

GLP-1 Digital Care and Companion Platforms

What drives results - and why patients discontinue

A publication-ready review of digital GLP-1 care, engagement, medication persistence, discontinuation, safety, and the role of non-clinical companion platforms.

Published by SALUNOTE
September 2026

GLP-1 Digital Care and Companion Platforms: What Drives Results - and Why Patients Discontinue

Executive summary

GLP-1 receptor agonists and dual GIP/GLP-1 medicines have changed the treatment of obesity and type 2 diabetes. The World Health Organization now frames obesity as a chronic, relapsing disease requiring integrated, person-centered and potentially lifelong care.[12] Yet prescribing an effective medicine is only the beginning. Patients must be able to start treatment, tolerate dose escalation, obtain medication consistently, afford continued treatment, and sustain the behavioral changes needed for long-term health.

Digital GLP-1 care platforms attempt to support this journey through telehealth prescribing, coaching, education, self-monitoring, messaging, symptom reporting, and medication follow-up. The emerging evidence is encouraging - but it also exposes a fundamental challenge: people who remain engaged can achieve substantial weight loss, while many users discontinue medication or leave the service before long-term benefits are realized.

Across the available studies, four conclusions stand out:

- 1 Medication effectiveness and program effectiveness are not the same. Clinical trials demonstrate what GLP-1-based therapy can achieve under controlled conditions. Digital-care studies show what happens when access, cost, engagement, and continuity of care enter the picture.[1-4]
- 2 Engagement is consistently associated with better outcomes. In large observational digital-care cohorts, weight tracking, coaching, education, feedback, and regular follow-up were associated with stronger observed weight-loss outcomes.[3,4,6]
- 3 Persistence is the principal bottleneck. In one US claims study of commercially insured adults with obesity and without diabetes, 32.3% remained persistent at one year and only 27.2% met the study's adherence threshold.[1]
- 4 The most important reasons for discontinuation often sit outside the app. Interrupted follow-up, adverse effects, loss of insurance coverage, and higher out-of-pocket costs can all undermine treatment continuity.[8,9]

Digital platforms therefore create the most value when they operate as continuity infrastructure around treatment, rather than as simple online prescribing channels.

Important: This paper reviews population-level evidence and digital-care models. It does not provide personal medical advice or recommend a particular medicine, dose, or provider. GLP-1-based medicines require assessment and ongoing supervision by a qualified healthcare professional.

This white paper is published by [SALUNOTE](#), a wellness and lifestyle companion for people using GLP-1-based treatment under the care of their own doctor. SALUNOTE does not prescribe medication, provide medical advice, interpret health data, or replace professional care.

What is a GLP-1 digital care platform?

A GLP-1 digital care platform is an app-based or telehealth service that supports some or all of the patient journey around GLP-1 receptor agonist treatment. Some platforms provide comprehensive obesity care through a multidisciplinary team; others primarily facilitate a clinical consultation and prescription.

A typical pathway includes:

- 1 Eligibility and medical-suitability assessment
- 2 Clinician consultation and treatment selection

- 3 Medication initiation and dose-escalation planning
- 4 App onboarding and education
- 5 Weight, nutrition, activity, and symptom tracking
- 6 Coaching or behavioral support
- 7 Adverse-event monitoring and clinical escalation
- 8 Prescription renewal, treatment adjustment, or discontinuation review



Figure 1. A digital care pathway should connect treatment initiation with lifestyle support, monitoring, clinical follow-up, access review, and a planned next phase. The companion layer does not replace clinical decision-making.

The distinction between a digital companion and a digital pharmacy front end matters. A companion platform is designed to help patients navigate treatment over time. A prescription-led service may make treatment easier to start but offer limited support after dispensing.

It is also useful to distinguish both models from a standalone lifestyle companion. This kind of product does not prescribe, select, or manage medication. Instead, it helps the user organize the everyday behaviors and observations that take place between clinical appointments - and gives the user a clearer record to discuss with their own physician.

Where SALUNOTE fits

SALUNOTE follows the standalone companion model. It is designed for the non-medical, everyday side of a GLP-1 journey: meals, movement, habits, self-monitoring, reminders, and progress. Medication decisions and medical interpretation remain with the user's own doctor.

Its current public feature set includes:

- 1 A short onboarding process that creates a four-week lifestyle plan
- 1 Protein-priority meal planning across Iranian, Mediterranean, and international cuisines
- 1 Progressive movement plans for home or gym use, including seated alternatives
- 1 Tracking for weight, waist circumference, water, steps, digestive symptoms, and self-reported injections
- 1 Optional on-device reminders for medication, meals, hydration, and movement
- 1 A choice between a gentle motivational mode and an optional challenge-based coach mode

- 1 A bilingual English and Persian interface with native right-to-left presentation
- 1 A Personal Metabolic Handbook that can be exported as a PDF and shared by the user with their physician

These features are described on SALUNOTE's [features page](#). The app stores its working data on the user's phone, requires no account for app use, and states that the company does not collect that app data. Its reports present self-recorded trends and consistency without interpreting them ([SALUNOTE privacy approach](#)).

This boundary is deliberate. The evidence reviewed in this paper supports regular tracking, lifestyle support, and better continuity between appointments, but it does not establish that a wellness app should make medication decisions. WHO guidance places GLP-1-based treatment within integrated, person-centered care that includes behavioral support.[12] SALUNOTE therefore leaves diagnosis, prescribing, dose changes, adverse-event assessment, and interpretation to qualified clinicians.

SALUNOTE's public roadmap also describes a future verified-doctor portal for receiving patient-authorized reports and a future AI lifestyle companion. Those functions are not presented here as current capabilities. According to the platform, the planned AI would address meals, movement, and habits while directing medical questions back to the user's doctor ([SALUNOTE for doctors](#)).

The efficacy-persistence gap

Randomized trials demonstrate that GLP-1-based treatment can produce substantial average weight loss under protocol-driven care.[10] Real-world treatment is less controlled: insurance restrictions, out-of-pocket costs, adverse effects, interrupted follow-up, and varying levels of clinical support can affect whether treatment is started or continued.[1,2,8,9]

A US claims analysis followed 4,066 commercially insured adults with obesity who did not have diabetes. Persistence was 46.3% at 180 days and 32.3% at one year. Mean proportion of days covered was 51.0%, and 27.2% of patients met the study's adherence criterion.[1] A subsequent JAMA Network Open analysis of 126,984 commercially insured adults without diabetes reported 24.5% persistence at 12 months, while 20.6% switched GLP-1 agents during follow-up.[2]

These figures do not mean that the medicines are ineffective. They show that the health-system result depends on more than pharmacology. A treatment cannot produce its expected long-term benefit when patients cannot or do not continue it.

What outcomes have digital programs reported?

Several large observational cohorts suggest that digital programs can support clinically meaningful weight loss among retained and engaged users.

In a UK app-based cohort of 57,975 people receiving semaglutide or tirzepatide, engaged users had lost 11.53% of baseline weight at five months, compared with 8.0% among users categorized as not engaged. At month five, tirzepatide users had lost 13.9%, compared with 9.5% for semaglutide users.[3]

A later national cohort of 106,653 participants found that engaged users reached weight-loss milestones faster and achieved greater observed weight loss than users classified as not engaged. Reported weight loss at month 11 was 21.5% among engaged participants and 17.0% among those not engaged.[4]

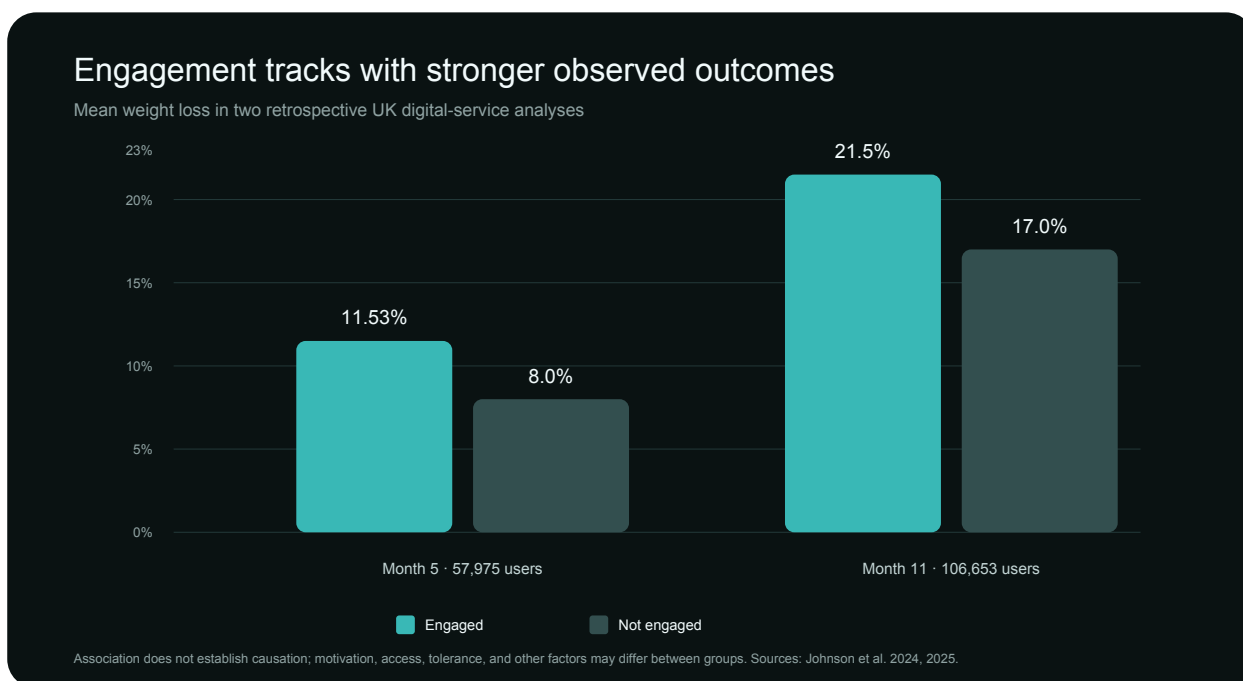


Figure 2. Greater digital engagement was associated with greater observed weight loss in two retrospective service cohorts. These analyses demonstrate association, not causation.[3,4]

WeightWatchers Clinic reported outcomes from 53,590 patients receiving anti-obesity medication through telehealth. Mean weight loss was 8.9% at three months, 14.1% at six months, 17.7% at nine months, and 19.4% at 12 months among patients with measurements at those time points.[5]

A remotely delivered specialist program operated by Second Nature reported that 39.6% of its original 341-person cohort maintained an active subscription at 12 months. Among active participants with 12-month measurements, mean weight loss was 19.1%. The authors explicitly cautioned that high withdrawal and a completer analysis limit generalizability.[6]

Selected persistence evidence at a glance

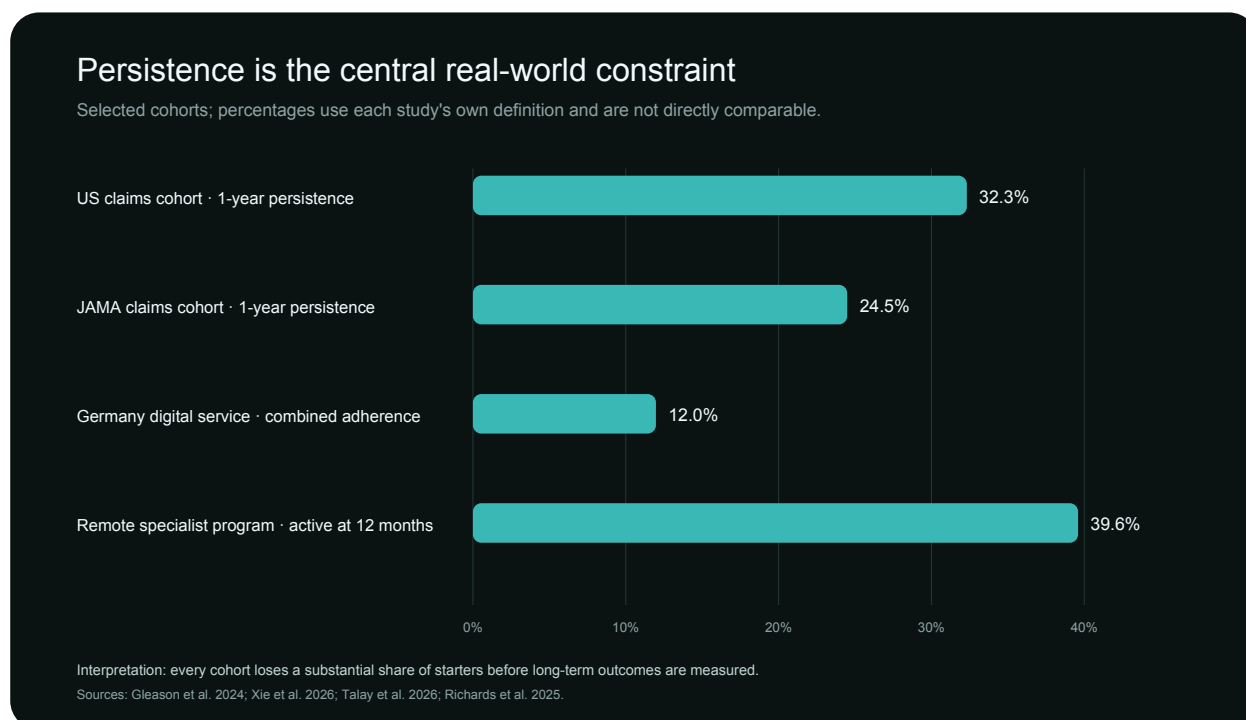


Figure 3. Long-term participation varies across real-world cohorts. Definitions differ: claims persistence, combined medication-and-data adherence, and an active paid subscription are not interchangeable.[1,2,6,7]

These results should not be treated as a league table. The studies used different drugs, populations, follow-up periods, engagement definitions, adherence rules, and approaches to missing data. In particular, outcomes among completers or adherent users can overstate the result expected across everyone who initially enrolled.

Engagement appears useful - but association is not proof of causation

Digital engagement repeatedly correlates with stronger outcomes. The most commonly reported activities include:

- 1 Recording weight regularly
- 1 Messaging a health coach or care team
- 1 Logging meals and physical activity
- 1 Completing educational content
- 1 Attending scheduled clinical reviews
- 1 Reporting symptoms and adverse events

The two large UK cohorts found that use of the app's behavioral-support components was associated with greater weight loss and faster achievement of weight-loss milestones.[3,4] The Second Nature evaluation combined app-based education, self-monitoring, connected scales, and personalized feedback from qualified health coaches, but its observational design could not isolate the effect of any single component.[6]

These findings are directionally consistent, but they require careful interpretation. People who engage frequently may also have greater motivation, fewer financial barriers, better medication access, or better tolerance. Most available platform studies are retrospective and observational, so they cannot establish that app engagement alone caused the difference.

The practical conclusion is not that more screen time automatically produces more weight loss. It is that digital interactions are most likely to matter when they support meaningful clinical and behavioral work: identifying side effects, reinforcing achievable habits, detecting disengagement, and helping patients navigate barriers.

Why patients discontinue

Attrition is not a single problem. It is shaped by treatment affordability, clinical follow-up, tolerability, expectations, and personal circumstances. In an 853-patient health-system cohort, 24.7% of patients who were prescribed a GLP-1 medicine never obtained it, and 35.6% discontinued within two years. Among those who discontinued, the most frequent documented reasons were loss to follow-up with the prescriber (26.6%), side effects (23.7%), and loss of insurance coverage (21.4%).[8]

A separate study of commercially insured US adults initiating semaglutide for weight management found that 46% had discontinued by month five. Discontinuation ranged from 41% in the lowest monthly copay quintile to 51% in the highest, supporting a relationship between financial burden and treatment continuity.[9]

Why treatment stops in real-world care

Established peer-reviewed cohorts point to follow-up, tolerability, and affordability.

Two-year health-system cohort · 853 prescribed



Shares are among 304 patients who discontinued, not all 853 prescribed.

Five-month semaglutide claims study · copay gradient



Design implication: useful engagement features cannot substitute for continuous clinical access and affordability.

Sources: Abdel-Bary et al., Diabetes Obesity and Metabolism (2025); Xu et al., Obesity (2025).

Figure 4. Real-world evidence links discontinuation to interrupted follow-up, adverse effects, insurance loss, and higher out-of-pocket cost.[8,9]

This variation is important. A platform may have an excellent interface and still experience high attrition if patients cannot obtain or afford medication. Conversely, a platform may improve persistence by addressing operational barriers - even without adding more app features.

What happens after stopping treatment?

Discontinuation is not merely a lost subscription or an incomplete data point. For many patients, stopping GLP-1-based treatment can be followed by weight regain, particularly when no maintenance plan or alternative support is provided.

The STEP 1 trial extension found that participants regained approximately two-thirds of their prior semaglutide-associated weight loss during the year after withdrawal; several cardiometabolic measures also moved back toward baseline.[10] A later systematic review and meta-analysis of 18 randomized trials found a pooled 5.63 kg weight regain after GLP-1RA discontinuation among participants with obesity, although heterogeneity was very high.[11]

A responsible platform should therefore support several possible next steps:

- 1 Clinical assessment of the reason for stopping
- 1 Management of adverse effects
- 1 Review of access or affordability options
- 1 Adjustment, switching, or temporary interruption when clinically appropriate
- 1 Behavioral and nutritional maintenance support
- 1 Monitoring for weight regain and metabolic deterioration

The objective should not be indefinite medication at any cost. It should be informed, clinically supervised continuity - whether the patient continues, changes, pauses, or stops treatment.

Continuity of care and safety

Digital services can measure care processes that are difficult to observe in conventional care, including message frequency, response time, symptom reports, missed weigh-ins, and gaps in contact.

Simple activity counts are insufficient. Ten generic reminders are not necessarily better than one timely clinical intervention. Platforms should measure whether the right concern reached the right professional within an appropriate period - not only how many messages were exchanged. The published digital-care studies measured engagement differently, ranging from app use and weight entry to active subscription status; this limits comparisons across platforms.[3,4,6,7]

In a large analysis covering 290,050 patient-months, the reported adverse-event incidence was 1.57 per 1,000 patient-months, with no higher incidence among engaged than nonengaged participants.[4] This is reassuring about engagement, but it does not remove the need for clear triage rules, emergency instructions, clinician oversight, and pharmacovigilance.

What should a high-quality GLP-1 companion platform include?

The current evidence supports a platform model built around six capabilities.

1. Clinically governed onboarding

Eligibility, contraindications, current medicines, relevant medical history, pregnancy status where applicable, and treatment goals should be reviewed by qualified professionals. Onboarding should set realistic expectations about weight-loss variability, dose escalation, adverse effects, and the possibility of long-term treatment.

2. Low-friction self-monitoring

Weight, symptoms, medication use, nutrition, activity, and relevant metabolic measures should be easy to record. Connected scales can reduce effort, but patients should not be excluded when they prefer manual entry.

This principle informs SALUNOTE's current tracking design: users can record weight, waist, hydration, steps, digestive symptoms, and their own injection history in a single on-device interface. These entries are records - not clinical interpretations - and can be summarized for discussion with a physician.

3. Human support with defined escalation

Coaches can support behavior change, while prescribing and safety decisions remain with appropriately qualified clinicians. Platforms should define which issues can be handled through education, which need routine clinical review, and which require urgent or emergency care.

For a non-clinical companion such as SALUNOTE, that boundary is even clearer: medical questions, dose decisions, and concerning symptoms belong with the user's doctor or an appropriate urgent-care service. The app's role is to help the user organize lifestyle activity and self-reported information - not to triage or treat.

4. Early identification of disengagement

Missed check-ins, unreported weights, unanswered messages, prescription gaps, and repeated side-effect reports may signal impending discontinuation. Outreach should focus on resolving the likely barrier rather than sending generic notifications.

5. Access and affordability support

Because insurance loss and higher out-of-pocket cost are associated with discontinuation, platforms need workflows for coverage checks, transparent pricing, refill planning, and clinician-led consideration of appropriate alternatives.[8,9]

6. Structured discontinuation and maintenance care

Every discontinuation should have a documented reason and follow-up plan. This produces safer care and better evidence about where the service is succeeding or failing.

Metrics buyers and platform operators should demand

Headline weight loss among active users is not enough to evaluate a GLP-1 platform. Buyers, employers, payers, clinicians, and patients should ask for outcomes based on the full starting population.

Recommended measures include:

Domain	Recommended measures
Access	Time to first consultation; prescription approval; time to medication start; refill success
Persistence	Active treatment at 3, 6, 12, and 24 months; median treatment duration; treatment gaps
Adherence	Proportion of days covered; dose-escalation completion; refill adherence
Engagement	Weekly weight reporting; meaningful coach interactions; clinical-review completion
Effectiveness	Mean percentage weight change; proportions achieving at least 5%, 10%, 15%, and 20% loss
Safety	Adverse events; serious adverse events; response and escalation times; discontinuation due to side effects
Equity	Outcomes by age, sex, geography, income or coverage type, ethnicity where lawful and appropriate, and comorbidity
Discontinuation	Reason for stopping; planned versus unplanned stop; restart and switching rates
Maintenance	Weight change after discontinuation; continued behavioral engagement; follow-up completion
Experience	Patient-reported treatment burden, confidence, satisfaction, and care continuity

Results should specify the denominator, missing-data method, medication and dose, indication, follow-up window, and whether the analysis includes all starters or only completers. Without those details, apparently impressive outcomes may be difficult to interpret.

Implications for healthcare buyers and platform builders

For healthcare buyers, the critical question is not simply, "How much weight do successful users lose?" It is:

How many eligible patients start treatment, remain supported, continue safely, and achieve a clinically meaningful outcome - and what happens to everyone else?

For platform builders, the largest opportunity lies in reducing avoidable friction across the care pathway. Personalized coaching and a polished app can help, but they cannot compensate fully for opaque pricing, unreliable medication access, weak clinical governance, or the absence of a plan when treatment stops.

The strongest product strategy is therefore not to maximize app activity. It is to build a measurable continuity system that connects the patient, medication, clinician, coach, pharmacy, and payer around shared outcomes.

Not every product needs to occupy every position in that system. SALUNOTE is intentionally focused on the patient-controlled layer: supporting daily lifestyle routines, keeping personal records on the phone, and helping users bring a more structured account of the period between visits to their own doctor. This narrower role may complement clinician-led care without confusing wellness support with medical treatment.

Conclusion

Digital GLP-1 care can support substantial weight loss, especially among patients who remain engaged and on treatment. But the population-level value of these services is constrained by low persistence and by barriers that extend beyond software.

The evidence favors comprehensive programs that combine medication management with self-monitoring, coaching, personalized feedback, safety escalation, and multidisciplinary follow-up. It also argues for more transparent reporting. Weight loss among completers should always be presented alongside retention, medication persistence, discontinuation reasons, and post-treatment outcomes.

The future of GLP-1 digital care will not be determined by which platform generates the most notifications. It will be determined by which platforms help the greatest number of appropriate patients navigate treatment safely, sustain benefit, and receive continuous support when circumstances change.

SALUNOTE's contribution to that future is deliberately bounded: a calm, bilingual companion for diet, movement, habits, and self-recorded progress, with medication and medical judgment left to the patient's own clinician. Readers can explore the current product at salunote.com.

Clinical evidence references

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SALUNOTE product sources

These first-party pages support descriptions of the platform; they are not cited as evidence of clinical efficacy:

- 1 [SALUNOTE overview](#)
- 1 [Current SALUNOTE features](#)
- 1 [SALUNOTE privacy policy](#)
- 1 [SALUNOTE for doctors and product roadmap](#)

Editorial and evidence note

This article is based primarily on peer-reviewed retrospective observational studies and service evaluations, supplemented by a randomized-trial extension, a systematic review and meta-analysis, and WHO guidance. Definitions of engagement, adherence, persistence, and retention differ across studies. Associations should not be interpreted as proof that a particular digital feature caused an outcome. Conference abstracts, preprints, and non-indexed adherence reports were excluded from the evidence set used for quantitative claims. Publication should still be preceded by independent medical and legal review.

SALUNOTE is the publisher of this white paper and is mentioned where its current or planned functions illustrate the companion-app model. Product descriptions were checked against SALUNOTE's public website on 8 September 2026. References to planned functions are explicitly identified as roadmap items. No study cited in this paper evaluated SALUNOTE itself, and no clinical outcome should be attributed to the platform on the basis of the external evidence reviewed here.