The purpose of this form is to invite Langley Medical Staff to identify and submit initiatives for consideration and funding. Initiatives should be focused on **(1) engagement of physicians in relevant initiatives and/or (2) identifying opportunities to partner with the MSA and LMH site leadership to improve patient care[[1]](#footnote-1).** The Langley Memorial Hospital Medical Staff Association Working Group will review all submitted initiatives. The author will receive notification of the status of the application within 4-6 weeks of submission.

|  |  |
| --- | --- |
| **Project Title:** |  |
| **Date of Submission** |  |
| **Project Lead Name & Position, email** |  |
| **Department Head (if applicable):** Name, email |  |
| **Health Authority Sponsor (if applicable):**\*Director level or aboveName, Position, email |  |
| **Proposed Timeline:** Start and estimated end date  |  |
| **Total Funding Request (anticipated costs)** |  |
| **Annual Recurring Project** | Yes[ ]  No[x]  |

***Activity Purpose/Summary***

**Should include:** Problem/issue that the activity is addressing, approach and expected outcome/s

|  |
| --- |
| **Issue:** *(Please state the problem clearly and include any data to support it).* **Approach/Methodology:** *(How would you address the problem? Who are involved? What are the barriers/ challenges) Please specify the time required for activities where possible)***Outcome/Impact:** (What is the expected outcome? How will it improve engagement?) |

***How will you measure your activity's success in each objective? These objectives will be evaluated in the interim report and/or at the end of project date as appropriate***

**Example:**

* *Evaluation Strategy*
* *How do you know the change resulted in improvement in engagement?*
* *Timeline*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| OBJECTIVE | METRIC | DATA SOURCE | TIMELINE (approx.) | CRITERIA FOR SUCCESS |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

***What other sources are you receiving funds from this or related work?*** Please provide dollar amount where appropriate

|  |
| --- |
|  [ ]  Physician Quality Improvement : $ [ ]  Health System Redesign funding: $ [ ]  Research Grant: $ [ ]  HA contribution (resources, staff time, etc.) [ ]  Others, please specify : [ ]  No alternate source of funding |

***Alignment***

Choose the MSA priority the project aligns with. It should align with at least one of the following priorities.

|  |
| --- |
| **MSA Priority:** |
| [ ]  Support and Enhance Medical Staff Experience |
| [ ]  Improve the quality of healthcare and service delivery |
| [ ]  Strengthen Relationship between Health Authority and Medical Staff |
| [ ]  Strengthen and Clarify MSA/Facility Engagement Structure |

***Stakeholder Engagement***

**Note:** Any proposed activities involving patient care, work flow, environment, data analytics, allied health, resources for sustainability would benefit from early consultation with stakeholders.

|  |  |
| --- | --- |
| Stakeholders involved (check all that apply**)** |  [ ] Physicians [ ] Departments/Divisions [ ] Allied care providers [ ] Partner Organisations [ ] Health authority administration [ ] I need help with appropriate contact/s [ ] Not applicable |

***Specific stakeholders contacted/involved in the project***

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | **Title** | **Department** | **Contribution** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

***Estimated Budget***

**Note:** Please complete the proposed budget to the end of the fiscal year. When budgeting for the fiscal year, consider the estimation of costs required to reach required milestones. For approved engagement activities, Project Managers will continuously monitor the progress of the budget with respect to the milestones. If an activity experiences unexpected delays (e.g. into the next fiscal year), the activity budget would be adjusted accordingly to free up the allocated budget.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Expenses** | **To March 31st 2023** | **After March 31st, 2023** | **Total Amount** | **Comments**  |
| **Physician Expenses** |  |  |  |  |
|  **Sessional Fees** (Specialists X hours)$171.05/hr |  |  |  |  |
|  **Meals** |  |  |  |  |
|  **Venue** |  |  |  |  |
|  **Other costs**  |  |  |  |  |
| **Total requested** |  |  |  |  |

**In submitting this proposal, I acknowledge (please apply check mark):**

[ ] I will submit quarterly reports to update on activity status (such as budget progress, barriers and risks, and activity changes) to the MSA project staff/working group

[ ] This proposal may be circulated to adjudication committees, partners, and funders as appropriate.

[ ] I have received written approval from my Division/Department head for this work (where applicable).

**Engagement Activity Approval**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MSA/Society Executive Approval Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Physician Lead Approval Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Health Authority Sponsor (where appropriate) Date**

***Please submit all completed forms to: Program Manager, Facility Engagement***

Ann Nienaber (beatrixann.nienaber@gmail.com)

1. Please refer to the MOU and the FEI funding guidelines [↑](#footnote-ref-1)