STROKE ADVISORY COUNCIL MEETING MINUTES
February 15, 2022
Webinar 1 - 2:30 pm

Members/Partners

Present: Wally Ainsworth, NC Office of Emergency Management Services (NCOEMS); Michael Aquino, UNC Nash; Sue Ashcraft, Novant Health; Pat Aysse, American Heart Association (AHA); Sharon Biby, Cone Health; Melanie Blacker, FirstHealth; Blaise Bolan, New Hanover Regional Medical Center (NHRMC); Aleasia Brown, DPH Cancer Prevention & Control Branch (DPH CPCB); Anna Bess Brown, Justus-Warren Heart Disease and Stroke Prevention Task Force (JWTF); Katie Buck, CarolinaEast Health; Nicole Burnett, UNC Health; Tory Cairns, WakeMed; Adrienne Calhoun, AAA Piedmont Triad Regional Council; Amber Carter, Cone Health; Shannon Chesney, Duke; Sylvia Coleman, RN; Ron Cromartie, Innovative Healthcare Consulting; Tom Curley, NHRMC; Rizza de la Guerra, Johnson & Johnson; Eric Deshaies, Novant Health; Yolanda Dickerson, AHA representative, JWTF; Ronda Doward, DHHS, Director of Tobacco Prevention; Chelsea Dunston, Atrium Health; Nada El Husseini, Duke Health; Michael Erwin, BELIEVE Stroke Recovery Foundation; Meg Fenu, WakeMed; Heather Forrest, Duke; Melissa Freeman, Duke; Claudia Giraldo, DPH, Community and Clinical Connections for Prevention and Health Branch (CCCPH); Emily Gobble, UNC Health; Melanie Greenway, Mission; Amy Guzik, Atrium Wake Forest Baptist (AWFB); Katherine Hall, Vidant Health; Lesli Hall, Novant Health; Lindsey Haynes-Maslow, JWTF member, NCSU; Jenisha Henneghan, AAA Triangle J Council of Governments (TJCOG), Area Agency on Aging Assistant Director; Sally Herndon, DPH, Tobacco Prevention and Control Branch (TPCB); Kristie Hicks, DPH, CCCPH; Michele Horvath, Vidant Health; Amy Ising, NC DETECT, UNC; Sarah Jacobson, AHA; Rayetta Johnson, AWFB; Robin Jones, Mission HCA; Essete Kebede, DPH, CCCPH; Joanna Keeter, Vidant Health; Justine Knight, Triangle Aphasia Project; Diomelia Laues, Cape Fear Valley Medical Center (CFVMC); Sydney Lawrence, Lake Norman Regional Medical Center; Sarah Lycan, AWFB; Sandra Maney, Genentech; Penelope McCabe, Onslow Memorial; Barb McGrath, FirstHealth; Lucinda McLean, Columbus Regional Healthcare; Terri Moore, DPH, CCCPH, Coverdell Stroke Program; Margaret Murchison, WFJA Radio; Kathy Nadareski, WakeMed; Peg O'Connell, Stroke Advisory Council (SAC) chair; Kimberly Oyler, NHRMC; Mehul Patel, UNC Dept. of Emergency Medicine; Diane Perkins, Atrium Health; William Pertet, DPH, CCCPH; Ruth Phillips, JWTF member, Community Health Coalition; Dawn Phipps, Davis Regional; Joey Propst, JWTF member; Shannon Quinby, Tobacco 21; Julia Retelski, Atrium Health; Ray Riordan, DPH TPCB; Ciara Rukse, DPH CPCB; Meg Sargent, DPH CCCPH; Chris Shank, NC Community Health Center Association; Birtha Shaw, Diabetic Supply; Alan Skipper, NC Medical Society; Cara Smith, Angel Medical, Mission Health; Chuck Tegeler, AWFB, SAC vice chair; Sarah Van Horn, UNC Health Blue Ridge; Andrea Ward, Atrium Health High Point; Julie Webb, Duke; Marie Welch, RN; Gwendolyn Wise-Blackman, MWHA; Erica Yourkiewicz, NHRMC; Meg Zomorodi, UNC

Welcome

Peg O'Connell, Chair

Peg welcomed everyone to the webinar and stated Chuck Tegeler, vice chair, was also on the webinar. Peg thanked everyone for joining- especially stroke survivors and stakeholders who are joining us in our work in preventing stroke and improving stroke care in North Carolina. She wished all a very happy Heart Health Month with a shout out to friends at the American Heart Association/American Stroke Association.

Peg welcomed new board members voted in by the Justus-Warren Heart Disease and Stroke Prevention Task Force in December:

- Eric Deshaies, MD with Novant Health has been appointed by NC Healthcare Association.
- Meg Zomorodi, PhD, RN with UNC School of Nursing was appointed by NC Area Health Education Centers.
- Erika Yourkiewicz, RN with New Hanover Regional Medical Center fills the Stroke Rehabilitation seat. Erika has been active with the Council and presented to us on stroke education and outreach at our March meeting.
- Amy Guzik, MD with Atrium Health Wake Forest Baptist fills Stroke Telehealth Technologies seat. Dr. Guzik is the Director of the Comprehensive Stroke Center and of the Telestroke program at Wake Forest. Amy has served on several work groups and has presented to the Council multiple times including at our May meeting.

Peg called for the approval of the minutes from the last meeting, November 2, 2021. Reminded participants they had received an email with the minutes in advance of the meeting. The minutes were approved by acclamation with no "no" votes noted.

Peg invited everyone to attend A Social Festival for Stroke Warriors and their Community that will promote self-independence and offer resources that will aid in their transition/development on May 14 from 11-3 at E. Carroll Joyner Park, 701 Harris Road, Wake Forest, NC 27587, JoynerPark.com
There will be food, fun, games, a DJ, and multiple vendors with resources for functioning environment, survivor equipment, support groups, etc. This event is a collaboration among Triangle Aphasia Project, Believe Stroke Recovery Foundation, Steps for Recovery, & New Hanover Regional Medical Center. **For information please contact Michael Erwin at mterwin@gmail.com**

Coverdell Stroke Program Update
Anna Bess Brown, Executive Director, Justus-Warren Heart Disease & Stroke Prevention Task Force
Anna Bess welcomed everyone and introduced **Program Coordinator for the Coverdell Stroke Program, Terri Moore**, and provided the email for contacting her: terri.moore@dhhs.nc.gov

Anna Bess shared that the Coverdell Program continues to recruit for a **Program Evaluator**. The job listing will be posted soon and will be sent out via the listserv. She urged everyone to share the posting: we welcome applicants right out of school or young in their careers and are willing to train them.

In addition to staffing, Anna Bess explained that the Stroke Registry Workgroup continues to meet with our sister agency, the HIE, and their SAS colleagues. They are working toward a June deadline for the delivery of the stroke registry.

Anna Bess also explained that, as part of the reporting on data elements that the CDC requires of all Coverdell awarded states, we are working with American Heart Association and Get With The Guidelines® Stroke (GWTG) to get the data. She stated that hospitals should have received a request to join us by signing an amendment to the agreement with AHA so that information can be shared as part of the Coverdell layer. She encouraged all hospitals that use GWTG Stroke to sign that agreement. There's no cost to the hospital system, and the information about your stroke services will help us get more complete information.

Terri Moore, Program Coordinator, Coverdell Stroke Program
Terri expressed her excitement in joining the team and thanked the SAC members for their work and dedication.

She stated that the Coverdell program will fund two projects in year one: **Cape Fear Valley Health System** to train EMS on emergency stroke response; **Mission Health** to test two types of blood pressure measurement. The contract period for these two QI projects is April 1 to June 30, 2022.

Terri announced the **Year 2 RFA will be posted soon** on the CCCPH website, and we'll send out the notice on the listserv. Please pass this information along to everyone in your communities who is working on improving the SSC. This includes hospitals, EMS agencies, and community organizations. The goal of this program is to strengthen the SSC across NC by funding projects **especially targeting low-resourced communities.** We need to know what you need in your communities so that we can help support those efforts through funding of your needed projects.

Peg introduced **Jim Martin with the Tobacco Prevention and Control Branch** at the Division of Public Health to update everyone on Tobacco 21 which passed as a federal law and requires people be 21 or older to purchase tobacco products. The age to purchase tobacco products is currently still 18 in North Carolina. Peg explained that Jim has been working with an interagency group on shared recommendations on state implementation of the Tobacco 21 law. He

presented these to the Task Force in December, and Stroke Advisory Council leadership asked to examine this issue and take recommendations to the Task Force.

Tobacco 21 Legislation Recommendations
Jim Martin, Director of Policy and Programs, DPH Tobacco Prevention and Control Branch
Anna Stein, Legal Specialist, DPH Chronic Disease and Injury Section
Morgan Wittman Gramann, Executive Director of the NC Alliance for Health

Jim shared information on the burden of tobacco use in North Carolina and then focused on the data on tobacco use among young people. He shared that in our state we reduced tobacco use by teenagers, but we've seen a reverse trend with the use of e-cigarettes. He stated the higher level of nicotine in e-cigs leads to a quicker addiction. A survey conducted in NC schools in collaboration with CDC looked at use data. The findings from the survey suggest three top reasons for the increase in use/abuse: e-cigarettes being used in social situations, friend or family member use, and they come in inviting flavors.

Jim then focused attention on one of the solutions to addressing the impact of the burden of tobacco use in NC: raising the purchase age of tobacco products to 21. Even though the federal age to purchase tobacco and tobacco products (including e-cigarettes) was raised from 18 to 21 in 2019, NC is one of only 11 states whose laws don't match the federal law.

Jim stated that there's another federal law (Synar Amendment) that's been in place since the nineties that requires each state to enforce their state law to a specific level, and they must show that no more than 20% of retailers are selling tobacco products to underage youth. Or, if we go above that 20% threshold, the federal government may take away millions of federal dollars from substance abuse prevention and block grant funds.

Jim described the inter-agency T21 work group that has been meeting over the past year. The group is composed of representatives of the Department of Health and Human Services: the Division of Public Health and the Division of Mental Health, Developmental Disabilities and Substance Abuse Services which oversees Synar compliance and maintains the contract with FDA to enforce the federal law; the Department of Public Safety, Alcohol Law Enforcement (ALE) which is the state agency charged with enforcing the youth access tobacco law in our state; and the North Carolina Alcohol Beverage Control (ABC) Commission which is responsible for permitting alcohol retailers. The ABC Commission can take a lead role in licensing and permitting tobacco retailers based on the model system they have for alcohol. The Department of Revenue is also involved as they have a licensing system for tobacco wholesalers in collecting tobacco taxes.

Anna Stein discussed the deficiencies under current law. The ALE is unauthorized to inspect retailers; if they find a problem, they don't have the authority to go in and investigate, and they don't have a good handle on where tobacco is being sold. Current law leaves out a lot of retailers on the list. It is impossible to conduct compliance checks on retailers since there is not a comprehensive list.

She then proposed how our state could improve through licensing (or permitting) retailers that want to sell tobacco products. The benefits of permitting are that we'd know where products are sold; we'd be able to inspect those locations; there'd be a mechanism for enforcing the law; and it would also open up funding for education, inspections, and enforcement.

She then reiterated that the ABC Commission has said they are willing to oversee permitting of tobacco retailers. This works well because many retailers who sell alcohol also sell tobacco products. They already have the infrastructure in place. Many retailers are already in the database with their alcohol permit, and they already work with the ALE.

Anna shared the overall conclusions regarding taking the recommendations to the legislature:

- N.C. has experienced an **alarming increase** in the use of tobacco products by young people—especially e-cigarettes, which are mostly acquired from retailers.
- **Prevent** the sale of tobacco products to people **under age 21**.
- To match federal law and most other states, N.C. needs to **raise the age of purchase to 21.**
- NC is at risk of losing **millions of federal dollars** for substance use disorder treatment if it does not effectively prevent underage sales of tobacco products.
- A tobacco retailer permitting system is an **evidence-based measure** to reduce tobacco sales to youth.
- NC needs a level playing field among tobacco retailers to make it easier to **educate and inspect all retailers** to reduce illegal sales to underage youth.

Morgan Wittman Gramann is the Executive Director of the NC Alliance for Health, a statewide, independent, nonpartisan coalition of individuals and organizations. They convene, mobilize, support, and empower partners to advance equitable policies that reduce health disparities, prevent chronic disease, and promote health. She shared the successes in NC regarding tobacco laws and interventions 2005-present. (See slides.) She explained that they are striving to pass T21 in NC to apply to ALL tobacco products, and she emphasized the importance of requiring retailer licenses in order to hold retailers (not clerks) responsible for sales.

Peg thanked the presenters for their collaborative work on the implementation of this important law and asked for questions or comments.

Peg then called for a motion from SAC members to move this list of recommendations on the Tobacco 21 law to the Task Force for consideration as part of their Action Agenda. Chuck Tegeler made the motion, and Robin Jones seconded it. Peg then called for a vote on the motion from the voting members and asked for "no" votes to be written in the Questions box. The motion was adopted by acclamation.

Peg stated that we are honored to have North Carolina native and long-time SAC friend George Howard of the REGARDS Study at the University of Alabama at Birmingham to present on his extensive studies of Black-white disparities in Stroke.

George Howard
Dept. of Biostatistics, School of Public Health, University of Alabama at Birmingham
What May Be Driving the Black-White Disparity in Stroke and What We Can Do To Change That
(Please see slides for details.)
Dr. Howard began by thanking the Council for inviting him and shared that he was part of SAC 25 years ago and happy to share data from the REGARDS study.

Dr. Howard discussed stroke mortality rates among different racial groups. He noted that the group with the highest stroke mortality is African Americans. At ages 45 to 54, African Americans have a 250% excess compared to whites. It's marginally better at age 55 and a little bit better from 65 to 74. And then it falls off rapidly so that by the time you're over 80, the racial disparity in stroke mortality dissolves. So, are more Blacks having strokes (incidence) which would require increasing prevention activities? Or, are more blacks dying from strokes (case fatality) meaning they are not receiving the same quality of care? Or both?

For example, studies show that Blacks are less likely than their white counterparts to receive tPA following stroke.

Dr. Howard explained that the REGARDS Study is a general population study and not a stroke study. It is a study to understand why people have strokes. They recruited about 30,000 people; 56% from the stroke belt, the eight southern states in the southeastern United States; 42% are African American. REGARDS asks the question, "Do you have undiagnosed hypertension?" The study went to homes, took blood pressure, noted meds, etc. Since 2003 REGARDS has followed this cohort.

(See slides for data from the REGARDS Study.)
What is it that causes the black-white disparity? Hypertension and diabetes are more prevalent in Blacks. Studies show hypertension or diabetes approximately doubles your stroke risk.
Given that higher hypertension and diabetes is only a third or a fourth of the effect, what explains this difference? What about other risk factors?

Dr. Howard asked the following questions:

- What happens if we adjust for the Framingham Risk factors (hypertension, diabetes, cigarette smoking)?
  Answer: it accounts for SOME of the difference.
- What happens if we adjust further for socioeconomic status, lower income, and lower education?
  Answer: that effect is relatively small because a lot of the pathway of action for socioeconomic status is through the Framingham Risk Factors and we've already adjusted for those.

When looking at prevalence of stroke, risk factors and socioeconomic status account for about 50% of the black-white difference. That means if we're going to reduce the excess mortality for African Americans, we need to quit thinking about how we treat hypertension and think about how we prevent hypertension. We need to work further upstream to try to reduce that burden.

So what is causing the other half? How do we stop African Americans from having more hypertension and diabetes? It could be differential susceptibility to risk factors, psychosocial factors, discrimination, and other biomarkers such as inflammation. A lot of other things could be driving this, or it could be measurement error. George explained, as a statistician, one reason why we might not be able to explain things is we don't measure them as well as we could. So, he then suggested we look at the black-white difference in stroke risk with the context of age and systolic blood pressure. (See slides for this data.)

African Americans are more likely to have hypertension, to know they are hypertensive, and to be treated but less likely to be controlled with treatment. Hypertension is 30% less likely to be controlled in African Americans. Once blood pressure is not controlled, it is three times as bad for African Americans. A well-managed person who is on one med for hypertension is still at a 40% increased risk for stroke. Does the control of SBP really solve the problem/disparity?

Concluding Thoughts:

- This disparity has been going on for going on for at least 70 years, and we're not making it smaller.
- The excess risk of stroke mortality in African Americans is concentrated on those below age 75 where the risk is 2 to 3 times higher.
- 11% of deaths in stroke in whites are below age 65. 33% of deaths from stroke in African Americans are below age 60, and AAs are 3 times more likely to die from stroke below age 65.
- The black-white disparity in stroke mortality is nearly perfectly reflected in a black-white disparity in stroke incidence, but there's no apparent disparity in case fatality. It's being driven by incidence.
- This suggests that our focus needs to be on how to ensure Blacks do not have strokes in the first place. We've got to prevent it. Community-based intervention to reduce stroke risk in AAs will be key to reducing the stroke disparity.
- The high prevalence of the traditional risk factors and poorer socioeconomic status explain about half of the disparity.
- We really need to focus on the prevention of the risk factors in the first place.

George noted that the REGARDS study is approaching 700 published papers, 80% are first authored by people who are not part of the study, and there are funded 140 ancillary studies. REGARDS is supported by NINDS; and we thank the investigators, the staff, and most of all of the participants who have made these contributions possible.

Peg thanked George and said we will invite him back to talk about urban and rural differences in stroke.

Question for George
Anna Bess: What can we, as a Stroke Advisory Council, do? We have stroke stakeholders who passionately care about these issues.

George: What we need to do is work in the community to delay or prevent hypertension- particularly in African Americans. Of the part that is explained, hypertension accounts for about 50% of the black stroke incidence.

There are eight Level I-A studies that explain the things that delay or prevent hypertension: exercise, obesity, etc. All of these have been shown that, if we work on those, we prevent or delay the onset of hypertension. I'm not saying I don't care about controlling blood pressure. We have got to stop people becoming hypertensive.

We have a different paper that looks at what predicts the disparity in the development of hypertension. In other words, what is it that makes a person hypertensive? There's a great nutritional epidemiologist, Suzanne Judd, who developed something called the Southern Diet Index which is made up of foods AAs commonly eat. But, again, diet only explains 50% of the black-white difference in the incidence of hypertension.

Peg restated that we really have to find ways to prevent stroke in the first place.
She thanked all of the presenters, and she thanked all for attending.

Reminders: Please look out for the RFA release coming soon and think about applying to work with us on the Coverdell program.
We will be in touch about the Tobacco 21 progress and updates.
Our next meeting is May 10 at 1:00 via webinar.

Stroke Advisory Council Meetings
May 10
Sept. 13
Nov. 15
All meetings are Tuesdays 1-2:30