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FY2016 New Assembly/Committee Project Application

SECTION I - GENERAL PROJECT INFORMATION

1. PROJECT TITLE:
Optimizing Smoking Cessation Interventions in Lung Cancer Screening Programs
2. PROJECT PRIMARY ASSEMBLY:
Thoracic Oncology
3. PROJECT SECONDARY ASSEMBLY: (IF ANY)
Behavioral Science and Health Services Research , Clinical Problems , Nursing
- 3a. ATS SECTION: (IF ANY) --empty--
4. ATS COMMITTEE SUBMITTING PROJECT APPLICATION: *N/A*
5. What official ATS document will be developed as part of this project (choose 1)?
Research or Policy Statement

SECTION II - PROJECT DESCRIPTION

6. PROJECT DESCRIPTION

- A. Describe the problem and define the goals and objectives of the project.

****PLEASE NOTE THAT THIS REVISED PROPOSAL INCLUDES CHANGES MADE IN RESPONSE TO COMMENTS FROM THE SPONSORING ASSEMBLIES. THE SPECIFIC CHANGES MADE ARE HIGHLIGHTED IN THE ATTACHED COVER LETTER INCLUDED IN THE SUPPORTING DOCUMENTS SECTION. ***

Cigarette smoking is the leading cause of preventable death in the United States, yet nearly 42 million adults continue to smoke and only 1-6% of smokers successfully quit each year (1). The American Cancer Society estimates that 158,040 Americans will die from lung cancer in 2015 (2). Trial results from the 2011 NCI-funded multi-center randomized National Lung Screening Trial (NLST) trial indicate that low dose CT (LDCT) screening in middle-aged and older current and former smokers is associated with a reduction in mortality of approximately 20% (3). An estimated 8.6 million Americans are eligible for LDCT screening (4), and approximately 50% of screen-eligible patients are current smokers (5-8). The only more effective intervention to reduce lung cancer mortality in this high risk group is quitting smoking. Thus, providing smoking cessation treatment in conjunction with annual lung cancer screening offers the unprecedented opportunity to dramatically reduce smoking related morbidity and mortality.

There is an urgent need to develop interventions for smoking cessation in the specific context of lung cancer screening. The very act of undergoing LDCT screening may force smokers to confront their risk of lung cancer in a way they have not previously, thus serving as a potential “teachable moment” to motivate smoking cessation. But it may not be as simple as applying smoking cessation treatments shown to be effective in other settings. To be eligible for LDCT screening, individuals must be aged 55-74 with at least a 30 pack-year history of tobacco use – these are not casual smokers but older, heavily addicted ones, many of whom have made prior unsuccessful attempts to quit. These smokers may require more intensive interventions or innovative approaches to achieve sustained abstinence from tobacco use. Indeed, customizing smoking cessation advice to other specific contexts has been shown to be an effective motivator; for example, linking smoking cessation advice to delivery of “spirometric lung age” increases quit rates (9).

In a ground-breaking coverage decision released in February 2015, CMS now requires smoking cessation interventions be delivered in order to receive coverage for CT lung cancer screening. Similarly multiple professional organizations and the USPSTF recommend that smoking cessation interventions be delivered in conjunction with lung cancer screening. Yet the best approach for delivering successful interventions in this setting is not known and there is little guidance on how such services should be implemented. The National Cancer Institute has recognized the need for research to determine the optimal timing, methods, intervention, and delivery to current smokers in LDCT programs and has made this topic a priority area. This research is likely to be of great interest to other funding agencies as well, including the Department of Veterans Affairs, Department of Defense, American Cancer Society, and the Patient Centered Outcomes Research Institute (PCORI).

We now propose to develop a research statement to identify gaps in knowledge about smoking cessation in the context of lung cancer screening and to stimulate research on optimal smoking cessation interventions delivered in conjunction with LDCT lung cancer screening visits. The statement will focus on 4 areas:

(1) Evidence-based smoking interventions. It is unknown whether interventions such as counseling and pharmacotherapy approaches that have proven to be effective in the general population, are associated with successful cessation when applied to LDCT programs. LDCT screening provides an opportunity to deliver evidence-based smoking cessation interventions. A meta-analysis, reported in the US Public Health Service guidelines, indicate that smoking cessation medications combined with 8 sessions of counseling lead to long term abstinence rates of 33% compared to rates of 10-11% without counseling or medication (1). Previous research on smoking cessation needs to be applied with consideration of this new setting. Moreover, newer approaches such as financial incentives, mobile technology, patient navigation, and e-cigarettes as a bridge to quitting, should be explored in this unique context.

(2) Optimal timing of smoking cessation interventions. Participants enrolled in lung cancer screening programs may be more motivated to quit than those in the general population. Furthermore, studies suggest that successful smoking cessation interventions in the context of LDCT setting are linked to CT scan results (5,6,10,11). Some studies have indicated that the discovery of a screen-detected nodule or other abnormality may provide a “teachable moment” to promote smoking cessation (12), as smoking participants with abnormal CT results more likely to quit smoking than those with normal results (5,6,11). On the other hand, a concern is the potential adverse effects of a negative screen that may create the opposite effect, a “license to smoke” (10, 13). The timing of when to best deliver smoking interventions relative to the screening test (eg at the shared decision visit or at the time of results follow up) needs to be considered in LDCT screened participants.

(3) How to minimize health care disparities. Large disparities in tobacco use across racial/ethnic groups and between groups defined by educational level, socioeconomic status, and region exist. Smoking is directly correlated with income level and years of education. Smoking rates among low socioeconomic status (SES) African Americans are at least double the national average (14). Black smokers continue to be less likely than whites to receive and use tobacco-cessation interventions, even after control for socioeconomic and healthcare factors (15), and suffer disproportionately from smoking-related health disease including lung cancer. Determining how to best target smoking cessation interventions (eg patient navigator, health coach) to specific racial, ethnic, and socioeconomic groups within LDCT programs remains largely unanswered.

(4) Implementation strategies that are most effective in increasing and incorporating consistent smoking cessation interventions within LDCT programs. The U.S. Public Health Service clinical practice guideline recommends that clinicians consistently identify and document patients’ tobacco use status, and treat tobacco users employing a “5As” framework (Ask, Advise, Assess, Assist, and Arrange) (1). The Centers for Disease Control and Prevention reports that although 62.7% of outpatient visits included tobacco screening, only 20.9% of current tobacco users received counseling and 7.6% received a prescription for cessation pharmacotherapy during their visit (16). Pragmatic aspects of smoking cessation interventions within the LDCT screening will be addressed. Strategies to address barriers and stimulate research to improve implementation of effective interventions (eg provider training, decision support applications, and academic detailing) within LDCT programs will be discussed. It will also be important to consider costs and cost-effectiveness of implementing smoking cessation interventions in this context.

References:

1. Fiore, MC.; Jaén, CR.; Baker, TB.; Bailey, WC.; Benowitz, NL.; Curry, SJ., et al. Treating tobacco use and dependence: 2008 update clinical practice guideline. Rockville, MD: U.S. Department of Health and Human Services, Public Health Service; 2008.1
2. American Cancer Society. Cancer Facts and Figures, 2015.
3. Aberle DR, Adams AM, Berg CD, et al. Reduced lung-cancer mortality with low-dose computed tomographic screening. *N Engl J Med.* 2011; 365(5):395–409. [PubMed: 21714641]
4. Ma J, Ward EM, Smith R, et al. Annual number of lung cancer deaths potentially avertable by screening in the United States. *Cancer* 119:1381–1385, 2013.
5. Townsend CO, Clark MM, Jett JR, Patten CA, Schroeder DR, Nirelli LM, et al. Relation between smoking cessation and receiving results from three annual spiral chest computed tomography scans for lung carcinoma screening. *Cancer.* 2005; 103:2154–62. [PubMed: 15825210]
6. Ashraf H, Tonnesen P, Pedersen JH, Dirksen A, Thorsen H, Dossing M. Effect of CT screening on smoking habits at 1-year follow-up in the Danish Lung Cancer Screening Trial (DLCST). *Thorax.* 2009
7. Tammemägi MC, Berg CD, Riley TL, et al. (2014) *Impact of lung cancer screening results on smoking cessation. J Natl Cancer Inst* 106:dju084.
8. van der Aalst CM, van Klaveren RJ, de Koning HJ (2010) *Does participation to screening unintentionally influence lifestyle behaviour and thus lifestyle-related morbidity? Best Pract Res Clin Gastroenterol* 24:465–478.
9. Parkes G, Greenhalgh T, Griffin M, Dent R. Effect on smoking quit rate of telling patients their lung age: The step2quit randomised controlled trial. *BMJ* 2008;336:598-600.
10. Ostroff J, Buckshee N, Mancuso C, Yankelevitz D, Henschke C. Smoking cessation following CT screening for early detection of lung cancer. *Prev Med.* 2001; 33: 613–621
11. Styn MA, Land SR, Perkins KA, Wilson DO, Romkes M, Weissfeld JL. Smoking behavior 1 year after computed tomography screening for lung cancer: effect of physician referral for abnormal CT findings. *Cancer Epidemiol Biomarkers.* 2009; 18(12):3484–9.
12. Taylor KL, Sanderson L, Zincke N, Mehta L, McGuire C, Gelmann E. Lung cancer screening as a teachable moment for smoking cessation. *Lung Cancer.* 2007;56:125–34.
13. Weinstein N. What does it mean to understand a risk? Evaluating risk comprehension. *J Natl Cancer Inst Monogr.* 1999; 25: 15–20
14. Delva, J., Tellez, M., Finlayson, T. L., Gretebeck, K. L., Siefert, K., Williams, D. R., & Ismail, A. I. (2005). Cigarette smoking among low-income African-Americans. *American Journal of Preventive Medicine*, 29, 218–220.
15. Cokkinides V, Halpern MT, Barbeau EM, Ward E, Thun MJ. Racial and Ethnic Disparities in Smoking-Cessation Interventions: Analysis of the 2005 National Health Interview Survey 2008, *American Journal of Preventive Medicine* 34(5): 2008, 404–41215.

16. Jamal A, Dube SR, Malarcher AM, Shaw L, Engstrom MC; Centers for Disease Control and Prevention (CDC). Tobacco use screening and counseling during physician office visits among adults — National Ambulatory Medical Care Survey and National Health Interview Survey, United States, 2005–2009. *MMWR Morb Mortal Wkly Rep* 2012;61(Suppl):38–45.

B. What are the specific questions to be addressed? (for Clinical Practice Guidelines Only)

Applicants should list all questions relevant to daily clinical practice that are to be covered by the guideline.

Questions should be as specific as possible about the patients/populations to be included or excluded, types of diagnostic or therapeutic interventions to be considered or left out. Questions should be structured in PICO format, specifying the target patient population (P), the intervention or exposure (I), comparators (C), and outcomes of interest (O). While it is expected that the initial set of questions will undergo revision and refinement, applicants are encouraged to be as specific as possible about each one of the PICO elements.

--empty--

C. Are you aware of any non-ATS activities in this area

No

» If Yes please describe: --empty--

D. Describe why this project should be a priority for the ATS?

ATS has been a leader in advocating for smoking cessation and has recently released a broad statement on the need for research in tobacco control and treatment (17). To date, however, no organization or group has issued specific guidance on how smoking cessation interventions should be delivered in lung cancer screening programs. Within LDCT screening programs, for example, it is not known if delivery of smoking cessation interventions may be a “teachable moment” where smokers are particularly receptive to cessation interventions. Conversely, those with normal screening results may be reassured and feel that there is no urgency to quit (18), such that the smoking cessation intervention and/or the timing of the intervention may need to be individually tailored. The National Cancer Institute has recognized the need for research to determine the optimal timing, methods, intervention, and delivery to current smokers in LDCT programs and has made this topic a priority area.

As leaders in research of smoking related lung disease and in setting policy related to healthcare delivery and public health in pulmonary medicine, the ATS is ideally positioned to issue a research policy statement summarizing the evidence and context for implementation of smoking cessation within lung cancer screening programs. This proposal integrates the perspectives from various ATS committees. Dr. Frank Leone and the Tobacco Action Committee are enthusiastic participants in the proposal and recognize the need for targeting smokers in this setting. The goal of this statement is to identify gaps in the knowledge base and to stimulate research addressing these gaps to determine the most effective delivery of a pragmatic smoking intervention to reach the greatest number of patients in LDCT programs.

References:

17. Leone FT, Carlsen KH, Folan P, Latzka K, Munzer A, Neptune E, Pakhale S, Sachs DP, Samet J, Upson D, White A; ATS Tobacco Action Committee. An Official American Thoracic Society Research Statement: Current Understanding and Future Research Needs in Tobacco Control and Treatment. *Am J Respir Crit Care Med.* 2015 Aug 1;192(3):e22-41. doi: 10.1164/rccm.201506-1081ST. PubMed PMID: 26230245.

18. Zeliadt SB, Heffner JL, Sayre G, Klein DE, Simons C, Williams J, Reinke LF, Au DH. Attitudes and Perceptions About Smoking Cessation in the Context of Lung Cancer Screening. *JAMA Intern Med.* 2015 Jul 27. doi: 10.1001/jamainternmed.2015.3558. [Epub ahead of print] PubMed PMID: 26214612.

E. Describe the methodology that will be used to carry out the project objectives: For clinical practice guidelines (CPGs) include the following: Search Strategy, Review of Evidence, Grading of Evidence, Formulation of Recommendations or other key activities leading towards completion of this project. See page 6 of the Guidelines for ATS Documents (GATS) on the ATS website at: <http://www.thoracic.org/statements/document-development/index.php>

Pre-Meeting Agenda

1. Assembly of Project Team: Identify a project team comprised of the many stakeholders relevant to development and implementation of smoking cessation within lung cancer screening programs. We have taken care to include representatives from different practice settings including academic, community, and VA medical centers and representatives with experience on tobacco treatment programs internationally. The stakeholders include:

- Clinicians representing the disciplines of pulmonary medicine, leaders in tobacco dependence treatment, primary care, and nursing.
- Patients, specifically those who have either struggled with or successfully quit smoking and who have undergone LDCT screening. These patients will help us understand barriers and motivators to quitting smoking in the context of lung cancer screening.
- Representative from health insurers and large healthcare networks
- Members of the Tobacco Action Committee
- Experts in document development, health policy, health services research and implementation science.

2. Review Data Sources: Identify and review recent guidelines, systematic reviews, and research manuscripts related to smoking cessation interventions, particularly related to LDCT programs and reducing health care disparities. The research policy statement will be informed by multiple data sources, including:

- Existing systemic reviews and practice guidelines.
- Research Articles
- Expert opinion of multi-stakeholder project team

3. Assign each participant to a working group: Given the diverse backgrounds and expertise of our stakeholder team members, we will prepare a “briefing packet” including original scientific articles and guidelines as well as plain-language summaries of the findings of the data sources listed above. This briefing packet will be distributed to all team members prior to the initial conference call. During our

initial call we will clearly delineate the roles and expectations of all team members.

- Assign each participant to a working group. Each working group will include a patient representative.
- Confirm working group leaders
- Working group leaders formulate plans for sessions
- Review agenda with participants and solicit feedback

Meeting Agenda

1. Invited Speakers: 8:30 to 10:00 am (of note, 2 of 4 invited speakers are members of the ATS)

- Kathy Fennig, Patient representative: Opening talk to motivate importance of this topic, challenges of smoking cessation in context of lung cancer screening.
- Denise Jolicoeur MPH, CHES: Overview of tobacco addiction; PHS guidelines for smoking cessation, behavioral counseling and medication overview.
- Frank T Leone, MD: Barriers to effective smoking interventions and overview of treatment and implementation strategies to improve health care disparities.
- Hasmeena Kathuria, MD: Summary of evidence and research of smoking cessation interventions and implementation relating to LDCT programs.

2. Break: 10:00 to 10:15 am

3. Breakout Session I: 10:15 to 11:45 am

1. Each working group will summarize evidence, identify gaps in evidence and barriers to effective interventions, and formulate specific research questions
2. Breakout Groups 1 and 2
 - Group 1-Interventions: Behavioral counseling, medications, and other novel approaches (e.g., financial incentives, patient navigation, possible role for e-cigarettes): Anil Vachani and Scott Halpern, Facilitators
 - Group 2- Timing: Chris Slatore and Carlijn van der Aalst, Facilitators

4. Report back to group: 11:45 to 12:45 pm

5. Break for lunch: 12:45 to 1:45 pm

6. Breakout Session II: 1:45 to 3:15 pm

1. Each working group will summarize evidence, identify gaps in evidence and barriers to effective interventions, and formulate specific research questions
2. Breakout Groups 3 and 4
 - Group 3- Health care disparities: Patricia Rivera and Juan Wisnivesky, Facilitators
 - Group 4- Implementation/Dissemination: Renda Wiener and Michael Gould, Facilitators

7. Report back to group: 3:15 to 4:15 pm

8. Summation, Work Plan: 4:15 to 5 pm

Post-Meeting Agenda

1. Identify members of writing committee:
2. Determine content of Research Statement.

In each of the 4 focus areas:

- Summarize existing evidence.
- Identify barriers and gaps to implementation of smoking cessation in LDCT programs.
- Discuss research goals to overcome barriers.

3. Develop Policy statement

- June 2016: Co-chairs write outline of summary paper
- July 2016: Conference call to solicit feedback from working group leaders
- Sept 2016: Co-chairs coordinate with working group leaders/interested team members to develop first draft
- Oct 2016: Conference call to solicit feedback from all participants
- Nov 2016: Review/revise final draft until consensus is reached
- Dec 2016: Submit to the ATS Documents Development and Implementation Committee

F. Who will perform the systematic reviews? (for Clinical Practice Guidelines Only)

We encourage project teams to identify and make use of recently published, high quality systematic reviews performed by others. However, it is required that one or more members of the team have first-hand experience performing (and publishing) systematic reviews. Applicants are encouraged to recruit qualified individuals with adequate time to help perform systematic reviews. These may include junior members.

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G. HEALTH EQUALITY

Is the assembly project topic relevant to health equality?

Yes

If yes, how do you plan to incorporate the issue of health equality into your project.

Smoking prevalence remains discouragingly high in populations such as those with low socioeconomic status (SES). Furthermore, these subpopulations suffer disparately elevated risks related to smoking. Quitting smoking reduces these health risks in both the general population and more vulnerable populations. Determining how to best target smoking cessation interventions (eg patient navigator, health coach) to specific racial, ethnic, and socioeconomic groups within LDCT programs remains largely unanswered and is a major focus of our research policy statement. We have specifically recruited patient stakeholder representatives from low SES populations to ensure their voices are heard in this process.

H. All applicants who have or will have an official document as part of their Assembly/Committee project

must:

1. Review a set of document development vignettes (Module A) prior to submitting.
2. For Guideline developers only : Review Module B, guideline specific vignettes
3. For Guideline developers only: Develop 3-5 bullet points for a Clinician Summary and 3-5 bullet points for a Patient Summary.

Review a set of document-development vignettes prior to submitting this application. Please visit to access these vignettes. Note: Module A is for all document developers and Module B is also required for document developers who are preparing a clinical practice guideline. Yes, I have reviewed the ATS document development vignettes

Module A

I. FOR CME EDUCATIONAL PROJECTS/PRODUCTS ONLY: FOR MORE INFORMATION PLEASE SEE INSTRUCTIONS. PLEASE DESCRIBE THE FOLLOWING:

N/A

SECTION III - PROPOSED PARTICIPANTS

If your project does NOT intend to develop a Systematic Review or Clinical Practice Guideline. Please skip next three paragraphs and enter project participants.

ATS requests proposals from multidisciplinary teams that include those with relevant clinical expertise and those with expertise in methods of critical appraisal of the literature, systematic literature review and guideline development. ATS encourages involvement of diverse stakeholders, each bringing a unique and important perspective to the process. A typical team should generally include clinical experts (including physicians, nurses and respiratory therapists), clinical investigators, one or more experts in systematic review and guideline development, and one or more external stakeholders, including a patient or patient representative. For some guidelines, it may also be useful to have a health economist, a medical librarian, an expert in group facilitation and/or project management, and/or one or more members to represent the perspective of governmental and non-governmental payer and health plans.

Evidence synthesis requires appropriate methodology. The ATS requires a systematic literature review for Systematic Reviews and Clinical Practice Guidelines and use of GRADE to assess the quality of evidence and to rate the strength of treatment recommendations for Clinical Practice Guidelines. Starting in 2012, the ATS strongly encourages NEW project applications that intend to develop a Systematic Review or Clinical Practice Guidelines to include 1 or more individuals with documented experience in these methodologies (i.e., have designed a systematic review; have applied GRADE for treatment recommendations); such individuals will be expected to provide methodologic support for document development in collaboration with the ATS Methodologist. Alternatively, NEW project applications may include 1 or more junior ATS members (e.g., Fellows or Assistant Professors) with an interest in learning how to perform an evidence synthesis using methods required by the ATS; such individuals ("ATS Evidence Synthesis Scholar") will be expected to work in collaboration with the ATS Methodologist to design the systematic literature review and, where applicable, apply GRADE for treatment recommendations. Finally, upon request, the ATS will provide a guideline methodology trainee who will work with the supervision of the ATS methodologist to perform the methodological work for your committee.

If your project intends to develop a Systematic Review or Clinical Practice Guideline, please indicate below which of the project participants meet the criteria described above. Also, please indicate if they have documented expertise in applying the ATS requirements for evidence synthesis OR will serve as an Evidence Synthesis Scholar. For more information, please discuss with the Document Development and Implementation Committee (contact Judy Corn, DDIC Staff) at least 1 week before submitting the application to PRS.

To facilitate development of guideline derivatives, you will be required to submit a) 3-5 key points to be used to formulate a Clinician Summary and b) 3-5 key points to be used to formulate a Patient Summary, at the time you upload your final draft manuscript to ScholarOne.

7. PROPOSED PARTICIPANTS - *The proposed participants must have their conflict of interest disclosures vetted and may require approval by the co-sponsoring society before being formally added to the project committee.*

Name	Institution	"Role" on Project committee	Area of Expertise	E-mail	Society that participant will represent	Participant will require airfare	Participant will require Per Diem
Hasmeena Kathuria	Boston University	Co-chair	smoking cessation interventions; health care disparities		ATS		YES
Renda Wiener	Boston University Medical Center	Co-chair	patient centered outcomes, implementation research		ATS		YES
Denise Jolicoeur	University of Massachusetts	Invited Speaker: Overview; behavioral counseling	Project Manager Implementaion of Tobacco Cessation Treatment; Counseling		Invited Speaker	Domestic	YES
Frank T Leone	University of Pennsylvania	Invited speaker, overview, implementation	investigating treatment strategies for tobacco use disorder and methods for disseminating treatment strategies to physicians nationwide		ATS		YES
Anil Vachani	University of Pennsylvania	Group Facilitator: Interventions	health services perspective		ATS		YES
Scott Halpern	U Penn	Group Facilitator: Interventions, Novel therapies	financial incentives for smoking cessation		ATS		YES
Carlijn van der Aalst	Erasmus University Medical Center; Netherlands	Facilitator: Timing	international perspective	c.	ATS	International	YES
Christopher Slatore	Oregon Health Sciences University	Facilitator: Timing	evidence review of lung cancer screening for the USPSTF, including systematic review on smoking cessation		ATS		YES

Name	Institution	"Role" on Project committee	Area of Expertise	E-mail	Society that participant will represent	Participant will require airfare	Participant will require Per Diem
Juan Wisnivesky	Mount Sinai Hospital	Facilitator: Health Care Disparities	health care disparities and influence of cultural beliefs on LDCT screening; PCP perspective		ATS		YES
Patricia Rivera	University of North Carolina	Facilitator: Health Care Disparities	Improving health care disparities in LDCT screening		ATS		YES
Michael Gould	Kaiser Permanente	Facilitator: Implementation	health care policy; implementation research		ATS		YES
Georgia Narsavage	West Virginia University	nursing perspective	implementation and counseling		ATS		YES
Dona Upson	University of New Mexico	VA perspective; alternative therapies; e cigarettes	e-cigarettes; tobacco treatment specialist; VA Health Care perspective		Tobacco Action Committee		YES
Peter Mazzone	Cleveland Clinic	Implementation perspective	screening in US		ATS		YES
Steve Zeliadt	University of Washington	Patient perspective and patient centered outcome research	Influence of LDCT screening on patient attitudes towards smoking cessation		invited guest	Domestic	YES
Doug Arenberg	University of Michigan	timing of intervention	SDM; Lung cancer screening		ATS		YES
Pat Folan	North Shore-LIJ	nursing and tobacco trained specialist perspective	tobacco treatment specialist; tobacco action committee		ATS		YES
Patricia Gilda Miller	Boston University	patient perspective; community health coach	patient perspective		invited guest	Domestic	YES
Chunxue Bai	Shanghai Respiratory Institute	International Perspective	Asian perspective on smoking cessation		ATS		YES
Martin C. Tamm	Brock University	International Perspective	Impact of Lung Cancer Screening and smoking		ATS		YES

Name	Institution	"Role" on Project committee	Area of Expertise	E-mail	Society that participant will represent	Participant will require airfare	Participant will require Per Diem
Kathy Fennig	N/A	Patient Perspective	Attitudes toward smokers; screening perspective		Invited guest	Domestic	YES

SECTION IV - TIMETABLE

8. TENTATIVE TIMETABLE FOR COMPLETION OF THE PROJECT PLEASE INCLUDE A PROJECT COMPLETION DATE FOR EACH FUNCTION OR ACTIVITY.

Function/Activity	Proposed Dates	Location	#of Participants	Function Completion Date
Kick-off and Finish/Review Conference Calls	March, November 2016	Conference Calls	7	12/01/2016
Focus group Conference Calls (4)	June, July, Aug, Sept	Conference Calls	7	12/1/2016
In-person meeting at ATS International Conference	May 2016	ATS meeting	21	05/20/2016
c. Drafting of policy statement	initial draft summer 2016, revisions among team fall 2016, with submission no later than December 2016	Remote, conference calls	10	12/20/2016

9. Expected Project Completion Date

December 2016

SECTION V - PROJECT OUTCOMES

10. All products or works, whether in writing or in another form, that are created partly or completely with the assistance of funding provided by the American Thoracic Society will be the intellectual property of the ATS exclusively, unless otherwise stipulated in writing by the ATS. The disposition of these products or works will be at the sole discretion of the ATS. Recipients agree, as a condition of receipt of ATS funding, that ATS owns the copyright and all other rights to these products or works.

I- DERIVATIVES (please note that all printed documents are automatically posted on the ATS website)

Web-only fact sheet

II- Web Products --empty--

III- Educational Products --empty--

SECTION VI - BUDGETS

11. FY2015 PROPOSED ATS BUDGET

Round Trip Coach Airfare-Domestic (\$575 per person) Number of Persons? 4

Round Trip Coach Airfare-International (\$2000 per person) Number of Persons? 1

Hotel and per diem (Full Day Meeting at ATS Conference Fri & Sat Only) (\$425 per person) Number of Persons? 21

Breakfast Meeting at ATS Conference (\$50.00 Per Person) Number of Persons? --empty--

Lunch Meeting at ATS Conference (\$50.00 Per Person) Number of Persons? --empty--

Conference Calls (# of people x # minutes x 0.10)

of people 7

of minutes 60

of calls 6

Publication Costs (\$450.00 Per Page) Number of Pages? --empty--

Medical Librarian - This item requires approval and justifications from document development staff (up to \$5000)
--empty--

Outside Meeting 1 - Must provide Budget justification

Please note that this section is only for meetings that will not take place at the ATS International Conference. Please list activities using budget parameters below.

N/A

Outside Meeting 2 - Must provide Budget justification

N/A

Other Project Expenses

Please note this section is only for expenses other than outside meetings.

N/A

12. FY2015 BUDGET FROM OTHER SOURCES (JOINT PROJECTS ONLY)

N/A

SECTION VII

13. IF THIS PROJECT IS BEING CO-SPONSORED BY ANOTHER NON-CORPORATE ORGANIZATION (Foundation, government, other non-corporate organizations), please provide a letter from the potential co-sponsoring organization that indicates that the society is aware of the proposal. The letter is not intended to indicate that the potential co-sponsoring society is committed to the project, only that they are aware that they are being listed as a potential co-sponsor and will be contacted by the ATS at a later time to discuss potential collaboration. PLEASE COMPLETE THE FOLLOWING:

Organization	Contact Person	Funding Amount Requested	Funding Amount Approved
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SUPPORTING DOCUMENTS OR REFERENCES

ATS requires references for both chairs justifying their expertise in the field. In addition, a letter is required from each proposed co-sponsoring societies indicating that the society is aware of the project and interested in participating. (please merge multiple files into one document)

Documents (please merge all files into one file should not exceed 10 pages)

SECTION VIII - Conflict of Interest Management

Conflicts of interest (COI) are direct personal financial or intellectual relationships with a company that has a business interest in the subject matter of the project. Disclosure and management of COI is an integral part of ATS project development because COI can lead to biased generation or assessment of evidence and misinform healthcare decision makers. Medical professional societies are obliged to rigorously manage potential COI, particularly in the development of official documents that affect health care. Therefore, the ATS requires that:

1. For all proposed projects, **ATS must have on file (by time of consideration of this application) an up-to-date disclosure of any potential conflicts of interests of the proposed project chair or co-chair related to project subject matter.** Disclosure-to-ATS occurs through the annual online disclosure questionnaire available at the ATS COI Website (<https://thoracic.coi-smart.com>). Please note:
 - If you filed a 2015 disclosure questionnaire previously due to another ATS activity (such as the 2015 Denver International Conference), please return to the ATS COI Website to revise your disclosure to (a) add to your answer for Question 1 that your disclosure also applies to your consideration as a "Project Applicant" (simply click the box for that) and (b) make sure that the scope of your disclosures there includes anything relevant to the project you are proposing here. Please use the ATS-issued site Log-in ID that was previously issued to you, and your self-determined password, to access the COI site, and then follow the posted instructions to update your disclosure. If you've forgotten your Log-in ID, use the "Forgot Log-in ID" prompt on the website or contact John Harmon at ATS at coioffice@thoracic.org or 212-315-8611.
 - If you haven't yet completed the 2015 questionnaire, please contact John Harmon at ATS at coioffice@thoracic.org or 212-315-8611 to be registered and receive instructions.
2. All projects intended to result in an ATS clinical practice guideline (CPG) must meet additional conditions outlined in the [Policy for Management of Financial Conflicts of Interest in the Development of ATS Clinical Practice Guidelines](#)

ATS BUDGET SUMMARY CHART

Line Item	Budget Parameters	Number of Persons	Total
Round Trip Coach Airfare-Domestic (<i>\$575 per person</i>)	\$575.00	4	\$2,300.00
Round Trip Coach Airfare-International (<i>\$2000 per person</i>)	\$2,000.00	1	\$2,000.00
Hotel and per diem (Full Day Meeting at ATS Conference Fri & Sat Only) (<i>\$425 per person</i>)	\$425.00	21	\$8,925.00
Breakfast Meeting at ATS Conference (<i>\$50.00 Per Person</i>)	\$50.00		\$0.00
Lunch Meeting at ATS Conference (<i>\$50.00 Per Person</i>)	\$50.00		\$0.00
Conference Calls (<i># of people x # minutes x 0.10</i>)	7 x 60 x 0.10 = \$42.00	(# Calls) 6	\$252.00
Publication Costs (<i>\$450.00 Per Page</i>)	\$450.00		\$0.00
<ul style="list-style-type: none"> • Policy Statement – 8 Pages Max • Conference Proceedings & Workshops – 8 Pages Max • Technology Reviews & Standards 8 Pages Max • Guidelines & Recommendations – 15 Pages Max 			
Medical Librarian – This item requires approval and justifications from document development staff (<i>up to \$5000</i>)	N/A	N/A	N/A
Outside Meeting 1 – Must provide Budget justification	N/A	N/A	N/A
Outside Meeting 2 – Must provide Budget justification	N/A	N/A	N/A
Other Project Expenses – Must provide Budget justification	N/A	N/A	N/A
<i>Note: Your proposed budget may be adjusted by staff and/or PRS to comply with ATS budgetary Policies and Procedures.</i>			
		Total	\$13,477.00