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Digital Leadership and Strategies to Transform Post-Surgical Transition of Care (TOC)

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Abstract

Healthcare organizations are encountering increasing complexity as they extend care beyond clinical settings into the broader patient ecosystem to improve outcomes and reduce costs. This complexity arises from the growing involvement of external partners and patients in co-producing both treatment practices and services as a part of their community engagement models. Complexity theory suggests that organizations must engage in administrative, enabling, and adaptive leadership processes. *Enabling leadership* explores and evaluates new services to meet the strategic vision and goals set by *administrative leadership*, such as improving patient outcomes and reducing the cost of care delivery. *Adaptive leadership* assesses these ideas for their viability in supporting the vision. *Digital leadership* represents an enabling leadership process that leverages technologies in the design of new services being explored. This prompts the central question: How can digital leadership be operationalized to support a community model?

This paper proposes a methodology encompassing four core steps: need identification, idea generation, exploration, and evaluation. The *need identification* phase involves mapping the service pathways currently used to address organizational goals and assessing gaps in these services. The *idea generation* phase draws on established innovation methods to develop new services for exploration. The subsequent steps—*exploration* and *evaluation*—are intended to assess the effectiveness of proposed services prior to their adoption by the organization. We will use inter-organizational dynamic model research to define the roles of providers, patients, and partners in shaping service paths, as well as prior research on innovation methods to generate solution ideas for addressing service gaps. We will illustrate the first two phases of this digital leadership methodology, demonstrating how it can be used to improve transition of care (TOC) following the discharge of surgical patients through a case study of a healthcare organization. The paper will conclude with a discussion of future research directions, including an evaluation of the service ideas proposed for the case discussed.



Key words: Inter-organizational community model, patient readmission, Transition of care, Innovation, Relationship governance, Resource orchestration, Case study

1. Introduction

Unanticipated patient readmission after discharge often indicates suboptimal quality of care, inadequate patient education, and challenges patients face when transitioning from hospital to home¹. Multiple programs to reduce hospital readmissions have been introduced in the U.S. since the Affordable Care Act (ACA) prompted the Centers for Medicare and Medicaid Services (CMS) to initiate reimbursement penalties. These efforts, part of the Hospital Readmission Reduction Program (HRRP), aim to both improve patient satisfaction and reduce relatively high hospital readmission rates.

A review of readmission studies has identified several common preventable factors, including poor decision-making regarding admissions and readmissions, failure to relay important information to outpatient providers, premature patient discharge, and inadequate care-related discussions with patients suffering from serious illnesses^{2,3,4}.

Healthcare institutions have been implementing various strategies to reduce hospital readmissions, including care transition programs, medication reconciliation, patient education, care coordination, addressing social determinants of health, prompt follow-up, and engaging patients' family members⁵. There is increasing recognition that as institutions develop strategies to extend care into the patient ecosystem, they must co-produce the design of transition-of-care services with patients and partners. This ensures that services are both adhered to by patients and supported by external partners, just as treatment practices are co-produced with patients and families prior to admission⁶.

Such co-production of services becomes even more critical for patients at high risk for readmission (e.g., those with CHF, COPD, DM), where social determinants significantly influence adherence to symptom management and follow-up. Enlisting the support of social and community groups, including family members, and incorporating them into the coordinating team for both education and symptom management is considered an essential part of TOC strategy⁷. The organization and timely communication of information with clarity, particularly after surgery, when diverse members from various organizations provide both clinical and non-clinical support, are

inherently complex, especially when the TOC for such patients is dynamic and continually evolving.

Complexity theory suggests that organizations operating in dynamic environments move between stability and instability, or function within a state of "bounded instability," by continually adapting to evolving conditions through multiple leadership processes: administrative, enabling, and adaptive^{8,9,10}. While administrative and adaptive leadership processes help maintain organizational stability, enabling leadership processes allow organizations to venture into regions of instability by generating ideas and exploring their viability. In re-envisioning TOC post-surgery, there is a need for entrepreneurial leaders within surgical administration to act as champions, advancing new ideas that may conflict with the existing TOC model, and for enabling leaders to create the space and conditions necessary to explore these ideas by surfacing tensions and triggering the emergence of new solutions, as postulated by research on organizational adaptability¹¹. Given the prominent role of technology in today's healthcare environment, enabling leadership is increasingly understood as digital leadership. The goal of digital leadership, therefore, is to design digital platforms that connect clinical and non-clinical organizations and enable them to collaboratively explore solutions to the complex TOC challenges faced by high-risk patients after discharge.

Inter-organizational dynamic capability (IDC) research argues that no single organization can act as the sole focal point to manage the complexity of supporting the customer purchase journey; instead, a mix of organizations must coordinate this journey and develop both relationship governance and resource orchestration capabilities to remain competitive¹². This means that those engaged in the digital leadership of TOC must determine who among the mix of providers, partners, and patients (referred to as community models) will function as the focal organization to coordinate TOC activities. In cases involving multiple TOC activities, some may be coordinated by providers as focal organizations, while partners may lead others. Also, the gaps in services designed to support TOC and the solution ideas explored to address these gaps may originate from any of the partnering organizations.

This prompts the central question: What digital leadership processes are employed by the community model to generate and explore ideas that address evolving patient health needs and challenges in support of TOC?



This paper proposes a methodology to identify gaps in services used to support TOC and discusses the role community model partners can play in exploring solutions. The evaluation and adaptation of these ideas are addressed as part of future research. The paper is organized as follows: Section Two draws on prior research on patient readmission to identify best practices and prototypical TOC activities that inform the design of service paths connecting patients with providers and partners. Section Three discusses the role of community models in designing services that support TOC activities and the capabilities that coordinating focal organizations need to support these services. Section Four presents a case study illustrating how a healthcare organization coordinates TOC activities through multiple service encounters with patients. Section Five explains how innovation methods can be used to identify service gaps and generate solution ideas for future evaluation. Section Six offers discussion and directions for future research. Section Seven provides some concluding comments.

2. Research in Readmissions

When the Affordable Care Act was passed into law in 2010, the Hospital Readmissions Reduction Program (HRRP) was established to reduce payments to hospitals for heart failure patients who are readmitted within 30 days of discharge. The program called for comprehensive care transition initiatives to improve patient outcomes and reduce readmissions, including patient education, medication reconciliation, and timely follow-up appointments¹³. However, it is crucial that each health system tailors its readmission strategies to specific patient health conditions, such as heart failure, to ensure they are both cost-effective and capable of improving patient outcomes and overall health system performance¹⁴.

These strategies must be *comprehensive in nature* and may involve *multi-component interventions and interdisciplinary teams*, including patients, appropriate technologies, and external partners. For example, both hospital and post-acute care strategies for older adults with common cardiovascular conditions have incorporated multimodal interventions, multidisciplinary teams, and frequent longitudinal contact¹⁵.

Multi-component interventions consist of a combination of strategies tailored to address distinct patient needs. For example, a bundled care intervention for ischemic stroke patients included timely completion of discharge summaries, home care referrals, and

post-discharge telephone calls¹⁶. Project RED (Re-Engineered Discharge), by contrast, incorporates patient education, clinical follow-up, contingency plan reviews, written discharge instructions, and engagement of post-care providers for specific interventions¹⁷.

Multi-disciplinary teams – internal to the health system: Teams of clinicians have implemented high-intensity, multicomponent interventions to reduce all-cause readmissions among patients with heart failure. These interventions include patient education focused on heart failure self-care, pharmacotherapy emphasizing medication adherence, face-to-face follow-up after hospital discharge, systems for post-discharge medication adjustments, and streamlined communication channels such as patient hotlines¹⁸. Similarly, Project BOOST (Better Outcomes by Optimizing Safe Transitions) strengthens hospitalist programs to reduce care fragmentation through education, motivation, process improvement, and improved communication with patients about palliative care. This addresses both symptom management and psychological support needs, regardless of physician specialty¹⁹.

Multi-disciplinary teams – external to the health system: Some external partners can include *nursing professionals*. For example, one readmission reduction strategy involved hospitals partnering with community physicians and other hospitals to support nurse-led medication reconciliation at both admission and discharge, arrange follow-up appointments before discharge, transmit discharge paperwork to primary care physicians, and assign hospital staff to follow up on outstanding test results after discharge²⁰. Another initiative used clinical nurse consultants to support patients with acute kidney injury (AKI) and exacerbations of congestive heart failure (CHF) through education and action plans, renal function blood tests one week after discharge, telephone contact, and medication adjustments²¹.

Some multi-disciplinary teams include *pharmacies*. For example, a pharmacy was made responsible for optimizing COPD inhalers and ensuring a 30-day supply of insurance-compatible inhalers. Other pharmacy-led efforts have focused on patient education regarding inhaler use, providing standardized discharge instructions, and scheduling 15-day post-discharge follow-ups²². Additional transition of care interventions led by pharmacists have included patient counseling and medication reconciliation²³. In interprofessional team-led COPD care bundles, pharmacists have also played a key role in managing outpatient medications and escalating maintenance therapy²⁴.

Patients as partners: Patients, through their education and self-management capabilities, can become an integral part of readmission reduction strategies. For example, in cases where patients are admitted with acute exacerbation of COPD, early recognition of symptoms and prompt treatment can be supported through patient education on self-management, which has been shown to reduce readmissions²⁵. Additionally, tailored self-management support focused on symptom management is recommended for patients admitted with dyspnea and cardiac disease symptoms, enabling them to better respond to increased exacerbation symptoms²⁶.

Other external partners: Additional external partners that can support education, medication counseling, and outpatient follow-up include caregivers, home-based service providers (e.g., home visits), specialized care providers (e.g., ambulatory care centers managing mental health conditions), community-based organizations, and other healthcare partners. One example is the CMS-supported Community-based Care Transitions Program, which fosters partnerships between acute care hospitals and community-based organizations²⁷.

Care facilities other than home: These facilities include acute care hospitals, skilled nursing facilities, long-term care facilities, long-term acute care hospitals, and assisted living facilities²⁸. When patients are discharged to post-acute care facilities, recommended multicomponent interventions include enhanced communication, medication safety protocols, advance care planning, and comprehensive training on managing common medical conditions that often contribute to readmissions²⁹.

In summary, to support these efforts, Burke et al. [7] identified the following TOC activities that contribute to an ideal patient transition:

- Discharge planning
- Complete communication of information
- Availability, timeliness, clarity, and organization of information
- Medication safety
- Educating patients to promote self-management
- Enlisting the help of social and community supports
- Advance care planning
- Coordinating care among team members
- Monitoring and managing symptoms after discharge
- Outpatient follow-up

In support of all these efforts, there has been considerable discussion on the role technologies play in

influencing patients' ability to manage their health, engage in telehealth consultations, and use wearables to support remote tracking of health data³⁰. While remote monitoring technologies have shown promise for diagnostic interventions for patients discharged to home, it is important to acknowledge the greater ambiguity and contextualization required in interpreting vital signs. A balance must be struck between the accuracy of data and its acceptability before accelerating acute care transitions to the home setting³¹.

While the use of penalties for hospital readmissions led to an increased emphasis on TOC post-discharge, these efforts did not always appear to stimulate improvements in the quality of care for patients with COPD inside hospital³². Some of this may be a by-product of viewing readmission efforts as distinct from the clinical workflows used to support patient care within the hospital. In fact, research on readmission strategies has called for interventions that are integrated into clinical workflows and that use default options (opt-in unless declined), rather than voluntary actions, such as making discharge planning include the patient setting up their first follow-up appointment post-discharge³³ or requiring them to sign into a patient portal to check their prescription information. Improving the knowledge of frontline clinicians and exploring viable alternatives to hospitalization have also been suggested³⁴.

In summary, effective readmission strategies require both *multi-modal interventions* and *multi-disciplinary teams*—comprising both *internal* and *external* participants—to coordinate various TOC activities. Given the inter-organizational nature of these efforts, we will draw on inter-organizational dynamic capability (IDC) model research to explore how responsibility and accountability can be assigned across stakeholders to support readmission reduction efforts as a coordinated community initiative¹⁷.

3. Community Models to Support Transition of Care (TOC)

Designing services to tailor care to patient populations requires an understanding of their care journey. Service-dominant logic^{35, 36} argues that understanding the patient care journey, as with the customer purchase journey, requires multiple touchpoints to interact with and learn about patients as they seek access to healthcare and pursue their health goals. Since much of the patient care journey occurs within the broader patient ecosystem,

healthcare organizations need multiple touchpoints to engage patients and leverage external partners to create, fulfill, and assess the value delivered to patients. Specifically, providers require multiple opportunities to interact with patients and their families to co-produce treatment or preventive practices as part of value creation. More importantly, they need repeated points of interaction, not only between patients and providers but also with external partners, to co-produce services that support adherence to treatment practices, fulfill the value created, and gather feedback to assess gaps in patient health conditions or adherence ⁶.

Since our focus in this paper is on TOC, we will examine the touchpoints (or service encounters) used by healthcare organizations to design and coordinate services that fulfill value and gather feedback to assess gaps in TOC activities. For example, discharge planning may be coordinated by providers through direct interaction with patients, while medication safety is managed by providers interacting with both patients and partners, including primary care physicians and pharmacists. Monitoring and managing symptoms after discharge may be coordinated jointly by patients and providers, while outpatient follow-up may be coordinated by providers, partners, or both.

Dynamic capabilities theory suggests that an organizational strategy must integrate its own resources and competencies with those of its partners to meet the evolving needs of its customers ³⁷. To support this dynamism, organizations may adopt different inter-organizational dynamic capability (IDC) models to coordinate their services for customers. The choice of IDC model depends on the capabilities the organization can bring to support such coordination: relationship governance and resource orchestration ¹². IDC models may involve a single focal organization coordinating the services, joint coordination by a focal and one or more partnering organizations, or a network formed by all participating organizations.

Within healthcare, IDC models are referred to here as community models, unless they are fully coordinated by the provider organization (i.e., provider-centric: Q1 in Figure 1). However, often some TOC activities are provider-centric, while others are provider-coordinated with partner support. For example, discharge planning may be provider-centric but monitoring and managing symptoms after discharge can be coordinated by a provider with partner support (Q2 in Figure 1). In other cases, organizations may delegate some TOC activities to be

coordinated by a partner with provider support (Q3) or to a network that represents both providers and partners (Q4). For example, outpatient follow-up of cardiac patients can be coordinated by skilled nursing facility staff, with the provider lending some expertise to the SNF staff ³⁸, or diabetic patients who are asked to monitor their glucose levels using digital tools may be coordinated by a community organization, with the provider supporting them through technology and a telecommunications network to facilitate communication and consultation ³⁹. Less often, but when appropriate to address patients' social determinants of health and their evolving insecurities (e.g., food, transportation, etc.), a network model using an external agency may be chosen to coordinate patients' access to social services ⁴⁰, or even a public health agency to educate patients on self-management of diseases spread through infections.

IDC model research calls for two distinct capabilities: relationship governance and resource orchestration. While relationship governance involves the continual alignment of goals among participating actors in the model, resource orchestration focuses on designing an architecture or digital platform to support the communication of information and coordination of activities. Given the diverse challenges and competencies of patients pursuing their health goals, and the varying organizational and technological maturity of partners, community models chosen to support TOC require digital leadership to align the evolving goals of community model actors (as part of relationship governance) and lean management of

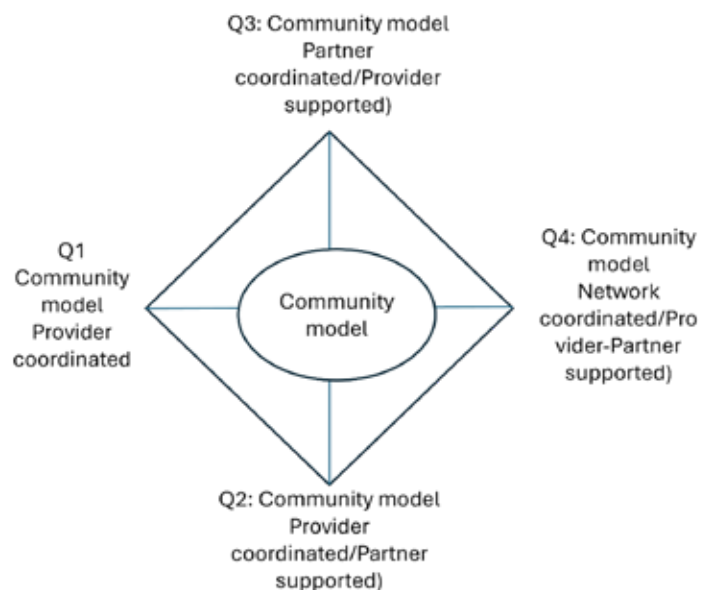


Figure 1: Community Models to Support TOC

resources, using technology when appropriate, to support resource orchestration. A methodology to support digital leadership of community models used for TOC is discussed in Section 5.

Before discussing this methodology, we will re-organize the TOC activities from the previous section (as shown below) and indicate which community model type may often be used to coordinate these activities. The TOC activities are renumbered for clarity. For example, TOC activities #1 to #4 may use community models described in Q1 and Q2 (provider-centric or provider-coordinated), while TOC activities #5 to #7 may use community models described in Q1, Q2, or Q3 (coordinated by providers or external partners, including patients). TOC activities #4 and #5 may also use a network model (Q4). Regardless of which type of community model is used to coordinate TOC, all must address the last three TOC activities (8 to #10) by developing their dynamic capabilities: relationship governance and resource orchestration (discussed next).

1. Discharge planning
2. Medication safety
3. Advance care planning
4. Enlisting the help of social and community supports
5. Educating patients to promote self-management
6. Monitoring and managing symptoms after discharge
7. Outpatient follow-up
8. Coordinating care among team members
9. Complete communication of information
10. Availability, timeliness, clarity, and organization of information

3.1 Dynamic Capabilities to Support TOC #8 to 10

Relationship governance to support TOC #8

Network theory argues that inter-organizational actors in complex networks weigh three dualities when making trade-offs before participating, assessing their interest in specific activities against their overall goals⁴¹. To support these trade-offs, focal or coordinating organizations must reduce the social and technical constraints that limit members' ability to participate in the collaboration and share in its benefits, both individual and shared. Moreover, each participating member engaged in TOC activities should be assigned clear responsibilities to influence the network's outcomes, along with defined metrics that hold them accountable for achieving those outcomes.

Resource orchestration to support TOC #9 and #10

Communication theory argues that members collaborating to achieve shared goals should define the network themselves, rather than having a pre-defined network imposed to support communication⁴². For example, requiring all coordination of TOC activities to occur through a provider's EMR (electronic medical record) or extended EMR may limit some partners' ability to effectively support the TOC activities for which they are responsible (e.g., activities 4, 5, 6, or 7). To keep such a communication network dynamic, an agile digital platform is needed, one that can coordinate all TOC activities (1 through 7), accommodate a mix of coordinating organizations, and enable the timely, clear, and complete exchange of information with those who need it.

The next section presents a case study illustrating how a healthcare organization's community model coordinates TOC activities and identifies potential areas for improvement, before discussing the role of digital leadership in generating ideas for exploration.

4. Leadership to Support Transition of Care (TOC) Strategy

The previous sections discussed how health systems have begun to use a service lens to co-produce value with patients in the design of treatment practices and to co-produce services that improve patient adherence to these practices as part of transition of care (TOC). The case study in this section focuses on the strategy used to coordinate TOC to reduce hospital readmission costs and improve patient care quality. Addressing the complexity of care delivery within the patient ecosystem requires both administrative leadership to design a TOC strategy and enabling (digital) leadership to continually assess the current strategy, identify gaps in services, and explore solution ideas for future evaluation, particularly in today's dynamic environment of evolving patient expectations and technological advances. This section will discuss the current TOC strategy, while the next will begin to generate ideas for future exploration and evaluation.

A brief discussion of the health system

McLaren Health Care Corporation, headquartered in Grand Blanc, Michigan, is a large health system that includes 13 acute care hospitals in Michigan, along with ambulatory care centers and imaging centers, serving both urban and regional patients populations living in Michigan and Indiana. McLaren operates Michigan's



largest network of cancer centers and providers, anchored by the Karmanos Cancer Institute, one of only 57 National Cancer Institute-designated comprehensive cancer centers in the U.S. With a network of 2,700 providers, employed and independent, both specialists and primary care physicians, it supports transition of care for patients post-discharge using a centrally based care team. This care team interacts with about 600 patients per week post-hospital discharge with chronic conditions including health failure, COPD, and stroke

The case study especially looks at the services designed by the care team to support transition of care of patients who suffered heart failure, and how the digital leadership methodology can be used assess potential gaps in services and generate ideas for exploration and evaluation. The TOC activities discussed here have incorporated multiple patient touchpoints, or service encounters, to engage patients as a part of post-discharge care transition. It has employed a mix of personal and automated interactions to gather feedback aimed at supporting the shared goals of improving care quality and reducing readmission costs. We will refer to the TOC activities listed in the previous section as we discuss each of these service encounters.

Discharge Instructions

As in other traditional discharge programs, the discharge instructions include several types of information communicated to patients. The document can be categorized into general patient and provider information, discharge diagnosis, immunizations administered (A), instructions on follow-up activities (B), discussion of medications (C), and notes on how to manage symptoms (D). While most of these elements are standard across patient populations, the symptom management section here is tailored to CHF patients and may vary for patients with other health conditions. Specifically, the discharge instructions combine several TOC activities (1, 2, 6, and 7).

For example, the discharge instructions include follow-up appointments, the care coordination process, future appointments with providers, lab orders, radiology, and nutritional information (TOC #7). They provide a complete medication list, including new prescriptions, medications that have not changed, and others with time limits, along with clarifications and instructions on how to take them (TOC #2). It includes follow-up instructions on symptom management for CHF patients (TOC #6). Specifically, it uses the BEFAST method, which instructs

patients to monitor for signs of physical challenges or discomfort in their balance, eyes, face, arms, and speech, and to recognize when it is time to call for emergency help. Additional symptoms to watch include chest discomfort, headache, nausea, seizure, and confusion. Education on fall risk outlines the symptoms to look for, where falls can occur, and what questions to ask a provider. The behavioral and mental health education section advises patients to watch for warning signs of depression, suicidal thoughts, mood changes, and related issues, and to seek help from family or friends, contact support services, or call 911 (TOC #5).

Even when the information is provided to patients prior to discharge, whether verbally or in hard copy form, based on patient preference, many of the concepts are reinforced throughout the hospital stay through multiple touchpoints with the care team. This repetition helps ensure patient understanding and retention. Following discharge, the hospital continues to engage patients through multiple service encounters coordinated by an interdisciplinary care team.

Remote patient monitoring system

One of the key post-discharge service encounters is patient enrollment in the MyCare remote patient monitoring (RPM) system. The system uses an algorithm to present patients with a series of symptom management questions, to which they respond by selecting one of the provided options. Questions focus on detecting conditions such as dyspnea, edema, weight changes, and physical fatigue. When responses indicate that a patient's condition is outside the acceptable range, the system generates alerts, ranging from yellow to red, which prompt different levels of response from the care team (discussed next). This supports TOC #6. The technology uses automated phone calls or SMS text messages, enabling timely data collection to help improve patient outcomes.

Outreach to patients based on alerts

Patients who trigger a red alert are contacted within two hours, while those with yellow alerts receive a message instructing them to contact the care team within three business days. Up to two contact attempts are made. These interactions focus on disease management, medication, and symptom management, contacting the provider when necessary, and sending referrals to care management services as appropriate. This supports TOC #6 and #7. The technology used includes phone calls and SMS text messaging systems.

Outreach to enroll patients in TCM (TOC #7)

The Transitional Care Management (TCM) outreach program is designed to:

- Assess patients' social determinants of health so a community health worker can be assigned for follow-up,
- Review care plan guidelines for CHF patients based on best practices,
- Assign a care team member to follow up within 72 hours (three business days) for high- or moderate-risk patients, as determined by LACE scores, and
- Schedule a follow-up appointment with a care provider.

Technologies used include phone calls and text messaging systems. Community health workers address social challenges, while primary care providers follow up with patients who do not enroll in the TCM program.

Outpatient follow-up on patients enrolled in TCM (TCM #7)

The goal here is to inform the patient about multiple symptoms they need to track (e.g., blood pressure, behavioral health, stress), multiple practices they need to engage in (e.g., taking medications, monitoring

weight, and managing their nutrition), and several activities they need to consider (e.g., reducing smoking, getting needed vaccines, thinking about palliative care), all as part of their TCM. During this follow-up, advance care planning (TCM #3) activities, along with other preventive health behaviors such as smoking cessation, are discussed. Technologies used to connect with patients include phone calls. Table 1 summarizes these observations.

In summary, the TCM strategy discussed in the case study uses multi-disciplinary team members and multiple interventions delivered through different service encounters with patients, supporting multiple TCM activities (1 to 7). The alignment of goals between patients and care teams from the provider organization in this case appears to result in about 65% of patients enrolling in the TCM program. The technology platform supporting communication between patients and providers—though limited to in-person interactions, automated phone calls, and SMS text messages—appears to primarily serve the provider-centric community model. However, leadership in a complex and dynamic environment such as TCM calls for continual assessment of service gaps and exploration of ideas for improvement using enabling or digital leadership. We will discuss this in the next section.

Patient Encounters	Service Goals	Brief List of Activities	Technology Used	Internal Staff	External Partners
Discharge instructions	Inform and educate patients on follow-up activities	Sharing of general information, discharge instructions and orders, medications, and follow-up on managing symptoms	In-person discussion in the provider ecosystem	Discharge team	Share it with providers?
Remote patient monitoring system	Help patients share information on specific conditions (weight changes, dyspnea, edema, physical stress)	Using an algorithm, ask patients multiple questions and provide options for responses to generate alerts for appropriate actions	Automated phone call or SMS text messaging system	TCM care team	
Outreach to patients based on alert status	Address patients with high-risk alerts	RN will schedule a call with patients who are classified as high risk. Those who are low to moderate risk are asked to schedule a conversation.	Phone call and an SMS text message	RN and other clinical personnel	Providers and referral care management services
Outreach to enroll patients in TCM	Enroll eligible patients to educate patients in follow-up activities	Contact patients for enrollment, ask them about social service needs, assign a community health worker (CHW) to address these needs, assign a team member to discuss follow-up practices, and schedule follow-up physician appointment	Phone call or text messaging	TCM staff	Providers and community health workers
Outpatient follow-up to discuss symptom management	Educate patients on symptoms to track behaviors to follow and/or avoid	Contact patients and discuss guidelines developed to manage symptoms and engage in good behaviors	Phone call	TCM care team assigned to patients	

Table 1: TOC activities supported by the current TCM strategy

5. Digital Leadership to Support TOC Transformation

As a part of this research, the proposed gaps are not explored in depth for generating and evaluating these ideas for viability. So, we will draw on knowledge of practices used by other organizations to begin formulating questions about current services and identifying potential gaps that warrant investigation. These gaps can serve as the basis for generating new ideas. In this section, we will examine four innovation methods that have been widely used to develop solutions addressing gaps in organizational performance and consider how they might provide a starting point for idea generation in the case discussed here. These innovation methods include:

- **Out-of-the-box thinking using brainstorming or best practices:** Generate ideas by drawing on prior research in healthcare or other fields, or by identifying best practices from research or proven approaches used in similar organizations.
- **Personalization:** Tailor services to address the distinct needs of different population groups.
- **Lean management/optimization of resources:** Leverage process redesign and technology to reduce the resources required to support services.
- **Strategic sourcing:** Delegate activities to those who are most effective in achieving the desired outcome.

Technologies may also be used to support customization by analyzing data and facilitating the communication and coordination of activities when TOC activities are

sourced to external partners. We will briefly review the service encounters discussed in the case study, reflect on the implied methods of innovation used in the implemented solutions, and pose questions to potentially identify gaps (shown in Table 2). Later in this section, we will apply the innovative methods discussed above to generate potential ideas to address these gaps. As noted earlier, assessing gaps and generating ideas to address them is the first step in digital leadership.

Discharge instructions – Ideas for exploration

Currently, the discharge instructions are developed based on best practices (as discussed in the previous section by mapping them to several TOC activities) and are provided to patients in hardcopy form to take home.

Extension of best practices: Other practices suggested in the literature discussed earlier include engaging additional external partners, such as pharmacists, in discussions related to medications, as well as outside providers and/or family organizations that support patient adherence to follow-up activities. The use of an interprofessional team comprising hospital staff and external partners has been recommended³³.

Strategic sourcing: Allowing patients to set up their first follow-up appointment prior to discharge might help them begin practicing their follow-up activities.

Use of technology to support personalization and possible optimization of staff resources: Providing a copy of the discharge instructions in electronic form for patients to download to their tablet or mobile phone, in addition

Patient Encounters	Service Goals	Internal Staff	Implied Use of Innovation Method	Questions to Ask to Support Further Investigation of Potential Gaps Prior to Generating Ideas for Exploration
Discharge instructions	Inform and educate patients on follow-up activities	Discharge team	Best practices	Are there other practices that can improve patient adherence, including broadening the engagement of those who influence their practice adherence?
Remote patient monitoring system	Help patients share information on specific conditions (weight changes, dyspnea, edema, physical stress) using opt-in option	TCM care team	Technology to support resource optimization	Are there other ways to engage patients or learn about their barriers and sustain their engagement to track their health conditions?
Outreach to patients based on alert status	Address patients with high-risk alerts	RN and other clinical personnel	Personalization	What if those with moderate alerts do not call in to report their condition? What feedback is received from providers and referral agencies?
Outreach to enroll patients in TCM	Enroll eligible patients to educate them on follow-up activities	TCM staff	Strategic sourcing	What population did not enroll in the program and why? What role can family or community organizations play in patient enrollment? What feedback does the CHW provide on patients?
Outpatient follow-up to discuss symptom management	Educate patients on symptoms to track behaviors to follow and/or avoid	TCM care team assigned to patients	Best practices	Who else can be included to inform and educate patients on symptom management?

Table 2: Posting questions to assess service gaps

to a hard copy, may give both patients and caregivers the opportunity to review the information at their convenience and ask questions when the care team contacts them. Tailoring discharge instructions for each patient on their MyCare portal, or providing an AI chatbot that references this document to answer patient questions at any time, may further assist those with technical capabilities or smartphones in learning about symptoms discussed for CHF patients, such as fall risk, mental health concerns, chest discomfort, and stress.

Remote patient monitoring -- Ideas for exploration

Currently, phone and text options are used to track certain patient health conditions, categorize them into low-, moderate-, and high-risk alerts, and follow up with patients with high-risk (red) alerts. Those with low to moderate risk are asked to contact the care team within a few business days.

Personalization and technology: An analysis of patients' responses to the questions using RPM may help identify those who use it regularly, occasionally, or very infrequently, and support discussions on the factors contributing to or hindering their use. Based on these insights, one can explore best practices on how patients use telehealth or text-based messaging systems to ask questions and engage in consultations, allowing features of the RPM technology to be extended to accommodate potential interactions to address their health and social concerns.

Strategic sourcing: More importantly, some of the patient's questions can be directed at community health workers so they can address these concerns. Similarly, certain patient responses related to physical exhaustion or lack of sleep can be shared with the patient's family or caregivers for home-based support, even if these issues do not trigger high-risk alerts.

Technology: Today, there are technologies available that connect a weight scale to an app, allowing a patient's weight to be tracked at home and transmitted to the remote care team. Such automatic tracking can analyze changes in weight gain and automatically trigger alerts based on the patient's health condition⁴³.

Outreach based on patient alerts – Ideas for exploration

As discussed earlier, if patients with low to moderate alerts do not contact the care team, what factors are contributing to their lack of response to the push message sent?

Strategic sourcing: Can these messages also be sent to select members of the patient's care team at home (family or caregivers) so they can follow up on the symptoms? Can the community health worker follow up with some of the patients who are not responding to identify any barriers that can be addressed? Often, patients are connected to peers who can encourage participation in preventive behaviors. If the barrier to participation is lack of motivation, can patients relate to peers to encourage their engagement?

Best practices using technology: When the clinical care team or specialists are used to address patients whose health condition has led to high-risk alerts, what preventive or follow-up practices are used to address their condition? Can these be collected as part of a knowledge base for the care team to learn from and incorporate into symptom management in the future?

Outreach to enroll patients – Ideas for exploration

While all patients who are discharged are provided with similar discharge instructions, currently only about 65% of the eligible patient population enrolls in the TCM program to support care team follow-up. One question to investigate is the reason for non-participation.

Best practices: Focus group or brainstorming discussions with non-participants can generate ideas for potential process improvements. Often, patients have difficulty finding time to respond to phone calls after discharge, making it challenging to reach and enroll them in the program. Some practices have suggested having patients sign up for such programs while they are still in the provider's office prior to discharge³³. Therefore, enrolling patients in the TCM program before discharge may be a viable idea to explore.

Strategic sourcing: Assigning the responsibility for enrollment outreach to patients' family members, community organizations, or a regional social worker may improve program participation rates. Peer engagement, as discussed earlier, can also help convey the benefits of participation to those who are reluctant. While community health workers are assigned to address social determinants of health, patients may not always disclose their needs or may not feel the need to seek resources at the time they are contacted. Providing patients with access to a portal from an organization that offers information on social support or enabling them to reach a community health worker via text messaging when assistance is needed, can facilitate just-in-time service.

Personalization: While phone or text messaging is currently used to contact patients for program enrollment, alternative mechanisms could be offered, such as allowing them to sign up through a web portal or an app at a time that is convenient for them.

Outpatient follow-up – Ideas for exploration

Today, the care team sets up phone calls to follow up with patients and discuss several symptoms they need to manage and behaviors they should follow. Multiple community strategies discussed in the literature argue for the use of external partners, especially those in the patient community, to engage in patient follow-up as a partner or to identify potential barriers patients face that need to be addressed to mitigate this gap^{44, 45, 46}.

Strategic sourcing: Given the number of areas patients are asked to follow up both in the discharge instructions and in symptom management discussion decisions may be made regarding which parts of the outpatient follow-up can best be delegated to family caregivers, primary care providers, pharmacists, or community organizations. Based not only on patient challenges but also on their competencies, as discussed in social diagnosis research classification, it may be possible to leverage the patient as a partner in their own self-management, depending on their role, reaction to the disease, relationships, and resources they possess⁴⁷.

Use of technology: With the growing use of technology and its ability to help patients track their health conditions and communicate with both providers and their community, one might explore the viability of expanding some aspects of outpatient follow-up by connecting them to the MyCare remote patient management system. The goal is not only to generate alerts to address serious health conditions but also to engage and empower patients with tools and knowledge to identify and access the resources they need.

Customization: With patient satisfaction and the reduction of readmissions being central drivers in TOC, surveying patients on their capabilities and willingness to self-manage certain follow-up activities could help identify opportunities to tailor TCM activities to better support distinct patient needs.

In summary, while ideas can be surfaced through research on best practices, customization of services to address distinct needs, optimization of resources through redesign and/or technology, and sourcing certain activities to external partners, these ideas must be explored

by leadership for their economic, social (patient or partner acceptance), and technical viability. The next section will discuss this as the next step in the digital leadership methodology.

6. Discussion on Idea Exploration and Directions for Future Research

In the two previous sections, we discussed how one TOC strategy used by a health system to support patients post-discharge can be analyzed and how to begin generating ideas for exploration by asking in-depth questions about each service. Viewing the TOC strategy in the case at a higher level of granularity, we can classify the TOC activities into three categories: those that occur inside the hospital prior to patient discharge but influence TOC (discharge instructions); those that occur in the patient ecosystem to track health conditions for anomalies (MyCare RPM and follow-up of high-risk alerts); and those that address practice adherence (enrollment in TCM, education on symptom management, and outpatient follow-up).

Using the taxonomy of inter-organizational community models discussed in Section 3, we can view the discussion of discharge instructions as part of the community model in Q1 (provider centric), and remote patient monitoring using MyCare as provider coordinated and partner supported, with referrals to care management service providers (Q2). Most of the TCM activities related to program enrollment and outreach to educate patients on symptom management also appear to be provider coordinated and partner supported (Q2), with partners including primary care providers, community health workers, and potentially family members. However, as discussed in the previous section, multiple ideas for exploring TCM activities that support adherence practices involve community models that are partner coordinated, and provider supported (Q3). This leads us to assessing the viability of these ideas as potential areas for ongoing study and directions for further research. We will briefly discuss these below and summarize them in Figure 2.

Redesign discharge instructions (DI) (TCM #1 in the hospital): Explore the viability of using inter-professional teams with external partners, such as pharmacies and community members, to encourage follow-up with patients. Tailor DI distribution using different technologies (hardcopy, portal, app) based on patients' technical capabilities and their ability to review and ask questions

for clarification. Ask patients to set up their first follow-up appointment while they are still in the hospital so they can begin their TCM journey. While such a redesign remains within the provider environment, it allows for strategically sourcing some activities to patients while in the hospital, engaging the patient community in certain education and follow-up activities, and leveraging technology options to engage and empower patients in self-managing their health post-discharge.

Expand remote patient management (RPM) (health condition monitoring under TCM #6 and #7): Extend RPM, when feasible, using wearables, sensors, or apps that can automatically track and transmit health data. For example, patient weight can be monitored via connected scales and sent automatically to the care team. Tailor interactions for low- to moderate-risk patients to include clinical consultations using different technologies—such as app-based text messaging or telecommunication through the MyCare portal—with hospital staff or local partners (e.g., community clinics, nursing partners, or primary care providers). In this model, consultations for low- to moderate-risk patients would be coordinated primarily by partners, with support from the TCM care team, effectively operating within a Q3 community model.

Redesign TCM enrollment and follow-up (practice adherence monitoring under TCM #2–#7): Tailor service pathways to reach patients who are not enrolling in the TCM program by engaging patient advocates or family members, and by offering enrollment options through apps or portals at the patient’s convenience. Source portions of the enrollment, follow-up, and symptom-management education to external partners (such as caregivers, community clinics, or community health workers) and provide them with digital resources to support their ability to answer patient questions. Develop an empathetic AI agent or chatbot to respond to patient inquiries, explain the importance of symptom tracking, and encourage healthy behaviors. Incorporate monitoring of the patient’s environment—such as proximity to a trusted physician or other partners, relationships with family and community, capability to use technology, and access to social peers—to better understand resource availability and help support distinct TOC activities.

Develop TCM community of practice (new TCM activity): Sustained patient engagement in following recommended practices often requires reminders, encouragement from peers, and timely answering of questions. Given the structured nature of many educational

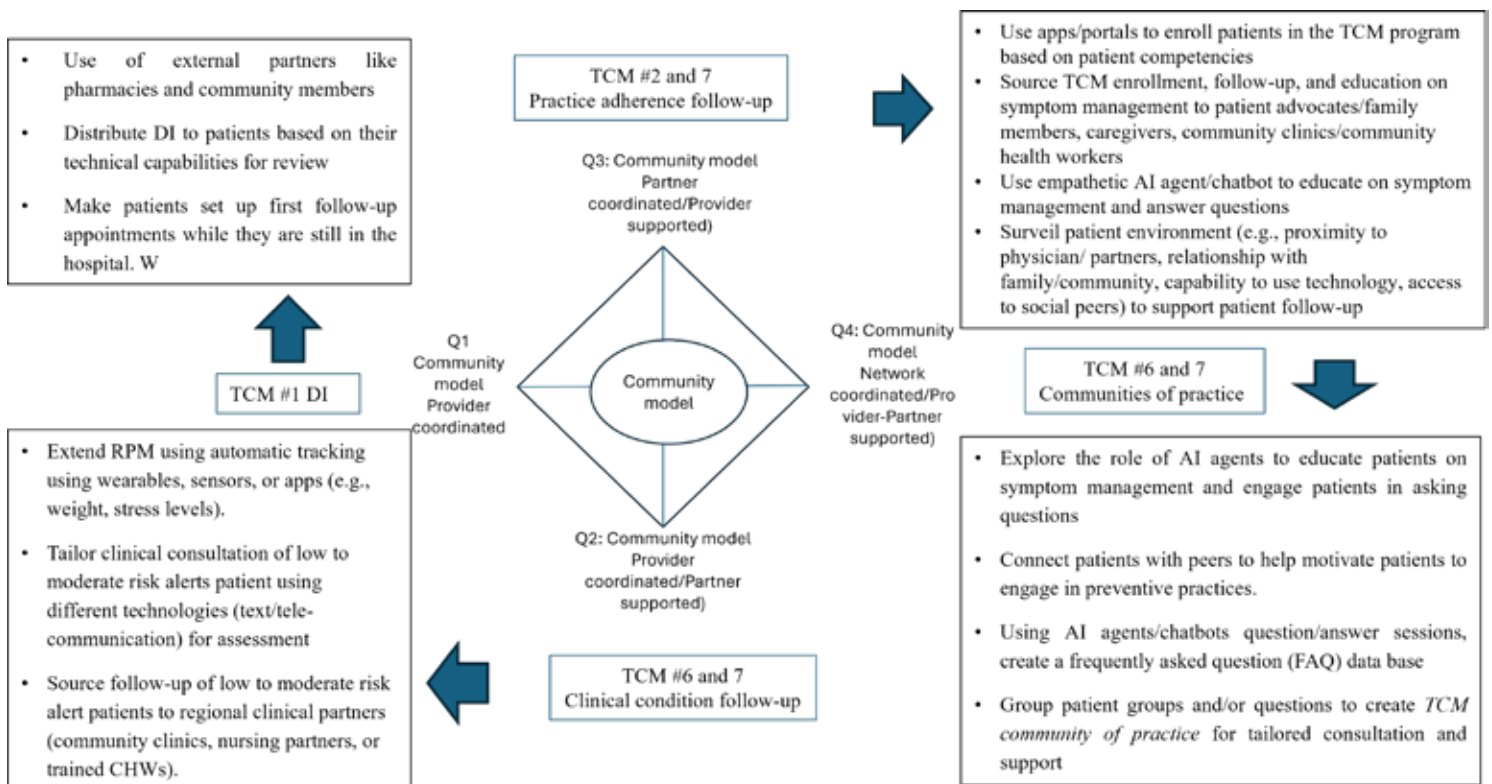


Figure 2: Ideas for Exploration and Evaluation

and healthy behavioral activities discussed in the case, the role of an AI agent could be explored to support such engagement and connect patients with peers who can help motivate adherence. AI agents or chatbots could also answer patients' questions using empathetic language, escalate complex inquiries to care teams, and track recurring questions to build a comprehensive FAQ knowledge base. In summary, AI could be leveraged to develop a *TOC community of practice* tailored to the needs of distinct population groups based on their health conditions.

In summary, these ideas are presented in Figure 2 below. While many suggestions are based on best practices and research, the role of leadership is to determine which are viable for further development and evaluation. More importantly, as discussed in Section 3.1, inter-organizational community models with external partner interactions need to develop relationship governance capabilities to align provider and partner goals, support shared patient outcomes, and utilize an integrated digital platform to orchestrate resources—in this case, to communicate information and coordinate TCM activities.

7. Conclusions

This paper proposed a digital leadership methodology to transform post-surgical transition of care (TOC) through a community-centered approach. By integrating complexity theory and inter-organizational dynamic capabilities, it highlighted how healthcare systems can coordinate provider, partner, and patient efforts to reduce hospital readmissions and improve patient outcomes. The case study illustrated a provider-centric strategy that incorporates multi-disciplinary teams, automated monitoring tools, and follow-up mechanisms already supporting several TOC activities.

However, to truly advance TOC transformation, healthcare organizations must adopt a more agile and adaptive leadership stance. This includes proactively identifying service gaps, engaging external partners, tailoring services to the distinct needs of patients, and leveraging digital tools to orchestrate resources across the care continuum. Strategic sourcing, customization, and technologies such as AI agents and remote monitoring platforms offer untapped potential to deepen patient engagement and enhance care coordination beyond the clinical setting.

Future research should evaluate the feasibility and effectiveness of the proposed service innovations in diverse community contexts, with particular attention to

relationship governance among stakeholders and the design of scalable, inclusive digital platforms that can adapt to the evolving needs of high-risk surgical patients. Ultimately, digital leadership grounded in co-production and community collaboration can enable healthcare organizations to reimagine TOC and achieve sustainable improvements in population health.

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