دائـــــرة الـصـــحـــة
DEPARTMENT OF HEALTH

Oncology & Hematology Services Jawda Guidance

Version 1.1

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1. Executive Summary

The Department of Health– Abu Dhabi (DOH) is the regulative body of the Healthcare Sector in the Emirate of Abu Dhabi and ensures excellence in Healthcare for the community by monitoring the health status of its population.

The Emirate of Abu Dhabi is experiencing a substantial growth in the number of hospitals, centers and clinics. These range from school clinics and mobile units to internationally renowned specialist and tertiary academic centers. Although, access and quality of care has improved dramatically over the last couple of decades, mirroring the economic upturn and population boom of the Abu Dhabi Emirate. However, challenges remain in addressing further improvements.

The main challenges that are presented with increasingly dynamic population include an aging population with increased expectation for treatment, utilization of technology and diverse workforce leading to increased complexity of healthcare provision in Abu Dhabi. All of this results in an increased and inherent risk to quality and patient safety.

DOH has developed a dynamic and comprehensive quality framework in order to bring about improvements across the health sector. This guidance relates to the quality indicators that DOH is mandating the quarterly reporting against by the operating general and specialist hospitals in Abu Dhabi.

The guidance sets out the full definition and method of calculation for patient safety and clinical effectiveness indicators.

For enquiries about this guidance, please contact jawda@doh.gov.ae

This document is subject for review and therefore it is advisable to utilize online versions available on the DOH website at all times.

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2. Introduction

2.1 The Department of Health– Abu Dhabi (DOH) is the regulative body of the Healthcare Sector in the Emirate of Abu Dhabi and ensures excellence in Healthcare for the community by monitoring the health status of the population. DOH is mandated:

- To achieve the highest standards in health curative, preventative and medical services and health insurance in the Emirate.
- To lay down the strategies, policies and plans, including future projects and extensions for the health sector in the Emirate, and to follow-up their implementation
- To apply the laws, rules, regulations and policies which are issued as they are related to its purposes and responsibilities, in addition to what is issued by the respective international and regional organizations in line with the development of the health sector.
- To follow up and monitor the operation of the health sectors, to achieve an exemplary Standard in the provision of health, curative, preventive and medicinal services and health insurance

2.2 DOH defines the strategy for the health system, monitors and analyses the health status of the population and performance of the system. In addition, DOH shapes the regulatory framework for the health system, inspects against regulations, enforce standards, and encourages adoption of world – class best practices and performance targets by all healthcare service providers in the Emirate of Abu Dhabi.

2.3 DOH also drives programs to increase awareness and adoption of healthy living standards among the residents of the Emirate of Abu Dhabi in addition to regulating scope of services, premiums and reimbursement rates of the health system in the Emirate of Abu Dhabi.

2.4 The Health System of the Emirate of Abu Dhabi is comprehensive, encompassing the full spectrum of health services and is accessible to all residents of Abu Dhabi. The system is driven towards excellence through continuous outcome improvement culture and monitoring achievement of specified indicators. Providers of health services are independent. Predominately private and follow highest international quality standards. The system is financed through mandatory health insurance.

In doing so DOH will:

- Drive structure, process and outcome improvements across health sector
- Put people first and champion their rights
- Focus on quality and act swiftly to eliminate poor quality of care
- Work with Stakeholders and apply fair processes.
- Gather information and utilize knowledge and expertise to improve care.
- Link the care to payment in a way that results in a continuous improvement and maximize the value of the care provided in Abu Dhabi.

3. Patient Safety and Clinical Effectiveness

Patient safety is 'the discipline in the health care sector that applies safety science methods toward the goal of achieving a trustworthy system of health care delivery'. Patient safety is also an attribute of health care systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events. Clinical effectiveness is "the application of the best knowledge, derived from research, clinical experience and patient preferences to achieve optimum processes and outcomes of care for Oncology & Hematology patients. The process involves a framework of informing, changing and monitoring practice" Clinical effectiveness is about doing the right thing at the right time for the right patient and is concerned with demonstrating improvements in quality and performance.

- **The right thing** (evidence-based practice requires that decisions about health care are based on the best available, current, valid and reliable evidence)
- **In the right way** (developing a workforce that is skilled and competent to deliver the care required)
- **At the right time** (accessible services providing treatment when the patient needs them)
- **In the right place** (location of treatment/services).
- **With the right outcome** (clinical effectiveness/maximising health gain)

Patient safety, clinical effectiveness, equity, patient experience, efficiency, and timeliness are recognized as the main pillars of quality in healthcare. In Abu Dhabi, the measurement of data related to these pillars aims to identify strengths and weaknesses in healthcare delivery, drive quality improvement, inform regulation, and promote patient choice. In addition to data on harm avoidance and success rates for treatments, providers will be assessed on aspects of care such as dignity and respect, compassion, and involvement in care decisions through patient satisfaction surveys.

The inclusion of patient safety, clinical effectiveness, and patient experience in quality performance is often justified on the grounds of their intrinsic value. For example, clear information, empathetic two-way communication, and respect for Oncology & Hematology patients' beliefs and concerns can lead to Oncology & Hematology patients being more informed and involved in decision-making, creating an environment where they are more willing to disclose information.

4. Planning for data collection and submission

In planning for data collection and submission Healthcare must adhere to reporting, definition and calculation requirements as set out in this guidance. Healthcare providers must also consider the following:

- Nominate responsible data collection and quality leads(s).
- Ensure data collection leads are adequately skilled and resourced.
- Understand and identify what data is required, how it will be collected (sources) and when it will be collected.
- Create a data collection plan.
- Ensure adequate data collection systems and tools are in place.
- Maintain accurate and reliable data collection methodology.
- Data collation, cleansing and analysis for reliability and accuracy.
- Back up and protect data integrity.
- Have in place a data checklist before submission.
- Submit data on time and ensure validity.
- Review and feedback data findings to the respective teams in order to promote performance improvement.
- Failing to submit valid data will be in breach of the licensing condition and could result in fines being applied, penalties associated with performance or revoke of license.
- When needed, documentation and tracks will be provided instantly to DOH, or their representative, to assure DOH that all dues' processes are being followed in collecting, analyzing, validating and submitting your performance

5. About this Guidance

5.1 This guidance sets out the Patient Safety and Clinical Effectiveness reporting requirements to ensure High quality and safety of healthcare services offered to Oncology & Hematology patients in the Emirate of Abu Dhabi. The guidance sets out the definitions, parameters and frequency by which JAWDA Quality indicators will be measured and submitted to DOH and will ensure Healthcare Providers provide safe, effective and high-quality services.

Q. Who is this guidance for?

All DOH Licensed Healthcare Hospitals providing Oncology & Hematology Services in the Emirate of Abu Dhabi.

Q. How do I follow this guidance?

Each Hospital will nominate one member of staff to coordinate, collect, quality control, monitor and report relevant Oncology & Hematology Inpatient and Medical Daycase data as per **communicated dates**. The nominated healthcare facility lead must in the first instance e-mail their contact details (if different from previous submission) to JAWDA@doh.gov.ae and submit the required quarterly quality performance indicators through Online Portal.

Q. What are 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 Hospital Healthcare Facilities in the Emirate of Abu Dhabi in accordance with the requirements set out in this Standard.

Glossary

ONCOLOGY & HEMATOLOGY PATIENTS: defined as patients with principal diagnosis of malignancy or encounter for malignancy treatments ***(ICD-10 code: C00-D09, Z51.0, Z51.11, Z51.12)***

Diagnosis Guidance*: All diagnosed cancer patients with biopsy completed at the reported facility. Use the final histopathology report date for staging cancer patients*

Localized cancer is usually found only in the tissue or organ where it began and has not spread to nearby lymph nodes or to other parts of the body. Some localized cancers can be completely removed by surgery.

INPATIENT: *Is a beneficiary registered and admitted to a hospital for bed occupancy for purposes of receiving healthcare services and is medically expected to remain confined overnight and for a period in excess of 12 consecutive hours.*

- *Daycase admission is not included in INPATIENT.*
- *Beds* ***excluded*** *from the Oncology & Hematology inpatient bed complement:*
  - ***Beds/cots for healthy newborns***
  - *Beds in Day Care units, such as surgical, medical, pediatric day care, interventional radiology*
  - *Beds in Dialysis units*
  - *Beds in Labor Suites (e.g. birthday beds, birthing chairs)*
  - *Beds in Operating Theatre*
  - *Temporary beds such as stretchers*
  - *Chairs, Cots or Beds used to accommodate sitters, parents, guardians accompanying Oncology & Hematology patients or sick children and healthy baby accompanying a hospitalized breast-feeding mother*
  - *Beds closed during renovation of patient care areas when approved by the competent authority*

EXAMPLE OF INPATIENT BED DAY COUNTING INITIATION AND TIME TO READMISSION:

MRN	Visit type	Urgent Care / Emergency Arrival Date & Time	IP admission date & time from UC	Discharge Date & Time
123456	Urgent Care converted to inpatient	01/01/2025 10:00	01/01/2025 13:39	03/01/2025 13:00
123456	Urgent Care converted to inpatient	12/01/2025 23:50	13/01/2025 02:00	13/01/2025 18:00

Readmission calculation: It will be 13/01/2025 (Admission Date) minus 03/01/2025 (Discharge Date) = 10 days

DAYCASE*: Daycase beds, also known as observation beds, are beds used in Day Care units such as surgical, medical, pediatric day care interventional radiology. They are not included in the inpatient bed complement.*

LONG TERM CARE and POST-ACUTE REHABILIATION PATIENTS: *They will be reported under LTCF and PAR Jawda Guidance*

CRITICAL CARE AREA: *A patient is in a Critical Care Area if they are receiving active cardiac monitoring (including telemetry) in an Intensive Care Unit, Emergency Room, Urgent Care Centre, Operating Room, Procedure Room, Anesthetic Induction Room or Recovery Area.*

PATIENT LEFT AGAINST MEDICAL ADVICE *is synonymous with the below:*

- *Discharge Against Medical Advice*
- *Against Medical Advice*

Emergency cancer surgery: immediate surgical intervention required to address urgent, life-threatening complications caused by cancer. These complications may include severe bleeding, obstruction of vital organs, or perforation of tissues, which necessitate swift surgical action to stabilize the patient and prevent further health deterioration.)

Palliative cancer treatment: focuses on providing relief from the symptoms and stress of cancer. The primary goal is to *improve the quality of life* for both the patient and their family. This type of treatment is NOT aimed at curing the cancer but at alleviating pain and other symptoms that accompany the disease and its treatment. Palliative care can be administered at any stage of the illness and is often provided alongside curative treatments.

Type: Quality Indicator **Indicator Number:** CA001

KPI Description (title):	**Percent of Patients Receiving First Cancer Treatment Within 30 Days of Biopsy**
Domain	**Timeliness**
Indicator Type	**Process**
Definition:	Percentage of patients who receive their first treatment for cancer within 30 days of their biopsy. Timely treatment initiation is crucial for improving patient outcomes.
Calculation:	***Numerator:*** Number of patients (18 years of age and older) in the denominator who received their first cancer treatment (all treatments: chemotherapy, immunotherapy, radiotherapy, and/or surgery) within 30 days of their biopsy date at the reporting facility ***Denominator:*** The total number of adult patients 18 years and older (inpatient and medical daycase) newly diagnosed with cancer during the reporting period. ***Report Separately patients with:*** a) Breast cancer b) Colorectal cancer c) Head & Neck cancer (including Thyroid) d) Gynecology cancer e) Prostate Cancer ***Denominator Exclusion:*** • Patient's choice of not proceeding with treatment or extending the recommended time for treatment at the reporting facility.
Reporting Frequency:	Quarterly
Unit of Measure:	Percent
International comparison if available	• Cancer Research UK. *ICBP research publications*. • Cancer Research UK. *International Cancer Benchmarking Partnership (ICBP)*. • Wilding S, Downing A, Selby P, et al. Exploring the role of leadership in facilitating change to improve cancer survival: an analysis of experiences in seven high-income countries in the International Cancer Benchmarking Partnership (ICBP). *BMJ Open*. 2020;10(7):e034833.
Desired direction:	>90%
Data sources and guidance:	• Electronic Medical Record (EMR)

Type: Quality Indicator **Indicator Number:** CA002

KPI Description (title):	**Percent of Patients Discussed at Multidisciplinary Team (MDT) Meetings Before Cancer Treatment**
Domain	**Patient-Centeredness**
Indicator Type	**Process**
Definition:	Percentage of cancer patients whose cases were discussed in MDT meetings prior to the initiation of treatment. MDT discussions are essential for comprehensive treatment planning.
Calculation:	***Numerator:*** Number of patients (18 years of age and older) in denominator whose cases were discussed in MDT meetings prior to the initiation of treatment. ***Denominator:*** The total number of Oncology & Hematology inpatient discharges (18 years and older) newly diagnosed with cancer during the reporting period. ***Report Separately patients with:*** a) Breast cancer b) Colorectal cancer c) Head & Neck cancer (including Thyroid) d) Gynecology cancer e) Prostate Cancer ***Denominator Exclusion:*** • Established patients who already started treatment at the reporting facility.
Reporting Frequency:	Quarterly
Unit of Measure:	Percent
International comparison if available	• Taylor C, Munro AJ, Glynne-Jones R, et al. Multidisciplinary team meetings in cancer care: barriers to implementation and effectiveness. *Lancet Oncology*. 2010;11(4):e58-e66. • Lamb BW, Brown KF, Nagpal K, Vincent C, Green JS, Sevdalis N. Quality of care management decisions by multidisciplinary cancer teams: a systematic review. *BMC Health Serv Res*. 2011;11:356. doi:10.1186/1472-6963-11-356 • Specchia ML, Frisicale EM, Carini E, et al. Understanding the effectiveness and quality of virtual cancer multidisciplinary team meetings (MDTMs): a systematic scoping review. *BMC Health Serv Res*. 2023;23
Desired direction:	>95%
Data sources and guidance:	• Electronic Medical Record (EMR)

Type: Quality Indicator **Indicator Number:** CA003

KPI Description (title):	**Severe Toxicity Incidence in Radiotherapy Cancer Treatment**
Domain	**Safety**
Indicator Type	**Outcome**
Definition:	Percent of cancer patients undergoing radiotherapy who experience severe (Grade III) or life-threatening (Grade IV) toxicities as defined by the Common Terminology Criteria for Adverse Events (CTCAE). It reflects the safety and tolerability of radiotherapy treatments
Calculation:	***Numerator: N***umber of patients (18 years of age and older) in the denominator who experienced at least one Grade III or IV toxicity (all symptoms) within 30 days after any radiotherapy session. ***Denominator:*** The total number of adult patients (18 years and older) from Oncology and Hematology inpatient and medical daycase discharges who began ***exclusive radiotherapy sessions*** (***without*** any concurrent chemotherapy) during the reporting period. ***Report Separately patients with:*** a) Breast cancer b) Prostate cancer ***Denominator Exclusion:*** • Palliative radiotherapy • Patients on *concurrent* chemotherapy treatment
Reporting Frequency:	Quarterly
Unit of Measure:	Percent
International Comparison if available	• Tree A. Performance indicators in radiotherapy. Presented at: National Prostate Cancer Audit (NPCA) Quality Improvement Event; 2024. • Donaldson MS, et al. Quality indicators for radiation oncology. International Journal for Quality in Health Care. 2008;20(3) • Trotti A, Colevas AD, Setser A, et al. A prospective comparison of Common Terminology Criteria for Adverse Events version 3 and version 4 in assessing oral mucositis for oral and oropharyngeal carcinoma. Annals of Oncology. 2010;21 • Prospective study on acute toxicities of external beam radiotherapy. Journal of Cancer Research and Therapeutics. 2020;17(3) • Altman DG, De Stavola BL, Love SB, Stepniewska KA. Review of survival analyses published in cancer journals. British Journal of Cancer. 1995;72(2):511-518. • Advances in oncology outcomes and measurement frameworks. The Lancet Oncology. 2024. doi:10.1016/S1470-2045(24)00720-4
Desired direction:	<10%
Data sources and guidance:	• Electronic Medical Record (EMR)

Type: Quality Indicator **Indicator Number:** CA004

KPI Description (title):	**30-Day Mortality Rate After Cancer Surgery**
Domain	**Effectiveness**
Indicator Type	**Outcome**
Definition:	Rate of patients who die within 30 days of undergoing major cancer surgery. This is a comprehensive measure of procedure-associated mortality.
Calculation:	***Numerator:*** Number of patients with cancer (18 years of age and older) in denominator who died within 30 days of surgery The date the patient exits the OR is POD0. ***Denominator:*** Total number of adult (18 years and older) Oncology & Hematology inpatient discharges that had undergone Cancer Surgery during the reporting period ***Report Separately patients with:*** a) Breast cancer b) Colorectal cancer c) Head & Neck cancer (including Thyroid) d) Gynecology cancer e) Prostate Cancer **Denominator Exclusion:** • Left against medical advice • Loss to follow-up
Reporting Frequency:	Quarterly
Unit of Measure:	Rate of 100 adult Oncology & Hematology inpatient discharges
International Comparison if available	Kazaure HS, Neely NB, Howard LE, et al. Primary care use and 90-day mortality among older adults undergoing cancer surgery. *JAMA Surgery*. Published online August 7, 2024. doi:10.1001/jamasurg.2024.2598
Desired direction:	<2%
Data sources and guidance:	• Electronic Medical Record (EMR)

Type: Quality Indicator **Indicator Number:** CA005

KPI Description (title):	**7-Day Mortality Rate After Chemotherapy Treatments**
Domain	**Effectiveness**
Indicator Type	**Outcome**
Definition:	Rate of patients who die within 7 days of receiving chemotherapy, as a quality/safety indicator reflecting treatment-related toxicity and supportive care effectiveness.
Calculation:	***Numerator:*** Number of patients with cancer (18 years of age and older) in denominator who died within 7 days of receiving any chemotherapy administration. ***Denominator:*** The total number of adult patients (18 years and older) from Oncology and Hematology inpatient and medical daycase discharges who began ***exclusive chemotherapy sessions solely***, ***without*** any concurrent radiotherapy during the reporting period. ***Report Separately patients with:*** • Breast cancer • Colorectal cancer • Head & Neck cancer (including Thyroid) • Gynecology cancer • Prostate Cancer **Denominator Exclusion:** • Left against medical advice • Received only oral hormonal therapy, targeted therapy, or immunotherapy without cytotoxic chemotherapy • Patients on *concurrent* radiation therapy treatment • Loss to follow-up
Reporting Frequency:	Quarterly
Unit of Measure:	Percent
International Comparison if available	• Centers for Medicare & Medicaid Services. *Quality ID #453: Proportion of patients with chronic myelogenous leukemia (CML) with a BCR-ABL1 transcript level ≤1% at 12 months*. 2017. • Bhatt VR, et al. Real-world outcomes and prognostic factors in hematologic malignancies. *Blood Cancer Journal*. 2023;13:Article 956. doi:10.1038/s41408-023-00956-x • Clinical outcomes and prognostic evaluation in oncology practice. *Journal of Clinical Medicine*. 2021;10(24):5768. doi:10.3390/jcm10245768 • Bland JM, Altman DG. Survival probabilities (the Kaplan-Meier method). *BMJ*. 1998;317(7172):1572-1580.
Desired direction:	<2%
Data sources and guidance:	• Electronic Medical Record (EMR)

Type: Quality Indicator **Indicator Number:** CA006

KPI Description (title):	**7-Day Mortality Rate After Radiotherapy Treatments**
Domain	**Effectiveness**
Indicator Type	**Outcome**
Definition:	Rate of patients who die within 7 days of receiving radiotherapy, as a quality/safety indicator reflecting treatment-related toxicity and supportive care effectiveness.
Calculation:	***Numerator:*** Number of patients with cancer (18 years of age and older) in denominator who died within 7 days of receiving any radiotherapy treatment. ***Denominator:*** The total number of adult patients (18 years and older) from Oncology and Hematology inpatient and medical daycase discharges who began ***exclusive radiotherapy sessions (without*** any concurrent chemotherapy) during the reporting period. ***Report Separately patients with:*** a) Breast cancer b) Colorectal cancer c) Head & Neck cancer (including Thyroid) d) Gynecology cancer e) Prostate Cancer **Denominator Exclusion:** • Left against medical advice • Patients on *concurrent* chemotherapy treatment • Loss to follow-up
Reporting Frequency:	Quarterly
Unit of Measure:	Percent
International Comparison if available	Locally developed with SMEs
Desired direction:	<2%
Data sources and guidance:	• Electronic Medical Record (EMR)

Type: Quality Indicator **Indicator Number:** CA007

KPI Description (title):	**1-Year Survival Rate After Localized Cancer Diagnosis & Staging**
Domain	**Effectiveness**
Indicator Type	**Outcome**
Definition:	Calculated rate of patients diagnosed with localized cancer during the previous 12 months reporting period.
Calculation:	***Numerator:*** Number of patients in the denominator who survive for one year after diagnosis and staging of cancer i.e. through day 365 post-diagnosis. ***Denominator:*** Total number of Oncology & Hematology inpatients (18 years and older) diagnosed & staged with localized cancer in the previous 12 months reporting period ***Report Separately patients with:*** a) Breast cancer b) Colorectal cancer c) Head & Neck cancer (including Thyroid) d) Gynecology cancer e) Prostate Cancer **Denominator Exclusion:** • Left against medical advice • Dead on arrival • Loss to follow-up
Reporting Frequency:	Quarterly
Unit of Measure:	Percent
International comparison if available	• Office for National Statistics. (n.d.). *Cancer survival methodology*. GOV.UK. • Rich, J. T., Neely, J. G., Paniello, R. C., Voelker, C. C., Nussenbaum, B., & Wang, E. W. (2010). *A practical guide to understanding Kaplan-Meier curves*. Otolaryngology–Head and Neck Surgery, 143(3), 331–336. • Cancer Research UK. (n.d.). *International Cancer Benchmarking Partnership (ICBP)*.
Desired direction:	> 95%
Data sources and guidance:	• Electronic Medical Record (EMR)

Type: Quality Indicator **Indicator Number:** CA008

KPI Description (title):	**Unplanned return to the operating room within 14 days of Localized Cancer Surgery**
Domain	**Effectiveness**
Indicator Type	**Outcome**
Definition:	Rate of return to operating room within 14 days **of Localize Cancer Surgery.**
Calculation:	**Numerator:** Total number of patients in the denominator who had unplanned return to the operating room within 14 days of Localized Cancer Surgery. The date the patient exits the OR is POD0. **Denominator:** Total number of adult (18 years and older) Oncology & Hematology inpatient discharges that had planned Localized Cancer Surgery during the reporting period ***Report Separately patients with:*** a) Breast cancer b) Colorectal cancer c) Head & Neck cancer (including Thyroid) d) Gynecology cancer e) Prostate Cancer **Denominator Exclusions**: • Patients who are discharged against medical advice. • Patients had planned Localized Cancer Surgery during the index hospitalization and subsequently transferred to another acute care facility. • Urgent or Emergent index procedure.
Reporting Frequency:	Quarterly
Unit of Measure:	Rate of 100 adult Oncology & Hematology inpatient discharges
International comparison if available	• Centers for Medicare & Medicaid Services (CMS). (2023). Quality ID #355: Unplanned reoperation within the 30-day postoperative period. • National Cancer Institute. (n.d.). Localized. NCI Dictionary of Cancer Terms.
Desired Direction	<10%
Data Source	• Electronic Medical Record (EMR)

Type: Quality Indicator **Indicator Number:** CA009

KPI Description (title):	**7-Day All-cause Emergency Department / Urgent Care Visit without Hospitalization for Oncology & Hematology patients**
Domain	**Effectiveness**
Indicator Type	**Outcome**
Definition:	Percentage of Emergency Department/ Urgent Care visit without Hospitalization for adult patients (18 years and older) after discharge for principal diagnosis cancer or treatment of malignancy.
Calculation:	***Numerator*:** Number of adult inpatients in the denominator who return to the emergency department or urgent care (and not admitted for acute care hospitalization) within 7 days of discharge from index hospitalization. (***If a patient has multiple visits within 7 days of discharge from the index admission, only the first ED/Urgent Care visit is considered)***. ***Denominator:*** Total number of adult (age 18 and older) Oncology & Hematology inpatient and medical daycase discharges during the reporting period, with principal diagnosis of malignancy or encounter for malignancy treatment ***(ICD-10 code: C00-D09, Z51.0, Z51.1)*** ***Report Separately patients with:*** a) Breast cancer b) Colorectal cancer c) Head & Neck cancer (including Thyroid) d) Gynecology cancer e) Prostate Cancer **Denominator Exclusion:** • Episodes with a discharge of death • Patients who were discharged/left against medical advice (AMA) • Patients who were transferred to another acute care facility during the index hospitalization • Records with an unavailable discharge date or time.
Reporting Frequency:	Quarterly
Unit of Measure:	Percent
International comparison if available	Parikh, R. B., Kakad, M., & Bates, D. W. (2019). Reducing avoidable emergency visits and hospitalizations with patient risk-based prescriptive analytics: A quality improvement project at an oncology and hematology care model practice. JCO Oncology Practice, 15(6), e585–e593.
Desired Direction	<5%
Notes for all providers	
Data Source	• Electronic Medical Record (EMR)

Type: Quality Indicator **Indicator Number:** CA010

KPI Description (title):	**30-Day All-Cause Unplanned Hospital Readmission Rate for Oncology & Hematology patients**
Domain	**Effectiveness**
Indicator Type	**Outcome**
Definition:	Percentage of unplanned readmissions for adult patients (18 years and older) after discharge for principal diagnosis cancer or treatment of malignancy. All related and unrelated readmissions should be included (please indicate whether each readmission is related or unrelated in the notes section)
Calculation:	***Numerator*:** Number of adult inpatients in the denominator who were readmitted to a hospital within 30 days of discharge from index hospitalization. (***If a patient has more than one readmission within 30 days of discharge from the index admission, only the first is considered as readmission)***. ***Denominator:*** Total number of adult Oncology & Hematology inpatient (age 18 and older) discharges during the reporting period, with principal diagnosis of malignancy or encounter for malignancy treatment ***(ICD-10 code: C00-D09, Z51.0, Z51.1)*** ***Report Separately patients with:*** a) Breast cancer b) Colorectal cancer c) Head & Neck cancer (including Thyroid) d) Gynecology cancer e) Prostate Cancer **Denominator Exclusion:** • Episodes with a discharge of death • Patients who were discharged/left against medical advice (AMA) • Patients who were transferred to another acute care facility during the index hospitalization • Records with an unavailable discharge date or time. • Readmissions within 30 days from the index discharge
Reporting Frequency:	Quarterly
Unit of Measure:	Percent
International comparison if available	MDinteractive. (2023). MIPS measure #479: Hospital-wide, 30-day, all-cause unplanned readmission (HWR) rate for the Merit-Based Incentive Payment System (MIPS) groups.
Desired Direction	<10%
Data Source	• Electronic Medical Record (EMR)

Type: Quality Indicator **Indicator Number:** CA011

KPI Description (title):	**Timely Referral of First-time Diagnosed Multiple Myeloma Patients to Consultation for Hematopoietic Stem Cell Transplantation or Advanced Cellular Therapy Assessment**
Domain	**Timeliness**
Indicator Type	**Process**
Definition:	Percentage of first-time diagnosed Multiple Myeloma patients (all ages) who are referred to consultation for hematopoietic stem cell transplantation (HSCT) or advanced cellular therapy assessment within 10 working days from confirmation of diagnosis.
Calculation:	***Numerator*:** Number of patients (all ages) in the denominator who are referred to consultation for hematopoietic stem cell transplantation or advanced cellular therapy portal within 10 working days from confirmation of diagnosis: ***Denominator:*** Total number of patients (all ages) with a confirmed first-time diagnosis of Multiple myeloma during the reporting period. **Denominator Exclusion:** • Patients already under active care for hematopoietic stem cell transplantation or advanced cellular therapy at the time of diagnosis confirmation • Patients with documented absolute contraindications to hematopoietic stem cell transplantation or advanced cellular therapy referral (e.g. life expectancy insufficient to complete evaluation, age above 70 years) • Patients who decline referral following counseling, with documented informed refusal
Reporting Frequency:	Quarterly
Unit of Measure:	Percent
International/Local comparison if available	• DOH Standard on Stem Cell Therapies and Products & Regenerative Medicine • 2025 EBMT Practice Recommendations (Greco R et al., Bone Marrow Transplantation, 2025) • 2020 ASTCT Guidelines (Kanate AS et al., Transplantation and Cellular Therapy, 2020) • NCCN Clinical Practice Guidelines: Hematopoietic Cell Transplantation, Version 3.2025 (Loren AW et al., JNCCN, 2025)
Desired Direction	≥95%
Data Source	• Electronic Medical Record (EMR)

Summary of Changes V1.1 2026

KPI #	**Changes**
All KPIs	Updated citation format in **International comparison if available,** and **Data sources and guidance**
CA011	Added new KPI