SUPPLEMENTARY MATERIAL

Identification of Diagnosis-based Outcomes

Coding Practices
Trained personnel assign standardized codes based on physician-recorded diagnoses in a patient's medical chart, but do not interpret any laboratory tests. For hospitalization records, up to 25 diagnostic codes can be assigned per hospitalization. As such, patients with codes for multiple study outcomes were accounted for in the assessment of each outcome.

Myocardial Infarction and Heart Failure
We defined myocardial infarction (ICD-9 codes 410, ICD-10 codes I21, I22) and heart failure (ICD-9 code 428, ICD-10 codes I500) when their codes appeared in the Most Responsible Diagnosis field of the CIHI-DAD. This field records the single diagnosis that contributed most to the patient's length of stay in hospital.

Ventricular Arrhythmia
For ventricular arrhythmia however (ICD-9 code 4271, ICD-10 code I490) we chose to maximize the sensitivity of the codes by accepting codes recorded in any of the diagnostic fields

Covariates Used in the Logistic Regression Analysis

Baseline variables
Age, year of cohort entry, sex, comorbid conditions (coronary artery disease, peripheral vascular disease, abdominal aortic aneurysm, diabetes mellitus, heart failure, stroke or transient ischemic attack).

General measures of comorbidity
Duration on dialysis, receipt of echocardiogram, Holter monitoring or stress testing.

Concomitant medications
Angiotensin receptor blockers, beta blockers, calcium channel blockers, statins).