AHWC
MOBILE HEALTHCARE CLINIC

INITIAL REPORT
2024/2025

ABORIGINAL HEALTH & WELLNESS CENTRE
OF WINNIPEG INC.

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Introduction

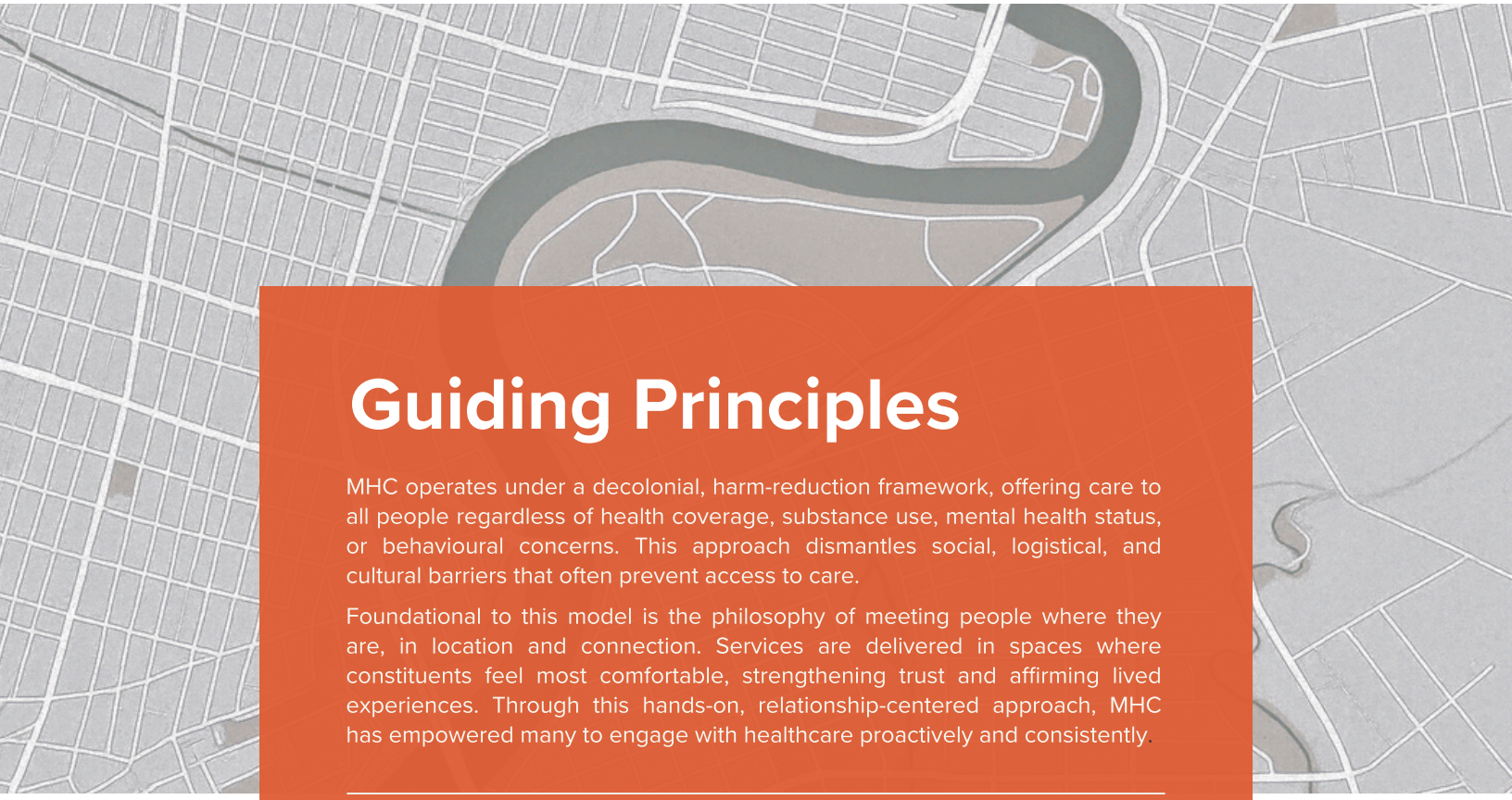
Overview

Launched in July 2024 through a partnership with the **Winnipeg Regional Health Authority** (WRHA) and operating from a van generously provided by **End Homelessness Winnipeg** (EHW), 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 encampments, shelters, and community hubs.

AHWC serves Winnipeg's Indigenous communities, referring 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.

Preparation for MHC's launch involved recruitment, onboarding, and training throughout June and early July 2024. Despite minor logistical challenges and physician availability delayed the planned July 6 launch, a soft opening on July 25 at the Neeginan parking lot allowed the team to fine tune its operations alongside its home base. The Clinic then officially launched with the RAAM Clinic on July 27 and since then has reached hundreds of community relatives facing systemic barriers to care.

Over its first eight months of operation, MHC's multidisciplinary team has delivered a wide array of services. These range from immediate and ongoing primary care, chronic disease management, and health education, to on-site mental health support. Another key aspect has been the clinic's role in facilitating access to housing and other systems navigation supports, specialist referrals, and other essential social services.



Guiding Principles

MHC operates under a decolonial, harm-reduction framework, offering care to all people regardless of health coverage, substance use, mental health status, or behavioural concerns. 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.

Goal

Through MHC's targeted partnerships and regular community presence, the clinic aims to maximize accessibility, build 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 Insights
Informing MHC Strategy

Between March and April 2024, two virtual meetings, along with four one-on-one engagement meetings took place among 13 community-based organizations. These engagements aimed to better understand community-specific needs, perspectives, and preferred referral pathways to optimize the clinic's operation.

Community partners highlighted the importance of building trust through consistent presence, emphasizing predictability in clinic availability at key locations to increase accessibility and uptake of healthcare services over time. They recommended strategically locating in areas with the highest concentration of vulnerability exists and where emergency medical services (EMS) data indicates high non-emergent call volumes. Specifically, Winnipeg Fire Paramedic Service (WFPS) partners noted a significant concentration of call (upwards of 10 per day) around the block-radius of MSP (637 Main Street) and N'Dinawemak (190 Disraeli). Regular MHC presence at these locations was recommended as a strategy to proactively manage primary care needs and alleviate strain on emergency response services.

Partners further identified common barriers experienced by constituents, including avoiding going to the hospital or other healthcare settings due to negative experiences, long wait times, and inadequate transportation – all of which contribute to cycles of unmet needs that deteriorate health. Additionally, they outlined specific service gaps in local healthcare delivery, notably mental health crisis support, urgent wound and foot care, and timely treatment for sexually transmitted and blood-borne infections (STBBIs).

Building Care Through Community Connections

Since July 25th, 2024, MHC has documented approximately 190 community partner interactions, which have been counted and recorded monthly by the clinic's operations team and placed in the MHC Data Library. These interactions are further detailed and outlined in monthly 'Mobile Clinic Board Reports'.

Collaboration with Winnipeg's (DCSP)

Downtown Community Safety Partnership (DCSP) frequently facilitates transportation to hospitals for constituents seen by the MHC team and assessed to need more specialized care.

Daily Referrals from Community Partners

Community partners consistently refer individuals from encampments and shelters who are in need of medical attention, highlighting the vital role of coordinated frontline healthcare efforts. MHC responds to as many of these calls as operational capacity allows. High volumes of referrals from partners such as Street Links, have expressed ongoing appreciation for the clinic's presence and impact. Across the network, partner continue to highlight the value and effectiveness of MHC's service model tin addressing urgent care gaps. As the clinic's visibility and trust in community grow, these referral relationships continue to strengthen.

Indoor Space During Winter

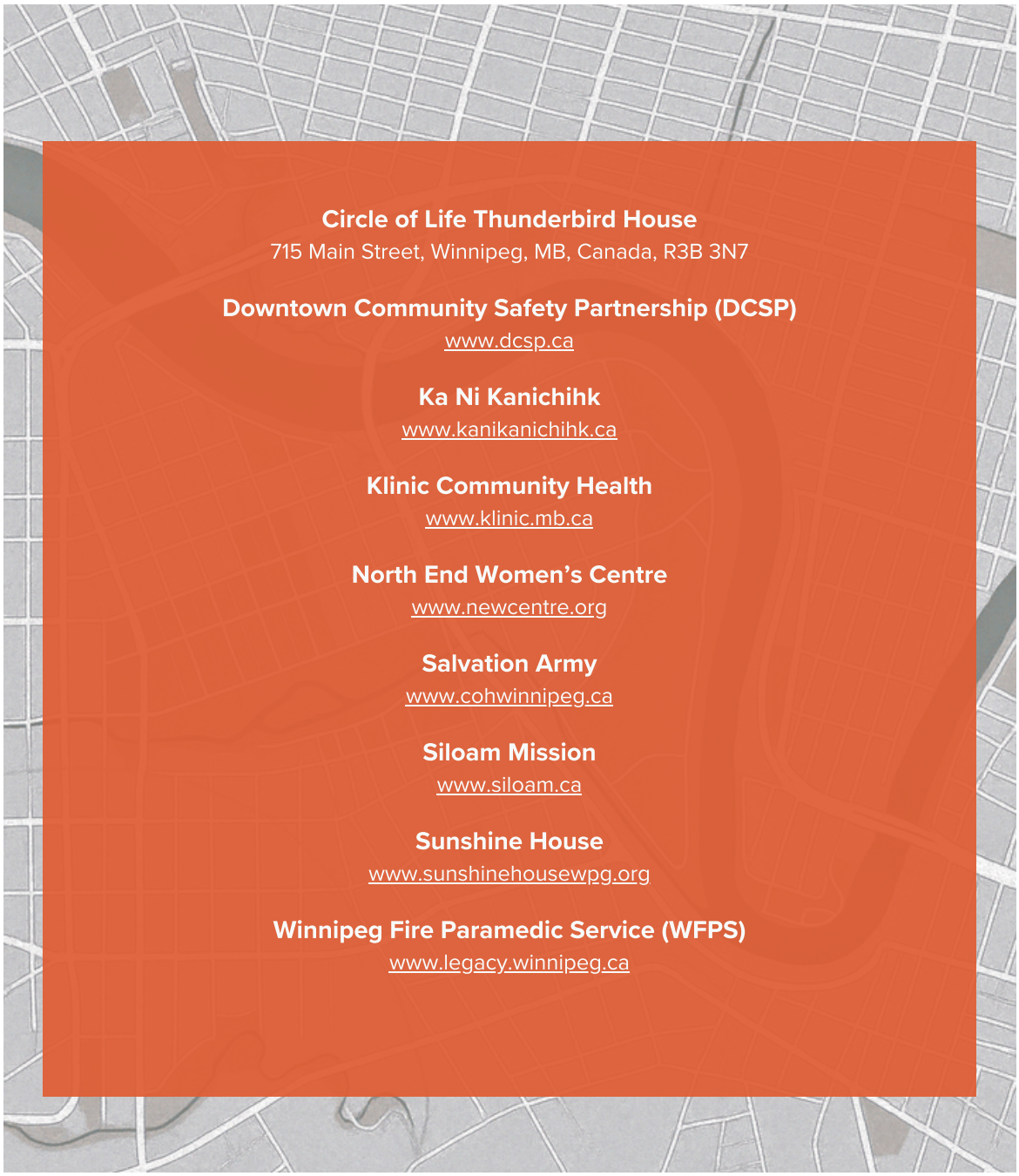
To ensure continuity during cold winter months, MHC has partnered with N'Dinawemak, North End Women's Centre (NEWC), Siloam Mission, and MSP who have generously offered indoor space for service delivery.

Access to Services through Siloam Mission

Siloam Mission provides full access to their clinic and staffing on Saturdays which has enabled MHC to significantly expand patient access on these days, however, demand has often exceeded capacity, prompting considerations for increased service hours and the potential of providing services simultaneously at two locations.

Addressing Operational Challenges

Cold weather poses challenges for the storage of temperature-sensitive supplies and equipment. While Salvation Army has graciously temporarily offered a heated garage space, this has prompted plans for a permanent heated garage at the forthcoming supervised consumption site (SCS) to ensure operational continuity and vehicle security year-round.



Circle of Life Thunderbird House
715 Main Street, Winnipeg, MB, Canada, R3B 3N7

Downtown Community Safety Partnership (DCSP)
www.dcsp.ca

Ka Ni Kanichihk
www.kanikanichihk.ca

Klinic Community Health
www.klinic.mb.ca

North End Women's Centre
www.newcentre.org

Salvation Army
www.cohwinnipeg.ca

Siloam Mission
www.siloam.ca

Sunshine House
www.sunshinehousewpg.org

Winnipeg Fire Paramedic Service (WFPS)
www.legacy.winnipeg.ca

Service Access

The clinic delivers essential care to locations where individuals experiencing homelessness or extreme poverty seek shelter and community, including encampments, bridges, and other community hubs located throughout downtown Winnipeg and its adjacent neighborhoods, Point Douglas, and Elmwood/East Kildonan. Services are consistently provided every Tuesday, Wednesday, and Thursday in these locations. On Fridays, the clinic alternates between North End Women's Centre (NEWC) and N'Dinawemak, while Saturdays alternate between Main Street Project (MSP) and Siloam Mission. The clinic also coordinates service delivery alongside other community-based organizations, including Sunshine House's Mobile Overdose Prevention Site (MOPS), West Central Women's Resource Centre (WCWR), and Velma's House, all of whom have identified primary healthcare as a critical unmet need among their constituents.

Hours of Operation:
Tuesday to Friday 11:00 AM – 7:00 PM; Saturday 9:00 AM – 4:30 PM.

CENTENNIAL

MOPS
646 Logan Avenue

Health Sciences Centre
820 Sherbrook Street

Siloam Mission
300 Princess Street

DOWNTOWN

Manitoba Métis Federation (MMF)
200 Main Street

Main Street Project
637 Main Street

McFadyen Park
416 Assiniboine

Beer Can
1 Granite Way

EXCHANGE DISTRICT

Waterfront Drive Area

Salvation Army
180 Henry Avenue

INKSTER

Stanley Knowles Park
1235 Logan Avenue

NORTH END

Ndinawe Youth Resource Centre
472 Selkirk Avenue

Sexual Wellness Lodge
765 Main Street

OLD ST. VITAL

Street Links
604 St. Mary's Road

OSBORNE VILLAGE

Fort Rouge Park
295 River Avenue

POINT DOUGLAS

N'Dinawemak
190 Disraeli

ST. JAMES

St. James Cemetery
525 Tylerhurst Street

WEST BROADWAY

Health Sciences Centre
820 Sherbrook Street

Nine Circles Community Health Centre
705 Broadway

WEST END

West Central Women's Resource Centre
640 Ellice Avenue

1560 Orange Street

WOLSELEY

Velma's House
1065 Portage Avenue

Vimy Ridge Park
821 Preston Avenue

Approach & Methodology

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

As biomedical western models of healthcare often 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). Moreover, the dominant monoculture of extracting data for health reports often perpetuates 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, Wilson, 2008), that Eurocentric formal standards of measurement do not capture or illustrate (Yanful et al. 2013).

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, as well as incorporating important epistemological aspects such as repairing trust, and other relational aspects (Smith, 2012; Wilson, 2008). 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 onsite treatment (acute and over the counter medication) that are provided from MHC stock that work to reduce transportation 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 – 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 in one visit 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.

EMR

A manual count of all EMR data was undertaking through Accuro to produce the primary raw dataset for this report. The data that was extracted from EMR will be outlined in the data extraction section below.

There are two main reasons why a manual extraction was implemented rather than pulling the EMR dataset electronically through Accuro:

(1) Systematically extracted datasets from the Accuro database are not always accurate due to:

- When a reason for the visit in the billings and appointment details are not added, these are captured as 'blanks' in the 'reasons' statistics in the electronic printouts of EMR data. When a manual count is undertaken, the encounter notes will detail the reason for the visit, and this will remove the false 'blanks' and only capture the true 'blanks'. True 'blanks', through the manual method, only occur when there is no reason indicated in the billing and appointment information AND there is no encounter note. A manual count increases the accuracy of the data by decreasing the number of blanks by locating and providing the 'reason' for the visit through the encounter notes.

- Sometimes the 'reason' in the billings and appointment details are selected by mistake or prior to the actual appointment. Due to this, the 'reason' selected in the billings and appointment details, which are captured when running the electronic statistics dataset through Accuro, are not always accurate and can misrepresent the true reason and actual services provided in the visit. A manual extraction reduces these errors to present a more accurate dataset by ensuring the 'reason' matches the encounter notes.

- Sometimes a patient is registered in the system, and in the billings and appointment details it indicates that this patient was seen. However, when you go into the encounter notes it says left without being seen (LWBS). This will produce inaccurate data on how many patients were seen and how many visits were recorded that day. A manual extraction reduces these errors by providing more accurate numbers on how many encounters/visits actually occurred.

(2) An EMR dataset produced systematically through Accuro only captures the 'main reason' for the encounter/visit rather than all the reasons/services provided within that encounter/visit. As MHC uses a decolonial healthcare services model, and the data extracted for this report is done through a decolonial lens, capturing all reasons of the services provided is essential to illustrate the breath, width, reach, and impact that are provided through the MHC Healthcare model. This also includes wider social supports and services not normally provided or captured in conventional healthcare models of care and data extraction (e.g., transportation arrangements to appointments for patients; on-site treatments and medications provided directly from the MHC stock; take home wound care dressings provided from the MHC stock etc.)

MHC Data Library

The MHC Data Library holds 3 raw datasets that have been produced by the Mobile Healthcare Clinic staff throughout the year:

Numbers Document. The MHC staff recorded daily counts for numerous items.

This raw dataset was used for: 'Patients Registered but not Seen'; 'Community Partner Interactions'; 'Sandwiches Handed Out'; Hygiene Kits Handed Out'; Medicine Kits Handed Out'; and 'Harm Reduction Kits Provided'.

Indicators Responses. The MHC staff produced this raw dataset from 4 iterations of optional questionnaire's constituents/patients could fill out at the time of registration. This dataset does not represent all 616 unique individuals who received services from the clinic, but rather only those who choose to answer these questions at the time of registration. Full numbers on how many individuals answered each question will be outlined in the report through n=.

Some questions in these optional questionnaires remained the same through the 4 iterations (e.g., Sexual Orientation), some questions shifted through the iterations (e.g., gender identity was asked through two distinct questions in the first 3 iterations and combined into one question in the 4th iteration), and some questions were removed or added throughout the 4 iterations.

This raw dataset was used for: 'Gender Identity', 'Two-Spirit Identity'; 'Sexual Orientation'; 'Indigenous Self-Identification'; 'Status Identification'; 'Housing Status'; 'Housing Support'; 'Access'; 'Barriers to Accessing Healthcare Services'; Modes of Transportation for Healthcare and/or Social Service Appointments'; 'Culturally Safe Care'; 'Technology and Health information Access'; 'Community Perceptions of Quality Care'; 'Mobile Outreach Locations Visit Count'; 'Fixed Locations Visit Count'; 'Patient Locations for Emergency Department or Urgent Care Visits'; and 'ER Deferrals Based on MHC Services'.

Story Quotes. These are quotes collected from community relatives (constituents) and community nurses, provided by MHC staff for the report. These were used to provide a qualitive component that speaks to the descriptive statistics and were integrated throughout the report.

Secondary Sources

AHWC Mobile Healthcare Clinic Report. This report was produced by the MHC staff and provided information for the Introduction Section of the report, all information on the Community Organization Meetings that were held between April – March 2024, as well as all information regarding the WRHA included in the report.

Monthly Clinic Board Report. These are monthly reports that are produced by the MHC staff and were used for providing information in the Introduction Section of the report, as well as for providing context and examples of Community Partner Interactions for this 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 EMR data capturing form for what is currently captured in Accuro was provided from MHC. Two data extractors developed the data extraction template (Appendix A) based on these data point categories provided, as well as added wider data points to reasons/services that weren't currently being captured in the form (e.g., On-site Treatment for Acute; Onsite Medications Provided). These added data points were agreed upon by both extractors.

The data extraction template includes capturing: 'Code' (Anonymous identifier code for each patient); 'Date' of each encounter; 'Non-Patients Seen'; 'Health Card Coverage'; 'Sex'; 'Age Category'; 'Service Type'; 'Duration of Encounter'; 'Duration of Visit'; 'Care Team'; 'Services Provided' (reasons/services categories can be seen in Appendix B); 'Notes for services provided'; 'Referred from MHC to [x]' by referral category (referral categories can be seen in Appendix C); 'Notes' for referrals.

The notes allowed the extractors to break down these data points even more, such as distinguishing locations of transitional housing referrals to report (e.g., Housing First, AHWC Housing, SBSL Housing, MSP Housing) and breaking down the "other" category (e.g., number of transportation services arranged and provided; number of wound care supplies provided to patient etc.)

Data Extraction 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 extractors created a protocol for extracting data as detailed:

- Data point definitions to determine the parameters for each reason/service provided and referral from MHC (see the Stat's Explained section for these parameters).

- Extracted data would capture the reasons/services ONLY when a patient was seen in the encounter and not when a service was provided without the patient being seen in the encounter, such as a chart or lab review, or when the MHC team went to provide follow up services to the patients at the encampment, but they were not home.
- Always refer to the Encounter Note for reason/services provided and referrals. If there is no encounter note, then the reason/service was extracted from the billings and appointment details (located through the f4 function).
- If the encounter note states LWBS (left without being seen), these encounters are not included in the extracted data.
- If there is no encounter note and the billings and appointment details report No Show: NO – then this encounter would be included in the data extraction.
- If there is no encounter note and the billings and appointment details report No Show: Yes – then the encounter would not be included in the data extraction.

Processes Prior to Piloting: All unique patients were extracted in a dual extraction process to reduce extraction errors and ensure greater accuracy (Mathes et al., 2017), and were provided a unique anonymous identifier code to be used for the data extraction. Following this step, the data extraction template was piloted.

Piloting: The data extraction tool was piloted by both the extractors, extracting the data for 5 unique patient identifier codes (001-005). 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 extractors 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=616) were split in half for each independent extractor 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 extractor 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, proportions, 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.). The story quotes were not included in any analysis and are used only to provide a qualitive component that speaks to the descriptive statistics presented.

Stats Explained

Number of Patients Registered and Seen	This number reflects only individuals who were captured in the EMR as unique registered patients provided services (initial visits). This number does not depict the total number of visits (initial and follow up) for those accessing the Mobile Healthcare Clinic for all it's available services.
Number of Patients Receiving Follow Up Services	The number of patients who came in for more than one visit.
Total Number of Visits	The total number of visits where patients were seen and services were provided (Initial visits and all follow up visits).
Total Number of Encounters	This number captures all the encounters that were provided per visit. For example, when some patients come in for their visit, they may have 2 different billing and appointment times in the same visit (1 encounter with a physician and 1 encounter separate with a counsellor). This number captures the distinct encounters for all visits.
Total Number of Service Days	The number of days that the Mobile Healthcare Clinic offered services from July 25th, 2004, to March 31, 2025. The days that the operation was not able to open (from Tuesday to Saturday) between these dates are attributed to the absence of medical staff due to scheduling challenges or staff illness, training days, office days, or holidays.
Total Number of Services Provided	While EMR data captures the indicated main reason they came in for services that are provided, our manual count captured all the reasons that they were provided services for each visit. Sometimes this was one reason only, but the majority of the times this was multiple reasons they were provided services per visit. This numbers captures all the reasons/services that were provided.
Number of Non-patient / Family Members Seen	This number indicates the number of constituents who were provided services for without registering who came into the visit with the registered patient and received services alongside the registered patient.

Number of Visits where Mental Health Crisis Supports were Provided	This number represents the total number of visits that involved mental health crisis counselling as well as referrals to Crisis centers or mental health community programs.
Number of Patients Registered but Not Seen	Registration of patients is on-going through-out clinic hours in order to maximize the amount of individuals that can access healthcare. The wait time for each registered patient is difficult to assess based on varying factors such as type of service required as well as this model of care does not require the appointment to adhere to a specific time constraint giving the patient time to tell their story if needed. As a result, either registered patients have decided that the wait is too long and choose to leave without being seen or clinic time has ended and patients who remain on the list and were still waiting in line were not able to be seen.
Number of Patients Referred from MHC to Health Services or Specialist	This number represents the number of patients that were referred by MHC to other health services (e.g., emergency departments, hospital, primary care provider, Indigenous community health provider, urgent care) or Health Specialist (e.g., Plastic Surgeon, Podiatrist, OBGYN, Orthopedics, Laryngologist, Dentist, Diagnostic imaging such as Xray and CT scans). This number does not include MB HIV program, mental health, or substance use referrals. Those will be captured in their own sections.
Primary Care	“Regular Check-Up”; “Wound Care”; “Treatment for Minor Injuries”; “Immunization”; “Health Promotion and Education”; “Minor Procedure (IUD, Mole removal, Any Skin Biopsy)”; “Referrals to other Health Services or Specialist”; Referrals to “Emergency Department (911)”; Referrals to “Emergency Department (non-withdrawal related)”; Referrals to “Urgent Care”; Referrals to “Hospital”; Referrals to “Primary Care Provider”; Referrals to “Indigenous Community Health Provider”
Chronic and Acute Condition Management	“Chronic Disease or Condition Management”; “On-site Treatment for Acute Condition”; “Diabetes Testing”; “Diabetes Treatment”
Medication and Prescriptions	“New Prescription”; “Prescription Renewal”; “Over-the-Counter Medication Provided”

Substance Use Support	“Substance Use Resources and/or Education Provided”; “Opioid Antagonist Therapy (OAT)”; “Main Street Project Forms (Detoxification)”, “Narcan/Naloxone Provided”; Referrals to “RAAM”; Referrals to “Withdrawal Management Services”, Referrals to “Other SUD-related Specialists”
Mental Health Support	“Counselling”; Referrals to “Community Mental Health Services/Programs”; Referrals to “Mental Health Services (Mental Health Crisis)”
Diagnostics	“Lab Services”; “Drug Screening Tests”
Other	The other category captures wider services that aren’t normally captured in EMR data such as arranging transportation for patients (rides to hospitals, detox, community programs, pharmacies, and bus tickets); extra wound care supplies provided; cloths, gloves, socks and handwarmers provided, as well as water/snacks.
Regular Check-Up	This number includes all reasons for services provided that are regarding sinus infections, headaches, gastrointestinal issues, respiratory acute (such as URTI, bronchitis etc.), urinary tract infections, joint or muscle pain, eye pain, allergies, lice etc.
On-site Treatment for Acute Conditions	This number includes any treatment provided directly from MHC stock (no prescription) such as antibiotics, antifungal, antiviral, antihistamine, lice treatment, etc.
Over-the-Counter Medication Provided	This number represents all the times that patients were provided over the counter medications (e.g. Tylenol, Advil) from the MHC stock.
Lab Services	This number refers to all onsite urine or blood lab services and requisition for lab services.

STBBI Testing	This number refers to all onsite STBBI testing and requisition for STBBI testing.
STBBI Treatment	This number refers to all treatments provided on-site from the MHC stock and all prescriptions provided for STBBI treatments.
Health Promotion and Education	Health promotion and education include discussions around such things as diet, exercise, when to visit the ER, wound dressing technique teaching, preventing infections, smoking cessation, importance of cancer screening etc.
Systems Navigation	Services that support patients in accessing and navigating complex health and social systems, such as housing, income, finding a PCP, EIA etc.
Substance Use Resources and/or Education Provided	This category represents when patients receive just substance use resources (from the counsellor) or education around substance use (from the nurse/physician) only (i.e., no MSP forms; no OAT; no WMS; no referrals)
Blank	This number represents any visit that does not provide a reason for the services provided. This category is only checked off if there was no reason in the billings and appointment note or the encounter note.

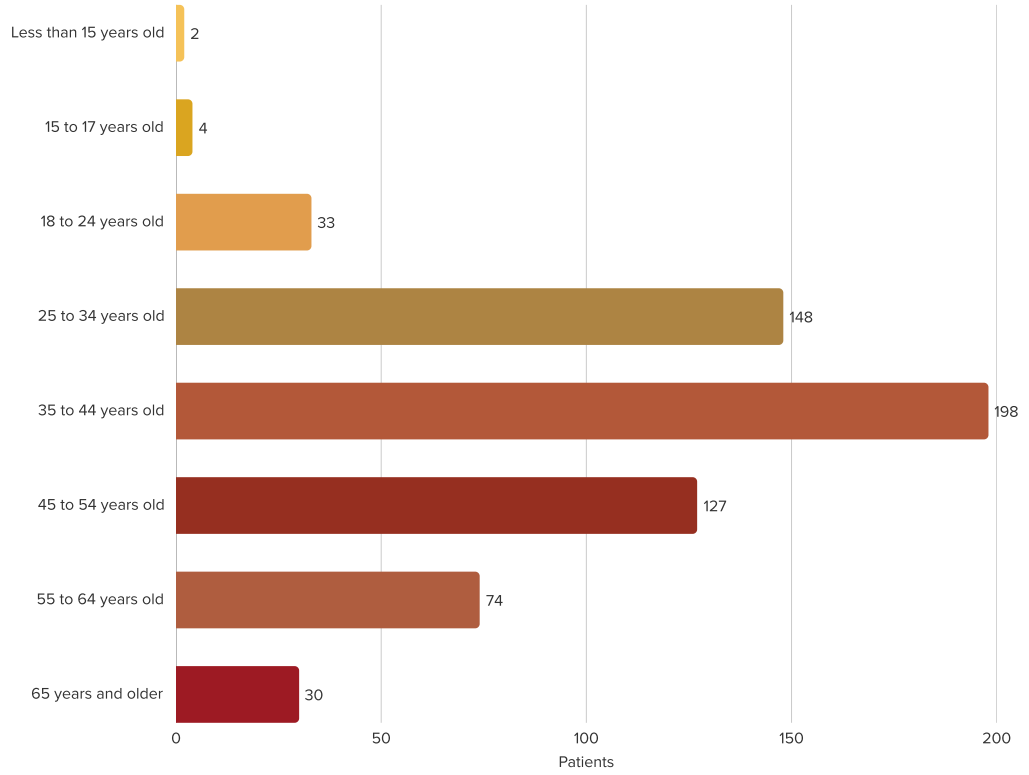
Demographics

MHC serves a diverse community which requires a nuanced understanding of its demographic composition in order to deliver its services effectively. This section details the demographic attributes of the clinic's constituents, including age group, biological sex, Indigenous self-identification, gender identity, sexual orientation, and housing status.

The demographic data has been retrieved from both the EMR data and the MHC Data Library. As outlined in the **Methods** section, the data retrieved from the MHC Data Library does not capture data that represents all 616 unique patients who received services from the clinic, but rather only those who choose to answer these demographic indicators as the data is gathered from an optional questionnaire that can be filled out at the time of registration.

Age Distribution

Understanding the age distribution provides insights on the clinic's reach across various life stages.



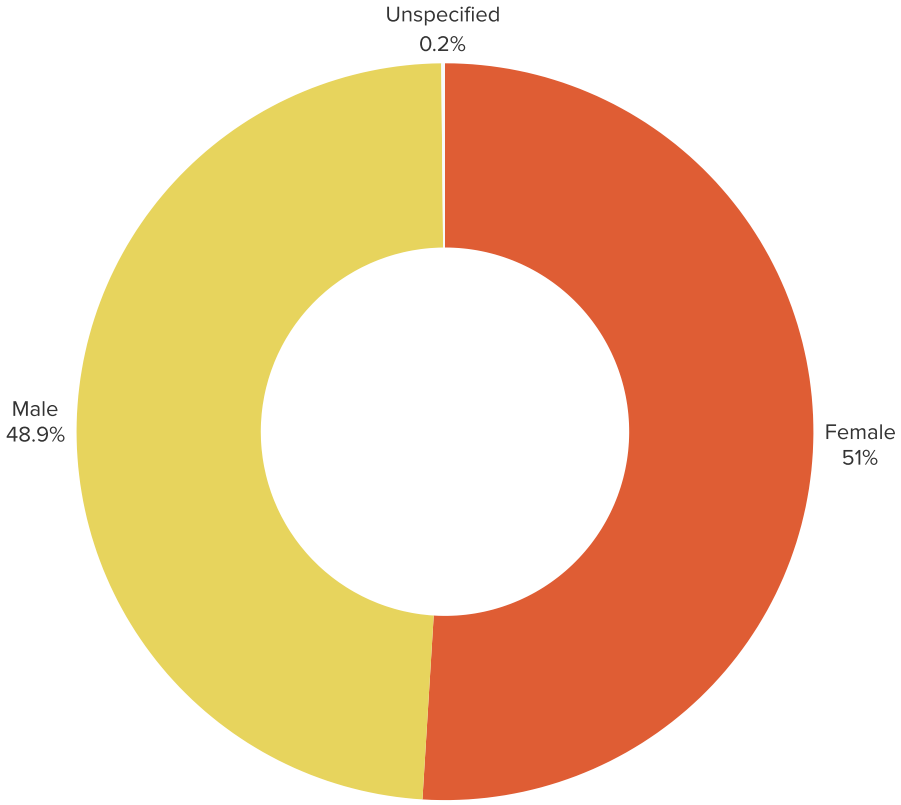
Data Source: EMR, n = 616.

The age distribution of patients accessing the clinic highlights a significant engagement with middle-aged individuals. The majority of patients fall within the **35 to 44 years** age range, with 198 individuals (**32.1%**) representing this age group. Following closely, the **25 to 34 years** age bracket accounts for 148 individuals (**24.0%**), and the **45 to 54 years** age group includes 127 individuals (**20.6%**), demonstrating substantial service uptake in these middle adulthood stages. There is a progressive decline in older age groups with 74 individuals (**12.0%**) aged 55 to 64 years and 30 individuals (**4.9%**) who are 65 years and older.

Younger adults aged **18 to 24 years** are also notably represented with 33 individuals (**5.4%**). The younger age groups, less than 15 years old and **15 to 17 years**, have the lowest engagement, with 2 and 4 individuals (both <**1%**) respectively.

Biological Sex

The EMR system 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.



Data Source: EMR, n = 616.

Of the total patients recorded in the EMR system, **51.0%** (314 individuals) identified as '**Female**' and **48.9%** (301 individuals) as '**Male**'. Only **0.2%** (1 individuals), was recorded as '**Unspecified**', suggesting that nearly all patients had their sex assigned at the point of entry into system.

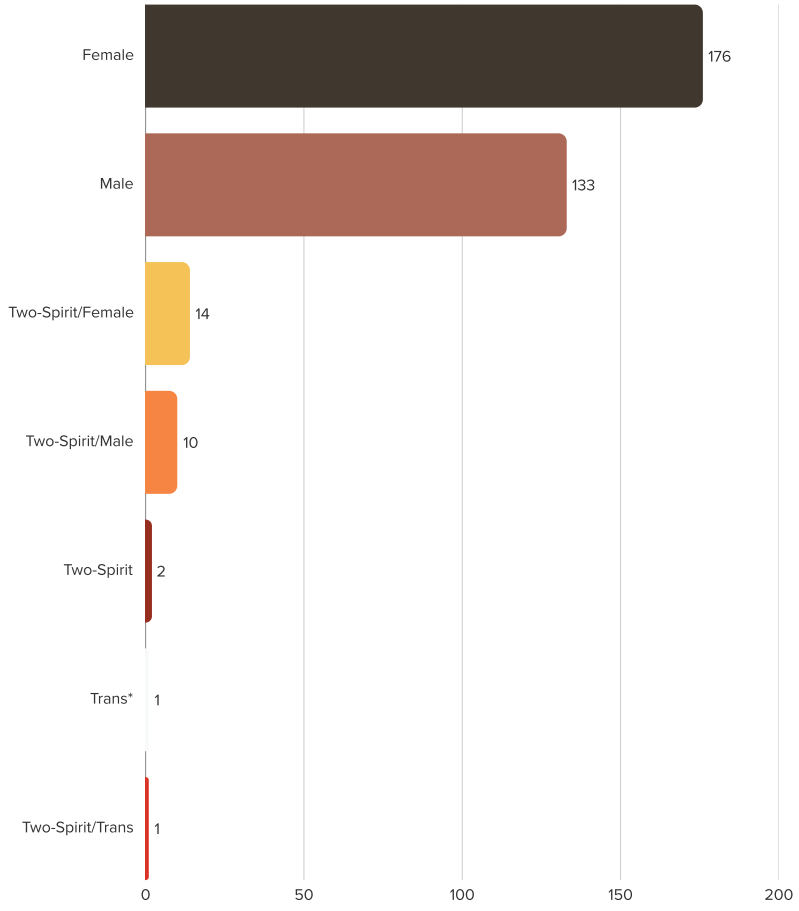
Self-Identified Gender

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, the clinic 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.

As outlined in **Methods**, gender identity data was collected through four versions of an optional registration questionnaire. The first three versions asked two distinct questions:

"Do you identify as Two-Spirit?" (response options: 'Yes' and 'No')
"What is your gender?" (response options: 'Female'; 'Male'; 'Trans'; 'Other')

The fourth version combined these questions into a single question: ***"What is your gender?"*** with response options expanded to include 'Female,' 'Male,' 'Two-Spirit,' 'Trans,' and 'Other'.



Of the total responses, the majority identified as **'Female'** (176 responses; 52.2%) or **'Male'** (133 responses; 39.5%).

A significant number of respondents also identified outside of the colonial binary:

'Two-Spirit/Female'
(14 responses; 4.1%)

'Two-Spirit/Male'
(10 responses; 3.0%)

'Two-Spirit'
(2 responses; 0.6%)

'Trans'
(1 response 0.3%)

'Two-Spirit/Trans'
(1 response; 0.3%)

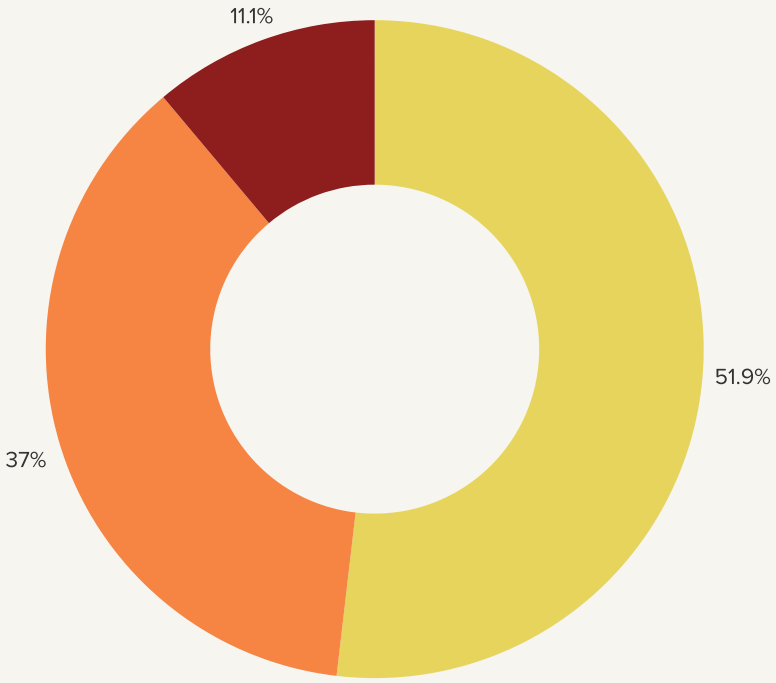
Data Source: MHC Data Library - Indicator Responses, n = 337.

*transgender, transsexual, gender queer

Two-Spirit (2S)

Two-Spirit constituents comprise **8.0%** (27 responses) of the of the '**Gender Self-Identification**' responses (n=337), which highlights their significant presence within the patient community.

Although smaller in comparison to binary gender categories, conventional healthcare datasets often fail to disaggregate or include Indigenous-specific gender identities. This visibility highlights the need for intentional inclusion of Two-Spirit perspectives and health needs at MHC.



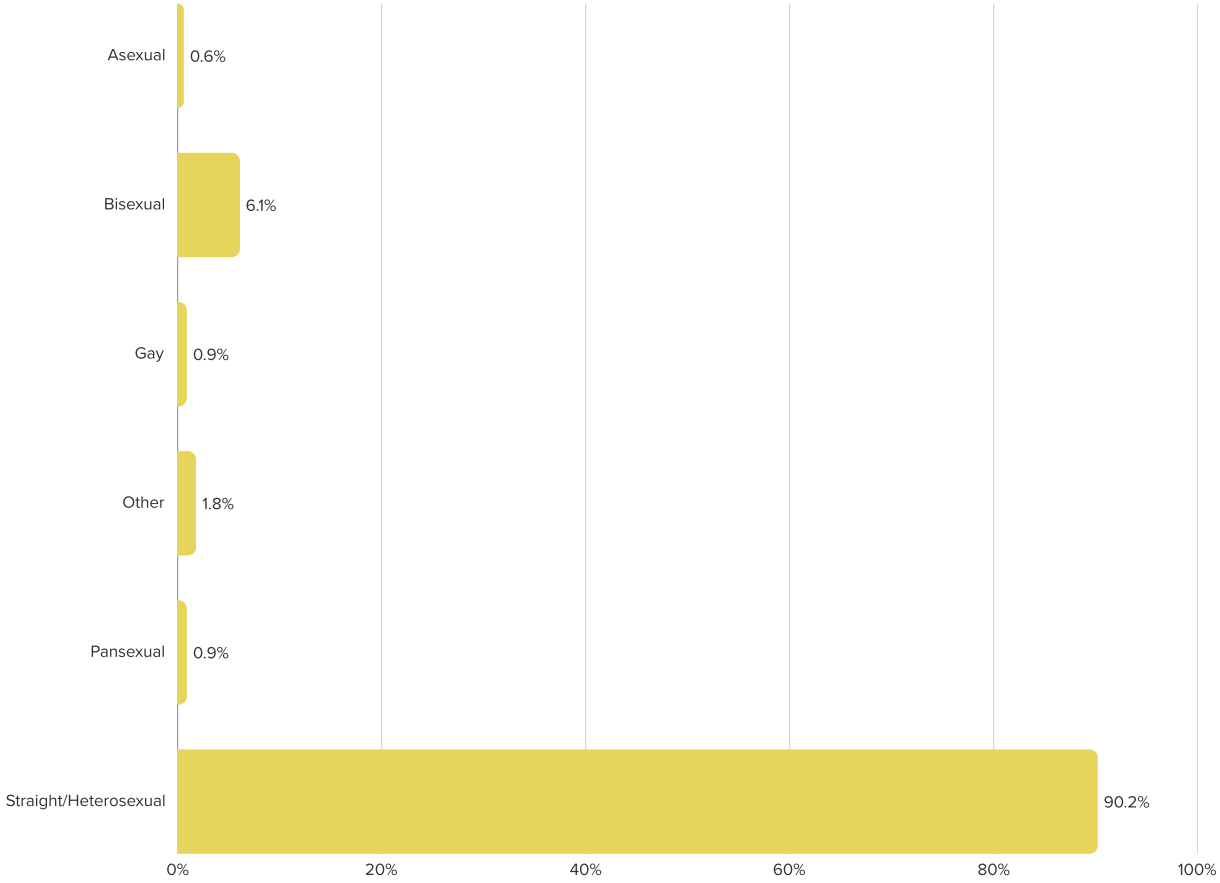
Data Source: MHC Data Library - Indicator Responses, n = 27.

Do you identify as Two-Spirit?

- **'Two-Spirit/Female'** (14 responses; 37.0%)
- **'Two-Spirit/Male'** (10 responses; 51.9%)
- **'Two-Spirit'** (3 responses; 11.1%)

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.



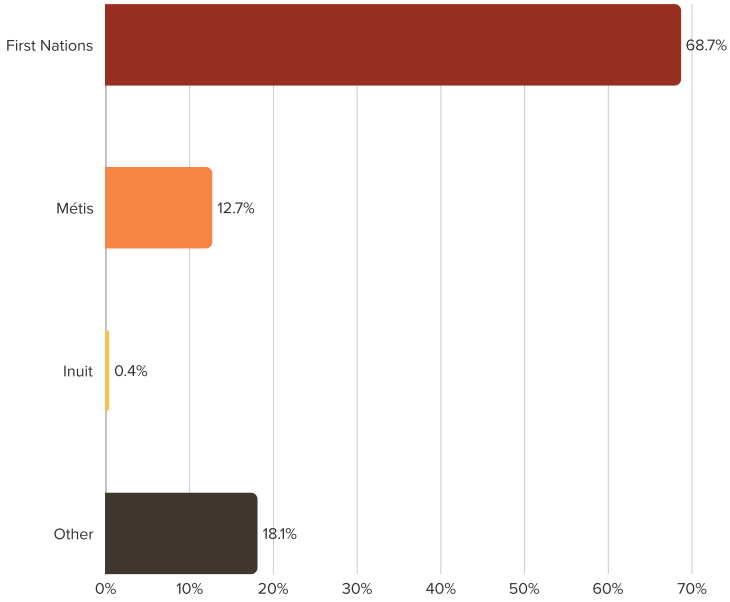
Data Source: MHC Data Library Indicator Responses, n = 329.

Among those who responded to the sexual orientation question at registration, the majority identified as **'Straight/Heterosexual'** (297 responses; 90.2%). Other orientations represented include:

'Bisexual' (20 responses, 6.1%)
'Other' (6 responses; 1.8%)
'Gay' (3 responses; 0.9%)
'Pansexual' (3 responses; 0.9%)
'Asexual' with (2 responses; 0.6%)

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.



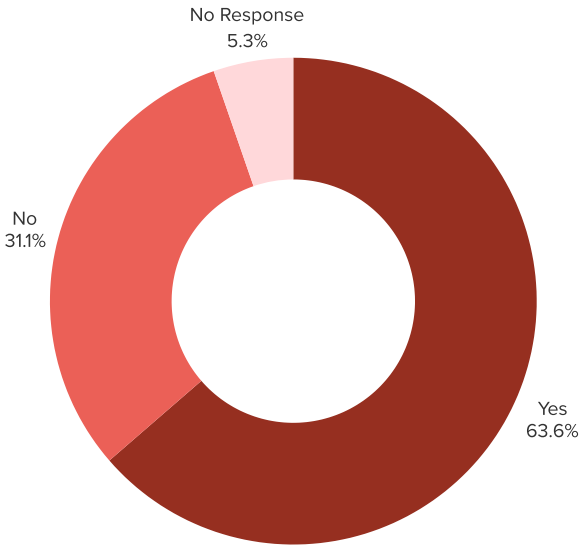
Data Source: MHC Data Library - Indicator Responses, n = 259.

The majority of respondents identified as **'First Nations'** (178 constituents; 68.7%), followed by **'Métis'** (33 constituents; 12.7%), with a small number identifying as **'Inuit'** (1 constituent; 0.4%). Additionally, 18.1% (47 constituents) identified as **'Other'**, which may include those with who do not identify as Indigenous, those with mixed ancestry, those who do not identify with specific categories offered, or those whose Indigenous ancestry may be complex or contextual.

Status

This chart reflects responses to the question of whether individuals identify as having Status under the Indian Act – a designation that carries legal and political meaning that may entitle people to certain federally funded programs, health benefits, and/or community-based services. Capturing this data allows providers to better understand and navigate these potential supports.

A clear majority of respondents (168 responses; 63.6%) indicated they have 'Status', while 31% (82 responses) indicated they do not. Additionally, 5.3% (14 responses) of respondents did not provide an answer, which may stem from various factors, including uncertainty about their eligibility, reluctance to disclose this information, barriers faced in the status processes, or other barriers that might impact their ability to provide a clear response.

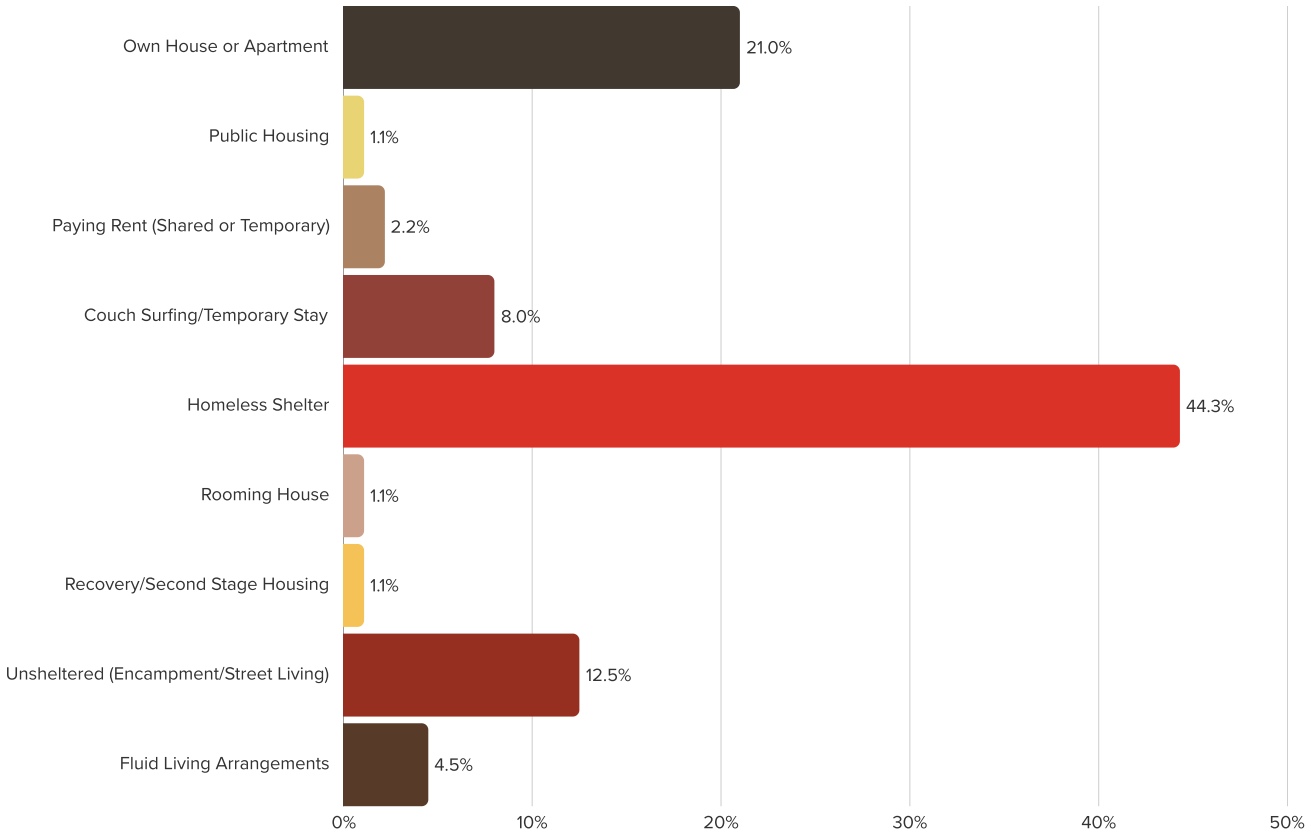


Data Source: MHC Data Library - Indicator Responses, n = 264.

Note: *The larger response size (n=264) suggests that some respondents who did not identify as First Nations still answered the Status question, which may include responses from Metis, Inuit, or Other-identifying individuals.*

Housing Status

Housing status is a critical social determinant of health that shapes both physical and mental well-being. Understanding how constituents are living allows the clinic to contextualize the environmental challenges that affect access to care.



Data Source: MHC Data Library - Indicator Responses, n = 88.

A substantial portion of the respondents (39 responses; 44.3.0%) reported staying in **'Homeless Shelters'**, while 12.5% (11 responses) reported being **'Unsheltered'** (living in encampments or the streets). Other precarious forms of housing included **'Couch surfing/Temporary Stays'** (7 respondents; 8.0%) and **'Fluid Living Arrangements'*** (4 responses; 4.5%), both often invisible in conventional data. Some reported living in more stable accommodations such as their **'Own House or Apartment'** (22 responses; 25.0%). Smaller proportions reported paying rent in **'Shared Temporary Arrangements'** (2 responses; 2.4%), **'Public Housing'** (1 response; 1.2%), and **'Recovery or Second Stage Housing'** (1 response; 1.2%).

Scope of Services

MHC offers up to 46 unique, integrated services to meet the complex and intersecting health needs of its constituents.

These specific services are also referred to as “reasons” for patient visits in the EMR system, which providers use to capture the primary focus of care provided during each patient encounter.

These 46 services are grouped into **9 key service categories** that reflect both clinical and social care priorities.

Primary Care

These **13 services** encompass a wide range of preventative care, treatment of minor health concerns, and overall health maintenance. Services include:

(**1.1**) Regular Check-Up
(1.2) Wound Care
(1.3) Treatment for Minor Injuries
(1.4) Immunization
(**1.5**) Health Promotion and Education
(1.6) Minor Procedure (IUD, Mole removal, Any Skin Biopsy)
(1.7) Referrals to other Health Services or Specialists
(1.8) Referrals to "Emergency Department (911)
(1.9) Referrals to "Emergency Department (non-withdrawal related)"
(1.10) Referrals to "Urgent Care"
(1.11) Referrals to "Hospital"
(1.12) Referrals to "Primary Care Provider"
(1.13) Referrals to "Indigenous Community Health Provider"

Chronic & Acute Condition Management

These **4 services** encompass the ongoing care and treatment of chronic illnesses (e.g., diabetes, hypertension, asthma, chronic obstructive pulmonary disease (COPD), arthritis, depression, anxiety) and responsive care for acute health concerns (e.g., allergic reactions, respiratory infections, sinus infections, urinary tract infections, headaches, muscle pain, gastrointestinal issues, lice). This category also captures treatments for these acute health concerns (e.g., antibiotics, antiviral, antifungal, antihistamines, Nix, etc.) that are provided on-site through MHC's stock. Services include:

(2.1) Chronic Disease or Condition Management
(2.2) On-site Treatment for Acute Condition
(2.3) Diabetes Testing
(2.4) Diabetes Treatment

Medication and Prescriptions

These **3 services** support patients in accessing necessary medication for both acute and chronic conditions. These include: issuing new prescriptions, managing prescription renewals for ongoing treatments, and providing over-the-counter medications (e.g., Advil, Tylenol, cold remedies) directly on-site from MHC's stock. Services include:

(3.1) New Prescription
(3.2) Prescription Renewal
(3.3) Over-the-Counter Medication Provided

Care in Every Corner

Sexual & Reproductive Health

These **9 services** entail comprehensive care to support sexual health, reproductive well-being, STBBI prevention, testing, and treatment. Services include:

(4.1) Contraceptive
(4.2) HIV Point of Care Testing
(4.3) HIV Management
(4.4) Pap Test Examinations
(4.5) Prep (Pre-Exposure Prophylaxis) (HIV Prevention)
(4.6) Pregnancy Test
(4.7) STBBI Testing
(4.8) STBBI Treatment
(4.9) Referrals to "MB HIV Program (Nine Circles, HSC, Brandon"

Substance Use Support

These **7 services** support patients in accessing necessary medication for both acute and chronic conditions. These include: issuing new prescriptions, managing prescription renewals for ongoing treatments, and providing over-the-counter medications (e.g., Advil, Tylenol, cold remedies) directly on-site from MHC's stock. Services include:

(5.1) Substance Use Resources and/or Education Provided
(**5.2)** Opioid Antagonist Therapy (OAT)
(5.3) Main Street Project Forms (Detoxification)
(5.4) Narcan/Naloxone Provided
(5.5) Referrals to "RAAM"
(5.6) Referrals to "Withdrawal Management Services"
(5.7) Referrals to "Other SUD-related Specialists"

Mental Health Support

These **3 services** encompass offering emotional support, counseling, and crisis intervention for individuals experiencing mental health challenges (e.g., stress, anxiety, depression, trauma, and grief). Services include:

(6.1) Mental Health Crisis Counselling
(6.2) Referrals to "Community Mental Health Services/Programs"
(6.3) Referrals to "Mental Health Services (Mental Health Crisis)"

Care in Every Corner

Systems Navigation & Forms

These **4 services** support patients in accessing necessary medication for both acute and chronic conditions. These include: issuing new prescriptions, managing prescription renewals for ongoing treatments, and providing over-the-counter medications (e.g., Advil, Tylenol, cold remedies) directly on-site from MHC's stock. Services include:

(7.1) Systems Navigation
(7.2) Forms (EIA, Treatment Forms, Tax Credit Forms, Disability Assessment Forms)
(7.3) Referrals to "Transitional Housing
(7.4) Referrals to "Homeless Shelter"

Diagnostics

These **2 services** offering emotional support, counseling, and crisis intervention for individuals experiencing mental health challenges (e.g., stress, anxiety, depression, trauma, and grief). Services include:

(8.1) Lab Services
(8.2) Drug Screening Tests

Other

All 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. This includes:

(9.1) Transportation coordination, provision of wound care supplies, medication and appointment reminders, provision of water/snacks, clothes, and winter gear such as gloves, socks and handwarmers.

Care in Every Corner

Impact **Indicators**

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

616

Unique Patients Registered & Seen

1,006

Encounters

189

Patients Received Follow-Up Services

130

Service Days

922

Visits

2,219

Services Provided

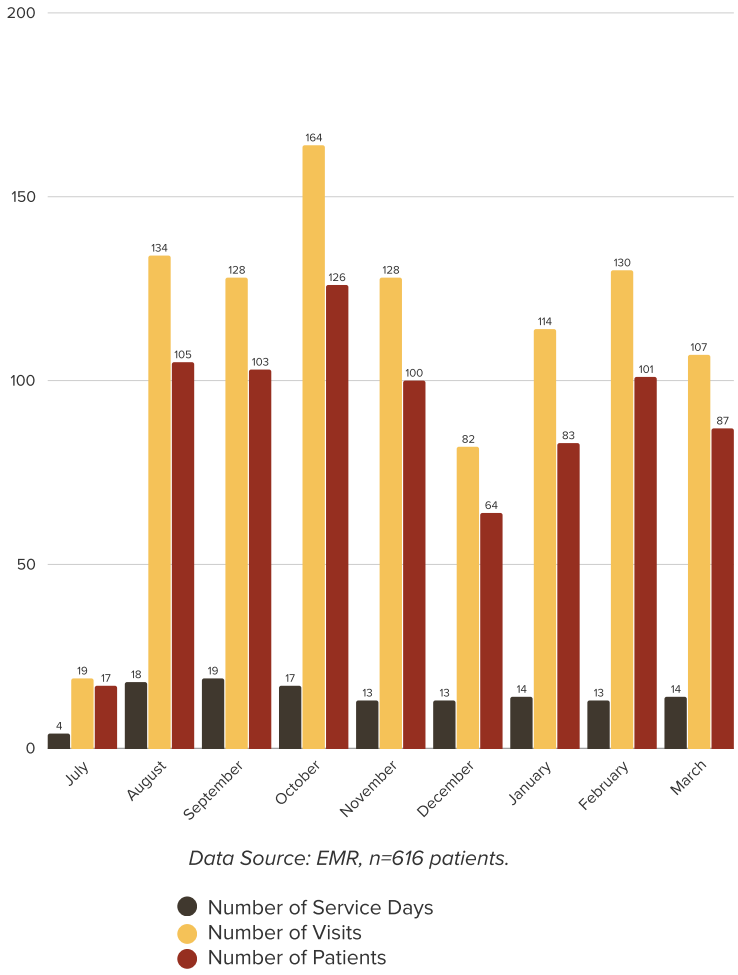
During the reporting period (between July 25, 2024 and March 31, 2025), the clinic registered and provided care to 616 unique patients across 130 service days, demonstrating the clinic's broad reach in the community.

Of these, 189 patients engaged in follow-up care, which highlights the clinic's vital role in fostering ongoing relationships and continuity of care. Among follow-up patients, the number of encounters ranged from 2 to 16.

In total, the clinic supported 922 visits across 1006 patient encounters, delivered over 130 service days.

Activity and Utilization

A detailed overview of service delivery patterns and patient engagement at MHC. Included are metrics on monthly patient flow and patient flow by Mobile Outreach Days (Tuesdays, Wednesdays, and Thursdays) and Fixed Location Days (Fridays and Saturdays).



Data Source: EMR, n=616 patients.

Monthly Visit and Patient Flow.

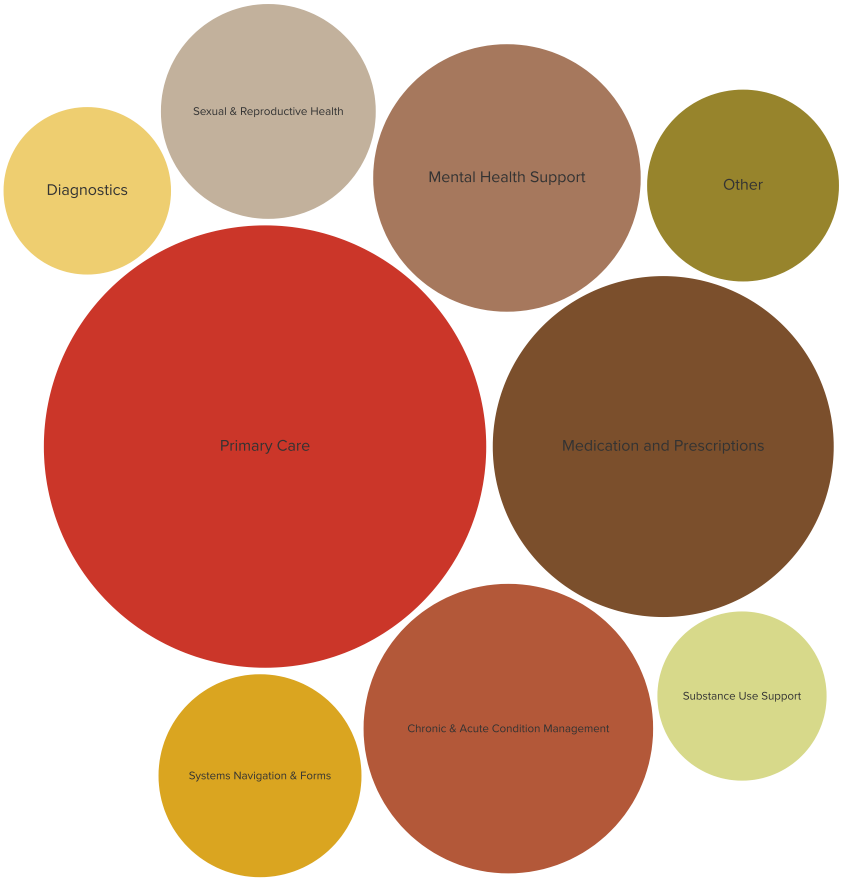
Monthly trends in service delivery at MHC from July 24, 2024, to March 31, 2025, comparing three metrics: **Service Days**, **Visits**, and **Patients.**

October demonstrates a service peak period across all metrics, with **164 visits (**126 patients over 17 service days), suggesting the highest service demand and clinic capacity utilization period.

August, September, November, and February show a steady patient flow across 13-19 service days , each with **over 100 visits** with 105, 103, and 100 unique patients each, respectively.

December stands out as the lowest activity month, with only **82 visits** and 64 patients across 13 service days.

July marks the clinic's launch period, with only 4 service days, **19 visits** with 17 unique patients.



Data Source: EMR, n = 2,219.

- Primary Care (670; 30.2%)
- Medication & Prescriptions (398; 17.9%)
- Chronic & Acute Condition Mgt. (287; 12.9%)
- Mental Health Support (245; 11.4%)
- Sexual & Reproductive Health (158; 7.4%)
- Systems Navigation & Forms (141; 6.4%)
- Other (126; 5.7%)
- Substance Use Support (98; 4.4%)
- Diagnostics (96; 4.3%)

Service Utilization by Service Categories.

A total of **2,219 services were provided** during the reporting period. The circles visually represent the distribution of patient encounters across **9 key service categories**, with each circle's size proportional to the total number of encounters.

'Primary Care' dominates service utilization, accounting for **30.2%** (670) of services provided.

'Medication and Prescriptions' is the second largest category, accounting for **17.9%** (398), highlighting the high demand for medication access and prescriptions.

'Chronic & Acute Condition Management' (12.9%; 287) and **'Mental Health Support'** (11.4%; 245) also represent significant portions of services provided.

'Sexual & Reproductive Health' (7.4%; 158 **'Systems Navigations & Forms'** (6.4%; 141), **'Other'** (5.7%; 126), **'Substance Use Support'** (4.4%; 98), and **'Diagnostics'** (4.3%; 96) while smaller in volume, these services are critical for supporting specific health needs including STBBI care, access to substance use-related services, and access to social supports.

Decolonial Dimensions **of Impact**

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 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 and support provided particularly for those navigating systemic marginalization and poverty.

Systems Navigation & Advocacy

Over the course of over **141 encounters** with **92 unique constituents**, members of the team served as guides and advocates, helping constituents navigate complex and often overwhelming bureaucratic network of support.

Key activities include assistance navigating housing, such as housing applications and referrals to housing programs (e.g., Street Links), EIA, and assistances with obtaining essential identification documents (e.g., through Citizen's Bridge) that are required for accessing social services. These activities are rooted in the recognition that constituents facing homelessness, poverty, or crises need both immediate supports and connections to broader social service networks for well-being.

Immediate Needs

MHC provided essential services aimed at meeting immediate and basic needs of constituents. These activities extended beyond healthcare to include the provision of food kits, water, juice boxes, snacks, hygiene supplies, and clothing items such as warm gloves, socks, hand warmers, and bags. Collaborations with organizations like Siloam Mission and Sunshine house supported the distribution of clothing, and hygiene kits. The team also provided resource guides to help individuals access showers and food resources across Winnipeg, as well as emergency food and shelter arrangements when needed.

While the MHC team started off capturing the numbers for 'sandwiches handed out', 'hygiene kits handed out', and 'medicine kits handed out', by counting how many they had started off with in stock to determine the number distributed, they found that this was not a sustainable way to track these numbers and tracking subsided. The MHC team is working on a way to capture these numbers for the next report. Below are the August numbers for these items as a sample month to present an idea of distribution for these immediate need items, and the reach provided for these items to the constituents/patients.

For those who came in for wound care, supplies were often handed out to help alleviate costs, breaking down barriers for the immediate needs for these supplies. Wound care supplies (dressings, bandages, dressings, etc.) were provided to **36 unique constituents** during **41 visits**.

**Note: While the data below reflect August 2024, subsequent months showed similar figures.*

600

Sandwiches handed out*

490

Hygiene Kits handed out*

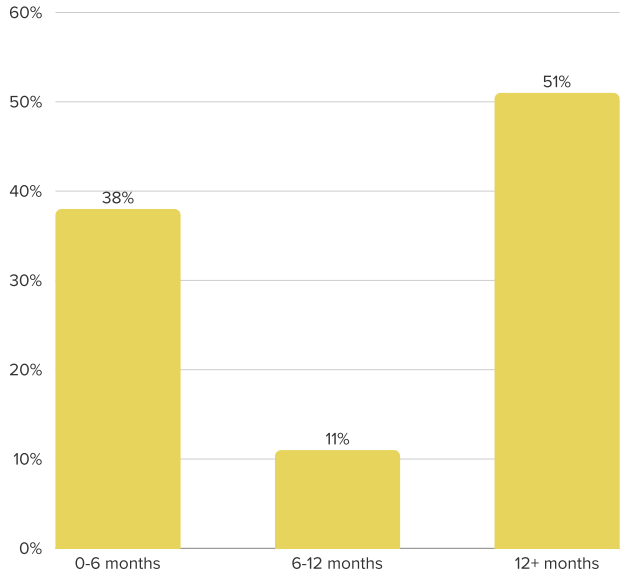
120

Medicine Kits handed out*

Housing Supports

MHC provided support through various housing-related processes, from liaising with several organizations to arrange and schedule sharing experiences through Naatamooskakowin (Coordinated Access), providing information on low-barrier housing programs (e.g. Turning Leaf, Behavioural Health Foundation, and Street Links), referring survivors of domestic violence to Willow Place and Tina's Safe Haven, to helping community relatives complete housing applications. In the first version of optional registration questionnaire, constituents were asked:

"How long have you been living rough/unsheltered/unhoused/homeless?"



Data Source: MHC Data Library - Indicator Responses, n = 100.

Duration of Homelessness Among Respondents.

This breakdown highlights that a significant portion of respondents have experienced long-term homelessness, with the largest group (51%) being unhoused for over a year.

In addition to connecting constituents with housing programs, MHC supported 13 constituents through broader system navigation efforts related to housing.

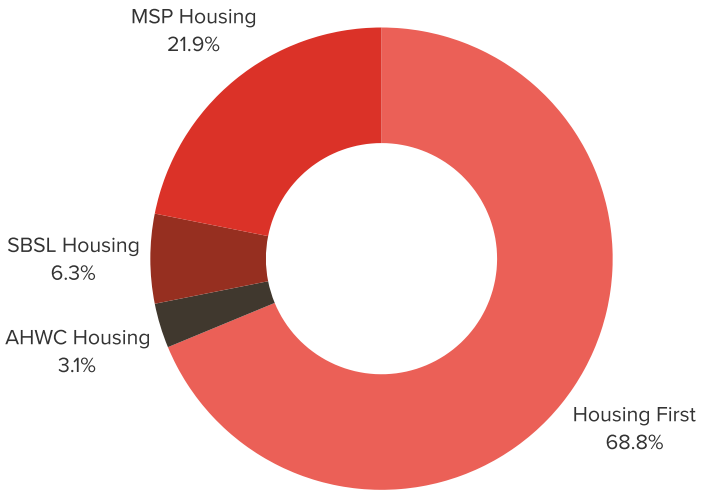
These included assistance with Manitoba Housing applications, drafting and submission of advocacy and support letters, providing pest control resources, and facilitating connections with organizations like North End Women's Centre (NEWC) for ongoing housing support.

Systems Navigation: Housing-related Supports.

This chart illustrates the distribution of housing-related systems navigation support provided by MHC.

Of the constituents assisted, 22 encounters (68.8%) were related to Housing First, 7 encounters (21.9%) to Main Street Project (MSP) Housing, 2 encounters (6.3%) to Street Links Housing, and 1 encounter (3.1%) to AHWC Housing.

**Note: While these numbers give insight into housing-related support provided by MHC, they are based on documented encounters and may not fully reflect all instances of housing help offered.*



Data Source: EMR, n = 32.

Connections to Healthcare

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, assisting with Manitoba Health Card applications, and arranging transportation to clinics, pharmacies, and hospitals.

The team routinely help constituents navigate the complex healthcare from liaising with multiple providers and programs to ensure continuous care. This has included guiding constituents through the Doctor Finder program, supporting access to family physicians/primary care providers, and helping many complete assessments for the RAAM (Rapid Access to Addictions Medicine), secure specialized care such as addictions recovery programs (e.g., CMHB, Withdrawal Management Services), and coordinate mental health consultations.

175

Referrals to “Other Health Services or Specialist”

Data Source: EMR.

21

Encounters involving “Transportation”

Data Source: EMR.

**Note: While categorized and reported under ‘Other’ this figure is included here to emphasize MHC’s role in facilitating transportation of patients to specialized healthcare services.*

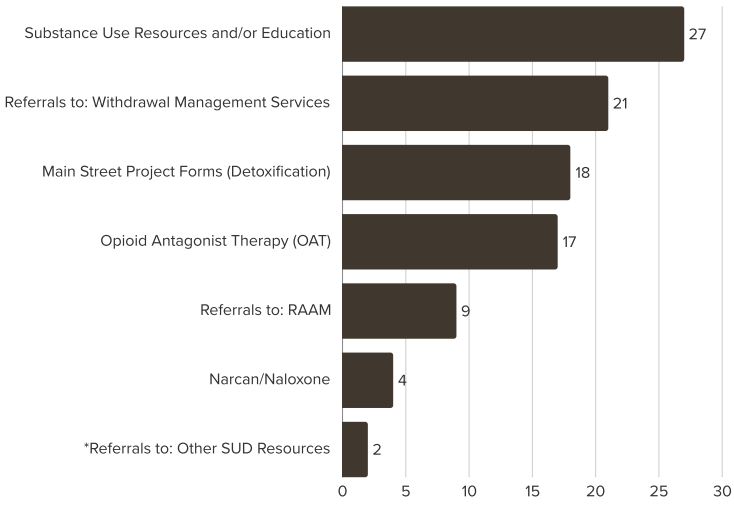
Some of the health services or specialists noted:

- Respiratory Specialist
- Laryngologist
- Podiatrist
- Dentist
- Reconstructive surgery
- OBGYN
- Hematologist
- Orthopedist

**Note: While categorized and reported under Primacy Care (i.e., “Referrals to other health services or specialist”), this figure is included here to emphasize MHC’s role in facilitating referrals and navigating access to specialized healthcare services.*

Substance Use Support

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 98 visits at the clinic were directly related to substance use as the reason services were provided.



Data Source: EMR, n = 98.

Service Utilization of Substance Use Support.

Substance use Resources and/or Education' accounts for **27.5%** of encounters.

These visits reflect a range of support, including the distribution of resources related to substance use, connections to recovery resources, and safer use strategies (both clinical and non-clinical).

Detoxification and referral coordination also represent a significant portion of substance use visits.

**Referrals to Other SUD Resources: these were referrals to specialized supports such as Addictions Foundation Manitoba (AFM) and an addictions-focused physician.*

In addition to the substance use support captured through EMR data, the MHC team also provided a significant number of harm reduction kits throughout the fiscal year. While the MHC team started off capturing these numbers in August by comparing stock levels to determine the number distributed, this method provided unsustainable, and systemic tracking eventually subsided. The MHC team is currently developing a more reliable method for capturing these figures in future reporting cycles.

Using August 2024 as a sample month, a total of **551 harm reduction kits** were provided to constituents upon request regardless of whether they were registered patients. This approach reflects the clinic's decolonial, trauma-informed framework, which prioritizes low-barrier, judgment-free access to care, and affirms the right to health and safety for all. Distributing harm reduction supplies is not only a critical aspect of public health intervention but is also a recognition of harm reduction as an essential pathway to healing, and that providing these essential resources without conditions is an act of respect and solidarity with people who use substances.

Unregistered Encounters

Extending Care to Relational Support

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 its 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.

One constituent captured this principle by saying:

> *"I feel safe coming to you guys. You people are what the community needed. You don't care if were using drugs, you'll still help me and my brother. We need that. We'll never forget you guys."*
>
> *- MHC Constituent*

Another constituent echoed this sense of relational inclusion and understanding:

> *"Me and my wife can always count on you guys to help us, even when the clinic kicks us out, you guys will see us. We can't help it, we're loud and talk lots, but we're still people who need help."*
>
> *- MHC Constituent*

11

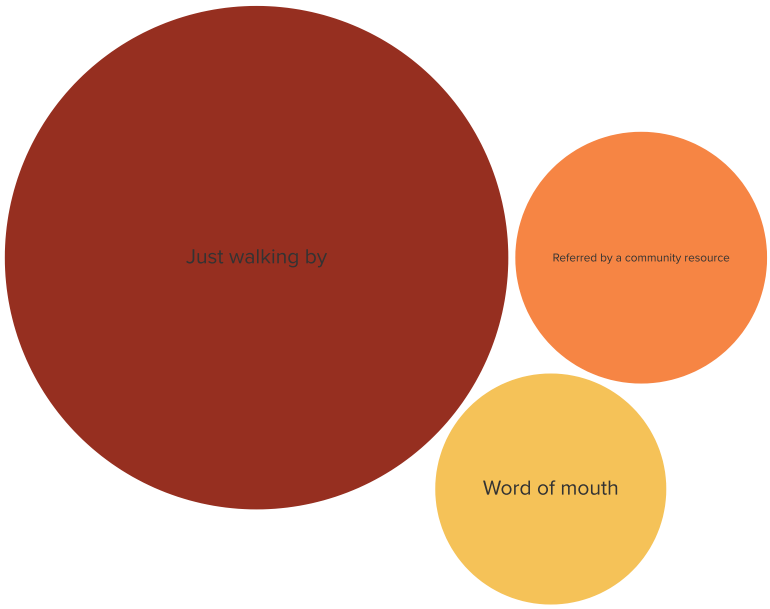
Non-Patient / Family Members Seen

Data Source: EMR, n = 616.

Accessing Care

As part of the first version of optional registration questionnaire, 100 constituents responded about how they heard about the Mobile Healthcare Clinic.

"***How did you hear about the Mobile Healthcare Clinic?"***



Data Source: MHC Data Library - Indicator Responses, n=111.

How Constituents Connected with MHC.

Responses reflect how accessible and visible the clinic is within the community:

- 76 responses (68.4%) indicated they learned about the clinic by **'Just walking by'**
- 19 responses (17.1%) reported they were **'Referred by a community resource'**
- 16 responses (14.1%) indicated **'Word of mouth'**

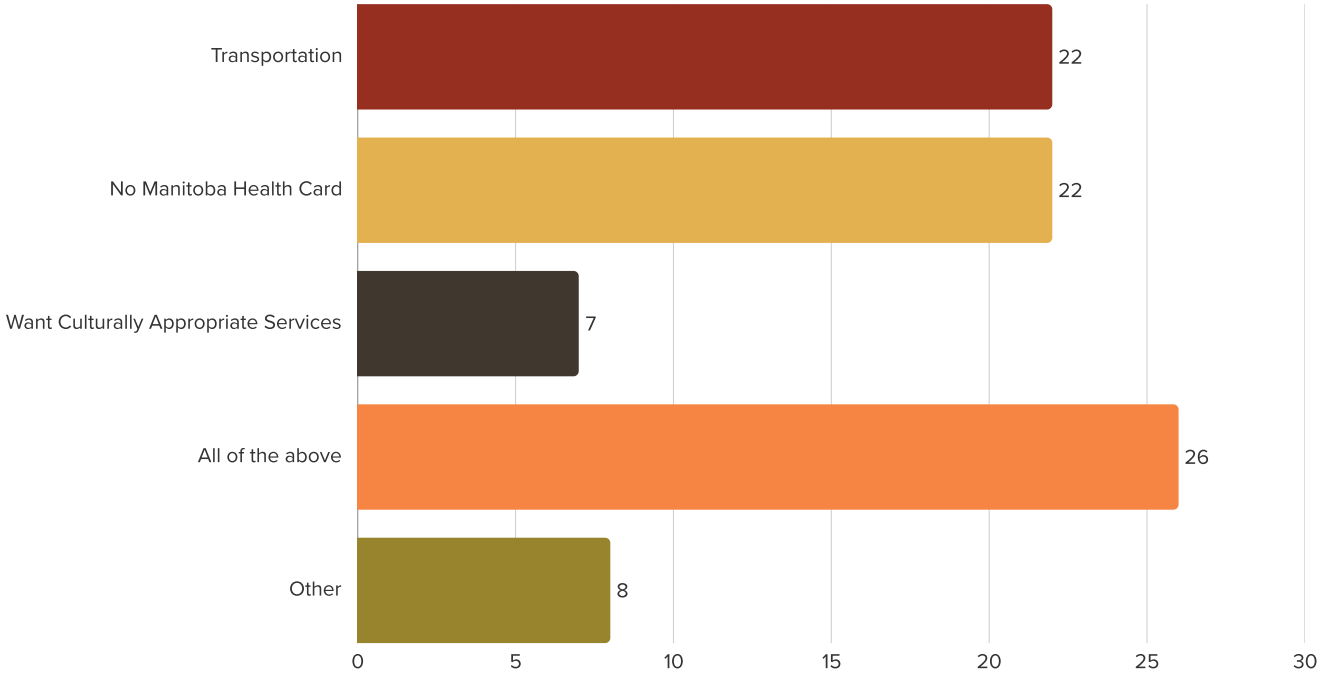
The large number of respondents who indicated walking by suggests that the location of the clinic and the physical presence/mobility of the clinic plays a role in service accessibility. This also highlights a strength in the clinic's approach in its ability to "meet people where they are" which removes many barriers to care for this population. Referrals from community resources and word of mouth also illustrate other important pathways to care.

Barriers to Accessing Healthcare Services

On the same optional registration questionnaire, 79 constituents responded to:

"What are the biggest challenges to accessing health care services?"

Respondents could select multiple barriers from the following options:
'Transportation', 'No Manitoba health card', 'Want culturally appropriate services', 'All of the above', and 'Other'.



Data Source: MHC Data Library Indicator Responses, n = 85.

Of 85 responses (from 79 respondents), the most frequently selected was **"All of the above"** (26 responses; 30.9%). This was followed by **'Transportation'** and **'No Manitoba Health Card'** (22 responses each; 26.2%).

A smaller number of respondents selected **'Other'** (8 responses; 9.5%) and **'Want culturally appropriate services'** (7 responses; 8.3%).

The data therefore reveals that many constituents experience multiple barriers simultaneously or different barriers over time in accessing healthcare services.

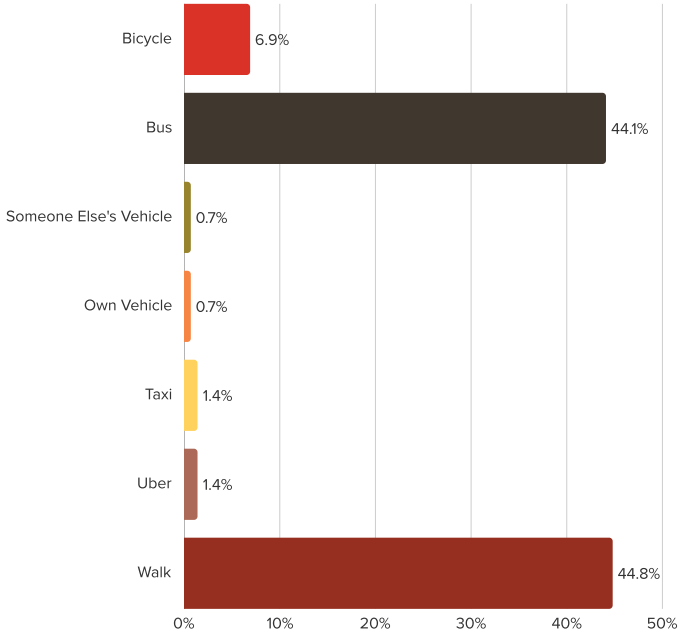
The following section demonstrates how MHC has taken steps to actively reduce these barriers for their constituents.

Transportation

Transportation was consistently identified as a major barrier to accessing healthcare services – both by MHC constituents and community partners. During the engagement sessions held in March and April 2024, community organizations repeatedly emphasized the challenges their community members face when trying to reach healthcare services.

These findings were echoed in responses to the optional registration question asking:

"How do you get to your healthcare and/or social service appointments?"



Data Source: MHC Data Library - Indicator Responses, n= 145.

A total of 98 constituents submitted 145 responses that highlighted a reliance on walking and public transportation.

44.8% (65 responses) reported **walking** to appointments

44.1% (64 responses) indicated using the **bus**

6.9% (10 responses) indicated using a **bike**

Only a small percentage indicated using **taxis** and/or **Uber** (both 2 responses; 1.4%), their **own vehicle** or **someone else's vehicle** (both 1 response; 0.7%).

These low figures suggest that only a very few number of individuals have access to more flexible transportation, which remains out of reach for the majority.

To mitigate these access challenges, MHC's service model seeks to actively reduce reliance on transportation barriers to receiving care by bringing their services to meet the people where they are.

During this reporting period, the MHC team has brought their operations to encampments, under bridges, parking lots, shelters, and street locations during 61 (of 130) service days. This is further discussed in **Going to the Community**.

In collaboration with DCSP, MSP, and NEWC, MHC has recorded at least **21 encounters** in which transportation was arranged or provided for constituents to various locations, including:

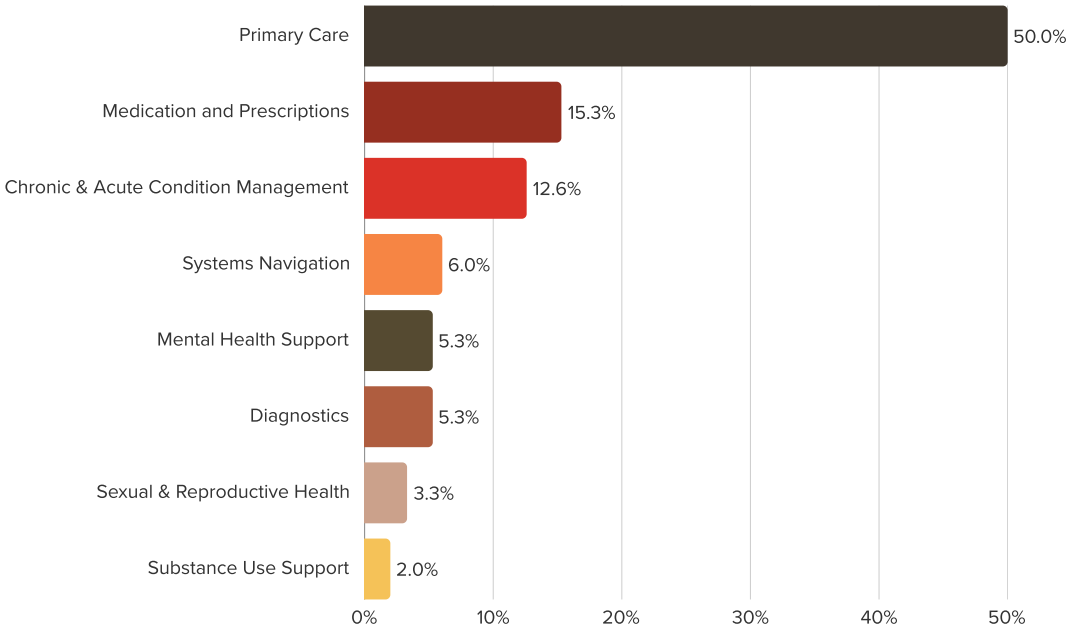
- Transfers to hospitals for referral appointments, Emergency, or Urgent care;
- Appointments at detox or recovery programs;
- Visits to shelters, community programs, pharmacies, and clinics.

These types of support, which fall outside of normative, conventional healthcare practices are essential to breaking the cycle of delayed or denied care. These practices center community realities, affirms limitations to mobility, and recognizes logistical coordination as a legitimate and vital part of care.

Health Card Status

In line with its decolonial approach that works to dismantle barriers, MHC ensures that those without a health card can access the full spectrum of services they provide to address the unique barriers faced by individuals who are excluded from conventional healthcare systems due to lack of a health card.

The EMR data shows that **9.7% (60 patients)** did not have a Manitoba Health Card at the time they received care from MHC.



Data Source: MHC Data Library - Indicator Responses, n= 150.

Most Common Service Encounters (by Service Category).

The chart outlines the distribution of services/reasons for visiting MHC by patients without Manitoba Health Cards.

There was a total of 68 visits with 60 unique patients during the reporting period, and a total of **159 encounters**.

The most reasons patients without a health card visited the clinic were for:
Regular check-ups (**36 encounters of 75** in the '**Primary Care**' category); followed by the provision of over-the-counter medications (**15 encounters of 23** in the **'Medication & Prescriptions'** category), on-site treatment for acute conditions (**14 encounters of 19** in the 'Chronic & Acute Condition Management' category), and wound care (**11 encounters of 75** in the **'Primary Care' category**).

While many patients are able to access a wide range of services at the clinic, a significant barrier that patients without health cards often seem to face is limited access to referrals for specialized healthcare, certain diagnostic services (e.g., lab work and imaging), which are often tied to provincial health insurance coverage, as well as prescriptions for medication.

MHC works to address some of these barriers by providing on-site treatment whenever possible, including antibiotics. These immediate treatments can therefore help prevent escalation of conditions that could lead to more serious health complications or the need for emergency care.

Culturally Safe Care

Culturally safe care was identified as a barrier to accessing health care services. To better understand patient preferences, MHC ask patients using the clinic:

"Do you prefer to visit the Mobile Clinic for all your primary care services?"

Data Source: Data Library - Indicator Responses, n = 80.

Patient Preference: MHC for Primary Care Services.

A remarkable 95% of respondents (76 patients) indicated a preference for receiving all their primary care through the Mobile Healthcare Clinic. This strong preference therefore highlights the importance of culturally safe, low-barrier services that meets patients where they are.

As one patient shared,

> *"I feel heard and cared about by all the staff and they really helped me when I needed it."*
>
> *- MHC Constituent*

Another patient noted,

> *"This is the first time I have felt safe getting medical help. I'm happy this service exists."*
>
> *- MHC Constituent*

Bridging Culture and Healthcare: **The 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.

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.

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.

Data points for these aspects were not tracked for this reporting year, however MHC is working on implementing tracking systems for both the EMR and MHC Data Library to include this essential work from a decolonial lens for the next fiscal year annual report.

Technology & Health Information Access

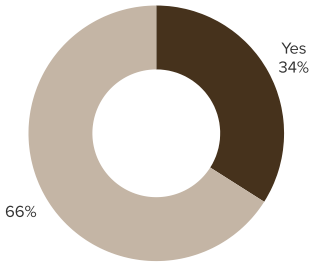
During the first version of optional intake questionnaire, 97 patients responded to three questions designed to assess access to technology for health-related information. The questions asked were:

"When needing to find healthcare information online –

...do you have tech access?"

...do you have the ability to borrow/use a cell phone or computer readily or reliably?"

...do you have access to a computer with Wi-Fi or data?"



Data Source: MHC Data Library - Indicator Responses, n= 97.

Access to Tech.

The data indicates notable barriers to digital access among constituents. Of the respondents who answered:

40.2% (39 responses) indicated having "tech access"

49.4% (48 responses) indicated having the ability to borrow a cell phone or computer readily or reliably

34.0% (33 responses) indicated having access to a computer with Wi-Fi or data

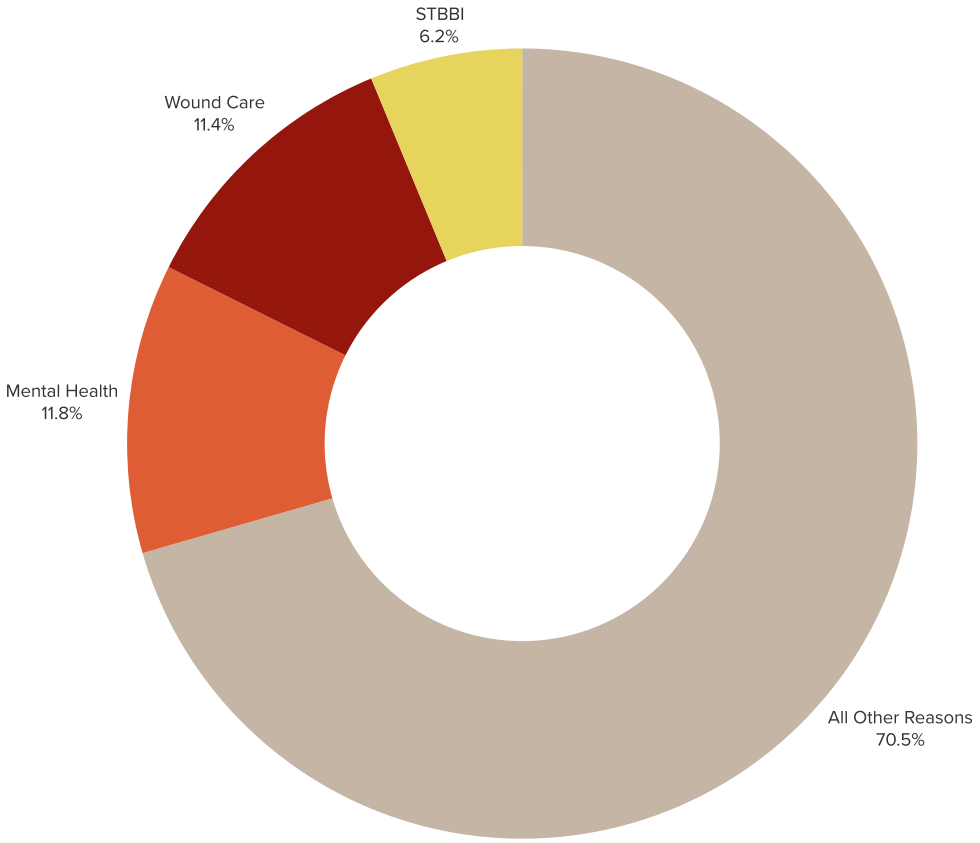
These findings speak to the importance of having the Mobile Healthcare Clinic visit the encampments, bridges, shelters, and community hubs to provide healthcare information. This model of care increases health care information accessibility, as technological barriers strongly hinder many constituents' ability to independently search for or receive health information online.

Plugging Identified Community Gaps
High Demand Care Services

During community partners engagement meetings, several critical gaps in care were identified as areas where MHC could provide targeted services to help alleviate community need. Partners highlighted a lack of mental health crisis support, an urgent need for wound care, and further STBBI care across the population they support.

Since these discussions, MHC has become increasingly embedded within the community and has been successful in developing trusting relationships through its efforts in addressing these identified gaps in care.

As reflected in the service utilization data, close to 30% of all visits have directly supported mental health interventions (11.8%), wound care (11.4%), and STTBI care (6.2%), collectively.



Data Source: EMR, n =2,219.

Snapshot of Mental Health Support

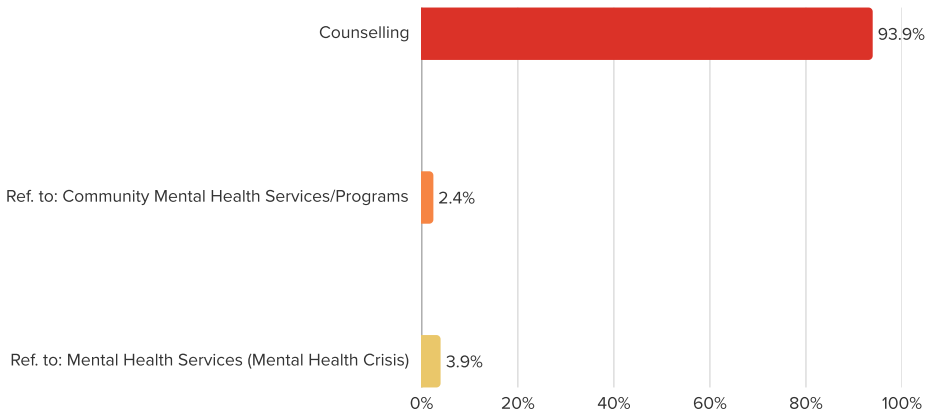
MHC's model of care values the importance of counselling services at the same level as physician services. With WRHA funding, MHC hired one full-time crisis counsellor. In response to high demand, the clinic added and funded an additional 0.5 FTE, bringing the total to 1.5 FTE crisis counsellors in the field. Together, they provided a total of **230 counselling visits**.

245
Mental Health Support Services*

70
Total Hours

162
Unique Constituents Supported

Note: This number represents the total services related to **'Mental Health Support' out of 2,219 total services provided. Mental Health Support includes: Mental Health Crisis Counselling, Referrals to Community Mental Health Services/Programs, and Referrals to Mental Heath Services (Mental Health Crisis).*



Data Source: EMR, n = 245.

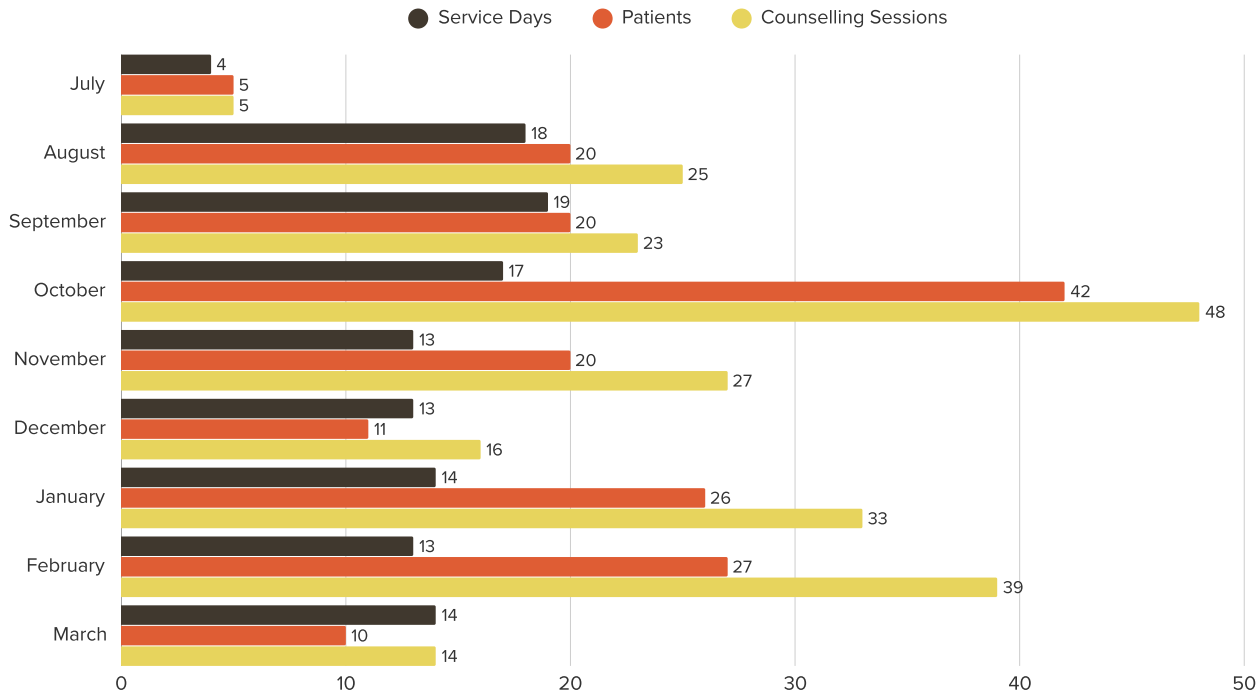
Breakdown of 'Mental Health Support' Services.

EMR data indicates that counselling accounts for **93.9%** (230) of Mental Health services provided, along with 9 referrals to further mental health crisis services (3.9%), and 6 referrals to mental health community programs (2.4%).

Mental health support represents the second most common reason for service at MHC, emphasizing its critical role in addressing psychosocial needs in the community.

These services are provided in a flexible and accessible way, either alongside physician or nurse visits, as dedicated one-one-one in-person sessions, or through follow-up counselling by phone. Counselling sessions ranged in length from 15 to 125 minutes, totaling over 70 hours of mental health support. On average, the clinic delivered of 2.3 counselling sessions per service day.

This level of service delivery directly responds to the gaps identified by the community partners, who highlighted the lack of accessible mental health crisis counsellors. MHC's model therefore helps fill this gap by offering barrier-free mental health support without financial cost, session limits, or waitlists.



Data Source: EMR, n = 230.

Counselling Service Utilization by Month

This chart compares three key metrics side-by-side: Service Days, Patient, and Counselling Sessions.

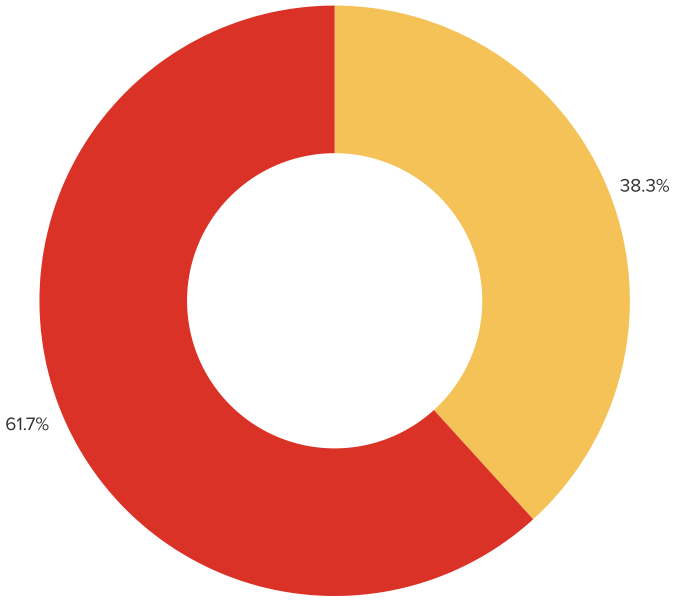
October stands out as the busiest month, with the highest number of encounters (48) and patients (42), delivered across 17 service days.
Higher counts in encounters that month are also attributed to multiple visits for some constituents.

February and **January** show moderate counselling service levels, with 39 and 33 encounters & 27 and 26 patients, respectively. While February did have fewer service days (13 days), the number of encounters is relatively high, suggesting a high demand in counselling during this time.

August, **September**, and **November** show a steady counselling demand, with encounters ranging between 23 to 27, with 20 patients each.

December and **March** had 16 and 14 encounters, respectively, and 11 and 10 patients.

July marks the launch of the clinic and shows the lowest level of activity due to its lower number of service days.



Data Source: EMR, n = 230.

Exclusive Counselling vs. Counselling Combined with Other Services.

This chart illustrates the distribution of counselling encounters at MHC, differentiating between counselling-only visits and those where counselling was provided alongside other services (e.g., wound care, regular check-ups, treatments for acute, etc.)

The majority, **61.7%**, of counselling sessions (142 encounters with 113 patients) occurred alongside other services, while **38.3%** (88 encounters with 61 patients) were dedicated exclusively to counselling.

This data highlights that counselling is often integrated into broader care at the clinic, in line with a holistic approach where mental health support is provided alongside physical health.

Snapshot of Wound Care

Wound care was identified as an urgent need in the third highest reason for patients seeking care at MHC. The clinic has provided wound care to **168 patients** in **230 encounters**, with many patients receiving treatment for multiple wounds in a single visit. Wound care services can involve cleaning, ointment application, dressing, and bandaging. The most common types of wounds included lesions, cellulitis, scrapes, abrasions, ulcers, sores, and abscesses. In the extreme cold winter months, many wound care services were due to frostbite.

In alignment with the clinic's commitment to reducing barriers to care for constituents, MHC has gone beyond just providing wound care on site and has distributed wound care supplies (i.e., bandages, dressings, ointment, etc.) to patients to take with them during **41 encounters** in an effort to aid in the prevention of infection.

To treat infected wounds, MHC administered up to **81 treatments on-site** for **67 unique patients**, decreasing the financial and transportation burden for patients who would otherwise face difficulty accessing prescribed medication. This approach not only works to provide immediate treatment and decreasing the likelihood of severe infection, but also challenges colonial barriers to care, such as the requirement for health cards to access prescription medication.

230

Wound Care Services

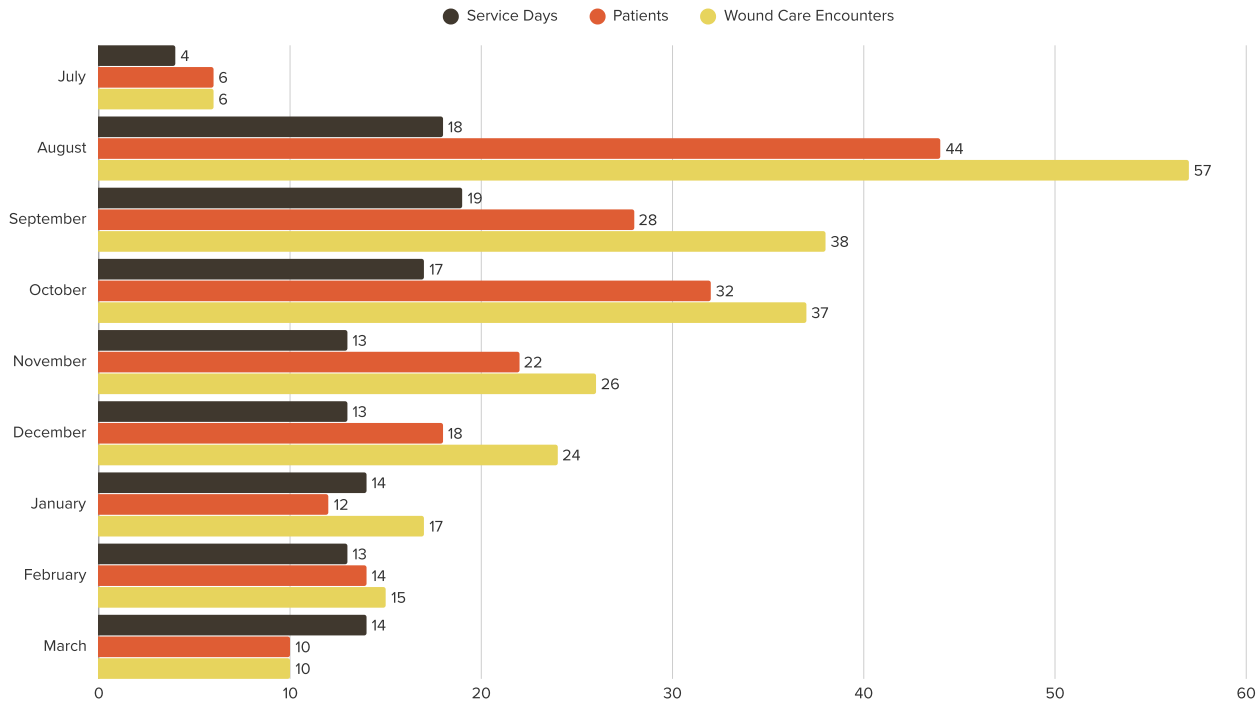
81

Patients Treated On-Site for Wound Care

41

Encounters Involving Provision of Wound Care Supplies

Data Source: EMR, n = 2,219.



Data Source: EMR, n = 230.

Wound Care Service Utilization by Month.

This chart compares three key metrics side-by-side: Service Days, Patients, Wound Care Encounters, and Patient (unique patients receiving wound care).

August, **September**, and **October** are the highest utilization months for wound care, suggesting periods of heightened demand and/or greater capacity to provide wound care such as the presence of a nurse until October 17 (detailed in **Human Resources**). Collectively, these three months account for **57.4% of wound care encounters** between July 25, 2024 and March 31, 2025:

57 encounters with 44 patients across 18 service days in August;
38 encounters with 31 patients across 19 service days in September;
37 encounters with 32 patients across 17 service day in October.

November shows moderate utilization in comparison, with 26 encounters (**11.3%**) with 23 patients.

December shows lower but consistent use of wound care services, with 24 encounters (**10.4%**) with 19 patients across 13 service days. **January** and **February** shows a slightly lower number of encounters, 17 (**7.4%**), with 12 patients, and 15 (**6.5%**) with 13 patients, respectively.

Snapshot of STBBI Care

MHC has delivered STBBI testing and referrals/requisitions to a total of 72 patients across 78 encounters.

A significant proportion of the treatments for was provided directly from the clinic's stock, which helped eliminate barriers to timely care. By offering on-site treatment for STBBI, (e.g., antibiotics such as Zithromax and Suprax), this enables immediate intervention, reducing the risk of complications and/or helping to prevent conditions from worsening.

78

STBBI Testing Services

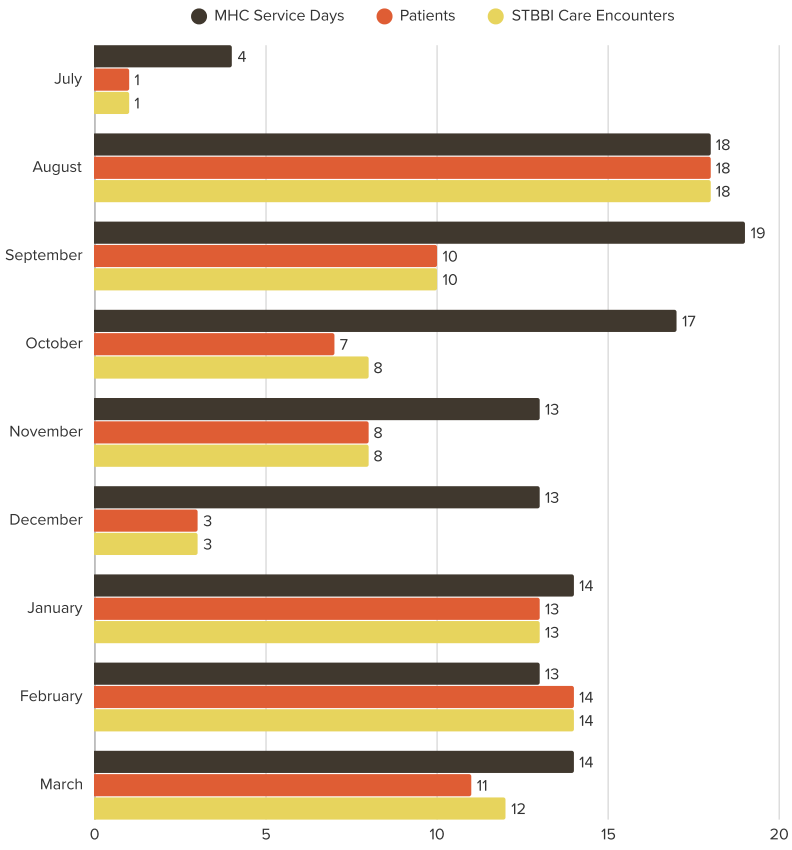
48

STBBI Treatment Services

45

Patients Treated On-Site for STBBI Care

Data Source: EMR, n = 87.



Data Source: EMR, n = 87.

STBBI Care Service Utilization by Month.

This chart compares three key metrics side-by-side: Service Days, Patients, STBBI Care Encounters.

August shows the highest volume, with 18 visits with 18 unique patients, indicating a more intensive start within the clinic's first month of operation. September and October saw a slight decrease with 10 visits and 10 patients, and 8 visits and 7 patients, respectively. November showed no further uptake in encounters and patients, with 8 encounters and 8 patients. December shows a sharp drop to only 3 encounters and 3 patients. January and February reported an increase to 13 and 14 encounters, respectively, and a minor decline in March with 12 encounters and 11 patients.

Quality **Indicators**

Working from a holistic model that seeks to provide trauma-informed, high-quality, and safe care, the Clinic aims to repair trust that has been broken by the healthcare system through an approach that de-emphasizes formality and conventional model limitations associated with receiving health care services.

This includes the number of services provided in each visit, the duration of visits, promoting a safe, respectful, stigma-free environment, bringing services directly within the community, providing on-site treatment when possible, and 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.

Services Provided per Visit

In conventional models of healthcare service, the number of reasons/services provided in one visit/appointment is typically limited for patients. MHC model challenges this formality by removing these limitations to the number of services/reasons for a singular visit.

The range of services spans from 1 service/reason per visit to 14 services/reasons per visit, showing the capacity that MHC has in providing fully holistic care for all needed reasons a patient is accessing MHC.

2,219

Services Provided

2.4

Average Number of Services Provided per Visit

Data Source: EMR.

Visit Duration

On average, the the length of visit at the clinic is **17.2 minutes**, ranging from **15 minutes to 125 minutes**. This emphasis on time is a unique aspect of MHC's model.

In comparison to the conventional model where time with providers is often rushed and limited within appointment, MHC aims to build a therapeutic environment where the community member can receive a combination of different services within a single visit with several different service providers (e.g., physician, nurse, Indigenous social planner, mental health crisis counsellors).

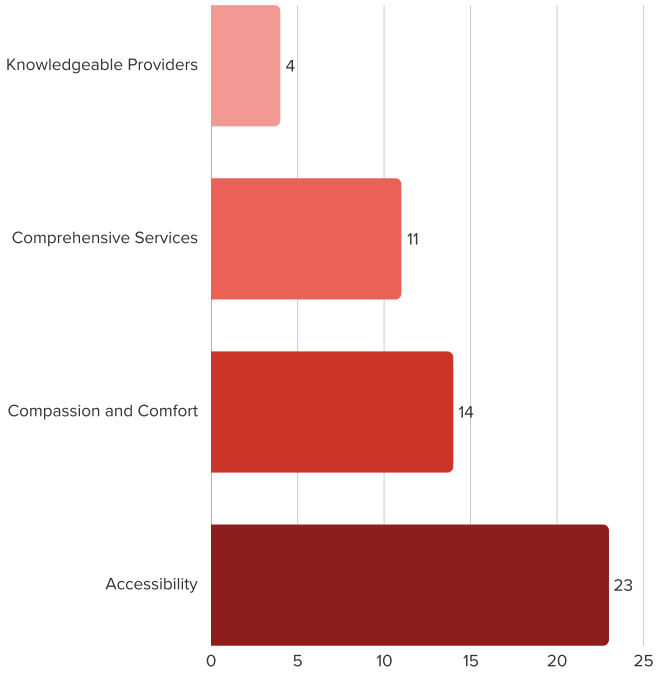
Data Source: EMR, n = 87.

Community Perceptions of Quality Care

Several aspects pertaining to the quality of care have been discussed with community partners, including how many community members avoid going to the hospital or other healthcare spaces due to negative past experiences, as well as the importance of trust and comfort.

Constituents' responses emphasize the importance of these aspects regarding quality of care. In the first version of the optional registration questionnaire, patients were asked:

"What is important to have included in your primary care services?"



Data Source: MHC Data Library - Indicators Responses, n=52.

A total of 52 responses indicated an emphasis on accessibility, compassion, and respect. The key themes emerged from responses include:

Accessibility was by far the most frequently mentioned aspect. Respondents used terms like "easy access", "easy accessibility", and "short wait times", which reflected their desire for more convenient and timely care.

Compassion and Comfort was reflected in responses like "someone who understands mental health issues," "non-judgmental space," "welcoming environment", "compassion", "comfort", "understanding", and "respect".

Comprehensive Services was reflected in responses like "regular checkups," "pregnancy tests, HIV testing, STI checks," "skin care", "diabetes" and "mental health support" were mentioned.

Knowledgeable Providers was reflected in responses like "good doctors," "someone who understands mental health issues", "proper medical attention", and "knowledgeable doctors".

"I'm happy that you guys are here bc I don't want to go and wait forever in the emergency room and be treated like crap."

- MHC Constituent

Going to the Community

Community partners communicated the importance of locating the clinic where the highest concentration of vulnerability exists and identified the importance of building trust through “being present” when community relatives need you. Unlike conventional models of healthcare, MHC brings care directly to constituents in their own spaces, including encampments, bridges, shelters, and community hubs through their mobile outreach service days. This model of healthcare provision works to create an accessible, caring and heard environment for the community relatives.

As one constituent expressed:

> *“Thank you for actually coming into the camps because I feel like no one cares that we are here, and we need help too.“*
>
> *- MHC Constituent*

Mobile Outreach Service Days.

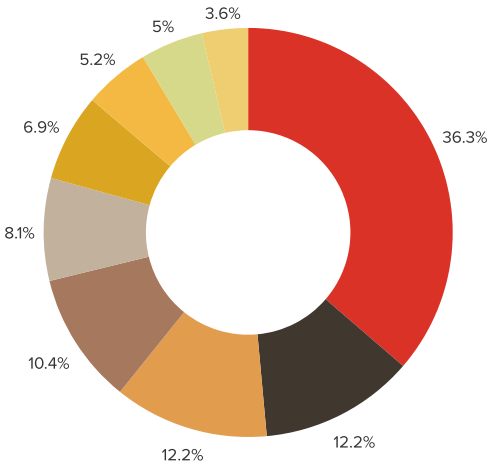
The Mobile Healthcare Clinic has worked to meet constituents where they are by reaching 41 different mobile locations for a total of 118 visits to these spots. It is important to note that in the MHC data library there were no specific locations provided for the month of July and not all service days indicated which location(s) they attended that day, or just noted “encampments” or “parking lots”, so these numbers for each location represents the minimum reach and not the full reach of the Mobile Healthcare Clinic locations.

The largest percentage of days where a specific location was visited was the Beer Can location, representing 13% of the total locations visited. Following this, the Waterfront location and Street Links represent 9% and 8.5%, respectively.

Data Source: MHC Data Library

Distribution and Service Utilization for Mobile Outreach Days.

The distribution of services provided (services provided) on 'Mobile Outreach Days' (Tuesday, Wednesday, Thursday) across the **9 key service categories.**



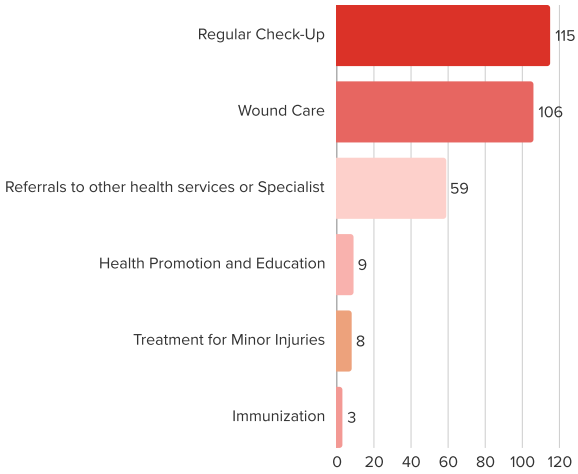
Data Source: EMR, n= 826.

- Primary Care (300 services provided; 36.3%)
- Chronic & Acute Condition Mgt. (101 services provided; 12.2%)
- Mental Health Support (101 services provided; 12.2%)
- Medication & Prescriptions (86 services provided; 10.4%)
- Other (67 services provided; 8.1%)
- Systems Navigation & Forms (57 services provided 6.9%)
- Sexual & Reproductive Health (43 services provided; 5.2%)
- Substance Use Support (41 services provided; 5.0%)
- Diagnostics (30 services provided; 3.6%)

EMR data shows that MHC provided a range of 29 (of a total of 46; 61%) unique services captured in the 9 key service categories. A total of 826 services provided were reported with 705 patients (not unique) on these days.

Breakdown of Primary Care Services Provided.

Primary Care encounters accounted for 36.3% of all services delivered during the Mobile Outreach Days (300 out of 826 total services provided).



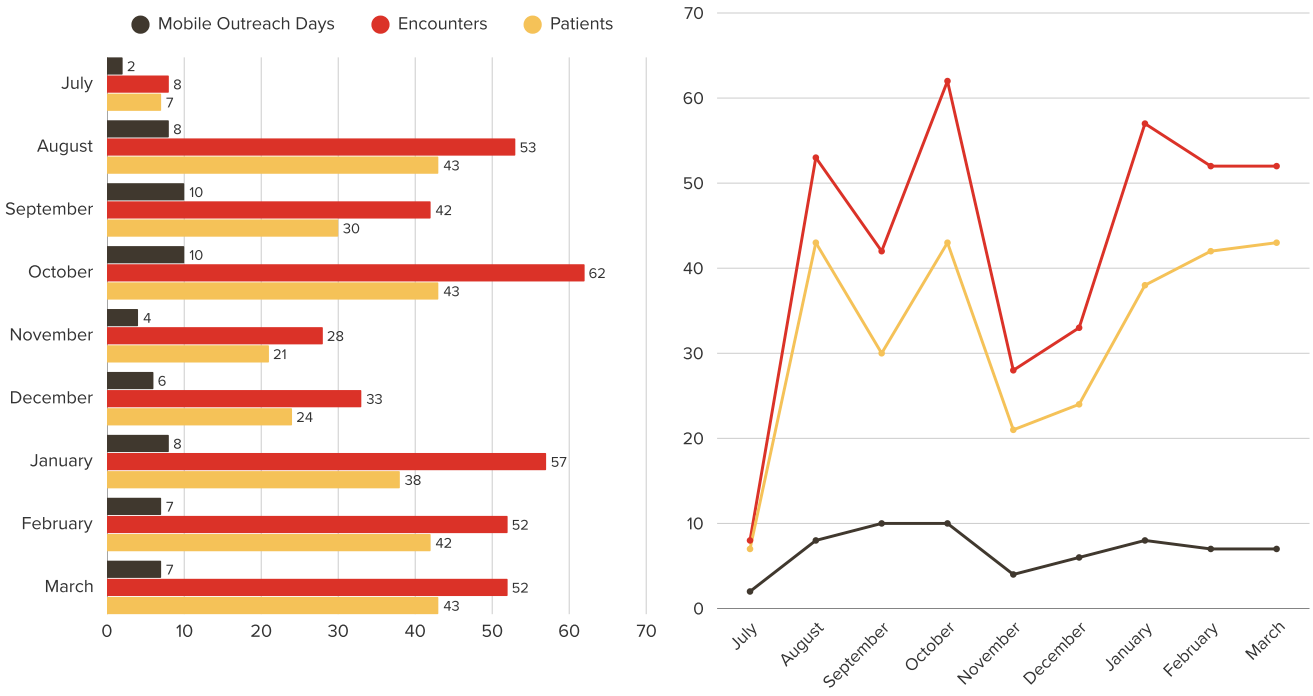
Data Source: EMR, n= 300.

The most frequently provided services included 'Regular Check-Ups' (115) and 'Wound Care' (106), together making up over 73% of all primary care visits. Other services in this category included 'Referrals to Other Health Services or Specialists' (59), 'Health Promotion and Education' (9), 'Treatment for Minor Injuries' (8), and 'Immunizations' (3).

Monthly Encounters: Mobile Outreach Days.

This chart shows a monthly comparison of three key metrics: Mobile Outreach Days, Encounters, and Patients.

Over the span of 62 Mobile Outreach Days, MHC supported 291 unique patients across 387 encounters. The bar chart below provides a breakdown of these figures , while the line graph visualizes the trends over time.



Data Source: EMR

October saw the largest uptake of encounters (62) with the highest patient reach (43), followed by January (57) and August (53). July had only 2 Mobile Outreach service days, which is reflected in its small number of encounters and patients.

Fewer service days strongly correlate with lower encounter and patient volumes, such as November (4 days) and December (6 days).

Fixed Locations

MHC has prioritized consistency and trust-building by establishing a regular presence at four key service locations. By returning frequently to the same sites, the clinic aims to foster familiarly. predictability, and increase accessibility.

On Fridays, the clinic alternates between NEWC and N'Dinawemak, while on Saturdays, it alternates between MSP and Siloam Mission. These locations were intentionally selected based on community knowledge and identified by community partners as areas with a high population with unmet healthcare needs.

Between July 25 and March 31, MHC provided care on at least 64 Fixed Location days. It is important to note that due to incomplete location data in the MHC data library – particularly for July and for some service days where no location was specified – this number likely underrepresents the full reach and extend of the clinic's reach at these sites.

NEWC

N'dinawemak

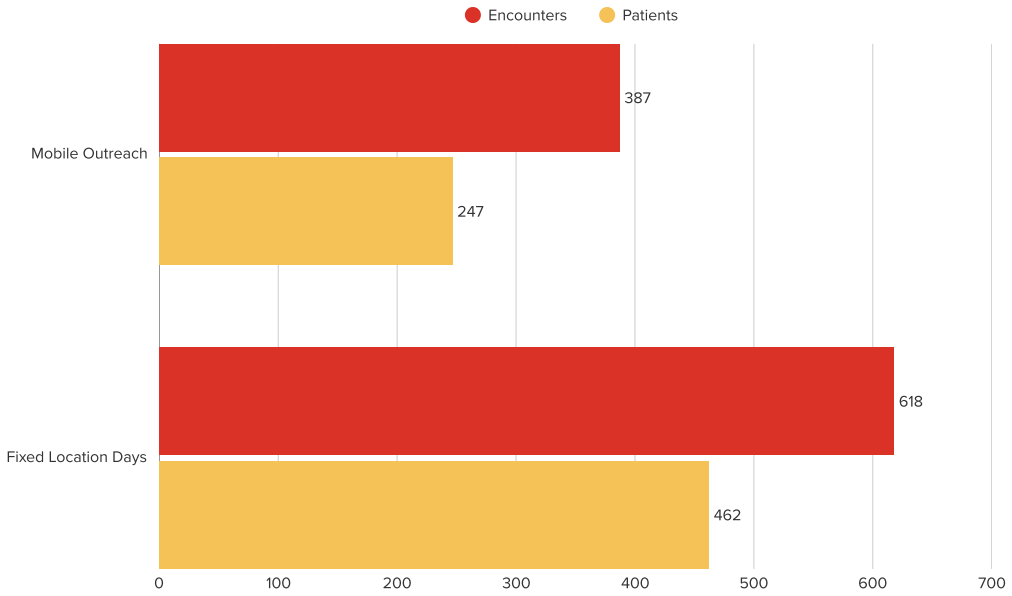
MSP

Siloam Mission

**Note: This map is intended for illustrative purposes only. Distances, sizes, and locations are not accurately scaled.*

Fixed Location Days vs. Mobile Outreach Days.

A comparison of volume of encounters and patients flow between the clinic's two service delivery models.



Data Source: EMR

Fixed Locations Days (Friday and Saturday) provided higher overall service volumes. This can be attributed to several factors such as: operating within established facilities, which can accommodate for more comprehensive service delivery in a controlled environment; referrals from partner/host organizations; and the predictability of fixed locations. These locations were identified by community partners as areas with high concentrations of individuals experiencing unmet healthcare needs, contributing to the high patient volume observed at these sites.

The **Mobile Outreach Days** (Tuesday to Thursday) provided **17% more** encounters per patient (1.57 encounters per patient) in comparison to the Fixed Location Days (1.34 encounters per patient), which reflects a high demand as well as the clinic's engagement efforts to reach patients directly in their environments and homes.

On-Site Treatment for Acute Conditions

Unlike conventional models of care, MHC offers on-site treatment for acute conditions using medications available within the clinic's stock, including as antibiotics, antifungals, antivirals, and lice treatments. This form of care intentionally reduces reliance on formalized prescription processes, helping to remove common barriers for patients such as cost, transportation challenges, and lack of a health card. By offering immediate, accessible treatment patients can be seen and treated in a single visit, which significantly improves access and uptake of necessary treatments.

Some of the acute conditions observed at MHC range from sinus infections, headaches, gastrointestinal issues, respiratory issues (such as upper respiratory infections, bronchitis etc.), urinary tract infections (UTIs), to joint or muscle pain, eye pain, allergies, and lice.

204

On-Site Treatment Services

170

Patients Treated On-Site for Various Acute Conditions

Data Source: EMR

"It's so easy to be seen and get help right on the spot. I'm too busy to wait at a doctor's office. So it's better."

- MHC Constituent

Need & Human Resources **Indicators**

Number of Patients Registered but Not Seen

A total of 199 constituents were reported to have registered for care, but were not seen by clinical staff within the reporting period.

199

Constituents Registered but Not Seen

Data Source: MHC Data Library – Numbers Document

This may indicate a mismatch between community need and service capacity. While these constituents demonstrated an interest in accessing care by taking the step to register, human resource limitations may have prevented the clinic from providing services, or the length of the wait time.

Potential Factors Contributing to Unmet Service Demand

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.

- Complex health and social needs of patients: Many patients 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.
- Limited Service Days During High-Demand Periods: In peak months such as September and October, 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 registered patients, outreach is often 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.

A Shift in Service Delivery Patterns

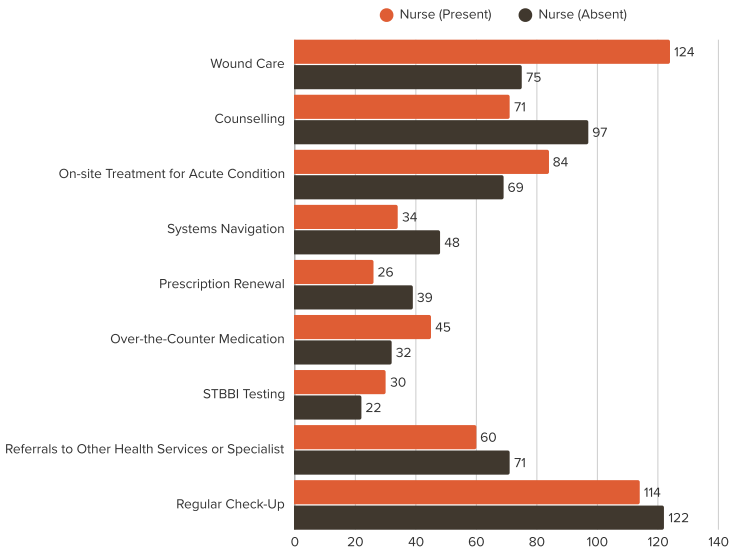
Between July 25 and October 17, 2024, MHC operated with a full clinical team that included a physicians, nurse, counsellors, and an Indigenous social planner. Together, they delivered services across 50 days with a nurse present.

During this period, the nurse provided 32 direct encounters to 31 unique patients, alongside supporting broader team-based care. The nurse's final 9 service days occurred in early to mid-October, after which, from October 18, 2024 to March 31, 2025, the clinic continued operations with physicians, counsellors, and the Indigenous social planner, but without nursing support. Over this latter phase, MHC remained in service for an additional 75 service days.

Service Delivery Following Nurse Departure: A Comparison.

The chart below compares the number of encounters across the **nine most common services** provided by the nurse, distinguished by two periods:

- Nurse Present (up to October 17, 2024; first 50 service days)
- Nurse Absent (October 18 to January 24, 2025; subsequent 50 service days following the nurse's departure)



Data Source: EMR, n = 2,219.

This data demonstrates that nursing presence is essential for sustaining clinical services, particularly in wound care, on-site treatment for acute conditions, and STBBI testing.

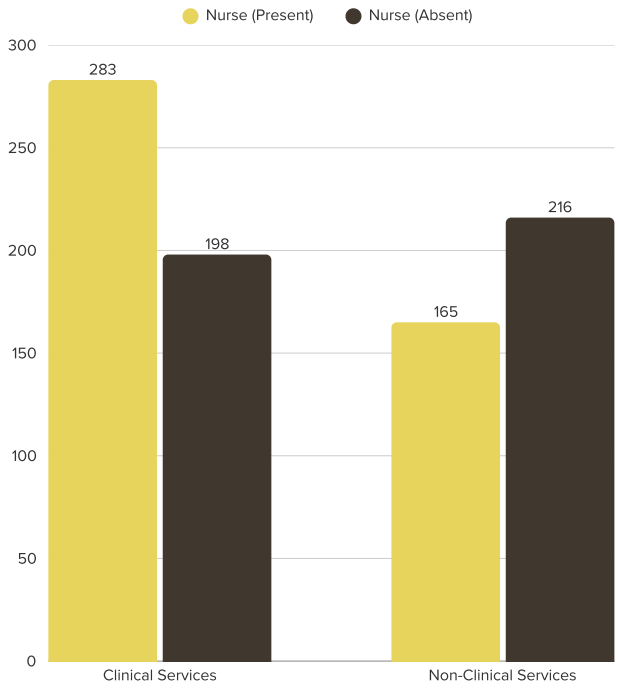
Clinical services experienced noticeable declines without nursing support:

- Wound care saw the most significant drop, falling from 124 to 75 (39% decrease);
- On-site treatment for acute conditions also declined from 84 to 69 encounters (18% decrease);
- STBBI Testing decreased from 30 to 22 encounters (27% decrease);
- OTC medication provision dropped 45 to 23 encounters (29% decrease).

These reductions may be directly tied to the loss of nursing capacity, as these services typically fall within a nurse's scope of practice.

Clinical vs. Non-Clinical Services.

In contrast, non-clinical and referral-based* services increased during the post-nurse period.



Data Source: EMR, n = 2,219

'Counselling' rose from 71 to 97 (**36.6% increase**), showing a significant shift in service delivery patterns. In the absence of a nurse, counsellors stepped in to support physicians, assisting with patient visits and ensuring continuity of care.

'**Systems Navigation'** increased from 34 to 48 (**41.2% increase**), and '**Referrals to Other Health Services or Specialists'** grew from 60 to 71 (**18.3% increase**), indicating a higher reliance on external resources to meet the needs of some patients that could not be addressed in-clinic.

'**Regular Check-Ups'** remained high across both periods, slightly increasing from 114 to 122 (**7.02% increase**), indicating a steady demand. However, the scope of care provided during these visits may have been limited without nursing support.

***Note:** Clinical Services = Wound care; On-site treatment for acute conditions; STBBI Testing; OTC medication provision. Non-Clinical/referral-based = Counselling and Systems Navigation.*

Operational Challenges and Adaptations

The nursing vacancy has posed some challenges to the delivery of services. Despite these limitations, the clinic team has been able to continue operations with the physicians, counsellors, and the Indigenous Social Planner. In the absence of a nurse, mental health crisis counsellors accompany patients during appointments to assist physicians when necessary, which also ensures a continued sense of safety and comfort for the patient.

A patient reflected this impact, highlighting both the compassion of the care team and the unmet demand for expanded services:

> *"I wish you guys had more clinics for us to use, the doctors and nurses are so kind and I feel like they really care."*
>
> *- MHC Constituent*

Recruitment efforts for a nursing position remain ongoing, with no candidates having been secured to date. Physicians have been gracious and adaptable in managing without nursing support, leaning on counsellors, the Indigenous Social Planner, and peer workers where possible.

Without a nurse, the service delivery model shifted heavily toward non-clinical and referral-based services, while clinical services (i.e., wound care, on-site treatment for acute conditions, and STBBI testing) saw substantial declines.

The data however does demonstrate consistent demand across both clinical and social care services. Expanding the MHC model to operate two clinics simultaneously would allow improvements in service delivery and the ability to address unmet needs while expanding its reach throughout the city.

With 199 registered patients that were not seen, there is clear evidence of missed opportunities to provide care, likely tied like tied to external factors outside of the team's control. Current staff workloads may be stretched thin, with physicians and counsellors covering nursing gaps. Expanding staff and splitting clinical and outreach focuses between two mobile units would optimize resource use, reduce strain on current staff, and improve patient outreach and care.

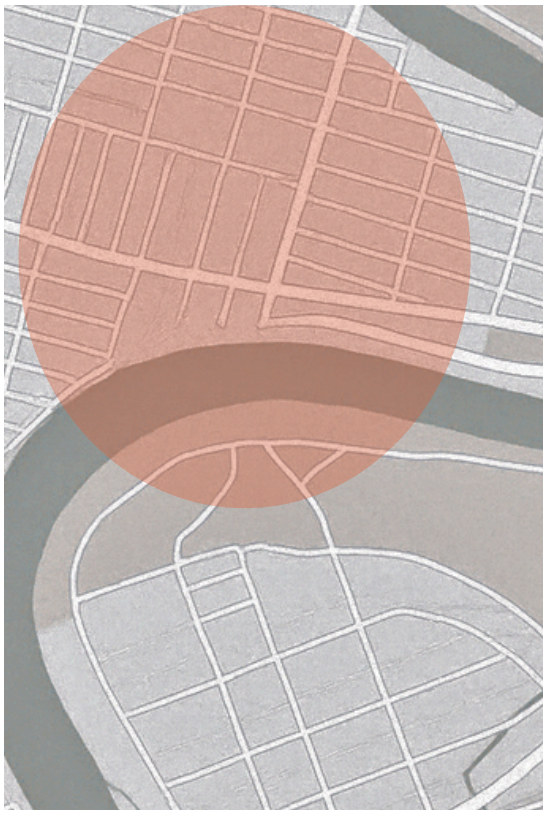
Emergency Department Deferral **Indicators**

Main Locations for Emergency & Urgent Care

At the time of the community partner meetings, WRHA identified the highest users of the healthcare system reside in Point Douglas, Downtown, and the River East areas. This aligns with early data collected through the first set of optional registration questionnaire, also indicating the Downtown area as having the highest emergency and urgent care use among MHC constituents.

Patients were asked whether they had accessed “emergency/urgent care” for themselves in the last 12 months. Those who responded “yes” were then asked to specify the location.

Among these responses, **50%** identified **Health Sciences Centre (HSC)** Emergency Department, followed by **Seven Oaks General Hospital (SOGH)** Urgent Care at **17%**, and **Saint Boniface Emergency Department** at **13%**, which indicate a high reliance on emergency-based care, especially in the central urban area.



**Note: This map is intended for illustrative purposes only. Distances, sizes, and locations are not accurately scaled.*

Main Locations with Highest Volume of EMS Calls

The community partner meetings report also identified the importance of locating the services in areas with consistent high volumes for emergency medical services (EMS) calls for non-emergency issues. The Winnipeg Fire Paramedic (WFPS) highlighted that up to 10 EMS calls per day are dispatched within the immediate block radius of Main Street Project (637 Main Street) and N’Dinawemak (190 Desraeli).

In direct response to this data and ongoing community need, MHC has prioritized service delivery at these locations by strategically rotating between these sites on its Friday and Saturday fixed-location services to help alleviate the primary care need. The total number of days that MHC visited MSP and N’Dinawemak is **30 service days**, allocating 24% of its total service days to reaching these two sites.

‘Main Reasons for ER Visit’ vs. ‘MHC Services’,

The community engagement report also indicates that WRHA identified **wound-related concerns** (skin issues) and **substance use disorders (SUD)** as two of the most common reasons identified for emergency department visits.

MHC’s EMR data shows that the clinic provides substantive services in these two areas, with wound care accounting for **10.4%** of all services provided, while substance use supports represent **4.4%** of total services.

This also demonstrates that the clinic is playing a vital role in implementing preventative emergency department measures by delivering responsive are for issues that often result in non-urgent EMS calls or Emergency Department visits.

This is particularly important in building trust with individuals who may feel judged or dismissed in conventional healthcare settings. As one constituent shared:

> *“You guys are really great. Never judge me even when I’m high. Makes me feel comfortable to talk to you about what’s going on in my life.”*
>
> *- MHC Constituent*

The ability for MHC to provide non-judgmental, trauma-informed care where and when people need it is most essential in addressing systemic barriers and creating effective pathways to support and recovery.

230
Wound Care Services Provided

57
Highest Month for Wound Care Encounters (August)

67
On-Site Antibiotic Treatments for Wound Care

38
Prescriptions Provided for Wound Care

41
Encounters Involving Provision of Take Away Wound Care Supplies

98
Substance Use Support Services Provided

17
OAT Service Provided

18
Main Street Project Detox Encounters

32
Substance Use-related Referrals

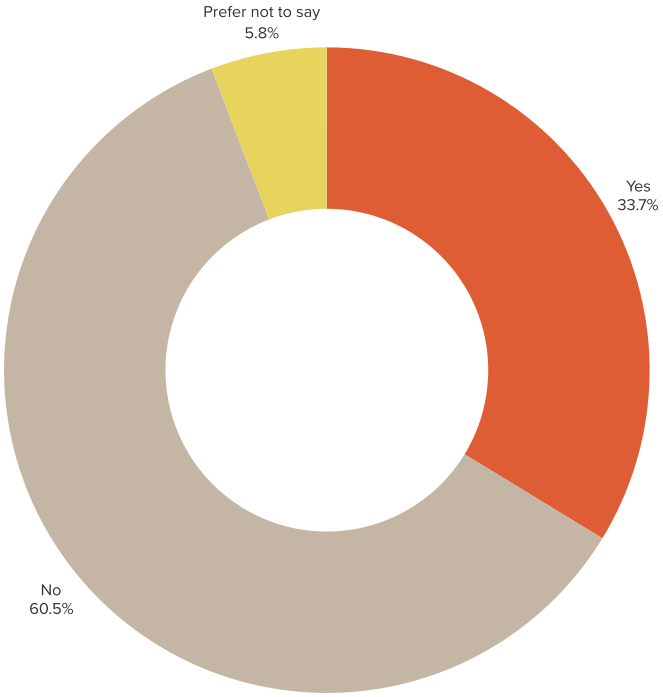
500
*Harm Reduction Kits Distributed
**Note: Limited to August reporting.*

ER Deferrals Based on MHC Services.

To better understand MHC's role in preventing avoidable emergency department visits, the last two versions of the optional intake questionnaire asked patients:

"If you did not receive these services from the Mobile Healthcare Clinic today, would you have accessed emergency care for this issue?"

This question was designed to help quantify the clinic's impact on emergency room deferral, capturing instances where MHC services prevented patients from seeking care through emergency departments.



Data Source: MHC Data Library - Indicators Responses, n = 86,

Out of 86 responses, **33.7%** indicated they would have sought out emergency care had they not accessed care through MHC.

In the final version of the questionnaire, those who responded "no", were asked to elaborate:

"If you answered "no" why, or why not?"

Out of the 52 respondents who indicated 'no', 26% provided a reason ('why not?').

The large majority (71%) reported that the wait times were too long, followed by barriers around emergency room systems navigation (14%), not feeling safe in the emergency room (7%), and not liking the services provided in the emergency room (7%).

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.

Fragmentation of Dataset Limitations

As this was the first year that MHC operationalized, their optional questionnaire that produced the Data Library Indicator Responses dataset was shifting and evolving to a total of 4 different iterations of data collection tools. While we recognize the need for fluid and changing iterations of the data collection methods for this dataset, it did make it difficult for consistency of all the questions into a complete data set and produced some fragmentation of the data. We worked to mitigate this by always indicating the exact number of respondents, the iteration the descriptive statistics represented, and being transparent if the question shifted over the iterations.

Incomplete Dataset Limitations

The Numbers Document from the MHC data library was incomplete, producing an incomplete dataset. This made it hard to accurately represent some data, such as how the kits (hygiene, harm reduction, medicine) and sandwiches, handed out were only captured for one month. To work to mitigate transparent representation, we always indicated that it was a sample month and fully disclosed that these data points were not collected/tracked throughout the year. MHC is actively working to figure out a sustainable way to capture these data points throughout this fiscal year for the next report.

Descriptive Statistic Limitations

A limitation of utilizing the descriptive statistics methods is that this type of analysis can only suggest correlations based on patterns and trends and cannot make predictions or generalize findings beyond the data set (no inference). Additionally, descriptive statistics are not able to explore relationships or causes behind observed patterns.

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Appendix

Appendix A

CODE	DATE	NON-PATIENTS SEEN	HEALTH CARD	SEX	AGE CATEGORY	SERVICE TYPE	DURATION OF ENCOUNTER	DURATION OF VISIT	TEAM	SERVICES	NOTES	REFERRED FROM MHC TO [x]	NOTES2

Appendix B

REASONS/ SERVICES PROVIDED by category (in EMR)
Blank
Chronic Dx or Condition Management
Contraceptive (Plan B, Depo, Birth Control)
Counselling
Diabetes Testing
Diabetes Treatment
Drug Screening Tests
Forms (EIA, Treatment Forms, Tax Credit Forms, Disability Assessment Forms)
Health Promotion and Education
HIV Management
HIV Point of Care Testing
Immunization
Lab Services
Main Street Project Forms (Detoxification)
Minor Procedure (IUD, Mole removal, Any Skin Biopsy)
Nursing (only)
Onsite Treatment for Acute Condition (e.g., antibiotics, antiviral, antifungal, etc.)
Opioid Antagonist Therapy (OAT)
Over-the-Counter Medication Provided Onsite (e.g., Tylenol, Advil)
Pap Test Examinations
PEER Support (only)
Pregnancy Test
Prep (Pre-Exposure Prophylaxis (HIV Prevention)
Prescription Renewal
Prescription (New)
Referrals to other Health Services or Specialist
Regular Check-Up
STBBI testing
STBBI treatment
Substance Use
Systems Navigation
Treatment for Minor Injuries
Wound Care
Other

Black indicates the reasons/services categories that EMR already captured.
Red Indicates the reasons/services categories that MHC added in to be captured.
Green indicates the reasons/services categories that the researchers added for this extraction.

Appendix C

REFERRED FROM MHC TO [x] by referral category
Harm Reduction Supplies ONLY
MB HIV Program (Nine Circles, HSC, Brandon)
Domestic or Interpartner Violence Referral
Emergency Department (911)
Community Mental Health Services (DCSP, Klinic) (Mental Health-Community Programs)
Mental Health Services (eg: CRC) (Mental Health-Crisis)
Emergency Department (non-withdrawal related)
Withdrawal Management Services
Employment Income Assistance (provincial)
Homeless Shelter
Employment Income Assistance (provincial)
Hospital
Child and Family Services
Spiritual Health Care Provider (e.g. elder, clergy)
RAAM
Police
Primary Care Provider
Indigenous Community Health Provider
Transitional Housing
Specialist
Urgent Care
Other

Black indicates the reasons/services categories that EMR already captured.
Red Indicates the reasons/services categories that MHC added in to be captured.
Green indicates the reasons/services categories that the researchers added for this extraction.