



CPP Innovation Grant Application

CPP Member Practice _____

Practice Address _____

Physician Champion _____ Email _____

Manager (Designee) Champion _____ Email _____

Innovative Idea

What is the aim of this innovation? What do you hope to improve in your practice?

What steps do you anticipate will be necessary to implement this innovative idea in your practice?

How will you measure the impact (patient/staff satisfaction, revenue, % of patients screened, etc.)?

Provide a plan for collecting baseline and resulting data that will demonstrate impact of innovation.

What do you predict will happen?

Are other CPP Member practices experienced with or currently utilizing this innovation? Yes No

If yes, please list practice names.

Are multiple CPP Member practices needed to test same or similar innovation for comparison purposes? If so, approximately how many total practices? _____

Please list practice names if other CPP practices are interested in testing this innovation.

Approximate budget for testing phase (per test site) _____

Approximate timeline for implementation and testing phase (target < 3 months) _____

Should a grant be awarded, I agree to test the innovation in my practice according to what is outlined in this application. I also agree to complete an Innovation Assessment (2 pages) at the end of the testing phase and allow my feedback to be shared with other CPP members.

Applicant Signature _____ Date _____