Appendix 2 (as supplied by the authors): Structured chart abstraction tool (codebook)[1]

GOALS AND VALUES *7 total items* *For scoring purposes – Goals of care can be EITHER specific OR non-specific*		
Goals of care (unspecified)	Documentation of a discussion about "goals" or "goals of care", without mention of specific goals or priorities. If any one or more of the following subdomains were addressed, a point was also given in this domain.	Examples: "We also discussed goals of care"; "30 minutes were spent discussing goals of care"
Goals, priorities, "is important to" (specific)	Documentation of a discussion about particular goals important to the patient, excluding "treatment decisions" (e.g. decisions about chemotherapy regimens).	Examples: "The patient wants to be at home/live as long as possible/not be a burden"; "His priority is to be able to teach his courses this fall" ; "It is important to her to be able to enjoy their trip to Hawaii in the spring"
Fears, worries	Documentation of a patient's fears, worries or concerns	Example: "He worries about becoming dependent and 'dying without dignity'"
Tradeoffs	Documentation of what a patient is willing to go through (e.g. for the possibility of more time)	Example: "He does not want to experience any major side effects unless there is a high likelihood of therapeutic benefit"
Function, abilities	Documentation of abilities that are critical to the patient	Example: "Maintaining his ability to interact with others is important to him"

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Quality of life	Explicit documentation of a discussion about the patient's quality of life or how the patient subjectively defines quality of life.	Example: "We had a long discussion re: quality of life today" References to symptom control on the ward do not qualify as a point for QOL. Example: "Patient given hydromorphone for pain"
Family involvement/Support for Family	Documentation of how much family knows about the patient's priorities/wishes; how much the patient wants family to be involved in further decisions; planning for family to be present at subsequent discussions; the role of the family in the patient's care or how the family is affected by the patient's illness. A mention that family was present for the conversation do not count as a point.	Examples: "We talked about how he and his wife might begin to have conversations with their daughters." ; "We talked about how her son has been helping her manage at home." "We talked about how she feels she is a burden on her son and how he needs more support as a caregiver."
PROGNOSIS OR PROGNOSTIC UNDERSTANDING *4 total items* *For scoring purposes – Prognosis is EITHER specific OR non-specific*		
Information preferences	Documentation of the patient's preferences to receive information about prognosis or the future.	Example: "Patient stated she would like to receive prognostic information frequently and in the presence of family"
Prognostic understanding	Documentation of the patient's understanding of illness or prognosis	Example: "We talked about his cancer today, and he understands that his tumor is incurable"; "He knows he only has weeks to live"

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Prognosis/life expectancy (unspecified)	Documentation of a discussion about prognosis or life expectancy, without specific communication of time, function, or QOL. If the following subdomain was addressed, a point was also given in this domain.	Example: “We discussed his prognosis today”; “30 minutes were spent today answering their questions about prognosis and treatment options”
Prognostic communication about time, function, or QOL; no more treatment options, progression of disease, worsening of disease, functional decline (specific)	Documentation of specific mentions of prognosis (in terms of time, function, or QOL) or discussion of no more treatment options, progression of disease, worsening of disease, functional decline	Example: “They had questions about prognosis. I shared that he likely has weeks to months left.” ; “We discussed this is likely the best the patient will feel and the disease will cause worsening decline”
END-OF-LIFE CARE PLANNING *4 total items*		
End of life, end of life planning, EOL, advance care planning (unspecified)	Documentation of any of these keywords in the context of a broader discussion. If any one or more of the following subdomains were addressed, a point was also given in this domain.	Example: “Today we discussed the patient’s end-of-life preferences.”
Palliative care, supportive care, comfort-focused care	Documentation of discussion about future use of, initiating or transitioning to palliative care, supportive care, or comfort-focused care (not including palliative chemotherapy). Report of use of palliative approach to care alone did not count without documentation of a discussion.	Example: “She and her family indicated that given the circumstances, they would like to start a comfort-oriented approach.”

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Hospice	Documentation of any of these keywords in a discussion.	Example: “After a lengthy discussion, we have opted to discontinue therapy and proceed with referral to hospice.”
Site of death/Practical planning	Documentation of a discussion indicating where the patient wants to be at death (e.g. at home, or at hospice) or about estate planning or legal documents.	Example: “Patient wishes to die at home”
CODE STATUS OR LIFE-SUSTAINING TREATMENTS *2 total items*		
Code status (DNR/DNI/Full code)	Documentation of discussion with keywords “Code Status” “Full Code”, “CPR” or “DNR”. Reports of code status alone do not count without documentation that a discussion occurred.	Example: “Today we discussed code status” “Patient states she wishes to switch to Full Code given these circumstances”
Life-sustaining treatments (Also: chest compressions/ intubation/shocks/ feeding tube/ICU)	Discussion specifying life sustaining treatments that are within patients desired scope of care.	Examples: “We talked about whether the patient would want CPR if her heart stopped beating”

Reference

1. Lakin JR, Koritsanszky LA, Cunningham R, et al. A systematic intervention to improve serious illness communication in primary care. *Health Aff (Millwood)* 2017;36:1258-64.

