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Patient satisfaction, engagement, and barriers to adoption of telemedicine in hypertension Management: A Systematic Review

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ABSTRACT

Several studies have demonstrated that telemedicine is an effective clinical tool for managing blood pressure. The majority of these studies, however, focus on the clinical efficacy of telemedicine and fail to consider the patient's experience with telemedicine, such as their level of engagement or satisfaction. This systematic review will synthesize the literature examining patient satisfaction, engagement, and barriers to adopting telemedicine for hypertension management. The databases of Web of Science, EMBASE, PubMed, and Scopus were queried for studies published between January 2018 and August 2025 that evaluated patient experiences with telemedicine for the treatment of hypertension. Thirteen studies, involving a total of 3248 participants, met the eligibility requirements for this review. Studies also reported the advantages of telemedicine from the patient's perspective (e.g., high levels of patient satisfaction) as well as its benefits (e.g., convenience, reduced travel time, improved access to healthcare). In addition to the facilitators of patients' use of telemedicine (provider support, family member involvement, and an easy-to-use user interface), perceived disease severity has been identified as an important factor in determining whether patients will adopt telemedicine. Digital literacy emerged as the strongest predictor of engagement with telemedicine. Telemedicine yields high patient satisfaction; however, it creates major barriers to patient engagement and participation, especially among vulnerable populations. Therefore, future telemedicine interventions will need to address digital literacy barriers, clearly communicate data privacy practices, and preserve patient-doctor relationships to achieve equal access and sustained engagement.

Keywords: telemedicine, patient satisfaction, hypertension, engagement, digital health

1. INTRODUCTION

The World Health Organization states that more than 1.3 billion people live with hypertension worldwide, and it continues to be one of the most preventable causes

of cardiovascular morbidity and mortality (Yang et al., 2024). Barriers in conventional in-person clinic encounters limit optimal blood pressure (BP) control by limiting clinic hours, the geographic distribution of clinics, and the burden of patient visits (Parati et al., 2023). Telemedicine and remote patient monitoring (RPM) are emerging as two solutions to expand capacity for hypertension management and increase accessibility, especially for underserved populations (Rodriguez et al., 2022). There is a significant amount of clinical data from multiple randomized controlled trials that present empirical evidence for the effectiveness of telemedicine, which has shown similar (if not superior) reductions in blood pressure when compared to the same level of in-person care (Yang et al., 2024; Parati et al., 2023). Yet there is a significant gap between the clinical data supporting telemedicine and its effective use in real-life situations. Many organizations implement telemedicine programs but experience low patient participation and/or high patient discontinuation rates (Xie et al., 2021). This demonstrates that, while clinically superior methods/programs can be developed, they may never reach their full potential if they do not match patient preferences, user expectations, or other practical barriers to adoption. Telehealth's long-term viability is dependent on a number of factors, including the extent to which patients are satisfied with their care delivery via digital means; as well as whether or not they will be engaged in care through that medium; and ultimately, if they will continue to engage in care delivery via that medium (Adeogun et al., 2021; Daughtry et al., 2021). Thus, it is important to understand what influences patient satisfaction with digital health and identify which patient populations experience barriers to adopting telemedicine, so that sustainable engagement can be facilitated. As health care organizations and government agencies continue to invest substantial money and resources in developing telemedicine infrastructure, it has become even more imperative that research focus on identifying and reporting patient-centered outcome data to support priority-setting and resource-allocation decisions (Eze et al., 2020). This systematic review set as an objective to synthesize current evidence related to: (1) Patient satisfaction outcomes; (2) Patient engagement and program retention; (3) Barriers to adoption and sustained engagement; and (4) Factors that facilitate patient engagement and adoption of remote monitoring technology.

2. REVIEW METHODS

2.1. Search Strategy and Study Selection

The literature was systematically reviewed using PRISMA guidelines as our framework for conducting this research. Search terms such as (telemedicine OR telehealth OR remote patient monitoring OR mHealth OR digital health OR virtual care) AND (hypertension or blood pressure) AND (satisfaction OR engagement OR adoption OR barriers OR facilitators OR acceptability OR adherence OR dropout OR user experience OR patient experience) were employed when we searched on four of the most prominent databases for studies (PubMed, Scopus, Web of Science, EMBASE) between January 1, 2018 and August 31, 2025.

2.2. Inclusion and Exclusion Criteria

Eligible studies for inclusion:

- Type of study: Quantitative studies (cross-sectional, cohort) and/or qualitative studies (focus group interviews; interviews) as well as studies applying a mixed-method methodology
- Population: All adult patients who have either Hypertension or Pre-hypertension.

Intervention: Telemedicine or RPM in controlling hypertension.

Outcomes: Primary outcome is patient satisfaction. Secondary outcomes include patient engagement, barriers, and facilitators to adoption.

Studies eligible for exclusion:

- Studies that reported only Clinical Outcome Data and no patient experience data.
- Editorial/Commentary/Opinion Pieces
- Duplicate Publications
- Non-English Language Publications
- Pediatric Populations

Figure 1 details the complete study selection process.

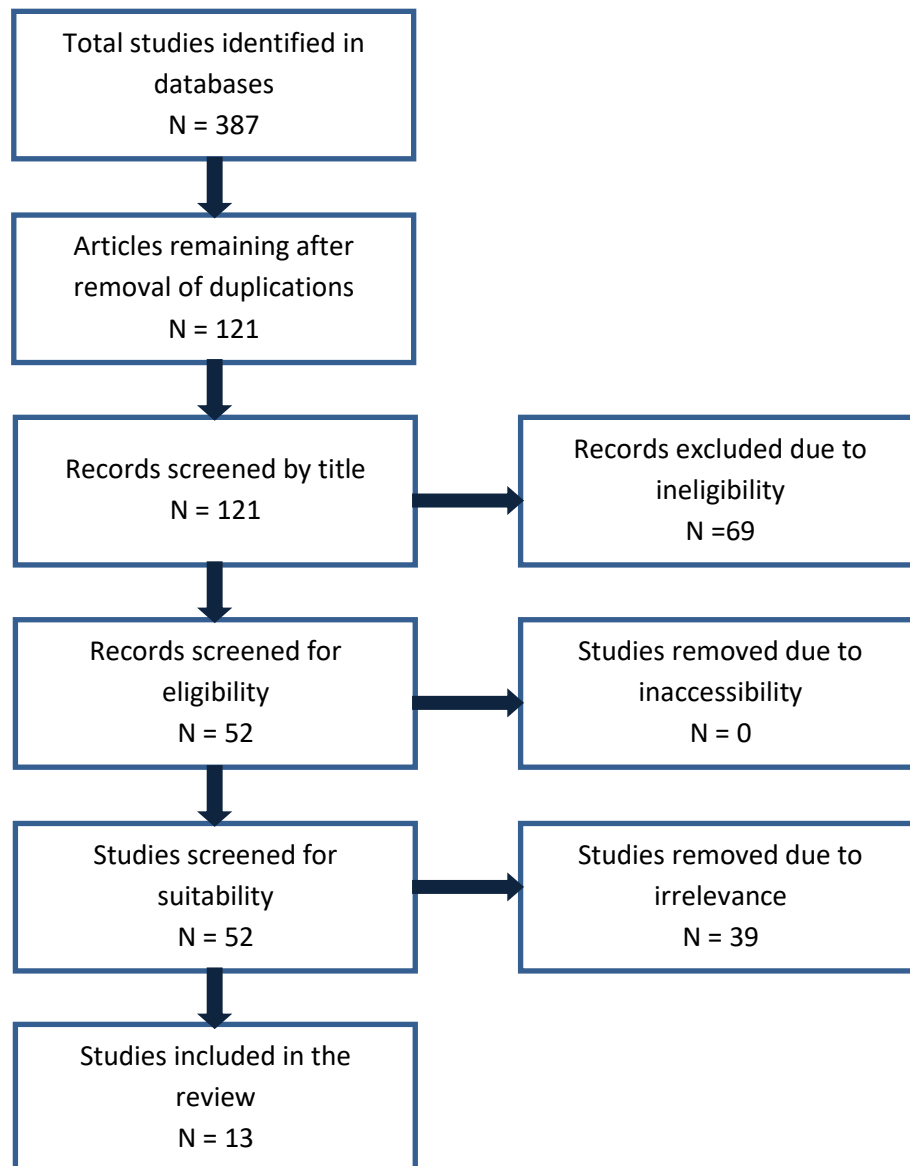


Figure 1. Study selection chart

2.3. Data Extraction and Quality Assessment

Title and abstract screening was performed by two independent reviewers. Reviewers then independently reviewed full texts of articles that met the criteria. Data abstraction included the following items from each study: study design and characteristics; demographic data for the sample; description of the intervention; description of outcome variables or measures used to assess outcomes; and the reviewer's assessment of key findings regarding participant satisfaction/engagement/barriers to the use of interventions. Each study was evaluated for overall quality using relevant tools for each study type (the Consolidated Criteria for Reporting Qualitative Studies for qualitative studies; the NIH Quality Assessment Tool for observational studies).

2.4. Data Synthesis

The data were synthesized using a storied approach due to differences in measurement tools and outcome variables. The results were grouped into four categories: (1) satisfaction outcomes, (2) engagement patterns, (3) adoption barriers, and (4) facilitating factors. Where possible, summary statistics were calculated for the satisfaction and engagement rates reported by participants.

3. RESULTS

3.1. Study Characteristics

Our literature review of the search process identified 387 citations in the database for which we searched. Thirteen studies were selected from these citations based on a specific set of inclusion criteria (Figure 1). The 13 studies included in this analysis involved 3,248 participants and were published from January 2018 and August 2025. The study design for the 13 studies was as follows: mixed-methods (n=8), qualitative (n=4), and cross-sectional surveys (n=1). The geographic locations from where the data for each of the 13 studies were collected included North America (n=7), Europe (n=4), and the Asia-Pacific region (n=2). Each of the 13 studies included different types of interventions; specifically, RPM without other interventions (n=5), mobile health applications (n=4), and RPM plus telemedicine consultations (n=4).

3.2. Patient Satisfaction Outcomes

Patient satisfaction with telemedicine for hypertension was reported at 75% to 95% across the studies reviewed. Patients were mostly satisfied with the telemedicine experience based on the following three categories of telemedicine experience:

- Convenience and accessibility (84-92% of patients)
- Quality of care (76-89%)
- Technology usability (72-85%)

Patient satisfaction across multiple domains of outcomes was measured in the included studies. In Table 1, the satisfaction percentages for the five main domains of outcomes, the number of studies that assessed the outcomes, and the sample sizes are presented.

Table 1. Patient Satisfaction Outcome Domains

Outcome Domain	Satisfaction Rate (%)	Number of Studies	Sample Size
1. Overall Satisfaction	75 – 95	13	3,248
2. Convenience & Accessibility	84 – 92	8	1,856
3. Quality of Care	76 – 89	10	2,134
4. Technology Usability	72 – 85	11	2,456
5. Communication Effectiveness	80 – 90	9	2,012

Satisfaction percentages reflect the levels reported in the included studies. The greatest satisfaction was reported in the convenience/accessibility domain (84-92%), while the greatest variability was reported in the technology usability domain (72-85%). Every study included reported an overall satisfaction rate greater than 75%.

As well as quantitative measures, several of the qualitative studies found that patients were satisfied with many of the elements of their telemedicine experience, but some also expressed a desire to have a hybrid model, one that used telemedicine for check-in appointments, but in-person appointments when they required more personal contact/physical exam.

3.3. Patient Engagement and Program Retention

Variability existed among studies regarding engagement levels.

- Engagement levels were defined as follows: high engagement ($\geq 80\%$ of expected patient data transmissions), moderate engagement (50-79% of expected patient data transmissions), and low engagement ($< 50\%$ of expected patient data transmissions).
- Active engagement (45-62% of all enrolled patients);
- Moderate engagement (50-79% of all enrolled patients);
- Low engagement ($< 50\%$ of expected data transmissions; up to 34% of enrolled patients).

Studies examining program retention found dropout rates of 15-42%. Engagement levels were categorized to standardize reporting across studies. Table 2 presents the distribution of patient engagement levels by category with corresponding data transmission rates and overall dropout rates.

Table 2. Engagement Category Classification

Engagement Category	Engagement Category	Engagement Category	Engagement Category
	Percentage of Patients (%)	Data Transmission Rate (%)	Dropout Rate (%)
High Engagement (≥80% data transmission) ≥80%	45 – 62	80	N/A
Moderate Engagement (50-79% data transmission)	34 – 45	50 – 79	N/A
Low Engagement (<50% data transmission) Up to	Up to 34	< 50	N/A
Overall Dropout Rate	-	-	15 – 42

The data represent ranges across the 13 included studies. Engagement levels declined significantly over the initial 3-6 months of program participation, with a mean dropout rate of 18-24% by month 4.

3.4. Barriers to Adoption and Sustained Engagement

The largest technological barriers to health information technology (HIT) use are a lack of technology comfort (reported by 24-38 percent of survey respondents), difficulty using electronic devices or applications that have been taught to them (reported by 12-18 percent of survey respondents), and perceived burdensome data entry when manual data transmission is required (reported by 14-21 percent of survey respondents). The digital competence barrier was the most significant predictor of abandonment; those with lower-than-average digital competency were 2.3-2.8 times more likely to discontinue use of the HIT system.

Concerns over privacy and security were also identified as important barriers to adoption and continued use. Concerns about data privacy were reported by 32-48 percent of respondents, uncertainty regarding data administration methods by 18-26 percent, and concern about a lack of provider transparency regarding data security by 15-22 percent.

Lastly, access and infrastructure issues were also important barriers to the adoption and continued use of health information technologies. Access to internet services was limited in rural areas, where 15-29 percent of respondents experienced this issue. Costs related to purchasing smartphones/devices represented an additional barrier to adoption (8-18 percent), particularly among lower-income populations. Bandwidth restrictions on the Internet were also a problem in many underserved areas.

Barriers to telemedicine adoption were categorized into four domains: digital competence, data privacy, infrastructure, and healthcare system factors. Table 3 summarizes the prevalence of specific barriers within each category as reported across studies.

Table 3. Barrier Category Classification

Barrier Category	Barrier Category	Barrier Category
	Specific Barrier	Reporting Respondents (%)
Digital Literacy	Lack of technology comfort	24 – 38
Digital Literacy	Difficulty using devices / apps	12 – 18
Data Privacy	Privacy concerns about data	32 – 48
Data Privacy	Uncertainty about data handling	18 – 26
Infrastructure	Limited internet access	15 – 29
Infrastructure	Device cost / affordability	8 – 18
Healthcare system	Lack of provider support	14 – 21
Healthcare system	Unclear clinical guidelines	9 - 15

Data represent percentage ranges of respondents reporting each barrier across the 13 included studies. Digital literacy emerged as the strongest predictor of program discontinuation, with patients having below-average digital literacy being 2.3-2.8 times more likely to discontinue telemedicine use.

Barriers to relationship/communication with providers, patient beliefs/motivation:

- Relationship/communication preferences:
 - + In-person provider preference (18-34%), as an influence on continuing with telehealth.
 - + Perceived depersonalization of care (12-20%)
 - + Lack of provider response to transmitted information (10-16%)
- Patient beliefs & motivation:
 - + Belief that they could control their BP and therefore no longer needed to monitor it (perceived control over disease), 16-24%, discontinued telehealth for this reason.
 - + Apathy/lack of health motivation (8-15%)
 - + Skeptical of the efficacy of technology (10-14%)

3.5. Factors that facilitate patient engagement and adoption of remote monitoring technology

a. Factors related to patient factors:

- Patient-perceived disease severity was a significant factor, contributing to engagement that was 1.8 to 2.1 times higher than among those who did not perceive their disease as severe.
- The presence of a supporting family member or caregiver has been shown to increase engagement by up to 2.0 to 2.4 times compared with those without support.
- Health literacy was found to be positively correlated with engagement, with levels up to 1.9-2.3 times higher than those of less literate individuals.

b. Design and development of the intervention:

- Bluetooth-enabled devices that automatically transmit data to clinicians achieved significantly higher engagement levels of 18-25% compared to patient-manual data entry.
- Easy-to-use interface designs led to longer-term engagement with RPM technology.
- Real-time, personally tailored feedback from their clinician has been shown to be the most influential factor in engaging patients in RPM technology. Studies that enabled clinicians to respond to patient data within 48 hours resulted in increased engagement at 12 months of 25-35%.
- When combining multiple components of interventions (education, RPM, and remote health consultations), the results indicated that multi-component interventions had better long-term engagement than single-component interventions.

c. System and relationship factors:

- Patients who continued to receive care from the same provider demonstrated an engagement rate 1.7 to 2.0 times higher than those who did not.
- Providers who proactively contacted their patients by phone or text to inquire about their well-being regained 8-12% of previously disengaged patients in pilot studies that used proactive outreach.
- Programs integrated into a patient's existing primary care practice had higher engagement rates than those delivered remotely as standalone programs.

3.6. Demographic differences in adoption and continued engagement in technology use are found to include age, education, socio-economic status, race, and ethnicity

a. Age-related differences:

- The youngest age group (40 – 60) had the highest percentage of participants continuing to be engaged in their health care (61 – 72 percent after 12 months).
- Participants between 65 – 74 years old were moderately active (48– 58 percent), while the oldest group (>75 years) was significantly less likely to continue being engaged (28 – 38 percent). Digital literacy issues were stated as the primary reason.
- Higher education and higher income groups had the greatest likelihood of sustaining a high level of engagement (68 – 75 percent), while those with lower levels of both had the lowest (42 – 52 percent).

- The disparity in continued engagement due to education and income is mainly attributed to the disparity in digital literacy among these groups; it was estimated that this accounted for 40 – 60 percent of the educational/income-based disparity.

b. Race/Ethnic Differences:

- While many studies have indicated a difference in engagement in minority races and ethnicities compared to the non-minority population, post-hoc analyses conducted to control for digital literacy and socio-economic status indicate that the previously noted differences are greatly reduced when controlling for these variables.
- Interventions designed to fit cultural needs, including multilingual support, were found to produce engagement rates similar to the general population.

4. DISCUSSION

4.1. Synthesis of Findings

There is a paradox surrounding the adoption of telemedicine to treat hypertension: while most patients are satisfied with the service they receive, a significant number have challenges engaging with it, as do patients with certain demographics.

While the majority of patients report being very satisfied with telemedicine (75–95%) (Canfield et al., 2020; Daughtry et al., 2021; Thakur et al., 2024), 15–42% discontinue use within the first year after initiating (Xie et al., 2021; Adeogun et al., 2022), with those from vulnerable populations discontinuing at even higher rates.

Satisfaction rates of this magnitude suggest that the design of interventions can produce genuine value for patients' healthcare experiences. Satisfaction is driven by three factors: convenience, reduced travel burden, and access to care. While these represent meaningful improvements in how healthcare services are delivered, many studies have limited their assessment of patient satisfaction to patients who remain engaged in the program, likely introducing selection bias into their results; i.e., patients who discontinued telemedicine use are unlikely to be included in patient satisfaction surveys.

4.2. Engagement Disparities and Digital Divide

A major disparity exists in engagement rates across demographics, ranging from 15 to 42%. These disparities clearly indicate that a person's digital literacy and demographics play a significant role in how they will experience Telemedicine. In fact, the only factor found to have a greater effect on sustaining an individual's engagement was their level of digital literacy. Individuals with lower levels of digital literacy were 2.3–2.8 times more likely to discontinue telemedicine use (Adeogun et al., 2022; Eze et al., 2021). A similar theme has been observed throughout the literature regarding digital health inequity; although telemedicine could potentially increase the accessibility to care for individuals who may be unable to visit a physician due to a lack of transportation, etc., it may also worsen the digital divide and create barriers to care for those with lower levels of digital comfort.

Another area of great concern is age-related disparities in engagement. Older adults make up a large percentage of the hypertensive population and may be able to realize the greatest benefits from reduced-burden monitoring; however, they also tend to have the least amount of sustained engagement. There is a large, clinically relevant difference between the oldest adult group (which had an average of 28–38% engaged) and the youngest adult group (which had an average of 61–72% engaged). Rather than indicating a lack of willingness on the part of older adults, this trend indicates the failure of many telemedicine programs to adapt to their needs; several studies have shown that simplifying the interface and providing phone-based support may considerably improve engagement among older adults.

4.3. Privacy Concerns and Trust

Data security/privacy concerns (expressed by 32–48% of study participants) were identified as a major yet addressable barrier to continued use of Telemedicine services (Zhou et al., 2020). Of particular interest, when healthcare providers proactively explain their data security practices, there was a corresponding decrease in expressed data security/privacy concerns (studies demonstrating transparency in communicating data security practices showed a 50% decrease in data security/privacy concerns). It appears these concerns stem primarily from the provider's inadequate communication about data security practices, rather than a lack of trust. As healthcare organizations continue to experience a high number of data breaches, patient concerns about data security/privacy are well-founded and require transparency in practice and strong data security measures.

4.4. Personalization and Patient-Provider Relationship

This study also identified a major finding: patients highly value personalized health care and continued provider relationships in a telemedicine setting. In particular, the majority of patients preferred the human element of the telemedicine experience (e.g., familiar providers, personal feedback, a continued relationship) over technology alone (Xie et al., 2022). Thus, this study provides evidence that optimal telemedicine is unlikely to be "technology maximum" in design but rather can be effectively created by preserving those valued human elements while achieving major technological efficiency gains.

Across all studies reported, the aspect of provider responsiveness was an important consideration: participants were significantly more engaged with telemedicine services when they could see that their providers had responded to the data they transmitted within 48 hours (i.e., the participant's data was being actively monitored/acted upon) (Byambasuren et al., 2023) compared to when there was a delay (or no response) from the provider. This supports the notion that participants are seeking a meaningful review of their data rather than just a collection process.

4.5. Implications for Implementation

The most significant ways to increase the likelihood of use and user engagement are to:

- Train and provide support to individuals as they become more digitally literate; and to create the same opportunity to those who have less knowledge or experience of using technology as well as elderly users.
- To create easier-to-use interfaces and technology-based tools that are simple and easy to use for those who are hesitant to use digital technologies (i.e., phone based).
- To establish and clearly articulate a policy on how you will protect user's personal data and communicate it early to users.
- To ensure that providers are responsive to patients and can deliver personalized feedback to users.
- To include family members/caregivers when possible.
- To integrate telemedicine into an existing relationship with a patient's primary care provider instead of creating a new program.
- To offer telemedicine options in combination with some on-site visits (hybrid model) versus offering all telemedicine services to a patient.
- To offer patients access to devices at no cost if they are uninsured/underinsured.

For health systems, the most effective way to support and expand telemedicine is to:

- Support and train your employees so that they can assist patients in developing their digital skills.
- Develop reimbursement models that take into consideration the amount of time needed to contact and re-engage patients.
- Analyze and track the level of engagement with telemedicine among different demographics and develop strategies to engage the groups that do not seem to be using this service.
- Ensure that your organization has the necessary technology to allow for the delivery of telemedicine services in rural or under-resourced communities.

4.6. Limitations

The limitations of this study are as follows: there is a strong likelihood that publication bias will occur because successful program studies are more likely to be published; there are limited long-term satisfaction studies available to assess participant satisfaction over time with most studies being completed within 12 months of the study; there is heterogeneity in the types of tools used to measure satisfaction; many of the qualitative studies had small sample sizes; and active participants were likely to have participated in the survey more often than inactive participants.

4.7. Research Gaps

There are significant gaps that need to be addressed by future research such as conducting longitudinal assessments of participant satisfaction (greater than 24 months) after they begin a study; comparing the effectiveness of various implementation methods to enhance participant engagement; assessing the cost-effectiveness of participant engagement interventions; and qualitative research examining the reasons why participants discontinued their participation in studies that included an assessment of participant satisfaction.

5. CONCLUSION

Although patients have shown strong interest in using telemedicine to treat their hypertension and report very high levels of satisfaction, much work remains before telemedicine can be considered to have fully realized its potential to improve access and user convenience for all groups in society. Barriers to achieving the goal of equitable, long-term use include increasing digital skills, raising awareness of the collection and dissemination of patient data, improving the relationship between patients and physicians, and enhancing coordination and communication across the entire health care system. As such, it is critical that all strategies to implement telemedicine recognize the inequities in adoption rates among older adults, individuals with lower incomes, and those who are less likely to have the digital skills required to use telemedicine effectively. Therefore, the design of telemedicine should be patient-centered; the providers of care should receive adequate support for their role in telemedicine; and an integrated approach that provides both the convenience of technology and the value of human interaction should be implemented to translate telemedicine's potential to improve outcomes into concrete improvements that are fairly distributed throughout society.

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Authors' Contributions

Sara Steć: Conceptualization, literature search, study selection, data extraction, writing original draft, supervision

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Lidia Kulig: Quality assessment, editing

Julia Malec: Data synthesis, editing

Piotr Dryżałowski: Literature search, study selection

Bartłomiej Wójcik: Data extraction, methodology

Katarzyna Czajka: Conceptualization, resources

Julia Borodacz: Literature search, data extraction

Martyna Czampiel: Data extraction, writing, review, and editing

Michał Nawracaj: Writing—review and editing, final approval

Katarzyna Zadrozna: Writing—review and editing, supervision

Natalia Syncerz: Writing—review and editing, supervision

Informed consent

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Ethical approval

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Conflict of interest

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Data and materials availability

All data associated with this study will be available based on the reasonable request to corresponding author.

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