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Division of Dockets Management

Food & Drug Administration
5630 Fishers Lane
Rockville, MD 20852

Docket Clerk
U.S. Department of Agriculture
Food Safety & Inspection Service
1400 Independence Avenue, SW
Washington, DC 20250

RE: FDA-2011-N-0400 and FSIS-2011-0014

Dear Sir or Madam:

The National Lipid Association (NLA) wishes to share our comments on approaches to reduce sodium consumption in the United States. The National Lipid Association is a multidisciplinary membership organization committed to enhancing the practice of lipid management in clinical medicine and reducing mortalities associated with atherosclerotic disease through Clinical Lipidology. The nearly 3,000 members of NLA actively participate in educational meetings and programs to enhance medical knowledge and clinical skills that provide for effective patient outcomes to reduce risk of cardiovascular diseases (CVD).

The NLA advocates for good nutrition and lifestyle practices for the prevention and treatment of CVD. For all individuals, and especially those at risk for CVD, the NLA supports the diet and lifestyle recommendations made by the American Heart Association, the National Heart, Lung and Blood Institute (and specifically the National Cholesterol Education Program and the Seventh Report of the Joint National Committee on the Prevention, Detection, Evaluation, and Treatment of High blood Pressure), as well as the Dietary Guidelines for Americans, 2010. A key recommendation common to all of these reports is the reduction of dietary sodium to achieve current recommendations. We write to provide our recommendations about the Food and Drug Administration (FDA) and the Food Safety and Inspection Services (FSIS) Docket "Approaches to Reducing Sodium Consumption; Establishment of Dockets; Request for Comments, Data, and Information".

The NLA commends the Food and Drug Administration (FDA) and the Food Safety and Inspection Services (FSIS) for soliciting public comment on this important public health topic. Excess sodium consumption contributes to the development hypertension, a major risk factor for CVD. Consequently, we

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believe there is pressing need for the FDA, FSIS, and other germane federal agencies to work together to develop new and effective strategies to reduce sodium intake in the United States.

Current sodium intake exceeds dietary recommendations by more than 2 to 3-fold. Given the magnitude of reduction needed to meet recommendations, it is apparent that a major public health campaign is required. Since approximately 77% of the sodium in the U.S. diet comes from salt used in the manufacture or preparation of foods, consumer education strategies alone are likely not sufficient to attain sodium intake goals. This, again, reinforces the need for the FDA, FSIS, and other federal agencies to work collaboratively to shift the population at large to a lower sodium intake that achieves sodium recommendations. We would be remiss if we did not passionately emphasize the need to launch a major, large-scale public health effort to realize this goal expediently.

In the spirit of launching a national initiative to markedly reduce dietary sodium, we first offer several recommendations for your consideration. We then provide answers to some of the questions that were in the FDA and FSIS Docket on Sodium Reduction.

NLA Recommendations for Significantly Reducing Dietary Sodium:

1. We endorse implementation of all of the recommendations in the Institute of Medicine's (IOM) report "Strategies to Reduce Sodium Intake in the United States." We strongly support the Primary Strategy of the IOM Report that the FDA promptly initiate a process to set mandatory national standards for the sodium content of foods. In particular, the FDA should modify the generally recognized as safe (GRAS) status of salt added to processed foods as a means to decrease the salt content of the food supply in a stepwise manner. We believe that implementation of this as a federal mandate would have a major impact on reducing sodium in the diet.
2. We believe that it is imperative that the IOM recommendation be implemented for menu items offered by restaurant/food service operations. Approximately 50% of American's food dollar is spent eating away from home. Thus, any initiative to reduce sodium in the American diet must target restaurant/food service operations.
3. We believe that standards for sodium (that meet the 2010 Dietary Guidelines for Americans) be required for all Federal and State Food Assistance Programs, including the National School Lunch and School Breakfast Programs, as well as WIC and SNAP.
4. We strongly urge FDA and USDA to revise and update the sodium provisions for nutrition labeling, related sodium claims, and disclosure or disqualifying criteria for sodium in foods, including a revision to base the Daily Value for sodium on the Adequate Intake (i.e., 1500 mg/day). It will be important also for the reason described in #2 above that FDA extends provisions for sodium content and health claims to restaurants/food service menu items. To achieve this goal, we recommend that Congress remove the exemption of nutrition labeling for food products intended solely for use in restaurant/foodservice operations. We believe that these regulatory efforts will incentivize the food and restaurant industry to lower the sodium content of foods manufactured/prepared.

5. Relative to II-6 in the Docket, NLA encourages the FDA and FSIS to review the American Heart Association (AHA) HeartCheck Program new Sodium Criteria (http://www.heart.org/idc/groups/heart-public/@wcm/@fc/documents/downloadable/ucm_432070.pdf) that promotes a step-wise reduction in the sodium criteria of different foods. An objective of the new sodium criteria and step-wise approach for sodium reduction was to incentivize the food industry to lower sodium in manufactured foods. NLA believes that there is great merit in have having a consistent sodium reduction strategy across federal agencies and non-profit health organizations (such as AHA). Therefore, we encourage FDA/FSIS to use a similar approach to reduce sodium so that a common (and consistent) message is delivered to consumer.
6. It is essential that all Federal agencies involved in this initiative effectively harmonize policy guidelines, as is typically done. In addition, NLA advocates partnering with reputable nonprofit health organizations, leading scientific societies and, importantly, the private sector.
7. The NLA believes that innovative public education campaigns that reduce sodium intake of the U.S. population are necessary to translate the “sodium health message” to the American public. In addition, it will be important to engage in education campaigns for health professional so that they can reinforce the sodium message to consumers and offer suggested strategies for decreasing sodium intake. This recommendation includes the precept that this be done in collaboration with other health organizations including the NLA.

NLA Responses to Docket Questions:

2. Comments and research related to consumer understanding of the role of sodium in hypertension and other chronic illnesses, sodium consumption practices, and motivation and barriers in reducing sodium in their food intakes;

The most effective therapy prescribed will control hypertension only if patients are motivated. Motivation improves when patients have positive experiences with, and trust in, the clinician. Empathy builds trust and is a potent motivator.

Barriers include inability to understand how to read a food label and its relationship to health and no realistic alternatives, medications (e.g. laxatives, pain relievers, antacids) and water softeners used for drinking and cooking all add sodium.

Another barrier is the high level of sodium in the food supply that comes from processed foods and restaurant foods. Furthermore, eating out has increased more than 200% from 1977 to 1995. As noted above, any strategy to reduce sodium intake in the US population must include the efforts of food manufacturers, food processors and restaurant industries. (1)

A report by the Institute of Medicine issued in 2010 noted that efforts for lowering sodium intake of Americans for past 40 years were unsuccessful due to lack of accountability amongst the multiple agencies aiming to reduce the sodium in the American diet. Just encouraging Americans to select low sodium foods has been ineffective in achieving sodium levels consistent with the Dietary Guidelines for Americans. Another barrier for reducing sodium is the lack of

partnership among public and private agencies. Strategies to reduce sodium intake in the US population must include efforts of food manufacturers, food processors, and restaurant industries in conjunction with key agencies. In the United Kingdom, this approach led to an estimated population-wide reduction in sodium intake of ~10% (8).

Lack of access to dietary education provided by Registered Dietitians in the US is another barrier for reducing sodium. Registered Dietitians are the experts by education and training to provide facilitation of dietary behavior changes. An Australian study examined the effect of dietary education to a reduction in salt consumption in 49 subjects. Participants received dietary education to choose foods identified by either Australia's National Heart Foundation Tick symbol or by the Food Standards Australia and New Zealand's low-salt guideline of 120 mg sodium/100 g food. Sodium excretion was assessed by 24-hour urinary sodium collections at baseline and weeks 4 and 8. Participants' experiences of following the education strategies were recorded by self-administered questionnaire. Forty-three participants completed the study. After 8 weeks, urinary sodium excretion decreased from 121±50 to 106±47 mmol/24 hours (7.3±3.0 to 6.4±2.8 g salt/24 hours) in the Tick group and from 132±44 to 98±50 mmol/24 hours (7.9±2.6 to 6.0±3.0 g salt/24 hours) in the Food Standards Australia New Zealand group (P<0.05, with no between-group difference). Barriers to salt reduction were limited variety and food choice, difficulty when eating out, and increased time associated with identifying foods. The study authors concluded that dietary sodium reduction is possible among free-living individuals who received dietary advice. (9)

A qualitative study in Los Angeles examined facilitators and barriers to a proposed food procurement policy that would require food purchasers, distributors, and vendors of food service in the County of Los Angeles government to comply with the recommendations. Three key facilitators were their organization's authority to impose nutrition standards, their organization's desire to provide nutritious food, and the opportunity to build on existing nutrition policies. Eight key barriers were: 1) unique features among food service settings, 2) costs and unavailability of low-sodium foods, 3) complexity of food service arrangements, 4) lack of consumer demand for low-sodium foods, 5) undesirable taste of low-sodium foods, 6) preference for prepackaged products, 7) lack of knowledge and experience in implementing sodium standards, and 8) existing multiyear contracts that are difficult to change. Despite perceived barriers, several participants indicated that their organizations have successfully implemented nutritional standards that include limits on sodium content. (10)

An interesting study of Canadians reported is that consumers are “less likely to be concerned about their own sodium intake. Further, many Canadians do not know what qualifies as “too much” sodium.” “The bottom line is that they find simple substitutions easy (like cutting down on salt at the table) but these are less important to sodium intake,” says project leader Professor Spencer Henson. “They find it more difficult cutting down on foods that are important to sodium intake, like baked goods.” <http://globalfoodsafetyresource.com/featured/what-do-consumers-really-think-about-salt.html>

References for Section 2 A:

1. Appel Circulation January 13, 2011.

2. Institute of Medicine. *Strategies to Reduce Sodium Intake in the United States*. Washington, DC: National Academy Press; 2010.
3. Anthonisen NR, Skeans MA, Wise RA, Manfreda J, Kanner RE, Connett JE; Lung Health Study Research Group. The effects of a smoking cessation intervention on 14.5-year mortality: a randomized clinical trial. *Ann Intern Med*. 2005;142:233–239
4. Cook NR, Sacks F, MacGregor G. Public policy and dietary sodium restriction. *JAMA*. 2010;303:1917; author reply 1917–1918.
5. Niels A. Graudal et al *Am J of Hypertension* online Nov 9, 2011. Effects of Low-Sodium Diet vs. High-Sodium Diet on Blood Pressure, Renin, Aldosterone, Catecholamines, Cholesterol, and Triglyceride (Cochrane Review)
6. Katarzyna Stolarz-Skrzypek et al. Fatal and Nonfatal Outcomes, Incidence of Hypertension, and Blood Pressure Changes in Relation to Urinary Sodium Excretion *JAMA* May 4, 2011
7. DJ Frenk The Nutrition Source Flawed Science on Sodium from *JAMA* May 4 2011 “Why you should take the latest sodium study with a huge grain of salt” www.hsph.harvard.edu Accessed Dec 13, 2011.
8. Food Standards Agency. Dietary Sodium Levels Surveys. <http://www.food.gov.uk/science/dietarysurveys/urinary>. Accessed December 10, 2011.
9. Ireland DM, et al *J Am Diet Assoc*. 2010 May;110(5):763-7).
10. Gase LN et al *Prev Chronic Dis*. 2011 Mar;8(2):A33. Epub 2011 Feb 15

Section 2 B: Research demonstrates that intense dietary education helps consumers’ understanding of the role of sodium in hypertension.

Multiple randomized trials such as the Dietary Approach to Stop Hypertension (DASH) studies have demonstrated that intense consumer education to lower sodium in the diet along with increasing intake of fruits, vegetables and nonfat dairy products and achieving optimal weight can lead to reduced BP in adults and children. In addition to the DASH studies, there are numerous other studies that show that sodium reduction via dietary education helps consumers understand the role of sodium in hypertension.

1. Meta-analysis of 12 trials in adults documented that a median reduction in urinary sodium of ≈ 1800 mg/d lowered systolic/diastolic BP by 2.0/1.0 mm Hg in non-hypertensive individuals and by 5.0/2.7 mm Hg in hypertensive individuals. (1)
2. Meta-analysis of trials in children showed a reduced sodium intake lowered mean systolic/diastolic BP by 1.2/1.3 mm Hg in children and adolescents and lowered systolic BP by 2.5 mm Hg in infants. (2)
3. Persons with uncontrolled hypertension, reducing sodium intake by 4600 mg/d lowered systolic/diastolic BP by 22.7/9.1 mm Hg (3).
4. Well controlled dose response trials in humans have provided compelling evidence of success on the effects of reducing sodium in the diet in several sub-groups eg. non-hypertensive individuals, hypertensive individuals, men, women, African Americans, non-African Americans. Each trial tested at least 3 sodium levels, and each documented statistically significant, direct, progressive, dose-response relations. The lowest level of sodium intake in each trial was ≈ 1500 mg/d, the level currently recommended by the

AHA. Specifically, decreasing sodium intake by 900 mg/d caused a greater reduction in BP when the starting sodium intake was 2300 mg/d than when it was 3500 mg/d (4-8).

5. Non-hypertensive Asian adults (n=2000), benefits of following a low sodium diet were noted in the Gen-Salt feeding study, which found that lowering sodium intake to 1500 mg/d reduced BP with mean systolic/diastolic BP 120/80 mm Hg (9).

References for Section 2 B:

1. He FJ, MacGregor GA. Effect of modest salt reduction on blood pressure: a meta-analysis of randomized trials. Implications for public health. *J Hum Hypertens.* 2002;16:761–770.
2. He FJ, MacGregor GA. Importance of salt in determining blood pressure in children: meta-analysis of controlled trials. *Hypertension.* 2006;48: 861–869.
3. Pimenta E, Gaddam KK, Oparil S, Aban I, Husain S, Dell’Italia LJ, Calhoun DA. Effects of dietary sodium reduction on blood pressure in subjects with resistant hypertension: results from a randomized trial. *Hypertension.* 2009;54:475– 481
4. Johnson AG, Nguyen TV, Davis D. Blood pressure is linked to salt intake and modulated by the angiotensinogen gene in normotensive and hypertensive elderly subjects. *J Hypertens.* 2001;19:1053–1060.
5. MacGregor GA, Markandu ND, Sagnella GA, Singer DR, Cappuccio FP. Double-blind study of three sodium intakes and long-term effects of sodium restriction in essential hypertension. *Lancet.* 1989;2:1244 –1247.
6. Sacks FM, Svetkey LP, Vollmer WM, Appel LJ, Bray GA, Harsha D, Obarzanek E, Conlin PR, Miller ER III, Simons-Morton DG, Karanja N, Lin PH, DASH-Sodium Collaborative Research Group. Effects on blood pressure of reduced dietary sodium and the Dietary Approaches to StopHypertension (DASH) diet. *N Engl J Med.* 2001;344:3–10.
7. Vollmer WM, Sacks FM, Ard J, Appel LJ, Bray GA, Simons-Morton DG, Conlin PR, Svetkey LP, Erlinger TP, Moore TJ, Karanja N, DASH Sodium Trial Collaborative Research Group. Effects of diet and sodium intake on blood pressure: subgroup analysis of the DASH-sodium trial. *Ann Intern Med.* 2001;135:1019 –1028.
8. Bray GA, Vollmer WM, Sacks FM, Obarzanek E, Svetkey LP, Appel LJ, DASH Collaborative Research Group. A further subgroup analysis of the effects of the DASH diet and three dietary sodium levels on blood pressure: results of the DASH-Sodium Trial. *Am J Cardiol.* 2004;94: 222–227.
9. He J, Gu D, Chen J, Jaquish CE, Rao DC, Hixson JE, Chen JC, Duan X, Huang JF, Chen CS, Kelly TN, Bazzano LA, Whelton PK, GenSalt Collaborative Research Group. Gender difference in blood pressure responses to dietary sodium intervention in the GenSalt study. *J Hypertens.* 2009;27:48 –54.

3. Comments and research related to effective strategies for sustainable and meaningful reduction of sodium in foods sold in packaged or prepared form across the food supply, including and in particular foods with a high sales volume;

The Institute of Medicine’ 2010 Strategies to Reduce Sodium Intake in the United States, recommends reducing sodium in packaged and prepared foods to a “safer level” and to carry out this process ”gradually, step-wise manner” to produce foods that are palatable to consumers.

The Department of Nutrition, Harvard School of Public Health and the Culinary Institute of America responded to the IOM's recommendations with twenty-five science-based strategies and culinary insights in "Tasting Success with Cutting Salt."

These strategies emphasize the need for sodium efforts to not "undermine flavor of our food and the role food plays in our lives."

1. Downsize portions – Less food, less calories and sodium.
2. Produce first – Fill ½ plate with fruits and vegetables.
3. Get fresh – Choose unprocessed and minimally processed foods.
4. Embrace healthy fats and oils - Healthy fats are low in sodium.
5. Stealth health – Most people can't detect a 25% reduction in sodium.
6. Retrain your taste buds: Savor foods with less salt.
7. Try a little romance – Instead a listing a product as low sodium, change language to something more enticing such as "with a touch of sea salt."
8. Target high volume sodium food sources that are consumed regularly. Top 10 food sources (based on sodium content and frequency of consumption:
 - a. Meat pizza
 - b. White bread
 - c. Processed cheese
 - d. Hot dogs
 - e. Spaghetti and sauce
 - f. Ham
 - g. Catsup
 - h. Cooked rice
 - i. White rolls
 - j. Flour tortillas
9. Scan label – Look for foods with less than 300 mg sodium per serving.
10. Compare nutrition facts labels- sodium levels vary widely.
11. Watch out for hidden sodium - Meats and poultry can be injected with sodium and this sodium is not listed on the label.
12. Scan the menu – Seek out low salt menu items when dining out.
13. Farm for flavor – Grow more flavorful food.
14. Shop the seasons – Get to know your farmer, go to Farmer's markets.
15. Spice it up – without salt.
16. Go nuts – nuts, peanuts, nut butters
17. Use "umami" to boost flavor - Cooked chicken, fish beef and soybeans naturally trigger our taste receptors.
18. Sear, sauté, brown or roast – Cooking methods build flavor without sue of salt.
19. Watch sodium budget – It adds up fast if you eat fast, processed foods.
20. Condiments and sodium – Use these sparingly.
21. Try International fare – Culinary traditions bring more variety healthier food choices.
22. Double jeopardy - Watch not to add many salty foods together. Pair salty with unsalted foods.
23. Rinse, wash and dilute – Drain and rinse canned foods and dilute broths with water to reduce sodium.
24. Whole grains – Beyond bread.

25. Taste before you salt or better yet get rid of the saltshaker.

References for Section 3

1. Institute of Medicine. Strategies to Reduce Sodium Intake. April 20, 2010
2. Department of Nutrition, Harvard School of Public Health and The Culinary Institute of America. “Tasting Success with Cutting Salt.” 2010

4. Comments and research related to existing or potential positive incentives for innovation in reformulating packaged and restaurant foods to reduce added sodium;

In the UK, the Scientific Advisory Committee on Nutrition (SCAN) published a report in 2003 on Salt and Health www.sacn.gov.uk/pdfs/sacn_salt_final.pdf. They concluded that a reduction in sodium intake to 6 grams per day was needed to reduce population blood pressure in the UK.

The UK Food Standards Agency (FSA) and the Department of Health (DH) made commitments to reduce salt intake in food industry – retail, manufacturing, trade associations, caterers and supplies as well as ongoing public awareness. www.food.gov.uk/healthiereating/salt/saltmodel. The model outlined strategies to target 6 grams per day using reduction in salt in food as well as in discretionary intake of salt.

The food industry was asked to voluntarily outline plans to reduce sodium. By 2009, 90 formal commitments were made by all sectors of food industry. Barriers in measurable commitments included:

- Consumer acceptance
- Technological barriers
- Microbial safety

Processed meat was a particular concern. Strategies were developed to address food safety, labeling and additives. Bread was another concern. Bread accounts for 20% of dietary salt intake. Research has been funded in this area.

In 2006, FSA developed proposed targets for salt levels in a range of food categories. Public consultation was requested from food industry, health-related organizations, academia and local authorities. 85 food categories of processed foods that contribute the most to the diet were established. Final targets were published in 2009.

All sectors of the food industry responded positively to encouragement to comply with program. The majority of companies agreed to meet or exceed targets by 2010 and to use FSA’s salt targets as benchmarks to monitor progress.

Monitoring programs have been designed. These programs include:

1. UK wide survey of salt intake determined by urinary sodium levels;
2. Processed food databank monitors salt in processed food.
3. Marketing data has been purchased to review sales and sodium levels in over 130,000 products.
4. Self-reporting framework is used to track progress in food industry in meeting targets.

A public awareness campaign has taken place since 2004 with website www.eatwell.gov.uk. Materials, leaflets and credit-card-sized prompts are also being used.

International work has encouraged similar programs across Europe. The European Salt Action Network (ESAN) was established in 2007. By 2008, 25 out of 27 Member States submitted commitments to salt reduction initiatives.

References for Section 4:

1. Food Standards Agency. Dietary Sodium Levels Surveys.
2. [http:// www.food.uk/science/dietarysurveys/urinary](http://www.food.uk/science/dietarysurveys/urinary). Accessed December 19, 2010.

5. Comments and research related to the recommendations from the April 2010 IOM Sodium report on ``Strategies to Reduce Sodium Intake in the United States,' ' including research related to information gaps identified in the IOM report (taste preferences for sodium, technological role of sodium/salt, role of food matrix, food safety, etc.);

The AHA “Heart Check” program offers an example for the food industry to set upper limits for sodium in food production and processing. The criteria that have been set were carefully considered and are most appropriate for the purpose of setting recommended amounts of sodium in different foods to achieve a reduction in sodium in the food supply. Lower sodium standards will be achieved by 2014 as the result of a step-wise reduction over time.

6. Comments and research related to the following: (a) Methods for establishing sodium reduction targets, including information on general target design (e.g., setting sodium reduction targets based on food categories, serving size, or formulations), (b) step-wise approaches to achieve sustainable sodium reductions and timeframes for achieving such reductions, and (c) methods for evaluating the impact of a sodium reduction strategy;

“The most promising sodium reduction strategy is to adapt the preference of consumers for saltiness by reducing sodium in products in small steps. This is a time-consuming approach that needs to be applied industry-wide in order to be effective. As a result, the food industry also is investigating solutions that will maintain the same perceived salt intensity at lower sodium levels. ... Currently applied approaches are resulting in sodium reductions of between 20–30%.” Strategies to Reduce Sodium Consumption: A Food Industry Perspective. Critical Reviews in Food Science and Nutrition. Volume 49, Issue 10, 2009

The JNC 7 endorses the American Public Health Association resolution that the food manufacturers and restaurants reduce sodium in the food supply by 50 percent over the next decade. <http://www.nhlbi.nih.gov/guidelines/hypertension/jncintro.htm>

MHealthy, the University of Michigan Health & Well-Being Services, added sodium guidelines to its updated nutrition guidelines in September, 2011 based on the 2010 Dietary Guidelines for Americans. These nutrition guidelines identify healthier choices in vending machines, at dining locations and through University of Michigan Catering. The guidelines assist people in controlling intake of total fat, saturated fat, trans-fat, sodium, and added sugar, while increasing

dietary fiber. Healthier items are labeled with the MHealthy logo. The MHealthy guidelines were developed by Registered Dietitians from the University of Michigan. Some food service establishments on campus have language written into their contracts that requires them to offer a minimum percentage of items that meet the MHealthy guidelines.

The experience of the Cardiovascular Center at the University of Michigan, serves as an example of the feasibility of implementing a café offering only heart healthy foods in a restaurant within a health care setting. The UM Atrium Healthy Heart Café opened in June, 2007. Four years of planning by a committee consisting of registered dietitians, hospital administrators, heart failure nurses, exercise physiologists, and food service administrators preceded the opening. The committee was charged and dedicated to planning a café that offered only cardio-protective foods. The mission of the café was “to lead a national shift toward heart healthy living by:

- * offering a wide selection of flavorful, enticing and nutritious foods,
- * inspiring the UM faculty, staff and guests to embrace and pursue wellness, and
- * establishing a successful business model in the health care setting.”

Based on the University of Michigan MHealthy Nutrition Guidelines for general population health, a team of registered dietitians developed a unique set of guidelines for each type of food offered at the café. Café guidelines were designed specifically for patients with heart disease, those trying to prevent heart disease, and individuals loving fresh and wholesome food. These guidelines are similar to the AHA Heart Check guidelines for 2014 including guidelines for sodium, total fat, saturated fat, trans-fat, added sugar, and dietary fiber. According to the food service contract, ninety percent of the foods served in the Atrium Healthy Heart Café must fit the guidelines. All other items were also approved by the team. Compliance is monitored at least once in a 12 month period. Signage encourages customers to look for the MHealthy heart logo to identify approved foods. Guidelines and nutritional information of foods in the cafe are available upon request and online. Educational signs show customers how to put together meals containing less than 600 mg sodium.

Challenges have included recipe reformulation, obtaining low sodium breads and baked goods, meats and salad dressings from food service distributors and cost of available products. Restaurant and most canned soups are notoriously high in sodium. Substituting low sodium broth bases did not provide the flavors of the quality products we wanted to serve. Utilizing a combination of herbs and spices, Aramark chefs developed a variety of outstanding and popular soups. These soups are now offered in the hospital’s large main cafeteria as well.

Brochures, cooking demonstrations, and special meal promotions educate customers about the importance and the enjoyment of heart healthy foods. Regular meetings of the café committee now including representatives from Aramark continue to review sales, customer requests/feedback, expand offerings, and plan educational events including special meals and cooking demonstrations. Sales in the café, now in its 4th year of operation, continue to increase by 7-8% annually and have surpassed sales expectations. The University of Michigan is committed to continue to provide healthy foods for all employees and guests.

9. Comments and research related to food formulation, processing, production, and other technology that could lead to meaningful and sustainable reductions in the amount of sodium in food, including specific food categories, targets, and methods to monitor;

“The development and sale of prepared foods with lower sodium content clearly has a key role to play in reducing sodium intake in Canada. On the other hand, taste differences between sodium-reduced and “regular” products were rated in the research as a significant barrier to reducing sodium intake. Clearly then there is a need for both the gradual reformulation of prepared foods and advances in food technology to limit the taste changes associated with reduced salt use.”

“Consistent with previous research findings, the Ontario Food Panel found that women and those aged between 50 and 59 years find it easiest to undertake behaviors directed at reducing sodium intake. Conversely, men and younger consumers found such behaviors much more difficult. This suggests that health professionals and marketers must tailor their messages towards the specific needs and challenges faced by particular sectors of the population.”

References for Section 10:

1. <http://globalfoodsafetyresource.com/featured/what-do-consumers-really-think-about-salt.html>

11. Comments and research on any advantages of sodium to consumers, including but not limited to, food safety, nutrition, and palatability;

Advantages of sodium in foods include: inhibits bacteria growth, longer shelf life, convenience products, taste, texture (crispy or crunchy) - greater palatability, lower cost.

12. Comments and research on the economic impacts of reducing sodium, including but not limited to, the cost of food, agricultural production, small businesses, jobs, and the health care system;

Asararia, P. et.al. Chronic disease prevention: health effects and financial costs of strategies to reduce salt intake and control tobacco use. *The Lancet*, 2007. [370: 9604](#); p. 2044 – 2053.

WHO Comparative Risk Assessment project to estimate shifts in the distribution of risk factors associated with salt intake and tobacco use, and to model the effects on chronic disease mortality for 23 countries that account for 80% of chronic disease burden in the developing world. Over 10 years (2006—2015), 13.8 million deaths could be averted by implementation of these interventions, at a cost of less than US\$0.40 per person per year in low-income and lower middle-income countries, and US\$0.50—1.00 per person per year in upper middle-income countries (as of 2005). These two population-based intervention strategies could therefore substantially reduce mortality from chronic diseases, and make a major (and affordable) contribution towards achievement of the global goal to prevent and control chronic diseases.

15. Comments and research related to effective methods for communicating to the public the health benefits associated with the sodium intake levels recommended by the 2010 Dietary Guidelines for Americans.

The NLA enthusiastically joins hands with the IOM, AHA and DGAC in their renewed emphasis on a population wide initiative to reduce sodium intake in the American diet. A population-wide initiative for reduced sodium intake can be achieved in partnership with public and private organizations.

1. The NLA applauds the FDA for its willingness to reduce sodium consumption in the American diet. While working on reducing sodium in the American diet, the NLA also urges the FDA to consider an overall update of the entire nutrition label to support an overall healthy diet as recommended by the 2010 Dietary Guidelines Advisory Committee (DGAC). This means that in addition to updating the nutritional label to achieve sodium reduction, the NLA also urges the FDA to update the nutritional label to target nutrients for optimal lipid levels [LDL cholesterol, triglycerides]. (1-3).
2. The NLA applauds the IOM for its newly proposed “Front of Package Nutrition Rating System and Symbols” consensus report dated October 21 2011. This is a simplified food labeling system (<http://www.iom.edu/Reports/2011/Front-of-Package-Nutrition-Rating-Systems-and-Symbols-Promoting-Healthier-Choices.aspx>). All foods in grocery stores will be rated on a scale of zero to three nutritional "points" according to their saturated and *trans* fats, sodium and added sugars. The rating will be based on the *Dietary Guidelines for Americans* and integrated with the Nutrition Facts panel, and will appear in a consistent location across all products. The NLA supports this system because it is an overall healthy system inclusive of sodium, saturated fats, trans-fats and added sugars (4).
3. The NLA strongly supports the IOM Front of Package Report Recommendations released on October 20, 2011

Summary/Conclusion: Persuasive evidence supports that a population-wide sodium reduction is needed to prevent cardiovascular disease, stroke, and kidney disease. This is a feasible goal and must be integrated with an updated food labeling system. The potential public health benefits for all Americans are enormous. The IOM consensus report dated October 21 2011 has proposed a new simplified front of package food rating and symbols system (<http://www.iom.edu/Reports/2011/Front-of-Package-Nutrition-Rating-Systems-and-Symbols-Promoting-Healthier-Choices.aspx>). All foods in grocery stores will be rated on a scale of zero to three nutritional "points" according to their saturated and *trans* fats, sodium and added sugars. The rating will be based on the *Dietary Guidelines for Americans* and integrated with the Nutrition Facts panel, and will appear in a consistent location across all products. The NLA supports this system because it is an overall healthy system inclusive of sodium, saturated fats, trans-fats and added sugars. Utilization of registered dietitians (www.eatright.org) for ongoing consumer education and food industry surveillance is also necessary to evaluate the progress of such strategies. The NLA also urges the FDA to encourage the Food industry to adopt the Heart Check Nutrition Labeling Program developed by the American Heart Association as criteria for the next generation of food labels. This program will help guide the FDA and the food industry partners to meet the AHA dietary guidelines to reduce sodium in the diet and to also update nutrition label for an overall heart healthy diet. Successful sodium reduction requires action and partnership at all levels—individuals, healthcare providers, professional organizations, public health agencies, governments, and industry. While there will be ongoing challenges, success is a realistic goal. The NLA supports an intensive focus on this critically important public health

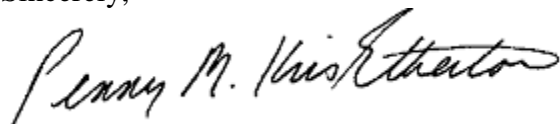
issue and looks forward to partnering with public and private organizations to achieve our shared goal of population-wide reduction in sodium intake.

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Thank you for the opportunity to share our perspectives about approaches for reducing sodium consumption in the United States.

Sincerely,



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President
Chair, Dietician Subcommittee