ARKA
ARKA-IP ? avoidable inpatient bed-days
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The one place a hospital is already on your side.

This section is for a CMO, a VP of Care Management, or a hospital medicine chair ? not the ACO medical director the rest of this page addresses.
Robinson 2022 published marginals and a synthetic fixture finding ? zero customer data. Figures from the ARKA-IP engine.

THE FINDING, FIRST

Only 56% of in-scope orders had an expected discharge date documented when the order was placed ? the gate cannot reach the rest. [illustrative]

THE DRG INCENTIVE

Under the Inpatient Prospective Payment System an admission groups to a DRG, and the hospital receives a fixed prospective amount for that stay. Inpatient imaging therefore generates no incremental revenue at all ? which is why a hospital is already on the side of moving a late study to outpatient.

THE PUBLISHED RESULT

53.9% of flagged orders were reviewed; 24.0% of reviewed orders were transitioned; 12.9% of all flagged orders overall (80/618). 46.1% of flagged orders were never reviewed, stated plainly. 267 avoided bed-days and $199,194 reported savings. Pre-post quality improvement at two large academic tertiary care centres in New York City over nine months. Email-based secondary review of inpatient MRI orders placed within 24 hours of the estimated date of discharge. 46.1% of flagged orders were never reviewed. The intervention was not underperforming; the delivery was. Review uptake is what the workflow controls; conversion among reviewed is what clinical judgement controls; the composite is their product, and the least useful of the three. [measured]

THE OPPORTUNITY GAP

At the published conversion among reviewed (24.0%), raising review uptake from 53.9% to 80.0% would produce 39 additional transitions (119 instead of 80), holding clinical judgement constant. That quantity appears nowhere in the literature. [modeled]

WHAT WE DO DIFFERENTLY
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1. A locked pre-period and a pre-specified non-equivalent control group are hard preconditions. No live flag fires without them. 2. ARKA-IP may recommend a second review; it may never cancel, convert, hold, or set the status of an order. 3. Review uptake and conversion among reviewed are reported separately. The composite is the product, and it is never the headline. 4. The retrospective path applies no intervention and needs no lock. That is the free analysis this page offers.

THE ASK

Nine months of retrospective, de-identified inpatient advanced-imaging orders with expected discharge dates, plus the encounters they belong to. No software, no integration, no cost, no PHI beyond what a BAA already covers.
- Retrospective. No prospective intervention, no EHR write access, no clinical risk. IRB-minimal-risk in most institutions.
- Four flat files. CSV is fine. So is a database view, a Clarity extract, or a spreadsheet.
- No PHI beyond identifiers you already hash. No names, no MRNs, no dates of birth, no free-text notes other than the order indication field ? and even that is optional.
- We return the analysis. You get your own conversion rate, your own review uptake, your own avoided bed-days, and the gap between them. If the number is not there, we say so.

The two rates, the lock, and the extract request are published before we see your data.
Robinson NB, Gao M, Patel PA, Davidson KW, Peacock J, Herron CR, Baker AC, Hentel KA, Oh PS. Secondary review reduced inpatient MRI orders and avoidable hospital days. Clin Imaging. 2022 Feb;82:156-160. PMID 34844100.

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