

CDC *Vital Signs* Town Hall Teleconference

Where's the Sodium? Transcript

February 14, 2012
2:00pm – 3:00pm EST

Coordinator: Thanks for standing by. At this time all participants are in a listen-only mode. During the question-and-answer session, please press star 1 and record your name as prompted. Today's conference is being recorded. If you have any objections, you may disconnect at this time.

I would now like to turn today's meeting over to Dr. Greg Holzman. Thank you. You may begin.

Dr. Greg Holzman: Thank you, (Carolyn). Good afternoon. I'm glad you could join us today to discuss the latest *Vital Signs* report on sodium, a very fitting topic considering February is American Heart Month. Far too many Americans consume more sodium than as recommended, but the main source of sodium in our diet may surprise you. Since sodium can be hidden in so many of our foods, public education is critical so people have the information and tools they need to make healthy food choices.

One of our presenters today will share how her state has been working to raise awareness about this topic. Equally critical, as we will hear from another presenter, is the need for communities to have healthy options accessible and affordable.

The National Prevention Strategy, which was developed and released this past spring by the National Prevention of Council, recommends three strategies that can address the environmental aspect of this public health issue: one,

increasing access to healthy and affordable foods in communities, two, implementing organizational and programmatic nutrition standards and policies, and three, improving the nutritional quality of food supply.

CDC's Public Health Law Program, which is part of the Office for State, Tribal, Local and Territorial Support, has completed a 50-state survey of state laws and state agency policies related to sodium restriction. These results should be released soon. If you have any questions, please go to the OSTLTS Web site and connect to the Public Health Law Program.

So without further delay, I will turn the teleconference over to Amanda Miller from the OSTLTS Communications Team who will introduce our speakers and facilitate the discussion portion of today's meeting.

Amanda Miller: Good afternoon everyone and thank you for joining us today. Before we get started, I want to remind you that you can download today's PowerPoint presentation and view bios for each of our presenters on the Town Hall Teleconference Web site.

This Web site has a new address, so you will want to update your bookmarks if you have the Web site saved. The new address is www.cdc.gov/stltpublichealth. That's S-T-L-T - public health at the end with no spaces. There's a link directly to the Town Hall Web site under "Highlighted Products and Resources" on the bottom right of the home page. This site is also, where we will add the audio recording and transcript for today's meeting, and they should be available early next week.

If you have any problems viewing the PowerPoint presentation, right click on the link and select "Save As" to download the presentation to your computer. This should eliminate any issues with your browser opening a large file.

There will be time for questions after our presentations today, but you can get in the queue to ask a question at any time during the teleconference. You'll just press star 1 and record your name when prompted. You will be announced into the conference by the operator to ask your question in the second half of today's call. I encourage you to take advantage of this opportunity to share strategies, lessons learned, challenges, and successes.

Now it is my pleasure to introduce our speakers. I will introduce all the speakers now, and then during the presentation each of them will hand off to the next one. Joining us today to provide a summary of this month's *Vital Signs* report is Dr. Mary Cogswell, a Senior Scientist in CDC's Division for Heart Disease and Stroke Prevention. She will also briefly highlight the public health opportunities state and local health departments have to address sodium and promote heart health.

Then (Susan Svencer), a Sodium Reduction Specialist with the Heart Disease and Stroke Prevention and Control Program at the Massachusetts Department of Public Health, will discuss formative research used to develop the Choose Less Sodium campaign as well as initial results on the campaign's impact in the state.

Our last speaker today is Glynnis Hunt, the Sodium Reduction in Communities Project Director at Schenectady County Public Health Services. She will share how a county-owned nursing home is making small changes that are adding up to significant sodium reduction in senior meals.

Now I will turn the call over to Dr. Cogswell.

Dr. Mary Cogswell: Okay. Please turn to Slide 5. Today I will highlight a few key findings from the recent *Vital Signs* report shown here and provide a brief overview of

why we should reduce sodium intake, who should reduce sodium intake and how intake can be reduced and what we can do as public health professionals.

Next slide, so why should we reduce sodium intake? Solid scientific evidence shows a direct-dose response relationship between systolic blood pressure and sodium intake. In 2008, high blood pressure was reported as a primary or contributing cause of about 348,000 U.S. deaths. About one in three U.S. adults have high blood pressure and fewer than half have high blood pressure controlled.

Reducing sodium intake is a key public health strategy to prevent and control high blood pressure, and it's been estimating that reducing average U.S. population sodium intake by 1200 milligrams daily could potentially save up to 20 billion healthcare dollars and prevent up to 81,000 U.S. deaths each year.

Next go to Slide 7. So who should reduce sodium intake? The 2010 Dietary Guidelines for Americans recommend the general population ages 2 years and older reduce sodium intake to less than 2300 milligrams, and those age 51 years and older, African-Americans and people who have high blood pressure, diabetes, or chronic kidney disease further reduce intake to 1500 milligrams. This latter group comprises nearly half the U.S. population in about 6 of 10 adults ages 18 years and older.

Next slide. About 90% of persons aged 2 years and older who should consume less than 2300 milligrams of sodium daily shown here in the orange bars and virtually all persons who should consume 1500 milligrams daily, shown in green, consume more than these levels. Even among children, age 2 to 17 years, the vast majority consume more sodium than recommended.

Please turn to Slide 9. It can be a challenge to reduce sodium intake, because most of the sodium in our diet is not added at the table. More than 75% of the sodium in our food is already there and mostly invisible in processed and restaurant foods. Only 12% is naturally occurring, and about 11% is added in cooking and at the table.

Please turn to Slide 10. Excluding the salt added at the table, 44% of U.S. sodium intake comes from just 10 types of foods. These foods in order are: bread and rolls, cold cuts, pizza, fresh and processed poultry, soups, sandwiches, cheese, pasta-mix dishes, meat-mix dishes such as meatloaf with tomato sauce, and savory snacks such as chips and pretzels. Some contributors like bread and poultry outlined in yellow here might not taste salty, but because we consume a lot, they add up in our diet.

Next slide. In addition the average amount of sodium per 1000 calories consumed is high, and it's similar across age groups, and the amount of sodium-per-calorie consumed is about 300 to 500 milligrams higher from foods obtained at restaurants than foods obtained from stores. This difference may be because of larger portion sizes and types of foods consumed as well as the amount of sodium in the foods served in restaurants.

Go to Slide 12 please. So what can be done? Please turn to Slide 13. The high average U.S. sodium intake reinforces the need for strategies to reduce sodium in the food supply. Importantly, the 2010 Institute of Medicine Report on Sodium Reduction Strategies recommended setting phased targets to reduce sodium content of processed, restaurant and other foods. The Food and Drug Administration and USDA's Food Safety and Inspection Service recently solicited comments on this and other strategies in scientific areas.

The Institute of Medicine also recommended industries voluntarily reduce the sodium content of foods. Several food manufacturers and restaurants have

committed to voluntary reductions in some of their food products. To monitor the impact of these changes over time, the Institute of Medicine recommended monitoring changes in sodium intake, salt-taste preference, and the sodium content of food.

Slide 14. To help reduce sodium intake, state and local health departments can develop and implement efforts that increase public awareness and policies to help reduce sodium in people's diets. They also can encourage government facilities and schools to adopt sodium standards and reductions in the amount of sodium in foods sold or served and promote innovative restaurant initiatives to reduce sodium content of restaurant meals.

Programs such as those being implemented in the sodium reduction in the communities demonstrate what can be done, and you'll hear more about them today.

Next slide. Sodium reduction is also an important component of community prevention in the Health and Human Services Million Hearts initiative which aims to prevent 1 million heart attacks and strokes in the next 5 years.

Please turn to Slide 16. Finally, as public health professionals, we can consider opportunities for changing nutrition standards in our own work environments, and we can also set a good example by choosing to purchase healthy options and talking to our grocers about stocking lower sodium choices, comparing and choosing foods with lower sodium content, asking for lower sodium options at restaurants, and eating fresh fruits and vegetables and frozen fruits and vegetables with no sauce.

For patients and people who need more information on lowering their sodium, the Dietary Approaches to Stop Hypertension eating plan is a good resource, and the Web site is shown at the bottom of this slide.

Slide 17. In summary, our collaborative efforts on the national, state, local and individual levels can make a difference and reduce sodium intake. It's estimated that even small reductions in the average daily sodium intake, about 400 milligrams or less than a quarter teaspoon of salt added to the foods we eat could potentially prevent thousands of deaths and save billions of healthcare dollars.

I would like to acknowledge a few of the people without whom this *Vital Signs* report would not have been possible. Next slide.

I'll now turn the presentation to (Susan). Please turn to Slide 19.

(Susan Svencer): Thank you. I'm (Susan Svencer) from the Massachusetts Department of Public Health. Let's move to Slide 20.

Massachusetts, like most of the U.S., has seen increasing prevalence of high blood pressure, and we know that many of the 25% of Massachusetts residents with high blood pressure do not have it controlled through lifestyle or medication, which puts them at a much greater risk for heart attack and stroke.

So clearly some sort of intervention is warranted, and we took a step back to examine what's causing hypertension. As you all know, there's a number of factors, but one that we were not specifically focusing on in Massachusetts is sodium intake.

And policies are a critical part of any institution's strategies for sodium reduction, and we're no different here. We have had two recent policies, one, an executive order signed by our Governor Deval Patrick setting nutrition standards for state agencies and another setting standards for nutrition

standards for competitive foods sold in schools. Both measures include strict sodium guidelines. So we're working to implement and support those.

We're also beginning our collaboration with the Massachusetts' based food industry, with food manufacturers to encourage participation in the National Salt Reduction initiative and with restaurants for changing procurement procedures, offering lower sodium, healthier options, healthy dining programs, et cetera. And we're looking to do this on the local level leveraging the existing relationships we have through Mass in Motion Communities, which is a program for our communities here that are funded for obesity prevention.

But in addition to policy, we felt very strongly that there's a need to educate the public about sodium. We, in public health, so often say that sodium consumption is not up to the individual, because of how much is in the food supply, and this certainly holds true to a large extent, but there are things consumers can do and certainly a lot that consumers need to learn when it comes to sodium.

There are perceptions and myth perceptions about the complexity of sodium, the burden of considering it on top of other nutrition factors, the poor taste of anything labeled low-sodium, as well as that you're doing enough if you just don't use the salt shaker. And some of these are valid, but in general, awareness and knowledge around sodium and what individuals can do about it is variable at best. So we decided to initiate a sodium-specific consumer awareness campaign.

Moving on to Slide 21. The goals of our campaign are quite simple. The first is to get sodium on consumers' radar screens, make it something that they know is potentially dangerous and therefore consider when making food choices, and the second is to give them specific - a specific way to take action.

Through this campaign, we provide a concrete example of how an individual can address sodium by comparing labels.

Now in terms of our concept development, we did not have our vendors start from scratch. Their initial designs were based on public education materials created by the New York City Department of Health and Mental Hygiene and funding for this project - this effort was from a Centers for Disease Control and Prevention grant.

And lastly, before I show you what - our campaign, to ensure that we designed a campaign that resonated with and was particularly compelling to Massachusetts residents, we conducted three focus groups, one in each of English, Spanish and Portuguese, which are the three languages in which our campaign is available.

So moving to Slide 22. You can see here our final ad. This is a picture of the transit ads we created. A few things to point out in terms of images. The color scheme here is deliberate. Red for the negative where we want you to stop - what we want you to stop purchasing, and green for the positive, go, please, you know, buy the lower sodium soup. But the brands here are fake, completely made up by our vendor, and there's no connection to actual products, which is a very important point.

We also deliberately avoided labeling the better, quote "the green option" as low sodium, because we want to help consumers understand that there are differences between quote-unquote "regular products," and avoid tapping into the perception that lower sodium products equals bad taste. So we want folks to think about the average products on their grocery store shelves.

In terms of texts, we did test the headline with the inclusion of high blood pressure, so too much salt can lead to high blood pressure, heart attack and

stroke, but our focus group respondents made it quite clear that blood pressure isn't scary. It's not motivating nor interesting enough.

They truly just felt like it was so commonplace that either they have high blood pressure or all their family members and friends have high blood pressure, that it wasn't something they were interested in hearing, and it did not grab their attention at all. So we eliminated that sort of middleman, and then focused on the connection between salt and the things that did grab and hold our focus group respondents' attention, heart attack and stroke.

You'll notice as well that we used both the words salt and sodium, and this was a point we made sure to review with our focus group respondents as well. So we asked at the very beginning of the group, if anyone knew the difference between salt and sodium, and across our three groups, only one person knew that there actually was in fact a difference and could explain it quite well.

But what we found to be the real takeaway was that no one cared that a difference existed. They were perfectly comfortable using the two terms interchangeably and found that to be acceptable. So we decided to not rock the boat and sort of go with that. There's only so much a viewer can digest when quickly glimpsing an ad, and we did not want to get into providing a chemistry lesson.

Now in addition to these print ads and posters that you see here, we have a 15-second video in all three languages as well, and we focus-group tested that too, but did not make any substantive changes. And you can find that video on our Web site, which you can see at the bottom of the ad here. It's mass.gov/gph/salt.

Moving on to Slide 23. In - we - in terms of placement, the campaign was distributed a variety of ways. The English ads we purchased space on local

and regional transit lines for the English ads, and the video was placed as a public service announcement throughout the state as well as then via local community access channels. We were able to leverage some of our relationships there.

The Spanish and Portuguese, we were able to do a media buy for the videos on the two Spanish and two Portuguese networks that air throughout the state, and we have the posters that we're distributing to community health and cultural centers in a number - through a number of other avenues.

We also have fact sheets that answer many of the questions raised by respondents in our focus groups. We found that folks in our groups were very engaged and interested in the sodium issue, but in a awareness campaign like this, we certainly couldn't answer all of their questions on a poster, though some of them asked that we do. So we took many of their question - their frequently asked questions and put them on our Web site and direct folks there whenever we can.

We also have DVDs and then the poster is available in three languages, and all of it is available free of charge through our clearinghouse Web site, which is maclearinghouse.com.

Slide 24. We certainly need to evaluate the campaign, and we're doing this through a series of three surveys with a combined Internet and telephone sample. So we have a pre-post and follow-up survey. Pre, obviously, was initiated prior to our campaign launching, the post about a month after the campaign ran, and the follow-up will be about five to six months after the campaign ran. So that will be this coming spring.

There's two objectives for our evaluation. The first is to collect some surveillance data, measure attitudes, awareness of sodium and some basic

behaviors, and the second objective is to evaluate our campaign, measure awareness of the campaign and potential impact on consumer behaviors.

Now we only recently received our post-campaign data, and our results are quite interesting thus far. We've seen substantial change in the number of respondents who say they saw our ads or our campaign in any form. And there were few noteworthy changes as well amongst those who say they were concerned or worried about sodium. We didn't see much of a shift from the pre- to the post-phase there.

But we did see a significant change in terms of some key behaviors, which is our ultimate goal of really any campaign. So significantly, more people said that they bought items in stores or restaurants that were labeled low sodium, and we asked specifically about some food items that they might have purchased and found that low-sodium purchases of soup had doubled and snacks, meats, cheeses and a few others also rose quite considerably.

More people also say that they in the post-phase survey also said that they were reading labels for sodium, and more say that they have not purchased an item after reading its sodium content on the nutrition label in the post phase, rather than the pre.

So these are all wonderful measures for our campaign. It is interesting that we did not ask people to specifically buy low-sodium products, but they say they have done so anyway, which is arguably the easiest way to implement the action that we asked of them in this campaign. It's easier to read the front of a can or a box, the front label rather than to decipher the nutrition label on the back. So possibly that's what's going on.

And it's also interesting that people say they have not seen our ads but have changed their behavior, specifically related to soup, when soup cans were the

featured product in our advertisement. So we're not entirely sure what's going on there, perhaps some subconscious views are sort of staying power for the images in our campaign or it could be because salt and sodium have been in the news so much lately.

We really can't say for sure, but any behavior change like what we've seen in our evaluation certainly supports our campaign and general sodium reduction goals. So we'll take it.

Moving on to Slide 25. In terms of next steps for our campaign, we're going to continue to distribute our materials through a number of channels and programs as you see listed here. We're hoping to do an additional media buy for the English ads, the English videos specifically, to increase viewership there, and we're certainly encouraging everyone to put these materials to use and order them through our clearinghouse, the Web site is listed there. And then we will be moving on to our - some our food industry targets and collaborations, hoping to keep the momentum going that we've been able to garner through this consumer campaign. And that's that. Certainly please touch base if you have any questions.

And now I will pass it over to Glynnis.

Glynnis Hunt: Thanks, (Susan). And again thank you to the CDC for asking us to participate in this. We're thrilled to be able to share some of our results from our first year of working on sodium reduction in our Senior Meals program.

My name is Glynnis Hunt. I'm the Sodium Reduction in Communities Project Director, and we have a wonderful team here at Schenectady County Public Health Services that has worked tirelessly to make this project a success. Jennifer Kahn is our Project Evaluator and June Schult is our Project Coordinator.

So to begin I'll just give you a little background on Schenectady County. We are located in Upstate New York just west of Albany, New York, the state capitol. Schenectady County has approximately 150,000 residents and is a mixture of one city, suburban, and rural areas as well.

Schenectady County is one of two counties in New York State currently funded by the CDC through the New York State Department of Health to administer the Sodium Reduction in Communities grant. We finished our first year of the grant in the fall of 2001, and our focus in Schenectady is on a gradual sodium reduction for seniors in the county. We're working in two areas, first, in the Senior Meals programs and also in restaurants that seniors frequent.

The presentation today, I'm going to focus on our success in reducing sodium in the Senior Meals program by 10% in Year 1. Our Year 3 goal is to reduce the sodium by 30%. So on Slide 29, we're currently, like I said, working with the Home Delivered Meals program and the congregate meal sites. The congregate meal sites are recreational sites throughout the county that seniors go to to have meals and participate in recreational activities.

Approximately 109,000 meals are served annually through these programs, reaching about 500 unique individuals. The average age of these participants is over 75, and the seniors reached through this program range from being homebound to being very active in the community.

We discovered that we have a somewhat complicated Senior Meal program in the county. However, the most simple component is that all meals prepared for the Home Delivered Meals program and the Senior Meal sites as well as the county nursing home are prepared at one facility, and this is the county-owned nursing home called Glendale Nursing Home. The county owns and

operates this facility, but a private for-profit food service management company administers the program.

So on Slide 30 you'll see some of the steps to change that we've gone through in the last year. We began in the fall of 2010, and we determined that we needed a baseline nutritional analysis of these meals, which included lunch and dinner.

The most recent nutritional analysis that we could find at that time was five years old, and we wanted more accurate, up-to-date information, so we contracted this service out to conduct the nutritional analysis and obtain the baseline sodium content. A hundred and five meals were analyzed, and these meals had multiple components that needed to be measured, such as the entree, the side dishes, the condiments, and dessert.

Once we did have the baseline, we worked with the food service management company and the county to determine what strategies we could take to begin to reduce the sodium in these meals. The - we knew that these strategies needed to be cost effective and time efficient.

So we determined three strategies to use, which you can see on Slide 30. The first one is modifying recipes, and this included the elimination of adding salt into recipes, decreasing or removing cheese in meals and lessening the amount of gravy or other sauces used in a meal.

The second strategy was substituting lower sodium products. The products that we were able to substitute included more sodium-friendly soup bases, a reduced ham. There were other products that were identified such as a lower sodium pork loin and turkey, but these products were too high in costs for them to fit in the budget and to be added onto the menu.

The third strategy was to change cooking techniques, and we worked with the cooks at Glendale Nursing Home to identify how we could make these happen. Some of them included rinsing canned beans and tuna and not adding any additional salt to the cooking water. It should be noted that none of the seniors were made aware of any of the changes being made to the meals.

So after we went through our strategies and meals were changed, a very, very time-intensive, complicated process of measuring the reduction in sodium took place. In order to measure the reduction in sodium we needed to find out exactly what product was used in the baseline calculation and find its sodium content. We then had to find the sodium content of the new product to measure the change, but in order to find the specific product information, we had to search multiple databases and sometimes even needing to find the UPC code in order to find the product.

We'll get into a little bit more of the difficulties in finding the product information when we talk about commercial labeling in a couple of minutes.

So on Slide 31, you can see our final outcomes. We were able to make ten product changes, and it should be noted too that each product was tested by the food service management company to make sure it was still palatable and tasted good for the seniors. So the ten products included a lower sodium hotdog, a no-sodium chicken, beef, pork and vegetable soup base, a lower sodium ham, lower sodium diced tomato and tomato sauce and using fresh mushrooms instead of canned.

In order for the low-sodium soup base to be cost effective, as well as palatable to the consumer, a mixture of 25% low-sodium soup base and 75% regular soup base was used. We discovered that low-sodium soup base is very expensive.

Like I said before, recipe and technique modifications were also made. So in total, 49 out of the 105 meals on the 5-week menu had some sort of sodium reduction. Because of the products changed, such as the soup bases and tomato sauces, a reduction occurred in many meals because a gravy or tomato sauce is frequently part of that meal. So in total, a 9.75% sodium reduction was achieved, and approximately 13,000 milligrams of sodium was removed from the menu.

We wanted to make sure that we were not changing any of the meals and making them unpalatable to seniors, so we decided to conduct a survey. No mention of sodium or salt was on the survey in order to not bias their answers. Seniors were asked to rate the meals on a 1 to 4 scale with 4 being flavorful. An extremely positive feedback was received. The vast majority of seniors rated the meals flavorful. No one made any comments about salt or sodium on their surveys as well.

What was interesting though was the Home Delivered Meals program did receive a few phone calls about the ham, because participants were surprised when a ham meal was delivered. These participants were on a low-sodium diet and were not eligible to get the ham meal because it was too high in sodium, but now with a lower sodium ham being used, it fit into the low-sodium diet category, and seniors could now receive this.

Many seniors were very happy about this. The ham alone decreased from 1000 milligrams of sodium to 600, and no negative reports were received about this dramatic change.

So in Slide 32, you'll see that we identified some larger systems changes that needed to be made. We came across a few roadblocks in lowering the sodium in our meals, and the first one is that nutritional labeling is not required in food used in commercial settings. It was therefore very time consuming for

our coordinator and evaluator to track down the sodium content of the products used.

Our evaluator had to go to several sources to track down product-specific information such as the manufacturer's Web site, the USDA Web site, the Cisco database, which is a local distributor's database that we obtained permission to access and through the food service management company's program director.

It's therefore very difficult for a food service company or anyone working in a commercial setting to know which products are available in a lower sodium version, what the sodium content is and if it is cost effective for them to make the change.

We also learned that many low-sodium products are not available in commercial sizes. For example, the low-sodium soup bases we are using are only offered in a 1-pound container instead of the 5- or 8-pound containers commonly used in food service operators.

So just to wrap up, we're very grateful that we've had the support from the county, the nursing home as well as the food service management company. We also like to express our thanks to the New York State Department of Health and the CDC, especially (Christie Mulgovero) for their technical assistance and support.

We hope to continue to learn more about how to reduce sodium and are hopeful that in Years 2 and 3, we will continue to identify lower sodium cost-effective products, modify recipes, and decrease the amount of processed foods in order to reach our 3-year goal of reducing sodium by 30%.

We know that in order to make a long-term sustainable change, we need to change the policy by adding sodium standards into the contract. You have the contact information for our team. It's available on the slides.

Both Jennifer Kahn, the Program Evaluator and June Schult, the Program Coordinator have done really a wonderful job tackling this complicated issue, and the results today that we've talked about is primarily due to their hard work and perseverance.

So thank you again for asking us to participate, and we look forward to answering any questions that you may have.