An Integrated Approach to Stakeholder Engagement

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Introduction

The Wait Time Information System (WTIS) project was a complex change-management initiative. For the first time in Ontario, wait time data would be captured directly from clinician offices and publicly reported in an effort to improve access to care. The change meant using new technology, new business processes and, most importantly, a new dimension of accountability for making improvements within the health system. Success required engaging thousands of individuals at all levels of healthcare, many of whom were skeptical and resistant to the upcoming change, and subsequently gaining their support and motivating them to use the WTIS and its data.

To achieve the level of stakeholder engagement that would be required to deploy and sustain the WTIS, the project team needed to address both the business reasons for change, and the emotional reactions to it. The team applied a three-pronged approach encompassing strong communications, compelling adoption efforts and hands-on training. Communication focused on awareness and education, ensuring that information was coordinated, consistent and transparent. Adoption efforts involved helping hospitals and users understand and prepare for the impact of change. Training provided hands-on practice to get people comfortable with using the system.

This article explores how information management/information technology (IM/IT) projects can integrate communications, adoption and training to drive stakeholder engagement.

It also provides insight around how, when used effectively, these functions can maximize limited resources and provide valuable benefits.

The Approach to Stakeholder Engagement

The WTIS project team approached stakeholder engagement using three steps (Figure 1): creating awareness (communications), building support (adoption) and making the change real (training). Importantly, these functions were executed

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using an integrated plan managed through a single Stakeholder Engagement Lead within the project leadership team. This differs from other projects or organizations, where communications, adoption and training are managed separately, often leading to inconsistent messages and a disconnected view for stakeholders. Through the course of each deployment phase,

Figure 1. The three components of successful stakeholder engagement
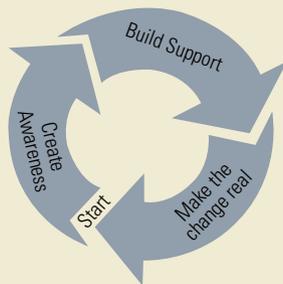
1. **Creating awareness** – Educate and generate momentum (Communications led)
2. **Building support** – Target stakeholder outreach (Adoption led)
3. **Making the change real** – Sustain new business processes (Training led)

there were stages where one function would lead and the others would support, as noted below.

This highly iterative approach relied heavily on lessons learned through each project phase to shape decisions and deliverables. As part of the project's Beta/Phase I, which deployed the WTIS in five hospitals, the project team learned that an integrated stakeholder engagement program reduced confusion and promoted clarity about activities and timelines. The support and involvement of key influencers and opinion leaders throughout the course of the project was also identified as critical in enabling the team to tailor its approach and messages to motivate change with various stakeholder groups. As a result, stakeholder engagement, post Beta/Phase I became increasingly important, and the project was able to leverage learnings to improve the process and program.

Strategic Levers to Support Stakeholder Engagement
In February 2004, an Ipsos-Reid/Ontario Medical Association poll found that most Canadian physicians reported feeling that their patients faced unreasonable delays in the areas of orthopedic surgery, diagnostic imaging, cardiac care and cancer treatment. There was recognition by hospital, clinical and Local Health Integration Network (LHIN) leaders that change was needed in order to reduce wait times and ultimately improve access to care. Also as a result of the Wait Time Strategy (the strategy), the Ontario government committed to start publicly reporting wait times across the province to create public accountability for performance improvements needed in the healthcare system.

The desire for change incented key influencers at various levels within the industry to be part of the project Steering Committee and Clinical Expert Panels (CEPs). These leaders provided guidance on how best to support the program and make it meaningful, particularly at the clinical level. They were

not just figureheads; they were willing to roll up their sleeves and work together to find solutions and options to support the deployment of the WTIS.

Another incentive for hospitals to participate in the strategy was funding committed by the federal and provincial governments. Initially, this funding helped bring stakeholders on board to use new business processes and the new system. In later phases, evidence-based improvements in wait times became an important part of the clinical engagement message.

1. Creating Awareness – Educate and Generate Momentum
This first step toward stakeholder engagement rested primarily with communications. From the Beta/Phase I experience, it was clear that stakeholders (hospital management, hospital project teams, clinicians and clinician administrative staff) needed to be fully aware of the WTIS and its purpose for successful adoption. As with any IM/IT project, however, delivery cost is a significant concern, and budgeting for a dedicated communications function is often not considered a priority. However, Sarah Kramer, Wait Time Information Strategy Lead, understood the cost/benefit
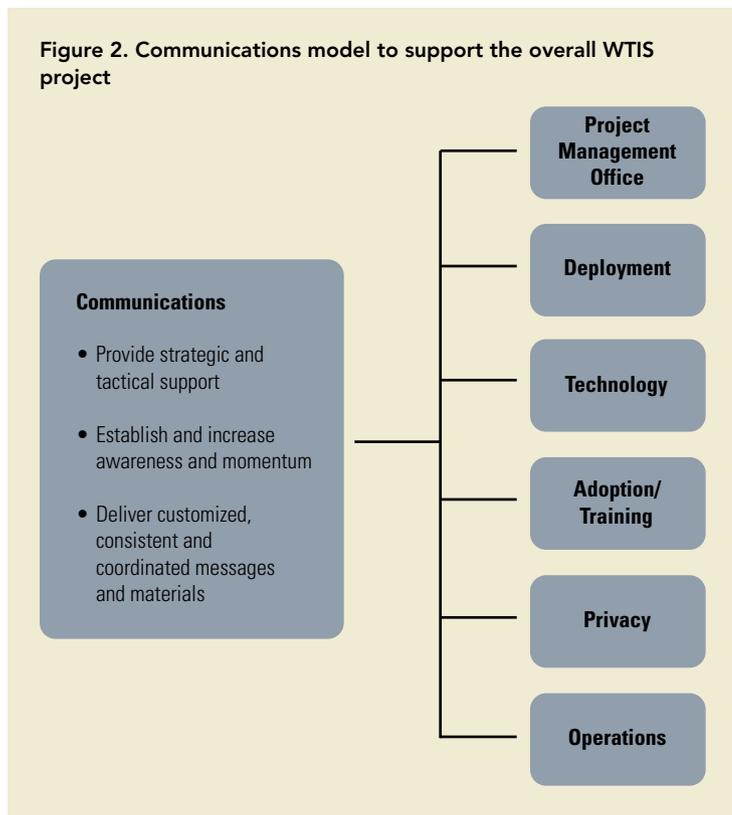
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trade-off between awareness and adoption, and made a strategic decision to ensure communications resources were available to the project. If the audience does not know what to expect and when, why it is important and what is in it for them, resistance will be high and adoption low. In the early stage of deployment, communicating high-level strategic messages was integral in helping to educate stakeholders and generate momentum for using the WTIS. As deployment progressed toward "go-live," communications became more tactical and messages focused on specific project work streams.

Embed Communications across the Project
The communications function operated under an agency model to support the project team. Like an agency, communicators were assigned major project work streams as "clients," working closely with them to create effective messages for their respective stakeholders. This role required communicators to intimately

Figure 2. Communications model to support the overall WTIS project

Communications

- Provide strategic and tactical support
- Establish and increase awareness and momentum
- Deliver customized, consistent and coordinated messages and materials

- Project Management Office
- Deployment
- Technology
- Adoption/ Training
- Privacy
- Operations

of plans and high-level messages. Being embedded, communications specialists also had a cross-functional view of activities and access to subject-matter experts; this was important in helping to tailor messages and providing timely, tactical support.

Focus on a Few Key Concepts

Recognizing that various stakeholders would be compelled by different reasons to change, the WTIS project team knew that a "one size fits all" approach to communications would not work. Message, delivery mechanisms and tactical activities needed customizing to account for unique perspectives and to achieve the level of engagement required across all stakeholder groups. At the same time, it was important to balance customization and consistency in messages, as well as cost-effectiveness. Recognizing this, the project team focused on a few key strategic concepts that would have the most impact and carry the weight for the program.

One of the first steps was developing an inventory and analysis of all stakeholders, capturing the specific needs, concerns and expectations of each group. Through this process, the team identified more than 20 stakeholder groups that would be touched by the WTIS. They then created and tested key messages with the various stakeholders.

From here, the project team sought credible "champions" to act as advocates of the program and as communications channels to deliver messages. These champions had to be known and respected leaders in the field who could influence and motivate change among their peer groups. For example, at the executive level, Dr. Alan Hudson, Access to Services and Wait Time Strategy Lead, Sarah Kramer, Wait Time Information Strategy Lead, were used to communicate directly with hospital and LHIN CEOs and CIOs. Clinical leadership messages came from members of the CEPs, who helped guide the development of province-wide standards and targets for the assessment of care and could speak to specific clinical issues by specialization. Clinician champions were also secured across the province and within individual hospitals to provide local support. The provincial clinician champions were available for information sessions and collegial discussions to support hospital clinical leaders in their clinician engagement efforts. Hospitals were also required to identify clinical leaders from within their facility as advocates for the WTIS. These local champions also provided important feedback to the project about how the field was responding to the deployment. The value of these early adopters and their endorsement was a key contributor to the successful adoption of the system.

With champions secured, the project team developed tactical

understand the challenges and issues facing both their client and stakeholder groups in order to provide proactive and effective strategic and tactical support.

Embedding communications supports within all facets of the project team was a new model for many project team members and required an adjustment period as new workflows

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and expectations were established. Some early success in the ability of communications to support issues management served to expand the function's role to that of strategic communications advisors (Figure 2).

Communications specialists' ability to provide strategic counsel was rooted in their exposure to and understanding of the activities, challenges and potential issues at all levels of the project. As a member of the project leadership team, the Stakeholder Engagement Lead was able to provide crucial insight and context from an overall program perspective to guide the development

Awareness Tactics
- WTIS information package and workshop to introduce Hospital PMs to the program
- Frequently Asked Questions documents addressing common inquiries and concerns and an online Question & Answer database for "self-serve" reference
- Testimonial posters using individuals at various levels within hospitals to endorse the program
- WTIS demonstration DVD with step-by-step overview of how the system works
- WTIS overview booklet with background on the importance of the system to the Wait Time Strategy
- Targeted stakeholder newsletters for regular project updates
- Locally planned and delivered WTIS information sessions that utilized communication material and support (presentations, speakers) provided by the project team

activities, materials and vehicles through which to deliver information. Communications materials were carefully crafted and disseminated on a schedule to various target stakeholders, with clear communication directions and suggestions. The team also ensured there was flexibility to communicate critical messages when needed. Champions were equipped with packaged materials to support their role in endorsing and advocating the project in the field.

Project Managers (PMs) within each hospital who were responsible for implementing the WTIS helped to streamline the distribution of project information to clinicians and customize materials for local needs. Hospital PMs became the single point of contact for clinicians seeking information on the WTIS. Filtering information through this single point of contact allowed the project team to ensure all communications remained consistent with the project's overall plan, goals and timelines.

Through the support of champions and Hospital PMs, the project team could use a cascading approach, where these individuals received information first and were tasked with disseminating messages and materials. This approach ensured that the right messages were delivered to the right people at the right time by the right person. A major emphasis was placed on ensuring hospital executives, Hospital PMs and other leaders were informed of any major decisions before they were communicated to front-line hospital staff or clinician offices. This allowed hospital leaders to anticipate questions and concerns and be prepared to support staff and other stakeholders when necessary. The WTIS project's internal team was also an inherent component of this cascading model. Project leaders kept internal team members well-informed, not only to secure their continued critical engagement in the program, but also to ensure they were equipped with current information

and prepared to respond with accurate and consistent answers if contacted by external stakeholders.

2. Building Adoption Support – Targeted Stakeholder Outreach
While the Communication component of the stakeholder engagement plan sought to create awareness of why the change was important, the Adoption component sought to create a receptive environment for the change and prepare people for a new way of working. The program also involved identifying observable behaviours warning of a risk that the change would not be adopted.

In the early stage of deployment, communicating high-level strategic messages was integral in helping to educate stakeholders and generate momentum for using the WTIS. As deployment progressed toward "go-live," communications became more tactical and messages focused on specific project work streams.

To set the pace and degree of the change-management activities, the project team determined where the biggest barriers existed. Although engaging the support of a number of different hospital stakeholders was important, the project team chose to focus the majority of outreach and adoption efforts on the group that would be most affected by the WTIS: clinicians and their office staff. Care decisions are made with patients within clinicians' offices, and WTIS data would be inputted there, too.

Trade Resistance for Value
Clinicians expressed a number of reservations about the WTIS project. Some were concerned about having to share their wait list information and exposing the private operations of their practice, or potentially putting personal health information at risk. Others were concerned about the time and effort involved in learning the processes and the additional workload they would create for already overtaxed office staff. Several clinicians who were not comfortable with web-based technology were reluctant to have a computer and Internet service in their office. Effective adoption of the WTIS required all these areas of resistance to be addressed using clearly articulated value propositions for clinicians. The project team also understood that value would be best driven through the appropriate agents of change, and sought to identify and leverage these agents to support the overall adoption effort.

Lessons Learned in Establishing Awareness

1. **Support and represent adoption, communications and training at the project leadership table** – in order to maintain a full picture of what issues and concerns are top of mind for stakeholders.
2. **Under aggressive deployment schedules, start communications to the field right away.** Strategic long-term planning is needed in parallel with "get-you-through-the-night" activities.
3. **Complete an extensive stakeholder analysis and integrated message plan** to customize messages to manage expectations, eliminate fears and generate trust and goodwill with your audience.
4. **Make communication a two-way, ongoing dialogue** between the project and your audience.
5. **Consider what people want to hear,** and then determine the most appropriate method to reach that audience.
6. **Find industry leaders or "champions" who have credibility with your primary stakeholders** – and equip them to support adoption in the field.
7. **Internal project champions are equally important in the engagement process.** Solicit their leadership to advocate for your project among employees, keep communications open and invite feedback to help refine future plans and tactics.
8. **Different communications vehicles work for different audiences** – pick what will have the highest impact with each stakeholder group.

The Government as an Agent of Change

Hospitals and clinicians had been raising the issue that more money was needed to fund efforts to improve access to care in the province. As mentioned earlier, funding committed by the federal and provincial governments became an important strategic lever for encouraging hospitals and clinicians to participate in the Wait Time Strategy. Funding allowed hospitals to make better use of resources and increase operating room capacity so that more people could get the treatment they needed faster. Adoption messages highlighted the link between clinicians entering wait time data into the WTIS and improved access to OR resources.

When the MOHLTC agreed to provide wait time funding, it did so on the basis of certain commitments from hospitals and clinicians. Government created policy to reinforce the need for change. Hospitals agreed to collect and report data, and they had to persuade clinicians to report their wait time information through the WTIS in a timely manner and according to the standards set by the province. Clinicians also needed to be transparent with their wait lists and share relevant information with hospitals so that access to care could be systemically managed.

Hospital Management as Agents of Change

Conditions of wait time funding, laid out in Hospital Accountability Agreements between hospitals and the MOHLTC, put the onus of engaging clinicians on the hospital. It was important that hospitals maintained ownership for clinician engagement and that the provincial project team remained in a supporting role to help hospitals meet their commitment. For example, the project team supplied Hospital PMs with an

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agenda and support for their discussions about the hospital's clinician adoption environment with their Chief of Surgery.

Once wait times started to be publicly reported, showing widely disparate wait times across facilities, hospitals were keen to improve their results and demonstrate – specifically to their local communities – that they were working diligently to reduce wait times and improve efficiencies. With accountability for performance improvements resting on their shoulders, hospitals needed the ability to compare wait lists across clinicians so that they could manage processes and make evidence-based OR resource decisions.

In most cases, however, hospitals had little insight into wait times. Clinicians maintained their wait lists on paper within their own offices and were often reluctant to share them for fear of losing autonomy over their private practice and potentially being penalized for inappropriate wait times. To overcome these fears, the program stressed that only aggregate data by hospital would be reported to the MOHLTC and on the public wait times website (www.ontariowaittimes.com). If access issues existed, hospitals now had the means to review the data at a more granular level. They could work with clinicians to understand the root causes and, if required, help them reduce their wait lists. This meant that clinicians would now have the necessary support to manage their waits and make the case for more operating room resources.

When the WTIS project began, many clinician offices did not have computers and/or Internet connectivity. A study of IT prevalence in Canada commissioned by Canada Health Infoway found that only 20% of Canadian physicians reported having electronic medical records or used technology in clinical care (Protti 2007). Anecdotal information suggested the reason was that clinicians

were concerned about having to transmit patient information electronically, potentially compromising privacy. In some cases, clinicians were simply unaccustomed to using technology or not willing to incur the additional costs associated with purchasing new computer equipment and Internet service.

Figure 3. Example of a priority assessment tool

To overcome these challenges, some hospitals decided to purchase computers for their clinicians and contracted with the former Smart Systems for Health Agency (now part of e-Health Ontario) to provide secure Internet access at no cost to clinicians. The pay-off on this investment would benefit both clinicians and hospitals in a number of ways beyond the WTIS. The technology would enable faster and more secure communications with clinicians, particularly those in remote offices who previously relied heavily on couriers and faxes to get information from hospitals. It would also create new efficiencies by allowing other manual activities to be performed electronically. And, finally, it meant that clinicians would be better equipped for future IM/IT initiatives. To date 500-plus Internet connections have been provided to clinician offices.

Clinical Leads as Agents of Change
Recognizing wait times as a growing concern, most clinicians saw the need to standardize how care was prioritized from practitioner to practitioner. Clinical advisors serving on Clinical Expert Panels (CEPs) and the project Steering Committee addressed this by establishing standardized, province-wide targets for how quickly patients should receive treatment, according to the urgency of their condition. The CEPs also designed and validated priority assessment tools for their specific areas of care to support clinicians in making prioritization decisions and ensuring more consistent and equitable access to care across the province. These priority assessment tools and the standardized reporting requirements were incorporated into pocket-sized quick reference cards (see Figure 3) and delivered to all participating clinicians. These efforts supported clinicians across Ontario in using a common and consistent approach to determine priority for care. Importantly, guidelines on how to use the assessment tools emphasized they were not a substitute for a clinician's experience and professional judgment when deciding on appropriate treatment.

Approximately a month before go-live, each clinical lead hosted a teleconference to discuss the clinical requirements with their peer group. This was an important opportunity for clinicians to seek clarification and for the clinical leads to reinforce the importance of capturing wait times data using the standards and guidance provided.

Clinical Champions as Agents of Change
The project team understood that clinicians would be more receptive to receiving WTIS information from respected colleagues than from someone perceived as working with a government agenda, or some "technical guru." As mentioned previously, early phases of the project focused on engaging strong and credible spokespeople for the WTIS and creating awareness of the program among their colleagues across the province. As the project progressed, the provincial clinician champions were leveraged to support hospitals' adoption efforts. Champions were recommended strategies for addressing clinicians who were still resistant. Interactive forums such as teleconferences,

face-to-face sessions or one-on-one calls were organized for clinicians to openly discuss concerns and share solutions with peers. The project also benefited tremendously from having Dr. Alan Hudson, the Access to Services and Wait Time Strategy Lead, front the charge for change within the province. As a well-regarded former surgeon, he became a strong champion for the WTIS and was relentless in telling practitioners and administrators the compelling story of why change was needed. With the expansion of WTIS reporting, clinician consultants were added to the adoption effort and acted as spokespersons for the Access to Services and Wait Times Lead. These consultants lobbied both individuals and Chiefs of Staff/Medicine to garner acceptance of the principles underlying the impetus for wait times reporting.

Table 1. Performance indicators used to monitor clinician adoption

- Network order agreements for Internet connectivity
- Hospital chiefs attend clinical engagement kick-off call
- Clinician landscape review
- Progress assessment of clinician engagement
- Distribution of priority assessment tool cards
- Outstanding network order agreements for Internet connectivity
- End user training plan developed
- Clinician connectivity complete
- Train-the-trainer session
- End user training

Two important lessons were learned at this time. First, the value of engaging senior practitioners within each hospital to be local champions and address site-specific issues became evident. Hospital clinicians could have their day-to-day concerns addressed by this respected colleague. Over time, the project team better understood the attributes that made clinician champions particularly effective, such as decision-making authority and cross-departmental influence. The support of a local hospital champion became a key indicator for adoption throughout deployment, and hospitals that lacked a strong advocate encountered more adoption challenges. Second, clinician administrative staff also played a critical role in gaining clinician buy-in. Administrative staff were direct users of the WTIS, entering the wait time data themselves and benefiting from efficiencies provided by an electronic system. This stakeholder group proved to be key influencers, particularly to resistant clinicians. As a result, the WTIS project team also provided guidance and support to help Hospital PMs connect with clinician office teams.

The Project Team as Agents of Change

Early on in the project, adoption efforts focused primarily on supporting provincial and local champions in getting the WTIS message out. Their presence in the field was particularly important in building credibility and trust with clinicians. As awareness of the WTIS grew, the project team evolved their approach to work directly with hospitals and implemented a number of support tactics and tools to help individual facilities manage the change and drive adoption within their clinician community.

Adoption Toolkit Tactics

- Structured discussions to understand the clinician environment and assess a hospital's progress in achieving adoption
- Adoption coaching sessions to help Hospital PMs deal with resistance and overcome objections
- Specialty-specific information sessions (via teleconference) with Clinical Expert Panel chairs, where colleagues could share common concerns and solutions
- Frequently Asked Question documents and other materials designed specifically for, and targeted to, clinicians and their offices
- Local champions who can be advocates within hospitals and across the province

Adoption Lessons Learned

1. **Focus on the business benefits** – in this case getting patients treated faster.
2. **Be clear on where you need to have the maximum impact.**
3. **Integrate adoption with the overall project team** and have a horizontal view of the project to look for warning signs of resistance.
4. **Use clinical leaders as early adopters** and leverage them as much as possible to communicate a message "by clinicians, for clinicians."
5. **Identify meaningful value propositions** that align to expressed resistance points.
6. **Utilize the appropriate agents of change** to drive value messages. Equip these agents with supports and clear delivery suggestions.
7. **Hold on-site information sessions** with local and provincial champions at a time that works for busy clinicians (often early morning or evening hours).
8. **Build measurable indicators** for clinician engagement into your overall project plan.
9. **Review on a daily basis**, leading and lagging indicators that can predict where challenges may crop up.

To address some clinicians' lack of understanding about what the system would do and how long it would take to input data, the project team worked with Hospital PMs to educate clinicians and their office staff on the value and ease of using the new technology.

Education included creating demonstration/testimonial videos and booklets featuring user experiences from previous phases. These tools were effective in showing that in a few easy steps, data

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Training Tactics
- Train-the-trainer sessions
- Comprehensive training materials – presentations, FAQs, application screen shots
- Training hotline
- Training tip sheets
- Demonstration DVD
- Access to subject matter experts
- Online e-learning tutorials

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could be entered into the system and permanently stored, leading to efficiencies in wait list management. They also showed how automated reporting using centralized and easily accessible data would help clinicians more proactively manage wait lists without increasing workload for their administrative staff.

The Adoption Assessment Profile tool (Figure 3) proved to be valuable in identifying areas of resistance. It listed observable behaviours that indicated adoption was on track. The assessment profile was completed through structured phone meetings with Hospital PMs and/or the hospital clinician champions at key intervals throughout deployment. The project team supported hospitals in developing strategies and techniques to manage their particular set of clinician adoption issues uncovered through the analysis.

With these tools and tactics, the WTIS project team identified and refined measurable performance indicators to monitor support and resistance to change by hospital. With effective root cause analysis, certain indicators were effective in identifying adoption challenges. As an example, over time the project team noticed a pattern where hospitals with clinicians who were resistant to installing an Internet connection were often the same hospitals with clinician adoption challenges. It turned out that difficulties in getting approval from a clinician to establish Internet connectivity were often early signs of resistance to the WTIS.

Once the WTIS was deployed, work was still required to ensure the system and its data would be used for performance improvements. In subsequent phases of the project, the project team worked closely with the WTIS operations team, which monitored compliance with data reporting and data quality to see how effectively the system was being used. This information helped identify trends and predict potential challenges for future stages of the project so that the teams could plan accordingly and provide the necessary level of support.

3. Making the Change Real – Sustain New Business Processes

The third component of the stakeholder engagement program – Training – focused on providing hands-on, practical interaction with the WTIS and ensured that people were given the opportunity to learn how to track wait times. This step was also important in showing people that the functionality described through the communications and adoption stages was actually being delivered.

During Beta/Phase I, the training program began with a subset of users at the five Beta hospitals. As the project progressed through Phases II and III, that number grew and the user groups became exponentially larger. During initial deployment of the WTIS, trainers had to prepare materials and lead the effort to train new users. As the system expanded to track wait times for more service areas, the ratio of new users dropped considerably and the focus of training shifted to new system functionalities, relying on already trained users at the hospital to support subsequent on-site training.

Training Lessons Learned
1. **Build a scalable and adjustable** training program.
2. **Identify local trainers** to deliver training to individual hospitals.
3. **Create materials that can be customized** to the needs of individual facilities.
4. **Listen to and use lessons learned** in developing and delivering future training materials.
5. **Create a training "sandbox"** with practice scenarios to allow users to experiment and become familiar with the actual application.
6. **Build training indicators** into your project plan.

Transfer Project Expertise to the Local Level

The WTIS project used a "train-the-trainer" approach, which involved the project team instructing Hospital PMs or other assigned hospital trainers how to use the WTIS so that they could train their clinicians. Train-the-trainer sessions were held face-to-face in regional locations, or via on-the-phone coaching or webinars. Extensive training presentations (including direct screen shots from the application), Frequently Asked Questions documents, a demonstration video and learning tutorials were

created to show system functionality. Like adoption indicators, performance indicators were also used to monitor hospitals as they planned for and conducted training.

To further help hospital trainers, a training "sandbox," or simulation environment, was available so that trainees could become familiar with the system in a safe and secure real-world environment using fictional patient data. Hospital trainers were

As more sites went live, the operations team's role in training increased. Once a hospital was live on the WTIS, both hospital staff and project team members relied on the operations staff to help answer questions about how the system worked and how decisions were recorded in the WTIS.

encouraged to customize training materials to suit the needs of their facilities (e.g., to include local processes or language common to their hospital), as long as core training elements remained intact and addressed.

In addition to hands-on training on the system, hospital trainers were coached on overcoming objections. Initially, user questions were as fundamental as "Why do I have to learn this?" In later stages, as more people began using the system, resistance noise was replaced by voices of inquiry. People began asking how the application functioned, and why it did or did not function in a certain way, or about process and policy compliance. Questions now took the form of, "Why does the application do X and not Y?" or "When I do X, why does Y error result?" or "At what point does a wait start?" and "What is the starting date for a patient who was waiting at one hospital and then was transferred to another hospital for the surgery?"

As the project progressed, training materials became more structured and were packaged into e-learning modules that were available online. This reduced the variations in local training delivery and increased data quality in the system.

Sustain Training through Operations

As more sites went live, the operations team's role in training increased. Once a hospital was live on the WTIS, both hospital staff and project team members relied on the operations staff to help answer questions about how the system worked and how decisions were recorded in the WTIS. This team continues to manage the day-to-day operations of the WTIS and reporting to the MOHLTC. They are a source of information and support to their internal colleagues and external clients in training as well as other areas.

Results

With a complex change program that needed to be developed and deployed within aggressive timelines, the WTIS project team had to work quickly to build traction and a level of comfort among stakeholders early in the project. The team's ability to effectively integrate and leverage communications, adoption and training efforts allowed them to build awareness, mobilize support and get people using the system quickly. The stakeholder engagement approach rallied the support of leaders at 82 hospitals across the province and more than 2,600 clinician offices to start using the WTIS and helped deliver on the government's commitment to report and reduce wait times in less than two years. Currently more than one million patients in Ontario benefit from this change annually.

Reference

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