Supplement

Defining the pathway to timely diagnosis and treatment of interstitial lung disease: a US Delphi survey

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19 **Supplementary Results Table S1.** Delphi panel demographics

	Overall (n=49)	Survey 1 (n=48)	Survey 2 (n=40)*	Survey 3 (n=36)
Primary specialty				
Pulmonary +/- critical care medicine	43 (87.8%)	42 (87.5%)	35 (87.5%)	32 (88.9%)
Academic/teaching hospital	20 (40.8%)	20 (41.7%)	19 (47.5%)	18 (50.0%)
Community	23 (46.9%)	22 (45.8%)	16 (40.0%)	14 (38.9%)†
Primary care: Internal medicine	2 (4.1%)	2 (4.2%)	1 (2.5%)	1 (2.8%)
Academic/teaching hospital	1 (2.0%)	1 (2.1%)	1 (2.5%)	1 (2.8%)
Community	1 (2.0%)	1 (2.1%)	0 (0.0%)	0 (0.0%)
Primary care: Family medicine	4 (8.2%)	4 (8.3%)	4 (10.0%)	3 (8.3%)
Academic/teaching hospital	1 (2.0%)	1 (2.1%)	1 (2.5%)	1 (2.8%)
Community	3 (6.1%)	3 (6.3%)	3 (7.5%)	2 (5.6%)
Years involved in caring for patients with respiratory symptoms				
5 years‡	5 (10.2%)	5 (10.4%)	4 (10.0%)	4 (11.1%)
6–10 years	12 (24.5%)	12 (25.0%)	10 (25.0%)	10 (27.8%)
11–15 years	10 (20.4%)	10 (20.8%)	8 (20.0%)	7 (19.4%)
>15 years	22 (44.9%)	21 (43.8%)	18 (45.0%)	15 (41.7%)†

	Overall (n=49)	Survey 1 (n=48)	Survey 2 (n=40)*	Survey 3 (n=36)
Number of patients with ILD diagnosed/managed/treated in past 12 months				
Pulmonologists				
1–50	25 (51.0%)	25 (52.1%)	19 (47.5%)	17 (47.2%)
51–100	10 (20.4%)	10 (20.8%)	8 (20.0%)	7 (19.4%)
101–150	4 (8.2%)	4 (8.3%)	4 (10.0%)	3 (8.3%)
151–200	2 (4.1%)	2 (4.2%)	2 (5.0%)	2 (5.6%)
>200	7 (14.3%)	7 (14.6%)	7 (17.5%)	6 (16.7%)
Unknown	1 (2.0%)	0 (0.0%)	0 (0.0%)	1 (2.8%)†
Geographic location of practice				
West	6 (12.2%)	6 (12.5%)	6 (15.0%)	5 (13.9)
Midwest	4 (8.2%)	4 (8.3%)	3 (7.5%)	3 (8.3%)
South	22 (44.9%)	22 (45.8%)	17 (42.5%)	13 (36.1%)
Northeast	17 (34.7%)	16 (33.3%)	14 (35.0%)	15 (41.7%)†

*Two panellists provided partial responses, which were included in the analysis.

†One panellist completed Survey 3 without completing Surveys 1 and 2.

‡Pulmonologists with 4 years of clinical experience were included if they had 1 year of clinical experience during their fellowship that was ILD-focused.

ILD, interstitial lung disease.

Supplementary Results Table S2. Consensus statements

Consensus statement	Number of responses	Level of consensus agreement
1. Guidelines		
The current guidelines on the diagnosis and management of ILD are not completely clear.	36	94.4%
There is a need for increased awareness and education around ILD for patients and PCPs.	40	100%
There is a need for guidelines for PCPs that include when to suspect ILD and when to refer to a pulmonologist.	40	100%
PCPs need more guidance on PFTs.	38	100%
There is a need for increased awareness and education around ILD for pulmonologists and rheumatologists.	36	97.2%
Pulmonologists need further guidance on how to manage and when to refer patients with ILD.	35	94.3%
Radiologists need additional guidance on what to include in CT reports.	37	94.6%
ILD centres need improved guidance on co-management of patients with ILD.	36	97.2%
2. Community screening		
PCPs should consider ILD in patients with chronic cough and/or dyspnoea when cardiac disease, asthma, bronchitis, and allergies have been ruled out as the cause.	36	97.2%

Consensus statement	Number of responses	Level of consensus agreement
In the primary care setting, ILD should be considered in patients with any of the following unexplained symptoms: chronic cough, dyspnoea, crackles on auscultation, clubbing on fingernails, oxygen desaturation with ambulation, or hypoxemia at rest.	36	97.2%
Patients presenting with chronic cough and dyspnoea in the primary care setting should be asked questions in review of systems about CTD.	35	94.3%
For patients presenting with a chronic cough and dyspnoea, spirometry (if available at PCP office), chest X-ray, and oximetry (including simple 500-feet ambulatory pulse oximetry with 3-point drop) should be ordered by the PCP.	35	85.7%
PCPs need clearer guidance on ordering an HRCT scan for patients with suspected ILD.	37	100%
If ILD is suspected in a patient following workup, a PCP should order an HRCT scan prior to pulmonologist referral if they are familiar with the correct imaging technique to request and can ensure adequate quality.	36	94.4%
A different course of action should be considered after 1–3 months in patients with chronic cough and/or dyspnoea with normal FVC and chest X-ray who do not respond to prescribed treatment or management in primary care, and a pulmonology referral should be considered.	36	97.2%

Consensus statement	Number of responses	Level of consensus agreement
PCPs, rheumatologists, and cardiologists should always consider ILD if a patient has cough, dyspnoea, and crackles on auscultation that are not explained by workup.	36	100%
Patients presenting in primary or rheumatology care with clinical features including chronic dry/non-productive cough, dyspnoea, auscultatory crackles, and oxygen desaturation, which are not explained by workup, should be co-managed with a pulmonologist.	36	100%
Cardiologists should consider concurrent workup or diagnostic testing with a pulmonologist for patients who do not have cardiac dysfunction and present with chronic dry/non-productive cough, dyspnoea, auscultatory crackles, or oxygen desaturation with ambulation.	35	100%
Patients with a CTD should be screened for ILD at baseline and then every 12–18 months depending on the underlying disease.	33	90.9%
Patients with a history of scleroderma and no respiratory symptoms or crackles on lung auscultation should be screened for ILD using at least full PFTs (spirometry plus measurement of lung volumes and diffusion capacity).	38	94.2%
Further research is needed to determine which patients with rheumatoid arthritis would benefit from HRCT screening.	35	94.3%

Consensus statement	Number of responses	Level of consensus agreement
Irrespective of respiratory symptoms, patients aged 50 years or older with a family history of familial pulmonary fibrosis should be screened for ILD using at least full PFTs (spirometry plus measurement of lung volumes and diffusion capacity).	35	83.9%
Further research and guidance are needed to determine whether patients with one single first-degree relative with pulmonary fibrosis/IIP in the family and no respiratory symptoms or crackles on lung auscultation should be screened for ILD.	36	97.2%
3. Community diagnosis		
A pulmonologist should include medical history, physical examination, PFTs, serology, 6MWT, and HRCT in the workup of a patient with suspected ILD.	32	96.9%
In patients with suspected ILD, questionnaires should be used to obtain a detailed medical history.	33	97.0%
When a specific ILD diagnosis is being considered, ILD-specific patient questionnaires should be used where possible.	32	93.8%
Serologic panel testing should always be ordered as part of the workup for ILD and should be used to facilitate a differential diagnosis.	32	96.9%
It is important to make a specific ILD diagnosis whenever possible.	33	3 (1)*

Consensus statement	Number of responses	Level of consensus agreement
In patients with non-specific ILD symptoms, the most important serologies to order are: ANA, CCP, RF, SSA, and Scl 70.	31	80.7%
For patients with a non-productive cough and dyspnoea, an HRCT scan should be ordered if not already available following referral to a pulmonologist if they have any one of the following: auscultatory crackles, clubbing of fingernails, oxygen desaturation with ambulation, bibasilar abnormalities on chest X-ray, abnormal FVC, abnormal DLco, or confirmed CTD.	33	100%
When sending an HRCT requisition for a patient with suspected ILD to radiology, it is important to specify whether expiratory, inspiratory, or both views are needed, whether prone, supine, or both images are needed, and that it needs to be presented in thin sections.	31	87.1%
Where possible, radiologists should use a standardized template for reporting HRCT results in ILD.	33	2 (1)*
The most important elements to include in an HRCT report are the description of features and the probable diagnosis.	33	97.0%
MDDs should take place during the diagnosis of ILD if there is at least diagnostic uncertainty or if any lung biopsy is being considered.	33	93.9%
An MDD may not be required for cases of suspected ILD if there is no diagnostic uncertainty.	30	86.7%

Consensus statement	Number of responses	Level of consensus agreement
Local ILD multidisciplinary teams should consist of at least a pulmonologist, ideally a thoracic radiologist, a pathologist with expertise in ILD, and a rheumatologist when CTD is suspected.	32	100%
MDDs are most effective when all disciplines are involved (face to face or virtual).	33	100%
4. Community management		
Pulmonologists should follow up with their ILD patients every 3–6 months, depending on the diagnosis and disease severity.	32	100%
At follow-up visits for patients with ILD, pulmonologists should evaluate disease progression, physical function, symptom severity, quality of life, suitability for clinical trials, suitability for lung transplant, and side effects of medication.	33	100%
Cough, dyspnoea, fatigue, and the emotional well-being of patients with ILD should be monitored regularly in patients with ILD.	33†	100%
Common comorbidities that should be monitored/assessed in patients with ILD are pulmonary hypertension, GERD, sleep disordered breathing, COPD, and lung cancer if appropriate.	33†	100%
When following up with a patient with ILD, HRCT scans should be considered if clinical deterioration is observed.	32	96.9%

Consensus statement	Number of responses	Level of consensus agreement
Pulmonologists should monitor for ILD progression using at least spirometry and measurement of diffusion capacity.	32	96.9%
The decision to carry out PFTs (spirometry, measurement of lung volumes, and diffusion capacity) when following up with a patient with ILD depends on the specific diagnosis, disease severity, and treatment.	32	93.8%
It is important to discuss pulmonary rehabilitation; lung transplant and clinical trial opportunities; symptom management; advanced care planning and goals of care; and palliative care when managing patients with ILD.	32	100%
Patients with any CTD-associated ILD should be co-managed with a rheumatologist and pulmonologist.	33	97.0%
Shared decision-making with ILD patients is important when prescribing treatment.	33	3 (0)*
5. Specialist referral		
Pulmonologists should consider referral of a patient with ILD to a specialist ILD or PFF centre if there is diagnostic or treatment uncertainty, the patient requests referral, the patient is a transplant or clinical trial candidate, or if there is disease progression despite treatment.	32	100%

Consensus statement	Number of responses	Level of consensus agreement
Patients with IPF should receive early referral to an ILD centre if they are young at disease onset, transplant eligible, or have rapid disease progression.	33	100%
Patients who are potential transplant candidates or have rapidly progressing disease should be given priority access to an ILD centre upon referral.	33	100%
When selecting an ILD centre for referral of a patient with ILD, a pulmonologist should consider whether they are part of the PFF Care Center Network, have clinical trial opportunities, and if they are a lung transplant centre, as well as their reputation and proximity to the patient.	31	96.8%
Referring physicians should always share all relevant patient medical records when referring to an academic centre.	38	100%
When referring a patient with ILD to a specialist ILD or PFF centre, the referral package should ideally contain the PFT history, CT scan images and reports, biopsy results, serologies if available, pulmonary and rheumatology clinic notes, and reasons for referral.	32	100%
When referring a patient with ILD to a specialist ILD or PFF centre, the referral package should state whether the patient should be returned to community care after consultation.	30	90.0%
It should be the shared responsibility of the referring community physician, the pulmonologist at the ILD centre and	32	93.8%

Consensus statement	Number of responses	Level of consensus agreement
the patient to ensure that the referral package is shared with the ILD centre.		
Sharing the referral package with the ILD centre on referral should not be the responsibility of the patient alone.	32	93.8%
A reasonable access time to a specialist ILD or PFF centre upon referral is 4–6 weeks.	32	96.9%
Telehealth should be made available in ILD centres.	42	100%
Pulmonologists at ILD centres should review all records before carrying out any further tests on patients referred with ILD.	33	3 (1)*
ILD centres should share all relevant patient medical records when returning patients to community care.	33	3 (1)*
Following referral to an ILD centre, patients should be co-managed by a community pulmonologist and ILD centre if possible.	31	100%
Patients who are eligible for transplant, enrolled in clinical trials, have rapidly progressing or complex disease, or are receiving specialized treatment should remain in the care of a pulmonologist at an ILD centre.	31	100%

*For statements assessed on a 7-point Likert scale, the data are median (IQR). The scale was from –3 (strongly disagree) to +3 (strongly agree).

†Statements were developed based on high/unanimous consensus agreement achieved on two related questions at Survey 2, which were combined but were not presented to the panel.

6MWT, 6-minute walk test; ANA, antinuclear antibodies; CCP, cyclic citrullinated peptide; COPD, chronic obstructive pulmonary disease; CT, computed tomography; CTD, connective tissue disease; DLco, diffusing capacity of the lung for carbon monoxide; FVC, forced vital capacity; GERD, gastroesophageal reflux disease; HRCT, high-resolution computed tomography; IIP, idiopathic interstitial pneumonias; ILD, interstitial lung disease; IQR, interquartile range; MDD, multidisciplinary discussion; PCP, primary care physician; PFF, Pulmonary Fibrosis Foundation; PFT, pulmonary function test; RF, rheumatoid factor; SSA, Sjögren's-syndrome-related antigen A.

Supplementary Results Table S3. Guidelines: evolution of statements from Survey 1 to 3

Survey 1			Survey 2		Survey 3	
N	**Question/statement**		**N**	**Question/statement**	**N**	**Question/statement**
47	The current guidelines on the diagnosis and management of ILD are clear.*	1 (2)	40	The current guidelines on the diagnosis and management of ILD are not completely clear. **82.5% agreement**	36	The current guidelines on the diagnosis and management of ILD are not completely clear. **94.4% agreement**
48	Is there a need for increased awareness and education around ILD? 1. Patients 2. PCPs 3. Pulmonologists 4. Rheumatologists 5. Cardiologists 6. Other	 87.5% 97.9% 68.8% 66.7% 33.3% 2.1%	40 36	There is a need for increased awareness and education around ILD for patients and PCPs. **100% agreement** There is a need for increased awareness and education around ILD for pulmonologists and rheumatologists. **97.2% agreement**		

Survey 1			Survey 2		Survey 3	
N	**Question/statement**		**N**	**Question/statement**	**N**	**Question/statement**
44	Should PCPs have guidelines on what to look out for in ILD?		40	There is a need for guidelines for PCPs that include when to suspect ILD and when to refer to a pulmonologist.		
	1. Yes	95.5%		**100% agreement**		
	2. No	4.5%				
45	Should PCPs have guidelines on when to refer a patient with possible ILD?					
	1. Yes	97.8%				
	2. No	2.2%				
41	Do PCPs need more guidance on PFTs?		38	PCPs need more guidance on PFTs.		
	1. Yes	100%		**100% agreement**		
	2. No	0%				
43	Do radiologists need additional guidance on what to include in CT reports?		37	Radiologists need additional guidance on what to include in CT reports.		
	1. Yes	81.4%				

Survey 1			Survey 2		Survey 3	
N	**Question/statement**		**N**	**Question/statement**	**N**	**Question/statement**
	2. No	18.6%		**94.6% agreement**		
41	Do pulmonologists need further guidance on how to manage and when to refer patients with ILD to an ILD centre?		35	Pulmonologists need further guidance on how to manage and when to refer patients with ILD.		
	1. Yes	80.5%		**94.3% agreement**		
	2. No	19.5%				
32	Do ILD centres need additional guidance on co-management of patients with ILD?		34	ILD centres need improved guidance on co-management of patients with ILD.	36	ILD centres need improved guidance on co-management of patients with ILD.
	1. Yes	62.5%		**82.4% agreement**		**97.2% agreement**
	2. No	37.5%				

*For statements assessed on a 7-point Likert scale, the data are median (IQR). The scale was from –3 (strongly disagree) to +3 (strongly agree).

CT, computed tomography; ILD, interstitial lung disease; IQR, interquartile range; PCP, primary care physician; PFT, pulmonary function test.

45 **Supplementary Results Table S4.** Community screening: evolution of statements from Survey 1 to 3

Survey 1			Survey 2		Survey 3	
N	**Question/statement**		**N**	**Question/statement**	**N**	**Question/statement**
48	Which of the following causes should a PCP explore in a patient presenting with chronic cough and/or dyspnoea?		39	PCPs should always consider ILD in patients with chronic cough and/or dyspnoea when cardiac disease, asthma, bronchitis, allergies, and GERD have been ruled out as the cause. **94.9% agreement**	36	PCPs should consider ILD in patients with chronic cough and/or dyspnoea when cardiac disease, asthma, bronchitis, and allergies have been ruled out as the cause. **97.2% agreement**
	1. Cardiac	87.5%				
	2. Asthma	95.8%				
	3. Bronchitis	83.3%				
	4. Allergies	83.3%				
	5. Pneumonia	62.5%				
	6. Obesity	52.1%				
	7. ILD	91.7%				
	8. Autoimmune/rheumatologic	54.2%				
	9. Other	14.6%				

Survey 1			Survey 2		Survey 3	
N	**Question/statement**		**N**	**Question/statement**	**N**	**Question/statement**
48	In the primary care setting, which of the following should be considered as signs of ILD?		40	In the primary care setting, ILD should always be considered in patients with any of the following: chronic cough, dyspnoea, crackles on auscultation, clubbing on fingernails, oxygen desaturation with ambulation, or hypoxemia at rest. **97.5% agreement**	36	In the primary care setting, ILD should be considered in patients with any of the following unexplained symptoms: chronic cough, dyspnoea, crackles on auscultation, clubbing on fingernails, oxygen desaturation with ambulation, or hypoxemia at rest. **97.2% agreement**
	1. Chronic dry cough	97.9%				
	2. Dyspnoea	97.9%				
	3. Chest pain	8.3%				
	4. Chest tightness	16.7%				
	5. Wheezing	10.4%				
	6. Auscultatory crackles	95.8%				
	7. Clubbing of fingernails	97.5%				
	8. Oxygen desaturation with ambulation	93.8%				
	9. Hypoxemia at rest	85.4%				
	10. Other	4.2%				

Survey 1		Survey 2		Survey 3	
N	**Question/statement**	**N**	**Question/statement**	**N**	**Question/statement**
41	If a patient presents with chronic cough and/or dyspnoea, should a PCP ask questions about CTD? 1. Yes 90.2% 2. No 9.8%	38	Patients presenting with chronic cough and/or dyspnoea in the primary care setting should be asked questions about CTD. **94.7% agreement**	35	Patients presenting with chronic cough and dyspnoea in the primary care setting should be asked questions in review of systems about CTD. **94.3% agreement**
48	Which of the following assessments should a PCP order/perform for a patient presenting with a chronic cough and/or dyspnoea in the primary care level? 1. Spirometry 87.5% 2. Chest X-ray 97.9% 3. Ambulatory oximetry/6MWT 52.1% 4. CT scan 43.8%	39	For patients with a chronic cough and/or dyspnoea, spirometry and chest X-ray should be ordered by the PCP. **94.9% agreement** Should a PCP perform/order oximetry for a patient presenting with a chronic cough and/or dyspnoea in the primary care level? 1. Yes 84.6%	35	For patients presenting with a chronic cough and dyspnoea, spirometry (if available at PCP office), chest X-ray and oximetry (including simple 500-feet ambulatory pulse oximetry with 3-point drop) should be ordered by the PCP.

Survey 1			Survey 2			Survey 3	
N	**Question/statement**		**N**	**Question/statement**		**N**	**Question/statement**
	5. Echocardiogram	47.9%		2. No	15.4%		**85.7% agreement**
	6. Oximetry	75.0%					
	7. Other	6.3%					
46	What clinical features should prompt a rheumatologist to suspect ILD?		40	Should rheumatologists always consider co-management with a pulmonologist for patients presenting with chronic dry/non-productive cough, dyspnoea, auscultatory crackles, or oxygen desaturation with ambulation?		36	Patients presenting in primary or rheumatology care with clinical features including chronic dry/non-productive cough, dyspnoea, auscultatory crackles and oxygen desaturation, which are not explained by workup, should be co-managed with a pulmonologist.
	1. Chronic dry/non-productive cough	93.8%		1. Yes	95.0%		**100% agreement**
	2. Dyspnoea	93.8%		2. No	5.0%		
	3. Chest pain	12.5%					
	4. Chest tightness	20.8%					
	5. Wheezing	12.5%					
	6. Auscultatory crackles	89.6%					
	7. Oxygen desaturation with ambulation	93.8%					
	8. Other	6.3%					

Survey 1		Survey 2		Survey 3	
N	**Question/statement**	**N**	**Question/statement**	**N**	**Question/statement**
46	What clinical features should prompt a cardiologist to suspect ILD? 1. Chronic dry/non-productive cough 95.8% 2. Dyspnoea 81.2% 3. Chest pain 4.2% 4. Chest tightness 12.5% 5. Wheezing 12.5% 6. Auscultatory crackles 87.5% 7. Oxygen desaturation with ambulation 89.6% 8. Other 6.3%	39	Should cardiologists always consider concurrent workup or diagnostic testing with a pulmonologist for patients presenting with chronic dry/non-productive cough, dyspnoea, auscultatory crackles, or oxygen desaturation with ambulation? 1. Yes 84.6% 2. No 15.4%	35	Cardiologists should consider concurrent workup or diagnostic testing with a pulmonologist for patients who do not have cardiac dysfunction and present with chronic dry/non-productive cough, dyspnoea, auscultatory crackles, or oxygen desaturation with ambulation. **100% agreement**
41	If a patient has cough and/or dyspnoea with crackles on auscultation that are not	40	PCPs should always consider ILD if a patient has cough, dyspnoea, and crackles	36	PCPs, rheumatologists, and cardiologists should always

	Survey 1			Survey 2			Survey 3	
N	**Question/statement**		**N**	**Question/statement**		**N**	**Question/statement**	
	explained by workup, should a PCP explore possible ILD?			on auscultation that are not explained by workup.			consider ILD if a patient has cough, dyspnoea, and crackles on auscultation that are not explained by workup.	
	1. Yes	97.9%		**100% agreement**				
	2. No	2.1%					**100% agreement**	
47	If a patient with chronic cough and/or dyspnoea has an abnormal FVC on spirometry, bibasilar abnormalities on chest X-ray, and oxygen desaturation with ambulation, what should a PCP do next?							
	1. Refer to a pulmonologist	48.9%						
	2. Order a CT scan	48.9%						
	3. Carry out further diagnostic assessments	2.1%						

Survey 1			Survey 2		Survey 3	
N	**Question/statement**		**N**	**Question/statement**	**N**	**Question/statement**
	4. Other	19.2%				
45	If ILD is suspected in a patient following workup, should a PCP order a CT scan?		39	If ILD is suspected in a patient following workup, a PCP should order a CT scan prior to pulmonologist referral if they are familiar with the correct imaging technique to request.	36	If ILD is suspected in a patient following workup, a PCP should order an HRCT scan prior to pulmonologist referral if they are familiar with the correct imaging technique to request and can ensure adequate quality.
	1. Yes	75.6%		**89.7% agreement**		**94.4% agreement**
	2. No	24.4%				
31	If yes, should they order a CT scan prior to pulmonologist referral?					
	1. Yes	96.8%				
	2. No	3.2%				

Survey 1			Survey 2			Survey 3	
N	**Question/statement**		**N**	**Question/statement**		**N**	**Question/statement**
29	If yes, is it clear what type of CT scan a PCP should be ordering? 1. Yes 2. No	 72.4% 17.6%	37	Do PCPs need clearer guidance on ordering an HRCT scan for patients with suspected ILD? 1. Yes 2. No	 100% 0%		
29	As a pulmonologist, would you prefer to have the HRCT in advance of a patient referral, or would you prefer to order it yourself? 1. In advance 2. Order own HRCT	 70.0% 30.0%					
40	If a patient with chronic cough and/or dyspnoea with normal FVC and chest X-ray does not respond to prescribed treatment or		39	How long should a patient with chronic cough and/or dyspnoea with normal FVC and chest X-ray, not responding to		36	A different course of action should be considered after 1–3 months in patients with chronic

Survey 1			Survey 2			Survey 3	
N	**Question/statement**		**N**	**Question/statement**		**N**	**Question/statement**
	management, how long should a PCP observe them before considering a different course of action?			prescribed treatment or management be observed in primary care before considering a different course of action?			cough and/or dyspnoea with normal FVC and chest X-ray who do not respond to prescribed treatment or management in primary care, and a pulmonology referral should be considered.
	1. 0–3 months	58.3%		1. 1 month	10.3%		**97.2% agreement**
	2. 3–6 months	39.6%		2. 2 months	7.7%		
	3. 6–9 months	2.1%		3. 3 months	76.9%		
	4. 9–12 months	0%		4. 4 months	0%		
	5. >12 months	0%		5. 5 months	0%		
				6. 6 months	5.1%		
				7. >6 months	0%		
48	If a patient with chronic cough and/or dyspnoea with normal FVC and chest X-ray does not respond to prescribed treatment or		40	If a patient with chronic cough and/or dyspnoea with normal FVC and chest X-ray does not respond to prescribed treatment or			

Survey 1			Survey 2			Survey 3	
N	**Question/statement**		**N**	**Question/statement**		**N**	**Question/statement**
	management, should a PCP consider referral to a pulmonologist?			management in primary care, pulmonology referral should always be considered?			
	1. Yes	97.9%		**95.0% agreement**			
	2. No	2.1%					
44	Should patients with a history of RA and no respiratory symptoms or crackles on lung auscultation be screened for ILD? Screening can include PFTs and/or CT imaging.		31	Should asymptomatic patients with a history of RA be screened for ILD with at least PFTs?		35	Further research is needed to determine which patients with RA would benefit from HRCT screening.
	1. Yes	65.9%		1. Yes	77.4%		**94.3% agreement**
	2. No	34.1%		2. No	22.6%		
30	If yes, which test(s) would you recommend?		33	Would you consider HRCT screening for ILD in asymptomatic patients with a history of RA if limited to 1 per year?			
	1. Only spirometry,* no HRCT	3.3%		1. Yes	60.6%		
	2. Full PFTs,† no HRCT	43.3%					
	3. HRCT alone	0%					

Survey 1			Survey 2			Survey 3	
N	**Question/statement**		**N**	**Question/statement**		**N**	**Question/statement**
	4. Only spirometry* plus HRCT	3.3%		2. No	39.4%		
	5. Full PFTs† plus HRCT	50.0%					
44	Should patients with a history of SSc and no respiratory symptoms or crackles on lung auscultation be screened for ILD? Screening can include PFTs and/or CT imaging.		38	Patients with a history of SSc and no respiratory symptoms or crackles on lung auscultation should be screened for ILD using at least full PFTs.†			
	1. Yes	93.2%		**94.2% agreement**			
	2. No	6.8%					
41	If yes, which test(s) would you recommend?						
	1. Only spirometry,* no HRCT	2.4%					
	2. Full PFTs,† no HRCT	43.9%					
	3. HRCT alone	0%					
	4. Only spirometry* plus HRCT	0%					
	5. Full PFTs† plus HRCT	53.7%					

Survey 1			Survey 2		Survey 3	
N	**Question/statement**		**N**	**Question/statement**	**N**	**Question/statement**
41	Should patients with a family history of familial PF and no respiratory symptoms or crackles on lung auscultation be screened for ILD? Screening can include PFTs and/or CT imaging. 1. Yes 70.7% 2. No 29.3%		34	Patients with a family history of familial PF and no respiratory symptoms or crackles on lung auscultation should be screened for ILD using at least full PFTs.† **85.3% agreement**	35	Irrespective of respiratory symptoms, patients aged 50 years or older with a family history of familial PF should be screened for ILD using at least full PFTs.† **83.9% agreement**
29	If yes, which test(s) would you recommend? 1. Only spirometry,* no HRCT 6.9% 2. Full PFTs,† no HRCT 55.2% 3. HRCT alone 0% 4. Only spirometry* plus HRCT 0% 5. Full PFTs† plus HRCT 37.9%				32	Irrespective of respiratory symptoms, patients with RA, SSc, or a family history of familial PF should be screened for ILD using at least full PFTs.† **68.8% agreement**

Survey 1		Survey 2		Survey 3	
N	**Question/statement**	**N**	**Question/statement**	**N**	**Question/statement**
39	Should patients with one first-degree relative with PF/IIP in the family and no respiratory symptoms or crackles on lung auscultation be screened for ILD? Screening can include PFTs and/or CT imaging. 1. Yes 61.5% 2. No 38.5%	36	Is further guidance needed on whether patients with one first-degree relative with PF/IIP in the family and no respiratory symptoms or crackles on lung auscultation should be screened for ILD? 1. Yes 86.1% 2. No 13.9%	36	Further research and guidance are needed to determine whether patients with one first-degree relative with PF/IIP in the family and no respiratory symptoms or crackles on lung auscultation should be screened for ILD. **97.2% agreement**
15	If yes, which test(s) would you recommend? 1. Only spirometry,* no HRCT 13.3% 2. Full PFTs,† no HRCT 60.0%	32	Which patient groups should be screened with HRCT in addition to PFTs? 1. Patients with RA 43.8% 2. Patients with SSc 87.5%	36	Patients with SSc should be screened for ILD using HRCT in addition to PFTs. **72.7% agreement**

Survey 1			Survey 2			Survey 3	
N	Question/statement		N	Question/statement		N	Question/statement
	3. HRCT alone	0%		3. Patients with a family history of familial PF	78.1%	36	Patients with a family history of familial PF should be screened for ILD using HRCT in addition to PFTs. **69.7% agreement**
	4. Only spirometry* plus HRCT	0%		4. Patients with one first-degree relative with PF/IIP in the family	37.5%		
	5. Full PFTs† plus HRCT	26.7%					
38	How often should an asymptomatic patient with a CTD be screened for ILD?		33	How often should an asymptomatic patient with a CTD be screened for ILD?		33	Patients with a CTD should be screened for ILD at baseline and then every 12–18 months depending on the underlying disease. **90.9% agreement**
	1. 0–3 months	0%		1. < Every 9 months	3.0%		
	2. 3–6 months	5.3%		2. Every 9–10 months	0%		
	3. 6–9 months	7.9%		3. Every 11–12 months	27.3%		
	4. 9–12 months	36.8%		4. Every 12–13 months	48.5%		
	5. >12 months	50.0%		5. Every 13–14 months	0%		
				6. Every 15–16 months	3.0%		
				7. > Every 16 months	18.2%		

*No measurement of lung volumes or diffusion capacity.

†Spirometry plus measurement of lung volumes and diffusion capacity.

6MWT, 6-minute walk test; CT, computed tomography; CTD, connective tissue disease; FVC, forced vital capacity; GERD, gastroesophageal reflux disease; HRCT, high-resolution computed tomography; IIP, idiopathic interstitial pneumonias; ILD, interstitial lung disease; PCP, primary care physician; PF, pulmonary fibrosis; PFT, pulmonary function test; RA, rheumatoid arthritis; SSc, systemic sclerosis.

Supplementary Results Table S5. Community diagnosis: evolution of statements from Survey 1 to 3

Survey 1		Survey 2		Survey 3	
N	**Question/statement**	**N**	**Question/statement**	**N**	**Question/statement**
38	From a pulmonologist's perspective, should questionnaires be used to obtain a detailed medical history of a patient with suspected ILD? 1. Yes 94.7% 2. No 5.3%	33	In patients with suspected ILD, questionnaires should be used to obtain a detailed medical history. **97.0% agreement**		
32	If yes, should ILD-specific questionnaires be used when a specific ILD diagnosis is being considered? 1. Yes 87.5% 2. No 12.5%	32	When a specific ILD diagnosis is being considered, ILD-specific patient questionnaires should be used where possible. **93.8% agreement**		
42	Following referral to a pulmonologist, which	33			

Survey 1			Survey 2		Survey 3	
N	**Question/statement**		**N**	**Question/statement**	**N**	**Question/statement**
	clinical features would prompt you to order an HRCT scan in a patient with a non-productive cough and dyspnoea.			For patients with a non-productive cough and dyspnoea, an HRCT scan should be ordered if not already available following referral to a pulmonologist if they have any one of the following: auscultatory crackles, clubbing of fingernails, oxygen desaturation with ambulation, bibasilar abnormalities on chest X-ray, abnormal FVC, abnormal DLco, or confirmed CTD.		
	1. Chest pain	7.1%		**100% agreement**		
	2. Chest tightness	9.5%				
	3. Wheezing	9.5%				
	4. Auscultatory crackles	97.6%				
	5. Clubbing of fingernails	92.9%				
	6. Oxygen desaturation with ambulation	92.9%				
	7. No obstruction on spirometry	33.3%				
	8. Bibasilar abnormalities on chest X-ray	92.9%				
	9. Abnormal FVC	92.9%				

	Survey 1			Survey 2		Survey 3	
N	**Question/statement**		**N**	**Question/statement**	**N**	**Question/statement**
	10. Abnormal DLco	92.9%				
	11. Confirmed CTD	90.5%				
42	What should a pulmonologist include in the workup of a patient with suspected ILD?		32	A pulmonologist should include medical history, physical examination, PFTs, serology, 6MWT, and HRCT in the workup of a patient with suspected ILD. **96.9% agreement**		
	1. Medical history	100%				
	2. Physical examination	100%				
	3. PFTs	100%				
	4. Serology	95.2%				
	5. 6MWT	83.3%				
	6. HRCT	100%				
	7. Other	4.8%				
42	What should the radiologist be told when they receive an HRCT requisition for a patient with suspected ILD?		33	When sending an HRCT requisition for a patient with suspected ILD to radiology, how	31	When sending an HRCT requisition for a patient with suspected ILD to radiology, it is

N	Survey 1 Question/statement		N	Survey 2 Question/statement		N	Survey 3 Question/statement
				important is it to explain each of the following?*			important to specify whether expiratory, inspiratory, or both views are needed; whether prone, supine, or both images are needed; and that it needs to be presented in thin sections. **87.1% agreement**
	1. Reasons for ordering HRCT 2. It needs to be presented in thin sections 3. Whether expiratory or inspiratory 4. Request no contrast image 5. Other	100% 66.7% 61.9% 47.6% 21.4%		1. It needs to be presented in thin sections 2. Whether expiratory, inspiratory, or both views are needed 3. Whether prone, supine, or both images are needed	3 (1) 3 (1) 2 (1)		
42	Which findings on HRCT scans are most valuable to a pulmonologist when considering ILD?			How important are each of the following HRCT findings to a pulmonologist when considering ILD?*			

1.	Pattern as defined by ATS/Fleischner Society	88.1%	
2.	The radiologist's overall impression	54.8%	
3.	Differential diagnosis	54.8%	
4.	Size of pulmonary artery	40.5%	
5.	Presence/absence of hiatal hernia	45.2%	
6.	Presence/absence of honeycombing	100%	
7.	Presence/absence of ground glass opacities	97.6%	
8.	Presence/absence of reticulation	90.5%	
9.	Presence/absence of bronchiectasis	83.3%	
1.	Pattern as defined by ATS/Fleischner Society	-2 (3)	
2.	Presence/absence of honeycombing	-2 (1)	
3.	Presence/absence of ground-glass opacities	-1 (0)	
4.	Presence/absence of reticulation	0 (2)	
5.	Presence/absence of bronchiectasis	1 (1)	
6.	Presence/absence of emphysema	2 (1)	
7.	Presence/absence of cystic changes and size, characteristics	2 (2)	

10. Presence/absence of adenopathy	61.9%
11. Presence/absence of nodules or masses	64.3%
12. Presence/absence of emphysema	73.8%
13. Presence/absence of cystic changes and size, characteristics	71.4%
14. Presence/absence of pleural disease	52.4%
15. Distribution of findings	88.1%
16. Quantification of disease presence	61.9%
17. Other	2.4%

Survey 1			Survey 2			Survey 3	
N	**Question/statement**		**N**	**Question/statement**		**N**	**Question/statement**
41	Where possible, radiologists should use a standardized template for reporting HRCT results in ILD.*	2 (1)	33	Where possible, radiologists should use a standardized template for reporting HRCT results in ILD.*	2 (1)		
42	From a pulmonologist's perspective, what would you like to be included in an HRCT report from the radiologist? 1. Description of features 2. Probable diagnosis 3. Recommendations for pulmonology referral 4. Other	 97.6% 81.0% 28.6% 2.4%	33	The most important elements to include in an HRCT report are the description of features and the probable diagnosis.	**97.0% agreement**		
42	From a pulmonologist's perspective, in what circumstance would you recommend an MDD for the diagnosis of ILD?		33	MDDs should take place during the			

Survey 1			Survey 2			Survey 3	
N	**Question/statement**		**N**	**Question/statement**		**N**	**Question/statement**
	1. Whenever ILD is suspected	33.3%		diagnosis of ILD if there is at least diagnostic uncertainty or if any lung biopsy is being considered. **93.9% agreement**			
	2. If there is diagnostic uncertainty	88.1%					
	3. Once ILD is confirmed to obtain a differential diagnosis	33.3%					
	4. If CTD is suspected	35.7%	27	For what reasons is an MDD not needed if ILD is suspected?		30	An MDD may not be required for cases of suspected ILD if there is no diagnostic uncertainty. **86.7% agreement**
	5. If CTD is confirmed	31.0%		1. Limited access to MDT	70.4%		
	6. If considering any lung biopsy	83.3%		2. It is too expensive	7.4%		
	7. Following any lung biopsy	64.3%		3. It takes too long	33.3%		
	8. Other	2.4%		4. Other	44.4%		
42	Do you (as a pulmonologist) have a local MDT available to facilitate ILD diagnosis?		42	Local ILD MDTs should consist of at least a pulmonologist, ideally a		32	Local ILD MDTs should consist of at least a pulmonologist, ideally a thoracic radiologist, a
	1. Yes	61.9%					

	Survey 1			Survey 2		Survey 3	
N	**Question/statement**		**N**	**Question/statement**	**N**	**Question/statement**	
	2. No	38.1%		thoracic radiologist, and pathologist with expertise in ILD. **97.0% agreement**		pathologist with expertise in ILD, and a rheumatologist when CTD is suspected. **100% agreement**	
26	If yes, who is part of your MDT?						
	1. General pulmonologist(s)	61.5%					
	2. ILD pulmonologist(s)	88.5%					
	3. General radiologist(s)	11.5%					
	4. Thoracic radiologist(s)	92.3%					
	5. General pathologist(s)	23.1%					
	6. Thoracic pathologist(s)	76.9%					
	7. Rheumatologist(s)	61.5%					
	8. Clinical nurse specialist(s)	42.3%					
	9. Cardiothoracic surgeon(s)	15.4%					
	10. Other	3.9%					
26	How often do you meet with your MDT to discuss patients with suspected ILD?						

Survey 1			Survey 2		Survey 3	
N	**Question/statement**		**N**	**Question/statement**	**N**	**Question/statement**
	1. More than once per week	0%				
	2. Once per week	23.1%				
	3. Twice per month	38.5%				
	4. Once per month	30.8%				
	5. Less than once per month	7.7%				
40	From a pulmonologist's perspective, what MDD or MDT structure do you prefer?		33	MDDs are most effective when all disciplines are involved (face to face or virtual).		
	1. Meeting in a virtual setting	45.0%		**100% agreement**		
	2. Meeting face to face	62.5%				
	3. Separate pulmonologist-driven discussions with each discipline	10.0%				
	4. Discussion with all disciplines together	87.5%				

Survey 1			Survey 2			Survey 3	
N	**Question/statement**		**N**	**Question/statement**		**N**	**Question/statement**
	5. ILD expertise in each discipline	67.5%					
	6. Other	5.0%					
42	It is important to make a specific ILD diagnosis whenever possible (i.e., the subtype).*	3 (1)	33	It is important to make a specific ILD diagnosis whenever possible (i.e., the subtype).*	3 (1)		
42	Serology panel testing should always be ordered when ILD is suspected or diagnosed.*	3 (1)	32	From a pulmonologist's perspective, at which point would you order a serologic panel test?		32	Serologic panel testing should always be ordered as part of the workup for ILD and should be used to facilitate a differential diagnosis. **96.9% agreement**
				1. If ILD is suspected but not diagnosed, before HRCT	9.4%		
				2. If ILD is suspected but not diagnosed, after HRCT	21.9%		
				3. If ILD is diagnosed but before differential diagnosis	46.9%		

N	Survey 1 Question/statement		N	Survey 2 Question/statement		N	Survey 3 Question/statement
				4. If ILD is diagnosed and a differential diagnosis has been confirmed	21.9%		
				5. I would not order a serologic panel test	0%		
42	In a patient with non-specific ILD symptoms, which serologies should a pulmonologist order?		33	In a patient with non-specific ILD symptoms, which serologies are essential to order?		31	In patients with non-specific ILD symptoms, the most important serologies to order are: ANA, CCP, RF, SSA, and Scl 70. **80.7% agreement**
	1. ANA	100%		1. ANA	100%		
	2. CCP	95.2%		2. CCP	97.0%		
	3. RF	97.6%		3. RF	87.9%		
	4. dsDNA	61.9%		4. dsDNA	36.4%		
	5. SSA	81.0%		5. SSA	78.8%		
	6. SSB	78.6%		6. SSB	69.7%		
	7. Scl 70	83.3%		7. Scl 70	87.9%		

Survey 1		Survey 2		Survey 3	
N	**Question/statement**	**N**	**Question/statement**	**N**	**Question/statement**
	8. ANCA (MPO/PR3)	66.7%	8. ANCA (MPO/PR3)	66.7%	
	9. RNP	66.7%	9. RNP	51.5%	
	10. Myositis-related antibodies	73.8%	10. Myositis-related antibodies	63.6%	
	11. Other	4.8%			

*For statements assessed on a 7-point Likert scale, the data are median (IQR). The scale was from –3 (strongly disagree/not at all important) to +3 (strongly agree/extremely important).

6MWT, 6-minute walk test; ANA, antinuclear antibodies; ANCA, antineutrophil cytoplasmic antibodies; CCP, cyclic citrullinated peptide; CTD, connective tissue disease; DLco, diffusing capacity of the lung for carbon monoxide; dsDNA, double-stranded DNA; FVC, forced vital capacity; HRCT, high-resolution computed tomography; ILD, interstitial lung disease; IQR, interquartile range; MDD, multidisciplinary discussion; MDT, multidisciplinary team; MPO, myeloperoxidase; PFT, pulmonary function test; PR3, proteinase-3; RF, rheumatoid factor; RNP, ribonucleoprotein; SSA, Sjögren's-syndrome-related antigen A; SSB, Sjögren's-syndrome-related antigen B.

Supplementary Results Table S6. Community management: evolution of statements from Survey 1 to 3

Survey 1		Survey 2			Survey 3	
N	**Questions/statement**	**N**	**Questions/statement**		**N**	**Questions/statement**
42	As a pulmonologist, how often do you follow up with your ILD patients? [Free text question]	31	How often should a pulmonologist follow up with their ILD patients? 1. Every 3 months 2. Every 4 months 3. Every 6 months 4. >6 months between follow-ups	67.7% 16.1% 16.1% 0%	32	Pulmonologists should follow up with their ILD patients every 3–6 months, depending on the diagnosis and disease severity. **100% agreement**
		33	Should the period between follow-ups depend on the diagnosis and disease severity? 1. Yes 2. No	93.4% 6.6%		

Survey 1			Survey 2			Survey 3	
N	**Questions/statement**		**N**	**Questions/statement**		**N**	**Questions/statement**
42	As a pulmonologist, how often do you perform PFTs when following up with an ILD patient?		32	When following up with a patient with ILD, how often should PFTs be performed?		32	The decision to carry out PFTs when following up with a patient with ILD depends on the specific diagnosis, disease severity, and treatment.
	1. Every time	33.3%		1. Every time	12.5%		**93.8% agreement**
	2. Not every time	66.7%		2. Every 1–3 months	21.9%		
				3. Every 4–6 months	50.0%		
				4. Every 7–9 months	0%		
				5. Every 10–12 months	15.6%		
			33	Should the frequency of PFTs depend on the diagnosis and disease severity?			
				1. Yes	90.9%		
				2. No	9.1%		

Survey 1		Survey 2		Survey 3	
N	**Questions/statement**	**N**	**Questions/statement**	**N**	**Questions/statement**
42	As a pulmonologist, how often do you order an HRCT when following up with an ILD patient? 1. Every time 2.4% 2. Not every time 97.6%	33	As a pulmonologist, how often do you order an HRCT when following up with an ILD patient? 1. Every 6–12 months 6.1% 2. Every year 15.2% 3. Every year if on treatment 12.1% 4. Every 2–3 years 21.2% 5. If a clinical deterioration is observed 75.8%	32	When following up with a patient with ILD, HRCT scans should be considered if clinical deterioration is observed. **96.9% agreement**
42	What should the pulmonologist evaluate at follow-up visits? 1. Disease progression 100% 2. Physical function 95.2% 3. Symptom severity 100% 4. Disease stage 54.8%	33	At follow-up visits for patients with ILD, pulmonologists should evaluate disease progression, physical function, symptom severity, quality of life, suitability for clinical trials, suitability for lung transplant, and side effects of medication.		

Survey 1			Survey 2			Survey 3	
N	**Questions/statement**		**N**	**Questions/statement**		**N**	**Questions/statement**
	5. Quality of life	92.9%		**100% agreement**			
	6. Suitability for clinical trials	88.1%					
	7. Suitability for lung transplant	97.6%					
	8. Side effects of medication	97.6%					
	9. Other	2.4%					
42	As a pulmonologist, what symptoms do you regularly assess/monitor in patients with ILD?		33	Cough, dyspnoea, and fatigue should be monitored regularly in patients with ILD.		–	Cough, dyspnoea, fatigue, and the emotional well-being of patients should be monitored regularly in patients with ILD.
				100% agreement			
	1. Cough	97.6%	32	Should the emotional well-being of patients with ILD be monitored regularly?			
	2. Dyspnoea	100%		1. Yes	100%		
	3. Fatigue	88.1%		2. No	0%		
	4. Depression	35.7%					
	5. Other	2.4%					

Survey 1		Survey 2		Survey 3	
N	**Questions/statement**	**N**	**Questions/statement**	**N**	**Questions/statement**
42	As a pulmonologist, which patients do you co-manage with rheumatologists? [Free text question]	33	Patients with any CTD-associated ILD should be co-managed by a rheumatologist and pulmonologist. **97.0% agreement**		
40	From a pulmonologist's perspective, which assessments should you use to monitor for ILD progression? 1. Only spirometry,* no HRCT 7.5% 2. Full PFTs,† no HRCT 35.0% 3. HRCT alone 0% 4. Spirometry* plus HRCT 7.5% 5. Full PFTs† plus HRCT 50.0%	32	Pulmonologists should monitor for ILD progression using at least full PFTs.† **84.4% agreement**	32	Pulmonologists should monitor for ILD progression using at least spirometry and measurement of diffusion capacity. **96.9% agreement**

Survey 1			Survey 2			Survey 3	
N	**Questions/statement**		**N**	**Questions/statement**		**N**	**Questions/statement**
42	Shared decision-making with ILD patients is important when prescribing treatment.‡	3 (1)	33	Shared decision-making with ILD patients is important when prescribing treatment.‡	3 (0)		
42	As a pulmonologist, which of the following do you discuss with your patients when considering non-pharmacologic ILD management? 1. Pulmonary rehabilitation 2. Support groups 3. Patient education materials 4. Palliative care 5. Clinical trial opportunities 6. Lung transplant (if suitable) 7. Symptom management	 100% 69.1% 66.7% 71.4% 78.6% 97.6% 97.6%	33	How important are each of the following non-pharmacologic aspects in ILD patient management?‡ 1. Pulmonary rehabilitation 2. Palliative care 3. Clinical trial opportunities 4. Lung transplant (if suitable) 5. Symptom management 6. Guidance on advanced care planning and goals of care	 3 (1) 2 (0) 2 (1) 3 (1) 3 (1) 3 (1)	32	It is important to discuss pulmonary rehabilitation; lung transplant and clinical trial opportunities; symptom management; advanced care planning and goals of care; and palliative care when managing patients with ILD. **100% agreement**

N	Survey 1 Questions/statement		N	Survey 2 Questions/statement		N	Survey 3 Questions/statement
	8. Guidance on advanced care planning and goals of care	71.4%					
	9. Other	2.4%					
42	Which common comorbidities should pulmonologists investigate/assess at ILD patient follow-up?		33	Common comorbidities that should be monitored/assessed in patients with ILD are pulmonary hypertension, GERD, sleep disordered breathing, and lung cancer (if appropriate). **100% agreement**		–	Common comorbidities that should be monitored/assessed in patients with ILD are pulmonary hypertension, GERD, sleep disordered breathing, COPD, and lung cancer (if appropriate).
	1. Pulmonary hypertension	100%	32	Should comorbid COPD be investigated/assessed by pulmonologists at ILD patient follow-up?			
	2. GERD	100%		1. Yes	96.9%		
	3. COPD	78.6%		2. No	3.1%		
	4. CAD	59.5%					
	5. Sleep disordered breathing	85.7%					
	6. Lung cancer screening (if appropriate based on history)	92.9%					
	7. Other	2.4%					

*No measurement of lung volumes or diffusion capacity.

†Spirometry plus measurement of lung volumes and diffusion capacity.

‡For statements assessed on a 7-point Likert scale, the data are median (IQR). The scale was from –3 (strongly disagree/not at all important) to +3 (strongly agree/extremely important).

CAD, coronary artery disease; COPD, chronic obstructive pulmonary disease; CTD, connective tissue disease; GERD, gastroesophageal reflux disease; HRCT, high-resolution computed tomography; ILD, interstitial lung disease; IQR, interquartile range; PFT, pulmonary function test.

66 **Supplementary Results Table S7.** Specialist referral: evolution of statements from Survey 1 to 3

Survey 1		Survey 2		Survey 3	
N	**Question/statement**	**N**	**Question/statement**	**N**	**Question/statement**
42	How should a pulmonologist identify an academic centre/ILD specialist to refer a patient to? [Free text question]	33	What are the most important factors when selecting an academic centre/ILD specialist to refer a patient to?* 1. Proximity to patient 2 (0) 2. If they are a lung transplant centre 2 (1) 3. If they have clinical trial opportunities 2 (1) 4. If they are a PFF ILD Center of Excellence 2 (1) 5. If they have a good reputation 2 (0)	31	When selecting an ILD centre for referral of a patient with ILD, a pulmonologist should consider whether they are part of the PFF Care Center Network, have clinical trial opportunities, and if they are a lung transplant centre, as well as their reputation and proximity to the patient. **96.8% agreement**
42	Which IPF patients should receive early referral to an ILD centre?	33	Patients with IPF should receive early referral to an ILD centre if they are young at		

	Survey 1			Survey 2		Survey 3	
N	**Question/statement**		**N**	**Question/statement**	**N**	**Question/statement**
	1. Familial IPF	69.1%		disease onset, transplant eligible, or have rapid disease progression.		
	2. Early age at disease onset	83.3%		**100% agreement**		
	3. Rapid progression	85.7%				
	4. Transplant eligible	100%				
	5. Other	2.4%				
42	When should a patient be referred to an academic centre?		33	Patients with ILD should be referred to an academic centre if diagnostic uncertainty remains, there is treatment uncertainty, the patient requests referral, or the patient is a transplant or clinical trial candidate.	32	Pulmonologists should consider referral of a patient with ILD to a specialist ILD or PFF centre if there is diagnostic or treatment uncertainty, the patient requests referral, the patient is a transplant or clinical trial
	1. If biopsy is being considered	40.5%		**97.0% agreement**		
	2. To confirm diagnosis already made	23.8%	31	Should a patient with ILD that has progressed despite treatment be referred to an academic centre?		
	3. If diagnostic uncertainty remains	92.9%				
	4. If no access to MDD or MDT	52.4%				

Survey 1			Survey 2			Survey 3	
N	**Question/statement**		**N**	**Question/statement**		**N**	**Question/statement**
	5. If disease has progressed despite treatment	71.4%		1. Yes	93.6%		candidate, or if there is disease progression despite treatment.
	6. If there is treatment uncertainty	88.1%		2. No	6.4%		**100% agreement**
	7. If patient requests referral	88.1%					
	8. If patient is transplant candidate	100%					
	9. If patient is clinical trial candidate	90.5%					
	10. If patient has any ILD	14.3%					
	11. If patient has IPF	21.4%					
	12. If patient has familial IPF	52.4%					
	13. If patient has pulmonary hypertension as comorbidity	40.5%					
	14. Other	4.8%					

Survey 1			Survey 2		Survey 3	
N	**Question/statement**		**N**	**Question/statement**	**N**	**Question/statement**
42	Should telehealth be made available in ILD centres to improve accessibility? 1. Yes 2. No	 100% 0%	–	Telehealth should be made available in ILD centres.		
38	When should referring physicians share patient medical records with an ILD centre? 1. Always 2. Only if it does not cause delays 3. Never	 100% 0% 0%	–	Referring physicians should always share all relevant patient medical records when referring to an academic centre.		
42	What should be included in the referral package when referring a patient with ILD to an academic centre?		33	When referring a patient with ILD to an academic centre, the referral package should contain the PFT history, CT scan	32	When referring a patient with ILD to a specialist ILD or PFF centre, the referral package

Survey 1			Survey 2		Survey 3	
N	**Question/statement**		**N**	**Question/statement**	**N**	**Question/statement**
	1. PFT history	100%		images and reports, biopsy results,		should ideally contain the PFT
	2. CT scan images	100%		pulmonary and rheumatology clinic notes,		history, CT scan images and
	3. Biopsy results	97.6%		and reasons for referral.		reports, biopsy results,
	4. Pulmonary and	100%		**100% agreement**		serologies (if available),
	rheumatology clinic notes					pulmonary and rheumatology
	5. Reasons for referral	100%				clinic notes, and reasons for
	6. Whether patient should be	71.4%				referral.
	returned to community care					**100% agreement**
	after consultation					
	7. Other	7.1%	30	When referring a patient with ILD to an	30	When referring a patient with
				academic centre, should the referral		ILD to a specialist ILD or PFF
				package state whether the patient should be		centre, the referral package
				returned to community care after		should state whether the
				consultation?		patient should be returned to

N	Survey 1 Question/statement	N	Survey 2 Question/statement	N	Survey 3 Question/statement
			1. Yes 86.7% 2. No 13.3%		community care after consultation. **90.0% agreement**
40	Who should be responsible for ensuring the referral package is shared with the ILD centre on referral of an ILD patient? 1. Referring community physician 30.0% 2. Academic pulmonologist at ILD centre 5.0% 3. Patient 2.5% 4. Shared responsibility 62.5%	32	If there is a shared responsibility for ensuring the referral package is shared with the ILD centre on referral of an ILD patient, who is it shared between? 1. Referring community physician and academic pulmonologist at ILD centre 43.8% 2. Referring community physician and patient 12.5% 3. Patient and academic pulmonologist at ILD centre 6.3%	32	It should be the shared responsibility of the referring community physician, the pulmonologist at the ILD centre, and the patient to ensure that the referral package is shared with the ILD centre. **93.8% agreement**

Survey 1			Survey 2			Survey 3	
N	**Question/statement**		**N**	**Question/statement**		**N**	**Question/statement**
				4. Referring community physician, academic pulmonologist at ILD centre, and patient	37.5%		
			29	The patient should not be responsible for sharing the referral package with the ILD centre on referral. **55.2% agreement**		32	Sharing the referral package with the ILD centre on referral should not be the responsibility of the patient alone. **93.8% agreement**
42	Pulmonologists at ILD centres should review all records before	3 (1)	33	Pulmonologists at ILD centres should review all records before	3 (1)		

Survey 1		Survey 2		Survey 3	
N	**Question/statement**	**N**	**Question/statement**	**N**	**Question/statement**
	carrying out any further tests on patients referred with ILD.*		carrying out any further tests on patients referred with ILD.*		
42	What is a reasonable access time to an ILD centre upon referral? [Free text question]	33	What is a reasonable access time to an ILD centre upon referral? 1. 1–3 weeks 6.1% 2. 4–6 weeks 78.8% 3. 7–9 weeks 9.1% 4. 10–12 weeks 6.1%	32	A reasonable access time to a specialist ILD or PFF centre upon referral is 4–6 weeks. **96.9% agreement**
42	Which patients should receive priority access to an ILD centre upon referral? 1. Potential transplant candidates 92.9% 2. Clinical trial candidates 61.9%	33	Patients who are potential transplant candidates or have rapidly progressing disease should be given priority access to an ILD centre upon referral. **100% agreement**		

Survey 1			Survey 2			Survey 3	
N	**Question/statement**		**N**	**Question/statement**		**N**	**Question/statement**
	3. Patients needing diagnostic procedures	50.0%					
	4. Patients with rapid progression	92.9%					
	5. Patients with familial PF	28.6%					
	6. Patients under age 65 years	47.6%					
	7. Patients under age 75 years	9.5%					
	8. Patients under age 85 years	2.4%					
42	ILD centres should share all relevant patient medical records when returning patients to community care.*	3 (0)	33	ILD centres should share all relevant patient medical records when returning patients to community care.*	3 (1)		
38	From a pulmonologist's perspective, what should be the default patient pathway following ILD centre referral?		31	Following referral to an ILD centre, patients should be co-managed by a community pulmonologist and ILD centre if possible.			

Survey 1			Survey 2			Survey 3	
N	**Question/statement**		**N**	**Question/statement**		**N**	**Question/statement**
	1. Patients should be returned to community care	10.5%		**100% agreement**			
	2. Patients should remain at ILD centre	5.3%					
	3. Patients should be co-managed	84.2%					
42	Which patients should remain in the care of an academic pulmonologist at an ILD centre? [Free text question]		33	How important is it for each of the following patients to remain in the care of an academic pulmonologist at an ILD centre?* 1. Transplant patients 2. Clinical trial participants 3. Patients with rapidly progressing disease 4. Patients with complex disease	3 (1) 3 (1) 3 (1) 2 (1)	31	Patients who are eligible for transplant, enrolled in clinical trials, have rapidly progressing or complex disease, or are receiving specialized treatment should remain in the care of a pulmonologist at an ILD centre. **100% agreement**

Survey 1		Survey 2		Survey 3	
N	**Question/statement**	**N**	**Question/statement**	**N**	**Question/statement**
			5. Patients receiving specialized treatment	2 (1)	
			6. Patients with multiple comorbidities	2 (2)	

*For statements assessed on a 7-point Likert scale, the data are median (IQR). The scale was from –3 (strongly disagree/not at all important) to +3 (strongly agree/extremely important).

CT, computed tomography; ILD, interstitial lung disease; IPF, idiopathic pulmonary fibrosis; IQR, interquartile range; MDD, multidisciplinary discussion; MDT, multidisciplinary team; PF, pulmonary fibrosis; PFF, Pulmonary Fibrosis Foundation; PFT, pulmonary function test.