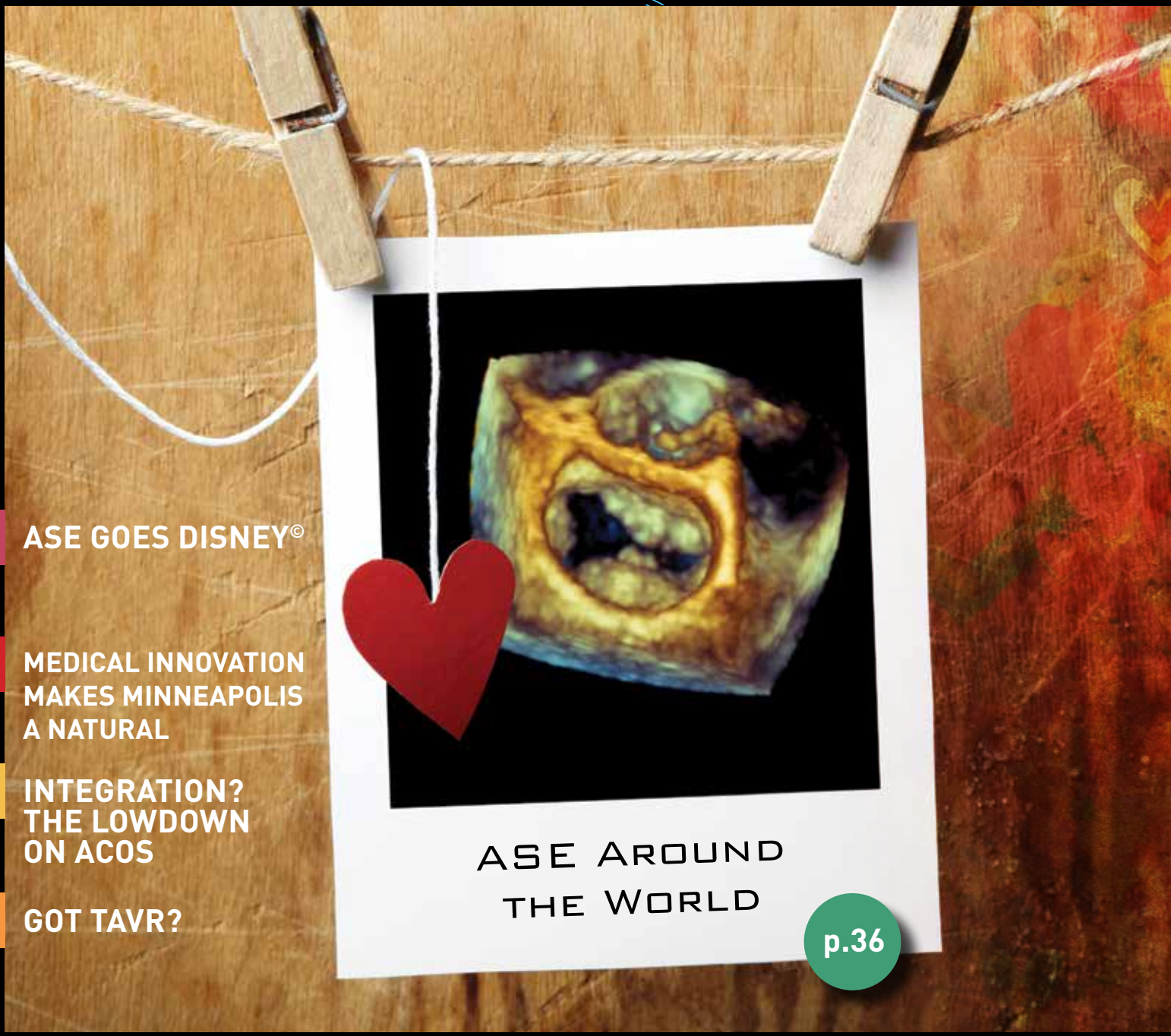
ECHO



ASE AROUND THE WORLD

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VOLUME 1, ISSUE 1 | **SEPTEMBER 2012**

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ASE American Society of Echocardiography

ECHO

A MEMBER NEWS SOURCE
VOLUME 1, ISSUE 1 | **SEPTEMBER 2012**

YOUR ASE World. Engaging. Informational. Entertaining.

ABOUT ASE

The American Society of Echocardiography (ASE) is a professional organization of physicians, cardiac sonographers, nurses and scientists involved in echocardiography, the use of ultrasound to image the heart and cardiovascular system. The organization was founded in 1975 and is the largest international organization for cardiac imaging.

ASE'S MISSION

ASE is committed to excellence in cardiovascular ultrasound and its application to patient care through education, advocacy, research, innovation and service to our members and the public.

Our members are the Heart and Circulation Ultrasound Specialists. They use ultrasound to provide an exceptional view of the cardiovascular system to enhance patient care.

COMMENT AND CONTRIBUTE

Like what you read? Have an idea for a future article? We want to hear from you! Email echo@asecho.org

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AMERICAN SOCIETY OF ECHOCARDIOGRAPHY

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ASE MEMBERS:

Welcome to *ECHO*. I am pleased to bring you the inaugural issue of a bi-yearly member magazine that will communicate information about your society in a new and innovative way. Here you will find in-depth information and thoughtful articles about member activities, association projects, trends in practice management, and developments in the field of cardiovascular ultrasound.

As our membership continues to grow and diversify, we at ASE renew our commitment to provide essential and trusted information, support, and guidance to our members and all users of cardiovascular ultrasound. And, as the fields of echocardiography and healthcare in general are dynamic and shifting, we are mindful of where we are going and where we have come from. This is an arena which ASE is uniquely poised to influence, and we do so with the support of our members and many partners. Echocardiography is a valuable and evolving technology; through new member initiatives, volunteer opportunities, guidelines, research efforts, and relevant educational tools, ASE continues to guide you and this vibrant technology forward. We bring you relevant and important information so that you can focus on your work and your patients.

It is my hope that *ECHO* will inform and interest you so that you continue to be empowered to focus on your goals. Together we can achieve much. You are important to the field and to ASE.

Thank you for your continued support.

Patricia Pellikka, MD, FASE, *ASE President*

[Managing Editor: Sarah Bidgood
[Contributors: Ian Robinson, Meredith Morovati, Angela Dart, Hilary Lamb, Sue McKeon, Cheryl Williams, Irene Butler, Rhonda Price

executive COMMITTEE

president

(term expires June 2013)

Patricia A. Pellikka, MD, FASE

Mayo Clinic «

Dr. Pellikka was born in Minneapolis and grew up in various small towns in Minnesota. She received her bachelor's degree Summa Cum Laude with majors in chemistry and biology from Gustavus Adolphus College in 1979. She graduated from Mayo Medical School in 1983, served an internship at New England Deaconess Hospital in Boston, and then returned to Mayo for the remainder of her residency and cardiology fellowship. She joined the cardiology faculty at Mayo Clinic in 1989, where she serves as co-director of the echocardiography laboratory and professor of medicine. She introduced stress echocardiography to the clinical practice at Mayo Clinic and directs the Mayo Clinic Cardiac Ultrasound and Vascular Physiology Research Unit. She has served on the External Advisory Council to the National Space Biomedical Research Institute, the AHA Cardiac Imaging Committee, and the editorial boards of *JASE, JACC, JACC Imaging, American Heart Journal, Clinical Cardiology, European Heart Journal,* and *ACCEL*. She is co-director of the annual CME program, Echocardiography in the Nation's Capital. She has published over 200 original manuscripts and over 200 abstracts.

Dr. Pellikka has been an active member of ASE, having served on the Guidelines and Standards Committee since 1998; she chaired this committee from 2007-2010. She has lectured at many ASE programs, including the annual board review courses and annual Scientific Sessions. She served on the Board of Directors from 2004–2007 and has been active in numerous task forces, committees, and writing groups.

I look forward to working with the ASE members and staff to promote quality in the practice of cardiovascular ultrasound, to promote research that supports echo's essential role in improving outcomes, and to improve the health of patients worldwide.

president-elect

(term expires June 2013)

Benjamin F. Byrd III, MD, FASE

Vanderbilt University Medical Center «

Dr. Byrd was born in Nashville and, after graduating from Princeton University with a degree in history in 1973, followed in the footsteps of his father and grandfather by graduating from the Vanderbilt University School of Medicine in 1977. He completed his medical residency at Vanderbilt after one year as a resident in psychiatry at Harvard University and then did two years of clinical cardiology fellowship at Vanderbilt before a research year in echocardiography at the University of California, San Francisco. He joined the Department of Medicine in Cardiology at Vanderbilt in 1984 as director of the echocardiography laboratory. He introduced transesophageal and stress echocardiography to Vanderbilt and was a co-founder of its Adult Congenital Heart Clinic, which he now heads. In addition to serving for a decade on the editorial board of JACC and reviewing for JASE and other major cardiology journals, he served on the Canada Foundation for Innovation, Study Section on Medical Imaging Research in 2000 and 2001. He has been professor of medicine at Vanderbilt University since 2002.

Dr. Byrd has devoted many years to volunteer activities at both ASE and other cardiology organizations. He was president of the American Heart Association - Tennessee Affiliate in 2003, and he received their Gold Heart Award in 2004. He served on the AHA National Public Policy Committee from 1997-2003. He represented the American College of Cardiology (ACC) on the Board of Directors of the Intersocietal Commission for Accreditation of Echocardiography Laboratories (ICAEL) at its inception in 1997, and was ICAEL president from 2003-2005. He was chair of the ASE Membership Committee from 2003-2007 and co-chair of the ASE Advocacy Committee from 1999-2007. From 2007 to 2010, he chaired the ASE Advocacy Committee, and he served on the ASE Industry Roundtable from 2001-2011. In 2009, he received the ASE Meritorious Service Award.

He is board certified in Cardiovascular Disease and Internal Medicine, and is a fellow of the American College of Cardiology (FACC) and the American Society of Echocardiography (FASE). When not seeing patients, teaching, or reading echocardiograms, Dr. Byrd enjoys golf, reading, and spending time with his family.

I'm looking forward to meeting more of our great echocardiographer members over the course of this year - and to positioning ASE for success in the health care system which will take final form after this November's election.

vice president

(term expires June 2013)

Neil J. Weissman, MD, FASE

MedStar Research Institute,

Washington Hospital Center «

Dr. Weissman is President of MedStar Health Research Institute, Professor of Medicine at Georgetown University School of Medicine and Director of the Cardiovascular Core Laboratories at MedStar Washington Hospital Center in Washington, DC. Prior to joining the MedStar Health system, he was the Director of the Clinical Echocardiography Lab at MedStar's Georgetown University Hospital.

Dr. Weissman's research interests include valvular heart disease, left ventricular remodeling, and intravascular imaging. His ultrasound core laboratory has served as a site for more than 100 multi-center trials, including multiple studies on the pharmacologic effects of valvular and ventricular function, prosthetic valve assessments, and intracoronary therapies. Additionally, Dr. Weissman has served as principal investigator for numerous national and international multi-center trials and is currently the national principal investigator on a cardiac safety studies with more than 7000 participants.

He received his medical degree from Cornell University Medical College in New York. He completed his internship, residency, and chief

residency in internal medicine at New York Hospital. He followed his residency training with a clinical and research fellowship in cardiology and a fellowship in cardiac ultrasound at Massachusetts General Hospital in Boston, MA.

Internationally recognized as an expert in cardiac ultrasound, Dr. Weissman serves as an advisor on the Food and Drug Administration's Cardio-Renal Advisory Committee, has served on several national organizations, and is on editorial boards for various internationally recognized journals. He has published hundreds of original reports, as well as written several review articles and book chapters. He is a frequent author of cardiovascular guidelines and is an executive leader in the ASE.

The power of echocardiography is getting greater recognition. It is such a useful diagnostic tool, under so many clinical conditions, that many non-cardiologist are embracing its utility. The American Society of Echocardiography has a great opportunity to take a leadership role to insure that echo is used appropriately, with high standards for training and quality and thus helping its dissemination to the patients that need it. This will give us the chance to work with many other health professionals and professional societies.

treasurer

(term expires June 2015)

Sherif F. Nagueh, MD, FASE
Methodist DeBakey Heart & Vascular Center «

Dr. Nagueh is the Medical Director of the Echocardiography Laboratory at Methodist DeBakey Heart and Vascular Center in Houston, Texas, and is Professor of Medicine at Weill Cornell Medical College. His research interests include left ventricular systolic and diastolic function and hypertrophic cardiomyopathy. He was among the ASE Young Investigator finalists and has mentored other finalists for this award. He is the second ASE member to deliver the Feigenbaum lecture.

Dr. Nagueh served on several ASE committees and task forces, including the Research and Education Committees and the International Relations Task Force. He has been a member of the Finance Committee for the past 3 years and a member of ASE Board of Directors from 2007 to 2010. He chaired 2 ASE writing groups: one for the echocardiographic evaluation of LV diastolic function and the other for multimodality imaging of patients with hypertrophic cardiomyopathy. He is currently one of the associate editors of JASE, and was the chair of ASE Scientific Sessions for 2012.

As the Treasurer, I am looking forward to help ASE achieve its financial aims to meet the goals of its members in education, advocacy, and research.

secretary

(term expires June 2013)

Marti L. McCulloch, MBA, BS, RDCS, FASE
Methodist DeBakey Heart & Vascular Imaging Center «

Marti McCulloch is the administrative director of The Methodist DeBakey Heart & Vascular Center in the Texas Medical Center, where she is responsible for supporting and directing the strategic plan and growth of the center. She has an undergraduate degree from the University of Houston-Clear Lake in human fitness and performance and a graduate degree from The University of St. Thomas in business administration with a minor in health care administration. Marti has actively been a member of the ASE, Society of Diagnostic Medical Sonographers (SDMS) and the Greater Houston Society of Echocardiography (GHSE). Locally, she serves as the secretary on the Board of Directors of GHSE and is on the advisory board of the Alvin Community College. Marti has served on multiple committees within ASE, including as the chair of the Sonographer Council, co-chair of the Public Relations Committee, and member of the Awards Committee. In addition, she has been on the Editorial Board of *JASE* and *Cardiac Ultrasound Today*. Her research and publication interests include 3D imaging, contrast, and ergonomics.

The ASE is a fantastic resource for education and I always look forward to the new guidelines and recommendations in JASE. This coming year, we should see a comprehensive document on multi-modality imaging of the aorta. Additionally, ASE supports professional growth and development of sonographers by providing funds and initial sponsorship of the COA, which is a foundation necessary to move forward with the Advanced Practice Sonographer model. And of course, I can't wait to attend Echo Florida (NEW!), Echo Hawaii and the Scientific Sessions in Minneapolis!

member-at-large

(term expires June 2013)

Sue Maisey, MBA, RDCS, RCS, FASE
St Luke's Episcopal Hospital/TX Heart Institute «

Sue Maisey is the Director of the Non-Invasive Cardiology/Arrhythmia Center/Cardiology Education/Fellowship program at St. Luke's Episcopal Hospital in Houston, TX. She has administrative oversight of several clinical health system departments and an off-site diagnostic and treatment facility, including strategic planning and operational control to ensure budgeted targets are met. She holds an undergraduate degree and a Master's in Business Administration from LeTurneau University. Sue has been involved with ASE for many years having served as a member of the advocacy committee, the sonography council board, and a speaker at ASE's annual Scientific Sessions. Most recently, she traveled to a remote corner of India to provide a record-breaking number of free screening echocardiograms to an undeserved population. She also serves as a program director for the Society of Diagnostic Medical Sonographers and, locally, as treasurer of the Greater Houston Society of Echocardiography.

Serving on the ASE Executive committee has been very invigorating to date and I am inspired to continue the quest to help echocardiography save the lives of our patients as we enter a new era of healthcare.

immediate past president

(term expires June 2013)

James D. Thomas, MD, FASE
Cleveland Clinic «

Dr. Thomas was born and raised in Oklahoma City and received his Bachelor's Degree in applied mathematics *summa cum laude* from Harvard College in 1977. After medical education at Harvard and clinical training at Massachusetts General Hospital and the University of Vermont, he served as Assistant Professor of Medicine at Harvard and Massachusetts General Hospital before assuming his current position at The Cleveland Clinic Foundation in 1992. Dr. Thomas is the Charles and Lorraine Moore Chair of Cardiovascular Imaging within the Department of Cardiovascular Medicine and a Professor of Medicine and Biomedical Engineering at the Ohio State University and Case Western Reserve University. He also serves as Lead Scientist for Ultrasound to the National Aeronautics and Space Administration (NASA) and is a consultant to the Department of Defense and the NIH. He currently serves on the Cardiovascular Board of Examiners for the American Board of Internal Medicine and was co-chairman for the 2007 ACC Annual Scientific Sessions. Dr. Thomas has over 500 peer reviewed research manuscripts (published or in press), 100 invited articles and book chapters, and over 600 abstract presentations. He has had long involvement with the ASE, receiving the Young Investigator Award at the first national scientific sessions in 1991. He spearheaded ASE's role in the development of the DICOM ultrasound standard and was an early champion of digital echocardiography. He served as chairman of the scientific sessions in 2002 and chaired the Industry Roundtable prior to his post as Treasurer. He received the 2005 Richard Popp Award in recognition for his mentorship of many young echocardiographers.

In my post presidency year, I look forward to some of our exciting international ventures, with two new humanitarian and educational missions to India and Vietnam and planning for the next world summit of echo societies. Our outreach strengthens echocardiography in America and around the world. ❤

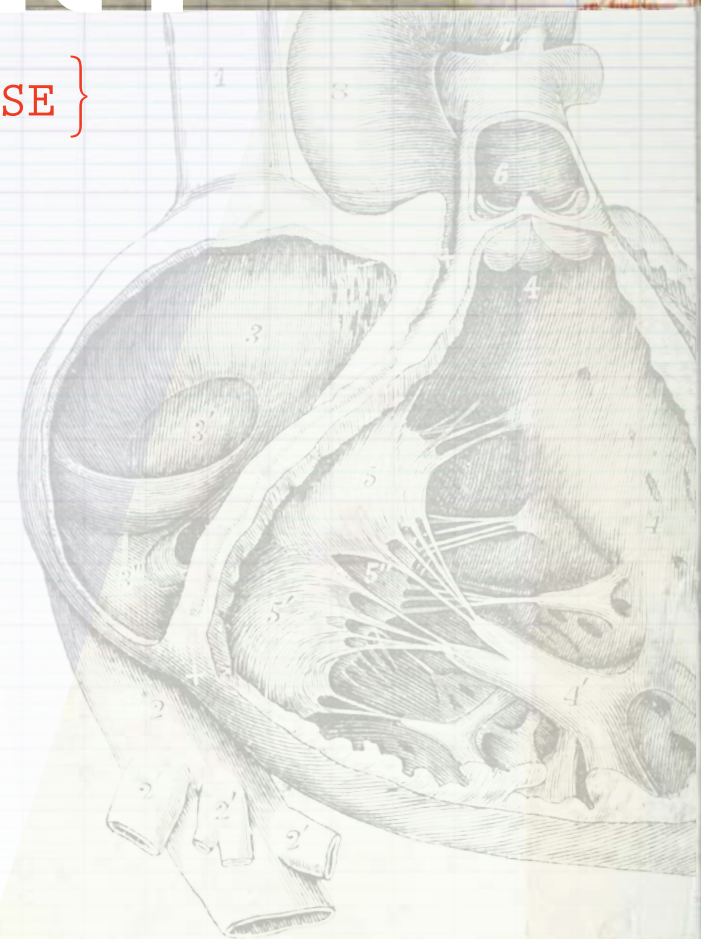
I researched it, I wrote it, now what?

{ a guide to submitting to JASE }

Are you interested in submitting a manuscript to JASE but don't know where to begin? The good news is, the mechanics of submission could not be simpler! Here's how to get started:

1. Visit http://ees.elsevier.com/jase
2. Register as an author if you don't have an account already
3. Click on the "Submit Paper" tab at the top of the page
4. Select an article type (*Original Investigation, Review Article, Forum, Editorial comment, or Special Report*) and upload the necessary components following the instructions provided by the website.
5. Approve your submission. This last step is important; if you do not approve your submission, the editorial office will not be able to process it further.

Once your original research has been received by the editorial office, it will be sent on to the editors to begin the peer review process. Manuscripts are reviewed by at least two referees in almost all cases. Once reviewers have provided their feedback and comments to the handling editor, the associate editors and Editor-in-Chief Alan S. Pearlman, MD, FASE discuss the manuscripts and the reviewers' suggestions as a group and reach a decision regarding the priority of the manuscript for publication. The Editor-in-Chief will then craft a decision letter, which he will email directly to the corresponding author. \\\



/// **If you have questions about how to submit, please email: jaseoffice@asecho.org or sbidgood@asecho.org.**

At the JASE editorial office, we receive a number of questions each day from authors whose manuscripts are in various stages of the peer review process. Additionally, at ASE's 2012 Scientific Sessions, Dr. Pearlman answered questions from prospective authors about JASE and the types of studies the editors consider. The questions raised at this session may prove useful as you prepare to submit your manuscript:

Q: What is JASE's acceptance rate?

A: Over the past year, it has been 29%. However, the JASE editors remind authors that acceptance/rejection metrics depend heavily on the quality of manuscripts received in a given time period. The acceptance rate will fluctuate depending on the number of manuscripts received; more submissions will probably cause the acceptance rate to fall because of limitations in the number of editorial pages available. The editors are however more concerned with the quality of the papers published than they are with the acceptance rate.

Q: What kinds of studies does JASE accept?

A: JASE favors prospective studies over ones that are performed retrospectively because of the thought that goes into designing and executing prospective work. Retrospective studies can be very instructive and can lead to new insights and hypotheses to be tested, but in general such studies tend to show associations rather than proving cause and effect. That being said, JASE certainly publishes many good retrospective studies.

Q: Does JASE favor "pure" echo papers over multimodality papers?

A: The editors appreciate a general interest in multimodality studies, and they do believe that it is important to recognize not only the strengths of echocardiography, but also those situations in which other modalities provide additional valuable understanding. Hence, the editors are certainly interested in multimodality papers. That being said, echo needs to figure prominently in any papers submitted for consideration in JASE.

Q: What are common pitfalls for new authors?

A: The most common mistakes are the most obvious, i.e. authors forget to number their pages or format their references correctly. The most frequently seen major pitfall authors make is forgetting to identify a question their paper will answer. Selecting a title after the paper is written that explains accurately the central thesis is of key import. Other important problems include failing to explain methods carefully enough, using inappropriate analytical methods, drawing conclusions that are not supported by the data presented, and failing to make clear the novelty and relevance of study findings.

Q: What is JASE's timeline from submission to first decision?

A: The editors try to reach a first decision within 1 month of submission, but this timeline can be extended if reviews are not received in a timely manner, or when a manuscript needs to be sent out for additional statistical review. Alternatively, this timeline can be shortened if the editors believe that a given manuscript merits an expedited rejection.

Q: Is it possible to submit a systematic review paper to JASE?

A: This is not at all uncommon. The editors welcome author-initiated papers of this type. These are valuable papers as long as they cover an important topic in a comprehensive and balanced manner, and are well illustrated.

Q: How does JASE regard authors who cite themselves?

A: The editors certainly will not hold this against authors if they are experts in the field and have done extensive research in the area about which they are writing. If this is done gratuitously, however, it is frowned upon. The major concern is that previous work that is relevant to the current article is cited, and in a balanced manner.

Q: What overarching advice do you have for new authors who want to craft a well-received paper?

A: Pick an important question that has not been answered already. Make clear how your paper adds to the current literature. If you have published a similar paper around the same time, make sure that you are open about this and make a compelling case for why you are submitting a second paper. Dividing a complicated study into parts can be justified in some cases, but most editors frown on what is often termed "salami science". ❤

JASE is eager to consider for publication any suitable articles on topics pertaining to cardiovascular ultrasound. The Editors are most interested in clinically relevant studies that provide new insights and/or will lead to better patient care. They also believe that basic non-clinical studies, in models or using animals, can provide important new insights, especially when such studies could not realistically be done in humans and when some clinical application is likely in the future.

get involved!

// DR. KIRK SPENCER

Chair of Guidelines & Standards Committee

By providing standards for practitioners to follow – we help raise the quality bar in cardiovascular imaging. Better quality healthcare – better for our patients' health.
- Dr. Kirk Spencer

// DR. VERA RIGOLIN

Chair of FASE Committee

Serving on an ASE committee is an honor. Significant personal and professional satisfaction is achieved when the committee's projects and ideas come to fruition.
- Dr. Vera Rigolin

Committee membership is one of the most valuable ways that an individual member can affect the course of ASE and stay involved with the organization on a day-to-day basis. Committees are member-driven bodies that support the society and its staff in implementing ASE's mission of improving the qualities and standards of cardiovascular ultrasound. Meeting on a diverse range of topics from Membership and FASE to Publications and Research these vital components of ASE shape the direction and goals of the society for the coming year.

//

Below is a list of committees to which you have the opportunity apply, given that there is a vacancy and that you have the interest and expertise:

// ACCME COMMITTEE

Is charged with overseeing ASE's educational materials meet ACCME requirements and review the program content of ASE educational activities.

// ADVOCACY COMMITTEE

Communicates with members regarding ASE's position on legislative or regulatory issues and monitors federal and state legislative, coding and reimbursement issues.

// BYLAWS & ETHICS COMMITTEE

Oversees association practices to ensure that ethical practices are followed and reviews all bylaws change requests and makes recommendations to the board.

// EDUCATION COMMITTEE

Reviews educational plans for ASE activities to ensure that each activity has a unique identity and reviews course evaluations and proposed agendas to assist in quality improvement of ASE activities.

// FASE COMMITTEE

Members of this committee are already FASE. They review and approve FASE candidates while defining criteria for new pathways when appropriate and making recommendations to the executive about new pathways for FASE.

// FINANCE, STRATEGY & DEVELOPMENT COMMITTEE

Monitors the long-term financial structure of the association and oversees ASE and ASE Foundation investments and financial strategies.

// GUIDELINES & STANDARDS COMMITTEE

Reviews and edits new standards documents for consistency and alignment with society's standards and values, and supervises task forces and councils that are developing standards and training documents.

// INFORMATION TECHNOLOGY COMMITTEE

Is charged with responding to the ever changing technological needs of ASE's membership by creating content and content delivery systems that allow members to access educational content via the web and other platforms.

// MEMBERSHIP STEERING COMMITTEE

Works closely with the membership department to develop strategies and activities to improve retention and enhance the growth of ASE.

// PUBLIC RELATIONS COMMITTEE

Enhances the public's perception of the field of echocardiography and the public and medical profession's perception of the skill and abilities of the cardiologist and sonographer.

// RESEARCH COMMITTEE

Develops strategies for securing funding for furthering technological advances in cardiovascular imaging and therapy using ultrasound and plans major research initiatives.

// RESEARCH AWARDS COMMITTEE

Oversees ASE Foundation research awards and grants process.

Those interested in joining a committee must be active members in good standing of ASE. Several committees have requirements beyond membership that must be fulfilled before a candidate can be considered for a committee opening, e.g., all FASE Committee members must be FASE themselves. Be sure to look over the openings and committee description for other requirements. Each committee has an ASE staff liaison with whom the committee has regular contact about ASE policy. The staff liaison is charged with leveraging the knowledge and experience of committee members in cardiovascular ultrasound toward achieving the goals that ASE has laid out for the year.

The application process typically opens in November and closes in January, with terms after the Scientific Sessions. The most effective committee members are those who are willing to attend one to two face-to-face meetings (usually held in conjunction with ACC annual meeting and the ASE annual meeting) and engage in several conference calls a year. Your term on the committee will be for one year with opportunity to be renewed for up to three years. Most committees have a third of their membership rotate off each year.
If you have not previously served on an ASE standing committee, you will need to provide a recommendation letter, preferably from a FASE level member or a senior person in the cardiovascular ultrasound field, to accompany your application.

We encourage all of our members to look over this year's list of committee opening and to apply for any and all vacancies that interest you. Committees are a unique way for individual members to leave a permanent positive mark on ASE. ❤

YOUR PERFORMANCE STANDS OUT, SO SHOULD YOU

Reap the benefits of your diligence by being recognized as FASE (Fellow of the American Society of Echocardiography), a designation that lets colleagues and patients know that you're part of an outstanding group of cardiovascular ultrasound professionals.

For those who meet the rigorous standards, FASE recognizes the dedicated member with proven professional contributions and a diverse set of skills and comprehensive knowledge of all aspects of cardiovascular ultrasound.

Strive for FASE. You may already be eligible.

Learn the professional benefits and review the application at www.asecho.org/FASE.

FASE Fellow of American Society of Echocardiography

LEAD. CONTRIBUTE. BE RECOGNIZED.

WHAT'S NEW IN CONNECT@ASE

connect@ase is our online members-only forum where you can discuss the field of cardiovascular ultrasound with experts and fellow members from around the world.

You can join discussions already underway or start a new one by sending a question that you might have to all of our members. Our largest and most popular discussion group has over 12,000 active ASE members with a wealth of knowledge and experience waiting to help fellow members.

Connect@ASE helps make communication between members easier. Through our online member directory, you can easily locate members in your area or find others who share your particular interests in cardiovascular ultrasound. You can even communicate with fellow members via the internal messaging system. The ease of use of the member directory makes it simple to reconnect with former colleagues on Connect@ASE.

The site allows any user to create a community based upon his or her specific interests. You can create a community of peers based upon any and all specialty criteria or topics that you choose. You will then be able to post images, videos and documents related to that interest with fellow community members.

By searching for members who share in your special interests, you can invite any ASE member to join your community and grow it into an integral part of the Connect@ASE experience.

The site is also home to our Image Library. There are currently over 300 cases in the Image Library. This member specific benefit can be accessed only through Connect@ASE. After you view a case, you can leave a comment, ask a question or start a discussion. You can even start a community to help fellow members use the slides and images more effectively.

You can access Connect@ASE from our main web page **www.asecho.org** by selecting the 'Connect@ASE' link or by going directly to connect.asecho.org. There is a single login for all ASE associated websites. Simply sign in to either site with your ASE user ID and password to start connecting with other ASE members. ❤


MEMBERSHIP?

FASE: LEAD, CONTRIBUTE, BE RECOGNIZED

The FASE designation recognizes members that have a diverse set of skills and comprehensive knowledge of all aspects of echocardiography while continually working to strengthen the field of cardiovascular ultrasound. The Fellow of the American Society of Echocardiography (FASE) program has been distinguishing accomplished members for over ten years. Being FASE means that you're part of an outstanding group of cardiovascular ultrasound professionals. The designation is open to all ASE members, recognizing those who have achieved the highest level of contributions to the field in the areas of teaching, leadership and research.

Members who achieve FASE have demonstrated a solid foundation of credentials, education and membership. Applicants submit documentation of their contributions and recommendation letters attesting to their commitment to the advancement of the field of cardiovascular ultrasound. Candidates undergo a lengthy application process that culminates in a vote of approval by a committee of leaders in the field of echocardiography.

1406 members of ASE, less than 10% of the total membership, have earned this title. Benefits, in addition to earning the entitlement to use designation of fellow (FASE), include:

- ♥ FASE certificate
- ♥ Access to FASE lounge at Scientific Sessions for unique networking and VIP amenities
- ♥ Listing for the public by state on the ASE public information website **www.SeeMyHeart.org**
- ♥ FASE pin
- ♥ The ability to be an ASE board member and/or a committee chair
- ♥ Special FASE ribbon at ASE meetings
- ♥ Early bird registration for Scientific Sessions
- ♥ Recognition at ASE meetings and in the Scientific Sessions Final Program
- ♥ Press release notification

Applicants may apply for FASE in any of the four quarterly cycles: March 1, June 1, September 1 or December 1. Applicants are usually awarded FASE within six to eight weeks after the application deadline.

The FASE credential recognizes dedicated ASE physicians and sonographers with extraordinary commitment to the field and whose credentials demonstrate fulfillment of training and performance requirements to cardiovascular ultrasound. FASE are our members who lead, contribute and are recognized. To see if you too are eligible for this prestigious designation, view www.asecho.org/FASE. ❤

NEWLY APPOINTED FASE FROM 2011

Ameeta Ahuja, DO, FASE
Wael A. AlJaroudi, MD, FASE
Mouaz Al-Mallah, MD, MSc, FASE
Mirvat Abdullah Alasnag, MD,FASE
Anne R. Albers, MD, PhD, RVT, FACC, FASE
Allan L. Anderson, MD, FACC, FASE
Iris M. Aronson, RCS, FASE
Robert R. Attaran, MBChB, FASE
Dalia A. Banks, MD, FASE
Manish Bansal, MD, DNB Cardiology, FASE
Paul M. Bastiansen, RDCS, FASE
Demir Baykal, MD, FACC, FASE
Dr. Ricardo J. Benenstein, MD,FASE
Kevin J. Berlin, DO, FASE
Kapil Mohan Bhagirath, MD, FRCPCC, FASE
Lori A. Blauwet, MD, FASE
John W. Bokowski, AE, PE, FE of ARDCS, PhD, FASE
Allyson Ballard Boyle, BS, RDCS, FASE
Duane Brook, BS, RDCS, FASE
Renee Patrice Bullock-Palmer, MD, FASE
Nitin J. Burkule, MD, DM, FACC, FASE
Gustavo P. Camarano, MD, PhD, FASE
Barry B. Canaday, MS, RN, RDCS, RCS
Stefano Caselli, MD, PhD, FASE
Wong Toi Chong, MD, MRCPI, FASE
Mary J. Clark, RDCS, FASE
David Michael Coleman, MBChB, FRACP, FRCPI, FASE
Saretta C. Craft, MS, RDCS, RVT, FASE
William C. Culp, Jr., MD, FASE
Nancy Goldman Cutler, MD, FASE
Iyad Nassim Daher, MD, FASE
Sabe K. De, MD, FRCPC, FASE
Georges Desjardins, MD, FRCPC, FASE
Karim Assaad Diab, MD, FACC, FASE
Holly D. Diglio, AA, CCT, RCS, FASE
Homeyar K. Dinshaw, MBBS, FASE
Sheng-Jing Dong, MD, FASE
Adam L. Dorfman, MD, FASE
Kristin V. Doster, RDCS, FASE
Jaynel Lin Dunlap, RDCS, FASE
Elizabeth A. Ebert, MD, FACC, FASE
Jeremy Edwards MD FRCPC FASE
Sibel Catirli Enar, MD, FASE
Ibrahim E. Fahdi, MD, FASE
Carrie Wynn Ferguson, RDCS, FASE
Mark K. Friedberg, MD, FASE
Monique Ann-Patrice Freund, MD, FASE
Jorge A. Garcia, MD, FASE
Lorraine A. Gattuso, MSN, RDCS, RVT, FASE
Dan W. Giebel, MD, FASE
Satish C. Govind, MBBS, PhD, FASE
Judi Catherine Green, RDMS, RVT, RDCS, FASE
John N. Hamaty, DO, FASE
Tammy Hartfiel, RDCS, FASE
Brandy A. Hattendorf, MD, FAAP, FASE
Arthur Bart Hodess, MD, FASE
Kyaw Htyte, MD, RDMS, RCS, FASE
Jill B. Inafuku, RDCS, FASE
Ron Mathew Jacob, MD, FACC, FASE
Amer Johri, MD, MS, FRCPC, FASE
Mandisa-Maia Jones-Haywood, MD, FASE
Subodh B. Joshi, MBBS, FRACP, MPH, FASE
Sarah E. Joyner, MD, MPH, FASE
Swaminathan Karthik, MD, FASE
Dennis Katechis, DO, FASE
Paul Madison Kirkman, MD, FASE
Matthew A. Klopman, MD, FASE
Kim Marie Kutzke, RDCS, FASE
Willis Chun-wai Lam, MBChB, MRCP, FASE
Bryana M. Levitan, BA, RDCS, FASE
Jennifer E. Liu, MD, FACC, FASE
David J. Lomnitz, MD, FACC, FASE
Judy A. Malone, BS, RDCS, FASE
Richard M. Martinez, MD, FASE
Timothy M. Maus, MD, FASE
Karen Keller Meslar, BS, RDCS, FASE
Giovannina McGrath, RDCS, FASE
Janet Morgan Methvien, RVS, MSHCM, FASE
Hector Ignacio Michelena, MD, FASE
Sally Jean Miller, RDCS, RT(R), FASE
Alexander J.C. Mittnacht, MD, FASE
Sara Mobasseri, MD, FACC, FASE
Otfried N. Niedermaier, MD, FASM, FASE
Jill A. Odabashian, RDCS, FASE
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Daniel J. Oliver, RCS, FASE
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Vinod Patel, MD, FASE
Florentina Petillo, RDCS, FASE
Juan C. Plana, MD, FASE
David G. Platts, MD, FRACP, FASE
Bogdan A. Popescu, MD, PhD, FASE
Mohammed S. Rais, MD, FASE
Ellis G. Reef, MD, FASE
Larry W. Revels, RDCS, FASE
Eileen K. Richardot, RCS, RDCS, FASE
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Sanjay Sarin, MD, FACC, FASE
Igal A. Sebag, MD, FRCPC, FACC, FASE
Sanjay G. Shah, MD, FASE
Fadi Shamoun, MD, FASE
Syed Nayyar Hasnain Shamsi, MD, MRCP, FACC, FASE
Kathleen E. Shibley, RDCS, CCT, FASE
Douglas C. Shook, MD, FASE
Jeffrey Jacob Silbiger, MD, FASE
Richard Silver, MD, FASE
Nancy M. Szabo-Boryczewski, RDCS, AE, PE, FASE
Dennis Anthony Tighe, MD, FASE
Mani A. Vannan, MBBS, FACC, FAHA, FASE
Esther Vogel-Bass, RDCS, RCCS, FASE
Peter von Homeyer, MD, FASE
Mary-Pierre Waiss, RDCS, FASE
Mary A. Wallace, RRT, RDCS, FASE
Kevin S. Wei, MD, FASE
Elizabeth Welch, MD, FASE
Scott D. Werden, DO, FACC, FASE
Julie E. White, RDCS, FASE
Richard V. Williams, MD, FASE
Don S. Wilson, RDCS, FASE
Leslie A. Wilson, RDCS, FASE

ASE gets appy

Do you use your smartphone or tablet for patient care? If you do, you are part of a rapidly growing majority of practitioners utilizing mobile devices for patient care. That initial burst of interest and enthusiasm hasn't slowed in the slightest according to a new report from Manhattan Research. In fact, mobile device use by US physicians has nearly doubled in the past year and adoption is set to continue to rise at a meteoric rate over the next twelve months. According to that same study, 85% of physicians use a smartphone professionally, and two thirds of doctors are now using online video sources to expand and update their skills.

The report also noted that physician iPad adoption has soared and that 62% of U.S. doctors report using one for professional purposes. Half of iPad-owning doctors also reported using their device at the point of care. "Physicians are evolving in ways we expected – only faster," noted Monique Levy, vice president of research for Manhattan Research.

Going forward, the research firm expects to see even greater adoption and is predicting that two thirds of U.S. physicians will be using iPads professionally by 2013. That puts them a bit ahead of the curve compared to doctors in Europe, where a similar study showed only 26% of physicians owned iPads and used them professionally.

One of the tenets of ASE's mission is to help improve patient care. To this end, the ASE Information Technology Committee began developing iASE in November 2010. "Point of care applications, like iASE, provide real time value for education and patient care. Immediate access of information, common calculations, guidelines, standards, and normative data, improves quality and promotes standards of care," said IT Committee Chair Dr. Andrew Keller, Associate Clinical Professor of Medicine, Columbia University and Medical Executive Director at Praxair Regional Heart and Vascular Center of Danbury Hospital, Danbury, CT, where he is also Chief of the Cardiology Section.

In addition to the full PDF of each guideline document as it was published, iASE contains a well-organized guideline summary including key tables, reference values, and figures that are quick and easy to review, with tips and tricks on how to measure appropriately. One of the most popular features is the calculator section, which contains over 20 commonly used formulas. In addition to doing the math for you, the calculators include explanations of what the formula does, definitions of the variables, and illustrations of what part of the heart is being measured.

The first version of the app was released in June 2011 and included four of the most popular ASE Guidelines: Chamber Quantification (2005), Right Heart (2010), Valvular Regurgitation (2003), Valvular Stenosis (2009).

iASE 2.0 was released in June 2012 as an update and includes 2 more guidelines: Evaluation of Prosthetic Valves (2009) and Diastolic Function (2009). This version of iASE incorporates several videos and reference tables of many different types of prosthetic valves. 2.0 also has flow charts to help with the grading of diastolic dysfunction and estimation of filling pressures. ❤

iASE is available for iPhone, iPad, and Droid operating platforms.

At only $4.99 this is an app you can't afford to be without. ❤

overheard on Connect@ASE

In this space, we will regularly feature questions and conversations posted on our online member forum Connect@ASE. This exclusive member benefit allows you to connect in real-time with members the world over about topics related to the field of echocardiography which are relevant to your practice. Connect@ASE launched late last year, and it has since grown to include over 12,000 subscribers to our largest discussion group. We encourage all of our members to take advantage of the expertise of their fellow members and join us online. And now to the threads.

/// SOLICITING ADVICE FROM COLLEAGUES

PHYSICIAN IN FL ASKS FOR HELP SETTLING A DEBATE:

There is an ongoing debate at my institution about the appropriate role of stress echocardiography for detecting coronary artery disease. I was wondering if anyone had any data about the sensitivity of stress echocardiography for detecting single vessel coronary disease. Also how that sensitivity may vary according to disease of the left anterior descending, right and circumflex coronary arteries.

PHYSICIAN IN CT ASKS A QUESTION ABOUT CONTRAST:

We are revising our age assessment for contrast injection for PFO/ASD, any consensus as to an age where it is not routinely evaluated in the setting of a CVA/TIA?

SONOGRAPHER FROM MO ASKS FOR TECHNICAL HELP:

I'm trying to figure out how to change the DDP, Reject, Compress, Edge Enhancement, etc, under my own preset. I'm using my fellow tech's machine and having to change them every time I use their machine. I want to have them load at the levels I want them to be at when the probe loads. I've logged in as the admin and gone to the Application screen under Config, but can't figure it out. Any help is greatly appreciated...

/// PATIENTS AND THEIR PREFERENCE OF SONOGRAPHER GENDER

SONOGRAPHER IN PA WRITES,

Our office would like to implement a policy to address echocardiography services by a male sonographer. Occasionally female patients would prefer a female sonographer, but I am the only sonographer in my office.

Sonographer in TN suggests,

You can offer to have a female staff member in the room while you perform your scan.

Physician in NY agrees with this suggestion,

Our facility implemented a chaperone policy for all exams and procedures that involved sensitive areas in female patients. At the time I thought it was overkill; however we finally had one patient make a complaint about my echo tech. That one experience out of 20 some years will make you realize how worth it is to have the chaperone.

Sonographer in VA replies,

I truly believe that it's also in how comfortable you make the patient feel when they walk through the door.

Sonographer in BC concurs,

Perhaps a little more empathy with our patients would go much further than any policy we could implement.

If you would like to join either of these or similar discussions, or start one of your own, go to connect.asecho.org and begin connecting with your fellow members. When considering replying to a post or starting one of your own, remember that the more specific the question or reply, the more likely a thread will continue to grow and thrive. ❤

INAUGURAL
Echo Florida:
Contemporary Echocardiography

Disney ©

October 6 - 10, 2012

Disney's Contemporary Resort
Walt Disney World®, **FL**

Comprehensive Review
of Echocardiography including
special sessions on hand
held echocardiography
and echocardiography for
transcatheter interventions

Register at www.asecho.org/EchoFlorida

INTRODUCING echo FLORIDA

ASE is proud to announce the debut of a brand new course for 2012! Held at the beautiful Disney© Contemporary on October 6-10, Echo Florida is a comprehensive review of cardiovascular ultrasound in clinical practice with a special emphasis on interventional echocardiography. ASE Past-President and Course director Michael H. Picard, MD, FASE has assembled a program in which international and domestic experts discuss the strengths and limitations of established and emerging technologies within the context of improving patient care in a cost conscious way.

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Unlike ASE's State-of-the-Art and Echo Hawaii courses, Echo Florida features a full day devoted to Point of Care echocardiography. Brief lectures with case illustrations will discuss protocols for use of small echocardiographic devices in various settings such as the emergency room, intensive care unit and community screening programs. Want to make sure you have a chance to interact with the devices? This special course feature allows for ample time for hands-on training with multiple types of equipment.

Another exciting feature of ASE's Echo Florida course is its learning lab, which allows participants to receive individualized instruction at computer work stations. Using real cases, attendees get hands-on instruction on quantitative echocardiography using real cases. Covering a range of topics including quantitation of LV heart size and function, quantitation of LV diastolic function, quantitation of right heart function, quantitation of valvular stenosis and regurgitation, 3D/4D echo image set cropping, display and quantitation of strain, torsion and other new parameters of myocardial function, the small group setting of the lab allows for ample time to interact with experts.

Preceding the main conference on Sunday will be a full-day Interventional Echocardiography symposium. This segment of the course is a unique feature of Echo Florida and will deploy case based lectures to demonstrate now 2D and real time 3D/4D echocardiography are used to select, guide, and follow these interventions. According to Echo Florida faculty member Rebecca Hahn, MD, FASE, this segment of the course "will appeal to the multidisciplinary Heart Teams involved in these new endeavors." Upon completion, participants will be better able to identify eligible patients for TAVR procedures and recognize and assess the function of percutaneous cardiac devices by echocardiography.

About this course, director Dr. Picard says:

> ***For our inaugural echo course in Orlando, we have lofty goals - not only will we provide a comprehensive review of echocardiography for the indications we deal with every day, but we will also dedicate a day to the new modality of point of care echocardiography and a full day to use of echocardiography to guide transcatheter interventions in structural heart disease. We have assembled a fantastic faculty. I am particularly excited about our point of care echocardiography as it is an opportunity for ASE to assist in the training of users of these small devices with our hands on training session.***

Not only does Echo Florida have an exciting curriculum to recommend it, its location can't be beat. The Contemporary sits between Bay Lake and Seven Seas Lagoon, and features monorails within its atrium that ferry guests to and from Magic Kingdom® park and Epcot®. Spacious guest rooms, spectacular amenities, and world-renowned Disney© service make the Contemporary a not to be missed destination. ❤

to register for Echo Florida,
please vist www.asecho.org/echoflorida

education corner

For each individual, educational preferences are different. Some are best educated in a classroom-like environment, complete with didactic lectures, clinical examples and the opportunity for questions. Others learn better on their own, preferring a self-study approach where pace and topic can be self-selected. Another group may crave an interactive experience: maybe it is the opportunity for hands-on practice, or simply the opportunity for interaction with peers and field experts. Others enjoy selecting from a variety of formats, depending on topic availability, cost and licensing/credentialing deadlines.

No matter your style, ASE offers education to fit your needs. Great care is taken to ensure quality, relativity and adherence to the latest guidelines and standards. ASE's educational portfolio brings together a wide variety of content, formats and faculty to ensure that all of the Society's members have an educational experience worth sharing.

Let's start with ASEUniversity, an online CME site free to all of ASE's members. Throughout the year, ASEUniversity maintains between 15 and 20 hours of free content on hot topics, such as strain, 3D and diastology. This content is divided between Webcasts, recorded by ASE leaders and field experts like past presidents William Zoghbi, MD, FASE and James Thomas, MD, FASE, and article-based activities that highlight ASE's guidelines and standards, state-of-the-art review papers and other phenomenal submissions to the Journal of the American Society of Echocardiography (JASE).

New in 2012 is the opportunity to attend live Webinars presented by ASEUniversity. Based on the latest guidelines and clinical recommendations, these webinars provide an exclusive opportunity to have the guidelines explained to you by the lead U.S. author. Time will be taken to answer questions directly from the audience live on the call. Free to everyone, this is a great opportunity to pull your echo lab staff, local society members, or friends together to watch, listen and learn as a team. Upcoming Webinars include:

SEPTEMBER 24, 2012 – Presented by Victor Mor-Avi, MD, FASE
"Current and Evolving Echocardiography Techniques for the Quantitative Evaluation of Cardiac Mechanics"

Can't find the topic you want on ASEUniversity? Not a problem. Prolibraries.com/ASE, a content driven Website, rounds off ASE's online materials with recordings available from some of ASE's biggest events, including the annual Scientific Sessions and the yearly ASCeXAM/ReASCE Review Course. Purchase a session specific to a topic of interest, or purchase the whole course to see what you missed by not attending our live events.

So you can learn at home, or on the road, but what about ASE's live events? ASE boasts a core of five, multi-day, multi-topic activities designed to be a one-stop shop for each of your learning needs.

Want to start the winter off in just the right warm, sunny location? Then **Echo Hawaii,** held in January each year, is right for you. Perhaps one of ASE's most clinically-based courses, Echo Hawaii brings ASE together with other echocardiography societies, including the Korean Society of Echocardiography and new for 2013, the Canadian Society of Echocardiography, with a focus on emerging technologies. In addition, Echo Hawaii features an abstract and poster competition to provide attendees the opportunity to showcase their original research. With a course schedule that allows you time to explore the island, it's time to pack up the family and join **Course Director James Thomas, MD, FASE in Hawaii from JANUARY 21-25, 2013.**

Next up is **February's State-of-the-Art Echocardiography,** held in Scottsdale, AZ: another great winter getaway. State-of-the-Art Echocardiography has a case-based focus, integrating case examples into nearly all of the topics discussed. In addition, State-of-the-Art Echocardiography is one of two ASE courses to feature a computer-based learning lab, providing you with hands-on learning in quantitative echocardiography in a small-group setting. **Join Course Directors Roberto Lang, MD, FASE; Bijoy Khandheria, MD, FASE; Vera Rigolin, MD, FASE and Peg Knoll, RDCS, FASE on FEBRUARY 9-13, 2013 to experience this interactive course.**

Preparing for examinations can be stressful, especially when balanced with a busy work schedule, so ASE has developed the **ASCeXAM/ReASCE review course** to help take the some of the pressure out of preparing for the National Board of Echocardiography (NBE) Examination of Special Competence in Adult Echocardiography. Using illustrative cases, lectures and interactive sessions featuring an audience response system, this course is one of the most comprehensive courses you will find in preparing for the ASCeXAM or ReASCE. Join **Steven Lester, MD, FASE in Boston from APRIL 28-30, 2013 for this intensive review of echocardiography.**

The start of June can only mean one thing: it is time to start gearing up for ASE's biggest meeting of year, **the annual Scientific Sessions.** Rotating around the country to some of America's most desirable locations, the annual Scientific Sessions features educational tracks for everyone. Mix and match between today's hottest topics, including interventional imaging, pediatric and congenital heart disease, and advocacy tracks. Or, take in a little bit of everything by joining expert faculty in case-based discussions, research presentations and instructional symposia. **2013's Scientific Sessions will be held in Minneapolis from JUNE 29-JULY 3 and chaired by Judy Hung, MD, FASE.** ***For more on ASE 2013, see page 20.***

Rounding out ASE's annual events is **Echo Florida,** an inaugural activity for 2012. Held in the easy-to-access and popular Walt Disney World© location, Echo Florida is a disease-based program focusing on coronary artery disease, valvular heart disease and heart failure. Plus, a full day will be dedicated to new percutaneous valve interventions, and how echo can be used to select, guide and follow these interventions. But wait, there is more! Echo Florida also includes not one, but two hands-on workshops. The first provides a full day of education on point of care echocardiography, including brief, case-based lectures and time dedicated to hands-on training on multiple devices. A second workshop provides an opportunity for learners to get individualized instruction at computer workstations on quantitative echocardiography. Join the Disney© gang, along with **Course Director Michael Picard, MD, FASE, for a magical experience starting OCTOBER 6-10, 2012.** ***For more information on Echo Florida, see page 16.***

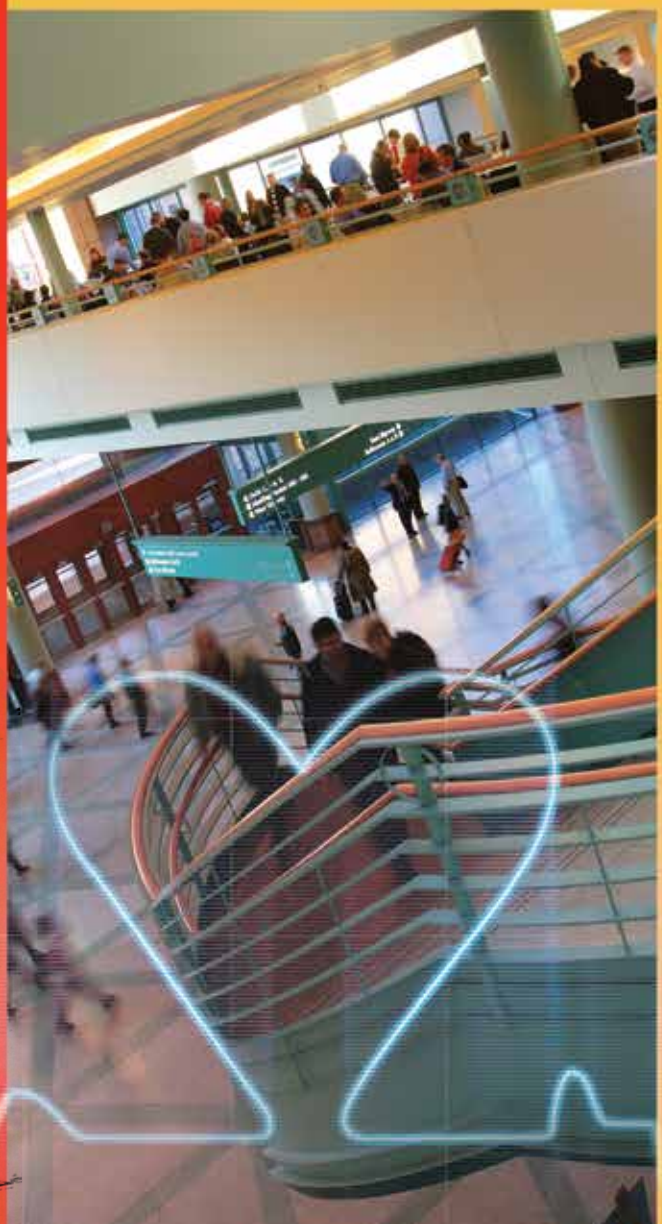
In addition to these courses, ASE provides shorter activities tailored to niche audiences, including the **Chicago Sonographer Update – Adult Congenital Heart Disease Series, a Focused Cardiac Ultrasound Workshop, and CEU programs,** which are designed to allow individuals who participate in regional or hospital-based activities the opportunity to receive credit for their participation. Visit **www.asecho.org/education** to get all the details on all of the opportunities noted here.

One thing I left out – **ASE's opportunity for peer-to-peer networking and interaction with industry.** ASE makes a dedicated effort to provide time during each of its core events for you to ask industry your questions on their latest technology in our exhibit hall, relax with coffee and a snack as you discuss all of the great lectures you just heard with your peers and colleagues, or to sneak up to the podium and engage in conversation with any of our excellent faculty members.
As the landscape of education changes, rest assured that ASE with change with it, providing you with the latest information and technology in a place that you can enjoy. Whether it's in your home, office or one of our destination locations, we look forward to assisting you with all of your cardiovascular ultrasound educational needs! ❤

MEDICAL INNOVATIONS MAKE

Minneapolis a natural

Did you know that Minneapolis is a world class biomedical engineering and healthcare powerhouse, with both Medtronic and St. Jude Medical headquartered just outside the city limits and Mayo Clinic less than 100 miles away? It's also one of the most vibrant and lively metropolitan areas in America. With its big city feel and easy-going Midwestern attitude, Minneapolis is poised to become one of your new favorite destinations. And ASE is going there for its 2013 Scientific Sessions.



If contemporary, fit, and lively aren't the adjectives that come to mind when you think of Minneapolis, it's high time you revisited. Voted "best metro area for business" by *MarketWatch* twice, Minneapolis has more corporate headquarters per capita than any U.S. region save one. Far from being all business, however, Minneapolis is also the third largest theatre market in the nation with the most seats per capita of any city except New York. Listed on the American Fitness Index's "fittest cities in America," Minneapolitans also find time to indulge in the natural beauty that surrounds and pervades the downtown area. Its world-class art and music scene will wow even the most skeptical critics, and its restaurants are sure to make foodies' mouths water.

Not quite ready to buy your tickets yet? We saved the best part for last: it's all navigable by this green city's innovative Skyway System, an interlinked network of enclosed pedestrian footbridges spanning over 7 miles that connects buildings in the downtown area with the convention center. Want to know more? Yeah, there's an app for that: Look up "Minneapolis Skyway Tour" on iTunes for more details. **Visit http://www.downtownmpls.com/ for more information.**

It's a tall task to list all the myriad activities and experiences Minneapolis has to offer, but here are some highlights from the City of Lakes that we bet will take you by surprise. You'll be amazed by what you never knew you couldn't miss:

THINGS TO SEE

ART «

Minneapolis Institute of Arts (www.artsmia.org/)
One of the largest arts educators in Minnesota, the Minneapolis Institute of Arts is visited by more than a 500,000 people a year. A free museum operated for the benefit of the general public, the MIA's permanent collection features art of various media from a wide range of cultures and time periods. From contemporary art to textiles, local works to African art, the 80,000 objects visitors can explore is comparable to that of the country's most well-known museums.

Katherine Nash Gallery (www.art.umn.edu/nash/)
The University of Minnesota's own museum, the Nash gallery is, in its own words, "a research laboratory for the practice and interpretation of the visual arts" (from website). Housed in a 5,000 square foot space, the Nash gallery is one of the finest exhibit spaces in the Midwest, and exhibits work by local, domestic, and international artists. Recent exhibits include *Power and Place*, a collection of photographs by American artists, and *Mni Sota*, a group exhibition of contemporary Native American artwork.

The Science Museum of Minnesota (www.smm.org/)
Situated in a spectacular location on the Mississippi River, the Science Museum of Minnesota receives more than a million visitors a year to its interactive exhibits and large format films. With both research and education facilities, and the only convertible dome IMAX omnitheatre in the country, the SMM has something for all members of the family.

MEDICAL INNOVATION MAKES

Minneapolis a natural

THINGS TO SEE

ART (CONT.) «

Walker Art Center (www.walkerart.org/)
Contemporary art and sculpture find their Midwestern home at the Walker Art Center. With its focus on visual, performance, and media arts, the Walker's collection distinguishes it from other museums in the region and the country. A permanent collection that includes works by Pablo Picasso and Henry Moore is augmented by visiting exhibitions from influential figures including photographer Cindy Sherman and curator John Waters. The museum's dynamic collection and space has made it one of the top 5 contemporary art museums in the country.

THEATRE «

Guthrie Theatre (www.guthrietheater.org/)
Founded in 1963, the Guthrie presents both classical literature and newer works from diverse cultures and traditions. Situated in Downtown Minneapolis on the west bank of the Mississippi river, the Guthrie has a diverse lineup of events scheduled for the coming year: a new musical based on the film *Roman Holiday* (starring Gregory Peck and Audrey Hepburn) is followed by a traditional staging of *Twelfth Night* and a new adaptation of Homer's *The Iliad*. These not-to-be-missed performances have something to offer everyone.

Minnesota Public Radio's Fitzgerald Theater
(http://fitzgeraldtheater.publicradio.org/)
Has the extent of your Midwestern experience taken place in your living room while listening to Garrison Keillor's tales of Lake Wobegone? Come experience the real event and watch the Prairie Home Companion crew record their Saturday night show live on the Fitzgerald stage. If tales of freezing winters aren't your thing, other upcoming productions from award-wining artists and performers include Henry Rollins' "Capitalism" tour and Connor Oberst of the band Bright Eyes.

THINGS TO DO

GO OUTSIDE «

Grand Rounds National Scenic Byway
[http://www.minneapolisparks.org/grandrounds/)
The National Scenic byway is an interlinked network of roads, pedestrian, and bike paths that winds around the seven byway districts of Minneapolis. Depending on what you're in the mood for, you can explore more metropolitan areas or get out into nature on a short jaunt or a longer trek. The Grand Rounds National Scenic Byway offers something to everyone: the Downtown Riverfront byway district is a 1.2 mile stretch that takes visitors by the historic West Side Milling District as well as Nicollet and Boom Islands. The Chain of Lakes byway district, conversely, is a 13.3 mile loop around the lakes for which Minneapolis is famous. A bird sanctuary and rose garden can all

be accessed from this path. Don't have a bike? The Minneapolis Nice Ride bike subscription program lets you take a bike from a local station and return it when you're done.

Go to a MLB game downtown! (http://minnesota.twins.mlb.com)
The Twins' new downtown stadium, Target Field, provides spectacular views, fantastic concessions, and a wide range of exciting amenities, including WiFi! You can even take a tour of the field, which has been rated the #1 fan experience in all of major league sports by ESPN the Magazine. Tickets and tours can be purchased online.

See the Mississippi river by kayak!
[http://www.abovethefallssports.com/]
The River Visitor Center is located inside the Science Museum of Minnesota.

SHOPPING «

Visit Mall of America (http://www.mallofamerica.com/home)
With its 520 stores and attractions ranging from Stuart Weitzman to the massive Nickelodeon Universe, The Mall of America is legendary for its vastness and variety. Located in Bloomington, MN, an easy-to-reach suburb of the Twin Cities, the Mall hosts over 400 events each year, including concerts and celebrity meet and greets. Described as a "city within a city," the MOA is one of the top tourist destinations in the country.

PLACES TO EAT & DRINK

Minneapolis' food offerings make it clear what an eclectic but unstuffy town this is. World-class cooking available steps from the downtown convention center provides something for every palate. Here are a few exceptional highlights:

DINNER «

Hell's Kitchen (http://www.hellskitcheninc.com/)
Located in the heart of downtown Minneapolis, Hell's Kitchen is known for its self-proclaimed "damn good food." Offering breakfast, lunch, dinner and drinks 7 days a week, this Zagat rated restaurant serves up made-from-scratch meals that have been raved about in Gourmet magazine and NWA World Traveler. Be sure to stop in on Thursdays, Fridays, and Saturdays for live "rock the house" shows.

DRINKS «

Barrio (http://barriotequila.com/)
Chef Bill Fairbanks serves up traditional Mexican street food with a twist at this funky and fresh tequila bar and restaurant in downtown Minneapolis. With over 100 tequilas behind the bar and a mixture of homey and lofty food offerings, Barrio has won numerous accolades from both local and national publications. Reasonable prices and exciting atmosphere make this a not-to-be-missed stop on your culinary tour of downtown.

MEDICAL INNOVATION MAKES

Minneapolis a natural

AMERICANA «

Butcher & the Boar (http://butcherandtheboar.com/)
Editor's Pick of Mpls St. Paul magazine, Butcher and the Boar is a "den of meat and bourbon" that offers one of the best nights out in town. The smoked meats and sausages chef Jack Riebel prepares in house have been lauded by local critics as "magnificent," and the pre-prohibition cocktails offered are practically medicinal in strength and flavor. Small-batch, refined bourbons including Blanton's and Bakers 7 year are served in simple, unfussy flights. An American experience in the best sense of the word.

LUNCH «

Depot Tavern (http://thedepottavern.com/about/)
Hungry for a quick and tasty lunch? Look no further than the Depot Tavern, a cornerstone of the national music scene housed in an art deco Greyhound bus station. Hotdogs (and hotdog eating contests) are a prominent feature of the Depot Tavern experience. Reinterpretations of American classics, such as Fresh Herb Mac and Cheese, embody the feel of Minneapolis: Midwestern with an edge. Open daily starting at 11:00 AM.

OTHER PLACES TO EAT «

112 Eatery | 112eatery.com | 612.343.7696
Bar La Grassa | barlagrassa.com | 612.333.3837
Be'wiched Sandwiches and Deli | bewicheddeli.com | 612.767.4330
Black Sheep Pizza | blacksheeppizza.com | 651.227.4337
Brasa Rotisserie | brasa.us | 651.224.1302
Broders' Cucina Italiana | broders.com/cucina-italiana | 612.925.3113
HauteDish | haute-dish.com | 612.338.8484
In Season | inseasonrestaurant.com | 612.926.0105
La Belle Vie | labellevie.us | 612.874.6440

WHO IS THERE?

One of the largest commercial centers between Chicago and the West Coast, Minneapolis is home to 16 of the Fortune 500 largest corporations in the US. The Twin Cities also house 30 Fortune 1000 companies, not to mention some of the world's largest private producers of medical equipment, electronics, farm machinery, and construction equipment.

BIG BUSINESS

TARGET – The second largest discount retailer in the United States behind Walmart, Target is ranked number 33 on the Fortune 500 and is part of the S&P 500. The corporation has its massive world headquarters on Nicollet Mall in downtown Minneapolis.

MEDICAL SUPPLIES AND FACILITIES

ST. JUDE MEDICAL – St. Jude Medical develops medical technology and services that help to put control in the hands of those who treat cardiac, neurological and chronic pain patients. The product portfolio includes implantable cardioverter defibrillators (ICDs), cardiac resynchronization therapy (CRT) devices, pacemakers, electrophysiology catheters, mapping and visualization systems, vascular closure devices, structural heart products, spinal cord stimulation and deep brain stimulation devices. (http://www.sjm.com/corporate/about-us.aspx)

MEDTRONIC – Founded in 1949, Medtronic has grown to become the world's largest independent medical technology company. Each year, Medtronic therapies help more than seven million people. CardioVascular, Medtronic's third largest business, offers a vast portfolio of medical devices and technology that are used to treat an array of chronic diseases affecting the vascular system, including the heart, the aorta and the peripheral arteries. The business markets the industry's broadest line of heart valve products for replacement and repair; auto-transfusion equipment and disposable devices for handling and monitoring blood during major cardiac surgery; and cardiac ablation devices to treat a variety of heart conditions.

MAYO CLINIC – Fewer than 100 miles away from Minneapolis, Mayo Clinic is a not-for-profit medical practice and medical research group specializing in tertiary care. Mayo Clinic has been on the list of America's "100 Best Companies to Work For" published by Fortune magazine for eight years in a row. While Mayo started out as a small family practice, it grew into America's first integrated group practice, a model that is now standard in the United States. Mayo's heart care practice is one of the broadest in the world, and cardiologists in this division administer care to approximately 55,000 patients annually.

THE UNIVERSITY OF MINNESOTA – The U of M Academic Health Center's Center for Cardiovascular Repair became the first facility in the world to grow a beating heart in 2008. A research powerhouse, the Center for Cardiovascular Repair is currently part of a multi-million-dollar project aimed at using stem cell therapy to treat heart disease. Working alongside faculty and students at the U of M's Lillehei Heart Institute, these research teams study gene variation that causes facioscapulohumeral dystrophy and work to develop a genetic therapy that will treat this condition.

CODING AND QUALITY CONTROL SOFTWARE 3M – Among 55,000 other products, 3M produces software to aid in efficient coding, compliance, and chart reviews in addition to coordinating technologies that assist in synchronizing clinical documentation improvement (CDI) and other quality metrics. Headquartered in St. Paul, 3M (formerly the Minnesota Mining and Manufacturing Company) was number 97 on the Fortune 500 list in 2011. ❤

THE BOTTOM LINE

When you think about Minneapolis, the first image that comes to mind may not be of a lush city that emphasizes green living, world-class art and culture, and booming industry. But this is what you will find when you attend ASE 2013 in the City of Lakes. Don't miss your chance to explore the sophistication and excitement of this Midwestern powerhouse – it's a whole lot more than meets the eye. **Registration for ASE 2013 opens in December 2012.**

Accountable Care Organizations: Information and Advice You Can't Afford to Miss

New developments within the health care market landscape as well as ever changing regulations on how to provide patient care can make it challenging to determine how to remain competitive and profitable in private practice.

As lawmakers struggle to find ways to reduce the national deficit, and with Medicare costs poised to soar over the next several years, overspending in Medicare and Medicaid has become the target of scrutiny by the department of Health and Human Services. With this scrutiny have come a myriad of changes to the models by which physicians are expected to deliver care, all of which are aimed at incentivizing hospitals and private practices to keep costs low. Although physicians are able to thrive in this new environment by meeting specific quality benchmarks, finding information on how to do so can be a challenge.

Perhaps the most complex and expensive component of healthcare reform is the emergence of Accountable Care Organizations, or ACOs. ACOs, which are networks of doctors and hospitals that share responsibility for providing care to patients, agree to manage the healthcare needs of at least 5,000 Medicare beneficiaries for at least 3 years under healthcare reform laws. This new model moves away from a fee-for-service reimbursement schema to one based on flat fees issued per Episode of Care. An Episode of Care is defined as the set of services required to manage a particular medical condition from the time of a patient's initial visit through the next 12 months. ACOs must show that the care they administer achieves the three-part goal of « ❶ better population health, ❷ better individual care, and ❸ lower cost per capita.

While this model is targeted to save Medicare up to $960 million within these first three years, it can end up costing doctors a substantial amount of money to implement. Indeed, although ACOs who are able to save money while administering quality care would receive bonuses under the new law (as much as 60% of savings), ACOs who are not able to save money will have to foot the bill for the cost of investments made to improve care.

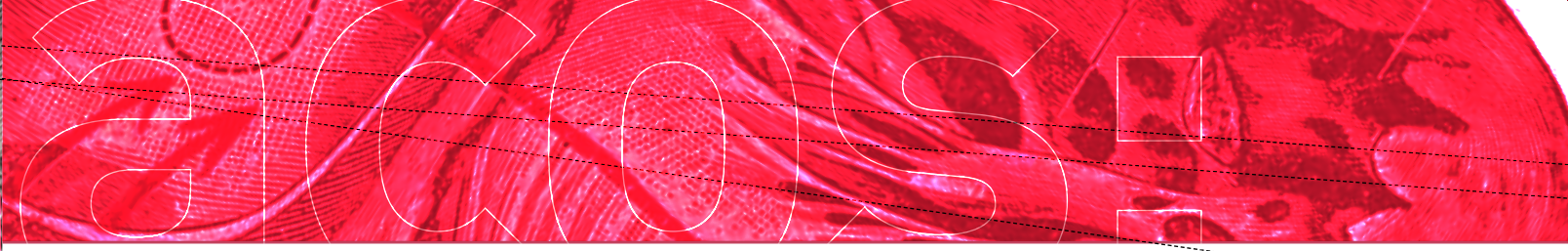
While ACO adoption is not yet mandated as part of the Patient Protection and Affordable Care Act (ACA), many care providers are moving early to align themselves with a potential future mandate. Medicare ACOs are currently in a three year trial phase during which they will report annually on their efficiency, savings, and patient health outcomes. But the line to form ACOs has grown and at ASE we are determined to help our members navigate these complicated waters.

/// ACO: NOT AN HMO

The three-letter acronym and umbrellaed nature of ACO services seem almost intentionally designed to bring to mind the dreaded Health Maintenance Organization (HMO), but this new construct is not the return of a 1990s bogeyman. It is in fact a new type of organization designed not to limit patient care and access to medical help, but instead to make physicians and hospitals more accountable to patients while bringing down the currently ballooning costs of medical coverage.

The primary difference between an ACO and an HMO lies in the fact that ACOs do not lock patients into using only providers within the ACO for their healthcare needs. While ACOs have an incentive to push beneficiaries toward using their colleagues, beneficiaries may still seek outside consultation and care without penalty. That means that a beneficiary may be assigned to an ACO for hospital visits but can still access primary care from his or her regular primary care physician, or vice versa.

While healthcare is not significantly more integrated today than it was in the era of HMOs, ACOs are designed to incentivize integration among hospitals, specialists and primary care physicians. Because they will be part of a single team in the ACO, and it is this overall entity through which cost savings will be measured, ACOs should enhance communication and efficiency in every step of the healthcare process. This process is intended to eliminate the painfully fractious communication problems of the HMO era when a hospital and primary care physician often ordered duplicate tests due to communication breakdown.



The ACO, however, does not do away completely with the fee-for-service model or change how payments from Medicare are bundled; it is designed instead to limit the amount of repeat trips to the hospital and unnecessary testing that plagued previous fee-for-service plans. The HMO era healthcare system often inadvertently encouraged hospitals and physicians to send home patients before necessary care was given due to a lack of continued reimbursement for subsequent care. The new ACO-led system forces providers to take more of a stake in the final outcome of care. A metric upon which ACOs are measured is patient readmission rates and attitudes of patients toward the care that they received. This added metric of care measurement should ensure that ACOs avoid this particular pitfall of HMOs.

/// MSSP

As part of the passage of the Affordable Care Act of 2010, The Centers for Medicare and Medicaid Services initiated the Medicare Shared Savings Program (MSSP) to create a financial motivation for ACOs to achieve the three goals these Organizations have been charged with« ❶ Bettering population health ❷ Bettering individual care ❸ Lowering costs per capita.

The Shared Savings Program provides financial rewards to ACOs who are able to lower their growth in healthcare costs while maintaining a high quality of care as defined by 33 discrete measures, ranging from timely care delivery to administering influenza immunizations. Providers who are able to deliver quality care at below-benchmark costs will split those savings with CMS, which is one way ACOs stand to make money. Benchmark costs are calculated based on the per capita Part A and Part B (inpatient and outpatient) Medicare costs of beneficiaries that would have been assigned to a given ACO in the three years prior to its formation; these numbers are updated annually based on the projected absolute amount of growth in Part A and Part B fee-for-service expenditures. A beneficiary is considered part of an ACO if he or she receives the plurality of his or her primary care from primary care physicians within the ACO, or if he or she receives a plurality of his or her primary care services from specialist physicians and certain non-physician practitioners. As a result, even specialists can help accrue the required 5,000 beneficiaries required for ACOs.

The 33 measures against which MSSP evaluates the success of ACOs are divided into 4 domains: Patient/Caregiver experience, Care Coordination/Patient Safety, Preventative Health, and At-Risk Populations. By asking ACOs to deliver quality care at below benchmark prices in these 4 areas, MSSP hopes to incentivize these Organizations to standardize patient care while decreasing the cost of its delivery. CMS rates an ACO's success against these measures using Clinician & Group Consumer Assessment of Healthcare Providers and Systems (CG CAHPS) surveys to evaluate patient experience, Group Practice Reporting Options, electronic medical records, and claims data.

HOW IS COST SHARING CALCULATED?

ACOs can choose one of two payment methods according to the amount of risk they wish to assume. Under the first, a one-sided model, ACOs do not assume any financial risk, and receive a portion of any savings once the minimum shared savings rate threshold of 2% is reached. Under the second, a two-sided model, ACOs take on both shared losses and shared savings. Because with greater risk comes greater reward, ACOs who adopt the two-sided model stand to gain 60% of all savings with no minimum threshold, whereas ACOs under the one-sided model can share only 50% above the 2% minimum.

PERFORMANCE ANXIETY?

If you are feeling overwhelmed by the thought of meeting all 33 measures right away, you are not alone. CMS recognizes that achieving these newly defined standards for successful care will take time, so it allows new ACOs to phase in adherence over a three-year period. During the first year, a new ACO only needs to report on the 33 measures, not perform in them. During the second year, an ACO must report on all 33 measures, but perform only on 25 of them. Only in the third year will an ACO be required to perform on all 33 measures, by which time it will be comfortable delivering care in this new setting.

/// KEYS TO SUCCESS & PITFALLS

APPLY FOR STARTUP CAPITAL

Implementing the infrastructure required to coordinate care among ACO participants takes both time and money. In order to alleviate some of the financial pressure that comes with starting an ACO, CMS has established an Advanced Payment Model, which is designed to aid physician-based and rural providers who have the desire, but not the capital, to form an Accountable Care Organization. When asked about the Advanced Payment Model, President and CEO of Cardiovascular Management of Illinois Cathie Biga notes: "The announcement that 15 of the 90 [new ACOs formed last month] will be participating in the Advanced Payment Model is of particular note to the physician community since it would allow smaller physician practices some start up funding." This funding could prove invaluable to non-hospital participants who would otherwise be hard pressed to streamline and integrate the ways they deliver care. This money does not come without strings attached, however. Biga reminds physicians considering applying for this funding that Advanced Payment Model funding will later be recouped in shared savings; ACOs that do not generate enough shared savings their first year will continue to repay this loan in subsequent years.

Even with these restrictions, however, the financial support provided by this program, which is doled out both in a lump sum and as upfront, monthly payments, can help providers gain access to the technology and staff necessary to a successful and profitable ACO. Interested readers can visit http://innovations.cms.gov/initiatives/ACO/Advance-Payment/Application-Info.html to find out more about their eligibility and the application process.

REPORT THE CARE YOU PROVIDE:

As outlined above, ACOs stand to make substantial profits, but only if they have enough startup capital to be successful. In particular, ACOs need sufficient time, money, and tech-savvy to implement a data-sharing architecture that will allow them to get "credit" for the better outcomes and reduced cost care they provide. One of biggest stumbling blocks for new ACOs is figuring out how to structure the sharing of Electronic Health Records (or EHRs) for their beneficiary population. An EHR is a digital record for individual patients that can be shared across providers. Setting up a sharable database for EHRs requires significant initial investments of time and money with no guarantee of return. Without an IT structure that allows ACOs to record patient outcomes and their cost, however, they have no way of reporting their successes to CMS, so finding ways to structure EHR sharing is a necessary evil. One way to improve the likelihood that EHRs are recorded, shared, and analyzed in an effective way is to use traditional business intelligence reporting software rather than pricey products designed specifically for the healthcare market. Businesses have been sharing and mining data granularly with disparate users for years, and the software developed for these markets is more sophisticated than newer software designed specifically for the healthcare market.

Another tool newer and smaller ACOs can use to create an effective reporting system that suits their needs is called the Direct Project. This open government initiative allows for the secure communication of health data among health care participants in a simple, secure, scalable, standards-based way over the Internet. It's less expensive than the business analytics software described above, and is customizable. More information can be found at www.directproject.org.

STUDY YOUR PATIENT BODY:

ACOs are frequently formed to administer care to a particular geographic region. Before determining which types of physicians, specialists, and facilities an ACO ought to include, providers should examine their community of patients to determine how best to administer integrated care to this group. Looking for trends within local patient populations will help ACOs be prepared to meet the medical needs of this group.

FIGURE OUT HOW MUCH CARE ACTUALLY COSTS:

Unlike old fee-for-service models, CMS now pays ACOs bundled, negotiated reimbursements for all the services that go into one episode of care (a heart attack, for example). Under this model, CMS issues one check to an ACO to cover everything from hospital stays to specialist care to rehab post-procedure. While the individual price tags for each of these services are based on physician claims from 2010 and updated each year, they may not correspond exactly with the amount an individual provider spends providing care. One step physicians and specialists who are considering joining an ACO can take to prepare is to figure out what the actual cost is of the procedures they perform. Catherine Hanson, JD, who is Vice President of the AMA's Private Sector Advocacy and Advocacy Resource Center, considers this to be a critical procedure for physicians who hope to form an ACO. She writes that, under the new payment system, "the primary driver of the economic result to the physician practice is the extent to which the actual cost of providing care to a patient population varies from the projected budget for those costs – physicians who come in at or under-budget prosper, while physicians who exceed the budget are penalized." [1] In other words, determining how much it costs to perform one transthoracic echo, from the electrical costs to the salaries of the sonographers, for example, will allow providers joining an ACO to craft a realistic and financially viable budget for administering care to their patient population. Once practitioners have this kind of information, they will have a better sense of how far the amount of the bundled reimbursement to which they are entitled will go, helping them cover operating costs under these new payment models. (See https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Calculations.html for more information.)

[1] Hanson, Catherine. "Evaluating and Negotiating Emerging Payment Options: A new physician resource published by the American Medical Association." *The American Medical Association.* 2012.

MAKE PATIENT CARE THE PRIMARY FOCUS, NOT COST SAVINGS:

Cutting costs should not be the only goal of an ACO. Indeed, it is important to keep in mind that reducing superfluous treatments and readmissions is, at the end of the day, to the benefit of the patient. Experts remind us that the 33 quality and efficiency measures laid out by the MSSP to help ACOs become profitable should empower physicians to provide better care to their beneficiaries. While coming in under benchmark cost is important to the financial viability of ACOs, it should be undertaken as a means to improved patient outcomes through integrated care. Providing quality, streamlined care also ensures that beneficiaries do not leave the ACO (called "leakage). As with any market driven business model, a better product means a better relationship with the customer, resulting in higher demand: in this way, better care increases an ACO's chances of success.

/// THE FUTURE OF PRACTICE, IN PRACTICE?

It is not only organizations that rely on Medicare Shared Savings Program for extracting potential savings that are forming ACOs. Some insurers and care providers are banding together to form commercial ACOs that are taking the integration models and ideals set forth in the ACA to find pockets of inefficiency and waste within their organizations. They are distinguishable from Medicare ACOs because it is the commercial payer, usually an insurer, that is providing the financial incentive to lower costs. These commercial ACOs are often termed Accountable Care Initiatives, or ACIs, in order to distinguish themselves from the Medicare ACO alternative.

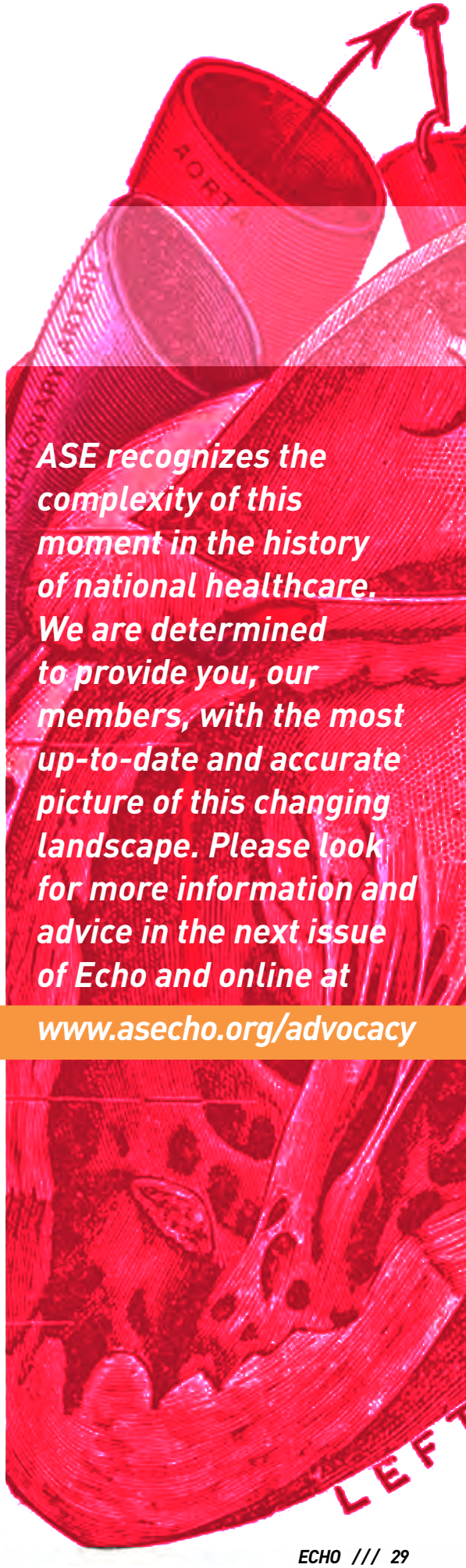
But there is wariness surrounding the use of ACIs to lower the cost of care. Using ACIs to implement cost savings strikes some as allowing commercial insurers to pay healthcare providers to lower the costs of treating beneficiaries without basing the incentives on outcomes. While one of the measures of success for a Medicare ACO is better patient health, there is no systematic way to be sure that ACIs are providing better, or even comparable, care to patients while cutting costs.

On July 1 of this year, the CMS and the Health and Human Services Secretary announced that 89 new ACOs had been added to the list of those organizations participating in the purely voluntary MSSP. These are the first true tests of the ACO model, the results of which will not be known for some time. Prior to this, the only participants in any form of shared savings programs were providers testing different models of savings payment, not those using the standard model outlined in the ACA.

The addition of these organizations brought 1.2 million new people with Medicare in 40 states and the District of Columbia into an ACO program. There is a wide variation among these organizations based on their geographical location and specialties. Almost half of the 89 new ACOs are physician-driven organizations with fewer than 10,000 beneficiaries on their rolls. The variation in size and location should provide ample evidence and practical advice for those considering starting their own ACO once they begin reporting on their progress in 2013.

On January 1, 2012, CMS began testing its Pioneer ACO Model, which took 32 regional organizations from around the country that had prior experience in coordinated, patient-centered care and placed them in an ACO-like organization. These select organizations are testing a higher risk, higher reward shared savings plan than that proposed in the ACA to see if it is more effective in controlling cost and providing better patient care. This program still provides the protection for patient care that a typical ACO would and also allows the patient to seek treatment outside of the Pioneer ACO.

Both the typical MSSP ACO and the Pioneer ACO programs are currently closed for new applicants. The Pioneer ACO program has no plans to reopen for admission, at least while the initial three year test period is still in progress. The MSSP ACO program will continue to take applications even before the 89 new ACOs have completed their initial reporting phases. The application window for 2013 ACOs closed on September 1, 2012. Please go to **www.cms.gov** for more information concerning future application windows and for updates on the progress of current ACOs. ❤



ASE recognizes the complexity of this moment in the history of national healthcare. We are determined to provide you, our members, with the most up-to-date and accurate picture of this changing landscape. Please look for more information and advice in the next issue of Echo and online at www.asecho.org/advocacy

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❤ HOW THE RUC IMPACTS YOU

The RUC, or Relative Value Scale Update Committee, was formed by the AMA to serve as an expert panel to advise the Centers for Medicare and Medicaid Services (CMS). It evaluates the relative values of Current Procedural Terminology (CPT) codes using the Resource-Based Relative Value Scale (RBRVS). The RUC is responsible for making recommendations regarding new and revised physician services to CMS. Although the RUC does not make final decisions, its clout as an advisory body is well documented: historically, CMS accepted 85 percent or more of the RUC's recommendations. The RUC's impact is amplified further because **many private payers base their fee structures on Medicare's.** Currently the RUC's recommendations affect almost every form of reimbursement your practice receives.

The RUC's recommendations are based on information collected through a formal survey process. Physicians who are selected to participate in these surveys are asked to provide information on codes in current use, which the RUC then compares to new or revised code values. Because the credibility of the recommended value is determined by the quality of the survey, it is essential that you complete and return any surveys in which you are asked to participate.

These surveys are an opportunity for you to participate in the RUC process and influence the code valuation. They allow you to contribute your thoughts and experiences to the assessment of the time, complexity and work value of a procedure. This data is the only current means available to ensure a fair and adequate reflection of the effort and difficulty involved with each procedure. It cannot be stressed enough how vital your

help the table cuts}

involvement is in gathering this data. Only those societies that are full members of the American Medical Association House of Delegates (HOD) can directly participate in the AMA CPT and RUC processes. At present, ASE is not a HOD member and is excluded from this process except when invited by a seated HOD member to participate in the development of coding changes and relative values of particular relevance to echocardiography services.

ASE is working diligently to secure an advisor seat in the HOD so that we can influence policy that affects our members. Securing an advisor seat in the HOD would give ASE the ability to provide directly information on issues that determine the future of echocardiography. To qualify for an advisor seat in the AMA HOD, however, ASE must demonstrate that 25%, or 1,000, of its physician members in the United States are also AMA members. ASE is very close to reaching that target but needs your help! Right now, 991 individuals are members of both associations. While we recognize that many of you feel the AMA does not always represent your interests, with the system currently in place, the AMA HOD is the only effective means currently available to have a voice in establishing Medicare reimbursement and performance in the future. We ask for your support in qualifying for an advisor seat in the HOD to protect echocardiography. Without a seat, ASE is unable to advocate directly on your behalf on issues relating to Medicare reimbursement code change review and valuation, a fee structure to which many private payers have tied their reimbursement rate.

❤ **We urge you to help us represent your interests by joining the AMA today! Your participation will ensure that we can advocate on your behalf on the issues most important to you, our members.** ////////////////////////////

ASE is proud to say that there have been recent victories for echocardiography. While recently most codes reviewed by the RUC have been recommended to receive a reduction, ASE and the American College of Cardiology (ACC) recently presented results of an American Medical Association (AMA) survey to maintain the current valuation for several key echocardiography codes. ASE is your voice, advocating for quality echocardiography; help us make it heard! ❤

TAVR:

WHAT IT IS, WHO IT HELPS, AND HOW TO GET PAID FOR IT

WHAT IS IT?

Transcatheter Aortic Valve Replacement, or TAVR, has been on the rise as a treatment option for patients suffering from senile aortic valve stenosis in the United States following the PARTNER trial's successful deployment of the Edwards Sapien Aortic Valve among nonsurgical candidates in 2010. The minimally invasive treatment delivers an artificial valve into the heart through a catheter. The collapsed valve is then inflated using a balloon inside the native valve, where it resumes the work the narrowed valve can no longer perform almost immediately. Although higher rates of stroke and aortic insufficiency are seen in conjunction with TAVR, the procedure provides an alternative for patients deemed inoperable or high risk by a multidisciplinary team of practitioners.

TAVR relies heavily on echocardiography to provide the most accurate view of heart valves from diagnosis to post-procedure.

Although cardiac catheterization was traditionally considered to be the most appropriate technique for quantifying aortic stenosis, it has been eclipsed by Doppler echocardiography as the gold standard for identifying aortic stenosis over the course of the past decade; this is owing in part to the convenience and widespread applicability of transthoracic echocardiograms (TTE). Echocardiography enables physicians to assess the anatomy of the valve, to quantify the severity of the stenosis and calculate the size of the aortic valve area, and to determine whether the valve leaks, all before the procedure begins. Physicians typically use 3-dimensional TTE or, when image quality is suboptimal, transesophageal echocardiography (TEE), to perform this preprocedural diagnostic workup of patients with AS.

WHY IS THIS CONDITION ON THE RISE?

Senile aortic valve stenosis is a degenerative disease that affects the elderly. Approximately 300,000 patients in the United States have aortic stenosis, and nearly 30% of these are too old or have too many comorbidities to survive surgical replacement. As the average age of populations in the developed world rises, these numbers will increase. Because TAVR is a less invasive approach than open heart surgery, it provides hope for this growing older cohort.

WHO PERFORMS TAVR?

Because the preprocedural evaluations necessary to determine whether a patient is a candidate for TAVR are complex, a heart team is required to provide interdisciplinary care and expertise. According to Centers for Medicare and Medicaid Services regulations, this team must include a cardiovascular surgeon who has performed a high volume of Aortic Valve Replacements, an interventional cardiologist with vast experience in structural heart disease procedures, echocardiographers and imaging specialists, heart failure specialists, cardiac anesthesiologists, intensivists, nurses, and social workers. Each member of the team must have received device-specific training from the manufacturer.

WHAT ARE THE CURRENT RULES ON MEDICARE AND MEDICAID REIMBURSEMENT FOR TAVR PROCEDURES?

On May 1st, 2012, the Center for Medicare and Medicaid Services (CMS) determined that it would cover TAVR under the Coverage with Evidence Development. This development is used for procedures that are not considered "reasonable and necessary for the diagnosis or treatment of illness" under typical national coverage determinations; this statutory provision is often used for novel techniques that would traditionally lack sufficient medical and scientific evidence required for them to qualify for Medicare payment. This victory followed a National Coverage Decision request from the American College of Cardiology (ACC) and the Society of Thoracic Surgeons (STS) in late 2011.

In order to receive Medicare/Medicaid coverage for TAVR, a series of conditions must be met.

These include the following «

- The procedure is furnished with a complete aortic valve and implantation system that has received FDA premarket approval for that system's FDA approved indication
- Two cardiac surgeons have independently examined the patient face-to-face and evaluated the patient's suitability for open aortic valve replacement surgery; and both surgeons have documented the rationale for their clinical judgment and the rationale is available to the heart team.
- The patient (preoperatively and postoperatively) is under the care of a heart team.
- The heart team's interventional cardiologist(s) and the cardiac surgeon(s) must jointly participate in the intraoperative technical aspects of TAVR.
- The heart team and hospital participate in a prospective, national, audited registry that consecutively enrolls TAVR patients, accepts all manufactured devices, follows the patient for at least 1 year and complies with regulations for protecting human research subjects. *Currently, the only FDA-approved transcatheter valve is manufactured by Edwards.*

WHAT CRITICISMS DO THESE REQUIREMENTS ELICIT FROM PHYSICIANS, AND WHAT EFFECT MIGHT THEY HAVE ON PATIENT CARE?

Some physicians feel that the minimum experience the heart team must meet in order to participate in a Medicare-covered TAVR program will restrict access to TAVR too severely, preventing sick patients from accessing this life-saving procedure. These critics view the stipulation that interventional cardiologists must have performed 50 TAVR procedures as an arbitrary requirement that does little to identify individuals who are capable of performing TAVR successfully. Conversely, proponents of the requirements feel that there are sufficient numbers of high-volume PCI physicians with long-term experience in structural interventions who will meet the CMS requirements that there will not be holes in access to TAVR across the country. Proponents of these requirements include ASE advocacy committee chair David Wiener, MD, FASE who writes:

> ASE supports the emphasis on quality which is embodied in CMS' decision on TAVR. The TAVR team approach is in line with the latest guidelines for surgical and percutaneous interventions promulgated by our sister cardiovascular societies. ASE also affirms the concept that specific numbers of procedures must be performed in order to achieve and maintain competence, an idea that permeates the medical literature as well as ASE's own guidelines. We further endorse the requirement to enroll patients in a registry, as registries allow quality to be judged on clinical rather than claims data, and provide a fruitful source for future research.

THESE SENTIMENTS ARE ECHOED BY ASE ADVOCACY COMMITTEE MEMBER MICHAEL MAIN, MD, FASE WHO WRITES:

> I believe the CMS heart team and operator experience requirements for TAVR are well-founded and will maximize the prospects for positive patient outcomes. Patient candidates for TAVR are extremely complex – elderly and frail, with multiple co-morbidities, and oftentimes difficult vascular access issues. Appropriate patient selection and procedural success are dependent on multi-disciplinary collaboration amongst cardiac surgeons,

TAVR: WHAT IT IS, WHO IT HELPS, AND HOW TO GET PAID FOR IT

interventional cardiologists, cardiac anesthesiologists, and echocardiographers. The current CMS requirements for TAVR in the only group so far approved for commercial use (patients with severe symptomatic aortic stenosis who are deemed inoperable) nicely balance patient safety and access to care issues.

As these informed opinions illustrate, finding a balance between establishing a high level of expertise required for those performing this complicated procedure while allowing new startup sites to qualify to perform TAVR is both complex and nuanced. Indeed, in a recent interview with *Cardiac Interventions Today,* Ted E. Feldman, MD, director of the Cardiac Catheterization Laboratory at Evanston Hospital in Evanston, IL, sums up the issue in saying:

> The fundamental question is, how many sites in the United States can be sustained with current indications for the procedure? At the extreme, it is clear that we cannot have all 1,000-plus cath and surgery programs doing TAVR and expect operators to maintain volumes that are adequate to keep them performing at a highly confident level. At the other end, we cannot have criteria that are so restrictive that the procedure is not available.[i]

The efficacy of surgery programs performing TAVR to provide insight into clinical practice patterns and patient outcomes under the CMS's requirements will be monitored through registry participation.

HOW WILL THE CMS'S APPROVAL CRITERIA IMPROVE PATIENT CARE?

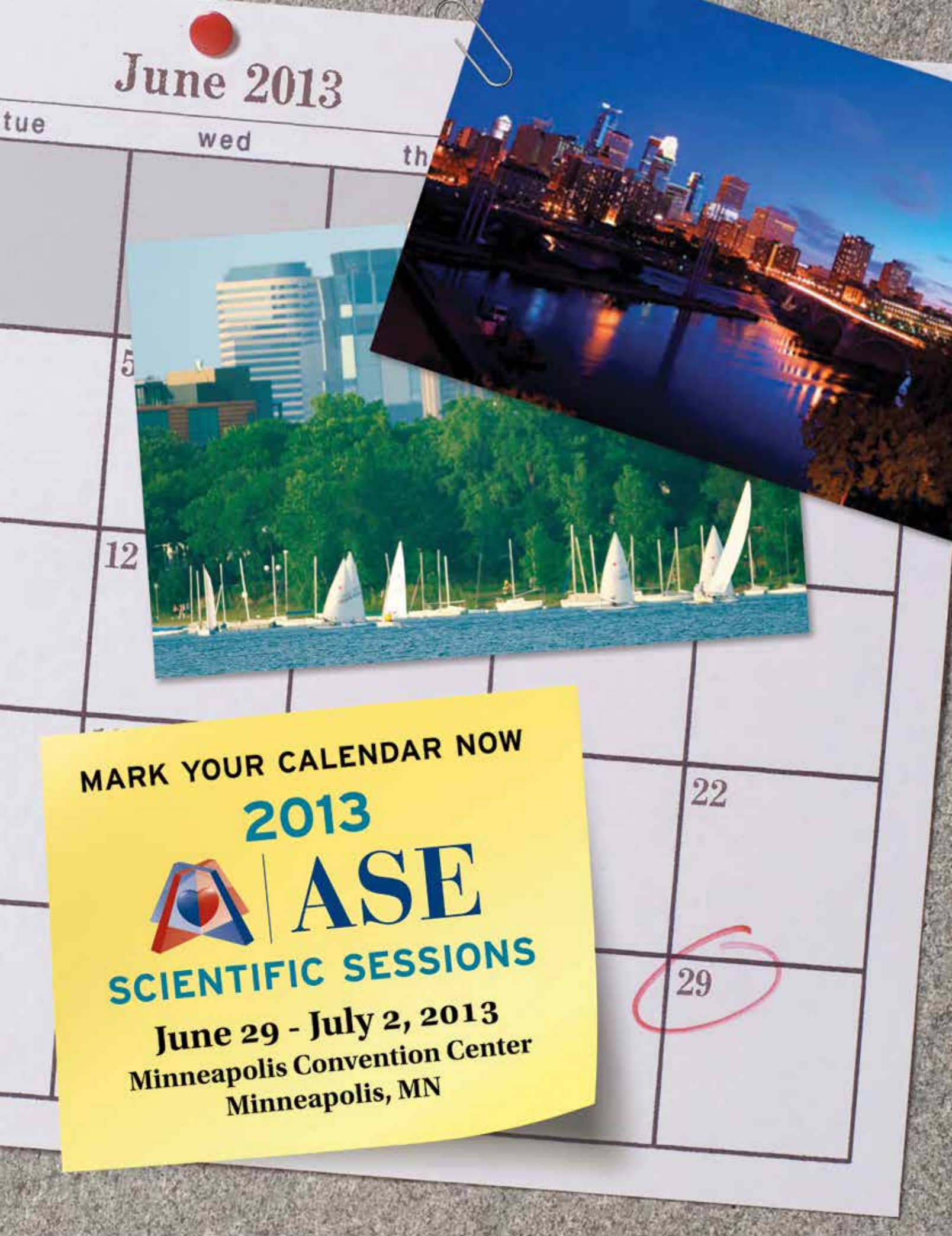
The requirement that a heart team work in concert to prepare for, perform, and monitor TAVR pre-, peri-, and postoperatively will ensure the best outcome for patients undergoing this procedure. This model of providing care is particularly appealing to those who are eager to see formal collaboration between practitioners with different areas of expertise rather than a turf war. Experts suggest that there is tangible benefit in having representatives of different specialties work together in the evaluation and treatment of patients with AS. The multidisciplinary approach the CMS requires is appropriate to a procedure as complex as TAVR, especially in patients with numerous comorbidities.

WHAT'S NEXT FOR TAVR?

Under current CMS regulations, reimbursement for TAVR is only approved for inoperable patients. On June 13th of this year, however, the FDA's Circulatory Systems Device Panel voted 11-0 with 1 abstention to recommend the Edwards SAPIEN valve for approval in high-risk surgical aortic valve replacement candidates. If the FDA adopts this recommendation, which, in all likelihood it will, the Edwards SAPIEN valve will be approved for candidates who face a >15% risk of mortality from surgical AVR. The FDA will decide whether to follow the recommendation in the next several months. ASE will be monitoring this issue closely and will keep you informed.

The PARTNER 2 trial is currently underway at 50 sites nationwide to evaluate the success of TAVR in intermediate risk patients (> 4% risk of mortality from surgical AVR). Results from this trial could be available as early as December 2014. Additionally, a series of new valves are currently in trial both in the United States and abroad. Valves from Medtronic (CoreValve®), St. Jude Medical (Portico), and Direct Flow Medical (DFM) are currently under development domestically. These 2nd and 3rd generation valves theoretically present a number of advantages over the SAPIEN valve that will help to improve patient outcomes: first, the valves under development have a lower delivery profile (18 French catheter vs. the 22 French catheter that is commercially approved). Second, the new valves are repositionable, ensuring that they are accurately placed. Third, these valves incorporate a variety of mechanisms to limit paravalvular leakage, helping to eliminate insufficiency, which remains a primary shortcoming of today's equipment. TAVR technology and the skills of those who perform it will continue to grow in effectiveness and ability, making this procedure the appropriate option for an increasing number of patients. ❤

[i] "The TAVR National Coverage Decision: How will this record announcement affect your patients and practice?" *Cardiac Interventions Today*. June 2012.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ase AROUND THE WORLD

Did you know that ASE's reach is not limited to North America? We have members in over 116 different counties across the world. We are constantly developing new initiatives aimed at strengthening ASE's relationship with the international echocardiography community, and we work hard to impact lives all around the world.

In 2011, ASE traveled to the Great Wall International Congress on Cardiology in Beijing, where we distributed copies of our guidelines translated into Mandarin; in that same year, we also attended Euroecho, where we hosted our first international ASE-member event in the historic city of Budapest. ASE has also had a presence at echocardiography meetings all over the world, including in Japan, India, Great Britain, Canada, South and Central America, and the Middle East. Utilization of ASE guideline documents goes well beyond our own membership, serving as an excellent and popular tool for promoting the global standardization of echocardiography.

ASE's Guidelines CD, a favorite takeaway at domestic and international meetings, continues to be distributed heavily throughout the U.S. as well as in Japan, India, Canada, South America, France, Scotland and Hungary, placing this valuable information in the hands of thousands of echocardiographers. Similarly, the guidelines section of www.asecho.org is consistently the most frequently visited location on our site. Links to these ASE guidelines can now be found on echocardiography society websites worldwide.

Recent collaborations with the European Association of Echocardiography (EAE) have resulted in the publication of three joint documents in 2011 alone, with five more collaborative documents in the pipeline. These documents include the recent 3D image acquisition and display document and an upcoming Echo in Cancer document. These collaborations with EAE, as well as with other echocardiography societies worldwide, will allow the international medical community to enhance patient care across the globe.

As technology moves forward, so does the dissemination of these documents. A recent smartphone and iPad app has put four popular guideline documents in the pockets of echocardiographers at a modest cost. ASE's guideline apps perform accurate calculations for better patient care. ASE Foundation funding will continue to contribute to the dissemination of ASE's guidelines and standards moving forward.

/// The main goals of ASE Global's outreach initiatives are:

- Enhancing the global perception and utilization of cardiovascular ultrasound.
- Improving patient access worldwide through ASE guideline documents.
- Providing a forum for international members with similar interests to network.

SECOND ECHOCARDIOGRAPHY

Societies World Summit is scheduled for October 25-27, 2013 in New Delhi, India.

Following the success of the First Echocardiography Societies World Summit held in Buenos Aires, Argentina in July 2011, the Second World Summit on Echocardiography is scheduled for October 25-27, 2013 in New Delhi, India. Under the leadership of Dr. Partho P. Sengupta and Dr. J.C. Mohan, the 2013 World Summit is an educational collaboration by the American Society of Echocardiography, European Association of Echocardiography, a branch of the European Society of Cardiology, Indian Academy of Echocardiography, Asociacion de Ecocardiografia de la Sociedad Interamericana de Cardiologia, Chinese Society of Echocardiography, Japanese Society of Echocardiography, Korean Society of Echocardiography, and Canadian Society of Echocardiography. For more information, please visit **www.wsecho.org.**

"The first ASE Global initiative was a historic event and the first ever of its magnitude for the Society."

- Dr. Partho Sengupta

ASE GLOBAL SPECIAL PROJECT

FOCUS ON INDIA

A partnership between the American Society of Echocardiography (ASE) and GE Healthcare (GE) utilized technological innovations in the field to bring cardiovascular ultrasound to an underserved population in rural India.

Sponsored by ASE, nine US-based cardiovascular sonographers traveled to a remote location in northwest India in late January 2012, where an estimated 12 million people had gathered for a meditation camp. The sonographers and their India-based physician counterparts from Medanta Medicity Hospital in Delhi used technology to provide education to local clinicians and free imaging services on January 23 and 24 to 1,030 pre-identified people.

The project, ASE Global: Focus on India, elevated cardiovascular ultrasound to a new level, taking it out of the lab to people who can benefit from increased access to the technology. "The first ASE Global initiative was a historic event and the first ever of its magnitude for the Society," said Dr. Partho Sengupta, India liaison for the ASE International Relations Task Force and leader of the project. "It engaged physicians, sonographers and engineers across the globe at once for many different reasons – humanitarian, cultural and educational exchange, global health research, new technology evaluation and patient care applications." Dr. Sengupta, who is an Associate Professor and Director of Cardiovascular Ultrasound Research at New York's Mount Sinai School of Medicine and an ASE board member, added that the project "ushered in a new and exciting era that connects point-of-care ultrasound performed at remote underserved regions with specialists consulting from around the world."

Clinicians leveraged GE Healthcare technology, including the Vscan* pocket-sized visualization tool, to facilitate the

- Exploring strategic alliances and collaboration with other international organizations to create more resources for ASE members (education, guidelines, etc.)
- Creating a forum of exchange on co-sponsored meeting sessions, young investigator awards and practice guidelines.
- Giving the honorary Fellow (FASE) designation to recognize leading cardiovascular ultrasound experts abroad.

acquisition of the images and provide an educational and awareness vehicle for India-based physicians. The Vscan systems were used on loan from GE Healthcare, which also provided an educational grant for the project to help support travel for sonographers. Vscan leverages ultrasound technology to provide clinicians with an immediate, non-invasive method to help obtain visual information about what is happening inside the body. In remote areas, as well as in today's clinical setting, the ability to take a "quick look" inside the body may not only help clinicians detect disease earlier but also better triage patients.

Seventy-five board-certified physicians at locations worldwide, ranging from major U.S. and Canadian hospitals to countries such as Georgia, Bulgaria, Greece and Saudi Arabia, were part of the image consultation. Several physicians attending ASE's 22nd Annual Echo Hawaii conference also participated in the consultations and read echos from across the world.

"In this way," said Patricia Pellikka, MD, FASE, ASE President, "the expertise of members of the ASE was shared with more than 1,000 patients with suspected heart disease who would likely never have had access to echocardiograms. Physicians were able to help without leaving their practices, and sonographers from the U.S., specially trained in acquiring the images, were able to offer the one-on-one patient care that makes this technique so unique." Dr. Pellikka also noted that "with technology like Vscan in the hands of trained professionals, echocardiography is portable, and can be helpful in heart assessment."

"The ASE Focus on India project was an incredible experience – not only in its mission to bring ultrasound technology to the most rural areas of India - but in the collaborative spirit it fostered between physicians all over the world," said Al Lojewski, General Manager, Cardiovascular Ultrasound for GE Healthcare. "These elements combined to bring a level of care never before available in this rural area in India, and demonstrated that with the help of technology, access to care to those in need can be boundariless. GE is honored to have been part of this important project."

Cardiovascular disease is a growing concern in India, recently having replaced communicable diseases as the country's leading killer. According to Dr. R.R. Kasliwal, Chairman of Clinical & Preventive Cardiology and the Community Outreach and Education Program at Medanta Heart Institute, most of those affected live in rural areas.

"ASE is proud to have been involved in such a meaningful project. Many of these patients had not had access to contemporary medicine, and this one encounter may change their lives," said ASE Past President James Thomas, MD, FASE, Charles and Lorraine Moore Chair of Cardiovascular Imaging at the Cleveland Clinic Foundation. "At the time of this mission, I was chairing ASE's Echo Hawaii conference, and members of our faculty were able to consult on 99 studies. Many cases were of severe heart disease, including valve dysfunction. It was humbling to realize the impact we could have from 8,000 miles away."

*Trademark of General Electric Company

NORTH CAROLINA BASED FIRM PROVIDES TRANSMISSION SOLUTION

ASE collaborated with neighboring NC-based firm Core Sound Imaging, Inc. to use their web-based Studycast® system to send the acquired images from India to readers all over the world, and then back to India for follow-up care by local physicians.

During the medical camp, ASE-member sonographers acquired the images, mimicking the state of the practice in the U.S., where the medical system relies on the expertise of sonographers in acquisition. Studycast® is cloud-based, which allowed ASE-member physicians at numerous hospitals in the United States and around the world to read the images and send their reports back to physicians in India for further follow-up and care.

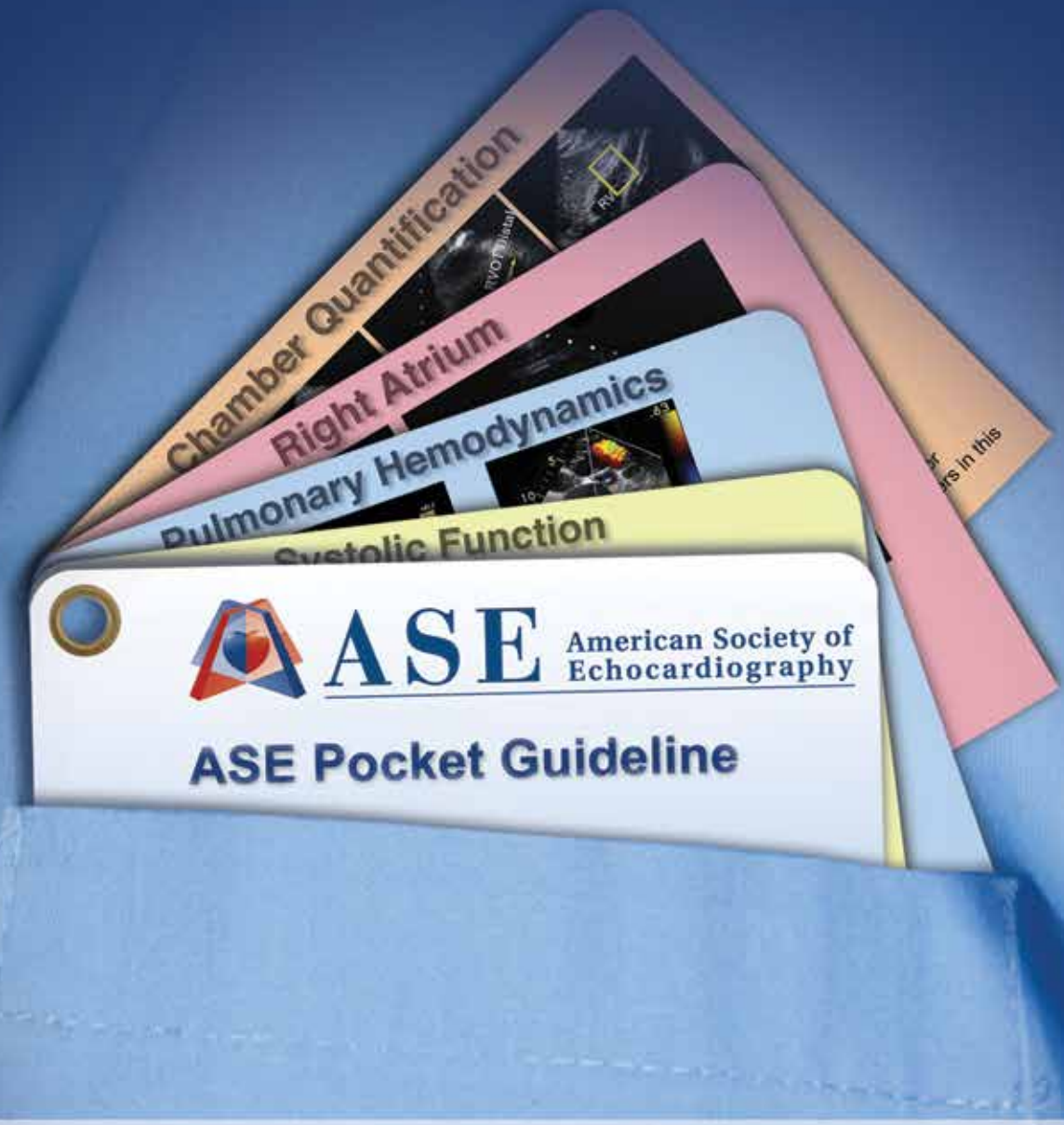
The collaboration was a good fit, according to Dr. Sengupta. "When we met the team from Core Sound Imaging in 2011, the challenges for the India Camp were manifold, particularly for developing a unique platform that could train and communicate with physicians here and overseas and transcend time zones and geographical boundaries. We are so pleased with the enthusiasm and team effort that made this historical event a technological reality."

"This is a great opportunity to make people think about imaging and collaboration in a whole new way. We've never before been able to work on such a global level," said Laurie Smith of Core Sound Imaging, who provided its Studycast® Web-based transmission solutions as a donation to the project.

"Remote assessment in real time allows you to do many things, such as teaching sonographers how to improve the quality of their images or focus on certain aspects of a particular examination," explained Michael H. Picard, MD, FASE, ASE past president and Director of Clinical Echocardiography at Massachusetts General Hospital. "But the real excitement generated by this project is around the fact that echocardiographic exams can be performed at almost any site in the world, and experts recruited to weigh in on complicated cases that some may only see once in a lifetime."

"The technological achievement of this event cannot be overstated. In just two days, these exams were digitized, uploaded to the Internet "cloud," and interpreted by dozens of volunteer readers all over the world, usually within eight hours of acquisition," said Dr. Thomas. "Given the 15.5 hour time difference between India and Hawaii, many of these studies were interpreted even before they were performed!"

ASE continues to forge ahead in making a global impact on the ever evolving world of echocardiography. Future humanitarian missions are being planned, including a return trip to India and a trip to Vietnam in the spring of 2013. For more information about how to get involved with ASE's humanitarian efforts, please visit www.asecho.org/WorldView ❤



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ASE American Society of Echocardiography

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ASE Foundation

As a 501(c)3 organization, contributions made to the ASE Foundation are tax deductible to the fullest extent of law.

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ASE'S MISSION

ASE is committed to excellence in cardiovascular ultrasound and its application to patient care through education, advocacy, research, innovation and service to our members and the public.

/// **www.asecho.org**