

Jawda counts what you wrote down, not what you did.

What Abu Dhabi's outpatient rehabilitation indicators ask a clinic to record, and when.

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Summary of the argument

From the fourth quarter of 2026, every outpatient rehabilitation provider licensed in Abu Dhabi reports twelve Jawda indicators to the Department of Health each quarter. Ten of them ask whether patients improved on a named measure: pain, strength, balance, mobility, goals, speech and swallowing, dizziness, walking distance and gross motor function. Two ask whether children with cerebral palsy had a hip X-ray and a feeding assessment on time.

Every indicator is computed from the clinic's own record. A patient counts only with a baseline written before therapy, a reassessment on the same measure at a fixed point (day 42, 60, 84, 90 or 180), and a discharge assessment or a recorded reason to be left out. A patient whose reassessment was missed stays in the denominator and counts as not improved.

The paper sets out the twelve indicators side by side, the five things each outcome indicator needs from the record, why a missed reassessment costs more than a poor result, what most clinics already write down and where it gets lost, the two cerebral palsy indicators that depend on people outside the clinic, the points to confirm with the Department, and where to start.

1 • What changed, and when

In May 2026 the Department of Health – Abu Dhabi issued Version 1 of its **Outpatient Rehabilitation Service Jawda guidance**: twelve performance indicators, numbered REH001 to REH012, that every DOH-licensed facility providing outpatient rehabilitation in the emirate reports each quarter. Cerebral palsy rehabilitation is included. The guidance took effect in the fourth quarter of 2026, which means the first quarter being counted is the one now under way.

Ten of the twelve are outcome indicators: they ask whether patients got better on a named measure. Two are process indicators for children with cerebral palsy: whether a hip X-ray and a feeding assessment happened on time. Every one of them names the same data source: the electronic medical record.

The mechanics are simple to state. Each provider nominates one member of staff to coordinate, collect and monitor the indicators, and submits the quarter's data through the Jawda e-notification system. The

guidance also says the Jawda team may use the claims a provider has submitted through the Shafafiya portal to validate what it reports. The clinical record and the claim are expected to agree.

Jawda does not ask a clinic to treat differently. It asks the clinic to prove, from its own record, that the treatment worked.

2 • The twelve indicators

The table puts the twelve side by side. The “desired direction” column is the guidance’s own; where it says only that higher is better, no number is set.

Indicator	Who is counted	Counted as improved	Reassessed at	Target
REH001 • Pain	Musculoskeletal or orthopaedic outpatients aged 12+, physiotherapy or OT	Pain down 2 points or more on NRS (or the VAS equivalent)	Day 42, or discharge	≥ 70%
REH002 • Strength	Physiotherapy or OT, all ages, with a strength deficit	More than one clinically significant improvement in muscle strength	Day 42 (MSK, ortho) · day 84 (neuro)	≥ 70%
REH003 • Balance	Adults with neurological conditions, physiotherapy	Functional Reach Test up 3.7 cm or more	Day 42, or discharge	≥ 70%
REH004 • Mobility	Ambulatory adults with neurological conditions	Timed Up and Go faster by more than 2.9 seconds	Day 60, or discharge	Higher is better
REH005 • Goals	Children under 18 (not speech therapy, not cerebral palsy)	At least one goal at 0 or better on Goal Attainment Scaling	Day 42, or discharge	≥ 75% (baseline-dependent)
REH006 • Speech	All ages, speech and language therapy	Communication or swallowing up 0.5 or more on TOMs	Day 90, or discharge	≥ 70%
REH007 • Dizziness	Adults in vestibular rehabilitation	Dizziness Handicap Inventory down 18 points or more	Day 42, or discharge	≥ 70%
REH008 • Walking	Adults in cardiorespiratory rehabilitation	Median change in 6-Minute Walk distance, in metres	Day 42, or discharge	≥ 14 m
REH009 • Goals (CP)	Children with cerebral palsy	At least one goal at 0 or better on Goal Attainment Scaling	Day 180, or discharge	≥ 60% (baseline-dependent)
REH010 • Motor (CP)	Children with cerebral palsy	Any increase in GMFM-66 score or GMFM-88 percentage, same version both times	Day 90 first, then every 180 days	≥ 70%
REH011 • Hips (CP)	Children with cerebral palsy, GMFCS II–V, due for hip surveillance	A pelvic X-ray within the 12 months before the last visit	Each quarter	Higher is better
REH012 • Feeding (CP)	Children with cerebral palsy at nutritional or feeding risk, referred	Seen by a dietitian and a speech-language pathologist within 28 days of referral	From referral	Higher is better

Every outcome indicator is reported as a percentage of patients, except REH008, which reports the median change in metres across the eligible patients. REH001 and REH002 are reported separately for musculoskeletal and for orthopaedic patients, and REH002 separately again for neurological patients. Source: DOH Outpatient Rehabilitation Service Jawda Guidance, Version 1, May 2026.

3 • Five things every outcome indicator needs from the record

Read the ten outcome indicators together and the same five requirements repeat. None of them is a clinical skill. All of them are things the record either holds or does not.

- **The patient in the right cohort.** The condition cluster (musculoskeletal, orthopaedic, neurological, vestibular, cardiorespiratory, speech, paediatric, cerebral palsy) and the age decide which indicators a patient counts in. A knee replacement and a low-back pain patient are reported in different lines of REH001.
- **A baseline written before therapy starts.** Each denominator includes only patients with a documented baseline on the named measure “before initiating therapy”. A score taken at the second visit is not the baseline the guidance describes.
- **A clock for each indicator.** Day 42 for most, day 60 for Timed Up and Go, day 84 for strength in neurological patients, day 90 for speech and swallowing and for the first GMFM, day 180 for goals in cerebral palsy. One patient can be on several clocks at once.
- **A reassessment on the same measure, inside the quarter.** When more than one reassessment falls in the quarter, the latest one counts. For GMFM the guidance is explicit that a different version at reassessment (GMFM-66 at baseline, GMFM-88 later) is non-compliant.
- **A discharge assessment, or a recorded reason to leave the patient out.** Discharge is defined as completing the course or a formal release “with a documented discharge assessment”. Exclusions are specific: a patient who refused or did not comply with treatment, a baseline pain score of 1 or less, no strength deficit, unable to stand, non-ambulatory, cognitive or behavioural barriers to a safe test.

4 • A missed reassessment is not neutral

The guidance says it plainly: a patient whose reassessment was not done in the quarter is not counted in the numerator. That patient stays in the denominator. So a missed reassessment is not a gap in the data. It is recorded as a patient who did not improve.

The arithmetic is worth doing once. Suppose 200 patients reach day 42 this quarter, 80% are reassessed on time, and 85% of those reassessed have pain down by two points or more. The clinic reports $160 \times 85\% = 136$ patients improved, out of 200: 68%, against a 70% target. The treatment worked for 85% of the patients it was measured on. The figure says 68%, because 40 patients were never measured.

The fastest way to move a Jawda figure is rarely better treatment. It is making sure every patient who reached day 42 was measured on day 42.

That example is illustrative arithmetic on REH001’s counting rule, not a measured result. The rule itself is in the guidance, and it applies to every outcome indicator in the set.

5 • What most clinics already write down

Physiotherapists already measure. Pain on a 0–10 scale, muscle grades, a Timed Up and Go, a reach test: these are routine parts of a physiotherapy assessment, and they are usually written down somewhere. The question Jawda asks is narrower. Can the clinic find, for each patient, the right score, on the right measure, on the right day, in a form that can be counted?

Where the reading lives decides the answer. If the score is a number in a structured field with a date, the indicator is a query. If it is a sentence in a treatment note (“pain much better, 3/10 on stairs”), someone has to find it at quarter end, decide which visit was the reassessment, and type it into a spreadsheet. If it is on a paper form scanned into the record, it may not be found at all.

The same is true of the parts around the score:

- **The cluster tag.** Musculoskeletal or orthopaedic is a clinical judgement made at the first visit. If it is not recorded as a field, it has to be inferred later from the diagnosis code, patient by patient.
- **The due date.** Day 42 is counted from the start of therapy. Unless the reassessment is booked when the plan is made, it depends on someone remembering.
- **The patients who stop coming.** A patient who simply stops attending has not had a discharge assessment. Once that patient reaches the reassessment point, they count, and with no reassessment they count as not improved.
- **The exclusions.** A refusal or a baseline of 1 is a valid reason to leave a patient out, but only if it is recorded at the time, not reconstructed at quarter end.

None of this is new work for the therapist. It is the same assessment, written once in the place the indicator reads from.

6 • Children with cerebral palsy: two indicators that sit outside the clinic

REH011 and REH012 are different in kind. They measure whether something happened on time, and both depend on people outside the rehabilitation team.

- **Hip surveillance (REH011).** Children with cerebral palsy at GMFCS levels II to V who are due for surveillance under the AACPD care pathway should have a pelvic X-ray within the 12 months before their last visit in the quarter. An X-ray taken elsewhere counts, if it is documented in the EMR. Level I, surgically stabilised hips and documented family refusals are excluded.
- **Feeding and nutrition (REH012).** Children identified as high-risk (recurrent aspiration, failure to thrive, a weight-for-age score of ≤ 2 as the guidance writes it, or oropharyngeal dysphagia) and referred to the nutrition and dysphagia clinic should be assessed by both a dietitian and a speech-language pathologist within 28 days of referral. External referrals count if documented.

For both, the record has to hold something the rehabilitation team did not produce: a radiology result, another clinician’s assessment. The work is in the referral and in bringing the result back into the record.

7 • Questions to confirm with the Department of Health

Version 1 leaves some points open to reading. A clinic should settle these with the Jawda team (jawda@doh.gov.ae) before building its process around one interpretation:

- **REH002's measure.** The indicator asks for "more than one clinically significant improvement in muscle strength" but does not name the instrument. Is a one-grade change on manual muscle testing enough, or more than one grade?
- **The reassessment window.** The guidance counts a reassessment "done in the measurement quarter" and takes the latest when there are several. How early before day 42 can a reassessment be taken and still count as the day-42 reassessment?
- **Patients who stop attending.** Is a patient who drops out without a discharge assessment counted at the reassessment point, or excluded under non-compliance with treatment?
- **REH012's weight threshold.** High risk includes a "weight-for-age score ≤ 2 ". Is that a z-score of -2 or below, as growth charts usually express it?
- **Episodes that cross quarters.** Which quarter does an episode belong to when the baseline falls in one quarter and the reassessment point in the next?

This paper is Xamun's reading of the guidance, not the Department of Health's. Where it matters, confirm with the Department, with your quality lead, or with a regulatory adviser before you submit.

8 · Where to start

Most of the work is a review of the record, not a new system. In order:

- **Pull last quarter as if it counted.** Take every patient who reached day 42 (or 60, 84, 90, 180) and check for a baseline, a reassessment on the same measure, and a cluster. The share with all three is the ceiling on your figure today.
- **Make the baseline a field.** The score, the measure, the date and the cluster, recorded at the first visit, before treatment.
- **Book the reassessment when the plan is made.** Put the due date on the plan, and show the team who is due or overdue this week, not at quarter end.
- **Close every episode.** A discharge assessment, or a recorded reason: refused, did not comply, below threshold at baseline.
- **Name the coordinator early.** The guidance requires one. Give them the figure as the quarter runs, with the patients pulling it down listed first.

We built this into **ClinicOS** for physiotherapy and outpatient rehab: baselines and reassessment clocks on the physiotherapist's board, and a Jawda view by site with the patients pulling the figure down listed first. Its definitions are confirmed against the published guidance before any submission. If it helps, we will build the first step for you: send an extract of last quarter's rehab data and we will show where your REH001 figure stands, at no cost.

Questions a clinic should ask

What are the outpatient rehabilitation Jawda indicators?

Twelve quality indicators, REH001 to REH012, set by the Department of Health – Abu Dhabi in its Outpatient Rehabilitation Service Jawda guidance, Version 1, issued May 2026. Ten measure outcomes (pain, strength, balance, mobility, goal attainment, speech and swallowing, dizziness, walking distance and gross

motor function); two measure process for children with cerebral palsy (hip surveillance and timely feeding assessment).

Who has to report them, and from when?

All DOH-licensed healthcare facilities providing outpatient rehabilitation in the Emirate of Abu Dhabi, including cerebral palsy rehabilitation. The guidance is effective from the fourth quarter of 2026 and is reported quarterly through the Jawda e-notification system, by one member of staff the provider nominates.

What happens if a patient misses the 42-day reassessment?

The patient is not counted in the numerator but stays in the denominator, so a missed reassessment counts the same as a patient who did not improve. If 80% of patients are reassessed on time and 85% of those improve, the clinic reports 68%.

Which reassessment counts if there are several in a quarter?

The latest one in the measurement quarter, on the same measure as the baseline. For the gross motor indicator, using a different GMFM version at reassessment than at baseline is non-compliant.

Does the baseline have to be taken before therapy starts?

Yes. Each outcome indicator counts only patients with a documented baseline on the named measure before therapy was initiated, such as an NRS or VAS pain score for REH001 or a Functional Reach Test for REH003.

Which patients can be excluded?

Each indicator lists its own exclusions. Common ones are patients who refused or did not comply with the recommended treatment. Others are specific: a baseline pain score of 1 or less (REH001), no strength deficit (REH002), unable to stand independently (REH003), non-ambulatory or with cognitive or behavioural barriers to a safe test (REH004). The reason needs to be in the record.

Can the Department of Health check the data?

The guidance says the Jawda team may use the claims data providers submit through the Shafafiya portal to validate what they report through the Jawda portal, so the clinical record and the claims should agree.

Where should a clinic start?

By pulling last quarter as if it counted: every patient who reached a reassessment point, checked for a baseline, a reassessment on the same measure and a condition cluster. Then make the baseline a structured field, book the reassessment when the plan is made, and close every episode with a discharge assessment or a recorded reason. Confirm open definitions with the Department of Health at jawda@doh.gov.ae.

About this paper

This is the tenth paper in a series on enterprise AI as an operating system rather than a tool, and the first written for healthcare providers. Every paper is readable at xamun.ai/whitepapers.

This paper is Xamun's own reading of the Department of Health's guidance. It is not issued, reviewed or endorsed by the Department of Health – Abu Dhabi. Indicator definitions are summarised in our words; the guidance itself is the authority, and the Department advises using the latest version it publishes. Check with the Department, your quality lead or a regulatory adviser before you rely on it for a submission.

Sources and references

1. Department of Health – Abu Dhabi, "Outpatient Rehabilitation Service Jawda Guidance", Version 1, issued May 2026, effective Q4 2026 — the twelve indicators REH001–REH012, their definitions, inclusions, exclusions, targets and reporting rules.
2. Department of Health – Abu Dhabi, Muashir and Jawda quality programme pages, doh.gov.ae.
3. American Academy for Cerebral Palsy and Developmental Medicine (AACPDM), "Hip Surveillance in Cerebral Palsy: Care Pathway" — as cited by REH011.
4. European Society for Paediatric Gastroenterology, Hepatology and Nutrition (ESPGHAN), guidelines for the evaluation and treatment of gastrointestinal and nutritional complications in children with neurological impairment (2017) — as cited by REH012.
5. Xamun Position Papers No. 1 to No. 9 (August–October 2026), xamun.ai/whitepapers.

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