Reviewer's report

**Title:** Overview of the Consortium of Hospitals Advancing Research on Tobacco (CHART)

**Version:** 2 Date: 29 November 2011

**Reviewer:** David Warner

**Reviewer's report:**

Major compulsory revisions

1. Page 6, paragraph 2. Please be a bit more specific regarding how Tier 1 measures will be used to measure total costs. I assume this will be by making assumptions using DRGs? Procedure codes? Etc. I also don’t understand how, if healthcare utilization in the utilization is to be used as a primary outcome (as specified in the original RFA), healthcare utilization in the year post-hospitalization can be a Tier 2 (optional) measure. It is a very difficult thing to measure actual cost and utilization – can you give more detail about how it is proposed that this be done in a common fashion across centers?

2. Page 7. Can you provide justification for 30-day vs. 7 day point prevalence? Refer to the Hughes 2003 recommendation (if this is recommended – if not, why 30 days?). Why not prolonged abstinence – this would seem well-suited especially if biochemical verification will not be obtained. In general, this is an important point, but parts of the lengthy discussion seem redundant and suggest editing for length.

3. Page 9, paragraph 1. “Usual care” for smoking cessation is likely very heterogeneous both within (e.g., cardiac patients may be approached very differently than a healthy smoker in for a hernia operation) and among centers (e.g., in some centers, “usual care” is nothing). Does this not pose real problems in pooling results among centers? Also, could you discuss the potential ethical issues of providing “usual care”, which may include nothing, to a patient who volunteers for an intervention study? As a patient, why would I volunteer for a study in which I have a 50% chance of having no benefit beyond what a usual patient would receive, since most volunteers for intervention studies want help? Also, given that this is a 5-year award, what happens when “usual care” changes over the course of the study period? Could the existence of the study within a medical center paradoxically delay advances in “usual care” provided to patients due to concerns about interfering with the conduct of studies? And will it really possible to compare the efficacy of “usual care” across centers, given the multiple other factors that may affect cessation rates? I know that you can’t have an in-depth discussion of all this, and I can understand the practical reasons for making this choice, but I do think that some of the potential disadvantages should at least be mentioned.
Minor essential revisions

4. In table 1, under Richter's project, please define “warm handoff”

5. Page 8, last line. Clarify – you are specifically comparing misreporting rates between control and intervention groups across multiple studies, correct?

Discretionary revisions

6. In general, it would be useful to create more headers in the “Common Measures” section to help your reader navigate.

Level of interest: An article whose findings are important to those with closely related research interests

Quality of written English: Acceptable

Declaration of competing interests:

I declare that I have no competing interests' below