**Supplementary methods**

Cohort definition

 We included all adult (age ≥ 18 years) decedents with at least one day of intensive care unit (ICU) care during their terminal admission from 9/1/2019 to 8/31/2020 at Johns Hopkins Hospital or Bayview Medical Center. Patients diagnosed with Covid-19 on their terminal admission were excluded (N = 106). We specified models including and excluding the 33 crossover patients who were admitted pre-policy but died after the policy was implemented on 3/21/20 because we could not accurately determine the timing of meetings, conversations, and decisions about end-of-life care made by these patients, their families, and their care teams relative to the date of policy implementation.

Regression discontinuity

 We used the policy implementation date (3/21/20) as a sharp cutoff and treated restricting family presence in the hospital as an intervention. In the absence of a policy effect, the regression of admission date on a given outcome should be continuous around the cutoff. However, if restricting family presence affects an outcome, we expect to observe a discontinuity in the regression around the policy implementation date. Patient demographics hypothesized to confound the relationship between policy implementation and the outcomes (age, sex, self-reported race) were included in all models as independent variables.

Time-to-event analysis

This survival analysis was limited to the 685 patients who were full code at ICU admission. The primary end point was a new order changing a patient’s code status from full code to do not resuscitate (DNR)/intubate (I), DNR/do not intubate (DNI), or comfort care. Comparison between the pre- and post-policy periods was assessed using a Cox proportional-hazards model adjusted for age, sex, and self-reported race. Death while full code was treated as a competing event.