crossbeam
HEALTH

Crossbeam Health (working name, draft)

One line: An advisory panel inside Epic that brings your own specialists' judgment to the moment a primary care clinician decides whether to refer.

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Shared for feedback, not a solicitation. Please do not forward.

The problem

More than 100 million specialty referrals are generated in US ambulatory care each year, and only about half are ever completed (pmc.ncbi.nlm.nih.gov/articles/PMC3160594/). The clinician making the referral decision gets no specialist input at that moment: no system-specific protocol, no view of what the receiving specialty actually wants worked up first, so the referral goes out as an order plus free text and the queue sorts it out. The queue is long and getting longer: the average new-patient appointment wait across 15 major metros hit 31 days in 2025, with gastroenterology at 40 days and Boston as high as 65 (amnhealthcare.com/amn-insights/physician/whitepa). Meanwhile the follow-up burden lands back on primary care: Epic In Basket system-generated messages grew from 58 million in 2017 to 206 million in 2024 (sciencedirect.com/science/article/abs/pii/S08835), and above-average In Basket load is associated with roughly 40 percent higher odds of burnout (healthaffairs.org/doi/10.1377/hlthaff.2018.05509). On top of that, 40 to 70 percent of referrals leak out of network, and 30 to 50 percent never complete at all (advisory.com/topics/physician/2024/12/reduce-ref). Nothing about any of these episodes, whether the referral was needed, what the specialist did, what happened to the patient, ever feeds back into the next referral decision.

The concept in one paragraph

Crossbeam is an advisory sidebar inside Epic that the primary care clinician opens by choice at the referral decision moment. It matches the case to a protocol authored and versioned by the specialists at your own institution, pre-populates the relevant chart context (labs, meds, prior workup, red flags) and shows exactly which data it used, then offers a three-way disposition menu: manage in primary care with suggested orders pended for signature, send a one-click eConsult with the question and context pre-assembled for the specialist, or refer with the specialty's preferred workup attached so the visit that happens is a complete one. Every recommendation carries the protocol version, the authoring division's name, and the evidence basis, and outcomes are tracked against claims and chart data, not just surveys, so the protocols improve over time. The clinician always decides. Nothing fires automatically, nothing interrupts, and the full referral is always one click away.

What we are NOT building

- No autonomous triage: the system never disposes of a case on its own.

- No "do not refer" directives: guidance is advisory, and the referral path is never blocked, gated, or slowed.
- No black box: every suggestion shows its protocol version, its authors, its evidence basis, and the patient-specific data it used, all reviewable before you act.
- No interruptive alerts or pop-ups: the panel opens only when the clinician opens it.

What we want to learn from you

We are trying to find out whether this thesis is wrong before anyone builds it. Five open questions:

1. In your own practice, what share of the referrals you send (or receive) genuinely did not need the specialist visit, and how do you actually know? For calibration: Ontario's provincial eConsult program reports 51 percent referral avoidance (self-reported by the referring clinician at case close), while the program's only randomized trial on claims data found a non-significant reduction of about 6 percent (pmc.ncbi.nlm.nih.gov/articles/PMC6558850/). Where does your honest number sit?
2. Who at your organization would actually pay for something like this, and what has your organization ever paid for in this category? What happened to it?
3. If referral volume dropped 10 to 15 percent because more patients were managed in primary care, who in your building gains and who loses (time, panel, procedure revenue, compensation), and would the losers fight it?
4. What would guidance like this have to do, or carefully avoid doing, to earn a click in your real workflow instead of being ignored like most decision support?
5. What would make you trust, or permanently distrust, a protocol match authored by your own specialty divisions, and where do you believe responsibility sits when you follow it?

How to give feedback

Feedback form: https://docs.google.com/forms/d/e/1FAIpQLSd4RZGojA5Xu4BtR1aX9DELviqutIoHa0PhGe2HYstL_UyHYA/viewform

Or just tell us on the call. Blunt is better than polite; we are looking for the reasons this fails, not the reasons it might work.
