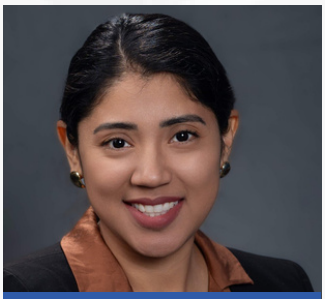
CRISP QUARTERLY

FROM THE CRISP STAFF



Jessica Heslop, MHA

I am excited to be leading the new Engagement Strategy Team, a dedicated group focused on helping our partners maximize value through trainings, personalized support, and proactive communication. The Engagement Strategy Team is committed to hearing feedback and working collaboratively to re-engage with users in meaningful ways. Our team will actively seek to understand organization's priorities and challenges, sharing relevant use cases and success stories to inspire innovation and improve outcomes. We welcome anyone to reach out to start these meaningful conversations.

Email: MDCommunications@crisphealth.org

IN THIS ISSUE

HIGHLIGHTS

Did you know that after performing a patient query in the CRISP Portal, more applications become available to select? On the left-hand side of the screen, enter a patient's first name, last name, and date of birth to perform a direct patient query. From here, you can view the full list of applications by clicking on the line item for the patient whose information you wish to view.

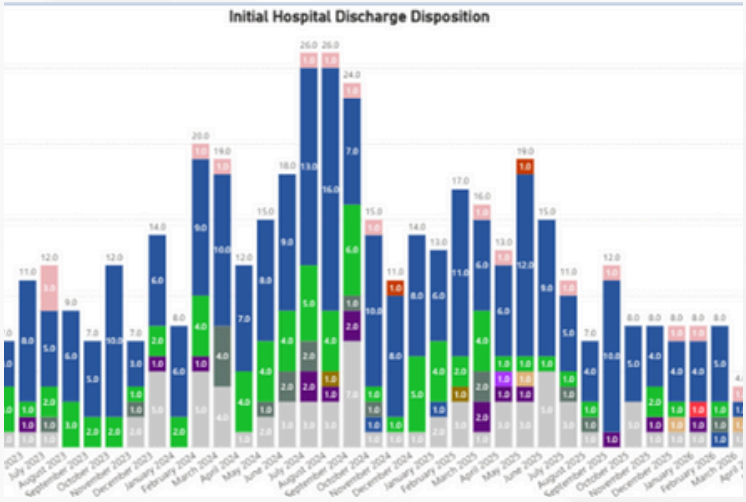
Did you know that non-CDS dispense data is now available in CRISP? The Dispensed Medications subtab, located under the Medication Management tab, displays non-controlled medications that have been reported for a patient through RxGov by dispensers. This data includes information required in state regulations.

WHAT'S NEW WITH CRISP

COMING SOON - CLINICAL DATA: REPORTING & ANALYTICS

CRISP is excited to announce the pilot of the new Clinical Data: Reporting & Analytics suite. This innovative application will provide near real-time access to clinical data extracted directly from EHRs, ADT messages, CCDs, and connected lab results. This tool helps care teams quickly spot population patterns, track discharge trends, and identify care gaps—enabling faster, more informed decisions.

Clinical Data: Reporting & Analytics helps track hospital revisits to SNFs or LTC Facilities, analyze Race, Ethnicity, and Language data, and identify prevalent chronic conditions to strengthen population health management, enabling earlier intervention and better care coordination.

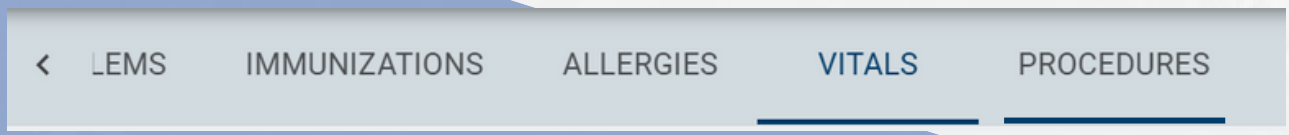


Organizations will have the opportunity to request access to the reporting suite starting March 2026 - reach out now if your organization would like to participate and be among the first to experience these advanced reporting capabilities!

NEW CLINICAL DATA: INCONTEXT

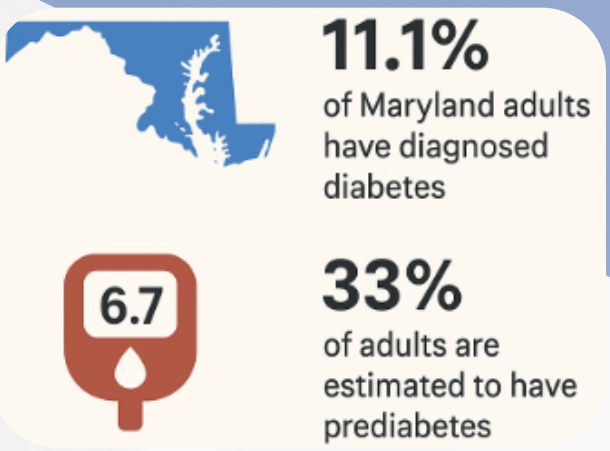
Within InContext, each tab has subtabs containing different categories of data. Under the Clinical Data tab, two new subtabs have been added: Procedures and Vitals.The addition of this data will allow users to see a more complete view of a patient's medical history within InContext. All new data in InContext is available alongside other clinical data, helping support more informed clinical decision making.

InContext can now extract, parse, and display vital and procedure entries directly from Continuity of Care Documents (CCDs), a function not previously available within InContext. This data is available under the respective Procedures and Vitals subtabs.



SMARTER ALERTS FOR DIABETES CARE

As we transition out of Diabetes Awareness Month (November) into December, we're spotlighting how our Logic-Based Alerts in the Population Explorer can help health-care organizations take a more proactive, targeted approach to patients living with or at risk for diabetes and pre-diabetes.



https://diabetes.org

Prediabetes often goes undetected; many individuals don't know they're at risk. Because diabetes is linked to serious complications — cardiovascular disease, kidney disease, amputations, and higher health-care costs — the opportunity for early detection, follow-up, and intervention is meaningful.

Standard encounter alerts are valuable — but they cast a wide net. **Logic-Based Alerts (a.k.a. Intelligent Alerts)** enable more selective, criteria-based notifications. These are especially useful for large patient panels where care teams need to focus on specific conditions, patterns, or risk groups.

Within Population Explorer, these alerts appear in yellow and can be filtered by Notification Type. They allow care teams to hone in on patients who meet particular criteria, such as elevated HbA1c, multiple hospital visits in a short time frame, or recent discharge with a diagnosis of diabetes. For providers and care managers, this means earlier identification of at-risk patients, timely intervention to help prevent avoidable readmissions, and better alignment of resources through improved continuity of care so teams can prioritize high-risk individuals with actionable insights.

Three diabetes-focused alerts now available include are in the table below. To learn more or enable these alerts, contact your CRISP Outreach Representative or visit our website.

Alert Name	What It Detects	How It Helps Providers
Potential Prediabetes (Type 1 or 2)	Flags patients with elevated HbA1c results from inpatient, emergency, or observation encounters	Identifies patients who may be at risk and may need early outreach or follow-up
Timely Follow-Up (Diabetes) – Primary Only	Alerts when a patient's primary diagnosis at discharge is diabetes	Helps ensure timely follow-up after hospitalizations directly related to diabetes
Timely Follow-Up (Diabetes) – Primary & Secondary	Captures discharges where diabetes appears as any diagnosis (primary or secondary)	Expands visibility into patients whose diabetes may not be the main reason for the encounter but still requires attention

CRISP IN ACTION

UNIVERSITY OF MARYLAND MEDICAL SYSTEM

Partnership Automates Receipt and Filing of EMS Patient Care Reports

A long-standing goal of automating EMS Patient Care Reports (PCRs) into the EMR became a reality through a strong partnership between UMMS, CRISP and MIEMSS. By replacing a manual process of downloading, printing, barcoding, and scanning, the new automated workflow puts the PCRs directly into the patients visit within UMMS' Epic. This process now meets compliance requirements while reducing administrative burdens. ***"We gave back valuable time to our clinicians to focus on what's most important,"*** said Angela Johnson, Clinical Informatics Manager at The University of Maryland Medical System.

Consistent workflows, real-time visibility, and proactive stakeholder engagement not only boosted efficiency but also sparked new opportunities for future automation—proving the power of partnership to transform patient care.

Find out more details and instructions for getting started in this one-pager.

RESOURCES

- **RESOURCE LIBRARY**
- **WEBSITE**
- **YOUTUBE**
- **LINKEDIN**

UPCOMING WEBINARS

- **InContext**
  Dec 10, 12:00 PM
- **Consent Tool**
  Dec 17, 12:00 PM
- **New User Training**
  Jan 15, 12:00 PM
- **HIE Admin Tool**
  Jan 22, 12:00 PM
- **Population Explorer**
  Jan 29, 12:00 PM