# HL7 PHR WG Parking Lot

**John Ritter**

Version Date:

20171221

20170426

20170419

20170324

20170104

20160330

20150114

20150107

20141126

20140903

**Purpose of this document:** Collect the various items that need to be addressed for inclusion in the next release of the PHR System Functional Model

Ranking of an Item’s Priority:

* “1” is the highest priority and should be tackled first (due to high criticality or because the item will be easy to accomplish)
* “25” is the lowest priority (and is subject to being dismissed)

Marking key (via highlighting):

* YELLOW=Not-yet-addressed
* RED=Troublesome
* GREEN=Done

Xxxxxxxxxxxxxxxx

# Explanation-of-Benefits

20170308

QUESTION: Should explanation-of-benefits information be listed in section S.2.2 -- or in another section?? A new section should be created that contains healthcare instance (medical and financial) transactions (that likely ought to include corresponding explanations-of-benefits). This keeps S.2.2 as purely insurance offerings; and reserves a different section insurance transactions.

Here are the CC that can comprise a newly-created function:

**NAME**: Manage Administrative, Financial, and Medical Transactions

**DESCRIPTION:** Administrative and Financial information can supplement clinical (and other) health-related information. Such information can benefit the PHR Account Holder and a clinician when attempting to research insurance coverage and patient health conditions.

CC x: The system SHOULD provide the ability to manage the information derived from financial and/or medical transactions according to user-preference, organizational policy, and/or jurisdictional law.

CC y: The system SHOULD provide the ability to manage corresponding explanations-of-benefits regarding the information derived from financial and medical transactions.

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# Reference-addition

Was the following reference successfully added to the Overview document? NO. Please add the following to the Overview Document:

The Regenstrief Institute and LOINC, c/o Medical Informatics, 1101 West Tenth Street, Indianapolis, IN 46202. https://loinc.org or http://www.regenstrief.org/ For ICD-10, see www.who.int or [www.cms.hhs.gov/ICD10](http://www.cms.hhs.gov/ICD10)

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# Reference-addition

Note: The Pilot Agreement between HL7 and ISO TC215 is currently being re-evaluated. Therefore, please add the following language to the ReadMe Guide; and ISO can easily remove it (if they desire).

We will add the following reference to the ReadMe document:

“…which was approved as a standard in 2014 by HL7 International, ANSI, and ISO TC215."

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# Nutrition-and-allergy language

20170426: Lorraine will poll experts from the following domains and perform some Glossary-related research.

(Talk to the Nutrition experts, Patient Care Work Group, EHR WG, and the Structured Documents Work Group about the following items.)

20170324

For Function PH.5.2: Include a note in the READ ME files (for balloting), stating that some of the new CC in PH.5.2 need to be redistributed to their proper Functions (after the ballot).

It would be good to have the Patient Care Work Group and the Structured Documents Work Group examine our current list of all Allergies, Intolerances, Sensitivities, and/or Adverse Reactions stuff (because they have some expertise in this arena).

PH.2.5.4 It might be good to use the following phrase universally throughout the PHR-S FM: “…allergy, intolerance, sensitivity, and/or adverse reaction…” wherever “allergies” alone are mentioned.

20150812

Place the following text in the Nutrition section (perhaps in section PH.2.5.11): “See also: PH.2.5.4 (allergy intolerance, sensitivity, adverse reaction, cross-reactivity.” Perhaps additional text ought to be added in sections that deal with pharmacy, prescription, decision support engine, Discharge Instructions, or the Problem/Condition/Genetic-status/Genetic-predisposition list.

20160707

CONSENSUS: We agree to revert the PH.2.5.4 function name to its originate state, and to create enhanced functionality for nutrition interactions, and move some of the PH.2.5.4 CC to that section, perhaps naming the new section “Manage Drug-Nutrient Interaction List”. Many substances causing allergies, intolerances, or adverse reactions are not orally (or otherwise) "consumed".

20150826

Add sensitivities to all CC?

TO DO: Add a definition of the terms "intolerances" and "sensitivities" and "side effect" describe the differences between them in the Glossary.

See the DESCRIPTION of EHR-S FM R2 CP.1.2

EHR-S FM R2 CP.1.2 Manage Allergy, Intolerance and Adverse Reaction List. The PHR-S FM needs an updated vision of the term "allergy"(see the EHR-S FM) where it is used to refer to allergies, intolerances, adverse reactions and sensitivities.

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# User Help

20170426 RESUME HERE NEXT TIME

See PH.1.1 CC01

We need to create a corresponding CPS section that is similar to the EHR-S FM's CPS.10 (Manage User Help).

The system SHALL conform to function??? (Manage User Help).

Perhaps it would be good to create an overarching “HELP” conformance criterion in the Overarching Section. (see the EHR-S FM’s Overarching section for an example.)

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# Work-and-Health validation

*VALIDATE THAT THE FOLLOWING WERE REVIEWED FOR POSSSIBLE “WORK” FUNCTIONALITY (Can Monica and Christina take a look at this??)*

These sections will likely require EHR-S FM -matching functions/CC for enhanced Work-functionality

PH.0

PH.1

PH.1.1

PH.1.2

PH.1.5

PH.2.1

PH.2.3

PH.2.4

PH.2.5

PH.2.5.1

PH.2.5.2

PH.2.5.4

PH.2.5.5

PH.2.5.6

PH.2.5.7

PH.2.5.8

PH.2.5.10

PH.2.5.11

PH.3

PH.3.1

PH.3.1.1

PH.3.2

PH.3.3

PH.3.4

PH.3.5

PH.3.5.1

PH.3.5.3

PH.3.5.4

PH.3.5.6

PH.3.6

PH.3.6.1

PH.3.6.2

PH.4

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# Dependent-clause validation and/or addition

The PHR WG ought to examine the possible applicability of the following phrase when creating DEPENDENT Conformance Criteria: "...PHR Account Holder's preferences and/or consents, user role, organizational policy, and/or jurisdictional law."

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# Disappearing language

20170324

PH.1.5 CC11 disappeared somehow. Was this intentional?

The item appears in “PHRS\_FM\_R2\_N1\_2012SEP\_C3\_FunctionList\_20130626.xls”, but then vanishes afterwards. Research the reason for the disappearance.

Xxxxxxxxxxxxxxxxxxxx

# Problem List

20141210

Examine the full suite of functionality offered by EHR-S FM CP.1.4 (regarding Problems) and consider importing it into the PHR-S FM (perhaps in PH.2.5.1).

Yes! The entire list of Problem-related functionality (likely) belongs in the PHR-S FM.

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# Care Plan language

*Was the following item successfully added to the PHR??*

PH.3.3 CC14

NEW CRITERION: The PHR-S MAY provide the ability to manage multiple care plans, treatment plans, or health activities (including those care plans, treatment plans, or health activities that are self-generated) according to user preferences and/or consents, organizational policy, and/or jurisdictional law.

2015-03-09 2016-02-24 This is probably new, yet difficult, functionality (akin to the EHR system's identification of a "super" clinical user -- who has governance of multiple care plans and sets of care providers). Thus, this functionality needs a good bit of thought. This note serves as a placeholder for future work. What about the concept of a citizen's "concierge" or "hospitalist", who can serve as an intermediary between the "super" clinical user and the citizen. And what about the introduction of FHIR resources into the question of muti-care-plan coordination (that is, is there a "FHIR-Care-Plan resource")? Is this question similar to the questions related to medication-reconciliation? Perhaps a Functional Profile could be created that envisions certain people who are specialists that have (perhaps certified) expertise in handling the citizen's data (a "concierge"), such as: a school nurse who manages certain children's-data; a chaplain who manages interactions with veterans regarding mental health substance abuse, appointments, medication adherence, etc; a rural health worker who captures videos of the citizens' gait, exercise, medication adherence, pregnancy appearance, skin conditions, and other telehealth functionality, etc; employer-specific specialist who collects information about a population of workers’ health; an auditor who collects population-health surveillance and who has a need to inspect certain that population's PHR.

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# Dietician language

*(Get input from ISO/TC 251 experts)*

Replace all occurrences of "dietitian" (or “dietician”) with “registered dietitian /nutritionist”. (Could there be liability issues??) Perhaps a universal term could be invented such as “Recognized (or Professional) dietician / nutritionist”?

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# Registry-versus-Directory language

NOTE: This has been accomplished and simply needs verification.

20160525

Verify that all uses of “registry” and “directory” are appropriate.

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# Effectiveness of Treatments

*(Invite a full set of domain experts to contribute to the investigation of a possible “effectiveness data-set” for the PHR and/or EHR)*

Add the following to the PHR-S FM??

(Per John Snyder / John Ritter 20150318)

S.3.7 DESCRIPTION contains the phrase “…validation of compliance with treatment regimens…” we need to add functionality that captures the overall effectiveness of regime therapy for resolving a diagnosis (or condition). For example, a physician initially prescribes amoxicillin for sinus infection; it was ineffective; so for the follow up encounter, the physician then prescribes a Z-Pack instead of the amoxicillin.

NOTE: SEE PH.3.2 for a new CC that may address this concept.

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# Individually-referenced Conformance Criteria

20150422

PH.3.5.3 CC03

We need to specify all of the individual functions within the SS section regarding registration (and not simply name the entire section -- because otherwise, this CC is untestable).

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# Definition of De-Identify

*(Per John Snyder / John Ritter 20150318)*

Add a definition of “de-identity” to the GLOSSARY: “….For example, a system may DE-IDENTIFY data for a researcher who wants to perform an analysis of drug effectiveness….” We need functionality that provides the ability to capture the effectiveness of a given drug.

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# Organizational Policy distinctions

Note: The following type of explanation regarding the distinction between types of "organizational policy" (in BLUE) targets needs to be inserted into the Overarching section, and perhaps into the Glossary, and perhaps into the Overview Chapter.

NOTE: (Per Lorraine Doo) Examine ONC’s recent guidance about it being the citizen’s responsibility regarding the liability of self-entered data.

PH.3.1.1 CC04

The PHR-S MAY provide the ability to capture the PHR Account Holder's self-reported mental health status according to organizational policy (e.g., using certain privacy and security protections). For example, the PHR Account Holder notes that the medication that has been prescribed by his physician is causing feelings of anger and depression (and suicidal ideation). The healthcare organization notes that the PHR Account Holder's self-reported mental health status must be masked for members of the care team who do not have explicit permissions to view that data (i.e., only authorized health care provider(s)). The vendor organization that hosts the PHR system software notes that the PHR Account Holder's self-reported mental health status will not be exported without explicit consents and/or authorizations by the PHR Account Holder.

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# Drug-Herb notices

*(Invite nutritionists to contribute)*

In PH.2.5.11 CC07

Do we also need a CC that says: The system SHOULD conform to xyz to get drub/herb -related alerts/notifications/rules from Public Health orgs???

Also, how about a CC that says: The system SHOULD get drug/herb -related alerts/notifications/rules from Pharmacy/Pharmacist systems??

Also, does the inclusion of such proposed CC elevate the PHR-S (from a wellness-focused PHR-S) to fall under an umbrella as an FDA-regulated device??

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# Nutrition and Diet information

*(Invite nutritionists to contribute)*

In PH.2.5.11 (Nutrition and Diet Information), is it true that the EHR-S FM is not as robust as the PHR-S FM? If so, should the EHR-S FM be upgraded with some of these items?

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# Making information available to surveillance experts

*(Ping Health Record Banking Alliance (HRBA); Dr. Richard Gibson is helping to lead the HRBA; Bill Yasnoff??; How about School Health PHR FP (John Ritter))*

S.4.2 DESCRIPTION says:

Support the automated transfer of formatted demographic and clinical information to local disease-specific registries (and other notifiable registries) to enable PHR Account Holder to participate, if and as desired, in provider and public health monitoring and subsequent epidemiological analysis.

Question: Should PHRs and EHRs be opened (by governmental mandate) in order to help discover widespread disease outbreaks (and perhaps performed in a de-identified manner)?

Do we ever envision where PHR-held data would be mandated to be transferred to a Public Health registry? [DONE: We believe that the current functionality is adequate; no new functionality is needed.]

Question: Should new PHR functionality be added that helps an authority glean disease outbreak information from PHRs?? Or should that data come from hospital’s EHR systems and clinical systems?? Or should the PHR data be easily extracted and sent to a clinicians’ system. [DONE: We believe that the current functionality is adequate; no new functionality is needed.]

Action: Contact HRBA to offer them a brief survey of the PHR-S FM; then to ask them whether they would like to coordinate with the PHR WG in some (tbd) manner.

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# Possible Functional Profiles

*(Ping Health Record Banking Alliance; Mr. Gibson??; Bill Yasnoff??; How about School Health PHR FP John Ritter))*

**FUNCTIONAL PROFILE POSSIBILITIES:**

1. Proposed Functional Profile:

* A functional profile should be created that envisions “Extensive-Care-Coordination” functionality. Such a FP should include:
  + Task and Workflow management and coordination
  + Assessment templates
  + Sharing of care plans (including self-generated care plans)
  + Medication reconciliation
  + Diet and nutrition aspects
  + Exercise, wellness, and goals
  + Communication with various stakeholders

1. PHR-Lite: Disposable or short-term PHR (App-For-That) that is only truly useful for about a month or so.

* Mosquito
* Surveillance of a certain disease or food-borne illness
* Pregnancy
* Weight loss
* Return-to-work
* Local health department fashion/tailored short-term disease-specific templates.
* Note: the citizen could opt to keep the PHR after its original intended use (if desired).

1. Proposed Functional Profile: Public Health -related

* State Public Health Departments
* Public Health Authorities (e.g., Disease Surveillance specialists; Zika virus reporting for a geolocation that is at high risk; County Health Departments; (personal) symptomatic, suspected-case, reports versus (validated) lab value reports)

1. Proposed Functional Profile:

* The care-plan functionality that currently exists in the PHR-S FM, contains a sufficient number of nuances that it seems that the entire suite of functionality (that comprises a full Care Plan set of functionality) ought to be specified through the eventual creation of a “*Care Plan –oriented Functional Profile of the PHR-S FM*”. Such a FP should include:
  + Assessment templates
  + Sharing of care plans (including self-generated care plans)
  + Medication reconciliation
  + Diet and nutrition aspects
  + Exercise, wellness, and goals
  + Communication with various stakeholders

NOTE: Consider also the use of FHIR resources in handling Workflow and Task and Communication issues (for complex healthcare situations).

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# Various items

*(Ping Health Record Banking Alliance; Mr. Gibson??; Bill Yasnoff??; How about School Health PHR FP (John Ritter))*

(POSSIBLE) TASKS:

* First task, review the old items of the "PHR WG Parking Lot 20120720a.doc".
* PH.1.3 CC04 Seems to not really apply to PHR systems. Can we delete it??
* Should we replace "family member" with a different term? If so, which term??
* The Problem List and the Medication List needs to be aligned between the PHR-S FM and the EHR-S FM (specifically, EHR-S FM CP.1.4 and CP.1.3 and PHR-S FM PH.2.5.1 and PHR-S FM PH2.5.2). Also, the method of the use of the Problem List needs to examined (specifically, the "Tethered" approach versus the "Untethered" approach within the EHR-S FM). In the future we must:
  + Include the concepts of "Chronology, Chronicity, and Severity, etc" of Problems. It would be good to make a side-by-side comparison of EHR-S FM CP1.4 and PHR-S FM 2.5.1.
* QUESTION for the EHR WG: Please define the term "chronicity duration" (see EHR-S FM CP1.4 CC05).
* THIS WAS PROBABLY DONE ALREADY:
  + PROBLEM: The PHR-S FM does not yet successfully contain functionality that enables the PHR-Account-Holder to consent to share, and also to share, some selected PHR-Account-Holder data with Public Health / Population Health surveillance stakeholders. E.g., public-health-targeted-medications (e.g., retroviral medications), symptoms, non-compliance, refills (or lack thereof),
* THIS WAS PROBABLY DONE ALREADY:
  + PROBLEM: The PHR-S FM does not yet successfully contain functionality that enables certain PHR-Account-Holder test results to be shared with Public Health / Population Health surveillance stakeholders. E.g., public-health-targeted-communicable-disease-lab-results,

Where is the functionality that enables the account holder to order a (direct-to-consumer) lab test?

Where is the functionality that links the orders/results back to a specific condition, med, or care plan?

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# Self-Referrals

20160120

PH.6.6

NOTE: The concept of "self-referrals" has not been sufficiently covered in the current versions of the EHR-S FM or in the PHR-S FM. Since self-referrals are new concepts, it seemed best to the PHR WG to delegate the following proposed functionality to the PHR WG's PARKING LOT and considered for inclusion in a future iteration of the PHR-S FM.

Self-referral concepts:

* Certain self-generated data (either from the PHR-Account-Holder (e.g., symptoms or a Chief Complaint), or from some device, or from self-research)
* Coordination with an EHR system (so that the PHR-Account-Holder can acquire some data from an EHR system and assemble it as part of the self-referral packet)
* Offering the recipient some direct references to current/past members of the care team (e.g., provider's names, roles, and phone numbers)
* It would be good to formally inform members of my current care team that I am beginning to perform self-referral activities.
* How can the potential recipient best handle illicit, devious, imaginary, previously-denied-by-a-professional-caregiver, etc. "self-referrals"?? (That is, the receiver will likely need an ability for triaging troublesome self-referrals and rejecting them in a controlled fashion.)
* What about the creation of a registry where abusive self-referrals can be collected by professionals into a sharable database (e.g., a list of people who are frequent drug-seekers or who like to chew up the doctor’s time because they are lonely or are hypochondriacs)?
* How to pay the care-team members for their "consultation" during a self-referral?
* What about possibly sending certain proposed self-referral data to a public health surveillance service (e.g., to help surveillance experts to detect disease outbreaks or to report FDA-regulated medical product problems)?
* What about others who desire to surreptitiously glean health care data by scanning social-media (and reuse that data for surreptitious purposes -- either with ill intent or with legitimate intent)? E.g., "If you've ever taken Drug-X and suffered Symptom-Y, then contact Person-Z via a self-referral".

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# Making Conformance Criteria self-explanatory

20160713 Gary Dickinson and John Ritter

The entire EHR-S FM and PHR-S FM often mention a certain action (such as tagging an item on a list; or sorting a list), but fails to mention the particular item or the particular list. Instead, the FMs expect the unfortunate reader to scan the header function to determine the category that the Conformance Criteria are tackling. It might be good to be consistent and make each CC a standalone requirement (with respect to the subject and verb of each CC).

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# Record longevity and correctness

*NOTE: It would be good to talk to NATE and Health Record Banking Alliance regarding means by which these kinds of trust-relationships (see below) can be created, challenged, used, and cloned.*

|  |  |  |  |
| --- | --- | --- | --- |
| **Date** | **Questions for evaluating the correctness of R2 of the PHR-S FM** | **Status** | **Notes** |
| 8/13/2014 | Does the PHR-S FM envision the need to create a trust relationship between a phr-s and an ehr-s (or another phr-s) or other external source of health data? |  |  |
| 8/13/2014 | Is data provenance envisioned by the PHR-S FM? Does it envision the metadata required for data provenance? And does it envision the connection with the EHR-S that supports such provenance? An what about the portal serving as the provenance mechanism? |  |  |
| 8/13/2014 | does the phr-s adequately envision Record longevity or lifespan? |  |  |

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# Various items

* Normalize the phrase “care plan” (kill “plan of care”).
* Consider altering the phrase “care plan” to “care plan, regimen, and/or treatment” where appropriate. [Yes, we agree to make this change.]
* Add a definition of “Provider” to the Glossary. Also, “Provider Organization”. Also, identify a new term that can cover the concept of “Provider-Like” (e.g., a nutritionist who is acting as a primary care provider who signs a diet-order).
* In PH.2.5.6, we need to distinguish between “medical history” (of the PHR-S FM) and “clinical history” (of the EHR-S FM R2). That is, we should align the granularity of the various types of histories to match that of the EHR-S FM R2 (family history, social history, occupational history, surgical history, immunization history, etc).

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# Information Content versus Metadata

In PH.2.5.6, CC06 we may need another CC that will distinguish between the ‘content’ of the arriving (external) data, and the ‘metadata’ of the arriving (external) data.

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# Re-examine certain priorities

In PH.2.5.6, CC05, CC06, and CC07 might they be a ‘SHOULD’ instead of a ‘SHALL’?

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# Various types of education

*(Invite nutritionists to contribute)*

20250902

PH.2.5.11 CC13

Does the EHR-S FM have CC that offers general education (as opposed to this specific education as mentioned in this CC)? And should the EHR-S FM specifically name the education that will help the patient understand the effect that some nutrients may have on medications. See the PHR-S FM CC in this section.

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# Request-for-correction

[DONE]

In PH.2.5.10, CC03 (and others), shouldn’t we relocate the ability to transmit a request-for-correction to the OverArching Section (and eliminate individual occurrences throughout the other Sections? See the Public Health Functional Profile’s Parking Lot suggestions (which are similar). [DONE: We believe that the current functionality is adequate; no new functionality is needed.]

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# Types of Care Team members

DONE

20170104

Re-Examination of the Supportive Section (S.1.1)

Should the PHR-S FM begin to include “many other types of care team members”?

* Social Networking Groups
* Support Groups (weight, drugs, behavioral health, mental health, diabetes)
* Exercise “coaches”
* School Nurses
* Nutritionists
* Care managers
* Health (volunteer) community worker (perhaps serving as a data entry clerk)

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# Clinician-Restricted data

[DONE 20170419]

NOTE: This seems to be impossible functionality for the PHR, but much more appropriate for an EHR.

20160601

PH.3.5.3 CC02

Should this be in the PHR-S FM??? John: Ask UPMCHS PHR Experts about the value of posting data-that-is-intended-to-be-read-only-by-the-clinician in the PHR]) ???????ARE THERE OTHERS??????????

20150422: Question: Does the EHR-S FM contain new/updated functionality regarding consents and authorizations that should be unified/aligned with the list of Actors in this function's registries??

20161026 THIS DESERVES A GOOD BIT OF DISCUSSION BY THE GROUP:

- What about the need to include clinical notes in the PHR -- such that the citizen cannot change the clinician's note?

- What about the need to hide some clinical notes from the citizen (such as "this person is a drug-seeker")?

1. If we implement this CC, it ought to be split into several for referring to the different conforming CC.

2. In mentioning each "actor in the directory", are we referred to providers that the AH specifies as being allowed access to the PHR-S?

3. With regard to the question by John and Lisa, I'm not clear on exactly how this is relevant to this Criterion.

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ALL OF THE ITEMS BELOW ARE “NEW” AND HAVE NOT YET BEEN DISCUSSED BY THE PHR WG OR THE EHR WG (as of 20171221:

# Normalize the use of the term “Indication” (not “Indicator”)

Since there can be many types (and levels) of "incoming messages", it is very difficult to select a single, overarching term. Consider the different nuances among the following terms: notification, indication, alert, inquiry, report, message, request, demand, survey, acknowledgement, confirmation, validation, receipt, etc.

# PH.3.3 CC12

Consider enhancing: The EHR-S FM and the PHFP set probably contain richer functionality regarding sources of external instructions.

# “Examples” in the DESCRIPTION field

The use of "Examples" in the DESCRIPTION portion of the standard could be improved throughout the entire document. Perhaps a future team can perfect all Examples in all DESCRIPTIONS.

# Need for a wiki

Work-effort materials are routinely offered as attachments in the weekly “Agenda” emails, but it would be better to post the materials on a wiki.

# Alignment of the PHR-S FM with the (EHS-FM) Release 2 format

PHR-S FM R2 tasks:

* PHR-S FM needs an Overarching Section
* PHR-S FM needs an Administrative Section
* PHR-S FM needs an Population Health Section
* PHR-S FM needs the IN Section replaced with an RI and TI section
  + Note: the current PHR-S FM IN section was adapted for consumers by using the EHR-S FM’s (clinically-focused) IN section. Simply replacing the PHR-S FM’s IN section with the EHR-S FM R2’s RI and TI section would inadvertently cause the loss of all that “consumer-focused tailoring”. Therefore, we need to get the old maps that revealed the PHR-to-EHR mappings and apply them to the RI and TI sections.
* PHR-SFM Glossary might need to be harmonized with the EHR-S FM and updated
* Conformance Clause needs to be updated, including:
  + Description of Companion Functional Profiles
  + Explanation of the concept of a “Skinny” Functional Profile (that is, a description of a “derived Functional Profile that is based on a Companion Functional Profile”.
  + Alignment with the EHR-S FM’s Conformance Clause. See: “*C:\Ritter\HL7\EHR TC\Projects\Conformance Clause\Updating the EHR-S FM Conformance Clause - Minutes 20170814.docx”*
  + x

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