



**Association of State Public Health Nutritionists**  
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April 21, 2020

Tina Naiman  
Chief  
School Programs Branch  
Policy and Program Development Division  
Food and Nutrition Services  
U.S. Department of Agriculture  
P.O. Box 2885  
Fairfax, Virginia 22031

Re: Simplifying Meal Service and Monitoring Requirements in the National School Lunch and School Breakfast Programs (FNS-2019-0007)

Dear Ms. Naiman:

Founded in 1952, ASPHN is a non-profit membership organization that provides state and national leadership on food and nutrition policy, programs and services aimed at improving the health of our population. ASPHN's membership is composed of more than 500 public health nutritionists located throughout all 50 states, the District of Columbia and five U.S. territories. ASPHN's vision is "healthy eating and active living for everyone." ASPHN is an affiliate of the Association of State and Territorial Health Officials. ASPHN is comprised of registered dietitians, nutritionists, and other health professionals who are closely involved in the implementation of federal nutrition programs. More information about ASPHN members and resources is available on the web at [www.asphn.org](http://www.asphn.org) and on Facebook at [www.facebook.com/asphn](http://www.facebook.com/asphn).

The Association of State Public Health Nutritionists (ASPHN) appreciates the opportunity to share our experience with Food and Nutrition Service (FNS) at the U.S. Department of Agriculture. We have members who work to implement the National School Lunch Program (NSLP) and National School Breakfast Program (NSBP) as well as the Child and Adult Care Food Program (CACFP), and we see the proposed rule as having the potential to negatively affect school meal programs and students. We are using our varied experiences to share the following points of consideration regarding the impact of the Food and Nutrition Service (FNS), U. S. Department of Agriculture (USDA) Proposed Rule 85 FR 4094 on public health.

ASPHN is very concerned that if finalized, Proposed Rule 85 FR 4094 would jeopardize the progress many schools are currently making to provide healthier food to vulnerable children by decreasing the overall healthfulness of school meals. **We strongly advise FNS to eliminate the *a la carte entrée* exemption and uphold the whole grain-rich entrée regulation.** In the proposed ruling the *a la carte* side exemption extends the existing junk food options making foods high in calories, fats and sugars like pizza,



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French fries, and grain-based desserts more available for lunch every day of the school week. Neumark-Sztainer et. al surveyed 1088 randomly selected high school students and concluded that when given the option, students were significantly more likely to choose foods high in calories, fats and sugar. <sup>(1)</sup> A study by Wang et. al., illustrated that when overweight adolescents between the ages of 12-17 years consume between 700 to 1,000 more calories each day over what is needed for the growth, physical activity and body function, the excess caloric intake will accumulate to more than 50 pounds within the course of just 10 years. <sup>(2)</sup> Converse to the proposed rule, Neumark-Sztainer et. al. suggest current school food policies prohibit nutrient-poor, high fat and sugar food items and implement strategies that make healthier food alternatives more available and appealing in appearance, flavor, and price. <sup>(3)</sup>

**ASPHN is also opposed to the re-introduction of grain-based desserts for the Child and Adult Care Food Program (CACFP).** The consumption of grain-based desserts (cakes, snack cakes, cookies, or pastries) is already widespread among young children. In fact, grain-based desserts are one of the top sources of added sugars and empty calories in the diets of children two to eight years of age; 27 percent of 12- to 17.9-month-olds and 36 percent of 18- to 23.9-month-olds consume sweet bakery items on a typical day. <sup>(4, 5.)</sup> At the same time, childhood obesity is occurring at progressively younger ages. <sup>(6)</sup> Establishing healthy food preferences during childhood is essential for proper growth and development and to thwart adverse health conditions later in life. The CACFP has a direct impact on the health and well-being of toddlers and preschoolers through the foods and drinks they offer. The CACFP meal pattern just recently changed to reflect the most current Dietary Guidelines and nutrition research after 50 years of remaining the same – we cannot go backwards. Many CACFP providers have not had sufficient time to continue the positive menu changes, not to mention learn grain ounce equivalencies, which do not take regulatory effect until October 1, 2021. Young children deserve better than being served dessert for breakfast and snack up to four meal (0.5 serving of grain for children 3-5 years old is current minimum requirement) service times a week under these changes. Preschool programs need to provide healthier options over sweet treats to facilitate healthy food preferences. Decreasing the rates of overweight and obesity during childhood is vitally important, as habits formed early in life have a propensity to pass on into adulthood. <sup>(7)</sup>

**ASPHN ardently recommends the FNS maintain the current fruit regulation.** Based on recommendations from pediatricians, nutritionists, and school food experts the Healthy, Hunger-Free Kids Act (HHFKA), required more fruits and vegetables in our nation's school lunches, not less. <sup>(8)</sup> The proposed rule reduces student access to whole fruits and increases their consumption of sugar sweetened juice beverages. Research demonstrates that the current school meal nutrition standards have a positive impact on student food selection and consumption, especially for fruits and vegetables. <sup>(9)</sup> Students who participate in the school meal programs consume more milk, fruits, and vegetables during meal times and have better intake of certain nutrients, such as calcium and fiber, than nonparticipants. <sup>(10,11, 12)</sup>



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The Dietary Guidelines for Americans (DGAs) has long recommended a healthy eating pattern that gives emphasis to an array of vegetables and fruits, whole grains, lean protein foods, and low-fat and fat-free dairy products. The DGAs also recommend dietary patterns limit calories from solid fats (major sources of saturated and trans fatty acids) and added sugars, and reduce sodium intake. <sup>(13, 14)</sup> By law, notable changes in the school meal programs standards must be consistent with current dietary guidance and nutrition recommendations to promote health—as provided by the *Dietary Guidelines for Americans* and the Dietary Reference Intakes from the Institute of Medicine—with the ultimate goal of improving children’s diets by reducing the apparent prevalence of inadequate and excessive intakes of food, nutrients, and calories; coupled with the short and long term health consequences that follow childhood obesity. **If finalized, proposed rule 85 FR 4094 would decrease the overall healthfulness of school meals.**

The proposed changes fail to put children’s health first, which is the clear goal of school nutrition programs under statute. Expanding the a la carte options, is both a fiscal risk to school meal programs and a health risk to America’s children. The combined changes would enable children to consume more processed foods that are higher in sodium, saturated fat, and empty calories. While at the same time, childhood obesity is one of America’s most serious public health concerns in this century. <sup>(15)</sup>

A 4-year-old child with obesity has a 20% likelihood of becoming an adult with obesity, and a teenager with obesity has up to an 80% probability of becoming an adult with obesity. <sup>(16)</sup> From 2003-2006, more than 23 million of America’s children and youth was overweight or obese. <sup>(17)</sup> From 2015-2016 the prevalence of obesity among U.S. youth was 18.5%. <sup>(18)</sup>

Overweight and obese children are at greater risk of having high blood pressure and high cholesterol, which are risk factors for cardiovascular disease (CVD). <sup>(19)</sup> Childhood obesity not only increases CV risk in adulthood, but is also associated with CV damage during childhood. <sup>(20)</sup> Non-congenital cardiovascular disease (CVD) should be rare among children yet is becoming more prevalent in conjunction with the rise in childhood obesity. <sup>(21, 22)</sup> In 2007 it was predicted that in the United States, the number of additional cardiovascular (CV) events attributable to excess weight in adolescence is expected to be >100,000 by 2035. <sup>(23)</sup> In a population-based sample of 5- to 17-year-olds, 7% of obese children had at least one CVD risk factor while 39% had two or more CVD risk factors. <sup>(24)</sup> Recent reports that childhood obesity is often accompanied by concurrent CV abnormalities, suggesting the problem is not only one of future or long-term CVD risk but rather, one requiring immediate attention to prevent progressive CV damage in childhood. <sup>(25)</sup>

Although traditionally viewed as an “adult” illness, the rise in childhood overweight and obesity has corresponded to an increasing proportion of youths with type 2 diabetes, particularly among adolescent minority populations. <sup>(26)</sup> Diabetes is a life-threatening and

costly disease. <sup>(27, 28, 29)</sup> Overweight and obesity are also associated with a 52% and 60% increased risk, respectively, for new diagnoses of asthma among children and adolescents. <sup>(30)</sup> A cross-sectional study using data from the Third National Health and Nutrition Examination Survey 1988–1994 showed that one of the highest risk groups for developing asthma were children over the age of 10 with a BMI greater than or equal to the 85th percentile. <sup>(31, 32, 33)</sup> Additionally, overweight and obese children suffer from joint problems and musculoskeletal discomfort, <sup>(34)</sup> fatty liver disease, gallstones, and gastro-esophageal reflux (i.e., heartburn), <sup>(35)</sup> psychological problems such as anxiety and depression, <sup>(36)</sup> low self-esteem and lower self-reported quality of life, <sup>(37)</sup> and social problems such as bullying and stigma. <sup>(38)</sup>

Along with its serious public health consequences, obesity has tangible economic costs that affect all of us. The estimated annual health care costs of obesity-related illness are a staggering \$190.2 billion or nearly 21% of annual medical spending in the United States. <sup>(39)</sup> In the 10 cities with the highest obesity rates, the direct costs connected with obesity and obesity-related diseases, disability, and unemployment are roughly \$50 million per 100,000 residents. If these 10 cities cut their obesity rates down to the national average, the combined savings to their communities would be \$500 million in health care costs each year. <sup>(40)</sup> The direct and hidden health costs of obesity hold back businesses and organizations that stimulate jobs and growth in U.S. cities. Businesses grapple with obesity-related job absenteeism (\$4.3 billion annually). These costs also will continue to rise. <sup>(41)</sup> Being overweight or obese is the most common reason so many young adults are ineligible for military service; jeopardizing national security. <sup>(42)</sup>

Childhood obesity is estimated to cost \$14 billion annually in direct health expenses, and children covered by Medicaid are nearly six times more likely to be treated for a diagnosis of obesity than children covered by private insurance. <sup>(43)</sup> Obesity-related medical costs in general are expected to rise significantly, as roughly two-thirds of normal weight children will eventually become overweight or obese and today's obese children are likely to become tomorrow's obese adults. <sup>(44, 45)</sup> Longitudinal studies show that 77% to 92% of obese teenagers remain obese in adulthood. <sup>(46, 47, 48, 49)</sup> The incremental lifetime medical cost of an obese child relative to a normal weight child who maintains normal weight throughout adulthood ranges between \$16 310 and \$19 350, closer to the upper bound estimate. Multiplying the lifetime medical cost estimate of \$19 000 times the number of obese 10-year-olds today generates a total direct medical cost of obesity of roughly \$14 billion for this age alone <sup>(50, 51, 52, 53, 54, 55, 56)</sup>

**ASPHN concurs with USDA's concerns regarding the continued level of food waste generated by our school meals service. However, food waste was a large concern even before HHKFA's implementation.** Citing food waste and decreased participation as the justification for diluting current regulations is contrary to data showing the quantity of measured food waste was similar pre- and postimplementation of the HHFKA <sup>(57)</sup> plus participation is highest in schools with the healthiest meals. <sup>(58, 59, 60)</sup> As a result, it is highly unlikely attenuating the current standards will have a meaningful impact.



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The research literature suggests that food waste can be decreased by adjusting schedules, increasing mealtime efficiency, placing recess before lunch, providing opportunities to try new foods and recipes, and innovatively working with community partners. Healthier options to addressing food waste and participation might instead include serving lunch during traditional lunch hours. Unfortunately, many schools start with lunch periods before 11:00 AM. <sup>(61, 62)</sup> What's more, students need enough time to eat. Research suggests that when lunch periods are at least 30 minutes long there is significantly less food waste. <sup>(63, 64)</sup> Studies show that providing more time for lunch is associated with increased consumption of food and key nutrients, <sup>(65)</sup> as well as increased selection and consumption of fruits and vegetables, lunch entrée, and milk. <sup>(66, 67)</sup>

Creating more efficient meal periods could include increasing the number of serving lines, refining cashier proficiency, and with adequate funding/resources employ automated point of sales systems. <sup>(68)</sup> Elementary schools could also offer recess prior to the lunch period, so students needn't rush through lunch to go out to play. <sup>(69)</sup> Many school food programs have successfully increased meal consumption by offering students and the school nutrition service staff opportunities to learn about new foods and try new recipes through taste-tests, and partnering with resident chefs, neighboring culinary schools, regional farmers, and their local Expanded Food and Nutrition Education Programs (EFNEP). Lastly, to reduce food waste it is not enough to just focus on healthier meals. Consideration must also be given to presentation, palatability and cultural appropriateness.

**ASPHN opposes any further weakening of the nutrition standards.** School-based and after-school meal programs can be healthy, successful, cost-effective and even cost-saving. Schools can adopt policies and practices that help young people eat more fruits and vegetables, eat fewer foods and beverages that are high in added sugars or solid fats, and increase daily minutes of physical activity. <sup>(70, 71, 72, 73, 74, 75, 76)</sup> We invite FNS to sustain school meal programs in their efforts to serve healthier, more delicious food to their students. FNS has a duty to focus its time and resources on providing more technical assistance to any school that is struggling with offering more healthy food options. We support stronger policies within the legislative process which update the laws governing all child nutrition programs, including school meals and snack standards that are in alignment with the national Dietary Guidelines. **Because the next revision to Dietary Guidelines is expected in the year 2020 ASPHN recommends all revisions to the school meal programs include a way to adapt current modifications to the Dietary Guidelines via judicious and congruent methods.**



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Thank you for your considerations in this matter.

With regards,

Diane Golzynski, PhD, RD  
President, ASPHN Board of Directors

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