Health

HEALTH FAQ

Coronary artery disease: What you need to know

Coronary artery disease happens when the arteries supplying blood to the heart become narrowed or blocked by plaque made of cholesterol, fat, and calcium. This reduces blood flow to the heart and can lead to chest pain or angina. If left untreated, it can result in a heart attack.

Q: What are some common symptoms of coronary artery disease?

A: Symptoms include chest discomfort; this is commonly described as a pressure, tightness or heaviness sensation in the center or lower chest. This discomfort may sometimes radiate to the jaw or arms. Additional symptoms, including shortness of breath, fatigue, or nausea, may also occur. Particularly, in women and people with diabetes, atypical symptoms such as nausea or unusual fatigue, may be the predominant symptom.

Rohit Masih, MD
UNC Health Southeastern

Q: Can coronary artery disease occur without symptoms?

A: Yes. Many people have silent coronary artery disease and may not realize it until a heart attack occurs. Routine screening is essential, especially for those with risk factors. Risk factors include age, family history of heart disease, diabetes, high blood pressure, high cholesterol, physical inactivity, being overweight, smoking and substance use including cocaine and marijuana.

Hiten Patel, MD
UNC Health Southeastern

Q: How can coronary artery disease be prevented?

A: Prevention includes not smoking, eating a heart-healthy diet, exercising regularly, maintaining healthy blood pressure and cholesterol, managing diabetes, and reducing psychosocial stress.

Q: What are the warning signs of a heart attack?

A: Warning signs include chest pain lasting more than a few minutes, pain spreading to the arm or jaw, shortness of breath, sweating, nausea, lightheadedness/dizziness or passing out. If these occur, Call 911 immediately to get immediate medical assistance.

Q: What is the most important Heart Month message?

A: Know your numbers, know your risk, and take action early. Small lifestyle changes and regular checkups can prevent heart attacks and save lives.

Know Your Numbers:

Blood Pressure:

— Normal: Less than 120/80 mmHg

— Goal blood pressure if taking blood pressure medication: ≤ 130/80 mmHg

— High blood pressure often has no symptoms but significantly increases heart attack and stroke risk.

Cholesterol (LDL – 'Bad' Cholesterol):

— Goal for most adults: Less than 100 mg/dL

— Lower targets may be recommended for those with heart disease or diabetes.

Hemoglobin A1c (Blood Sugar Control):

— Normal: Less than 5.7%; diabetes: 6.5% or higher

— Good diabetes control reduces heart disease risk.

Rohit Masih, MD, is a cardiology fellow with UNC Health Southeastern. Hiten Patel, MD is an interventional cardiologist and endovascular specialist as well as the program director for UNC Health Southeastern's Cardiovascular Diseases Fellowship Program.

In addition to offering services you'd expect from a community healthcare system, UNC Health Southeastern provides a number of specialized services that are unique to our system and not available anywhere else in the region. To schedule an appointment, call our referral line at 984-974-CARE. To learn more, visit UNCHealthSE.org. To submit questions for consideration for a Frequently Asked Questions article, email unchsoutheasterninfo@unchealth.unc.edu.

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Dr. Ahmed Ahmed is a third-year internal medicine resident at UNC Health Southeastern in Lumberton.

Healing rural NC, one doctor at a time

Morgan Casey
Border Belt Independent

LUMBERTON — When Dr. Ahmed Ahmed clocks out after a 12-hour hospital shift in Lumberton, his work isn't done.

At the grocery store, the gym, any time he's out in the community, Ahmed fields questions from patients and their loved ones. Are colonoscopies really necessary? What does he think of this or that medication?

As a third-year internal medicine resident at UNC Health Southeastern, Ahmed faces more challenges than 80-hour work weeks. Robeson is one of the poorest and least healthy counties in North Carolina, and like many rural areas, it does not have enough doctors to treat patients with disproportionate rates of diabetes and heart failure.

Ahmed, 37, attended medical school in Shenyang, China, and has lived all over the world. But he figured he could learn a lot and make a big impact practicing medicine in a rural area like southeastern North Carolina.

"As a rural physician, you definitely have to step up and try to cover some of the gaps," Ahmed said, "because you can't just tell the patient, 'All right, go down the street and see a nutritionist.' You have to do some of that work yourself."

North Carolina hospitals and health systems have 402 accredited residency and fellowship programs in which doctors spend three to seven years in clinical training after completing medical school, according to the Accreditation Council for Graduate Medical Education. But only 10 are in rural areas, where nearly 3 million people live.

That's less than in some states with similar rural populations. Pennsylvania and Ohio have 21 rural programs to train doctors to serve 3 million and 2.8 million people in rural communities, respectively, according to the Rural Residency Planning and Development Program and the U.S. Census Bureau.

North Carolina needs to nearly double its number of programs to obtain and retain enough doctors to adequately treat its rural population, according to the state's five-year Rural Health Transformation Plan. State health officials want to add eight to 12 rural residency and fellowship programs by 2031. The increase could add 165 physicians in rural areas, said Emily Hawes, director of the North Carolina Graduate Medical Education Technical Assistance Center (NCGME) and a clinical pharmacist in Boone. The center helps health care organizations throughout the state build and expand residency programs, connecting them to funding sources and technical training.

The state program is funded through the federal Centers for Medicare & Medicaid Services' Rural Health Transformation Program, which was created under the One Big Beautiful Bill Act that President Donald Trump signed into law last summer. Congress added the five-year, $50 billion program to the legislation to appease the bill's Republican holdouts, including Sen. Thom Tillis from North Carolina, who said the bill's deep cuts to Medicaid would gut rural health care.

North Carolina received $213 million from the Rural Health Transformation Program this year, the 10th largest amount in the nation. State officials have yet to specify how much funding will go to creating new rural residency programs. The state also plans to use the money to establish more certified community behavioral health clinics, increase access to virtual health care for rural residents, and build capacity at rural hospitals and clinics.

"The funding will help us think about how we create sustainable change in these communities where oftentimes access is the biggest problem," N.C. Health and Human Services Secretary Dev Sangvai said at a virtual town hall last month. "This is really a once-in-a-lifetime opportunity to transform health care in North Carolina."

No lack of interest

Ahmed saw how poor access to health care affected his younger sister during part of his childhood spent in rural eastern Africa. His sister couldn't readily get treatment for her Type 1 diabetes. So he dedicated himself to practicing medicine.

"I thought, 'I can actually do this myself,'" Ahmed said. "I can become a doctor and help the people I care about, and also people who are in the same circumstances in terms of having poor access to care.'"

After living and traveling in China, Egypt, India, Saudi Arabia, and Illinois, Ahmed began working as a medical scribe at UNC Health Rex in Raleigh. He applied to UNC Health Southeastern's internal medicine residency program because he wanted to treat a range of conditions and work with patients with limited access to preventative care.

It can be tough to recruit physicians to rural areas because of lower pay and fewer available resources, according to the National Rural Health Association. But plenty of doctors are interested in rural residency programs, Hawes said.

The patient tower at UNC Health Southeastern in Lumberton. (Les High for Border Belt Independent)

Nearly 100% of the state's rural residency positions are filled every year, according to Hawes. She said the problem is that there aren't enough slots; 165 of the state's 3,700 current residency positions, or about 4%, are in rural areas.

It can cost up to $1 million to create a new residency program, according to Lori Rodefeld, NCGME's graduate medical education and policy adviser. The price tag is out of reach for many rural hospitals, which are more likely to have negative operating margins than their urban counterparts, according to an analysis by KFF, a nonprofit health policy research organization.

"We don't have as many residencies in this state because there has been limited startup funding given to rural health facilities for that purpose," Hawes said.

Medicare is the largest federal funder of graduate medical education, according to the U.S. Government Accountability Office. The health care program funded 2,343 resident positions in North Carolina as of 2022, according to the American Association of Medical Colleges. Congress sets caps on how much Medicare funding each teaching hospital receives to cover those costs. Health organizations that start their first residency programs have five years before a cap on funded positions is set.

"With the limited federal funding, there has been really no way to grow more programs," Rodefeld said.

North Carolina already provides money to residency programs through the University of North Carolina System's Rural Residency Medical Education and Training Fund, which offers $8 million annually to help hospitals start, maintain, and expand programs.

Expanding rural-based residency programs "is a proven strategy to increase rural provider retention," North Carolina health officials wrote in the state's Rural Health Transformation Plan. More than 50% of family physicians in rural residency programs choose to continue practicing there, according to a 2023 survey.

Ahmed is one of them. He's already accepted a position as a hospitalist at UNC Health Southeastern after he completes his final months of residency.

"I want to have an impact," Ahmed said, "helping the people who really need my help."

'Untapped opportunities'

Hawes said that NCGME has already identified about 20 rural hospitals to engage in general surgery training and 30 for an obstetrics program. The new programs are critical, she said, given that 25 of the state's 100 counties have no practicing general surgeon and 27 have no practicing OB-GYN.

"Our research shows there are untapped opportunities to increase rural physician training," she said, but added that a local physician is often necessary to champion the effort.

That's what it took to establish a family residency program in Boone, said Dr. Bryan Hodge, chief academic officer for Mountain Area Health Education Center (MAHEC).

On a Friday evening in 2019, Hodge got a drink with Dr. Charlie Baker, a family physician who has delivered more than 2,000 babies in Avery County.

Baker asked Hodge what he thought about the prospect of a new residency program, not realizing that Hodge was part of the startup efforts. After Hodge explained how the program could build the local health care workforce, Baker helped get buy-in from the rest of the local medical community.

"He was so known and trusted that he said, 'Hey, we're going to build this, and we think we really have something to offer learners that will result in us having a workforce for the future,'" Hodge said.

The state's plan to develop new residency programs "will be community-driven and regionally tailored," said Summer Tonizzo, a spokesperson for the N.C. Department of Health and Human Services. She said the state will establish six Rural Organizations Orchestrating Transformation for Sustainability Hubs, or NC ROOTS Hubs.

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