Intensive support to improve clinical decision making in cardiovascular care: a randomised controlled trial in general practice

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Objective: To evaluate the effects of feedback reports combined with outreach visits from trained non-physicians on the clinical decision making of general practitioners (GPs) in cardiovascular care.

Design: Pragmatic cluster controlled trial with randomisation of practices to support (intervention group) or no special attention (control group); analysis after 2 years.

Setting: 124 general practices in The Netherlands.

Participants: 185 GPs.

Main outcome measures: Compliance rates for 12 evidence-based indicators for the management of patients with hypertension, hypercholesterolaemia, angina pectoris, or heart failure. The evaluation relied on the prospective recording of patient encounters by the participating GPs.

Results: The GPs reported 30 101 clinical decisions at baseline and 22 454 decisions after the intervention. A significant improvement was seen for five of the 12 indicators: assessment of risk factors in patients with hypercholesterolaemia (odds ratio 2.04; 95% CI 1.44 to 2.88) or angina pectoris (3.07; 1.08 to 8.79), provision of information and advice to patients with hypercholesterolaemia (1.58, 1.17 to 2.13) or hypertension (1.55, 1.35 to 1.77), and checking for clinical signs of deterioration in patients with heart failure [4.11, 2.17 to 7.77]. Single handed practices, non-training practices, and practices with older GPs gained particular benefit from the intervention.

Conclusions: Intensive support from trained non-physicians can alter certain aspects of the clinical decision making of GPs in cardiovascular care. The effect is small and the strategy needs further development.
these criteria crucial for the conduct of the improvement project. Our offer included a certificate for six hours of accredited training for each participating GP (a GP in The Netherlands has to collect 40 hours of accredited training per year), and for the control group also feedback reports and 225 Euro per practice. The feedback reports for the control group were based on post-intervention measurement, supported by a manual to improve the general practice management of patients at high cardiovascular risk, and were sent after the trial. The first practices started their baseline measurement in November 1996 and the last practices finished their post-intervention measurement in July 1999.

**Intervention**

The GPs in the intervention practices received feedback reports and support from facilitators to improve clinical decision making for patients with hypertension, hypercholesterolaemia, diabetes, angina pectoris, heart failure, transient ischaemic attacks, or peripheral arterial disease. The intervention comprised seven outreach visits per practice (one outreach visit per medical condition). Each practice received support from one facilitator; in partnerships, the facilitator could see more than one GP at the same time. Before each visit all GPs in the practice received a feedback report on the medical condition to be addressed during the visit. The feedback reports were based on baseline performance data and informed the GPs about their current clinical decision making in relation to the key recommendations from the national guidelines issued by the Dutch College of General Practitioners (DCGP). During the visit the facilitator and the GPs discussed the content of the feedback reports, prioritised specific aspects of decision making for improvement, and made change plans. The facilitator provided guidance, support, and educational materials to achieve improvement (box 1).

The intervention was part of a larger implementation project concerned with both practice organisation and clinical decision making with regard to patients at high cardiovascular risk. The focus of the project was on the implementation of a comprehensive programme of recommendations derived from the DCGP guidelines and consensus procedures. The facilitators conducted 15 outreach visits per practice, lasting an average of one hour per visit, equally distributed across a period of 21 months. The first eight visits concerned practice organisation; the other seven visits concerned clinical decision making. The protocol for the visits was highly standardised to limit variation and based on a model of change. The facilitators were specially trained to carry out the project protocol and to support the GPs. The training comprised lectures by the researchers (80 hours including 25 hours on clinical decision making for patients at high cardiovascular risk) and outreach visits in one pilot practice per facilitator. Each facilitator was supervised by one of the GP researchers during the entire

<table>
<thead>
<tr>
<th>Table 1 Summary of a series of studies in a project on the quality of cardiovascular and diabetes care in general practice (n=124 practices)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Topic</strong></td>
</tr>
<tr>
<td><strong>Quality assessment</strong></td>
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<td><strong>Practice organisation</strong></td>
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<td><strong>Clinical decision making</strong></td>
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<td><strong>Risk perceptions</strong></td>
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<td><strong>Randomised controlled trial</strong></td>
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<tr>
<td><strong>Practice organisation</strong></td>
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<td><strong>Clinical decision making</strong></td>
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<td><strong>Clinical decision making</strong></td>
</tr>
<tr>
<td><strong>Quality of life</strong></td>
</tr>
</tbody>
</table>

**Box 1 Support from the facilitators**

Each GP in the intervention group received support from a facilitator to improve the clinical decision making for patients at high cardiovascular risk. The support for each medical condition consisted of the following steps:

- **Discussion of feedback reports based on national guidelines and baseline compliance rates.** The facilitator asked about barriers to change and provided additional information in case the GP had doubts about specific results or recommendations.
- **Selection of one or two of the following clinical issues for improvement: assessment of risk factors, provision of information and advice, prescription of medication, checking clinical parameters, and scheduling a follow up appointment.** Criteria for selection were the preferences of the GP and his/her baseline levels of compliance.
- **Selection of one or more of the following methods to achieve change: study of guidelines, specific articles, or other educational materials; knowledge tests; retrospective or prospective audit of personal clinical decision making; or arrangements for the practice organisation.**
- **Provision of materials and advice: during the visit the facilitator provided the GP with educational materials, knowledge tests, audit facilities, and advice for organisational arrangements, if necessary.**
- **Provision of a reminder: after the visit the facilitator made a written report of the plans and sent the report to the GP by mail.**
- **Evaluation: as part of a next visit the facilitator discussed the extent to which the plans were carried out, the impact of the change activities on the clinical decision making, and which aspects of clinical decision making needed further attention.**

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Box 2 Example of outcome measures: the provision of information and advice to patients with treated hypertension

The hypertension guidelines issued by the Dutch College of General Practitioners in 1991 pertain to patients aged 18–80 years and define hypertension as a sustained diastolic blood pressure (DBP) of 95 mm Hg or above. The target blood pressure in case of pharmacological treatment is a DBP of <90 mm Hg. The guidelines recommend GPs to provide treated hypertensive patients with advice on healthy lifestyle including smoking cessation, a body mass index (BMI) below 30 kg/m², and no excessive alcohol consumption. The guidelines also recommend non-pharmacological measures to control blood pressure including the reduction of salt consumption, body weight, and alcohol consumption. Furthermore, GPs should address a patient’s compliance with treatment.

Using the guidelines, a panel of five GPs selected the following key recommendations with regard to the provision of information and advice at follow up visits of hypertensive patients aged 18–80 years:

- discuss salt consumption in patients with uncontrolled hypertension;
- discuss body weight in patients with uncontrolled hypertension or BMI of >30 kg/m²;
- discuss alcohol consumption in patients with uncontrolled hypertension or excessive alcohol consumption;
- advise current smokers to stop smoking;
- discuss compliance with treatment in patients on antihypertensive medication.

The recommendations are thus detailed descriptions of specific information or advice together with clinical situations calling for the provision of such information or advice.

The set of selected recommendations formed the indicator "treated hypertension, provision of information and advice". The compliance rate for the indicator was the number of clinical situations in which the GPs actually offered the recommended information or advice divided by the total number of clinical situations calling for such information or advice. The compliance rate for that indicator was one of the outcome measures of the present trial and the practice was the unit of analysis.

*Uncontrolled hypertension is DBP >90 mm Hg (95 mm Hg or above for patients without antihypertensive medication).

**Assessments**

Using the key recommendations, forms were developed for the prospective recording of patient encounters for each of the medical conditions considered in the trial. Because of the high incidence of hypertension, separate forms were created for newly diagnosed and already treated (with or without medication) hypertension. The encounter forms included items pertaining to the age, sex, and clinical characteristics of the patient, and also the decisions regarding the performance (yes/no) of specific clinical actions. While the forms were based on the key recommendations, they did not contain any clues to the recommendations. GPs have been shown to complete similar forms reliably (kappa=0.79; Spies TH, personal communication).

The GPs completed encounter forms during routine consultation hours at baseline and post-intervention measurement for a period of 2 months. They were asked to complete the forms immediately after eligible encounters. The data from the encounter forms were then entered into a computer by personnel blind to group allocation.

The characteristics of the participating practices were derived from a questionnaire completed by one GP per practice at baseline. Data were collected on type of practice (single handed versus partnership), practice location, number of GPs and practice assistants, working hours of each professional, age of GPs, patient list size, and involvement in GP vocational training.

**Costs**

The costs of the 21 month intervention were calculated using data provided by the facilitators and salary scales. The calculations included the time which the facilitators spent preparing and making the visits, their travel costs, and also the time spent by GPs to attend the visits. Moreover, the amount of time the GPs spent reading the feedback reports and carrying out the change plans was obtained by the facilitators and included in the calculations. The calculations did not include the costs for generating the feedback reports and training the facilitators because, per practice, these costs are strongly influenced by the number of participating practices.

The costs of the intervention for clinical decision making were estimated for the four medical conditions studied—that is, hypertension, hypercholesterolaemia, angina pectoris, and heart failure. An exact calculation was not possible because organisational arrangements and the implementation of guidelines for diabetes, transient ischaemic attacks, and peripheral arterial disease may also have influenced the clinical decision making studied. We estimated the costs of the intervention reported in this paper at 40% of the calculated costs for the entire 21 month intervention.
Randomisation
Immediately after the baseline measurement each practice was randomly allocated to receive intensive support (intervention group) or no special attention (control group). The practices were numbered and the person responsible for the randomisation process was blind to the practice identities. A random number generator was used to select permuted blocks with a block size of four. Practices were stratified according to practice type (single handed versus partnership) as this characteristic has been found to predict change in practice organisation.

Statistical analysis
The practice was the unit of analysis for describing changes in clinical decision making. Data from the encounter forms were used to calculate the mean compliance rate for each indicator at baseline and the mean change from baseline. The compliance rate for an indicator was the number of decisions in accordance with the recommendation(s) of that indicator divided by the total number of decisions made with respect to that indicator. The calculations pertained mainly to clinical actions performed during the patient encounters included by the GPs. Particular actions were, however, also taken to be performed when the GP reported performance in a previous contact (such as advice on smoking cessation) or within the recommended period (such as blood pressure measurement within the last 12 months). Actions with missing data were considered not performed. As already mentioned, the calculations took detailed account of the clinical situations.

Multilevel logistic regression analysis (GLMMIX procedure in SAS) was used to assess the influence of the intervention on clinical decision making. Multilevel analysis takes into account the relatedness of the clinical decisions made within a particular practice. We also used these analyses to identify practice characteristics which were related to success of the intervention and to determine the influence of the baseline compliance rates of the different practices on the effect of the intervention. p values of <0.05 were considered statistically significant.

RESULTS
A total of 157 practices were assessed for eligibility and 33 (21%) were excluded (fig 1). Table 2 shows the baseline characteristics of the 124 participating practices (185 GPs) and the number of patient encounters. Four intervention practices (4/62 = 6%) did not receive a per protocol intervention. These practices received feedback but no support from a facilitator with regard to clinical decision making. Three other practices were lost to follow up, so 121 practices (98%) completed the trial (fig 1). In general, the age and sex of the patients were found to be evenly distributed between the intervention and control groups for the encounters at baseline and post-intervention measurement. The proportion of men with

![Diagram](https://example.com/diagram.png)
Table 3 Baseline mean compliance rates and mean changes in compliance rates across practices by trial group

<table>
<thead>
<tr>
<th>Medical condition; indicator (number of key recommendations included in the indicator)</th>
<th>No of practices</th>
<th>No of decisions</th>
<th>Compliance rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Baseline</td>
<td>Post-intervention</td>
<td>Baseline</td>
</tr>
<tr>
<td>Newly diagnosed hypertension; assessment of risk factors (9)</td>
<td>Intervention 46</td>
<td>40</td>
<td>1098</td>
</tr>
<tr>
<td></td>
<td>Control 48</td>
<td>44</td>
<td>1377</td>
</tr>
<tr>
<td>Newly diagnosed hypertension; provision of information and advice (10)</td>
<td>Intervention 46 &amp; 40</td>
<td>860</td>
<td>688</td>
</tr>
<tr>
<td></td>
<td>Control 48 &amp; 44</td>
<td>1102</td>
<td>742</td>
</tr>
<tr>
<td>Treated hypertension; provision of information and advice (5)</td>
<td>Intervention 62 &amp; 61</td>
<td>4822</td>
<td>3585</td>
</tr>
<tr>
<td></td>
<td>Control 62 &amp; 60</td>
<td>4567</td>
<td>3991</td>
</tr>
<tr>
<td>Treated hypertension; increasing the antihypertensive medication* (1)</td>
<td>Intervention 62</td>
<td>57</td>
<td>700</td>
</tr>
<tr>
<td></td>
<td>Control 61</td>
<td>60</td>
<td>681</td>
</tr>
<tr>
<td>Treated hypertension; scheduling a follow up appointment (3)</td>
<td>Intervention 62</td>
<td>61</td>
<td>1756</td>
</tr>
<tr>
<td></td>
<td>Control 62</td>
<td>60</td>
<td>1615</td>
</tr>
<tr>
<td>Hypercholesterolaemia; assessment of risk factors (9)</td>
<td>Intervention 53</td>
<td>51</td>
<td>2223</td>
</tr>
<tr>
<td></td>
<td>Control 57</td>
<td>53</td>
<td>2592</td>
</tr>
<tr>
<td>Hypercholesterolaemia; provision of information and advice (7)</td>
<td>Intervention 53</td>
<td>51</td>
<td>1449</td>
</tr>
<tr>
<td></td>
<td>Control 57</td>
<td>53</td>
<td>1699</td>
</tr>
<tr>
<td>Angina pectoris; assessment of risk factors (2)</td>
<td>Intervention 48</td>
<td>39</td>
<td>292</td>
</tr>
<tr>
<td></td>
<td>Control 46</td>
<td>24</td>
<td>280</td>
</tr>
<tr>
<td>Angina pectoris; provision of information and advice (4)</td>
<td>Intervention 48</td>
<td>39</td>
<td>341</td>
</tr>
<tr>
<td></td>
<td>Control 46</td>
<td>24</td>
<td>325</td>
</tr>
<tr>
<td>Angina pectoris; prescribing aspirin and sublingual nitrate (2)</td>
<td>Intervention 49</td>
<td>41</td>
<td>338</td>
</tr>
<tr>
<td></td>
<td>Control 49</td>
<td>26</td>
<td>332</td>
</tr>
<tr>
<td>Heart failure; checking for clinical signs of deterioration (4)</td>
<td>Intervention 41</td>
<td>25</td>
<td>460</td>
</tr>
<tr>
<td></td>
<td>Control 36</td>
<td>22</td>
<td>484</td>
</tr>
<tr>
<td>Heart failure; provision of information and advice (3)</td>
<td>Intervention 41</td>
<td>25</td>
<td>345</td>
</tr>
<tr>
<td></td>
<td>Control 36</td>
<td>22</td>
<td>363</td>
</tr>
</tbody>
</table>

*Increasing the dosage or starting a drug from a different class in case of a diastolic blood pressure above 90 mm Hg.

Outcome measures
The intervention resulted in statistically significant improvement for five of the 12 indicators (intention to treat analyses, table 4): assessment of risk factors in patients with hypercholesterolaemia or angina pectoris, provision of information and advice to patients with hypercholesterolaemia or treated hypertension, and checking for clinical signs of deterioration in patients with heart failure. Exclusion of those practices which did not provide data for a particular indicator either before or after the intervention had marginal effects on the findings for that indicator. Single handed practices, non-training practices, and practices with older GPs benefited most from intensive support on the provision of information and advice to patients with hypercholesterolaemia or treated hypertension. Other practice characteristics were found to be associated with effects for only one or no indicators (table 5).

The baseline compliance rates of the different practices did not influence the effect of the intervention.

Table 4 Effect size of the intervention on clinical decision making*

<table>
<thead>
<tr>
<th>Medical condition; indicator</th>
<th>Odds ratio</th>
<th>95% CI</th>
<th>p value</th>
<th>Intraclass correlation coefficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newly diagnosed hypertension; assessment of risk factors</td>
<td>1.07</td>
<td>0.77 to 1.47</td>
<td>0.696</td>
<td>0.08</td>
</tr>
<tr>
<td>Newly diagnosed hypertension; provision of information and advice</td>
<td>1.32</td>
<td>0.94 to 1.86</td>
<td>0.109</td>
<td>0.17</td>
</tr>
<tr>
<td>Treated hypertension; provision of information and advice</td>
<td>1.55</td>
<td>1.35 to 1.77</td>
<td>&lt;0.001</td>
<td>0.15</td>
</tr>
<tr>
<td>Treated hypertension; increasing the antihypertensive medication†</td>
<td>0.87</td>
<td>0.61 to 1.24</td>
<td>0.432</td>
<td>0.06</td>
</tr>
<tr>
<td>Treated hypertension; scheduling a follow up appointment</td>
<td>0.96</td>
<td>0.75 to 1.22</td>
<td>0.727</td>
<td>0.11</td>
</tr>
<tr>
<td>Hypercholesterolaemia; assessment of risk factors</td>
<td>2.04</td>
<td>1.44 to 2.88</td>
<td>&lt;0.001</td>
<td>0.13</td>
</tr>
<tr>
<td>Hypercholesterolaemia; provision of information and advice</td>
<td>1.58</td>
<td>1.17 to 2.13</td>
<td>0.003</td>
<td>0.09</td>
</tr>
<tr>
<td>Angina pectoris; assessment of risk factors</td>
<td>3.07</td>
<td>1.08 to 8.79</td>
<td>0.037</td>
<td>0.00</td>
</tr>
<tr>
<td>Angina pectoris; provision of information and advice</td>
<td>1.02</td>
<td>0.61 to 1.71</td>
<td>0.929</td>
<td>0.06</td>
</tr>
<tr>
<td>Angina pectoris; prescribing aspirin and sublingual nitrate</td>
<td>1.44</td>
<td>0.86 to 2.41</td>
<td>0.168</td>
<td>0.03</td>
</tr>
<tr>
<td>Heart failure; checking for clinical signs of deterioration</td>
<td>4.11</td>
<td>2.17 to 7.77</td>
<td>&lt;0.001</td>
<td>0.22</td>
</tr>
<tr>
<td>Heart failure; provision of information and advice</td>
<td>0.85</td>
<td>0.43 to 1.67</td>
<td>0.636</td>
<td>0.13</td>
</tr>
</tbody>
</table>

*Multilevel analysis with adjustments for baseline compliance, practice characteristics, and patients’ age and sex.
†Increasing the dosage or starting a drug from a different class in case of a diastolic blood pressure of >90 mm Hg.
but had some drawbacks. For some indicators, such as the
support with the provision of information and advice.
practices, and practices with younger GPs seem to need extra
decision making with other GPs. Partnerships, training
handed practices do not have to share support for clinical
available to optimise practice organisation while GPs in single
for this discrepancy is that partnerships have more people
participation between partnership and improving the organisation of
by Hulscher
12 indicators remains unclear. Comparison across the indica-
tors is hindered by differences in the baseline compliance rates
and power of the study. Moreover, we do not have insight into
ment, satisfaction with the care delivered, and health
outcomes, whereas lifestyle interventions aimed at patients at high
cholesterol risk have been shown to reduce morbidity and
mortality.13–16
Just why the intensive support was effective for five of the
12 indicators remains unclear. Comparison across the indica-
tors is hindered by differences in the baseline compliance rates
and power of the study. Moreover, we do not have insight into
the motives of the GPs for apparently ignoring certain recom-
mendations. All kinds of professional, patient, and environ-
mental barriers may undermine clinical decision making.7
Remarkably, the trial did not show an increase in the prescrip-
tion of recommended medication. This lack of an effect is in
contrast to the findings of a review which showed that
intervention than at baseline, possibly due to a lack of motiva-
tion. Finally, prospective recording appears to be less suitable
for the assessment of compliance with recommendations for
the diagnosis of diseases and risk factors, because practition-
ers will obviously fail to include encounters in which they
overlook the diagnosis.

**DISCUSSION**

Intensive support from facilitators improved the clinical deci-
sion making of GPs with regard to the assessment of risk fac-
tors and the provision of information and advice for certain
types of patients with high cardiovascular risk, and also the
checking for clinical signs of deterioration in patients with
heart failure. Single handed practices, non-training prac-
tices, and practices with older GPs gained particular benefit
from the intervention. The effects on the clinical decision making
were, however, small and the average cost per practice was
1500 Euros.

The intervention may also ultimately improve patient
outcomes. Identification of the presence of risk factors
provides opportunities to reduce risk, whereas early detection
of deterioration in patients with heart failure may promote
adjustment of treatment and thereby prevent hospitalisation.17
Furthermore, the provision of information by doctors has been found to improve compliance with treat-
ment, satisfaction with the care delivered, and health
outcomes, whereas lifestyle interventions aimed at patients at high
cholesterol risk have been shown to reduce morbidity and
mortality.13–16

Just why the intensive support was effective for five of the
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tion. Finally, prospective recording appears to be less suitable
for the assessment of compliance with recommendations for
the diagnosis of diseases and risk factors, because practition-
ers will obviously fail to include encounters in which they
overlook the diagnosis.

**Limitations**

At the post-intervention measurement the GPs in the
intervention group may have selectively recorded patient
encounters in comparison with the control group, because the
GPs were not blind to the allocation of their practice. Selective
recording is nevertheless unlikely because the groups did not
differ substantially in the number of patient encounters, mean
age of patients, or the proportion of men. Moreover, the inter-
vention did not improve compliance for all indicators.

Our study has several other limitations. The practices
volunteered to participate and may therefore have been more
interested and motivated than other practices. Furthermore,
there were 25% fewer clinical decisions at post-intervention
than at baseline. Bias due to the lower response at post-
intervention is nevertheless unlikely because we took
totalled account of the clinical situations when we assessed
the compliance rates. Finally, we did not explore the effects on
patient outcome. The outcome measures were nevertheless
based on well accepted recommendations.

**Implications for the future**

Intensive support from non-physicians improved the clinical
decision making for some aspects of cardiovascular care, but
overall the effects were small. Research is needed to identify
the barriers to change because insight into the factors which
appear to prevent change will certainly help us to improve the
present implementation strategy. The facilitators asked the
GPs about barriers to change but may need more insight
and training to be able to recognise and tackle these barriers. The
effectiveness of support from non-physicians is important in
terms of the costs compared with support from physicians.
Furthermore, some effects of the intervention were more pro-
nounced for certain practice characteristics. These findings
suggest differences in the intensity of support required across
practices and call for further research to explore the
associations between practice and successful change. In our
opinion, the strategy of having a non-physician to help GPs
improve their clinical decision making merits further develop-
ment.

**Table 5** Practice characteristics predicting success (p<0.05) of the intervention*  

<table>
<thead>
<tr>
<th>Medical condition, indicator and practice characteristic</th>
<th>Odds ratio†</th>
<th>95% CI</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treated hypertension; provision of information and advice</td>
<td>1.70</td>
<td>1.19 to 2.43</td>
<td>0.004</td>
</tr>
<tr>
<td>Non-training practice</td>
<td>1.52</td>
<td>1.11 to 2.08</td>
<td>0.008</td>
</tr>
<tr>
<td>&lt;2500 patients per full time equivalent GP</td>
<td>1.42</td>
<td>1.04 to 1.93</td>
<td>0.024</td>
</tr>
<tr>
<td>&lt;0.8 full time equivalent practice assistant employed per 2500 patients</td>
<td>1.42</td>
<td>1.03 to 1.95</td>
<td>0.031</td>
</tr>
<tr>
<td>Single handed</td>
<td>1.35</td>
<td>1.01 to 1.82</td>
<td>0.046</td>
</tr>
<tr>
<td>Mean age of GPs &gt;45 years</td>
<td>3.11</td>
<td>1.38 to 6.98</td>
<td>0.006</td>
</tr>
<tr>
<td>Hypertension; assessment of risk factors</td>
<td>4.21</td>
<td>2.19 to 8.09</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>&gt;0.8 full time equivalent practice assistant employed per 2500 patients</td>
<td>2.87</td>
<td>1.28 to 6.44</td>
<td>0.011</td>
</tr>
<tr>
<td>Hypercholesterolaemia; provision of information and advice</td>
<td>2.66</td>
<td>1.29 to 5.49</td>
<td>0.008</td>
</tr>
</tbody>
</table>

*Multilevel analysis.
†Practice characteristic present versus not present.
Key messages

- Many aspects of cardiovascular care in general practice need improvement.
- A combination of feedback reports and outreach visits from trained non-physicians improved certain aspects of the clinical decision making of general practitioners in cardiovascular care.
- The effects on clinical decision making were small and the strategy needs further development.

References