National Jewish Health®

Grant ID: US IME_2025_00010587
Final Outcomes Summary
6/30/25 – 3/31/2026

COLLABORATIVE ILD CARE:

Building Community in PULMONOLOGY AND RHEUMATOLOGY

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Executive Summary

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Program Chairs

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Division of Pulmonary, Critical Care & Sleep Medicine
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Program Overview

This 10-month pilot program engaged community-based and academic rheumatologists and pulmonologists by fostering a community of practice focused on early diagnosis, evidence-based treatment, and multidisciplinary collaboration to improve care for patients with interstitial lung disease (ILD). The program featured 9 online video modules, 4 case-based live-virtual meetings, and an expert-facilitated community forum, fostering collaboration, knowledge retention, and professional networking.

Learning Objectives

1. Describe the pathophysiology and classification of ILD.
2. Recognize signs, symptoms, and risk factors for ILD.
3. Apply evidence-based diagnostic strategies to provide timely and accurate diagnosis of ILD.
4. Implement multidisciplinary approaches for the early identification of and treatment of ILD.
5. Appy up-to-date guidelines for the treatment of ILD.
6. Evaluate current and emerging approaches for ILD treatment.

Target Audience & Accreditation

Target Audience: Rheumatologists, pulmonologists and advanced practice providers who may care for patients with ILD.

Accreditation
National Jewish Health designates the activities for up to 10.0 *AMA PRA Category 1 Credits* ™ and 10.0 ABIM MOC points. Learners may only claim credit for the portion of the activity they completed.

Program Formats and Timeline:
Video Modules: 6/30/2025 – 3/31/2026
Community Forum: 7/31/2025 – 3/31/2026
Live Virtual Meetings: 8/27/2025, 10/30/2025, 1/13/2025, 3/10/2026

Program Features

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OVERALL PROGRAM GOAL

To build community and collaboration between academic and community clinicians and between rheumatologists and pulmonologists to improve ILD care

Educational Video Modules: Covering ILD pathophysiology, diagnostic testing, and treatment advances, these modules ensure a strong foundation for all participants.

Live Virtual Case-Based Meetings: Facilitated by academic experts and community practitioners, these interactive sessions provide real-world insights, foster trust, and encourage the application of updated guidelines.

Community Conversation Boards: A platform for ongoing peer-to-peer engagement, case discussion, and knowledge sharing.

"This program was a great way to connect community physicians with academicians and have an open discussion about the approaches to patients with rheumatic disease and ILD. The forum was a way to connect and interact openly and honestly with great feedback and thoughts on cases. I personally enjoyed updating my knowledge base on therapeutics and approaches." *– Barbara Goldstein, MD, Program Chair*

Program Faculty

Final Outcomes Summary

Vivianne Allsop, MD
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Mehrnaz Maleki Fischbach, MD
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Program Faculty

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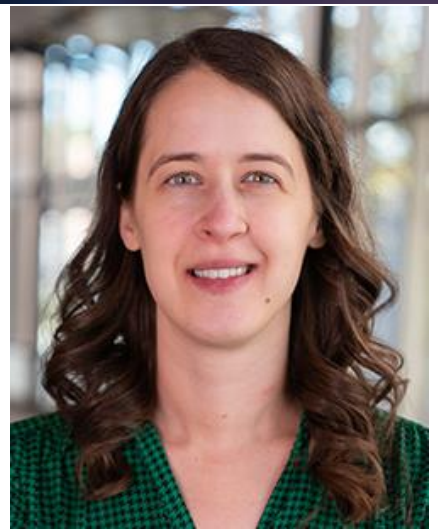

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Division of Pulmonary, Critical Care & Sleep Medicine
National Jewish Health

Audience Generation

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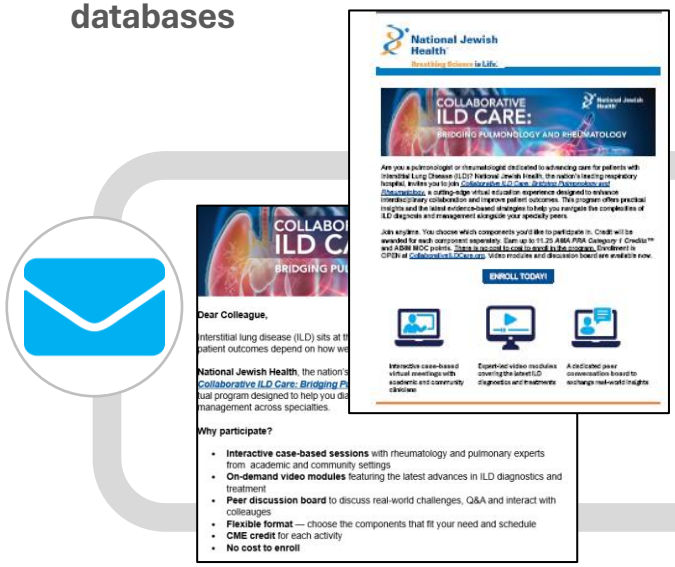
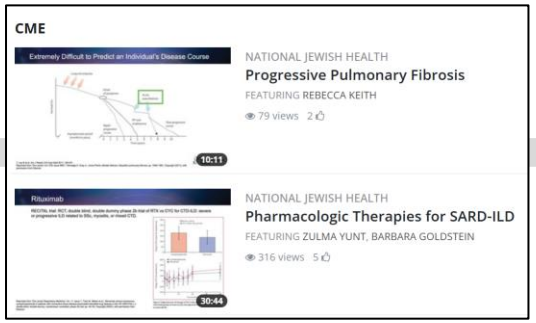
Personalized emails sent to National Jewish Health faculty and provider databases



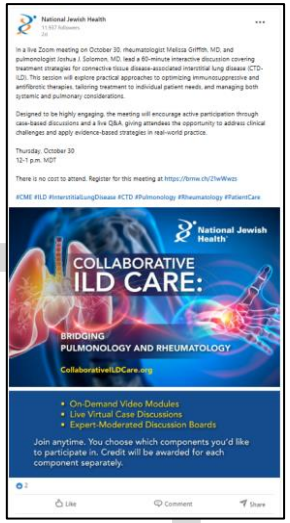
Emails to purchased lists of pulmonologists and rheumatologists

Flyer distributed to providers' offices



Module videos promoted on Vumedi website

Social media ads and posts



Live virtual meetings promoted on FreeCME website and emailed to targeted audiences

Learner Definitions and Guarantees

Final Outcomes Summary

Category	Definition	Guarantees	Actuals
Overall Program Participant	Registered on the Collaborative ILD Care program website and/or participated in one or more program components	80 physicians	**176** physician participants **274** total participants
Online Enduring Learner	Participated in at least one video module	N/A	**53** physician learners **69** total learners
Live Virtual Meeting Learner	Attended one or more of the live virtual meetings	N/A	**74** physician learners **121** total learners
Certificate	Passed the post-test, completed the evaluation and claimed credit on the Collaborative ILD Care program website (for any component of the program)	N/A	**111** total certificates

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Overall Program Participation

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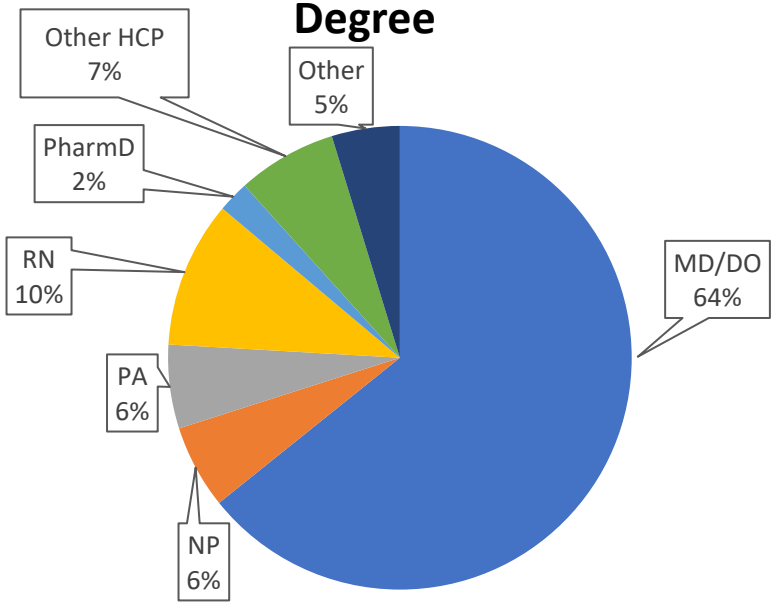
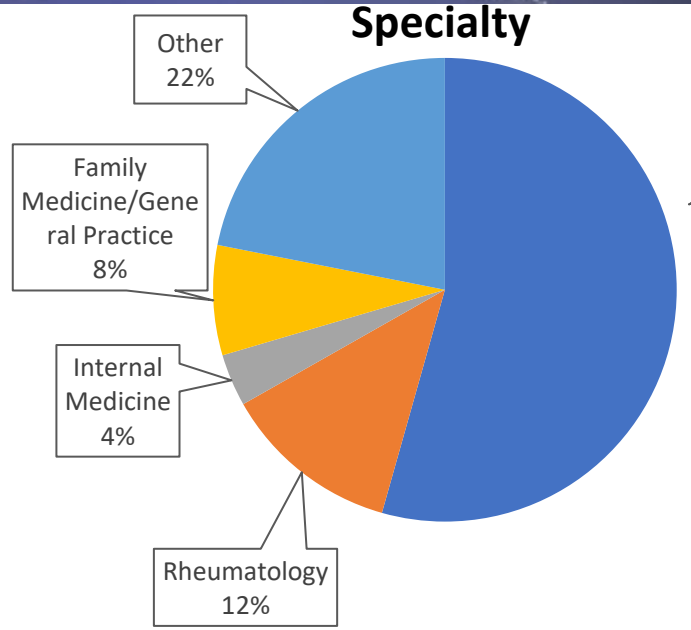
Degree



MD/DO=176
NP=16
PA=16
RN=28
PharmD=6
Other HCP=19
Other=13
Total Participants=274

76% of participants are physicians and APPs

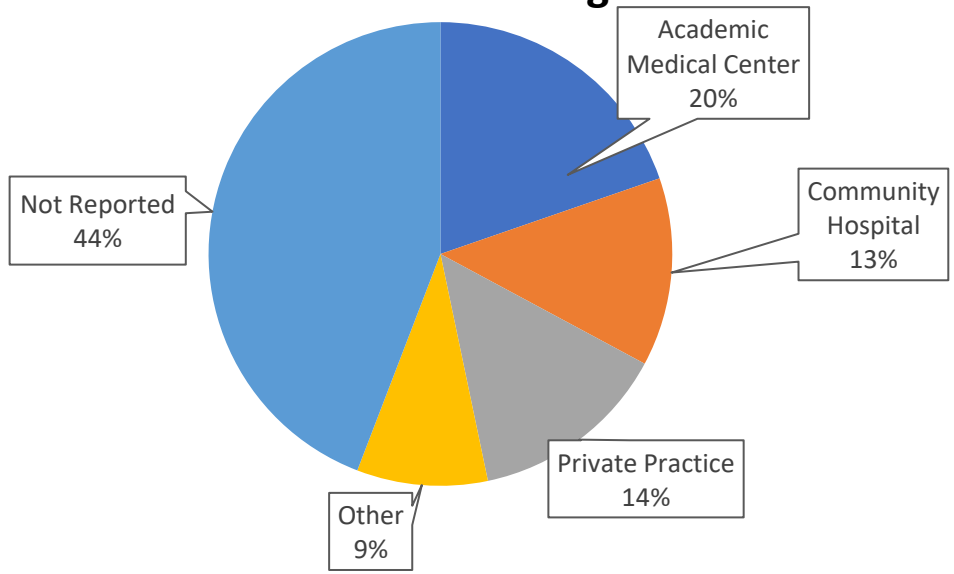
Specialty



Pulmonology=149
Rheumatology=34
Internal Medicine=10
Family Medicine/General Practice=21
Other=60
Total Participants=274

67% of participants are in pulmonology and rheumatology

Practice Setting



Academic Medical Center=54
Community Hospital=36
Private Practice=38
Other=25
Not reported=121
Total Participants=274

Note: While we originally proposed a maximum of 80 learners in the program, we allowed more participation because we found that most learners were not participating in every component of the program. We increased the overall program participation beyond the maximum to ensure that each of the online modules, live virtual meetings, and community forum has robust participation and engagement.

Online Modules: Overview

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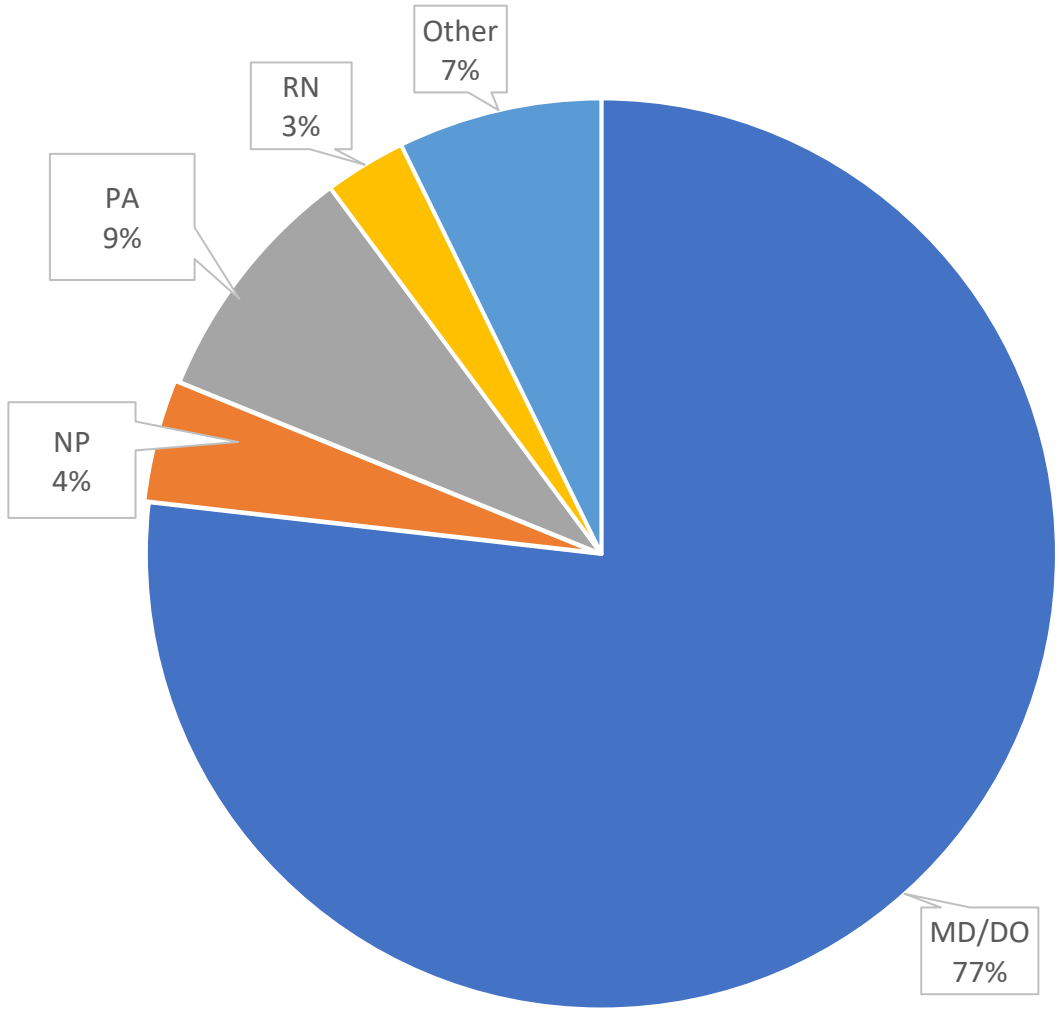
Online Modules Released June 30, 2025

1. Introduction to Interstitial Lung Disease (ILD) – 0.25 Credits
2. Progressive Pulmonary Fibrosis – 0.25 Credits
3. Recognizing SARD-ILD: Diagnosis and Screening – 0.75 Credits
4. Pharmacologic Treatment of SARD-ILD:

   Lung-Targeted Immunomodulatory and Anti-Fibrotic Therapy – 0.5 Credits
5. Multidisciplinary Medication Management in ILD Care – 0.5 Credits
6. Non-Pharmacologic Approaches to ILD Management – 0.25 Credits
7. Comorbidities of SARD-ILD – 0.25 Credits
8. Pulmonary Hypertension in Rheumatologic Disease – 0.25 Credits
9. Strategies for Multidisciplinary Collaboration in ILD Care – 0.25 Credits

Online Modules: Level 1 Participation

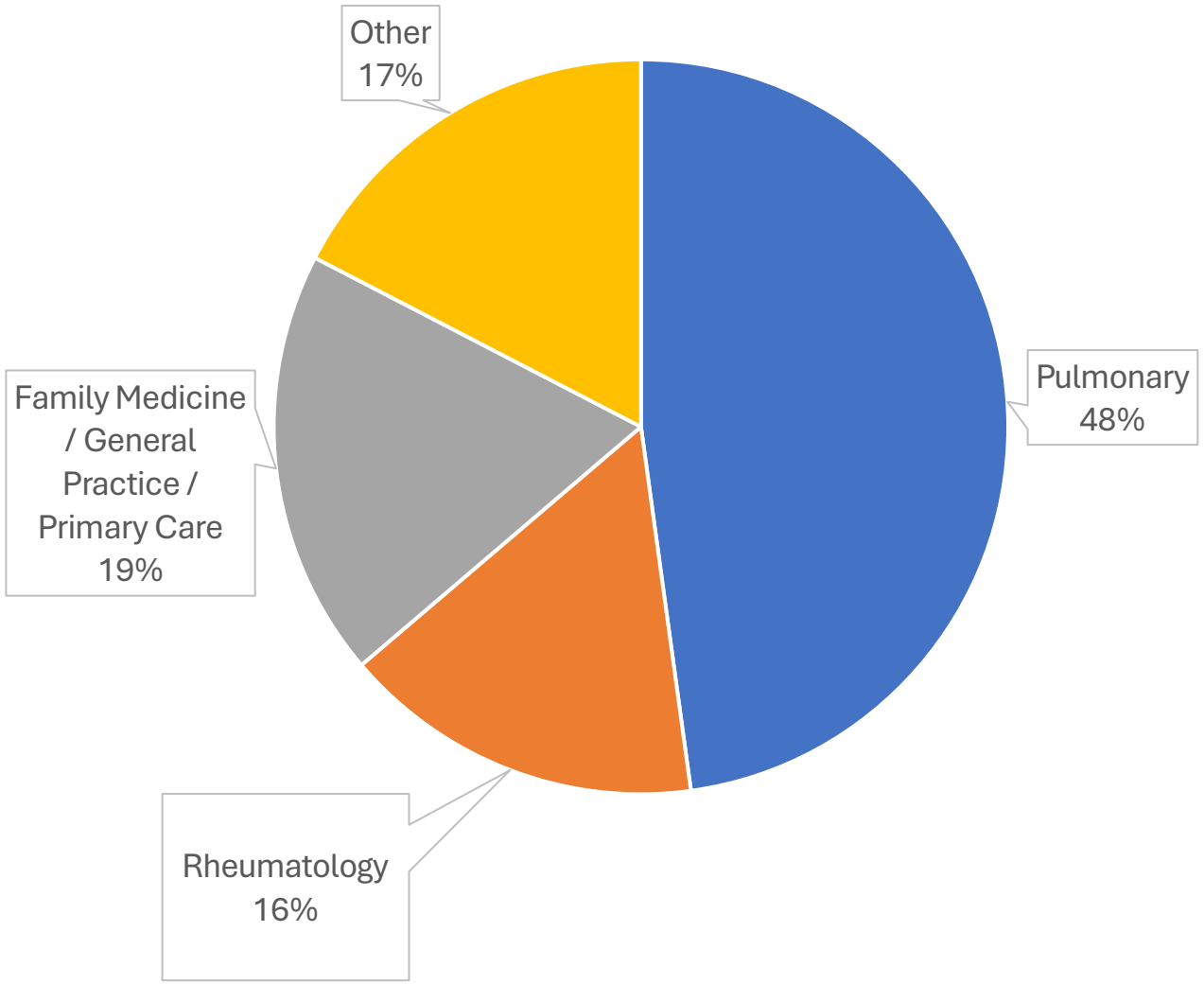
Final Outcomes Summary



Designation	Total
MD/DO	53
NP	3
PA	6
RN	2
Other	5
Total Learners	**69**

Online Modules: Level 1 Participation

Final Outcomes Summary

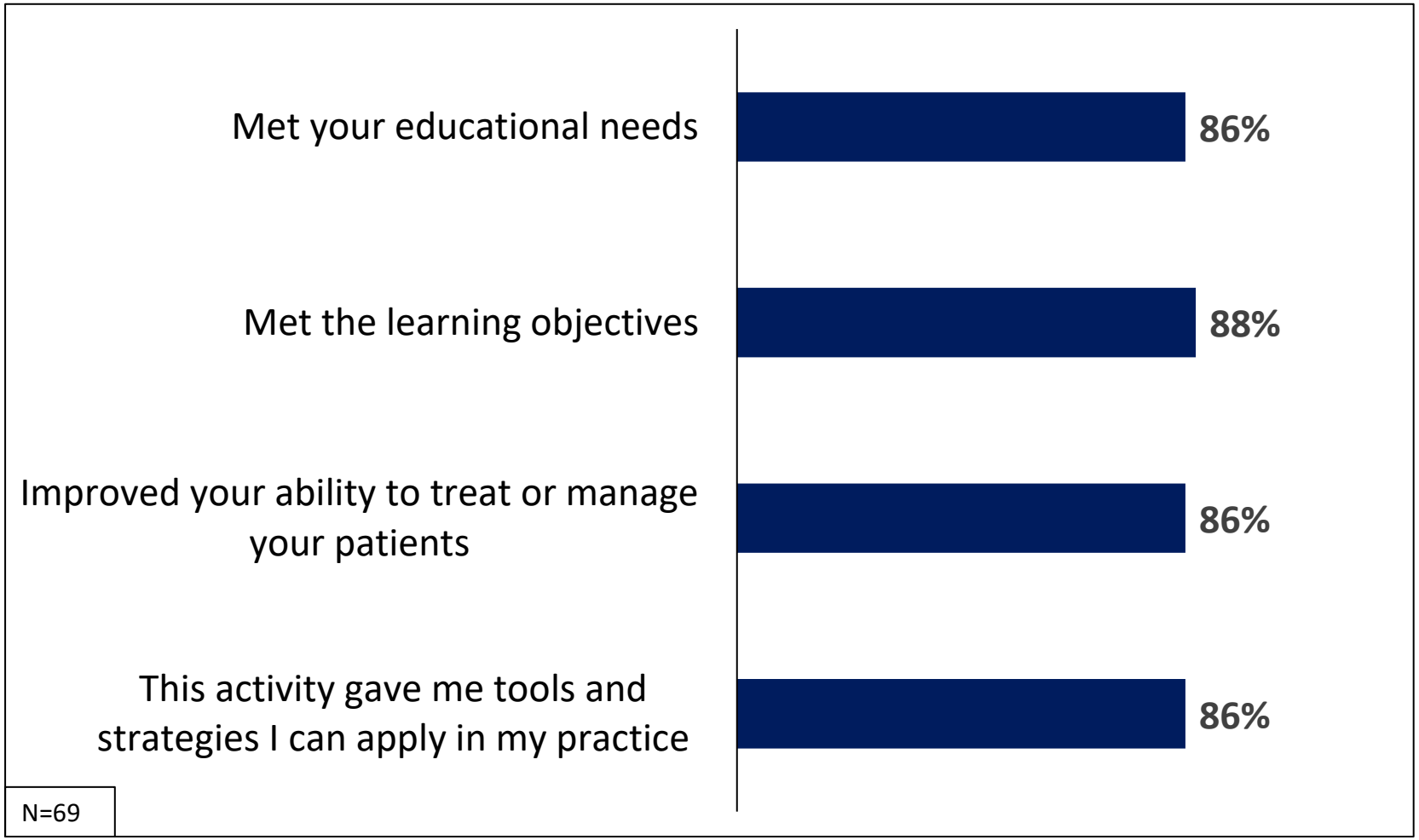


Specialty	Total
Pulmonary	33
Rheumatology	11
Family Medicine / General Practice / Primary Care	13
Other	12
Total Learners	**69**

Online Modules: Level 2 Satisfaction

Final Outcomes Summary

Evaluation Respondents reported that the activity:



N=69

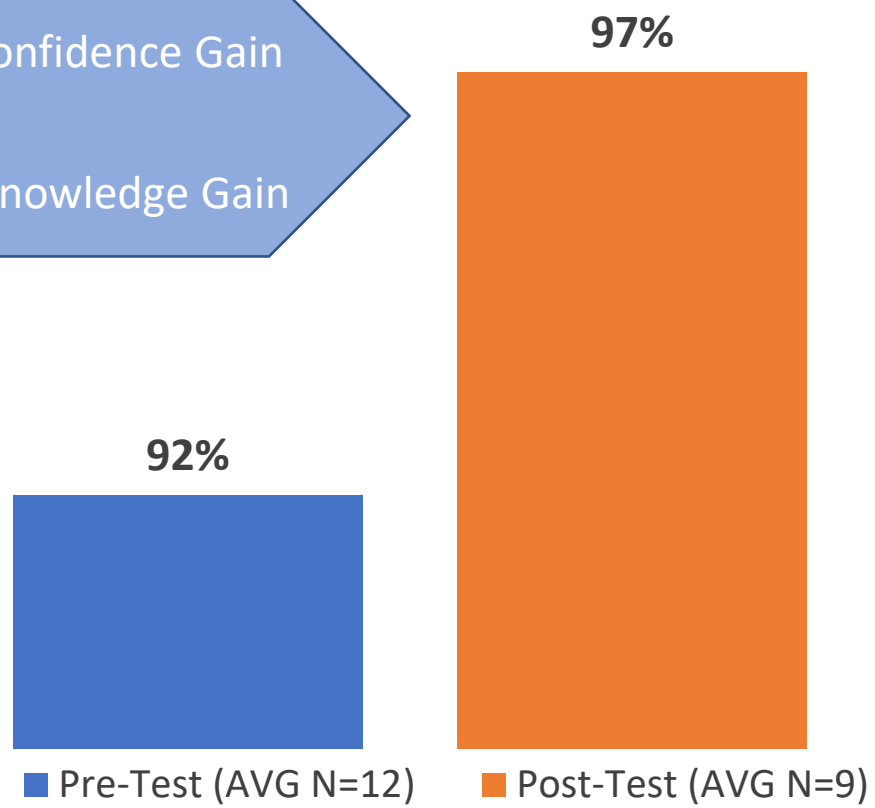
Online Modules: Level 3 & 4 Knowledge and Competence

Final Outcomes Summary

Overall Knowledge Gain across Video Modules

5% Relative Confidence Gain

5% Absolute Knowledge Gain



Online Modules: Level 3 & 4 Knowledge and Competence

Final Outcomes Summary

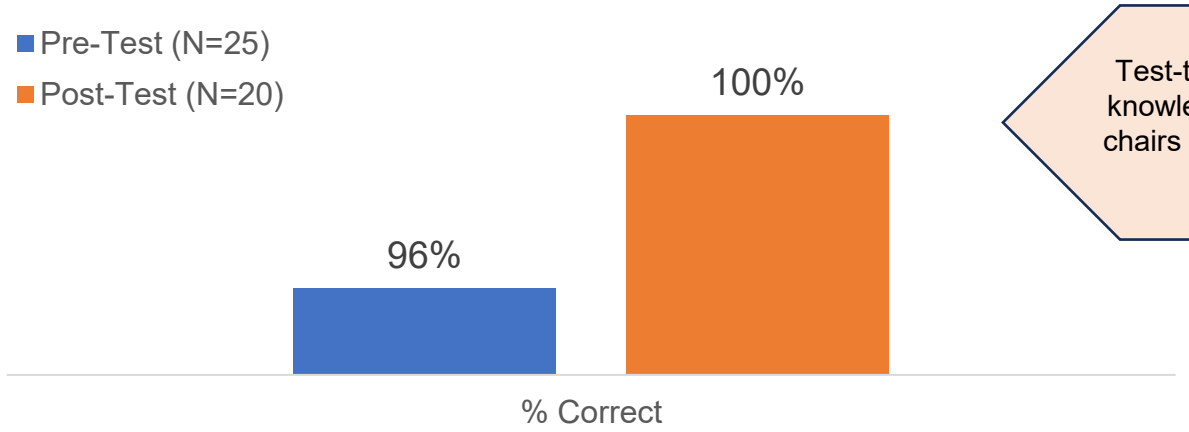
In the interim outcomes analysis, learners demonstrated high baseline knowledge at pre-test for many assessment items. At that time, program chairs reviewed all test questions to determine whether changes were needed to ensure rigor, quality and effectiveness in measuring achievement of the learning objectives. Revisions were made to the questions, which are reflected in the following slides.

Online Modules: Level 3 & 4 Knowledge and Competence

Final Outcomes Summary

Question 1: Which of the following best reflects the predominant classification strategy for interstitial lung diseases (ILDs) according to recent guidelines and consensus statements?

A) ILDs are classified by radiologic pattern into fibrotic (UIP versus non-UIP) and non-fibrotic types.
B) ILDs are classified into four major etiologic categories: idiopathic interstitial pneumonias, ILDs associated with connective tissue disease, ILDs related to environmental or occupational exposures and ILDs secondary to drugs or other known causes.
C) ILDs are classified based on pathologic diagnosis as UIP, NSIP, LIP, DIP, organizing pneumonia, granulomatous, or other unclassifiable pattern.
D) ILDs are classified based on the presence or absence of progression in fibrosis (progressive pulmonary fibrosis) using specific criteria using imaging, physiology, and patient reported symptoms.



Test-takers demonstrated high baseline knowledge of ILD classification. Program chairs revised this question to better align with the learning objective.

Rationale:
The correct answer is B. This classification reflects the consensus in the medical literature, which emphasizes categorization by etiology—idiopathic, connective tissue disease–associated, exposure-related, and drug-induced or other known causes—as the foundation for clinical management and prognosis.

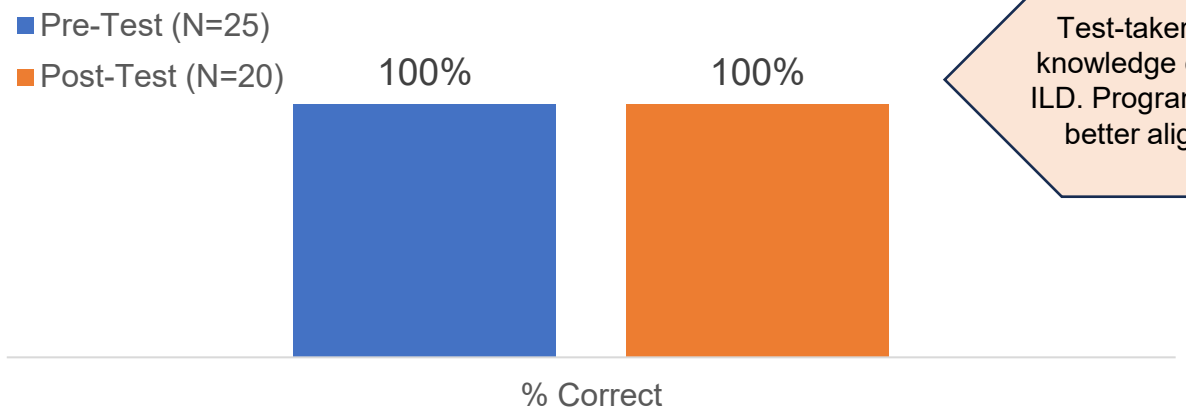
Module: Introduction to Interstitial Lung Disease (ILD)
Learning Objective: Describe the pathophysiology and classification of ILD

Online Modules: Level 3 & 4 Knowledge and Competence

Final Outcomes Summary

Question 2: Which of the following clinical findings is most characteristic of the initial presentation of interstitial lung disease (ILD)?

A) Subacute chest discomfort, shallow breathing, and weight loss.
B) Productive cough with fever but no acute infiltrates.
C) Progressive exertional dyspnea and chronic dry cough
D) Wheezing or chest tightness and shortness of breath



Test-takers demonstrated high baseline knowledge of initial signs and symptoms of ILD. Program chairs revised this question to better align with the learning objective.

Module: Introduction to Interstitial Lung Disease (ILD)
Learning Objective: Recognize signs, symptoms, and risk factors for ILD

Rationale:
The correct answer is C. Progressive exertional dyspnea and chronic dry cough are the most common presenting symptoms of ILD, often accompanied by fatigue and, in some cases, unintended weight loss. Physical examination may reveal bibasilar inspiratory crackles and, in advanced cases, digital clubbing or resting hypoxemia. These features are well described in the medical literature and are emphasized in recent reviews and guidelines on ILD clinical presentation.

Online Modules: Level 3 & 4 Knowledge and Competence

Final Outcomes Summary

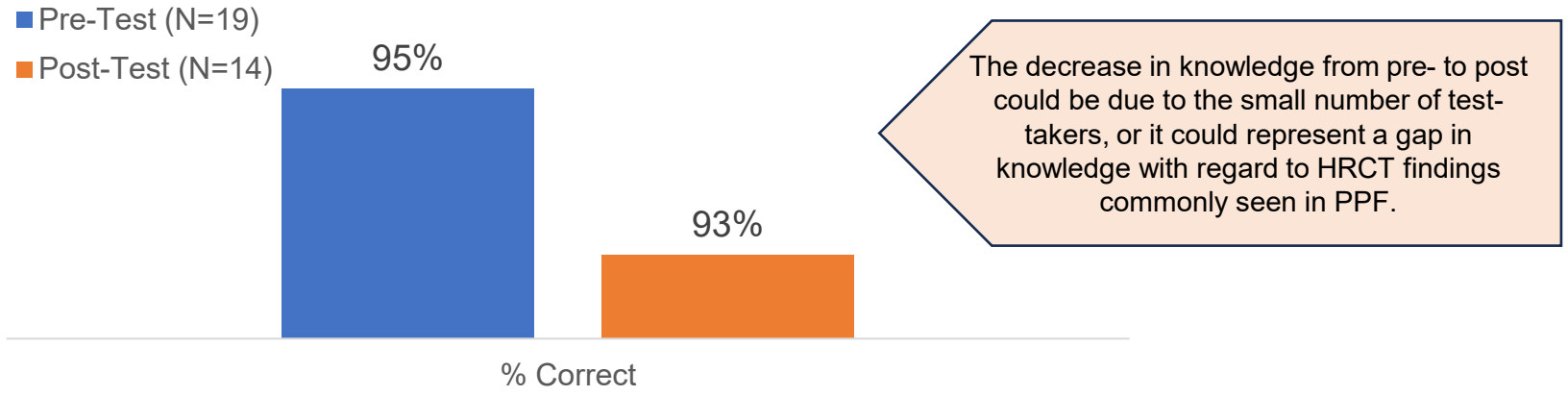
Question 3: Which of the following high-resolution computed tomography (HRCT) findings is most indicative of progressive pulmonary fibrosis in a patient with fibrotic interstitial lung disease?

A) New or increased ground-glass opacities with or without associated traction bronchiectasis

B) Increased extent of traction bronchiectasis and honeycombing

C) Increased pleural thickening and lower lobe volume loss

D) Reticulation and honeycombing that persists on prone imaging



The decrease in knowledge from pre- to post could be due to the small number of test-takers, or it could represent a gap in knowledge with regard to HRCT findings commonly seen in PPF.

Module: Progressive Pulmonary Fibrosis

Learning Objective: Recognize signs, symptoms, and risk factors for ILD

Rationale:
The correct answer is B) Increased extent of traction bronchiectasis and honeycombing. Progressive pulmonary fibrosis is characterized radiographically by an increased extent of fibrotic features such as traction bronchiectasis, bronchiolectasis, and honeycombing, as well as increased reticulation and lobar volume loss. These findings are best appreciated by comparing serial HRCT scans for interval progression. The American Thoracic Society and collaborating societies emphasize that these features, particularly the progression of traction bronchiectasis and honeycombing, are strong predictors of disease progression and mortality in idiopathic pulmonary fibrosis and other fibrotic interstitial lung diseases.

Online Modules: Level 3 & 4 Knowledge and Competence

Final Outcomes Summary

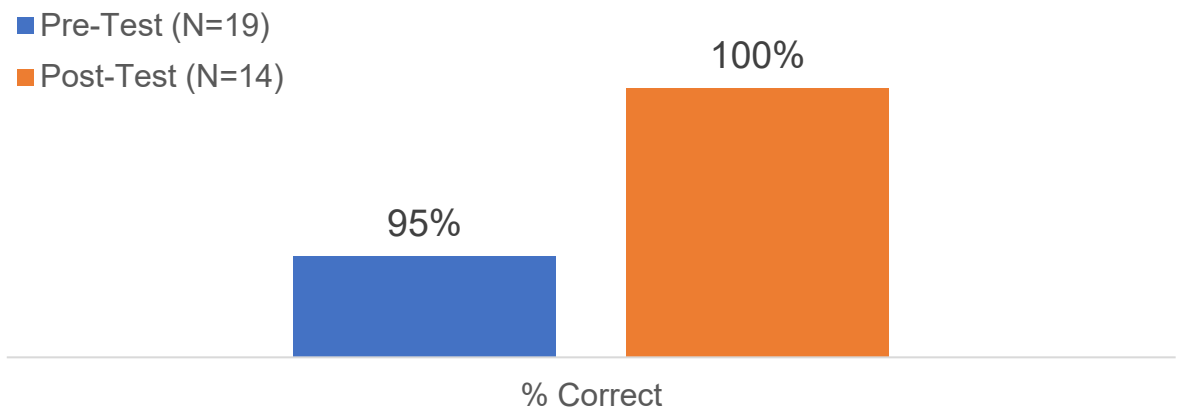
Question 4: Which of the following best reflects current best practices for monitoring patients with interstitial lung disease (ILD) for progressive pulmonary fibrosis (PPF) according to recent clinical guidelines?

A) Chest radiograph and symptom assessment every 3-4 months

B) Annual HRCT scans even in the absence of reported worsening in symptoms or PFT findings

C) Pulmonary function tests (PFTs) including FVC and DLCO, symptom assessments, and HRCT when there is clinical suspicion of progression

D) Questionnaires assessing changes in cough or dyspnea every 6 months



Module: Progressive Pulmonary Fibrosis

Learning Objectives: Recognize signs, symptoms, and risk factors for ILD; Apply evidence-based diagnostic strategies to provide timely and accurate diagnosis of ILD

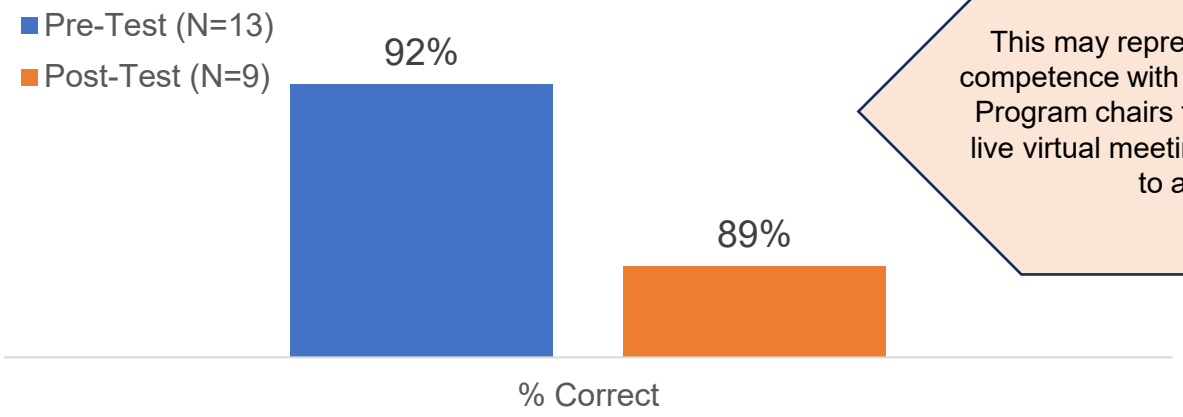
Rationale:
The correct answer is C. Best practices for monitoring ILD patients for PPF involve a multimodal approach: regular assessment of symptoms, serial PFTs (notably FVC and DLCO) and HRCT imaging when there is evidence of clinical or physiological progression. Ambulatory desaturation testing (e.g., 6-minute walk test) may be considered as an adjunct, especially in patients with symptom progression. This approach is supported by the American Thoracic Society and the American College of Rheumatology, which recommend combining PFTs and HRCT for optimal monitoring, reserving HRCT for cases of clinical suspicion or uncertainty to balance diagnostic yield with radiation exposure. There is no consensus on the optimal frequency of HRCT, but more frequent monitoring is suggested for patients with worsening symptoms or rapidly progressive disease features.

Online Modules: Level 3 & 4 Knowledge and Competence

Final Outcomes Summary

Question 5: A 58-year-old woman presents to your clinic with progressive dyspnea, dry cough, and crackles at the lung bases. HRCT shows NSIP pattern. You suspect an underlying autoimmune etiology. Which of the following laboratory tests is most appropriate to include in the initial serologic workup for SARD-ILD?

A) B-type natriuretic peptide (BNP) and troponin
B) ANCA and HIV serology
C) ANA, RF/CCP, SSA/SSB, and myositis-specific antibodies
D) Alpha-1 antitrypsin levels and serum protein electrophoresis
E) Sputum eosinophil count and IgE levels



This may represent a gap in knowledge and competence with regard to diagnostic strategies. Program chairs focused the content of the first live virtual meeting on difficult diagnostic cases to address this need.

Module: Recognizing SARD-ILD: Diagnosis and Screening
Learning Objectives: Apply evidence-based diagnostic strategies to provide timely and accurate diagnosis of ILD

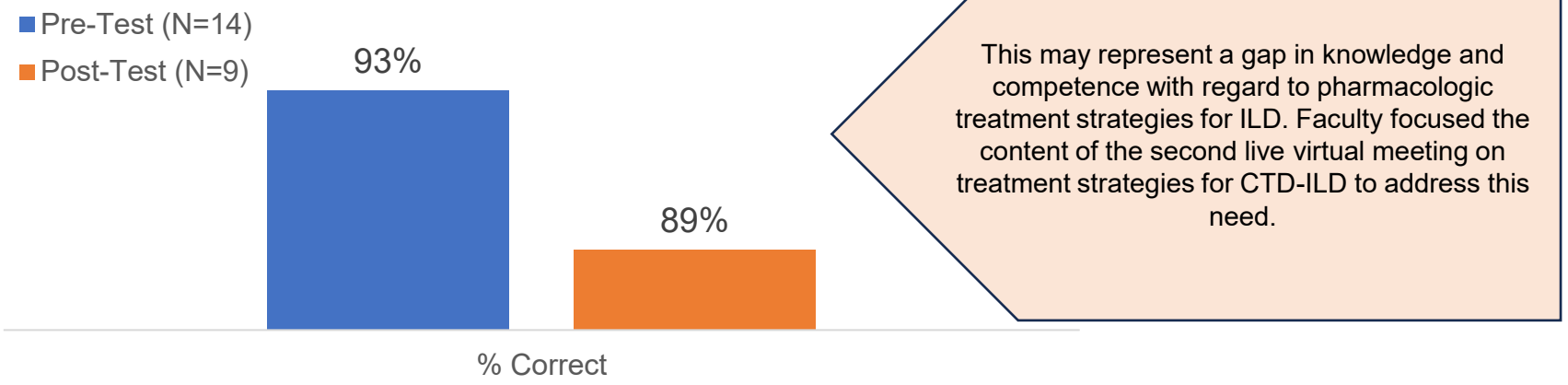
Rationale:
The correct answer is C. Patients with suspected autoimmune-related ILD should undergo a targeted serologic evaluation that includes antinuclear antibody (ANA), rheumatoid factor (RF), anti-cyclic citrullinated peptide (CCP). Additional serologic panels including those for myositis-specific antibodies (e.g., anti-Jo-1, PL-7, MDA-5) and for systemic sclerosis are often performed. These biomarkers help identify underlying connective tissue diseases such as RA, Sjögren's disease, myositis, or systemic sclerosis. The other options are not routinely included in the initial evaluation for SARD-ILD.

Online Modules: Level 3 & 4 Knowledge and Competence

Final Outcomes Summary

Question 6: A 60-year-old man with systemic sclerosis-associated ILD shows evidence of progressive fibrosis on serial HRCT and declining FVC. He is currently receiving mycophenolate mofetil (MMF). According to current guidelines and clinical trial data, which of the following is the most appropriate next step?

A. Discontinue MMF and switch to methotrexate
B. Add antifibrotic therapy such as nintedanib
C. Initiate TNF-α inhibitor therapy
D. Begin empiric corticosteroids as monotherapy
E. Substitute MMF with hydroxychloroquine



Module: Pharmacologic Treatment of SARD-ILD: Lung-targeted Immunomodulatory and Anti-fibrotic Therapy
Learning Objectives: Appy up-to-date guidelines for the treatment of ILD

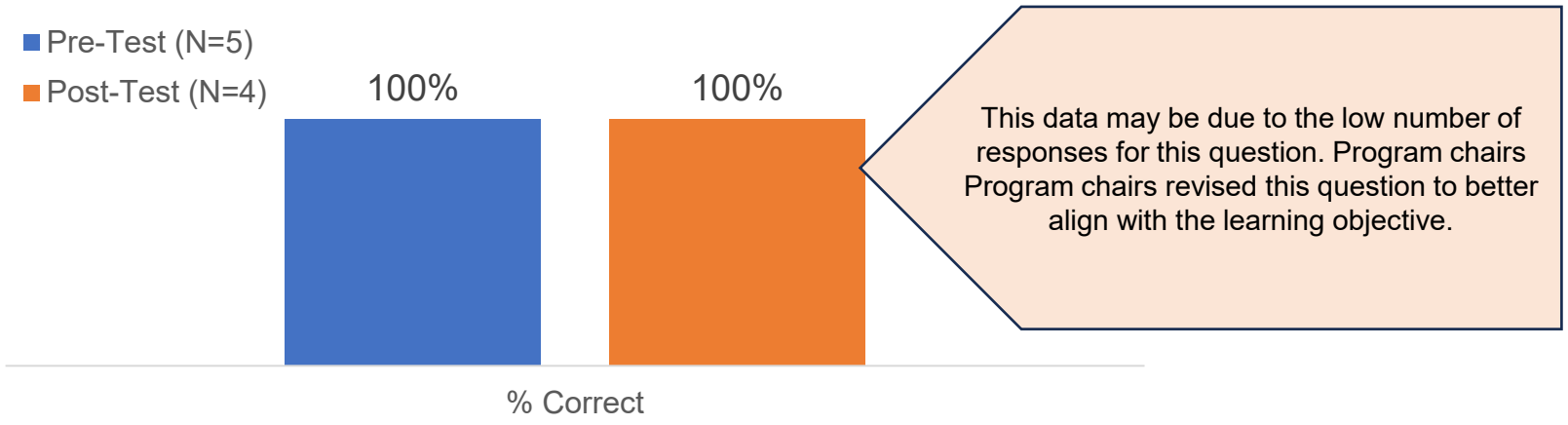
Rationale:
The correct answer is B. Nintedanib has shown benefit in slowing progression of fibrosis in SSc-ILD and is FDA approved for this indication. It can be used in combination with immunosuppressive therapy like MMF, as seen in the SENSCIS trial. Methotrexate and TNFi have limited or contraindicated roles in SARD-ILD due to potential pulmonary toxicity or lack of efficacy. Hydroxychloroquine is generally not sufficient for fibrosing ILD, and steroids alone are not the preferred treatment for progressive fibrosis.

Online Modules: Level 3 & 4 Knowledge and Competence

Final Outcomes Summary

Question 7: A 64-year-old male with rheumatoid arthritis (RA) develops dyspnea and dry cough. Workup reveals ILD with mixed pattern of both organizing pneumonia and mild fibrosis on HRCT. Bronchoscopy rules out infection and identifies a lymphocytic alveolitis (41% on BAL). Current treatment is etanercept (TNF inhibitor) for joint disease which is currently well controlled. What is the best course of action for management of his new ILD?

A. Inform the patient that in addition to RA he also now has IPF, and start nintedanib, an antifibrotic medication.
B. Increase dosing of etanercept given that there is worsening lung inflammation, but also add nintedanib given the new finding of mild fibrosis.
C. **Coordinate a discussion between the patient's rheumatologist and pulmonologist to review the patient's new diagnosis of RA-related ILD and discuss therapeutic options to target both joint and lung inflammation. An antifibrotic could also be indicated.**
D. Etanercept toxicity is the most likely cause of both lymphocytic alveolitis and lung fibrosis in this case. Stop the medication and monitor.



Module: Multidisciplinary Medication Management in ILD Care
Learning Objective: Implement multidisciplinary approaches for the early identification of and treatment of ILD

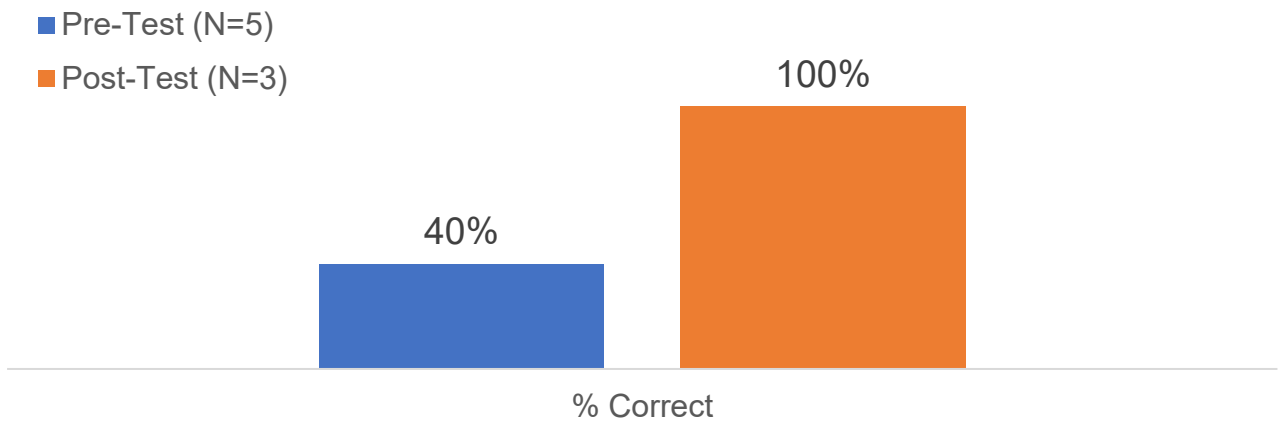
Rationale:
The correct answer is C. In this clinical scenario with new organizing pneumonia and mild fibrosis in the setting of known RA, the diagnosis is consistent with RA-ILD and once infection is ruled out, lung-targeted therapy is indicated to control inflammation. Combination therapy may be required. The patient's pulmonologist and rheumatologist should discuss options for the safest and most effective therapy. An antifibrotic could also be indicated, but active lung inflammation should be treated first. Etanercept is not effective in treating ILD in the setting of RA, so increasing the dose will not help. While there are case reports of ILD occurring due to lung toxicity of TNF-inhibitors like etanercept, the link is unclear and this is rare. The much more likely etiology of these imaging features is RA and alternative treatment will need to be started.

Online Modules: Level 3 & 4 Knowledge and Competence

Final Outcomes Summary

Question 8: A 65-year-old man with fibrotic ILD presents with increasing exertional dyspnea. He is already on antifibrotic therapy. A 6-minute walk test reveals oxygen desaturation to 85%. Which of the following non-pharmacologic interventions is the most appropriate next step?

A. Begin supplemental oxygen therapy during exertion
B. Refer for pulmonary rehabilitation
C. Initiate palliative care for symptom management
D. Refer for lung transplant evaluation
E. Recommend mindfulness-based stress reduction and routine exercise at home



Rationale:
The correct answer is A) Begin supplemental oxygen therapy during exertion. Oxygen desaturation to ≤88% during a 6-minute walk test meets guideline-based criteria for initiating supplemental oxygen in ILD patients. While all listed options are valid components of a comprehensive non-pharmacologic approach, oxygen therapy is the most immediate and appropriate intervention for exertional desaturation. Pulmonary rehab and transplant referral may also be appropriate but are not as urgent in this context.

Module: Non-Pharmacologic Approaches to ILD Management
Learning Objective: Evaluate current and emerging approaches for ILD treatment; Apply up-to-date guidelines for the treatment of ILD

Online Modules: Level 3 & 4 Knowledge and Competence

Final Outcomes Summary

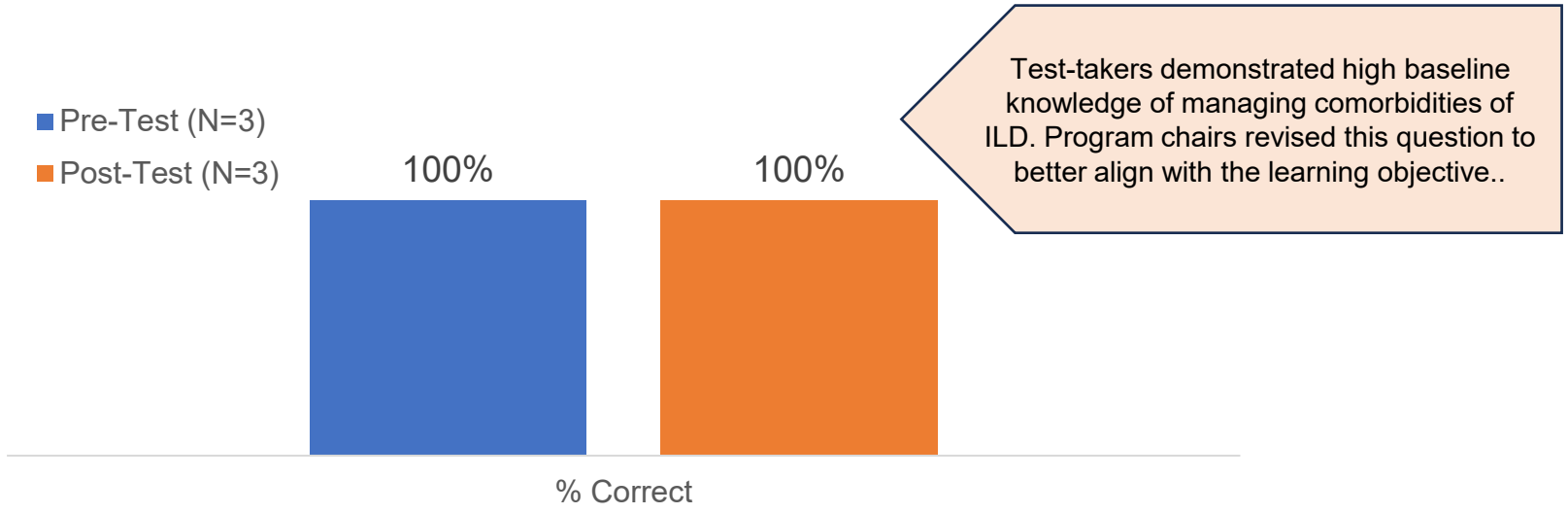
Question 9: Which of the following statements it most accurate regarding atherosclerotic cardiovascular disease (ASCVD) in patients with SARD-ILD?

A. Inflammation is now understood to contribute to ASCVD pathophysiology, therefore immunosuppressive therapies are indicated in those with known coronary disease.

B. Aside from autoimmunity, patients with autoimmune disease have similar risk factors for ASCVD as those without autoimmunity.

C. Treadmill stress tests are less sensitive for the detection of CAD in patients with SARD-ILD relative to those without autoimmunity, therefore this test is not recommended in this population.

D. LDL targets in SARD-ILD are comparable to those of patients with a known history of CVA or myocardial infarction.



Test-takers demonstrated high baseline knowledge of managing comorbidities of ILD. Program chairs revised this question to better align with the learning objective..

Module: Comorbidities of SARD-ILD

Learning Objective: Apply up-to-date guidelines for the treatment of ILD

Rationale:
Patients with autoimmune disease have an increased risk for atherosclerotic cardiovascular disease (ASCVD). A study of 85,512 patients with autoimmunity concluded that these patients have similar risk factors for CAD as the general population (Type 2 diabetes, hypertension, current smoking, elevated LDL-C of > 4 mmol/L and low HDL-C of <1mmol/L). This risk was accentuated by the presence of autoimmunity. There are no distinct guidelines for screening, diagnosing, or treating patients with ASCVD in the setting of autoimmunity as opposed to the general population. Therefore, answers a, c, and d are incorrect. Reference: Mortensen, MB et al, Association of Autoimmune Disease with Coronary Atherosclerosis Severity and Ischemic Events.

Online Modules: Level 3 & 4 Knowledge and Competence

Final Outcomes Summary

Question 10: Which of the following statements best reflects the prevalence of pulmonary hypertension (PH) in patients with connective tissue disease-associated interstitial lung disease (CTD-ILD)?

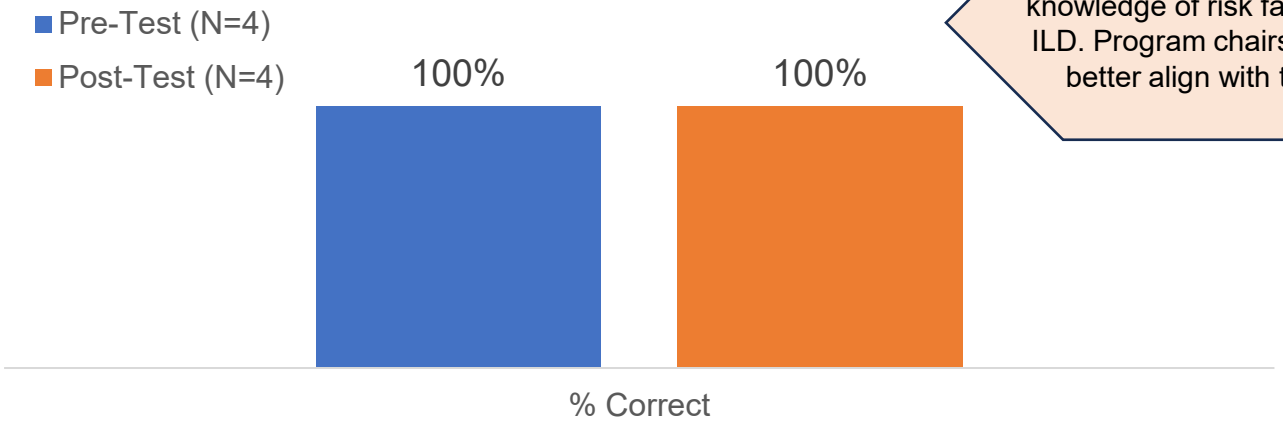
A. PH is uncommon in CTD-ILD and usually presents only in advanced SLE.

B. PH occurs almost exclusively in patients with both ILD and sleep apnea or nocturnal hypoxia.

C. PH is common in CTD-ILD, with systemic sclerosis showing a prevalence of 5–19% for PAH

D. PH in CTD-ILD typically occurs only after immunosuppressive therapy has failed

E. Due to high prevalence, routine screening for PH with right heart cath is recommended for patients with mixed connective tissue disease (MCTD)



Test-takers demonstrated high baseline knowledge of risk factors for comorbidities of ILD. Program chairs revised this question to better align with the learning objective.

Rationale:
The correct answer is C. Pulmonary hypertension is a common and serious complication of CTD-ILD, particularly in systemic sclerosis, where prevalence of pulmonary arterial hypertension (PAH) ranges from 5% to 19%. It may also be seen in other rheumatic conditions like SLE and MCTD. Routine screening is recommended in systemic sclerosis, and early recognition is critical due to its poor prognosis and distinct treatment implications.

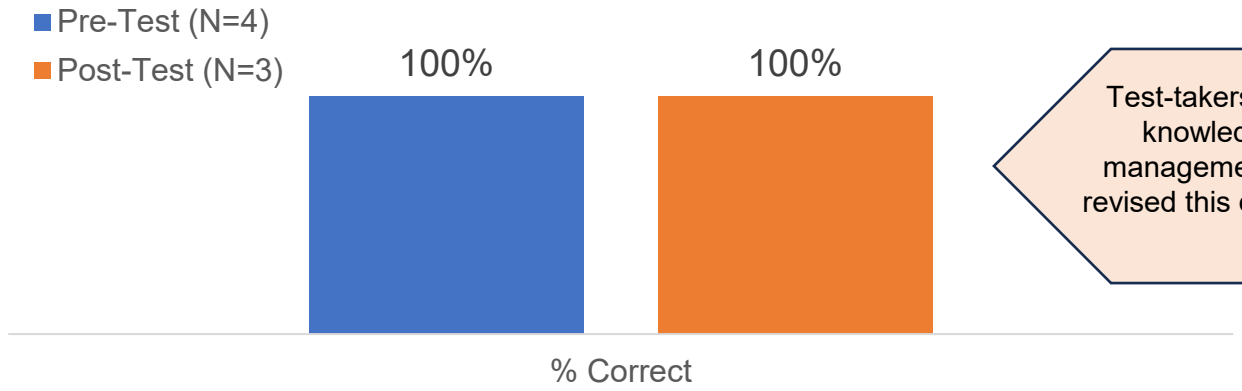
Module: Pulmonary Hypertension in Rheumatologic Disease
Learning Objective: Recognize signs, symptoms, and risk factors for ILD

Online Modules: Level 3 & 4 Knowledge and Competence

Final Outcomes Summary

Question 11: A 58-year-old man with longstanding rheumatoid arthritis and RA-ILD presents to rheumatology clinic reporting worsening exertional dyspnea and oxygen requirement. He is already on rituximab. Joint disease is well controlled but recent pulmonary evaluation indicates a more rapid decline in oxygen on 6 min walk test, and fibrosis has continued to progress on imaging. The patient is currently enrolled in pulmonary rehab and has oxygen equipment at home. Which of the following would NOT be an appropriate consideration for management?

A. Evaluation for comorbid pulmonary hypertension (PH). There is now therapy for ILD-related PH and this could offer an avenue for treatment.
B. Referral to a tertiary care center for ILD for additional treatment recommendations and consideration of drug trials in ILD.
C. Recommend discontinuation of exercise. Inform patient that he will need to limit exertion going forward so as to avoid episodes of oxygen desaturation.
D. Discuss referral for lung transplant evaluation.
E. Discuss adding immunosuppressant versus anti-fibrotic agent.
F. A and E
G. A, B and E
H. All of the above



Test-takers demonstrated high baseline knowledge of multidisciplinary ILD management strategies. Program chairs revised this question to better align with the learning objective.

Module: Strategies for Multidisciplinary Collaboration in ILD Care

Learning Objective: Implement multidisciplinary approaches for the early identification and treatment of ILD

Rationale:
The correct answer is G. This patient is a good candidate for further PH workup to see if this is a new aspect of their disease. They are also a good candidate for evaluation for ILD specific care, which could be completed by a Pulmonologist who is comfortable with ILD evaluation, or at an academic center. This patient is also a very good candidate for more aggressive therapeutic intervention with immunosuppressant versus anti-fibrotic or even combination therapy.

Online Modules: Level 4 Competence

Final Outcomes Summary

97%

Evaluation respondents intend to make changes in practice as a result of what they learned in the online modules

N=64

Changes that evaluation respondents intend to make in practice after participating in the modules:

- Closer follow up with the patient
- I will continue to refer pulmonary problem patients to specialists for treatment
- More thorough physical exams focused on extrapulmonary manifestations of SARD
- Incorporate specific labs
- Improve history taking
- PFT every 3 months in the first year of diagnosis, HRCT yearly
- Frequency of PFTs and ambulatory O2 monitoring
- High resolution CT
- Rheumatology referral pattern change based on single ANA alone
- Lab evaluation
- More specific use of serology workup
- More use of antifibrotic
- More multidisciplinary discussion
- Screen patients sooner for ILD and continue to refer when necessary
- Pay attention to comorbidities
- I will screen more aggressively for PH and referring to physicians currently in PH treatment

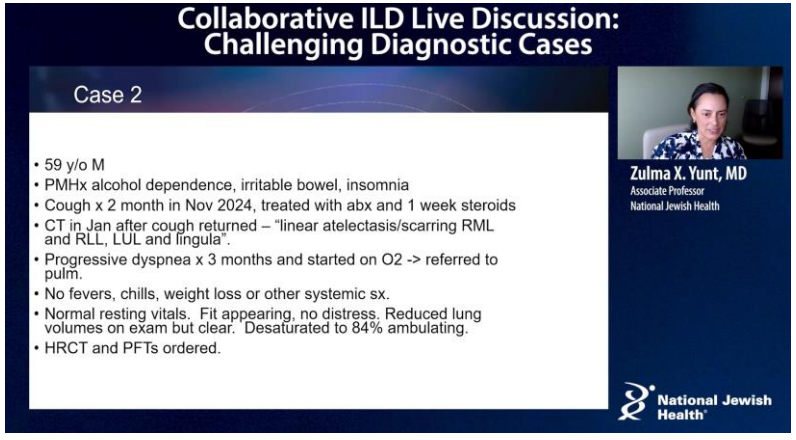
Live Virtual Meetings: Overview

Final Outcomes Summary

Live Virtual Meeting #1: Difficult Cases and Unmet Needs
August 27, 2025

Zulma X. Yunt, MD
Associate Professor
Department of Medicine, Division of Pulmonary, Critical Care & Sleep Medicine, Clinic Director, Interstitial Lung Disease Program, Medical Director, Office of Professional Education
National Jewish Health

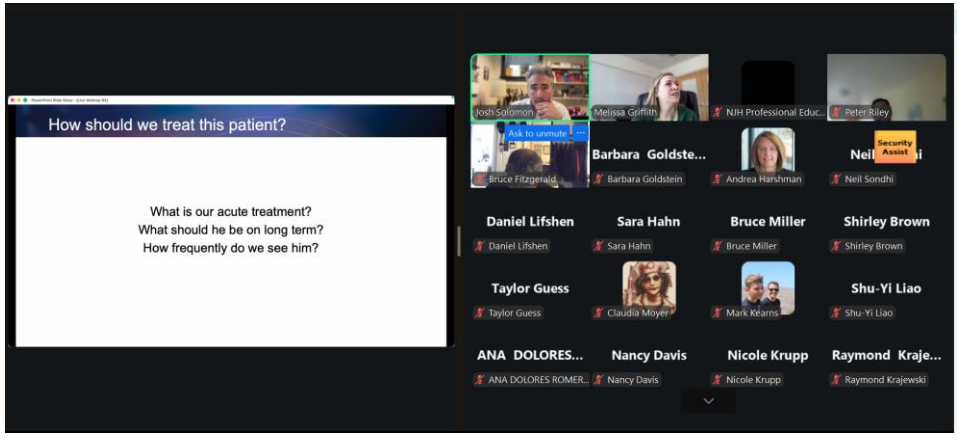
Barbara Goldstein, MD, MMSc
Physician
Denver Arthritis Clinic



Live Virtual Meeting #2: Tailoring Treatment in CTD-ILD
October 30, 2025

Joshua Solomon, MD
Director, Interstitial Lung Disease Program
Professor
Department of Medicine
Division of Pulmonary, Critical Care & Sleep Medicine
Section of Critical Care Medicine
National Jewish Health

Melissa Griffith, MD, RhMSUS
Associate Professor of Medicine
Division of Rheumatology
University of Colorado School of Medicine



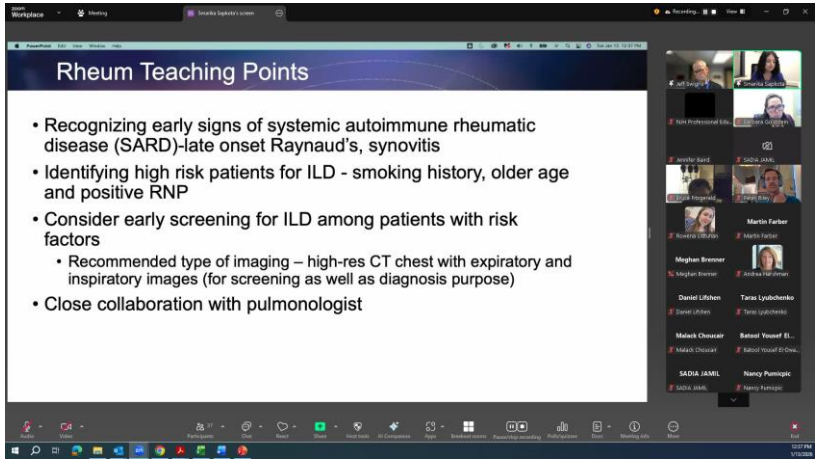
Live Virtual Meetings: Overview

Final Outcomes Summary

Live Virtual Meeting #3: Diagnosing ILD: Patterns, Pitfalls, and Phenotypes
January 13, 2026

Smarika Sapkota, MD, RhMSUS
Assistant Professor
Director, Rheumatology Clinic
Director, Ultrasound Clinic
Department of Medicine
Division of Rheumatology
National Jewish Health

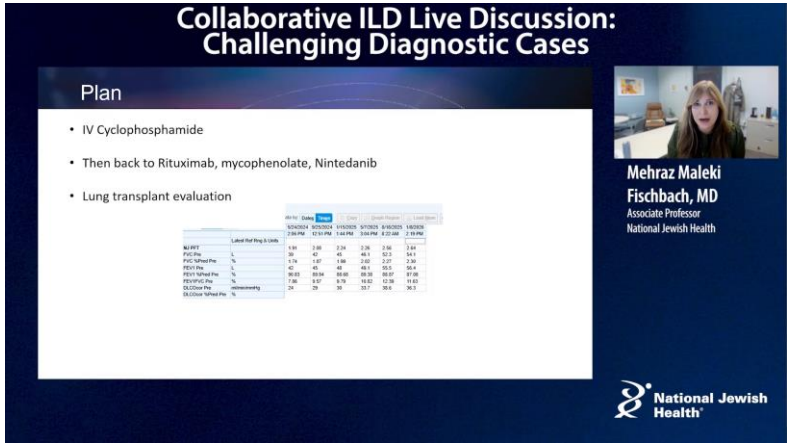
Jeff Swigris, DO, MS
Professor
Department of Medicine
Division of Pulmonary, Critical Care & Sleep Medicine
National Jewish Health



Live Virtual Meeting #4: Combination Therapy in ILD: Practical Management Strategies
March 10, 2026

Rebecca C. Keith, MD
Associate Professor
Department of Medicine
Division of Pulmonary, Critical Care & Sleep Medicine
Interstitial Lung Disease Program
Autoimmune Lung Center
National Jewish Health

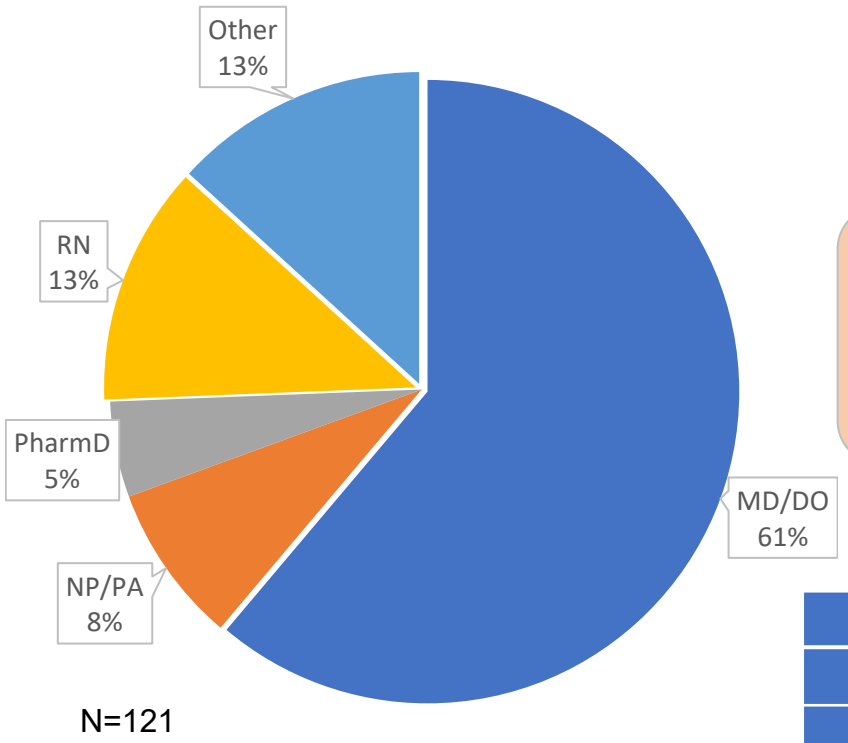
Mehrnaz Maleki Fischbach, MD
Chief, Division of Rheumatology
Director, Scleroderma Center
Co-Director, Sjogren's Clinic
Professor
Department of Medicine
National Jewish Health



Live Virtual Meetings: Level 1 Participation (All Meetings)

Final Outcomes Summary

Degree

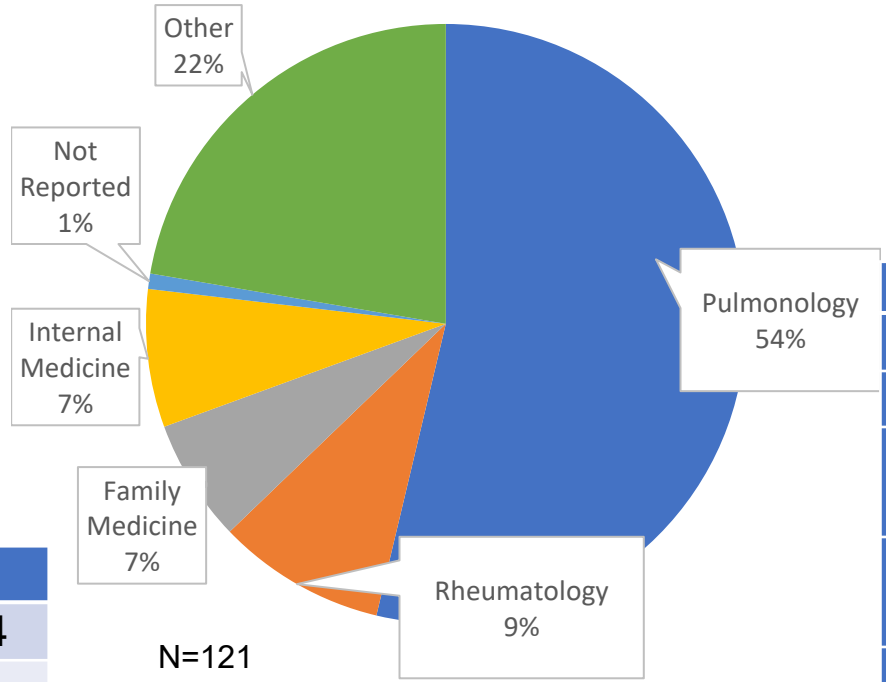


N=121

69%
of learners in the live meetings were physicians and APPs

Degree	
MD	74
NP	5
PA	5
PharmD	6
RN	15
Other	16
Total Learners	121

Specialty



N=121

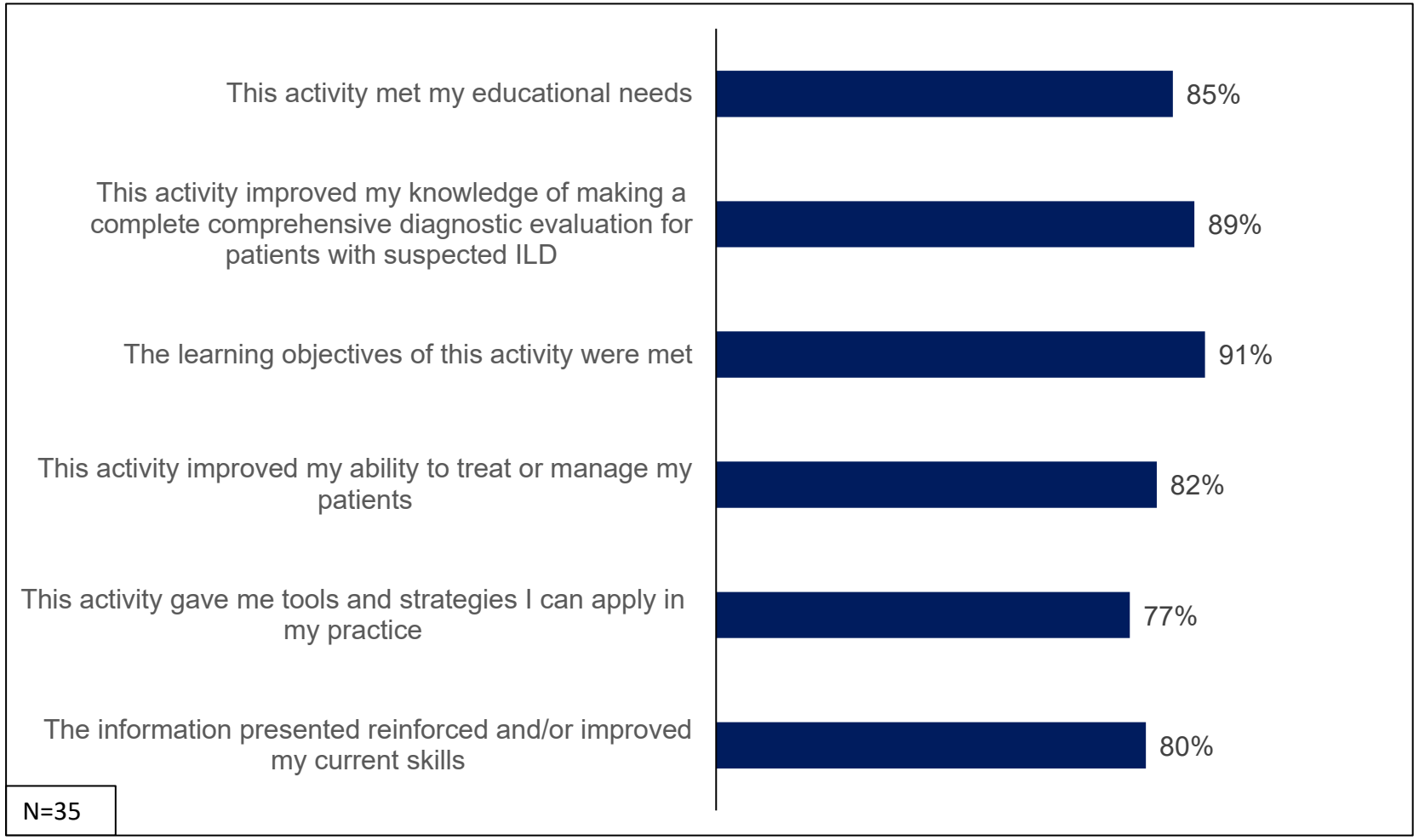
63%
of learners in the live meetings were in pulmonology and rheumatology

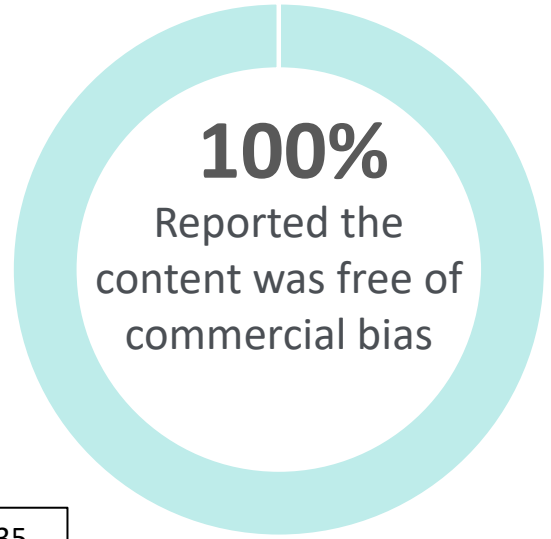
Specialty	
Pulmonology	65
Rheumatology	11
Family Medicine	8
Internal Medicine	9
Not Reported	1
Other	27
Total Learners	121

Live Virtual Meetings: Level 2 Satisfaction (Combined Webinar Evaluation)

Final Outcomes Summary

Evaluation Respondents reported that the activity:



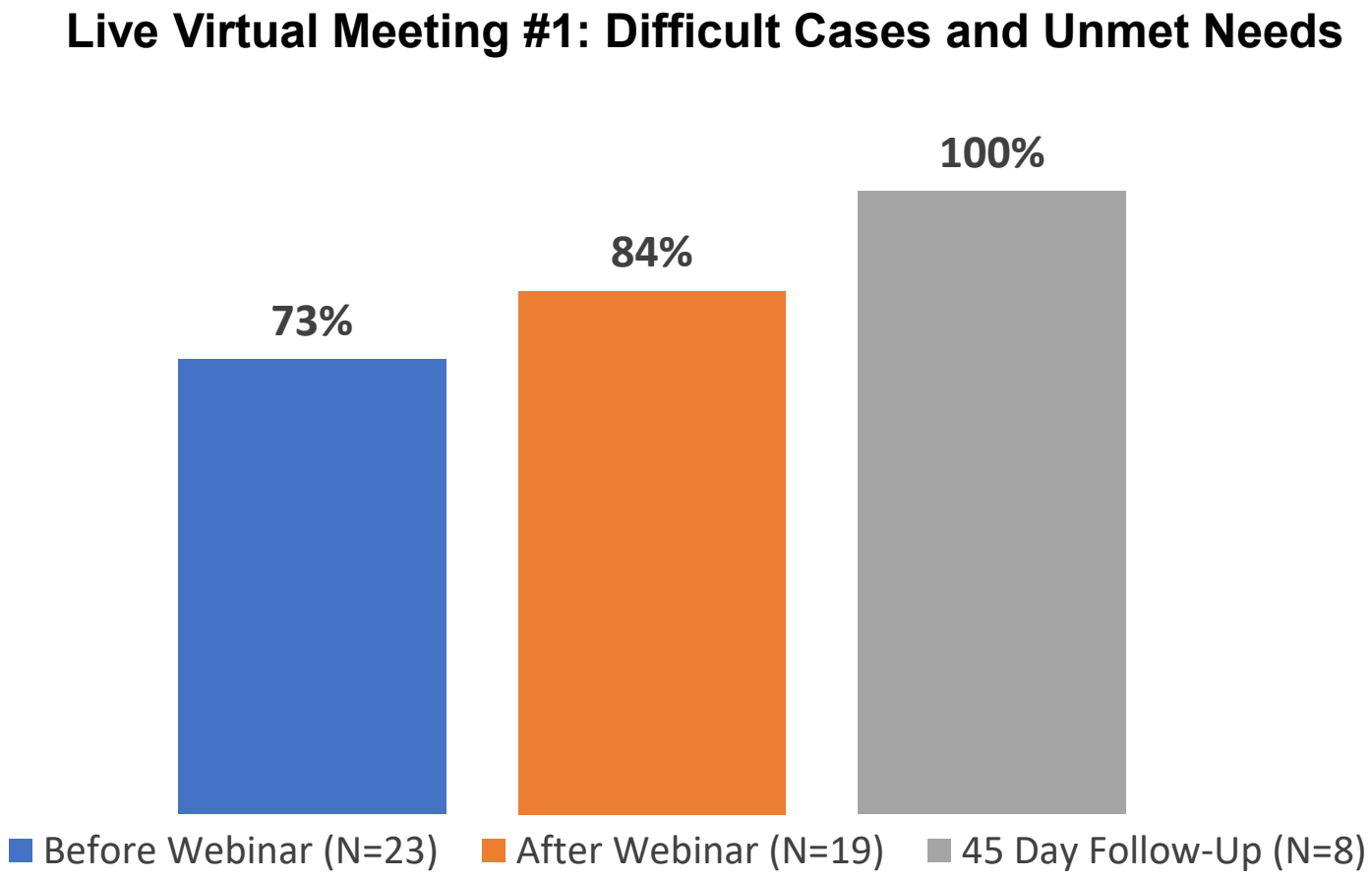


N=35

Live Virtual Meetings: Level 4 Competence (Meeting #1)

Final Outcomes Summary

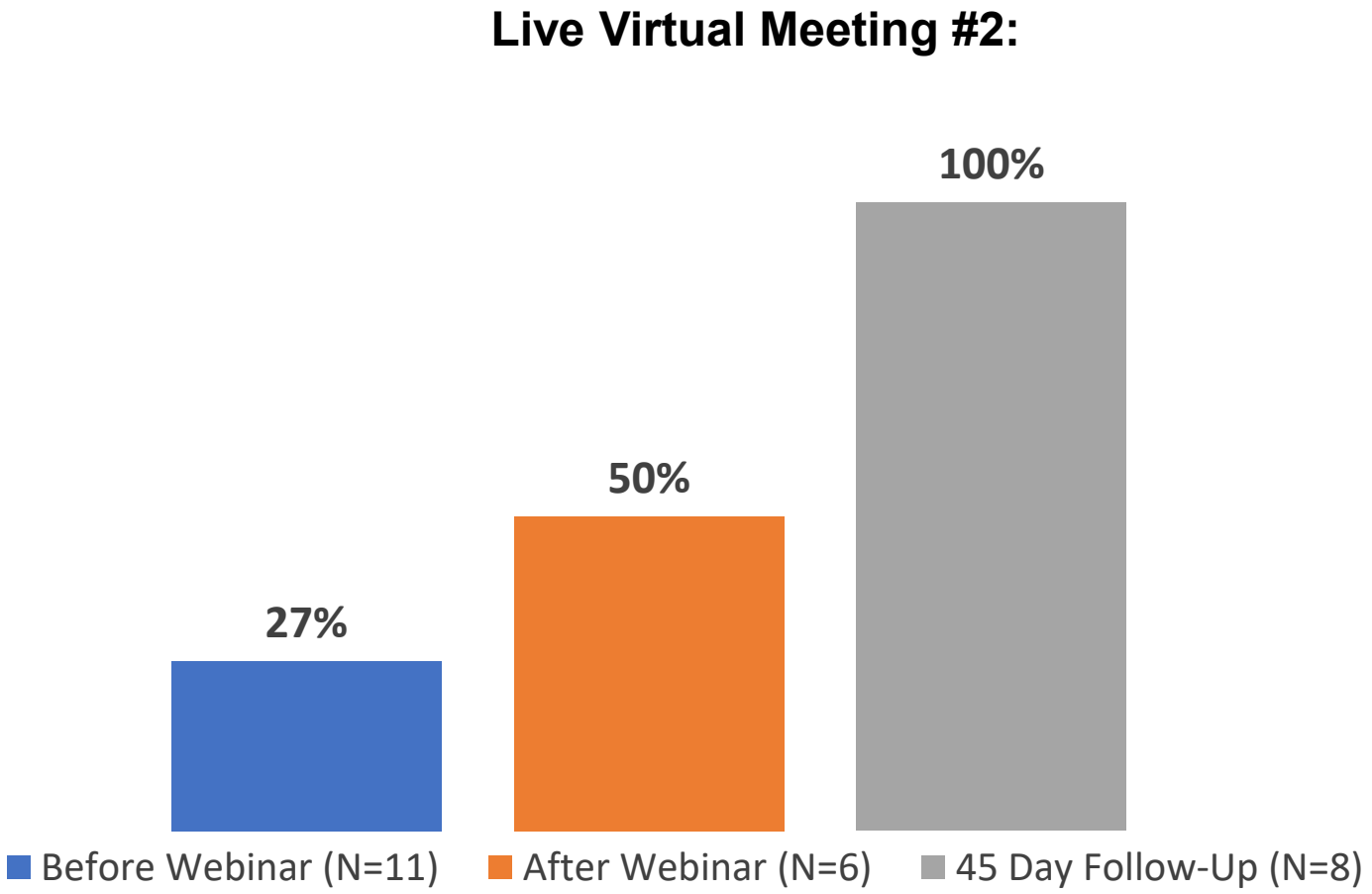
Evaluation respondents report they are "Very Confident" to "Somewhat Confident" in their ability to complete a comprehensive diagnostic evaluation for patients with suspected ILD



Live Virtual Meetings: Level 4 Competence (Meeting #2)

Final Outcomes Summary

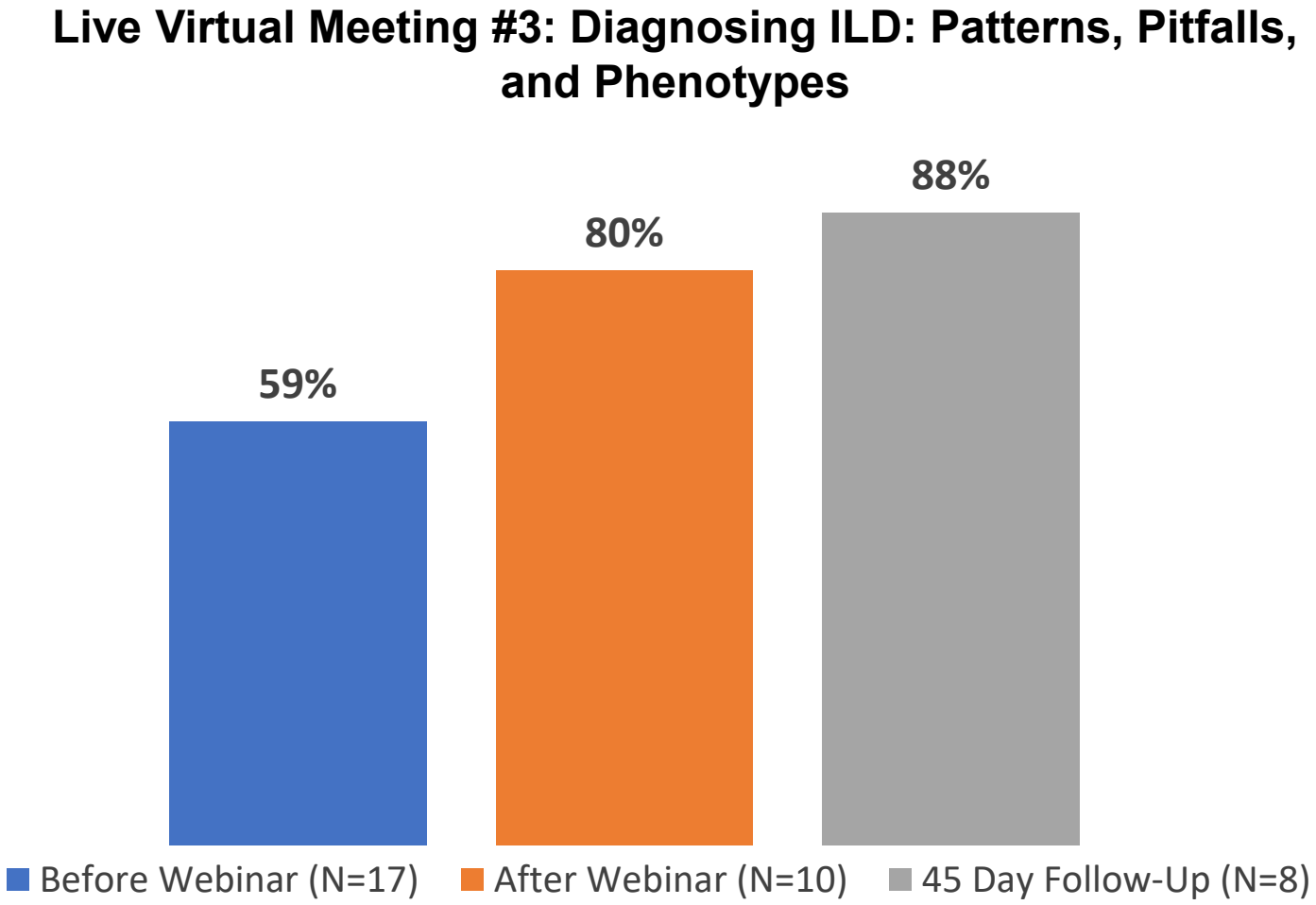
Evaluation respondents report they are "Very Confident" to "Somewhat Confident" in their ability to select individualized treatment strategies for patients with CTD-ILD



Live Virtual Meetings: Level 4 Competence (Meeting #3)

Final Outcomes Summary

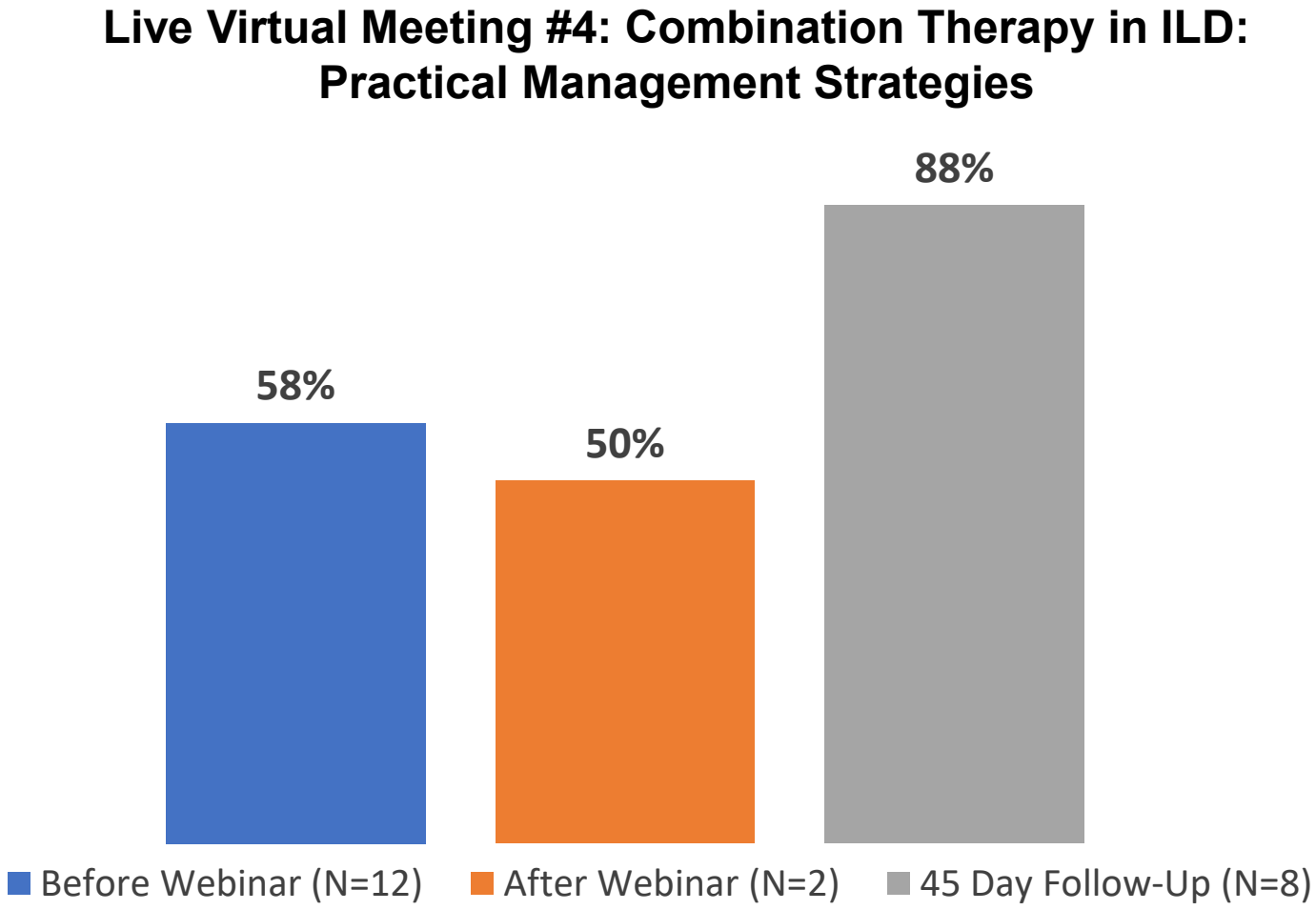
Evaluation respondents report they are "Very Confident" to "Somewhat Confident" in their ability to diagnose and classify ILD



Live Virtual Meetings: Level 4 Competence (Meeting #4)

Final Outcomes Summary

Evaluation respondents report they are "Very Confident" to "Somewhat Confident" in their ability to use combination therapy to treat patients with ILD



Live Virtual Meetings: Level 4 Competence (All meetings)

Final Outcomes Summary

93%

Evaluation respondents intend to make changes in practice as a result of the activity

N=28

Changes that evaluation respondents intend to make in practice after participating in the live virtual meetings:

- Diagnosis and therapy
- More confidence around Rx
- Rheum medication options
- More likely to prescribe nintedanib in PPF patients with bleeding risk factors with shared decision making
- Being mindful of side effects of nintedanib.
- Considering cellcept or rituximab + nintedanib
- Send autoimmune patients to pulmonary clinic if they have respiratory symptoms (for pulmonary care)
- Ensuring I am reviewing every CT scan I can and not going off of the radiologist read alone
- To have a better understanding of NSIP
- Collaborate with pulmonary

Community Forum

Final Outcomes Summary

In patients with rapidly-progressive ILD with high suspicion for anti-MDA5, the ACR guidelines conditionally recommend up-front triple therapy. This includes pulse IV steroids with 2 additional therapies (options include rituximab, cyclophosphamide, IVIG, mycophenolate, calcineurin inhibitor, and JAK inhibitor). Of these options, what therapies do you typically prefer? Any specific factors that you take into account?

Reply

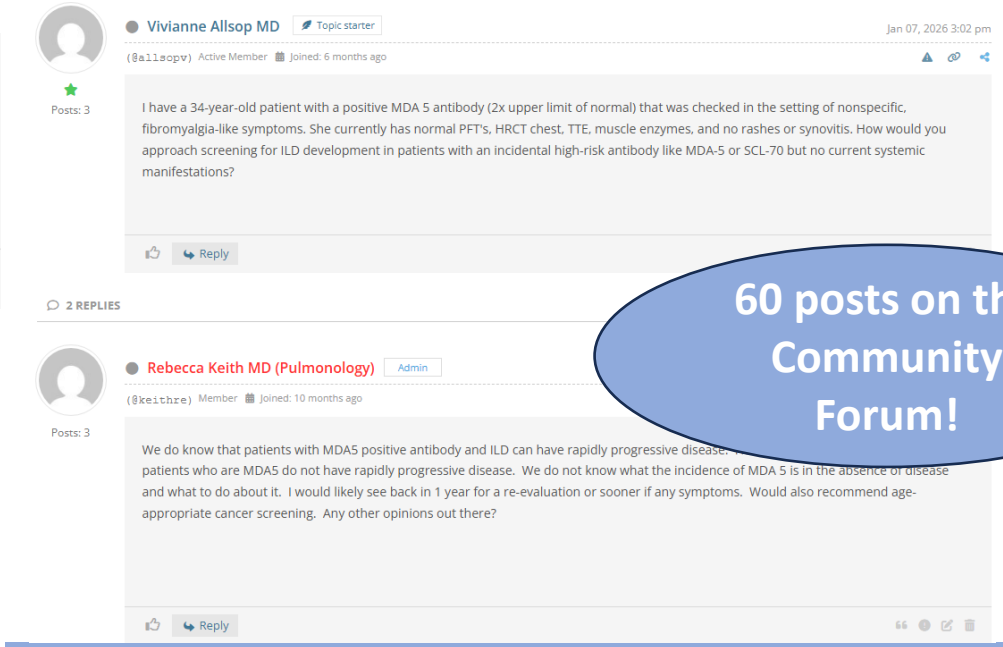
What is your approach to management of new onset symptomatic ILD in a patient with RA who is otherwise well controlled joint wise on methotrexate or leflunomide?

Reply

4,104+ views on the Community Forum!

Fascinating, but as far as I know we don't yet have any info. Clinically, we are using Otezla in practice for psoriatic arthritis. I find that it's a good drug for mild to moderate disease. Patient side effects are an issue for some and that can be an issue. What has been so helpful it that it's not immunosupressing. So I use it as monotherapy or in combination with other agents.

Reply



60 posts on the Community Forum!

Example Questions in the ILD Discussion Forum

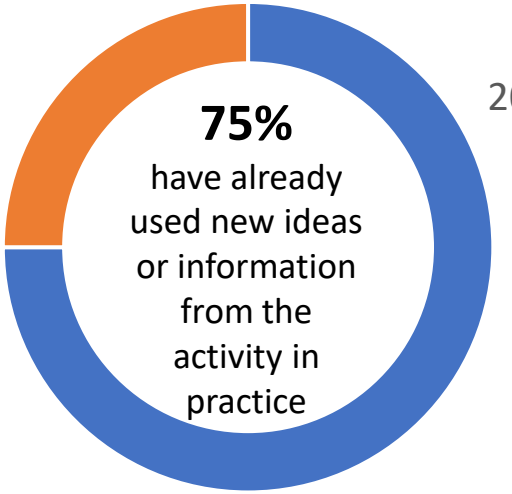
- Discussed a case today about a patient that presented with respiratory distress. Found to have lung consolidations. Had hemoptysis and transferred to the ICU. Bronchoscopy revealed diffuse alveolar hemorrhage on 3 serial lavages. What would your work-up be for causes?
- What are your current strategies for coordinating ILD care between rheumatology and pulmonology in your practice?
- What is your approach to selecting immunosuppressive therapy for patients with both arthritis and ILD?

Level (5) Outcomes: Performance

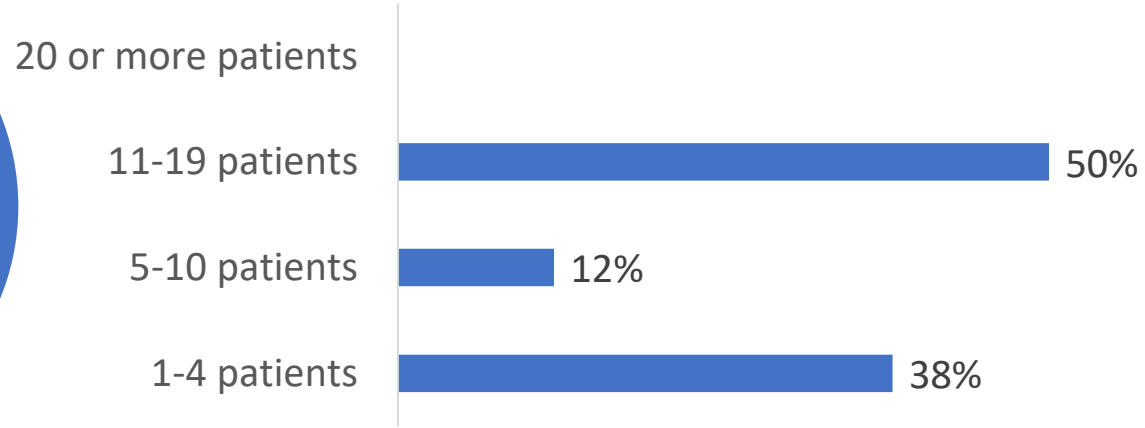
Final Outcomes Summary

45-day follow-up survey respondents report the impact of the activity on their practice (N=8)

While the response rate to the follow-up survey was low with only eight respondents, their responses indicate that participation in the activity has made a positive impact on their practice and their patients.



How many patients do you see per week affected by conditions discussed in this activity?



6 out of 7 reported that the activity helped address barriers in their practice.

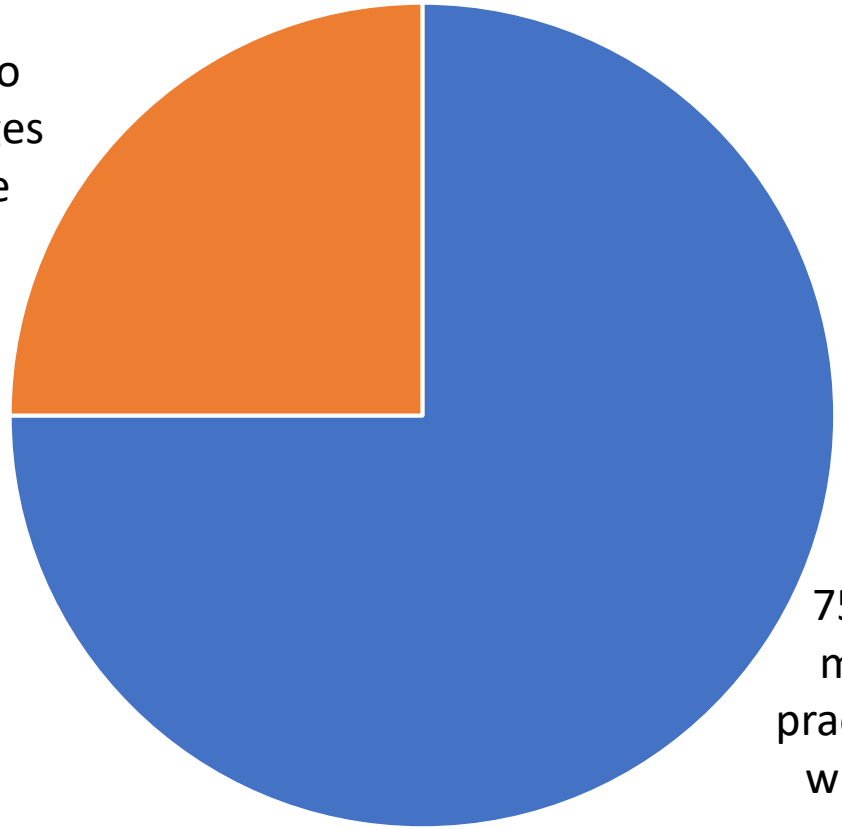
Barriers still faced include:

- Lack of familiarity with diagnostic and/or treatment guidelines
- Uncertainty in treatment selection
- Limited access to multidisciplinary care
- Insurance/access barriers

Level (5) Outcomes: Performance

Final Outcomes Summary

45-day follow-up survey respondents report the impact of the activity on their practice (N=8)



Examples of changes made in practice

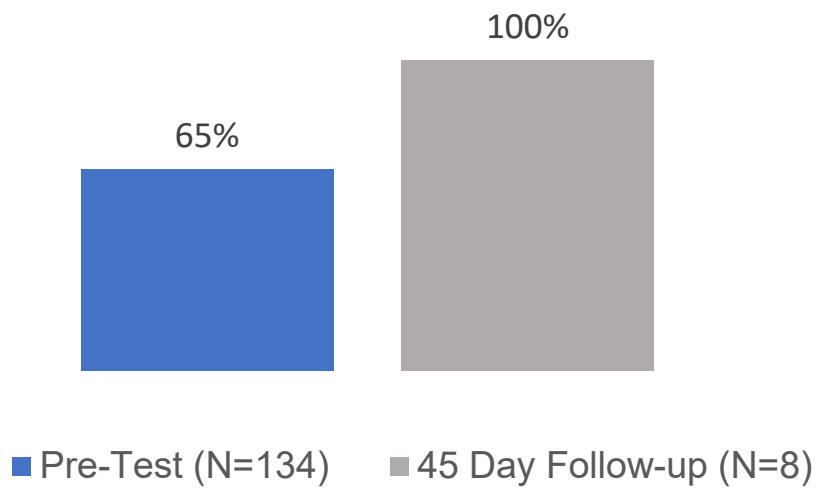
- Incorporated new information into patient encounters.
- Being less reluctant to due multimodal treatment of ILD
- Screening and monitoring for ILD
- I am now more familiar with the latest treatment strategies.

Level (5) Outcomes: Performance

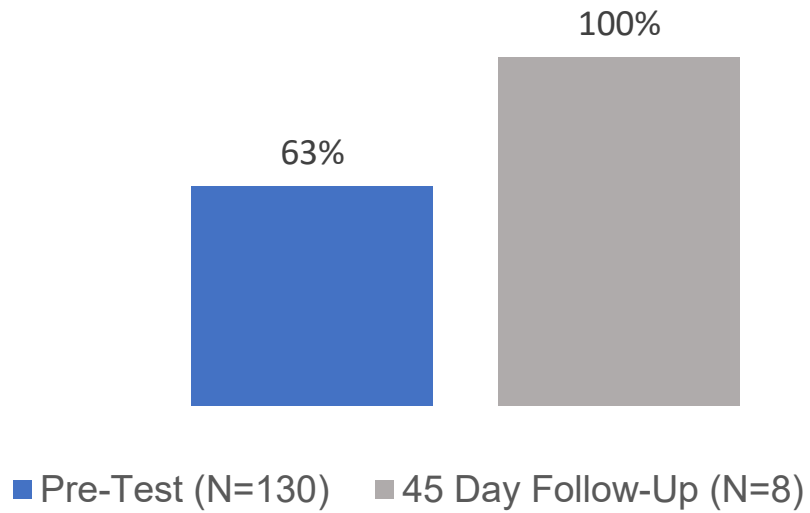
Final Outcomes Summary

Upon registration, participants were asked about their confidence in ILD diagnosis and management to get a baseline. Post-program confidence data was collected 45 days after the pilot program ended.

How confident are you in your ability to identify early signs of ILD in your patient population? (Percentage of respondents that answered somewhat-very confident)



Which best describes your familiarity with current ILD diagnostic and treatment guidelines? (Percentage of respondents that answered somewhat-very familiar)



Learners who participated in the program demonstrated significant gains in confidence.

Overall Program: Evaluation Results

Final Outcomes Summary

Key Takeaways

- The connection to arthritic and autoimmune disease.
- That more specific ILD diagnosis improves treatment selection
- The diagnostic algorithm for ILD
- ILD pattern on CT
- Differentiating the type of ILD
- The importance of collaboration with rheumatology colleagues
- Diagnose early and screen aggressively in high-risk patients. Combination therapy appropriate and continued expansion of treatment options via biologic therapies
- Need multidisciplinary care
- Screening early for ILD

Future Topics

- HP
- GI
- GERD
- Nutrition
- New research

Barriers Addressed

- Cost / Insurance
- antifibrotics and coverage
- Antifibrotic barriers
- The hurdles with obtaining Pirfenidone in PPF
- Referral to other specialties
- Prior authorization

Program Insights

Final Outcomes Summary

• This pilot program more than doubled its participation goal, engaging 176 physicians and 274 total learners, with 67% of participants representing pulmonology or rheumatology. This reach demonstrates considerable demand for longitudinal, multidisciplinary ILD education.

• Among the 45-day follow-up survey respondents, confidence in identifying early signs of ILD increased from 65% to 100%, and familiarity with current diagnostic and treatment guidelines increased from 63% to 100%. In addition, 75% reported already applying new knowledge in practice. These data provide encouraging evidence of continued practice impact.

• The community forum generated more than 4,100 views, despite no credit being claimed for forum participation, suggesting that access to peer and expert exchange was valuable to learners. Feedback suggests that future programs should consider a mobile-friendly platform or app to make participation more convenient and sustain engagement.

"I liked that the program was multifaceted - you could choose various platforms for education. The forum and videos were available anytime, which fits busy schedules nicely. The live meetings were engaging and while less convenient in terms of scheduling, they offered an opportunity for interaction with field experts.

This program spanned a 10-month period which I felt was a strength; it was available to revisit. I feel this is important for the sake of building community."

– Zulma Yunt, MD, Program Chair

Accreditation

Interim Outcomes Summary

National Jewish Health is accredited with Commendation by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians. The NJH Office of Professional Education produced and accredited this program and adhered to the updated ACCME guidelines.

National Jewish Health designates the live and enduring activities for a maximum of 10.0 *AMA PRA Category 1 Credits*™ and 10.0 ABIM MOC points.