenous and community-led understandings of health, healing, and relational care. Grounded in MHC's decolonial outreach model and trauma- informed framework, the indicators center community voices and lived realities, and extend beyond diagnostic or treatment metrics to capture the broader scope of services, relationships, and support provided particularly for those navigating systemic marginalization and poverty, and those who have been lost within, or denied access to the traditional healthcare system. MHC acts to break down barriers, provide substance use supports, provide services for unregistered encounters, increase access to care, and provide high demand care services to constituents.

Breaking Down Barriers to Restore Pathways to Care

A large portion of MHC's work is focused on breaking down the barriers that constituents face within systems that actively exclude or limit their access to care. From a decolonial and Indigenous lens, breaking down barriers involves a proactive, culturally grounded, relational framework that is vital and foundational in working to restore pathways to care for their health and well-being, which largely exist outside conventional biomedical models. These efforts include systems navigation, improving access to needed care through provision of on-site treatments, providing health services provided to those without a Manitoba health card or Identification, and offering wider relational care supports that address immediate needs. This work also includes culturally safe and inclusive supports provided through the Indigenous Social Planner, all rooted in community and connection.

Systems Navigation & Advocacy

Visits in which systems navigation and/or advocacy was provided reflects a broad range of non-clinical, coordination focused activities that support patients in accessing services, securing resources, and navigating complex systems. These services are highly relational and administrative in nature, and address social determinants of health such as housing, income support, and continuity of care. While systems navigation components exist outside of conventional, biomedical models, these components are imperative when looking through a preventative and decolonial healthcare model services lens in restoring and rebuilding pathways to care for health and wellbeing for constituents.

Across 294 documented encounters, systems navigation work was primarily centered on helping constituents interact with external systems. This includes acting as an advocate and liaison, as well as providing additional support to constituents navigating complex processes such as accessing housing and housing program, obtaining identification documents, securing income supports, coordinating healthcare services and appointments, and connecting to broader community supports. While systems navigation can be seen as lying outside conventional healthcare provider roles, MHC strongly supports systems navigation as a decolonial, preventative, and wholistic health measure that works to break down barriers, decrease crisis, and improve health and wellness.

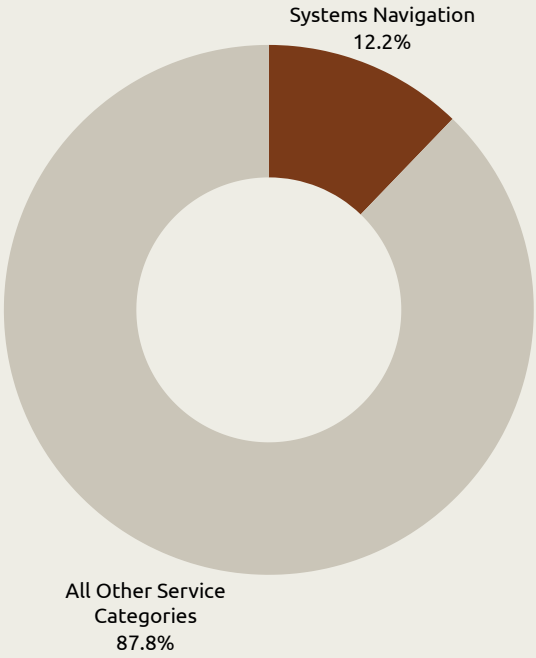
A significant portion involved assisting constituents with completing and submitting forms, particularly income assistance (EIA), housing applications, and disability or support program documentation, which often required explanation and consent. Housing-related navigation was another major component that included applying for housing programs, communicating with housing providers, and supporting shelter access or transitions. Many encounters also involved linking constituents to services and coordinating care such as connecting with community programs, following up on referrals, and communicating with other providers or support workers.

One such systems navigation example involved a constituent who had to miss an appointment, due to barriers in accessing care secondary to homelessness. The physician wrote a letter explaining the situation, noting that the constituent lost vision in one eye due to these barriers and requested another appointment to support treatment for the other eye. The letter also asked that the MHC care be informed of the appointment date so they can help mitigate the barriers and support the constituent in attending this critical specialist visit. Following the appointment, the MHC team worked to address additional barriers by picking up the prescription, locating the constituent, and administering the required eye treatment. The constituent reports feeling very grateful for the MHC team. This is but one example found in the encounter notes of the direct impact that MHC has in providing and including systems navigation in breaking down barriers as a pathway to care.

Additionally, some of these encounters involved collaborative systems meetings with the MHC team and wider networks such as Housing Authority, WCWC, Andrew Street Family Centre, N'Dinawemak, HOCS, SOGH, St. Boniface Hospital Liaison, Manitoba Housing, and other partners. AccuroEMR data identified 12 documented systems meetings involving 4 unique constituents. These meetings reflect intensive, collaborative care efforts with partner organizations for constituents requiring ongoing or complex support and care (Source: AccuroEMR).

Beyond these Accuro documented numbers, the MHC team is also actively partnering with Velma's House, 145 Powers, HOCS and HSHR to support 46-51 additional constituents (Source: MHC Data Library; Work Tracker Document).

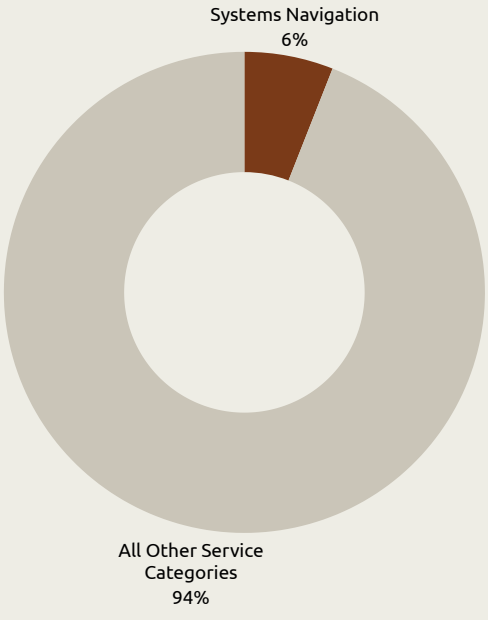
Service Category Distribution with Focus on Systems Navigation



Source: AccuroEMR

During this reporting year, Systems Navigation accounted for 12.2% of all services provided, representing a significant portion of overall service delivery.

Comparison of Systems Navigation to Year 1, 2024-2025



Source: AccuroEMR

Systems Navigation encounters increased substantially from 141 (6%) in 2024-2025 to 294 (12.2%) in 2025-2026, representing more than a doubling of service volume over the reporting period. It is important to note that the 2024-2025 reporting period was shorter (July 27, 2024-March 31, 2025) compared to the full-year in 2025-2026 (April 1, 2025 to March 31, 2026). However, even when considering the shorter timeframe, the increase in systems navigation services remains significant.

This large increase suggests a growing demand and may also reflect the expanding role of MHC in providing advocacy, coordination, and relational support, as well as the expanding role and capacity of MHC in providing these services.

Brian's Story

Brian's story illustrates the depth and impact of this systems navigation work. He was first connected to MHC in acute crisis following a traumatic injury, having lost a finger due to gang violence. At that time, he was unhoused, navigating ongoing safety concerns, and facing significant barriers to accessing support, as he had been excluded from multiple service environments and required off-site coordination of care. The MHC team provided consistent outreach and began with immediate clinical care, including wound management, while simultaneously engaging in intensive systems navigation.

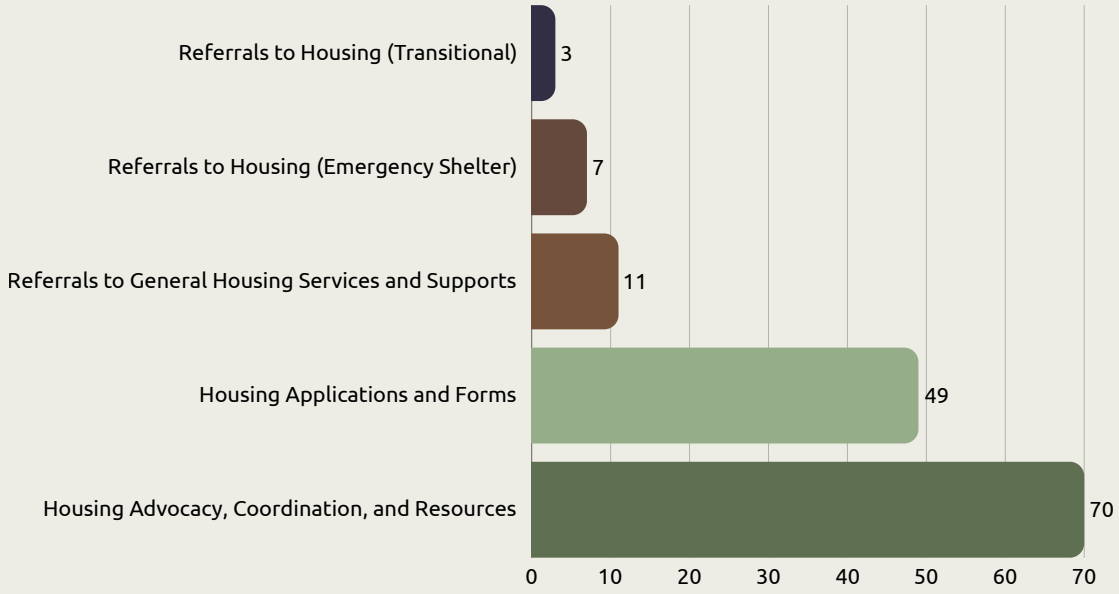
This included connecting Brian to new housing resources, transporting him to obtain identification, and assisting him in regaining access to his bank accounts. Over time, MHC supported coordination of his healthcare needs, including medication management and daily access to OAT, as well as supporting his engagement with appointments and legal obligations. Through consistent relationship-building and coordination across systems, Brian was able to transition into housing, maintain his health needs, and engage more independently with services.

Source: MHC Data Library; Stories and Quotes Document

Housing Support

A large portion of the systems navigation was around housing-related support, such as referrals to and assistance with applications and required documents, and support in accessing transitional housing and emergency shelters. MHC also worked with constituents to explore housing options, develop housing plans, and communicate or liaise with housing programs and organizations, or advocating on the constituent's behalf. These numbers also reflect the wider services MHC provided such as submitting/dropping off housing applications on behalf of constituents and providing updates on application status.

Systems Navigation involving Housing Support



Source: AccuroEMR, n=140.

Support around navigating housing systems represented 47.5% of all systems navigation encounters (140 of 295), with the largest areas consisting of supporting constituents with housing, coordination, or advocating with housing program on constituents behalf, as well as supporting constituents with housing application forms/dropping off applications for constituents, and updating constituents on the application.

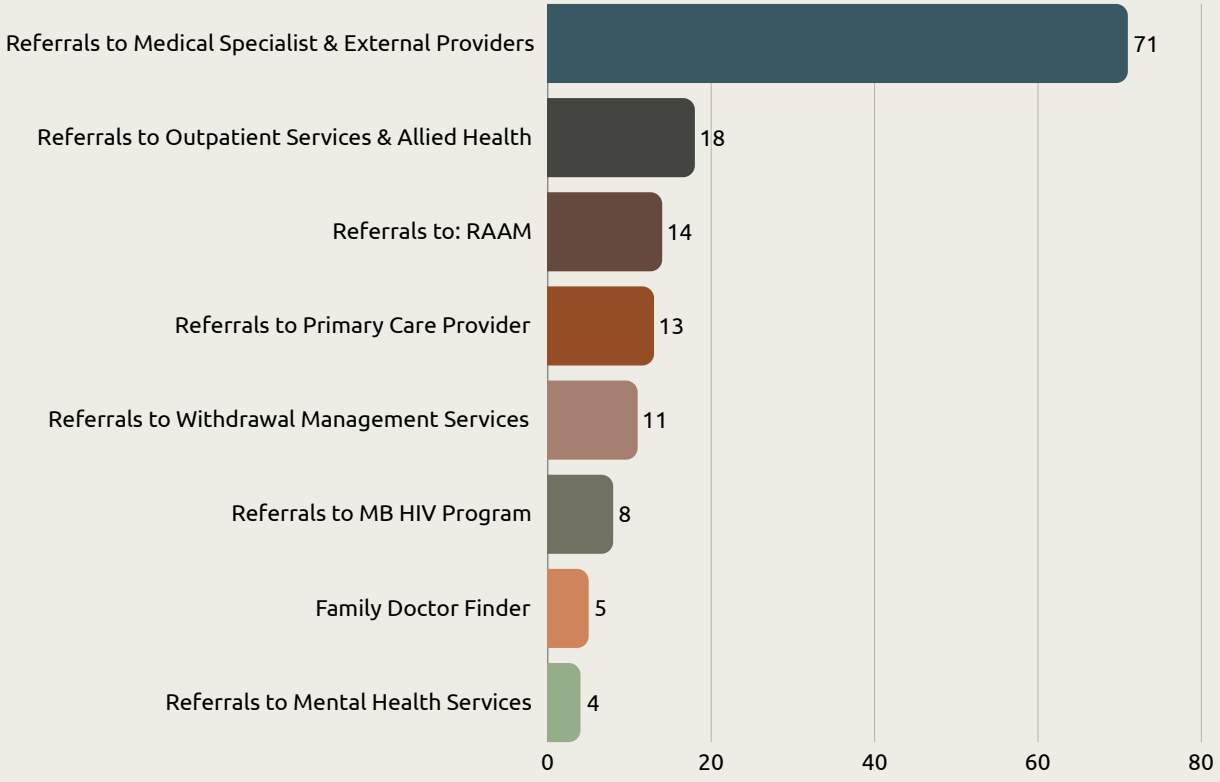
Out of the 49 'Supporting Constituents with Housing Application Forms', 32 represent the filling out of MB Housing Forms.

Source: MHC Data Library; Worker Tracker Document

Referrals: Connections to Health Care

MHC plays a vital role in coordinating care and bridging systemic gaps that often create barriers for constituents. This includes a wide range of behind-the-scenes supports such as facilitating medical referrals for different medical specialists, allied health, and external providers. The team routinely helps constituents navigate complex healthcare by liaising with multiple providers and programs to ensure continuous care. This has included referring and guiding constituents through Family Doctor Finder, which supports access to family physicians/primary care providers and helping many become aware of community-based options such as RAAM (Rapid Access to Addictions Medicine), and withdrawal management programs, and other specialized supports such as Mental Health Services.

Referrals and coordination efforts also span a broad range of health services and specialties, including the following: allergy/immunology; cardiology; dermatology; ear, nose, & throat (ENT); gastroenterology; hematology/infectious disease; nephrology/oncology; neurology; obstetrics & gynecology; ophthalmology/vision care; orthopedics/sports medicine; plastic surgery; psychiatry; dental; and rehabilitation (occupational therapy, physiotherapy, orthotics).



Source: AccuroEMR

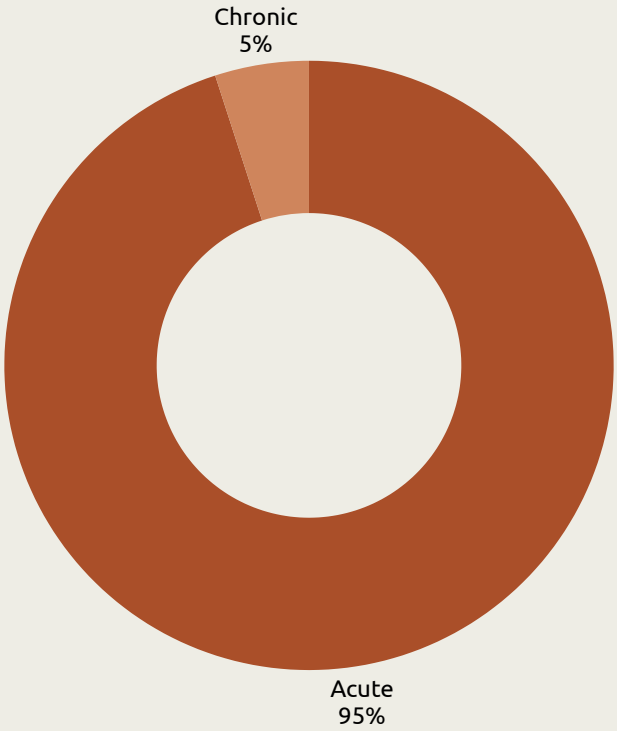
MHC Treatments

Unlike conventional models of care, MHC offers point-of-care treatment, for both acute and select chronic conditions using medications available directly from the clinic's stock instead of providing a prescription, such as antibiotics, antifungals, antivirals, and antiparasitic treatments (e.g., for lice), anti-inflammatory, bronchodilators, alpha blockers, corticosteroids, and antidepressants.

This form of care intentionally reduces reliance on formalized prescription processes, helping to remove common barriers for constituents such as cost, transportation challenges, and lack of a health card or identification. By offering immediate, accessible treatment, constituents can be assessed and treated within a single visit, which significantly improves access to and uptake of necessary care.

Common acute conditions addressed at MHC range from sinus infections, headaches, gastrointestinal issues, respiratory issues (e.g., upper respiratory tract infections, bronchitis), urinary tract infections (UTIs), to joint or muscle pain, eye conditions, allergies or allergic reactions, and lice infestations. Chronic conditions addressed at MHC range from hypertension, asthma, chronic obstructive pulmonary disease (COPD), hernias arthritis, osteoarthritis, prostatic hyperplasia, chronic pain, cancer, and herniated disks.

Point-of-Care Treatment: Acute vs Chronic Conditions



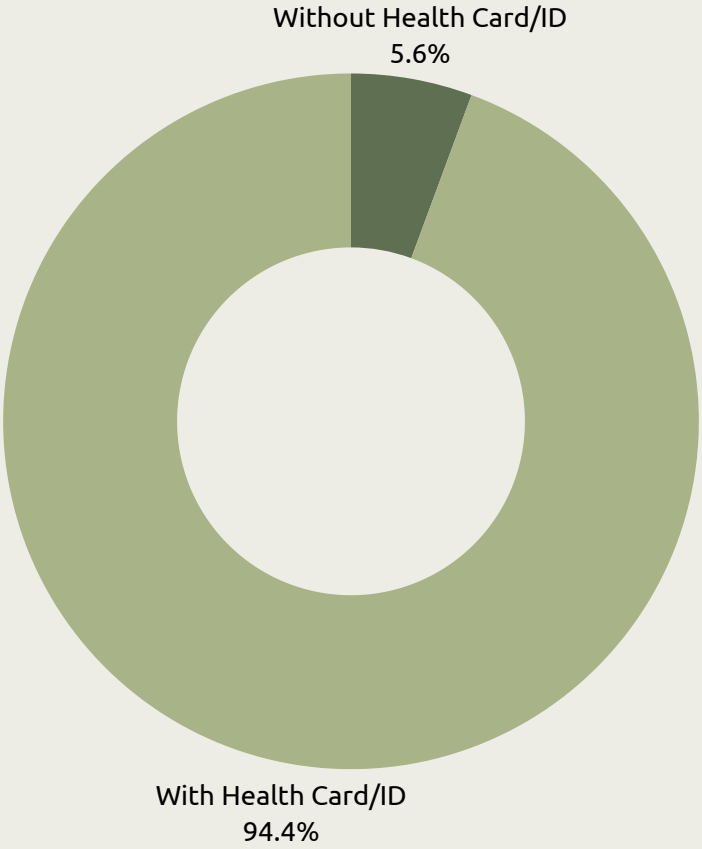
Source: AccuroEMR, n = 301.

The majority of point-of-care treatment services were related to acute health concerns, which indicated that most treatments from MHC's stock were provided in response to immediate health needs. This distribution highlights the significant demand for on-site, same-day care, while also demonstrating substantial portion of services to continued commitment to supporting chronic condition management.

Care Provided Without Health Card or Identification

In alignment with its decolonial approach to care, MHC actively works to reduce barriers that prevent constituents from accessing healthcare, including the requirement for a health card or formal identification. Recognizing that several constituents are excluded from conventional healthcare systems due to these requirements, MHC ensures access to the full spectrum of services regardless of coverage or identification status.

This approach enables MHC to respond quickly and flexibly to urgent health needs, as well as provide preventative care. For example, when a constituent received a prescription from urgent care but was unable to fill it due to lack of coverage, MHC provided the medication directly from the clinic stock and delivered it to them. In another case, a constituent was unable to obtain a prescribed blood pressure monitor due to financial barriers and lack of coverage, and MHC supported access to the necessary equipment. Similarly, when a constituent was denied bloodwork at a laboratory due to lack of identification, MHC intervened to help facilitate access to testing.

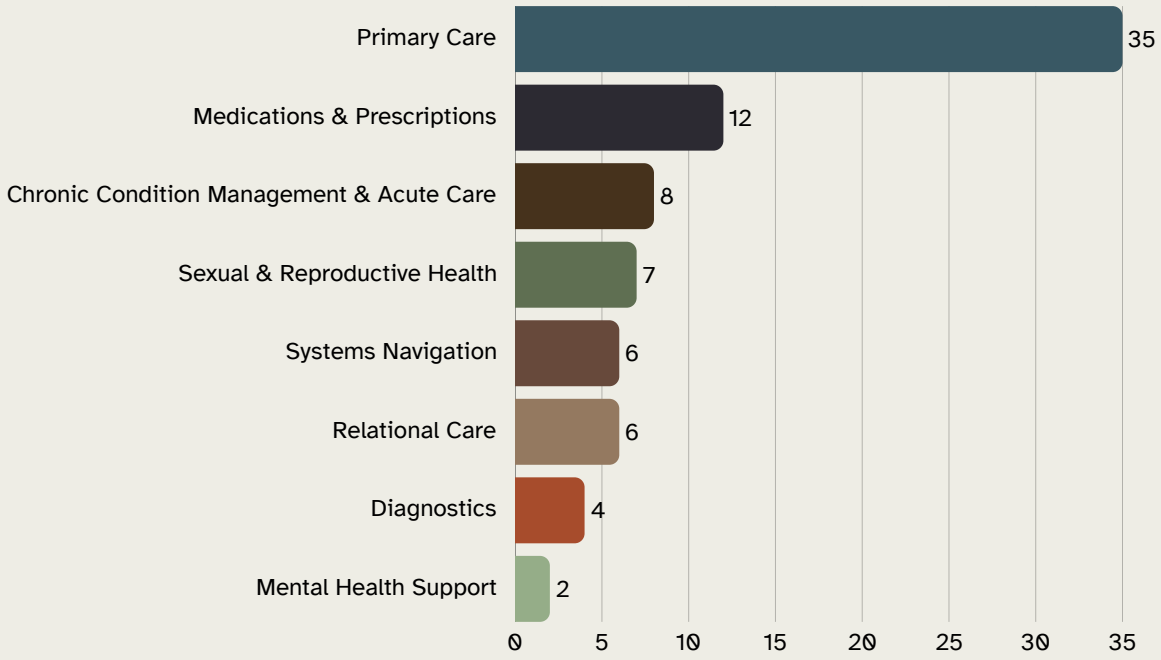


Source: AccuroEMR

While the vast majority of constituents (94.4%; 536) had a health card of identification, a smaller but notable proportion (5.6%; 32) of constituents did not.

Overall, there were 45 encounters where services were provided to constituents without a health card (with 35 involving a physician), providing 81 distinct services with 32 unique constituents.

Access to Care Without Health Coverage or Identification



Source: AccuroEMR

The majority of these visits fell under Primary Care services representing 43.7% of these encounters, followed by Medication & Prescriptions (15.0%), Chronic & Acute Care (10.0%), Sexual & Reproductive Health (8%), Systems Navigation/Forms and Relational Care (7.5% each), Diagnostics (0.5%), and Mental Health Support (0.25%).

Relational Care Supports

"I have never forgotten when you held my hand and gave it a little pat – it meant so much more than I actually realized at that time."

These supports extend beyond conventional clinical care to address broader social, environmental, and relational needs of constituents, and recognize that health is deeply connected to dignity, and access to quality, basic resources. Through their decolonial, relational model that places constituents at the centre, MHC is making changes in how constituents see and experience healthcare. This is a version of healthcare, where all are treated with value, compassion, and community – a place where all are deserving of relational care supports which not only improves health, but also happiness. It is important to note that these supports are integral to improve both quality of care and quality of life. By providing what is needed, when it is needed, MHC takes on a proactive and preventative approach to care.

This past year, MHC has provided a wide range of essential items, including nutritious food, proper clothing and footwear, needed outdoor equipment, household supplies, and other specialty items:

Food & Nutrition: Food provided includes snacks, sandwiches, prepared meals made in-house and pre-made meals sourced from established grocery retailers (e.g., Costco, Superstore), with an emphasis on quality and nutritional value. MHC places a strong emphasis on providing high-quality, nutrient-dense food, recognizing that this often comes at a higher cost but is essential to supporting health and wellbeing. Rather than relying on low-cost or bulk items with limited nutritional value, MHC prioritizes food that is sustainable, balanced, and appropriate for meeting constituents' needs. This approach also reflects an understanding that access to adequate, nutrient rich food is a critical component to preventative care for health and medical concerns, such as Type 2 Diabetes, associated with poor nutrition.

Clothing & Footwear: MHC sources and provides new, appropriately sized, good quality items such as socks, underwear, seasonal clothing, and winter gear (jackets/coats, snow pants, gloves, scarves, hats, boots). Proper footwear is essential for constituents experiencing homelessness, as ill-fitting or poor-quality shoes can contribute to significant foot and musculoskeletal issues, leading to increased footcare needed. Additionally, access to clean, well-fitting, and appropriate clothing and footwear supports overall wellness by helping constituents feel comfortable, confident, and dignified, which are closely connected to both physical and mental wellness.

Outdoor Equipment: For constituents living outdoors, MHC provides equipment such as tents, sleeping bags, emergency blankets, and other essential supplies to support safety and survival in harsh conditions. While the goal is to support constituents in finding housing for those who identify it as a need, these items acknowledge the immediate realities faced by constituents and ensure that they have the necessary tools to live outside with greater safety and comfort in mind.

Household Supplies: For those who have transitioned into housing, MHC provides cleaning items, bed sheets, small appliances, and other household items. These supports help reinforce housing stability and recognize the significance of securing housing, while serving to strengthen relationships and maintain ongoing connection to care. Access to these items supports constituents in settling into their space, promotes a sense of pride and ownership, and contributes to sustaining long-term housing stability.

Specialty Items: This includes birthday gifts, holiday gifts, art supplies, gift cards, and occasional restaurant meals, which all play a meaningful role in relationship-building. They may also include more personalized items such as make-up or bike- repair tools, which reflect individual interests and identities. While seemingly small, these items communicate care, respect, and recognition of each person's value. They also support emotional wellbeing and help "feed the soul," contributing to a sense of belonging, dignity, and personal identity, while strengthening trust between constituents and providers.

Additional Support Items: This includes practical and cultural items such as harm reduction supplies, naloxone kits, cultural items (e.g., smudge kits, beads, drums), phone chargers, power cords, and pet food and supplies.

Source: MHC Library Data

Indigenous Social Planner

The visible presence of Indigenous staff within MHC affirms Indigenous identities, knowledge, and practices within a healthcare setting. The Indigenous Social Planner (ISP) at MHC is key to creating this culturally safe and inclusive space. This role embeds Indigenous cultural practices into the clinic's daily operations to address the holistic health needs of constituents and to nurture a sense of belonging.

Functioning as a bridge between MHC and the community, the ISP emphasizes the importance of culturally grounded navigation within the clinic's framework. This involves relationship-building with Elders and Knowledge Keepers, and community partner organizations to coordinate cultural workshops, Kookum's Circles (via Elder Council Meetings), and gatherings. The ISP also plays a proactive role in cultural engagement by sharing information about local events, ceremonies, and cultural activities in Winnipeg.

Each service day begins with a ceremonial drum song, setting a tone of cultural affirmation and inclusion. Smudging and traditional medicines are made accessible to anyone wishing to participate. These practices are not just symbolic, but are critical acts of spiritual and cultural continuity, and healing.

The ISP's work is rooted in community connections and emphasizes the importance of these culturally specific services. Requests for home blessings, cleansing ceremonies, and cultural activities like beading and crafting demonstrate the meaningful connections that have been established with MHC's constituents.

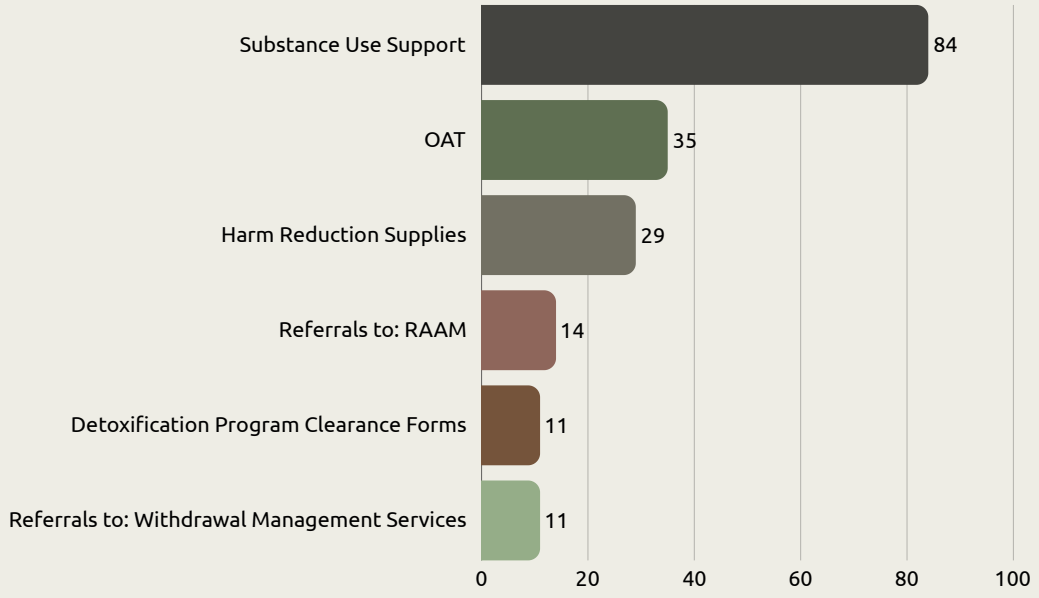
This year, the most frequent activity led by the ISP was smudging, which was documented multiple times across reported months (ranging from 7 to 17 instances), alongside drum songs (10) and in-home cleansing ceremony (1). In addition to ceremony, there was a consistent integration of cultural skill-building and creative activities, including beading (up to 17 instances), sewing (1), and the provision of beading kits. Note: this data does not include activities from June to October 2025; as such, the frequencies reported here likely underestimate the full scope of cultural supports provided throughout the year.

Source: MHC Data Library; Registrations and Daily Tracking

Substance Use

MHC provides substance use support rooted in a decolonial, trauma-informed, and harm-reduction framework. Care is offered unconditionally, recognizing the complex realities of constituents who may be navigating substance use disorders (SUD) or actively using substances. Services are delivered without judgment or requirement for abstinence, acknowledging that safe, dignified care is a human right, regardless of substance use before or during encounters. These services promote safer substance use practices, facilitate access to treatment for constituents navigating substance use, and provide resources and education around substance use, while creating stronger relationships and trust. A total of 184 encounters at the clinic were directly related to substance use as a reason services were provided.

Service Utilization of Substance Use Support



Source: AccuroEMR

The majority of encounters fall under Substance Use Support (84 encounters), indicating that counselling, assessment, and provision of resources make up the largest portion of care within this service category. Opioid Agonist Therapy (OAT) also represents a significant component with 35 encounters.

The distribution of Harm Reduction Supplies (29 encounters) is another key area. In addition, 14 encounters involved referrals to Rapid Access to Addictions Medicine (RAAM), alongside more targeted supports such as Detoxification Program Clearance Forms (11 encounters) and referrals to Withdrawal Management Services (11 encounters).

No encounters were recorded for Drug Screening, suggesting limited use or need within this context.

Lynn's Story

MHC's approach to substance use support is illustrated in the story of one constituent, who had initially been seen for a dog bite. Through follow-up and relationship building, the team learned that she had been living with severe opioid use disorder for 4 years following the traumatic loss of her brother, who was fatally shot by the police. She reported experiencing over 30 opioid poisonings in 2025 alone, alongside a history of abuse and complete estrangement from family, with no existing supports.

Over several weeks, as trust was established, she shared her goals of stopping substance use and reconnecting with her adult children. She also expressed a desire to restore her dental health, noting she did not want her children to see her in her current state. Through MHC's support, she initiated OAT and is now stabilized on Sublocade. While she continues to use some stimulants, she has now stopped using opioids.

MHC also coordinated broader supports, including arranging and accompanying her to a dental appointment, with a plan for full dental restoration. She has since expressed openness to pursuing family reunification once this process is complete. Her experience reflects the impact of MHC's consistency and non-judgmental care – captured in her own words ***"I don't understand why you care so much. No one has ever cared about me like this."***

Unregistered Encounters

Dad's Story

The MHC team had become very involved with a family, and overtime learned that their "dad" was reasonably resistant to health care. He was the husband of the late adopted mother of sisters that we see. In her passing, their step dad had become their only point of familial contact. Dad had a challenging relationship with the sisters as his upbringing in the Residential School system brought many difficulties and beliefs that did not align well with the lifestyles of the sisters. With the hardships, dad continued to remain present and make sacrifices to keep the sisters housed and stabilized to the best of his abilities.

Dad was elusive for many months, until one day he had sustained a deep cut from broken glass. He sought care from the nurse on the MHC, and stayed to chat a while. Over time of connecting with the sisters consistently, dad started to present as well with different health questions, and requests for care. Soon, dad was texting in and calling to check in, and work collaboratively to support the sisters with the team, and look at his own healthcare needs. Dad had become a regular in our portfolio, and became looped in with the additional support services that his daughters took on, also supporting him with his social needs. Dad texts regularly, and sends TikToks to the nurses text line weekly.

15

Encounters with Non-Patient / Family Members

Source: AccuroEMR

MHC extends its services not only to those who are registered patients, but also to those within their broader relational circles, including chosen family, partners, or biological family members who may accompany them to a visit. This approach reflects a commitment to culturally safe, community-centered care that honours relational values and interconnectedness to health and well-being.

By welcoming and supporting those who come alongside patients, MHC creates space for trust-building, belonging, and ensures that no one is turned away when in need. This flexible and inclusive practice reinforces the clinic's role as a relational hub.

Rob's Story

The MHC team developed a strong connection with the St. John's Park encampment over time, building trust through consistent presence and care. One constituent in particular was initially not open to receiving services; however, their engagement began indirectly through their partner, who was regularly seen by the team over several months. The first point of contact occurred when the constituent sought care from male physicians on the mobile clinic for a broken rib. From there, the team maintained consistent, day-to-day check-ins, gradually strengthening the relationship.

During one visit, the constituent was in acute crisis. An MHC nurse and Peer Support Worker stayed with them, following ASIST protocol to provide immediate support. During this interaction, the constituent shared that they often felt like "just a paycheque" to other workers and organizations that visited encampments. In contrast, MHC team's consistent presence helped build trust over time, leading the constituent to become increasingly open to care—not only from physicians, but also from nursing, counselling, and the broader team. The constituent eventually began reaching out directly to the nurse via text message to communicate their needs.

The constituent was later housed through the Your Way Home Program and was doing well living independently with their partner. Although they continued to face challenges related to substance use and gang affiliations, they were able to sustain their housing until a recent fire in their unit resulted in eviction. Despite this setback, the constituent has remained connected to the MHC team and continues to engage with supports to navigate this transition.

In response, the MHC team has worked to reconnect the constituent with their case manager and partner organizations, including the Your Way Home Program and West Central Women's Resource Centre to support rehousing and continuity of care.

Access to Care

Transportation

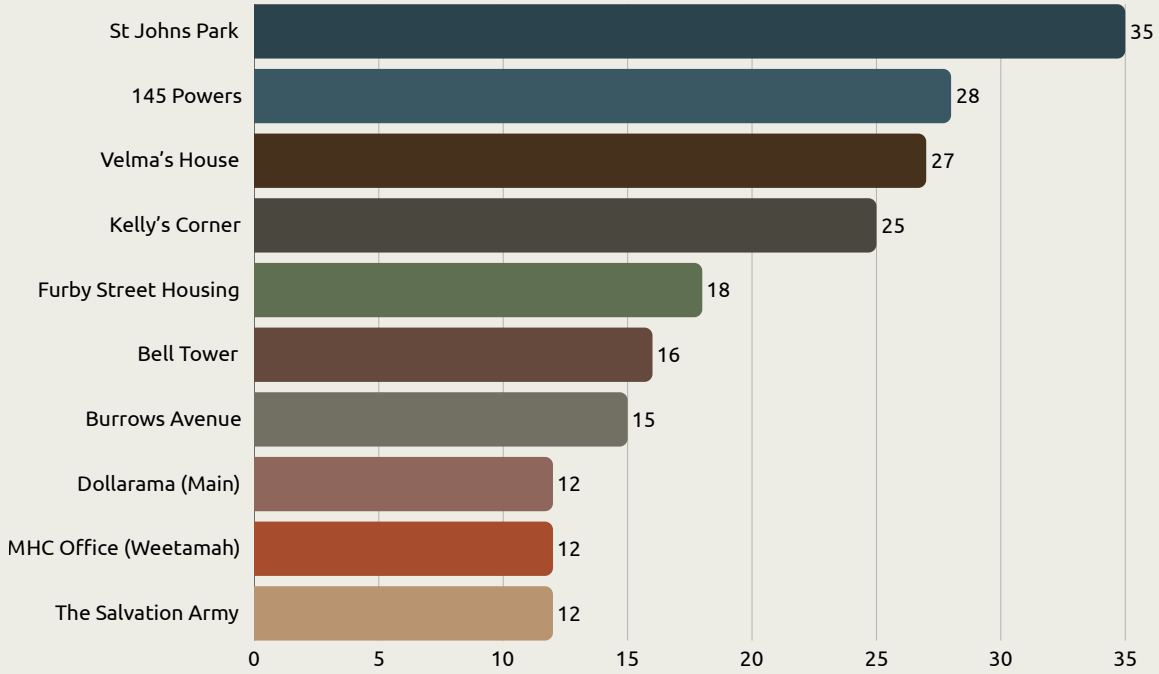
Transportation has been identified as a major barrier in accessing healthcare services for MHC constituents, with community partners consistently emphasizing the challenges their community members face in reaching care. To mitigate these challenges and improve access, MHC's service model seeks to actively reduce transportation barriers by both bringing services to meet people where they are at and supporting constituents in travelling to needed care. This includes assisting with transportation to medical appointments, pharmacies, hospitals, Emergency Departments or Urgent Care, as well as connections to other essential services, and locations for care. Support may involve coordinating transportation with partner organizations such as DCSP, MSP and NEWC, providing bus tickets, cab fare, or rideshare options, or direct transportation of constituents by MHC providers. Over the past year, MHC was able to assist **52 unique constituents** with **106 transportation needs**.

These wider supports, that improve access to essential care and help restore pathways to care by adressing financial and logistical barriers often fall outside of conventional healthcare models. However, they are critical within a preventative, proactive, relational, and decolonial model of care. By centering constituents' needs and recognizing transportation as a foundational component of access, MHC helps disrupt cycles of delayed or denied care, and ensures constituents receive the services and care they need.

Bringing Care Services to the Community

MHC aims to locate clinic services where the highest concentrations of vulnerability exist, recognizing the importance of building trust by being present where constituents are in need. Unlike conventional healthcare models, MHC brings services directly to constituents in their own spaces, including encampments, community hubs, bridges, shelters and outside community organizations, through its mobile outreach days. This approach focuses on creating accessible pathways to care, where constituents feel heard, seen and cared for, while meeting the needs of many that are often left behind from conventional models of care.

This year, across **156 mobile outreach days**, MHC was able to reach 80 distinct locations resulting in a total of 387 mobile visits. It is important to note that within the MHC data library's Registration and Daily Tracking document, not all service days included specific locations data. Some entries were recorded as "follow ups" (17), "encampments" (6), "everywhere" (1), and undisclosed "parking lot" (2). As such, the reported number for locations represents a minimum estimate and does not capture the full reach of MHC's mobile outreach service areas.



Source: Registration and Daily Tracking Document

The largest percentage of days where a specific location was visited was St. Johns Park, representing 9% of total locations visited. Following this, 145 Powers, Velma's House, Kelly's Corner, and Furby Street Housing represent 7.2%, 6.9%, 6.5%, and 4.5%, respectively.

As the MHC care team continues to grow and has the capacity to expand their services, such as being able to provide services with **2 teams in a day for 17 days** this past year, as well as **16 days where they were able to provide service at both a fixed location and mobile outreach,** this year realized a **95% increase** of locations reached and a **227.96% increase** in locations visited during mobile outreach location days, in comparison to the last fiscal year.

Doreen's Story

Doreen's story illustrates how this approach translates into meaningful impact. As a frequent MHC constituent, Doreen has developed a strong, trusting relationship with the team over time, maintaining regular communication with the nurse to address both her ongoing health and social needs. While navigating significant challenges, including an abusive relationship and instability within the encampment, Doreen has been supported by MHC in taking gradual steps toward change. This has included assistance with obtaining identification, connecting with support workers for housing and detox services, and ensuring continuity with medications and treatment.

Despite experiencing setbacks and trauma, Doreen consistently returns to MHC for support – whether to reconnect to services or address immediate health concerns. The team has always supported her in accessing care beyond clinical needs, including arranging transportation to casting clinics for injuries and assisting with care for her pet.

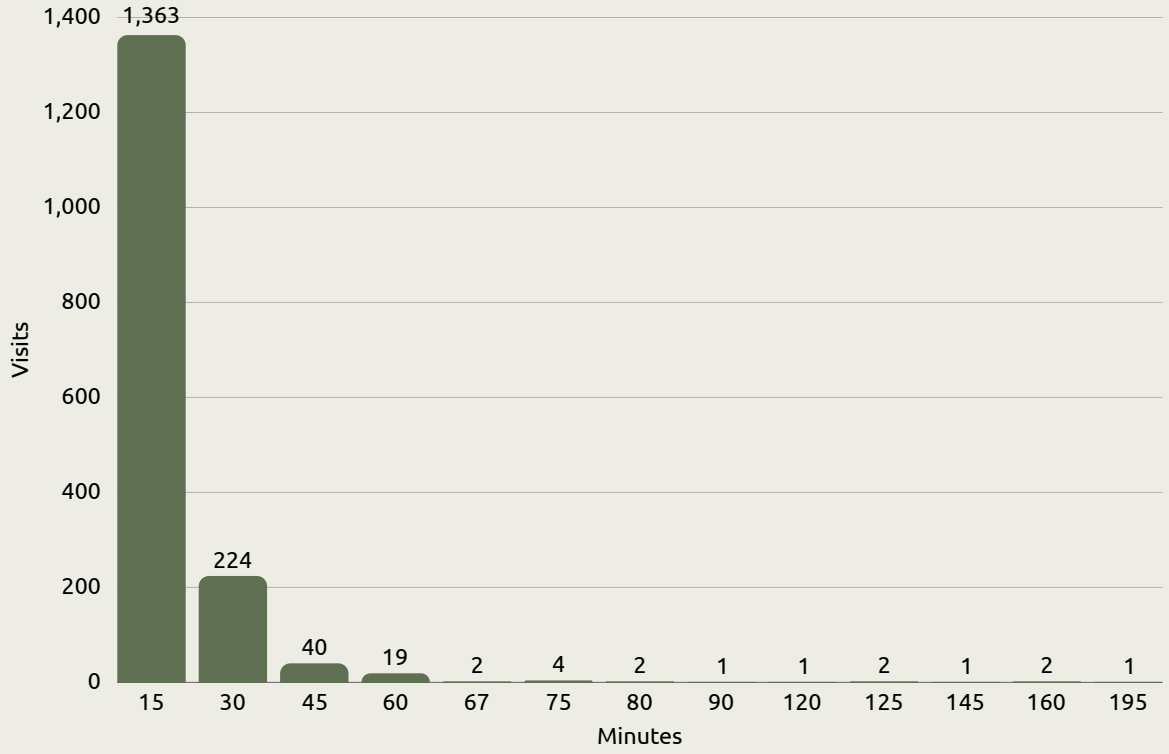
Through this relationship, Doreen has also become a connector within her community, introducing MHC to others who may be hesitant to engage with traditional healthcare systems. Her story highlights how trust-building within encampments not only supports individual care but also strengthens broader community networks, which allows MHC to reach more individuals and promote a sense of shared support and connection among constituents.

Service Quality Indicators

Working from a wholistic model that seeks to provide trauma informed, high quality & safe care, MHC seeks to repair the trust that has been broken by the healthcare system through an approach that de-emphasizes colonial formality and traditional model limitations associated with receiving health care services. This includes the number of services provided in each visit, the length of time per visit, ensuring a safe, respectful and non-judgmental environment, going to where the community is to provide services, providing on-site treatment for acute conditions, as well as providing patients with over-the-counter medications when needed. These are important aspects that speak to the unique extent of the quality of care offered to the community through this model, one that seeks to reduce barriers, and provide respectful and relational interactions where the patient feels seen, safe and heard.

Visit Duration

Constituent visits durations by category, including the number of visits and the total minutes spent in each duration category. Visit lengths ranged from short (15 minutes) to extended visits up to 195 minutes.



Source: AccuroEMR

The data shows that visits are heavily concentrated in shorter durations, with the majority consisting of 15-minute visits (1,363 visits totaling 20,445 minutes), followed by 30-minute visits (224 visits totaling 6,720 minutes). Combined, over 95% of all visits are 30 minutes or less.

In contrast, visits lasting 45 minutes or longer occur relatively infrequently, representing only about 2.4% of visits, yet they contribute a disproportionate large share of the total provider time, highlighting greater resource demands of more complex visits.

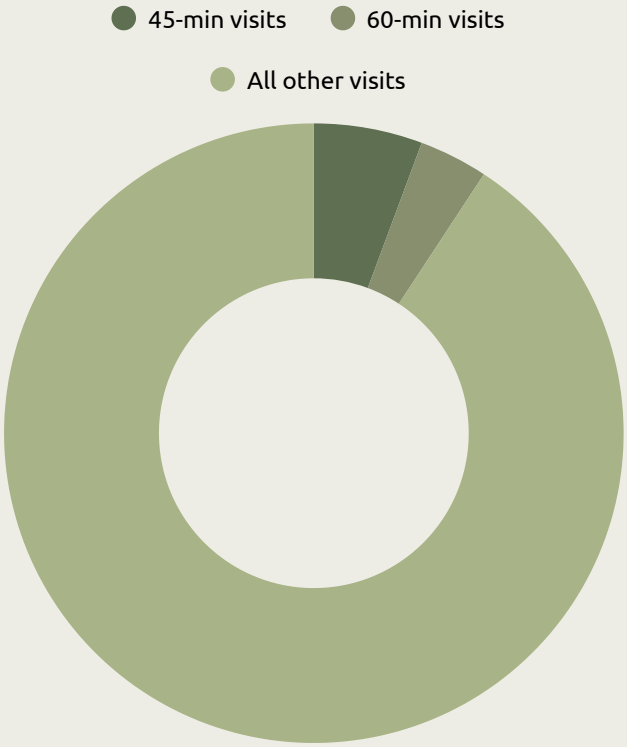
Shorter Extended Visits (45 and 60 minutes)

The 45- and 60-minute visits reflect complex, multi-service encounters that required more time than routine appointments. These visits were characterized by the integration of multiple services within a single encounter, rather than a single focused issue.

Counselling and Systems Navigation are the most frequently occurring services and were often provided together or alongside other services such as referrals, support/completion of forms (e.g. disability or treatment-related documentation), and Health Promotion and Education. This pattern indicates that these visits addressed both clinical and social needs, requiring providers to support constituents in navigating healthcare systems, accessing resources, and managing broader social determinants of health.

In addition to coordination and support, these visits frequently included clinical care such as wound care, provision of treatments and medications, and lab services. These were often delivered in combination, reflecting providers' management of multiple health concerns within a single visit, which increased the time required.

Overall 45- and 60-minute visits function as a bridge between routine short visits and more intensive long visits, supporting more comprehensive, integrated care that addresses medical, psychosocial, and system navigation needs within one visit/appointment.



Source: AccuroEMR

45- and 60-Minute Visits in Relation to Total Care in Time

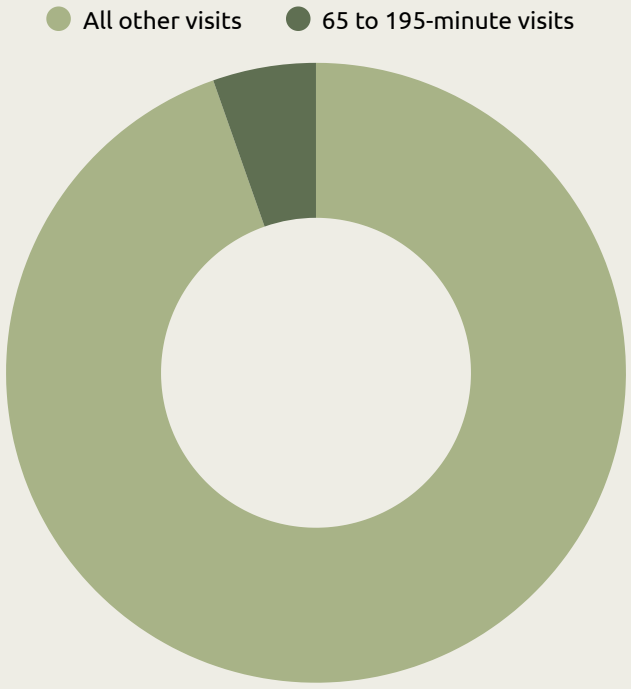
Proportion of total care in time by visit duration, highlighting 45-minute visits (1,800 minutes) and 60-minute visits (1,140 minutes) in comparison to all other visit durations (28,845 minutes).

Longer Extended Visits (65-195 minutes)

Building on the pattern observed in 45- and 60-minute visits, visits lasting between 65 and 195 minutes represented the highest level of complexity and intensity of care within the dataset. While 45- and 60-minute visits seem to have functioned as a bridge between routine and more complex care, these longer extended visits reflected situations where multiple intersecting needs required sustained provider time and deeper engagement.

Similar to the shorter extended visits, these visits were characterized by the integration of multiple services, including Counselling, Systems Navigation, and clinical care (e.g., wound care, treatment of acute or chronic conditions). However, in this longer duration range, the scope and depth of services were greater.

The longest visits (e.g., 120 minutes and above) mostly represent high complexity encounters, such as comprehensive assessments, crisis intervention, or extensive care planning. These situations therefore demanded prolonged provider engagement and involved coordinating multiple services or addressing urgent intersecting constituent needs. Although they were infrequent, they were essential to meeting the needs of constituents requiring the most comprehensive and coordinated support.



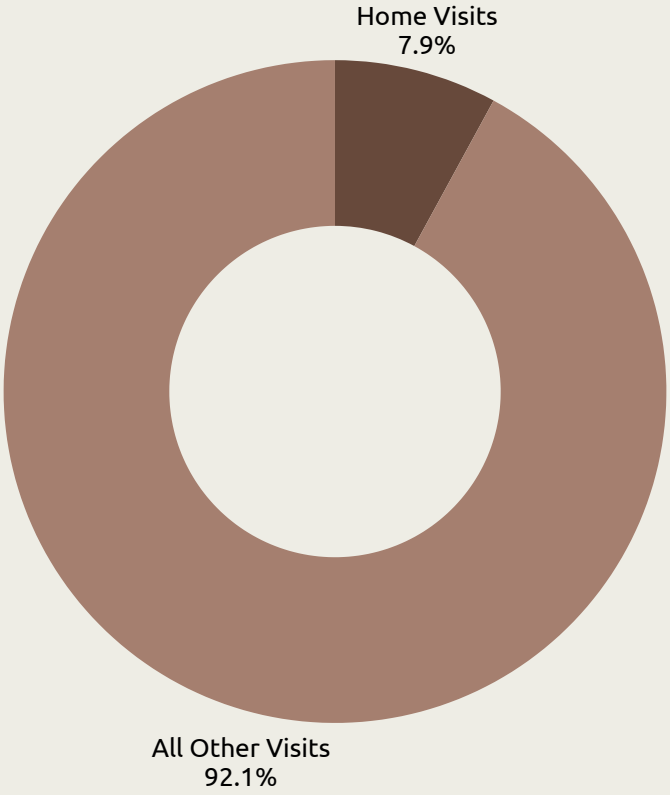
Source: AccuroEMR

65- to 195-Minute Aggregated Visits in Relation to Total Care in Time

Proportion of total care in time by visit duration, highlighting aggregated 65- to 195-minute visits (1,710 minutes) in comparison to all other visit durations (30,075 minutes).

Home Visits

This year has also seen an increase in home visits, providing 222 services, during 132 encounters, over 120 visits, with 33 unique constituents at their home, which further reflects the need for adaptable, person-centered care. Home visits were particularly important for individuals with mobility challenges, complex health conditions, or heightened vulnerability, as they allowed providers to deliver care in a safe and familiar environment while also gaining a deeper understanding of patients' living conditions and needs. Home visits also happen when trust has been built, and these visits continue to strengthen the strong relationships with constituents that the MHC care team is a part of.



Source: AccuroEMR

While home visits represent a smaller share of overall visits types, they reflect an important component of MHC's care model. This highlights the clinic's capacity to reach constituents facing barriers to accessing care and reinforcing a flexible approach that values accessibility and responsiveness to community needs.

Kendall's Story

The impact of home visits are illustrated in the care of a constituent who initially approached the team on the street for harm reduction supplies and was subsequently identified as pregnant with untreated syphilis. Although she was connected to midwifery services, she was unable to attend clinic-based care throughout her pregnancy. Through ongoing engagement and coordination with the midwifery team, MHC was able to provide home-based prenatal care, ensuring continuity of care despite barriers.

As her pregnancy progressed, she developed pregnancy-induced hypertension, requiring urgent intervention. MHC collaborated with obstetrics to support her care by picking up and delivering antihypertensive medication, facilitating attendance at an urgent fetal assessment, and completing outstanding bloodwork and swabs within the community. She has since completed treatment for syphilis. While she remains at risk for preterm labour, she has received consistent prenatal care through home visits, despite never attending a traditional clinic appointment.

Bob's Story

Bob has been avoidant of any type of help from any area of service. He frequently shares of his time as a biker in his young years and firmly believes he is still participating in business as usual. This constituent was experiencing issues with his arm, and it required him to be seen in hospital. It was expected that this constituent would not continue to connect with MHC; however, with persistence and consistency, this constituent was able to be followed up for multiple different areas of care. It had become a mission to have this constituent seen for ocular issues, which did not go well from the side of the specialist. The constituent was very against continuing his health care journey to assist in the saving of his eye and was fed up with the care he received. With more persistence and consistency, the MHC was able to locate his necessary prescriptions, pick them up for him, and deliver them to him where he was at. He was extremely grateful and became excited to connect with us day over day. It took many peanut butter and jam sandwiches with juice boxes for trade – but now this constituent calls us his "sweethearts" and is very open and willing for our care and help. We are currently working out what is needed to get this cst housing before winter. We were even able to talk him into going back to the eye specialist for monitoring his other eye – he is very agreeable.

Bob has since been housed and living stably and independently on his own. He has gone to his appointments and has been adequately stabilized. MHC team checks in with Bob regularly to bring him sweet treats, and chat.

Wider Impact Indicators

Medical Student Learners

Access to meaningful exposure to street medicine and community-based care for those experiencing homelessness is limited within traditional medical training. Most early learning opportunities, such as "community exposure days" for first- and second-year medical students, have historically taken place in conventional family medicine clinic settings. In response, MHC has partnered with UM's Faculty of Medicine to provide an alternative learning environment, hosting several medical students this year.

This model of learning reflects a "classroom of the street" approach, aligning with the broader international street medicine movement (Doohan & Mishori, 2019) . By situating education within real-world settings, learners are able to gain practical insights into delivering care in non-traditional spaces while developing skills in advocacy and patient-centred care. As one student reflected, ***"the first thing that surprised me was seeing what a shelter is actually like... I had never actually been to, or inside one,"*** highlighting how direct exposure challenges assumptions formed in classroom-based learning. Through this model, learners also begin to understand care beyond a biomedical lens. Students observed that encounters often focused not only on clinical concerns but also on broader wellbeing and barriers to care. The same student noted, ***"many of the questions [were] focused on the welfare and overall well-being of patients rather than a traditional medical history."***

A central theme across learner reflections was the importance of relationship-building and trust. As one student observed, ***"Your unit's trust and rapport with the unhoused community surprised me the most. Your rapport seemed to greatly affect how honest the patients we saw were about their struggles."*** Similarly, another student noted that first appointments prioritized ***"building trust and getting to know the patients rather than hyper-focusing on specific tasks."***

Learners also gained insights into the structural and logistical barriers faced by constituents, including transportation, communication, and scheduling. As one student reflected, "Scheduling and transportation can be such a fundamental hurdle for the population that you serve, and that was something I did not have a proper appreciation for." Another student highlighted the challenges of accessing care "with no mobile phone, to traveling to appointments on time especially during winter."

Importantly, students recognized the role of healthcare providers in advocacy and systems navigation. As one student noted, ***"Small actions, such as submitting additional welfare requests that require physician approval, can have a big impact."*** Another student reflected on the importance of ***"systemic advocacy and collaboration work that healthcare workers can do to help our vulnerable community members."***

The impact of this training also extends beyond the learners, as it creates a ripple effect within the healthcare system as students carry these experiences into future practice, regardless of whether they ultimately work in community-based settings. Early exposure to street medicine is therefore critical in shaping future providers understanding and delivery of care. Through direct engagement in community settings, learners are introduced to principles of cultural safety, trauma-informed care, and relational practice, which are approaches that may significantly influence their clinical perspective throughout their training and future careers. This experience challenges conventional biomedicine and broadens understanding of the social determinants of health and the realities faced by individuals who are often excluded from traditional healthcare systems.

In addition to early-year medical students, MHC has hosted a range of learners, including nursing students, physician assistant (PA) students, and fourth-year medical students completing electives. Building on this interest, MHC has developed a dedicated street medicine elective for fourth-year medical students which has already shown strong demand.

Plans moving forward include continuing to host first- and second-year medical students and exploring integration into mandatory service components within medical education programs and training.

Source: MHC Data Library; Medical Student Learner Document

Karis's Story

I've been working as a casual registered nurse with the Mobile Healthcare and Wellness clinic for the past year and it's been such a rewarding experience. I appreciate the opportunity to connect with constituents, meeting them where they are at and in ways they feel comfortable with, hearing their stories, and working together toward what is important for them. I've been so touched to see how individuals who've experienced so much are able to show up for themselves and those around them, despite all of the obstacles and challenges. After working within the WRHA for over 10 years, it's so refreshing to be part of something that is truly accessible and responsive to people within the community, and especially for those who have been discarded by society. Last summer when we were checking in at various encampments, one man expressed how much it meant that we were there and how good it was to just be together as humans. For me, that sums up the significance of this work.

Healthcare System

Individuals experiencing homelessness are more likely to rely on emergency services due to lack of access to primary care, leading to:

- repeated emergency department visits
- preventable hospital admissions & prolonged hospital stays due to discharge barriers
- preventable ambulance use

These patterns are among the most expensive forms of healthcare utilization in Manitoba, as visits are often higher acuity, more complex, and more likely to result in admission due to unmet upstream needs such as housing, mental health, addictions care, and access to primary care.

MHC addresses these gaps by delivering l**ow-barrier, street-based, and culturally informed care** to 568 individuals annually —most of whom are Indigenous and experiencing significant barriers to care— the program delivers accessible, culturally informed healthcare while reducing reliance on emergency departments, hospital admissions, and crisis ambulance services.

With an annual budget of approximately $1.2 million, MHC provided 1,847 visits at an average cost of ~$650 per visit, which is significantly lower than the average emergency room visit cost of ~$1,500.

By intervening earlier and in community settings, MHC reduces reliance on high-cost acute care services, including:

- infections treated (STBBI etc.)
- wound care on-site
- medication continuity
- crisis stabilization

For example, EMR data this year has shown substantive on-site wound care services, playing a vital role in implementing preventative care measures by delivering care that can often result in emergency/urgent care visits.

428

Wound Care Services Provided

88

Encounters in which Wound Care Supplies Were Provided

95

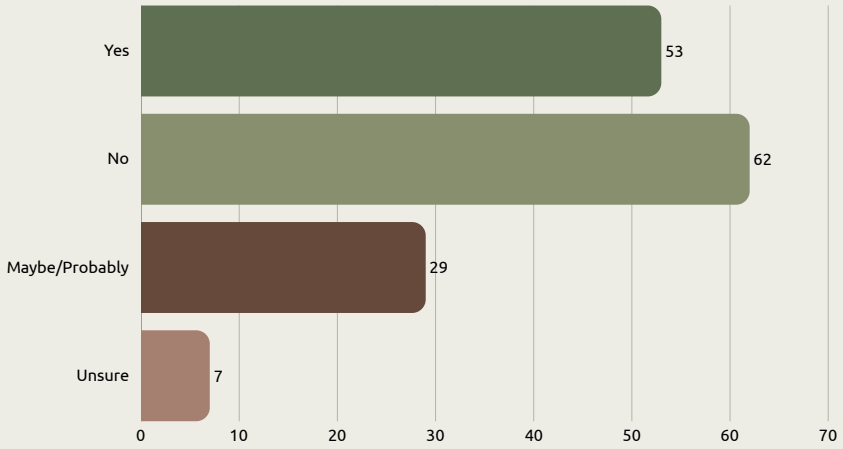
Treatments for Wound Care from MHC Stock

14

Prescriptions Provided for Wound Care

Source: AccuroEMR

Additionally, responses from the New Patient Questionnaire in which constituents were asked ***"If you weren't visiting the Mobile Healthcare Clinic today for your health issue/concern, would you have gone to the Emergency Department/Urgent Care instead?"*** indicate that approximately 34.8% of clients would have gone to the emergency department or urgent care if MHC were not available, with an additional 19% indicating they likely would have—supporting an overall estimate that roughly 45% of visits represent true ED diversion.



Source: Registrations and Daily Tracking, n = 152.

Cost Analysis

Key Metrics:

- Annual Visits: 1,847 (AccuroEMR)
- Unique Constituents: 568 (Accuro EMR)
- Cost per MHC Visit: ~$650 (MHC Data Library)
- MHC Emergency Room Deferral Data (MHC Data Library; New Patient Questionnaire)
- Average Emergency Room (ER) Visit Cost: ~$1,500 (CIHI, 2023)
- Homelessness-related Hospital Admission Cost: ~$16,800 (CIHI, 2024)
- Ambulance Utilization Cost: ~$250-700 (CIHI, 2021)

A cost analysis shows that MHC generates system savings through four key pathways:

- Emergency department diversion: based on the New Patient Questionnaire, approximately 45% of MHC visits represent true diversion from ER use, resulting in an estimated ~$60,000 in annual savings;
- Avoided hospital admissions: Assuming 10% of patients would otherwise require admission, approximately 57 admissions are avoided each year, at an average cost of ~$16,800 per admission, resulting in ~$957,000 in savings;
- Reduced repeat ED utilization: By stabilizing high-frequency users, MHC contributes an estimated ~$252,000 in savings;
- Reduced ambulance utilization: By providing accessible care, MHC decreases reliance on emergency transport services resulting in approximately ~$63,000 in savings.

The total estimated annual savings are approximately **$1,332,000**.

Key Insights

- The majority of savings are driven by preventing high-cost escalation, particularly hospital admissions;
- Direct ER diversion represents a portion of total system impact;
- The program addresses systemic gaps in access to care for high-need populations.

Oliver's Story

Oliver's story illustrated this impact in practice. Living with a long-term Foley catheter while experiencing chronic homelessness, Oliver faced significant barriers to accessing appropriate care. Due to safety restrictions, home care services were not available in shelter settings, leaving the Emergency Department or Urgent Care as his only option when complications arose. He experienced frequent catheter issues including bypassing recurrent UTIs, skin breakdown, and ongoing discomfort, which are conditions that would typically require repeated hospital visits.

Through consistent engagement, MHC has been able to provide ongoing catheter management in the community, including performing catheter changes, troubleshooting complications, and supporting symptom management. The team has also coordinated access to urology appointments to address his longer-term care needs, while ensuring smoother transitions if emergency care is required. Oliver now checks in regularly with the team, which allows for early identification and management of issues before they escalate.

Needs Indicators

Advancing MHC's Model of Care

The ongoing growth in service delivery of MHC highlights several key operational needs for the clinic.

Development of a Cultural Patient Space

One important development is the creation of a cultural patient space, with a teepee room currently being created. This space is intended to support culturally safe care by providing an environment that respects and reflects the traditions and experiences of constituents, helping to build trust, comfort, and meaningful engagement during care.

Resource Need

MHC has seen a significant increase in snapshot indicators from 2024-2025 to 2025-2026. As MHC continues to grow and expand to meet the demand in services needs for constituents and improve access to care, further resources may be required to handle the current capacity that MHC is working at.

Indicators	2024-2025	2025-2026	Increase
Visits	922	1,662	80.2%
Encounters	1,006	1,847	83.6%
Service Days	130	212	63.07%
Service Provided	2,219	3,420	54.1%
Fixed Locations	4	8	100%
Mobile Locations	41	80	95%
Days with 2 MHC teams	0	17	N/A
Days with Combined Fixed and Mobile Days	0	16	N/A
Partnerships	9	23	155.6%

Note: *The reporting period of 2024-2025 was approximately three months shorter than that of the 2025-2025 reporting period. This difference in duration may therefore deflate percentage increase when compared to a longer period. However, the observed percentage increase even when taking this into account is substantial.*

Need for Additional Outreach Vehicle

The expansion of services, particularly the increase in visits, outreach locations, and days with two teams operating simultaneously, has placed greater demand on transportation resources. MHC currently operates with two vehicles, however there is a clear need for a third vehicle to support this growth. An additional vehicle would allow more consistent deployment of multiple teams, expand reach, reduce scheduling constraints, and improve MHC's ability to respond flexibly to constituents' needs.

Expansion of Landing Space

"Hey, are you around? I need help"

As MHC continues to build and strengthen relationships within the community, an increasing number of constituents are seeking out MHC services more than ever before. Recognizing the importance of a consistent landing space became clear, as constituents point to the need for a familiar and safe place to connect with the MHC care team. This led to the establishment of a landing space at The Salvation Army Weetamah in June 2025, where constituents could access services through office visits. This space also supports needed storage of medical and provisional/program supplies and allows the care team to connect and coordinate. As the MHC model continues to grow and serve constituents, securing a permanent landing space will be vital for maintaining and expanding capacity.

Recommendations for coming 2026-2027 fiscal year

That WRHA:

- Approve capital funding for additional clinic vehicles
- Increase operational funding to support staffing and expanded hours
- Provide additional funding to support purchasing/leasing space for MHC offices and a clinic base site with a culturally safe space.

The Mobile Healthcare Clinic is a proven, high-impact program. However, without additional vehicles and operational funding, expansion is not possible. The existing funding has been maximized beyond effectiveness. Strategic investment will enable scalable growth, significantly increase system savings, and improve equitable access to care for Winnipeg's most vulnerable populations.

LIMITATIONS

Acknowledging limitation is a critical component for data accuracy, representation, and transparency. This section will present these limitations that are embedded in this report.

Undocumented Service Details & No Show: Yes/Left Without Being Seen

Out of 1847 total encounters with constituents where patients were seen, there were 215 “services provided” blanks. Out of these 215, 36 met the criteria for ‘True Blanks’. The remaining 179 blanks are ‘Unidentified Blanks’.

Month	“True Blanks” in Services Provided	“Unidentified Blanks” in Services Provided	No Show: YES or LWBS
April 2025	5	0	6
May 2025	0	1	12
June 2025	1	2	8
July 2025	3	7	13
August 2025	3	8	7
September 2025	1	13	19
October 2025	7	26	26
November 2025	2	21	17
December 2025	3	23	17
January 2026	4	47	10
February 2026	2	16	13
March 2026	5	15	25
TOTAL	**36**	**179**	**173**

Throughout the reporting period, approximately 2% of all encounters were “True Blanks” (36 of 1847), and approximately 9.6 % of all encounters (179 of 1847) were “Unidentified Blanks”. True Blanks occur when the Billings and Appointment details indicates “No Show: Yes”, meaning that they were provided services, but there is no reason/service documented in the Billings and Appointment details and no encounter note to identify a reason/service provided. These “True Blanks” led to an underreporting of full services provided, and impact the service provided category only.

“Unidentified Blanks” means that the “No Show” was masked in the Billing and Appointment details, with no reason/service provided in the Billings and Appointment details, and no encounter note to identify a reason/service provided. This means that these 179 blanks could either be “True Blanks” or “Left Without Being Seen”. Out of these 179 “Unidentified Blanks”, there were 77 unique constituents receiving services for these blanks.

This lack of detail impacts the following:

- Underreporting of full services delivery provided;
- Underreporting of total number of encounters and visits;
- Underreporting on service category counts;
- Underreporting of LWBS;
- Disproportionately affects certain providers total number of encounters/visits.

This introduces potential bias into the dataset, distorting the distribution of reported services, and limiting the accuracy about care patterns. These gaps also affect key performance and utilization metrics, such as services per encounter and provider productivity.

To mitigate this for the next report, we have requesting that all service providers (Crisis Counsellors and Nurses) Billings and Appointment details be “unmasked” so that these blanks can be properly placed in No Show: Yes, or the True Blank categories.
There were 173 constituents that were registered but not seen. This includes when the provider has indicated that the constituent left without being seen in the encounter note, when the Billing and Appointment details indicates “No Show: Yes”, and when there was a scheduled time for a home visit, but the constituent was not there upon providers arrival.

While these constituents demonstrated an interest in accessing care by taking the step to register, limitations may have prevented the clinic from providing services, or the length of the wait time. Despite MHC and its providers’ dedication to providing time and holistic care, several factors – largely beyond the clinic’s control – can limit the number of patients reached on any given day and could indicate a mismatch between community need and service capacity in some cases.

- Complex health and social needs of constituents: Many constituents present with multiple and intersecting health and social concerns, requiring longer appointment times and often the involvement of more than one provider on the team per visit.
- Limited-Service Days During High-Demand Periods: In peak months, the high volume of care needs can exceed the clinic’s staffing and scheduling capacity.
- Challenges with Outreach and Follow-Up: While the clinic’s team makes every effort to follow up with constituents, it can be limited to external factors such as housing instability, frequent relocation, lack of phone access, or general disconnection from formal systems of care.

These factors, while impactful, are largely structural and systemic in nature, and not within the clinic’s direct control. Nonetheless, the team continues to adapt and respond to community needs with persistence, creativity, and care.

Fragmentation of Dataset Limitation and Incomplete Datasets

Incorporating data from the MHC Data Library can present certain challenges and limitations in reporting, particularly when working with fragmented data and incomplete datasets.

Fragmented Dataset: The optional questionnaire used to produce the New Patient Questionnaire data underwent two iterations. While updates to data collections tools are necessary to ensure that relevant and meaningful information are captured, these changes can lead to fragmented datasets. In this case, there was only a minor difference between the two iterations, with one question added in the second iteration that was not in the first. To maintain consistency and comparability, this question was excluded from reporting.

Incomplete Datasets: Although the MHC team is working diligently to complete the MHC Data Library documents, some datasets contain missing information, which can limit the accuracy and completeness of the data presented. To address this limitation, transparency is prioritized throughout the report by clearly identifying incomplete datasets and specifying what information is missing. Efforts are ongoing in collaboration with MHC to develop sustainable processes for capturing these data points more consistently throughout this fiscal year.

Descriptive Statistic Limitations

A limitation of utilizing the descriptive statistics methods is that they can only suggest correlations based on patterns and trends and do not allow predictions or generalization of findings beyond the dataset (i.e., no inference). Additionally, descriptive statistics do not explore relationships or causes behind observed patterns.

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APPENDIX A

CODE	DATE (yyyy-mm-dd)	DAY	HEALTH CAR	SEX	AGE CATEGOR	SERVICE TYP	DURATION OF ENCOUNTE	DURATION OF VISI	CARE TEAN

SERVICE	SERVICES (OTHER/NOTES	REFERRED FROM MHC TO [	REFERRALS (OTHER/NOTES	SYSTEMS NAVIGATION (NOTES	SUBSTANCE USE (NOTES	NON-PATIENTS SEE

APPENDIX B

SERVICES PROVIDED AT MHC
Health Promotion and Education
Immunization
Minor Procedure
Regular Check-Up
Treatment for Minor Injury
Wound Care
Chronic Disease or Condition Management
Diabetes Testing
Diabetes Treatment and Management
Point-of-Care Treatment for Acute Health Concerns
Point-of-Care Treatment for Chronic Disease or Condition
New Prescription
Non-Prescription Medication
Prescription Refill
Contraceptives
HIV Management
HIV Point-of-Care Testing
Pap Test Examinations
Pregnancy Testing
PrEP (Pre-Exposure Prophylaxis for HIV Prevention)
STBBI Testing
STBBI Treatment
Detoxification Program Clearance Forms
Drug Screening Test
Harm Reduction Supplies
Opioid Agonist Therapy (OAT)
Substance Use Support
Counselling
Mental Health Supports
Forms
Systems Navigation
Lab Services
Requisitions
Appointment Reminders
Building Rapport
Medication Support
Provision of Basic Needs
Transportation Support
Care Coordination
Documentation
Follow-Up and Outreach Activities

APPENDIX C

REFERRALS CATEGORIES
Referrals to Emergency Department (General)
Referrals to Indigenous Community Health Provider
Referrals to Medical Specialists & External Providers
Referrals to Outpatient Services & Allied Health
Referrals to Emergency Department (911/EMS)
Referrals to Primary Care Provider
Referrals to Spiritual Healthcare Provider or Supports
Referrals to Urgent Care
Referrals to Manitoba HIV Program
Referrals to RAAM
Referrals to Withdrawal Management Services
Referrals to Mental Health Services
Referrals to Domestic or Intimate Partner Violence Supports
Referrals to General Housing Services and Supports
Referrals to Housing (Emergency Shelter)
Referrals to Housing (Transitional)