**Supplemental Digital Content 2.** Other barriers listed by respondents that “prevent you from using ultrasound alone to evaluate for catheter position and for a central line-related pneumothorax?”

* What's wrong with double checking? Also Chest xray is not only used to r/o ptx, but to verify that the central line is in the right place and doesn't need to be advanced. Additionally, other pathologies may be found as well utilizing Chest xray in conjunction with ultrasound. Like anything in medicine we should always have a back up and DOUBLE CHECK.
* Don't know how to confirm position, aware of screening for pneumothorax, but don't routinely use it.
* Standard of care in our teaching hospitals to get CXR prior to RN using line unless emergent.
* Cannot confirm position of total length of line using ultrasound. X-ray shows not just ptx but catheter position along entire length of catheter.
* CXR is used primarily for depth/position. Not aware of us confirmation for depth of placement. Also suspect that admitting service would not accept ED US confirmation at my facility and cxr would be done later anyway. We still use oral contrast for all abd CTs until 2 months ago.
* Simply used to relying on CXR and others would trust a CXR more despite our knowledge of the increased sensitivity with US.
* I think the standard of care is still to use CXR and other providers in the ICU or on the floor need to follow it.
* I don't think agitated saline to confirm venous placement would rule out a subclavian CVC going UP an IJ.
* Expectation other services will want CXR confirmation
* No ultrasound images in the permanent medical record leading to increasing medicolegal risk nursing comfort and expectation. The cxr is ordered under resident's name as line is sewn in.
* If I'm really concerned, I'll immediately ultrasound. Otherwise cxr will also give me depth of line, will make others in the hospital more comfortable as they can see the film, and since I don't have to perform the cxr but would the ultrasound is one less thing that I have to do and it is incredibly easy with little downside to obtain a cxr.
* Good communication for others to confirm placement as well.
* Can't store ultrasound images at my facility.
* Not convinced ultrasound as specific in confirming catheter position as chest x-ray radiography also allows assessment of distal tip of catheter.
* I often perform SC lines (note: I always use US for IJs) and therefore don't always have the US in the room for line placement.