Remote Patient Monitoring With Virtual Care Management Facilitates Longitudinal Blood Pressure Control: A Retrospective Real-World Cohort Analysis

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Abstract

This retrospective cohort analysis examines the effectiveness of a remote patient monitoring (RPM) program with structured virtual care management aimed to improve blood pressure (BP) control in adults diagnosed with hypertension. The study included a retrospective analysis of a total sample population of 655 patients at the 3-month mark, with 324 patients (49.5%) providing data through the 9-month mark. All patients had a diagnosis of hypertension, defined as a 14-day baseline BP at stage 1 hypertension (SBP=130-139 mmHg or DBP=80-89 mmHg) or above. Participants were monitored over 9 months, during which time they engaged in regular remote physiologic monitoring of their blood pressure and ongoing consultations with care managers. The study found significant reductions in blood pressure over the monitoring period, with an overall 6.3% reduction in systolic blood pressure (SBP), a 7.4% reduction in diastolic blood pressure (DBP), and a 7.0% reduction in mean arterial pressure (MAP) at the 9-month mark. While all groups benefited from the intervention, those entering the program with stage 2 hypertension showed the greatest reductions, with a 9.1% reduction in SBP, a 9.7% reduction in DBP, and a 9.5% reduction in MAP. A clear severity gradient was observed, showing that patients with higher baseline BP have greater opportunity for improvement in hypertension. This demonstrates that patients already near target thresholds have clinically meaningful reductions, but may primarily benefit from maintenance of BP control rather than large additional decreases. These findings also suggest that RPM programs with structured virtual care management are a viable approach for aiding in the reduction and management of hypertension. Additionally, analysis of patient engagement revealed that BP reductions were largely independent of data frequency. Patients with moderate engagement (2-15 days of data/month) achieved a 6.6% reduction in MAP at 9 months, compared to 7.1% reduction in high-engagement patients (16+ days of data /month). These findings suggest that the structured virtual care component of the RPM program provides significant clinical value even for patients who transmit BP readings for less than 16 days per month.

Introduction

Hypertension remains one of the most prevalent chronic conditions in older adults, affecting 30-40% of the adult population worldwide (1). Traditional management approaches often involve scheduled in-person visits to healthcare providers, which may not be as effective for continuous blood pressure (BP) control, especially in older populations who may face barriers to frequent in-person care (2).

Remote physiological monitoring, also referred to as remote patient monitoring (RPM), has rapidly emerged as a solution to chronic disease management (3). RPM leverages connected medical

devices, such as cellular-connected blood pressure monitors, to collect patient data in real time and securely transmit it to healthcare providers (4). RPM enables continuous monitoring outside of the traditional care setting and more proactive management of chronic conditions, leading to reduced hospital readmissions, emergency department visits, and total hospital days (5). Clinical professionals oversee this process, reviewing incoming data, adjusting treatment plans as needed, and providing timely patient outreach.

A growing body of clinical research has demonstrated RPM's effectiveness in improving hypertension outcomes. Multiple studies show significant reductions in both systolic blood pressure (SBP) and diastolic blood pressure (DBP) among patients enrolled in structured RPM programs compared to those receiving standard care (6).

The RPM program implemented by Prevounce Health, Inc., in partnership with healthcare providers utilizing Prevounce's cellular RPM devices and staffed care management services, was designed to offer a more consistent and comprehensive approach to hypertension management. This retrospective cohort study involved regular remote monitoring of BP readings and check-ins with care managers who provided guidance and adjusted non-pharmacological treatment plans (e.g. lifestyle, diet, adherence coaching) as needed. This study aims to retrospectively assess the impact of the RPM program on BP control over a 9-month period across various populations of patients with hypertension.

Methods

Study Design

This study is a retrospective cohort analysis that is structured to evaluate the impact of RPM intervention with structured virtual care management on BP control in a population of hypertensive patients. The study sample population consisted of patients with a documented diagnosis of hypertension with a clinical need for remote monitoring, whether for active BP reduction or sustained maintenance, as determined by the patient's healthcare provider. These patients were provided with a cellular-connected BP monitor and assigned a dedicated care manager delivering structured and consistent virtual care management. The analytical cohort was treated as a dynamic population to reflect real-world engagement patterns. A total of N=655 patients provided data at the 3-month mark. Participation followed a longitudinal decay pattern common in digital health interventions, with n=493 patients remaining at 6 months and n=324 at 9 months. Analysis was conducted on an available-case basis.

The initial cohort of N=655 patients who provided BP data at the 3-month interval met the following inclusion criteria: 1. A documented diagnosis of hypertension with a clinical need for remote monitoring, as determined by the patient's healthcare provider; 2. A 14-day mean baseline BP at stage 1 hypertension (SBP=130-139 mmHg or DBP=80-89 mmHg) or above.

Intervention Protocol

The program utilized Prevounce cellular-connected BP devices, specifically models Pylo 802-LTE and Pylo 900-LTE, for remote BP measurement. These devices met validation standards for accuracy and reliability in clinical settings per FDA 510(K) clearance and the American Medical Association's Validated Device Listing (7), devices were integrated with the HIPAA-compliant Prevounce portal for real-time data oversight by each patient's care manager and supervising provider.

Participants were instructed to record daily BP measurements to capture trends and ensure consistent monitoring. Patients were instructed to take one reading every day after a 5-minute rest period. During the measurement, they were to be seated with their back supported, legs uncrossed, and arm at heart level to ensure accuracy. Measurements were scheduled based on discussions between the patient, their care manager, and their healthcare provider, ensuring convenience and adherence.

Structured Virtual Care and Communication Between Care Managers and Patients

Prevounce care managers conducted regular check-ins with participants at least monthly, with additional contacts occurring more frequently as needed, with a mean of 2.71 calls per patient per month. Check-ins varied in frequency by patient based on physician orders, treatment plan, and patient acuity. These check-ins provided an opportunity for education, feedback, and adjustments to treatment plans based on trends in the recorded BP data. Care managers were healthcare professionals with backgrounds in nursing or clinical social work, trained to communicate effectively and support patient engagement.

Data Extraction and Variables

Data were extracted from the Prevounce platform, a HIPAA-compliant digital care management and RPM platform that aggregates physiologic readings transmitted from connected devices for each participant. The platform captures time-stamped BP measurements and maintains longitudinal records for patients enrolled in RPM.

Independent variables:
The independent variables included age and baseline hypertension stage. Age was categorized in two cohorts as <65 years (*n*=148) and ≥65 years (*n*=507). Baseline hypertension stage was classified according to established American College of Cardiology (ACC) and American Heart Association (AHA) guidelines as stage 1 hypertension (SBP=130-139 mmHg or DBP=80-89 mmHg), or stage 2 hypertension (SBP ≥140 mmHg or DBP ≥90mmHg) within the first 14 days of enrollment. The initial population distribution per hypertensive stage cohort were: stage 1 hypertension (*n*=268), stage 2 hypertension (*n*=387). Adherence level was determined by the frequency of blood pressure data transmission and was categorized into moderate engagement (2-15 days of data per month) and high engagement (16+ days of data per month).

Dependent variables:
The dependent variables were the percentage change in SBP, DBP, and MAP measured at 3, 6, and 9 months relative to baseline values obtained at initial enrollment.

Percentage change was calculated for each participant using the formula:

$$Percentage\ Change\ =\ \frac{Follow\text{–}up\ BP\ -\ Baseline\ BP}{Baseline\ BP}\times\ 100$$

Mean arterial pressure was derived using the standard formula:

$$MAP\ =\ DBP\ +\ \frac{1}{3}(SBP\ -\ DBP)$$

Ethical Considerations

Ethical review and institutional approval were waived for this study due to its retrospective design and the use of pre-existing data. All analyses were conducted within a secure data environment.

Statistical Analysis

Statistical analyses were performed to assess longitudinal changes in BP parameters across demographic and clinical subgroups. To minimize the impact of acute fluctuations and regression to the mean, baseline values were established using a 14-day mean rather than a single intake measurement. This provides a more stable physiological baseline for longitudinal comparison. Changes over time were evaluated using paired-sample t-tests to compare mean baseline values against mean readings at 3, 6, and 9-month intervals. Data were stratified by age and baseline hypertension stage to evaluate differential treatment effects. All statistical tests were two-tailed, and a p-value of $p<0.05$ was considered the threshold for statistical significance.

Results

The study demonstrated association of RPM with significant reductions in SBP and DBP, as well as MAP, across all patient categories analyzed. Across the dataset, p-values were consistently $p \leq 0.003$, confirming that the observed improvements are statistically significant and highly unlikely to be due to chance.

Blood Pressure Reductions: Overall Trends

The “total” data revealed steady and consistent improvements in BP over the 9-month period of monitoring (Table 1). After 3 months, SBP decreased by 5.5%, and DBP decreased by 6.2%. These reductions continued progressively with patients who remained in the study (n=324), with a decline of 6.3% in SBP and 7.4% in DBP at the 9-month mark (figure 1). Similarly, MAP reflected these improvements, decreasing by 7.0% at the end of the study (figure 2). These findings emphasize the efficacy of the RPM program in achieving sustained BP control.

Results by Age Groups

Stratification of results by age demonstrated similar trends across age-groups (Table 1), indicating that the intervention produced comparable effects in patients younger than 65 years and those aged 65 years and older.

- **Under 65 Years:** For participants under 65 years, at the 9-month mark (n=48), SBP decreased by 7.5%, while DBP decreased by 8.4% (figure 3). MAP decreased by 8.1% (figure 4) over the same period.
- **65+ Years:** For participants aged 65+, at the 9-month mark (n=276) SBP decreased by 6.1%, and DBP by 7.3% (figure 3), with a corresponding MAP reduction of 6.8% (figure 4)

Results by Hypertension Stage

The intervention demonstrated substantial improvements in stage 1 and stage 2 hypertension, with stage 2 hypertension showing the greatest improvements over time (Table 1):

- **Stage 1 hypertension:** Patients with stage 1 hypertension at the 9-month mark (*n*=128) achieved greater reductions, with a 2.0% decrease in SBP and a 3.9% (figure 5) decrease in DBP. MAP showed a corresponding reduction of 3.0% at the 9-month mark (figure 6).
- **Stage 2 hypertension**: Substantial improvements were seen in patients with stage 2 hypertension at the 9-month mark (*n*=196), where SBP decreased by 9.1%, DBP by 9.7% (figure 5), and MAP by 9.5% (figure 6). These findings highlight the RPM program's potential to deliver the greatest reductions in BP to patients with stage 2 hypertension.

Results by Adherence Level

The clinical impact of the RPM program remained robust across varying levels of patient engagement (Table 1).

- **Moderate engagement patients (2-15 days of data/month):** At the 9-month mark, the moderate engagement group (*n*=103) maintained a substantial 6.6% reduction in MAP (figure 7).
- **High engagement patients (16+ days of data /month)**: At the 9-month mark, the high engagement group (*n*=221) achieved a 7.1% reduction (figure 7). The narrow margin of difference between these two cohorts suggests that the efficacy of the intervention is not strictly dependent on daily monitoring, but rather on the cumulative effect of consistent program participation.

Table 1. Percent Change in SBP, DBP, and MAP by Cohort

Interval	Cohort	*n*	SBP change		*p*	DBP change		*p*	MAP change		*p*
			%	95% CI		%	95% CI		%	95% CI	
Longitudinal Blood Pressure Reductions Total											
3 months	Total	655	-5.5	-6.1, -4.9	<.001	-6.2	-6.8, -5.6	<.001	-5.9	-6.5, -5.3	<.001
6 months	Total	493	-6.5	-7.2, -5.8	<.001	-7.3	-8.0, -6.6	<.001	-7.0	-7.7, -6.3	<.001
9 months	Total	324	-6.3	-7.2, -5.4	<.001	-7.4	-8.2, -6.6	<.001	-7.0	-7.8, -6.2	<.001
Longitudinal Blood Pressure Reductions by Age Cohort											
3 months	Under 65	148	-5.9	-7.1, -4.7	<.001	-6.3	-7.4, -5.2	<.001	-6.2	-7.2, -5.2	<.001
	65+	507	-5.4	-6.1, -4.7	<.001	-6.2	-6.9, -5.5	<.001	-5.9	-6.6, -5.2	<.001
6 months	Under 65	94	-8.1	-9.6, -6.6	<.001	-8.2	-9.7, -6.7	<.001	-8.2	-9.6, -6.8	<.001
	65+	399	-6.2	-7.0, -5.4	<.001	-7.1	-7.9, -6.3	<.001	-6.7	-7.5, -5.9	<.001
9 months	Under 65	48	-7.5	-10.2, -4.8	<.001	-8.4	-11.0, -5.8	<.001	-8.1	-10.6, -5.6	<.001
	65+	276	-6.1	-7.0, -5.2	<.001	-7.3	-8.2, -6.4	<.001	-6.8	-7.6, -6.0	<.001
Longitudinal Blood Pressure Reductions by Hypertension Stage Cohort											
3 months	Stage 1	268	-1.6	-2.5, -0.7	<.001	-2.7	-3.4, -2.0	<.001	-2.2	-2.9, -1.5	<.001
	Stage 2	387	-8.2	-9.0, -7.4	<.001	-8.7	-9.5, -7.9	<.001	-8.5	-9.2, -7.8	<.001
6 months	Stage 1	199	-1.4	-2.4, -0.4	0.003	-3.1	-4.0, -2.2	<.001	-2.4	-3.3, -1.5	<.001
	Stage 2	294	-10.0	-10.8, -9.2	<.001	-10.1	-11.0, -9.2	<.001	-10.1	-10.9, -9.3	<.001
9 months	Stage 1	128	-2.0	-3.2, -0.8	<.001	-3.9	-5.1, -2.7	<.001	-3.0	-4.1, -1.9	<.001
	Stage 2	196	-9.1	-10.2, -8.0	<.001	-9.7	-10.8, -8.6	<.001	-9.5	-10.5, -8.5	<.001
Longitudinal Blood Pressure Reductions Stratified by Adherence*											
3 months	High adherence	372	-5.9	-6.6, -5.2	<.001	-6.5	-7.2, -5.8	<.001	-6.3	-7.0, -5.6	<.001
	Mod. adherence	280	-5.1	-6.2, -4.0	<.001	-6.1	-7.1, -5.1	<.001	-5.7	-6.7, -4.7	<.001
6 months	High adherence	290	-6.7	-7.6, -5.8	<.001	-7.4	-8.2, -6.6	<.001	-7.1	-7.9, -6.3	<.001
	Mod. adherence	201	-6.2	-7.5, -4.9	<.001	-7.1	-8.3, -5.9	<.001	-6.8	-8.0, -5.6	<.001
9 months	High adherence	221	-6.7	-7.7, -5.7	<.001	-7.5	-8.5, -6.5	<.001	-7.1	-8.0, -6.2	<.001
	Mod. adherence	103	-5.5	-7.2, -3.8	<.001	-7.3	-8.9, -5.7	<.001	-6.6	-8.1, -5.1	<.001

Values are percent change from 14-day mean baseline. 95% confidence intervals presented as lower bound, upper bound. All p-values are two-sided. *Note: data for patients with less than 2 days of monitoring per month were omitted as the sample size was insufficient to reach statistical significance.

Figures

Figure 1

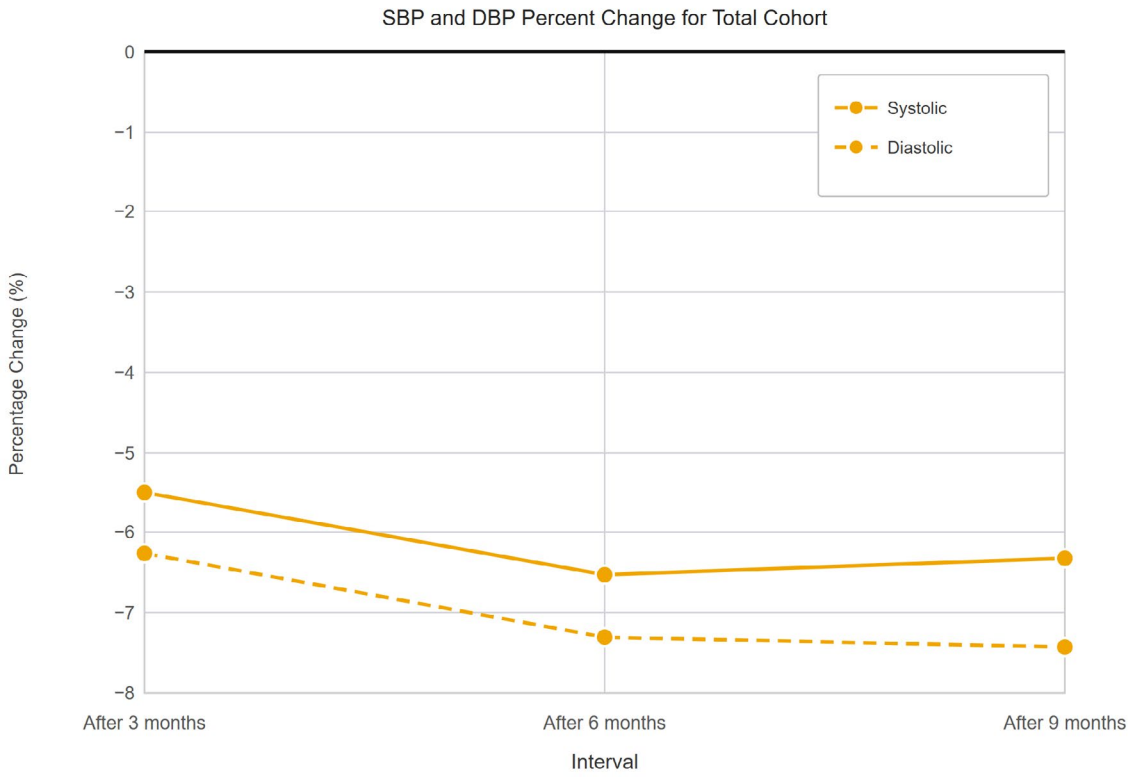


Figure 2

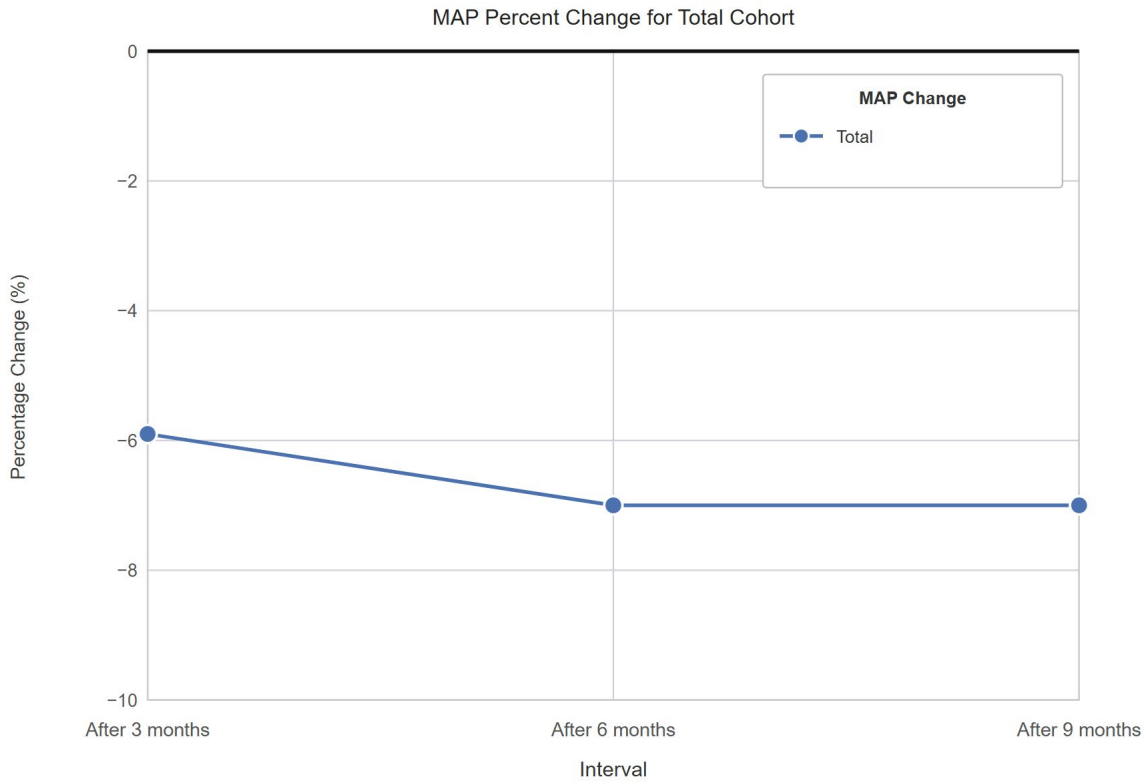


Figure 3

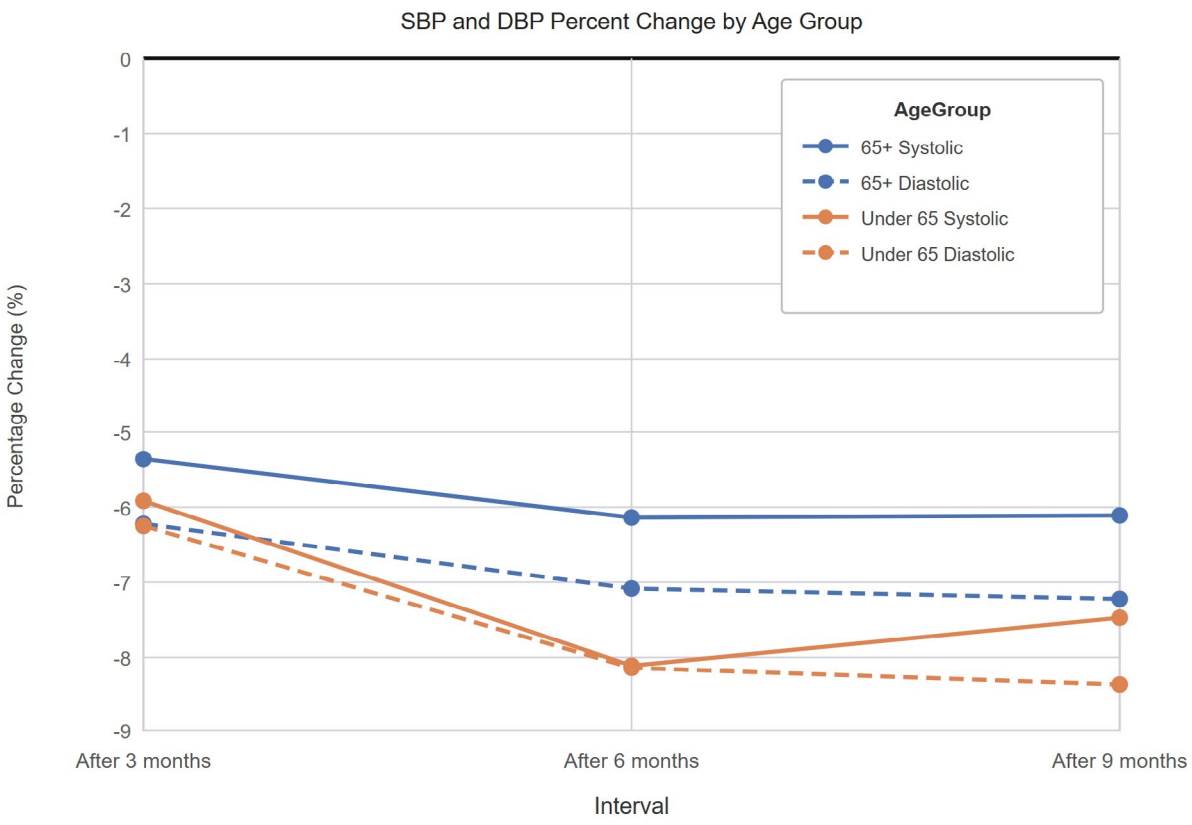


Figure 4

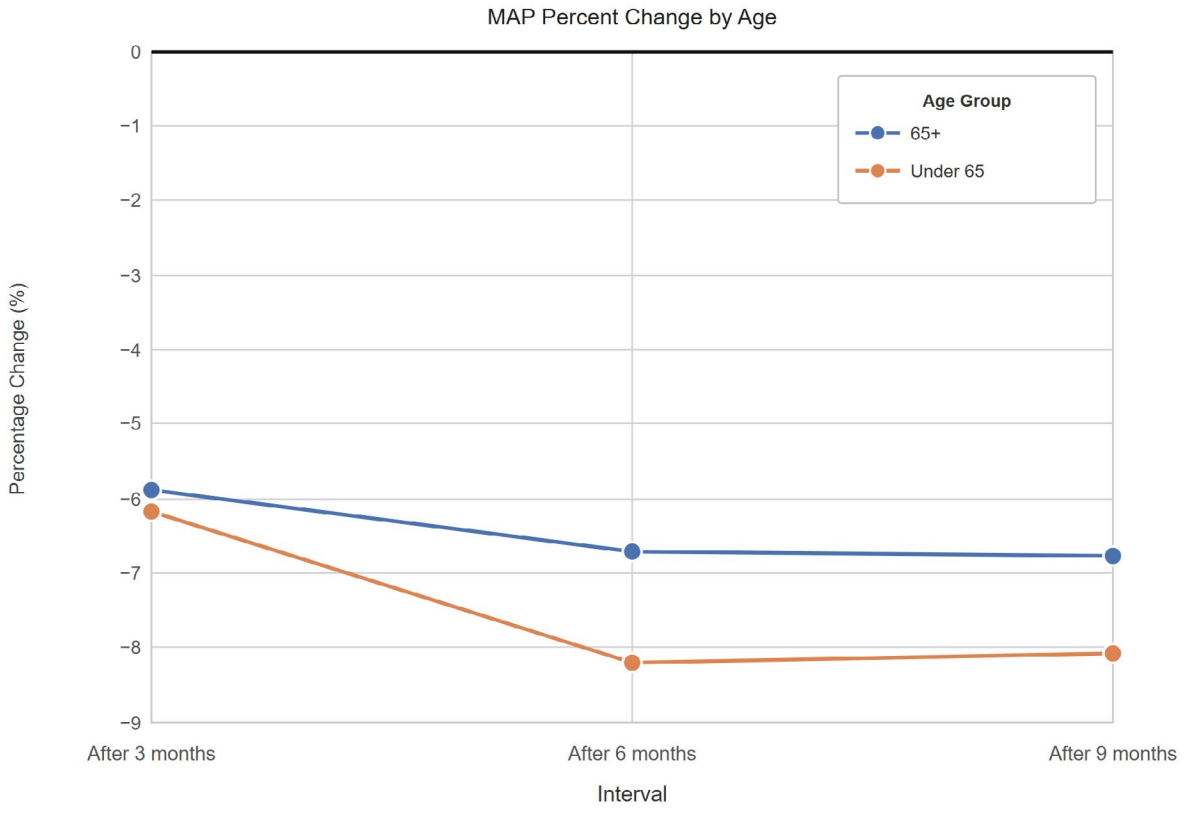


Figure 5

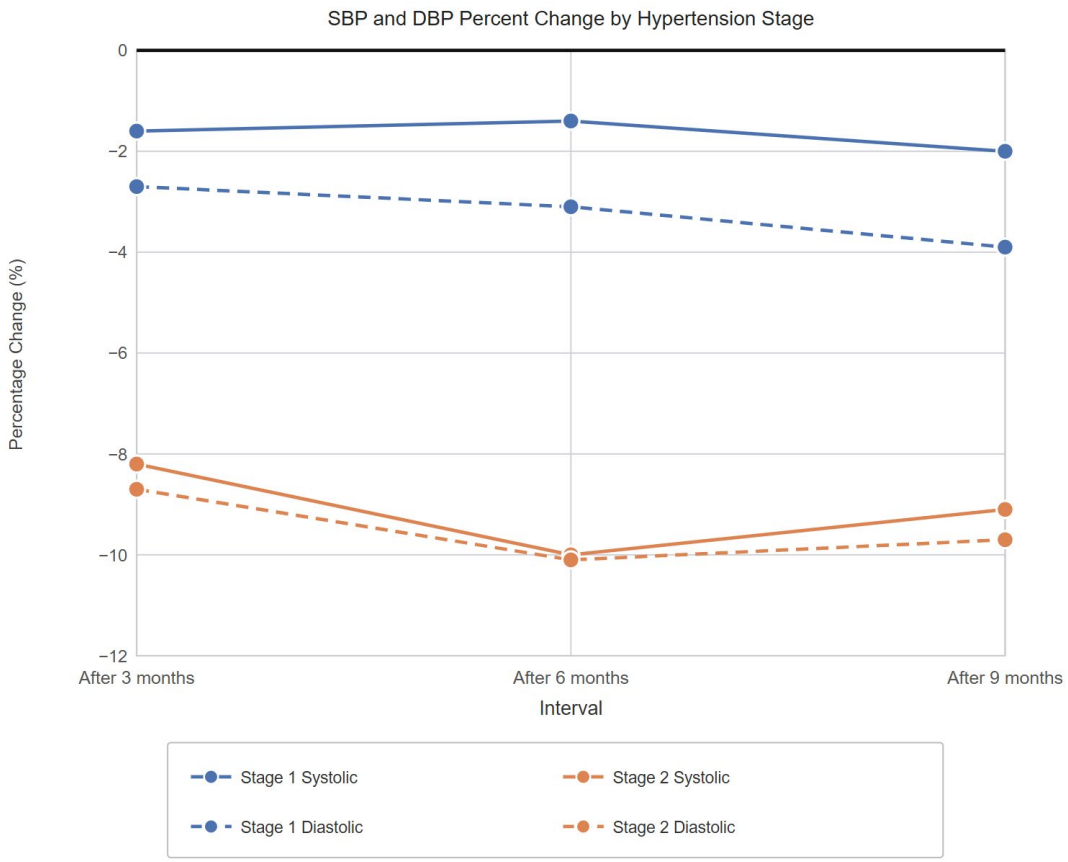


Figure 6

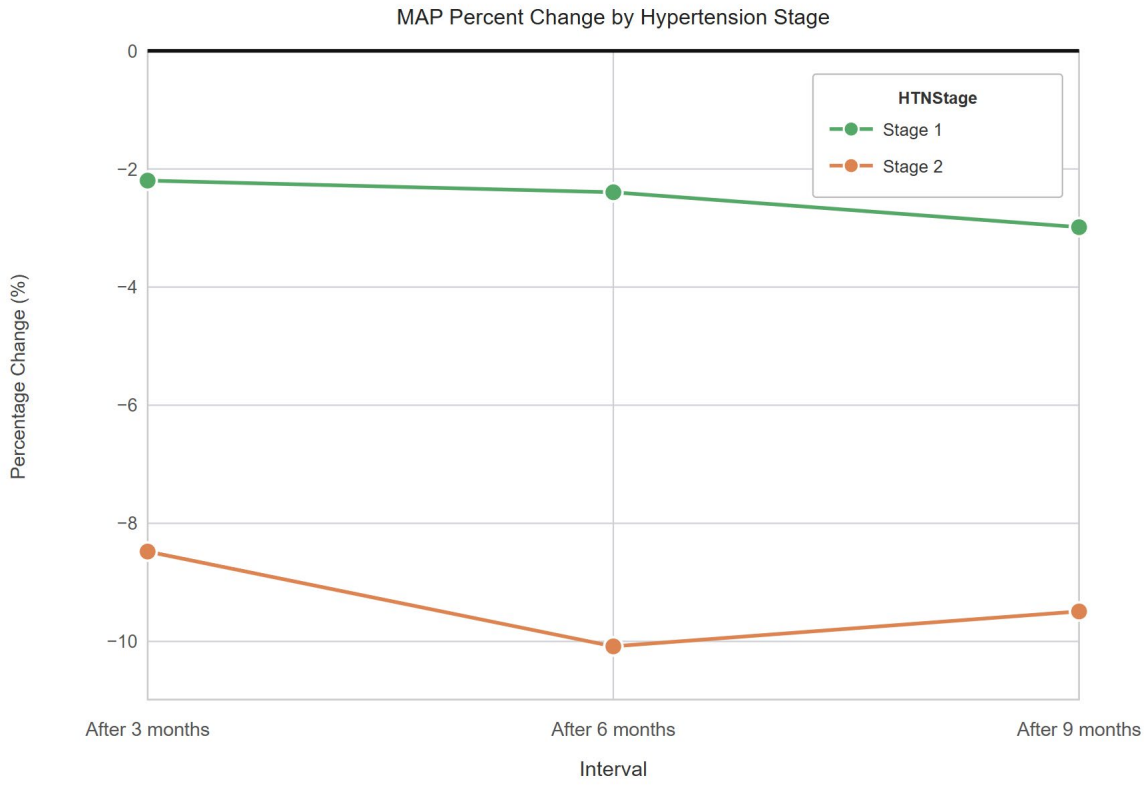
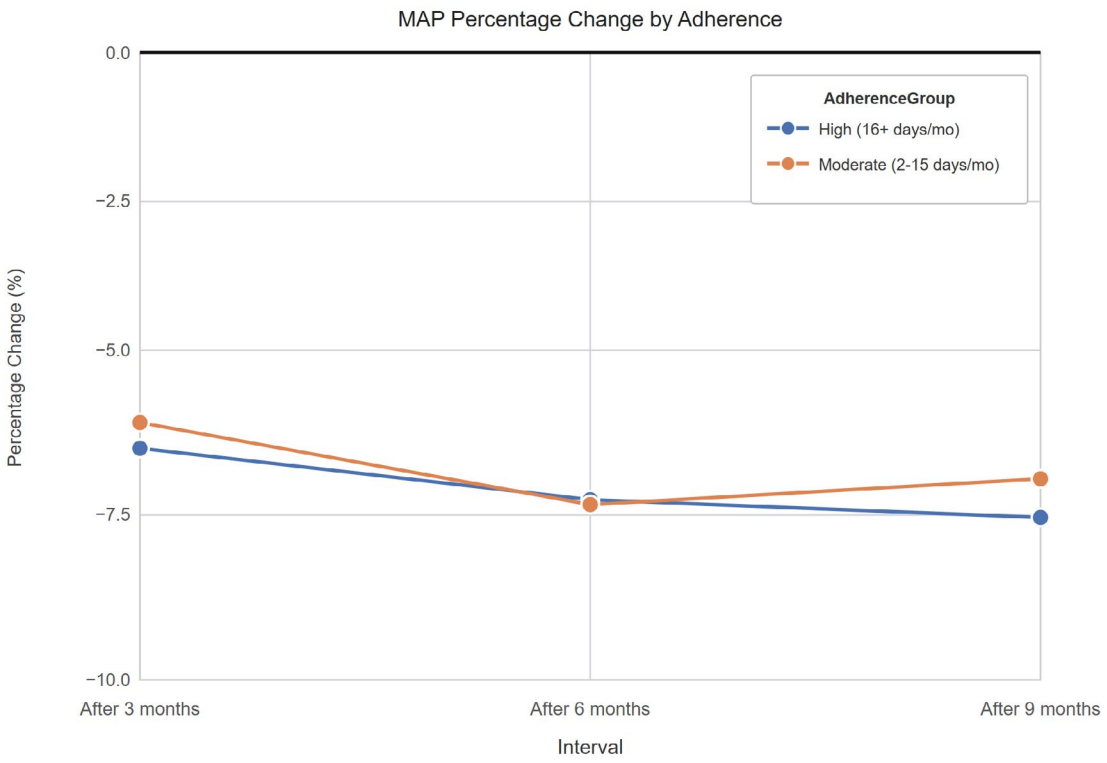


Figure 7



Discussion

The findings from this study demonstrate the significant impact of an RPM program combined with virtual care management in managing BP across a wide range of hypertensive patients. The observed reductions in SBP and DBP, along with improvements in MAP, support the efficacy of RPM as a practical tool for hypertension management, both in reducing BP in patients with uncontrolled hypertension and maintaining sustained longitudinal control.

Interpretation of Findings

The longitudinal reductions in BP across all subgroups highlight the importance of continuous monitoring and timely interventions enabled by the RPM program. The “total” data showed sustained improvement throughout the study, indicating that RPM facilitates sustained BP control.

A clear severity gradient was observed by hypertension cohort: the largest reductions occurred among patients with stage 2 hypertension, followed by those with stage 1 hypertension. This pattern is consistent with the principle that patients with higher baseline BP have greater opportunity for improvement in hypertension. This also demonstrates that patients already near target thresholds may benefit from maintenance of BP control rather than large additional decreases.

Younger participants (under 65 years) experienced slightly greater reductions in SBP, DBP, and MAP compared to the 65+ cohort, which may reflect better adherence to program protocols and greater physiological responsiveness to lifestyle or medication adjustments.

A significant takeaway from this study is the comparable efficacy of the RPM program across both high and moderate engagement cohorts. While a modest response relationship was observed, with patients in the high engagement cohort (16+ days/month) achieving the greatest overall reduction in MAP (7.1%), the clinical utility of the intervention remained robust in the moderate engagement group. From a physiological perspective, the 6.6% reduction in MAP observed in the moderate engagement group (2-15 days of data transmission per month) demonstrates significant clinical value.

The primary driver of hemodynamic improvement appears to be both consistent data transmission and structured virtual care management. These findings indicate that even when data is transmitted less frequently than 16 days per month, the physiologic data provided is sufficient to empower clinicians to make evidence-based adjustments that result in significant clinical value.

By establishing a minimal threshold for inclusion, which involved excluding patients with fewer than two days of data per month, we ensured that the reported trends represent stable physiological shifts and legitimate clinical progress rather than acute fluctuations in blood pressure. Consequently, RPM should be viewed as a flexible clinical tool capable of providing cardiovascular risk mitigation even in populations where 16+ days of data transmission is not feasible.

Comparison with Existing Literature

The findings in this study are directionally consistent with prior evaluations of remote patient monitoring hypertension programs. In a 2025 *JMIR Cardio study* (8), a team-based, EHR-integrated remote monitoring intervention incorporating BP devices and clinical support demonstrated significant SBP reductions using a semiparametric event-study design focused over 24 months following referral to the program. Among 2,206 referred patients, SBP decreased by -9.76 mmHg in the hypertension-only cohort (baseline SBP 138.4 mmHg), by -6.61 mmHg among patients with hypertension and either diabetes or ischemic heart disease, and -6.0 mmHg for those with all three conditions. Adjusting for engagement, the average treatment effect for active participants was a SBP reduction of 16.83 mm Hg for the hypertension-only group, 13.22 mm Hg for those with hypertension and either diabetes or ischemic heart disease, and 16.01 mm Hg for those with all three chronic conditions.

In a study published in *Hypertension* (9), office BP readings from 3,601 participants enrolled in a remote hypertension program were evaluated for up to 42 months following enrollment. The program incorporated home BP monitoring and algorithm-guided medication titration, and longitudinal office BP trends were analyzed using a linear mixed-effects regression model. Participants were categorized into four program-defined pathways: maintenance (achieved goal home BP ≤130/80 mm Hg), early exit (discontinued prior to goal attainment), education-only, and white coat hypertension. Across all groups, mean office BP remained below qualifying baseline values throughout follow-up. Among participants who achieved control and entered the maintenance pathway, 89.7% maintained systolic BP at goal over time, compared with 63.5% in the early exit group, 69.4% in the education-only group, and 90.7% in the white coat hypertension group.

This provides context for the comparatively smaller BP reductions observed in patients in the stage 1 cohort. For patients already near guideline-recommended targets at baseline, the principal clinical benefit of RPM may lie in sustaining BP control and preventing regression rather than producing large additional reductions.

Differences in effect magnitude across studies likely reflect variation in study design. The *JMIR Cardio* analysis estimated post-referral changes within a defined time window and explicitly examined engagement-adjusted effects, whereas the Hypertension study emphasized long-term maintenance after goal attainment.

The present analysis contributes to this literature by demonstrating hypertension stage-dependent BP reductions in a real-world RPM cohort and by incorporating MAP as an additional hemodynamic measure. Collectively, these findings suggest that hypertension RPM programs may yield the greatest benefit among patients with stage 2 hypertension while continuing to provide clinically meaningful benefits for patients with stage 1 hypertension through sustained maintenance of target BP levels.

Strengths and Limitations

This study has several notable strengths. First, the stratified analyses by age and baseline hypertension stage allow for a longitudinal assessment of program impact across clinically relevant subgroups, and the applicability of findings to personalized care strategies. The inclusion of mean arterial pressure (MAP) as an additional hemodynamic measure further strengthens the analysis by providing a measure of overall arterial load beyond SBP and DBP alone. The use of validated BP monitoring devices integrated within a structured RPM platform, combined with standardized clinical review and escalation protocols, supports the reliability and consistency of the collected data.

The stratification into engagement cohorts is a notable strength of this analysis. By demonstrating that significant clinical value is maintained even among moderately engaged patients, this study provides evidence for the real-world scalability of RPM and its utility in patient populations where 16+ days of data per month may be impractical.

Several limitations should be considered. The most significant limitation is the attrition observed over the 9-month period, with the analytical cohort decreasing from N=655 at three months to n=324 at nine months. This introduces survivorship bias, as the final participants likely represent a subset of patients with higher health literacy, greater motivation, or a more positive initial response to the intervention. Consequently, the reported BP reductions may reflect the efficacy of the program specifically for persistently engaged patients rather than the broader hypertensive population.

While the study evaluates the frequency of data transmission, it does not fully capture the qualitative nature of patient engagement. We cannot account for the specific depth of the interactions between patients and care managers or the exact extent to which lifestyle modifications were implemented.

The retrospective design introduces the potential for selection bias. Enrollment in the RPM program was determined by healthcare providers, who selected patients with the clinical objective of reducing elevated blood pressure or maintaining sustained control among those already near goal BP. Therefore, the study population may not be fully representative of the broader hypertensive population.

Because this was a severity-stratified retrospective study, the influence of regression to the mean cannot be entirely eliminated, as patients at higher physiological extremes, particularly in the stage 2 cohort, are inherently susceptible to this statistical artifact. This influence is substantially attenuated by the use of a 14-day average baseline, rather than the use of a single acute measurement. Additionally, the regression to the mean is an early-phase effect, whereas the BP reductions observed in this study were sustained across each interval. This longitudinal observation suggests that the reductions observed in this study are more consistent with a sustained treatment effect rather than a statistical artifact.

Future research should focus on prospective, randomized controlled methodology to isolate treatment effects and assess the influence of adherence and engagement on BP outcomes.

Clinical Implications

The results of this study suggest that RPM programs should be a standard part of hypertension management, especially for patients at higher risk, such as those with stage 2 hypertension. The reductions in BP observed here suggest that RPM, paired with structured virtual care management, can play a significant role in reducing the risk of cardiovascular disease and improving overall patient outcomes. Existing clinical evidence supports the clinical relevance of BP reductions of this magnitude and the proportional benefits.

In an individual participant-level meta-analysis (10) of 48 randomized trials (*N*=344,716), each 5 mmHg SBP reduction was associated with about a 10% lower risk of major cardiovascular events, with consistent proportional benefits across baseline SBP strata and in both primary and secondary prevention populations.

Similarly, a systematic review and meta-analysis (11) of 123 trials (*N*=613,815) found that every 10 mmHg reduction in SBP was associated with a 20% reduction in major cardiovascular events (relative risk [RR] 0.80, 95% confidence interval 0.77–0.83). A 10 mmHg reduction was also associated with lower risk of coronary heart disease (RR 0.83, 95% CI 0.78–0.88), stroke (RR 0.73, 95% CI 0.68–0.77), and heart failure (RR 0.72, 95% CI 0.67–0.78). Across the studied populations, these risk reductions corresponded to a 13% decrease in all-cause mortality (RR 0.87, 95% CI 0.84–0.91).

When compared to existing literature, the BP reductions observed in the present study suggest that RPM-based hypertension programs may contribute meaningfully to cardiovascular risk mitigation. The stage-dependent gradient observed, where patients with stage 2 hypertension experienced the largest absolute reductions, further supports prioritizing RPM for higher-risk individuals, while also recognizing its role in maintaining control among those already near goal BP. The maintenance of clinically significant blood pressure reductions across both moderate and high engagement cohorts suggests that RPM-based interventions are resilient with lower levels of data transmission. Collectively, these findings reinforce the value of RPM as an accessible, scalable strategy to deliver consistent, individualized hypertension management with significant downstream benefits in cardiovascular morbidity and mortality.

Conflict of Interest

The authors of this study are employees of Prevounce Health, Inc., the developer of the RPM platform, employer of care managers, and the provider of the Pylo BP hardware utilized in this analysis. This research was conducted as part of the company's commitment to clinical validation and quality improvement.

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