evidence that toxins from artificial playing surfaces may be to blame.[8] A lesser elevated, nonsignificant risk was found for cancers of the lip, oral cavity, and pharynx, which is of interest in light of concerns about tobacco chewing among baseball players. In an effort to address these concerns, MLB stated in 2016 that any player who debuts in 2017 or later will be prohibited from using smokeless tobacco on the field.[3] Death from melanoma and skin cancers were less common in baseball players than in the general population of American men, but rates were elevated among players who had longer careers. In 2015, MLB enacted a skin cancer control program called Play Sun Smart to raise awareness and offer prevention messages and screening to the baseball community.

Although MLB players possess unique characteristics, the study by Nguyen and colleagues[1] offers insights for the broader population of men. Causes of longevity are probably not specific to baseball but are instead specific to lifestyle. Maintaining a proper weight, exercising, and remaining fit are effective in increasing life expectancy, especially if begun at an early age, as was likely the case for these players. The study of occupational groups exposed intensely over a long period of time to factors that may elevate disease risks or decrease them are of value because the results may apply to people having similar exposures but of lesser intensity and duration. As such, results from the current study of professional athletes are consistent with previous studies demonstrating health benefits of physical activity and routine exercise in the general population.[9,10]

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1. Nguyen VT, Zafonte RD, Kponee-Shovein KZ, Paganoni S, Weisskopf MG. All-cause and cause-specific mortality among Major League Baseball players [published online July 22, 2019]. *JAMA Intern Med*. doi:10.1001/jamainternmed.2019.1218

2. Abel EL, Kruger ML. The healthy worker effect in Major League Baseball revisited. *Res Sports Med*. 2006;14(1):83-87. doi:10.1080/15438620500528406

3. Major League Baseball. Details of MLB, MLBPA labor agreement. https://www.mlb.com/news/details-of-mlb-mlbpa-labor-agreement/c-210125462. Published December 2, 2016. Accessed June 18, 2019.

4. McCrea M, Guskiewicz KM, Marshall SW, et al. Acute effects and recovery time following concussion in collegiate football players: the NCAA Concussion Study. *JAMA*. 2003;290(19):2556-2563. doi:10.1001/jama.290.19.2556

5. Conwell Y, Van Orden K, Caine ED. Suicide in older adults. *Psychiatr Clin North Am*. 2011;34(2):451-468, ix. doi:10.1016/j.psc.2011.02.002

6. Waterbor J, Cole P, Delzell E, Andjelkovich D. The mortality experience of Major-League Baseball players. *N Engl J Med*. 1988;318(19):1278-1280. doi:10.1056/NEJM198805123181917

7. Nguyen VT, Zafonte RD, Chen JT, et al. Mortality among professional American-style football players and professional American baseball players. *JAMA Netw Open*. 2019;2(5):e194223. doi:10.1001/jamanetworkopen.2019.4223

8. Luzer D. Artificial turf and cancer risk. *J Natl Cancer Inst*. 2016;108(12):djw311. doi:10.1093/jnci/djw311

9. O'Donovan G, Lee IM, Hamer M, Stamatakis E. Association of "weekend warrior" and other leisure time physical activity patterns with risks for all-cause, cardiovascular disease, and cancer mortality. *JAMA Intern Med*. 2017;177(3):335-342. doi:10.1001/jamainternmed.2016.8014

10. Arem H, Moore SC, Patel A, et al. Leisure time physical activity and mortality: a detailed pooled analysis of the dose-response relationship. *JAMA Intern Med*. 2015;175(6):959-967. doi:10.1001/jamainternmed.2015.0533

COMMENT & RESPONSE

Unified Approach Needed to Implement Nutrition Support Services

To the Editor We applaud Berkowitz and colleagues' recent Original Investigation[1] and were encouraged that enrollment in a medically tailored meal (MTM) program was associated with fewer hospital admissions and less overall medical spending. We serve as primary care clinicians who care for a small panel of high-need, high-cost Medicaid patients at a clinic in East Baltimore that is located in a food desert. Every day, we witness the harms that food deserts and food insecurity, along with other socioeconomic disparities, inflict on the health of our community. We strongly support adopting a "food as medicine" approach to improve health equity, and we appreciate the work by Berkowitz and colleagues to demonstrate the benefits of MTM for the most vulnerable patients.

The authors highlight that MTM interventions are relatively costly and therefore need to be targeted to individuals who would benefit most, as well as that more research is needed to determine how to identify those patients.[1] In the accompanying commentary, Mozaffarian and colleagues[2] emphasize that nutrition must be incorporated into health care and that a structure should be created to ensure patients are referred to the right program. In our experience, not all patients will require MTM, but they may benefit from less intensive and less costly food interventions. For example, patients with higher functional status or more robust social support, but who are still struggling with food insecurity and malnutrition, might benefit from a simple educational intervention paired with food distribution.

We agree with Berkowitz and colleagues and Mozaffarian and colleagues that incorporating a range of nutrition services, such as MTM, will eventually be an essential component of clinical care and be financially supported by health insurance reimbursements.[3] In addition to further research, clinician advocacy is needed to give a voice to our vulnerable patients and to ensure incorporation of nutrition services into clinical care. In particular, we need to ask our elected representatives at the state and federal levels to pass laws that require reimbursement of MTM and other nutrition support services. Second, we need to advocate for meaningful integration of government agencies and programs to combat the "wrong pockets problem."[4] Ultimately, nutritious food is a right, not a privilege, and access should be coordinated by a cohesive, unified administration.

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1. Berkowitz SA, Terranova J, Randall L, Cranston K, Waters DB, Hsu J. Association between receipt of a medically tailored meal program and health care use. *JAMA Intern Med*. 2019;179(6):786-793. doi:10.1001/jamainternmed.2019.0198

2. Mozaffarian D, Mande J, Micha R. Food is medicine—the promise and challenges of integrating food and nutrition into health care. *JAMA Intern Med*. 2019;179(6):793-795. doi:10.1001/jamainternmed.2019.0184

3. Rediger K, Miles DRB. Clinical-community partnerships to reduce food insecurity among high-need, high-cost Medicaid patients. *Ann Intern Med*. 2018;169(7):490-491. doi:10.7326/M18-1104

4. What is the "wrong pockets problem"? Urban Institute Pay for Success Initiative. https://pfs.urban.org/faq/what-wrong-pockets-problem. Published June 12, 2017. Accessed July 22, 2019.

In Reply We appreciate the thoughtful letter from Rediger and Miles regarding our study[1] and offer a few additional points. Given the importance of nutrition for health, we share the view that a broad range of nutrition options should be available to patients. In our view, medically tailored meal programs are one important tool that we hope becomes more widely available.

Improving our knowledge regarding interventions to address food insecurity is an ongoing process, but we believe that implementation of existing interventions can cooccur with the further expansion of this evidence base. For example, Community Servings, in partnership with the Center for Health Law and Policy Innovation at Harvard Law School, is leading the development of a Food is Medicine State Plan in Massachusetts.[2] The goal of this plan is to not only address the nutritional needs of individuals through the health care system, but also to foster education, advocacy, and systems change regarding nutrition needs. An opportunity to help put this plan into action is coming in January 2020, when the Massachusetts Medicaid system will introduce financing mechanisms that allow for a broad array of beneficiary nutrition services, including medically tailored meals in appropriate circumstances. Nationwide, a major opportunity for similar work is that Medicare Advantage plans now have the ability to cover nutritional services via changes enacted in the Creating High-Quality Results and Outcomes Necessary to Improve Chronic Care Act.[3]

Although meeting individual-level health-related social needs, such as food and nutrition, is a vital component of care, we also think it is important to view unmet health-related social needs as the end result of many social and environmental factors that affect health. Addressing these social determinants of health goes beyond clinical programs for individuals and requires collaboration among health care systems, public health systems, government, human services organizations, local communities, and families. Ultimately, we think it is critical not only to provide the appropriate services for those in need, but also to understand, and address, why health-related social needs arise.

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1. Berkowitz SA, Terranova J, Randall L, Cranston K, Waters DB, Hsu J. Association between receipt of a medically tailored meal program and health care use. *JAMA Intern Med*. 2019;179(6):786-793. doi:10.1001/jamainternmed.2019.0198

2. Massachusetts Food is Medicine Coalition. https://foodismedicinema.org/. Accessed June 7, 2019.

3. Willink A, DuGoff EH. Integrating medical and nonmedical services—the promise and pitfalls of the CHRONIC Care Act. *N Engl J Med*. 2018;378(23):2153-2155. doi:10.1056/NEJMp1803292

CORRECTION

Funder and Disclaimer Added: In the Research Letter titled "Association of Health Status With Receipt of Supplemental Security Income Among Individuals With Severe Disabilities and Very Low Income and Assets,"[1] published online April 1, 2019, and in the June print issue, a funder and disclaimer were added. This article has been corrected online.

1. Sonik RA, Parish SL, Mitra M. Association of health status with receipt of Supplemental Security Income among individuals with severe disabilities and very low income and assets. *JAMA Surgery*. 2019;179(6):842-843. doi:10.1001/jamainternmed.2018.8609

Correction to Number in Abstract: In the Original Investigation titled "Financial Implications of 12-Month Dispensing of Oral Contraceptive Pills in the Veterans Affairs Health Care System,"[1] published online July 8, 2019, in the Abstract, the cohort size was incorrectly given in one instance as 240 309; the correct value is 24 309. This article was corrected online.

1. Judge-Golden CP, Smith KJ, Mor MK, Borrero S. Financial implications of 12-month dispensing of oral contraceptive pills in the Veterans Affairs health care system [published online July 8, 2019]. *JAMA Intern Med*. doi:10.1001/jamainternmed.2019.1678

Error in References: In the Viewpoint titled "The Ketogenic Diet for Obesity and Diabetes—Enthusiasm Outpaces Evidence,"[1] published online July 15, 2019, reference 2 was incorrect. This article has been corrected online.

1. Joshi S, Ostfeld RJ, McMacken M. The Ketogenic diet for obesity and diabetes—enthusiasm outpaces evidence [published online July 15, 2019]. *JAMA Intern Med*. doi:10.1001/jamainternmed.2019.2633

Errors in Figure Headings: In the Original Investigation titled "Association of Weight Loss Interventions With Changes in Biomarkers of Nonalcoholic Fatty Liver Disease: A Systematic Review and Meta-analysis," published online July 1, 2019,[1] there