Supplementary Table 1. Reasons for non-adherence to SCAMP recommendations on discontinuing RRT

Reasons for continuing RRT when SCAMP recommended to discontinue N=36*	**N (%)**
Remains volume overloaded	25 (69%)
Worsening creatinine	9 (25%)
Remains uremic	6 (17%)
Disagree with SCAMP recommendation	2 (6%)
Other:	11 (31%)
receiving intravenous fluids	3
acute respiratory distress syndrome	2
therapeutic trial to see if mental status improves	1
worsening creatinine off CVVH	1
tumor lysis syndrome	1
RRT continued because patient on chemotherapy	1
lung transplant team requested continuation	1
not enough clearance	1
Reasons for discontinuing RRT when SCAMP recommended to continue N=19	**N (%)**
Medical futility	10 (53%)
Comfort measures only	10 (53%)
Other:	8 (42%)
patient passed away	2
unable to tolerate CVVH due to very poor hemodynamics	1
hypoxemia, SaO2 69%, on ventilator with FiO2 100%	1
discontinued catheter due to fever, question of sepsis	1
line holiday given infection, potassium at goal	1
creatinine improving	1

Values represent N (%) unless otherwise stated. Abbreviations: RRT, renal replacement therapy; SCAMP, standardized clinical assessment and management plan; CVVH, continuous venovenous hemofiltration; SaO2, saturation of oxygen; FiO2, fraction of inspired oxygen
*Multiple selections were possible, therefore total number of deviations greater than N=36

Supplementary Table 2. Patient demographics and clinical characteristics based on SCAMP adherence

Patient Characteristics	Adhered N=102	Did Not Adhere N=60	p-value
Male	58 (57%)	35 (58%)	0.86
Age, median (IQR)	59 (49, 70)	63 (54, 72)	0.28
Race			
White	82 (82)	51 (86)	1.00
African American	11 (11)	5 (8)	
Hispanic	6 (6)	2 (3)	
Asian	1 (1)	1 (2)	
Reasons for Acute Kidney Injury[a]			
Hypotension	55 (54)	34 (57)	0.73
Sepsis	42 (41)	34 (57)	0.06
Pre-renal azotemia	34 (33)	17 (28)	0.51
Contrast	8 (8)	8 (13)	0.26
Other nephrotoxin	10 (10)	5 (8)	0.76
Cardiorenal syndrome	2 (2)	5 (8)	0.05
Obstruction	4 (4)	3 (5)	0.74
Rhabdomyolysis	6 (6)	0 (0)	0.06
Thrombotic microangiopathy	4 (4)	2 (3)	0.85
Hepatorenal syndrome	1 (1)	5 (8)	0.02
Hemolysis	2 (2)	3 (5)	0.28
Vasculitis	4 (4)	0 (0)	0.12
Glomerulonephritis	2 (2)	2 (3)	0.59
Tubulointerstitial nephritis	4 (4)	0 (0)	0.12
Other	16 (16)	8 (13)	0.68
Chronic Health Condition			
Chronic hypoxemia	12(12%)	13(22%)	0.02
Malignancy	43(42%)	21(35%)	0.37
Immunosuppresive therapy	33(32%)	18(30%)	0.76
Cardiovascular disease	16(16%)	24(40%)	0.005
Post-surgery	10(10%)	4(7%)	0.49
Vitals at Enrollment			
Mean arterial pressure (mean(sd))	78 (14)	75 (13)	0.25
Serum albumin (mean(sd))	2.5 (0.6)	2.5(0.7)	0.88
FiO2 $\geq$ 0.6	34(33%)	21 (35%)	0.82
Mechanical ventilation	45 (44%)	38 (63%)	0.02
Type of RRT by Enrollment			
None	58(57%)	32(53%)	
CVVH	8 (8%)	4(7%)	
HD	27(26%)	15(25%)	

CVVH and HD	9(8%)	9(15%)	0.20
Length of Stay (LOS), median (IQR)			
MICU (days)	18(4,65)	65(16,65)	0.006
Hospital (days)	47(16,119)	119(27,119)	0.03
Probability of 60 day mortality[b]	0.45 (0.03, 0.95)	0.55 (0.07, 0.97)	0.02

Values represent N (%) unless otherwise stated. Abbreviations: RRT, renal replacement therapy; CVVH, continuous venovenous hemofiltration; HD, hemodialysis; MICU, medical intensive care unit.

a.Clinical diagnoses of acute kidney injury specified by clinicians caring for the patient

b. Risk equation by Demirjian S, Chertow GM, Zhang JH et al. (18)

Supplementary Table 3. Patient demographics and clinical characteristics based on SCAMP adherence for patients with low disease severity

Patient Characteristics	Adhered N=63	Did Not Adhere N=31	p-value
Male	38(60%)	17(55%)	0.61
Age, median (IQR)	58 (48, 68)	66 (49, 72)	0.30
Race			
White	53 (87)	26 (87)	1.00
African American	5 (8)	2 (7)	
Hispanic	3 (5)	1 (3)	
Reasons for Acute Kidney Injury[a]			
Hypotension	31 (49)	13 (42)	0.51
Sepsis	22 (35)	12 (39)	0.72
Pre-renal azotemia	23 (37)	9 (29)	0.47
Other nephrotoxin	8 (13)	1 (3)	0.14
Contrast	3 (5)	3 (10)	0.36
Obstruction	3 (5)	3 (10)	0.36
Rhabdomyolysis	4 (6)	0 (0)	0.15
Thrombotic microangiopathy	3 (5)	1 (3)	0.73
Cardiorenal syndrome	1 (2)	3 (10)	0.07
Vasculitis	4 (6)	0 (0)	0.15
Hemolysis	1 (2)	2 (6)	0.21
Glomerulonephritis	2 (3)	1 (3)	0.99
Tubulointerstitial nephritis	3 (5)	0 (0)	0.22
Hepatorenal syndrome	0 (0)	2 (6)	
Other	8 (13)	7 (23)	0.24
Chronic Health Condition			
Chronic hypoxemia	8 (13%)	6 (19%)	0.03
Malignancy	24 (38%)	7(23%)	0.12
Immunosuppresive therapy	20(32%_	5(16%)	0.11
Cardiovascular disease	10(16%)	13(42%)	0.006
Post-surgery	8 (13%)	3 (10%)	1.00
Vitals at Enrollment			
Mean arterial pressure (mean(sd))	79(15)	76(11)	0.46
Serum albumin (mean(sd))	2.7(0.6)	2.7(0.7)	0.79
FiO2 $\geq$ 0.6	8 (13%)	1 (3%)	0.26
Mechanical ventilation	20 (32%)	17((55%)	0.03
Type of RRT by Enrollment			
None	43(68%)	18(58%)	
HD	6(10%)	3 (10%)	
CVVH	12 (19%)	7 (23%)	
CVVH and HD	2(3%)	3(10%)	0.008
Length of Stay (LOS), median (IQR)			

MICU (days)	6 (3, 65)	65(5,65)	0.01
Hospital (days)	27 (15, 119)	119(14, 119)	0.06
Probability of 60 day mortality[b]	.19 (.02, 0.52)	0.25(0.05, 0.55)	0.24

Values represent N (%) unless otherwise stated. Abbreviations: RRT, renal replacement therapy; CVVH, continuous venovenous hemofiltration; HD, hemodialysis; MICU, medical intensive care unit.

a.Clinical diagnoses of acute kidney injury specified by clinicians caring for the patient

b. Risk equation by Demirjian S, Chertow GM, Zhang JH et al. (19)

Supplemental Methods

The medical intensive care unit (MICU) at Brigham and Women's Hospital consists of 20-beds, and is staffed by nurses, residents, fellows and attendings. The nephrology service functions as a consulting service in the MICU, providing recommendations to the primary team, and makes decisions and writes orders regarding renal replacement therapy (RRT) initiation, modality choice and discontinuation. Patients with AKI requiring RRT all therefore require a nephrology consult. Patients with previous MICU admissions during hospitalization were excluded. This exclusion criterion was chosen for two reasons: 1) to avoid multiple admissions of the same individual during the same hospitalization, since some patients are in fact transferred multiple times as disease severity changes and MICU or floor bed availability changes; and 2) to avoid having periods of missing data for such individuals. The SCAMP served as a real-time prompt for clinicians as they were asked to complete the SCAMP form during their daily assessment of the patient. The SCAMP forms were available during the daily rounds completed by the nephrology fellow and the attending.