crossbeam
HEALTH

A conversation about specialty referrals at Cedars-Sinai.

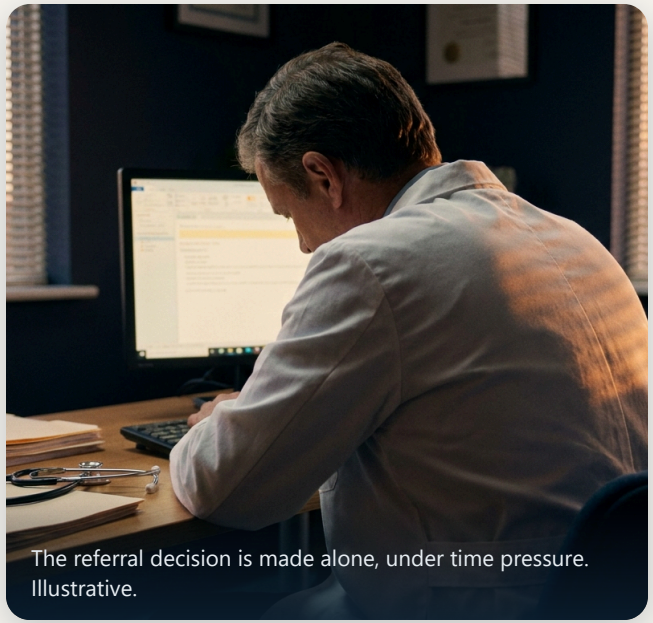
Crossbeam Health is an early-stage clinical software company studying how primary care and specialty care collaborate. Before we propose anything, we want to understand the problem from your side.

Prepared for Cedars-Sinai | July 2026 | crossbeamhealth.com

FOR DISCUSSION

THE PROBLEM, AS WE UNDERSTAND IT SO FAR

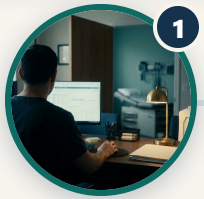
Nationally, the referral journey breaks quietly at every step.



The referral decision is made alone, under time pressure. Illustrative.

Measure	What national data shows	Source
Referral volume	100M+ ambulatory specialty referrals a year in the US; only about half are ever completed.	MedCity News, 2025
Specialist wait	31 days on average for a new-patient appointment across 15 major metros, up 48 percent since 2004.	AMN Healthcare survey of physician appointment wait times, 2025
Network leakage	45 percent of referral revenue from employed primary care physicians leaves the network.	Advisory Board, 2024
Clinician burden	206M in-basket messages at one large academic health system in 2024, up from 58M in 2017.	Journal of Arthroplasty, 2025

Published national figures, our synthesis of the literature. What we want from these meetings is your picture: where this holds at Cedars-Sinai, where it does not, and what the real numbers are.



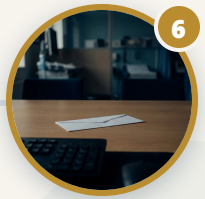
DECISION
Made alone, under time pressure

ORDER
Goes out information-poor

TRIAGE
Sorted by scheduling, not need

SCHEDULING
Patients drop in the gap

THE VISIT
Starts over from scratch



LOOP CLOSURE
The result often never returns

WHAT GOOD LOOKS LIKE

Where referrals work today, and why that is hard to copy.

What clinicians describe	Inside a fully integrated system
About a one-week wait	Internal-medicine referrals at Kaiser Permanente land in roughly a week, against a 31-day national average.
Protected video consult slots	Specialists hold dedicated slots for quick video consults, so advice does not wait for clinic space.
A screener in every specialty	Each department has a specialist screener who reviews every PCP referral and approves, declines, or advises.
PCPs consult the screener directly	The screener either sends a plan back to the PCP or approves the referral, before the patient moves.
One connected network	Outpatient and inpatient run on one tightly connected system, so the loop rarely drops.

Crossbeam clinician interviews, July 2026: three Kaiser Permanente clinicians, relayed secondhand, so directional. Wait-time benchmark: AMN Healthcare, 2025. A benchmark, not an endorsement.

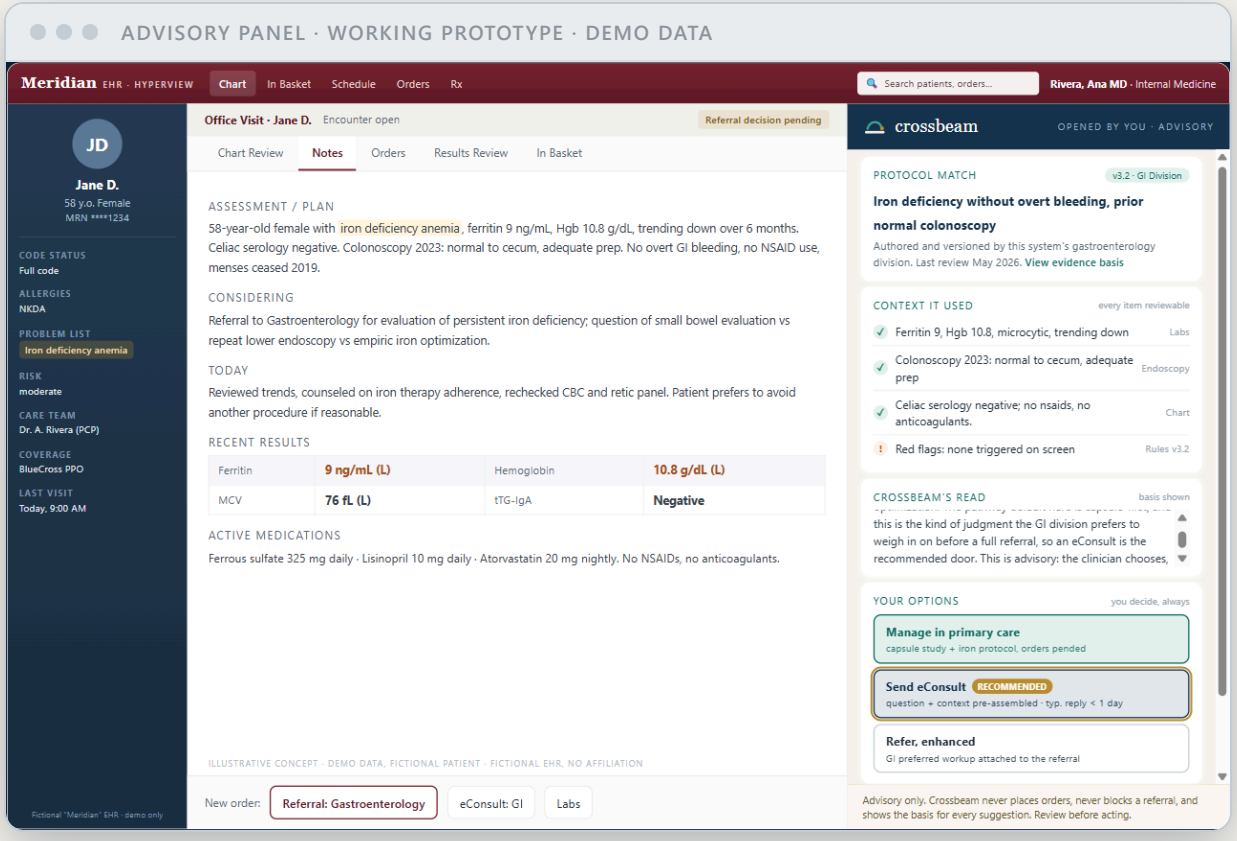
Why it works there. Kaiser is a fully integrated payer plus provider (UPMC is similar): the same organization pays for care and delivers it, so specialist time spent screening referrals pays for itself. Clinicians at standalone academic systems describe the opposite experience, long waits and little feedback, precisely because that integration is missing.

The question we want to explore with Cedars-Sinai: can software carry the screener's judgment to the referral decision moment inside a system that is not payer-integrated, without restructuring anything?

Method Clinician-interview synthesis, stated with its limits: secondhand relay, small sample, and integrated-system economics that do not transfer one for one.

THE DIRECTION WE ARE EXPLORING

The hallway consult, rebuilt inside the EHR.



Three paths, one panel	What happens, and who decides
Manage in primary care	Specialty-authored workup and orders arrive ready for the PCP to review and sign.
Send an eConsult	Question and chart context are pre-assembled; a specialist answers asynchronously and the PCP acts.
Refer, enhanced	The referral leaves with the specialty's preferred workup attached, so the specialist sees a prepared patient.
HOW IT BEHAVES	
Advisory only	The clinician always decides. A full referral stays one click away.
Invited, not interruptive	Opened by choice at the decision moment. No pop-ups, no hard stops.
Inside existing workflow	Lives in the EHR and rides the messaging rails clinicians already use.

This is a direction, not a product. What we build should follow what we learn here, starting in one specialty chosen together from your own pain-point data, then expanding specialty by specialty.

Status Working prototype with demo data, shown for orientation only. Live walk-through at crossbeamhealth.com. No product claims made or implied.

WHAT WE WANT TO LEARN FROM YOU

Seven questions we hope you will answer candidly.

	Question	Why we ask
THE PROBLEM, IN YOUR WORDS		
1	Where does the referral experience break down most often, and for whom?	Your picture, not ours.
2	Walk us through a recent complex referral, end to end.	The real process, not the process chart.
SEVERITY AND OWNERSHIP		
3	How often do referrals stall or leave the network, and what does each one cost?	Sizes the problem in revenue and access.
4	Who owns this problem today: clinical leadership, finance, or the board? And who feels it most day to day?	Different owners see different problems; the owner is who drives change.
5	What has Cedars-Sinai already tried or bought here, and how has it worked?	What we build must beat what exists.
PRIORITY AND SUCCESS		
6	Is fixing referral management a top priority this year, or a known issue you can live with?	Honest priority beats polite interest.
7	What would make this a clear win for your team, and what would make it not worth your time?	Your success criteria become our test.

Prefer to answer in writing?

cedars.crossbeamhealth.com

Five minutes, in your own words, whenever suits you. Your answers go directly to our team and are never shared or published.

"This is not actually a problem" is one of the most useful answers you can give us.

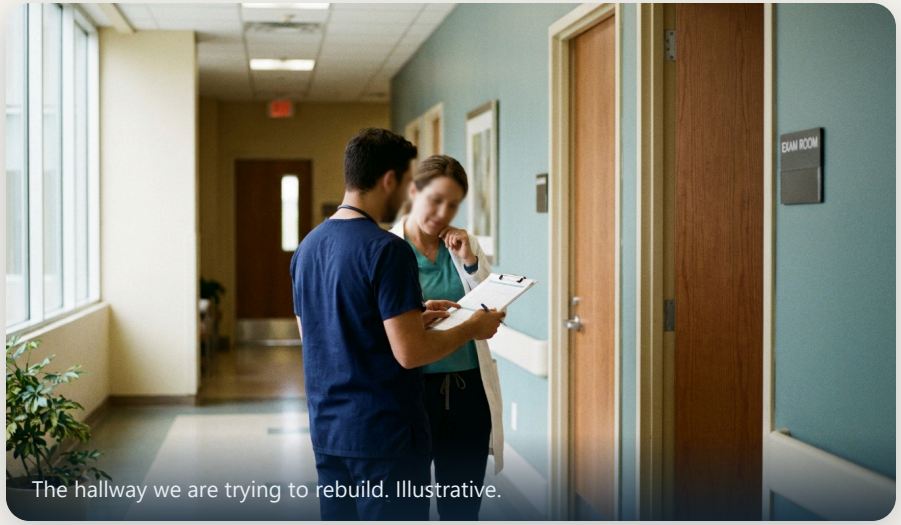
Method Built on established discovery practice: ground in past events, quantify severity, locate ownership, and define success in your terms.

WHAT HAPPENS NEXT

Listen first. Then a problem statement we write together.

Working session	What we do together	What you get
1 · Find the owner	Time with your clinicians and teams, watching how referrals actually move, and finding whose problem this really is: clinical leadership, finance, or the board. No selling, no demos.	An accurate picture of the problem, in your words, with the right people in the room.
2 · Validate with your data	A written problem statement brought back for correction, and the single most painful specialty identified from your own referral data.	A veto over our understanding, early, and evidence in your numbers.
3 · Co-design the model	If the problem holds, we shape the commercial structure and a focused pilot together, success criteria agreed before anything starts. How does Cedars-Sinai typically structure arrangements like this? That question is yours to answer.	A structure that makes sense for everyone. No open-ended pilots.

We would rather hear a clear no early than run a polite pilot that goes nowhere.
Tell us where we are wrong; that is the most useful thing this meeting can produce.



The hallway we are trying to rebuild. Illustrative.

Share your answers with us.

Scan, or visit **cedars.crossbeamhealth.com**.
Everything you tell us stays with our team.