

Beyond Medication Reviews: A Proposed Quality-based Pharmacist Remuneration Framework

Alberta and British Columbia

A Quality-Based, Collaborative Care Model

Built upon the existing Alberta Blue Cross Pharmacy Compensation Plan

DRAFT FOR DISCUSSION

March 15, 2026

Executive Summary

Canada's primary care system is under unprecedented strain: 1 in 5 Canadians lacks a regular primary care clinician, and 50% either do not have a primary care physician or cannot see one in timely fashion (Angus Reid, <https://angusreid.org/health-care-access-family-doctor-canada-2026/>). Chronic diseases account for 58% of annual health expenditure. Community pharmacists are ideally positioned to address this gap, with rigorous evidence demonstrating that pharmacist-led interventions can reduce cardiovascular risk by 21% (Rx EACH, JACC 2016), reduce systolic blood pressure by 6.6 mmHg beyond usual care (Rx ACTION, Circulation 2015), and improve outcomes in diabetes (Nicoletta et al. 2024), CKD (Sarafidis et al. 2008), COPD (Lin et al 2023), and osteoporosis (McCloskey et al 2021).

The existing Alberta Blue Cross (ABC) Pharmacy Compensation Plan reimburses pharmacists primarily for process-based activities (prescription renewals, adaptations, medication reviews). While foundational, it does not incentivize the achievement of clinical outcomes or systematically link payment to the quality of care delivered. The CARES Pathways framework (CPJ 2026) provides the clinical architecture to enable a more sophisticated model.

This document proposes a three-tier remuneration framework that:

- Preserves and enhances the existing ABC base fee structure (Tier 1)
- Adds CARES Pathway-specific service codes for structured, algorithm-guided chronic disease management (Tier 2)
- Introduces Pharmacy-Sensitive Quality Indicator (QI) Achievement Bonuses tied to objective clinical outcomes (Tier 3)

The framework incorporates robust “anti-gaming” provisions to ensure that corporate pharmacy chains cannot capture QI bonuses through volume manipulation, quota-setting, or patient cherry-picking. It also establishes a complementary physician-pharmacist care model to prevent conflict over who is responsible for - and remunerated for - achieving quality targets.

Based upon the Rx EACH study results, we estimate that the new remuneration framework could save \$1.1 billion over a 30 year time horizon if applied to only 15% of the eligible population in BC and AB, mainly due to a reduction of 2.2 million cardiovascular events. *As a next step, we propose to apply this model to the results of PR_xOACT, to determine the cost-effectiveness of such a program.*

Key Principles

- Remunerate outcomes, not just processes
- Tie bonuses to objective, externally verified measurements
- Pay the individual pharmacist, not the corporate owner
- Require documented physician communication as a condition of QI payment
- Protect against gaming through population-level audit and baseline documentation requirements

1. Background and Rationale

1.1 The Evidence Base for Pharmacist-Led Care

The case for expanding pharmacist remuneration to include outcomes-based payment rests on a well-established evidence base from Canadian randomized controlled trials:

Trial	Design	Key Outcome	Relevance to QI Framework
RxACTION(Circulation 2015)	248 pts, 23 community pharmacies, Alberta; 6-month pharmacist prescribing for hypertension	6.6 mmHg greater SBP reduction vs usual care (p=0.0006); 2.3x more likely to reach BP target	Validates BP control as a pharmacist-attributable QI; also tested fee-for-service vs pay-for-performance sub-study
RxEACH(JACC 2016), Rx EACH Economic Analysis(CPJ 2019), Rx EACH qualitative (CPJ 2018)	723 pts, 56 community pharmacies, Alberta; pharmacist case-finding and CV risk intervention	21% relative reduction in estimated CVD risk at 3 months; SBP - 9.4 mmHg, LDL - 0.2 mmol/L, HbA1c -0.92%	Validates case-finding (CARES 'C' step) and multi-risk-factor management as pharmacist-attributable QIs
PRxOACT(in progress)	1,000 pts, Alberta; CARES Pathway for cardiovascular risk management using electronic algorithm	Results expected Summer 2026; cost-effectiveness modelling estimates >\$4B savings if widely adopted	Live validation of the CARES Pathway model with embedded quality indicator measurement

1.2 Limitations of the Current ABC Framework

The current Alberta Blue Cross Pharmacy Compensation Plan (Ministerial Order 627/2019) represents an important foundation but has several limitations when considered against the CARES Pathways vision:

1. Outcome-agnostic: CACP (\$100 initial / \$20 follow-up) and SMMA (\$60 initial / \$20 follow-up) fees are paid regardless of whether patients achieve guideline targets. There is no financial incentive to optimize therapy or follow up until targets are reached and the process can be “gamed”.
2. Process fragmentation: Billing codes are designed around individual encounters rather than longitudinal care pathways, creating perverse incentives to bill for more visits rather than achieving and maintaining outcomes.
3. No case-finding payment: The CARES 'C' step - proactive identification of undiagnosed or inadequately managed patients - is not separately remunerated, despite being shown to be highly effective in Rx EACH.

4. Corporate gaming risk: Current flat fees paid to pharmacies (not individual pharmacists) create conditions where corporate owners can extract fees without ensuring clinical quality, and can pressure pharmacists to enrol patients who do not require intensive management.
5. Physician-pharmacist ambiguity: The framework does not specify how remuneration interacts with physician billing for the same conditions, creating potential for either under-servicing (each assumes the other is managing) or conflict.

1.3 The CARES Pathways Architecture

The CARES Pathways (Tsuyuki, Boivin & Liu, CPJ 2026) provide the clinical scaffold upon which this remuneration framework is built. The five CARES steps map directly to distinct, billable activities:

CARES Step	Clinical Activity	Current ABC Code	Proposed New Code
C - Case-Finding	Proactive identification of patients at risk of or with the condition of interest (using pharmacy records, screening tools, electronic algorithm)	Not billable	CARES Case-Finding Fee
A - Assessment	Thorough evidence-based assessment including BP measurement, labs, CVD risk calculation, shared decision-making discussion	CACP/SMMA Initial	CARES Pathway Enrollment
R - Red Flags / Referral	Identification and documentation of red flag symptoms or conditions requiring specialist or emergency referral	Not billable	CARES Referral Documentation
E - Evidence-Based Treatment	Guideline-concordant pharmacotherapy initiation or optimization; prescription adaptation or new prescribing (APA required)	APA Prescribing (\$25)	APA Prescribing + Algorithm Adherence Bonus
S - Structured Follow-Up	Regular review and optimization of care; quality indicator measurement; physician communication	CACP/SMMA Follow-up (\$20)	CARES Structured Follow-Up

A crucial element of the CARES framework is the integration of quality indicators throughout the pathway, enabling real-time benchmarking of care against evidence-based guidelines. This built-in measurement architecture is what makes a meaningful quality-based remuneration model possible.

2. Framework Overview

The proposed framework operates in three tiers. Tier 1 preserves the existing ABC base fees with modest enhancements. Tier 2 introduces CARES Pathway-specific service codes replacing and evolving the CACP/SMMA structure. Tier 3 adds Quality Indicator Achievement Bonuses paid when patients reach guideline-concordant targets.

Tier	Type	Mechanism	Who is Paid	Anti-Gaming Protection
Tier 1	Base Process Fees	Fee-for-service for discrete pharmacist activities (prescribing, adaptations, injections, emergency care)	Individual pharmacist registration number	Existing claim validation; APA credential requirement
Tier 2	CARES Pathway Fees	Enrollment, structured follow-up, case-finding, and referral documentation within a recognized CARES Pathway	Individual pharmacist registration number	Electronic algorithm use required; patient must have ≥ 1 uncontrolled QI at enrollment; physician notification within 7 days
Tier 3	QI Achievement Bonuses	One-time and maintenance bonuses paid when a patient achieves a guideline-concordant quality indicator target, verified by objective measurement	Individual pharmacist registration number	Baseline documentation required; objective external measurement only; minimum 3-month enrollment before bonus claimable; population-level audit trigger

3. Tier 1: Base Service Fees

Tier 1 preserves the existing ABC Pharmacy Compensation Plan structure. The fees below reflect the current schedule with proposed adjustments noted. These apply in both Alberta and BC (with BC-specific notes where applicable).

Service	Current AB Fee	Proposed Fee	Notes
Prescription Renewal	\$20.00	\$20.00	No change
Prescription Adaptation / Insulin Order Alteration	\$20.00	\$20.00	No change
Prescribing - Initial Access or Ongoing Management (APA required)	\$25.00	\$25.00	No change; APA credential remains mandatory
Emergency Prescribing	\$20.00	\$20.00	No change
Continuity of Care in Emergency	\$20.00	\$20.00	No change
Refusal to Fill	\$20.00	\$20.00	No change
Trial Prescription (Follow-up Assessment)	\$20.00	\$20.00	No change
Injection Administration	\$20.00	\$20.00	Max 2/day; no change
Publicly Funded Vaccine Administration	\$13.00	\$13.00	No change

BC Adaptation Note

British Columbia pharmacists operate under the BC College of Pharmacists Bylaws and PharmaCare benefit schedules. Tier 1 fees should be aligned with equivalent PharmaCare Pharmacist Professional Services codes. The CARES Algorithm-Guided Prescribing Bonus is a new code requiring negotiation with BC PharmaCare. BC pharmacists do not currently have the same scope of prescribing authority as Alberta pharmacists with APA designation; the framework should be implemented in BC as scope of practice legislation evolves.

4. Tier 2: CARES Pathway Service Codes

Tier 2 replaces and significantly evolves the existing CACP and SMMA billing codes. These new codes are tied to the CARES Pathway architecture and require use of the electronic algorithm, baseline documentation, physician communication and billing system (Billing will come directly from the electronic algorithm and the payor will have the ability to audit any and every bill they get). CACP and SMMA remain available for patients not enrolled in a CARES Pathway.

4.1 CARES Case-Finding Fee (New Code)

Parameter	Detail
Code	CARES-CF
Fee	\$15.00 per newly identified eligible patient
Description	Proactive case-finding activity to identify patients who are at risk of or have an ambulatory care-sensitive condition and are not receiving optimal management. This includes review of pharmacy dispensing records, use of case-finding triggers (e.g., metformin for diagnosed diabetes, antihypertensives, obesity, or diabetes medications for uncontrolled BP), and brief screening.
Eligibility Requirements	Patient must not already be enrolled in a CARES Pathway for the identified condition; pharmacist must document the case-finding trigger used; patient must subsequently be offered CARES enrollment
Claim Limit	Once per patient per condition per 12 months
Anti-Gaming Note	Claimed only when patient proceeds to CARES enrollment; not payable if patient declines or is found to be at target

4.2 CARES Pathway Enrollment Fee (Evolving CACP/SMMA)

Parameter	Detail
Code	CARES-EN
Fee	\$120.00 per enrollment (replaces CACP \$100 initial / SMMA \$60 initial)
Description	Comprehensive enrollment assessment using the CARES electronic algorithm. Includes: thorough patient assessment (history, physical measurements, laboratory review); cardiovascular risk calculation where applicable; evidence-based shared decision-making discussion; development of a CARES Care Plan; identification of at least one uncontrolled quality indicator; and physician notification.
Eligibility Requirements	(1) Patient must have at least one ambulatory care-sensitive condition (cardiovascular disease, hypertension, type 2 diabetes, CKD, COPD, asthma, or osteoporosis/musculoskeletal disease); (2)

Parameter	Detail
	at least one relevant quality indicator must be documented as not at guideline target at baseline; (3) physician notification submitted within 7 business days of enrollment; (4) electronic CARES algorithm documented as used
Claim Limit	Once per patient per condition per 12 months; more than one condition could be addressed per visit
AB vs BC	Alberta: payable under Ministerial Order 627/2019 amendment. BC: payable under PharmaCare Professional Services (pending new code negotiation)

4.3 CARES Structured Follow-Up Fee (Evolving CACP/SMMA Follow-Up)

Parameter	Detail
Code	CARES-FU
Fee	\$35.00 per visit (replaces CACP/SMMA follow-up of \$20)
Description	Structured follow-up assessment within an active CARES Pathway. Must include: measurement of at least one QI (e.g., blood pressure, blood glucose, weight); review of medications and adherence; adjustment of therapy if indicated; documentation in CARES algorithm; physician communication if therapy changed.
Eligibility Requirements	Patient must be actively enrolled in a CARES Pathway (CARES-EN claimed within past 12 months for that condition); QI measurement must be documented at each visit; minimum 14-day interval between claims
Claim Limit	Maximum 12 per patient per condition per 12 months
Anti-Gaming Note	Follow-up cannot be claimed if patient is already at all applicable QI targets for more than 2 consecutive visits, unless there is documented clinical justification (e.g., medication change, new comorbidity)

4.4 CARES Red Flag Referral Documentation Fee (New Code)

Parameter	Detail
Code	CARES-RF
Fee	\$20.00 per documented referral
Description	Documentation and facilitation of referral for patients identified through the CARES 'R' step as having red flag symptoms or conditions requiring specialist or emergency assessment (e.g., hypertensive urgency, suspected new diagnosis requiring physician confirmation, renal function decline).

Parameter	Detail
Eligibility Requirements	Referral must be documented in CARES algorithm; referring pharmacist must send written communication to physician or emergency service within 24 hours; copy of referral documentation retained in patient file
Claim Limit	Maximum 4 per patient per condition per 12 months

4.5 Comparison: Current CACP/SMMA vs. Proposed CARES Pathway Fees

	Current CACP	Current SMMA	Proposed CARES
Eligible Conditions	2+ chronic diseases	1 chronic disease + 3+ medications	Any ambulatory care-sensitive condition
Initial Assessment Fee	\$100.00	\$60.00	\$120.00 (CARES-EN)
Follow-Up Fee	\$20.00	\$20.00	\$35.00 (CARES-FU)
Case-Finding Fee	N/A	N/A	\$15.00 (CARES-CF)
Referral Documentation	N/A	N/A	\$20.00 (CARES-RF)
Algorithm Requirement	No	No	Yes (electronic CARES algorithm)
QI Measurement Required	Recommended	Recommended	Mandatory at every visit
Physician Notification	Recommended	Recommended	Mandatory within 7 days of enrollment and on therapy changes
Anti-Gaming Provisions	Minimal	Minimal	Baseline uncontrolled QI required; population audit; pharmacist-level payment

5. Tier 3: Quality Indicator Achievement Bonuses

Tier 3 is the most novel element of this framework. QI Achievement Bonuses reward pharmacists when patients enrolled in a CARES Pathway reach guideline-concordant clinical targets. The bonus structure is informed by the RxACTION pay-for-performance sub-study, which tested outcome bonuses of \$125 (50% of BP target) and \$250 (full target) and demonstrated sustained engagement with the model.

These bonuses are paid to the individual pharmacist's registration number - not to the pharmacy or corporate owner - and are subject to strict verification and anti-gaming requirements described in Section 6.

5.1 QI Achievement Bonus Schedule

Quality Indicator	Guideline Target	Code	Achievement Bonus	12-Month Maintenance Bonus
Blood Pressure Control	< 130/80 mmHg (or individualized per Hypertension Canada guidelines)	QI-BP	\$100	\$35
LDL-Cholesterol Control	<= 2.0 mmol/L (or < 50% reduction from baseline for high-risk patients)	QI-LDL	\$100	\$35
Glycemic Control (HbA1c)	<= 7.0% (or individualized target agreed with patient and physician/pharmacist)	QI-A1C	\$100	\$35
Tobacco Cessation	Self-reported cessation confirmed at 6 months	QI-SMO K	\$150	\$50
SGLT2 Inhibitor Initiation (Diabetes/CKD)	Patient with T2D or CKD and eGFR >= 20 prescribed a guideline-recommended SGLT2 inhibitor	QI-SGLT 2	\$75	N/A
Statin initiation for statin indicated conditions	- LDL ≥5.0 mmol/L (or ApoB ≥1.45 g/L or non-HDL-C ≥5.8 mmol/L) (familial hypercholesterolemia)	QI-STATI N	\$75	N/A

Quality Indicator	Guideline Target	Code	Achievement Bonus	12-Month Maintenance Bonus
	or genetic dyslipidemia). - Most patients with diabetes: (Age $\geq 40y$, Age $\geq 30y$ & DM $\geq 15y$ duration, Microvascular disease) - Chronic Kidney Disease (Age $\geq 50y$ and eGFR < 60 mL/min/1.73 m² or ACR > 3 mg/mmol) - Atherosclerotic Cardiovascular Disease (ASCVD): (Myocardial infarction (MI), acute coronary syndromes (ACS), Stable angina, Stroke/TIA, Peripheral arterial disease, Abdominal aortic aneurysm (AAA))			
Osteoporosis Pharmacotherapy	Patient with T-score ≤ -2.5 or fragility fracture initiated on bisphosphonate or denosumab	QI-OSTE O	\$75	N/A
Inhaler Technique (COPD/Asthma)	Patient demonstrates correct inhaler technique assessed by validated tool	QI-INH	\$50	\$25
Composite Achievement Bonus	Patient achieves ALL applicable QI targets for their enrolled condition(s) within 12 months	QI-COMP	+\$100	+\$35

5.2 Bonus Calculation Example: Cardiovascular Patient

Example: Mr. J.S., 64 years, type 2 diabetes, hypertension, dyslipidemia

Enrolled in CARES Cardiovascular Pathway. Baseline: BP 152/94, LDL 3.1 mmol/L, HbA1c 8.4%. Not on SGLT2 inhibitor.

Fees earned over 12 months:

- CARES Case-Finding: \$15
- CARES Enrollment (CARES-EN): \$120
- CARES Follow-Up x 5 visits (CARES-FU): \$175
- QI-BP Achievement (BP reaches 126/78): \$100
- QI-LDL Achievement (LDL reaches 1.8 mmol/L): \$100
- QI-A1C Achievement (HbA1c reaches 6.9%): \$100
- QI-SGLT2 Initiation: \$75
- QI-COMP Composite Bonus (all 3 QIs achieved): \$100

Total Year 1 Pharmacist Remuneration: \$785

Year 2 and thereafter maintenance (if all QIs maintained): \$120 (annual assessment) + \$70 (follow-up) + \$140 (QI maintenance) = \$330/y

The Proposed Remuneration Framework in Perspective

Comparison to existing ABC remuneration: CACP (\$100) + 4 follow-ups (\$100) + 3 prescribing fees (\$75) = \$275 year 1; CACP (\$100) + 2 follow-ups (\$50) + 3 prescribing fees (\$75) = \$225/y thereafter

Relation to previous R_xEACH economic analysis:

When the individual-level results of the economic analysis were applied to the Canadian population with the assumption of a 15% uptake rate, the intervention was associated with more than **\$4.4 billion in savings** and more than 8.9 million fewer CV events over 30 years. If the uptake increased to 30% or 45% the savings increased to more than \$8.8 billion and \$13.2 billion, respectively and the number of avoided CV events increased to 17.8 million and 26.7 million, respectively (Al Hamarneh, et al. Can Pharm J 2019;152:257-266).

Using a “back of the envelope” calculation, if we apply these findings to the population of Alberta and BC and account for the remuneration costs of the suggested model (\$785 for the first year, \$330 for maintenance from year 2 to year 30) remuneration for pharmacists’ comprehensive cardiovascular care would still be associated with more than **\$1.1 billion in savings** and more than 2.2 million CV events avoided if applied to 15% of the eligible population over a 30 year time horizon. If the uptake increased to 30% or 45% the savings will increase to more than \$2.2 billion and \$3.3 billion respectively and the number of avoided CV events will increase to 4.5 million and 6.7 million respectively.

6. Anti-Gaming Provisions

A fundamental design concern is the susceptibility of quality-based payment models to gaming by corporate pharmacy chains, which may seek to maximize bonus revenue through patient selection, quota-setting, or documentation manipulation rather than genuine clinical improvement. The following provisions are designed to make gaming difficult, detectable, and financially unattractive.

6.1 Pharmacist-Level (Not Pharmacy-Level) Payment

All Tier 2 and Tier 3 fees are paid to the individual pharmacist's registration number, not to the pharmacy's corporate billing number. This means:

- Corporate pharmacy chains cannot direct bonus revenue to head office or to shareholders
- Individual pharmacists retain a direct financial stake in patient outcomes
- Corporate employers cannot mandate clinical targets as employee performance metrics (attempting to do so would constitute professional misconduct under college bylaws)
- Pharmacists who leave a corporate pharmacy retain their QI achievement history

Implementation Note

This requires both the Alberta College of Pharmacy and the College of Pharmacists of BC to maintain a billing registry linked to individual registration numbers rather than pharmacy licence numbers. Alberta Health and BC PharmaCare would need to modify their billing infrastructure accordingly. We recommend a phased pilot (see Section 9) to test this administrative model.

6.2 Mandatory Baseline Uncontrolled QI Documentation

A QI Achievement Bonus (Tier 3) can only be claimed if:

6. The patient's QI was documented as NOT at target at the time of CARES enrollment (CARES-EN)
7. The baseline measurement was obtained using an objective method (see 6.3)
8. The baseline was recorded in the CARES electronic algorithm and submitted to the payer at the time of enrollment

This prevents pharmacists from enrolling patients who are already at target and then claiming QI Achievement Bonuses for no meaningful clinical contribution.

6.3 Objective Measurement Requirements

QI measurements used to claim Achievement Bonuses must be obtained by objective, validated methods:

Quality Indicator	Acceptable Measurement Method	Not Acceptable
Blood Pressure	Validated automated device (e.g., BpTRU, Microlife); minimum 3 readings per visit; home BP monitoring with validated device if ≥ 5 days of readings	Single manual auscultatory reading; patient self-report without device
LDL-Cholesterol	Laboratory report from accredited external laboratory (within past 6 months)	In-pharmacy point-of-care testing without external confirmation
HbA1c	Laboratory report from accredited external laboratory (within past 6 months)	Patient self-report; in-pharmacy point-of-care without external confirmation
Tobacco use Status	Self-report confirmed at two consecutive visits ≥ 1 month apart; carbon monoxide testing encouraged but not mandatory	Single self-report; pharmacist assessment alone
SGLT2 Initiation	Dispensing record confirming prescription filled	Prescription written but not filled
Inhaler Technique	Validated inhaler technique assessment checklist (minimum 7-step assessment documented)	Pharmacist observation without standardized tool

6.4 Minimum Enrollment Period Before Bonus Claim

No QI Achievement Bonus may be claimed within the first 90 days of CARES Pathway enrollment. This ensures:

- The bonus reflects genuine clinical improvement, not pre-existing good control identified at enrollment
- Pharmacists have adequate time to implement and titrate evidence-based treatment
- The bonus is not claimable for patients enrolled just before a known lab test date

6.5 Population-Level Audit Trigger

The payer (Alberta Health, BC PharmaCare, or the insurer) will conduct quarterly analysis of QI Achievement rates at the pharmacist level. An automatic audit is triggered when:

- A pharmacist's QI achievement rate exceeds 80% across their enrolled patient panel (indicative of cherry-picking easy-to-control patients)
- A pharmacist's enrollment rate exceeds 150% of the provincial average per pharmacist FTE (indicative of excessive enrollment without adequate follow-up)
- More than 40% of a pharmacist's enrolled patients are lost to follow-up within 6 months (indicative of enrollment without genuine engagement)
- A pharmacy location's aggregate QI claims exceed 3 standard deviations above the provincial mean for that pharmacy size (indicative of corporate-level manipulation)

Audits review a random 20% sample of patient files for documentation completeness. Pharmacists found to have submitted inaccurate claims are subject to repayment and college referral.

6.6 Prohibition on Patient Exclusion After Enrollment

Once a patient is enrolled in a CARES Pathway, the pharmacist must document the outcome (whether QI target was achieved or not). A pharmacist who enrolls a patient and then has no follow-up documentation will be flagged for audit. This prevents the strategy of enrolling patients, realizing they are unlikely to achieve targets, and then abandoning them to avoid recording a failure.

6.7 Maximum Panel Size for QI Bonus Eligibility

To prevent volume gaming - enrolling large numbers of patients superficially - QI Achievement Bonuses are only claimable for a pharmacist's first 75 enrolled patients per condition per 12-month period. Panel sizes above this threshold require demonstration to the payer that the pharmacist has adequate time and resources to deliver meaningful care. This threshold may be adjusted upward for pharmacists working in dedicated chronic disease management clinics with appropriate support staff.

7. Physician-Pharmacist Care Coordination

One of the most important design elements of a pharmacist QI framework is ensuring it does not create conflict with physicians over who is responsible for - and financially rewarded for - achieving clinical quality targets. This section establishes the principles and mechanisms for complementary, non-conflicting care.

7.1 The Complementary Care Model

Pharmacists and physicians address different - and complementary - dimensions of chronic disease management. The framework reinforces this division of responsibility rather than creating competition:

Domain	Primary Responsibility	Pharmacist Role	Physician Role	QI Payment
Medication optimization (dosing, titration, adherence)	Pharmacist (APA)	Initiate, adjust, and optimize pharmacotherapy within CARES algorithm	Informed via mandatory communication; retains authority to override	Pharmacist
Disease diagnosis	Physician	Case-finding and red flag identification; refers to physician for diagnosis confirmation	Confirms diagnosis; provides diagnostic codes for CARES enrollment	Physician (existing fee schedule)
Guideline-concordant medication targets (BP, LDL, HbA1c)	Shared	Initiates and adjusts medications; monitors QI at each visit	Manages overall disease; may also adjust medications	See 7.2 for attribution rule
Specialist referrals	Physician	Identifies red flags; recommends referral; documents	Executes referral; specialist communication	Pharmacist (CARES-RF); Physician (existing referral fee)
Lifestyle counselling	Shared	Evidence-based lifestyle guidance within CARES pathway	Reinforced during physician visits	Both, within respective billing codes

Domain	Primary Responsibility	Pharmacist Role	Physician Role	QI Payment
Emergency and acute care	Physician / Emergency Medicine	Continuity of care in emergency (existing code); identifies urgency	Primary management	Pharmacist (emergency code only); Physician (emergency billing)

7.2 QI Attribution Rule: Preventing Double-Payment

When a patient achieves a QI target, only one provider may claim the QI Achievement Bonus for that target in that period. The following attribution rules apply:

9. If the patient is enrolled in a CARES Pathway with a pharmacist AND has an active family physician: the pharmacist may claim the QI Achievement Bonus for medication-related targets (BP, LDL, HbA1c, SGLT2 initiation, tobacco cessation). The physician may not claim an equivalent QI bonus for the same target in the same period.
10. If the patient has no active family physician or is accessing care through the pharmacy as their primary point of care: the pharmacist may claim all applicable QI Achievement Bonuses.
11. A patient is considered to have an "active family physician" if a physician has billed a primary care service for that patient in the preceding 12 months.
12. Physicians who wish to dispute attribution must submit a care coordination record demonstrating their specific contribution to the QI achievement within 60 days of the pharmacist's claim.

Design Intent

This rule is intentionally designed so that pharmacist QI bonuses do not come "at the expense" of physician income. Physicians continue to bill their existing fee codes for patient visits, assessments, and management. The pharmacist QI bonus is a new payment that recognizes an additional layer of care - the systematic monitoring, adjustment, and documentation of QI achievement - that physicians are generally not billing for separately. The two payment streams are complementary, not competitive.

7.3 Mandatory Physician Communication Standards

The following communication requirements are a condition of eligibility for all Tier 2 and Tier 3 payments. Failure to document physician communication results in clawback of the associated fee.

Trigger Event	Required Communication	Timeframe	Method
CARES Pathway Enrollment	Notification letter to patient's physician including: condition enrolled, baseline QI values, proposed care plan summary	Within 7 business days	Fax, secure email, or eReferral platform; copy retained in CARES record
New or Changed Prescription (APA)	Notification of prescription change including drug,	Within 48 hours	Fax, secure email, or eReferral platform

Trigger Event	Required Communication	Timeframe	Method
	dose, indication, and monitoring plan		
Red Flag / Referral Identified	Urgent referral communication including clinical findings and recommended action	Within 24 hours (same day if acute)	Telephone with written follow-up; fax; or direct eReferral
QI Target Achieved	Summary communication to physician noting which QI was achieved, current values, and continuing management plan	Within 7 business days of claiming QI bonus	Fax or secure email; copy retained
Patient Lost to Follow-Up (> 3 months)	Notification to physician that patient has not engaged with CARES follow-up; recommend physician follow-up	Within 30 days of missed appointment	Fax or secure email

7.4 Collaborative Care Bonus

To actively incentivize pharmacist-physician collaboration (rather than merely preventing conflict), the framework includes an optional Collaborative Care Bonus:

Collaborative Care Bonus: \$50 per patient per year

Payable to the pharmacist when:

- Physician formally acknowledges receipt of CARES enrollment notification (signed return fax or electronic confirmation)
- At least one documented two-way communication between pharmacist and physician regarding the patient's CARES care plan during the year
- Physician provides or confirms diagnostic codes and/or relevant clinical history to support CARES pathway enrollment

This bonus is designed to reward the pharmacist for investing time in building a collaborative relationship, and to give physicians a financial reason to engage with CARES communications promptly.

8. Quality Indicators by Condition

The following quality indicators are drawn from national and international evidence-based guidelines for ambulatory care-sensitive conditions. These are the same conditions targeted by the CARES Pathways framework. Pharmacists may enrol patients in one or more condition-specific CARES Pathways.

8.1 Cardiovascular Disease and Hypertension

Quality Indicator	Guideline Target	Evidence Source	Measurement
Blood pressure - primary target	< 130/80 mmHg (or individualized for frail elderly)	Hypertension Canada 2025; CCS 2020	Validated automated device (see www.hypertension.ca/devices); 3-reading average
LDL-Cholesterol	<= 2.0 mmol/L (high risk); > 50% reduction from baseline (very high risk with ASCVD)	CCS Dyslipidemia 2021	Accredited external laboratory within 6 months
Antiplatelet therapy	Prescribed aspirin or P2Y12 inhibitor for eligible high-risk patients (documented reason if not prescribed)	CCS ACS Guidelines 2018	Dispensing record
Statin therapy	High-intensity statin for ASCVD patients; moderate-intensity for primary prevention if 10-yr risk > 20%	CCS Dyslipidemia 2021	Dispensing record
Smoking cessation	Self-reported cessation at 2 consecutive visits >= 1 month apart	CCAR / Ottawa Model	Self-report x2 + NRT/pharmacotherapy dispensing record if applicable
Composite CVD QI	All applicable CVD QIs achieved	RxEACH; CARES Pathways	All above verified

8.2 Type 2 Diabetes

Quality Indicator	Guideline Target	Evidence Source	Measurement
HbA1c	$\leq 7.0\%$ (or individualized; $< 8.5\%$ for frail elderly)	Diabetes Canada 2022	External laboratory within 6 months
Blood pressure	$< 130/80$ mmHg	Hypertension Canada 2025	Validated automated device
LDL-Cholesterol	≤ 2.0 mmol/L	Diabetes Canada 2022	External laboratory
SGLT2 inhibitor (with CV/renal risk)	On guideline-recommended SGLT2 inhibitor if eGFR ≥ 20 and appropriate indication	Diabetes Canada 2022; CREDENCE; DAPA-HF	Dispensing record
GLP-1 agonist (if BMI ≥ 30 and A1c not at target)	On GLP-1 agonist or documented reason for non-use	Diabetes Canada 2022	Dispensing record
Foot examination	Annual foot examination documented	Diabetes Canada 2022	CARES algorithm documentation

8.3 Chronic Kidney Disease

Quality Indicator	Guideline Target	Evidence Source	Measurement
Blood pressure	$< 130/80$ mmHg	KDIGO 2021; Hypertension Canada 2025	Validated automated device
SGLT2 inhibitor (if eGFR ≥ 20)	On SGLT2 inhibitor or documented contraindication	CREDENCE; DAPA-CKD; KDIGO 2022	Dispensing record
ACE inhibitor / ARB (if proteinuria)	On ACEi or ARB or documented reason for non-use	KDIGO 2021	Dispensing record
Nephrotoxin avoidance	NSAID and other nephrotoxin review documented; unnecessary nephrotoxins discontinued	KDIGO 2021	CARES algorithm documentation + dispensing review
eGFR monitoring	eGFR and ACR measured within past 6 months	KDIGO 2021	External laboratory report

8.4 Respiratory Disease (COPD and Asthma)

Quality Indicator	Guideline Target	Evidence Source	Measurement
COPD: Inhaler technique	Correct technique demonstrated on validated checklist (≥ 7 of 10 steps correct)	GOLD 2024; Canadian Thoracic Society	Standardized checklist in CARES algorithm
COPD: GOLD-concordant pharmacotherapy	On appropriate maintenance inhaler(s) per GOLD ABCD classification	GOLD 2024	Dispensing record + CARES algorithm
COPD: Smoking cessation (if current smoker)	Cessation confirmed at 2 visits ≥ 1 month apart	GOLD 2024	Self-report x2
Asthma: ACT score ≥ 20 (well-controlled)	Asthma Control Test score ≥ 20 at 2 consecutive visits	GINA 2023	Validated ACT instrument in CARES algorithm
Asthma: ICS adherence	ICS prescription refilled on time (PDC $\geq 80\%$)	GINA 2023	Dispensing record - proportion of days covered

8.5 Musculoskeletal Disease (Osteoporosis)

Quality Indicator	Guideline Target	Evidence Source	Measurement
Osteoporosis screening (women ≥ 65 , men ≥ 70)	BMD test ordered or confirmed within past 36 months	Osteoporosis Canada 2023	Lab/imaging requisition in CARES record
Pharmacotherapy (if T-score ≤ -2.5 or fragility fracture)	Bisphosphonate or denosumab initiated and maintained	Osteoporosis Canada 2023	Dispensing record
Calcium and Vitamin D	On calcium supplement (if dietary intake insufficient) and Vitamin D 800-2000 IU/day	Osteoporosis Canada 2023	Dispensing record or documented dietary assessment
Fall risk assessment	Validated fall risk assessment documented annually	Osteoporosis Canada 2023	CARES algorithm documentation

9. Implementation Considerations

9.1 Alberta-Specific Implementation

Alberta is uniquely well-positioned to implement this framework, given:

- Existing APA prescribing framework (Health Professions Act 2007; now established in practice)
- Existing CACP/SMMA billing infrastructure under Ministerial Order 627/2019
- Existing laboratory ordering authority for pharmacists with APA
- EPICORE Centre / PRxOACT providing real-world validation infrastructure and electronic CARES algorithm
- AbSPORU providing health services research evaluation capacity

Proposed implementation pathway for Alberta:

13. Negotiate proposed Tier 2 and Tier 3 billing codes with Alberta Health as an amendment to Ministerial Order 627/2019
14. Engage Alberta Blue Cross and other supplementary insurers to mirror the same codes in private plans
15. Use PRxOACT infrastructure as the electronic algorithm platform for CARES enrollment documentation
16. Pilot in 20-30 pharmacies across urban, rural, and remote settings
17. 12-month pilot evaluation with EPICORE Centre; adjust fee levels based on actual claims data
18. Province-wide rollout with 24 months of audit monitoring before full implementation

9.2 British Columbia-Specific Implementation

BC implementation is more complex given different regulatory architecture, but the model is directly applicable:

- BC pharmacists have scope of practice to adapt prescriptions; independent prescribing authority is being expanded
- PharmaCare Pharmacist Professional Services program provides the billing infrastructure
- BC College of Pharmacists supports expanded practice roles
- Key gap: BC lacks an equivalent to Alberta's APA - the scope of practice legislation must evolve for full Tier 3 implementation

Recommended BC approach:

19. Negotiate with BC PharmaCare to create new CARES-specific billing codes within the existing Professional Services framework
20. Implement Tier 1 and Tier 2 codes immediately (all within current BC scope of practice)
21. Implement Tier 3 QI bonuses for non-prescribing QIs (inhaler technique, SGLT2 dispensing confirmation, osteoporosis pharmacotherapy) immediately
22. Phase in prescribing-dependent QI bonuses (BP, LDL) as BC scope of practice legislation expands
23. Use a BC-based CARES Pathway pilot in 10-15 pharmacies to generate provincial evidence

9.3 Recommended Fee Review Schedule

Fee levels should be reviewed every two years. The review should consider: actual pharmacist claim data; QI achievement rates across the enrolled population; inflation adjustment; and any changes to underlying clinical guidelines. An independent technical advisory committee including pharmacists, physicians, payers, and patient representatives should oversee the review.

10. Evaluation Framework

Consistent with the CARES Pathways design principle of comprehensive evaluation, the remuneration framework itself should be evaluated prospectively. The following metrics are recommended:

Evaluation Domain	Metric	Data Source	Target
Clinical Outcomes	Proportion of enrolled patients achieving each QI target at 6 and 12 months	CARES algorithm; payer claims data	$\geq 50\%$ of enrolled patients achieving primary QI at 12 months
Equity	QI achievement rates by postal code rurality index; by income quintile	CARES algorithm linked to administrative data	No significant gap in QI achievement by geography or socioeconomic status
Physician-Pharmacist Collaboration	Rate of documented physician communication per CARES enrollment	CARES algorithm communication log	$\geq 90\%$ of enrollments with documented physician notification within 7 days
Anti-Gaming Effectiveness	Rate of pharmacists triggering population-level audit; rate of audit findings	Payer audit data	$< 5\%$ of pharmacists triggering audit per year; $< 1\%$ with substantiated findings
Pharmacist Uptake	Number of pharmacists enrolling patients in CARES Pathways per year; geographic distribution	Payer claims data	Progressive increase over pilot period; rural pharmacists represented proportionally
Economic Impact	Cost-effectiveness of QI bonuses relative to avoided hospitalizations and ER visits	Linked administrative data (CIHI, provincial health data)	Positive net benefit within 3 years; comparable to Rx EACH modelled savings
Unintended Consequences	Rate of patient complaints; rate of pharmacist burnout	College of Pharmacy;	No significant increase in complaints; physician satisfaction maintained

Evaluation Domain	Metric	Data Source	Target
	indicators; physician satisfaction surveys	EPICORE evaluation surveys	

10.1 Role of EPICORE Centre in Evaluation

EPICORE Centre is the natural home for the independent evaluation of this framework. EPICORE's 25-year track record in clinical trial coordination, biostatistical analysis, data management, and health services research - including its role as the leading and coordinating centre for R_xACTION, R_xEACH, and PR_xOACT - positions it as the ideal evaluator. EPICORE's open-access model means evaluation can be conducted independently of any pharmacy corporate interest.

It is our intention to apply this model to the results of PR_xOACT, to determine the cost-effectiveness of such a program.

Appendix A: Complete Proposed Fee Schedule Summary

Tier 1: Base Service Fees

Code	Service	Fee (AB)	Fee (BC)
T1-REN	Prescription Renewal	\$20.00	\$20.00
T1-ADP	Prescription Adaptation / Insulin Alteration	\$20.00	\$20.00
T1-APA	Prescribing - Initial / Ongoing Management (APA required)	\$25.00	Pending scope
T1-EMG	Emergency Prescribing	\$20.00	\$20.00
T1-COC	Continuity of Care in Emergency	\$20.00	\$20.00
T1-RTF	Refusal to Fill	\$20.00	\$20.00
T1-TRX	Trial Prescription Follow-Up	\$20.00	\$20.00
T1-INJ	Injection Administration (max 2/day)	\$20.00	\$20.00
T1-VAX	Publicly Funded Vaccine Administration	\$13.00	\$13.00
T1-APB	CARES Algorithm-Guided Prescribing Bonus (NEW)	+\$15.00	Pending scope

Tier 2: CARES Pathway Service Codes

Code	Service	Fee (AB)	Fee (BC)
CARES-CF	Case-Finding Fee (NEW)	\$15.00	\$15.00
CARES-EN	CARES Pathway Enrollment (replaces CACP initial/SMMA initial)	\$120.00	\$120.00
CARES-FU	CARES Structured Follow-Up (replaces CACP/SMMA follow-up; max 12/year)	\$35.00	\$35.00
CARES-RF	Red Flag Referral Documentation (NEW; max 4/year)	\$20.00	\$20.00
CARES-COL	Collaborative Care Bonus (NEW; max 1/patient/year)	\$50.00	\$50.00

Tier 3: Quality Indicator Achievement Bonuses

Code	Quality Indicator	Achievement Bonus	12-Mo Maintenance
QI-BP	Blood Pressure Control (< 130/80 mmHg)	\$100.00	\$50.00
QI-LDL	LDL-Cholesterol Control (<= 2.0 mmol/L)	\$100.00	\$50.00
QI-A1C	Glycemic Control (HbA1c <= 7.0%)	\$100.00	\$50.00
QI-SMOK	Smoking Cessation (confirmed at 6 months)	\$150.00	\$75.00
QI-SGLT2	SGLT2 Inhibitor Initiation (where indicated)	\$75.00	N/A
QI-OSTEO	Osteoporosis Pharmacotherapy Initiation (where indicated)	\$75.00	N/A
QI-INH	Correct Inhaler Technique (validated checklist)	\$50.00	\$25.00
QI-COMP	Composite Achievement Bonus (ALL applicable QIs achieved)	+\$100.00	+\$50.00

Appendix B: Corporate Gaming Risk Matrix

The following matrix identifies known gaming strategies used in quality-based payment models and maps each to the specific anti-gaming provision in this framework.

Gaming Strategy	How It Works	Risk Level	Mitigation in This Framework
Cherry-picking	Enrol only patients already at or near target, claim QI bonus for minimal effort	HIGH	Mandatory baseline uncontrolled QI documentation; 90-day minimum enrollment before bonus; population audit trigger at >80% achievement rate
Patient dumping	Enrol patients, collect enrollment fee, then disengage from difficult patients	HIGH	Prohibition on enrollment without follow-up documentation; lost-to-follow-up audit trigger; follow-up fee requires QI measurement at each visit
Corporate quota-setting	Corporate owners set pharmacist targets (e.g., 'enrol 30 patients/month') to maximize fee revenue	HIGH	All fees paid to individual pharmacist registration number, not to pharmacy; college professional standards prohibit externally mandated clinical quotas
Documentation inflation	Document QI measurements as worse than actual at baseline, better than actual at follow-up	MEDIUM	External laboratory requirement for LDL/A1c; validated automated device for BP; random 20% audit of patient records
Volume flooding	Enrol very large numbers of patients superficially for enrollment fees	MEDIUM	Maximum panel size of 75 patients per QI per year for bonus eligibility; follow-up fee requires documented QI measurement (not just a visit)
Condition bundling	Enrol single patient in multiple conditions simultaneously to multiply fees	LOW	One CARES-EN per condition per patient per year; total enrollment fees per patient audited for reasonableness
Phantom visits	Bill for follow-up visits that did not occur	LOW	Existing anti-fraud provisions in ABC/PharmaCare; audit requirement for documentation; patient confirmation mechanism

- End of Document -

DRAFT | March 2026 | Prepared in consultation with EPICORE Centre, University of Alberta