IHE Work Item Proposal (Short)

# Proposed Work Item: mCSD Whitepaper

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# The Problem

Since mCSD doesn’t require a particular set of FHIR resources to support, there is a need to define various implementations and the additional requirements they would have. For example, a Facility Registry would require supporting mCSD with Location and Organization resources, and a Health Worker Registry / Provider Directory would require Practitioner resources.

This whitepaper would describe these various use cases and how mCSD can be utilized to support various implementations.

# Key Use Case

The existing use cases all give good examples of specific implementations, such as:

1. A developing country has decided to implement a Master Facility List (MFL) based on recommendations from the WHO in the MFL Resource Package (https://www.who.int/healthinfo/country\_monitoring\_evaluation/mfl/en/). This resource includes a minimum data set to uniquely identify, location, and contact a specific facility. Since this will be a single source of information for the country, there may be differing hierarchies that need to be supported for the facilities. For example, one hierarchy would be the administrative hierarchy for the country (region, district, county). Another would be the supply chain hierarchy where hubs may be located separately from administrative regions. Yet another could be a reporting hierarchy used to send data to health system managers, and on up to international organizations.
2. To support health system planning, resource management, and patient referral workflows, it will be important to be able to relate healthcare facilities with the health services that are provided there. An interlinked registry may be operationalized that leverages mCSD to cross-reference a code list of health services with the unique list of facility IDs. Such a cross reference may include information related to service provision availability (days and times of day).
3. A Health Worker Registry could be operationalized by collecting and collating underlying provider demographic content from multiple clinical colleges (e.g. College of Physicians and Surgeons, College of Nurses, College of Pharmacists, etc.). These Colleges exert governance over their membership, which may include a requirement of licensure in the self-governing body in order to legally practice in a jurisdiction. As such, the underlying Colleges will maintain the content and a Health Worker Registry would periodically refresh its content from these multiple underlying sources and execute necessary cross-referencing and de-duplication workflows to support an interlinked registry relating WHICH workers provide WHAT SERVICES, WHERE.

# Standards & Systems

mCSD, FHIR

# Discussion

These various implementation scenarios would add too much optionality to the supplement so a whitepaper seems like a good place to cover how mCSD can be used. A number of example cases from both LMIC and “OECD” contexts will be leveraged to illustrate the ways mCSD satisfies a set of key use cases. The white paper will endeavour to distill common patterns from these examples.