Chronic disease cohorts-congestive heart failure (CHF)

Alternate Name*

Chronic disease cohorts-congestive heart failure (CHF)

INDICATOR DESCRIPTION

Description*

Percentage of patients with CHF by the physician, group, LHIN and the province.

Indicator Status*

Active

HQO Reporting tool/product

Personalized/Custom Reports (includes Practice Reports)

Dimension*

Equitable

Type*

Outcome

DEFINITION AND SOURCE INFORMATION

Unit of Measurement*

Percentage

Calculation Methods*

Numerator/ Denominator * 100

Numerator including inclusion/exclusion*

Number of patients with CHF by the physician, group, LHIN, and the province

Denominator including inclusion/exclusion*

Total number of patients by the physician, group, LHIN, and the province as of March 31st the previous year

Adjustment (risk, age/sex standardization)- detailed

This data is unadjusted. Unadjusted data reports the physician's actual practice data. This is useful for comparing one's own data over time.

Data Source

National Ambulatory Care Reporting System (NACRS)

Ontario Health Insurance Plan (OHIP) Claims History Database

Ontario Mental Health Reporting System (OMHRS)

Discharge Abstract Database (DAD)

Data provided to HQO by

Institute for Clinical Evaluative Sciences (ICES)

OTHER RELEVANT INFORMATION

Caveats and Limitations

Does not capture patients whose date of last contact not within 7 years of index

Comments Detailed

A patient is said to have CHF if they had one hospital admission (either from the DAD or from OMHRS) with a CHF diagnosis or an OHIP claim/NACRS ED record with a CHF diagnosis followed within one year by either a second record with a CHF diagnosis from an source. ICD 9 codes: 28, ICD 10 codes: I500, I501, I509 Further information on how this cohort was generated: The case-definition algorithm to identify patients with CHF links different databases at ICES National Ambulatory Care Reporting System (NACRS), and OHIP and is based on one hospital inpatient record with a CHF diagnosis (as defined by ICD 9 code: 428 or ICD10 codes: I500, I501, I509) or one ambulatory care record with a CHF diagnosis followed by a second record with a CHF diagnosis from any source within one year. The administrative data case-definition algorithm for CHF has a sensitivity of 85%, a specificity of 97%, and a PPV of 56%.2

TAGS

TAGS*

Primary Care

Outcome

Chronic Disease

Equitable

National Ambulatory Care Reporting System (NACRS)

Ontario Health Insurance Plan (OHIP) Claims History Database

Ontario Mental Health Reporting System (OMHRS)

Discharge Abstract Database (DAD)

PUBLISH

Ontario
Health Quality Ontario

PUBLISH DATETIME*

11/04/2016 16:19:00