



Agency for Health Care Administration

# STATEWIDE VENOUS THROMBOEMBOLISM SURVEILLANCE REPORT

Pursuant to House Bill 1421(2025) – the Emily Adkins Family Protection Act, Section 4

**REPORTING PERIOD:  
JULY 1, 2024 – JUNE 30, 2025**



**HB 1421 (2025) | May 2026**



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## 1. EXECUTIVE SUMMARY

This report is issued under House Bill (HB) 1421 (2025), the Emily Adkins Family Protection Act (Act). Section 4 of the Act directed the Agency for Health Care Administration (AHCA), in collaboration with the Florida Department of Health, to establish a statewide venous thromboembolism (VTE) registry, require licensed hospitals with emergency departments (EDs) to report nationally recognized VTE measures, and submit a detailed analytic report using inpatient and outpatient data to the Governor, the President of the Senate, and the Speaker of the House of Representatives. Under section 408.0621, Florida Statutes (F.S.), the Act establishes the Blood Clot and Pulmonary Embolism Policy Workgroup, which has been studying these issues since 2024.

To carry out this charge, AHCA reviewed more than 16.4 million health care encounters submitted by licensed Florida hospitals, EDs, and ambulatory surgical centers (ASCs) between July 1, 2024, and June 30, 2025. A diagnosis of VTE was documented in 96,416 of these encounters, about six out of every 1,000 records reviewed. Most blood clot encounters occurred in the inpatient setting (nearly 74 percent), where the most acute care is delivered; EDs accounted for approximately 22 percent, and ASCs accounted for the remaining 4 percent. Almost half of all encounters involved adults aged 65 to 84, the demographic in which chronic disease, surgery, immobility, and clot risk all converge. Nearly six in 10 encounters were paid by Medicare, and the five most populous Florida counties (Miami-Dade, Broward, Hillsborough, Palm Beach, and Orange) together accounted for roughly a third of all cases statewide.



The data also showed that blood clots are rarely a stand-alone event. Across the 96,416 encounters identified, 123,500 individual VTE diagnoses were recorded, indicating that many patients received more than one type of clot diagnosis during a single visit. Cardiovascular disease, kidney injury, respiratory failure, sepsis, and long-term anticoagulant use appeared repeatedly alongside VTE diagnoses, and almost 45 percent of patients hospitalized with a blood clot were readmitted within 15 days of discharge.

**At A Glance**

Value	Measure
16,479,194	Total records reviewed across inpatient, ED, and ASC
96,416	Encounters with at least one VTE diagnosis
123,500	Total VTE diagnosis recorded encounters
71,044 (73.68% of VTE Total)	Inpatient VTE encounters
21,658 (22.46% of VTE Total)	ED VTE encounters
3,714 (3.85% of VTE total)	ASC VTE encounters
65–84 (46.5%)	Most affected age group
Medicare (56.9%)	Largest payer category
Dade, Broward, Hillsborough, Palm Beach, Orange	Top five counties by encounter count
44.98%	Inpatient readmission rate (within 15 days)
11.22%	ED visits linked to a prior inpatient admission (within 15 days)
0.11%	VTE rate following ambulatory surgery (within 15 days)

## 2. BACKGROUND

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### What is a blood clot?

A blood clot, known clinically as a thrombus, is a gel-like clump of blood that forms inside a blood vessel. Clotting is a normal and necessary process that allows the body to seal injuries and stop bleeding. When a clot forms in the wrong place, at the wrong time, or fails to dissolve when it should, it can block the flow of blood and cause serious, sometimes fatal harm.

Two related conditions account for most of the clinical burden, and together are referred to as venous thromboembolism, or VTE:

- **Deep vein thrombosis (DVT)** is a clot that forms in one of the body's deep veins, most commonly in the leg, but also in the arms, the abdomen, or, less commonly, the brain. A DVT can cause swelling, pain, redness, and warmth in the affected limb, but it can also exist without obvious symptoms.
- **Pulmonary embolisms (PEs)** occur when a clot, usually one that started as a DVT, breaks loose and travels through the bloodstream until it lodges in an artery in the lungs. A PE can interrupt blood flow and oxygen exchange, and at its most severe, can cause sudden cardiac arrest and death.

DVT and PEs are not separate diseases; rather, they are two presentations of the same underlying problem. As evident within the 123,500 diagnosed VTE encounters, many patients have both during the same care episode.

### Why do blood clots matter?

Nationally, the [U.S. Centers for Disease Control and Prevention](#) estimates that as many as 900,000 Americans experience a VTE event each year, and that as many as 100,000 deaths annually are associated with the condition. Many of those events are linked to identifiable risk factors such as recent hospitalization, surgery, prolonged immobility, cancer, pregnancy, certain medications, and inherited clotting disorders, which means a meaningful share of cases are, in principle, preventable.

### 3. DATA SOURCES AND SCOPE

This report draws on three statewide administrative datasets that AHCA collects from licensed Florida facilities in accordance with [Chapter 59E-7, Florida Administrative Code \(F.A.C.\)](#), and [Chapter 59B-9, F.A.C.](#) Submission is mandatory, providing near-complete coverage of in-state hospital and ambulatory surgical activity.

Dataset	Source Facilities	Records Reviewed (7/1/2024 – 6/30/2025)
Inpatient Discharge Encounter Data	Licensed Florida Hospitals (Acute and Specialty Care)	3,174,512
ED Encounter Data	Licensed Florida Hospitals with EDs	9,705,704
ASC Encounter Data	Licensed Florida ASCs and Hospital Outpatient Surgery	3,598,978
<b>Total Records Reviewed</b>		<b>16,479,194</b>

Each record contains a standardized core dataset that includes an encrypted patient identifier, age, sex, county of residence, primary and secondary diagnoses (ICD-10-CM), procedures (ICD-10-PCS for inpatient; CPT for outpatient), admission and discharge dates, principal payer, discharge status, the Present-on-Admission (POA) indicator, and condition codes, including the P7 code that identifies an inpatient admission as having occurred through the facility's ED. The complete list of variables used in the analysis is documented in Section 10.4 of the Technical Appendix.

To identify VTE encounters, AHCA used 65 qualified [ICD-10-CM](#) diagnosis codes spanning six clinical categories:

- Acute DVT
- Proximal DVT (the codes also used in [AHRQ Patient Safety Indicator PSI-12](#))
- PE
- Post-thrombotic syndrome (PTS)
- Pregnancy-related VTE
- Other venous thromboses (including portal, hepatic, renal, vena cava, and cancer-related)

As administrative coding depends on clinical documentation and coding practices, the figures in this report reflect only those VTE encounters that were diagnosed, coded, and submitted by facilities. They do not capture events that went undiagnosed; were documented in the medical record but assigned an ICD-10-CM code outside the qualifying set; or occurred in care settings not represented in the data, such as physician offices, urgent care clinics, or out-of-state hospitals. The figures should therefore be read as a complete account of what was coded and reported, but also as a conservative lower bound on the total prevalence of VTE in Florida.

## 4. METHODOLOGICAL APPROACH

### 4.1 Reporting Period

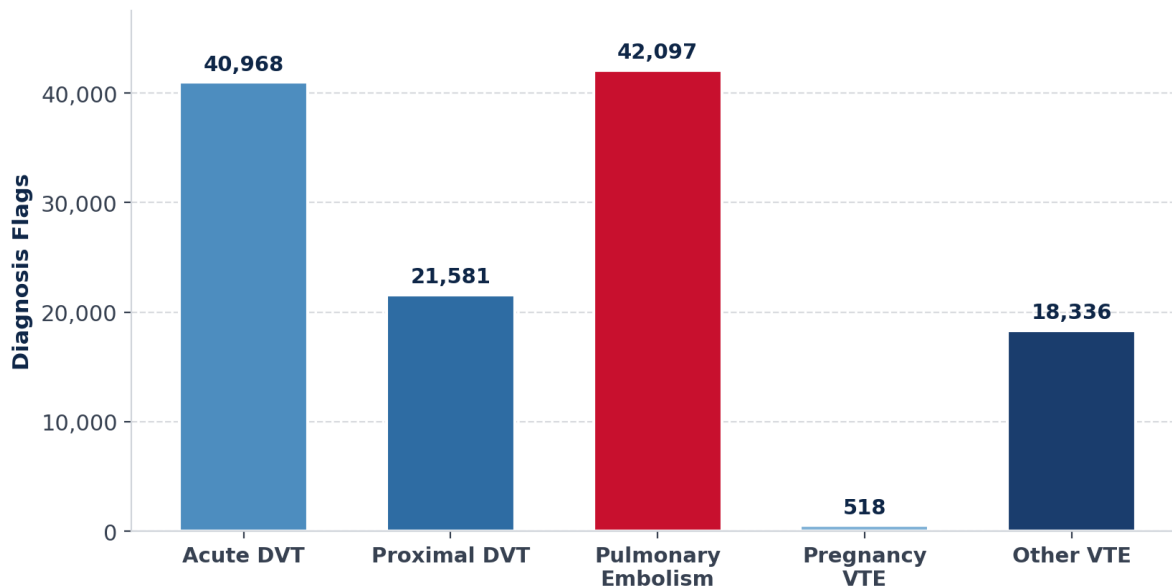
The primary reporting window is July 1, 2024, through June 30, 2025. Encounters were assigned to the reporting period using the discharge date for inpatient records and the encounter date for ED and ambulatory records.

### 4.2 Case Definition: Identifying VTE Encounters

A VTE encounter was defined as any inpatient discharge, ED encounter, or ambulatory surgical encounter occurring during the reporting period in which one or more of 65 qualifying ICD-10-CM diagnosis codes appeared in the primary diagnosis field or in any secondary diagnosis field. The complete code list, organized into six clinical categories, is provided in Technical Appendix Section 10.3.

VTE Diagnostic Category	Codes (n)	Diagnosis Flags
Acute DVT	16	40,968
Proximal DVT (AHRQ PSI-12 aligned)	12	21,581
PE	4	42,097
PTS	4	—
Pregnancy-Related VTE	10	518
Other Venous Thromboses (incl. cancer-related)	19	18,336
<b>Total qualifying codes</b>	<b>65</b>	<b>123,500</b>

**VTE Diagnosis Flags by Clinical Category**



### 4.3 Unit of Analysis: Encounters

Unless explicitly stated otherwise, the unit of analysis is the health care encounter, not the unique individual. A patient with multiple VTE-related encounters appears multiple times. This is a standard convention for state-level surveillance; encounters are a consistent unit of health care delivery, payment, and reporting.

### 4.4 Encounters versus Diagnosis Flags

Two related counts appear throughout this report:

- **VTE encounters (n = 96,416):** the number of unique inpatient, ED, or ambulatory surgical records in which at least one qualifying ICD-10-CM diagnosis code appeared. An encounter is counted once regardless of how many qualifying codes it contains.
- **VTE diagnosis (n = 123,500):** the number of qualifying ICD-10-CM codes appearing across all encounters. A single encounter can produce multiple diagnoses. For example, a patient hospitalized with both an acute DVT and a PE contributes one encounter and two diagnoses.

The 27,084-diagnosis difference between the two totals is informative. It indicates that VTE often presents as a layered or compound clinical event in which multiple thromboembolic conditions are documented in the same care episode.

### 4.5 Cross-Setting Patient Linkage and the 15-Day Window

Records were linked across inpatient, ED, and ASC datasets using AHCA's encrypted patient identifier (MaskSSN). Linkage is required to compute three of the report's metrics: inpatient readmission rate, ED visits linked to a prior inpatient admission, and inpatient VTE admissions following an ambulatory surgical procedure.

Each of these metrics tracks what happens in the 15 days following an initial event. A 15-day window captures the period when blood clot risk is highest after discharge, while avoiding the problem of linking events that are too far apart in time to reasonably connect. If a later encounter occurs within 15 days of an initial event, that does not establish the earlier event caused it; the window simply provides a consistent, uniform timeframe for describing patterns in the data.

At times, a subset of records containing an unknown or invalid MaskSSN value can prevent records from being linked reliably. A total of 7,561 such records were identified within the linkable VTE-relevant population. Their treatment varies by metric and is documented explicitly in Section 10.5 of the Technical Appendix.

### 4.6 Specifications for Calculated Metrics

Each linkage-dependent metric is defined below. Section 10.5 of the Technical Appendix provides the formal numerator, denominator, exclusion, and result for each.

Metric	Source(s)	Result
Inpatient VTE readmission within 15 days	Inpatient data	<b>44.98%</b>

Metric	Source(s)	Result
ED visit linked to a prior inpatient admission within 15 days (P7 condition code)	Inpatient data	<b>11.22%</b>
Inpatient VTE admission within 15 days following ambulatory surgery	Ambulatory + inpatient data	<b>0.11%</b>

#### 4.7 Demographic, Geographic, and Encounter-Level Variables

Age, sex, county, payer, and discharge status were drawn directly from facility-submitted records and grouped according to the standardized mappings documented in Sections 10.4.2 – 10.4.4 of the Technical Appendix.

#### 4.8 Present-on-Admission (POA) Analysis

POA analysis was restricted to inpatient encounters in which a qualifying VTE code appeared as the primary diagnosis (n = 24,562). This restriction is methodologically appropriate, since POA is most interpretable when a diagnosis is itself the principal reason for admission. Among those encounters, 24,554 (99.97%) were coded with the VTE diagnosis present on admission, and the remainder were coded as not present on admission or as an unknown POA value. POA does not measure preventability and should not be interpreted as such.

#### 4.9 Top Diagnoses, Procedures, and Secondary Diagnoses

Frequency rankings were generated for the top 10 primary diagnoses, primary procedures, and secondary diagnoses appearing in inpatient VTE encounters. Rankings are descriptive, are not adjusted for age or severity, and are drawn from PRINDIAG, PRINPROC (ICD-10-PCS), and other diagnoses (ICD-10-CM) fields, respectively.

#### 4.10 Data Quality and Statistical Approach

All facility-submitted records pass through AHCA's standard validation pipeline before inclusion in the analytic dataset. No medical-record chart abstraction or imaging review was performed.

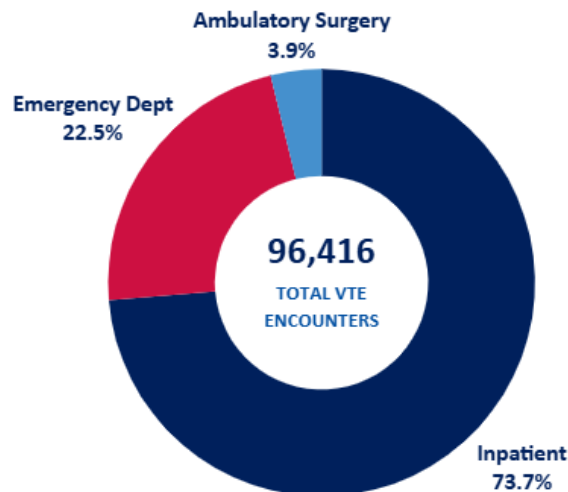
All analyses are descriptive. Counts, percentages, and rates are reported without confidence intervals because the analytic universe is the full reporting population rather than a sample. No risk adjustment, regression modeling, or inferential testing was performed. Datasets were prepared and analyzed in AHCA's standard analytic environment.

## 5. STATEWIDE VTE FINDINGS

### 5.1 Statewide Incidence Overview

Across more than 16.4 million inpatient, ED, and ASC records, about six in every 1,000 included at least one documented VTE diagnosis, totaling 96,416 VTE encounters.

Setting	Total Encounters	VTE Encounters	Share with VTE
Inpatient	3,174,512	71,044	2.24%
ED	9,705,704	21,658	0.22%
ASC	3,598,978	3,714	0.10%
<b>Statewide</b>	<b>16,479,194</b>	<b>96,416</b>	<b>0.59%</b>



Nearly three-quarters of VTE encounters occurred in the inpatient setting, the largest share by far. This matters as patients admitted to the hospital are generally sicker than those treated in other settings. A blood clot found in a hospitalized patient may be the reason for the admission, or it may develop alongside or as a complication of other serious conditions such as infection, respiratory distress, heart disease, or kidney dysfunction.

ED encounters made up the second-largest share. This pattern is consistent with the symptom profile of acute VTE; chest pain, sudden shortness of breath, swelling, and unexplained leg pain are precisely the kinds of symptoms that prompt urgent evaluation. Although the ASCs accounted for the smallest share of VTE encounters, they play a larger role in analyses that follow patients across care settings over time (see Section 5.8).

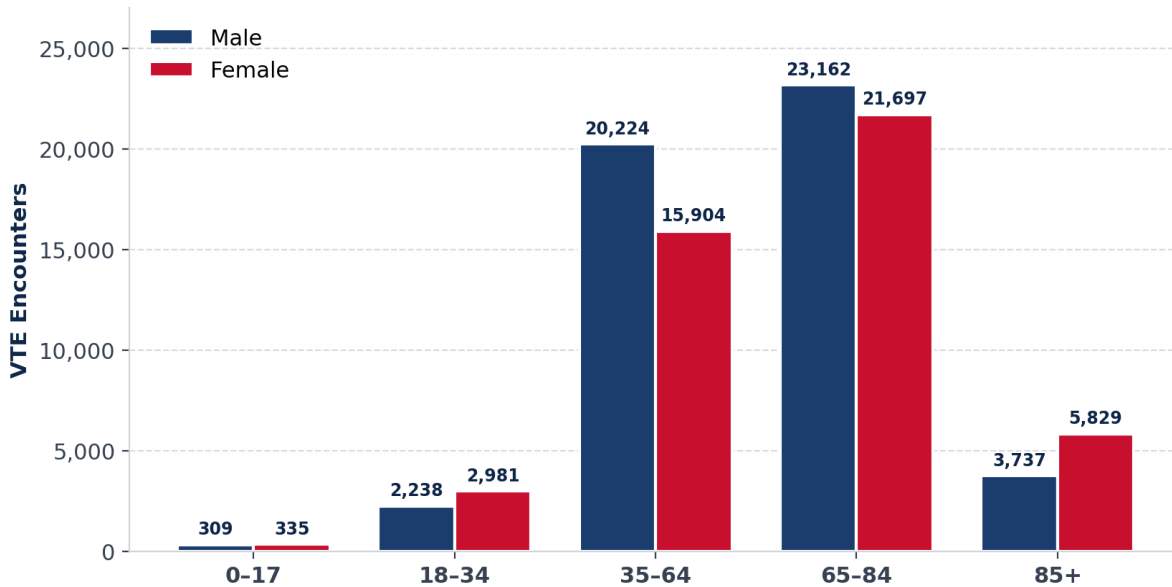
### THE ENCOUNTER–DIAGNOSIS GAP

96,416 encounters produced 123,500 VTE diagnoses. The 27,084 difference indicates that VTE often presents as a layered, compound event, with patients receiving more than one type of clot diagnosis during a single visit.

PEs and DVT frequently co-occur, and patients can present with embolic disease at multiple anatomic sites simultaneously, suggesting that the burden of blood clots is more medically layered than a single diagnosis count can capture.

## 5.2 Who Is Affected: Age and Sex

VTE Encounters by Age Group and Sex



Age Group	VTE Encounters	Share	Male	Female
0-17	644	0.7%	309 (48.0%)	335 (52.0%)
18-34	5,219	5.4%	2,238 (42.9%)	2,981 (57.1%)
35-64	36,128	37.5%	20,224 (56.0%)	15,904 (44.0%)
65-84	44,859	46.5%	23,162 (51.6%)	21,697 (48.4%)
85+	9,566	9.9%	3,737 (39.1%)	5,829 (60.9%)
<b>Total</b>	<b>96,416</b>	<b>100.0%</b>	<b>49,670 (51.5%)</b>	<b>46,746 (48.5%)</b>

Blood clot encounters increase with age and peak among adults aged 65 to 84, who account for nearly half of all VTE encounters. This pattern aligns with what is already known about clot risk: older adults are more likely to

experience hospitalization, prolonged immobility, cardiovascular disease, cancer treatment, surgery, and medication use, all of which contribute to clot formation.

The data also reveals something beyond aging alone. More than one-third of all VTE encounters occurred among adults aged 35 to 64. Working-age adults still account for a meaningful portion of documented blood clots, suggesting that VTE exists across a broader range of health circumstances than may often be assumed.

At the opposite end of the age spectrum, pediatric and adolescent encounters were rare, reflecting fewer than one percent of all documented cases. This low volume helps explain why pediatric VTE research is less developed and why blood clot surveillance has historically focused on adult populations.

Sex differences were relatively balanced (51.5 percent male, 48.5 percent female), but age-specific patterns reveal a more nuanced picture. Men make up the majority of encounters in working- and Medicare-age groups (35–84), while women make up the majority of encounters in the 85-and-older group.

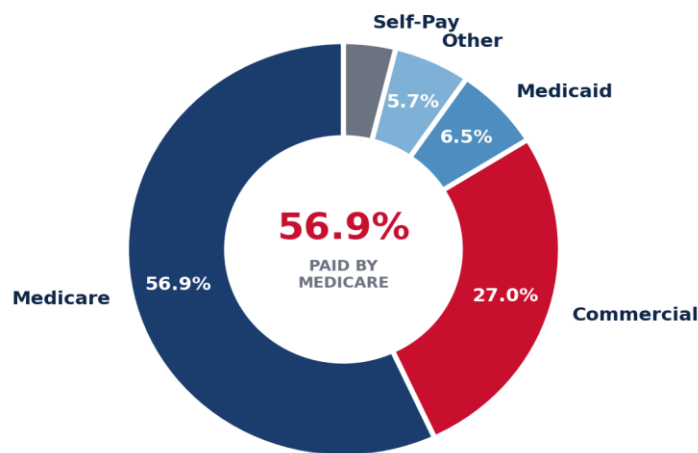
**READING THE AGE DATA**

Age is the single strongest demographic predictor in the data. The 65-to-84 demographic makes up about 46 percent of VTE encounters and is larger than every other age group combined except 35–64. Together, those two demographics account for 84 percent of all VTE encounters.

**5.3 Who Pays: Payer Distribution**

The payer distribution closely mirrors the age distribution and tells a complementary story about who is being treated for blood clots in Florida.

**VTE Encounters by Principal Payer**



Payer Category	Encounters	Share
Medicare	54,865	56.9%
Commercial Insurance	26,000	27.0%

Payer Category	Encounters	Share
Medicaid	6,298	6.5%
Other (incl. military, workers' compensation, other government)	5,507	5.7%
Self-Pay	3,746	3.9%
<b>Total</b>	<b>96,416</b>	<b>100.0%</b>

Medicare accounts for nearly six in every 10 VTE encounters statewide. That is consistent with the age findings; since the most affected age group (65–84) is also the population for whom Medicare is the primary payer, the concentration of Medicare encounters effectively reflects the concentration of VTE among older adults.

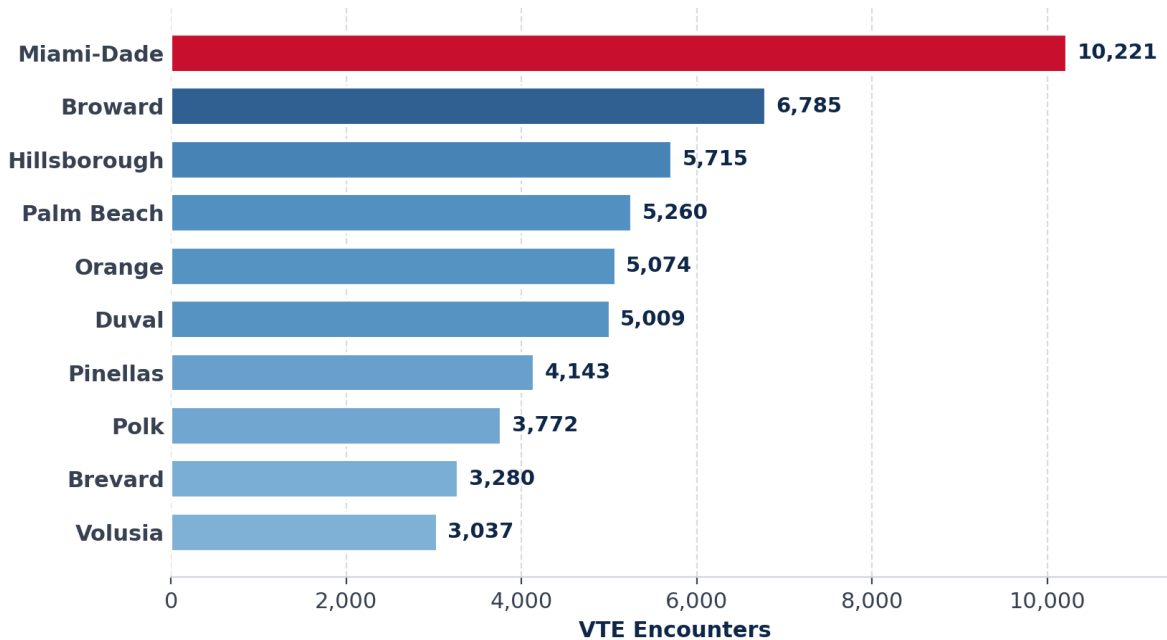
Commercial insurance accounts for the next-largest share (27 percent), reflecting the working-age 35–64 population, and continues to underscore that blood clots are not exclusively a condition of older age. Medicaid (6.5 percent) and Self-Pay (3.9 percent) together represent about 10 percent of encounters. The "Other" category captures military, workers' compensation, and other government payers.

#### 5.4 Where the Encounters Happen: Geographic Distribution

VTE encounters were distributed across all 67 Florida counties. As expected for a population-weighted measure, the highest absolute encounter counts occurred in Florida's most populous counties.

Rank	County	VTE Encounters	Share of Statewide
1	Miami-Dade	10,221	10.6%
2	Broward	6,785	7.0%
3	Hillsborough	5,715	5.9%
4	Palm Beach	5,260	5.5%
5	Orange	5,074	5.3%
6	Duval	5,009	5.2%
7	Pinellas	4,143	4.3%
8	Polk	3,772	3.9%
9	Brevard	3,280	3.4%
10	Volusia	3,037	3.1%

### Top 10 Florida Counties by VTE Encounter Count



These ten counties together account for slightly more than half of all VTE encounters statewide. A small number of records (4,686, or 4.9 percent of the total) had an unknown patient county and could not be assigned to a specific geography.

It is important to treat these counts as encounter counts, not as rates of disease. A higher absolute count in Miami-Dade County compared to a less populous county does not mean Miami-Dade County residents are more likely to develop a blood clot; it means more Miami-Dade County residents, and more health care encounters overall, exist in Miami-Dade County. Future analysis could layer in population-adjusted rates by county once denominator data has been aligned. The county distribution, however, illustrates where the system-level burden of VTE care is concentrated, and therefore where post-discharge follow-up programs, anticoagulation management resources, and patient education campaigns may have the greatest reach.

## 5.5 What the Clinical Picture Looks Like

In the inpatient setting, the data reveals three complementary views of blood clot care: the conditions for which patients are admitted, the procedures they receive, and the other diagnoses that appear alongside VTE. Together, those three views describe a population that is medically complex, often acutely ill, and rarely presenting with VTE in isolation.

### 5.5.1 Was the blood clot present on admission?

Among inpatient encounters in which a VTE code was the primary diagnosis (n = 24,562), 99.97 percent were coded as present on admission (POA).

POA Status (Inpatient, VTE primary diagnosis only)	Count	Share
Yes, present on admission	24,554	99.97%

POA Status (Inpatient, VTE primary diagnosis only)	Count	Share
No, not present on admission or Unknown	8	0.03%
<b>Total</b>	<b>24,562</b>	<b>100.00%</b>

This finding aligns with clinical expectations. When a blood clot is itself the reason a patient is admitted, the clot is almost always present at the time of admission. POA does not measure preventability, and this analysis does not capture hospital-acquired VTE, clots that develop during a hospitalization for a different primary reason.

### 5.5.2 Top inpatient primary diagnoses

Another common primary diagnosis associated with VTE inpatient encounters was "other pulmonary embolism without acute cor pulmonale" (I26.99), accounting for more than 10,700 hospitalizations. Pulmonary embolism codes dominate the top of the list, indicating that lung-related clot complications represent a significant portion of severe VTE presentations in Florida hospitals. These are not incidental clot discoveries but acute events requiring immediate medical attention.

Code	Description	Count
I26.99	Other pulmonary embolism without acute cor pulmonale	10,789
A41.9	Sepsis, unspecified organism	6,013
I82.412	Acute DVT of deep veins of the left upper extremity	2,614
I82.411	Acute DVT of deep veins of the right upper extremity	2,082
I26.09	Other pulmonary embolism with acute cor pulmonale	1,349
I26.92	Saddle embolus of pulmonary artery without acute cor pulmonale	1,145
I82.432	Acute DVT of left popliteal vein	884
I13.0	Hypertensive heart and chronic kidney disease with heart failure	856
I11.0	Hypertensive heart disease with heart failure	840
I26.02	Saddle embolus of pulmonary artery with acute cor pulmonale	706

Notably, sepsis (A41.9) emerged as the second most common primary diagnosis associated with VTE inpatient care. Sepsis is the body's extreme, life-threatening response to infection. Its prominence here raises important questions: are patients with systemic infection at higher risk for clotting, or do severe inflammation and prolonged hospitalization produce a clinical environment in which clots are more likely to form and be detected?

Hypertensive heart disease with heart failure (I11.0) and hypertensive heart and chronic kidney disease (I13.0) also appear in the top ten. Their presence reinforces a picture in which VTE often coexists with serious underlying cardiovascular and renal illness.

### 5.5.3 Top inpatient primary procedures

The procedure data reflects the types of interventions most frequently performed for patients in the dataset who also had a VTE diagnosis.

Code	Description	Count
06H03DZ	Insertion of intraluminal device (e.g., IVC filter) into inferior vena cava	1,724
02CQ3ZZ	Extirpation of matter from right pulmonary artery (clot removal)	1,536
30233N1	Transfusion of nonautologous red blood cells into peripheral vein	1,310
0W9G3ZZ	Drainage of peritoneal cavity, percutaneous	1,182
02HV33Z	Insertion of infusion device into superior vena cava	1,061
02CR3ZZ	Extirpation of matter from left pulmonary artery (clot removal)	904
3E033GC	Introduction of other therapeutic substance into peripheral vein	748
5A09357	CPAP respiratory ventilation, less than 24 consecutive hours	738
5A1955Z	Mechanical ventilation, greater than 96 consecutive hours	722
0BH17EZ	Insertion of endotracheal airway into trachea	677

In the dataset, placement of an inferior vena cava (IVC) filter appears most frequently. Procedures involving removal of material from the pulmonary arteries, performed on both the right and left sides, are also common and represent a substantial portion of interventional activity among these patients.

Respiratory care procedures, such as continuous positive airway pressure (CPAP) support, endotracheal intubation, and prolonged mechanical ventilation, are also common, indicating that many patients required assistance with breathing or oxygenation. Additional interventions, such as blood transfusion and placement of infusion devices, further suggest that patients frequently require intensive monitoring and supportive care.

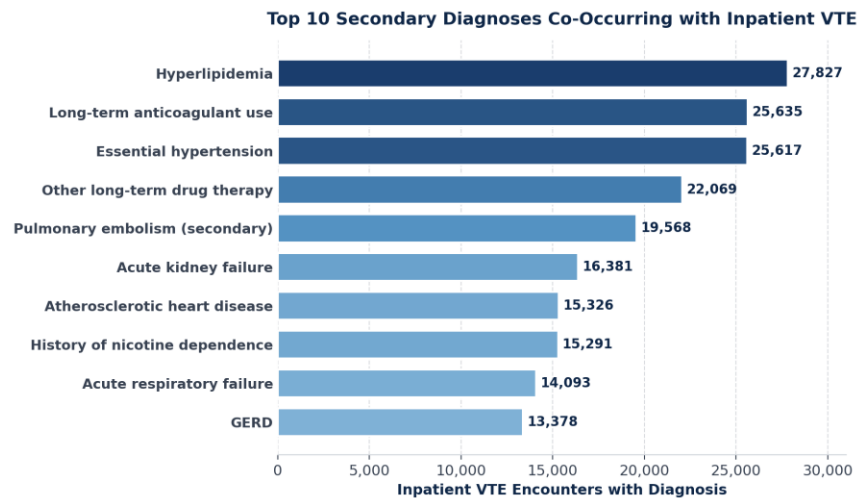
Overall, the procedure patterns reflect the types of care commonly provided to patients in this population, without implying that these interventions are causes of VTE.

#### WHAT THE PROCEDURE DATA TELLS US

The most common inpatient procedures associated with VTE are not screening or routine. They are device placement, clot removal, respiratory support, and transfusion. Many VTE encounters in Florida hospitals involve serious illness, not low-acuity presentations.

### 5.5.4 Top secondary diagnoses

Secondary diagnoses provide the surrounding context. What else is happening in patients' bodies when a blood clot appears?



Code	Description	Count
E78.5	Hyperlipidemia, unspecified	27,827
Z79.01	Long-term (current) use of anticoagulants	25,635
I10	Essential (primary) hypertension	25,617
Z79.899	Other long-term (current) drug therapy	22,069
I26.99	Other pulmonary embolism without acute cor pulmonale (as secondary)	19,568
N17.9	Acute kidney failure, unspecified	16,381
I25.10	Atherosclerotic heart disease without angina	15,326
Z87.891	Personal history of nicotine dependence	15,291
J96.01	Acute respiratory failure with hypoxia	14,093
K21.9	Gastro-esophageal reflux disease (GERD) without esophagitis	13,378

Several patterns emerge quickly from the secondary diagnosis list. Cardiovascular disease is pervasive: hypertension (I10), hyperlipidemia (E78.5), and atherosclerotic heart disease (I25.10) all appear in the top ten.

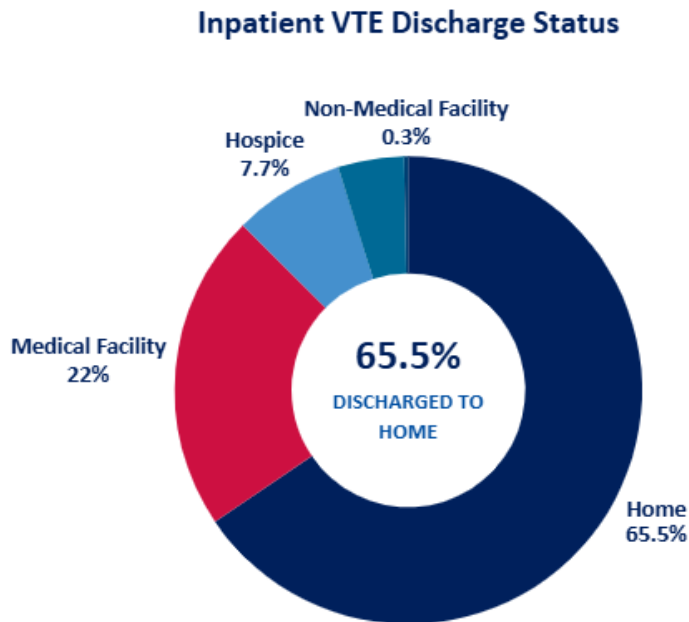
The second most common secondary diagnosis, long-term anticoagulant use (Z79.01), is particularly notable. It indicates that more than 25,000 inpatient VTE encounters involved patients who were already on a blood-thinning medication at the time of the encounter. That may reflect prior clot history or raise clinically important questions about anticoagulation management.

Acute kidney failure (N17.9) appears more than 16,000 times. Its frequent co-occurrence with VTE is consistent with severe illness. Acute respiratory failure with hypoxia (J96.01) appears more than 14,000 times, consistent with the prominence of pulmonary embolism in primary diagnoses and the procedure data on respiratory

support. A history of nicotine dependence (Z87.891) appears more than 15,000 times, reflecting the long-term cardiovascular risk associated with smoking.

## 5.6 What Happens at Discharge

Among the 71,044 inpatient VTE encounters, the largest share, about two in three, ended with the patient going home. Roughly one in five were discharged to a medical facility for continued care, and a smaller but important share ended in hospice or death.



Discharge Destination	Inpatient Encounters	Share
Home	46,532	65.5%
Medical Facility (SNF, rehab, long-term acute care, transfer)	15,612	22.0%
Hospice (home or facility)	5,443	7.7%
Passed Away (in-hospital)	3,258	4.6%
Non-Medical Facility	199	0.3%
<b>Total</b>	<b>71,044</b>	<b>100.0%</b>

Two figures deserve particular attention. First, in-hospital mortality (4.6 percent) is meaningful at this scale: 3,258 Floridians died during an inpatient stay involving a blood clot. Second, discharges to hospice (7.7 percent) represent another 5,443 encounters in which the patient transitioned to end-of-life care. Together, more than one in eight inpatient VTE encounters ended in death or hospice, a reminder that severe VTE remains a serious clinical event.

The 22 percent of patients discharged to a medical facility points to substantial post-acute care needs. Skilled nursing, rehabilitation, and long-term acute care play a real role in VTE recovery.

## 5.7 What Happens After Discharge: Return Visits

What happens after a patient is discharged from a blood clot hospitalization?

Return-Visit Metric (within 15 days)	Numerator	Denominator	Rate
Inpatient VTE readmission	<b>31,954</b> <i>Inpatient VTE readmissions within 15 days</i>	<b>71,044</b> <i>Total inpatient VTE encounters</i>	<b>44.98%</b>
ED visit linked to a prior inpatient admission (P7 condition code)	<b>7,971</b> <i>Inpatients with a P7 code indicating they went to the ED following a VTE encounter</i>	<b>71,044</b> <i>Total inpatient VTE encounters</i>	<b>11.22%</b>

**45%**

ALMOST HALF COME BACK

Among the 71,044 patients who had an inpatient VTE encounter, approximately 45% had another inpatient encounter within 15 days of discharge. An additional 11% had an ED visit that traced back to that prior admission.

These numbers are large enough that interpretation requires care. The 44.98 percent inpatient readmission figure captures any subsequent inpatient admission with a qualifying VTE diagnosis within the 15-day window, meaning the readmission itself involves a blood clot. A 15-day VTE-to-VTE readmission rate of nearly half indicates that patients hospitalized for blood clots frequently experience another clot-related inpatient encounter shortly after discharge. The 11.22 percent ED-linkage figure adds another layer. Using the P7 condition code, the analysis isolates inpatient encounters that arrived via the ED after a prior VTE admission. This pattern is consistent with what clinicians describe as "VTE recurrence anxiety", the worry, in some cases warranted, that returning symptoms represent another clot.

Both metrics reinforce the value of structured post-discharge follow-up. Patients who have just been hospitalized for a blood clot are interacting with the health care system at a high rate in the days after discharge.

## 5.8 Blood Clots Following Ambulatory Surgery

Florida outpatient surgery is a high-volume enterprise: more than 3.5 million ambulatory surgical encounters were submitted during the reporting period. Of those, after excluding records with non-linkable patient identifiers, the denominator for post-procedure VTE analysis was 3,591,417.

Post-Ambulatory Surgery Metric	Numerator	Denominator	Rate
Inpatient VTE admission within 15 days following ambulatory surgery	<b>3,794</b> <i>Inpatient readmissions within 15 days after an ambulatory surgery</i>	3,591,417 <i>Total ambulatory records</i>	<b>0.11%</b>

Approximately one in every 950 ambulatory surgical encounters was followed by an inpatient VTE admission within 15 days. As a population level rate, 0.11 percent is low. As an absolute count, it represents 3,794 Floridians, a meaningful number whose VTE encounter occurred shortly after an ambulatory procedure.

Identification within the 15-day window does not establish that the surgery caused the blood clot. Patients undergoing ambulatory surgery often have other risk factors like age, immobility, cancer, or prior VTE history that independently increase clot risk. What this metric does provide is a consistent surveillance signal that can be tracked over time and compared across procedure types as data accumulates.

## 6 FLORIDA HEALTH FINDER: VTE REPORTED MEASURES

FloridaHealthFinder is AHCA’s public health care quality and pricing transparency platform. Among other measures, it reports Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicator 12 (PSI-12), [Perioperative Pulmonary Embolism or Deep Vein Thrombosis Rate, for individual Florida hospitals](#).

### 6.1 How PSI-12 works

PSI-12 was developed by AHRQ using inpatient hospital discharge data and is updated quarterly on FloridaHealthFinder. Its purpose is to identify preventable post-surgical blood clots, clots that occurred after surgery and were not present when the patient was admitted. During the April 2024 – March 2025 reporting window that informs current FloridaHealthFinder values, Florida evaluated 496,843 adult surgical discharges to determine whether a preventable postoperative blood clot occurred. That denominator is not the total number of blood clot cases in Florida; it is the population of adult inpatient surgical discharges whose hospital stays met the federal criteria for [PSI-12 measurement](#).

### 6.2 Hospital star ratings

Each Florida hospital receives a star rating that compares its observed PSI-12 rate to what would be expected given its patient mix:

**3 stars:** Fewer complications than expected; better than expected.

**2 stars:** Expected number of complications given patient mix; as expected.

**1 star:** More complications than expected; worse than expected.

**N/A:** Not enough data to calculate a reliable rating.

PSI-12’s denominator adjusts for patient complexity, and its inclusion logic uses the POA indicator to exclude clots that occurred before hospitalization. Rates are reported per 1,000 surgical patients, allowing fair comparison across hospitals of different sizes.

### 6.3 Why PSI-12 cannot be compared to this report’s totals

PSI-12 and this report’s surveillance methodology answer different questions and use different data scopes. PSI-12 measures hospital-quality performance on preventable post-surgical VTE in adult inpatient surgical discharges only. The methodology in this report measures the population-level burden of all VTE encounters across all ages and across three care settings, using a much broader code list. The two are complementary but not directly comparable.

PSI-12 helps consumers understand how well individual hospitals protect surgical patients from preventable clots and supports hospital-level quality improvement. This report’s surveillance methodology helps the state understand the full population-level burden of blood clots and supports legislative oversight, health planning, and trend monitoring under HB 1421.

Element	This Report (Surveillance)	AHRQ PSI-12 (Quality Measure)
Purpose	Statewide surveillance of VTE burden, per HB 1421	Hospital-level quality measurement of preventable post-surgical VTE
Setting	Inpatient + ED + Ambulatory Surgery	Adult inpatient surgical discharges only
Age scope	All ages	18 years and older
Diagnosis scope	65 qualifying ICD-10-CM codes across 6 clinical categories	PEs and proximal DVT only
Code position	Primary or secondary diagnosis	Specific code-position rules with PSI-12 inclusion/exclusion logic
POA handling	Reported descriptively for primary-diagnosis VTE	Used to exclude pre-existing clots
Risk adjustment	None (descriptive surveillance)	Risk-adjusted for patient complexity

## 7 STATEWIDE TREND ANALYSIS

Across the dataset, several patterns emerge repeatedly, and with enough regularity to stand out as meaningful signals rather than isolated findings. These recurring trends suggest underlying dynamics in the data that merit closer analysis and may point to broader systemic, clinical, or population-level factors.

### **Blood clots are concentrated among older adults, but not exclusively.**

Adults aged 65 to 84 account for nearly half of all VTE encounters. The size of that concentration is striking, but so is the share of working-age adults: more than 37 percent of encounters involve patients aged 35 to 64. Blood clots are not exclusively a condition of aging.

### **VTE is heavily inpatient, and often acute.**

Hospitalization is the dominant care setting for VTE encounters among the three settings (inpatient, ED, and ASC) examined in this report, and the diagnosis and procedure data inside that setting describe acute, often severe presentations. PEs are the most common primary diagnosis. IVC filter placement, pulmonary artery clot removal, and respiratory support are among the most common procedures.

### **VTE rarely appears alone.**

The encounter–diagnosis gap (96,416 encounters generating 123,500 diagnoses) signals that clot diagnoses often co-occur. The secondary-diagnosis data extends that picture: hypertension, hyperlipidemia, kidney injury, respiratory failure, and long-term anticoagulant use appear repeatedly alongside VTE codes. Most patients are navigating multiple layers of clinical complexity at once.

### **Short-term return utilization is high.**

About 45 percent of patients hospitalized with a blood clot had another inpatient VTE encounter within 15 days, and about 11 percent had an ED visit linked to a prior inpatient admission. Whether these patterns reflect ongoing clot disease, treatment complications, recurrence, planned follow-up, or symptom-driven anxiety is something this report cannot determine, but the pattern itself is unambiguous.

### **Geographic burden tracks population centers.**

Florida's most populous counties account for the majority of encounters. Considerations for future would be to layer in population-adjusted rates so that geographic differences in risk, as opposed to volume, can be described and tracked.

### **The findings raise important questions.**

Among them:

- Why is sepsis so prominent among the top primary diagnoses associated with inpatient VTE encounters?
- What explains the 45 percent inpatient readmission rate at 15 days, and how does it vary by patient age, comorbidity, and discharge destination?
- How do post-acute care settings (skilled nursing, rehabilitation, long-term acute care) interact with VTE recovery and recurrence?
- How does VTE incidence vary across counties when adjusted for population, age structure, and underlying chronic disease prevalence?

## 8 OPPORTUNITIES FOR FUTURE MONITORING

This report is a baseline. As HB 1421's surveillance framework matures, several enhancements could deepen what Florida can learn from the data.

- ▶ **Population-adjusted county rates.** Layering county-level population denominators onto VTE encounter counts will allow geographic comparisons of risk, not just volume across Florida's 67 counties.
- ▶ **Trend analysis across reporting periods.** Year-over-year comparison once a second cycle of data is available will reveal whether incidence, readmission, and post-procedure rates are stable, rising, or declining.
- ▶ **Integration with post-acute care data.** About 22 percent of inpatient VTE encounters are discharged to medical facilities. Linking those records through the Health Information Exchange to skilled nursing, long-term acute care, and rehabilitation data would close an important gap in the post-discharge picture.
- ▶ **Targeted analysis of high-risk subpopulations.** Cancer patients, post-surgical patients, pregnant and postpartum women, and patients with prior VTE history are well-defined groups for whom evidence-based preventive measures are well established but adoption varies.
- ▶ **Hospital-level dashboarding.** Pairing the statewide surveillance view in this report with hospital-level VTE measures published on FloridaHealthFinder provides consumers, clinicians, and policymakers with a complete picture of both the system burden and the facility-level variation that contributes to it.
- ▶ **Coordination with the Blood Clot and Pulmonary Embolism Policy Workgroup.** Florida's existing workgroup, established under section 408.0621, F.S., has issued recommendations on prevention, treatment, surveillance, and education. The findings in this report can directly inform the implementation of those recommendations.

## 9 CONCLUSION

Blood clots appear in less than one percent of Florida’s reviewed health care encounters; however, the data in this report show that they carry a disproportionate level of medical complexities.

Across inpatient, ED, and ambulatory surgical settings, VTE encounters were closely tied to hospitalization, chronic disease, respiratory compromise, cardiovascular illness, and repeated interaction with the health care system. Older adults represented the largest share of encounters, but the findings also show that VTE affects a broad adult population. The 96,416 encounters identified in this report, along with the more than 123,000 individual diagnoses, describe how blood clots appear within Florida’s health care system: who experiences them, where they are documented, and what conditions often accompany them.

This report does not explain why a clot occurred. It does not determine preventability. It does not establish causation. What it does provide is a statewide baseline. It is the first comprehensive look at how blood clots appear across more than 16 million health care encounter records in a single year.

Florida is the first state in the nation to require this kind of surveillance. As the framework under HB 1421 matures, the data, methods, and findings in this report could be refined, extended, and integrated with hospital-level quality measures, post-acute data, and the work of the Blood Clot and Pulmonary Embolism Policy Workgroup. The result, over time, will be a clearer and more actionable picture of how blood clots shape health outcomes across the state, and how Florida’s response can be measured, adjusted, and improved.

## 10 TECHNICAL APPENDIX

This appendix documents the operational definitions, code sets, variables, and calculation specifications underlying the analyses in this report. It is intended to support reproducibility, peer review, and recurring application of the methodology in subsequent reporting periods.

### 10.1 Glossary of Terms and Acronyms

Term	Definition
AHCA	Florida Agency for Health Care Administration.
AHRQ	U.S. Agency for Healthcare Research and Quality.
DVT	Deep vein thrombosis. A blood clot that forms in a deep vein, most often in the lower extremity.
Encounter	A single inpatient discharge, ED visit, or ambulatory surgical record. The unit of analysis throughout this report.
FHF	FloridaHealthFinder.gov, AHCA's public health care quality and pricing transparency platform.
HB 1421	Florida House Bill 1421 (2025), the Emily Adkins Family Protection Act.
ICD-10-CM	International Classification of Diseases, Tenth Revision, Clinical Modification — diagnosis coding system.
ICD-10-PCS	International Classification of Diseases, Tenth Revision, Procedure Coding System — inpatient procedure coding system.
MaskSSN	Encrypted patient identifier used by AHCA for cross-encounter and cross-setting linkage.
PE	Pulmonary embolism. A blood clot that has traveled to the lungs.
POA	Present on Admission indicator. A field on inpatient records noting whether each diagnosis was present at the time of admission.
PSI-12	AHRQ Patient Safety Indicator #12: Perioperative Pulmonary Embolism or Deep Vein Thrombosis Rate. A hospital-quality measure.
P7 condition code	Inpatient condition code indicating that the patient was admitted through the facility's ED.
VTE	Venous thromboembolism. The clinical category encompassing DVT, PEs, and related venous embolic conditions.

## 10.2 Data Sources and Reporting Frameworks

Dataset	Reporting Authority	Frequency	Records Reviewed
Inpatient Discharge	Ch. 408, F.S., and Ch. 59E-7, F.A.C.	Quarterly	3,174,512
ED Encounter	Ch. 408, F.S., and Ch. 59B-9, F.A.C.	Quarterly	9,705,704
Ambulatory Surgical Encounter	Ch. 408, F.S., and Ch. 59B-9, F.A.C.	Quarterly	3,598,978

## 10.3 Complete ICD-10-CM Diagnosis Code List

The 65 ICD-10-CM diagnosis codes below constitute the qualifying VTE case-identification set, organized by the six clinical categories defined in Section 4.2.

### 10.3.1 Acute Deep Vein Thrombosis (16 codes)

ICD-10-CM Code	Description
I82.401	Acute embolism and thrombosis of unspecified deep veins of right lower extremity
I82.402	Acute embolism and thrombosis of unspecified deep veins of left lower extremity
I82.403	Acute embolism and thrombosis of unspecified deep veins of lower extremity, bilateral
I82.409	Acute embolism and thrombosis of unspecified deep veins of unspecified lower extremity
I82.411	Acute embolism and thrombosis of deep veins of right upper extremity
I82.412	Acute embolism and thrombosis of deep veins of left upper extremity
I82.413	Acute embolism and thrombosis of deep veins of upper extremity, bilateral
I82.419	Acute embolism and thrombosis of deep veins of unspecified upper extremity
I82.451	Acute embolism and thrombosis of deep veins of right proximal lower extremity
I82.452	Acute embolism and thrombosis of deep veins of left proximal lower extremity
I82.453	Acute embolism and thrombosis of deep veins of proximal lower extremity, bilateral
I82.459	Acute embolism and thrombosis of deep veins of proximal lower extremity, unspecified
I82.491	Acute embolism and thrombosis of deep veins of right distal lower extremity
I82.492	Acute embolism and thrombosis of deep veins of left distal lower extremity
I82.493	Acute embolism and thrombosis of deep veins of distal lower extremity, bilateral
I82.499	Acute embolism and thrombosis of deep veins of distal lower extremity, unspecified

### 10.3.2 Proximal DVT — AHRQ PSI-12 Aligned (12 codes)

These codes correspond to proximal lower-extremity DVT and are aligned with the diagnosis component of AHRQ Patient Safety Indicator PSI-12. PSI-12, however, applies a much narrower denominator and exclusion logic; see Section 10.7.

ICD-10-CM Code	Description
I82.4Y1	Acute embolism and thrombosis of unspecified deep veins of right proximal lower extremity
I82.4Y2	Acute embolism and thrombosis of unspecified deep veins of left proximal lower extremity
I82.4Y3	Acute embolism and thrombosis of unspecified deep veins of proximal lower extremity, bilateral
I82.4Y9	Acute embolism and thrombosis of unspecified deep veins of unspecified proximal lower extremity
I82.421	Acute embolism and thrombosis of right iliac vein
I82.422	Acute embolism and thrombosis of left iliac vein
I82.423	Acute embolism and thrombosis of iliac vein, bilateral
I82.429	Acute embolism and thrombosis of unspecified iliac vein
I82.431	Acute embolism and thrombosis of right popliteal vein
I82.432	Acute embolism and thrombosis of left popliteal vein
I82.433	Acute embolism and thrombosis of popliteal vein, bilateral
I82.439	Acute embolism and thrombosis of unspecified popliteal vein

### 10.3.3 Pulmonary Embolism (4 codes)

ICD-10-CM Code	Description
I26.02	Saddle embolus of pulmonary artery with acute cor pulmonale
I26.09	Other pulmonary embolism with acute cor pulmonale
I26.92	Saddle embolus of pulmonary artery without acute cor pulmonale
I26.99	Other pulmonary embolism without acute cor pulmonale

### 10.3.4 Postthrombotic Syndrome (4 codes)

ICD-10-CM Code	Description
I87.01	Postthrombotic syndrome with ulcer
I87.02	Postthrombotic syndrome with inflammation

ICD-10-CM Code	Description
I87.03	Postthrombotic syndrome with ulcer and inflammation
I87.09	Postthrombotic syndrome without complications

### 10.3.5 Pregnancy-Related VTE (10 codes)

ICD-10-CM Code	Description
O22.30	Deep phlebothrombosis in pregnancy, unspecified trimester
O22.31	Deep phlebothrombosis in pregnancy, first trimester
O22.32	Deep phlebothrombosis in pregnancy, second trimester
O22.33	Deep phlebothrombosis in pregnancy, third trimester
O22.50	Cerebral venous thrombosis in pregnancy, unspecified trimester
O22.51	Cerebral venous thrombosis in pregnancy, first trimester
O22.52	Cerebral venous thrombosis in pregnancy, second trimester
O22.53	Cerebral venous thrombosis in pregnancy, third trimester
O87.1	Deep phlebothrombosis in the puerperium
O87.3	Cerebral venous thrombosis in the puerperium

### 10.3.6 Other Venous Thromboses (18 codes)

ICD-10-CM Code	Description
I81	Portal vein thrombosis
I82.0	Budd-Chiari syndrome (hepatic vein thrombosis)
I82.210	Acute embolism and thrombosis of superior vena cava
I82.211	Chronic embolism and thrombosis of superior vena cava
I82.220	Acute embolism and thrombosis of inferior vena cava
I82.221	Chronic embolism and thrombosis of inferior vena cava
I82.290	Acute embolism and thrombosis of other thoracic veins
I82.291	Chronic embolism and thrombosis of other thoracic veins
I82.3	Embolism and thrombosis of renal vein
I82.61	Superficial vein DVT

ICD-10-CM Code	Description
I82.62	Deep vein DVT
I82.811	Embolism and thrombosis of superficial veins of right lower extremity
I82.812	Embolism and thrombosis of superficial veins of left lower extremity
I82.813	Embolism and thrombosis of superficial veins of lower extremities, bilateral
I82.819	Embolism and thrombosis of superficial veins of unspecified lower extremity
I82.890	Acute embolism and thrombosis of other specified veins
I82.891	Chronic embolism and thrombosis of other specified veins
I82.90	Acute embolism and thrombosis of unspecified vein

### 10.3.7 Cancer-Related Hypercoagulable State (1 code)

ICD-10-CM Code	Description
D68.6	Other thrombophilia (used for hypercoagulable states, including cancer-related)

## 10.4 Data Fields and Variable Definitions

### 10.4.1 Core Encounter Variables

Field	Description	Used For
MaskSSN	Encrypted patient identifier	Cross-encounter and cross-setting linkage
AGE	Patient age in years at admission/encounter	Age category assignment
SEX	Patient sex	Sex distribution
PT_COUNTY	Patient county of residence	Geographic distribution
PRINDIAG	Primary diagnosis (ICD-10-CM)	Case identification (primary position)
OTHDIAG1–OTHDIAGn	Other diagnoses (ICD-10-CM)	Case identification (secondary position); top secondary diagnosis analysis
PRINPROC	Primary procedure (ICD-10-PCS for inpatient)	Top procedure analysis
OTHPROC1–OTHPROCn	Other procedures	Procedure incidence (FHF measures)

Field	Description	Used For
ADMDATE(BEGINDATE) / DISCHDATE(ENDDATE)	Admission and discharge dates	Reporting period filter; linkage windows
PT_STATUS/DISCHSTAT	Discharge status code	Discharge status mapping
PAYER	Principal payer code	Payer group assignment
POA_PRIN_DIAG	Present-on-Admission indicator for principal diagnoses	POA analysis (Section 6.9)
CONDTN	Condition codes (UB-04)	Identification of condition code P7 for ED-linked admissions

#### 10.4.2 Age Category Standardization

Standardized Age Category	Definition (years)
0–17	AGE < 18
18–34	18 ≤ AGE ≤ 34
35–64	35 ≤ AGE ≤ 64
65–84	65 ≤ AGE ≤ 84
85+	AGE ≥ 85

#### 10.4.3 Payer Group Definitions

Payer Group	AHCA Payer Codes
Medicare	A - Medicare, B – Medicare Managed Care
Medicaid	C - Medicaid, D-Medicaid Managed Care
Commercial	E – Commercial Health Insurance
Self-Pay	L- Self Pay
Other	H – Workers' Compensation, I - TriCare or Other Federal Government, J - VA, K- Other state/Local Govt, M - Other, N – Non-payment, O - Kidcare, Q-Commercial Liability Coverage

### 10.4.4 Discharge Status Mapping

Reported Category	AHCA Discharge Status Description
Home	Discharged to home or self-care; home under care of organized home health service organization; home IV provider
Medical Facility	Discharged or transferred to another short-term general hospital, skilled nursing facility, intermediate care facility, rehabilitation facility, long-term care hospital, or other medical institution
Non-Medical Facility	Discharged to court/law enforcement, or to a non-medical institution
Hospice	Discharged to hospice care (home or facility)
Passed Away	Expired

### 10.4.5 Present-on-Admission (POA) Code Mapping

Reported Category	POA Indicator Values
Yes (present on admission)	Y, W
No (not present on admission)	N
Unknown / Exempt	U, 1, blank

## 10.5 Detailed Calculation Specifications

### 10.5.1 Total VTE Encounters by Setting

Setting	Numerator	Denominator	Result
Inpatient	Inpatient records with $\geq 1$ qualifying VTE diagnosis (any position)	All inpatient records in reporting period (3,174,512)	<b>71,044</b> <b>(2.24%)</b>
Emergency Department	ED records with $\geq 1$ qualifying VTE diagnosis	All ED records in reporting period (9,705,704)	<b>21,658</b> <b>(0.22%)</b>
Ambulatory Surgery	Ambulatory records with $\geq 1$ qualifying VTE diagnosis	All ambulatory records in reporting period (3,598,978)	<b>3,714</b> <b>(0.10%)</b>
<b>Combined</b>	All qualifying encounters across settings	All reviewed encounters (16,479,194)	<b>96,416</b> <b>(0.59%)</b>

### 10.5.2 VTE Diagnosis Flags by Category

Category	Inpatient	ED	Ambulatory
Acute DVT	30,258	9,621	1,089
Proximal DVT	16,319	4,890	372
Pulmonary Embolism	34,935	6,312	850
Pregnancy/Postpartum VTE	331	183	*
Other VTE	12,852	3,803	1,681

(\*) Depicts less than 5 encounters.

### 10.5.3 Linkage-Dependent Metrics

Metric	Numerator	Denominator	Exclusions	Result
Inpatient VTE readmission within 15 days	31,954	71,044	Records with unknown MaskSSN (n=7,561) excluded from linkage	<b>44.98%</b>
ED visit linked to prior IP admission within 15 days (P7)	7,971	71,044	MaskSSN unknown (n=7,561); ED records with condition code 00 excluded	<b>11.22%</b>
Inpatient VTE admission within 15 days after ambulatory surgery	3,794	3,591,417	MaskSSN unknown (n=7,561) excluded from ambulatory denominator	<b>0.11%</b>

### 10.6 Present-on-Admission (POA) Analysis Detail

POA analysis was limited to inpatient encounters in which a qualifying VTE code was listed as the primary diagnosis. This restriction yields the most interpretable POA distribution and avoids over-interpretation of POA values reported for incidental or secondary VTE codes.

POA Status (Inpatient, VTE primary diagnosis only)	Count	Percentage
Yes, present on admission	24,554	<b>99.97%</b>
No, not present on admission	8	0.03%
<b>Total</b>	<b>24,562</b>	<b>100.00%</b>

### 10.7 Comparison: Surveillance vs. AHRQ PSI-12

Element	This Report (Surveillance)	AHRQ PSI-12 (Quality Measure)
Purpose	Statewide surveillance of VTE burden, per HB 1421	Hospital-level quality measurement of preventable post-surgical VTE

Element	This Report (Surveillance)	AHRQ PSI-12 (Quality Measure)
Setting	Inpatient + ED + Ambulatory Surgery	Adult inpatient surgical discharges only
Age scope	All ages	18 years and older
Diagnosis scope	65 qualifying ICD-10-CM codes across 6 clinical categories	Pulmonary embolism and proximal DVT only
Code position	Primary or secondary diagnosis	Specific code-position rules with PSI-12 inclusion/exclusion logic
POA handling	Reported descriptively for primary-diagnosis VTE	Used to exclude pre-existing clots
Exclusions	Identifier-based for linkage only	Trauma, brain/spinal injury, hemorrhage, ECMO, obstetric, and other PSI-12 exclusion codes
Risk adjustment	None (descriptive surveillance)	Risk-adjusted for patient complexity