New or Revised Clinical Initiative Proposal (Draft V1.1 7.17.2018)

Proposal Submitted By:

Name:

Date Submitted:

On behalf of:

Department:

E-mail:

Phone #:

Describe the gap or concern addressed by this improvement proposal:

Priority Type

- Current Patient or Provider Harm
- Provider Safety Improvement
- New Clinical Evidence
- Research/Innovation
- Other
- Patient Safety Improvement
- Clinical Error Reduction
- Cost/Waste Reduction

Proposal Type:

Be Specific

Use this checklist to ensure your attached proposal includes ALL of these REQUIRED items. Incomplete proposals will be returned.

My Proposal addresses and/or includes (check if submitted):

- Detailed description of proposal
- Why this is needed
- Clinical literature & sources are cited
- Alternative solutions to this proposal
- How this proposal resolves the gap(s)
- Benefits provided by this proposal
- Disadvantages, challenges and/or risks
- Why proposed is better than alternatives

Describe your improvement proposal providing as much detail as possible. If necessary, submit separate attachments via e-mail (e.g., photos, technical information, links to clinical literature, etc.). Use the checklist above to help you submit a complete proposal.

THANK YOU: You will be notified when we receive your complete proposal. Please SAVE this completed form. Then, E-mail the completed form along with any additional pertinent attachments to: **CIR@austintexas.gov** .