

Lee Kirksey ([00:10](#)):

Welcome to the peripheral artery disease podcast titled Health Disparities in PAD, Solutions Across Diverse Communities. This is the sixth podcast of a series of podcasts from the American Heart Association PAD initiative and it's part of the PAD National Action Plan. I'm Dr. Lee Kirksey. I'm a vascular surgeon at the Cleveland Clinic and the vice chair of our vascular surgery department. I'm very excited to have my esteemed colleagues who are renowned for their respective expertise in PAD.

([00:44](#)):

They're joining me today for a robust discussion around some critical issues. PAD is unique in the disproportionate impact that it has on vulnerable communities across various dimensions, including low-income Americans of all races, the indigenous American community, and Black and Hispanic communities, as well as geographically rural and female gender members of our society. I'd like to have the members of our panel today introduce themselves. So would you please go ahead?

David Armstrong ([01:16](#)):

Well, typically, it's ladies first, but since it's alphabetical, I'll make an exception. I'm David Armstrong, professor of surgery and I run our Southwestern Academic Limb Salvage Alliance, or SALSAs here at the Keck School of Medicine of USC in beautiful, sunny Southern California where even when it's not sunny like today, it's still sunny.

Lee Kirksey ([01:39](#)):

Dr. Mena.

Carlos Mena ([01:41](#)):

Thank you for having me. My name is Carlos Mena. I'm an interventional cardiologist by training. I am the director of vascular medicine at Yale University. Thank you very much.

Lee Kirksey ([01:51](#)):

Dr. Powell.

Dr. Powell ([01:53](#)):

Hi. Thanks again for having me. I'm a fifth year vascular surgery resident at the University of Michigan.

Lee Kirksey ([02:00](#)):

Concha-Moore.

Dr. Concha-Moore ([02:02](#)):

Hi, my name's Dr. Concha-Moore. Thank you so much for having me today. I graduated from the University of Arizona College of Medicine in Tucson, completed three years of integrated vascular surgery residency at University of Washington, and I'm currently back at the University of Arizona in the vascular surgery department doing a year of research.

Lee Kirksey ([02:26](#)):

Maybe first, we can kick it off. We know that we have differing communities, differing barriers and challenges to identifying PAD. So maybe Dr. Powell, we'll begin with you. What are some examples in

your experience, you've done a lot of research in this area, of opportunities to increase community awareness?

Dr. Powell ([02:47](#)):

Yeah. So I think about this a lot because I don't think the lack of awareness is due to a dearth of information. There's so much information on the internet, but I think we have to question how accessible is it and who's accessing it. I was just at SABS in Puerto Rico and someone had presented about how health literacy among vascular patients was poor overall, but particularly worse for Black Americans and Hispanics, and considering that there's also some studies looking at the fact that many popular vascular surgery websites are written at a college level.

([03:26](#)):

But they should be written at a more sixth grade or even eighth grade level. I think that's low hanging fruit to adjust how accessible even those websites are, but then also there are communities that have no internet access or no technology, and so I think really thinking about how can we leverage and thinking about the community aspect, how can we leverage some of the establishments within the community? So a lot, I think, has been done in the stroke world or even in the general cardiovascular health world around partnering with churches or even salons.

([04:03](#)):

Places that those of those communities value to lead some of the educational sessions or community fairs, and even if we're not partnering with establishments, thinking about are there people or connectors who we can partner with who have leverage within their communities to spread awareness, and all of this is on the patient side of things, but I think many of the same approaches could be used for the provider where we look at who is accessing all of the AHA website information from a provider's standpoint. Are there more effective ways to increase awareness among providers?

Lee Kirksey ([04:45](#)):

Yeah. I think you raised some very important points. The message is important, the messenger is important, and the format of the delivery of that message is equally important. Maybe we can think about this idea of our varying communities. Dr. Mena, maybe you can pipe in here. The Hispanic community, what do you think are some challenges that exist within our traditional way that we approach and enter a Latinx community?

Carlos Mena ([05:18](#)):

Yes, excellent question and is a very complex question. The first part is that the Hispanic community is not uniform. We are very heterogeneous and it depends on which part of the world we're coming from. The background or upbringing and our heritage is very different, and that's the first mistake that is often made. Just because you speak Spanish, it doesn't mean that your perception of your disease and the way how you manage or deal or prioritize things are the same. Second, obviously, the language barrier. Our first language is Spanish and now because we're here, we all speak English and it's a real problem because if you can't communicate, you cannot really say things.

([06:10](#)):

Obviously, you won't be able to be careful. The Hispanic community are very sensitive to the providers and they often prefer providers who are Hispanic as well, and the reason is number one and number two that I just mentioned. So the problem is that sometimes those issues are not recognized and providers in the US sometimes they feel that, well, they don't really talk, they don't really say much, they

don't really take care of themselves, but it's all this cultural background what is in the middle, and unless you make an effort to try to understand it, to try to be compassionate, not compassionate in the sense of listening to the patient per se.

[\(07:00\)](#):

But compassionate about all the social issues that they bring to the table because it's not often the patient itself, he or she, but it's also their family. In our culture, when someone gets sick, it's just not that person. We bring the entire family into it and it is a little bit more dramatic, if you will. I can say that because I'm Latin myself growing up in Colombia, so it's just very different. So as it relates to PAD in our culture, PAD is often overlooked. You have a wound in your toe. Well, it doesn't matter. I just change my shoe and I figure it out. It's the fact that we don't fully understand the implications, the needs and the management associated.

[\(07:51\)](#):

As you all know, if you have PAD, you'll likely have coronary artery disease and [inaudible 00:07:56] vascular disease and is often until you bring those issues up, they don't realize that that little small wound in their toe is actually very meaningful and they need care, and that's how things begin. So the cultural sensitivity around the Latinx community is incredibly important and if I can just make a plea, the one thing that is important is not all the Hispanic people are the same. We are very heterogeneous and you need to make an effort to understand that concept. I'll pause there.

Lee Kirksey [\(08:27\)](#):

Well said. The idea that all of our communities, whether it's the indigenous community, the Black American or the Hispanic American community, they're different subsets, different economic issues, social challenges within the respective subgroups of those communities. So that does raise an issue about community health workers and the role that community health workers may play, and maybe as we get into some of the clinical trial barriers to enrollment, we can touch on that topic of community health workers and the role that they may play in bridging this gap. How about Dr. Concha-Moore? Will you comment a little bit on what you think the unique challenges to entry, awareness, treatment within the indigenous American community may be and how those are addressed?

Dr. Concha-Moore [\(09:20\)](#):

Yeah. Piggybacking on what Dr. Powell and Dr. Mena are saying, I think all of us come from communities that have such variability and you can grow up in one community and be part of the larger, say, Black or Hispanic community, but you may not necessarily understand that whole community, and I think that's where we have to talk about. There's a lot of emphasis on cultural competency and I don't think any one of us in medicine is actually truly culturally competent, and sometimes I like to transition and use the word culturally safe or culturally aware so that we are just cognizant of the many challenges and differences when we approach our patients.

[\(10:01\)](#):

I think one thing that's really important from my own community is to recognize that there are 547 federally recognized tribes in the American Indian tribes in the US and even 228 federally recognized tribes in Alaska, and that's not even to include our relatives to the north in Canada who identify as First Nations, Inuit, Matisse, and all the aboriginal and indigenous communities across the world, and so I think all of these communities for generations have already had their distinct languages, cultures, and traditions, and we just have to be very cognizant of how we approach each patient and be respectful for

each patient when we provide them care, no matter what clinical facility or background you're coming from.

[\(10:52\)](#):

I think for many challenges in the American Indian community, particularly in the US, is that the US actually has a federal trust obligation to provide care to American Indian tribes, which goes all the way back to the tribes being recognized as sovereign nations back in our constitution. However, we still have some of the highest health disparity rates among all minority populations, and we're here talking about peripheral arterial disease today.

[\(11:22\)](#):

But I think there's a lot of, oftentimes, we're left out of the conversation because we're a smaller minority compared to others in the US, but I think we still have to be aware that we have some of the highest rates of diabetes of all people in the United States, which lead to diabetic foot infections, amputations, and lower life expectancy overall, and so I think many of us here have seen it, but I think it's just, it's good to be aware that we just have to be culturally safe when we enter in a community and be respectful of all the patient's backgrounds when we try to create ways to help improve their health.

Lee Kirksey ([12:06](#)):

Excellent comments. Dr. Armstrong, you practiced in multiple communities of the southwest and at your SALSA facility, worked with the indigenous American community. You guys identified some very important strategies to addressing some of the challenges. Maybe you can comment on those and some of the learnings that you've had.

David Armstrong ([12:33](#)):

Yeah. If by learnings, you mean just mistakes, and our patients, they're like our family, but meeting them where they are, and this sounds so easy to do on the podcast, just meet the patient where they are, but I was listening to Dr. Concha-Moore talk about, and she's back in Arizona now and there's like, we were working with 22 different Native American nations back when I was there just a few years ago and these are different nations, each one with different problems, just like a sovereign nation would've different problems anywhere else in the world, and while there are some similarities, there are also a lot of differences.

[\(13:13\)](#):

And meeting those differences where they are with not only folks within that community but without the community and trying to harmonize this is really a massive challenge. Now, I've moved from the desert to another kind of desert. You have food deserts, you have urban deserts where it's really hard to get consistent care across a region. I'm in Los Angeles County and there's 10.1 million folks here in LA County, a massive richness and diversity, not just diversity in terms of ethnicity, but diversity in terms of economics. You look at PAD, you look at amputation, there is now a tenfold difference in amputation in people with PAD and with diabetes, depending on your zip code.

[\(14:07\)](#):

It is a zip code lottery now in LA County, and so based on you roll into one zip code versus another, but so that tells you there's maybe some top down stuff that you could control, but then you zoom in further on your Google Maps of disparities and you go into just an individual neighborhood like where I am right now. I'm 0.7 miles from three or four different hospitals. There is a sixfold variation in amputation in these hospitals around me right now, and so what that says is not only top down policies can make a difference, but bottom up ones can make a difference. An individual nurse, an individual

promotora if you're a [inaudible 00:14:57], an individual teacher, a barber, a physician, surgeon can make a difference just as well as a health minister. So I think there's a lot we can do.

Lee Kirksey ([15:10](#)):

Thanks so much. So I'm going to do a quick round-robin, please, and I'd like for each of you to offer maybe an idea about how to better increase awareness, diagnoses within one of the key demographic communities that we're talking about here, just focusing on the diagnoses and awareness. How do you get out into the community and make a meaningful improvement in awareness and diagnoses? We'll begin with Dr. Powell.

Dr. Powell ([15:39](#)):

That is tough. I'm going to hijack an idea that my mentor recently came up with, and certainly not of his own, but adopted from the public health world, but identifying, like I said, these connectors within the community. So people who do have access to the health system, which obviously, in and of itself is a privilege and trying to understand whether or not there are people who they know.

([16:12](#)):

Who they can identify who have PAD or at least risk factors and seeing how we can then loop in their network and who they know to bring awareness to the people who they are around. So trying to use the health system as a point of contact or at least an in to a community recognizing that that is not perfect, but at least they might be aware of those who that privilege or don't have that access. So we can at least a little bit more readily pinpoint how we can bring some of our interventions or expertise and partner with those in that community.

Lee Kirksey ([16:47](#)):

Great answer. Dr. Concha-Moore.

Dr. Concha-Moore ([16:52](#)):

I would echo also what Dr. Powell is saying is if you empower people from the community with knowledge and they are the ones who are able to access those communities. I think like I was saying, there's so many different tribal communities, not just in Arizona, for instance, where I'm living now, that have people who understand the challenges, the barriers, the terrain of how to access the tribal members and also have a cultural way of going into that community that builds trust. I think a lot of us who work in these ivory towers, who we have an immense amount of knowledge and access to medical knowledge and care facilities, but being able to translate that out to a community, sometimes you have to go in in a way to empower the community to empower themselves.

([17:48](#)):

And I think they have many ways that they have that are already in place to heal those communities, and I think bringing in that knowledge and building relationships over long periods of time because I think also that really does matter of building long-term relationships, being consistent, being reliable, and making an open two-way street for people to have connections to an institution, but as well as to the tribal communities that they can trust and rely on you as somebody who's working, say, from in a higher institution or somebody who's a tertiary care center. So I would say that would be my biggest thing is empower communities in a cultural way.

Lee Kirksey ([18:33](#)):

I like the idea of elevating awareness to the outside community of these connectors and these groups that represent how we respectfully access the community, and I know working with the Strong Heart team, I've learned a lot about how the indigenous American community and the tribal leaders work in terms of the process because it really is a process of respect and trying to work with that community. Dr. Mena, maybe some comments about, I know you and Kim [inaudible 00:19:09] have done some great work on community health workers.

Carlos Mena ([19:14](#)):

A couple of comments. I agree with what has been said, but speaking specifically about the Hispanic community and using this podcast and the American Heart Association as a platform, I think that there are substantial changes that need to be made at the political advocacy level, the Hispanic population, we look and we published this in the Journal of Vascular Surgery, and we look in the NIS sample over the last 15, 20 years, and the main place where Hispanics with PAD, critical ischemia seek attention is emergency room, and there is a variety of reasons why that is. So they use the emergency rooms as their primary care and that is totally and fundamentally wrong because that's the wrong place to go in someone who has PAD.

([20:08](#)):

Obviously, they have an acute issue, it's different, but for long-term chronic care. So our politicians, our health system, a lot of the things at that level need to change because we can educate them as much as we can, but if they don't have a way to get access to a provider who can actually care for them, give them medications and do necessary tests, then all these efforts are going to be for nothing. So I would strongly invite that idea of influencing our politicians or health systems to try to incorporate changes that are inclusive because many of the minorities, Hispanics in this case, for instance, are here in an illegal base, but they're here. So it is what it is and we got to figure out a way to care for them because if we don't do it upfront, we're going to pay in the back when they are receiving amputations, complex interventions of any nature. So we have to figure this out because at the end of the day, it's a human being looking for attention. So I'll pause there.

Lee Kirksey ([21:19](#)):

Absolutely. And that's a lead into a plug to reinvigorate the Amputation Reduction Compassion Act that was championed by Congressman Payne to improve the resources for access for patients because as you said, if the awareness can improve the diagnoses, but if these patients don't have access, appropriate and timely access, where are we going with this effort? And finally, let's cap it off with Dr. Armstrong because I'm sure that he has not only humor, but he has a valid.

David Armstrong ([21:57](#)):

Well, I'll start with a couple of things that are happening because I was listening to what everyone was talking about and everyone, there's so many great ideas here and call to improve care away from the ED and more toward maybe the home, and I see some of the challenges that are happening in literally my backyard right here at our Los Angeles County Hospital at LAC. It's one of the biggest county hospitals in the country and one of the busiest emergency departments for sure. What has happened here out of necessity, but also I think there's been a really progressive benefit here, is that the emergency department has been developing now an urgent care center, which is run by my friend, Carla Gonzalez.

([22:39](#)):

She's awesome, and so a lot of patients now with PAD, with maybe diabetes, lower extremity complications are getting kicked up to there to an urgent care center, which is more just like a clinic.

Those patients now, if they're relatively well, are getting sent over now to the first ever, it's really this cool wellness center, which is part of our old county hospital and it's really just a community gathering place. If you're Black, if you're Latino or Hispanic, you are able now to go to this facility as well, and you will see people and meet people that not just literally and figuratively speak your language, but culturally, this is meaningful and this is happening in a county hospital.

[\(23:31\)](#):

In addition to this, Brad Spielberg, who's our CMO, got a guy named Chris Lynch who's an ID doc to start this program called Safer at Home During the Pandemic, Safer at Home. Now, the most common people that are being treated at Safer at Home are people with diabetes, lower extremity complications, and with PAD. So this now is happening, so patients are getting treated in their home and virtually, every single patient is a patient of color that would normally never get this level of care, and this is happening now in these county run facility. So that's great, but then I'll just tell you, one other thing I'll tell you that we've been doing.

[\(24:11\)](#):

We got a grant from the UniHealth Foundation to do this where we've been out in the community increasing awareness about lower extremity complications, not only of diabetes, but of peripheral artery disease. We started something called the Foot Selfie program and we're having people just send a picture of their feet in if they have any questions, and that goes into a central area, and then once a week now, we have collectively foot selfie rounds, 7:00 every Monday morning and we get through 100, 200 photos. It's amazing, super fast, and now we're adding, of course, AI onto this too. So it's pretty exciting, and that's such a super simple thing because it's free and this kind of thing can, to overuse the word scale, it can scale. So here's to that and here's to making a difference.

Lee Kirksey [\(25:00\)](#):

Those are great ideas, thoughtful ideas that are able to be implemented readily. As you said, no one needs to go to the CFO to have a patient submit their selfie. Let's shift now to the healthcare setting, patient in the healthcare system. They've been diagnosed. We know that not only are these vulnerable communities diagnosed in a less timely fashion, more likely to present in a delayed fashion for all of the access issues and other variables that we described.

[\(25:33\)](#):

But once in the hospital, the outcomes for these vulnerable communities are not the same as they are for the more resourced comparator, and so we know that there's some implicit bias or call it across class, across race, ethnicity, gender that exists. What do we talk about as a community about some ways to name this first, and then to address this? So maybe Dr. Concha-Moore, maybe you can speak about this, some of your thoughts about what happens to the individual, high risk in the hospital? Why are some patients undergoing primary amputation without any revascularization attempt?

Dr. Concha-Moore [\(26:19\)](#):

Yeah. I think some of these are, we have to look upstream in terms of what are the social determinants of health that lead our patients to present late, present with a worse diagnosis, a worse foot ulcer that's non-salvageable, that's leading to our amputations. Are our patients getting adequate primary care? Are their diabetes being controlled, and if not, what are the problems that are leading to them to have earlier complications, presenting at an earlier age, presenting with worsening PAD and peripheral vascular disease leading to ultimate amputation, which as we all know, it happens and it's life altering for patients.

[\(27:04\)](#):

And the morbidity, mortality is devastating for not only the individual, but the family who's taking care of that individual, for the community. The loss of language and culture from my community when our elders have such severe consequences is really devastating because you lose out on so much. I'll just tag in that I'm a true believer in experience and education, and we all know that bias exists within the healthcare field, and one thing that I really wanted to mention is that we need to be really cognizant and vocal about making our fields, whether it's medicine, vascular surgery, podiatry, more inclusive for racial ethnic minorities to feel supported to pursue healthcare fields.

[\(27:53\)](#):

I think it takes mentorship and sponsorship, and it's hard to pursue a field if you don't feel represented in that field or see anybody who looks like you in that field, but on the flip side, it is also frustrating to know your community, who's suffering from worse outcomes, are not being taken care of by providers who don't come from those same communities or look like those patients, and so I think that is one way that we can all pitch in and support students, pre-med students, medical students, to pursue the career fields that are going to make an impact in peripheral arterial disease.

Lee Kirksey [\(28:26\)](#):

Thank you. Dr. Powell.

Dr. Powell [\(28:29\)](#):

Yeah. This is something that I feel like I have a challenge with in trying to figure out ways to best address, and ultimately, I think there's just no one right answer. One thing that I've been thinking about is the use of enhanced recovery protocols or at least more standardized care, recognizing that standardization doesn't necessarily mean trying to take autonomy away from the provider. At least it provides some sort of metric with which you can reflect on, am I following these certain protocols? I think in the cancer world, some institutions have found success that way.

[\(29:09\)](#):

But going back to Dr. Mena's comment about the system, it's hard to have a system level approach to some of this when it is the outcomes are the result of systematic failures or systematic racism, classism, sexism, all the things, and so how do we take it up another level to address it at the system such that patients don't have to go to segregated hospitals that then only treat them a certain way where outcomes are worse or go to low resource hospitals, and so I said I don't think there's any one answer, but perhaps a system level, policy level approach at least might have some trickle-down effect that way.

Lee Kirksey [\(29:57\)](#):

Yeah. No, personally I'd love to see one day where just like we have accredited stroke centers, where if you don't have a multidisciplinary team, including a stroke interventionalist, a neurologist, a neuro-interventionalist, that you just can't treat stroke patients and that raises some challenges in terms of will patients receive timely care in under-resourced centers while they're waiting to be transferred, but somehow, we figured it out when we figured out what quality metrics are within respective areas.

[\(30:35\)](#):

And I think that should be a goal of our peripheral artery disease and our diabetic foot because we can't forget that patients lose their limbs without peripheral artery disease for diabetic foot problems, but if we can find some quality metrics that we can hold ourselves and our community accountable for, it



seems like we'll have some standardized benchmarks. Dr. Mena and Dr. Armstrong, comments on this idea of how we do better when patients are within our system.

Carlos Mena ([31:08](#)):

Well, the only thing that I would add to what has been said is that the medical community, we need to decentralize the efforts. We need to go into the communities, infiltrate the communities, and familiarize ourselves with what they want, what they need, and what their problems and priorities are and why they are thinking one way or not the other. I say that because when we started our vascular medicine program, the traditional thinking here at Yale was that, well, all the patients with PAD should come to the main clinic in the main campus, and I started looking at that and I realized that there were so many barriers to that. There's no parking.

([31:56](#)):

Well, these people have PAD. How are they going to walk into the clinic, and we starting to uncover why people were not coming to these clinics and people would say, "Well, there's no PAD in New Haven," and I said, "That can't be it." People, they're just not coming. You got to figure out why. We decentralized all our clinics, and at the beginning, everybody thought that I was crazy because I was making the drive around and into clinics outside the Yale main campus, but then suddenly, all the patients are starting to come in and our volume of patients with PAD and CLI increased, and we went into these communities and we put ourselves out there.

([32:40](#)):

We had conversations, we talked with ambassadors that you guys were mentioning earlier. The only way how we can tackle this bias and such is to let a white guy understand why this Black guy doesn't want to come to clinic or this Hispanic guy who doesn't speak English thinks that rice is the best thing in the world, but he will never understand if he doesn't go into those kitchens and understand why is rice the most important piece of their meal? We say now it's full of carbohydrates and your A1C is going to go through the roof. They don't care. They grew up eating rice. So if you don't take the time to understand, but really understand, not just saying it, we're never going to change it.

Lee Kirksey ([33:27](#)):

Well stated, well stated. So Dr. Armstrong, maybe a couple comments for those non-medical listeners to the podcast today that they may hear these calls for more interventions, more peripheral. We spend all of our conferences talking about revascularizing patients and we can obliterate the amputation epidemic if we just can get better widgets and tools and revascularization instruments that we forget about that 50% of patients that are purely amputation from diabetic foot ulceration and the complications there. So what are some challenges and what are some solutions in that realm?

David Armstrong ([34:13](#)):

Well, look, I was just with one of our trainees a few minutes ago in the operating room and they had just put on a big external fixation device, a big testosterone inducing big device that looks tall and it was really nice repair, and I looked at her and said, "Nothing ruins a good surgical result like follow up," and either the repair is going to go down eventually or the person will, the patient will, and you should be around with her or with him when that happens, and when the patient knows, when she, he knows that you're going to go to the mat for them, that transcends a lot and that kind of thing is really important, and it's not about being in the operating room or outside of the operating room. So that's the patient to patient, that's the person to person action.

[\(35:11\)](#):

But as regards, so much that can be done now outside the operating room that doesn't require a balloon, a stent, whether it loots a drug or not, or a big external fixation device. If you just see your foot doctor along with another member of the diabetes team, I'll give you an example, your risk for getting an amputation in the next six years reduces anywhere from just under 20% to just under, no kidding, just under 8-0, 80% depending on the data that you look at, and usually, the more severe the problem, in this case, the better the response and the better the action. Here's some more data. We have just found, and this is from one of my mentees, Tze-Woei Tan, who's a vascular surgeon here, the expansion of access to people of color when they usually hear so much bad stuff about a limitation of care.

[\(36:18\)](#):

But these data were just published this last year, expansion of access to foot care for people of color now in early adopter states reduced high level amputations by 33% if you're Black, if you're a Native American, or if you were Hispanic and Latino, and so this now is good news that's coming out of some of this, not a lot of bad stuff that you often hear, but some of the things I'd say for you, man. If you're going in to see your doctor, whatever her or his specialty is, or if it's not a specialty or if it's a nurse or anyone, just knock your socks off. Get those shoes and socks off. Let them see your feet and that'll force them in that five or 10 minutes that they have only to spend with you to have a look at that, and I know that's going to make a difference for someone somewhere across the United States listening to this.

Lee Kirksey [\(37:15\)](#):

Thank you for those closing comments. I appreciate the time all of you have committed to this very important topic. It's pretty clear that you're not only knowledgeable, but you're passionate about this vulnerable community that we care for. Thank you all for participating in the podcast with me today. A lot of important points. This podcast is part of the American Heart Association PAD initiative sponsored by Janssen Scientific Affairs, LLC and Novo Nordis Incorporated.

[\(37:46\)](#):

And in closing, I'd like to remind everyone listening to encourage your patients to play an active role in their medical care by advocating for themselves and their family members. The views and opinions in this podcast are those of the speakers and reflect the synthesis of science. Content should not be considered as the official policy of the American Heart Association. To get additional information, please visit AHA's PAD website for more education. Thank you so much for your time and your attention.