

The value of engagement in digital health technology research: Evidence across six unique studies

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Abstract

Background: Wearable digital health technologies and mobile apps (personal DHTs) hold great promise for transforming health research and care. However, engagement in personal DHT research is poor.

Objective: The objective of this paper is to describe how participant engagement techniques and different study designs affect participant adherence, retention and overall engagement in research involving personal DHTs.

Methods: Quantitative and qualitative analysis of engagement factors are reported across six unique personal DHT research studies that adopted aspects of a participant centric/end-user design. Study populations included: 1) a frontline healthcare worker population, 2) a conception, pregnant and postpartum population, 3) individuals with Crohn's disease, 4) individuals with pancreatic cancer, 5) individuals with central nervous system tumors, and 6) families with a Li Fraumeni Syndrome affected member. All included studies involved the use of a study smartphone app that collected both daily and intermittent passive and active tasks, as well as using multiple wearable devices including smart watches, smart rings, and smart scales. All studies included a variety of participant centric engagement strategies centered on working with participants as co-designers and regular check-in phone calls to provide support over study participation. Overall retention, probability of staying in the study, and median adherence to study activities are reported.

Results: The median proportion of participants retained in the study across the six studies was 77.3% (range: 58.3%-96.4%). The probability of staying in the study stayed above 80% for all studies during the first month of study participation and stayed above 50% for the entire active study period across all studies. Median adherence to study activities varied by study population. Severely ill cancer populations, and postpartum mothers showed the lowest adherence to personal DHT research tasks, largely

the result of physical, mental and situational barriers. Except for the cancer and postpartum populations, median adherence for the Oura smart ring, Garmin and Apple smartwatches were over 80% and 90%, respectively. Median adherence to the scheduled check-in calls was high across all but one cohort (50%: low engagement cohort). Median adherence to study-related activities in this low engagement cohort were lower than all other included studies. Race/ethnicity and age were associated with significant differences in adherence.

Conclusions: Participant-centric engagement strategies aids in participant retention, and maintaining good adherence in some populations. Primary barriers to engagement were participant burden (task fatigue and inconvenience), physical, mental and situational barriers (unable to complete tasks) and low perceived benefit (lack of understanding in the value of personal DHTs). More population specific tailoring of personal DHT designs is needed so that these new tools can be perceived as personally valuable to the end-user.

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Original Manuscript

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Abstract

Background: Wearable digital health technologies and mobile apps (personal DHTs) hold great promise for transforming health research and care. However, engagement in personal DHT research is poor.

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Results: The median proportion of participants retained in the study across the six studies was 77.1% (range: 58.3%-96.4%). The probability of staying in the study stayed above 80% for all studies during the first month of study participation and stayed above 50% for the entire active study period across all studies. Median adherence to study activities varied by study population. Severely ill cancer populations, and postpartum mothers showed the lowest adherence to personal DHT research tasks, largely the result of physical, mental and situational barriers. Except for the cancer and postpartum populations, median adherence for the Oura smart ring, Garmin and Apple smartwatches were over 80% and 90%, respectively. Median adherence to the scheduled check-in calls was high across all but one cohort (50%: low engagement cohort). Median adherence to study-related activities in this low engagement cohort were lower than all other included studies. Race/ethnicity and age were associated with significant differences in adherence.

Conclusion: Participant-centric engagement strategies aids in participant retention, and maintaining good adherence in some populations. Primary barriers to engagement were participant burden (task fatigue and inconvenience), physical, mental and situational barriers (unable to complete tasks) and low perceived benefit (lack of understanding in the value of personal DHTs). More population specific tailoring of personal DHT designs is needed so that these new tools can be perceived as personally valuable to the end-user.

Key Words: Wearables, apps, engagement, adherence, retention

Introduction

Wearable digital health technologies (DHTs)[1,2] and mobile apps facilitate the remote, real-world assessment of health including objective signs of disease that are typically confined to healthcare visits and healthcare provider interpretation. These specific categories of DHTs, herein referred to as 'personal DHTs', hold promise in dramatically transforming health research by the new ability to capture high resolution, high-frequency, in the moment health-related multimodal information in decentralized ways. Through the provision of personal DHTs in clinical care, individuals could be better empowered to navigate their health outside the healthcare system with greater accessibility, agency and accuracy than currently possible[1,2]. One of the largest challenges in the future of digital health that involves the use of personal DHTs is end-user engagement. Patients will need to use these new tools remotely in their daily lives. While direct comparisons of engagement in personal DHT research is challenging due to the heterogeneous reporting of retention and adherence factors and a lack of consensus on a definition of "engagement" [3–5], accumulating evidence supports that so far engagement in the use of personal DHTs has been poor. Specifically, retention in personal DHT research studies and in the use of health-related apps is generally low across diverse populations and applications[6–8]. Attrition biases have emerged in dangerous ways resulting in

insufficient representation of minority populations in personal DHT research[6]. Further, adherence to completing active app-based research tasks and surveys and using wearable technology for long-term periods has proven a challenge resulting in large amounts of missing data. This missing data problem results in challenges in artificial intelligence (AI) models from insufficient volumes of data to follow individual patterns, and limits app-based context ‘label’ data. This ‘label’ data is crucial for validating passively collected information from personal DHTs, particularly given the early state of the field and as the utility of certain approaches such as Knowledge graphs and Large Language Models emerge.

Critical barriers to successful personal DHT research and potential implementation as healthcare tools are starting to be identified, now that a number of personal DHTs health research studies have started to surface[6–11]. These barriers include: technical problems with the technology and in collecting the data, usability, perceived value and benefit, privacy concerns and digital literacy. Many of these barriers point to a need to retain a human element in the research process, and to include an aspect of co-designing with end-users. Emerging personal DHT research studies that show better engagement in terms of retention and adherence consistently retain some form of ‘human-in-the-loop’ (regular contact with research staff) and co-design/end user approach[10–14]. Among these studies, retention rates of 80% and higher have been observed, while average adherence to wearable device use and daily app surveys have been shown to be >90% and 70% respectively[10–14].

The promise of digital health rests on the assumption that end-users can be engaged in the long-term use of personal DHTs for health monitoring, yet this remains to be seen among most existing research applications. Furthermore, there have been increasing international calls for the inclusion of patients in the design and conduct of health research[15–17]. In this paper, we report on engagement across six unique personal DHT health research studies that adopted different aspects of a participant centric/end-user design, but each with distinct population and design features. The objective is to describe how participant engagement techniques and different personal DHT designs affect participant adherence, retention and overall engagement in personal DHT health research.

Methods

Six personal DHT research studies are included in this quantitative and qualitative analysis of engagement that span diverse populations including a frontline healthcare population (The Stress and Recovery in Frontline Healthcare Populations Study)[10], a conception, pregnancy and postpartum population (Better Understanding the Metamorphosis of Pregnancy Study)[18], and populations with different diseases including Crohn’s disease (Stress in Crohn’s: Forecasting Symptom Transitions), Li Fraumeni Syndrome (Stress and Li-Fraumeni Syndrome (LFS): A Feasibility study of Wearable Technologies to Detect Stress in Families with LFS), and patients with pancreatic and central nervous system (CNS) tumors (Help Enable Real Time Observations (HERO) in Pancreatic (PANC) and Central Nervous System Tumors (CNS) Studies)[19]. All of these studies were conducted by 4YouandMe - a non-profit (charitable) organization that conducts open source research into the application of personal DHTs for healthcare and its partners[19]. Characteristics of these studies can be found in [Supplemental Material](#) Table 1 and additional methodological detail can be found in [Supplemental Material](#) A. All included studies were approved by the local Institutional Research Ethics Boards at their local sites ([Supplemental Material](#) A). All studies involved the use of a bespoke study smartphone app built by 4YouandMe and the use of the Oura smart ring, the Garmin smartwatch, the Apple smartwatch, an Empatica smartwatch and the Bodyport smart scale. Details of these devices can be found in [Supplemental Material](#) B)

Statistical Analysis

Definitions of adherence in digital health research studies are heterogeneous[3–5]. Consistent criteria

for adherence across all included studies was attempted. While many different wearable features could be used as the basis for the use of the device, features that were most reliably monitored were selected. For studies using the Oura smart ring, daily adherence was defined as at least one sleep data event present for the prior night. For studies using the Garmin smartwatch, daily adherence was defined as step data present for that day. For the Empatica smartwatch, daily adherence was defined as at least one data event (worn properly in a day). Adherence to the Bodyport smart scale was defined as the proportion of days where a weight event was present divided by the total number of expected follow-up days. Adherence to in-app task completion was defined as the proportion of tasks completed when prompted in the app divided by the total number of tasks that should have been completed over study follow-up. For example, all included studies had a daily survey. In a study with a minimum of four months of follow-up expected from participants, the total number of expected daily surveys is approximately 120. For a weekly app survey, the total number of expected surveys for a four-month study follow-up would be 16. Adherence to bi-weekly check-in calls was defined as the proportion of calls completed divided by the total number of expected calls over study follow-up. Medians and ranges are described since the adherence distributions were non-normally distributed. All adherence estimations were performed only among retained participants.

Differences in adherence and retention by socio-demographic characteristics were estimated using chi-square, Fisher's exact, Mann-Whitney U and ANOVA tests where appropriate among studies that have sufficient sample sizes (Stress and Recovery, BUMP, and Stress in Crohn's). Survival probabilities using the Kaplan-Meier approach were calculated to display probability of retention over the course of each included study. Retention (total proportion of participants completing the study among all enrolled) is also reported. Additional information on how retention was calculated for each unique study can be found in [Supplemental Material C](#).

Results

Description of included studies

Study design characteristics of all studies are described in the Multimedia Appendix. All studies included the use of at least one wearable device plus a study app that involved daily, as well as intermittent surveys (daily question prompts, validated questionnaires) and active tasks (cognitive active/physical function tasks (e.g., walk tests), video diaries). In all included studies, participants were required to use their own Android or iPhone smartphone for study activities. Recruitment mechanisms differed across studies with some including a remote recruitment through digital advertisements on social media, professional organizations and newsletters, and patient portals (Stress and Recovery, BUMP) while others recruited patients in person through specialty clinics (Stress in Crohn's, HERO studies, Stress and LFS). The daily burden of app active tasks across studies ranged from two to seven minutes. Study follow-ups across studies ranged from four up to 18 months. Across all studies except the Stress and LFS study, participants were offered to keep some of the study wearable devices (most often the ring and the watch). Two studies included the option for modest financial compensation (BUMP and Stress in Crohn's).

All studies included an engagement strategy that centered around a bi-weekly phone check-in with a consistent engagement specialist that served the purpose of supporting participants, helping them with onboarding, resolving potential technological problems and discussing and collecting study experience feedback. Additionally, all included studies included different strategies centered on working with participants as co-designers. These strategies included making app changes that were driven by direct participant feedback during active follow-up, offering a 'Your data' section in the app that allowed participants to track key symptoms over time, hosting optional investigator - participant zoom calls where participants could meet the study team, receive study updates, preliminary results, and could offer more feedback, and inviting participants to contribute to, and be

listed as co-authors on published work.

Adherence by study population

Median adherence in engagement phone check-in calls, wearable device use, daily app survey completion, and in-app active tasks can be found in Figures 1-4, respectively. Median adherence varied across study populations. The Stress in Crohn's MSSM site had a lower adherence on the engagement check-in calls (50%) compared to other studies many of which had 100% adherence on these calls (Figure 1). This study site is herein referred to as the low engagement cohort. In this low engagement cohort, median adherence to completing daily app surveys, to wearing the Empatica smartwatch, and to using the Bodyport smart scale were lower than all other study cohorts that included these study activities (with the exception of the BUMP postpartum cohort). Further, median adherence to using the Oura smart ring was lower in the low engagement cohort compared to other cohorts with the exception of the postpartum and severely ill cancer populations.

The HERO studies included the most severely ill participants including patients with active diagnoses of CNS and pancreatic tumors. Some HERO participants were undergoing chemotherapy, some had therapy-related complications, some had infections and some had progressive, life-threatening tumor growth. While the total number of participants in these studies were low, these studies showed low adherence on the daily survey (<55%) and wearable device use (<65% HERO-CNS only). Interestingly, HERO-PANC participants exhibited high wearable device use median adherence (83.3% Oura and 95.5% Garmin), despite the health status of this population. Further, median adherence to in-app cognitive active tasks were higher among the HERO studies compared to most other studies. Engagement check-in call adherence was also high in the HERO studies. Qualitative feedback from participants and research staff in these studies highlighted that participants were highly engaged, but too ill to complete many of the study activities. Among the BUMP postpartum cohort, there was consistently lower adherence on all study tasks except for the engagement check-in calls compared to other studies, particularly in comparison to the BUMP prenatal cohort. Specifically, median adherence to Oura ring, Garmin smartwatch use and the Bodyport smart scale in the BUMP-prenatal cohort compared to the BUMP postpartum cohort dropped from 87.2% to 55.0%, 96.7% to 62.5%, and 74.7% to 33.1%, respectively (Figure 2). Qualitative feedback from postpartum participants and research staff highlighted the expected significant challenge in completing study activities while navigating the early postpartum period.

Adherence by study activity

There were differences in adherence rates across different study activities. Adherence to wearable device use was consistently higher across studies compared to in-app activities, which is not surprising given the passive nature of these devices. Excluding the postpartum and HERO-CNS study, median adherence to Oura ring use was >80% across all studies, and as high as 99.0% (Stress in Crohn's - Oxford site) (Figure 2). There were also differences in adherence across specific wearable devices. Garmin and Apple smartwatch adherence was >95% in BUMP pregnant individuals and in HERO-PANC participants, while median adherence for the Empatica Watch was lower among the studies that used this device (Stress in Crohn's-Oxford, 72.5%, Stress in Crohn's-MSSM [low engagement cohort], 26.0%, and Stress in LFS, 86.8%). Median adherence to the Bodyport smart scale was 74.7% among BUMP pregnant individuals, 79.5% in HERO-PANC participants (Figure 2). Excluding the postpartum and HERO study populations and the low engagement cohort, in-app daily survey adherence was >60% for all studies (Figure 3). Finally, adherence to in-app active tasks were lower in general compared to other activities such as wearable device use, or in-app surveys. Tasks that involved walking (gait and walk task) or speaking (video diaries) showed lower adherence compared to other active tasks (e.g., cognitive and emotional bias tasks) (Figure 4).

Adherence by study recruitment and engagement strategy

There did not appear to be any meaningful difference in median adherence rates across study activities by study recruitment methods (in-clinic vs remote) or follow-up time. Two studies that included modest financial compensation, in addition to engagement strategies showed higher adherence rates compared to some of the other studies (i.e., BUMP and Stress in Crohn's), but the impact of compensation is difficult to disentangle from other study characteristics such as population differences and these studies did not show superior adherence rates compared to the Stress and Recovery study that did not offer financial compensation.

Retention

The median proportion of participants retained in the study across the six studies was 77.1% (range: 58.3%-96.4%) (Table 1). The probability of staying in the study stayed above 80% for all studies during the first month of study participation and stayed above 50% for the entire active study period across all studies ([Supplemental Material D](#)).

Table 1. Retention across studies

Study	Proportion retained at study completion % (retained/enrolled)
Stress & Recovery	81.4 (297/365)
BUMP-C	72.7 (134/187)*
BUMP	72.3 (379/524)
Stress in Crohn's - MSSM	84.2 (117/139)
Stress in Crohn's - Oxford	96.4 (54/56)
HERO-CNS	58.3 (7/12)
HERO-PANC	73.1 (19/26)**
Stress & LFS	91.8 (45/49)

HERO-CNS: Help enable real time observations - Central nervous system; HERO-PANC: Help enable real time observations - Pancreatic cancer; BUMP: Better Understanding the Metamorphosis of Pregnancy; BUMP-C: BUMP-Conception; LFS: Li Fraumeni Syndrome; MSSM: Mount Sinai School of Medicine

*Only includes participants who were enrolled in the BUMP-C specific app

**HERO-PANC has unique factors to consider when interpreting the proportion retained until study completion, since the study aimed to monitor patients until they developed progressive disease or died, or the study end date (October 31, 2022) (See [Supplemental Material C](#)).

Adherence and retention by participant socio-demographic characteristics

Median adherence for the Oura smart ring, a smartwatch (Garmin, Apple and Empatica) and the Bodyport smart scale was lower among younger participants compared to older participants across most studies ([Supplemental Material E Table 2](#)). Specifically, Oura smart ring adherence was significantly lower in 18-25 year olds compared to 26+ year olds in the BUMP study ($P=0.03$), Stress in Crohn's-MSSM study ($P=0.02$) and was lower in the BUMP-C and Stress and Recover

study, but this difference was not statistically significant ($P=0.59$) and ($P=0.08$), respectively. Median adherence for Apple smartwatch use was significantly lower in 18-25 year-olds compared to 26+ year-olds in the BUMP study ($P=0.02$), while median adherence for Garmin smartwatch use was lower, but not statistically significant ($P=0.06$). Median adherence for the Bodyport smart scale was significantly lower in 18-25 year-olds compared to 26+ year olds in BUMP ($P<0.01$) and Stress in Crohn's-MSSM ($P<0.01$).

In the BUMP study, Black/African American ethnicity had significantly higher median adherence to completing the in-app daily survey compared to other race/ethnicity groups ($P=0.01$). This trend was observed in the Stress and Recovery study ($P=0.07$) and the Stress in Crohn's-MSSM study ($P=0.24$), although the difference was not statistically significant. In contrast, median adherence to Oura smart ring, smartwatch, and Bodyport smart scale use was lower among Black/African American individuals compared to other race/ethnicity groups, although these differences were not statistically significant ([Supplemental Material E Table 2](#)).

Retention did not significantly differ by age group or gender ([Supplemental Material E Table 3](#)). Retention likelihood was significantly different by race/ethnicity groups in BUMP-C ($P<0.0001$), BUMP ($P=0.001$). Specifically, participants of white ethnicity were more likely to stay in the study in both BUMP-C and BUMP, while participants reporting their race/ethnicity as either unknown or not reporting this item were less likely to be retained ([Supplemental Material E Table 3](#)).

Barriers to engagement (Qualitative synthesis of participant feedback)

Figure 5 describes key themes that impacted participant retention, adherence and overall engagement that cut across all included studies. These themes include participant burden and forgetfulness, digital literacy, physical and mental barriers, personal and altruistic benefit and privacy and confidentiality. Qualitative feedback from participants, research staff and investigators across these five themes is summarized in [Supplemental Material F](#). The top three barriers to engagement in active study tasks were: 1) participant burden and in particular fatigue with the repetitiveness of tasks; 2) physical/mental and situational barriers that prevented the ability to complete tasks; and 3) personal and altruistic benefit, namely the perception that the use of the personal DHTs were not personally useful for health benefit or a lack of understanding as to why and how certain features (e.g., heart rate variability) could be useful to track for health benefit.

Discussion

Evidence across six unique and diverse studies involving the longitudinal use of personal DHTs supports that participant-centric engagement strategies aids in participant retention, and maintaining good adherence in some populations. These strategies centered around human contact with an engagement specialist as often as every two weeks, investigator - participant meetings during active study follow-up, offering returned symptom data in the app, inviting participants to contribute as co-authors in published work and real-time modifications to the study app based on participant feedback.

In the majority of included studies, the probability of staying in the study stayed above 90% for the first month, and stayed above 50% for active study periods for all studies. Lower retention was observed among studies that included a severely ill cancer population and a postpartum population. Reasons for attrition in these studies was largely the result of physical and situational barriers to participation. Retention and adherence rates observed in these studies are higher than typically reported by other personal DHT research studies that tend to show a dramatic drop in retention after the first month of participation[6–8,11,12,20]. Importantly, the included studies in this analysis were high burden in comparison to other studies that request for example, weekly or bi-weekly active

tasks of participants[13, 20] , or only involve the use of a smartwatch. Specifically, across included studies here, participants were expected to complete on average five minutes a day of app activities in addition to continuously using multiple wearable devices.

While different variations of participant centric strategies were used across the six included studies, a key common feature was a bi-weekly check-in call with an engagement specialist. These calls served the purpose to provide support and build rapport with participants, working through onboarding and technological issues with study devices, tracking adherence and receiving study-related feedback from participants. Numerous challenges arise in the conduct of remote, personal DHT research and without frequent check-in, and semi-regular data monitoring by research staff, knowledge of these issues is a black box. The most significant drop in retention in personal DHT research studies tends to be during the first few weeks of participation[6]. These early onboarding weeks are crucial in working with participants to ensure they can get into a rhythm of participation. The passive sensing nature of personal DHTs have much potential to inform new objective measures of health; however, are not always intuitively understood as personally important for unique diseases (e.g., heart rate variability, or phone screen time). Personal DHT studies allow for 'light touch' research approaches that enable data collection without traditional research coordinator contact, but this may come with a cost that inadvertently creates a less engaging study environment for participants and limits the opportunity to help participants understand the value in their participation. Of the included six studies, one cohort had much lower engagement on the check-in calls (50% adherence) compared to other included studies, and in turn consistently demonstrated lower adherence on study related activities. Still, even with extensive engagement designs, populations that had physical, mental and situational barriers to study task completion (i.e., severely ill, postpartum mothers) showed lower adherence to wearable device use and active smartphone tasks compared to other study populations. Top reported barriers to engagement included participant burden, physical, mental and situational barriers and low perceived value of personal DHTs for healthcare.

Excluding studies of a severely ill and postpartum population and the low engagement cohort in the Stress in Crohn's study, adherence to Oura smart ring and Garmin smartwatch use was 80% and as high as 99% in some cohorts and in the Bodyport smart scale was 75% in a pregnant population over study follow-up. This supports that different participant and patient populations can successfully be engaged in the use of wearable devices in the long term with adequate support. Lower adherence was observed for unique wearable devices (e.g., Empatica and Bodyport) and this may reflect that these devices were originally developed for specific medical purposes, and in turn do not offer the same features and returned information that other consumer brand wearable smart rings and watches offer. Further, there were unique challenges in using the Bodyport scale in a perinatal population where some participants preferred not to track their weight.

All included studies required participants to use their own smartphone for study related tasks referred to as a 'bring your own device, BYOD' approach. This approach significantly reduces study related costs, and potentially enhances engagement as the user is already familiar with their smartphone. These findings support that a BYOD approach to app-based activities is feasible.

Irrespective of engagement approach, adherence to in-app surveys and tasks was lower than wearable device use, which is not surprising given the higher burden related to in-app activities. The self-reported information captured from frequent or momentary in-app assessments is extremely valuable as context information. This context information or 'label' data is useful for validating objectively captured information, yet remains the most difficult to capture in sufficient detail. Further, certain in-app activity adherences were consistently lower than others. Namely, activities that required the user to be active (walk in a straight line, or complete a video diary) were low across studies. Still,

adherence to daily in-app surveys was >60% for all studies excluding the postpartum and HERO study populations.

Limitations

This quantitative and qualitative analysis compared observational data across different digital health studies. However, no true comparison cohort that did not include engagement strategies was included. Therefore, inferred casualty of participant check-ins with engagement specialists on retention and adherence rates cannot not be concluded. We are formally testing whether the bi-weekly check-in significantly increases adherence and retention in an ongoing study with an appropriate comparison arm without check-in support (NCT05753605). One of the included studies (Stress and Recovery) was conducted during the early 2020 COVID-19 pandemic. There is some evidence that engagement in research was higher during the early pandemic time periods[21]. It cannot be ruled out that the higher observed retention and adherence in this study compared to others was not due to this potential time period bias. The Stress in Crohn's Oxford site included a population of patients some of which were already engaged in the use of electronic monitoring of symptoms. In turn, this could have contributed to the high retention and higher adherence observed at this site compared to the other Stress in Crohn's MSSM site. The results presented on barriers to engagement were primarily qualitative and collected from conversations with participants, research staff and investigators across studies.

Conclusions

Globally, mobile apps are used for a variety of purposes in everyday life, while the use of smartwatches for activity monitoring are gaining increasing popularity. However, the use of these tools for health still remains a challenge. These findings support that human support via phone and other participant centric engagement strategies centered on giving back to participants and working with them as co-designers can support sufficient retention and adherence in personal DHT research across diverse populations. This has implications for the utility, and potential necessity of a digital support worker in digital healthcare, as highlighted by others[22]. A power of personal DHTs is enabling the patient to be in control of their health through self-monitoring, but this new role comes with a responsibility. This important shift in role from doctor to patient outlines how crucial it is to include patients in the early design phase of personal DHT health research. Further work is needed to inform app designs that support habitual forming activities around task completion so that app-related activities become a part of participants' daily routine and are perceived as personally valuable.

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Conflicts of Interest

CB is a consultant for Depuy Synthes, Bionaut Labs, Galectin Therapeutics, Haystack Oncology and

Privo Technologies. CB is a co-founder of Belay Diagnostics and OrisDx

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Abbreviations

AI - Artificial Intelligence

BYOD - Bring Your Own Device

BUMP - Better Understanding the Metamorphosis of Pregnancy

CNS - Central Nervous System

DHT - digital health technologies

HERO - Help Enable Real Time Observations

LFS - LiFraumeni Syndrome

PANC - Pancreatic

MSSM - Mount Sinai School of Medicine

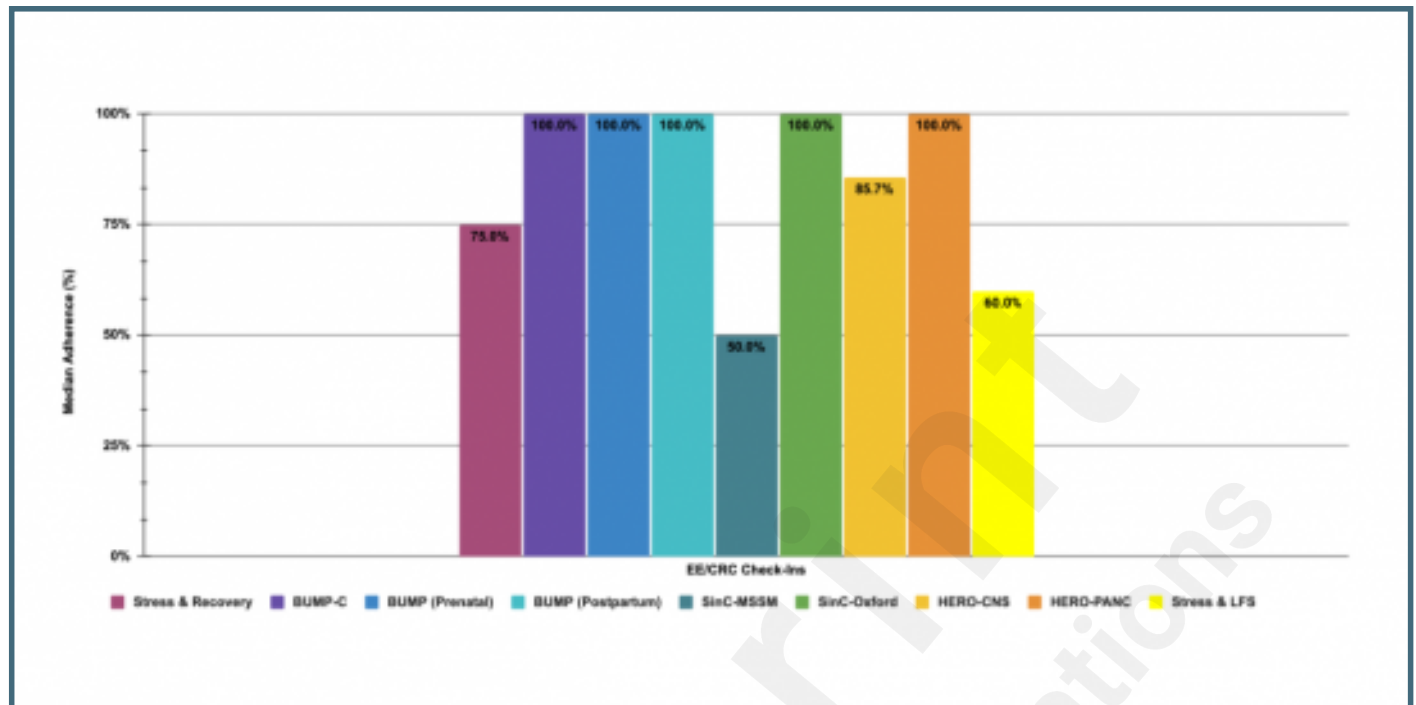
Supplementary Files

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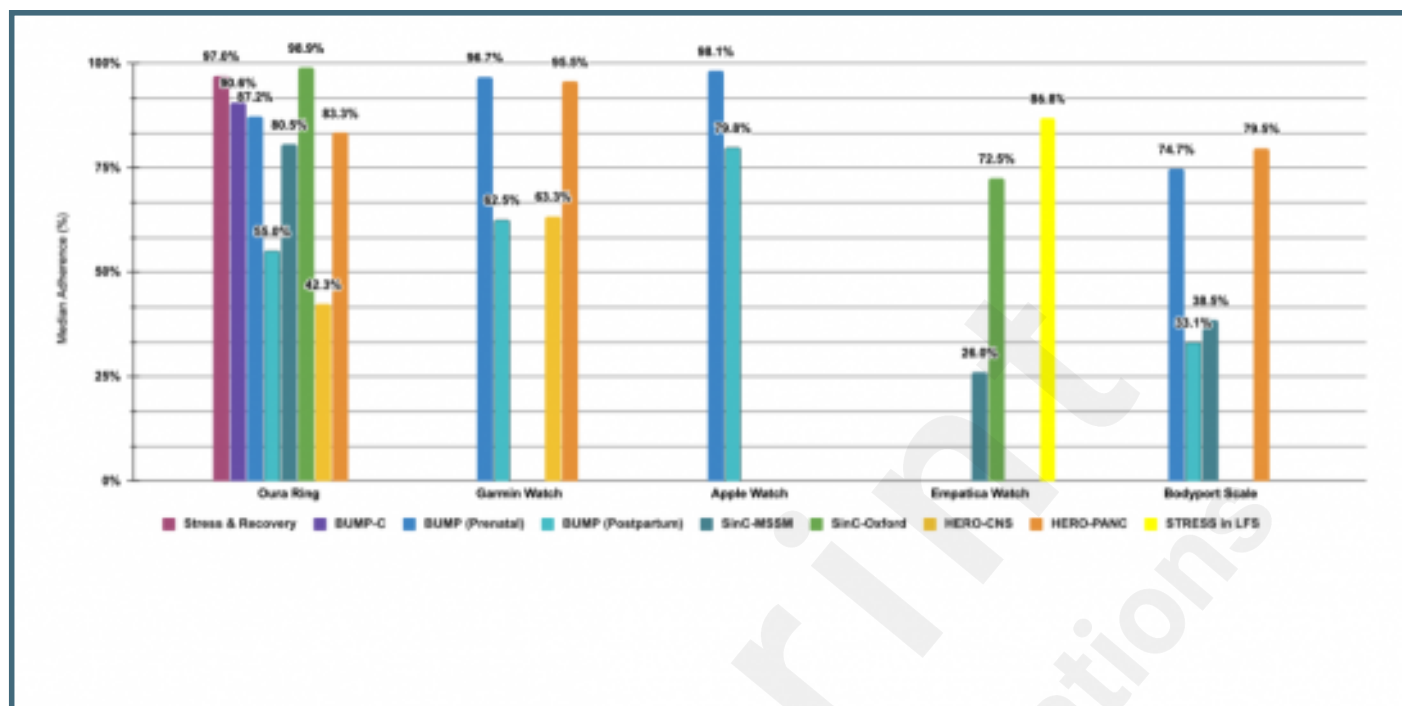


Figures

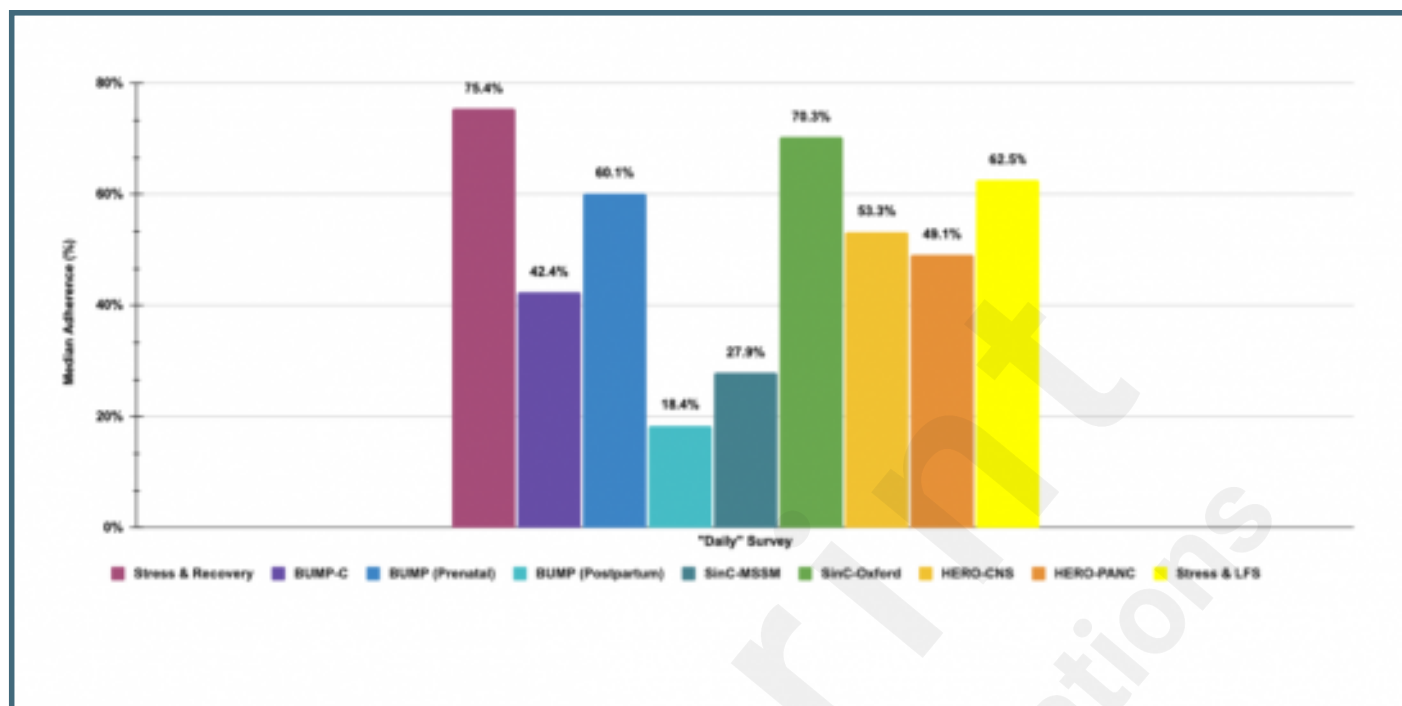
Median adherence to engagement check-in calls across studies.



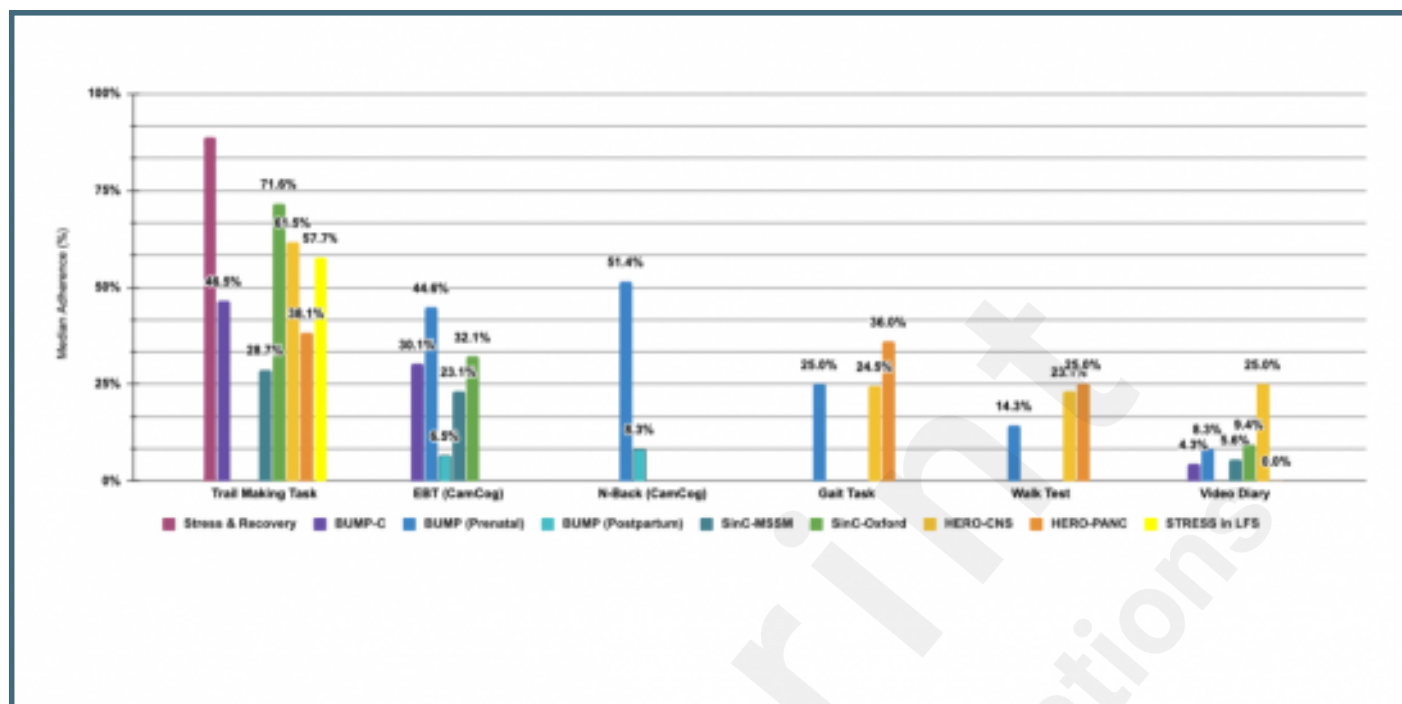
Median adherence to wearable device use across studies.



Median adherence to an in-app daily survey across studies.



Median adherence to in-app active tasks across studies.



Five key participant engagement barrier themes.



Multimedia Appendixes

Supplemental Material.

URL: <http://asset.jmir.pub/assets/f3eb2668057b467355a7237254df9618.docx>

