



STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene

201 W. Preston Street • Baltimore, Maryland 21201

Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – John M. Colmers, Secretary

January 21, 2010

The Honorable Peter A. Hammen, Chair  
House Health & Government Operations  
Committee  
Lowe House Office Building, Room 241  
Annapolis, MD 21401 - 1991

The Honorable James Hubbard  
Maryland House of Delegates  
House Office Building, Room 363  
Annapolis, MD 21401 - 1991

The Honorable Doyle Niemann  
Maryland House of Delegates  
House Office Building, Room 203  
Annapolis, MD 21401 - 1991

Dear Chair Hammen and Delegates Hubbard and Niemann:

On behalf of the Department of Health and Mental Hygiene's (the Department) Food Policy Workgroup, I am pleased to submit this legislative report on proposed strategies to create a healthier food environment in Maryland. The Workgroup convened over the legislative interim to carefully consider issues surrounding trans fats prohibition and menu labeling as well as a comprehensive approach to healthy eating. As a result, the Department would support a menu labeling bill that aligns with the federal legislation related to menu labeling. However, the Department does not support a trans fat prohibition due to failure to prevent obesity, limited evidence for preventing cardiovascular events, and the complexity of implementation.

The Department thanks you for the opportunity to provide you with the enclosed report, particularly given the increasing obesity epidemic and the high cardiovascular disease prevalence in Maryland. We appreciate your interest in promoting legislative policies to enhance the nutritional wellness of Maryland citizens. If you have any questions, please contact Wynee Hawk, Director, Office of Governmental Affairs, at (410) 260-3190.

Sincerely,

John M. Colmers  
Secretary

Enclosure

cc: Wynee Hawk, R.N., J.D.  
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**Food Policy Workgroup**  
**Maryland Department of Health and Mental Hygiene, Public Health Services**  
**January 2010**

The Department of Health and Mental Hygiene (the Department) convened a workgroup to study issues related to trans fats prohibition and menu labeling requirements in restaurants during the 2009 legislative interim. As a result, the Department would support a menu labeling bill that aligns with the federal legislation related to menu labeling. However, the Department does not support a trans fat prohibition due to failure to prevent obesity, limited evidence for preventing cardiovascular events, and the complexity of implementation.

The workgroup was established in an agreement between legislators and the Department in lieu of the General Assembly's passage of House Bill 567 (2009) entitled "Food Service Facilities – Artificial Trans Fats – Prohibition" and House Bill 601 (2009) entitled "Public Health – Chain Restaurants – Nutrition Information Labeling." Consequently, during the summer of 2009, a Food Policy Workgroup comprised of public health professionals met regularly to review, discuss, and make recommendations for policies that could improve the eating habits of Marylanders. The Food Policy Workgroup consisted of the following public health representatives from the Department: Dr. Alan Brench, Debra Celnik, Sharmi Das, Dr. Maria Prince, and Dr. Audrey Regan. Issues related to menu labeling and trans fats also were discussed by the previously established Maryland Health Quality and Cost Council's Wellness and Prevention Workgroup, as well as the State Advisory Council on Heart Disease and Stroke's Committee on Childhood Obesity (see Appendix 1 for the Membership of the Health Quality and Cost Council and the Committee on Childhood Obesity).

In its review of nutrition labeling and trans fats issues, the Food Policy Workgroup studied professional publications and materials presented at national conferences. The Workgroup's review of nutrition labeling included an assessment of the proposed federal legislation which focuses on caloric information. With respect to trans fat issues, the Workgroup considered the impact, implementation, and enforcement of a trans fat prohibition on Maryland public health agencies. In addition, the Workgroup examined a more comprehensive strategy to improving nutrition behaviors beyond a ban on trans fats.

The Food Policy Workgroup worked in collaboration with the Maryland Health Quality and Cost Council, which was established by Executive Order in the fall of 2007. The Health Quality and Cost Council is chaired by Lt. Governor Anthony Brown with Secretary John Colmers serving as Vice Chair. Within its Wellness and Prevention Workgroup, the Health Quality and Cost Council has prioritized the *Healthiest Maryland* strategy in its recommendations to improve health for all Maryland citizens.

*Healthiest Maryland* is a Statewide movement to create a culture of wellness—an environment that makes the healthiest choice an easy choice. There are three components of *Healthiest Maryland* -- Healthiest Maryland Businesses, Healthiest Maryland Education, and Healthiest Maryland Communities. Within each of the sectors, there is a peer-to-peer recruitment campaign to engage leadership and conduct an assessment, as well as corresponding policies and environmental changes to create the culture of wellness.

## *Why address nutrition policy?*

Obesity is the direct result of poor nutrition and failure to be physically active. Currently ranked 25<sup>th</sup> in adult obesity in the United States, Maryland reflects the national trend of rising rates of obesity. The 2008 Behavioral Risk Factor Surveillance System (BRFSS) indicates that adult obesity prevalence in Maryland has increased 47% between 1999 and 2008. Data from 2006 provided by the Maryland WIC Program indicate that 16% of participating children ages 2-5 years are overweight and 15% of participating children ages 2-5 years are obese. Public school children participate in the Maryland Youth Tobacco Survey, and 2006 results indicate that 15% of children between ages 13-18 years are overweight and 11% are obese.

Diets high in total energy, fat and sugar, but low in fruits, vegetables and fiber are all too common with Maryland residents and contribute greatly to Maryland's obesity epidemic. In 2007, only 26% of Maryland adults reported consuming the recommended five servings of fruits and vegetables per day. Variation exists by jurisdiction, with a range of 19% to 31% of Maryland adults consuming the recommended servings.

Healthy eating habits and regular physical activity are associated with marked improvements in overall health and decreased risk for a range of chronic conditions, and therefore, the State's efforts in this area would have significant health and fiscal benefits. For instance, a person who is overweight and maintains a 10% weight loss will reduce his or her lifetime medical costs by approximately \$2,200-\$5,300 per year due to lowering costs associated with hypertension, type 2 diabetes, heart disease, stroke, and high cholesterol (Centers for Disease Control and Prevention (CDC), 2008).

### Proposed Strategy #1: Implement policies that mandate the posting of caloric and nutritional content in restaurants with 20 or more establishments within the State of Maryland.

The Department, along with the Health Quality and Cost Council and the Committee on Childhood Obesity, support the implementation of policies that mandate the posting of caloric and nutritional content (i.e., calories from fat, total fat, saturated fat, trans fat, cholesterol, sodium, carbohydrates, sugars, dietary fiber, and protein) in restaurants with 20 or more establishments within the State of Maryland. In accordance with the CDC, priority should be given to strategies, such as menu labeling, that provide environmental and policy change to support behavior change for healthy eating and active living. The social ecological model serves as a framework for the State's nutrition interventions. This model emphasizes the importance of public policy and community approaches to influence personal behavior.

More than 20 states and localities are considering policies that would require fast-food and other chain restaurants to provide calories and other nutrition information on menus and menu boards—four have already passed policies. National legislation also has been introduced as part of the health care reform legislation to require calories on menus, menu boards, and drive-through displays. The federal legislation would require chain restaurants with 20 or more outlets to provide additional nutrition information upon request. The national legislation is the result of an agreement between the Center for Science in the Public Interest and the National Restaurant Association, brokered by federal legislative representatives to establish a national standard for

the declaration of calorie information on menus referred to as the Labeling Education and Nutrition (LEAN) Act (see Appendix 2 for a summary of the federal menu labeling legislation). The national legislation is worded to supersede State laws on this topic. A Maryland specific bill could serve as a safety net if the national health care reform effort fails.

Several studies have suggested that menu labeling may succeed in lowering caloric intake. Bassett et al. (Am J Public Health, 2008) reported that customers who saw the calorie information at Subway consumed 52 fewer calories on average than those who did not see the calorie information. Roberto et al. (Am J Public Health, in press) reported that groups who received calorie-only labels or calorie and recommended caloric intake labels consumed 14% fewer calories during the study than subjects who were given no labels at all. However, this caloric reduction was only sustained in those who were given labels that included recommended daily caloric intake.

Elbel et al. (Health Affairs, 2009) evaluated the success of New York City's menu labeling law in a low-income and racially and ethnically diverse population. They found that while 27.7% of study subjects who saw the calorie labels subjectively reported that the labels influenced their food choices, researchers did not detect a change in the calories that were actually purchased. However, research indicates that certain subsets of the population, such as women and those with higher education are influenced most by nutrition labels on packaged goods (Roberto et al., Am J Preventative Med, 2009). It is possible that menu labeling may only be succeeding in particular population subsets. These studies together suggest that calorie labels on restaurant menus may impact food choices and that adding a recommended daily caloric requirement label may increase this effect, but more research is needed to determine the relative impact of these changes on various subsets of the population.

Recently Starbucks, Cosi and other restaurants have reformulated menu items to reduce the calories. Evaluating the effectiveness of Maryland's menu labeling policies would be a necessary element for determining whether the policies are working, including seeing if calorie count postings led to healthier offerings. Specifically, evaluating the willingness of restaurants to adhere to State policies without significant enforcement efforts is essential. The evaluation also should include an assessment of the accuracy of posted caloric content. Furthermore, a research model that can estimate overall daily caloric intakes, as well as monitor additional nutrient consumption would be advantageous.

Proposed Strategy #2: Advance efforts that promote a comprehensive approach to a healthy diet, including focusing efforts on improving the availability of healthy foods.

At this time, the Department does not support State-level prohibition of trans fat as a means of improving the nutritional behaviors of Maryland residents. Poor nutrition habits extend beyond the consumption of artificial trans fats. As previously mentioned, only 26% of Maryland adults reported consuming the recommended five servings of fruits and vegetables per day. A reduction in trans fat consumption may not contribute to an increase in healthy food selections. As such, a trans fat prohibition would not address the obesity epidemic. Rather, the Department recommends focusing on comprehensive efforts that improve the nutritional habits of Marylanders through promoting healthy diets and improving access to healthy foods.

The elimination of trans fat from the public food supply is a growing trend. California, Philadelphia, Seattle, and New York have passed laws regarding artificial trans fat prohibitions. Additionally, two Maryland jurisdictions, Baltimore City and Montgomery County, have implemented artificial trans fat prohibitions. Howard County recognizes restaurants that voluntarily remove trans fats from their menus.

For all individuals, and particularly those with cardiovascular disease, it is recommended that they limit both trans fat and saturated fat consumption. Trans fatty acid intake adversely affects several cardiovascular risk factors and contributes significantly to increased risk of coronary heart disease events. The most rigorously demonstrated adverse cardiovascular effects of trans fatty acid consumption include increased LDL ('bad cholesterol'), decreased HDL ('good cholesterol'), and increased total cholesterol/HDL-cholesterol ratio which are independently associated with increased risk of coronary heart disease. Saturated fatty acids also increase LDL, but saturated fatty acids increase HDL leading to no significant change in the LDL/HDL ratio (see Appendix 3 for more information on trans fats as cited in the U.S. Food and Drug Administration Web site).

However, there are currently no randomized controlled trials which demonstrate a direct cause-and-effect relationship between reduced trans and/or saturated fatty acids and clinical end points, such as major cardiac events. With additional time and evaluation, a more thorough analysis can serve as the basis for sound conclusions on the population-based health benefits associated with artificial trans fat prohibitions.

The Department wishes to draw attention to the fact that the functionality of oil- and fat-containing ingredients frequently depends on the presence of both solid and liquid fat (e.g., in the production of batters for baked goods). If trans fats are removed from an ingredient, it is necessary to replace it with another type of fat. Gram for gram, trans fats have a more adverse effect on the lipid profile than saturated fat; however, saturated fat is still identified as a cause for high blood cholesterol.

Furthermore, animal fats do not contain artificial trans fats, but generally contain more saturated fat than vegetable oils and significant levels of trans fats that are generated naturally. In 1999, only 20% of American's total trans fatty acid intake was from naturally generated sources. There is some disagreement about the effect of these naturally-derived trans fatty acids compared to artificially-derived trans fatty acids; however multiple studies provide concordant evidence that at the amounts present in usual diets, these trans fatty acids are unlikely to contribute in a major way to cardiovascular risk (Mozaffarian et al., *Eur J Clin Nutr*, 2009). Again, the complexity of this issue leads to the need for a comprehensive approach to healthy eating.

Another challenge of an artificial trans fat prohibition exists with the enforcement within community restaurants. The Federal Nutrition Labeling and Education Act (NLEA) of 1990 requires nutrition labeling on foods regulated by the FDA, but specifically excludes restaurants from the labeling requirements. There exists a substantial burden for sanitarians charged with identifying and sanctioning violators. Sanitarians would be required to conduct in-depth investigations to determine if foods contained trans fat. Regulations would be required to determine the process for identifying and enforcing trans fat prohibitions, as well as establishing

exemptions when suitable alternatives are not available. This requires training and technical assistance for the sanitarians, as well as additional resources for the increased workload.

To improve the nutritional habits of Marylanders, the Department recently submitted two grant proposals in response to the federal government's American Recovery and Reinvestment Act (ARRA), Communities Putting Prevention to Work funding opportunity announcement. Award announcements are expected in February.

*ARRA Grant Proposal One: Eliminating Food Deserts by the Healthy Stores Environmental & Policy Change Program*

Maryland seeks to improve health equity through policy and environmental changes that reduce the existence of food deserts (areas without access to nutritious foods) and improve healthy eating behaviors throughout Maryland. The Baltimore City Healthy Stores Project has been implemented and evaluated successfully by Dr. Joel Gittelsohn from the Johns Hopkins University, Center for Human Nutrition. The Healthy Stores Project aims to improve health and prevent obesity and disease in low-income communities through culturally appropriate store-based environmental change that increases the supply and promotes the purchase of healthy foods. Maryland proposes to collaborate with Dr. Gittelsohn to expand this effort Statewide. The grant amount requested was \$3 million.

*ARRA Grant Proposal Two: Maximizing Outcomes for Maryland's Children with Healthy Eating Opportunities in the Childcare Environment (MOM's CHOICE)*

Maryland requested additional support to implement "Maximizing Outcomes for Maryland's Children with Healthy Eating Opportunities in the Childcare Environment" (MOM's CHOICE). This initiative aims to reach over 200,000 children served in the licensed child care environment by directly impacting the food and beverages consumed by these children. The Department proposes this initiative in close collaboration with the Maryland State Department of Education (MSDE), which houses the Office of Child Care Licensing, the Child and Adult Care Feeding Program, and the Child Care Subsidy Program. Specifically, the initiative's goals include implementing policy and environmental change in licensed childcare to improve nutrition by: (1) Limiting access to unhealthy food and drinks; and (2) Improving access to healthy food and drinks (i.e., water, skim or 1% milk, fruits and vegetables, whole grains). Both strategic goals will use targeted media to promote healthy food/drink and discourage unhealthy food and drink. The grant amount requested was \$1.5 million.

## **Conclusion**

The comprehensive, evidence-based efforts outlined in this report will improve the food supply for both obese and overweight individuals and those with cardiovascular disease. Resources are best utilized in developing a healthy environment that promotes and enables overall healthy eating habits beyond trans fat elimination.

Appendix 1: Membership of the Health Quality and Cost Council and the Committee on  
Childhood Obesity

**Maryland Health Quality and Cost Council**  
MEMBERS AND AFFILIATIONS

Chair: Anthony G. Brown, Lieutenant Governor, State of Maryland

Vice Chair: John M. Colmers, Secretary, Department of Health and Mental Hygiene

Appointees:

Jill A. Berger, M.A.S.

Vice President, Health and Welfare Plans, Marriott International

Debbie Chang, M.P.H.

Senior Vice President and Executive Director

Nemours Health and Prevention Services

James S. Chesley, Jr., M.D.

Practicing Gastroenterologist

Richard "Chip" Davis, Ph.D.

Vice President for Innovation and Patient Safety, Johns Hopkins Medicine (JHM)

Executive Director, JHM Center for Innovation in Quality Patient Care

Senior Director, JHM East Baltimore Ambulatory Operations

Barbara Epke, M.P.H., M.S.W., M.A.

Vice President, LifeBridge Health System

Thomas A. LaVeist, Ph.D.

William C. and Nancy F. Richardson Professor in Health Policy

Johns Hopkins Bloomberg School of Public Health

Director, Center for Health Disparities Solutions

Roger Merrill, M.D.

Chief Medical Officer, Perdue Farms Incorporated

Peggy O'Kane, M.H.S.

President, National Committee for Quality Assurance (NCQA)

E. Albert Reece, M.D., Ph.D., M.B.A.

Vice President for Medical Affairs, University of Maryland

Dean, University of Maryland School of Medicine

Leslie Simmons, R.N., B.S.N., M.A.

Chief Operating Officer, Carroll Hospital Center

Senior Vice President of Patient Care Services, Carroll Hospital Center

Reed Tuckson, M.D.  
Executive Vice President and Chief of Medical Affairs  
United Health Group

Kathleen White, Ph.D., R.N., C.N.A.A., B.C.  
Associate Professor, Johns Hopkins University School of Nursing (JHSON)  
Director of the Master of Science in Nursing Program, JHSON  
Interim Director, Doctor of Nursing Practice Program, JHSON

#### STAFF

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Director, Maryland Health Quality and Cost Council  
Department of Health and Mental Hygiene

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Physician Advisor, Office of the Deputy Secretary for Health Care Financing  
Department of Health and Mental Hygiene

Frances Phillips, R.N., M.H.A.  
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Department of Health and Mental Hygiene

Maria Prince, M.D., M.P.H.  
Medical Director, Office of Chronic Disease Prevention  
Department of Health and Mental Hygiene

Audrey Regan, Ph.D.  
Director, Office of Chronic Disease Prevention  
Department of Health and Mental Hygiene

Karen S. Rezabek  
Health Policy Analyst  
Maryland Health Care Commission

Ben Steffen  
Director, Center for Information Services and Analysis  
Maryland Health Care Commission



## **Committee on Childhood Obesity Membership**

### Members of the State Advisory Council on Heart Disease and Stroke

The American Heart Association- Rhonda Chatmon  
The Department of Health and Mental Hygiene- Dr. Maria Prince  
The Johns Hopkins Medical Institutions- Dr. Marlene Williams  
The Maryland Association of County Health Officers- Roger Harrell  
The Maryland Hospital Association, Inc.- Dr. David Meyerson  
The Maryland Nurses Association- Sandra Bryan  
The Medical and Chirurgical Faculty of the State of Maryland- Dr. Howard Garber  
The Monumental City Medical Society- Dr. Royce Fagan  
The University of Maryland School of Medicine- Dr. Marcella Wozniak  
The Maryland Academy of Family Physicians- Dr. Chan-Hing Ho  
The American College of Emergency Physicians, Maryland Chapter- Dr. William Jaquis  
The American Stroke Association- Dr. Barney Joel Stern  
The American Society of Internal Medicine- Vacant  
The Maryland Institute for Emergency Medical Services- Lisa Myers  
The Maryland State Council on Physical Fitness- Dr. Surina Ann Jordan  
The Maryland Chapter of the American College of Cardiology- Dr. Chen Tung  
The Maryland Pharmacy Association- Catherine Cooke

### Members of the general public:

Eileen Bucanan  
Dr. Albert Heck  
Alexander Martin  
Jose Maldonado  
Heide Morgan

### Appointed Members for the Childhood Obesity Report

Maryland Chapter of the American Academy of Pediatrics- Dr. Alan Lake  
Children's National Medical Center- Dr. Anjali Jain  
Johns Hopkins Children's Center- Dr. Richard Katz  
Maryland Association of Boards of Education- Sandra Barry

### Additional Participants:

Dr. Maureen Black  
Jeanne Charleston  
Toni Chittams  
Dr. Maiya Clark  
Debra Celnik  
Dr. Cheryl DePinto  
Dr. Donald Fedder  
Michaelene Fedder  
Dr. Richard Fornadel  
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Shelonda Stokes  
Lauren Thomas  
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Peggy Yen

## Appendix 2: Summary of Federal Legislation Related to Menu Labeling

### **Harkin-Carper Negotiated Agreement Summary Proposed Menu Labeling Law**

#### Requirements –

- Establishments in a chain of 20 or more locations under the same trade name.
- Standard menu items offered for sale at least 60 days per calendar year.
  - Does not include condiments, daily specials, custom orders, and customary test marketing (i.e., on the menu less than 90 days).
- On menu, menu board or drive thru board –
  - Number of calories per standard menu item;
  - Succinct statement concerning suggested daily caloric intake; and
  - Referral statement regarding the availability of additional nutrition information.
- Additional written information available upon request includes –
  - Calories, calories from fat, total fat, saturated fat, cholesterol, sodium, carbohydrates, sugars, dietary fiber and protein. Also, FDA is expected to require trans fat.
- Implementation deadline to be set by regulations, probably 20 to 30 months from enactment.

#### Voluntary Menu Labeling –

- Available to non-chain restaurants, as well as chain restaurants before mandatory program becomes effective.
- Register with FDA and meet the mandatory program requirements.
- Provides the same uniformity protection as the mandatory menu labeling program.

#### Protections –

- Nutrition information determined by “reasonable basis” (e.g., nutrient databases, cookbooks, laboratory analyses, or other reasonable means).
- Regulations must consider “reasonable variation” in serving size and formulation of menu items.
- National uniformity for nutrient content disclosures of the type chain restaurants would be required to provide.
  - Preempts all State and local menu labeling requirements in effect today.
  - Protection from frivolous litigation over accuracy of nutrient content disclosures.
- Uniformity protection is less than the industry sought because it does not include nutrition labeling other than content disclosures (e.g., dietary advisory statements, traffic lights and nutrition related warnings).
  - Nutrition-related warnings linking certain nutrients (i.e., sodium, sugar) to specific diseases should be viewed by the courts as nutrition labeling and subject to NLEA preemption. However, the courts have not addressed that question and it is possible such health warnings could be held to be beyond the reach of NLEA preemption.

## Appendix 3: Trans Fats Information Cited by the U.S. Food and Drug Administration

(Source: FDA Web site at:  
<http://www.fda.gov/Food/ResourcesForYou/Consumers/ucm079609.htm>)

### **Where will I find *trans* fat?**

Vegetable shortenings, some margarines, crackers, cookies, snack foods, and other foods made with or fried in partially hydrogenated oils.

Unlike other fats, the majority of *trans* fat is formed when liquid oils are made into solid fats like shortening and hard margarine. However, a small amount of *trans* fat is found naturally, primarily in some animal-based foods. Essentially, *trans* fat is made when hydrogen is added to vegetable oil -- a process called hydrogenation. Hydrogenation increases the shelf life and flavor stability of foods containing these fats.

*Trans* fat, like saturated fat and dietary cholesterol, raises the LDL (or "bad") cholesterol that increases your risk for CHD. On average, Americans consume 4 to 5 times as much saturated fat as *trans* fat in their diet.

Although saturated fat is the main dietary culprit that raises LDL, *trans* fat and dietary cholesterol also contribute significantly. *Trans* fat can often be found in processed foods made with partially hydrogenated vegetable oils such as vegetable shortenings, some margarines (especially margarines that are harder), crackers, candies, cookies, snack foods, fried foods, and baked goods.

### **Are All Fats the Same?**

Simply put: no. Fat is a major source of energy for the body and aids in the absorption of vitamins A, D, E, and K, and carotenoids. Both animal and plant-derived food products contain fat, and when eaten in moderation, fat is important for proper growth, development, and maintenance of good health. As a food ingredient, fat provides taste, consistency, and stability and helps us feel full. In addition, parents should be aware that fats are an especially important source of calories and nutrients for infants and toddlers (up to 2 years of age), who have the highest energy needs per unit of body weight of any age group.

Saturated and *trans* fats raise LDL (or "bad") cholesterol levels in the blood, thereby increasing the risk of heart disease. Dietary cholesterol also contributes to heart disease. Unsaturated fats, such as monounsaturated and polyunsaturated, do not raise LDL cholesterol and are beneficial when consumed in moderation. Therefore, it is advisable to choose foods low in saturated fat, *trans* fat, and cholesterol as part of a healthful diet.

## **What Can I Do About Saturated Fat, *Trans* Fat, and Cholesterol?**

When comparing foods, look at the Nutrition Facts panel, and choose the food with the lower amounts of saturated fat, *trans* fat, and cholesterol. Health experts recommend that you keep your intake of these nutrients as low as possible while consuming a nutritionally adequate diet. However, these experts recognize that eliminating these three components entirely from your diet is not practical because they are unavoidable in ordinary diets.

## **How Do Your Choices Stack Up?**

With the addition of *trans* fat to the Nutrition Facts panel, you can review your food choices and see how they stack up. Don't assume similar products are the same. Be sure to check the Nutrition Facts panel (NFP) when comparing products because even similar foods can vary in calories, ingredients, nutrients, and the size and number of servings in the package. When buying the same brand product, also check the NFP frequently because ingredients can change at any time and any change could affect the NFP information.

## **Do Dietary Supplements Contain *Trans* Fat?**

Would it surprise you to know that some dietary supplements contain *trans* fat from partially hydrogenated vegetable oil as well as saturated fat or cholesterol? It's true. As a result of FDA's new label requirement, if a dietary supplement contains a reportable amount of *trans* or saturated fat, which is 0.5 gram or more, dietary supplement manufacturers must list the amounts on the Supplement Facts panel. Some dietary supplements that may contain saturated fat, *trans* fat, and cholesterol include energy and nutrition bars.

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