4Step iCare Plan

Goals of Care Coalition of NJ

An Individualized Advance Care Plan

Helping patients make medical decisions

HCP

Conversation Assistant

The 4Step iCare Plan provides a template for informed, patient-centered medical decision-making. This 4-step guide will help you facilitate a conversation with your patients to ensure that, in Step 1, they understand their **diagnosis**; in Step 2, they understand their **prognosis**; in Step 3, they express their **goals** and wishes in light of the prognosis; which allows you, in Step 4, to recommend a course of **treatment** that aligns with your patient's goals of care. This model includes critical steps often overlooked in advance care planning.

The left column below highlights what is covered in the patient's form; the right column provides corresponding guidelines and prompts to help you lead this process of shared decision-making.

PAGE 1 OF PATIENT FORM

STEP 1 Understand Diagnosis

Ask your doctor or health care provider:

- What is my diagnosis? (What is my exact medical problem or condition?)
- What other medical problems do I need to consider?
- Do you have additional written material that I can read about my diagnosis?

HCP:

Share information on the patient's diagnosis

When sharing bad news with the patient, begin with a "warning shot" such as, "Unfortunately, I have bad news…"

Then share the news using no medical jargon. Avoid asking yes/no questions; instead, prompt patients to articulate their understanding.

STEP 2 Discuss Prognosis

Ask your doctor or health care provider:

- What is my prognosis? (How will my medical condition affect my future?)
- Will I be able to do my favorite activities?
- How much time will I have?
- Will I be able to live independently?
- Will I have symptoms such as pain or trouble sleeping?
- How will the time I have remaining and the quality of that time change with or without aggressive medical treatments?

HCP:

Share information on the patient's prognosis

Ask questions aimed at gauging how well the patient understands the prognosis.

"What's your understanding of your future and what may happen next?

"Would it be helpful to you to learn more about your prognosis?"

"How much detail will be helpful to you as we discuss the progress of this condition and possible treatment options?"

"What questions or concerns do you have about your prognosis?"

"What is your understanding of how long you can live with this condition?"

PAGE 2 OF PATIENT FORM

Identify Goals of Care

STEP 3

Tell your doctor or health care provider:

- What matters to you most at this time
- What hopes and goals are most important to you
- Whether it is important to you to remain in your home
- How much quality of life you are willing to sacrifice for the sake of living longer
- How important it is for you to remain comfortable and avoid unpleasant treatments
- At what point you want to forego aggressive treatment and focus just on remaining comfortable and achieving the best possible quality of life

HCP:

Establish patient's personal goals in the context of the prognosis

"In light of the prognosis we have discussed, what is important to you during this time?"

"What are your fears and concerns?"

"What gives your life meaning and joy?"

"Are there any events are you looking forward to, or what goals do you want to accomplish?"

"How willing are you to prolong your life through aggressive treatment that may diminish your quality of life?"

"At what point might you prefer to focus on receiving palliative care and having the best possible quality of life for whatever time you have left?"

Align Treatment

STEP 4

Ask your doctor or health care provider:

- What are the treatment options given my prognosis and personal goals of care?
- What are the benefits and risks associated with these options?
- Are there additional treatments I should consider and/or additional doctors I should consult that will help me achieve my goals?
- What treatments are no longer necessary?
- Would returning to the hospital be right for me?
- Would beginning or continuing the treatments of artificial nutrition (feeding tube) and hydration (IV fluids) align with my goals of care?
- What are my chances of surviving cardiopulmonary resuscitation (CPR)?
- Would attempting emergency lifesaving procedures like CPR help me achieve my goals of care?
- Which of my medications, if any, are no longer necessary?
- Is it appropriate for me to complete a NJ POLST* form at this time?

HCP:

Align available treatments with the patient's goals of care

Make an effort to recommend only those treatment modalities that help achieve personal goals of care (as determined in Step 3). Itemize every test, procedure, medication, or consult in light of the question, "Is this helping…?"

You may suggest to the patient: "Based on what is important to you, this is what I recommend…"

POLST forms are appropriate in patients who are in their final years of life.

POLST stands for Practitioner Orders for Life-Sustaining Treatments. These are **medical orders** from a physician or advance practice nurse that address patient goals, scope of therapies, returning to the hospital, artificial nutrition, and resuscitation status.

The form is portable across all health care settings in New Jersey, from hospital to post-acute levels of care and even in the private home. **These orders are actionable and, by law, must be followed by the medical teams caring for the patient.**

Learn more and download a NJ POLST form at **goalsofcare.org**.