Term	Definition
Panel Management	(Also known as Population Health Management) A proactive approach to health care. "Population" refers to the panel of patients associated with a provider or a care team. Population-based care means that the care team is concerned with the health of the **entire** population of its patients, not just those who come into the clinical setting for visits. The panel (a group of patients assigned to a PCP) allows care teams to oversee and track proactively the health care needs of patients on their panels and ensure that all patients receive the services they need to optimize their health and well-being. Panel management ensures that all patients, not just those who come in for appointments, are getting the preventive and chronic condition care they need. For example, a practice may use panel management to ask "Have all of our patients between 50 and 75 years of age received colorectal cancer screenings at the appropriate time intervals? Have all of our patients with a diagnosis of diabetes had lab tests for HbA1c, eye exams and urine microalbumin at the appropriate times?" Key benefits of a PHM approach to patient care: 1) better health outcomes, 2) disease management, 3) closing care gaps, 4) cost savings for providers. 1. Better health outcomes: The ultimate goal of PHM is simple – improving the quality of care while reducing costs. 2. Disease management: PHM improves the care of those with chronic and costly disease by using IT solutions that track and manage their care. 3. Closing care gaps: A fully integrated HBI tool helps close gap sin care by allowing organizations and physicians to have real-time access to track and address patient needs. Laboratory, billing, electronic health record and prescription data can easily pinpoint unmet needs and gaps in data or service delivery. 4. Cost savings for providers: As with all advances in healthcare management, PHM is a win-win. By leveraging data analytics, PHM improves clinical outcomes while reducing costs.
Gap Management	A collaborative, deliberate effort to oversee, track and analyze primary care quality metrics and performance to identify then actualize a team-based approach to closing gaps in care. Gaps include preventive measures, chronic conditions measures, HCC updates (risk gaps), information gaps and completion of Annual Wellness Visits. Success metrics include: percentage of panels with care gaps closed, percentage of patients not attributed to a PCP with care gaps closed, percentage of preventive screenings and immunizations complete, percentage of panels with chronic disease management states that are "controlled". System-wide, a dedicated approach is used to identify then prioritize commonalities in below-threshold performance on HEDIS measures (care gaps) across the health system. The intent is to evaluate, foster and operationalize a systematic approach to operationalize a systematic approach to adopt best practices in workflows and patient care approaches,

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	respective of the diversities that exist in care team models and patient populations.
Panel Maintenance	A process to ensure accuracy of panels for Primary Care Providers that includes provider validation and approval, removal of patients who are deceased or have not been seen in the past 3 years, and empaneling the unassigned patients.
Empanelment	A deliberate effort to link and assign patients with correct Primary Care Providers and a care team in a manner that considers patterns of care, types of visits over a period of time and most importantly patient and family experience. Empanelment is a building block to population health management and the key to care continuity.
Care Gap	HEDIS prevention and screening metrics (quality measures) must be met with each eligible Medicare patient according to each measure's measurement criteria. When these HEDIS measures are not met based on these criteria, this results in a "Care Gap." Care Gaps are tracked by individual patient, provider, clinic, organization and system. A gap in care exists when a patient is overdue for a preventive healthcare service that should be done periodically or when a patient is not meeting the goal range for a particular disease or condition, such as having a HbA1c greater than the recommended target.
Risk Gap	Providers must diagnosis and document their patients' diagnoses (acute, chronic, co-existing), which means updating these diagnoses each year. Year-to-year, HCCs (Hierarchical Condition Category) help to identify which individuals with serious or chronic illness and assigns risk factor score based upon a combination of health conditions and demographic details. Determines the Risk Adjustment Factor (RAF).
Information ('Info') Gap	The disparity in data exchange between the health system and the payers relating to clinical quality care measures. This results in a misinterpretation by the payer that a quality measure metric was not met for an individual patient, when in fact the healthcare service was completed based on the measurement's criteria. Assure payers have accurate and up-to-date information at the patient-level to close real quality care gaps versus missing information gaps at the clinic and system level.
HEDIS measure	Healthcare Effectiveness Data and Information Set (HEDIS) is a tool used to measure performance on important dimensions of health care and service across more than 90% of the U.S.' health care providers. HEDIS progress and performance results are used to identify where our health system needs to focus its improvement areas. Our UW Medicine health system's performance on HEDIS measures determines the reimbursements and incentives we receive the following year, which largely contributes to our funding ability to gain the resources to provide the highest quality of care for all our patient populations.