



OPTIMIZING HEALTH HOMES

Recommendations for enhancing health homes in Nova Scotia

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Executive summary

Health homes are the future of primary care in Nova Scotia. When family physicians and other health professionals work together as a team, patients benefit from better access, better coordination and more comprehensive care.

A health home is a patient-centred, team-based model of primary care in which family medicine specialists work in close collaboration with other health professionals, such as nurse practitioners, family practice nurses, pharmacists and social workers, to provide comprehensive and coordinated care. This is not an all-encompassing list of providers who may be a part of a health home, as all teams should be built based on community needs.

Health homes are not always a centralized physical location, but most often an integrated, collaborative approach designed to better support the health needs of a community.¹

The health home model is a well-known model of care globally, and the benefits are well documented. Health homes provide better patient care at a lower cost, meet community needs, and are a more sustainable model for healthcare providers, family physicians in particular.^{2,3,4}

1 College of Family Physicians of Canada. *A new vision for Canada: Family Practice—The Patient's Medical Home* 2019. Mississauga, ON: College of Family Physicians of Canada; 2019.

2 Nasser Albarqi M. Continuity and sustainability of care in family medicine: Assessing its association with quality of life and health outcomes in older populations-A systematic review. *PLoS One*. 2024 Dec 23;19(12):e0299283. doi: 10.1371/journal.pone.0299283. PMID: 39715241; PMCID: PMC11666006.

3 Glazier RH. Our role in making the Canadian health care system one of the world's best: How family medicine and primary care can transform-and bring the rest of the system with us. *Can Fam Physician*. 2023 Jan;69(1):11-16. doi: 10.46747/cfp.690111. PMID: 36693751; PMCID: PMC9873296.

4 Grant, Roy, and Danielle Greene. "The Health Care Home Model: Primary Health Care Meeting Public Health Goals." *American Journal of Public Health*, vol. 102, no. 6, June 2012, pp. 1096–1103, <https://doi.org/10.2105/ajph.2011.300397>.

Important commitments have been made to support team-based primary care through the implementation and assessment of health homes in Nova Scotia. At the time of this paper, the provincial government reports that more than 120 health homes have been established across the province.⁵

The Nova Scotia Department of Health and Wellness has made significant investments in stabilizing and strengthening primary care. Optimizing health homes is one of the most effective ways to ensure those investments deliver lasting value. In addition, Nova Scotia Health's commitment to strengthening primary care and supporting interdisciplinary teams has provided valuable insights into the factors that contribute to effective team-based practices and has created a foundation for ongoing system improvement. Physicians support the health home model and want to help optimize it. This paper is a constructive contribution to that ongoing work.

Nova Scotia is fortunate to have a variety of team-based practices across the province, many clinically led by physicians, each with unique interprofessional healthcare teams.

Existing health home practices (or, more accurately, team-based practices) vary; some are more robust, more mature and/or better resourced than others, and all would benefit from additional support.

Doctors Nova Scotia (DNS) believes that in order for the benefits of health homes to be fully realized and optimized, which is essential to a stable and flourishing primary care system, enhancements in the areas of governance, infrastructure, interoperability and collaboration between providers are required.

Doctors Nova Scotia has long advocated for truly integrated, interdisciplinary models of care in which all providers are able to practise to their full scope. Our healthcare system has changed drastically over the last several decades; provider scopes of practice, patient needs and system capabilities have all changed. However, amid that changing landscape, health system partners have not come together to have a strategic conversation about how providers can most effectively do their best work in this new reality. As the voice of physicians in Nova Scotia, DNS is committed to working with system partners to ensure that the currently siloed pockets of primary care across the province are meaningfully connected and fully integrated.

In the absence of a consistent definition for health homes and a collaborative approach to primary care, this paper seeks to articulate family physicians' perspective on the operational, clinical and system-level conditions needed for success and offer recommendations for optimizing health homes in Nova Scotia. The recommendations outlined in this paper are intended to complement and build upon existing improvement efforts by identifying opportunities for further enhancement through continued collaboration among physicians and the broader healthcare system.

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⁵ Government of Nova Scotia. (2026). *Defending Nova Scotia: Planning for the long term*. Retrieved from the Government of Nova Scotia website: <https://www.novascotia.ca/sites/default/files/documents/7-4172/address-budget-2026-27-en.pdf>.

Introduction

Nova Scotia's healthcare system, like that of many of our fellow provinces and territories, is under significant strain. While significant investments and improvements have been made to the delivery of primary care in the province, many Nova Scotians are still left without attachment to a health home, resulting in delayed access to primary care, long specialist waits and a lack of longitudinal care over their lifespan.

Current systems of care in Nova Scotia are fragmented, often leaving patients in limbo between pockets of siloed care access points. Doctors Nova Scotia (DNS) firmly believes that eliminating siloed healthcare for patients means establishing a truly integrated healthcare system for providers. By optimizing health homes in Nova Scotia, we can ensure that patients receive the right care, in the right place, at the right time, and that providers have the tools and support required to work effectively in integrated interprofessional teams.

Following consultation with family medicine specialists, the Nova Scotia Department of Health and Wellness (DHW), Nova Scotia Health (NSH) and other healthcare providers, DNS has developed key recommendations that support the optimization of health homes, so Nova Scotians not only have access to a family physician but also have access to timely and continuous primary care throughout their life.

Doctors Nova Scotia's definition of a health home

Doctors Nova Scotia supports the following definition of a health home: A primary care practice where family medicine specialists, guided by a community health needs assessment, clinically lead a team of healthcare providers, including nurse practitioners, family practice nurses and social workers, among others, to provide coordinated, easy-to-access, patient-focused care.¹

How patients experience a health home

In a health home model, patients access a family physician, who is part of the health home team and can act as a quarterback for their care. Every Nova Scotian deserves access to a family physician who, through a trusted, longitudinal relationship, provides clinical leadership and continuity of care in a way unique to their training and expertise.

In a health home model, patients may see a different provider within their care team at any point in time, depending on their specific health needs. The healthcare provider who has the primary responsibility for the patient for their specific reason for visiting the health home is called the most responsible primary care provider (MRPCP). This term comes from the Nova Scotia Department of Health and Wellness Standards for Health Homes (still in development at time of publication). The MRPCP is an important concept in a health home because it allows providers to work autonomously within their optimal scope and competency, while also recognizing that the MRPCP is fluid based on a patient's care needs. Inherent in this is the acknowledgment that different patients will require the unique skills of different providers at different points of time, and that each provider in a health home has a unique and distinct value to provide a patient.



BENEFITS OF A HEALTH HOME

The benefits of health homes are well documented, including improved care at a lower cost, improved provider wellness and better community engagement. Key benefits for patients, providers and the healthcare system are better care, lower cost and improved sustainability.⁶

Better care

Patient-centred care is at the core of the health home model. In this model, patients, their families and/or personal caregivers, and all healthcare providers in the health home team are partners in care, working together to achieve the patient's goals and engaging in shared decision making.⁷ Research tells us that "strategies that lead to excellent patient-centred care, lead to healthcare organizations and settings that are high performing overall, have excellent health outcomes, are safe and desirable workplaces, and are financially strong."⁸ Not only is the patient at the core of service delivery, but ultimately the health home itself is designed based on the needs of the patient population.

Health homes are optimized when they're designed in response to community needs.¹ Their composition is informed by local gaps in care, disease prevalence and social service requirements. In Nova Scotia, the social determinants of health play a significant role in shaping patient outcomes. Factors such as an aging population, increased immigration without sufficient

housing and social supports, and a large rural population with more limited access to healthcare services must be central considerations in the design and implementation of health home teams.

Optimized health home teams meet the needs of their community by providing services such as extended hours, building strong connections to social services, and spending time collaborating to help patients better understand their own health status and care plans.

Finally, health homes provide better care by focusing on continuity of care. Rooted in a long-term patient-provider relationship, the health home team, through the patient's family physician or other members of the team who know the patient's history, can integrate new information and decisions from a whole-person perspective, efficiently without extensive investigation and record review.¹

6 Yu C, Xian Y, Jing T, Bai M, Li X, Li J, Liang H, Yu G, Zhang Z. More patient-centered care, better healthcare: the association between patient-centered care and healthcare outcomes in inpatients. *Front Public Health*. 2023 Oct 19;11:1148277. doi: 10.3389/fpubh.2023.1148277. PMID: 37927879; PMCID: PMC10620693.

7 National Academies of Sciences, Engineering, and Medicine. 2021. *Implementing high-quality primary care: Rebuilding the foundation of health care*. Washington, DC: The National Academies Press. <https://doi.org/10.17226/25983>.

8 Edgman-Levitan S, Schoenbaum SC. Patient-centered care: achieving higher quality by designing care through the patient's eyes. *Isr J Health Policy Res*. 2021 Mar 5;10(1):21. doi: 10.1186/s13584-021-00459-9. PMID: 33673875; PMCID: PMC7934513.

Lower cost

Research indicates that the health home model provides clinical benefits and savings to the healthcare system.^{9,10,11,12,13} Additionally, research indicates that the savings to the broader health system far exceed the cost of implementing health homes.⁴ Various global studies on the implementation of the health home model also show cost savings for the greater system through reduced hospital and emergency department use, lower medication use and fewer tests.¹⁴ These savings are greater for patients with chronic and complex health needs.

Further, global healthcare systems with strong primary care systems are associated with greater equity, lower mortality, and fewer disparities in measures of health outcomes and healthcare use.¹⁵ From 2000 to 2006, the Government of Canada funded initiatives through the Primary Health Care Transformation Fund, providing increased opportunities for providers to participate in team-based care. Across the initiatives, patients reported increased access to health services, improved access to appropriate service providers, greater willingness to visit and accept services from different providers, increased satisfaction with services received and better coordination in health services delivered.¹⁶

More sustainable

Data from the 2025 Canadian Medical Association *Physician Wellness Report* notes that across Canada, physicians continue to struggle with heightened levels of burnout that have still not returned to pre-Covid-19 levels.¹⁷ New family physicians are looking for a better work-life balance in their practices, with the ability to take parental leave and sick leave, access to a pension, and an organizational structure that reduces their administrative burden and facilitates team-based care.¹⁸ According to seminal research from Sinsky, et al., a core component of facilitating physician wellness through joy is sharing clinical care among a team.¹⁴ Further, we know that health homes are designed to be optimal spaces for medical and healthcare provider education,¹ encouraging sustainability through teaching practices focused on the essential roles of family physicians and interprofessional teams as part of the continuum of the healthcare system. Collaborative work where physicians feel supported, valued and connected to their colleagues has been shown to reduce burnout and enhance physician well-being. By leveraging team-based care and effective task delegation, physicians can establish an improved work-life balance and robust peer support network.

9 Vreugdenhil J, Somra S, Ket H, Custers EJFM, Reinders ME, Dobber J and Kusurkar RA (2023) Reasoning like a doctor or like a nurse? A systematic integrative review. *Front. Med.* 10:1017783. doi: 10.3389/fmed.2023.1017783

10 Glazier RH. Balancing equity issues in health systems: perspectives of primary healthcare. *Heal Pap.* 2007;8:35-45.

11 Macinko J, Starfield B, Shi L. The contribution of primary care systems to health outcomes within OECD countries, 1970–1998. *Health Serv Res.* 2003;38: 819–853.

12 Starfield B, Shi L. Policy relevant determinants of health: an international perspective. *Health Policy.* 2002; 60(3):201–216.

13 Paustian ML, Alexander JA, El Reda DK, Wise CG, Green LA, Fettes MD. Partial and incremental PCMH practice transformation: implications for quality and costs. *Health Serv Res.* 2014;49(1):52-74.

14 Sinsky CA, Willard-Grace R, Schutzbank AM, Sinsky TA, Margolius D, Bodenheimer T. In search of joy in practice: a report of 23 high-functioning primary care practices. *Ann Fam Med.* 2013 May-Jun;11(3):272-8. doi: 10.1370/afm.1531. PMID: 23690328; PMCID: PMC3659145.

15 Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. *Milbank Q.* 2005;83(3):457-502.

16 "Primary Health Care Transformation Fund - Collaborative Care." Collaborative Care, Government of Canada, Mar. 2007, www.canada.ca/content/dam/hc-sc/migration/hc-sc/hcs-sss/alt_formats/hpb-dgps/pdf/prim/2006-synth-collabor-eng.pdf.

17 Canadian Medical Association (CMA), Ipsos. CMA 2025 National Physician Health Survey. Ottawa: The Association; 2026 Feb. Available: <https://digitallibrary.cma.ca/link/digitallibrary1418>

18 Owens B. Work-life advantages of becoming a salaried physician may be oversold. *CMAJ.* 2019 Jan 28;191(4):E113-E114. doi: 10.1503/cmaj.109-5699. PMID: 30692113; PMCID: PMC6342687.



CRITICAL SUCCESS FACTORS FOR THE OPTIMIZATION OF HEALTH HOMES IN NOVA SCOTIA

Significant investments have been made to support team-based care in Nova Scotia. To realize the benefits of those investments, we must now develop a shared strategy for patients and providers. To fully experience the key benefits of health homes in Nova Scotia, critical actions must be taken; the most pressing of which is ensuring the provincial government, NSH, family physicians and other healthcare providers have a shared definition and understanding of health homes.

Share a clear vision for health homes

Many organizations and providers are working toward implementing health homes in Nova Scotia, but it is unclear whether everyone is working toward the same vision and definition of a health home. As outlined above, DNS defines health homes as a primary care practice where family medicine specialists, guided by a community health needs assessment of their community, clinically lead a team of healthcare providers, including nurse practitioners, family practice nurses and social workers, to provide coordinated, easy-to-access and patient-focused care.

To develop, implement, enhance and evaluate health homes, all system partners, particularly healthcare providers, need to have a shared understanding of the definition of health homes and be aligned on their individual roles in implementing them. This will help support the optimization of health homes and several of the other critical success factors outlined below.

► **Doctors Nova Scotia recommends system partners and interprofessional healthcare providers align around a shared definition and implementation strategy for health homes in Nova Scotia.**

Have all primary care partners at the table

To create and build a shared definition, all interprofessional healthcare providers need to contribute to, align with and implement a shared strategy for health homes in the province. Although there is system and provider alignment around the importance of health homes, significant work is required to ensure all providers are working toward the same shared vision and have the tools required to work most effectively within interprofessional teams. Without a coordinated approach, health homes will not be optimized.

► **Doctors Nova Scotia recommends the creation of a primary care provincial coordination working group to support the implementation and ongoing evaluation of health homes in the province through shared definitions, policies, and provider and system role clarity. Although some of this work is happening, it is often done in silos, with limited provider input.**

Support interprofessional best practices through appropriate compensation

A core component of the health home model is its team of providers. It is important that health homes are built to meet the evolving needs of patients and include a mix of interprofessional healthcare providers working cohesively. Each provider should be empowered to work to their optimal scope in the context of the community and patient population they serve, collaborating with other team members often.

Research shows that the success factors for interprofessional practices are effective communication, effective task coordination, and creating a work culture that promotes collaboration and respect.¹⁹ Fundamentally, trust is at the core of successful team-based care. To meet these success factors and build trust, teams should prioritize shared decision-making processes and effective conflict resolution, as well as clearly defined roles and responsibilities.

Most family medicine specialists leading health homes in Nova Scotia are compensated through the Longitudinal Family Medicine (LFM) payment model. That model was introduced in 2023 and has been critically important to supporting the recruitment and retention of family physicians to the province and has also supported family physicians in providing exemplary patient care across the lifespan and at all levels of complexity of care. The LFM relies on fee codes to track and compensate family physicians for the services they provide to patients. However, Nova Scotia does not have fee codes to capture the essential work that family physicians must do to optimize their role within a health home. As a result, physicians suffer a financial penalty for time spent collaborating with other providers within the health home. Compensating physicians for these essential activities is a necessary step to support family physician collaboration and leadership in health homes. These activities include:

- patient-specific collaboration with other health providers in their health home
- daily practice meetings with their interprofessional team
- case management for patient-specific care coordination
- team development and mentoring
- quality and safety meetings and initiatives

¹⁹ McLaney E, Morassaei S, Hughes L, Davies R, Campbell M, Di Prospero L. A framework for interprofessional team collaboration in a hospital setting: Advancing team competencies and behaviours. *Healthc Manage Forum*. 2022 Mar;35(2):112-117. doi: 10.1177/08404704211063584. Epub 2022 Jan 20. PMID: 35057649; PMCID: PMC8873279.



- reviewing labs and reports while covering other members of the practice while they are away, to ensure seamless and timely care for all patients in a health home

Without these payment model improvements, physicians choosing to practise in a truly collaborative manner will continue to be disadvantaged compared to those practising as an independent physician in a solo practice.

► **Doctors Nova Scotia recommends physicians be compensated for time spent on team building, collaborating, mentoring, making decisions and resolving conflicts within a health home.**

Design physical infrastructure that supports mentorship and teaching

Health homes must serve as training sites for medical students, family medicine residents, nurse practitioners and physician assistants. One of the goals of family medicine residency training, for example, is to learn to function as a member of an interprofessional team, caring for patients in a variety of settings, including family practice offices, hospitals, long-term care and other community-based institutions, and patients' residences.²⁰

To be certified in family medicine by the College of Family Physicians of Canada (CFPC), family medicine residents must demonstrate capacity in 105 (at time of writing) priority topics.²¹ These priority topics are the essential skills, core clinical problems and observable behaviours expected of a family physician entering independent practice. Further, family medicine training is increasingly focused on achieving and maintaining competencies defined by the CFPC Triple C Family Medicine Curriculum. The triple C includes five domains of care: care of patients across the life cycle; care across clinical settings (urban and rural); a defined spectrum of clinical responsibilities; care of marginalized/disadvantaged patients and populations; and a defined list of core procedures.²² Health homes allow family medicine students and residents to achieve those competencies of the Triple C curriculum while also providing an ideal environment to train in the 105 priority topics needed for their certification.

Ultimately, training within health homes is essential to improving our healthcare system. This learning culture and the will to constantly improve quality and access to care is essential to ensure health homes continue to support high-performing care teams.

Advancing interprofessional education and establishing health homes to serve as future training sites will help new graduates cultivate their collaborative skills early in their careers.

Additionally, to enable more providers to co-locate and provide space for teaching interprofessional teams, health home spaces should be designed with purpose. Continuity of care also requires continuity in medical settings, information and relationships.¹ Having most primary care services provided or coordinated in the same place by one's family physician and team has been shown to result in better health outcomes.²³

This requires the efficient and effective set-up and design of reception, administration and clinical areas in the office. This may require investments in new spaces, redesign or partnerships with owners of building and infrastructure. Each health home must ensure space for team collaboration, as well as ample clinic space for teaching and mentoring.

► **Doctors Nova Scotia recommends working directly with providers and communities to build, redesign or enhance existing infrastructure to ensure that health homes are designed effectively for patients and their care teams. When co-location may not be possible, the healthcare system must establish an effective tool for communication between providers and sharing of patient records.**

20 Tannenbaum D, Kerr J, Konkin J, Organek A, Parsons E, Saucier D, Shaw L, Walsh A. *The Scope of Training for Family Medicine Residency: Report of the Working Group on Postgraduate Curriculum Review*. Mississauga, ON: College of Family Physicians of Canada; 2011.

21 Crichton T, Schultz K, Lawrence K, Donoff M, Laughlin T, Brailovsky C, Bethune C, van der Goes T, Dhillon K, Pélissier-Simard L, Ross S, Hawrylyshyn S, Potter M. *Assessment Objectives for Certification in Family Medicine*. Mississauga, ON: College of Family Physicians of Canada; 2020

22 Gutkin C. Triple C: New competency-based family medicine curriculum. *Can Fam Physician*. 2011 Jul;(57)7:856. PMID: PMC3135459.

23 Khatri R, Endalamaw A, Erku D, Wolka E, Nigatu F, Zewdie A, Assefa Y. Continuity and care coordination of primary health care: a scoping review. *BMC Health Serv Res*. 2023 Jul 13;23(1):750. doi: 10.1186/s12913-023-09718-8. PMID: 37443006; PMCID: PMC10339603.



Share health information between providers

Nova Scotia is leading the way in introducing innovative e-health solutions to assist with information sharing, reducing unnecessary administrative burden and putting information into the hands of patients. As technology and integration capabilities expand, the potential to improve patient care, enhance provider satisfaction and support collaborative care also grows. While many new clinics and care centres are being built across the province, we know that some health homes may not be able to operate in a co-located environment. No matter where a physician or other healthcare provider sees a patient, they should be able to access the relevant components of a patient's medical record to provide safe, effective care.

When One Person One Record (OPOR) is fully implemented in Nova Scotia, hospital-based physicians and other providers will be able to access patient medical records, no matter which facility care is delivered in across the province.

However, at present, providers working in health homes outside of a hospital have access to patient information but cannot contribute to a patient's chart in real time. This creates a gap in information between the primary care environment and hospital settings, which can impact continuity of care, care coordination and timely decision-making.

Interoperability must extend beyond hospitals to encompass the full spectrum of primary care. Health homes, community-based physicians, nurse practitioners, community pharmacists and other primary care access points all play critical roles in managing patient health. For health home teams to work collaboratively

and communicate effectively, an interoperable system is needed; this would enable all providers to access and contribute to patient records, share data seamlessly and utilize tools for scheduling, billing and analytics. This level of integration supports proactive care management, reduces duplication of services and ensures patients receive coordinated care no matter where they present.

► **Doctors Nova Scotia recommends the implementation of a digital health solution in primary care that fully integrates health homes, community-based physicians, nurse practitioners, pharmacists and other primary care access points with OPOR. This system should allow all providers to access and contribute to patient records in real time, enabling seamless communication, coordinated care and patient-centred outcomes across all care settings.**



Move past episodic care

Connectivity and effective communication within and across settings of care is a crucial concept of a health home. This ensures that the care patients receive is coordinated and continuous. Giving Nova Scotians the best health care requires creating an integrated health system along the full continuum of care – a system based on interprofessional healthcare teams that ensure a patient can see the right provider at the right time, in the right place, for the right care.

To address gaps in access and attachment, the DHW and NSH have supported the creation of many alternative access points for patients (for example, community pharmacy primary care clinics, mobile primary care clinics, urgent treatment centres, Virtual Care NS). While these initiatives have helped increase opportunities to access primary care, they are ineffective long-term solutions.

The episodic, siloed nature of these alternatives exacerbates problems with continuity of care that can result in patient harm and increased system costs, and can increase risk of medical harm, especially for patients without a family physician or nurse practitioner to provide follow-up care.^{24,25}

Current access points are welcome as interim measures. However, the ultimate goal for stabilizing primary care requires integrating these interim access points and providers into a larger health home to better serve the community.

According to the CFPC, expanding on the health home model to build a health neighbourhood enables family practices to coordinate and share responsibility for patient care with other social and community programming.²⁶ This intentional coordination, design and sophisticated information sharing mechanisms offer multiple benefits, including improved patient outcomes, safety and patient experience; lower costs through reduced duplication of services; improved delivery of health prevention services; and more evidence-based patient care.²⁷ Optimizing health homes in Nova Scotia is imperative. However, our goal should be to ensure all components of the healthcare system are integrated as part of a health neighbourhood.

► **Doctors Nova Scotia recommends ensuring existing episodic care access points are connected to a health home, striving to transition to becoming part of a patient's health neighbourhood.**

Embrace clinical leadership by family physicians

Every Nova Scotian deserves access to a family physician who can serve as the central coordinator of their care throughout their life and help them navigate the broader healthcare system. While many interprofessional healthcare providers play essential and complementary roles within a health home team, family physicians provide clinical leadership and continuity in a way that is unique to their training, scope and long-term relationships with patients.

Family physicians are medical specialists with broad and diverse training, clinical experience and expertise in caring for patients across the full lifespan. They bring a comprehensive understanding of both individual health needs and the wider healthcare system in which that care is delivered.

While family physicians' scope of practice may overlap with other providers, they have distinct medical education and clinical expertise. In their day-to-day practice, family physicians integrate large volumes of complex information, including diagnostic imaging and laboratory results, specialist consultation notes, and care plans from nursing and other interprofessional healthcare providers. They excel at synthesizing these diverse clinical inputs and perspectives to inform sound clinical judgment and support optimal patient care. The value of a family physician is particularly evident in the breadth of medical training required to manage undifferentiated complex and multi-system illness, and to provide continuity across primary, urgent, hospital and procedural care.²⁸

Family physicians are uniquely positioned to diagnose and manage complex and evolving health issues, bridging frontline clinical practice with the latest research and evidence-based guidelines. They are experts in coordinating care, recognizing when additional expertise is required, and engaging the appropriate specialists and health professionals, such as other physician specialists, pharmacists, nurse practitioners, physiotherapists and nutritionists.

Importantly, family physicians do this work while maintaining strong, trusted therapeutic relationships with patients. When the completeness of clinical information leads to difficult or

24 Lau RS, Boesen ME, Richer L, Hill MD. Siloed mentality, health system suboptimization and the healthcare symphony: a Canadian perspective. *Health Res Policy Syst.* 2024 Jul 17;22(1):87. doi: 10.1186/s12961-024-01168-w. PMID: 39020412; PMCID: PMC11253392.

25 Andoko, Dewanto & Nababan, Janet & Setyawan, Surya. (2026). THE SILO EFFECT IN MEDICINE AND ITS IMPLICATIONS FOR HOSPITAL COSTS: A SYSTEMATIC LITERATURE REVIEW. *The International Conference on Sustainable Economics Management and Accounting Proceeding.* 2. 1098-1107. 10.32424/icsema.v2i1.630.

26 College of Family Physicians of Canada. *Best Advice guide: Patient's Medical Neighbourhood.* Mississauga, ON: College of Family Physicians of Canada; 2020.

27 College of Family Physicians of Canada. *Patient's Medical Neighbourhood Best Advice Guide: Quick Reference.* Mississauga, ON: College of Family Physicians of Canada; 2019.

28 Kolber MR, Korownyk CS, Young J, Garrison S, Kirkwood J, Allan GM. The value of family medicine: An impossible job, done impossibly well. *Can Fam Physician.* 2023 Apr;69(4):269-270. doi: 10.46747/cfp.6904269. PMID: 37072193; PMCID: PMC10112714.

life-altering diagnoses, they are well positioned to communicate this information in a compassionate, patient-centred way, providing continuity, support and guidance through some of the most challenging moments in a patient's life. The value of a family physician is greatest when a patient's needs extend beyond a single condition or care setting. Their broad medical training allows them to diagnose across systems, manage complexity and connect care across the continuum – from community to hospital and back.

Optimizing health homes in Nova Scotia ensures that patients have access to different medical expertise, no matter the MRPCP, ultimately leading to better health outcomes. Further, optimizing health homes establishes a robust, supported and truly integrated healthcare system, enabling family physicians to fully realize their potential as family medicine specialists and clinical leaders who support health homes and neighbourhoods.

► **Doctors Nova Scotia recommends that family medicine specialists act as clinical leaders within health home teams, leveraging their expertise in managing complex cases and delivering longitudinal and integrated care to ensure coordinated, patient-centred outcomes.**

Be driven by community need

Understanding the needs of the patient population is foundational to determining the appropriate composition of a health home team. While health homes focus primarily on the care of individuals and their families, effective teams must also understand and respond to the broader health challenges facing their practice population and surrounding community.¹ Identifying the key social determinants of health affecting health home populations is a critical first step in determining the right mix of healthcare providers needed to deliver responsive, comprehensive and equitable care. As part of conducting a community health needs assessment, efforts should be made to ensure that the diversity of the health home team reflects the diversity of the community it serves.

Completing a community health needs assessment enables a health home to collect baseline data that will inform the structure of the practice. Community health needs assessments are processes that “describe the state of health of local people, enable the identification of the major risk factors and causes of ill health, and enable the identification of the actions needed to address these.”²⁹ Although many physicians and collaborative teams in the province have completed assessments, they are completed on an ad hoc basis.

Completing a community health needs assessment can lead to

the introduction of new providers to an existing clinic, building stronger links with a community pharmacy or developing stronger relationships with community services, for example, Mobile Outreach Street Health in Halifax.

► **Doctors Nova Scotia recommends that when establishing a new health home, a community health needs assessment is completed to ensure that community needs are met. Ideally, this should be done jointly between family physicians and NSH, in consultation with other providers and the broader community.**

Provide education and change management support for patients and providers

Health homes may introduce a new or different experience for patients accessing primary care. Many patients are accustomed to seeing the same provider at every visit or may have a strong preference for a particular clinician. At the same time, introducing health homes also represents a significant change for physicians and interprofessional healthcare providers within a healthcare system that is already undergoing near-constant transformation. Ensuring that appropriate change management supports are in place for both physicians and care teams is essential to the successful and sustainable implementation of health homes in Nova Scotia.

► **Doctors Nova Scotia recommends the government educate the public about the benefits of health homes and what to expect as a patient of a health home.**

► **Doctors Nova Scotia also recommends that when establishing a new health home or transitioning an existing clinic into a health home, family physicians and other providers should be provided change management support to optimize the implementation and adoption of health homes.**



²⁹ Ravaghi H, Guisset AL, Elfeky S, Nasir N, Khani S, Ahmadnezhad E, Abdi Z. A scoping review of community health needs and assets assessment: concepts, rationale, tools and uses. *BMC Health Serv Res.* 2023 Jan 17;23(1):44. doi: 10.1186/s12913-022-08983-3. PMID: 36650529; PMCID: PMC9847055.

SUMMARY OF KEY RECOMMENDATIONS

Doctors Nova Scotia recommends the following actions to optimize health homes.

1

Share a clear vision for health homes

System partners, DNS, family medicine specialists and other inter-professional providers align around a shared definition and implementation strategy for health homes in Nova Scotia.

2

Have all primary care partners at the table

Create a primary care provincial coordination working group that supports the implementation and oversight of health homes in the province through setting definitions and policies, ensuring role clarity (for both provider and system roles), supporting collaboration, identifying gaps and opportunities for improvements, and sharing best practices.

3

Support interprofessional best practices through appropriate compensation

Allow physicians to participate fully in the collaborative and team-based health home by removing the financial disincentives and fostering interdisciplinary best practice, ensuring that physicians are compensated for time spent team-building, collaborating, mentoring, making decisions and resolving conflicts within a health home.

4

Design physical infrastructure that supports teaching and mentoring

Build, redesign or enhance existing infrastructure to ensure that health homes are designed for optimal team-based healthcare delivery. Infrastructure decisions must include space for learners, health homes must serve as training sites for medical students, family medicine residents and those training to become nurses, nurse practitioners and other healthcare providers.

5

Share health information between providers

Implement a digital health solution in primary care to ensure that health homes and all other care settings are connected to OPOR, and providers can access and contribute to the medical record to care for patients in all care settings.

6

Move past episodic care

Ensure existing episodic care access points are connected to a health home, and transition to becoming part of a patient's medical neighbourhood.

7

Embrace clinical leadership by family physicians

Health homes should be clinically led by family medicine specialists, leveraging their expertise in managing complex cases and delivering longitudinal and integrated care to ensure coordinated, patient-centred outcomes.

8

Be driven by community need

When establishing a new health home, a community health needs assessment should be completed to ensure that community needs are met. Ideally, this should be done between family physicians and NSH in consultation with other providers and community.

9

Provide education for patients and providers

Government should educate the public about the benefits of health homes, and what Nova Scotians can expect when they are a patient in a health home.

10

Change management

When establishing a new health home, or transitioning an existing clinic into a health home, family physicians and other providers should be provided with change management support to optimize the implementation and adoption of health homes.

CONCLUSION

The future of primary care is team-based care. When family physicians collaborate with other interprofessional healthcare providers, patients benefit from more accessible, coordinated and comprehensive care. This paper builds on the progress already being made by identifying opportunities to further strengthen health homes, so all Nova Scotians can experience the full benefits of the model.

The provincial government has made significant investments to stabilize and strengthen primary care. Optimizing health homes is one of the most effective ways to ensure those investments deliver lasting value. Our healthcare system has changed, and so should our strategies. It is imperative that we come together as a system to build on this momentum and ensure health homes reach their full potential for patients, providers and communities.

Optimizing health homes requires a shared vision, strong clinical leadership by family medicine specialists, robust interprofessional collaboration, interoperable digital infrastructure and meaningful engagement with communities to ensure care is tailored to local needs.

Equally important are the supports required to manage change for patients, physicians and care teams within a healthcare system already experiencing significant transformation.

Doctors Nova Scotia is encouraged by the shared commitment among healthcare partners to continuous improvement and remains dedicated to working with the provincial government, NSH, physicians and other partners to advance these recommendations. By strengthening health homes now, Nova Scotia can build a more integrated, sustainable and patient-centred primary care system – one that delivers better health outcomes for all Nova Scotians.

KEY DEFINITIONS

Health home: A primary care practice where family medicine specialists, guided by a community health needs assessment of their community, clinically lead a team of healthcare providers including nurse practitioners, family practice nurses and social workers, among others, to provide coordinated, easy-to-access and patient-focused care.

Physician clinical leadership: Family physicians act as the navigator for a patient's care and ensure a continuum of care from primary to tertiary care, while also supporting the other health home team members. Health homes may be administratively led by a non-physician; however, DNS believes that all health homes should be clinically led by a family physician.

Most responsible primary care provider (MRPCP): The family physician, nurse practitioner or other regulated healthcare professional who has overall responsibility for directing and coordinating the care and management of a patient at a specific point in time.

Interprofessional healthcare providers: Healthcare providers from diverse scopes of practice working collaboratively with colleagues, patients, families and communities to ensure high-quality patient care. Interprofessional healthcare providers share expertise, engage in joint-decision making and coordinate care based on team scopes and competencies, ensuring patients are seeing the right provider at the right time, in the right place, for the right care.

Health neighbourhood: Expanding on the health home model, the health neighbourhood framework represents a broader network of healthcare providers, community resources and social programming that work together to support a patient's comprehensive health needs.

Primary care: Primary healthcare is the backbone of Nova Scotia's healthcare system. It is the first place people go for healthcare or wellness advice and programs, treatment of a health issue or injury, and diagnosis and management of a health condition.

Scope vs. competency: Scope refers to the legal and regulatory boundaries that define what interventions are authorized within a given profession. Competency varies between providers and refers to an individual practitioner's demonstrated ability to perform a given task or intervention. Scope is applied universally to all licensed practitioners; however, not all that is in scope may be part of core training or core service delivery.

Co-located health home: A group of interprofessional healthcare providers, such as physicians, nurses and social workers, among others, located in the same facility providing a single point of access for a range of coordinated services for a shared group of patients.

Non-co-located health home: A group of interprofessional healthcare providers, such as physicians, nurses and social workers, among others, located across various facilities providing coordinated patient care across multiple access points for a shared group of patients using shared e-health tools, triaging systems and connected administrative teams.

REFERENCES

- College of Family Physicians of Canada. A new vision for Canada: Family Practice—The Patient's Medical Home 2019. Mississauga, ON: College of Family Physicians of Canada; 2019.
- Nasser Albarqi M. Continuity and sustainability of care in family medicine: Assessing its association with quality of life and health outcomes in older populations-A systematic review. *PLoS One*. 2024 Dec 23;19(12):e0299283. doi: 10.1371/journal.pone.0299283. PMID: 39715241; PMCID: PMC11666006.
- Glazier RH. Our role in making the Canadian health care system one of the world's best: How family medicine and primary care can transform-and bring the rest of the system with us. *Can Fam Physician*. 2023 Jan;69(1):11-16. doi: 10.46747/cfp.690111. PMID: 36693751; PMCID: PMC9873296.
- Grant, Roy, and Danielle Greene. "The Health Care Home Model: Primary Health Care Meeting Public Health Goals." *American Journal of Public Health*, vol. 102, no. 6, June 2012, pp. 1096–1103, <https://doi.org/10.2105/ajph.2011.300397>.
- Government of Nova Scotia. (2026). Defending Nova Scotia: Planning for the long term. Retrieved from the Government of Nova Scotia website: <https://www.novascotia.ca/sites/default/files/documents/7-4172/address-budget-2026-27-en.pdf>.
- Yu C, Xian Y, Jing T, Bai M, Li X, Li J, Liang H, Yu G, Zhang Z. More patient-centred care, better healthcare: the association between patient-centred care and healthcare outcomes in inpatients. *Front Public Health*. 2023 Oct 19;11:1148277. doi: 10.3389/fpubh.2023.1148277. PMID: 37927879; PMCID: PMC10620693.
- National Academies of Sciences, Engineering, and Medicine. 2021. Implementing high-quality primary care: Rebuilding the foundation of health care. Washington, DC: The National Academies Press. <https://doi.org/10.17226/25983>.
- Edgman-Levitan S, Schoenbaum SC. Patient-centred care: achieving higher quality by designing care through the patient's eyes. *Isr J Health Policy Res*. 2021 Mar 5;10(1):21. doi: 10.1186/s13584-021-00459-9. PMID: 33673875; PMCID: PMC7934513.
- Vreugdenhil J, Somra S, Ket H, Custers EJFM, Reinders ME, Dobber J and Kusurkar RA (2023) Reasoning like a doctor or like a nurse? A systematic integrative review. *Front. Med*. 10:1017783. doi: 10.3389/fmed.2023.1017783
- Glazier RH. Balancing equity issues in health systems: perspectives of primary healthcare. *Heal Pap*. 2007;8:35-45.
- Macinko J, Starfield B, Shi L. The contribution of primary care systems to health outcomes within OECD countries, 1970–1998. *Health Serv Res*. 2003;38: 819–853.
- Starfield B, Shi L. Policy relevant determinants of health: an international perspective. *Health Policy*. 2002; 60(3):201–216.
- Paustian ML, Alexander JA, El Reda DK, Wise CG, Green LA, Fettes MD. Partial and incremental PCMH practice transformation: implications for quality and costs. *Health Serv Res*. 2014;49(1):52-74.
- Sinsky CA, Willard-Grace R, Schutzbank AM, Sinsky TA, Margolius D, Bodenheimer T. In search of joy in practice: a report of 23 high-functioning primary care practices. *Ann Fam Med*. 2013 May-Jun;11(3):272-8. doi: 10.1370/afm.1531. PMID: 23690328; PMCID: PMC3659145.
- Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. *Milbank Q*. 2005;83(3):457-502.
- "Primary Health Care Transformation Fund - Collaborative Care." *Collaborative Care*, Government of Canada, Mar. 2007, www.canada.ca/content/dam/hc-sc/migration/hc-sc/hcs-sss/alt_formats/hpb-dgps/pdf/prim/2006-synth-collabor-eng.pdf.
- Canadian Medical Association (CMA), Ipsos. CMA 2025 National Physician Health Survey. Ottawa: The Association; 2026 Feb. Available: <https://digitallibrary.cma.ca/link/digitallibrary1418>
- Owens B. Work-life advantages of becoming a salaried physician may be oversold. *CMAJ*. 2019 Jan 28;191(4):E113-E114. doi: 10.1503/cmaj.109-5699. PMID: 30692113; PMCID: PMC6342687.
- McLaney E, Morassaei S, Hughes L, Davies R, Campbell M, Di Prospero L. A framework for interprofessional team collaboration in a hospital setting: Advancing team competencies and behaviours. *Healthc Manage Forum*. 2022 Mar;35(2):112-117. doi: 10.1177/08404704211063584. Epub 2022 Jan 20. PMID: 35057649; PMCID: PMC8873279.
- Tannenbaum D, Kerr J, Konkin J, Organek A, Parsons E, Saucier D, Shaw L, Walsh A. The Scope of Training for Family Medicine Residency: Report of the Working Group on Postgraduate Curriculum Review. Mississauga, ON: College of Family Physicians of Canada; 2011.
- Crichton T, Schultz K, Lawrence K, Donoff M, Laughlin T, Brailovsky C, Bethune C, van der Goes T, Dhillon K, Pélissier-Simard L, Ross S, Hawrylyshyn S, Potter M. Assessment Objectives for Certification in Family Medicine. Mississauga, ON: College of Family Physicians of Canada; 2020
- Gutkin C. Triple C: New competency-based family medicine curriculum. *Can Fam Physician*. 2011 Jul;(57)7:856. PMCID: PMC3135459.
- Khatri R, Endalamaw A, Erku D, Wolka E, Nigatu F, Zewdie A, Assefa Y. Continuity and care coordination of primary health care: a scoping review. *BMC Health Serv Res*. 2023 Jul 13;23(1):750. doi: 10.1186/s12913-023-09718-8. PMID: 37443006; PMCID: PMC10339603.
- Lau RS, Boesen ME, Richer L, Hill MD. Siloed mentality, health system sub-optimization and the healthcare symphony: a Canadian perspective. *Health Res Policy Syst*. 2024 Jul 17;22(1):87. doi: 10.1186/s12961-024-01168-w. PMID: 39020412; PMCID: PMC11253392.
- Andoko, Dewanto & Nababan, Janet & Setyawan, Surya. (2026). THE SILO EFFECT IN MEDICINE AND ITS IMPLICATIONS FOR HOSPITAL COSTS: A SYSTEMATIC LITERATURE REVIEW. *The International Conference on Sustainable Economics Management and Accounting Proceeding*. 2. 1098-1107. 10.32424/icsema.v2i1.630.
- College of Family Physicians of Canada. Best Advice guide: Patient's Medical Neighbourhood. Mississauga, ON: College of Family Physicians of Canada; 2020.
- College of Family Physicians of Canada. Patient's Medical Neighbourhood Best Advice Guide: Quick Reference. Mississauga, ON: College of Family Physicians of Canada; 2019.
- Kolber MR, Korownyk CS, Young J, Garrison S, Kirkwood J, Allan GM. The value of family medicine: An impossible job, done impossibly well. *Can Fam Physician*. 2023 Apr;69(4):269-270. doi: 10.46747/cfp.6904269. PMID: 37072193; PMCID: PMC10112714.
- Ravaghi H, Guisset AL, Elfeky S, Nasir N, Khani S, Ahmadnezhad E, Abdi Z. A scoping review of community health needs and assets assessment: concepts, rationale, tools and uses. *BMC Health Serv Res*. 2023 Jan 17;23(1):44. doi: 10.1186/s12913-022-08983-3. PMID: 36650529; PMCID: PMC9847055.