**AL-7 EHR Work Group - Reducing Clinician Burden Project**  
**Clinical Documentation - Calibrate, Share, Use - Information Flow Example - Including Interactions with Clinician Burden and Safety Concerns**

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**Interoperability Continuum - End-to-End - Source to Use**

- **EXCHANGE** - from Source/Sending EHR/HIT System to Receiving EHR/HIT System
  - Inbound
  - Outbound
  - Verify (if needed)

**Inbound Lifecycle Event - Documentation is Retained by Receiving System**

- Receiving clinician or system
- Receiving EHR/HIT system
- EHR/HIT system
- EHR/HIT system
- Receiving EHR/HIT system

**Outbound Lifecycle Event - Documentation Content is Transmitted**

- Clinician (one)
- EHR/HIT system
- Scribe (one)
- Patient (one)

**Verification (if needed)**

- System users are properly authenticated
- Actors are properly identified
- System users are authorized to access proper credentials
- Actors are properly authorized

**Related Data Exchange artifact to documentation dataset**

- Documentation dataset
- Documentation dataset
- Documentation dataset
- Documentation dataset

**What - Action(s)**

- Documentation is made exchange artifact to documentation dataset
- Documentation is exchange artifact to documentation dataset
- Documentation is exchange artifact to documentation dataset
- Documentation is exchange artifact to documentation dataset

**When - Action Taken**

- After exchange artifact(s) are received
- When exchange is necessary
- If/when data exchange is necessary
- If/when data verification is complete and data is available

**What - Action(s)**

- Documentation content/context (what the documenting clinician documented)
- Documentation content/context (what the documenting clinician documented)
- Documentation content/context (what the documenting clinician documented)
- Documentation content/context (what the documenting clinician documented)

**When - Action Taken**

- Documentation is stored in persistent data storage
- Documentation is retained for clinical documentation
- Documentation is stored in persistent data storage
- Documentation is retained for clinical documentation

**What - Action(s)**

- Documentation is made exchange artifact to documentation dataset
- Documentation is exchange artifact to documentation dataset
- Documentation is exchange artifact to documentation dataset
- Documentation is exchange artifact to documentation dataset

**What - Action(s)**

- Documentation content/context reviewed/verified (what the verifying clinician verified)
- Documentation content/context reviewed/verified (what the verifying clinician verified)
- Documentation content/context reviewed/verified (what the verifying clinician verified)
- Documentation content/context reviewed/verified (what the verifying clinician verified)

**Disjunction: Purpose of Capture ≠ Purpose of Use**

- Disjunction: Original documentation content/context (what the documenting clinician documented)

**Disjunction: Purpose of Capture ≠ Purpose of Use**

- Disjunction: Original documentation content/context (what the documenting clinician documented)

**What - Data**

- Patient (one)
- Patient (one)
- Patient (one)
- Patient (one)

**What - Actor Values**

- Act: Ad hoc activity
- Act: Admission (hospitalization)
- Act: Discharge (hospitalization)
- Act: Consultation
- Act: Examination
- Act: Procedure
- Act: Admission (ambulatory care)
- Act: Consultation
- Act: Procedure
- Act: Admission (emergency)
- Act: Consultation
- Act: Procedure

**What - Applicable Data Standard**

- HL7 CDA R2 Documents
- HL7 FHIR R4 Resources
- HL7 v2, X12, NCPDP
- Trusted E2E