Furthermore, when applying patient relationship codes to encounters, there could be confusion if the clinician has different relationships based on the patient's different diagnoses. For example, a patient presents to his/her family physician for treatment of an upper respiratory infection, which is an acute, time-limited illness. While the patient is present, the family physician also manages the patient's diabetes and hypertension, which represent chronic conditions that the family physician is managing on a continuing basis. Thus, the family physician in this situation has both a continuing care relationship and an acute care relationship with the patient, which will make the family physician's choice of a patient relationship category for this encounter potentially confusing. Thus, the AAFP notes that choosing a patient relationship category based on CMS's proposed categories would also increase the administrative burden borne by the clinician. Without more knowledge of how patient relationship codes will be used and applied, it is difficult to comment on which level of association would be most appropriate for the given use case.

2. As described above, we believe that there may be some overlap between several of the categories. To distinguish the categories, we are considering the inclusion of a patient relationship category that is specific to non-patient facing clinicians. Is this a useful and helpful distinction, or is this category sufficiently covered by the other existing categories?

The AAFP does not believe this would be useful. Rather, we recommend (v.) needs to be modified to the new definition provided in our answer to the first question.

3. Is the description of an acute episode accurately described? If not, are there alternatives we should consider?

No, the AAFP does not believe it is accurately described. We recommend rewording the Acute Episode Definition to be, "Acute episodes may encompass an exacerbation for a given disease, a new time-limited disease (e.g. acute bronchitis) or clinical issue, a time-limited treatment (e.g., surgery, either inpatient or outpatient) or any defined portion of care (e.g., post-acute care) so long as it is limited, usually by time, but also potentially by site of service or another parameter of healthcare. Continuing care occurs when an episode is not acute, and requires the ongoing care of a clinician."

For the purposes of differentiating acute from continuing care, skilled nursing care is considered acute if preceded by a related inpatient stay or if ordered by a clinician for a time-limited period related to an acute event or condition. Otherwise, skilled nursing care that is not related to an acute event or condition, as well as long-term care (traditionally referred to as long-term acute care), are considered continuing care for the purpose of differentiating an acute episode from continuing care.

4. Is distinguishing relationships by acute care and continuing care the appropriate way to classify relationships? Are these the only two categories of care or would it be appropriate to have a category between acute and continuing care?

Conceptually, classifying relationships by acute and continuing care makes sense. However, there are challenges in implementation as the borders between these two can be fuzzy and discontinuous. Other classification levels for consideration could include:

1. Whole person (not limited by problem origin, organ system, or diagnosis);
2. Disease; and
3. Procedure.