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Appendix A. Goals of Care Documentation Evaluation

GOC documentation trained qualitative analysts utilized the codebook and electronic submission form demonstrated in the image below to submit their evaluations of electronic records. This survey was created using Microsoft Forms and the output format was Microsoft Excel spreadsheet. The survey has 11 possible questions with 7 questions which must answered at minimum. A “no” answer to Question 3 prompts the addition of 1 more question which evaluates if the GOC documentation is in an alternative, inappropriate location. A “yes” answer to Question 5 prompts the addition of 4 more questions which evaluate 1) clear statement and discussion of prognosis, 2) clear articulation of the patient’s values and goals; 3) clear and detailed articulation of the next steps in clinical management (e.g. change in code status, time limited trial), and 4) narrative description of the conversations and decision-making process.

The form questions are as follows:

1) What is the study patient’s FIN number [Freetext]

2) What is the study patient’s last name? [Freetext]

3) Is there a GOC note in the appropriate location? Look in ortho consult note, H&P (ortho, ICU, hospitalist), Progress note (ortho, ICU, hospitalist), or GOC powernote in GOC section. [Yes or No]

4) [Only if “No” to question 3] If GOC note is not documented in the appropriate location, is there clear GOC documentation in an alternate, inappropriate location? i.e. Ortho attending attestation, ortho operative note, H&P, or progress note by ortho, ICU, or Hospitalist services? [Yes or No]
5) Does the GOC note contain free text for the following variables: prognosis, patient values and goals, description of decision, and description of next steps? Even if only one of the variables contain free text respond, Yes. [Yes or No]

6) [Only if “Yes” to Q4] Is there any description of Prognosis? [Yes or No]

7) [Only if “Yes” to Q4] Is there any description of the patient's values or goals? [Yes or No]

8) [Only if “Yes” to Q4] Is there any description of the decision about what to do next? [Yes or No]

9) [Only if “Yes” to Q4] Is there any description of the next steps regarding decision making for specific treatments? [Yes or No]

10) GLOBAL ASSESSMENT: Was this a high quality GOC note? For this, looking for your opinion as to whether the note documents a good faith effort to actually clarify and document GOC. It may not have all four of the variables listed above, but it should evidence a clear attempt to step back, take stock and engage in a conversation aimed at goal clarification. Most surgeons don't know this entails prognosis or values and thus may make a good faith effort without these aspects. [Yes or No]

11) Please any comments that you may have related to this patient event. [Freetext]
Goals of Care Evaluation for Ortho/Trauma Pause

1. What is the study patient's FIN number?
   123456789

2. What is the study patient's last name?
   Doe

3. Is there a GOC note in the appropriate location?
   - Yes
   - No

4. Does the GOC note contain free text for the following variables: prognosis, patient values and goals, description of decision, and description of next steps?
   - Yes
   - No

5. Is there any description of Prognosis?
   - Yes
   - No

6. Is there any description of the patient's values or goals?
   - Yes
   - No

7. Is there any description of the decision about what to do next?
   - Yes
   - No

8. Is there any description of the next steps regarding decision making for specific treatments?
   - Yes
   - No

9. GLOBAL ASSESSMENT: Was this a high quality GOC note?
   - Yes
   - No

10. Please any comments that you may have related to this patient event.
    Enter your answer
Appendix B. Goals of Care Documentation Interface

GOC documentation was indented to be recorded within a predetermined section of the medical record using the note template reproduced below. A GOC note within this note template constituted a note within an “appropriate location”. Trained qualitative analysts reviewed the medical record for the presence of goals of care documentation within the intended section or anywhere otherwise within the electronic medical record, rating each document with codebook in Appendix A.

<table>
<thead>
<tr>
<th>Goals of Care/Family Meeting Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clinicians attending</strong></td>
</tr>
<tr>
<td><strong>Family members attending</strong></td>
</tr>
<tr>
<td><strong>Topics Discussed</strong></td>
</tr>
<tr>
<td><strong>Main points of conversation and decisions that were made</strong></td>
</tr>
<tr>
<td><strong>What is the followup plan with communicating with the family</strong></td>
</tr>
</tbody>
</table>