#### **Supplemental Material**

Supplementary Table 1

- A) Primary CVD Prevention (39):
- B) Secondary CVD Prevention (13):

Supplementary Figure 1: Validity Assessment Tools:

Supplementary Figure 2: Funnel plot for CVD outcomes among primary and secondary prevention along with heart failure.

Supplementary Figure 3: Systolic Blood Pressure and DHI.

Supplementary Figure 4a: Total-Cholesterol and DHI.

Supplementary Figure 4b: LDL-Cholesterol and DHI.

### Table 1A) Primary CVD Prevention (39):

Study ID (Name, Year)	Study Type	Study Length (mo)	Total (N)	Digital Health (N)	Study Population	Digital Health Intervention	Findings
Andersen 2013 <sup>34</sup>	RCT	2.5	160	106	Primary Prevention	Email	Workplace email intervention with high adherence increased exercise capacity (1.45 mL/min/kg (95% CI 0.64-2.27) and reduced BP (4.81 mmHg (95% CI 0.47- 9.16), (weight reduction not significant) especially those who started with a low fitness level to begin with.
Appel, 2011 26	RCT	24	415	139	Primary Prevention, Hypertensi on	Web-based	Larger, healthcare site obesity intervention delivered remotely or in person significantly reduced weight (-4.6 kg and -5.1 kg, respectively) above controls.
Bennett, 2010 <sup>35</sup>	RCT	3	101	51	Primary Prevention	Web-based	Healthcare delivery of weight loss intervention showed improved weight loss in a dose-dependent fashion (quartile 4 vs. 1: -4.16 kg; 95% CI -1.47, -6.84) over controls.
Bennett, 2012 <sup>36</sup>	RCT	24	365	180	Primary Prevention, Obesity	Telemedicine and web- based	Healthcare delivered weight loss intervention in underserved, primarily black population, showing a significant reduction in weight at 12 months (-1.03 kg 95% CI, -2.03 to -0.03 kg) with no effect on blood pressure.
Bennett, 2013 <sup>37</sup>	RCT	12	194	97	Primary Prevention, Obesity	Telemedicine	Healthcare delivered multi-faceted weight loss intervention in underserved, primarily black population, demonstrating significant weight reduction at 12 months ( $-1.4$ kg; 95%CI, $-2.8$ to $-0.1$ kg; P = .04).
Bove, 2013 <sup>38</sup>	RCT	6	241	120	Primary Prevention, Hypertensi on	Telephone, Web-based	Healthcare-delivered telemedicine hypertension program in primarily underserved, African American women showed no additional improvement with intervention.
Broekhuizen, 2010 <sup>39</sup>	RCT	12	340	181	Primary Prevention	Telephone, Web-based	Healthcare-delivered, web-based lifestyle intervention in familial hyperlipidemia had no benefit over usual care.
Claes, 2013	RCT	36	314	195	Primary Prevention	Telephone, Web-based	Personalized online and one-to-one coaching with self- employed lawyers in Belgium showing similar reductions in FRS, cholesterol, and blood pressure.
Colkesen, 2011 <sup>41</sup>	Cohort	7	176	176	Primary Prevention	Web-based	Workplace-delivered HRA and prevention program improved 10-yr CVD risk scores after 6 mo by 5% with

							more prominent reductions occurring in higher risk participants.
Dekkers, 2011 <sup>42</sup>	RCT	6	185	93	Primary Prevention	Web-based	Workplace-delivered, internet-based primary prevention program showed non-significant reductions in body weight (-2.1 kg, 95%CI -4.4 to 0.2) and aerobic fitness (2.3 ml/kg/min, 95%CI -0.2 to 4.8).
Frisch, 2009 <sup>43</sup>	Cohort	12	200	200	Primary Prevention, Metabolic Syndrome	Telephone, Smart Phone, Data Monitoring	Transmission of weight data in overweight patients showed improvements in calorie restriction and weight reduction (5.8±6.1 kg and 4.3±5.1 kg).
Goessens, 2008 <sup>44</sup>	Cohort	6	50	50	Primary Prevention	Web-based	Nurse-led internet-based risk factor reduction program was scarcely used (1.3 log ins/wk) with a relative reduction in risk factors, but no specific surrogate CVD marker data reported.
Green, 2009 30	RCT	12	778	520	Primary Prevention	Telephone, Web-based	Hypertensive patients assigned to usual care vs. a web-based or telephone-based intervention showed those using the web-based platform had a greater percentage of achieving target BP (56%; 95% CI, 49%- 62%; P < .001). Increased adverse events in intervention group.
Hansen, 2012 45	RCT	3	12287	6055	Primary Prevention	Web-based, Email	Population health intervention of internet-based lifestyle changes showed poor compliance (22%) and no increase in physical activity (1575; 845-2580 vs. 1560; 840-2520).
Jacobs, 2011 46	RCT	6	314	208	Primary Prevention	Telephone, Web-based, Email	A multi-faceted digital health intervention in highly educated participants showed no difference versus usual care in terms of lifestyle behaviors or CVD surrogates
Joo, 2007 <sup>47</sup>	Cohort	3			Primary Prevention	SMS text	Cohort using a population health SMS text intervention showed reductions of weight (1.6 kg; P<0.001), waist circumference (4.3 cm; P<0.001), and BMI (0.6 kg/m <sup>2</sup> ; P< 0.001), respectively.
Kim, 2013 <sup>48</sup>	Cohort	2	18	18	Primary Prevention	Web-based	Small, cohort, workplace, pilot study to improve physical activity showed significant reductions in Framingham CVD risk (-2.4%), waist circumference (- 2.9 cm), diastolic blood pressure (-9.9 mm Hg), and fasting plasma glucose (-16.7 mg/dL).
Kiselev, 2012	RCT	17.6	199	97	Primary Prevention, Hypertensi	Web-based, Email, SMS text	Healthcare-guided SMS intervention in hypertensive patients had a relatively high withdrawal rate (36%) but showed a 5-fold improvement in adherence to ideal BP

					on		(77%) compared to control group.
Kulick, 2013 50	RCT	3	61	32	Primary Prevention	Web-based, Email	Three-month healthcare-delivered internet and email- based intervention showed improvements with both diet scores and lipids with the digital health intervention and high-intensity counseling without apparent differences between the two.
Lieber, 2012	Cohort	3	972	972	Primary Prevention	Web-based	Population-based, web-based intervention showed an improvement in physical activity in low-moderate risk female participants.
Logan, 2012	RCT	12	110	55	Primary Prevention, Diabetes/H tn	Telephone, Email, SMS text, Data Monitoring	Diabetic and hypertensive patients provided data monitoring and an automated educational system had significantly reduced SBP from baseline ( $9.1\pm15.6$ mmHg; P < 0.0001), and compared to telemonitoring alone ( $7.1\pm2.3$ mmHg; P < 0.005). There was more pronounced depression and antihypertensive effects in the treatment arms.
Lombard, 2010 <sup>53</sup>	RCT	12	250	127	Primary Prevention	SMS text	Young urban women with young children in Australia cluster randomized to support group and SMS texting intervention. Those in the treatment group lost weight (-0.2 kg; -0.90 to 0.49) compared to the control group who gained weight (+0.83 kg; 0.12 to 1.54), however the response rate was only 12%.
Marquez Contreras, 2004 <sup>54</sup>	RCT	6	104	52	Primary Prevention, Hypertensi on	SMS text	Healthcare intervention on clinics in Spain showed SMS text reminders for hypertension had no significant improvement in medication compliance and attainment of target BP goals over control for 6 months.
McManus, 2010 <sup>19</sup>	RCT*	12	527	263	Primary Prevention, Hypertensi on	Telephone, Data Monitoring	Unblinded, open-label data monitoring and telemedicine RCT showed significant improvement in antihypertensive effects in both arms of the program (difference between groups 3.7 mm Hg, 0.8-6.6; p=0.013).
McTigue, 2009 <sup>55</sup>	Cohort	12	50	50	Primary Prevention, Obesity	Web-based, Email	Clinic-based, multifaceted cohort study in patients with obesity showed significant reductions in SBP (7.33 <u>+</u> 11.36 mm Hg) and weight (4.79 <u>+</u> 8.55 kg) with reasonably high compliance.
Nolan, 2011 56	RCT	6	680	415	Primary Prevention	Telephone	Clinical setting with participants at high risk of CVD demonstrating that telephone intervention reduces blood pressure, lipids, and 10 year CVD risk through improvements in physical activity and diet.

Nolan, 2012 57	Cohort	4	387	194	Primary Prevention, Hypertensi on	Web-based, Email	Initially a clinic-based RCT for antihypertensive treatment through an online portal diluted by crossover of patients, essentially rendering a cohort study finding no differences between the two groups; however in those participants who received over 8 messages throughout the trial had substantial benefit in blood pressure, lipids, and 10-yr risk scores.
Park, 2012 <sup>58</sup>	Cohort	3	79	42	Primary Prevention	Web-based, SMS text	Clinic-based observational study in overweight, post- menopausal women compared to a similar cohort had significant reductions in waist circumference (3.0 cm) weight (2 kg), blood pressure (6.5/4.6 mmHg), and LDL-C (-11.3 mg/dL).
Rossi, 2009 <sup>59</sup>	Cohort	3	50	50	Primary Prevention, Diabetes	SMS text, Smart Phone	Smart-Phone application studied in a cohort of overweight participants in Italy showed significant improvements in diet, moderate physical activity, weight (-2.5 kg; -3.2, -1.8), waist circumference (-3.7 cm; -4.6, -2.9), and BMI (-1.0; -0.7, -1.2) kg/m <sup>2</sup> with 82% adherence.
Rossi, 2010 <sup>60</sup>	Cohort	5	140	140	Primary Prevention	Telephone, SMS text, Smart Phone	Clinic-based feasibility study utilizing a smart phone application to assist type 1 diabetics in managing glucose levels and insulin dosing showed reductions in fasting plasma glucose (-6.7%), but not HbA1c, without adverse events.
Senesael, 2013 <sup>61</sup>	RCT	6	57	26	Primary Prevention	Email	Clinic-based study in patients at moderate risk for CVD showed similar reductions in BP in both groups, and no further changes in other surrogate CVD markers after 6 mo.
Sheridan, 2011 <sup>21</sup>	RCT*	3	160	81	Primary Prevention	Web-based	Clinic-based primary prevention intervention using an online decision aid and adherence messages with high retention (96%) reduced CVD risk scores -1.1% (- 0.16%, -2%), especially in higher risk subgroups.
Stuckey, 2011 <sup>62</sup>	Cohort	2	24	24	Primary Prevention	Smart Phone, Data Monitoring	Clinic-based data monitoring intervention in overweight patients in underserved communities showed significant reductions in physical activity, diet, BMI, blood pressure, and lipids.
Thiboutot, 2013 <sup>63</sup>	RCT	12	500	282	Primary Prevention	Web-based	Clinic-based trial encouraging patients to discuss certain lifestyle and preventative measures with their PCPs. There were no changes in blood pressure after 12 months, and only slight adjustments in interactions with PCPs.

Verheijden, 2004 <sup>64</sup>	RCT	8	146	73	Primary Prevention	Web-based	Clinically based web intervention in 73 higher-risk Canadian patients demonstrating no difference in weight, blood pressure, or lipids. Very low uptake of the program.
Wakefield, 2011 <sup>65</sup>	RCT	12	302	195	Primary Prevention	Telephone	302 US war veterans with hypertension and diabetes randomized to intensive home reporting system showed no change in HbA1c between groups and only a difference between control and high-intervention groups for blood pressure.
Widmer, 2014 <sup>66</sup>	Cohort	3	508	462	Primary Prevention	Web-based, Smart Phone	Workplace-generated single-cite observational study demonstrating further surrogate Framingham CVD risk reduction (- $0.6+0.1\%$ ) in a low-risk population of primarily younger females.
Wister, 2007	RCT	12	296	153	Primary Prevention	Telephone	611 divided into primary and secondary prevention randomized for 12 months demonstrating only a significant change in Framingham 10 year CVD risk.
Wong, 2013 <sup>67</sup>	RCT	12	104	54	Primary Prevention	SMS text	Workplace SMS intervention on reducing the incidence of diabetes in primarily inactive, men showing a reduced risk of disease development (RR = 0.35; 95% CI: 0.10-1.24).

#### B) Secondary CVD Prevention (13):

Study ID (Name, Year)	Study Type	Study Length (mo)	Total N	Digital Health N	Study Population	Digital Health Intervention	Findings
Blasco 2012 <sup>27</sup>	RCT	12	203	102	Secondary Prevention	SMS text, Smart Phone	Healthcare secondary prevention trial showing improved secondary prevention outcomes (repeat CVD events, rehospitalizations, or all-cause mortality; $RR = 1.4$ ; 95% CI = 1.1-1.7) with telemonitoring and SMS text.
Dendale, 2012 <sup>28</sup>	RCT	6	160	80	Secondary Prevention, Heart Failure	Telephone, Data Monitoring	Healthcare-delivered telemonitoring service in HF patients showed significantly reduced all-cause mortality (5% vs. 17.5%, $P = 0.01$ ) and non-significant improvements in hospitalizations per patient (0.24 vs. 0.42, $P = 0.06$ ).
Frederix, 2013 <sup>29</sup>	RCT	4.5	80	40	Secondary Prevention	Email, SMS text, Data Monitoring	Body sensor in CR patients improved exercise capacity (26.88+220.33 ml/min vs. 285.89+385.44 ml/min, P= 0.014) and a non-significant improvements in rehospitalizations.

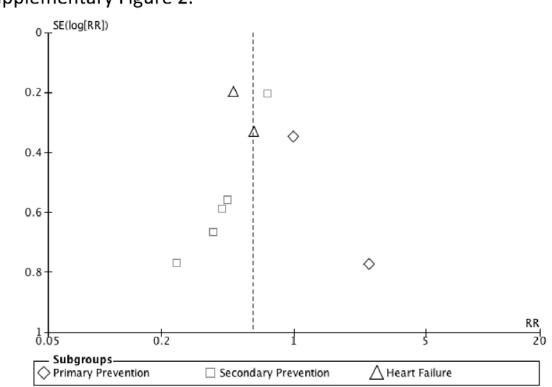
Korzeniowska- Kubacka, 2011 <sup>68</sup>	Cohort	2	62	32	Secondary Prevention	Telephone, Data Monitoring	Data monitoring in post-MI patients showed no significant difference in aerobic exercise parameters compared to control group with both groups significantly improving above baseline.
Lee, 2013 <sup>69</sup>	RCT	3	60	30	Secondary Prevention	Telephone, Web-based, Data Monitoring	Data monitoring in post-MI patients showed significant improvements in aerobic activity metrics compared to usual care; however no change in resting blood pressure, and no other outcomes or metrics reported.
Maric, 2010 <sup>70</sup>	Cohort	6	20	20	Secondary Prevention, Heart Failure	Web-based	Recently hospitalized HF patients utilized data monitoring through a web portal showing non- significant improvements in QOL, surrogate markers (BNP), and 6MWT.
Reid, 2012 <sup>31</sup>	RCT	12	223	115	Secondary Prevention	Web-based	Internet-based data monitoring for physical activity in post-MI patients showed significant improvements in physical activity and QOL compared to usual care. The intervention had a small, non-significant effect on hard CVD outcomes.
Scherr, 2009 <sup>20</sup>	RCT*	6	120	54	Secondary Prevention, Heart Failure	Telephone, SMS text, Data Monitoring	Data monitoring in patients with recent decompensated HF showed a high attrition rate; yet a 50% reduction in CVD endpoints and hospitalizations with a mean improvement in NYHA class by one category in the treatment group.
Southard, 2003 <sup>32</sup>	RCT	6	104	53	Secondary Prevention	Web-based	Internet-based secondary prevention tool reduced CVD endpoints (15.7% vs. 4.6%) and provided a significant cost savings. The intervention group had a more robust weight loss (-3.68 lbs. vs. 0.47 pounds, P =.003), with no other surrogate markers of CVD achieving statistical significance.
Theissing, 2013 <sup>71</sup>	RCT	3	164	58	Secondary Prevention	Web-based	Online, clinic-based intervention in obese patients showed substantial improvements in lifestyle behaviors related to diet, however no significant differences between the group for waist circumference and weight.
Vernooij, 2012 <sup>33</sup>	RCT	12	330	164	Secondary Prevention	Web-based	Clinic-based online risk factor improvement tool showed a significant reduction in Framingham scores (-14%; -25% to -2%) after 12 months in patients randomized to the intervention.
Wister, 2007 <sup>17</sup>	RCT	12	296	153	Primary	Telephone	611 divided into primary and secondary prevention

					Prevention		randomized for 12 months demonstrating only a significant change in Framingham 10 year CVD risk.
Zutz, 2007 <sup>72</sup>	RCT	3	15	8	Secondary Prevention	Web-based	Small, hospital-based RCT testing "virtual CR" in patients with a primary indication for such. Although user feedback was positive, there were no significant benefits to the intervention.

### Supplementary Figure 1: Validity Assessment Tools:

	Page 3	of 12	Page 4 of 12
Patient Type	primary prevention     secondary prevention     heart failure     diabetes     metabolic syndrome     hypertension	Are results likely to be similar across the range of ways the outcome was measured (shorter v. longer follow up)?	□ Yes □ No
mHealth Intervention	□ telemedicine □ web-based □ email	Cohort Study Quality Assessment	
	SMS text smart-phone data-monitoring	Is the case definition adequate?	☐ Yes ☐ No
Study Length (months)	non-mhealth	Representativeness of the exposed cohort	Obviously representative series of cases     Somewhat representative     Selected group
Study Type	RCT     Observational/Cohort		No description
	Case Control Case Series Unknown	Control Selection	Similar community Non-similar community No mention
Percent of approached patients enrolled		Definition of Controls	☐ No h/o disease ☐ h/o disease
RCT Quality Assessment		Comparability of cases and controls on the basis of	□ Yes
Blinding	□ single □ double □ non-blinded	the design or analysis, eg study controls for differences in groups?	
Random Sequence Generation	□ Yes □ No	Ascertainment of outcome	<ul> <li>blinded, secure record</li> <li>record linkage</li> <li>self report</li> </ul>
Allocation (to test groups) concealment (selection bias)	Yes No		no description
Blinding of participants	□ Yes □ No	Adequacy of follow up?	□ Yes □ No
Blinding of study personnel	☐ Yes ☐ No	Adequacy of follow up of cohorts	Complete follow up - all subjects accounted for Subjects lost to follow up unlikely to introduce bias; small number lost
Blinding of outcome assessment	Yes No		Follow up rate adequate and/or no description of those lost
Similar baseline characteristics	□ Yes □ No		no statement
Percent Loss to Follow Up		Author Contact Returned?	☐ Yes ☐ No
Selective Reporting	ITT Per Protocol Unknown	Data additions/changes?	□ Yes □ No
Incentives Offered?	Yes No		
Are results likely to be similar across the range of patients included (older/younger, sicker)?	☐ Yes ☐ No		
Are results likely to be similar across the range of interventions or exposures studied (higher/lower dose)?	□ Yes □ No		

Supplementary Figure 2: Funnel plot for CVD outcomes.



Supplementary Figure 2.

#### Supplementary Figure 3: Systolic Blood Pressure and DHI.

		tal Hea			ual Ca			Mean Difference	Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	Weight	IV, Random, 95% CI	IV, Random, 95% CI
1.8.1 Primary Prevention									
Andersen 2013	-2.62	13.8	106	-1	2.4	54	3.3%	-1.62 [-4.32, 1.08]	
Bennett 2012	-1.38	1.7	180	3.4	1.6	185	3.6%	-4.78 [-5.12, -4.44]	•
Bennett 2013	-1.6	14.3	97	-1.6	14.6	97	3.0%	0.00 [-4.07, 4.07]	
Bove 2013	-18.2	2	120	-13.9	18.2	121	3.2%	-4.30 [-7.56, -1.04]	
Broekhuizen 2012	0	1.5	181	-1.1	1.7	159	3.6%	1.10 [0.76, 1.44]	•
Claes 2013	-2.54	1.86	195	-6.32	2.7	100	3.6%	3.78 [3.19, 4.37]	+
Dekkers 2011	-0.8	3.7	93	-1.7	2.1	92	3.5%	0.90 [0.03, 1.77]	-
Green 2008	-10.6	0.4	520	-4.8	0.7	258	3.6%	-5.80 [-5.89, -5.71]	
Hansen 2012	0.1	0.3	6055	0	0.3	6232	3.6%	0.10 [0.09, 0.11]	+
Kiselev 2012	13.5	1.3	97	33.3	1.2	102	3.6%	-19.80 [-20.15, -19.45] 4	
_ogan 2012	0	14.7	55	-1.7	12.1	55	2.8%	1.70 [-3.33, 6.73]	
Marguez Contreras 2004	-8.7	14.4	52	-23.7	13.1	52	2.7%	15.00 [9.71, 20.29]	
McManus 2010	-19.1			-11.7		264	3.5%	-7.40 [-8.90, -5.90]	
Nolan 2011	-4.83	15.2		-2.84		268	3.4%	-1.99 [-4.23, 0.25]	
Nolan 2012	-17.2		194		12.1	193	3.2%	-12.20 [-15.27, -9.13]	
Park 2012	-8.9	8.9	42	0.9	7.2	37	3.1%	-9.80 [-13.35, -6.25]	
enesael 2013	-6.5	3.8	26	-14	3.8	26	3.4%	7.50 [5.43, 9.57]	
iheridan 2011	3.1	4.1	81	9	4.3	79	3.5%	-5.90 [-7.20, -4.60]	
hiboutot 2013	-4.4	1.2	282	-3.5	1.4	218	3.6%	-0.90 [-1.13, -0.67]	
/erheijde 2004	-1.9	8.8	73	-5.2	7.6	73	3.3%	3.30 [0.63, 5.97]	
Vakefield 2011	-2	8.8		-1.98		107	3.1%	-0.02 [-3.72, 3.68]	
Wister (primary) 2007	-7.49			-3.58		158	3.1%	-3.91 [-7.41, -0.41]	
Wong 2013	-1.1	3.4	54	-1.4		50	3.5%	0.30 [-1.05, 1.65]	+
Subtotal (95% CI)		5.1	9533		5.0	8980	76.6%	-2.12 [-4.15, -0.09]	•
Heterogeneity: Tau <sup>2</sup> = 22.96; 0	$Chi^2 = 29$	403.84	4, df = 2	22 (P <	0.000	01); I <sup>2</sup> =	= 100%		
Test for overall effect: $Z = 2.05$	5 (P = 0.0)	04)							
1.8.2 Secondary Prevention									
Blasco 2012	-5.1	31.4	102	-0.8	29.2	101	2.0%	-4.30 [-12.64, 4.04]	
rederix 2013	10	4.9	40	-1		40	3.4%	11.00 [8.92, 13.08]	
Korzeniowska-Kubacka 2011		12.8	30		11.1	32	2.5%	0.70 [-5.28, 6.68]	
.ee 2013	0.4	3.7	30	-1.3	4.9	30	3.4%	1.70 [-0.50, 3.90]	
outhard 2003	-0.7	3.4	53	-2.1	3.9	51	3.5%	1.40 [-0.01, 2.81]	-
/ernooij 2012	-3	1.9	164	-3	2	166	3.6%	0.00 [-0.42, 0.42]	+
Wister (secondary) 2007	-5.64					143	3.0%	-3.66 [-7.78, 0.46]	
Zutz 2007		10.8	8	-3	4	7	2.0%	7.00 [-1.05, 15.05]	
Subtotal (95% CI)		10.0	580	-		570	23.4%	1.98 [-1.05, 5.01]	•
Heterogeneity: $Tau^2 = 14.61$ ; ( Fost for overall effect: $Z = 1.28$			df = 7 (F	P < 0.00	0001);	$l^2 = 94$	%		
Fotal (95% CI)			10113			9550	100.0%	-1.18 [-2.93, 0.57]	•
Heterogeneity: Tau <sup>2</sup> = 22.17; (	$^{-}$ hi <sup>2</sup> = 29	524.1		30 (P <	0.000				
Test for overall effect: $Z = 1.32$			., ui		0.000		100/0		20 –10 0 10 purs (experimental) Fayours (control)

Test for overall effect: Z = 1.32 (P = 0.19) Test for subgroup differences: Chi<sup>2</sup> = 4.84, df = 1 (P = 0.03), l<sup>2</sup> = 79.4%

Favours [experimental] Favours [control]

Supplementary Figure 4a: Total-Cholesterol and DHI.

# Supplementary Figure 4a.

	Digita	al Heal	th	Usu	al Can	e		Mean Difference	Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	Weight	IV, Random, 95% Cl	IV, Random, 95% CI
1.11.1 Primary Prevention	ı								
Bennett 2013	-4.9	25.7	97	-2.4	25.2	97	4.6%	-2.50 [-9.66, 4.66]	
3ove 2013	-12.6	12.5	120	-6.2	8.3	121	5.7%	-6.40 [-9.08, -3.72]	
Broekhuizen 2012	-3.9	5.3	181	-3.9	5.2	159	5.9%	0.00 [-1.12, 1.12]	- +
laes 2013	-6.25	14.7	195	-10.59	11.9	100	5.6%	4.34 [1.23, 7.45]	
ekkers 2011	11.6	5.1	93	3.9	4	92	5.9%	7.70 [6.38, 9.02]	-
ulick 2013	-10.4	12.9	32	3.5	9.9	29	5.0%	-13.90 [-19.64, -8.16]	
ombard 2010	-0.8	4	127	7.7	4.7	123	5.9%	-8.50 [-9.58, -7.42]	-
Iolan 2012	-9.3	12.5	194	1.9	8.3	193	5.8%	-11.20 [-13.31, -9.09]	
ark 2012	-12.9	5.4	42	7.4	5.3	37	5.7%	-20.30 [-22.66, -17.94]	<b>—</b>
heridan 2011	-1.9	5.3	81	-1.1	5.3	79	5.8%	-0.80 [-2.44, 0.84]	
erheijde 2004	-3.1	14.7	73	-4.3	11.9	73	5.3%	1.20 [-3.14, 5.54]	
vister (primary) 2007	-15.9	42.5	157	5.4	42.5	158	3.9%	-21.30 [-30.69, -11.91]	<b>←</b> →−−
Vong 2013	-4.3	6.4	54	-1.6	6.6	50	5.7%	-2.70 [-5.20, -0.20]	
ubtotal (95% CI)			1446			1311	70.7%	-5.39 [-9.80, -0.99]	-
leterogeneity: Tau <sup>2</sup> = 61.4	44: Chi <sup>2</sup> =	709.	31. df :	= 12 (P <	0.00	001); I <sup>2</sup>	= 98%		
est for overall effect: Z =									
.11.2 Secondary Prevent	ion								
lasco 2012	-36.23	5.4	102	-34	6.1	101	5.8%	-2.23 [-3.82, -0.64]	
rederix 2013	12.6	21.1	40	6.1	6.7	40	4.6%	6.50 [-0.36, 13.36]	
outhard 2003	-5.7		53	-7.5	6.9	51	5.6%	1.80 [-1.15, 4.75]	
ernooij 2012	-5.9		164	1.9	4.1	166	5.9%	-7.80 [-8.66, -6.94]	-
lister (secondary) 2007	-3.9	31.7	153	-3.1	32.9	143	4.5%	-0.80 [-8.17, 6.57]	
utz 2007		12.1	8		15.2	7	2.8%	-11.30 [-25.34, 2.74]	•
ubtotal (95% CI)			520			508	29.3%	-1.80 [-6.23, 2.64]	-
eterogeneity: Tau <sup>2</sup> = 22.	77: Chi <sup>2</sup> =	= 80.3	0, df =	5 (P < 0)	.0000	1); $ ^2 =$	94%		
est for overall effect: Z =									
fotal (95% CI)			1966			1819	100.0%	-4.29 [-7.48, -1.09]	•
leterogeneity: Tau <sup>2</sup> = 44.	87: Chi <sup>2</sup> #	825.	86. df	= 18 (P <	0.00	001): I <sup>2</sup>	= 98%		
est for overall effect: Z =									-20 -10 0 10 20 Favours [experimental] Favours [control]
and the statement with the									

Supplementary Figure 4b: LDL-Cholesterol and DHI.

# Supplementary Figure 4b.

	Digita	al Heal	th	Usu	al Can	e		Mean Difference	Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	Weight	IV, Random, 95% CI	IV, Random, 95% CI
1.12.1 Primary Prever	ntion								
Bennett 2013	-5.2	29.5	97	0.1	27.2	97	6.7%	-5.30 [-13.29, 2.69]	
Bove 2013	-0.8	9.5	120	0.6	10.1	121	8.0%	-1.40 [-3.88, 1.08]	
Broekhuizen 2012	-3.9	4.9	181	-3.9	5.2	159	8.2%	0.00 [-1.08, 1.08]	+
Kulick 2013	-6.6	11.1	32	7.4	10.3	29	7.5%	-14.00 [-19.37, -8.63]	
Lombard 2010	5.1	3.7	127	12.7	4	123	8.2%	-7.60 [-8.56, -6.64]	-
Park 2012	-11.3	5.3	42	4.3	20.5	37	7.1%	-15.60 [-22.40, -8.80]	
/erheijde 2004	-2.7	9.5	73	-3.9	10.1	73	7.9%	1.20 [-1.98, 4.38]	
Vong 2013	-0.8	5.3	54	1.2	6.9	50	8.1%		
Subtotal (95% CI)			726			689	61.7%	-4.96 [-8.54, -1.38]	◆
leterogeneity: Tau <sup>2</sup> =	22.41; C	:hi² = ∶	149.12,	df = 7 (	P  < 0.	00001)	; $I^2 = 959$	6	
Fest for overall effect:	Z = 2.72	(P = 0	).007)						
.12.2 Secondary Prev	vention								
Blasco 2012	-28.02	4.Z	102	-33.01	5.4	101	8.2%	4.99 [3.66, 6.32]	-
rederix 2013	8.2	4.5	40	4.4	5.1	40	8.1%	3.80 [1.69, 5.91]	
outhard 2003	-7.5	7.1	53	-0.7	5	51	8.1%	-6.80 [-9.15, -4.45]	
/ernooij 2012	-13.7	2.2	164	1.6	3.7	166	8.2%	-15.30 [-15.96, -14.64]	•
Zutz 2007	-48.8	8.3	8	-4.3	13	7		-44.50 [-55.72, -33.28]	
ubtotal (95% CI)			367			365	38.3%	-10.43 [-21.69, 0.83]	
leterogeneity: Tau <sup>2</sup> =	158.71;	Chi <sup>2</sup> =	945.44	4, df = 4	(P < 0	00000	l); $l^2 = 10$	00%	
lest for overall effect:	Z = 1.82	(P = 0	0.07)						
fotal (95% CI)			1093			1054	100.0%	-6.96 [-11.86, -2.05]	◆
leterogeneity: Tau <sup>2</sup> =	76.19: C	$hi^2 = 1$	1303.60	0. df = 1	2 (P <	0.0000	(1); $ ^2 = 9$	99%	
					-				-20 -10 0 10 20
Fest for overall effect:	z = z.76	(P = 0)	1.0051						Favours (digital health) Favours (usual care)