Reviewer’s report

Title: THE EFFECT OF A CLINICAL DECISION SUPPORT SYSTEM ON PROMPTING AN INTERVENTION FOR RISKY ALCOHOL USE IN A PRIMARY CARE SMOKING CESSATION PROGRAM: A CLUSTER RANDOMIZED TRIAL

Version: 0 Date: 26 Apr 2019

Reviewer: Miranda Laurant

Reviewer's report:

With interest I read this paper which evaluated the effects of a clinical decision support system on prompting an intervention for risky alcohol use. This paper contributes to the existing scientific knowledge and shows that it is very difficult to change practitioners behaviour.

The authors emphasis in the conclusion that the intervention might have changed the way practitioners offer the resource as a significant change was seen in patients' acceptance of the resource. Nonetheless, this was not part of the research. Based on the measures even though the word 'might' is used, this conclusion is to my opinion to strong and needs to be formulate with more caution as it needs research into practitioners' behaviour to confirm this. I would recommend a reformulation in the abstract conclusion, contribution to the literature and also in the conclusion of the main text.

It is not clear what is meant by 'alcohol resource', is this the workbook, is this referral? The authors should elaborate on this in an early state and explain this a bit more in the methods. I assume referral (to whom?) is also available for the practitioners in the control group. Had the practitioners in the intervention group and control group the same possibilities with regard to offering 'resources', in other words was the only difference the prompting for risky alcohol use?

Figure 1 shows a lost to follow-up of practices for the secondary outcome (i.e. 93 vs 86 practices (intervention) and 92 practices vs 83 practices (control) which is not explained. Why is there a lost to follow-up as this data is derived from the electronic system if I understood it correctly? Similar why lost to follow-up for the tertiary outcome in participating practices, what is the explanation?
This paper would be even more interested, as it might give a more detailed insight, if not only per protocol analysis was carried out with regard to the last outcome, but if a secondary analysis could be added with including those patients who actually accepted the offered resources. As those patients (intervention 280 and control 203) received the health promotion and/or referral to addiction treatment (?). All other patients didn't receive the resources (so had less chance to change their behaviour).

Next, the authors mention that all practitioners, prior to the start, were offered a webbased SBIRT training. Do the authors know how many practitioners and who did actually follow this training, and if they do know. Can you relate this to the primary outcome. In other words, does adherence to the training have an impact on the primary outcome? Insight would be helpful for further implementation recommendations.

Minor comments:

It would help the reader if in the footnote table 2, also the number of inappropriate offer (n=45) was mentioned.

Table 2, it would help the reader to add a footnote, first two outcomes are derived from electronic system at practitioners level and 3rd outcome is derived from a patient questionnaire. This also explains different number in the denominator.

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