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Via Electronic Submission - http://www.regulations.gov

Re: Voluntary Sodium Reduction Goals: Target Mean and Upper Bound Concentrations for Sodium in Commercially Processed, Packaged, and Prepared Foods (FDA-2014-D-0055)

To Whom It May Concern:

The New York City (NYC) Department of Health and Mental Hygiene (DOHMH) appreciates the opportunity to comment on the United States Food and Drug Administration's request for comments on its voluntary sodium reduction goals (FDA-2014-D-0055).

High sodium intake increases blood pressure and the risk of heart disease and stroke. Heart disease and stroke are the first and sixth leading causes of death in NYC. In 2014, nearly 1 in 3 deaths (16,517) in NYC were from heart disease[1], which is similar to national trends.[2] The evidence for the health benefits associated with lowering sodium intake is robust, such that forty of the world's leading scientists working in the fields of cardiovascular disease and nutrition released a joint statement in 2014 affirming that reducing population sodium intake is a key strategy to reducing cardiovascular disease events and mortality in the US.[3] Despite clear evidence of negative health impacts, the average New Yorker consumes nearly 40% more sodium than the recommended daily limit of 2,300 mg per day[4] and sodium remains ubiquitous in the US food supply. It is difficult for consumers to lower their sodium intake when the vast majority (more than 75%) of sodium consumed is already in packaged and restaurant food when purchased.[5] Reducing sodium in the food supply is a necessary public health strategy to reduce sodium intake.

DOHMH launched the National Salt Reduction Initiative (NSRI) in 2009. The NSRI is modeled on an initiative coordinated by the FDA's counterpart in the United Kingdom, the Food Standards Agency, which set national, voluntary sodium targets for the food industry in 2006.[6] Researchers saw a significant reduction in salt intake (1.4 grams/day) and blood pressure (-2.7/1.1 mm Hg) between 2003 and 2011.[7] The NSRI is led by NYC and comprised of a collaboration of public health authorities and organizations, which collectively aimed to reduce sodium in the national packaged and restaurant food supply by 25% from 2009 to 2014 through voluntary corporate commitments to specific, stepwise sodium targets. The NSRI partnership's shared goal was to decrease sodium intake in Americans by 20% over the five year period of the NSRI. Nearly 30 companies from a cross-section of the food industry committed to NSRI sodium reduction targets, demonstrating industry's willingness to reduce sodium through a public, transparent process. Sodium reduction was modest (-6.8% decrease in packaged foods and -1.5% in restaurant foods) during the course of the NSRI.[8] While many companies made substantial changes in a wide array of foods, progress to date is not enough to meaningfully impact sodium intake at the population level. A sodium reduction program coordinated by a federal agency that has regulatory power, such as the FDA, and that levels the playing field by encouraging more companies to participate, has the potential to yield far greater reductions.

We applaud the FDA for its leadership in proposing sodium reduction targets. The comments that follow are based on our experience working with committed companies as they strive to meet the NSRI sodium reduction targets, and knowledge derived from two key data sources: the NSRI Packaged Food Database and MenuStat (www.menustat.org). The NSRI Packaged Food Database was built in 2009 by identifying branded products in the top 80% of sales in packaged food categories that contribute to sodium intake, then adding nutrition data obtained from Guiding Stars Licensing Company and product Nutrition Facts panels. The database was updated in 2012 and 2014. MenuStat grew out of DOHMH's experience building the NSRI Restaurant Food Database. MenuStat is a comprehensive and free national database that can be used to evaluate the nutrition of top chain restaurant food and beverages. It includes annual nutrition data from 2012 through 2015 for over 150,000 menu items from over 150 top national restaurant chains, which were among the top 200 restaurant chains (ranked by US national sales) that reported nutrition information. Detailed descriptions of these data sources is published elsewhere.[9,10]

We hope that our expertise in creating food categories, setting sodium targets, working with the food industry, and monitoring sodium in packaged food and restaurant food will aid the FDA in finalizing its sodium reduction goals.

1a. Are there categories where foods have been grouped together that should be separated on the basis of different manufacturing methods or technical effects relating to the potential for sodium reduction?

Yes. We identified four FDA categories where foods have been grouped together that we recommend separating based on differences in the potential for sodium reduction. Using the NSRI Packaged Food baseline data we know that the four FDA categories listed below contain clear subgroups of foods with varying levels of sodium. Splitting the FDA categories further will make the targets more relevant and precise.

FDA Category	FDA Baseline (2010) Sales-Weighted Mean (mg/100g)	NSRI Category	NSRI Baseline (2009) Sales-Weighted Mean (mg/100g)
Canned Vegetables (#19)	307	Canned vegetables	238
		Canned whole tomatoes	152
		Diced, crushed, and stewed tomatoes	289
		Canned beans	337
Grain-based Meals/Entrees, Dry- Mix (#129)	895	Seasoned pasta and stuffing mixes	700 mg/cup yield
		Seasoned grain mixes	837 mg/cup yield
Frozen Meals/Entrees (#128)	332	Frozen entrees and sides < 6 oz per serving	537
		Frozen entrees and sides 6-10 oz per serving	337
		Frozen entrees and sides ≥ 10 oz per serving	294
Donuts (#76)	365	Sweet breads and rolls	295
		Cakes, snack cakes, muffins, and toaster pastries which contains cake doughnuts	359

1b. Conversely, are there categories which could be merged due to similar sodium functionality and potential for reduction?

No. We do not recommend that the FDA merge any of their proposed food categories. Many very similar food products contain vastly different sodium levels. While any given category will include a mix of products with varying sodium levels, the category should not be so broad that the target is inapplicable (too high or too low) for a predominant product type. Additionally, creating clearly defined categories makes it easier for food companies to identify which category and target applies to their products. The FDA has successfully created categories of similar but not overly homogenous foods, which is necessary to ensure that targets are precise, appropriate, and flexible.

1c. Are there foods that contribute to sodium intake that we have not effectively captured?

The FDA has included a wide variety of foods that contribute to sodium in the US diet in its food categories, based on a comparison to National Health and Nutrition Examination Survey (NHANES) data on sodium intake, industry categories used for market research, categories used by the FDA and the USDA, and categories used by other sodium reduction efforts such as the United Kingdom salt campaign. One NSRI packaged food category, Refrigerated entrees and sides, does not appear to be included in the FDA categories. One type of product in particular, Refrigerated meal packs, dominates this food category. This product is often marketed as a children's lunch food and frequently includes two of the top sources of sodium in the US diet: cold cuts and cheese. We encourage the FDA to consider adding or identifying a food category that includes this product given its sales volume.

1d. Are the categories amenable for use by restaurant chains and if not, how should they be modified to make them amenable for use by restaurant chains?

Yes. The FDA categories are amenable for use by restaurant chains and include a wide range of foods purchased and served by restaurants. The FDA categories encompass and expand upon all of the food covered by the NSRI restaurant food categories.

We have two recommendations to strengthen targets for restaurants. First, given the recent release of FDA's guidance for menu labeling requirements, the FDA should describe how the categories apply not only to standard menu item builds but to variable menu items and combination meals as well. The second recommendation is to address a gap in data that limits the representativeness of the baseline values and may hinder the FDA's ability to monitor industry progress. The draft baseline values and targets proposed by the FDA are based on sodium concentration measured in milligrams of sodium per 100 grams or milliliters of a product's weight (mg/100g or mg/100mL), which allows for comparisons of similar foods with different serving sizes. Calculating sodium concentration requires that the restaurant provide serving size information in grams or milliliters. However, about half of the restaurant items listed in MenuStat do not include serving size weight. In fact, serving size weight is not required by the FDA's menu labeling requirements.[11,12] We recommend that the FDA maintain the proposed targets and upper bounds, and consider adding upper bounds that are measured in milligrams sodium per 100 calories. Unlike serving size weight, calories must be reported by chain restaurants starting next year. This would allow all chain restaurants to be represented in baseline and future analyses and does not unfairly create greater scrutiny of restaurants that offer more information to their customers by providing serving size data.

2. Are the baseline sodium concentration values reasonably representative of the state of the food supply in 2010? For categories that do not appear representative, what food products are not adequately represented? Are there situations in which our method of quantification could lead to unrepresentative baseline values?

Yes. Based on a comparison to baseline sodium values calculated in 2009 for the NSRI, we believe that the baseline sodium concentration values proposed by the FDA are reasonably representative of the state of the food supply in 2010. There are some limitations to the FDA's calculations, some of which the FDA may be able to address and others that are due to lack of available data. However, to assure the health of Americans

going forward, we do not recommend that the FDA make any changes that will delay the target setting process further.

First, the FDA excluded products labeled as no-sodium-added, low-sodium, and reduced-sodium in the baselined sales-weighted mean for all categories. The FDA's rationale was that these products had low sales volumes and did not impact the sales-weighted mean sodium concentration. However, these products make up a significant portion of sales in some food categories. Sales for these products have greater than 10% market share in the following NSRI food categories: Canned vegetables, Canned whole tomatoes, Diced, crushed, and stewed tomatoes, Vegetable juice, Asian condiments, Canned soup, and Broth and stock. Including these products in the FDA's analysis of baseline means will be more reflective of the food supply and may influence baseline sodium values. Additionally, some companies may choose to reformulate, manufacture more, and/or promote no-sodium-added, low-sodium, and reduced-sodium products as a strategy to drive their sales-weighted sodium levels down. Not counting these products as part of baseline or future monitoring efforts could disincentivize companies from making important investments in these products because they will not get credit as part of the FDA's current methods for analyzing sodium levels in the food supply. More investments should be made by industry in these products. We recommend that the FDA consider updating baseline sodium values to include no-sodium-added, low-sodium, and reduced-sodium labeled products and lower targets accordingly or, at a minimum, include these lower sodium products in future monitoring efforts.

Second, nutrition information for private label packaged food products (e.g. store brands) and all products sold by Walmart is missing from baseline values. According to the FDA, the private label limitation cannot be fixed due to missing Universal Product Codes (UPC), which provide unique identifying information about a product and are needed to obtain nutrition information. Private label products are a substantial contributor to the US diet, and sales of private label products have increased since 2009.[13] Excluding them in baseline sodium calculations may limit the representativeness of the targets, but it is not clear to what extent or in which direction. Emerging research in Australia suggests that nutrient content of private label products may be lower in sodium than similar branded products in Australia.[14] Additionally, food products sold by Walmart (both branded and private label) were not included in the baseline values due to lack of Nielsen sales data on Walmart sales at that time. We recommend that the FDA secure nutrition information for top-selling private label products and Walmart products to incorporate them into future monitoring efforts.

Third, the FDA's use of sodium concentrations (mg/100g or mg/100mL) is important for standardized comparisons of sodium in different products. As mentioned, serving size information is not available for about half of restaurant items.[15] This limitation cannot be corrected unless the FDA's menu labeling regulation is revised to require serving size in in grams and milliliters, but the FDA may consider alternative approaches to addressing this data limitation as described in response to question 1d.

Fourth, the FDA used restaurants' annual sales to weight the baseline mean sodium of a food category. As a result, lower selling items on a top restaurant's menu will disproportionately influence a target (e.g. low selling cookies sold in a major burger chain could affect a target more than high selling cookies sold in a smaller cookie chain). While less ideal than if the FDA had sales volume for each menu item, this methodology is a fair approach given the absence of item-level restaurant sales data.

Finally, the FDA's sodium reduction goals apply to products sold in supermarkets, served in restaurants and other food service establishments, and sold through food service operations; however, data from food service operations are noticeably missing from baseline sodium analyses because sales data, nutrition data, and unique identifiers of products from food service operations are not publicly available. Although this limitation cannot be corrected at this time given the lack of availability, it is worth noting that a lack of this data may limit the representativeness of the targets.

3. Are there categories for which the 2-year target concentration goals are infeasible? If so, why are these targets not feasible, e.g., for technical reasons? What goals would be feasible in the short-term (2-year), and why? For reference, a supplementary memorandum to the docket is provided to further describe the

type of information needed, "Target Development Example: Supplementary Memorandum to the Draft Guidance" (Ref. 7).

The proposed 2-year targets are feasible. This is exemplified by the results of an analysis of data available to us from the NSRI Packaged Food Database and MenuStat which revealed examples of packaged food on the market in 2014 and restaurant food on the market in 2015 that are already meeting the FDA's 2-year targets. Using the NSRI Packaged Food Database, a total of 2,442 foods in 78 FDA categories already meet the FDA's 2-year targets. Using MenuStat restaurant food data, 2,809 foods in 80 FDA categories already meet the FDA's 2-year targets. The FDA categories of Frozen Meals and Entrees and Poultry and Fish Based Sandwiches include as many as 298 and 243 foods that already meeting the 2-year targets, respectively. See Appendix A for a detailed summary table. The availability of food items across food categories that already meet targets show that the targets are achievable and do not compromise food safety or standards of identity for specific food types. For categories with a high number of foods meeting the FDA's 2-year target, we believe that the FDA should consider strengthening those targets by increasing the percent reduction so that it is closer to the percent reduction of the long-term target for that category.

4. Are the short-term (2-year) timeframes for these goals achievable? If the timeframes are not achievable, what timeframes would be challenging, but still achievable?

The short-term (2-year) timeframe for these goals are achievable. As described in response to question 3, there are already many products on the market that meet the FDA's 2-year targets. Further, we know sodium reduction has occurred since 2009. Twenty-one companies, including Kraft, Subway, and Unilever, met their commitments to NSRI 2012 targets, which are similar to the FDA's 2-year targets. During the NSRI (2009-2014), the US food industry as a whole made progress in reducing sodium: sales-weighted mean sodium density in top US packaged food declined significantly by 6.8% and mean sodium density in top restaurant food was driven by a small number of engaged restaurants to achieve a significant decline of 1.5%.[16] Finally, changes reported in the United Kingdom demonstrate the food industry's ability to reduce sodium in products in a relatively short timeframe.

Additional Recommendations – Monitoring and Reporting

In order to facilitate widespread adoption of the sodium targets and upper bounds by the food industry, we recommend that the FDA develop a comprehensive monitoring plan to accompany the final guidance on the targets. A monitoring plan should ideally include the use of nutrition databases that are public, branded, time-stamped, and comprehensive to ensure that monitoring efforts are robust, accurate, and transparent. Proprietary data strengthens analyses, but limits the amount of information that the FDA can share publicly.

There are multiple public packaged food databases coordinated by the USDA that could be augmented to capture nutrition information collected as part of this monitoring system. The existing framework to collect and analyze sodium in packaged foods is strong, but the federal government does not have comparable restaurant nutrition databases. MenuStat is the most comprehensive and current database for restaurant food nutrition information. The database is supported by robust data collection, well-developed data entry methodology, and a larger sample of chain restaurants than used by the FDA to create baseline values and targets, therefore increasing the generalizability of the data. Because of these characteristics, MenuStat should be considered as a potential tool through which the FDA can track the restaurant industry's progress toward the proposed sodium targets.

We recommend that the FDA produce a bi-annual report which updates baseline sodium concentrations in each category and provides an appendix of data sources. As part of this process, we recommend that the FDA issue a template for companies to voluntarily submit updated nutrition information for their products. This could address the potential lag in reporting updated sodium levels on Nutrition Fact panels from time of reformulation until listed on product Nutrition Fact panels. This appendix could also provide a mechanism for food companies to demonstrate their commitment to meeting targets, thus promoting transparency around industry progress.

Conclusion
Decades of evidence clearly point to the adverse health risks of excess sodium intake. There is opportunity to reduce the sodium density of our food supply, and the FDA's release of final sodium targets is urgently needed in order to encourage meaningful sodium reduction.

Sodium reduction has broad support in the US as demonstrated by the dozens of state and local health departments and organizations that have come together to form the NSRI partnership and nearly 30 companies that committed to the NSRI sodium reduction targets. FDA targets will build upon a national dialogue around sodium reduction, and the release of the final targets will facilitate the gradual sodium reduction in the American diet and bolster the sodium reduction work taking place in numerous jurisdictions around the country.[17] Action on sodium reduction at the federal level is an important step to facilitate continued progress in reducing the number of Americans that needlessly endure the pain of heart disease and death.

DOHMH strongly supports the FDA's proposal to set sodium targets for the food supply. We believe that incorporation of our recommendations will further strengthen the FDA's proposal and help to ensure that the adoption of this industry guidance will result in reduced sodium in the food supply and improved the cardiovascular health of the country.

DOHMH appreciates the opportunity to comment regarding the draft guidance. Thank you for your consideration.

Sincerely,

Mary T. Bassett, MD, MPH
Commissioner

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Appendix A. NSRI packaged foods that already meet the FDA's 2-year targets

FDA Food Category ID	FDA Food Category Name	N packaged foods	N brands	Minimum sodium density	Maximum sodium density	Mean sodium density	Short-Term Goals Sales-Weighted Target Mean (mg sodium per 100 g)
	All Items that already meet the FDA's 2-year targets	**2442**	**826**	**1**	**11600**	**538**	
3	Processed Cheese/Cheese Food (Semi-soft)	23	9	435	1190	959	1210
4	Monterey Jack and Other Semi-soft Cheese	5	3	571	609	593	610
5	Cream Cheese (Soft)	6	3	266	375	346	380
8	Pasta Filata Cheese (Soft)	28	14	583	679	646	680
10	Cottage and Other Soft Cheese	28	8	230	336	303	340
11	Cheddar and Colby Cheese (Hard)	49	11	571	611	606	615
12	Swiss and Swiss-type Cheese (Hard)	9	3	143	203	182	210
13	Parmesan and Other Hard Cheese	13	9	679	1464	1091	1480
15	Margarine and Vegetable Oil Spreads	23	8	571	679	631	680
16	Mayonnaise and Other Sandwich Spreads7	4	3	536	538	537	570
17	Salad Dressing7	123	30	283	867	700	880
19	Canned Vegetables	173	40	1	288	183	290
24	Vegetable Juice7	12	2	58	200	124	200
26	Fried Potatoes without Toppings	23	10	35	310	235	310
28	Hash Browns and Home Fries	10	6	35	417	282	480
30.b	Mashed Potatoes, Dry Mix	6	3	1035	1571	1405	1620
32	Nut/Seed Butters and Pastes	14	7	188	396	336	400
34	Canned, Ready-to-Eat Soup	52	4	83	213	175	230
35	Dry Mix Soup	2	2	200	1535	867	1640
36	Shelf Stable Liquid Broth and Stock	35	10	29	358	192	360
39	Soy Sauce	4	2	3667	3833	3750	6100
40	Asian-style Sauce	11	4	324	1588	904	1600
41	Mexican-style Sauce	2	1	433	517	475	550
42	Pesto	1	1	613	613	613	670
43	Tomato-based Sauce	17	11	301	484	406	510
44	Cheese-based Sauce	9	6	310	583	459	670
46	Gravy	18	7	250	500	428	520
47	Condiments	29	11	639	882	777	900

NSRI Packaged Foods

FDA Food Category ID	FDA Food Category Name	N packaged foods	N brands	Minimum sodium density	Maximum sodium density	Mean sodium density	Short-Term Goals Sales-Weighted Target Mean (mg sodium per 100 g)
48	Cheese-based Dips	3	2	625	765	718	820
49	Cream-based Dips	21	12	51	567	474	590
50	Bean-based Dips	2	2	422	438	430	470
51	Vegetable/fruit-based Dips	60	27	161	500	403	500
52	Dry Seasoning and Dry Sauce Mixes	34	10	2333	11600	6365	18000
54	Ready-to-Eat Cereal, Flakes	21	11	340	536	436	550
55	Ready-to-Eat Cereal, Puffed	80	43	71	469	361	470
56.b	Dry Mix Instant Cereal	5	3	268	395	338	460
58	White Bread	96	38	61	440	362	440
59	Wheat and Mixed Grain Bread	46	23	149	419	342	420
61	Rye Bread	2	1	531	531	531	540
63	Bagels and Soft Pretzels	19	8	203	419	350	420
64	English Muffins	9	4	197	351	295	360
65	Sweet Rolls	17	10	189	294	253	300
69	Muffins	14	6	194	300	273	300
70	Tortillas and Wraps	26	14	163	569	439	580
72	Crackers	37	15	231	750	576	750
74	Cake	40	13	133	266	220	270
76	Donuts	25	7	127	309	229	310
77	Cookies	99	50	94	300	240	300
78.a	Frozen/Refrigerated Breakfast Bakery Products	4	2	271	328	304	420
79	Frozen/Refrigerated Dough and Batter	2	1	325	351	338	400
81	Deli Meats - Ham	54	18	500	1000	838	1020
82	Deli Meats - Beef	2	2	732	839	786	980
83	Deli Meats -Turkey/Chicken	63	16	537	893	776	900
85	Frankfurters, Hot Dogs, and Bologna	43	11	607	895	823	900
86	Uncooked Sausage	9	7	488	589	550	590
87	Precooked Sausage	147	43	339	843	719	850
88.b	Cooked Bacon	25	16	696	1682	1338	1700
89	Salami and Pepperoni	5	3	1107	1536	1392	1630
100	Canned Meat	1	1	800	800	800	800

NSRI Packaged Foods

FDA Food Category ID	FDA Food Category Name	N packaged foods	N brands	Minimum sodium density	Maximum sodium density	Mean sodium density	Short-Term Goals Sales-Weighted Target Mean (mg sodium per 100 g)
101	Canned Sausage	1	1	492	492	492	630
102	Canned Poultry	3	2	250	318	273	320
104	Meat Substitutes and Analogues	1	1	200	200	200	280
107	Canned Fish and Seafood	27	4	247	357	300	360
109	Unflavored Potato and Vegetable Chips	28	14	317	500	412	500
110	Flavored Potato and Vegetable Chips	56	13	375	607	533	630
111	Unflavored Grain Chips	23	13	107	368	284	390
112	Flavored Grain Chips	12	7	321	571	478	590
113	Puffed Corn Snacks	14	9	500	857	716	870
115	Popcorn	65	23	92	676	453	680
116	Pretzels	48	7	317	1000	732	1020
117	Snack Mixes	26	4	140	839	571	860
122	Hot Dogs on Buns and Corn Dogs	1	1	430	430	430	610
124	Breakfast Sandwiches Not on Biscuits	2	1	254	282	268	540
128	Frozen Meals/Entrees	298	46	21	280	227	280
129	Grain-based Meals/Entrees, Dry- Mix	13	5	108	580	438	750
130	Canned Meals	55	10	234	328	277	330
145.b	Pizza: With Meat/Poultry or Seafood - Not Frozen	17	9	235	460	395	460
146.b	Pizza: Without Meat/Poultry or Seafood - Not Frozen	12	9	232	395	339	400

Appendix A. MenuStat restaurant foods that already meet the FDA's 2-year targets

FDA Food Category ID	FDA Food Category Name	N restaurant foods	N restaurants	Minimum sodium density	Maximum sodium density	Mean sodium density	Short-Term Goals Sales-Weighted Target Mean (mg sodium per 100 g)
	All Items that already meet the FDA's 2-year targets	**2809**	**793**	**26**	**1786**	**347**	
5	Cream Cheese (Soft)	25	5	226	376	299	380
14	Butter	2	2	500	564	532	580
15	Margarine and Vegetable Oil Spreads	3	3	564	677	627	680
16	Mayonnaise and Other Sandwich Spreads7	9	7	333	561	487	570
17	Salad Dressing7	236	60	32	875	633	880
21	Olives without Additions	7	4	494	776	701	800
25	Battered/Breaded Vegetables	24	11	196	485	367	490
26	Fried Potatoes without Toppings	40	18	26	296	164	310
27	Fried Potatoes with Toppings	13	7	147	460	289	480
28	Hash Browns and Home Fries	23	11	248	469	381	480
29	Potato Side Dishes	20	7	37	300	154	300
30.a	Mashed Potatoes, Prepared	5	4	245	278	265	280
37	Frozen Soup	59	10	32	230	181	230
40	Asian-style Sauce	2	2	745	1111	928	1600
43	Tomato-based Sauce	19	17	203	500	387	510
44	Cheese-based Sauce	2	2	571	613	592	670
46	Gravy	16	8	269	503	391	520
47	Condiments	72	45	89	862	643	900
48	Cheese-based Dips	6	5	343	721	548	820
51	Vegetable/fruit-based Dips	37	12	35	500	350	500
56.a	Prepared Cooked Cereal	15	9	56	97	77	100
58	White Bread	8	6	222	423	356	440
59	Wheat and Mixed Grain Bread	6	5	306	415	389	420
60	Garlic and Cheese Bread	23	12	320	548	471	550
61	Rye Bread	5	4	436	539	485	540
62	Breadcrumbs and Croutons	6	5	705	929	835	950
63	Bagels and Soft Pretzels	41	5	222	417	360	420
65	Sweet Rolls	22	10	182	294	251	300

FDA Food Category ID	FDA Food Category Name	N restaurant foods	N restaurants	Minimum sodium density	Maximum sodium density	Mean sodium density	Short-Term Goals Sales-Weighted Target Mean (mg sodium per 100 g)
66	Croissants	2	1	214	243	229	260
67.b	Prepared Biscuits	4	3	577	620	604	660
68	Cornbread	4	4	219	419	337	460
69	Muffins	14	6	106	294	227	300
70	Tortillas and Wraps	3	2	240	467	326	580
73	Cheesecake	3	3	131	209	180	210
74	Cake	43	19	80	267	197	270
75	Pastries, Pie, and Cobbler	105	10	46	219	147	220
76	Donuts	77	8	114	310	227	310
77	Cookies	78	28	50	299	223	300
78.b	Prepared Breakfast Bakery Products	48	9	135	336	250	340
88.b	Cooked Bacon	5	5	189	1583	1103	1700
91	Bone-in, Non-Breaded/Battered Poultry	9	4	124	310	222	330
92	Bone-in, Breaded/Battered Poultry	3	3	198	545	424	570
93.b	Boneless, Non-Breaded/Battered, Precooked Poultry	16	7	256	372	322	390
94	Boneless, Breaded/Battered Poultry	39	14	265	646	562	660
95	Reformed/Restructured, Breaded/Battered Chicken	12	4	325	557	507	570
96	Cured/Smoked Pork and Canadian Bacon	8	7	71	964	703	970
97	Whole Muscle Pork	3	3	392	500	458	510
98	Whole Muscle Beef	40	16	65	380	244	390
99	Reformed/Shaped Beef	3	3	77	393	270	480
103	Bacon Bits/Pieces	3	3	832	1786	1241	1850
109	Unflavored Potato and Vegetable Chips	10	8	61	376	248	500
110	Flavored Potato and Vegetable Chips	2	1	417	533	475	630
111	Unflavored Grain Chips	3	2	120	279	176	390
112	Flavored Grain Chips	1	1	558	558	558	590
118	Beef/Pork-based Sandwiches	1	1	391	391	391	420
119	Poultry/Fish-based Sandwiches	243	32	106	467	360	470
121	Deli Meat-based Sandwiches	36	7	187	480	336	480
122	Hot Dogs on Buns and Corn Dogs	2	2	214	480	347	610
123	Breakfast Sandwiches On Biscuits	18	6	215	656	548	660

MenuStat Restaurant Foods

FDA Food Category ID	FDA Food Category Name	N restaurant foods	N restaurants	Minimum sodium density	Maximum sodium density	Mean sodium density	Short-Term Goals Sales-Weighted Target Mean (mg sodium per 100 g)
124	Breakfast Sandwiches Not on Biscuits	118	21	177	540	450	540
125	Vegetarian Sandwiches	84	20	131	480	345	490
126	Hamburgers/Ground Meat Sandwiches: Without Cheese	93	20	53	340	248	340
127	Hamburgers/Ground Meat Sandwiches: With Cheese	80	23	172	477	381	480
131	Combination Meals/Platters	16	6	201	419	340	420
132	Grain-based Dishes	70	17	79	334	239	340
133	Vegetable-based Dishes	2	2	221	247	234	290
134	Egg-based Dishes	29	6	164	349	273	360
135	Meat/Poultry-based Dishes	190	36	88	440	314	440
136	Seafood-based Dishes - With Breading	6	4	263	522	386	570
137	Seafood-based Dishes -Without Breading	40	13	48	320	193	320
138	Lettuce/Green Salads: With Additions - With Dressing	127	34	28	280	185	280
139	Lettuce/Green Salads: With Additions - Without Dressing	43	15	26	218	135	220
140	Lettuce/Green Salads: Without Additions - With Dressing	11	9	58	227	131	280
141	Seafood/Meat-Based Salads	1	1	144	144	144	450
142	Grain/Vegetable-Based Salads	2	2	195	247	221	250
143	Filled Dough Appetizers	1	1	267	267	267	330
144	Cheese-based Appetizers	3	3	473	590	522	640
145.b	Pizza: With Meat/Poultry or Seafood - Not Frozen	125	14	252	460	409	460
146.b	Pizza: Without Meat/Poultry or Seafood - Not Frozen	86	12	185	400	346	400
147	Tacos, Burritos, and Enchiladas	98	16	90	389	309	390