ASCEND®
CARDIOVASCULAR

PROCUREMENT CHECKLIST
RSNA 2026 EDITION

THE ENTERPRISE CARDIOLOGY PROCUREMENT CHECKLIST

Does your enterprise imaging strategy **really cover cardiology?**

Ten questions every enterprise imaging evaluation should ask, and what to make each vendor prove on the show floor.



WRITTEN FOR

Enterprise imaging, radiology, and IT leaders evaluating platforms that will also serve cardiology.

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WHY CARDIOLOGY NEEDS ITS OWN LINE IN YOUR RFP

Cardiology is an **enterprise within the enterprise**

Ask any enterprise imaging vendor whether their solution "also covers cardiology," and the answer will almost always be yes. This checklist helps you find out what that yes actually means.

Enterprise imaging evaluations are usually built through a radiology lens: study volume, report turnaround, archive strategy, and universal viewer access. Those priorities are right for radiology, but cardiology works differently. When those differences are not written into requirements, cardiology inherits tools designed for someone else, and the cost surfaces later in workarounds, re-keyed data, and analytics that cannot be built.

	TYPICAL DIAGNOSTIC RADIOLOGY MODEL	CARDIOLOGY MODEL
Who interprets	Radiologist interprets; a referring physician manages the patient	Cardiologists perform, interpret, and act on results, often for their own patients
What a study produces	Images and a narrative report	Images plus hundreds of discrete measurements, hemodynamic and device data, and a structured report
Scope of care	Diagnostic imaging	Imaging plus catheter-based procedures, inpatient and ambulatory care across cardiology, cardiac surgery, and vascular
Time horizon	Comparison with recent priors	Lifelong disease tracking across modalities and procedures
Accountability	Volume, turnaround, diagnostic accuracy	Outcomes, complications, readmissions, registries, and total cost of care
Decision-making	Reading room to referring physician	Multidisciplinary Heart Team decisions, often in real time

CARDIOLOGY TERMS USED IN THIS CHECKLIST

Not an exhaustive glossary. These are the cardiology areas and terms referenced in this guide, grouped the way a cardiovascular service line is typically organized.

NON-INVASIVE IMAGING

Echo (TTE / TEE)
Ultrasound of the heart, through the chest wall or the esophagus. The highest-volume cardiac imaging study.

Vascular ultrasound
Ultrasound of arteries and veins outside the heart, such as carotid and peripheral studies.

Cardiac nuclear medicine
SPECT and PET imaging of blood flow to the heart muscle, often paired with stress testing.

Advanced cardiac imaging
Cardiac CT and cardiac MR, used to assess coronary arteries, structure, and heart tissue.

INVASIVE AND PROCEDURAL

Cath lab and hemodynamics
Catheter-based diagnosis and treatment, with pressures and flows recorded live.

EP (electrophysiology)
Diagnosis and treatment of heart rhythm disorders, including ablations and device implants.

Structural heart
Catheter-based valve repair and replacement (such as TAVR), heavily guided by imaging.

PATIENTS, PROGRAMS, AND DATA

CHD (congenital heart disease)
Heart defects present at birth, cared for from childhood into adulthood (adult congenital, or ACHD).

Z-scores
Pediatric measurements adjusted for body size, used in place of adult normal ranges.

Heart Team
Cardiologists, cardiac surgeons, and imaging specialists deciding together on complex treatment.

Registries
National quality databases (such as ACC NCDR) that cardiovascular programs report to.

KNOW THE GAPS BEFORE YOU SEE THE DEMO

Where general-purpose solutions **tend to fall short**

Enterprise imaging platforms and EHRs are essential, and most offer some form of cardiology capability. The question is depth. These four areas separate a cardiology checkbox from a cardiology solution.

GAP 01

Invasive vs. non-invasive depth

Many systems equate echo capabilities with cardiology coverage, but true enterprise support spans the full spectrum of non-invasive and invasive cardiology, from cardiac nuclear medicine to cath, EP, and structural heart cases.

GAP 02

Adult vs. pediatric and congenital

Pediatric cardiology is not adult cardiology scaled down. Congenital anatomy, classifications, z-scores, and diagramming need native support.

GAP 03

Data you can actually use

Measurements stored as PDFs, text, or in proprietary tables create data debt that blocks analytics, registries, and AI.

GAP 04

Cardiovascular domain expertise

Implementation and support teams built around radiology PACS may not bring cardiovascular informatics experience to your project.

The convenience trap

Adding cardiology to an existing enterprise contract can look like the path of least resistance. It is worth weighing what that convenience costs over the life of the system.

WHAT LOOKS EASIER TODAY	WHAT IT CAN COST OVER TIME
Uses an existing enterprise contract	Cardiology is fitted into tools designed for another specialty or for general documentation
Less configuration up front	Sonographers and physicians re-key measurements; turnaround and clinician satisfaction suffer
One vendor, one database	Measurements live as narrative text or PDFs, unusable for analytics, registries, or AI
“Cardiology: yes” checked on the RFP	Cath, EP, and pediatric teams end up on separate systems anyway

> Your EHR is the system of record. Your PACS and VNA are the systems of storage. **Cardiology also needs a system of clinical work** that connects to both.

THE CHECKLIST

Ten questions to ask **every vendor**

Each item explains why it matters in cardiology, gives you the question to ask, names a live demonstration to request, and shows how to tell a strong answer from a weak one.

01 Full service-line coverage

02 Measurement and device data capture

03 Structured reporting and efficiency

04 Context-aware image review

05 Longitudinal cardiovascular record

06 Pediatric and congenital care

07 Service-line intelligence and registries

08 Open data and AI readiness

09 Enterprise EHR, PACS, and VNA fit

10 Real-time clinical collaboration

IN RFI/RFP LANGUAGE
Paste the "Ask" questions into your requirements so every response is comparable.

IN THE BOOTH
Use "Ask them to show you" to turn claims into live demonstrations.

WHEN YOU SCORE
Record results on the scorecard on page 8 and compare vendors side by side.

01 Coverage across the full cardiovascular service line

Cardiology is not one modality. A service line spans echo, vascular, nuclear, cardiac CT and MR, cath, EP, structural heart, and often pediatric care. A solution that only covers adult echo leaves the highest-acuity, highest-revenue procedures on separate systems.

ASK Which cardiovascular subspecialties do you support with purpose-built structured reporting *in production today*, at organizations like ours, and which are still on the roadmap?

ASK THEM TO SHOW YOU A completed cath lab report and an EP report, not just an echo.

STRONG ANSWER
Native workflows for non-invasive and invasive, adult and pediatric cardiology on one platform and one data model.

WATCH OUT
"Cardiology support" turns out to mean adult echo. Cath and EP run elsewhere or in free text.

02 Measurement and device data capture

A single echo can generate hundreds of measurements. Cath and EP add hemodynamic and procedural data from devices made by many manufacturers. Re-keying these by hand is slow, error-prone, and a hidden staffing cost.

ASK How do you ingest and harmonize discrete measurements from multi-vendor ultrasound, hemodynamic, EP, nuclear, and CT/MR systems, and how do you normalize naming differences across vendors and software versions?

ASK THEM TO SHOW YOU Measurements from two different ultrasound vendors flowing into the same report with no manual entry.

STRONG ANSWER
Automated DICOM SR and direct device parsing, with vendor-neutral mappings maintained across every cardiovascular modality.

WATCH OUT
Manual re-entry, measurements stored as PDF attachments, or mapping that stops at echo.

03 Structured reporting and clinician efficiency

In cardiology, the report is the data. Discrete, structured findings drive quality reporting, registries, accreditation, coding, and AI, while cutting report time for physicians who also run clinics and procedure rooms.

ASK How does a study move from the sonographer's or technologist's preliminary findings to a signed physician report? How much is auto-populated rather than typed or dictated, and who can change templates: our clinicians, or only your services team?

ASK THEM TO SHOW YOU A cardiologist completing an echo report end to end. Count the clicks.

STRONG ANSWER
Measurement-driven findings and auto-generated text, accreditation-ready content, templates your team can maintain, and discrete results sent back to the EHR.

WATCH OUT
Generic dictation templates, narrative-only reports, or a paid services ticket for every template change.

04 Context-aware image review

An echo study can contain dozens to well over a hundred cine loops, saved in the order they were acquired rather than the order a cardiologist reads them. Comparing against prior studies is often the entire reason for the exam.

ASK How does your viewer organize a cardiac study for interpretation? Does it automatically classify views by anatomy and pathology, and align matching views from prior studies side by side with synchronized playback?

ASK THEM TO SHOW YOU An echo with at least two priors. Compare the same view across all three studies.

STRONG ANSWER
Automated (AI-driven) view classification, clinically organized layouts, and synchronized current-and-prior playback.

WATCH OUT
Studies display in acquisition order, and readers hunt for views and drag priors into place by hand.

05 A longitudinal cardiovascular record

Cardiac decisions rarely rest on one encounter. They draw on years of imaging, procedures, device data, and measurements. The value lies in connecting the complete cardiovascular story, not in any single image or report.

ASK Can a cardiologist see a patient's cardiovascular history across modalities and procedures in one place, including key measurements trended over time?

ASK THEM TO SHOW YOU Ejection fraction or a valve gradient trended for one patient across echo, MR, and cath.

STRONG ANSWER
A unified, longitudinal record built on discrete data, with trends available in the reading and reporting workflow.

WATCH OUT
History is a list of PDFs, and trending requires manual chart review.

06

Pediatric and congenital heart care

Congenital heart disease is lifelong care with complex anatomy. Pediatric measurements are interpreted against body-size-adjusted z-scores, not adult reference ranges. If you care for children, or adults born with heart disease, this applies to you.

ASK Do you support pediatric z-score calculation, congenital anatomy diagramming and classification, congenital cath, and tracking from childhood into adult congenital care?

ASK THEM TO SHOW YOU A congenital echo report with z-scores and an anatomical diagram.

STRONG ANSWER
Purpose-built pediatric and congenital workflows in use at children's hospitals.

WATCH OUT
Pediatric studies handled as adult studies with altered reference ranges.

07

Service-line intelligence, quality, and registries

Radiology is typically measured on volume, turnaround, and accuracy. Cardiology is also accountable for outcomes, complications, readmissions, and total cost of care, and carries a heavy registry and accreditation workload.

ASK How does your platform turn reporting data into service-line analytics (volumes, turnaround, quality measures, utilization) and support registry submission without manual re-abstraction?

ASK THEM TO SHOW YOU A service-line dashboard built from discrete report data, plus a registry data export.

STRONG ANSWER
Analytics native to the cardiovascular data model, with registry-ready discrete data and documentation that supports accurate coding.

WATCH OUT
Analytics depend on abstraction staff reading PDFs, or on a separate data-warehouse project.

08

Open data architecture and AI readiness

Centralizing data in a VNA or EHR is not the same as structuring it. Analytics and AI need discrete, consistently labeled data. PDFs and image files are effectively invisible to algorithms.

ASK Is clinical, procedural, and measurement data stored in an open-schema, standards-based model (DICOM SR, HL7, FHIR) that our analytics teams and third-party AI can access directly, without added licensing or custom interface fees?

ASK THEM TO SHOW YOU The data dictionary, and an example of querying a discrete measurement across a patient population.

STRONG ANSWER
An open schema, documented data, and standards-based interfaces that support building *toward* AI with your tools and *with* AI inside the platform.

WATCH OUT
A proprietary, locked database; access fees; or "we can build you an export."

09

Fit with your enterprise EHR, PACS, and VNA

Cardiology should not become a silo, and enterprise standardization should not flatten cardiology. The right answer extends the investments you have already made rather than duplicating them.

ASK How do you integrate with our EHR, enterprise PACS, and VNA through standard interfaces (orders, results, discrete data, launch-in-context, image storage) without duplicating infrastructure?

ASK THEM TO SHOW YOU A reference architecture from a live site running the same EHR and archive you do.

STRONG ANSWER
Bidirectional EHR integration, launch in context, and images that remain in your enterprise archive.

WATCH OUT
The proposal requires displacing your PACS or VNA, or runs as an isolated island.

10

Real-time clinical collaboration

Structural heart, EP, and complex interventional cases increasingly need expertise that is not in the room: across campuses, after hours, and for supervision.

ASK Can remote specialists join live studies and procedures with real-time audio and video plus streamed imaging and physiologic data, securely and regardless of modality vendor?

ASK THEM TO SHOW YOU A remote participant viewing a live modality feed with two-way audio.

STRONG ANSWER
Secure, vendor-neutral telepresence that streams live imaging and waveforms to remote clinicians.

WATCH OUT
Phone calls, consumer video, post-procedure screen sharing, or photos of monitors sent by text.

BEYOND THE DEMO

Questions about the **partner**, not just the product

EXPERTISE

Who will implement and support cardiology?

Ask whether the team includes cardiovascular informatics specialists and practicing clinicians, or generalists who primarily support radiology.

REFERENCES

Can we talk to cardiology, not just IT?

Request references from cardiology leaders at organizations of similar size and complexity, ideally running the same EHR and archive.

FOCUS

Where does cardiology sit on the roadmap?

Ask how much of the vendor's development investment is dedicated to cardiovascular care, and what shipped for cardiology in the last two years.

PARTNERSHIPS

Is the cardiology answer built in or partnered?

Either can work. Ask the vendor to name it, show it, and explain who owns support when something breaks.

TAKE IT TO THE SHOW FLOOR

Vendor **scorecard**

Write each vendor's name at the top of a column, then circle one letter per item. Items 01–10 come from the checklist; item 11 covers the partner questions. Bring a cardiology leader to the demo if you can.

EVALUATION AREA	VENDOR A	VENDOR B	VENDOR C
01 Full service-line coverage	M P G	M P G	M P G
02 Measurement and device data capture	M P G	M P G	M P G
03 Structured reporting and efficiency	M P G	M P G	M P G
04 Context-aware image review	M P G	M P G	M P G
05 Longitudinal cardiovascular record	M P G	M P G	M P G
06 Pediatric and congenital care	M P G	M P G	M P G
07 Service-line intelligence and registries	M P G	M P G	M P G
08 Open data and AI readiness	M P G	M P G	M P G
09 Enterprise EHR, PACS, and VNA fit	M P G	M P G	M P G
10 Real-time clinical collaboration	M P G	M P G	M P G
11 Cardiovascular partner expertise	M P G	M P G	M P G

(M) Meets (P) Partially meets (G) Gap or not demonstrated

Notes and follow-ups

TURNING THE CHECKLIST INTO ACTION

Build cardiology into the **evaluation from day one**

BEFORE RSNA

1. **Give cardiology a seat at the table**
   Add the cardiovascular service line administrator, the medical directors of the echo, cath, and EP labs, a lead sonographer or cath lab manager, the quality and registry lead, and pediatric cardiology if you serve children.

2. **Write cardiology into the requirements**
   Specify full service-line structured reporting, multi-vendor measurement capture, context-aware image review, and open data access. Do not accept a single "cardiology module: yes" line.

3. **Ask every vendor for their cardiology answer**
   Whether it is built in or delivered with a specialized partner, require them to name it and demonstrate it.

AT RSNA AND AFTER

4. **Make vendors show, not tell**
   Use the "Ask them to show you" prompts in every booth demo and record results on the scorecard.

5. **Talk to cardiology references**
   Hear from cardiology leaders, not only IT, at organizations that look like yours.

6. **Assess your current state**
   Request a cardiology workflow assessment to see where data is re-keyed, where systems overlap, and how a specialized cardiovascular layer would fit your EHR, PACS, and VNA.

SAMPLE RFP REQUIREMENT LANGUAGE

The proposed solution shall:

1. Provide purpose-built structured reporting, in production, for echocardiography, vascular, nuclear, cardiac CT and MR, cardiac catheterization, electrophysiology, structural heart, and (where applicable) pediatric and congenital cardiology.
2. Automatically ingest and harmonize discrete measurements from multi-vendor modalities and hemodynamic and EP systems without manual re-entry.
3. Organize cardiac images by anatomical view and align current and prior studies for synchronized comparison.
4. Store clinical, procedural, and measurement data in an open-schema, standards-based model accessible to the organization's analytics and third-party AI tools.
5. Integrate bidirectionally with the organization's EHR and with its existing enterprise PACS and VNA, without requiring their replacement.
6. Support real-time, vendor-neutral remote collaboration with live imaging and physiologic data.

> Enterprise Cardiology does not mean separating cardiology from the enterprise. It means giving cardiology **the clinical depth it requires** while integrating with the enterprise strategy you have worked hard to build.

ASCEND®
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HOW WE ANSWER THE CHECKLIST

Enterprise Cardiology, **powered by ASCEND®**

ASCEND was built for cardiology from day one and remains focused exclusively on cardiovascular care. Led by practicing cardiovascular clinicians, our vendor-neutral, open architecture creates a unified cardiovascular data foundation that works alongside your EHR, PACS, and VNA, not in place of them.

ASCEND Structured Reporting

Capture and structure the cardiovascular story across echo, vascular, CT, MR, cath, and other cardiovascular procedures, with measurements flowing in from multi-vendor devices.

CHECKLIST 01 · 02 · 03 · 05 · 06

ASCEND InView®

Image review built around how cardiologists think. AI-driven organization and our patented Categorical Hanging Image Protocol™ (CHIP) align current and prior studies by anatomy, pathology, and view.

CHECKLIST 04 · 05

ASCEND Analytics

Turn connected cardiovascular data into service-line intelligence, from the individual patient journey to the performance of the entire program.

CHECKLIST 07

ASCEND Catalyst LIVE™

Vendor-neutral telepresence that brings real-time audio, video, imaging, and physiologic data together so expertise can reach any room.

CHECKLIST 10

An open platform underneath it all. Standards-based interfaces, open APIs, and an open-schema data model connect ASCEND with your enterprise systems and make cardiovascular data accessible for your analytics and AI strategy.

CHECKLIST 08 · 09

Meet with our team at RSNA 2026

Bring this checklist to a meeting with ASCEND in Chicago and we will walk through every question with you, live. Prefer to start sooner? We can also schedule an executive briefing or demo in advance.

CONTACT OUR TEAM
TO BOOK A MEETING

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