Justus-Warren Heart Disease and Stroke Prevention Task Force

Minutes for Meeting October 7, 2025

Participants

Members: Tara Aker, Randolph County Health Director; Barbara Beatty, Catawba County Commissioner; Senator Jim Burgin, co-chair; Representative Becky Carney, co-chair; Adrienne Calhoun, NC Association of Area Agencies on Aging; Yolanda Dickerson, American Heart Association; Basheera Enahora, NCSU Cooperative Extension; Larry Greenblatt, DHHS State Health Director; Lindsey Haynes-Maslow, UNC; Senator Mark Hollo; Ashley Honeycutt, UNC Rex; Christy Land, FirstHealth Moore Regional Hospital Administrator; Ruth Phillips, Health Equity Director, Cone Health; Joey Propst, Stroke Survivor; Joel Schneider, NC Healthcare; Brittany Watson, NC Medicaid.

Partners: Sue Ashcraft, Novant Health; Anna Bess Brown, Justus-Warren Heart Disease and Stroke Prevention Task Force; Erin Brown, WISEWOMAN Program, Division of Public Health (DPH); Stacey Burgin, DPH Community and Clinical Connections for Prevention and Health Branch (CCCPH); Heather Carter, Division of Aging and Adult Services; Anne Geissinger, DPH Chronic Disease and Injury Prevention Section (CDI); Jamie Lynch, Cone Health; Jennifer McConnell, Atrium Health; Kimberly McDonald, DPH CDI; Meg Molloy, Tobacco 21 Coalition, NCPHA; Peg O'Connell, Stroke Advisory Council Chair, T21 Coalition; Kurt Ribisl, UNC Gillings School of Global Public Health; Tish Singletary, DPH CCCPH; Julie Webb, Duke Regional; Dena Williams, UNC; Jedrek Wosik, University of Pennsylvania.

Welcome and Introductions

Representative Carney began the meeting by greeting everyone and recognizing co-chair Senator Burgin who welcomed all. Representative Carney explained that the Agenda for the meeting, the Action Agenda, and handouts are posted on our website Start with your Heart.com. She offered a special welcome to newly appointed members of the Task Force:

- **Tara Aker**- Health Director, Randolph County Health Department
- **Larry Greenblatt, MD**- DHHS State Health Director & Chief Medical Officer
- **Senator Mark Hollo**- representing Caldwell and Catawba Counties
- **Christy Land**- Hospital Administrator FirstHealth Moore Regional Hospital
- **Joel Schneider, MD**- NC Healthcare cardiologist who resides in Carteret County

These new members will serve through June 30, 2027.

The minutes from the December 5, 2024 meeting were approved by acclamation. The meeting recording, minutes, and slides are posted on StartWithYourHeart.com.

Dr. Jedrek Wosik with the University of Pennsylvania, who was formerly at Duke and worked in Roxboro in Person County, presented his work and recommendations on testing and management of Lp(a) Lipoprotein.

Lp(a) Testing and Management

Jedrek Wosik, MD

Dr. Wosik explained Lp(a) testing can identify risk for stroke and heart disease and that one need test only once in a lifetime to determine if their Lp(a) puts them at risk for heart disease and stroke. Lp(a) is

genetically determined; therefore, screening is important. 10-30% of the population globally have elevated Lp(a), but testing prevalence is low. It is now possible to lower Lp(a).
The guidelines are not clear on whom to test; and some say to test if there's family or personal history, and the National Lipid Association and others say everyone should be screened.
The focus is to identify those with elevated Lp(a), test their first degree relatives, and modify risk factors. Multiple therapies for treatment are in clinical trials.

Questions and Answers
Q: Senator Burgin asked about microplastics and explained that a cardiologist told him that statins will not help with the damage from microplastics. He asked if microplastics are the next thing we'll be dealing with.
A: Dr. Wosik responded that we'll know more about microplastics in the future. He said that ideally you should have as little plaque as possible and that if you do have plaque, make sure it's stable. Plaques cause ruptures that cause myocardial infarction and stroke. Lp(a) is particularly prone to these types of ruptures and thromboses.
Q: Dr. Schneider asked how Lp(a) figures in population health.
A: Dr. Wosik responded that currently the test is recommended for those at high risk and that in the future we'll see the Guidelines recommend testing for all.
Q: Dr. Greenblatt asked if family members should be screened when a family member has elevated Lp(a). Also, how will testing impact rural health?
A: Dr. Wosik explained that Lp(a) is predominately inherited (from both sides). If you have elevated Lp(0), you could high-level test those around you. The strongest determination is to test if there is heart disease in family members who are younger than 55-65 (both males and females).
To influence rural health, we could start testing in rural areas and move in toward urban settings to allow rural health to lead the way to uncover risk.
Q: Yolanda Dickerson noted that she is a congenital heart disease survivor and that she pushes the use of the health family tree. Is it better for my brothers to get tested than my child?
A: Ideally we test everyone once. That's what Europeans do. The more info you have, the better.
Q: Meg Molloy asked if there are specialty clinics for managing Lp(a) at academic centers.
A: Dr. Wosik noted that there are clinical trials in process which will help with management. He said that primary care doctors can care for folks with Lp(a) and help manage hypertension, lipids, weight, diet, etc.

From the Chat:
Dr. Brittany Watson, NC Medicaid, noted in the Chat, "Awesome presentation! Aside from risk stratification, what do you say to those who might argue that we should be encouraging these lifestyle modifications in everyone, especially if they are considered high risk? How does it significantly change management at this time?"
A: Dr. Wosik responded that those with high Lp(a) should doubly focus on reducing risk.

Dr. Greenblatt noted, "Interesting topic! I think of the Lp(a) testing to identify higher risk that would be detected by conventional means. Doctors use tools like this one: https://www.mdcalc.com/calc/3398/ascvd-atherosclerotic-cardiovascular-disease-2013-risk-calculator-…. Individuals found to have higher risk might get more aggressive cholesterol treatment, attention to blood pressure, efforts at smoking cessation, etc."

Dr. Watson responded, "I am a fan of Lp(a) testing also. It is a valuable tool. But, I have found apprehension and slow uptake in the primary care space. The viewpoint I hear often is that it doesn't significantly change management, specifically in someone who is known to be high risk. Maybe more education for primary care providers on the ground will encourage more widespread use."

Dr. Greenblatt replied, “Dr. Watson, it seems it would be most useful for folks where the clinician or patient is on the fence about an intervention such as statin therapy. If the individual is a very low risk, don't test. If at high risk or has established ASCVD, treat no matter what the Lp(a) level is.”

Dr. Watson responded, “Absolutely, that's usually my main talking point, and how I have the conversation with students and residents. I love it as a tool to have shared decision-making conversations with patients who are on the fence. Looking forward to seeing it used more in the future.”

Stroke Advisory Council Report
Peg O’Connell, Chair
Peg explained that the Stroke Advisory Council (SAC) was established in statute soon after the Task Force was established and is part of the statutory scheme of heart disease and stroke prevention in the state. SAC works hand and glove with the Task Force.

At our March meeting, Dr. Jamila Minga, Speech Language Pathologist and researcher at Duke, presented on the importance of adding an ICD-10 code for right hemisphere stroke apragmatism, a communication deficit which affects context-appropriate language. SAC endorsed this addition to aid in education, recognition, and treatment of apragmatism. Dr. Minga has applied for an added ICD-10 code and has requested comments in support during the comment period which ends November 14. **During this time, the public can share their opinion on the proposal, its need, and potential benefits etc. Comments should be emailed to nchsicd10cm@cdc.gov. Please use the subject line: Apragmatism ICD-10 CM Code.**

In May SAC focused on the particular mental health needs of stroke survivors. A panel of experts, stroke survivors, and caregivers shared recommendations and resources. Constellation Quality Health also presented on their Regional Collaborative.

On September 5th SAC met in person and was hosted by UNC Health who shared their research projects and programs. We celebrated the 80 hospitals that qualified for recognition for AHA’s 2025 Get with the Guidelines®-Stroke Awards. The Stroke Nurse Coordinators also met in person on Sept. 5th, and throughout the year they met monthly to learn and share information about stroke prevention and care across the state.

Coverdell Acute Stroke Program Report
Tish Singletary, Head, Community and Clinical Connections for Prevention and Health Branch, DPH
Ms. Singletary shared that North Carolina Division of Public Health was awarded a Coverdell National Acute Stroke Program cooperative agreement by the CDC and that the Community and Clinical Connections for Prevention and Health branch will administer the funds and oversee the work. She said they are working on the second year of this five-year cycle of funding. See the slides.

Questions and Answers
Q: Dr. Greenblatt asked, “How concerned are you about losing the federal funding with recent CDC cuts?”
A: Ms. Singletary responded there is a line in the federal budget that supports the National Center for Chronic Disease Prevention. She added, “Wherever you can, speak for the need for funds for heart disease and stroke prevention, physical activity and nutrition, and diabetes prevention for our state.”

Action Agenda Status
Peg O'Connell, Chair, Stroke Advisory Council
This year of the long legislative session, the General Assembly has yet to agree on a budget. When this happens and we have no budget, the state reverts to the previous year's budget. That means the state is operating, but new things are not funded. Therefore, our Action Agenda items to endorse $3 million to expand tobacco cessation services and $17 million for tobacco use prevention are at a standstill. This is complicated by the fact that the federal administration has eliminated the Office on Smoking and Health at CDC which means there will be no federal funds for tobacco prevention or cessation flowing to states after the current fiscal year's funding ends in April 2026. As a result, North Carolina's Tobacco Prevention and Control Branch had to furlough nine staff. North Carolina will have to figure out how to fund tobacco prevention and control work.

The School Meals for All Coalition continues to advocate for recurring funding to provide free breakfast to all students in public schools in the state.

And AHA continues to work on codifying the T-CPR training requirement.

Tobacco 21 "Solly's Law" H430/S318
Peg O'Connell, JD
T21 Coalition, NCPHA
Meg Molloy, DrPH, MPH
T21 Coalition, NCPHA

Peg shared that vaping has serious consequences for our youth and is an epidemic. Solomon "Solly" Wynn of Wilmington died at age 15 of lung damage from vaping. Solly's Law (H430/S318) will raise the age from 18 to 21 to purchase tobacco products and establish a retail licensing system. The bill is in the House Rules Committee and also in the Senate Rules Committee.

Dr. Molloy shared that the Tobacco 21 Coalition which promotes Solly's Law has 135 endorsers from across the state and is expanding its number of youth members. Members of the public and the press are very interested in the vaping epidemic and supportive of getting the bill a hearing. She shared that one vape can contain 40-90 mg of nicotine (one cigarette contains about ten mg) and that vapes are highly addictive. It's very hard for youth to stop because of their developing brains. This law could limit the number of children with access to these products; and permitting will reduce addiction, give the state information on where these products are being sold, and more. See the Tobacco 21 slides.

Assessing the relationships between tobacco retailer density and tobacco use and tobacco-related health outcomes
Kurt Ribisl, PhD
Dr. Ribisl explained that he's been researching tobacco retail outlets for 31 years. He stated that the tobacco industry spends $6-7 billion/year (just under $1 million/hour) on marketing in retail outlets as they cannot advertise on TV, radio, or billboards anymore.
Many states and local governments have banned tobacco and vape shops near schools. He shared research showing 25 tobacco retailers for every one McDonalds. Some states are looking at regulating the distance between retailers and at banning sales in places like pharmacies.

What would happen if we had fewer tobacco retailers in NC? His research found higher smoking rates with more tobacco retailers. The product is more readily available, may be cheaper, and there's advertising in these stores.

His group's large-scale US study found more preterm births, low birthweight babies, and other worse birth outcomes in areas of high tobacco retailer density. Several studies have shown there are more hospitalizations for CVD in areas of high tobacco retailer density. One study found 19% higher hospitalization discharge rates, 22% more days in the hospital, and 30% higher hospital costs for COPD in areas of high tobacco retailer density.

Dr. Ribisl noted that his team of researchers thinks there's a relationship between the built environment and certain poor health outcomes. They're looking at what happens in heart disease and pulmonary outcomes when there are changes over time in tobacco retailer density. They think greater tobacco retailer density results in more smoking and poorer health outcomes. He added that we need policies to reduce tobacco retail density. He is happy to share research and an invited commentary on evidence-based point-of-sale policy to reduce youth tobacco use in North Carolina he wrote for the NC Medical Journal.

Questions and Answers
Q: Meg Molloy noted Kirk's table ends at 2017, and there's been an explosion of retailers in recent years. What does the change to 2025 look like? A Rural Center survey showed the #1 concern of respondents was the number of vape shops in their communities.
A: We have seen a dramatic increase in vape shops-especially in college towns and in neighborhoods with young people. We can get some data on retailers, and health data takes longer. Most products sold are not authorized by the FDA. Legislatively you can cap the number of retailers.
Q: Dr. Greenblatt asked if Kurt and his team are seeing an increase in smoking and vaping with the increase in retail shops.
A: Cigarette smoking rates are steadily declining, and vaping is way up. Much was driven by Juul which had 60-70% market share; Juul was restricted, and other companies now have filled the void. Retail outlets are selling to children at high rates. This is another reason you need Licensing. If these shops sell to minors, they could have their licenses revoked.
A: Meg added that H430 Solly's Law includes vapes and all tobacco products including pouches, cigarillos, etc.

Notes from the Chat:
Dr. Greenblatt noted, "In the US, about 6% of students under 18 report using nicotine vaping in the last 30 days."

Representative Carney thanked the presenters for the information and the participants for attending the meeting. She added that she hopes we can move these bills forward.

The next meeting will be December 2 from 10:30-12:30 at the new DHHS Headquarters, 1915 Health Services Way, Raleigh across from the NC Museum of Art.

Meeting and presentation slides, recording, and minutes are posted on the website startwithyourheart.com:
https://www.startwithyourheart.com/justus-warren-heart-disease-and-stroke-prevention-task-force/jwtf-meetings/