Hospital in Home, Community Living Center or CTraC

Patient is admitted to program/location

**PPC Conversation (Step 1)**

- Provider (ARNP/PA/MD/DO) or Team member (SW, PharmD, Psychologist, OT/PT, RN, Whole Health Coach) leads conversation
- PPC framework guides consultation/conversation
- Completed w/in first days to weeks of enrolment/admission

**Documentation**

- PPC template utilized in a specific “Patient Health Priorities’ note title or admission note
- All 5 core elements including the ‘One Thing’ should be included

**Care Alignment (Step 2)** (Optional approaches)

- Utilize team-based meetings to consider priorities and align care
- Insert the national ‘Age-Friendly 4M’s template’ as a way to organize recommendations or alignment in team-based meetings/documentation
- Alert PCP or other providers to PPC note if/when patients are discharged

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