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May 8, 2015

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Re: Report of the Dietary Guidelines Advisory Committee

Dear Dr. Olson, Dr. Casavale, Ms. Rihane, and Dr. Bowman:

On behalf of the American Heart Association (AHA), including the American Stroke Association, and more than 22 million volunteers and supporters, we appreciate the opportunity to provide comments in response to the Report of the 2015 Dietary Guidelines Advisory Committee.

AHA strongly supports the Advisory Committee's Scientific Report. We applaud the recommendations and the methodology used to develop a comprehensive, evidence-based review of the science that reflects the needs of today's population, which is largely overweight or obese, undernourished, and physically inactive. AHA appreciates the Committee's focus on healthy dietary patterns associated with a reduced risk of cardiovascular disease, overweight and obesity, and the need for broader policy and environmental change to help Americans make healthier choices. We thank the Committee for its work and we look forward to seeing the Committee's recommendations incorporated into the 2015 Dietary Guidelines for Americans later this year.

To help the Department of Health and Human Services (HHS) and the U.S. Department of Agriculture (USDA) translate the Advisory Committee's report into specific consumer guidance and develop federal policy, AHA offers the following comments and recommendations.

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Dietary Patterns, Foods and Nutrients, and Health Outcomes

AHA supports the continued focus on food-based dietary guidance and the total diet concept. As the Committee recognized, achieving an overall healthy dietary pattern is more important than any one specific food or nutrient. A variety of dietary patterns are linked to reduced risk of cardiovascular disease, and those diets share many of the same characteristics, including higher intakes of fruits, vegetables, low-fat dairy products, whole grains, poultry, fish, legumes, non-tropical vegetable oils and nuts, and lower intakes of sodium, added sugars, saturated fat, and red meat.

One benefit of a total diet approach is that it encourages personal choice. Individuals can consume a wide range of foods and meet nutrient needs in a variety of ways. This makes it easier for individuals to consume a healthy diet that is tailored to their individual physical needs and social and cultural preferences, but still meet the overarching recommendations for a healthy diet pattern. To illustrate this flexibility, we recommend that the Dietary Guidelines include several examples of specific diets that could meet the overarching healthy diet pattern recommendations.

Food Environment and Settings

Many of the Committee's recommendations (i.e., eat more fruit and vegetables, eat less sodium) have been made in previous editions of the Dietary Guidelines yet adherence to a healthy dietary pattern has not improved and obesity rates remain high. To reverse this trend, the Committee recommends a number of environmental and policy approaches designed to improve access to high quality, affordable, healthy foods. AHA strongly agrees with the Committee that a comprehensive, coordinated system-wide approach is needed to change dietary patterns on a broad scale.

We encourage HHS and USDA to prominently feature these recommendations in the Dietary Guidelines policy document. The Dietary Guidelines should emphasize the important role that the food environment and public policies play in the ability of Americans to follow the Dietary Guidelines' recommendations. **The Dietary Guidelines should also include a call to action for a wide range of stakeholders – including policymakers at all levels of government, public health experts, the food and beverage industry, restaurants and food retailers, schools, businesses, and others – to make healthy lifestyles and disease prevention top priorities.**

We note that many of the recommended population-level strategies involve changes in federal policies, and we urge HHS and USDA to work with its federal partners to move the Committee's recommendations forward. In particular, we recommend that the Agencies:

- Launch a consumer education campaign that helps consumers understand their calorie needs
- Help restaurants and other retailers implement the federal menu labeling law and evaluate its impact
- Develop a single front-of-package nutrition symbol overseen by the FDA
- Finalize revisions to the Nutrition Facts panel in a timely manner
- Update food label health claims to reflect current evidence-based dietary guidance

- Implement the recommendations in the 2010 Institute of Medicine Report “Strategies to Reduce Sodium Intake in the U.S.”, including establishing national standards for sodium across the food supply. We strongly believe this is an important nutritional recommendation that is critical to a comprehensive approach to the management of hypertension – a serious condition that affects approximately 80 million Americans and is estimated to impact 90% of our population as we age.
- Encourage and incentivize the food and beverage industry to produce and sell healthier options
- Help schools comply with the school meals and competitive foods nutrition standards that are transforming the school environment in a healthy, positive way providing students healthier food and beverage options and fostering a better learning environment
- Create and/or finalize robust nutrition standards for the Child and Adult Care Food Program, the Women, Infants, and Children Program, the Supplemental Nutrition Assistance Program, and other federally funded government feeding programs
- Increase funding for Healthy Food Financing Initiatives

Food Sustainability and Safety

Food Sustainability

As part of its deliberations, the Committee examined how traditional dietary guidance can be impacted by questions of food sustainability. The Dietary Guidelines have, for instance, long recommended that Americans increase their consumption of fruits and vegetables, as well as fish. In order for Americans to follow this advice there must be a sufficient and safe supply of these foods. This will require changes to the whole food supply chain, including food production, harvesting, and the associated economic and environmental sectors. For example, in order for all Americans to increase their fruit and vegetable consumption to recommended levels, there will have to be an increase in production; growers will have to adjust to changing growing conditions such as more volatile weather and declining water resources; the time from harvest to sale must be shortened to reduce food lost to spoilage; and costs must go down to make these foods more affordable for the public.

We appreciate the Committee raising this important issue and we encourage the Agencies to consider how they can support systems changes that may be necessary to improve food sustainability and ensure access to affordable, healthy foods. This may include updating the charter and scope of future Dietary Guidelines Advisory Committees to ensure that food sustainability is included as a component and that the Committee includes members with the appropriate expertise to advise on the topic.

Caffeine

The Advisory Committee recommends limited or no consumption of high caffeine drinks for children and adolescents. AHA supports this recommendation. High levels of caffeine, such as

those found in energy drinks, may disturb normal heart rhythm and increase blood pressure.¹ Energy drink consumption by children can also result in caffeine poisoning. Over a three year period, poison control centers received 5,156 calls related to energy drinks, 40% of which were in children under six years of age, some of whom experienced serious cardiac and neurological symptoms.²

We also support the Committee's recommendation against consuming energy drinks and alcohol at the same time. The poison control study found that moderate to major outcomes, such as abnormal heart rhythms, conduction abnormalities, and seizures were reported in 42% of cases combining energy drinks and alcohol.

Nutrient Adequacy and Nutrients of Concern

Potassium

AHA agrees with the Committee that current intake of potassium remains too low and that potassium deficiency can adversely impact health. The Dietary Guidelines should continue to recommend increased consumption of potassium-rich fruits and vegetables, as well as low-fat dairy.

Dietary Cholesterol

Previous versions of the Dietary Guidelines have recommended that cholesterol intake be limited to no more than 300mg per day. The 2015 Advisory Committee, however, has decided not to bring forward this recommendation. AHA supports the Committee's decision.

As the Committee notes in the Scientific Report, AHA and the American College of Cardiology (ACC) issued guidelines on lifestyle management in 2013 that concluded that scientific evidence does not support limiting dietary cholesterol to lower artery clogging LDL-cholesterol in the blood.³ AHA and ACC reached this conclusion after an extensive expert review of peer-reviewed, published scientific studies.

To help Americans lower LDL-cholesterol in the blood, the Dietary Guidelines should emphasize limiting saturated fat intake. Saturated fat and *trans* fat have been shown to raise LDL cholesterol in the bloodstream. Saturated fats are found in meats, full-fat dairy products, and tropical oils. Lowering saturated fat intake will also result in decreases in dietary cholesterol, because dietary cholesterol and saturated fat are often found in the same animal-based products. Thus, lowering saturated fat consumption will naturally keep dietary cholesterol within check.

¹ Energy drinks may increase blood pressure, disturb heart rhythm: American Heart Association Meeting Report. March 21, 2013. See <http://newsroom.heart.org/news/energy-drinks-may-increase-blood-pressure-disturb-heart-rhythm>.

² See <http://blog.heart.org/poison-control-data-show-energy-drinks-young-kids-dont-mix/>

³ Stone NJ, et al. 2013 ACC/AHA guideline on the treatment of blood cholesterol to reduce atherosclerotic cardiovascular risk in adults: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines. *Circulation*. 2013;00:000–000.

It will be important, however, for the Dietary Guidelines to explain that the removal of the cholesterol recommendation does not provide a “green light” to eat large amounts of dietary cholesterol. While consuming moderate amounts of dietary cholesterol as part of a diet low in saturated fat is generally not a reason for concern, people who eat large amounts of cholesterol-containing foods will also be consuming high levels of saturated fat. Americans need to be mindful that foods that contain cholesterol also contain saturated fat. To clarify this for consumers, we recommend that the Dietary Guidelines include specific examples of cholesterol-containing foods (both those with high and low amounts of saturated fats) and explain how much can be included in a healthy dietary pattern.

Fruits and Vegetables

We agree with the Committee that additional measures are needed to encourage consumption of fruits and vegetables as part of a healthy diet. Despite decades of consistent messaging advising Americans to eat more fruits and vegetables, intake levels remain low with less than 10% eating the daily recommended amount of vegetables and less than 20% eating the recommended amount of fruit. This indicates that a new and innovative approach is needed.

To increase consumption, HHS and USDA must move beyond public awareness efforts and pursue broad environmental and policy changes, such as strengthening policies that increase children’s access to more fruit and vegetables in the school environment; requiring a larger quantity and greater variety to be served to children in day care and in after school programs; providing incentives for the purchase of fresh fruits and vegetables such as the SNAP “double up food bucks” program; increasing access to fruits and vegetables in all other federal nutrition programs; and encouraging large restaurant and foodservice companies to serve and sell more fruits and vegetables. As discussed above, we also recommend that the Agencies explore what systems changes will be necessary to improve access and affordability.

Whole Grains

With respect to grain consumption, the Committee continues to recommend that individuals lower their intake of refined grains and substitute whole grain versions for at least half of their grain servings. AHA supports this recommendation; diets high in whole grains and fiber have been associated with increased diet quality and decreased risk of cardiovascular disease.

To help Americans implement this recommendation, the Dietary Guidelines must make clear that whole grains should be *substituted* for refined grain products, rather than added as extra grain servings. As the Committee found, Americans already consume more grain servings than necessary to meet their energy needs.

The Dietary Guidelines should also include illustrations to convey an appropriate serving size of pasta, rice, and other grain products, and provide specific examples of foods to consume such as 100% whole wheat bread, brown rice, rolled or steel-cut oats, or foods labeled 100% whole grain. Furthermore, the Guidelines should warn consumers that foods with labels such as “8 grams whole grain” or “made with whole grains” may still contain refined grain, and in some cases, may

contain more refined grain than whole grain. To help consumers identify the whole grain content, the FDA should require food manufacturers to include the percentage of whole grains on the food label.

The Guidelines should also explain that the presence of a whole grain ingredient does not necessarily ensure that the food product is a good source of fiber or other vitamins and minerals.

Cross-Cutting Topics of Public Health Importance

AHA is very pleased that the Committee's report places a significant emphasis on the need to lower consumption of sodium, saturated fat, and added sugars. Americans over-consume all three, leading to increased risk of cardiovascular disease, overweight and obesity, diabetes, and other negative health outcomes. While we believe the science supports even lower recommendations for sodium, saturated fat, and added sugars than the Committee recommended, the Committee's recommendations will move Americans in the right direction – promoting better cardiovascular and overall health. We, therefore, urge the Agencies to adopt the Committee's recommendations in the final policy report.

In addition, the Dietary Guidelines should explain that reductions in sodium, saturated fat, and added sugars should not occur in isolation; substitution is the key to achieving a healthy dietary pattern. Sodium, saturated fat, and added sugars should be replaced with healthy alternatives. For example, sources of saturated fats should be replaced with unsaturated fats, sugar-sweetened beverages should be replaced with water, and unsalted foods should be seasoned with spices and herbs instead of salt. However, as the Committee noted, industry efforts to reformulate, particularly to reduce sodium content, must be expanded in order to achieve significant shifts in dietary patterns. This reinforces the need for broad environmental and policy changes to improve the quality of the food supply.

We offer more detailed comments about sodium, saturated fat, and added sugars below.

Sodium

We applaud the Advisory Committee for emphasizing sodium reduction in its Scientific Report. Sodium continues to be a major public health problem with Americans consuming an average of 3,478mg per day – far more than the recommended amount. Excess sodium consumption is linked to the development and worsening of high blood pressure and an increased risk of heart disease, stroke, kidney failure, gastric cancer, and osteoporosis. Reducing sodium intake, on the other hand, can help control blood pressure and reduce overall cardiovascular risk. That is why the Advisory Committee, AHA, and many other well-respected scientific and professional health organizations all recommend reductions in sodium consumption.

We understand, however, that there is some research that questions whether sodium reduction is necessary, or if significant reductions could in fact be harmful. These questions are the result of observational studies that often have methodological problems, such as unreliable measures

of sodium intake or a focus on sick populations.⁴ These methodological issues severely limit the usefulness of these studies in guiding nutrition policy, much less revising longstanding recommendations to lower sodium consumption. Hence, we are very pleased that the Advisory Committee did not rely heavily on these flawed studies, but instead focused on high quality investigations and the robust body of evidence linking sodium with elevated blood pressure. After weighing all of the evidence, the Committee used the best available evidence to conclude that sodium reduction should continue to be a public health priority. We strongly agree.

To help Americans achieve a healthier sodium intake, the Committee has recommended that the general population limit sodium to less than 2,300mg or the age-appropriate Dietary Reference Intake (DRI) amount.⁵ We support this recommendation. Although we believe the ultimate target amount should be even lower (less than 1,500mg per day), 2,300mg is an appropriate recommendation based on current consumption levels and the amount of sodium in the food supply. Reducing sodium consumption to less than 2,300mg per day is a good first step.

We also agree with the Committee's conclusion that adults who would benefit from blood pressure lowering should lower their sodium intake. According to the Committee's report, individuals with hypertension or prehypertension should consume no more than 2,400mg per day; further lower consumption to 1,500mg per day for a greater reduction in blood pressure; or reduce intake by at least 1,000mg if they are unable to achieve the other goals. We understand that 2,400mg is recommended because it was the estimated average urinary sodium excretion in the DASH sodium trial; however, we are concerned that recommending less than 2,300mg for the general population and no more than 2,400mg for adults who would benefit from blood pressure lowering could result in confusion. We urge HHS and USDA to simplify the messaging in the final policy document and recommend less than 2,300mg for the general population and at-risk subgroups (which include middle-aged and older adults, African-Americans, and individuals with diabetes, hypertension, or chronic kidney disease). At-risk subgroups should also be advised that a greater reduction to 1,500mg could have additional benefits to blood pressure, and that if they cannot immediately reach either target level, that reducing sodium by at least 1,000 mg per day would be beneficial.

To help individuals lower their sodium intake, the Committee has recommended that a "primary emphasis be placed on policies and population-based strategies for sodium reduction while at the same time paying attention to consumer education." We strongly agree. Despite decades of dietary guidance advising Americans to reduce their sodium consumption, high intakes have persisted. It is clear that relying on education and individual behavior change alone is not enough. With nearly 80% of the sodium we eat coming from packaged and restaurants foods,

⁴ Cobb LK, et al. Methodological issues in cohort studies that relate sodium intake to cardiovascular disease outcomes: A science advisory from the American Heart Association. *Circulation*. 2014. See <http://circ.ahajournals.org/content/129/10/1173>.

⁵ We recommend that the final policy document specify the amount of sodium that corresponds to the DRI amount for each age group so that policies can be set accordingly. Per the 2005 IOM DRIs for sodium, the Upper Levels (mg/day) are: Age 1-3: 1,500; Age 4-8: 1,900; Age 9-13: 2,200; Age 14-18: 2,300

Americans will continue to have relatively little control over their sodium intakes and find it challenging to reduce their sodium intake unless there are changes to the food supply. As the Committee advised, HHS and USDA should work with the food and restaurant industry to lower the amount of sodium in the food supply. This can be achieved by implementing the recommendations contained in the 2010 IOM report “Strategies to Reduce Sodium Intake in the United States”, including modifying the GRAS status of salt and establishing sodium limits for foods.

The Agencies should also continue to move forward with existing efforts to reduce sodium intake in children. As the Scientific Report discusses, the concern over excess sodium consumption and negative health effects is not just limited to adults. Children are also at risk of developing heart disease and elevated blood pressure at an earlier age, because about 90% of them consume too much sodium. The prevalence of elevated blood pressure in children is already on the rise, and it is also well known that blood pressure rises with age. Fortunately, the evidence shows that in children, just like in adults, blood pressure decreases as sodium intake goes down. In addition, lowering sodium intake can significantly blunt the age-associated rise in blood pressure. Accordingly, there is a need for federal efforts to lower sodium intake in children, such as continuing the tiered reduction in the National School Lunch Program and the School Breakfast Program.

For children and adults, there is consensus the U.S. population has to reduce sodium intake. A target of 2,300 mg is reasonable for the general population with a recommendation to reduce further in at-risk sub-populations. Achieving these targets will not happen without a significant commitment from industry to reduce sodium in the food supply and for industry and consumers to reduce portion sizes. Additionally, reducing sodium in the foods purchased or made available in different environments like schools, government feeding programs, and workplaces is essential if we are going to achieve the health benefits of sodium reduction across the population.

Saturated Fat

AHA is pleased that the Committee continues to recommend that Americans reduce their saturated fat intake. Scientific evidence shows that diets low in saturated and *trans* fats reduce the risk of cardiovascular disease, in large part through their effects on LDL cholesterol levels, but data also show reductions in all-cause mortality among populations with lower saturated fat intake.

We are, however, disappointed that the Committee did not lower its recommendation from less than 10% of total calories to less than 6% of energy as recommended in the ACC/AHA 2013 guidelines on reducing cardiovascular risk through lifestyle management. The guidelines, which were originally initiated by the National Heart, Lung and Blood Institute in 2008 and later finished in collaboration with AHA and ACC, found that 5 to 6% of calories is an ideal target for saturated fat consumption.

Although AHA and the Committee disagree on the exact limit for saturated fat, we both agree that current consumption rates are too high and must be reduced. To help Americans reduce their

saturated fat intake, the Dietary Guidelines should emphasize the need to reduce saturated fat, provide clear examples of the types of foods that are high in saturated fat, and explain how foods high in saturated fat should be replaced with foods rich in polyunsaturated or monounsaturated fats. For example, the Dietary Guidelines should recommend replacing tropical oils that are high in saturated fat, such as palm or coconut oil, with olive or canola oils; replacing red meats high in saturated fat with poultry, fish, legumes, and nuts; and replacing full-fat dairy products with low-fat or fat-free versions.

In addition, the Dietary Guidelines should clarify that individuals should focus on the *quality* of the fat they eat rather than the total *quantity*. Research indicates that the quality of fat consumed is more important than the overall quantity. For example, lowering total fat intake (fat reduction alone) does not clearly have a benefit on cardiovascular events, while replacing some saturated fat with unsaturated fats (fat reduction and fat modification, or fat modification alone) may reduce the incidence of cardiovascular events.⁶ Therefore, the Dietary Guidelines should, as the Committee recommended, “put the emphasis on optimizing types of dietary fat and not reducing total fat.”⁷

Added Sugars

AHA applauds the Committee’s recommendation to reduce consumption of added sugars. Added sugars are a significant source of excess calories and are associated with greater overall calorie intake and higher body weight. Excess sugar consumption has also been linked to several metabolic abnormalities, adverse health conditions, and a shortfall of essential nutrients.

We also appreciate that the Committee – for the first time – has identified a quantitative recommendation for the consumption of added sugars. A quantitative limit will help Americans reduce added sugars by giving them a target or goal to work toward. The Committee’s recommendation of a maximum of 10% of total calories aligns with the World Health Organization’s (WHO) recommendation that individuals consume less than 10% of their calories from “free” sugars. However, we note that many adults and children have little room in their diet for empty calories with no nutritional value and they will need to go lower than 10% in order to have a healthy dietary pattern and meet their essential nutrient needs.

The Agencies should consider modifying the Committee’s recommendation to no more than 5 to 10% of calories. That recommendation would still align with the WHO, which has indicated that further reducing free sugar consumption from less than 10% to less than 5% of energy (6 teaspoons or 25g), will result in the greatest health benefit.⁸ It would also align with AHA’s recommendation that no more than one-half of discretionary calories should come from added

⁶ Hooper L, et al. Reduced or modified dietary fat for preventing cardiovascular disease. Cochrane Database of Systematic Reviews 2012, Issue 5. Art. No.: CD002137. DOI: 10.1002/14651858.CD002137.pub3.

⁷ Scientific Report of the 2015 Dietary Guidelines Advisory Committee. Part D. Chapter 6: Cross-Cutting Topics of Public Health Importance. Page 13.

⁸ World Health Organization. Guideline: Sugars intake for adults and children. March 2015.
<http://www.who.int/mediacentre/news/releases/2015/sugar-guideline/en/>

sugars. AHA recommends that most women consume no more than 100 calories (6 teaspoons) from added sugars per day and no more than 150 calories (9 teaspoons) per day for most men.⁹

In addition to providing a quantitative recommendation, the Dietary Guidelines should provide consumers with specific strategies for reducing added sugar consumption. This should include a clear description of the major sources of added sugars, and an explicit recommendation to avoid sugar-sweetened beverages. Drinking sugar-sweetened beverages, which are the primary source of added sugars in the American diet, leads to weight gain in both children and adults^{10,11,12} and is associated with higher blood pressure, leading to increased rates of hypertension.¹³ The Dietary Guidelines should advise replacing sugar-sweetened beverages with a healthy option, specifically water, or low-fat or fat-free milk for children.

To further help Americans implement the added sugars recommendation, HHS should direct the FDA to finalize its proposal to require a separate listing of “added sugars” on the Nutrition Facts Panel. Added sugars should be listed in both grams and teaspoons, and should include a percent Daily Value. This combination of recommendations is particularly important because it provides both a goal for reduction and the information source needed to implement the recommendation.

We are also concerned that consumers will have a difficult time implementing an added sugars recommendation based on a percentage of total calories. Consumers will have to know their overall calorie needs, determine how many calories represent no more than 10 (or 5) percent, and translate that percent of calories into the appropriate number of grams or teaspoons. To help consumers make this calculation, the Agencies should create consumer friendly education materials such as a chart that shows the maximum amount of added sugars – in calories, grams, and teaspoons – that an individual could consume based on a range of overall calorie needs. A chart that provides examples of how much added sugar, on average, is in products such as soda, candy, baked goods, etc. will also be useful.

Finally, we agree that policy changes at all levels of government are needed to support efforts to lower added sugars in beverages and foods and to limit availability of sugar-sweetened beverages and snacks, including the following:

- Add “added sugars” and a percent DV to the Nutrition Facts Panel
- Develop a single front-of-package nutrition symbol overseen by the FDA

⁹ Johnson RK, et al. Dietary sugars intake and cardiovascular health: a scientific statement from the American Heart Association. *Circulation*. 2009 June; 120:1011-1020.

¹⁰ Malik VS, et al. Sugar-sweetened beverages and weight gain in children and adults: a systemic review and meta-analysis. *Am J Clin Nutr* doi: 10.3945/ajcn.113.058362. 2013.

¹¹ Ebbeling CB, et al. A randomized trial of sugar-sweetened beverages and adolescent body weight. *N Engl J Med*. 2012 Oct 11;367(15):1407-16.

¹² De Ruyter JC, et al. A trial of sugar-free or sugar-sweetened beverages and body weight in children. *N Engl J Med*. 2012 Oct 11;367(15):1397-406.

¹³ Malik AH, Akram Y, Shetty S, Malik SS, Yanchou Njike V. Impact of sugar-sweetened beverages on blood pressure. *Am J Cardiol*. 2014;113:1574-1580.

- Economic and pricing approaches to limit added sugar intake including SSB taxes, and piloting the restriction of SSB purchases within the Supplementation Nutrition Assistance Program
- Continued efforts to reduce added sugars in foods and beverages in school meals and snacks
- Limit advertising of foods and beverages high in added sugars to children, youth, and adolescents
- Health promotion efforts and policies to reduce the availability of sugar-sweetened beverages in post-secondary institutions and workplaces
- Launch a consumer education campaign to raise public awareness of health harms and alternatives to added sugars

Low-Calorie Sweeteners

The Advisory Committee also looked at the use of low-calorie or non-nutritive sweeteners to replace added sugars. We appreciate the Committee's examination of this issue; as discussed above, reducing added sugars in the diet is important for improving overall nutrition and maintaining a healthy weight. We also agree with the Committee's conclusion that replacing added sugars with low-calorie sweeteners may reduce calorie intake, body weight, and adiposity. Thus, low-calorie sweeteners may be a component of a healthy diet when used judiciously and as long as the substitution does not lead to consuming additional calories elsewhere in the diet.¹⁴

We also agree with the Committee that further well-designed studies are needed to explore the role of low-calorie sweeteners for maintaining body weight and reducing risk for diabetes, cardiovascular disease, and other chronic conditions over a lifetime. We recommend that future Advisory Committees revisit this issue when additional data are available.

Water

AHA strongly agrees with the Committee that water should be promoted as the preferred beverage choice. Water is an essential nutrient, it provides hydration, and unlike sugar-sweetened beverages, it contains no calories and has virtually no adverse effects.¹⁵ Research shows that substituting water for sugary drinks can help reduce intake of calories from added sugars among both children and adults^{16,17} and reduce the risk of dental caries.

¹⁴ Gardner C, et al. on behalf the American Heart Association Nutrition Committee of the Council on Nutrition, Physical Activity and Metabolism, Council on Arteriosclerosis, Thrombosis and Vascular Biology, Council on Cardiovascular Disease in the Young, and the American Diabetes Association. Nonnutritive sweeteners: current use and health perspectives: a scientific statement from the American Heart Association and the American Diabetes Association. *Circulation*. 2012;126:509–519.

¹⁵ Popkin BM, et al. A new proposed guidance system for beverage consumption in the United States. *The American Journal of Clinical Nutrition*, 83 (3), 529-542.

¹⁶ Tate, D.F, et al. Replacing caloric beverages with water or diet beverages for weight loss in adults: main results of the Choose Healthy Options Consciously Everyday (CHOICE) randomized clinical trial. *The American Journal of Clinical Nutrition*, 95 (3), 555-563; 2012.

¹⁷ Zheng, M, et al. Substituting sugar-sweetened beverages with water or milk is inversely associated with body fatness development from childhood to adolescence. *Nutrition*, 31 (1), 38-44; 2015.

To encourage people to select water, water must be available in all public settings, including child care facilities, schools, and worksites, and in all places where beverages are offered. Messages promoting water should be included in all nutrition education materials, including the government's MyPlate food icon. MyPlate is a powerful teaching tool for young people, to whom sugar-sweetened beverages are heavily marketed.^{18,19} The addition of a water symbol would enable MyPlate to promote water consumption along with its other messages. We encourage the USDA to add a water symbol to the MyPlate icon.

Physical Activity

AHA appreciates the Committee's decision to address physical activity as part of its Scientific Report. Regular physical activity is associated with a healthier, longer life and with a lower risk of heart disease, high blood pressure, diabetes, obesity, and some cancers.²⁰ Being physical active is one of the most important health behaviors people can do to maintain cardiovascular health and quality of living.

To promote physical activity within the Dietary Guidelines, the ensuing consumer education campaign should emphasize the importance of adhering to the Physical Activity Guidelines for Americans. But the Agencies must go beyond simply telling Americans to be physically active; Americans have heard that message for years, but the majority still do not get the recommended amount of physical activity. Changes to public policies and the environmental setting are also needed. Specifically, we recommend that the Agencies work with federal, state, and local officials to:

- Update the Physical Activity Guidelines every ten years with a mid-course review every five years
- Require schools to include physical education as a core subject
- Require school districts and states to report on students' physical activity, including the amount of time spent in required physical education in relation to the recommended national standard
- Provide adequate funding for the Carol M. White Physical Education Program (PEP)
- Promote shared use agreements that allow schools to share their physical activity facilities with the community for recreation and exercise opportunities
- Improve the built environment to increase opportunities for safe, active transport such as walking or bicycling
- Encourage employers to provide opportunities for physical activity at the workplace
- Adapt exercise programs to meet the needs of individuals with disabilities

¹⁸ Yale Rudd Center for Food Policy and Obesity. Study Synopses: Sugar-Sweetened Beverage (SSB) Marketing to Youth. 2013.

¹⁹ Robert Wood Johnson Foundation. Food and Beverage Marketing to Children and Adolescents: Limited Progress by 2012, Recommendations for the Future.

²⁰ Eyre, H., et al. Preventing cancer, cardiovascular disease, and diabetes: a common agenda for the American Cancer Society, the American Diabetes Association, and the American Heart Association. *Circulation* 109(25): 3244-3255; 2004.

Closing

In closing, AHA would like to reiterate our strong support for the 2015 Dietary Guidelines Advisory Committee Scientific Report. We applaud the Committee's recommendations to reduce consumption of sodium, saturated fat, and added sugars. We support the Committee's emphasis on the total diet and the need to replace less healthy foods with healthier options; and we appreciate all of the Committee's recommendations for policy and environmental changes that will help make the healthy choice the easy, affordable, available, and attractive choice for more Americans.

The Committee's report provides the Agencies with a strong science-based foundation for the 2015 Dietary Guidelines and we encourage HHS and USDA to incorporate the Committee's recommendations into the final policy document. The Agencies should deflect efforts to weaken the Committee's recommendations; the Dietary Guidelines must reflect current nutrition science. Public health recommendations are made after weighing all of the evidence, including studies of greater and lesser strength of design and some with conflicting results. Some evidence is of higher quality and more methodologically sound than other evidence; the best available evidence should be used to form the 2015 Dietary Guidelines.

Finally, to ensure that the Dietary Guidelines will be of the most use to the public, they must be communicated to the public properly in a consistent and robust way. We urge HHS and USDA to make sure that the Advisory Committee report is translated into strong, easily understandable recommendations for the public that include examples of specific foods to consume and avoid. We also encourage the agencies to evaluate whether the guidelines and the resulting healthy eating messages are accurately interpreted and implemented by consumers.

If you have any questions or need any additional information, please do not hesitate to contact Susan Bishop, MA, Senior Regulatory Affairs Advisor, at (202) 785-7908 or susan.k.bishop@heart.org.

Thank you for your consideration of our comments.

Sincerely,

A handwritten signature in black ink, appearing to read "Elliott Antman", with a stylized flourish at the end.

Elliott M. Antman, MD, FAHA
President, American Heart Association