Most Americans consume too much sodium. High sodium consumption raises blood pressure, and high blood pressure is a major risk factor for heart disease and stroke—two of the nation’s leading causes of death. Research strongly shows a dose-dependent relationship between consuming too much salt and raised levels of blood pressure. When salt intake is reduced, blood pressure begins decreasing within weeks on average.

The 2010 Dietary Guidelines for Americans recommend limiting sodium to no more than 2,300 milligrams (mg) per day. Individuals who are 51 years and older; are African American; or have high blood pressure, diabetes, or chronic kidney disease should limit intake to 1,500 mg of sodium per day. These specific populations account for about half the US population, which includes children and the majority of adults. The average daily sodium intake for Americans ages 2 years and older is more than 3,400 mg, with the majority of sodium consumed coming from processed and restaurant foods. Only a small portion is used in cooking or added at the table.

Even among motivated consumers, maintaining a low-sodium diet can be difficult. Sodium has become so excessive and ubiquitous in the food supply that total sodium intake adds up quickly. Many foods, such as breads, cereals, and mixed dishes are significant sources of sodium intake because they are frequently consumed. For example, a regular slice of frozen cheese pizza can range from 450 mg to
1200 mg. As a result, consumers must watch each specific purchase closely. However, the variation in sodium content across similar products also demonstrates that lower sodium levels in the food supply can be achieved.

Calls for voluntary sodium reductions in the food supply have been ongoing for more than 40 years, but success to date has been limited. Public health action is needed at the federal, state, and local levels to improve the health content of food and reduce sodium intake. For these reasons, the Centers for Disease Control and Prevention (CDC) has placed an emphasis on strategies to gradually reduce sodium in the food supply. In order to track progress, CDC, in collaboration with other federal agencies including the Food and Drug Administration (FDA), United States Department of Agriculture (USDA), and the National Institutes of Health/National Heart Lung and Blood Institute (NIH/NHLBI), are working to strengthen surveillance systems for tracking sodium intake and consumption. These efforts include assessing the amount of sodium in the food supply (processed and restaurant foods) and how it changes over time; the amount of sodium consumed (using both dietary and biomarker data); and knowledge, attitudes, and behaviors pertaining to individual sodium intake.

In 2010, CDC launched the Sodium Reduction in Communities Program (SRCP) to help create healthier food environments by reducing sodium intake. Five programs were funded to promote and sustain policy, system and environmental change efforts in communities, and conduct program evaluation on their progress toward reducing sodium consumption in the population. Grantees include: California Department of Public Health (Shasta County), Kansas Department of Health and Environment (Shawnee County), Los Angeles County Department of Public Health, New York City Department of Health and Mental Hygiene, and New York State Department of Health (Broome and Schenectady counties). The SRCP will increase the number of policies and programs that support reducing sodium intake in communities, and expand public health efforts to implement sodium-related policies, surveillance, and evaluation in the short term. In the long term, the SRCP will help bring sodium intakes to within recommended limits and improve blood pressure control in their target populations. Examples of these sodium policy, system and environmental change efforts include:

**Restaurants and the Food Industry**

- Work with restaurants to implement sodium guidelines for menu items.
- Develop restaurant toolkits featuring sodium guidelines; encourage the toolkit to be a required part of the business licensing/renewal process.
- Work with convenience stores to develop and implement competitive pricing strategies to promote low-sodium foods and to increase purchase of fruits and vegetables.
- Work with large food service venues to implement system/environmental change to reduce sodium content in foods.
- Develop and establish the capacity to monitor menu labeling and sodium content in restaurant food.
- Reduce the sodium content of food purchased and served by independent restaurants; work with suppliers to provide lower sodium options.
- Increase the availability, sales, and point of purchase labeling of lower sodium products in grocery stores and in corner stores.
- Increase the sales of lower sodium items at restaurants frequented by seniors.

---

**Spectrum of Prevention**

May is National High Blood Pressure Education Month and good timing to release the spring issue of The DIGEST on “Population-wide Sodium Reduction for Primary Prevention of Hypertension.” The 2010 Dietary Guidelines for Americans note that the saltshaker on the table or in cooking is not a primary source of sodium in Americans’ diets. Rather, processed and prepared food items, eaten away from home, and at home are the primary sources of sodium in our diets. To best address sodium reduction, the Department of Health and Human Services, American Heart Association and the Institute of Medicine all recommend strategies that effect systems and change policies in order to reach the greatest number of people.

The “Spectrum of Prevention” is a framework, like the socio-ecological model, that differentiates between the individual and influences of individuals. The framework outlines a comprehensive approach that involves all levels of influence. The levels of influence include: changes in policy and organizational practices, fostering coalitions and networks, promoting community education, educating providers and strengthening individuals’ knowledge and skill. The topics in this issue were selected to reflect the full spectrum of prevention and provide resources members can turn to for more in-depth information. We have collaborated with Sports, Cardovascular, and Wellness Nutrition (SCAN) on content for the supplement with registered dietitians from both practice groups authoring and reviewing all articles.

On behalf of all that collaborated to bring this issue to our members, we hope you enjoy the breadth of information.

Alicia Moag-Stahlberg, MS, RD, LD (Guest co-editor for The Digest -Spring 2011)
Worksites

- Work with city and county departments and private and non-government employers to adopt and implement procurement policies that lower sodium content of foods sold or provided in worksites; promote practices at worksites that support healthy nutrition.

Schools

- Work with school districts to incorporate sodium reduction into menu items.
- Work with school districts to adopt and implement food policies to improve content of school meals.
- Work with school districts to incorporate sodium reduction into wellness policies.

Government

- Work with local governments to establish a policy that sets sodium guidelines for foods sold in government facilities.
- Create and implement food standards for retail food venues in public hospitals.
- Reduce sodium content in meals served at senior centers and senior residential facilities, as well as in home-delivered meals.

Resources from the Centers for Disease Control and Prevention

For States and Communities:

Improving the Food Environment Through Nutrition Standards: A Guide for Government Procurement focuses on leveraging dollars and contracting mechanisms to improve the nutritional quality of foods purchased, served, or made available.

Sodium-Reduction Awareness Toolkit provides information and materials related to sodium reduction awareness for state or tribal health departments, and private sector partners (non-profit organizations such as the American Heart Association, National Association of Chronic Disease Directors, and other organizations).

For Health and Other Professionals:

The educational session, Heart Health—What’s Salt Got To Do With It?, focuses on strategies to improve hypertension control and reduce sodium.

Salt and Your State, Strategies for Better Health Outcomes provides an overview of sodium reduction strategies and opportunities and the role of State Health Officials as champions of healthy eating. Salt and Your State: Using Purchasing Power to Improve Nutrition and Health highlights how nutrition, including sodium reduction, can be improved through procurement policies that require foods purchased, provided, or made available to meet minimum nutritional standards. These webinars are part of a series of sodium-related webinars hosted by CDC, in partnership with the Association of State and Territorial Health Officials (ASTHO).

For the General Public:

CDC has sodium-related resources for the general public, including a CDC website dedicated to salt, sodium-related podcasts, sodium e-cards, a salt 101 video, and a sodium fact sheet. CDC is also working to expand the evidence base for sodium reduction through published literature.

Vital Signs data related to hypertension and cholesterol control includes fact sheets, podcasts, and a town hall teleconference on Cardiovascular Disease: High Blood Pressure and Cholesterol.

Reducing sodium content of common foods will enable Americans to reach their respective sodium intake targets. This change will require action through partnerships among the public health community, food industry, health professionals, and consumers.

The findings and conclusions in this report are those of the author and do
Sodium Reduction continued from page 3

not necessarily reflect the view of the Centers for Disease Control and Prevention.

References


Clinical studies show that the blood pressure lowering effects of lifestyle modifications, including proper nutrition, can be equivalent to drug monotherapy. Lifestyle modification is best initiated and sustained through the coordinated efforts of health care professionals. The registered dietitian is the most qualified member of the health care team to make the appropriate nutrition recommendations that fit into the patient's lifestyle for long-term, meaningful changes. The following will review the definition of hypertension; present expert guidelines for prevention and treatment of primary hypertension; and summarize the results of the DASH diet.

Hypertension in Review

According to the American Heart Association, in 90–95% of cases, scientists don't know what causes high blood pressure. When the cause of hypertension is not well understood, this is called essential hypertension. In those with essential hypertension, other secondary causes of blood pressure, such as renovascular disease or renal failure, are not present. Instead, there may be other factors present, such as a genetic predisposition for hypertension; high sodium intake; and/or obesity. In the remaining cases, high blood pressure results from a recognizable underlying problem. This is called secondary hypertension. Some possible causes are a kidney abnormality, tumor of the adrenal gland, or congenital defect of the aorta. When the root cause is corrected, blood pressure usually returns to normal.

Fortunately, although scientists do not fully understand the causes of this disease, they have developed both non-drug and drug treatments that treat hypertension effectively. Individuals with pre-hypertension have twice the risk of developing hypertension compared to those with normal values; therefore, lifestyle and pharmacological therapies to lower blood pressure before the development of cardiovascular complications are essential.

The Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC)

The Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC) provides an evidence-based approach to the prevention and management of hypertension. The JNC guidelines are typically revised every 4-5 years; however, the latest report, JNC 7, was published in 2003. The next hypertension guideline update, JNC 8, is expected to be available for public review and comment in fall 2011, with expected release in spring, 2012.

The JNC 7 report refined the classification of hypertension to emphasize that the relationship between blood pressure and risk of cardiovascular disease (CVD) events is continuous, consistent, and independent of other CVD risk factors. Compared to a blood pressure of 115/75 mmHg, the risk of developing CVD doubles with each incremental increase of 20 mmHg in systolic blood pressure or 10 mmHg in diastolic blood pressure.

The JNC 7 defines “Stage 1 Hypertension” as a systolic blood pressure of 140 to 159 mmHg or a diastolic blood pressure of 90 to 99 mmHg. “Stage 2 Hypertension” includes a systolic blood pressure of 160 mmHg or higher, and a diastolic blood pressure of 100 mmHg or higher. Systolic blood pressure higher than 140 mmHg is a more important CVD risk factor than diastolic blood pressure in patients older than 50 years. To simplify blood pressure classification, Stages 2 and 3 of the 1997 guidelines were combined as Stage 2 hypertension in the JNC 7 report.

Reducing blood pressure has dramatic results. Antihypertensive therapy reduces cardiovascular and renal morbidity and mortality. In clinical trials, antihypertensive therapy has reduced the incidence of stroke by 35%
Nutrition Recommendations continued from page 5

to 40%, myocardial infarction by 20 to 25%, and heart failure by 50%. The target blood pressures are less than 140/90 mmHg for individuals with uncomplicated hypertension, and less than 130/80 mmHg for those with diabetes or chronic kidney disease. It has been estimated that just a 3 mmHg reduction in systolic blood pressure could lead to an 8% reduction in stroke mortality and a 5% reduction in mortality from coronary heart disease.

Lifestyle changes, including diet, exercise, stress management, and smoking cessation, should be used as the initial therapy in patients with hypertension. When medication is necessary, thiazide-type diuretics should be used as the initial pharmacologic for most patients with hypertension, either alone or combined with drugs from other classes. The majority of patients will require two or more antihypertensive medications to achieve the target blood pressure. Certain high-risk of myocardial infarction, high coronary disease risk, chronic kidney disease, and recurrent stroke are compelling indications for the initial use of other antihypertensive drug classes.


### The Dietary Intervention: The Dietary Approaches to Stop Hypertension Eating Plan (DASH)

The National Heart, Lung, and Blood Institute (NHLBI) has led in the development of an integrated set of cardiovascular guidelines supported by decades of research published in peer-reviewed journals establishing high sodium intake as an important cause of high blood pressure. The research has clearly demonstrated that reducing the amount of sodium in one’s diet can significantly lower blood pressure and can help safely prevent or control high blood pressure. The Dietary Approaches to Stop Hypertension (DASH) eating plan, combined with reduced sodium intake, may help individuals prevent the development of high blood pressure, as well as, benefit those with prehypertension and hypertension.

### The DASH Clinical Study

**Note:** The definitions for hypertension used in the Dash Clinical Study and the Dash-Sodium Clinical Study (cited below) are based on The Sixth Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC VI).

The initial DASH clinical study was funded by the NHLBI and published in 1997. The study involved 459 adults with systolic blood pressures of less than 160 mmHg and diastolic pressures of 80-95 mmHg. About 27% of the participants had high blood pressure; 50% of the participants were women; and 60% were African Americans.

### Table 1.

<table>
<thead>
<tr>
<th>Category</th>
<th>Systolic (mmHg)</th>
<th>Diastolic (mmHg)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal**</td>
<td>Less than 120</td>
<td>And</td>
</tr>
<tr>
<td>Prehypertension</td>
<td>120-139</td>
<td>Or</td>
</tr>
<tr>
<td>Hypertension**</td>
<td></td>
<td>80-89</td>
</tr>
<tr>
<td>Stage 1</td>
<td>149-159</td>
<td>Or</td>
</tr>
<tr>
<td>Stage 2</td>
<td>Greater than or equal to 160</td>
<td>Greater than 100</td>
</tr>
</tbody>
</table>

*Not taking antihypertensive drugs and not acutely ill. When systolic and diastolic pressure fall into different categories, the higher category should be selected to classify the individual’s blood pressure status. (Isolated systolic hypertension [ISH] is defined as SBP greater than or equal to 140 mmHg and DBP less than 90 mmHg and staged appropriately [e.g., 170/82 mmHg is defined as Stage 2 ISH].) In addition to classifying stages of hypertension on the basis of average blood pressure levels, clinicians should specify presence or absence of target organ disease and additional risk factors. This information is important for risk assessment and treatment.

**Optimal blood pressure with respect to cardiovascular risk is SBP less than 120 mmHg and DBP less than 80 mmHg. However, unusually low readings should be evaluated for clinical significance.

*** Based on the average of two or more readings taken at each of two or more visits after an initial screening.
The study compared three eating plans:

- A plan that included foods similar to what many Americans regularly eat;
- A plan that included foods similar to what many Americans regularly eat plus more fruits and vegetables;
- The DASH eating plan, which emphasizes fruits, vegetables, and low fat dairy foods, and is low in saturated fat, total fat, and cholesterol.

All three plans included about 3,000 milligrams of sodium daily. None of the plans were vegetarian or used specialty foods. Participants who followed both the plan that included more fruits and vegetables, and the DASH eating plan had reduced blood pressure. The DASH eating plan had the greatest effect, especially for those with high blood pressure. Furthermore, the blood pressure reductions occurred within two weeks of starting the plan.6

**The DASH-Sodium Clinical Study**

A subsequent study, conducted from 1997 through 1999, looked at the effects of the DASH diet and a reduced dietary sodium intake on blood pressure. The research involved 412 participants, aged 22 and older, with systolic blood pressures of 120-159 mmHg, and diastolic blood pressures of 80-95 mmHg. About 41% of the participants had high blood pressure; 57% of the participants were women; and 57% were African Americans.8 The servings for each food group in the DASH diet and the 9 nutrients focused on are shown in Table 2.

Participants were randomly assigned to follow either the DASH eating plan or a typical American diet for three months. During the study period, each group followed three different intakes of dietary sodium for one month each, in random order:

- 3,300 mg a day (the average level consumed by Americans)
- 2,400 mg a day (the upper limit recommended by the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure)

Lower sodium intake resulted in lower blood pressures for all participants on both the DASH eating plan and the typical American diet, including those without high blood pressure. The greatest blood pressure reductions were for the DASH eating plan at the sodium intake of 1,500 mg per day.6 Individuals with the highest blood pressure levels had the greatest reductions; pre-hypertensive participants also had large decreases. The trial showed that weight reduction in overweight or obese individuals can reduce systolic blood pressure by 5 to 20 millimeters (mm) of mercury for every 10 kilograms of weight lost.9 Individuals following the DASH eating pattern can decrease systolic blood pressure by 8 to 14 mm of mercury. Restricting dietary sodium intake to no more than 2.4 grams (2,400 mg) of sodium per day can lower systolic blood pressure by 2 to 8 mm of mercury.7 Lifestyle recommendations to further reduce risk are shown in Table 3 on page 8.

According to the American Heart Association (AHA), the current Dietary Guidelines’ recommendation that individuals consume less than 2,300 mg of sodium per day is too high.⁹

**Table 2. Components of DASH Diet**

<table>
<thead>
<tr>
<th>Component</th>
<th>Servings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grains</td>
<td>7-8 Servings</td>
</tr>
<tr>
<td>Vegetables</td>
<td>4-5 Servings</td>
</tr>
<tr>
<td>Fruits</td>
<td>4-5 Servings</td>
</tr>
<tr>
<td>Low-fat or Fat-free Dairy</td>
<td>2-3 Servings</td>
</tr>
<tr>
<td>Meats, poultry &amp; fish</td>
<td>2 or Less Servings</td>
</tr>
<tr>
<td>Nuts, seeds &amp; dry beans</td>
<td>4-5 Servings</td>
</tr>
<tr>
<td>Fats &amp; oils</td>
<td>2-3 Servings</td>
</tr>
<tr>
<td>Sweets</td>
<td>7-8 Servings</td>
</tr>
</tbody>
</table>

The DASH diet consists of recommendations for nine nutrients in a 2100 calorie diet—total fat (27% of the calories), saturated fat (6% of the calories), protein (18% of the calories), carbohydrates (55% of the calories), cholesterol (150 mg), sodium (2300 mg), potassium (4700 mg), calcium (1250 mg), magnesium (500 mg) and fiber (30 g).
The amount should be changed to the amount recommended in the 2005 DGA Guidelines for specific populations vulnerable to hypertension, which is no more than 1,500 mg of sodium per day. Because these vulnerable groups now constitute 70% of the total population, the 1,500 mg should apply to all populations. In response to the concern by AHA and other health organizations, Dietary Guidelines Advisory Committee Member Xavier Pi-Sunyer, MD, MPH, defended the committee at the Dietary Guidelines Advisory Committee Meeting, January 29-30, 2009. Dr. Pi-Sunyer responded that Americans today are eating an average of 3,400 mg of sodium a day. The 2005 Dietary Guidelines Advisory Committee suggested 2,300 mg as a tolerable level of sodium, since greater than 85% of Americans actually consume more. The issue, according to Dr. Pi-Sunyer, is how can health professionals get Americans down to what would be a tolerable level of sodium consumption. The USDA’s assertion that Americans have a difficult time decreasing sodium intake may be justified.

**Table 3.**

<table>
<thead>
<tr>
<th>Modification</th>
<th>Recommendation</th>
<th>Appropriate Systolic Blood Pressure Reduction (Range)***</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight Reduction</td>
<td>Maintain normal body weight (body mass index 18.5-24.9 kg/m²).</td>
<td>5-20 mmHg/10 kg</td>
</tr>
<tr>
<td>Adopt DASH** eating plan</td>
<td>Consume a diet rich in fruits, vegetables and low-fat dairy products, with a reduced content of saturated and total fat.</td>
<td>8-14 mmHg</td>
</tr>
<tr>
<td>Dietary sodium reduction</td>
<td>Reduce dietary sodium intake to no more than 100 mmol per day (2.4 g sodium or 6 g sodium chloride).</td>
<td>2-8 mmHg</td>
</tr>
<tr>
<td>Physical Activity</td>
<td>Engage in regular aerobic physical activity such as brisk walking (at least 30-45 minutes per day, most days of the week).</td>
<td>4-9 mmHg</td>
</tr>
<tr>
<td>Moderating of Alcohol Consumption</td>
<td>Limit consumption to no more than two drinks (e.g., 24 oz. beer, 10 oz. wine, or 3 oz. 80 proof whiskey) per day in most men and to no more than one drink per day in women and lighter-weight persons.</td>
<td>4-9 mmHg</td>
</tr>
<tr>
<td>Increase Dietary Potassium Intake</td>
<td>Increase dietary potassium intake to 4.7 gm per day (this is the amount provided in the DASH diet).</td>
<td>2-4 mmHg</td>
</tr>
</tbody>
</table>

*For overall cardiovascular risk reduction, stop smoking.

**DASH indicates Dietary Approaches to Stop Hypertension.

***The effects of implementing these modifications are dose- and time-dependent and could be greater for some individuals.


have found it hard to follow any healthy eating plan for an extended period as exemplified in a study by Researcher Philip B. Mellen, MD, MS, and colleagues from the Hypertension Center, Hattiesburg Clinic, Hattiesburg, Mississippi. Very few hypertensive patients follow the recommended DASH diet, as revealed by an analysis of data from the National Health and Nutrition Examination Survey (NHANES) during the 1988–1994 and 1999–2004 periods. These findings were reported in the February 2008 issue of the Archives of Internal Medicine. It should also be noted that the amount of sodium found in our food supply largely impacts Americans’ ability to lower sodium content in their individual diets (see below under “Reducing Sodium in the Diet Long-Term”).

It was noted that after appropriate adjustments for age and energy intake, only 19.4% of the subjects in 1999–2004 were in compliance with the DASH recommendations, compared to 26.7% during the 1988–1994 period. Several factors were related to adherence, including: older age, higher education, nonblack ethnicity, and history of coexisting diabetes.

**Reducing Sodium in the Diet Long Term**

Current guidelines on the prevention and treatment of hypertension prominently emphasize lifestyle modifications in addition to pharmacologic therapy. In particular, the National High Blood Pressure Education Program and the AHA have broadly recommended the DASH Diet, plus sodium reduction, to reduce high blood pressure.

In addition to modifiable lifestyle changes, we know that the food and restaurant industries play an important role in the amount of sodium consumed by Americans. The National Salt Reduction Initiative (NSRI) is being led by the New York City Department of Health and Mental Hygiene in partnership with 19 national health organizations, 9 national and regional health associations, and 44 cities, states and related entities. With funding from the federal Communities Putting Prevention to Work (CPPW) initiative, the NSRI has set salt-reduction targets for 62 packaged food and 25 restaurant food categories, with the overall goal of lowering Americans’ salt intake by 20% over five years. As of March 2011, 28 companies volunteered to lower salt in many of their products. Some of these salt-reduction targets will be met by 2012, while others will be fulfilled by 2014.

A full listing of the food companies working with the NSRI is available at www.nyc.gov. Many of these companies’ products are highly utilized among Americans, including: Au Bon Pain, Kraft, Heinz, Campbell’s, Starbucks, Hostess and Butterball.

Environmental change efforts related to the food industry stand to create huge impacts on Americans’ sodium intake; however, the risks for hypertension and the need for dietary and medical intervention will persist into the future. Registered Dietitians continue to have a vital role in education about sodium risks and the prevention of hypertension.

**References**


Sodium Regulation in the Emergency Food System

Rachel Staver, RD
Foodlink, Rochester, NY

Sodium-related health issues (as detailed in this edition of The Digest) plague individuals and communities across the socioeconomic spectrum. In fact, evidence suggests that rates of chronic disease, such as hypertension, are particularly high among individuals of lower socioeconomic strata. Concurrent with chronic disease, high rates of food insecurity also affect low-income populations.

Given the link between chronic disease, income status, and food insecurity, strategies to improve health in this population must include opportunities to influence food sources frequented by food insecure individuals. These sources include supplemental and emergency federal and non-profit nutrition programs.

How should the emergency food system respond to their clients who suffer from chronic diseases, such as hypertension? Private and non-profit sector support include food banks which serve networks of emergency food relief agencies across America. In 2010, over 200 food banks in Feeding America’s network provided three billion pounds of food to 1 out of 8 Americans. One such food bank is Foodlink in Rochester, NY, which serves over 400 agencies in a surrounding 10 county area. Over 12 million pounds of food pass through Foodlink’s doors to 125,000 individuals on an annual basis. This is a significant amount of food making its way to the tables of food-insecure Americans who are suffering from higher-than-average rates of diet-induced chronic diseases.

The issue of regulating food to low-income audiences is controversial. For example, the Food Research and Action Council (FRAC) notably opposes regulating the nutritional quality of foods purchased with food stamps. They believe that regulating foods purchased with federal dollars is a slippery slope and could lead to the regulation of other federal dollars, despite the fact that the Women, Infants and Children (WIC) program and initiatives covered under the recently updated Child Nutrition Act are currently subject to significant amounts of nutritional regulation. Some traditional food bankers, notably John Arnold of Western Michigan, agree with the hands-off approach. He advocates for accepting and distributing whatever food donors decide to donate—regardless of nutritional quality.

Without any regulation of emergency food quality, any efforts to change dietary intake (and therefore any change in rates of chronic disease) must focus on client education and promotion of healthy items. One can hope that such education will result in client behavior changes related to selection and consumption of healthier products. Without any assessment, however, clients are left to choose from the potluck of available products—a questionable amount of which food and nutrition professionals would consider “healthy.” Feeding America has been slower to act on the nutritional content of foods offered. However, they recently named a Director of Nutrition and are in the midst of thoughtful deliberation of a variety of methods and ideas to improve nutrition. One such approach in consideration is the Choose Healthy Options Program (CHOP), which was developed by the Greater Pittsburgh Community Food Bank (Pittsburgh, PA). This approach focuses on inventory assessment to assist with inventory decision-making and client education.

Support also runs deep for the hands-on approach, interpreting statistics of poverty, food insecurity, and chronic disease as a call for more intentional measures. New York State epitomizes this approach. The New York State Department of Health’s Hunger Prevention Nutrition Assistance Program (HPNAP) provides funding for food banks to purchase and distribute food, but these funds come with nutrition-related restrictions. On a broader scale, any food moved with HPNAP funds must be nutritious, as deemed by HPNAP guidelines. In brief, guidelines categorize MyPyramid foods and meal preparation ingredients as nutritious, while snacks, desserts, candy, and beverages (except for 100% fruit juice and milk) are deemed non-nutritious. In addition to rules governing eligibility of donated food, more recent guidelines have focused on specific criteria for foods purchased using HPNAP funds. For example, a set percentage of funds must be spent on produce and milk. Additionally, at least two whole grain items and lean meat items (as prescribed by an approved list) must be on hand for agencies to order through the food bank at all times.

Sodium is the next nutrient in the sights of HPNAP’s nutrition policy makers, and a working group has convened to research issues of availability, cost, and acceptability of low-sodium products for purchase on a large scale by New York State food banks. Following New York City Department of Health and Mental Hygiene’s aggressive approach to nutrient-based regulations, the Food Bank for New York City proactively and articulately described their position on the important role that nutrition can play at food banks in a position paper.

The future of food banks and the nutritional quality of emergency food

Sodium Regulation continued on page 13
Expanded Food and Nutrition Education Program Helps Families to Lower Sodium Intakes

Maria Carmen Lambea, MD, MPH, CHES
EFNEP State Director: Ohio
The Ohio State University Extension

Based on the most current scientific evidence review, the 2010 Dietary Guidelines for Americans (DGA) was recently released. This document reminds us that hypertension is a major risk factor for heart disease, stroke, congestive heart failure, and kidney disease. Thirty-four percent of US adults have hypertension, and 36% have prehypertension.

The Expanded Food and Nutrition Education Program (EFNEP) is a nutrition education program for limited income families funded by USDA’s National Institute of Food and Agriculture (NIFA). EFNEP serves a diverse community and, in Ohio, 40% of our 5,000 participants in 2010 were African American. As we know, the new DGAs propose that African Americans limit intake of sodium to 1500 mg each day. Because only 15% of what we eat in America currently meets the recommendations, and the average daily intake of sodium is approximately 3,400 mg, EFNEP’s role has become increasingly important in showing people small ways to reduce sodium intake that can make a large impact on their health. Information about the health consequences of increased sodium intake, as well as skills that facilitate the adoption of this recommendation, is important to our participants and could facilitate reduced cardiovascular risk.

Ohio EFNEP uses several strategies to help its participants lower their sodium intakes, which include EFNEP Professional Development activities for our frontline nutrition educator staff; EFNEP adult curriculum revision and updates; and Dietary Guidelines dissemination via webinars to the general public and to other community nutrition educators. The following is a synopsis of these various strategies:

Ohio EFNEP Professional Development Activities that have occurred or are planned include:

- During our Community Nutrition Conference in November 2010, attended by all Ohio Community Nutrition Programs staff, a summary of the DGA report was introduced, highlighting some of the new target messages, including the importance of sodium reduction.

- Our May 2011 EFNEP Mid-Year Conference, a professional development conference for our EFNEP supervisors and frontline educators, included a session on the new sodium recommendations; a description of the scientific background supporting the recommendations; and some practical strategies that our frontline educators can use in helping participants to meet these recommendations.

- As part of our EFNEP mid-year conference activities, our frontline

EFNEP Program Assistant Kim Frank from Clark County, OH, serves up some lower sodium and lower fat collard greens that were prepared with low-sodium chicken broth, garlic, onion, red pepper flakes, and lemon juice—instead of traditional salt pork or ham hocks. Kim presented the collard greens for sampling to the approximately 55 participants present at the annual Ohio EFNEP Mid-Year Conference at the Mid-Ohio Food Bank, Grove City, OH.
staff researched healthy, low-cost recipes that are easy to prepare; and prepared, tasted, and suggested some possible cultural adaptations that made these foods healthier and more attractive to some of the cultural groups we serve, including African-Americans. Many of the alternative recipes lowered sodium content, but maintained tastiness with herbs and spices. A group of approximately 15 frontline educators worked specifically with recipes related to traditional African American dishes, such as macaroni and cheese, collard greens, and fried chicken and catfish. These educators were specifically able to lower salt content in these foods by using low-sodium cheese in the macaroni and cheese dish; adding low-sodium broth and a variety of spice blends to flavor collard greens; and using lower-sodium breading, such as corn flakes, and herbs to bake chicken and catfish.

We emphasized educational content in our curriculum, “Eating Smart Being Active” (ESBA), that is related to lowering sodium. ESBA is a curriculum developed by Colorado State University Extension, and is used by Ohio EFNEP.

- Teaching our limited-income caregivers to read the nutrition facts label for information on the sodium content of foods has always been part of our curriculum, but is even more important now given the new guidelines. Learning how to read nutrition facts labels and making it a habit while grocery shopping is an important skill that will help participants to purchase foods low in sodium.

- Encourage the consumption of more fresh foods and fewer processed foods that are high in sodium.

Within the eight lesson ESBA curriculum, there is one lesson, “Make a Change,” that includes why we should limit salt, where we find salt in our diets, and strategies to reduce salt in our diets. After the release of the 2010 Dietary Guidelines, we reviewed and updated lessons to include the new sodium recommendations. After reviewing “Make a Change,” it now includes:

- The specific sodium intakes suggested in the DGA.

- A new visual activity for sodium. We selected a can of soup, a package of hot dogs, a package of noodles, and a box of macaroni and cheese dinner to illustrate the amount of sodium per serving in each product, calculated by using the information on the respective nutrition facts labels. We then labeled and filled a series of test tubes with the equivalent milligrams of salt per serving of each respective food item. This activity has helped participants to visualize the sodium content per serving of each food item and allowed them to visually compare the amount of sodium in each food with the recommended daily sodium intakes, shown in two other tubes—one with 2,300 mg of sodium and one with 1,500 mg.

- Modification of a previous activity that asked participants to look at nutrition facts from popular fast food restaurants and select a menu item that they usually eat. Participants then wrote down the amount of fat for each of their menu items. We expanded this activity and now participants also look at the sodium content of menu items and reflect on how these amounts relate to the recommended daily sodium intakes.

- Time for sharing of strategies participants are already using to reduce sodium intake in their families’ diets.

It is our hope that with these curriculum modifications, we will increase EFNEP participants’ ability to choose lower sodium options when eating at restaurants and also buying foods to prepare at home.

New dietary guidelines information will be disseminated via webinars developed in collaboration with the Ohio State University Department of Human Nutrition and the SNAP-Ed program. In June, the first webinar will be on the new sodium recommendations.
This webinar will be available to Ohio State University staff and the public alike. The webinar will include reasons that sodium recommendations are important to our participants, particularly African Americans; the science behind the recommendation; ways to implement sodium guidelines in everyday life, including food selection, eating habits, and food preparation techniques; and a food demonstration that illustrates a low-sodium recipe.

By increasing our participants’ awareness of the importance of reducing sodium and providing them with the information, strategies, and skills to do it with a limited budget, we are contributing to the development of a new behavior that we hope will translate to a healthier community.

Last year, 42% of 5,000 graduates statewide reported that they more often prepared foods without adding salt. We have also collected anecdotal information from participants that show they are encouraged to lower sodium after completing EFNEP:

“Because of EFNEP, I am trying to use less salt and butter when preparing foods. EFNEP taught me the effects that certain items have on the body and made me more aware of how much harmful stuff there is in our foods.” - Community college student, Garfield Heights, OH.

“I learned that there are other ways to add flavor to my meals besides adding salt.” - Mom, Cleveland, OH.

“Now, I am going to cook without adding salt, exercise 30 min/day and plan my meals ahead of time.” - Head Start teacher, Cleveland, OH.

“I am going to watch my salt and sugar intakes.” - Cleveland metropolitan housing resident, Cleveland, OH.

We expect that Ohio EFNEP’s efforts in staff training, dissemination of our new Dietary Guidelines, our curriculum update, and exploration on how to offer and prepare more low-cost and low-salt, tasty recipes to our participants will result in an even greater proportion of participants choosing to prepare foods without adding salt.

References

Sodium Regulation continued from page 10

is unfolding before us. Public health professionals, dietitians included, need to investigate and publish more thorough research on the implications of regulating the nutritional quality of supplemental and emergency food. Together, the future we build will be one informed by solid research to improve the health, respect, and well-being of clients in need of food relief services.

References


3. Farmer, Blake. NPR. All Things Considered: Overburdened food banks can’t say no to junk. NPR Web site.


Sodium Reduction Efforts: An American Heart Association Priority

Kimberly F. Stitzel, MS, RD
Director, Nutrition and Obesity Strategies, American Heart Association, PHCNPG Member

Monika Davis, M.Ed.
National Program Lead, Sodium Reduction, American Heart Association

Cardiovascular disease is one of the major risk factors. The 2020 goal of the American Heart Association (AHA) is to improve the cardiovascular health of all Americans by 20% while continuing to reduce deaths from CVD and stroke by 20%. Two of the key metrics for ideal cardiovascular health are blood pressure of <120/80 mm Hg and sodium consumption of <1500 mg/day by 2020.

An estimated nine in ten Americans will develop high blood pressure during their lifetimes. A high amount of sodium in the diet has been linked to high blood pressure and may also have other harmful effects on health, including increased risk for stroke, heart failure, osteoporosis, stomach cancer and kidney disease. Reducing sodium intake is a priority for AHA. The association advocates for a stepwise reduction in sodium consumption in the US diet to 1500mg/day by 2020.

Multiple scientific studies have demonstrated improved health through lowered sodium consumption. Despite the research, Americans consume an average of 3,436 mg of sodium each day. Over 75% of sodium in the diet comes from salt added to processed foods, beverages, and restaurant foods. Unfortunately, and for a variety of reasons which include cost and availability, not enough of the US population is eating an adequate amount of healthy foods that are low in sodium. Even more troubling, 97% of children and adolescents are eating too much salt, putting them at an even greater risk of cardiovascular disease as they age. Additionally, less than 3% of our youth get the recommended levels of fruits and vegetables.

Decreased fruit and vegetable consumption for both youth and adults becomes an issue for the prevention and treatment of hypertension. This is because fruits and vegetables are a major source of potassium in the diet, and potassium has been shown to decrease blood pressure in those with hypertension and in those at-risk for hypertension. While very few trials have looked at the direct effects of potassium intake from foods on hypertension (many trials have used supplements in the form of potassium chloride), the 2010 Dietary Guidelines Advisory Committee has still identified potassium as a public health nutrient of concern due to low intakes among Americans. The Adequate Intake (AI) for potassium is 4700 mg/day; however, most Americans consume considerably lower amounts. The average male consumes about 3200 mg/day, whereas the average female’s potassium intake is around 2400 mg/day. These amounts are even lower among non-Hispanic Blacks. Thankfully, Americans can achieve potassium from a variety of foods besides fruits and vegetables, including meat, poultry, and coffee. In fact, the number one source of potassium in Americans’ diet is reduced fat milk (2% and 1%).

Because potassium possesses vasoactive properties, it is clear that potassium plays an important role in opening up the arteries for blood flow. Research has also shown that increasing potassium among healthy individuals leads to a lowered risk of stroke, coronary heart disease, bone loss and kidney stones.

Inherent to the negative health effects of sodium are increasing healthcare costs. The direct and indirect costs of cardiovascular disease is staggering—over $400 billion in 2009, and projections that exceed $1 trillion by 2030. It is estimated that if the US population moved to an average intake of 1500 mg of sodium/day, there would be a 25.6% overall decrease in high blood pressure, and $26.2 billion in health care savings.

Over the next three years, the AHA will focus on helping Americans lower the amount of sodium they consume via three key strategies:

1. Reducing the amount of sodium in the food supply;
2. Making more healthy foods available (e.g. more fruits and vegetables, lower-sodium options, smaller portion sizes); and
3. Providing consumers with education and decision-making tools to make better choices.

Key initiatives and tactics within these strategies include:

- Supporting voluntary reduction efforts that include benchmarks and accountability, including the National Salt Reduction Initiative which is working with the food industry to reduce sodium content in packaged and restaurant foods.
- Working to achieve full implementation of the Institute of Medicine’s sodium recommendations with strategic partners committed to sodium reduction.
- Advocating for federal, state and local policies that:
  - Maximize technologies that remove sodium from the food supply;
Reduction Efforts continued on page 16

The American Heart Association’s work is founded on strong science, and scientific statements are used to develop all of our initiatives. The following scientific statements specifically address sodium and are useful to healthcare professionals:


In addition to the broader efforts towards sodium reduction and making more heart-healthy foods available, AHA offers many tools and resources to consumers, enabling them to make healthier food decisions:

- Heart Check Mark front-of-package labeling program. Foods displaying the AHA’s heart-check mark help consumers to quickly and easily spot heart-healthy foods in the supermarket. In addition to strong sodium standards, foods carrying the heart-check mark also meet AHA criteria for total fat, saturated fat, trans fat, cholesterol, and contain positive nutrients.

- The American Heart Association Low-Salt Cookbook, 3rd Edition. Encompassing everything from appetizers and soups to entrées and desserts, this cookbook is a collection of more than 200 low-sodium recipes. The American Heart Association Low-Salt Cookbook, 3rd Edition, has current information and tips on substituting ingredients, avoiding hidden sodium, and dining out, as well as new original illustrations.

- Web quizzes and tools:
  - Test Your Sodium Smarts Quiz. Many consumers are surprised to learn that a slice of bread can have more sodium than a bag of pretzels. This quiz tests consumers’ sodium smarts by answering ten questions about which food products are higher in sodium. The quiz is also available as a PDF to download and print.
  - Fat and Sodium Explorer Tool. This tool allows a patient to enter their height, weight, sex, and activity level, and the tool identifies a consumer’s daily calorie needs, recommended limits for fats and sodium, etc.
  - Patient brochures. Shaking Your Salt Habit: Reducing sodium to lower blood pressure.

All of these consumer resources, and more tips and information to help consumers lower the amount of sodium they eat can be found on our nutrition center web site at http://www.heart.org/nutrition.

Summary

Reducing sodium intake is a high priority for the American Heart Association because of the adverse effects of excess sodium—elevated blood pressure and increased risk of stroke, heart attacks and kidney disease. The cardiovascular benefits of reduced sodium intake are enormous and as critical to heart health as the benefits of population-wide reductions in tobacco use, obesity and cholesterol levels.

Several efforts are underway to support the recommendation and promote the health benefits of lowering sodium consumption to less than 1,500 mg of sodium daily. To access these resources and obtain more information on the American Heart Association’s sodium reduction efforts, visit the Nutrition Center, Sodium Section, http://www.heart.org/sodium or contact Monika Davis at monika.davis@heart.org.

References


Sodium Reduction Efforts continued from page 15


Institute of Medicine Reports Support Primary Prevention for Reducing Sodium in Food Supply (adapted from the IOM Report Briefs)

Alicia Moag-Stahlberg, MS, RD, LD

Over the past twenty years, consumers have had less and less direct control over the amount of sodium in their food because of the increased consumption of pre-prepared and processed food items comprising American’s diets. It is well recognized that without major changes in sodium consumption, hypertension and cardiovascular disease rates will continue to rise. In the end, if there is not aggressive action taken to address the sodium content in the food supply, we will pay the cost with increases in morbidity and mortality from hypertension.

Several months ago a major change took place as a result of the 2010 Institute of Medicine (IOM) report’s recommendations. The largest retail chain selling food, Walmart with 4,300 retail stores, announced a dedicated effort to provide healthier food choices and make those foods more affordable to consumers. This new initiative involves reformulating many packaged foods—both national brands and Walmart’s own Great Value brand—to reduce sodium and added sugars, and to eliminate trans fats by 2015. Walmart will ask its suppliers to reduce sodium by 25% in some foods and to report on their progress.

The first of two IOM committee reports on sodium and blood pressure control was released in February 2010. This report, A Population-Based Policy and Systems Change Approach to Prevent and Control Hypertension, identifies priority areas from the Division for Heart Disease and Stroke Prevention (DHDSP) current and proposed hypertension prevention and control activities. As an overarching recommendation, the committee says the DHDSP should give priority to population-based strategies that can reach large numbers of people and improve the well-being of entire communities. Population-based policy interventions and interventions directed at system improvements are likely to be more practical and realistic in today’s resource-constrained environment.

The primary recommendation is for the US Centers for Disease Control and Prevention (CDC) to shift the balance of hypertension priorities from individual-based strategies to population-based strategies to:

- Strengthen collaboration among CDC units (and their partners) to ensure that hypertension is included as a dimension of other population-based activities around healthy lifestyle improvement, particularly greater consumption of potassium-rich fruits and vegetables, increased physical activity, and weight management.

- Strengthen CDC’s leadership in monitoring and reducing sodium intake in the American diet to meet current dietary guidelines.

- Improve the surveillance and reporting of hypertension to better characterize general trends and trends among subgroups of the population.

- Promote policy and system change approaches to:
  - improve the quality of care provided to individuals by assuring that individuals who should be in treatment are in treatment and receive care that is consistent with current treatment guidelines.
  - increase the importance of treating systolic hypertension, especially among the elderly.


IOM Report continued on page 18
Remove economic barriers to effective antihypertensive medications:

- provide community-based support for individuals with hypertension through community health workers who are trained in dietary and physical activity counseling.

**Strategies to Reduce Sodium Intake in the United States**

The second IOM report was released on April 20, 2010, and sets a course for both public and private sectors for lowering consumption of sodium. Earlier this year, the 2010 Dietary Guidelines for Americans were released with a greater emphasis on sodium reduction and recommending lower consumption levels for some population sub-groups (older Americans, those at risk of and with hypertension).

A result of the report, the Department of Health and Human Services (DHHS), National Heart, Lung, and Blood Institute (NHLBI), US Food and Drug Administration (FDA), and the US Centers for Disease Control and Prevention (CDC) will form an interagency working group on sodium to review options, determine next steps, and promote collaborations among government agencies, professional and consumer organizations, the food industry, and public health partners to lower sodium intake in the United States. Strategies and recommendations for public and private sectors appear as written in the report brief below.

**Primary Strategies**

**Recommendation 1:** The US Food and Drug Administration (FDA) should expeditiously initiate a process to set mandatory national standards for the sodium content of foods.

- FDA should modify the “generally recognized as safe” (GRAS) status of salt added to processed foods in order to reduce the salt content of the food supply in a stepwise manner.

- FDA should likewise extend its stepwise application of the GRAS modification, adjusted as necessary, to encompass salt added to menu items offered by restaurant/foodservice operations that are sufficiently standardized so as to allow practical implementation.

- FDA should revisit the GRAS status of other sodium-containing compounds as well as any food additive provisions for such compounds, and make adjustments as appropriate consistent with changes for salt in processed foods and restaurant/foodservice menu items.

**Interim Strategies**

**Recommendation 2:** The food industry should voluntarily act to reduce the sodium content of foods in advance of the implementation of mandatory standards.

- The food industry, government, professional organizations, and public health partners should work together to promote voluntary collaborations to reduce sodium in foods.

**Supporting Strategies**

**Recommendation 3:** Government agencies, public health and consumer organizations, and the food industry should carry out activities to support the reduction of sodium levels in the food supply.

- FDA and the US Department of Agriculture (USDA) should revise and update—specifically for sodium—the 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.
- FDA should extend provisions for sodium content and health claims to restaurant/foodservice menu items and adjust the provisions as needed for use within the restaurant/foodservice sector.

- Congress should act to remove the exemption of nutrition labeling for food products intended solely for use in restaurant/foodservice operations.

- Food retailers, governments, businesses, institutions, and other large-scale organizations that purchase or distribute food should establish sodium specifications for the foods they purchase and the food operations they oversee.

- Restaurant/foodservice leaders in collaboration with other key stakeholders, including federal, state, and local health authorities, should develop, pilot, and implement innovative initiatives targeted to restaurant/foodservice operations to facilitate and sustain sodium reduction in menu items.

**Recommendation 4:** In tandem with recommendations to reduce the sodium content of the food supply, government agencies, public health and consumer organizations, health professionals, the food industry, and public-private partnerships should conduct augmenting activities to support consumers in reducing sodium intake.

- The Secretary of Health and Human Services (HHS) should act in cooperation with other government and non-government groups to design and implement a comprehensive, nationwide campaign to reduce sodium intake and act to set a timeline for achieving the sodium intake goals established by the *Dietary Guidelines for Americans.*

- Government agencies, public health and consumer organizations, health professionals, the food industry, and public-private partnerships should continue or expand efforts to support consumers in making behavior changes to reduce sodium intake in a manner consistent with the *Dietary Guidelines for Americans.*

**Recommendation 5:** Federal agencies should ensure and enhance monitoring and surveillance relative to sodium intake measurement, salt taste preference, and sodium content of foods, and should ensure sustained and timely release of data in user-friendly formats.

- CDC should collect 24-hour urine samples during NHANES or as a separate nationally representative “sentinel site” type activity.

- CDC should, as a component of NHANES or another appropriate nationally representative survey, begin work immediately with the National Institutes of Health (NIH) to develop an appropriate assessment tool for salt taste preference, obtain baseline measurements, and track salt taste preference over time.

- CDC in cooperation with other relevant HHS agencies, USDA, and the Federal Trade Commission should strengthen and expand its activities to measure population knowledge, attitudes, and behavior about sodium among consumers.

- FDA should modify and expand its existing Total Diet Study and its Food Label and Package Survey to ensure better coverage of information about sodium content in the diet and sodium-related information on packaged and prepared foods.

- USDA should enhance the quality and comprehensiveness of sodium content information in its tables of food composition.

- USDA in cooperation with HHS should develop approaches utilizing current and new methodologies and databases to monitor the sodium content of the total food supply.

The project leading to the consensus report was initiated by Congress and funded by Department of Health and Human Services including Centers for Disease Control and Prevention (CDC) with support from the NHLBI, the Food and Drug Administration (FDA), and the Office of Disease Prevention and Health Promotion.

Resources for Consumers

Reviewed and compiled by Alicia Moag-Stahlberg, MS, RD, LD

Your Guide to Lowering Your Blood Pressure with DASH

An easy-to-read fact sheet provides an overview of DASH research findings and suggestions on how to start and stay on the eating plan.

Deliciously Healthy Family Meals

This new cookbook from the National Heart, Lung, and Blood Institute (NHLBI) contains 40 kid-tested healthy and delicious recipes created for the NHLBI by a Culinary Institute of America-trained chef/instructor and father of two, in partnership with the National Institutes of Health.

American Heart Association: Every Step Counts

Over 74.5 million US adults have been diagnosed with high blood pressure. Understanding causes, treatment, and prevention are all critical components of comprehensive care for cardiovascular health. This website links to consumer friendly information that guides each person through a path particular to their situation, with nutrition and physical activity advise as core. This website has information that explains all elements of the disease and why prevention is important.
http://www.heart.org/HEARTORG/Conditions/HighBloodPressure/AboutHighBloodPressure/About-High-Blood-Pressure_UCM_002050_Article.jsp

American Heart Association’s Quick and Easy Meals

Get a delicious and heart-healthy meal on the table fast in 30 minutes or less recipes to prepare. Menu suggestions, shopping lists, and cooking tips make it a cinch to get a delicious and heart-healthy meal on the table fast.
https://shop.heart.org/AHAECOMM/en/ecommTemplate.jsp?pid=ahacomm.cat.product&categoryId=cat300001&parentId=shcat1050003&id=prod700000

Your Guide to Lowering High Blood Pressure

This is a site for people who are interested in learning more about preventing and controlling high blood pressure. Based on National Heart, Lung, and Blood Institute clinical guidelines and research studies, it provides up-to-date practical information on high blood pressure.

Resources for Professionals

Reviewed and compiled by Alicia Moag-Stahlberg, MS, RD, LD

JNC 7 Application for Palm OS and PocketPC 2003

The Palm OS (operating system) and PocketPC 2003 program for application of The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC 7) is now available. This interactive guideline tool will assist the clinician in implementing the JNC 7 High Blood Pressure Guidelines at the point of care.
http://hp2010.nhlbihin.net/jnc7/jnc7pda.htm

NHLBI Health Information Network (HIN) e-Newsletter

Provides regular updates on educational materials, useful articles, and links to tools and information. Information provided related to disease treatment, prevention and different audiences. Join today.

Improving the Food Environment Through Nutrition Standards: A Guide for Government Procurement

This document provides practical guidance to states and localities for use when developing, adopting, implementing, and evaluating a food procurement policy.
http://www.cdc.gov/salt/

Vital Signs: High Blood Pressure and Cholesterol

The Centers for Disease Control and Prevention (CDC) Vital Signs program is a call to action each month concerning a
single, important public health topic. CDC Vital Signs for February focuses on cardiovascular disease, specifically, control of hypertension and cholesterol. 
http://www.cdc.gov/dhdsp/vital_signs.htm

National Heart Disease & Stroke Prevention

This national, state-based heart disease and stroke prevention program funds 41 states and the District of Columbia; 28 as capacity building programs and 14 as basic implementation programs. Visit this site to find out what your state health department is doing with respect to stroke prevention and resources for professionals.
http://www.cdc.gov/dhdsp/programs/nhdsp_program/resources.htm

National Salt Reduction Initiative (NSRI)

The New York City Health Department is coordinating a national effort to prevent heart attacks and strokes by reducing the amount of salt in packaged and restaurant foods.

This public-private partnership has developed targets to guide company salt reductions in 62 categories of packaged foods, and 25 categories of restaurant foods.

The voluntary effort has both two- and four-year targets for average salt levels in each category of food. When a company signs onto the initiative, it pledges that its overall sales in a given category—canned soup, for example—will meet the relevant target for salt content, even if some individual products do not. When manufacturers and restaurants work in tandem to reduce average salt content, there will be greater consumer acceptance.

This effort includes mechanisms to monitor sodium in the food supply, and to track companies’ progress toward specific targets. In addition, the initiative will use urine analysis to monitor changes in people’s actual salt intake. The NSRI is modeled on a program in the United Kingdom, where food makers have reduced salt levels by 40% or more in some products. Below is the timeline for reducing salt levels in US products:

Relevant Journal Articles

Appel LJ et al. The Importance of Population-Wide Sodium Reduction as a Means to Prevent Cardiovascular Disease and Stroke: A Call to Action From the American Heart Association. Circulation. 2011;123. 
http://circ.ahajournals.org/cgi/reprint/123/10/1138

http://content.nejm.org/cgi/content/full/NEJMoa0907355

http://www.annals.org/content/early/2010/02/25/0003-4819-152-8-201004200-00214.full?aimhp

http://archinte.ama-assn.org/cgi/content/extract/170/8/732

http://www.annals.org/content/early/2010/02/25/0003-4819-152-8-201004200-00212.full?aimhp

Professional Education Opportunities

Cultural Competence for Providers

Although touted as a program for physicians, this is a good resource for registered dietitians working with individuals at risk or that have cardiovascular disease, especially hypertension. Uses videos with real patient scenarios, and case-based modules to increase awareness in the role of culture, and how to avoid stereotyping and bias. 
http://www.c-comp.org/

Social Marketing for Nutrition and Physical Activity

Web course provides training for public health professionals on the subject of how to use social marketing to plan nutrition, physical activity, and obesity prevention programs. 
http://www.cdc.gov/nccdphp/dnpa/socialmarketing/training/index.htm

Energize Our Families: Parent Program

Provides professionals with the skills needed to talk to parents about helping their kids balance calories in and out. Registered dietitians can apply for two continuing education credits. Information is basic healthful eating recommendations aligned with Dietary Guidelines for Americans, and therefore stresses fruits, vegetables, whole grains, and low fat and non-fat dairy products—all-important for providing nutrients that benefit healthy blood pressures. 
The views and statements appearing in The Digest do not necessarily reflect policies and/or official positions of the American Dietetic Association (ADA) or Public Health/Community Nutrition Practice Group (PHCNPG). Product names mentioned in this publication do not constitute endorsement by ADA or PHCNPG. © 2011 Public Health/Community Nutrition Practice Group, a dietetic practice group of ADA.