<table>
<thead>
<tr>
<th>Title</th>
<th>Implementation of mobile health tools</th>
</tr>
</thead>
<tbody>
<tr>
<td>Author(s)</td>
<td>Freeman, William D.</td>
</tr>
<tr>
<td>Citation</td>
<td>Freeman, W. D. (2014). Implementation of mobile health tools. JAMA, 311(14), 1447-1449.</td>
</tr>
<tr>
<td>Date</td>
<td>2014</td>
</tr>
<tr>
<td>URL</td>
<td><a href="http://hdl.handle.net/10220/23978">http://hdl.handle.net/10220/23978</a></td>
</tr>
<tr>
<td>Rights</td>
<td>© 2014 American Medical Association. This is the author created version of a work that has been peer reviewed and accepted for publication by JAMA, American Medical Association. It incorporates referee’s comments but changes resulting from the publishing process, such as copyediting, structural formatting, may not be reflected in this document. The published version is available at: [DOI:<a href="http://dx.doi.org/10.1001/jama.2014.1109">http://dx.doi.org/10.1001/jama.2014.1109</a>].</td>
</tr>
</tbody>
</table>
Your letter has been edited for conciseness and for consistency with JAMA style; please do not replace deleted material or add new material except where requested. To revise the document, please accept the changes in a clean copy; make any additional changes and respond to questions, including confirmation of financial disclosures, directly on the copy using Track Changes. Please do not remove the manuscript number or date at the top.
To the Editor:

Dr Steinhubl and colleagues\(^1\) presented an interesting argument for mobile health (mHealth) from the point of view of physicians and policy makers but insufficiently considered those who will actually have to use mHealth if it is to succeed: patients and the public. If people are not engaged by, and motivated to use, mHealth tools, then any clinical benefits will remain hypothetical.

The authors highlighted the popularity of health apps with unclear connections to established medical practice, offering a reminder of the gulf that can exist between physician priorities and what patients might need or want. mHealth interventions should integrate both perspectives, recognizing that enhanced convenience is not the only factor that will shape patient engagement. Particularly for chronic conditions, the benefits of self-management may be less immediately apparent. Behavioral tricks and rewards will play a role, but ultimately mHealth must address patient needs. Even when physician and patient goals overlap, the individual, social and situational determinants that make particular solutions appropriate must be understood.

Clinically useful, data-driven models can be enhanced to promote autonomy and skill acquisition, connect to peer and other forms of support outside traditional medical structures, or tackle affective aspects of health and illness. Such enhancements do not need to be complex: behavior can be changed using simple text message reminders\(^2\).

Patient perspectives also feature at a population level. mHealth must work at scale and over time, which raises issues of access and equity. The convenience of remote management may be attractive for many patients, but perhaps not for isolated elderly persons who stand to lose a
source of social interaction and support. Most people in developed settings may now have a smartphone, but issues like health literacy, privacy, platform fragmentation that segregates by sociodemographic group, rapid technology turnover, and data costs still stand as potential barriers. A credible roadmap for implementation for mHealth doesn’t just demand clinical trials; it needs an evidence base that addresses the breadth of issues relevant for real-world implementation, at scale\(^3\).

Novel gizmos and data flows create a context for change but, like many healthcare technology innovations before,\(^4\) patients will determine whether mHealth will succeed or fail.

Kit Huckvale, MB ChB, MSc

Josip Car, MD, PhD

Global eHealth Unit

Imperial College London

London, England

**Corresponding Author:** Kit Huckvale, MB ChB, MSc, Global eHealth Unit, Imperial College London, Reynolds Building, St Dunstans Road, London W6 8RP England

(c.huckvale@imperial.ac.uk).

We have received the [ICMJE Form for Disclosure of Potential Conflicts of Interest](#) from all authors. Please confirm that you have disclosed all potential conflicts of interest. Our policy requires that all authors disclose all potential conflicts of interest, including specific financial interests and relationships and affiliations relevant to the subject of their manuscript within the past 3 years and for the foreseeable future (eg, employment, consultancies, honoraria, stock ownership or options, expert testimony, grants or patents received or pending, royalties). For example, authors of a letter about hypertension should report all financial relationships they have with all manufacturers of products used in the management of hypertension, not only those relationships with companies whose specific
products are mentioned in the manuscript. For authors with disclosures under Part 3 of the ICJME form (Relevant financial activities outside the submitted work), please confirm that these disclosures are not relevant to the topic of the letter. If you are uncertain about what constitutes a relevant financial interest or relationship, please ask.

**Conflict of Interest Disclosures:** The authors have completed and submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest and none were reported.


