Justus-Warren Heart Disease and Stroke Prevention Task Force
Minutes for April 5, 2022 meeting

Agenda Item	Discussion Points	Action Items
Meeting Attendees	**Members:** Stephanie Dorko Austin (daughter born with heart defect); Senator Jim Burgin (Co-Chair); Commissioner Sherry Butler (Catawba County); Adrienne Calhoun (NC Association of Area Agencies on Aging); Rebecca Freeman (NC Div. Aging and Adult Services); Lindsey Haynes-Maslow (Agricultural and Human Sciences, NC State University); Ashley Honeycutt (Licensed Dietician, UNC Rex); Representative Frank Iler; Senator Steve Jarvis; Leatrice Martin (Duke Clinical & Translational Science Institute Research); Margaret Murchison (Media News Director); Ruth Gilliam Phillips (Director, Community Health Coalition); Joey Propst (Stroke Survivor); Douglas Schiller (Medical Director, Cardiac ICU, ECU Vidant Medical Center); Beth Strandberg (Office of Senator Lisa Barnes); Sherée Vodicka (Licensed Dietician; Eat Smart, Move More NC) **Partners:** Wally Ainsworth (Manager, NC Office of EMS); Michael Aquino (UNC Health); Susan Ashcraft (Novant Health); Pat Aysse (American Heart Association [AHA]); Josh Batten (NC Dept. of Public Safety, Alcohol Law Enforcement Div.); Sharon Biby (Cone Health); Annabelle Black (Novant Health); Haley Brennan (Novant Health); Aleasia Brown (DPH Cancer Branch); Anna Bess Brown (Justus-Warren Heart Disease and Stroke Prevention Task Force); Katie Buck (CarolinaEast Health); Tory Cairns (WakeMed); Alicia Clark (DPH Community and Clinical Connections for Prevention and Health Branch [CCCPH]); Michael Clay (Vidant Health); Ronda Doward (Div. of Mental Health, Developmental Disabilities and Substance Abuse Services); Chelsea Dunston (Atrium Health); Abby Fairbank (AHA); Meg Fenu (WakeMed); Heather Forrest (Duke); Michelle Gerolemon (WakeMed); Emily Gobble (UNC Health); Sally Herndon (DPH Tobacco Prevention and Control Branch [TPCB]); George Howard (University of Alabama at Birmingham); Angela Ivey (FirstHealth); Sarah Jacobson (AHA); Ed Jauch (Mission HCA); Robin Jones (Mission HCA); Justine Knight (Triangle Aphasia Project); Diomelia Laues (Cape Fear Valley Health); Ruth Marescalco (Novant Health New Hanover Regional Medical Center [NHRMC]); Jim Martin (TPCB); Desiree Metzger-Cihelka (Mission HCA); Catherine Michael (Atrium Health); Terri Moore (CCCPH); Allyson Mott (Rutherford Regional); Kathy Nadareski (WakeMed Cary); Peg O'Connell (Stroke Advisory Council Chair); William Pertet (DPH CCCPH); Elle Evans Peterson (NC Community Action Association); Walker Reagan (NC Alcoholic Beverage Control Commission); Julia Retelski (Atrium Health); Tammy Richardson (Atrium Health); Ray Riordan (TPCB); Birtha Shaw (Diabetics Supply); Tish Singletary (CCCPH); Elaine Sorenson (Rutherford Regional); Anna Stein (Legal Specialist, DPH); Lauren Stevenson (NHRMC); Asheli Stroup (Atrium Health); Keli Sykes (Johnson & Johnson); Chuck Tegeler (Atrium Wake Forest Baptist Health); Sarah Van Horn (Blue Ridge Health); Andrea Ward (Atrium Health High Point); Marie Welch (RN)	List of members posted under Task Force Members

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Welcome Senator Jim Burgin, Task Force co-chair	Senator Burgin opened the meeting by welcoming all in attendance.	
Member roll call and approval of minutes Anna Bess Brown, Task Force Executive Director	Anna Bess conducted a verbal roll call for members and asked each to note their response for approving the minutes of the December 10, 2021 meeting. The minutes were approved by members present with none abstaining from voting.	December 10, 2021 minutes posted at Task Force meeting minutes 12.10.21
Stroke Advisory Council (SAC) Report Peg O'Connell, Chair	The Stroke Advisory Council has been busy since the Task Force last met in December with work on the Paul Coverdell National Acute Stroke Program, tracking meetings of the Joint Legislative Committee on Access to Healthcare and Medicaid Expansion, and reviewing recommendations to implement Tobacco 21 in NC.	

Paul Coverdell National Stroke Program Updates Peg O'Connell, SAC Chair	In July NC began a cooperative agreement with the CDC to participate in the Paul Coverdell National Acute Stroke Program, and the work includes the following: ➢ Reduce disparities for those at risk of stroke and for stroke patients ➢ Strengthen the stroke system of care -Build Stroke Registry within the Health Information Exchange (HIE) -Fund hospitals, EMS agencies, and community organizations to improve the stroke system of care ➢ Year 1 ends June 30 ➢ Funding cycle runs 3 years ➢ In years 2-3 will fund additional Quality Improvement projects across the state The NC Coverdell Stroke Program has just awarded two hospital systems, Mission HCA and Cape Fear Valley Regional Medical Center, to conduct QI projects and has issued a Request for Applications which will fund up to 8 more. We are excited about this work to strengthen the stroke system of care and to identify and address health disparities.	Speaker presentations posted at Justus-Warren Heart Disease and Stroke Prevention Task Force meetings
Action Agenda Update Peg O'Connell, SAC Chair	Closing the Coverage Gap is alive and well but not all the way through yet. With Senator Burgin's leadership, two big steps were accomplished in the last legislative session. In the last budget, coverage for postpartum women had only been available for two months. Coverage will now extend for up to one year postpartum. The change is expected to lower maternal mortality rates. The second change addresses parents with Medicaid and their children. In the past, if children were moved to foster care, their parents would lose their Medicaid coverage. This change will allow parents to continue with Medicaid coverage if their children are moved to foster care. On the issue of closing the insurance coverage gap, a Joint Legislative Committee on Access to Healthcare and Medicaid Expansion was formed. The committee will be chaired by Senator Joyce Krawiec and Representative Donny Lambeth, both from Forsyth County, and co-chaired by Representative Larry Potts from Davidson County.	Speaker presentations posted at Justus-Warren Heart Disease and Stroke Prevention Task Force meetings

	The committee has met four times, three of which were focused on Medicaid Expansion; two additional meetings are scheduled. Peg noted two main themes from the meetings on Medicaid Expansion: -State agencies are prepared and ready -States testified to benefits of expansion	
Action Agenda Recommendations on Tobacco 21 Legislation Peg O'Connell, SAC Chair	**Proposal for Action Agenda Consideration** Stroke Advisory Council Recommendations for Tobacco 21 Legislation In 2019, federal law Tobacco 21 passed and made 21 the legal age for purchasing tobacco products. However, NC's legal age is still at 18. It's important for NC to align with federal law. Because 95% of tobacco users start before the age of 21, raising the age will help keep younger people from starting to use tobacco products and e-cigarettes. We need a well-planned, comprehensive law to ensure successful implementation of a Tobacco 21 law in North Carolina. An interagency group composed of NC Division of Public Health; NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services; NC Department of Public Safety's Alcohol Law Enforcement; NC Alcohol Beverage Control Commission; and NC Department of Revenue has been meeting to determine the best path forward for our state. Peg recognized representatives from the group in attendance on the webinar: Sally Herndon and Jim Martin with the Tobacco Prevention and Control Branch; Anna Stein, legal specialist with DPH; Walker Reagan, Legal Division of ABC Board; Ronda Doward with the Division of Mental Health, Developmental Disabilities and Substance Abuse Services; and Josh Batten with ALE. SAC reviewed these recommendations and presents them for Task Force consideration. The NC Tobacco 21 law should include the following: • Applies to all tobacco products • Requires retailer permit • Requires ID checks • Imposes minimal penalties for purchasers under 21 • Holds retailers responsible for violations, not just the clerk at the register • Requires signage • Requires employee training • Prohibits internet sales to people under 21 • Allows local government authority • Provides enough time for the state to implement and to educate retailers about the new law Peg stated that the Stroke Advisory Council submits these recommendations for a comprehensive Tobacco 21 law to the Task Force and requests an endorsement for adding this to the Action Agenda. This will allow advocates to begin educating legislators in the upcoming short legislative session. Senator Burgin called for questions, and there were none. Task Force members voted, and the endorsement request passed unanimously.	Speaker presentations posted at Justus-Warren Heart Disease and Stroke Prevention Task Force meetings
Urban-Rural Differences in Stroke Risk George Howard, REGARDS	Dr. Howard shared that NIH is required by law to investigate three disparities: racial/ethnic, rural/urban, and socioeconomic disparities. Very little work has been done in rural/urban disparities as there are not many major medical schools in rural areas. He encouraged all	Speaker presentations posted at Justus-Warren Heart Disease

Study, Dept. of Biostatistics, School of Public Health, University of Alabama at Birmingham	participating in the meeting to give thought to what we can do to further advance the understanding of urban-rural differences. Healthy People 2030 is the guiding document for all of HHS. Dr. Howard highlighted one of the principles of Healthy People 2030: eliminating disparities. He presented Urban-Rural Disparities in Stroke Mortality across the nation and noted that North Carolina is an unusual state in terms of stroke epidemiology. The small metro areas have large stroke mortality when it seems stroke mortality would be higher in the more rural areas. Small metro areas in the northeastern NC are in the buckle of the stroke belt which is particularly heavily burdened by stroke. While rates of heart disease and stroke have come down, the disparity remains high. There is excess stroke mortality in rural areas based on vital statistics. Are people in rural areas having more strokes or are they more likely to die if they have strokes? Dr. Howard conducts research for the REGARDS study (Reasons for Geographic and Racial Differences in Stroke Study) which is a general population study of 30,000 people. There are 3000 participants from NC, the state with the most participants. "Do you have undiagnosed hypertension?" is a tricky research question. The study follow them over the years to ask if they've had a stroke event. REGARDS has examined stroke incidence and case fatality and asks: are rural people having more strokes, or are you more likely to die from a stroke if you live in a rural area? What are the reasons rural residents are more likely to have a stroke? The REGARDS Study shows that higher risk of stroke appears to be related to higher incidence in rural areas. To reduce this disparity, we need to focus on preventing people in rural areas from having stroke. How much of the urban-rural difference is affected by risk factors? Hypertension and diabetes are more common in rural areas. Lower SES is associated with risk of stroke. Risk factors and SES play a role; however, over half of the association still remains. What is happening to the other half? Lots of things: psychosocial, structural (health insurance provided by employer compared to employed persons without health insurance), environmental, hypertension, measurement error, confounding, etc. We need more work to understand what is going on. We must focus on community-based efforts to prevent stroke. Questions/Comments: Senator Burgin shared his history in health insurance, service on the hospital board, monitoring mental health and health outcomes. His concerns are: Food deserts in rural areas and the amount of people that shop at the convenience or dollar stores for their food. Business news shows the dollar stores are targeting these small communities and don't offer quality products. Most are high in processed sugar, added sugar, nitrates and sodium.	and Stroke Prevention Task Force meetings

He noted that there are still about 5 counties in North Carolina that don't have a primary care physician; and in the other rural counties, care is very limited. Rural residents need more access to healthy food choices and physicians.
These situations are bad business deals for the state of North Carolina. Folks that end up with stroke and in a facility are not only disabled, they can't contribute to society. Stroke care is costly to families and to the state as well. How do we get resources to the rural areas, get them care at least twice yearly, start medication, and greatly reduce the burden of stroke?

George: Diet is not a big risk factor for stroke once you adjust for other risk factors but is the single biggest risk factor for developing hypertension and diabetes, and these two are the major risk factors for stroke. This is called primordial risk factor prevention. Best way to treat hypertension is to stop people from developing it in the first place, and the best way to do this is through diet and exercise. People in rural areas do not exercise as much as those in urban areas. Prevent risk factors in the first place.

Primary care physicians are absolutely important and a key part of community prevention. Having primary care physicians is essential.

Senator Burgin asked: what 3 things would you change in NC to stop stroke?

#1 Diet is the single biggest risk factor for the development of hypertension and single biggest contributor to black-white difference in hypertension.
#2 Reduce the burden of smoking. We know how to do this, and we need the courage to take action. Tax the hell out of tobacco, and a lot of these issues would go away.
#3 Raise community awareness of stroke risk factors: hypertension and diabetes.

Questions/Comments:

Comment: Sally Herndon noted that in North Carolina, according to BRFSS, 20.6% of rural residents smoke versus 11.2% of urban residents. That appears to be a significant disparity.

George: I don’t have the data specific to North Carolina. BRFSS is a powerful instrument and is self-reported.
Also, urban-rural in North Carolina is also confounded with race. In North Carolina, there is a substantial black rural population. A rural black community in New York is much harder to find than a rural black community in North Carolina. Part of the big difference in North Carolina may be the higher smoking rates among adult African Americans.

Council member Dr. Ruth Phillips noted that she has a friend in the hospital who had triple bypass surgery at age 58. This friend has been smoking since he was 13.
A: The history of tobacco is just so powerful. Tobacco leaves are the ornament in the US Capitol.

Peg shared that Senator Ed Warren (for whom the Justus-Warren Heart Disease and Stroke Prevention Task Force is named and who was the first chairman of the Task Force) was

	going in for heart surgery when Dr. Chitwood said, “We need to do something about heart disease and stroke in NC.” Senator Warren said to Task Force ED Libby Puckett, “We’re going to do something about heart disease and stroke, but we’re not going to talk about tobacco.” He realized over time that the Task Force must address tobacco in order to prevent heart disease and stroke. Representative Frank Iler: What is the relation of these statistics to county and state funds available for EMS and equipment to respond to stroke which is time sensitive? A: Anna Bess responded and noted that stroke is very complex. It depends on whether you are looking at incidence or care. Although prevention is key, when it strikes, stroke is an emergent condition and care is critical. These are the reasons for a stroke system of care and why the Task Force, the Stroke Advisory Council, and the Coverdell program look at our system of care; and the Task Force can make recommendations on all of these aspects of stroke from prevention to after-care. A: To reduce disparities, the Task Force can focus on stroke prevention instead of on improving care. Senator Burgin noted that access to care, healthy food, exercise, and personal security are critical for education and a healthy life. He noted concern about young people vaping. Dr. Ed Jauch commented: recent data suggests 96% of stroke patients are within 60 minutes of stroke care. To Dr. Howard’s point, prevention is the real opportunity. Comment: If you think you are having a stroke, call 911. Do not drive yourself. A: Dr. Howard noted that his wife’s research on stroke symptoms urges physicians to ask their patients if they have ever experienced stroke symptoms as many people have had symptoms they do not report to their physicians. People who have had stroke symptoms are at great risk of having a stroke. Senator Burgin asked if there is any correlation between COVID and heart disease and stroke. A: Dr. Howard responded that COVID is certainly inflammatory and these correlations are being studied widely. Dr. Howard’s presentation on black-white disparities in stroke to the Stroke Advisory Council is posted on the website. The meeting recording and slides are posted on StartWithYourHeart.com	
Closing remarks Senator Jim Burgin	Thanks to all members, presenters, and other attendees for your continued commitment to preventing heart disease and stroke. Short session will convene May 18, and the next Task Force will meet after session ends. Please watch for notice of the next meeting.	Justus-Warren Heart Disease and Stroke Prevention Task Force meetings