

› The 4Step iCare Plan is an individualized, simple, 4-step approach to help you make difficult medical decisions.

In **Step 1** you will discuss your diagnosis with your doctor or other healthcare provider to gain a better understanding of your medical problems. In **Step 2** you will discuss your prognosis to learn more about how it is likely to affect your future. In **Step 3** you will think carefully about your personal goals and wishes. In **Step 4** you and your healthcare provider will use this information to make the medical and personal choices that are best for you.

The goal is to make sure that you receive the care you need and no less, and the care you want and no more.



Step 1: Understand Diagnosis

Ask your healthcare provider:

- › What is my diagnosis? (What is my illness or condition?)
- › Are there other medical problems I need to consider?
- › Do you have additional information on my condition?

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WHEN TO HAVE THIS DISCUSSION

Conversations about advance care planning can be challenging, and the timing may never seem right. If you've been admitted to the hospital, received a diagnosis of a serious illness, or experienced a troubling change in your quality of life, it's a good time to have this conversation with your healthcare providers and your family caregivers. There is seldom a good reason to delay this discussion.



Step 3: Identify Goals of Care

Tell your healthcare provider:

- What matters most to you at this time?
- How important is it for you to remain at home?
- How much quality of life are you willing to sacrifice to live longer?
- How important is it for you to remain comfortable and avoid unpleasant treatments?
- At what point would you want to avoid aggressive treatment and focus on the best quality of life?

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FOCUS ON YOUR LIFE, NOT YOUR DISEASE

Now it's time to focus on what you want your life to be moving forward. Whatever the medical problem, this is your life—where and how you want to live, what you hope to accomplish, and your priorities.

PALLIATIVE CARE IS LIVING WELL

Palliative care is specialized medical care for adults and children with serious illness. It provides extra support to help manage symptoms, reduce stress, and improve quality of life so you can have more good days at home.

Palliative care is delivered by a team that may include doctors, nurses, social workers, and others who work together with your existing doctors — not replace them — to support you and your family. It can be provided at any age and at any stage of illness, even while you are still receiving treatment.

HOSPICE CARE IS DYING WELL

Hospice care is focused on comfort at the end of life. It is for patients expected to live six months or less and does not include active treatment for serious illness, such as chemotherapy for cancer.

4

Step 4: **Align Treatment**

Ask your healthcare provider:

- › What are the treatment options given my prognosis and goals of care?
- › What are the benefits and risks of these options?
- › What other treatments are there or which doctors I should consult?
- › What treatments or medications are no longer necessary?
- › Under what circumstances would returning to the hospital be necessary?
- › To what extent would beginning or continuing artificial nutrition (feeding tube) and hydration (IV fluids) align with my goals?
- › What are my chances of surviving cardiopulmonary resuscitation (CPR) and how would emergency procedures like that help me achieve my goals of care?
- › Is a POLST* form appropriate for me at this time?

NOTES: _____

THINGS TO CONSIDER

The aim is to ensure that, going forward, all medical decisions are based on your goals and wishes as defined in your iCare Plan. Before making treatment choices these are the kinds of questions you will need to discuss with your family and your doctor or healthcare provider.

* **POLST** stands for Portable Medical Orders. These are **medical orders** from a physician, physician assistant or advance practice nurse that addresses patient goals, scope of therapies, returning to the hospital, artificial nutrition, and resuscitation status.

The form is portable across all health care settings. **These orders are actionable and, by law, must be followed by the medical teams caring for the patient.**



Learn more by visiting polst.org/for-patients/faqs or goalsofcare.org/POLST. Although NJ is the example on the GOCCNJ website, the principles apply to any conversation and document that captures medical orders.