menting high-value, cost-conscious DM care, we can over-
come the challenges and make a positive difference in
our patients with type 2 DM.

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Published Online: October 8, 2012. doi:10.1001/2013
.jamainternmed.203

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Conflict of Interest Disclosures: None reported.

Additional Information: Both Drs Wilt and Qaseem are
members of the American College of Physicians Clinical
Practice Guideline Committee.

1. Qaseem A, Humphrey LL, Sweet DE, Starkey P, Sheikh P; Clinical Guidelines
Committee of the American College of Physicians. Oral pharmacologic treat-
ment of type 2 diabetes mellitus: a clinical practice guideline from the Ameri-


3. Coca SG, Ismail-Beigi F, Haq N, Krumholz HM, Parikh CR. Role of inten-
sive glucose control in development of renal end points in type 2 diabetes mel-
litus: systematic review and meta-analysis of intensive glucose control in

4. Gellad W, Mor M, Zhao X, Donohue J, Good C. Variation in use of high-
cost diabetes mellitus medications in the VA healthcare system [published

5. Duckworth W, Abraira C, Moritz T, et al. VADT Investigators. Glucose con-
2009;360(2):129-139.

6. The healthcare imperative: lowering costs and improving outcomes: work-
Imperative-Lowering-Costs-and-Improving-Outcomes.aspx. Institute of

7. Owens DK, Qaseem A, Chou R, Shekelle P; Clinical Guidelines Committee
of the American College of Physicians. High-value, cost-conscious health
 care: concepts for clinicians to evaluate the benefits, harms, and costs of medi-

8. Weinberger SE. Providing high-value, cost-conscious care: a critical sev-
386-388.

agnostic tests to foster high-value, cost-conscious care: Ann Intern Med.
2012;156(2):147-149.

10. Best health tests and treatments often cost less. Consumer Reports.
http://www.consumerreports.org/cro/2012/04/best-health-tests-and-

should nonetheless be interpreted while taking into ac-
count some issues, the most evident being that the much
higher mortality in the intervention group casts doubts
on the real comparability of the study arms.

Furthermore, the population studied was hetero-
genous with respect to the main disease. The experi-
ce with comprehensive geriatric assessment, how-
ever, clearly demonstrates that elderly and frail
patients benefit from a strategy of care tailored to indi-
vidual needs.2 There is no reason for thinking that
such a conclusion does not apply to telemonitoring. In
addition, the efficacy of telemonitoring may change
according to the main disease: despite some negative
trials, a recent Cochrane review indicates that in
patients with congestive heart failure, telemonitoring
is effective in reducing the risk of all-cause mortality
and congestive heart failure–related hospitalizations.3
The lack of focus on a specific disease may also reduce
the capacity of the telemonitoring team of detecting
changes in health status. For example, symptoms of
chronic obstructive pulmonary disease exacerbation
may be aspecific4 and may be missed by study person-
el not specifically trained for (tele)assisting people
with this disease.

The lack of specificity of the study is also reflected
in the top-down application of existing technologies to
monitor patients regardless of their individual charac-
teristics. A recent qualitative study shows that early
detection of acute deterioration is not effectively achieved by
current telemonitoring systems because telemonitoring
is driven by available technology rather than by users’
needs.5

In conclusion, this study adds to our knowledge on
telemonitoring by indirectly suggesting that homoge-
neous populations, ie, sharing the main disease, should
be the target of these interventions, or, otherwise, the
protocol and the technology used should be sufficiently elas-
tic to tailor the telemonitoring to highly different indi-
vidual needs.

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Conflict of Interest Disclosures: None reported.

COMMENTS AND OPINIONS

Telemonitoring in Older Adults: Does One Size Fit All?

The study by Takahashi et al1 provides useful
information about the effectiveness of teleme-
dicine. We believe that their negative results, al-
though in line with others reported in the literature,