Healthy Longevity Medicine Jawda Guidance

Version 1

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Executive Summary

The Department of Health – Abu Dhabi (DoH) is the regulatory body for the healthcare sector in the Emirate of Abu Dhabi. It ensures excellence in healthcare by monitoring the health status of the population.

Healthcare system faces increasing complexity driven by rapid population growth, rising patient expectations, accelerated adoption of advanced technologies, and a highly diverse workforce. Together, these factors intensify operational demands and elevate the inherent risks to healthcare quality and patient safety. In parallel, a growing global demand for Healthy Longevity Medicine reflects individuals' increasing focus on optimizing health span, accompanied by heightened expectations for credible, evidence-based guidance and interventions.

The Department of Health (DoH) has developed a dynamic and comprehensive quality framework to drive improvements across the healthcare sector. This guidance outlines the quality indicators required by the DoH for semi-annual reporting by all Healthy Longevity Medicine providers in Abu Dhabi.

The guidance sets out the full definition and method of calculation for clinical effectiveness indicators. For enquiries about this guidance, please contact jawda@DoH.gov.ae

This document is subjected for review and therefore it is advisable to always utilize online versions available on the DOH website.

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About this Guidance

This guidance outlines the definitions and reporting frequency of JAWDA Healthy Longevity Medicine performance indicators. The Department of Health (DoH), in collaboration with local and international subject-matter experts, has established these indicators to evaluate provider performance in delivering effective clinical care. Given their clinical expertise, healthcare providers play a central leadership role in defining and evaluating performance within Healthy Longevity Medicine services.

The JAWDA Healthy Longevity Medicine KPIs defined in this guidance focus on core outcome domains and are designed to assess the effectiveness of evidence-based clinical interventions, the achievement or maintenance of individualized health targets, and the sustained optimization of patient health span over time. KPI performance is defined as the proportion of patients demonstrating clinically meaningful improvement against individualized targets, such as risk-category improvement, percentile shift, gap closure, or appropriate stability using a patient-specific assessment approach grounded in baseline status, risk stratification, and individualized targets, rather than uniform percentage thresholds.

Who is this guidance for?

All DoH licensed healthcare facilities providing Healthy Longevity Medicine Services in the Emirate of Abu Dhabi.

How do I follow this guidance?

Each provider must designate a staff member responsible for coordinating, collecting, and monitoring quality indicators. Healthy Longevity Medicine providers are required to submit data semi-annually through the JAWDA e-notification system.

Note: Jawda team may use centrally collected claim data submitted by healthcare providers through Shafafiya portal to validate the data submitted by the providers through Jawda portal.

What is the Regulation related to this guidance?

- Legislation establishing the Health Sector
- As per DoH Policy for Quality and Patient Safety issued January 15th 2017, this guidance applies to all DoH Licensed Healthcare Facilities in the Emirate of Abu Dhabi in accordance with the requirements set out in this Standard.
- DoH Healthy Longevity Medicine Standard

Type: Quality Indicator **Indicator Number: LNG001**

<table>
<tr><td>KPI Description (title):</td><td>Improvement or Optimal Maintenance in Volume of Oxygen (VO2) Max Among Adult Patients</td></tr>
<tr><td>Domain</td><td>Effectiveness</td></tr>
<tr><td>Indicator Type</td><td>Outcome</td></tr>
<tr><td>Definition:</td><td>Measures the percentage of adult patients (aged 18 and above) who, upon reaching 12 months, either:
a) Achieved ≥5% improvement in peak Volume of Oxygen (VO_2) max from baseline to follow-up
OR
b) Were within the optimal or target VO_2 max range at baseline and remained within this range at follow-up (optimal maintenance).</td></tr>
<tr><td>Calculation:</td><td><u>Numerator a</u>: Number of adult patients (aged 18 and above) with ≥5% improvement in Volume of Oxygen (VO2) max upon reaching 12 months follow-up.

<u>Numerator b</u>: Number of patients (aged 18 and above) who maintained the target (optimal) level from baseline to follow-up, assessed every 12 months.

Numerator Guidance:
• In case of multiple follow-up visits, consider the VO2 max value in the latest visit.

<u>Denominator:</u> Total number of adult patients (aged 18 and above) who visited during reporting period
AND
underwent Volume of Oxygen (VO2) max baseline assessment during the previous 12 months reporting period.

Denominator Guidance:
• Include patients who had minimum 4 visits to the facility within the previous 12 months
• In case of multiple visits, consider the lowest recorded VO2 max value as baseline.

Denominator Exclusion:
• Patients that are actively taking medications during the reporting period that are affecting cardiorespiratory fitness:
o Over-the-counter cold and flu medications
o Beta-blockers
o Calcium channel blockers (CCBs)
o ACE inhibitors
o Fibrates
o Statins
o Digitalis
o Diuretics
o Oral medications for diabetes</td></tr>
</table>

	• Patients with medical conditions affecting cardiorespiratory fitness: ○ Cardiac conditions (e.g., stent placement, angioplasty, coronary artery disease, congestive heart failure, atherosclerosis, arteriosclerosis, peripheral vascular disease) ○ Musculoskeletal or neurological conditions that prevent them from undergoing a VO_2 max assessment
Reporting Frequency:	Semi-annually
Unit of Measure:	Percent
International comparison if available	Developed internally in alignment with The Effect of Training Intensity on VO2max in Young Healthy Adults: A Meta-Regression and Meta-Analysis - PMC
Desired direction:	Higher is better
Data sources and guidance:	• Electronic Medical Record (EMR)

Type: Quality Indicator **Indicator Number: LNG002**

KPI Description (title):	**Improvement or Optimal Maintenance in Metabolic Risk Profile Among Adult Patients**
Domain	**Effectiveness**
Indicator Type	**Outcome**
Definition:	Measures the percentage of adult patients (aged 18 and above) who, for each metabolic marker, either: **(1)** Achieved ≥20% gap closure toward the individualized target from baseline to follow-up OR **(2)** Were within the target range at baseline and remained within the target range at follow-up (optimal maintenance), assessed every 6 months. ***Report Separately in Numerator and Denominator for each of the metabolic markers*:** a) HbA1c b) blood pressure c) LDL cholesterol
Calculation:	***<u>Numerator 1</u>:*** Number of patients (aged 18 and above) achieving improvement gap closure of 20% between baseline and follow-up based on target value every 6 months. $\textit{Gap closure} = \frac{\text{baseline}-\text{follow up}}{\text{baseline}-\text{target}} \text{ x } 100\%$ ***<u>Numerator 2</u>:*** Number of patients (aged 18 and above) who maintained the target (optimal) level from baseline to follow-up, assessed every 6 months.

	Numerator Guidance: • *In case of multiple follow-up visits, consider the marker values in the latest visit.* • *Report separately Numerator 1 and Numerator 2* ***Denominator:*** Total number of adult patients (aged 18 and above) who visited during reporting period **AND** were baseline tested during the previous 6 months reporting period in the specified markers: • HbA1c • blood pressure • LDL cholesterol ***Denominator Guidance:*** • *In case of multiple visits, consider the highest recorded marker values as baseline.* ***Denominator Exclusion:*** • Patients with confirmed diagnosis of Genetic Dyslipidemia • Patients with confirmed diagnosis advanced Chronic Kidney Disease (End Stage Renal Disease) • Patients with confirmed diagnosis of Diabetes Mellitus Type 1.
Reporting Frequency:	Semi-annually
Unit of Measure:	Percent
International comparison if available	Developed internally in alignment with American Diabetes Association (ADA) and European Society of Cardiology (ESC) guidelines; local standards as applicable.
Desired direction:	Higher is better
Data sources and guidance:	• Electronic Medical Record (EMR)

Type: Quality Indicator **Indicator Number: LNG003**

<table>
<tr><td>KPI Description (title):</td><td>Improvement or Optimal Maintenance in Body Composition Among Adult Patients</td></tr>
<tr><td>Domain</td><td>Effectiveness</td></tr>
<tr><td>Indicator Type</td><td>Outcome</td></tr>
<tr><td>Definition:</td><td>Measures the percentage of adult patients (aged 18 and above) who, at 6-month follow-up after individualized nutrition interventions, either:
a) achieved body-composition improvement defined as subcutaneous fat reduction and/or visceral fat reduction AND muscle increase
OR
b) were within the individualized target range at baseline and remained within the target range at follow-up (optimal maintenance)</td></tr>
<tr><td>Calculation:</td><td><u>Numerator a</u>: Number of adult patients (aged 18 and above) who improved in body composition upon reaching 6 months follow-up for the following body composition:
• ≥10th percentile subcutaneous fat reduction AND/OR ≥10th percentile visceral fat reduction
AND
• ≥5th percentile muscle increase.

<u>Numerator b</u>: Number of patients (aged 18 and above) who maintained the target (optimal) level from baseline to follow-up, assessed every 6 months.

Numerator Guidance:
• In case of multiple follow-up visits, consider the values in the latest visit.

<u>Denominator:</u> Total number of adult patients (aged 18 and above) who visited during reporting period
AND
were baseline assessed for body composition using Dual-energy X-ray Absorptiometry (DEXA) Scan during the previous 6 months reporting period.

Denominator Guidance:
• In case of multiple visits, consider the worst recorded body composition values as baseline.

Denominator Exclusion:
• Patients that have medical conditions affecting improvement in body composition (e.g., uncontrolled hypothyroidism that hinders fat reduction)
• Patients that are actively taking medications during the reporting period that significantly alter fat metabolism (e.g., high-dose corticosteroids, antipsychotics)
• Pregnant patients
• Patients with confirmed genetic muscle disorders</td></tr>
</table>

Reporting Frequency:	Semi-annually
Unit of Measure:	Percent
International comparison if available	Developed internally in alignment with American Heart Association (AHA) – Guidelines on obesity management; local standards as applicable.
Desired direction:	Higher is better
Data sources and guidance:	• Electronic Medical Record (EMR)

Type: Quality Indicator **Indicator Number:** **LNG004** ***Effective H1 2027***

KPI Description (title):	**Improvement or Optimal Maintenance in Cognitive Function Among Adult Patients**
Domain	**Effectiveness**
Indicator Type	**Outcome**
Definition:	Percentage of adult patients (aged 18 and above) who met domain-level cognitive performance expectations within 12 months, as follows: **a)** Patients aged 18–64 years with baseline performance <75th percentile: achieving at least a 5% improvement in each domain from baseline to follow-up. or **b)** Patients aged 18–64 years with baseline performance ≥75th percentile: maintaining optimal performance in each domain from baseline to follow-up. or **c)** For patients aged 65 and above: maintaining or avoiding decline in each domain from baseline to follow-up. ***Report Separately in Numerator and Denominator for each of the domains*:** • Memory score • Executive function score • Processing speed
Calculation:	***Numerator a:*** Number of adult patients (aged 18-64) with baseline performance <75th percentile, who achieved at ≥5% improvement in each cognitive function domain from baseline to 12 months follow-up ***Numerator b:*** Number of adult patients (aged 18-64) with baseline performance ≥75th percentile: maintaining optimal performance in each cognitive function domain from baseline to 12 months follow-up. ***Numerator c:*** Number of adult patients (aged ≥65) maintaining or avoiding decline in each domain from baseline to 12 months follow-up. ***Numerator Guidance:*** • *In case of multiple follow-up visits, use the latest assessment within the 12-month follow-up window, applied per domain.*

	Denominator: Total number of adult patients (aged 18 and above) who visited during reporting period
	AND
	were baseline assessed for cognitive function using an evidence-based tool during the previous 12 months reporting period.
	
	Cognitive function domains are as follows:
	• Memory score
	• Executive function score
	• Processing speed
	
	Denominator Guidance:
	• *Include patients who had minimum 4 visits to the facility within the previous 12 months.*
	• *In case of multiple visits, consider the lowest recorded score values as baseline.*
	• *Recommended tools can be any of the following:*
	  o *CNS Vital Signs*
	  o *NeuroTrax*
	  o *Cambridge Cognition CANTAB*
	  o *Cogstate*
	
	Denominator Exclusion:
	Patients with acute neurological events (not limited to):
	• Acute cerebrovascular events
	  o Acute ischemic stroke
	  o Intracerebral hemorrhage
	  o Transient ischemic attack (in early recovery phase)
	• Acute confusional and encephalopathic states
	  o Delirium (any cause)
	  o Sepsis-associated encephalopathy
	  o Metabolic encephalopathy
	• Central nervous system infections
	  o Meningitis
	  o Encephalitis
	• Traumatic brain injury (including concussion with ongoing symptoms)
	• Post-interventional or perioperative states
	  o Post-anesthesia cognitive impairment
	  o Early post–major surgery cognitive dysfunction
	• Acute neurological exacerbations or chronic disease affecting cognition
	  o Multiple sclerosis relapse
	  o Epilepsy with recent seizure/post-ictal state
	• Acute or chronic toxic or medication-related states
	  o Sedative/opioid intoxication
	  o Acute adverse drug reactions affecting cognition

Reporting Frequency:	Semi-annually

Unit of Measure:	Percent
International comparison if available	Developed internally in alignment with WHO, ICOPE Guidelines, 2022; local standards as applicable.
Desired direction:	Higher is better
Data sources and guidance:	• Electronic Medical Record (EMR)