Brandon Walker:

physicians or healthcare providers, but in the patients who have atrial fibrillation. They need to know that if they are high or high-risk for atrial, they need to know that they are at high risk for stroke when they have atrial fibrillation, that there is a 70-80% reduction in the stroke risk. And I find that when we talk about patient's risk for stroke versus bleeding, the patient will always prefer to risk bleeding than a stroke. And we need to give that option to the patients, because most of us don't want to make anyone bleed, but we also don't want anyone to have a stroke. Strokes can be permanent, most bleedings are not permanent.

So I think that shared decision making would only be effective if the patient knows what the consequences are of making those decisions. The other thing about the AHA can do, of course, is to educate and make the public aware about what causes atrial

primary care providers to have to be looking in all kinds of different places, specialties to manage all of the clinical conditions that they have to manage. So, I'm not sure how realistic it is to ask primary care providers to know the AHA guidelines intimately. I think we coul

they're taking care of heart failure as well. And so, trying to include these individuals into the fold, I think will be also something that is very, very important. And that also then lends itself to what Dr. McCabe says as well, just so that primary care providers do know that the AHA is there to support them as well.

Brandon Walker: 09:10 Excellent, great perspective from everyone today so far, and let's goto another question here just regarding final thoughts on how we can begin to close some of these gaps that we're seeing in diagnoses and treatment within general practices. And I know we've heard a few thoughts a long those lines, but let's see if we can get any more, elaborate a little bit more. So, how about we hand it off to Dr. McCabe first, and then we'll go with Dr. Volgman, and then Dr. Paige, you can wrap us up on this last one.

Dr. McCabe: 09:38 Well, thank you. I think there have been some discussions about actually going to primary care practices, primary care organizations, to find out what they think would work for them, what their needs are, and having that collaborative discussion with how do we both be AHA and their particular organization, such as the family, Academy of Family Practice, and the American College of Physicians. How do we actually take on some of these challenges together to meet the needs of the patients? And rather than, maybe the American Heart Association not recognizing all of the challenges that primary care has, and I think having some insight and having those conversations with those groups would help to increase their awareness in some of the resources that you were talking about, Dr. Page. And then, maybe targeting what they think their needs really are.

The other is with regards to overall, is anticoagulation. I think one of the reasons why we didn't see a lot of patients, probably in their early 90s, beginning 2000s, is primarily people don't want the monitoring, the drug interactions, and all these issues with regards to Coumadin, we now have these newer anticoagulants, I guess they're not as new, we'll call them the NOAC, DOAC, whichever one you want to say, to the direct oral

join us and provide us with this great information. Your participation and insights have been invaluable. So, thanks for listening everyone. This podcast has been made possible through a grant from the BMS-Pfizer alliance. Views expressed in this podcast do not necessarily reflect the official policy or position of the American Heart Association, and American Stroke Association. For transcripts of this podcast, and more information about AFib, please visit heart.org/afib. And thank you very much, once again.