# New York State Ambulatory Care Study

A RESPONSE TO NEW YORK STATE BILL
S.6375/A.5713 CHAP. 736

12/22/21

NEW YORK STATE | Department of Health

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# Executive Summary

The Coronavirus Disease 2019 (COVID-19) pandemic undeniably impacted the ambulatory health care system. Multiple studies have reported on how the COVID-19 pandemic has affected the ambulatory care system in multiple ways. The purpose of this report is to summarize the ambulatory care setting experience in New York State at the time the legislation was enacted. Section 1 of a chapter of the laws of 2021 as proposed in legislative bills numbers S.6375 and A.5713 directs the Commissioner of Health to conduct a study of the delivery of ambulatory care and other medical care in response to the COVID-19 pandemic in New York State's regulated Article 28 facilities, excluding inpatient and ambulatory surgery.

In this report, ambulatory visits were categorized by type of service and total visits were summed quarterly from January 1, 2019, through December 31, 2022, for the following major service types: 1) emergency department visits (not resulting in an inpatient stay), 2) in-person outpatient services including visits to a federally qualified health center, hospital extension clinic or diagnostic and treatment center, and 3) telehealth services only.

Key Findings:

- Emergency department visits that did not result in an inpatient stay fell sharply in spring 2020, decreasing 48% from a baseline period of 2019. Emergency department visits have largely returned to pre-pandemic 2019 levels for most patients by the end of 2022.

- In-person outpatient visits fell sharply in spring 2020 and were 47% lower than baseline pre-pandemic period of 2019. While there appeared to be a resurgence of in-person outpatient visits in early 2021, but this resurgence appears to be largely driven by COVID-19 response activities. In-person outpatient visits for most conditions have largely returned to pre-pandemic baseline volumes by the end of 2022, except visits for Mental/Behavioral Disorders remain 35% lower.

- The COVID-19 pandemic showed that telehealth is a critical tool to expand access to care. Telehealth visits spiked early in the pandemic and most notably for Medicaid patients and patients in New York City. Telehealth visits for Mental/Behavioral Disorders were the largest proportion of visits early in the pandemic and by the end of the study period still represent 31% of the total visits for this condition.

# Introduction

The first case of Coronavirus Disease 2019 (COVID-19) was identified in the United States on January 20, 2020, and in New York on March 1, 2020. New York State was disproportionately affected by the emergence of the COVID-19 global pandemic, with morbidity and mortality exceeding all other states in the first months of the pandemic. Health systems quickly became overwhelmed with cases and shifted many of their available resources to concentrate on infection control and surge capacity for COVID-19 cases and hospitalizations. Multiple studies have reported on how the COVID-19 pandemic altered the ambulatory care system in many ways.[1,2,3,4] Utilization for non-COVID-19 care dropped due to the closure of health care settings early in the pandemic, the deferral of elective visits, patient hesitancy, the modification of practices to accommodate new infection control practices, and changes to practice workflow to increase the use of telehealth.[5] As in person visits declined in the early part of the pandemic, telehealth visits increased exponentially. The Centers for Medicare and Medicaid Services reported telehealth visits increased 63-fold in 2020 for Medicare fee-for-service beneficiaries.[6] Nationally telehealth use remained high in the latter part of 2020, but then declined into 2021 and 2022.[7,8] Throughout the United States, declines in emergency department visits and outpatient care were notable in March and April 2020. The volume started to return to expected levels beginning in November-December 2020, declined again with the second wave of the pandemic, and then rebounded in late 2021 and early 2022 to near expected pre-pandemic levels. [9] After the initial surge of cases, most patients with mild COVID-19 were able to be managed in an ambulatory care setting or at home. Many patients with COVID-19 who are unvaccinated have mild illness that does not

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[1] Whaley CM, Pera MF, Cantor J, et al.. Changes in health services use among commercially insured US populations during the COVID-19 pandemic. *JAMA Netw Open*. 2020;3(11):e2024984. doi: 10.1001/jamanetworkopen.2020.24984 [PMC free article] [PubMed] [CrossRef] [Google Scholar]

[2] Patel SY, Mehrotra A, Huskamp HA, Uscher-Pines L, Ganguli I, Barnett ML. Trends in outpatient care delivery and telemedicine during the COVID-19 pandemic in the US. *JAMA Intern Med.* 2020. [PMC free article] [PubMed] [Google Scholar]

[3] Martin K, Kurowski D, Given P, Kennedy K, Clayton E. The impact of COVID-19 on the use of preventive health care. Health Care Costs Institute. Published April 16, 2021. Accessed November 17, 2021. https://healthcostinstitute.org/hcci-research/the-impact-of-covid-19-on-the-use-of-preventive-health-care

[4] Hartnett KP, Kite-Powell A, DeVies J, et al.; National Syndromic Surveillance Program Community of Practice . Impact of the COVID-19 pandemic on emergency department visits—United States, January 1, 2019-May 30, 2020. *MMWR Morb Mortal Wkly Rep*. 2020;69(23):699-704. doi: 10.15585/mmwr.mm6923e1 [PMC free article] [PubMed] [CrossRef] [Google Scholar]

[5] The Impact of the COVID-19 Pandemic on Outpatient Visits: Changing Patterns of Care in the Newest COVID-19 Hot Spots. Impact COVID on Outpatient Visits: Changing Patterns & Hot Spots | Commonwealth Fund

[6] Samson, L., Tarazi, W., Turrini, G., Sheingold, S., Medicare Beneficiaries' Use of Telehealth Services in 2020 – Trends by Beneficiary Characteristics and Location (Issue Brief No. HP-2021- 27). Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. December, 2021.

[7] Karimi M, Lee EC, Couture SJ, Gonzales AB, Grigorescu V, Smith SR, De Lew N, Sommers BD. National Trends in Telehealth Use in 2021: Disparities in Utilization and Audio vs. Video Services. (Research Report No. HP-2022-04). Office of the Assistant Secretary for Planning and Evaluation, U. S. Department of Health and Human Services. Research Report. February 2022. Accessed August 2, 2022. https://aspe.hhs.gov/sites/default/files/documents/4e1853c0b4885112b2994680a58af9ed/telehealth-hps-ib.pdf

[8] Demeke HB, Merali S, Marks S, et al. Trends in Use of Telehealth Among Health Centers During the COVID-19 Pandemic — United States, June 26–November 6, 2020. Vol. 70.240–244. MMWR Morb Mortal Wkly Rep 2021. February 19, 2021 https://www.cdc.gov/mmwr/volumes/70/wr/mm7007a3.htm

[9] Mafi, J. N., Craff, M., Vangala, S., Pu, T., Skinner, D., Tabatabai-Yazdi, C., Nelson, A., Reid, R., Agniel, D., Tseng, C. H., Sarkisian, C., Damberg, C. L., & Kahn, K. L. (2022). Trends in US Ambulatory Care Patterns During the COVID-19 Pandemic, 2019-2021. *JAMA*, *327*(3), 237–247. https://doi.org/10.1001/jama.2021.24294

require medical intervention or hospitalization, and the proportion is even higher in patients who are vaccinated.[10]

The purpose of this report is to summarize the ambulatory care setting experience in New York State at the time the legislation was enacted. Section 1 of a chapter of the laws of 2021 as proposed in legislative bills numbers S.6375 and A.5713 directs the Commissioner of Health to conduct a study of the delivery of ambulatory care and other medical care in response to the COVID-19 pandemic. This report includes data from 2019 through the end of 2022 for the following types of health care facilities licensed under article twenty-eight of the public health law: federally qualified health centers, general hospital ambulatory care clinics, and other diagnostic and treatment centers.

## *Data Source*

Statewide Planning and Research Cooperative System (SPARCS) is a comprehensive all payer data reporting system established in 1979 as a result of cooperation between the healthcare industry and government. The system was initially created to collect information on discharges from hospitals. SPARCS currently collects patient-level detail on patient characteristics, diagnoses and treatments, services, and charges for hospital inpatient stays and outpatient (ambulatory surgery, emergency department, and outpatient services) visits; and ambulatory surgery and outpatient services visits to a hospital extension clinic and diagnostic and treatment center licensed to provide ambulatory surgery services for Article twenty-eight facilities submitting data to the department. Cost data represents information submitted as a part of the Institutional Cost Report (Schedule 1). The ICR is a uniform report completed by New York State hospitals to report income, expenses, assets, liabilities, and statistics to the Department of Health (DOH).

The enabling legislation for SPARCS is located under Section 28.16 of the Public Health Law (PHL). The regulations pertaining to SPARCS are under Section 400.18 of Title 10 (Health) of the Official Compilation of Codes, Rules, and Regulations of the State of New York (NYCRR). Under DOH regulations, (Part 86-1.2), Article twenty-eight hospitals are required to file financial and statistical data with DOH annually.

In this analysis Table 1 represents the total number of facilities reporting to SPARCS for each type of ambulatory service and facilities included in the Institutional Cost Report data by region. See the appendix for the breakdown by region and county and the count of those facilities that were excluded due to incomplete reporting or newly onboarded facilities not represented in the baseline period.

[10] Stokes EK, Zambrano LD, Anderson KN, et al. Coronavirus disease 2019 case surveillance—United States, January 22–May 30, 2020. MMWR Morb Mortal Wkly Rep. 2020;69(24):759-765. Available at: https://www.ncbi.nlm.nih.gov/pubmed/32555134

**Table 1. Number of Facilities by Region and Type of Service Included**

| Facility Region | Number of Facilities Included | | | |
|---|---|---|---|---|
| | SPARCS ED | SPARCS Outpatient | SPARCS Telehealth | Institutional Cost Report |
| **Statewide Total** | 232 | 297 | 195 | 161 |
| **Capital Region** | 8 | 13 | 7 | 9 |
| **Central NY** | 12 | 16 | 11 | 7 |
| **Finger Lakes** | 18 | 18 | 16 | 13 |
| **Long Island** | 25 | 32 | 17 | 18 |
| **Mid-Hudson** | 31 | 39 | 25 | 24 |
| **Mohawk Valley** | 14 | 17 | 13 | 9 |
| **New York City** | 65 | 93 | 60 | 40 |
| **North Country** | 15 | 15 | 13 | 12 |
| **Southern Tier** | 18 | 19 | 14 | 12 |
| **Western NY** | 26 | 35 | 19 | 17 |

Note: Not all outpatient facilities have telehealth capabilities or offer telehealth services.

# Summary of Guidance, Recommendations, and Policies Related to COVID-19

To put into context many of the health care utilization changes in the ambulatory care setting during the COVID-19 pandemic, it is important to be cognizant of guidance, recommendations, and policies related to COVID-19 pandemic. Of note much of the guidance related to COVID-19 was interim and updated as new as information was learned. Additionally, several community-level factors (e.g., COVID-19 case burden, COVID-19 hospitalizations, hospital capacity) drove some of the guidance, recommendations, and policies at a regional or county-level at different points in the pandemic. Three major topics highlighted here include surge planning, ambulatory care infection control practices, and telehealth.

Surge Planning

Initial guidance from the Center for Medicare and Medicaid Services in April 2020, provided recommendations to limit non-emergent, and elective medical services in the ambulatory setting.[11] These recommendations were put into place at a time where there was anticipated to be a significant rise in patients with COVID-19 and to maintain essential staff at critical points such as inpatient settings. The criteria used to determine the appropriate clinical setting for an in-person evaluation would have varied by location, institution, and capacity. Ultimately, decisions regarding care setting and the need for care remained the responsibility of the local health care delivery system and clinicians who had direct responsibility for the care of their patients. This may lead to variability in the resumption of care delivery in many ambulatory settings across the state.

[11] Non-Emergent, Elective Medical Services, and Treatment Recommendations (cms.gov)

COVID-19 Ambulatory Care Infection Control Practices

Infection prevention recommendations for ambulatory care settings were updated with the emergence of COVID-19. Recommendations for infection control practice changes needed to align with social distancing requirements, screening, and testing recommendations. Instituting screening protocols and initial evaluations remotely via telephone or video were some of the workflow changes recommended. Physical distancing methods such as signs, floor markers, and separate entrances and exits were additional recommendations. Any of these changes may explain some of the disruptions in ambulatory services seen early in the pandemic.

Telehealth

On March 17, 2020, the Centers for Medicare and Medicaid Services (CMS) took actions to expand Medicare telehealth, [12] allowing all beneficiaries to receive telehealth in any location, including their homes. The waivers also expanded the scope of Medicare telehealth services, making it easier for providers to offer a wider rand of telehealth services. New York State Medicaid followed suit with a broad expansion of telehealth for all Medicaid providers in all situations to use a wide variety of communication methods to deliver services remotely during the COVID-19 State of Emergency. [13] While many commercial insurances also expanded telehealth there may be variability in the application of the reimbursement of these services. These telehealth flexibilities remained in place throughout the entirety of the study period.

## Analysis of Utilization by Setting

Ambulatory visits were categorized, and total visits were summed quarterly from January 1, 2019, through December 31, 2022, for the following major service types: 1) emergency department visits (not resulting in an inpatient stay), 2) in-person outpatient services including visits to a federally qualified health center, hospital extension clinic or diagnostic and treatment center, and 3) telehealth services only, was analyzed separately as its own grouping. Ambulatory surgery and office-based surgery (non-Article 28 practices) were not included.

Outpatient visits were limited to in-person visits and displayed separately from telehealth visits. Telehealth visits were classified using telemedicine visit codes, revenue codes, and Healthcare Common Procedure Coding system codes for outpatient visits, based on guidelines published by Centers for Medicaid & Medicaid Services, New York State Medicaid, and SPARCS code review. [12,13]

All types of visits were used including both visits for COVID-19 and visits for non-COVID-19. The top diagnoses and procedures were classified by setting using the Clinical Classifications Software Refined (CCSR) aggregates *International Classification of Diseases, 10th Revision, Clinical Modification/Procedure Coding System* (ICD-10-CM/PCS) codes into clinically meaningful categories.[14]

Change in visits were assessed by comparing total visits by quarter to a baseline of the average of all four quarters in calendar year 2019. Results were stratified by setting, overall volume,

[12] CMS. MEDICARE TELEMEDICINE HEALTH CARE PROVIDER FACT SHEET | CMS

[13] COVID-19 Guidance for Medicaid Providers COVID-19 Guidance for Medicaid Providers (ny.gov)

[14] Clinical Classifications Software Refined (CCSR). https://hcup-us.ahrq.gov/toolssoftware/ccsr/ccs_refined.jsp

region of the state, and type of insurance (Commercial, Medicare, Medicaid, self-pay and other), Additionally proportions of all visits by quarter were stratified by various demographic characteristics such as ethnicity (Hispanic, non-Hispanic, multi-ethnic and unknown), race (White, Asian, Native Hawaiian and Pacific Islander, Black, American Indian and Alaskan Native, Multi racial and other) and age groupings (0-17 years, 18-39 years, 40-64 years, 65-79 years and 80+ years), and type of visit.

Institutional Cost Report data on allowable costs are summed across facility for the annual calendar periods (2019, 2020, 2021, and 2022- Emergency Department only). Costs are available for the following service areas: Emergency Department and outpatient clinics.

**Limitations**

This analysis has several limitations. First, the data reflects information collected from article twenty-eight facilities only. Results may not be generalizable across all New York State health care settings. While compliance with reporting from hospitals with inpatient and emergency department visits is high, not all article twenty-eight facilities are represented in outpatient reporting to SPARCS. Allowances were made during COVID-19 pandemic to allow facilities to pause reporting to focus on immediate surge needs. Any facility that was unable to catch-up on reporting was removed from both the pre and post COVID period. Not all outpatient facilities are currently reporting their data to the Department. While this analysis represents only a subset of the total outpatient facilities, there is representation from all regions of the state. To avoid skewing data due to the onboarding of new outpatient sites facilities, we have limited this analysis to only those outpatient facilities that were reporting to SPARCS data system consistently in both the pre and post period. In addition, as an emerging service type, trends related to telehealth services should be considered with caution. Differences between facilities in the capability to both provide and bill telehealth services in response to the public health emergency may have impacted telehealth volume and influenced the trends and distributions in this report.

This report does not present population-based services utilization rates. Population rates are a reliable measure when area's population counts, and demographics do not vary significantly throughout the year. During the COVID pandemic there were notable population shifts between NYS regions that are impossible to account for in this analysis. Additionally, at the time of this report, US Census Bureau has not yet released corrected 2020 population estimates for public use.

Article twenty-eight facilities continued SPARCS submission through the pandemic, but the submission compliance program was suspended from March 2020 through November 2021. Article twenty-eight facilities have provided submissions for the services for 2020 through 2022 and provided attestations of submission completeness when service volumes were lower than expected for those years. The SPARCS data was retrieved in August of 2023. The third and fourth quarter of 2022 are provisional at the time the data was accessed. Additionally, the reporting of information on race and ethnicity can vary by hospital. There has been a noted increase in reporting of unknown race and ethnicity post-COVID reporting period. Trends and patterns by race and ethnicity should be interpreted with caution.

Cost report data is not available for telehealth services alone, and it is not possible to isolate the costs due to in-person outpatient visits and telehealth visits. Additionally cost data for clinics are not available for 2022 at the time this report was put together. Only facilities reporting for all years were included in the pre and post comparisons of costs.

Finally, SPARCS data does not include information about staffing which directly impacts the capacity of hospitals, emergency department and out-patient settings. This report looks at the impact of the volume and types of services, but does not include impact to healthcare workforce staffing levels that have impacted New York and across the country.

## *Emergency Department visits not resulting in an inpatient stay*

### *1. Variation Across New York State*

Emergency Department visits not resulting in an inpatient stay in New York decreased sharply in the spring of 2020. The number of these emergency department visits fell 48% from baseline between January and April 2020. This represents visits, including those patients with COVID-19, for almost 11 million unique patients in the study period. The number of emergency department visits began to increase into September of 2020, when after a slight decline, they began increasing into 2021. Visits leveled off with the delta variant beginning in July 2021, which led to another decrease in visits as the Omicron virus emerged in December 2021. Emergency department visits overall in the state have not rebounded to pre-pandemic levels as of the fourth quarter of 2022. More research is needed to understand the extent to which patients were delaying emergency care versus the extent to which patients may have found other ways to access care for non-emergent issues (e.g., telehealth). The fact that emergency department visits have not returned to pre-pandemic levels could potentially signal a shift in the receipt of non-emergent issues to other settings and an opportunity for future exploration.

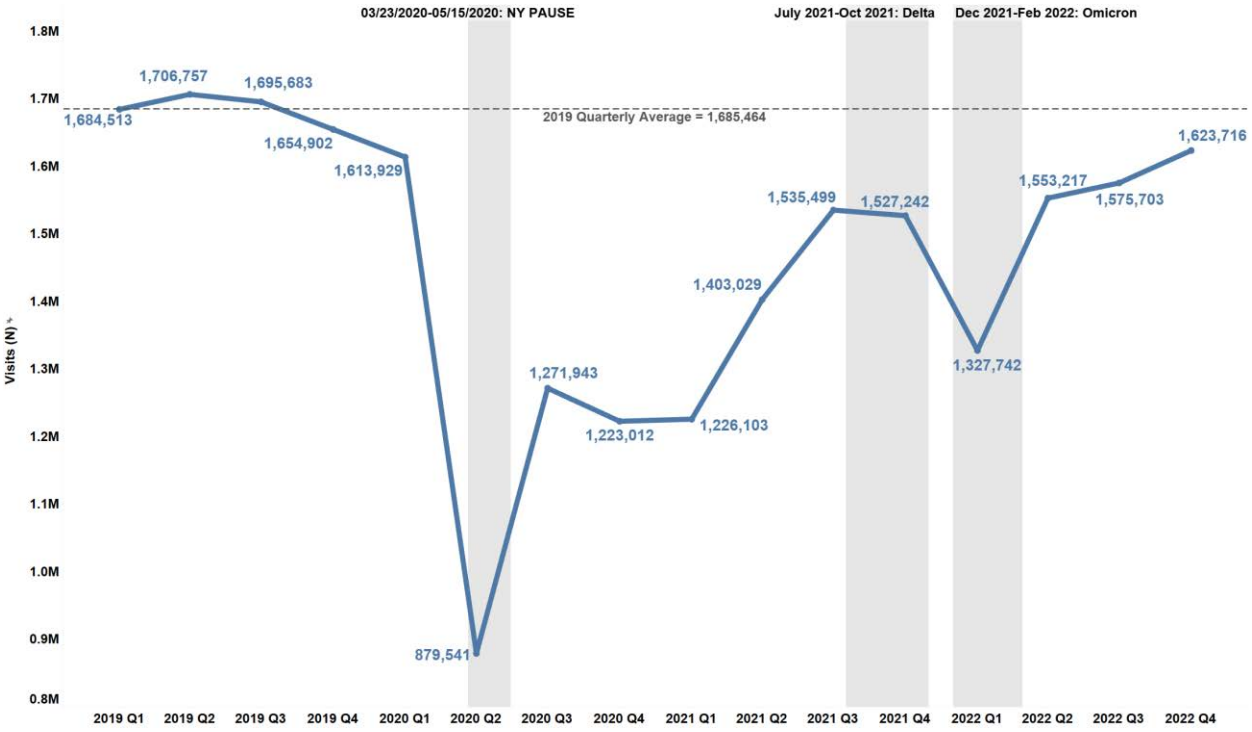
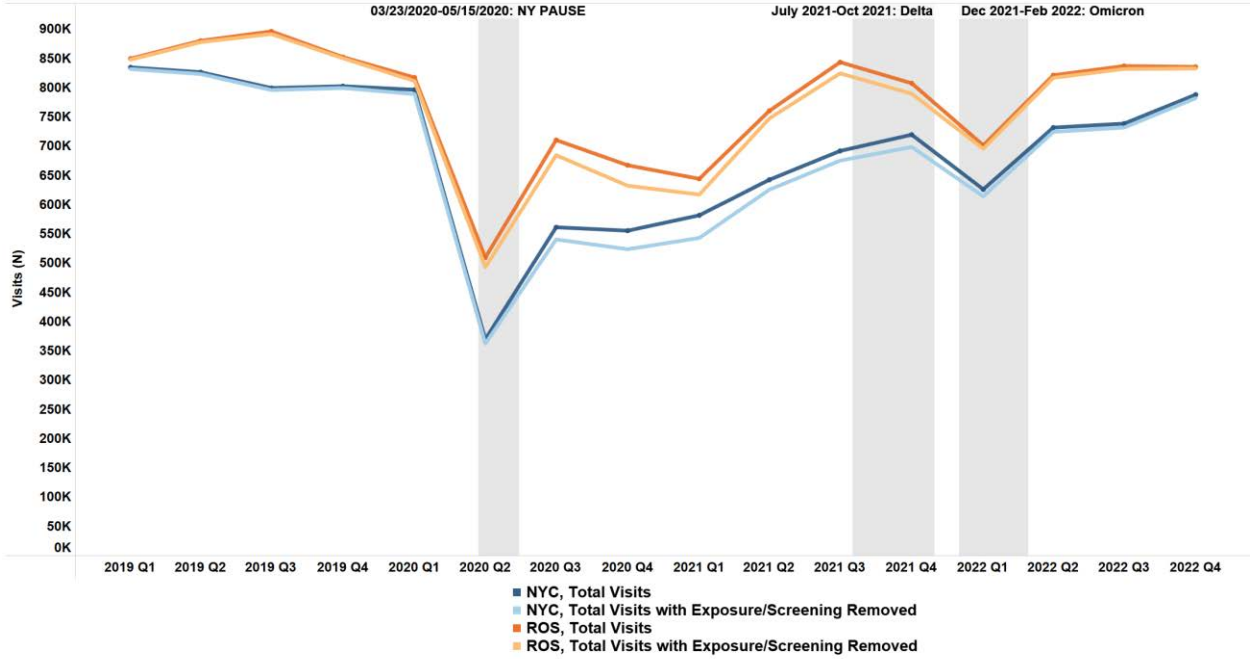



**Figure 1.1. Quarterly Number of Emergency Department Visits not resulting in an inpatient stay, Statewide January 1, 2019- December 31, 2022**

Trends seen statewide were largely mirrored regionally. One notable difference was in late 2020 through the first few months of 2021 in several upstate regions (e.g., Southern Tier, Finger Lakes, and Mohawk Valley) where there was a reduction in emergency department volume but in the New York City and Long Island regions volume increased during that same period. (see Appendix Figure 1.2.a) At this time vaccination was still limited to high-risk groups including, health care workers, nursing home residents and other limited high-risk professions. In Spring 2020, during the height of COVID-19 pandemic, the Department set up a Surge Operations Center (SOC) to assist with patient movement from hospitals that are congested to those that are not. Regional variation in emergency department visits might indicate differences due to high cases of COVID-19c, in addition to public health messaging and risk perceptions regarding COVID-19, stay-at-home policies, transmission patterns, access to testing and primary care, as well as other factors. [15]

To examine whether the resurgence in emergency department visits was being driven by COVID related visits such as COVID-19 related encounters, exposure, screenings or contact with an infectious disease, these visits were removed and trends by quarter were examined by region over time in Figure 1.3. While the volume decreased at several key points (e.g., 2020 quarter 3, 2021 quarter 1) overall trends remained like trends with COVID-related visits included.

[15] Adjemian J, Hartnett KP, Kite-Powell A, et al. Update: COVID-19 Pandemic–Associated Changes in Emergency Department Visits — United States, December 2020–January 2021. MMWR Morb Mortal Wkly Rep 2021;70:552–556. DOI: http://dx.doi.org/10.15585/mmwr.mm7015a3




* Exposure/Screening: CCSR Group is FAC016 - Exposure, encounters, screening or contact with infectious disease

**Figure 1.3. Quarterly Number of Emergency Department Visits not resulting in an inpatient stay, New York City and Non-New York City by COVID-Related Visit January 1, 2019- December 31, 2022**

Emergency department visits have rebounded to almost pre-pandemic levels for most regions outside of New York City. Selected counties throughout the state have also returned or in some cases exceeded pre-pandemic volume. The reasons for these rates of return are unknown. Identifying pandemic-specific and other factors associated with both decreases and subsequent rebounds in visit volume is important for planning purposes and is an area for future exploration.

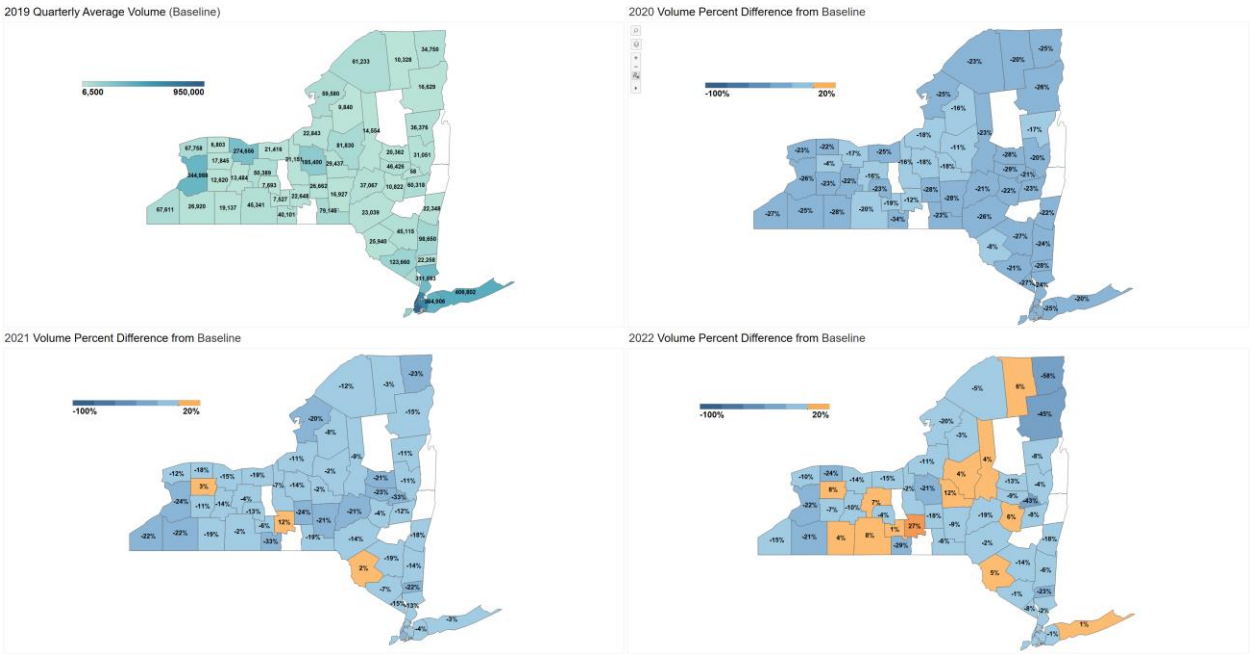


**Figure 1.3.a. Emergency Department Visits not resulting in an inpatient stay Volume Change by Facility County, January 1, 2019-June 30, 2022**

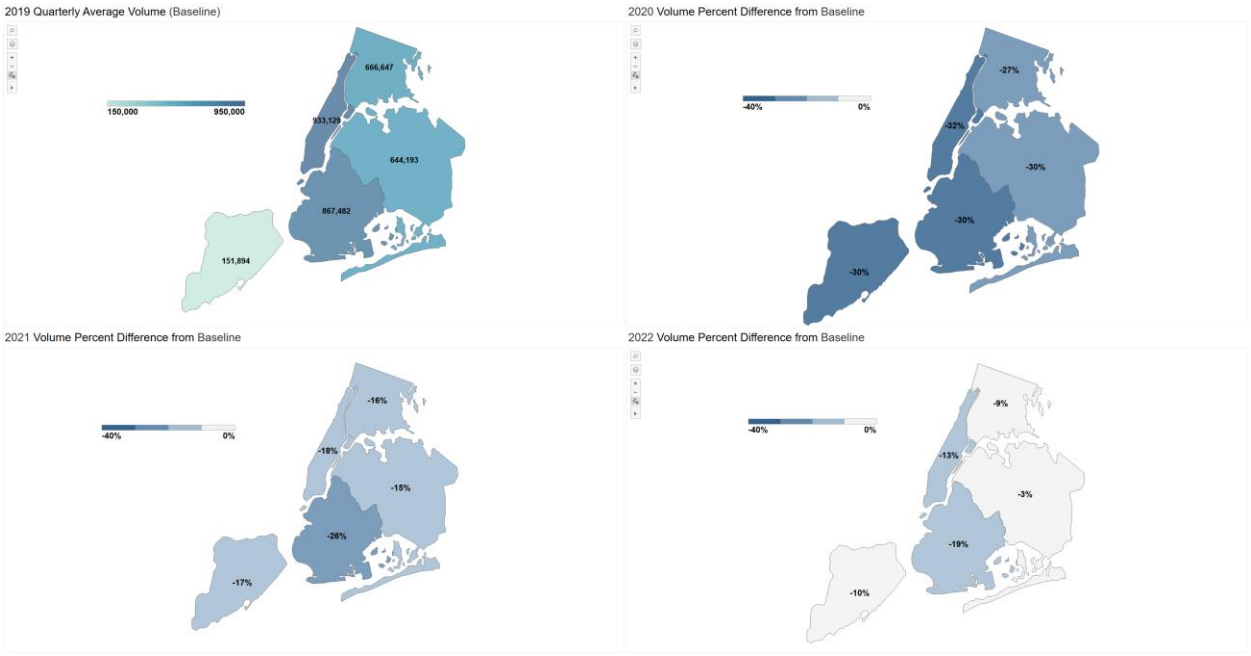



**Figure 1.3.b. Emergency Department Visits not resulting in an inpatient stay Volume Change by Facility County New York City, January 1, 2019-December 31, 2022**

### *2. Variation Across Insurance Type*

Emergency department visits not resulting in an inpatient stay had the sharpest declines for Medicaid patients as compared with other types of insurance early in the pandemic. As evidence in pre-pandemic baseline period, Medicaid patients have historically had the highest numbers of visits. High rates of emergency department utilization may indicate a lack of access to primary care, transportation barriers and lack of access to telehealth.[16]Rates of visits have rebounded in the Medicaid population to almost pre-pandemic levels and these patients still represent the largest proportion of the overall visits to emergency departments. The smallest decline was seen among Medicare patients, and it is in this group where levels have returned fully to pre-pandemic levels. This may in part be due to age and acuity of this population. It is important to note that a decline in visits that did not result in an inpatient stay may not equate to a decrease in overall emergency department visits. During the peak of the pandemic there was a disproportionate number of patients seeking emergency care at hospitals, and emergency departments were important in triaging those who needed to be admitted to the hospital for care. Future work is needed to fully understand both the inpatient and ambulatory side of emergency departments.

Visits have decreased and remained low for patients who indicate self-pay and other (includes no charge, charity, and no expected payment). The decrease in self-pay and other visits may in part be attributed to the increase in Medicaid enrollment the state has seen because of flexibilities around enrollment put in place during the Public Health Emergency (PHE). The Families First

[16] Weisz D, Gusmano MK, Wong G, Trombley J. Emergency department use: a reflection of poor primary care access? Am J Manag Care 2015;21:e152–60. PMID:25880489external icon

Coronavirus Response Act adopted continuous coverage and Maintenance of Effort (MOE) provisions that correspond with the PHE. [17] During the PHE, with limited exceptions, states receiving additional Medicaid funding from CMS, could not terminate or reduce the level of an individual's coverage, which increased the number of members on Medicaid in New York State. This is an area for further exploration to better understand whether the uninsured are forgoing or delaying necessary care, and whether self-pay will be affected by the COVID-19 unwind and Medicaid redetermination.

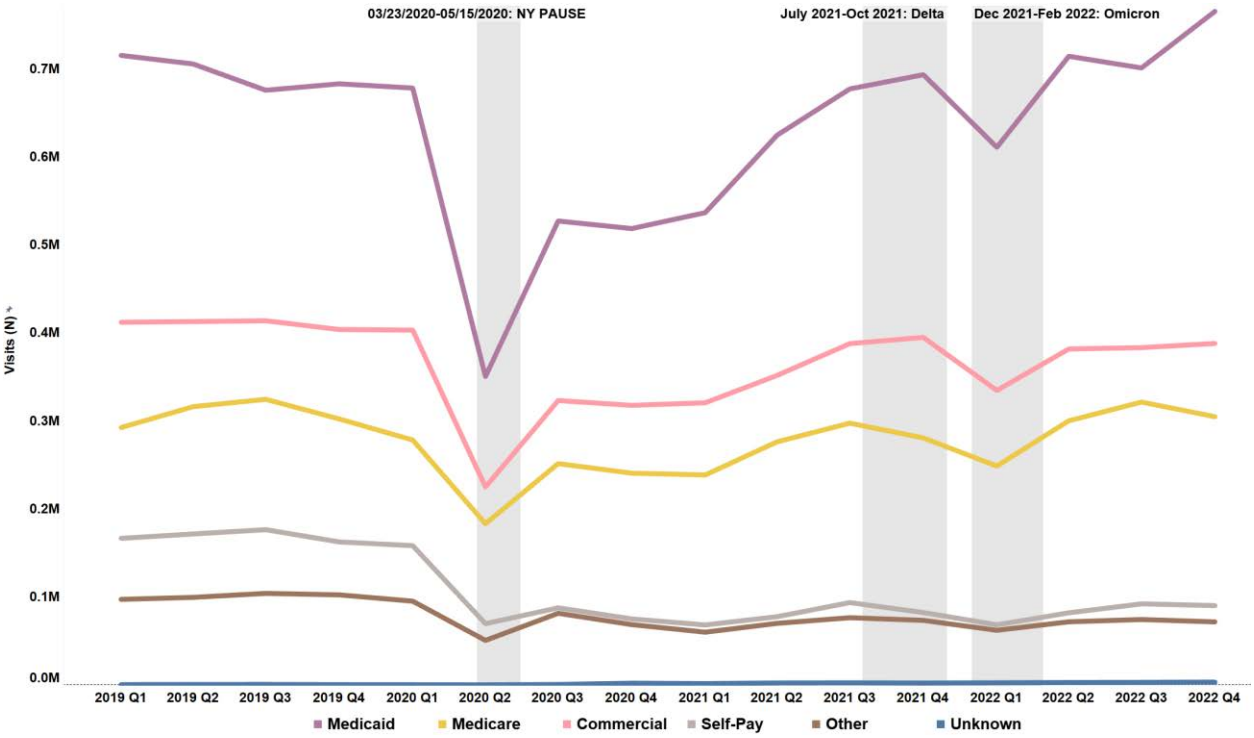



**Figure 2.1. Quarterly Number of Emergency Department Visit not resulting in an inpatient stay by Type of Insurance, January 1, 2019- December 31, 2022**

### *3. Variation Across Demographic Characteristics*

The findings by demographics offer an update on the changing profile of emergency department visits because of the COVID-19 pandemic. Emergency department visits for patients aged less than 17 years, females, non-Hispanic, and white patients had the sharpest decline immediately after the emergence of the pandemic.

The resurgence of visits particularly in the youngest age group (0 to 17 years) in the fourth quarter of 2021 was a precursor to an increase in both cases and a notable increase in hospitalization admissions for this age cohort at the very end of 2021. [18] The 2021- 2022 flu season was earlier than other seasons and compounded with respiratory syncytial virus may have contributed to increased emergency department visits for children.[19] Post-pandemic proportions

[17] Families First Coronavirus Response Act. https://www.congress.gov/116/plaws/publ127/PLAW-116publ127.pdf
[18] New York State Department of Health Issues Health Advisory Warning of An Increase In Pediatric Hospitalizations Associated With COVID-19 (ny.gov)
[19] Centers for Disease Control and Prevention. (2023). 2021-2022 Flu Season Summary. Retrieved from https://www.cdc.gov/flu/season/faq-flu-season-2021-2022.htm

of visits have largely returned to baseline for those ages 80 years of age and older and are now slightly higher towards the end of 2022 for those aged 0-17 years and 65-79 years as shown in Figure 3.1.

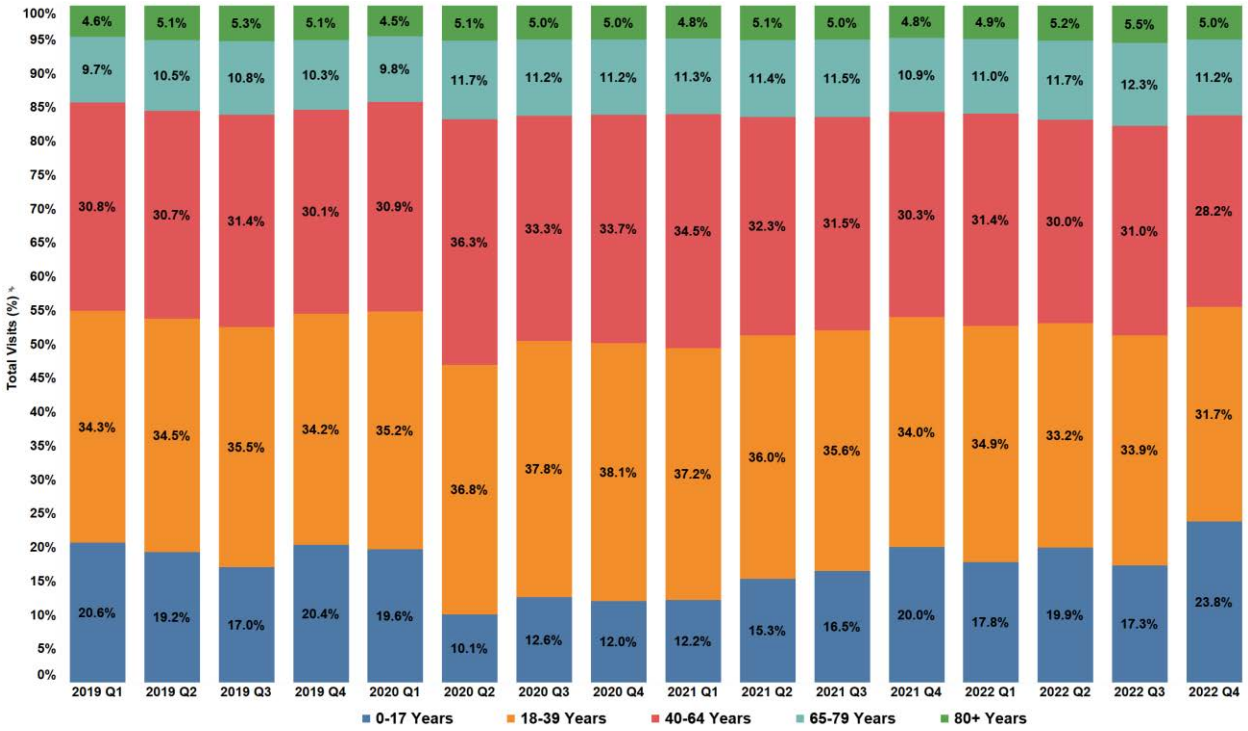



**Figure 3.1. Proportion of Emergency Department Visits not resulting in an inpatient stay by Age Group January 1, 2019- December 31, 2022**

With the exception of the early months of the pandemic (April 2020) the proportion of emergency department visits by sex have remained relatively stable. A slightly higher proportion of females are seen over males in emergency departments and these proportions have almost returned to the pre-pandemic levels.

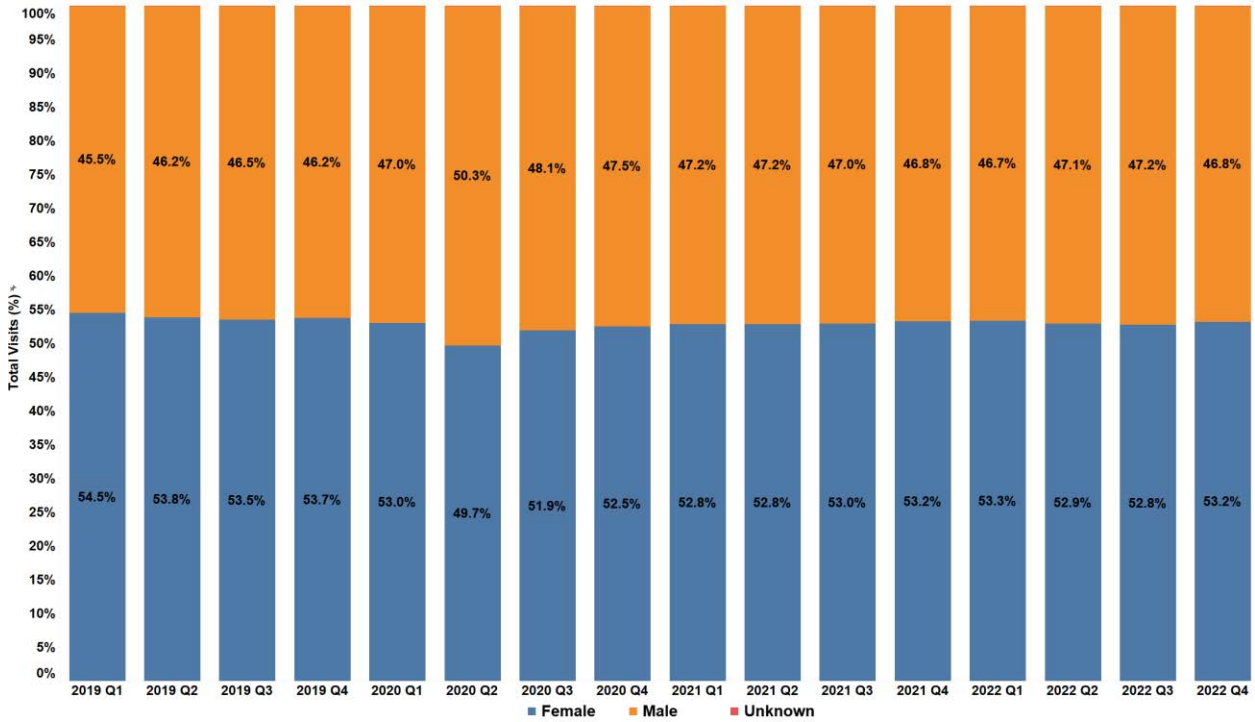



**Figure 3.2. Proportion of Emergency Department Visits not resulting in an inpatient stay by Sex January 1, 2019- December 31, 2022**

Following the sharp decline in emergency department visits among both non-Hispanic and white patients, the number of visits has returned to pre-pandemic levels for Hispanic patients and is nearing pre-pandemic levels for White patients. While the overall number of visits to emergency departments may not have reached pre-pandemic levels, examining those populations who have rebounded after the initial surge of COVID-19 may offer insights into communities that could benefit from better connectivity to primary care. Results should be interpreted with caution. The proportion of visits with unknown ethnicity increased starting in the third quarter of 2021, which will need to be explored in the future. Similarly return to pre-pandemic levels for races may be in part due to an increase in the proportion of visits with the race of other, which would include unknown responses. Future explorations into emergency department visits should examine potentially preventable visits.

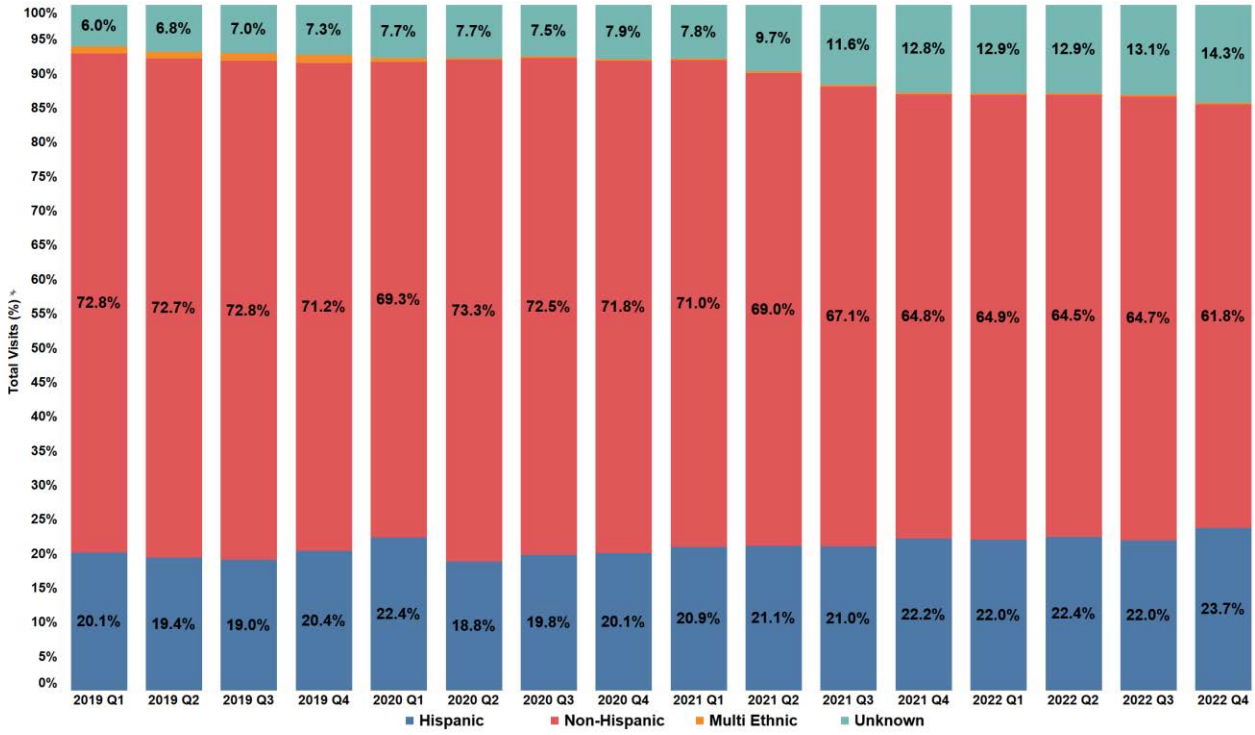



**Figure 3.3. Proportion of Emergency Department Visits not resulting in an inpatient stay by Ethnicity January 1, 2019- December 31, 2022**

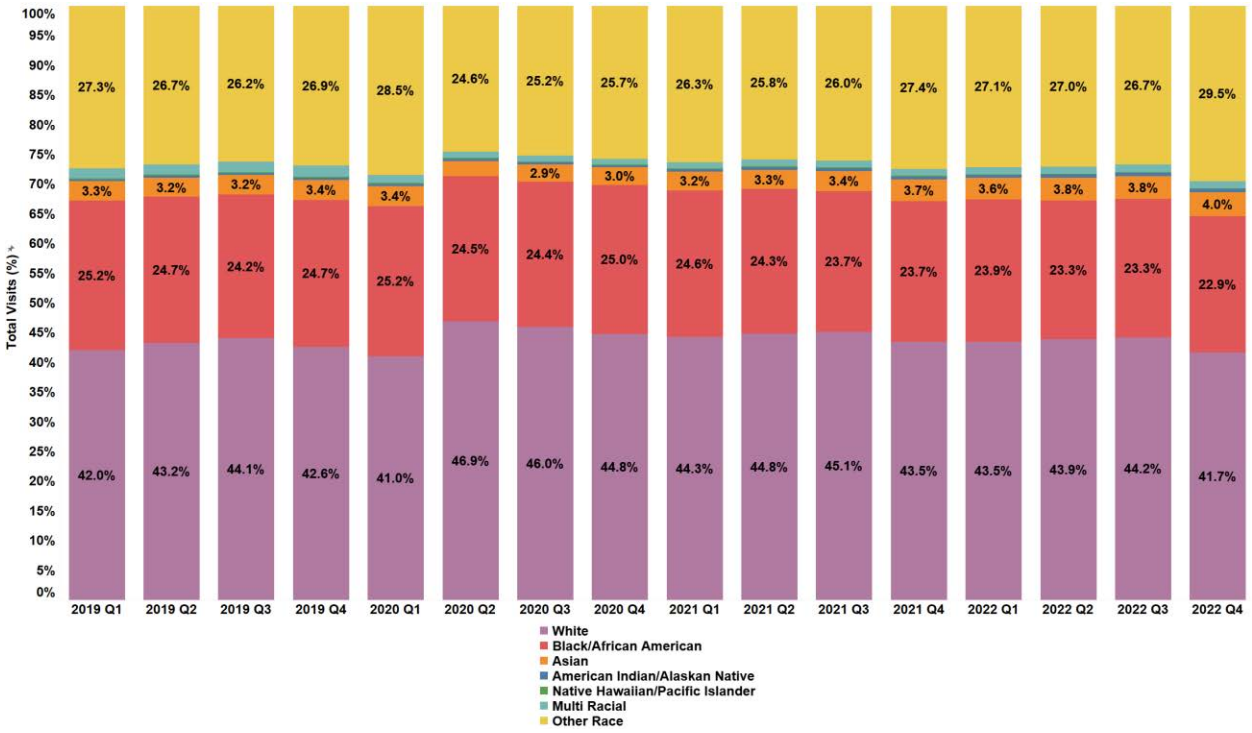



**Figure 3.4. Proportion of Emergency Department Visits not resulting in an inpatient stay by Race January 1, 2019- December 31, 2022**

### *4. Variation Across Reasons for a Visit*

In examining variation in reasons for emergency department visits not resulting in an inpatient stay, several conditions representing the highest acuity and highest volume of all visits were examined over time. Visits for injury and external causes represents highest proportion of visits to emergency departments both in the pre-pandemic baseline period and post-pandemic period. These include both sprains and strains that could be managed through primary or urgent care, as well as life-threatening conditions such as suicide attempt, overdose, occupational, or motor vehicle injuries.

There was a decrease during the height of the pandemic (second quarter of 2020) for all conditions, but the largest decrease in numbers of visits were for respiratory diseases. Visits for respiratory diseases including viral infections and influenza all increased in the first quarter of 2020 most likely as the result seasonal trends, as well as the potential misclassification of the novel SARS-CoV-2 virus. As official diagnostic coding came online in April 2020 many of those initial visit reasons were subsumed by visits pertaining to COVID-19 infection. However, visits for respiratory diseases remained lower than the baseline throughout the remainder of 2020

and 2021. Initial decreases in visits for conditions like respiratory illnesses and influenza may be a result of low circulation in combination with COVID preventative methods. [20]

Numerous studies have shown the prevalence of various mental health conditions worsened not only in the early months of the pandemic but well into 2021.[21,22,23,24] Emergency department visits for Mental and Behavioral Disorders, which includes substance use, while did not decrease as much as other selected conditions it should be noted that visits have not returned to pre-pandemic baseline levels. More work is needed here to understand if patients are delaying care or have been connected to outpatient resources to help manage their mental and behavioral health conditions.

Decreases in visits around circulatory diseases including acute medical conditions like nonspecific chest pain could be indicative of patients delaying needed care. More research is needed to understand the extent to which patients delayed care, whether there was less need, or if facilities were able to redirect care to the outpatient setting. The implications for policymakers, and other stakeholders include opportunities to amplify and assist patients in choosing appropriate settings for their care, and message when it is still appropriate to visit the emergency department and not delay care.

[20] Huang QS, Wood T, Jelley L, et al.; NPIsImpactOnFlu Consortium. Impact of the COVID-19 nonpharmaceutical interventions on influenza and other respiratory viral infections in New Zealand. Nat Commun 2021;12:1001. https://doi.org/10.1038/s41467-021-21157-9

[21] Blanchflower DG, Bryson A. Covid and mental health in America. PLoS One. 2022;17(7):e0269855. doi:10.1371/journal.pone.0269855

[22] Holingue C, Kalb LG, Riehm KE, et al. Mental distress in the United States at the beginning of the COVID-19 pandemic. Am J Public Health. 2020;110(11):1628-1634. doi:10.2105/AJPH.2020.305857

[23] Ettman CK, Abdalla SM, Cohen GH, Sampson L, Vivier PM, Galea S. Prevalence of depression symptoms in US adults before and during the COVID-19 pandemic. JAMA Netw Open. 2020;3(9):e2019686. doi:10.1001/jamanetworkopen.2020.19686

[24] Darcy AM, Mariano T. Mental health in America: a growing crisis. Psychiatric Times. August 6, 2021. https://www.psychiatrictimes.com/view/mental-health-america-crisis

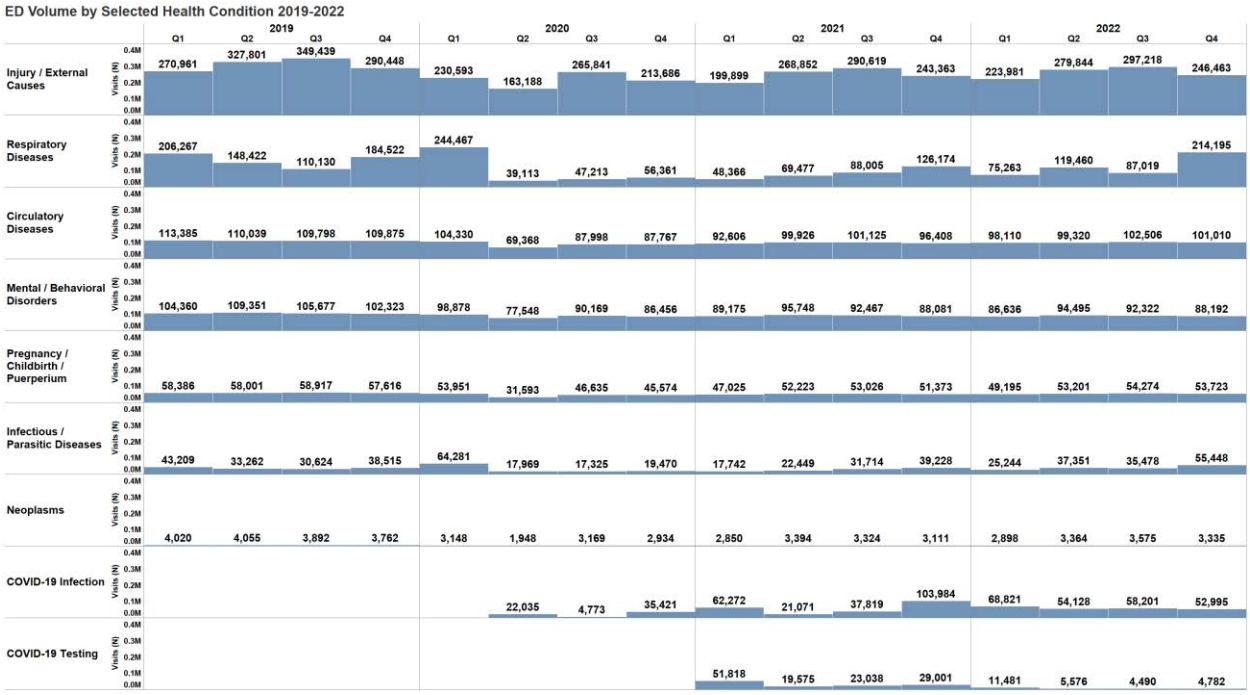



**Figure 4.1. Quarterly Number of Emergency Department Visits not resulting in an inpatient stay by Major Condition January 1, 2019- December 31, 2022**

### *5. Institutional Cost Report Data*

Estimates of facility costs for emergency room visits is shown in Table 2. There was an increase in costs reported every year from 2019 to 2022 with a 28% increase overall. While these costs do not include services for those patients admitted to the inpatient side of the hospital, it does encompass more than just patient care costs. When interpreting cost data, it is important to keep in mind that variations in cost may be attributed to many factors. Some of these include overall volume, teaching hospital status, facility specific attributes, geographic region and quality of care provided. There are also several factors that have been shown to drive up institutional costs in this such as increased costs of medical supplies and equipment, workforce shortages and an increase in contract labor, and the cost of drugs.[25] The exact cause of the increase in reported costs from the pre-pandemic cannot be determined with current data sources. This may be an area of further exploration.

[25] American Hospital Association. (2023) The Financial Stability of America's Hospitals and Health Systems Is at Risk as the Costs of Caring Continue to Rise. Accessed from https://www.aha.org/system/files/media/file/2023/04/Cost-of-Caring-2023-The-Financial-Stability-of-Americas-Hospitals-and-Health-Systems-Is-at-Risk.pdf

**Table 2. Institutional Cost Report (ICR) Data by Year for Emergency Room Costs**

| Report Year | Schedule 1 – Total Emergency Room Costs |
|---|---|
| 2019 | $ 4,885,956,607 |
| 2020 | $ 5,079,775,519 |
| 2021 | $ 5,449,510,020 |
| 2022 | $ 6,249,876,342 |

## *Outpatient Settings*

### *1. Variation Across New York State*

Data used from over 14 million unique patients showed that in-person outpatient visits decreased sharply early in the pandemic. By the lowest point in late April 2020 the number of outpatient visits had declined by 47%. In-patient outpatient visits demonstrated a rapid increase to almost near pre-pandemic levels by 2020 quarter 3 with visits increasing considerably through the first half of 2021. Visits peaked in early 2021 and then declined through the third quarter of 2021 when there was a slight increase in visits corresponding with the emergence of the Delta variant. Visits began to decrease beginning in the end of 2021 and into 2022 where in-person visits reached near pre-pandemic levels. While the overall trends point to a return to pre-pandemic baselines and even an increase in utilization of services, the increase in visits from the end of 2020 to mid-2021 can mostly be attributed to COVID response including encounters for COVID-19 and testing and tracing activities, and vaccinations. During this time home tests were not widespread and requirements for testing were in place for travel, return to work, and return to school. The vaccines for the prevention of COVID-19 in the United States were authorized for emergency use by the Food and Drug Administration in December 2020. The vaccine was rolled out in NYS in alignment with Advisory Committee on Immunization Practices to priority groups including health care workers and long-term residents and staff (Phase 1a), persons aged ≥75 years and frontline essential workers (non–health care workers) (Phase 1b), persons aged 65–74 years, persons aged 16–64 years with high-risk medical conditions, and essential workers not recommended for vaccination in Phase 1b should be offered vaccine (Phase 1c). [26]

[26] CDC. (2023). Vaccine Recommendations and Guidelines of the ACIP. Retrieved from https://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/covid-19.html

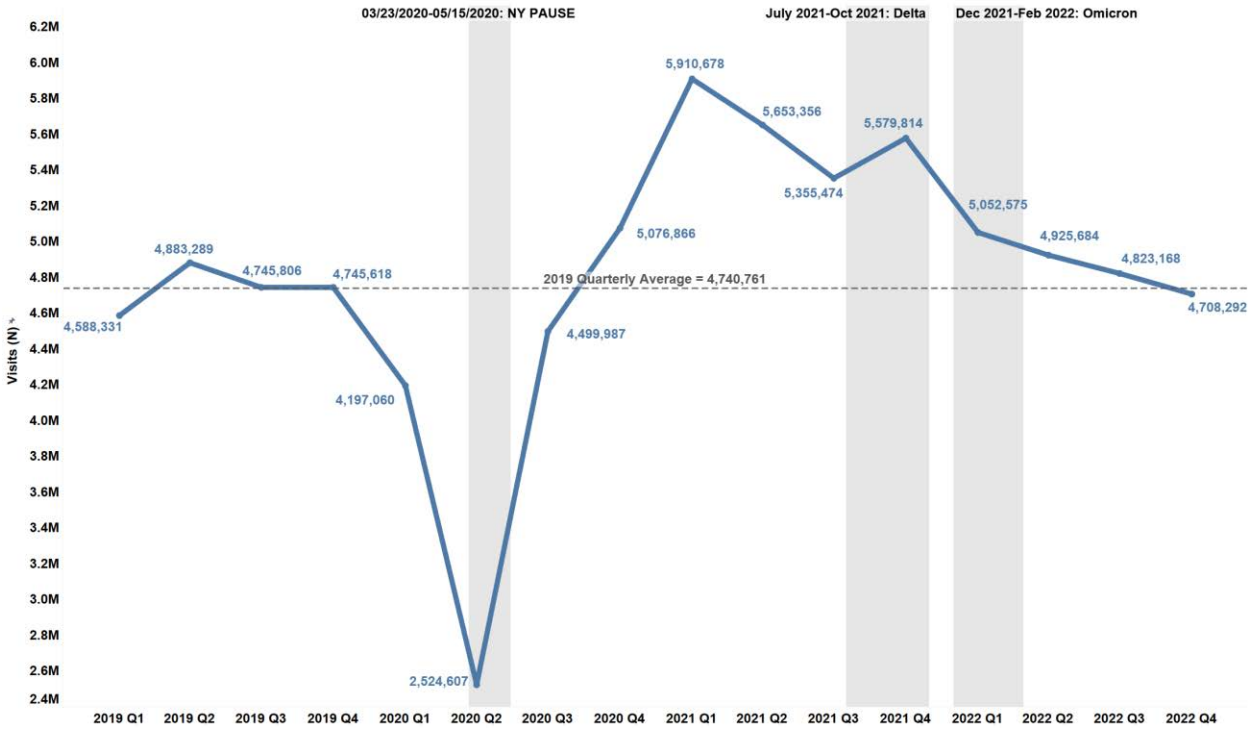



**Figure 5.1. Quarterly Number of Outpatient In-Person Visits Statewide, January 1, 2019- December 31, 2022**

Regional trends for in-person outpatient visits mirrored statewide trends in the early phase of the pandemic until the very end of 2020. Additional regions of the state have seen varying levels of return in visits to pre-pandemic levels. Some counties have returned and exceeded pre-pandemic levels but other counites, should be examined further. More work should be done to understand the differing health care landscape in different areas of the state to ensure access is available across the state.

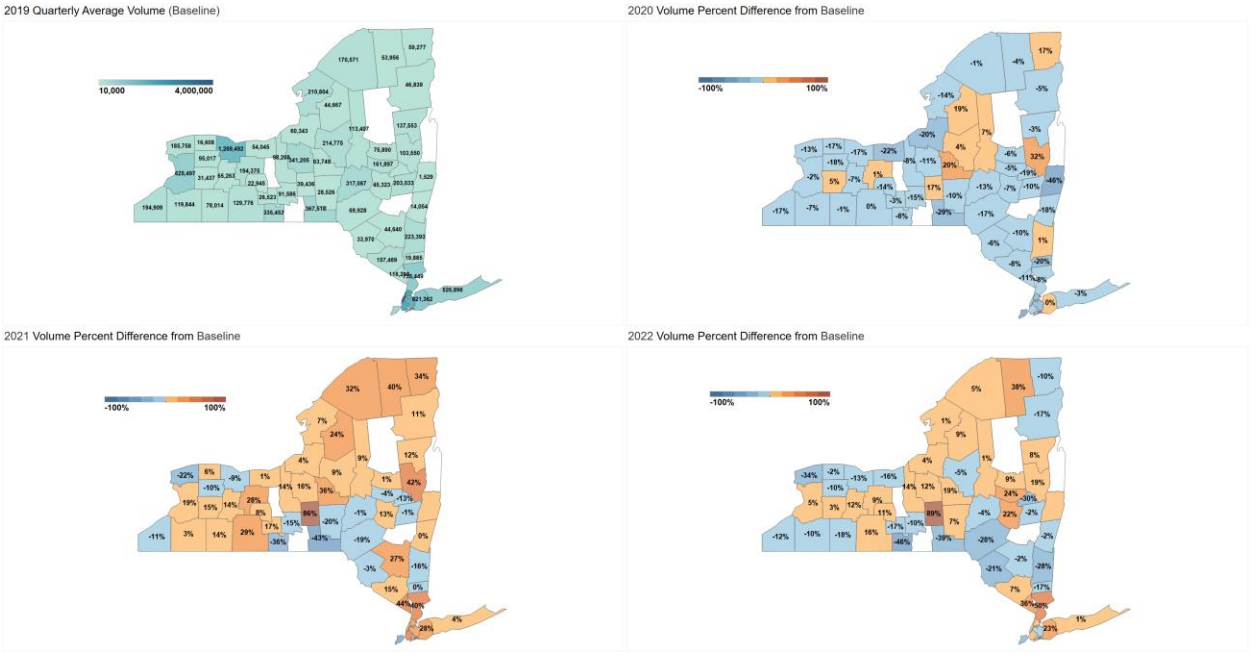



**Figure 5.2.a. Outpatient In-Person Visits Volume Change by Facility County, January 1, 2019-June 30, 2022**

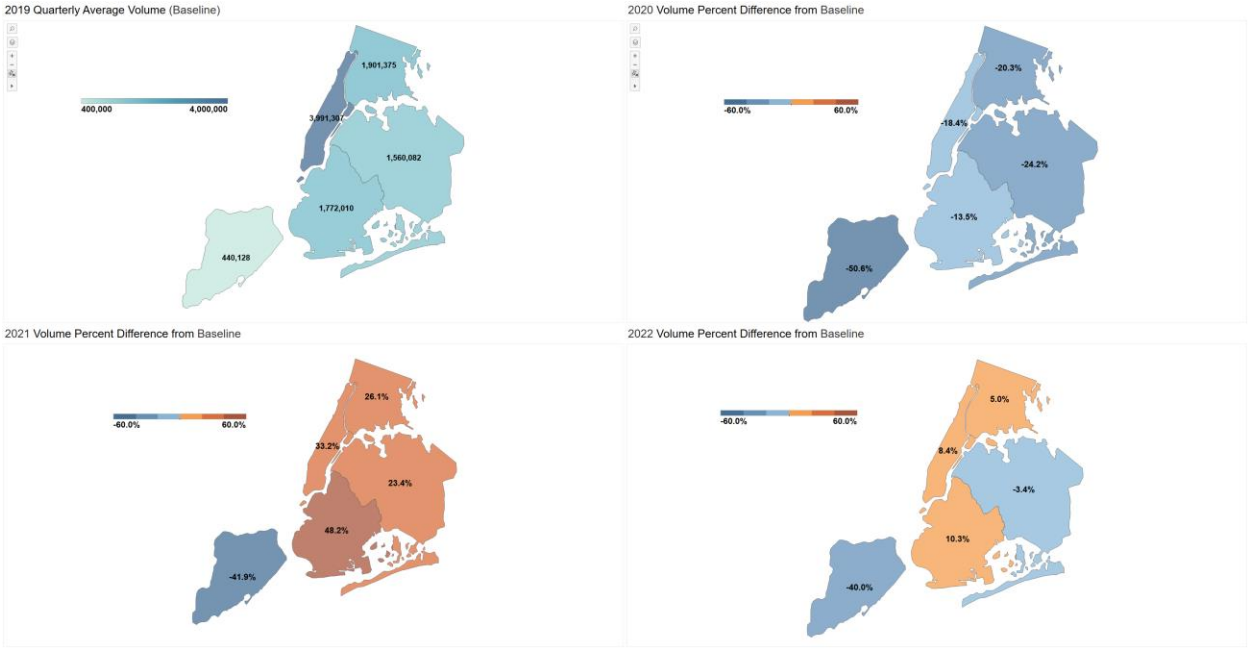



**Figure 5.2.b. Outpatient In-Person Visits Volume Change by New York City County, January 1, 2019-June 30, 2022**

When these encounters reflecting exposure to contact, screening, and vaccinations are removed (Figure 5.3), the picture of overall in-person outpatient visits mirrors what is seen in regions of the state outside of New York City and elsewhere throughout the country in which outpatient care had not rebounded to pre pandemic levels in 2021. Outpatient visits increase more gradually through end of 2020, 2021 and finally in late 2022 return to near pre-pandemic level. Future exploration on the long-term impact of the disruption of in-person outpatient visits, which would

include a delay in services like cancer screening, immunizations, and other care processes not able to be covered during a telehealth visit is an area that needs further attention.

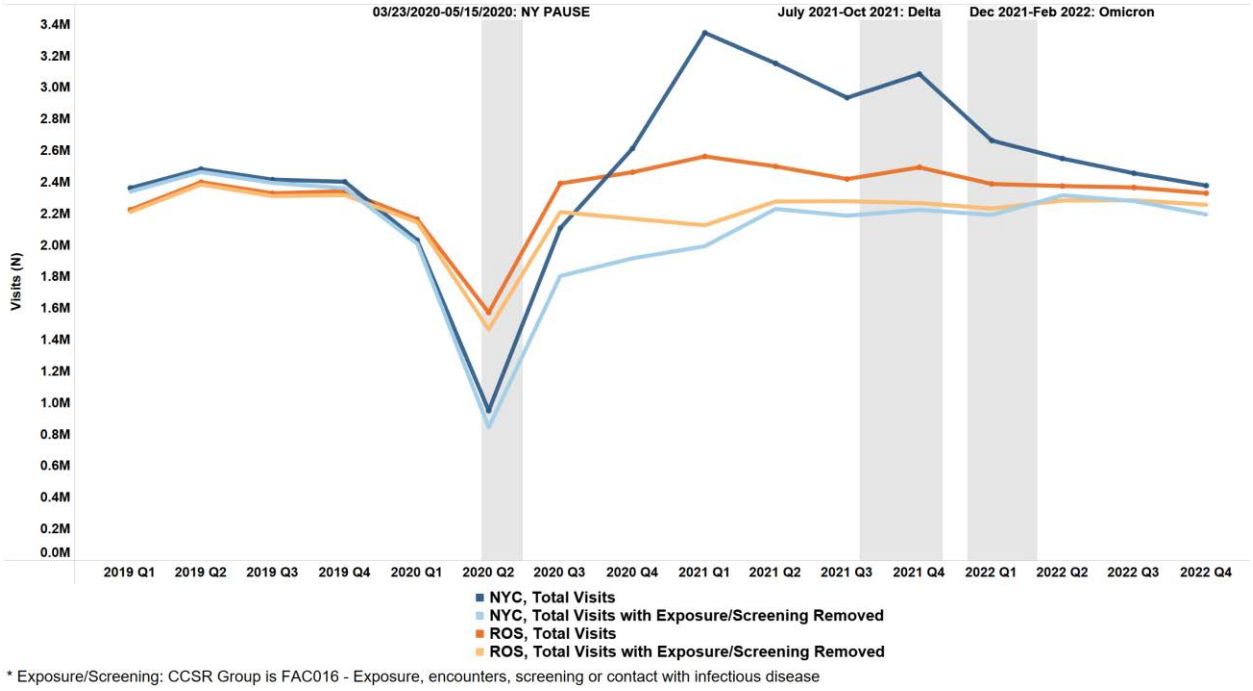



**Figure 5.3. Quarterly Number of Outpatient In-Person Visits by Region and COVID-Related Visits, January 1, 2019- December 31, 2022**

The sharp increase in-person outpatient visits seen statewide were largely driven by visits related to exposure, screening, and vaccination efforts. The split between those visits where a vaccine was administered ranged between 42% to 45% in regions outside of New York City and New York City respectively. The proportion of visits related to vaccine administration remained at 50% through the second quarter of 2021. Facilities in New York City and more than half of the increase in visits in this category from late 2020 to early 2021 in New York City came from facilities in the NYC Health + Hospitals' hospital network. This increase in visits may be attributed to efforts in New York City both in access to vaccinations and increase testing of positive cases and tracing of contacts. The NYC Test & Trace Corps led by the NYC Health + Hospitals Corporation managed hundreds of testing sites throughout the five boroughs, including City public school testing and more than 40 mobile units that are deployed in conjunction with partners such as community-based organizations. [27]

[27] NYC Test and Trace Corps. https://www.nyc.gov/site/coronavirus/get-tested/test-trace-corps.page

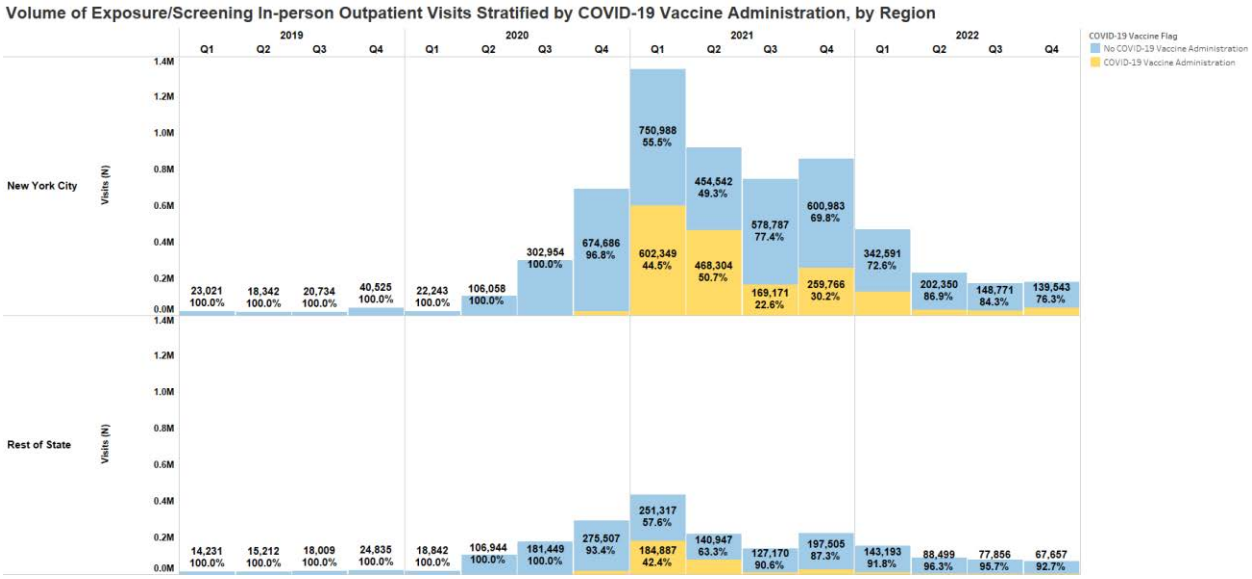



**Figure 5.4. Quarterly Number of Outpatient In-Person Visits Identified as Exposure and Screening Stratified by Region and COVID-19 Vaccine Administration, January 1, 2019- December 31, 2022**

### *2. Variation Across Insurance Type*

Patients with commercial insurance contributed the most visits of any payer for in-person outpatient visits in the pre-pandemic period and through the study period. The sharp decline in visits early in the pandemic were most notable among Medicaid and commercial patients. There were not substantial differences in the recovery of overall volume of outpatient visits by types of insurance to pre-pandemic level. Differences by types of insurance have persisted throughout the study period, which warrants further exploration to better understand whether new modalities such as telehealth are a factor and whether there are any underlying disparities in the quality of care received by these patients. More work is also needed to understand the extent that vulnerable populations such as Medicaid patients have access to needed outpatient care.

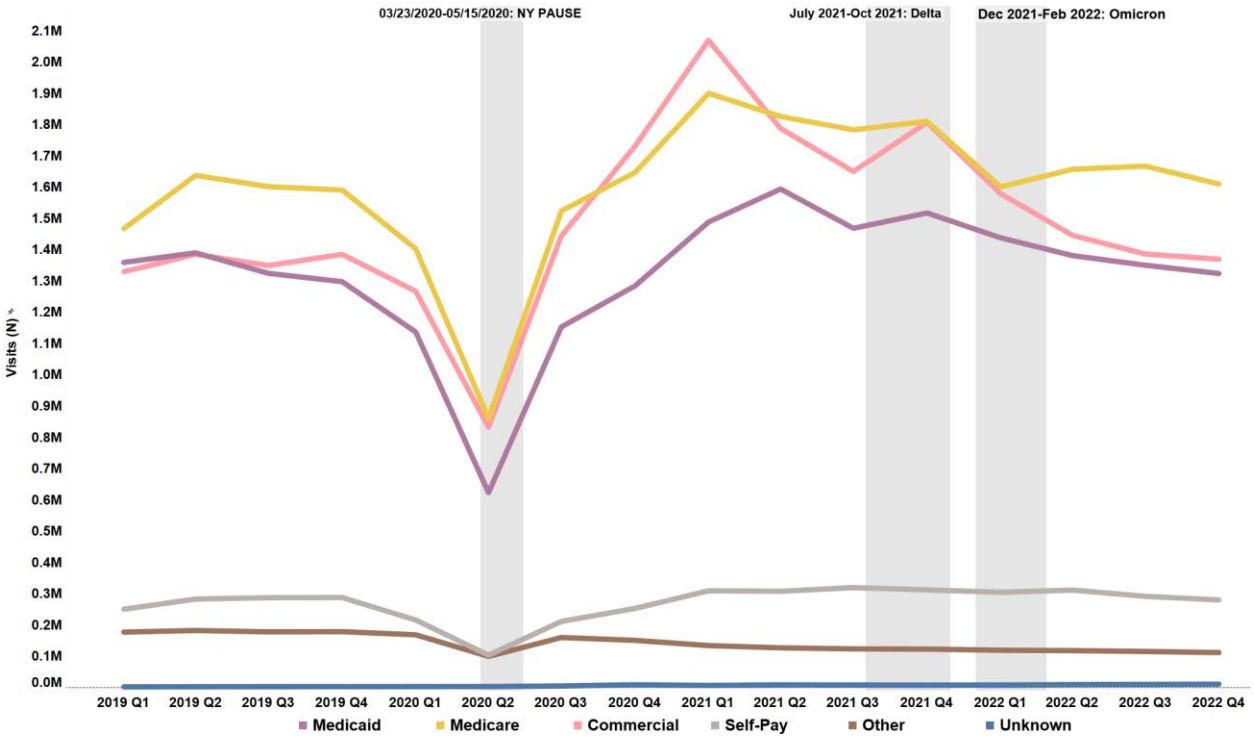



**Figure 6.1. Quarterly Number of Outpatient In-Person Visits by Type of Insurance, January 1, 2019-December 31, 2022**

### *3. Variation Across Demographic Characteristics*

The findings by demographics show a similar profile of in-person outpatient visits pre-pandemic baseline period through the end of the study period. While visits overall have returned to levels seen in the baseline period, this varies by several factors, most notably by age group.

The sharpest decline in-person visits early in the pandemic were among the youngest age group (0 to 17 years). While there was resurgence of visits most particularly in those aged 18 to 39 years in the fourth quarter of 2021, visits into 2022 remain just below baseline for these age cohorts. Delays in preventive health services can leave children at risk for poorer health outcomes.[28,29,30] Additional data is needed to better understand if delays in preventive care such as childhood immunizations, well visits, and cancer screenings existed.

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[28] Service use among Medicaid & CHIP beneficiaries age 18 and under during COVID-19. CMS. Accessed January 20, 2022. https://www.medicaid.gov/resources-for-states/downloads/medicaid-chip-beneficiaries-18-under-COVID-19-snapshot-data.pdf

[29] Stephenson J. Sharp drop in routine vaccinations for US children amid COVID-19 pandemic. JAMA Health Forum. 2020 May 1 (Vol. 1, No. 5, pp. e200608-e200608).

[30] Nguyen KH, Nguyen K, Lekshmi D, Corlin L, Niska RW. Delays in Children's Preventive Health Services During the COVID-19 Pandemic. Fam Med. 2022;54(5):350-361. https://doi.org/10.22454/FamMed.2022.922801.

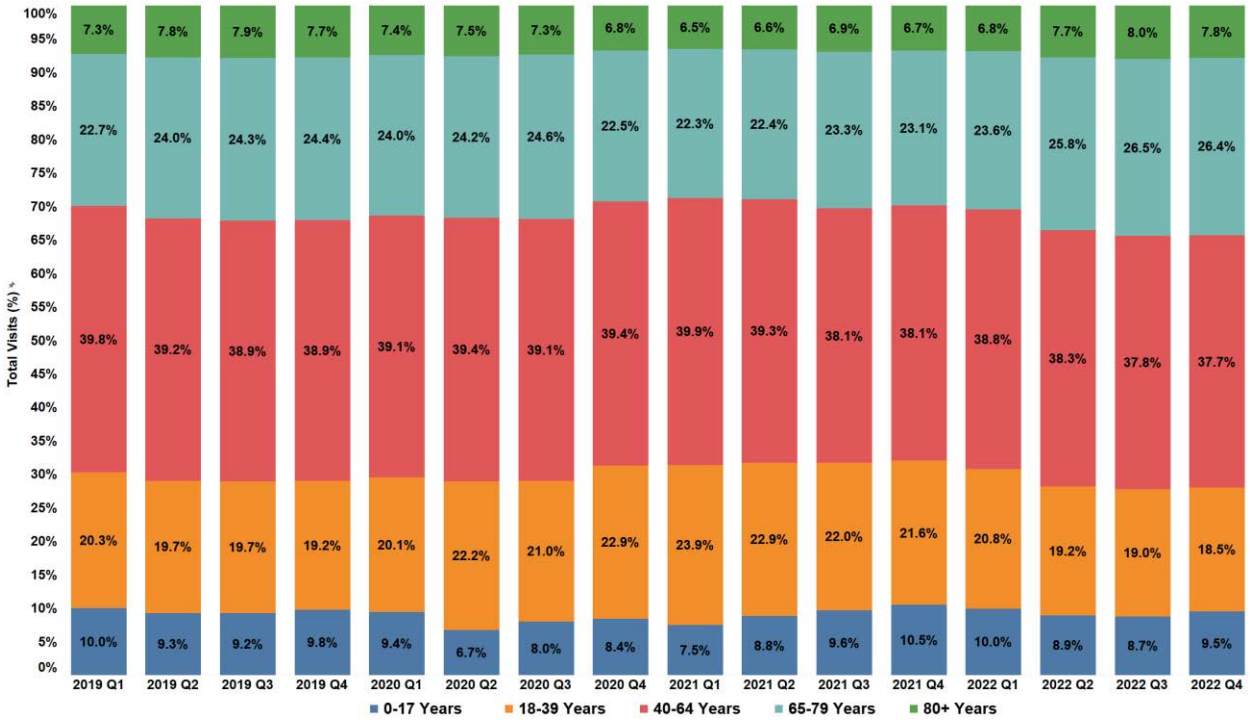


**Figure 6.2. Proportion of Outpatient In-Person Visits by Age, January 1, 2019- December 31, 2022**

Limited differences were seen in the composition of the patient population by sex for in-person outpatient visits over time. In both the pre-pandemic and through the study period about 60% of visits were among women. By ethnicity and race the sharpest decline in outpatient in-person visits early in the pandemic were among Hispanic patients, and Black patients. The composition of the population by ethnicity and race largely mirrors pre-pandemic levels.

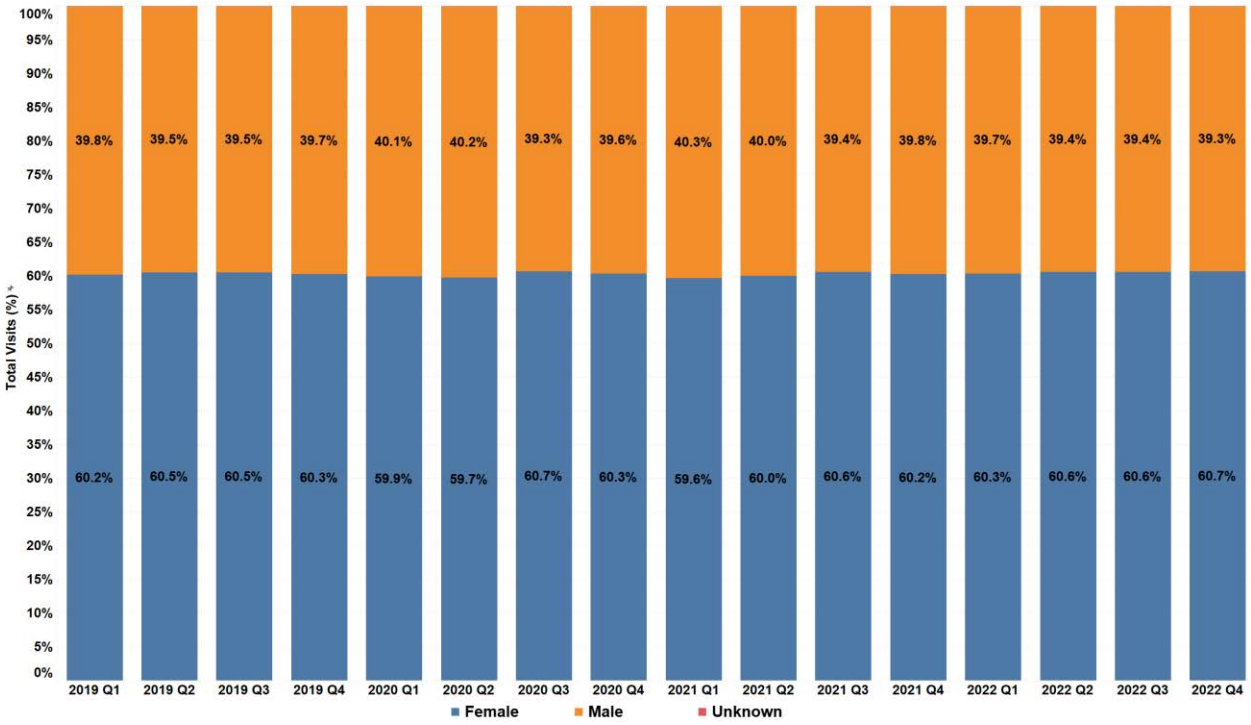


**Figure 6.3. Proportion of Outpatient In-Person Visits by Sex, January 1, 2019- December 31, 2022**

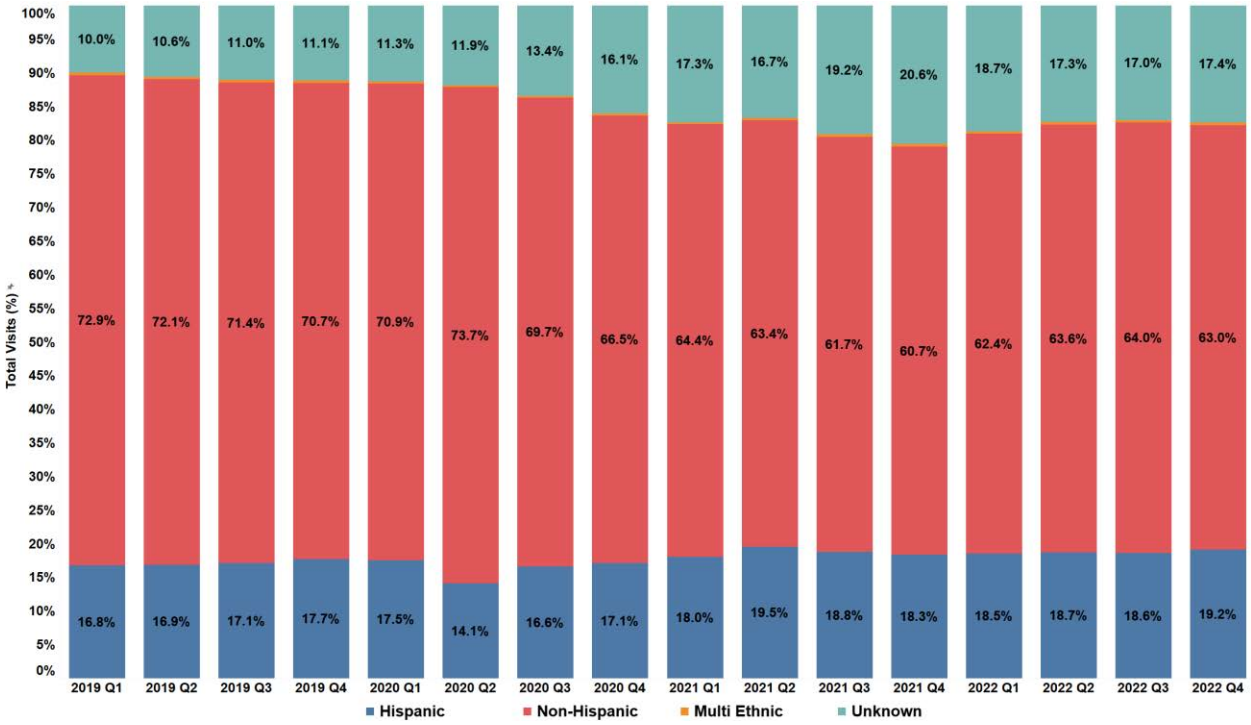


**Figure 6.4. Proportion of Outpatient In-Person Visits by Ethnicity, January 1, 2019- December 31, 2022**

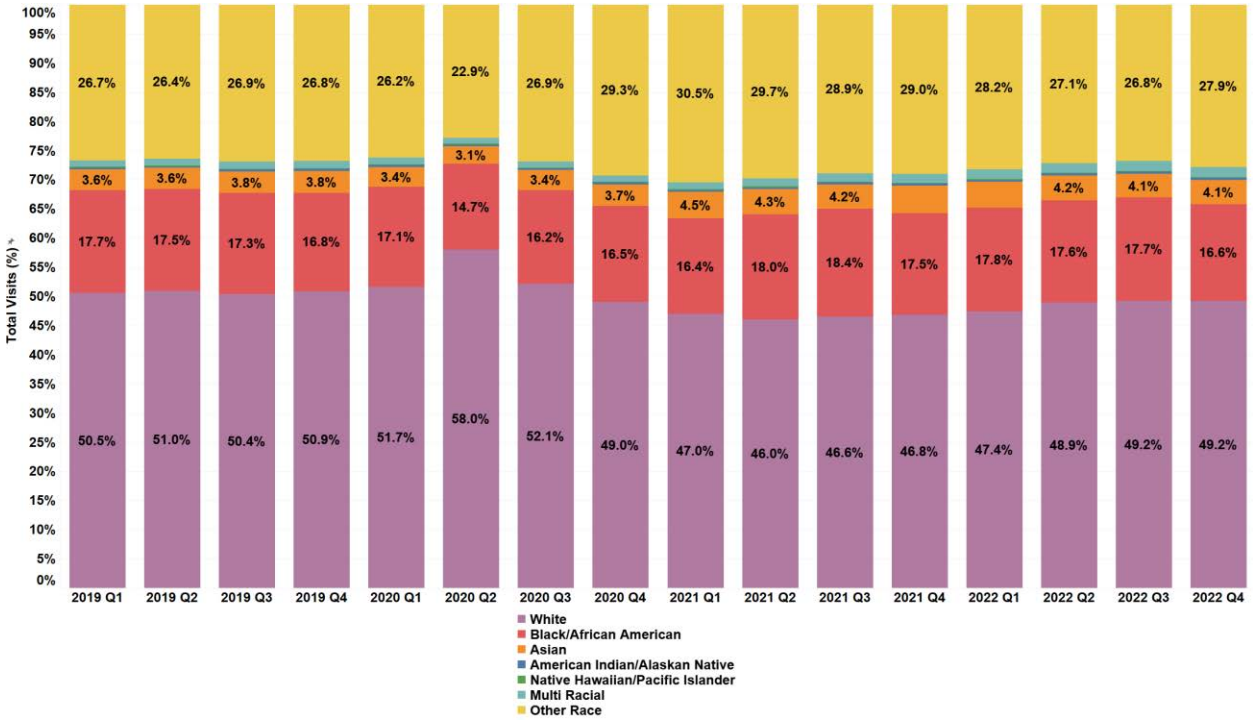


**Figure 6.5. Proportion of Outpatient In-Person Visits by Race, January 1, 2019- December 31, 2022**

### *4. Variation Across Reasons for a Visit*

In-person outpatient visits for several conditions were impacted by the initial surge of COVID-19 cases. The most notably declines early in the pandemic were seen among Mental/Behavioral Disorders with a 75% decrease in outpatient in-person visits (e.g., depressive disorders, schizophrenia spectrum and other psychotic disorders, and opioid related disorders). The next largest decline was in Respiratory Diseases (71% decrease), Infectious/Parasitic Diseases (68% decrease), Injury/External Causes (67% decrease) and Circulatory Diseases (60% decrease). In-person visits for Neoplasms have exceeded pre-pandemic levels, and visits for Respiratory Diseases, and Circulatory Diseases are nearing pre-pandemic baseline levels visits (within 10% of pre-pandemic baseline levels). In-person visits for Injury/External causes and Mental/Behavioral Disorders continue to lag pre-pandemic levels. Further exploration is needed to determine to the degree any services transitioned from the Article twenty-eight outpatient settings to other providers, such as expanded urgent care services and telehealth modalities.

In-person outpatient visits remain 35% lower for Mental/Behavioral Disorders. The disruption of in-person mental health and substance use outpatient services because of the COVID-19 pandemic has been documented nationally. [31]

[31] Davenport, Stoddard. Behavioral Healthcare Utilization Changes During the COVID-19 Pandemic, Milliman, February 2021. https://wellbeingtrust.org/wp-content/uploads/2021/03/Milliman-COVID-BH-Impact-2021-02-17.pdf

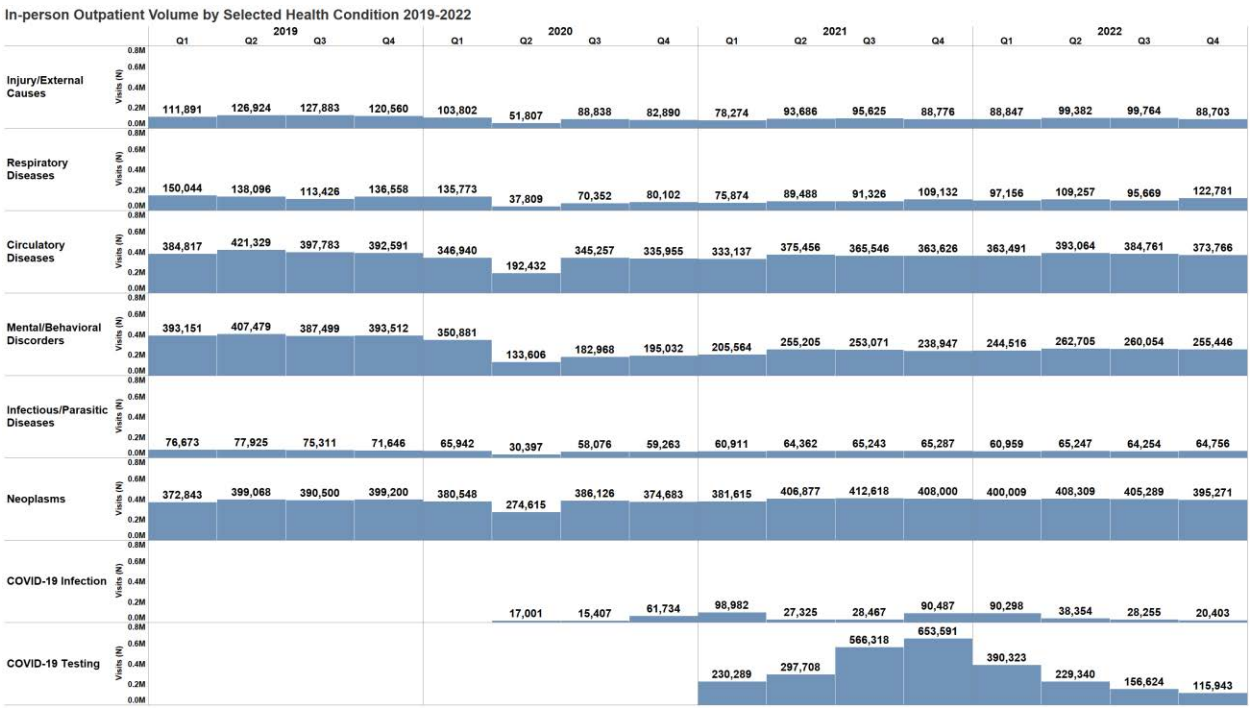


**Figure 7.1. Quarterly Number of Outpatient In-Person Visits by Major Condition, January 1, 2019-December 31, 2022**

### *5. Institutional Cost Report Data*

Estimates of facility costs for outpatient clinic visits in shown in Table 3. There was an increase in costs reported every year from 2019 to 2021 with a 18% increase overall. Cost estimates for outpatient clinics are not able to be segmented by in-person and telehealth visits. Costs attributed to telehealth visits may be included here. When interpreting cost data, it is important to keep in mind that variations in cost may be attributed to many factors. Some of these include overall volume, teaching hospital status, facility specific attributes, geographic region and quality of care provided. There are also several factors that have been shown to drive up institutional costs in this specific time period such as increased costs of medical supplies and equipment, workforce shortages and an increase in contract labor, and the cost of drugs.[32] The exact cause of the increase in reported costs from the pre-pandemic cannot be determined with current data sources. This may be an area of further exploration.

[32] American Hospital Association. (2023) The Financial Stability of America's Hospitals and Health Systems Is at Risk as the Costs of Caring Continue to Rise. Accessed from https://www.aha.org/system/files/media/file/2023/04/Cost-of-Caring-2023-The-Financial-Stability-of-Americas-Hospitals-and-Health-Systems-Is-at-Risk.pdf

**Table 3. Institutional Cost Report (ICR) Data for Outpatient Clinics by Year**

| Report Year | Schedule 1 - Total Clinic Costs |
|---|---|
| 2019 | $ 10,290,015,767 |
| 2020 | $ 11,094,803,486 |
| 2021 | $ 12,168,685,184 |
| 2022 | NA |

NA: Data not available

## *Telehealth Services*

1. Variation Across New York State

As other ambulatory care services declined in the early onset of the COVID-19 pandemic the overall volume of telehealth services increased and peaked in April and May 2020. Telehealth visits in this report covering just over 1 million unique patients increased by 368-fold from the pre-pandemic baseline volume. These visits declined sharply, and volume then leveled off and increased in the later part of 2020 and early part of 2021 as the second wave of cases hit the state. Volume then declined until the end of 2021 whereas visits increased through the early part 2022. Telehealth visits have started to decline again through the end of the study period, but even with these declines the volume of telehealth visits are still 145-fold greater than they were in the pre-pandemic baseline period. The small patient population represented in data in the study period raises questions about the generalizability of these results. Results should be reviewed with caution. It should be noted that among national survey data 22.5% of those who answered the survey reported having used telehealth services in the last four weeks.[33] It is unknown if telehealth is more prominent in settings outside of hospital-based outpatient clinics.

[33] ASPE Office of Health Policy. (2023). Updated National Survey Trends in Telehealth Utilization and Modality (2021-2022). Retrieved from https://aspe.hhs.gov/sites/default/files/documents/7d6b4989431f4c70144f209622975116/household-pulse-survey-telehealth-covid-ib.pdf

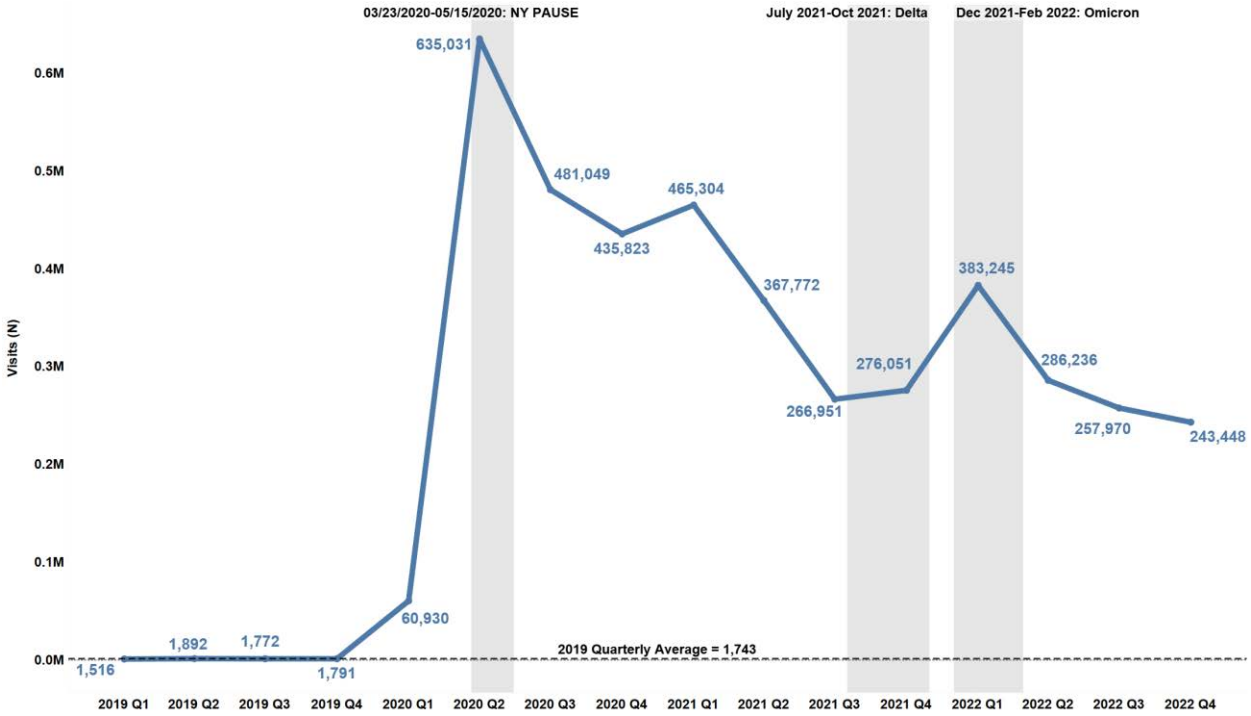


**Figure 8.1. Quarterly Number of Telehealth Visits Statewide, January 1, 2019- December 31, 2022**

The trends seen statewide are largely mirrored regionally with a few noted exceptions. The steepest incline of initial visits was seen in New York City. Additionally, decline in visits in the second half of 2021 was steeper in New York City as was the increase in visits see in the early to mid part of 2022. As a part of the Public Health Emergency, CMS was able to use special waiver authority to waive the geographic restriction services only be reibmursed for telehealth services provided in rural areas of the country. The disproportionate expansion of telehealth in urban areas has been noted in other studies.[34,35] Future work should focus on if there is equitable access to telehealth across the state.

[34] Bipartisan Policy Center. (2022). The Future of Telehealth After COVID-19. https://bipartisanpolicy.org/wp-content/uploads/2022/09/BPC-The-Future-of-Telehealth-After-COVID-19-October-2022.pdf

[35] Talbot, JA, Burgess, AR, Jonk, YC, O'Connor, H. Federal telehealth policy changes during the COVID-19 public health emergency: Associations with telemental health use among rural and urban Medicare beneficiaries. https://doi.org/10.1111/jrh.12776

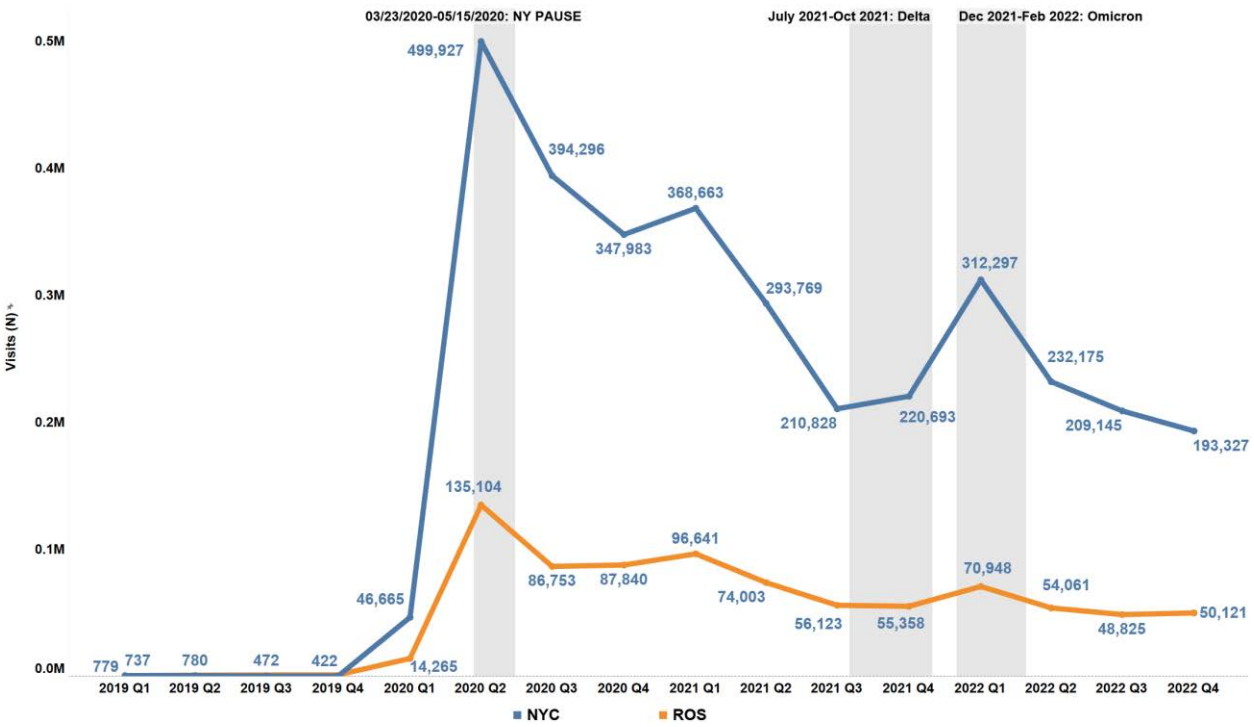


**Figure 8.2. Quarterly Number of Telehealth Visits by Region, January 1, 2019- December 31, 2022**

### 2. *Variation Across Insurance Type*

Telehealth visits for Medicaid patients increased the most among all types of insurance with Medicare coming in second. This can in part be attributed to telehealth flexibilities put into place due to the pandemic, which expanded the range of services that can be delivered via telehealth, payment parity with face-to-face visits, expanded telehealth modalities, and allowing additional provider types that could be reimbursed for telehealth services. [36] Trends by type of insurance largely followed trends seen statewide. At the conclusion of calendar year 2022 Commercial now exceeds Medicare in the number of telehealth visits by quarter. Future work in this area should focus on the availability and access of telehealth after the end of the public health emergency.

[36] COVID-19 Guidance for Medicaid Providers COVID-19 Guidance for Medicaid Providers (ny.gov)

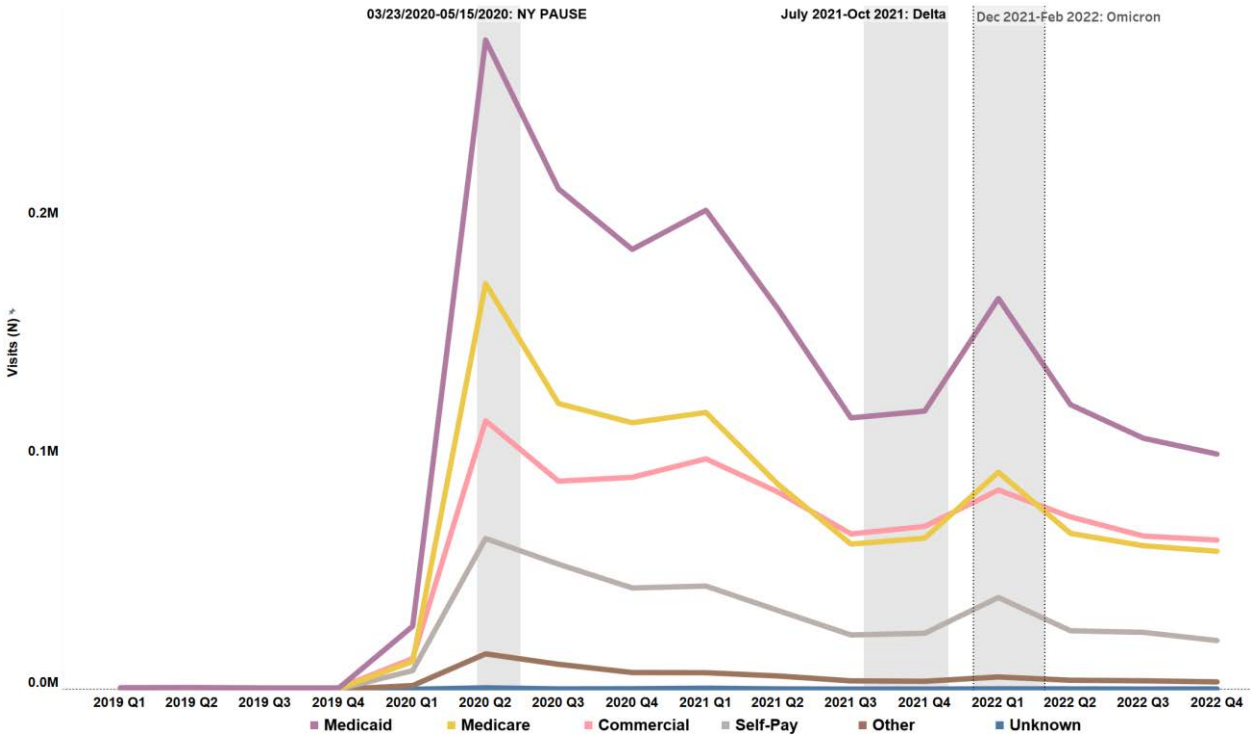


**Figure 9.1. Quarterly Number of Telehealth Visits by Type of Insurance, January 1, 2019- December 31, 2022**

### *3. Variation Across Demographic Characteristics*

Pre-pandemic baseline results demonstrate telehealth visits were most frequent among children aged 0 to 17 years, females, non-Hispanic, and white patients. Early in the pandemic the biggest increase in telehealth visits was seen among adults aged 40 to 64 years, females, Hispanic, and black African American patients. The levels of usage by various demographic characteristics have plateaued. Future opportunities around equitable access to care and the impact of telehealth on quality of care and patient outcomes should continue to be explored especially after the end of the Public Health Emergency (e.g., May 11, 2023).

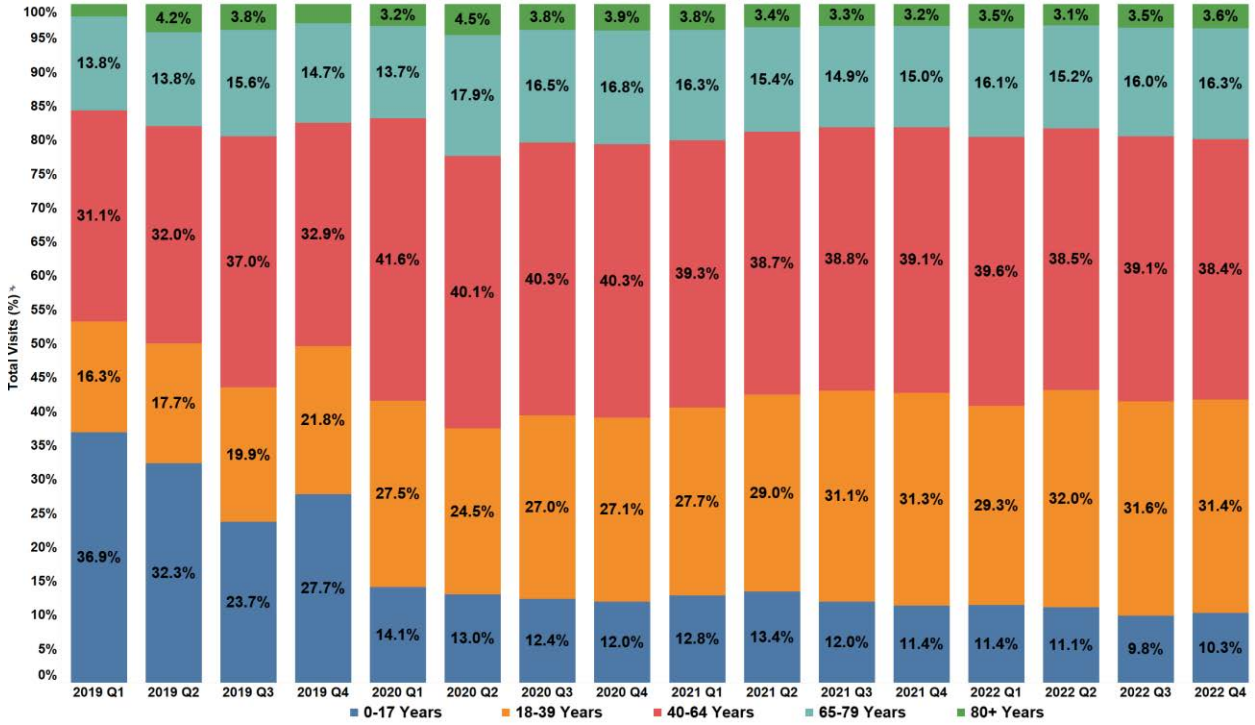


**Figure 10.1. Proportion of Telehealth Visits by Age, January 1, 2019- December 31, 2022**

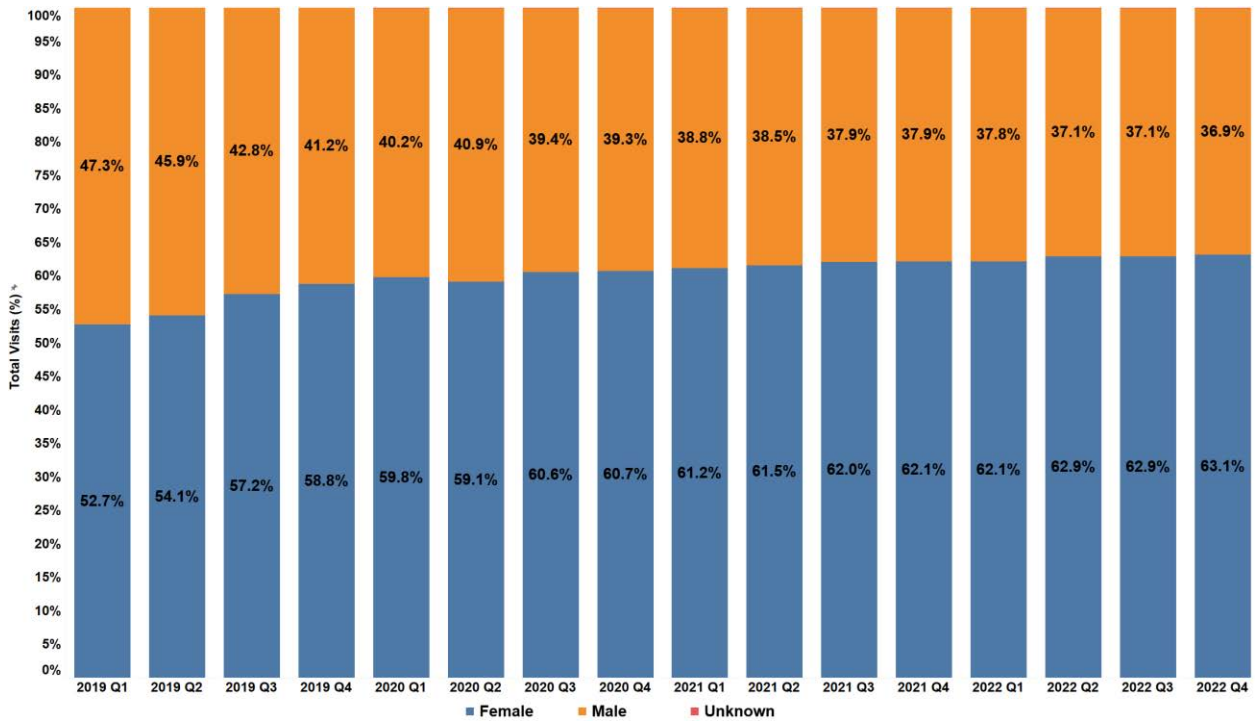

**Figure 10.2. Proportion of Telehealth Visits by Sex, January 1, 2019- December 31, 2022**

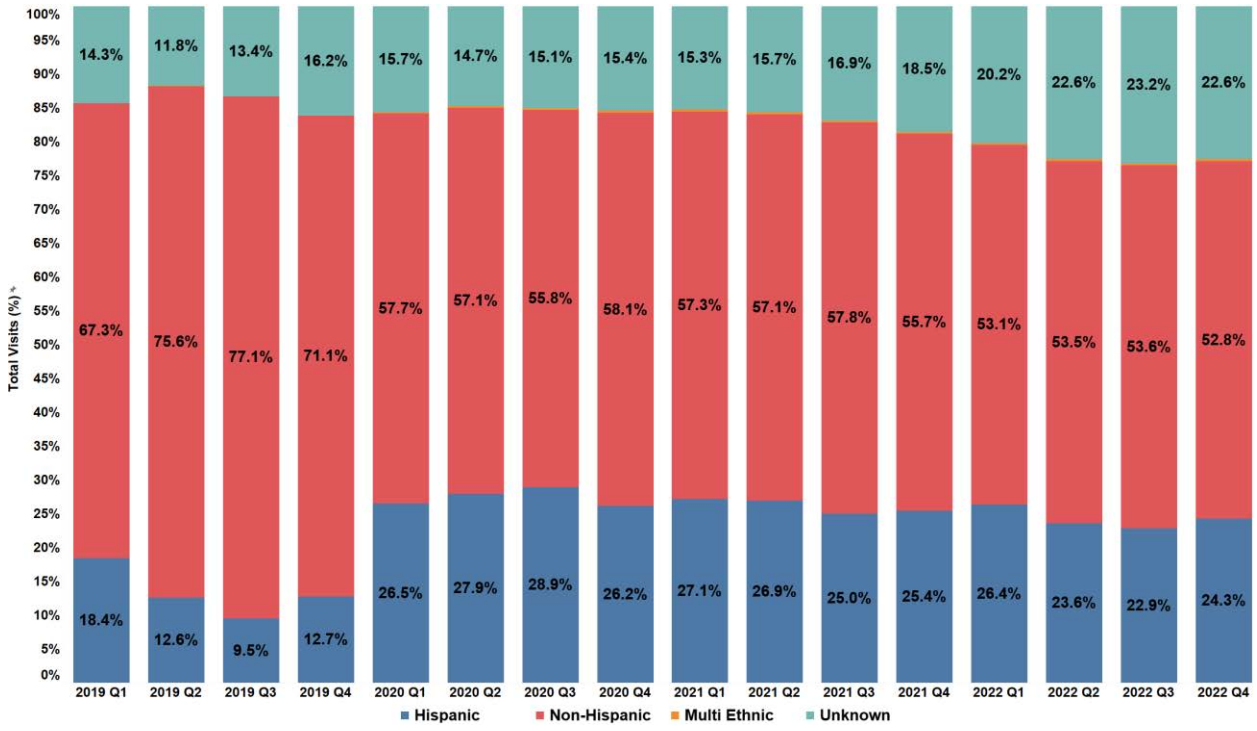


**Figure 10.3. Proportion of Telehealth Visits by Ethnicity, January 1, 2019- December 31, 2022**

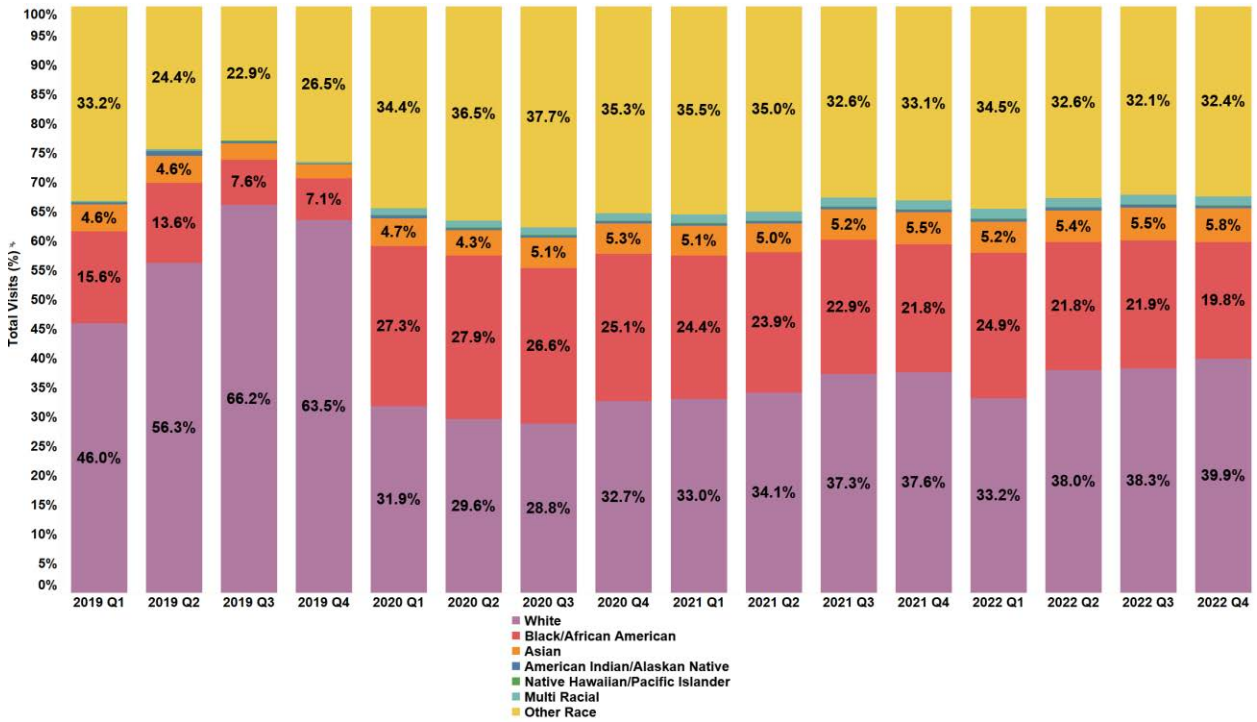


**Figure 10.4. Proportion of Telehealth Visits by Race, January 1, 2019- December 31, 2022**

### *4. Variation Across Reasons for a Visit*

Telehealth visits for Mental/Behavioral Disorders does represent the largest proportion of overall telehealth visits. Telehealth visits for Mental/Behavioral Disorders peaked early in the pandemic and has since declined but at the end of the study period still represents 31% of the total visits for this condition. Adding in those additional telehealth visits begins to close the gap on the number of visits for Mental/Behavioral Disorders but visits for this condition remain 6% below pre-pandemic baseline levels. Future work is needed to ensure equitable access to care is being met for all conditions.

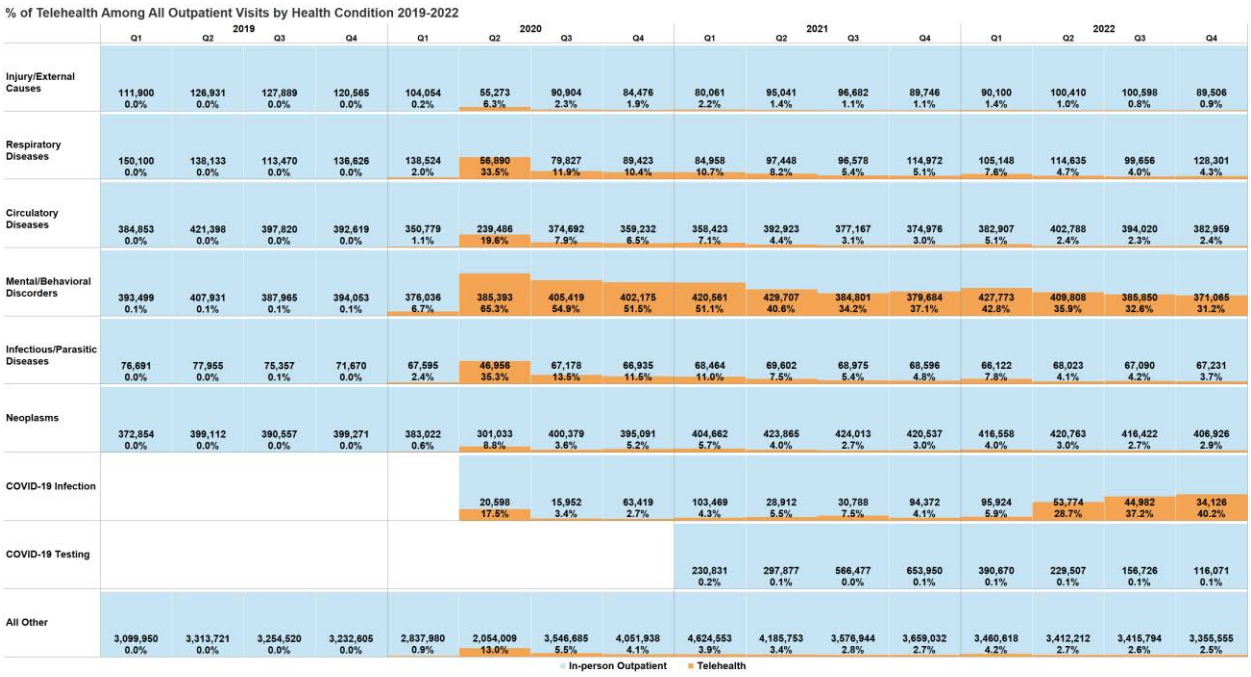


**Figure 11.1. Proportion of Telehealth Visits by Major Condition, January 1, 2019- December 31, 2022**

# Future Recommendations

While ambulatory services have appeared to return to pre-pandemic levels, it should be noted that may not be considered the optimal state. New York is committed to health equity, which means achieving the highest level of health for all people and shall entail focused efforts to address avoidable inequalities by equalizing conditions for health for those who have experienced injustices, socioeconomic disadvantages, and systemic disadvantages. One such effort includes the establishment of a Health Equity Impact Assessment (HEIA) to be filed with a Certificate of Need (CON) application as established by New York State legislation S1451A/A191 requiring information on whether a proposed project impacts the delivery of or access to services for the service area, particularly medically underserved groups.

The shift in the COVID-19 response activities to the ambulatory outpatient settings is another area that should be explored further. This finding appears to be unique to New York State and not seen in national trends. While shifting the response of COVID-19 out of the inpatient setting was important, the long-term impact of the disruption of in-person outpatient visits, which would include a delay in services like cancer screening, immunizations, and other care processes not able to be covered during a telehealth visit is an area for further exploration.

While telehealth proved to be critical early in the pandemic, future work in this area should focus on the availability and access of telehealth after the end of the public health emergency and more broadly across different settings outside of those included in this report. Especially for conditions like mental and behavioral health traditional in-person mental health visits quickly transitioned to a telehealth model for many patients and continues to be the most frequent telehealth visits condition. Future work should focus on whether telehealth is being deployed effectively and for those most at need.

Lastly, this report did not cover workforce in the ambulatory care setting. The COVID-19 pandemic put stress on the healthcare workforce such as burnout, exhaustion, and trauma, adding to already existing workforce shortage issues. [37] Health care workforce shortages may have impacted the results shown in this study. While we attempted to mitigate these impacts by only including facilities in both the pre-pandemic period that were also in operation in the post-pandemic period even facilities that remained open may have reduced patient care because of staffing challenges. Future exploration should consider including health care workforce when examining access to health care in the ambulatory care setting.

This legislatively mandated report was charged with examining the impact of the respective entities on the delivery, quality, accessibility, and cost of ambulatory health care in this state. This report was focused on health care delivery and cost in ambulatory care settings among article twenty-eight facilities through the end of calendar year 2022. While it has been shown that many visit trends (e.g., emergency department and in-person office visits) have largely returned to their pre-pandemic baseline these results are interim and only cover the delivery of services. Reported facility cost data show substantive increases in costs over time, but the cause is multifactorial and cannot be limited to COVID-19. The impact of COVID-19 on the quality and accessibility of ambulatory health care services requires both additional data collection, analysis, and more time to determine if these trends will continue.

[37] Impact of the COVID-19 pandemic on the hospital and outpatient clinician workforce: challenges and policy responses (Issue Brief No. HP-2022-13). Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. May 2022.
https://aspe.hhs.gov/sites/default/files/documents/9cc72124abd9ea25d58a22c7692dccb6/aspe-covid-workforce-report.pdf

# APPENDIX

## Methodology



## Emergency Department



## Outpatient

## Telehealth

# Methodology

**Table 1.1.a. List of ICD-10-CM Diagnosis Chapters and the Corresponding 3-Character Clinical Classifications Software Refined Classifications Abbreviation for the Body System, v2022.1**

| ICD-10-CM Diagnosis Chapter | 3-Character Abbreviation | Study Categories |
|---|---|---|
| Certain Infectious and Parasitic Diseases | INF | Certain Infectious and Parasitic Diseases |
| Neoplasms | NEO | Neoplasms |
| Diseases of the Blood and Blood Forming Organs and Certain Disorders Involving the Immune Mechanism | BLD | All Other |
| Endocrine, Nutritional and Metabolic Diseases | END | All Other |
| Mental, Behavioral and Neurodevelopmental Disorders | MBD | Mental, Behavioral and Neurodevelopmental Disorders |
| Diseases of the Nervous System | NVS | All Other |
| Diseases of the Eye and Adnexa | EYE | All Other |
| Diseases of the Ear and Mastoid Process | EAR | All Other |
| Diseases of the Circulatory System | CIR | Diseases of the Circulatory System |
| Diseases of the Respiratory System | RSP | Diseases of the Respiratory System |
| Diseases of the Digestive System | DIG | All Other |
| Diseases of the Skin and Subcutaneous Tissue | SKN | All Other |
| Diseases of the Musculoskeletal System and Connective Tissue | MUS | All Other |
| Diseases of the Genitourinary System | GEN | All Other |
| Pregnancy, Childbirth and the Puerperium | PRG | All Other |
| Certain Conditions Originating in the Perinatal Period | PNL | All Other |
| Congenital Malformations, Deformations and Chromosomal Abnormalities | MAL | All Other |
| Symptoms, Signs and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified | SYM | All Other |
| Injury, Poisoning and Certain Other Consequences of External Causes | INJ | Injury and External Causes |
| External Causes of Morbidity | EXT | Injury and External Causes |
| Factors Influencing Health Status and Contact with Health Services | FAC | All Other |
| Unacceptable principal diagnosis (inpatient data) or first-listed diagnosis (outpatient data) | XXX | All Other |
| COVID-19 Infection | From INF | COVID-19 Infection |
| COVID-19 Testing | From FAC | COVID-19 Testing |

**Table 1.1.b. Total Number of Faculties Included in this Report, and Number of Facilities Removed by County and Region**

| Facility Region | Facility County | Number of Facilities Included | | | Facility Removed (Reporting Issue) | | |
|---|---|---|---|---|---|---|---|
| | | ED | Outpatient | Tele-health | ED | Outpatient | Tele-health |
| **Statewide Total** | | **232** | **297** | **195** | **4** | **6** | **4** |
| Capital Region | Albany | 2 | 3 | 2 | 2 | 2 | 2 |
| | Columbia | 1 | 1 | 1 | | | |
| | Saratoga | 2 | 1 | 2 | | 2 | |
| | Schenectady | 2 | 3 | 1 | 1 | | 1 |
| | Rensselaer | 0 | 4 | 0 | | 1 | |
| | Warren | 1 | 1 | 1 | | | |
| | **Total** | **8** | **13** | **7** | **3** | 5 | 3 |
| Central NY | Cayuga | 1 | 1 | 1 | | | |
| | Cortland | 1 | 1 | 1 | | | |
| | Madison | 2 | 2 | 2 | | | |
| | Onondaga | 7 | 10 | 5 | | | |
| | Oswego | 1 | 2 | 2 | | | |
| | **Total** | **12** | **16** | **11** | | | |
| Finger Lakes | Genesee | 2 | 2 | 2 | | | |
| | Livingston | 1 | 1 | 1 | | | |
| | Monroe | 7 | 7 | 7 | | | |
| | Ontario | 4 | 4 | 3 | | | |
| | Orleans | 1 | 1 | 1 | | | |
| | Wayne | 1 | 1 | 1 | | | |
| | Wyoming | 1 | 1 | 1 | | | |
| | Yates | 1 | 1 | 16 | | | |
| | **Total** | **18** | **18** | **16** | | | |
| Long Island | Nassau | 14 | 16 | 10 | | | |
| | Suffolk | 11 | 16 | 7 | | | |
| | **Total** | **25** | **32** | **17** | | | |
| Mid-Hudson | Dutchess | 4 | 5 | 3 | | | |
| | Orange | 6 | 7 | 2 | | | |
| | Putnam | 1 | 1 | 1 | | | |
| | Rockland | 2 | 3 | 3 | | | |
| | Sullivan | 2 | 2 | 1 | | | |
| | Ulster | 3 | 3 | 2 | | | |
| | Westchester | 13 | 18 | 13 | | | |
| | **Total** | **31** | **39** | **25** | | | |
| Mohawk Valley | Fulton | 2 | 2 | 1 | | | |

| Facility Region | Facility County | Number of Facilities Included | | | Facility Removed (Reporting Issue) | | |
|---|---|---|---|---|---|---|---|
| | | ED | Outpatient | Tele-health | ED | Outpatient | Tele-health |
| | Herkimer | 1 | 2 | 2 | | | |
| | Montgomery | 2 | 2 | 2 | | | |
| | Oneida | 4 | 6 | 4 | | | |
| | Otsego | 3 | 3 | 3 | | | |
| | Schoharie | 2 | 2 | 1 | | | |
| | **Total** | **14** | **17** | **13** | | | |
| New York City | Bronx | 11 | 14 | 11 | | | |
| | Kings | 16 | 23 | 13 | | | |
| | New York | 25 | 37 | 23 | | | |
| | Queens | 10 | 15 | 10 | | | |
| | Richmond | 3 | 4 | 3 | | | |
| | **Total** | **65** | **93** | **60** | | | |
| North Country | Clinton | 2 | 2 | 1 | | | |
| | Essex | 3 | 3 | 3 | | | |
| | Franklin | 1 | 1 | 1 | 1 | 1 | 1 |
| | Jefferson | 3 | 3 | 3 | | | |
| | Lewis | 1 | 1 | 1 | | | |
| | Saint Lawrence | 5 | 5 | 4 | | | |
| | **Total** | **15** | **15** | **13** | **1** | **1** | **1** |
| Southern Tier | Broome | 4 | 4 | 3 | | | |
| | Chemung | 3 | 3 | 2 | | | |
| | Chenango | 1 | 1 | 3 | | | |
| | Delaware | 4 | 4 | 1 | | | |
| | Schuyler | 1 | 1 | 2 | | | |
| | Steuben | 3 | 3 | 3 | | | |
| | Tompkins | 2 | 3 | | | | |
| | **Total** | **18** | **19** | **14** | | | |
| Western NY | Allegany | 3 | 3 | 2 | | | |
| | Cattaraugus | 1 | 1 | 1 | | | |
| | Chautauqua | 6 | 6 | 4 | | | |
| | Erie | 11 | 19 | 9 | | | |
| | Niagara | 5 | 6 | 3 | | | |
| | **Total** | **26** | **35** | **19** | | | |

# Emergency Department

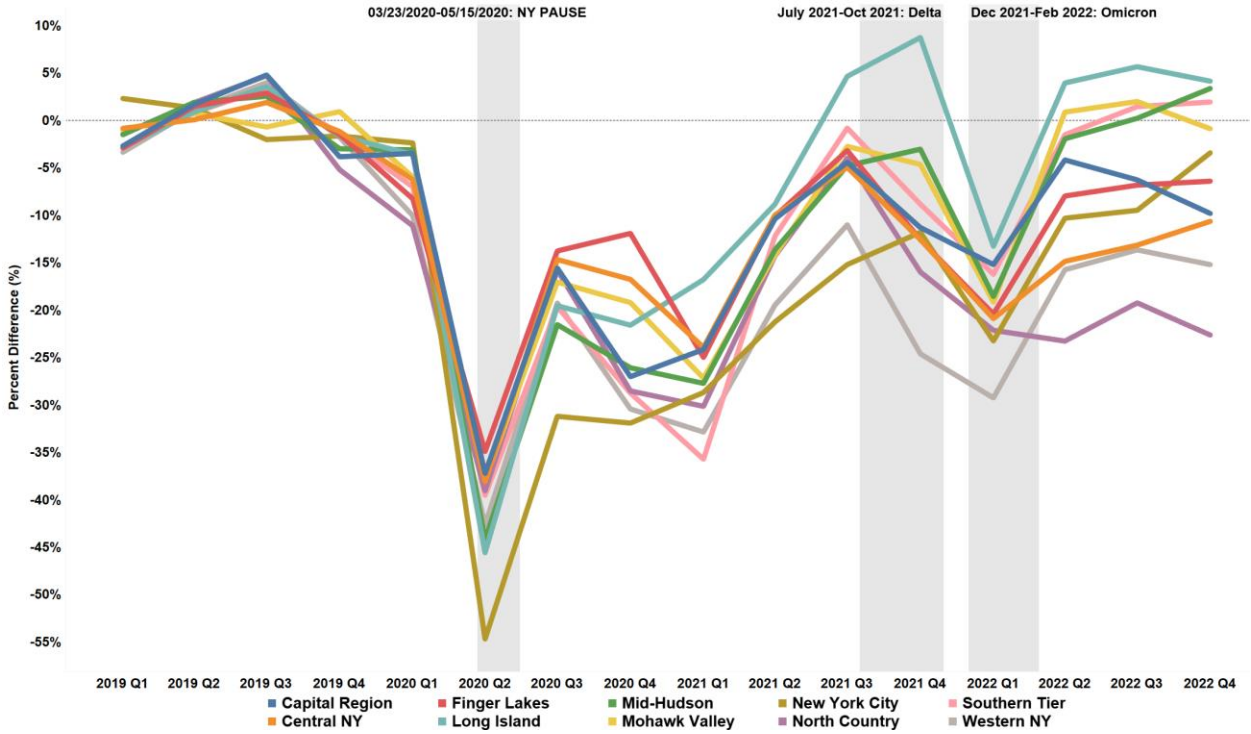


**Figure 1.2.a. Emergency Department Visits Volume Change by Region, January 1, 2019-December 31, 2022**

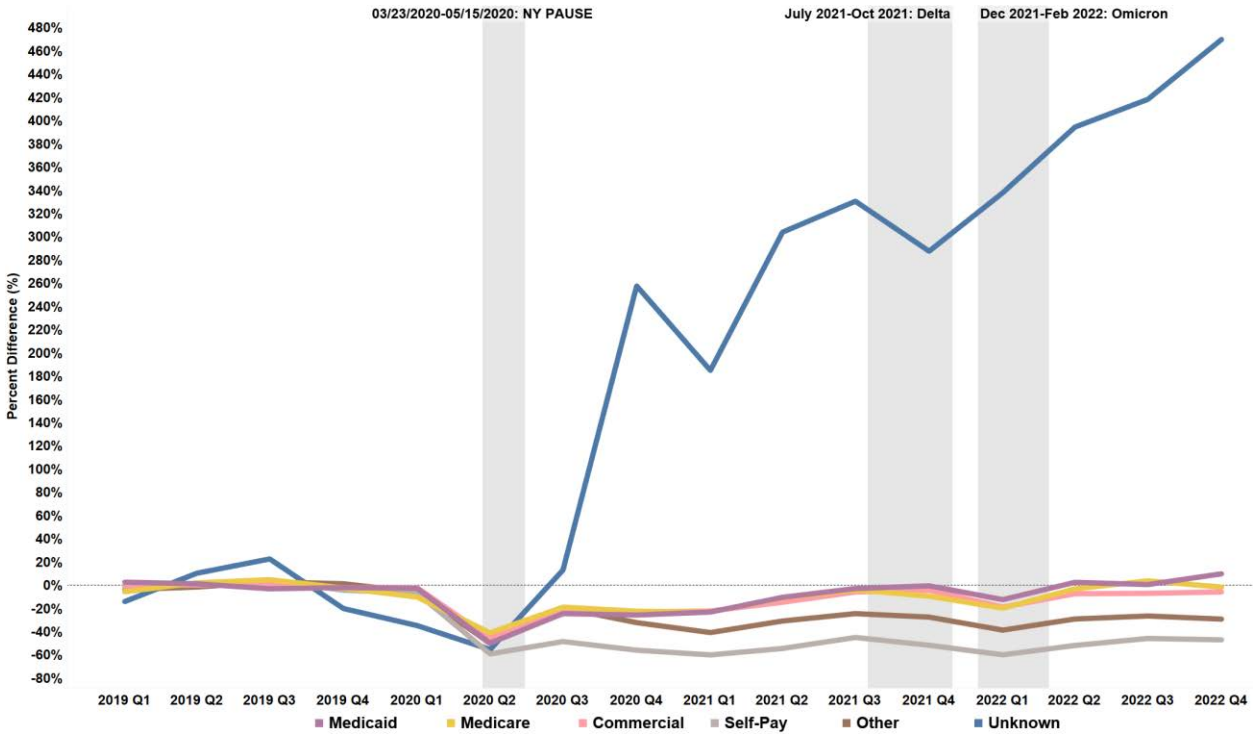


**Figure 2.1.a. Emergency Department Visits Volume Change by Type of Insurance, January 1, 2019- December 31, 2022**

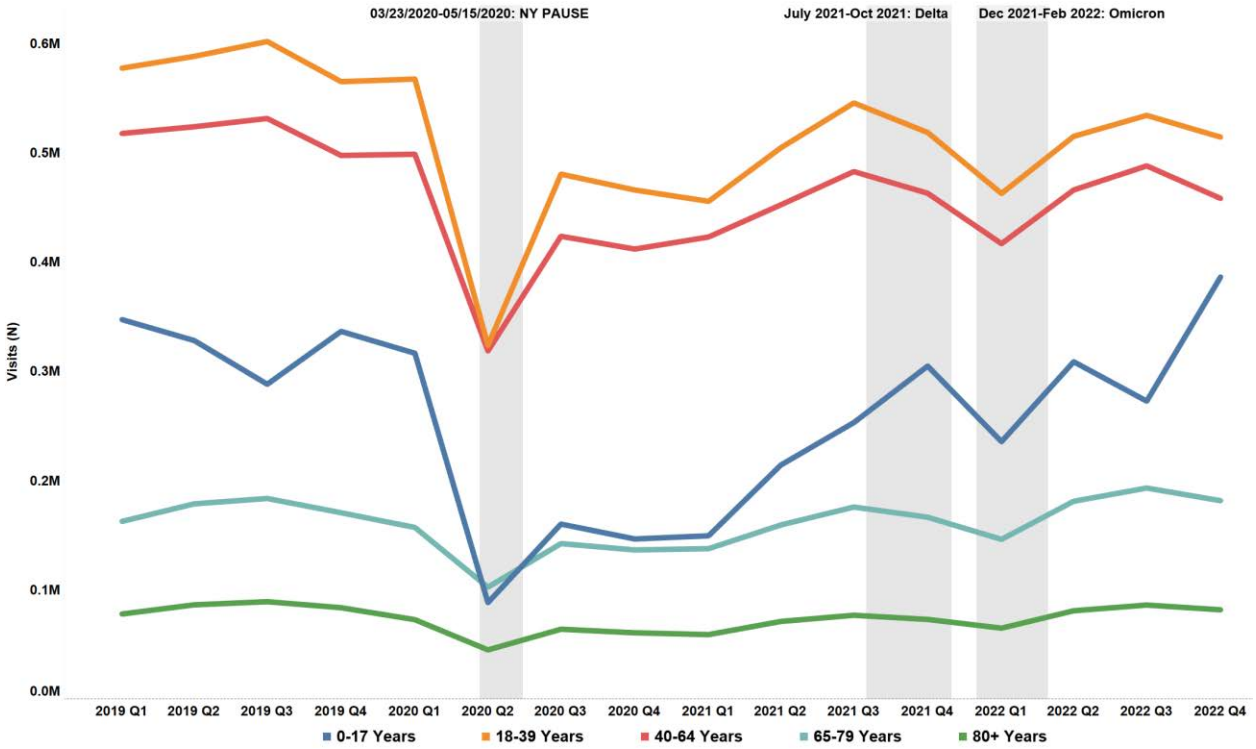


**Figure 3.1.A Quarterly Number of Emergency Department Visits by Age, January 1, 2019- December 31, 2022**

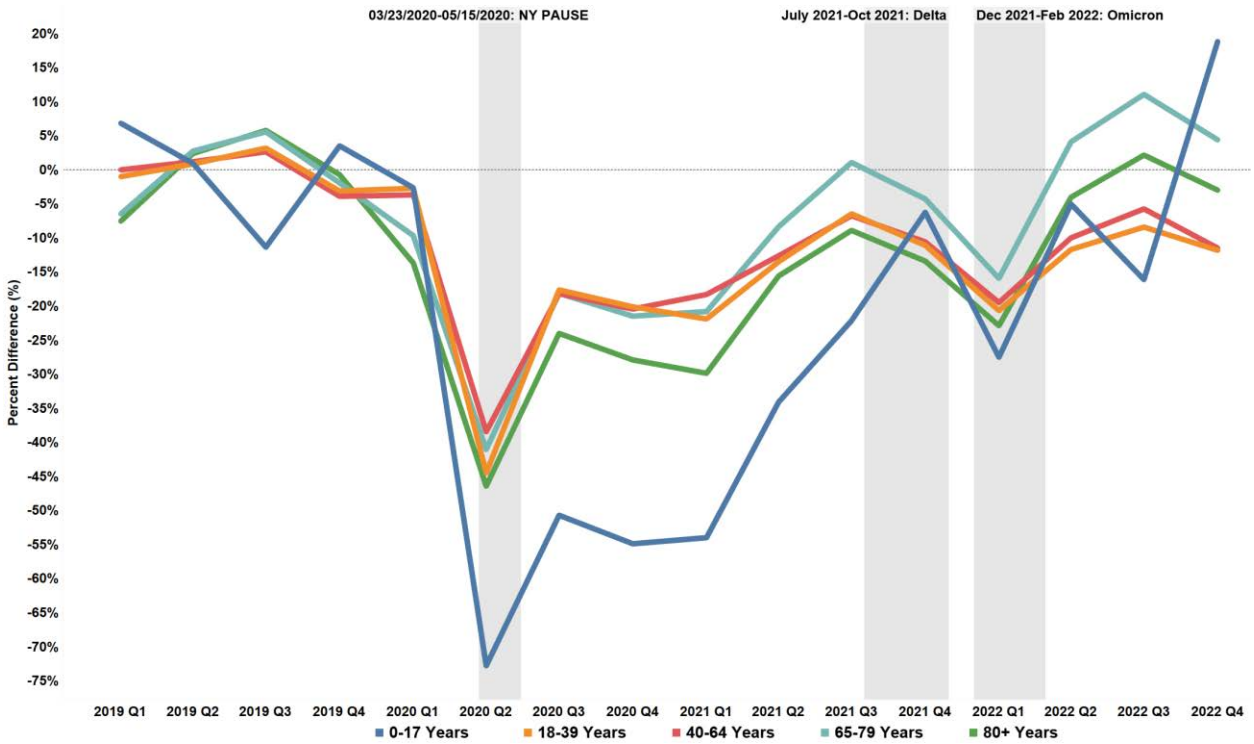


**Figure 3.1.b Emergency Department Visits Volume Change by Age, January 1, 2019-December 31, 2022**

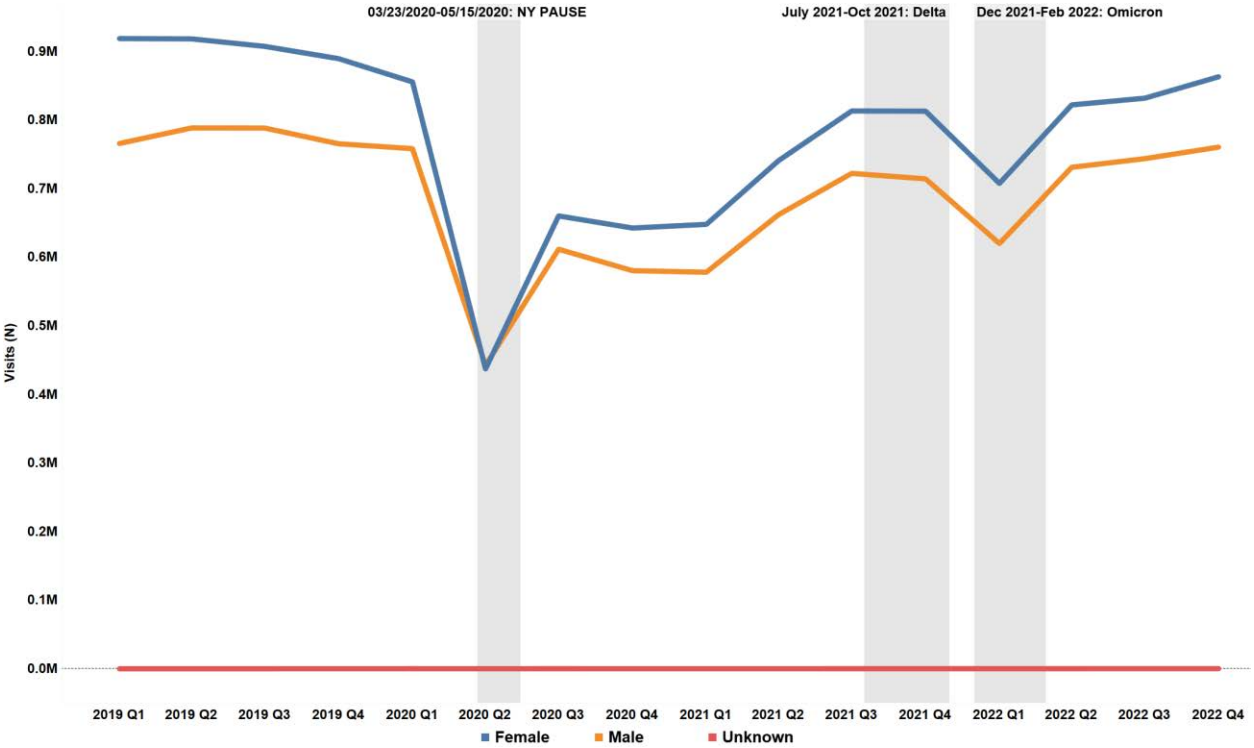


**Figure 3.2.a. Quarterly Number of Emergency Department Visits by Sex January 1, 2019- December 31, 2022**

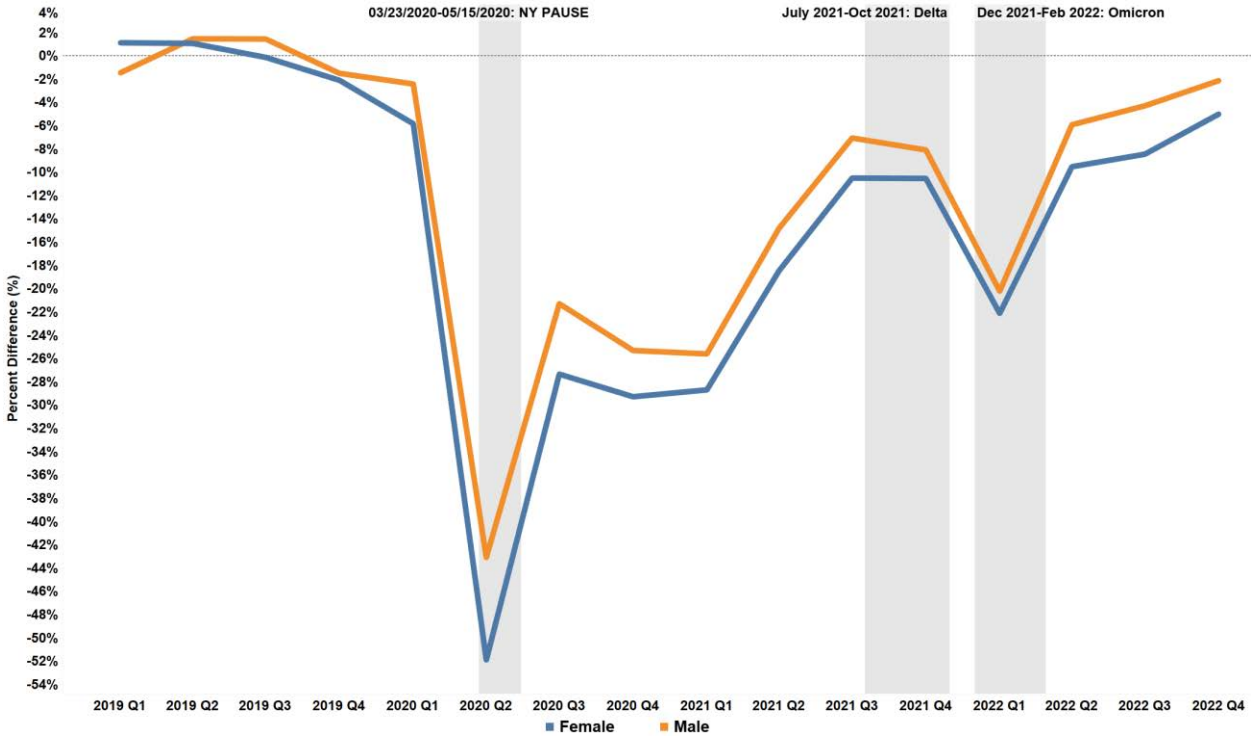


**Figure 3.2.b. Emergency Department Visits Volume Change by Sex, January 1, 2019-December 31, 2022**

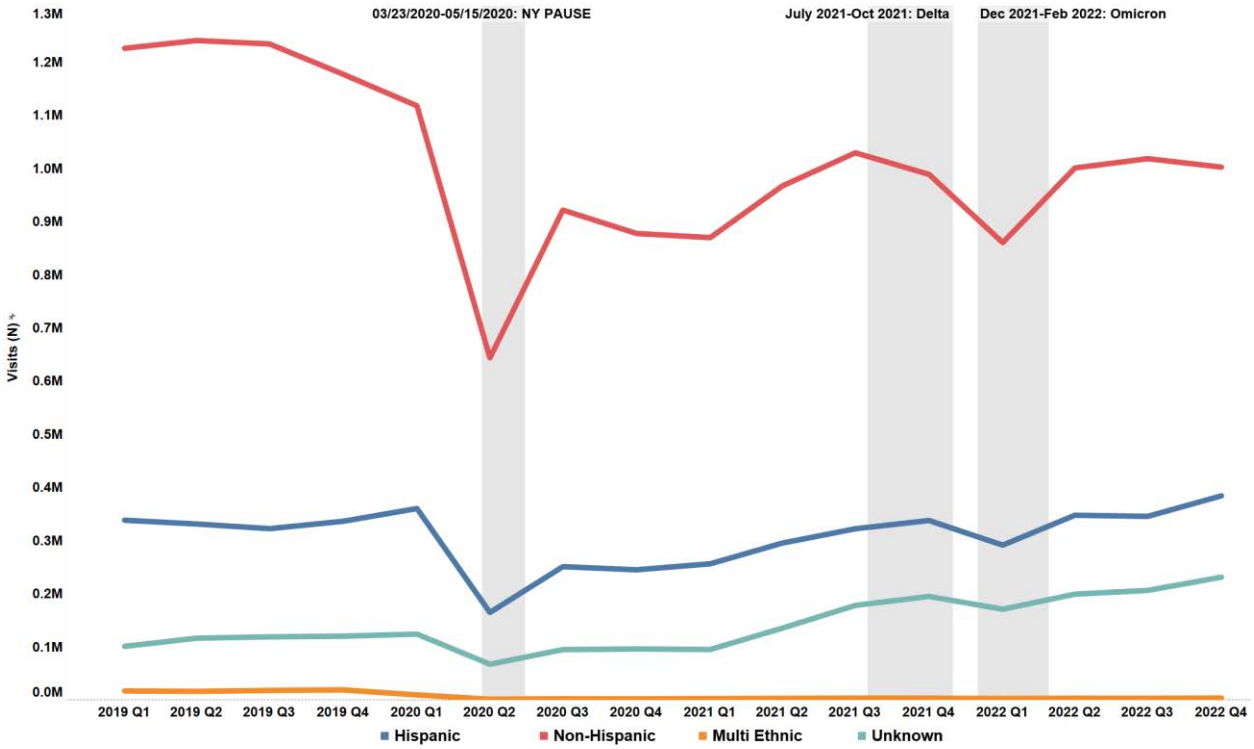


**Figure 3.3.a. Quarterly Number of Emergency Department Visits by Ethnicity January 1, 2019- December 31, 2022**

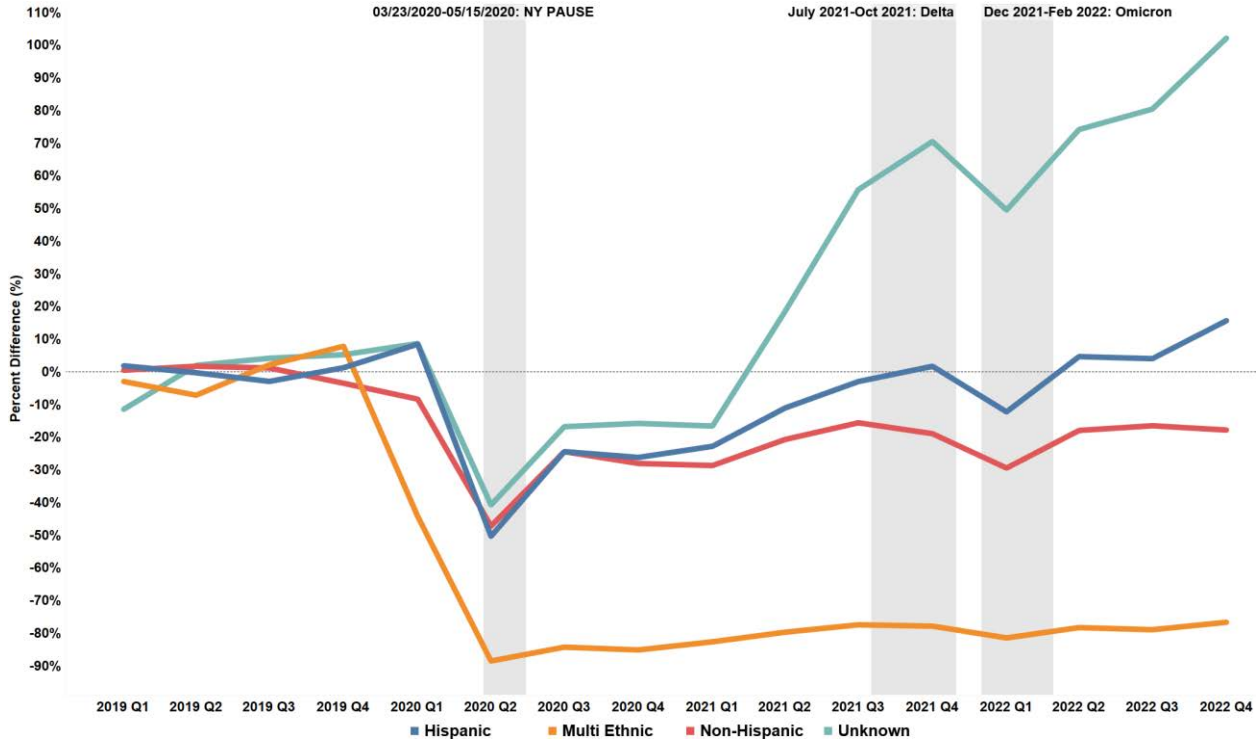


**Figure 3.3.b. Emergency Department Visits Volume Change by Ethnicity, January 1, 2019-December 31, 2022**

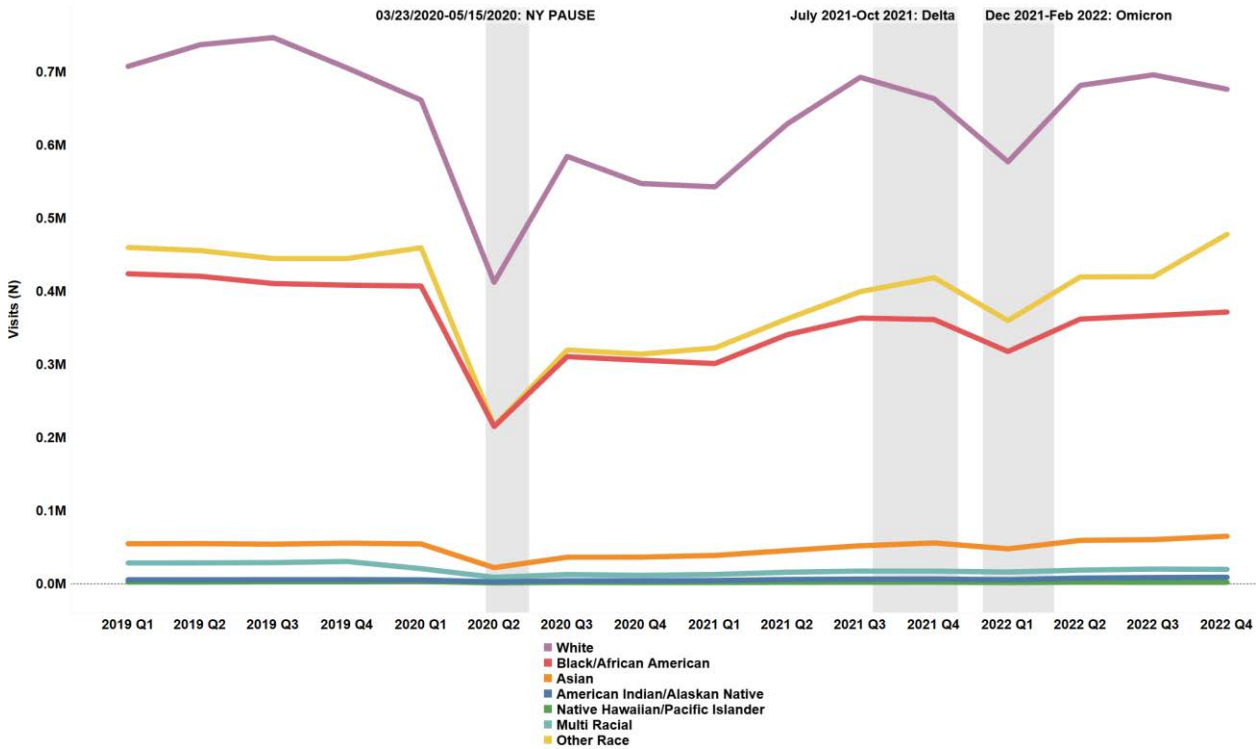


**Figure 3.4.a. Quarterly Number of Emergency Department Visits by Race, January 1, 2019- December 31, 2022**

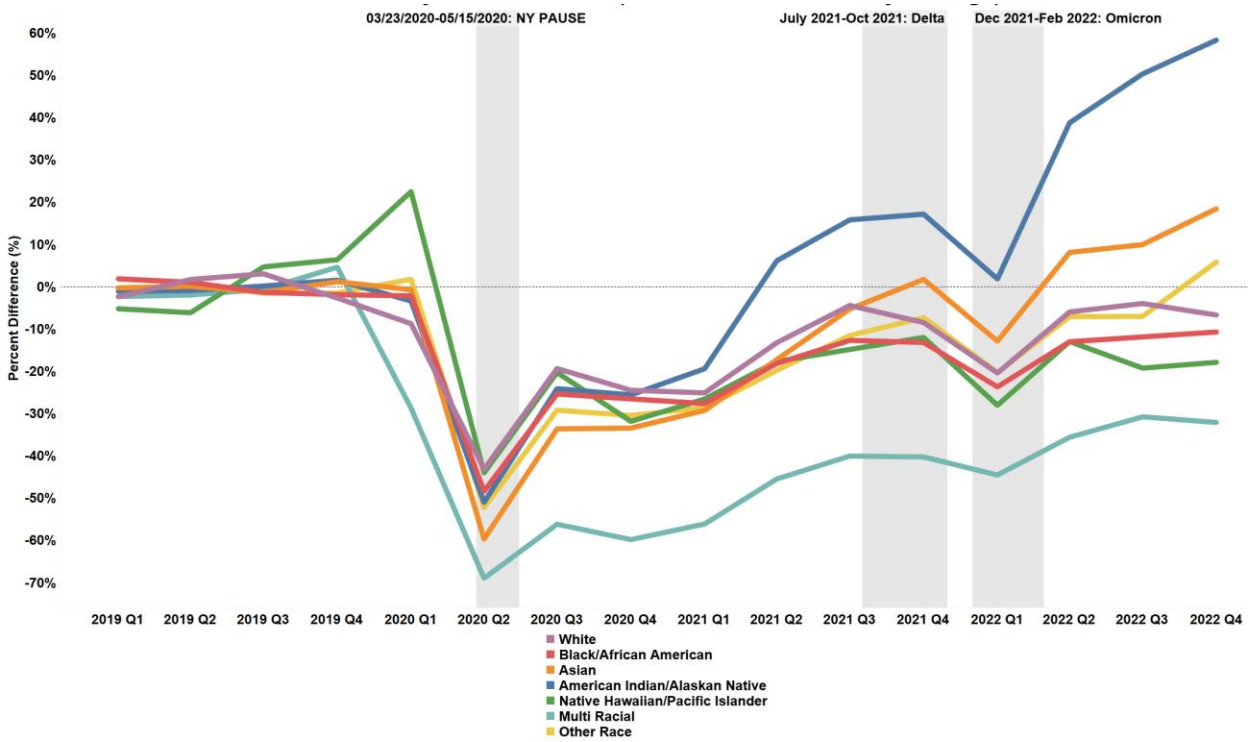


**Figure 3.4.b. Emergency Department Visits Volume Change by Race, January 1, 2019-December 31, 2022**

| | | 2019 | | | | 2020 | | | | 2021 | | | | 2022 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 |
| SYM006 | Abdominal pain and other digestive/abdomen signs and symptoms | 89,280 | 89,847 | 89,271 | 84,359 | 78,950 | 42,844 | 69,362 | 62,024 | 62,704 | 76,214 | 82,368 | 74,996 | 73,163 | 81,781 | 84,017 | 78,785 |
| MUS010 | Musculoskeletal pain, not low back pain | 74,406 | 81,725 | 82,196 | 74,913 | 61,959 | 32,695 | 57,393 | 54,054 | 53,252 | 69,779 | 72,053 | 65,921 | 61,371 | 74,279 | 76,488 | 69,327 |
| CIR012 | Nonspecific chest pain | 74,958 | 71,454 | 71,333 | 71,990 | 69,527 | 46,391 | 56,728 | 56,268 | 60,811 | 65,680 | 66,707 | 63,770 | 66,329 | 66,005 | 68,194 | 66,692 |
| INJ017 | Superficial injury; contusion, initial encounter | 53,456 | 71,668 | 72,562 | 58,319 | 43,907 | 29,703 | 49,648 | 39,262 | 35,328 | 52,734 | 55,916 | 45,176 | 40,189 | 55,166 | 57,230 | 46,135 |
| RSP006 | Other specified upper respiratory infections | 81,274 | 63,905 | 46,971 | 77,989 | 95,299 | 12,586 | 18,260 | 22,421 | 17,844 | 26,842 | 44,309 | 67,724 | 33,605 | 51,784 | 41,100 | 86,333 |
| SYM013 | Respiratory signs and symptoms | 45,362 | 40,860 | 35,695 | 46,385 | 63,436 | 30,216 | 25,914 | 30,971 | 31,125 | 34,991 | 37,715 | 45,276 | 35,081 | 42,024 | 35,217 | 54,537 |
| INJ024 | Sprains and strains, initial encounter | 43,290 | 48,397 | 48,922 | 42,800 | 33,296 | 16,855 | 30,742 | 25,515 | 24,599 | 33,201 | 34,836 | 30,534 | 27,609 | 33,480 | 32,718 | 29,600 |
| INF012 | COVID-19 | | | | | | 22,035 | 4,773 | 35,421 | 62,272 | 21,071 | 37,819 | 103,984 | 68,821 | 54,128 | 58,201 | 52,995 |
| NVS010 | Headache; including migraine | 38,869 | 40,247 | 41,458 | 38,366 | 34,364 | 16,171 | 27,341 | 26,594 | 27,323 | 31,309 | 33,224 | 31,600 | 29,076 | 32,209 | 34,489 | 32,561 |
| INJ012 | Open wounds to limbs, initial encounter | 26,866 | 38,064 | 43,488 | 31,250 | 24,284 | 24,681 | 37,285 | 27,091 | 23,013 | 33,745 | 37,622 | 27,882 | 22,752 | 33,518 | 37,846 | 26,894 |
| MBD017 | Alcohol-related disorders | 33,418 | 36,816 | 36,529 | 33,367 | 32,387 | 25,426 | 29,141 | 26,749 | 27,811 | 29,925 | 28,264 | 24,654 | 23,978 | 28,041 | 27,568 | 24,809 |
| GEN004 | Urinary tract infections | 30,888 | 33,642 | 37,502 | 31,966 | 26,905 | 14,834 | 26,084 | 23,161 | 21,245 | 25,764 | 31,070 | 27,784 | 23,807 | 28,353 | 32,549 | 29,433 |
| PRG028 | Other specified complications in pregnancy | 32,090 | 30,830 | 31,083 | 30,682 | 29,816 | 15,560 | 22,889 | 22,210 | 23,444 | 26,190 | 26,742 | 26,380 | 25,112 | 27,918 | 28,237 | 28,440 |
| INF008 | Viral infection | 35,532 | 25,035 | 21,127 | 30,443 | 57,623 | 14,018 | 10,593 | 13,666 | 12,541 | 16,133 | 24,112 | 33,261 | 19,960 | 31,416 | 28,223 | 49,662 |
| SKN001 | Skin and subcutaneous tissue infections | 25,617 | 30,977 | 37,597 | 28,893 | 22,787 | 14,703 | 25,388 | 20,320 | 18,195 | 24,226 | 29,630 | 23,171 | 19,127 | 24,645 | 29,158 | 23,425 |
| FAC016 | Exposure, encounters, screening or contact with infectious disease | 4,826 | 5,496 | 7,968 | 5,213 | 13,336 | 24,026 | 46,736 | 66,742 | 65,651 | 29,973 | 35,601 | 38,764 | 17,953 | 11,820 | 11,853 | 9,034 |
| INJ027 | Other unspecified injury | 25,476 | 28,249 | 28,762 | 27,073 | 21,528 | 12,297 | 20,785 | 19,243 | 18,744 | 23,614 | 25,304 | 23,996 | 25,000 | 28,649 | 28,758 | 26,513 |
| INJ011 | Open wounds of head and neck, initial encounter | 24,002 | 29,238 | 30,398 | 26,662 | 22,196 | 17,184 | 24,569 | 20,985 | 18,884 | 24,254 | 25,726 | 22,878 | 20,652 | 25,419 | 26,714 | 23,237 |
| MUS038 | Low back pain | 27,810 | 28,711 | 28,269 | 26,974 | 21,542 | 9,905 | 18,401 | 17,931 | 17,479 | 21,005 | 22,667 | 20,111 | 19,034 | 21,807 | 22,646 | 21,036 |
| SYM004 | Nausea and vomiting | 30,087 | 22,695 | 18,861 | 24,148 | 26,381 | 10,370 | 15,205 | 14,309 | 15,470 | 21,124 | 21,555 | 22,350 | 26,036 | 25,206 | 21,055 | 23,217 |
| MUS011 | Spondylopathies/spondyloarthropathy (including infective) | 24,218 | 26,350 | 27,123 | 24,914 | 19,749 | 10,253 | 18,589 | 17,369 | 16,470 | 21,363 | 22,860 | 20,066 | 18,425 | 21,991 | 23,928 | 21,507 |
| RSP009 | Asthma | 28,963 | 29,976 | 23,936 | 32,566 | 26,885 | 8,351 | 11,310 | 14,104 | 12,232 | 17,620 | 15,463 | 21,379 | 15,849 | 20,974 | 18,076 | 25,623 |
| DIG002 | Disorders of teeth and gingiva | 20,251 | 21,333 | 21,019 | 20,685 | 17,874 | 11,713 | 17,289 | 17,269 | 16,543 | 19,019 | 19,156 | 18,146 | 16,950 | 19,688 | 20,719 | 19,365 |
| SYM015 | General sensation/perception signs and symptoms | 19,053 | 21,363 | 22,466 | 19,325 | 17,395 | 9,510 | 15,729 | 14,383 | 14,664 | 18,409 | 19,572 | 16,673 | 15,616 | 19,212 | 21,138 | 18,098 |
| INJ004 | Fracture of the upper limb, initial encounter | 16,777 | 20,966 | 21,832 | 17,487 | 13,916 | 11,657 | 18,197 | 13,802 | 13,549 | 18,669 | 19,632 | 16,412 | 15,183 | 19,628 | 19,997 | 16,289 |
| SYM014 | Skin/Subcutaneous signs and symptoms | 16,138 | 19,512 | 21,141 | 16,494 | 13,643 | 8,402 | 13,718 | 11,521 | 11,855 | 15,489 | 17,698 | 13,831 | 12,594 | 16,613 | 21,381 | 15,794 |
| SYM002 | Fever | 16,010 | 15,443 | 15,484 | 14,580 | 24,508 | 8,970 | 10,197 | 8,792 | 8,703 | 12,274 | 15,833 | 14,700 | 9,651 | 15,620 | 15,423 | 19,941 |
| RSP003 | Influenza | 41,154 | 5,155 | 374 | 17,972 | 65,046 | 179 | 59 | 252 | 180 | 159 | 171 | 4,077 | 3,753 | 13,860 | 881 | 54,284 |

**Figure 4.1.a. Quarterly Number of Emergency Department Visits by Primary Diagnosis January 1, 2019-December 31, 2022**

| | | 2019Q1 | 2019Q2 | 2019Q3 | 2019Q4 | 2020Q1 | 2020Q2 | 2020Q3 | 2020Q4 | 2021Q1 | 2021Q2 | 2021Q3 | 2021Q4 | 2022Q1 | 2022Q2 | 2022Q3 | 2022Q4 | Overall |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| SYM006 | Abdominal pain and other digestive/abdomen signs and symptoms | 1 | 1 | 1 | 1 | 2 | 2 | 1 | 2 | 2 | 1 | 1 | 2 | 1 | 1 | 1 | 2 | 1 |
| MUS010 | Musculoskeletal pain, not low back pain | 4 | 2 | 2 | 3 | 6 | 3 | 2 | 4 | 5 | 2 | 2 | 4 | 4 | 2 | 2 | 3 | 2 |
| CIR012 | Nonspecific chest pain | 3 | 4 | 4 | 4 | 3 | 1 | 3 | 3 | 4 | 3 | 3 | 5 | 3 | 3 | 3 | 4 | 3 |
| INJ017 | Superficial injury; contusion, initial encounter | 5 | 3 | 3 | 5 | 8 | 5 | 4 | 5 | 6 | 4 | 4 | 7 | 5 | 4 | 5 | 9 | 4 |
| RSP006 | Other specified upper respiratory infections | 2 | 5 | 6 | 2 | 1 | 17 | 18 | 13 | 17 | 11 | 5 | 3 | 7 | 6 | 6 | 1 | 5 |
| SYM013 | Respiratory signs and symptoms | 6 | 7 | 12 | 6 | 5 | 4 | 11 | 7 | 7 | 5 | 7 | 6 | 6 | 7 | 8 | 5 | 6 |
| INJ024 | Sprains and strains, initial encounter | 7 | 6 | 5 | 7 | 10 | 11 | 7 | 11 | 10 | 7 | 10 | 11 | 9 | 9 | 10 | 11 | 7 |
| INF012 | COVID-19 | | | | | | 9 | 63 | 6 | 3 | 19 | 6 | 1 | 2 | 5 | 4 | 7 | 8 |
| NVS010 | Headache; including migraine | 9 | 8 | 8 | 8 | 9 | 12 | 9 | 10 | 9 | 8 | 11 | 10 | 8 | 10 | 9 | 10 | 9 |
| INJ012 | Open wounds to limbs, initial encounter | 17 | 9 | 7 | 12 | 17 | 7 | 6 | 8 | 12 | 6 | 8 | 12 | 15 | 8 | 7 | 14 | 10 |
| MBD017 | Alcohol-related disorders | 11 | 10 | 11 | 9 | 11 | 6 | 8 | 9 | 8 | 10 | 14 | 15 | 13 | 14 | 16 | 17 | 11 |
| GEN004 | Urinary tract infections | 13 | 11 | 10 | 11 | 13 | 14 | 10 | 12 | 13 | 13 | 12 | 13 | 14 | 13 | 11 | 12 | 12 |
| PRG028 | Other specified complications in pregnancy | 12 | 13 | 13 | 13 | 12 | 13 | 14 | 14 | 11 | 12 | 15 | 14 | 11 | 15 | 14 | 13 | 13 |
| INF008 | Viral infection | 10 | 19 | 22 | 14 | 7 | 16 | 27 | 25 | 25 | 25 | 18 | 9 | 17 | 11 | 15 | 8 | 14 |
| SKN001 | Skin and subcutaneous tissue infections | 18 | 12 | 9 | 15 | 18 | 15 | 12 | 16 | 16 | 15 | 13 | 17 | 18 | 18 | 12 | 18 | 15 |
| FAC016 | Exposure, encounters, screening or contact with infectious disease | 72 | 67 | 56 | 68 | 32 | 8 | 5 | 1 | 1 | 9 | 9 | 8 | 21 | 33 | 31 | 41 | 16 |
| INJ027 | Other unspecified injury | 19 | 17 | 15 | 16 | 21 | 18 | 15 | 17 | 15 | 16 | 17 | 16 | 12 | 12 | 13 | 15 | 17 |
| INJ011 | Open wounds of head and neck, initial encounter | 21 | 15 | 14 | 18 | 19 | 10 | 13 | 15 | 14 | 14 | 16 | 18 | 16 | 16 | 17 | 19 | 18 |
| MUS038 | Low back pain | 16 | 16 | 16 | 17 | 20 | 23 | 17 | 18 | 18 | 20 | 20 | 21 | 19 | 20 | 19 | 22 | 19 |
| SYM004 | Nausea and vomiting | 14 | 20 | 25 | 20 | 15 | 21 | 22 | 22 | 21 | 18 | 21 | 19 | 10 | 17 | 22 | 20 | 20 |
| MUS011 | Spondylopathies/spondyloarthropathy (including infective) | 20 | 18 | 17 | 19 | 22 | 22 | 16 | 19 | 20 | 17 | 19 | 22 | 20 | 19 | 18 | 21 | 21 |
| RSP009 | Asthma | 15 | 14 | 18 | 10 | 14 | 31 | 26 | 23 | 26 | 24 | 28 | 20 | 23 | 21 | 25 | 16 | 22 |
| DIG002 | Disorders of teeth and gingiva | 23 | 22 | 23 | 21 | 24 | 19 | 20 | 20 | 19 | 21 | 24 | 23 | 22 | 22 | 23 | 24 | 23 |
| SYM015 | General sensation/perception signs and symptoms | 24 | 21 | 19 | 22 | 25 | 25 | 21 | 21 | 22 | 23 | 23 | 24 | 24 | 24 | 21 | 26 | 24 |
| INJ004 | Fracture of the upper limb, initial encounter | 28 | 23 | 20 | 27 | 30 | 20 | 19 | 24 | 24 | 22 | 22 | 25 | 26 | 23 | 24 | 29 | 25 |
| SYM014 | Skin/Subcutaneous signs and symptoms | 29 | 24 | 21 | 29 | 31 | 30 | 23 | 28 | 27 | 27 | 25 | 28 | 29 | 26 | 20 | 30 | 27 |
| SYM002 | Fever | 30 | 28 | 26 | 30 | 16 | 26 | 30 | 34 | 34 | 29 | 27 | 27 | 32 | 27 | 27 | 23 | 28 |
| RSP003 | Influenza | 8 | 73 | 218 | 25 | 4 | 222 | 302 | 222 | 236 | 259 | 251 | 79 | 78 | 30 | 169 | 6 | 30 |

**Figure 4.1.b. Quarterly Rank Order of Emergency Department Visits by Primary Diagnosis January 1, 2019-December 31, 2022**

| | | 2019 | | | | 2020 | | | | 2021 | | | | 2022 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 |
| SYM006 | Abdominal pain and other digestive/abdomen signs and symptoms | 1.2% | 1.9% | 1.2% | -4.3% | -10.5% | -51.4% | -21.3% | -29.7% | -28.9% | -13.6% | -6.6% | -15.0% | -17.0% | -7.3% | -4.7% | -10.7% |
| MUS010 | Musculoskeletal pain, not low back pain | -5.0% | 4.4% | 5.0% | -4.3% | -20.9% | -58.2% | -26.7% | -31.0% | -32.0% | -10.9% | -8.0% | -15.8% | -21.6% | -5.1% | -2.3% | -11.5% |
| CIR012 | Nonspecific chest pain | 3.5% | -1.4% | -1.5% | -0.6% | -4.0% | -36.0% | -21.7% | -22.3% | -16.0% | -9.3% | -7.9% | -12.0% | -8.4% | -8.9% | -5.9% | -7.9% |
| INJ017 | Superficial injury; contusion, initial encounter | -16.5% | 12.0% | 13.4% | -8.9% | -31.4% | -53.6% | -22.4% | -38.7% | -44.8% | -17.6% | -12.6% | -29.4% | -37.2% | -13.8% | -10.6% | -27.9% |
| RSP006 | Other specified upper respiratory infections | 20.3% | -5.4% | -30.4% | 15.5% | 41.1% | -81.4% | -73.0% | -66.8% | -73.6% | -60.3% | -34.4% | 0.3% | -50.2% | -23.3% | -39.1% | 27.8% |
| SYM013 | Respiratory signs and symptoms | 7.8% | -2.9% | -15.2% | 10.2% | 50.8% | -28.2% | -38.4% | -26.4% | -26.0% | -16.8% | -10.4% | 7.6% | -16.6% | -0.1% | -16.3% | 29.6% |
| INJ024 | Sprains and strains, initial encounter | -5.6% | 5.5% | 6.7% | -6.7% | -27.4% | -63.2% | -33.0% | -44.4% | -46.4% | -27.6% | -24.0% | -33.4% | -39.8% | -27.0% | -28.6% | -35.4% |
| INF012 | COVID-19 | | | | | | | | | | | | | | | | |
| NVS010 | Headache; including migraine | -2.2% | 1.3% | 4.3% | -3.4% | -13.5% | -59.3% | -31.2% | -33.1% | -31.2% | -21.2% | -16.4% | -20.5% | -26.8% | -18.9% | -13.2% | -18.1% |
| INJ012 | Open wounds to limbs, initial encounter | -23.1% | 9.0% | 24.5% | -10.5% | -30.5% | -29.3% | 6.8% | -22.4% | -34.1% | -3.4% | 7.7% | -20.1% | -34.8% | -4.0% | 8.4% | -23.0% |
| MBD017 | Alcohol-related disorders | -4.6% | 5.1% | 4.3% | -4.8% | -7.6% | -27.4% | -16.8% | -23.6% | -20.6% | -14.6% | -19.3% | -29.6% | -31.6% | -20.0% | -21.3% | -29.2% |
| GEN004 | Urinary tract infections | -7.8% | 0.4% | 11.9% | -4.6% | -19.7% | -55.7% | -22.1% | -30.9% | -36.6% | -23.1% | -7.3% | -17.1% | -28.9% | -15.4% | -2.8% | -12.1% |
| PRG028 | Other specified complications in pregnancy | 2.9% | -1.1% | -0.3% | -1.6% | -4.3% | -50.1% | -26.6% | -28.7% | -24.8% | -16.0% | -14.2% | -15.4% | -19.4% | -10.4% | -9.4% | -8.8% |
| INF008 | Viral infection | 26.7% | -10.7% | -24.6% | 8.6% | 105.5% | -50.0% | -62.2% | -51.3% | -55.3% | -42.5% | -14.0% | 18.6% | -28.8% | 12.1% | 0.7% | 77.1% |
| SKN001 | Skin and subcutaneous tissue infections | -16.7% | 0.7% | 22.2% | -6.1% | -25.9% | -52.2% | -17.5% | -34.0% | -40.9% | -21.3% | -3.7% | -24.7% | -37.8% | -19.9% | -5.2% | -23.9% |
| FAC016 | Exposure, encounters, screening or contact with infectious disease | -17.9% | -6.5% | 35.6% | -11.3% | 127.0% | 308.9% | 695.4% | 1035.9% | 1017.3% | 410.1% | 505.9% | 559.7% | 205.5% | 101.2% | 101.7% | 53.8% |
| INJ027 | Other unspecified injury | -7.0% | 3.1% | 5.0% | -1.2% | -21.4% | -55.1% | -24.1% | -29.7% | -31.6% | -13.8% | -7.6% | -12.4% | -8.7% | 4.6% | 5.0% | -3.2% |
| INJ011 | Open wounds of head and neck, initial encounter | -13.0% | 6.0% | 10.2% | -3.3% | -19.5% | -37.7% | -10.9% | -23.9% | -31.5% | -12.0% | -6.7% | -17.0% | -25.1% | -7.8% | -3.1% | -15.7% |
| MUS038 | Low back pain | -0.5% | 2.8% | 1.2% | -3.5% | -22.9% | -64.6% | -34.1% | -35.8% | -37.4% | -24.8% | -18.9% | -28.0% | -31.9% | -22.0% | -19.0% | -24.7% |
| SYM004 | Nausea and vomiting | 25.6% | -5.2% | -21.2% | 0.8% | 10.2% | -56.7% | -36.5% | -40.2% | -35.4% | -11.8% | -10.0% | -6.7% | 8.7% | 5.3% | -12.1% | -3.1% |
| MUS011 | Spondylopathies/spondyloarthropathy (including infective) | -5.6% | 2.7% | 5.7% | -2.9% | -23.0% | -60.0% | -27.5% | -32.3% | -35.8% | -16.7% | -10.9% | -21.8% | -28.2% | -14.3% | -6.7% | -16.2% |
| RSP009 | Asthma | 0.4% | 3.9% | -17.1% | 12.8% | -6.8% | -71.1% | -60.8% | -51.1% | -57.6% | -38.9% | -46.4% | -25.9% | -45.1% | -27.3% | -37.4% | -11.2% |
| DIG002 | Disorders of teeth and gingiva | -2.7% | 2.5% | 0.9% | -0.7% | -14.2% | -43.7% | -17.0% | -17.1% | -20.6% | -8.7% | -8.0% | -12.9% | -18.6% | -5.4% | -0.5% | -7.0% |
| SYM015 | General sensation/perception signs and symptoms | -7.3% | 3.9% | 9.3% | -6.0% | -15.4% | -53.7% | -23.5% | -30.0% | -28.6% | -10.4% | -4.8% | -18.9% | -24.0% | -6.5% | 2.9% | -11.9% |
| INJ004 | Fracture of the upper limb, initial encounter | -12.9% | 8.8% | 13.3% | -9.2% | -27.8% | -39.5% | -5.5% | -28.4% | -29.7% | -3.1% | 1.9% | -14.8% | -21.2% | 1.9% | 3.8% | -15.4% |
| SYM014 | Skin/Subcutaneous signs and symptoms | -11.9% | 6.5% | 15.4% | -10.0% | -25.5% | -54.1% | -25.1% | -37.1% | -35.3% | -15.5% | -3.4% | -24.5% | -31.3% | -9.3% | 16.7% | -13.8% |
| SYM002 | Fever | 4.1% | 0.4% | 0.7% | -5.2% | 59.4% | -41.7% | -33.7% | -42.8% | -43.4% | -20.2% | 3.0% | -4.4% | -37.2% | 1.6% | 0.3% | 29.7% |
| RSP003 | Influenza | 154.6% | -68.1% | -97.7% | 11.2% | 302.4% | -98.9% | -99.6% | -98.4% | -98.9% | -99.0% | -98.9% | -74.8% | -76.8% | -14.3% | -94.5% | 235.8% |

**Figure 4.1.c. Emergency Department Visits Volume Change by Primary Diagnosis, January 1, 2019-December 31, 2022**

# Outpatient

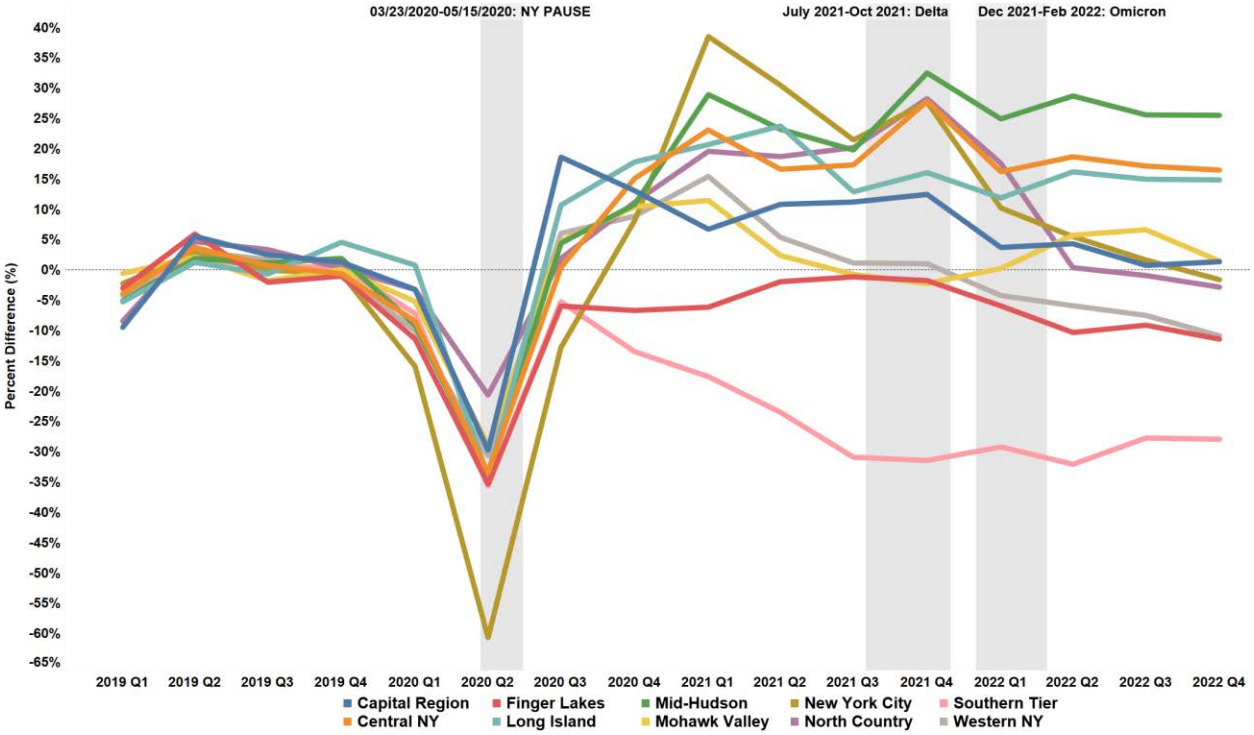


**Figure 5.2.a. Outpatient Visits Volume Change by Region, January 1, 2019-December 31, 2022**

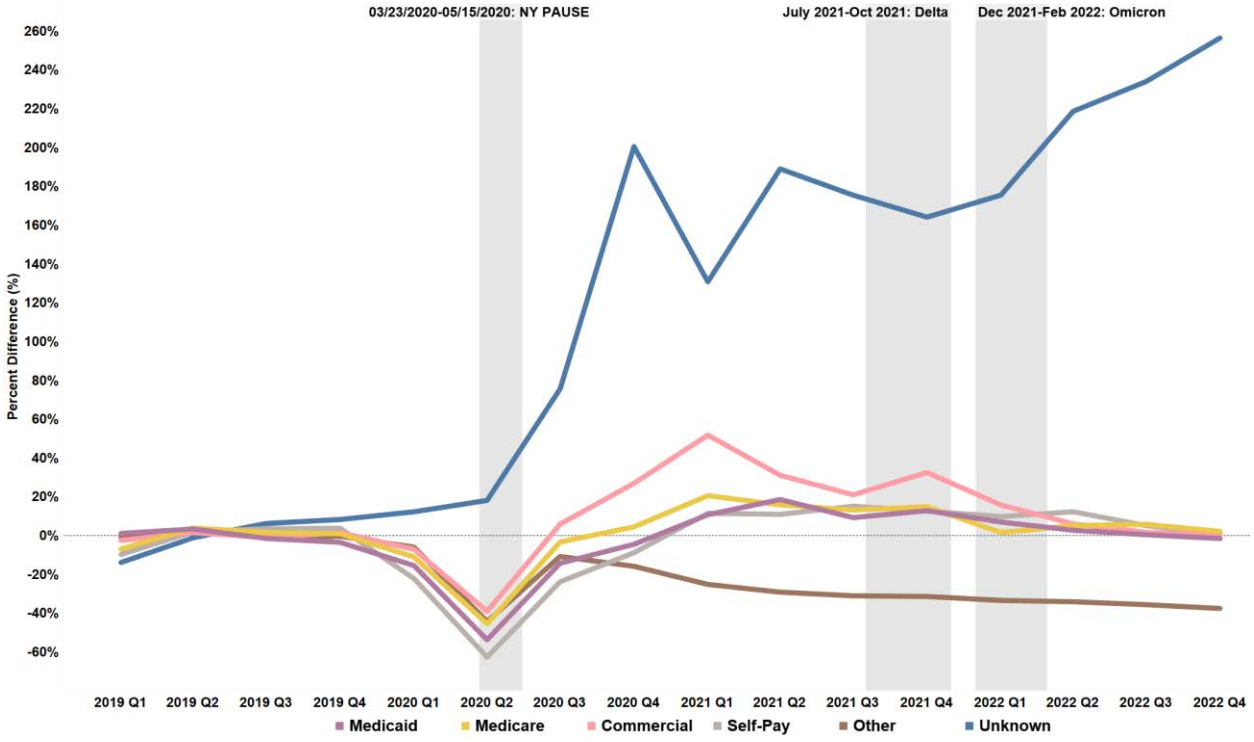


**Figure 6.1.a. Outpatient In-Person Visits Volume Change by Type of Insurance, January 1, 2019-December 31, 2022**

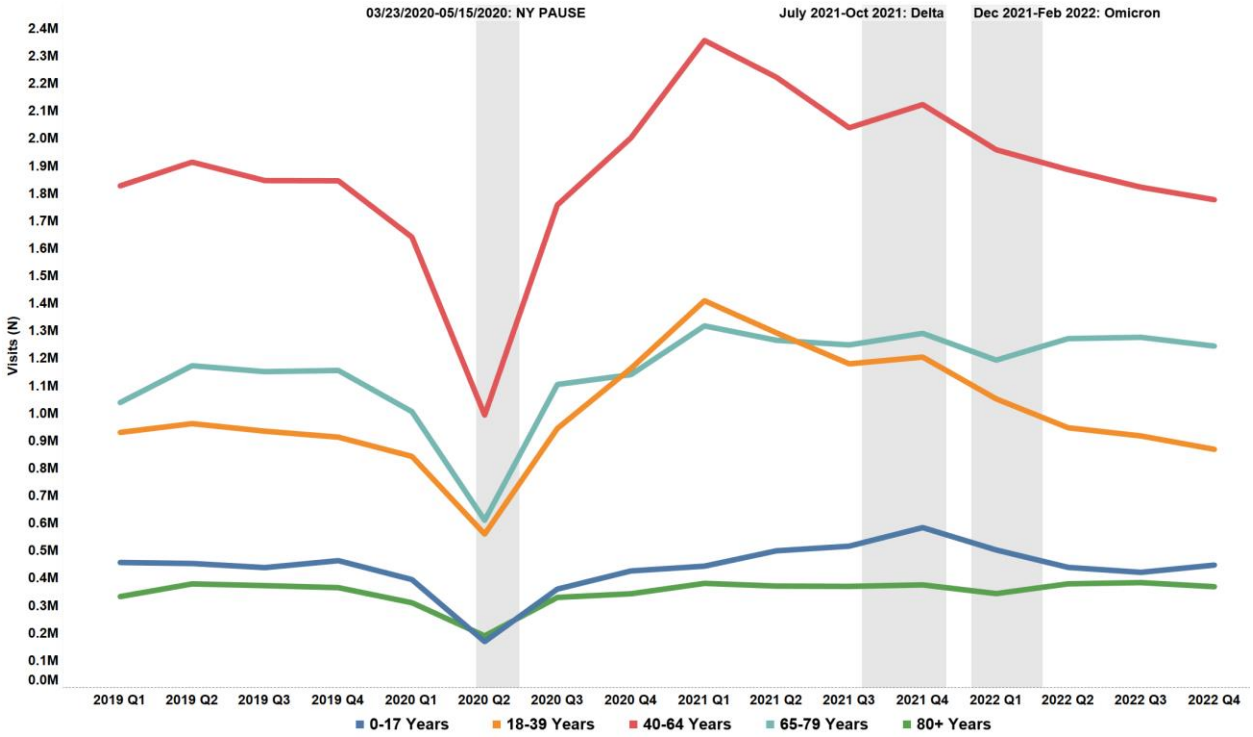


**Figure 6.2.a. Quarterly Number of Outpatient In-Person Visits by Age, January 1, 2019-December 31, 2022**

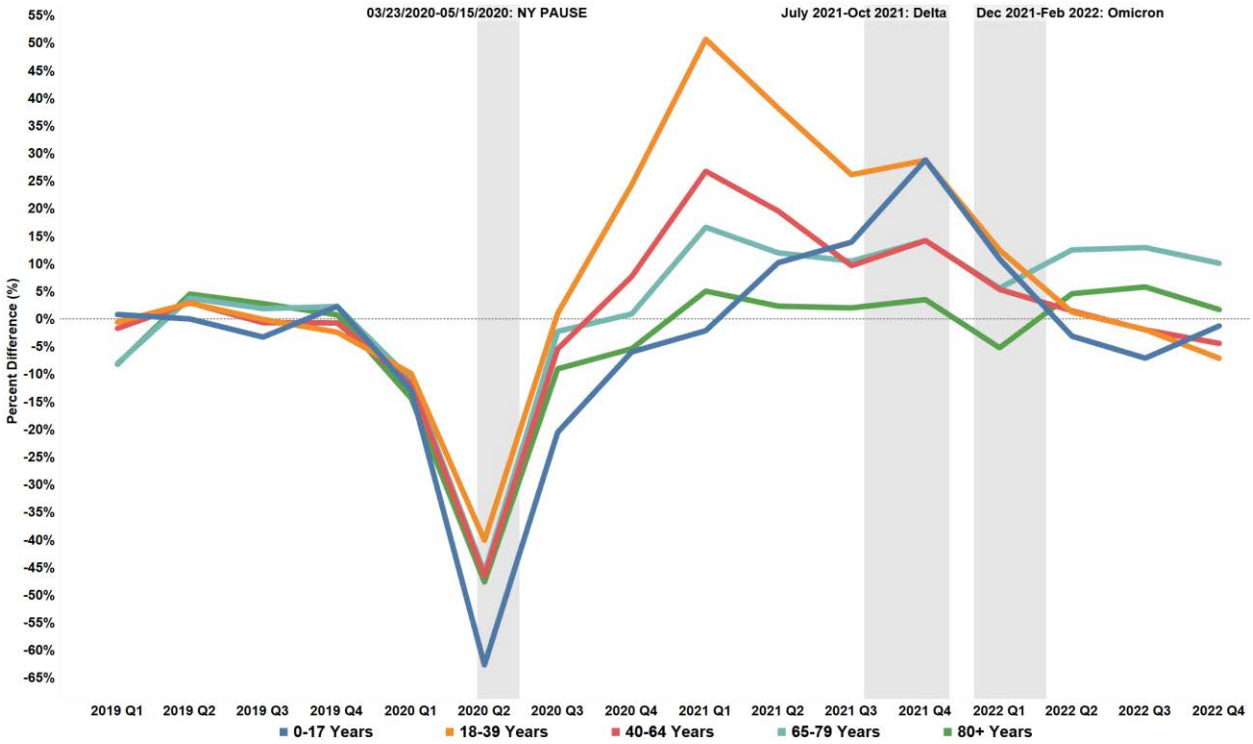


**Figure 6.2.b. Outpatient In-Person Visits Volume Change by Age, January 1, 2019-December 31, 2022**

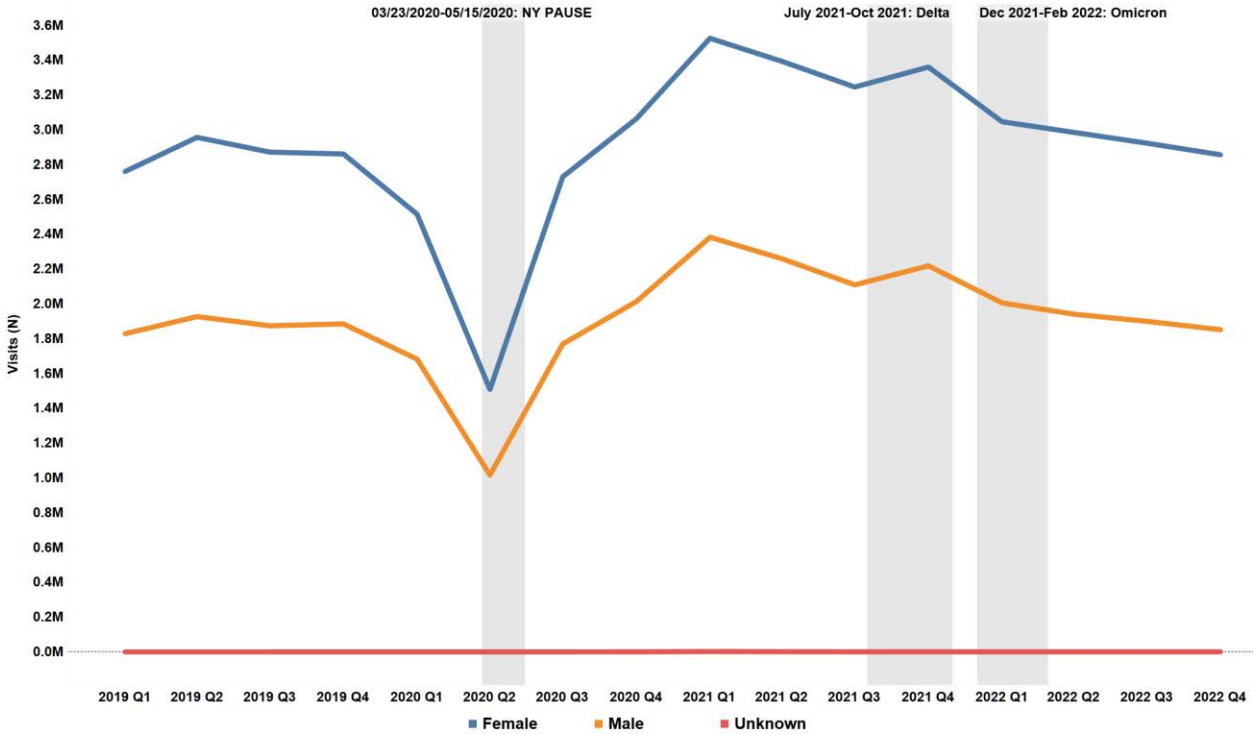


**Figure 6.3.a. Quarterly Number of Outpatient In-Person Visits by Sex, January 1, 2019-December 31, 2022**

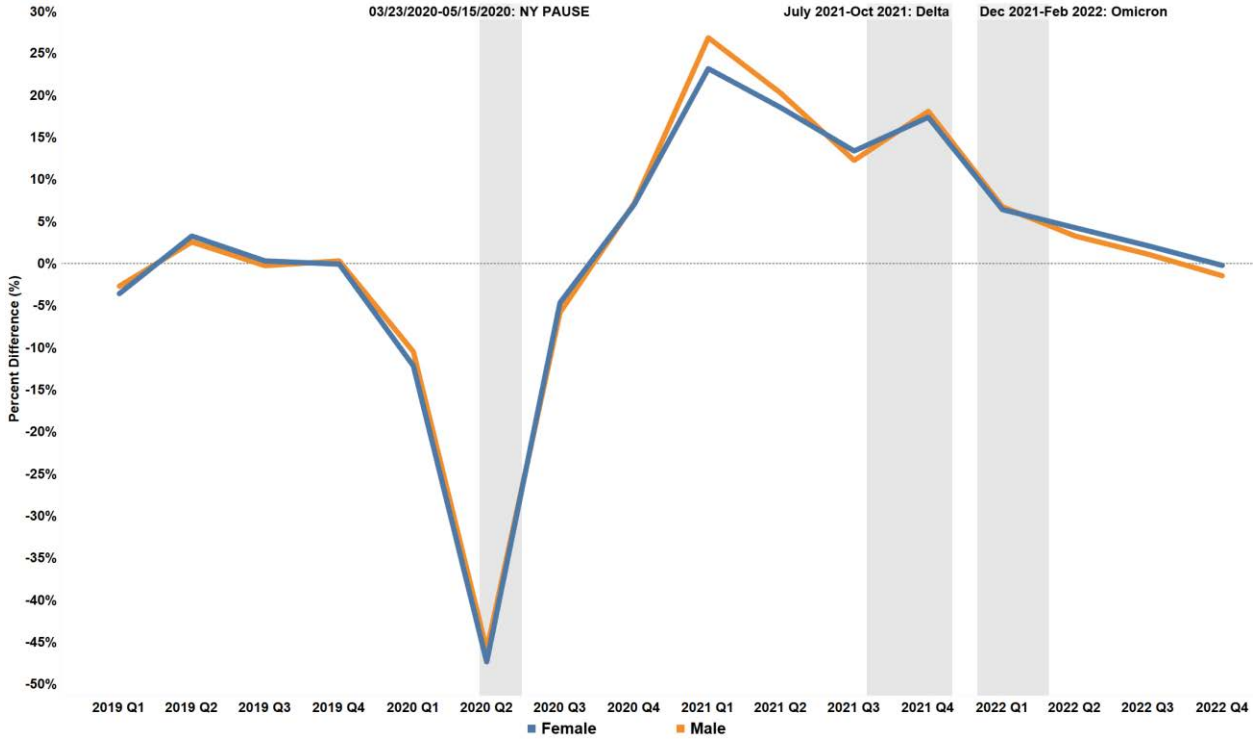


**Figure 6.3.b. Outpatient In-Person Visits Volume Change by Sex, January 1, 2019-December 31, 2022**

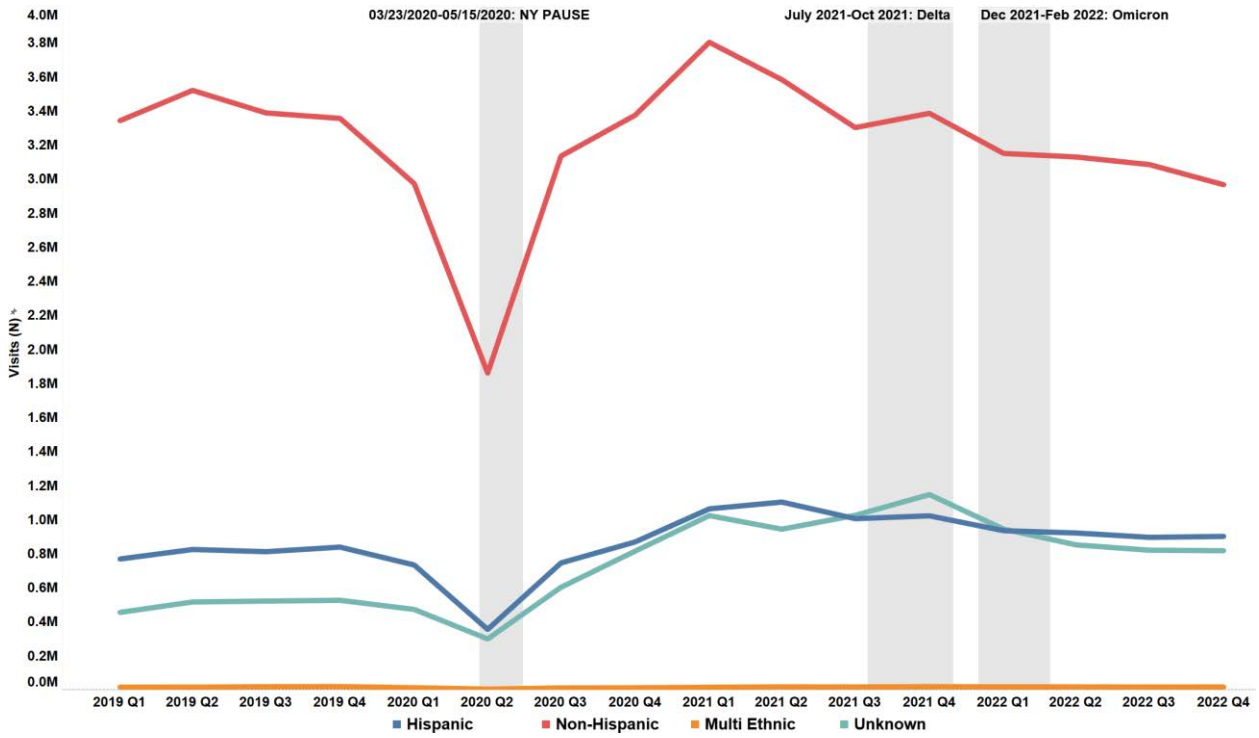


**Figure 6.4.a. Quarterly Number of Outpatient In-Person Visits by Ethnicity, January 1, 2019-December 31, 2022**

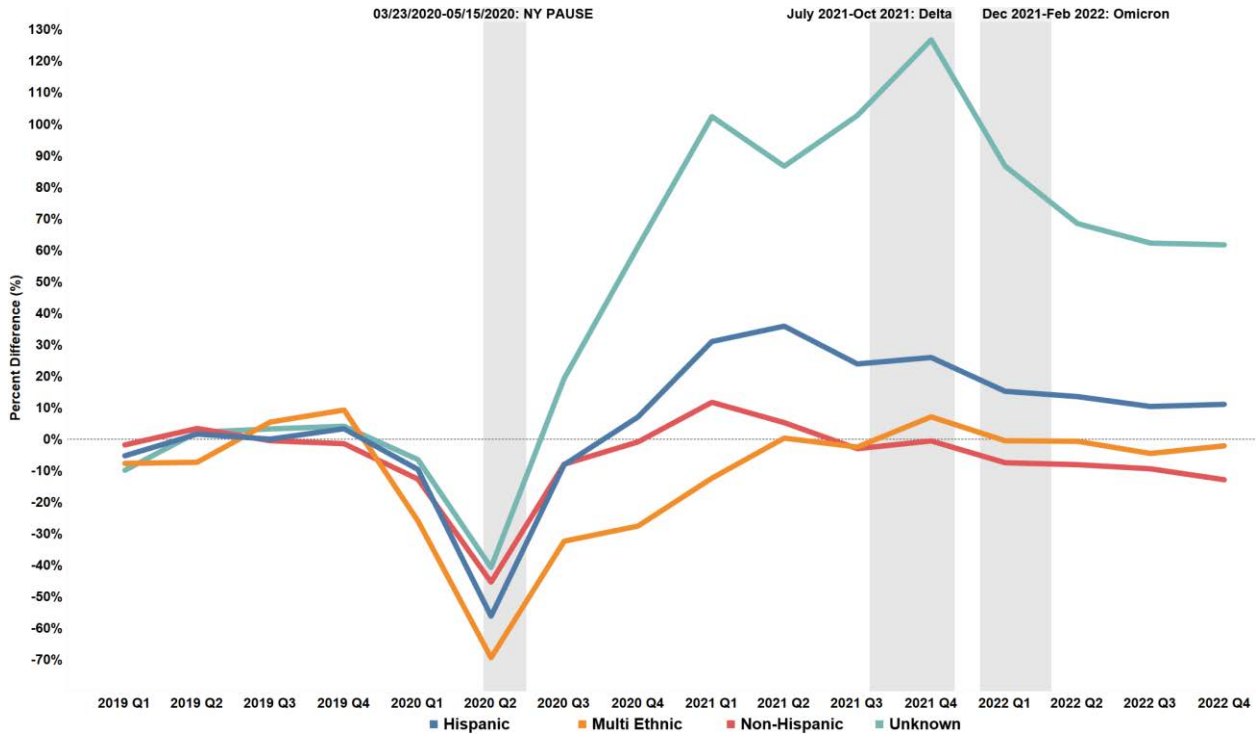


**Figure 6.4.b. Outpatient In-Person Visits Volume Change by Ethnicity, January 1, 2019-December 31, 2022**

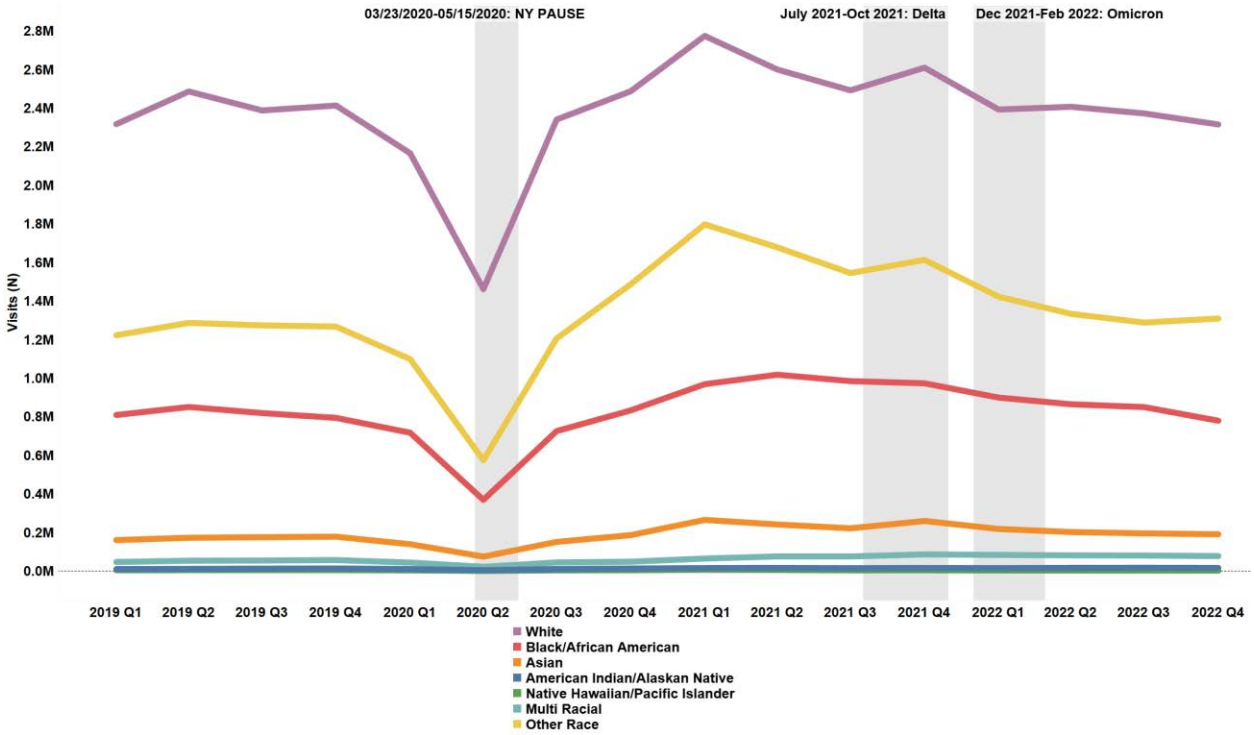


**Figure 6.5.a. Quarterly Number of Outpatient In-Person Visits by Race, January 1, 2019-December 31, 2022**

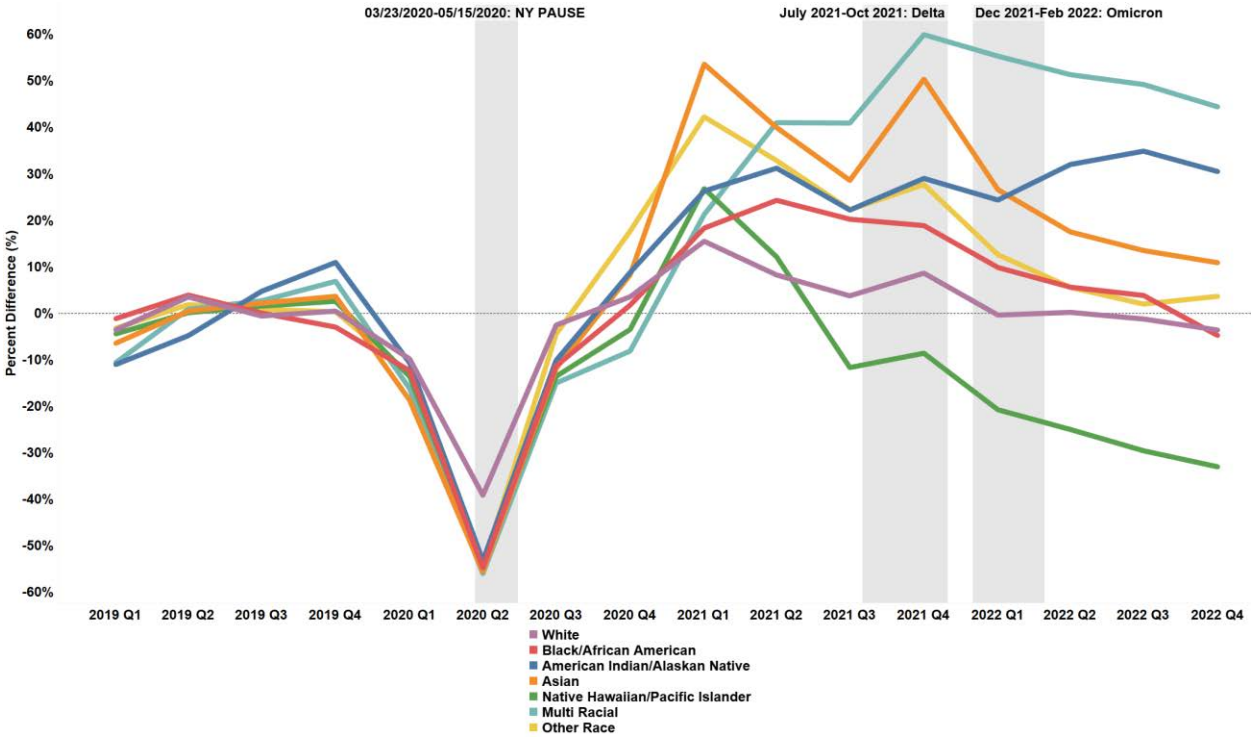


**Figure 6.5.b. Outpatient In-Person Visits Volume Change by Race, January 1, 2019-December 31, 2022**

| | | 2019 | | | | 2020 | | | | 2021 | | | | 2022 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 |
| FAC016 | Exposure, encounters, screening or contact with infectious disease | 37,252 | 33,554 | 38,743 | 65,360 | 41,085 | 213,002 | 484,403 | 991,589 | 1,789,541 | 1,145,676 | 888,253 | 1,086,937 | 627,740 | 324,901 | 257,734 | 255,979 |
| FAC014 | Medical examination/evaluation | 302,438 | 312,478 | 330,196 | 317,564 | 263,023 | 178,591 | 380,757 | 405,788 | 385,893 | 403,576 | 385,097 | 396,812 | 391,002 | 388,535 | 397,663 | 379,010 |
| FAC008 | Neoplasm-related encounters | 136,756 | 153,834 | 148,929 | 161,265 | 125,513 | 60,404 | 159,456 | 169,776 | 142,871 | 144,488 | 157,243 | 166,845 | 147,224 | 138,632 | 143,881 | 154,581 |
| MUS010 | Musculoskeletal pain, not low back pain | 146,331 | 161,988 | 157,367 | 151,204 | 130,776 | 61,013 | 127,903 | 124,554 | 127,099 | 152,597 | 147,969 | 141,052 | 139,664 | 152,469 | 147,118 | 137,210 |
| SYM017 | Abnormal findings without diagnosis | 118,521 | 130,097 | 128,114 | 128,766 | 112,273 | 62,178 | 116,224 | 117,592 | 120,028 | 132,819 | 131,674 | 132,019 | 131,240 | 139,998 | 139,798 | 137,831 |
| CIR007 | Essential hypertension | 127,157 | 137,548 | 127,528 | 126,395 | 105,637 | 53,148 | 100,928 | 100,184 | 100,836 | 110,951 | 104,975 | 105,597 | 105,954 | 118,400 | 113,176 | 113,031 |
| MUS011 | Spondylopathies/spondyloarthropathy (including infective) | 82,430 | 90,520 | 88,626 | 86,526 | 75,316 | 35,175 | 72,969 | 75,073 | 74,739 | 88,232 | 86,441 | 82,520 | 81,621 | 88,097 | 88,212 | 82,669 |
| END003 | Diabetes mellitus with complication | 83,927 | 90,249 | 88,178 | 85,198 | 76,315 | 42,045 | 71,835 | 73,012 | 73,542 | 83,237 | 80,955 | 78,540 | 77,887 | 84,328 | 85,252 | 80,955 |
| SYM006 | Abdominal pain and other digestive/abdomen signs and symptoms | 76,766 | 80,281 | 76,989 | 75,274 | 69,641 | 38,013 | 68,425 | 66,568 | 68,814 | 76,342 | 74,351 | 71,836 | 73,058 | 72,762 | 71,477 | 69,717 |
| END002 | Diabetes mellitus without complication | 74,814 | 80,035 | 76,080 | 75,277 | 63,886 | 34,299 | 59,936 | 59,159 | 61,674 | 67,027 | 65,592 | 64,767 | 64,548 | 71,767 | 70,338 | 67,695 |
| PRG029 | Uncomplicated pregnancy, delivery or puerperium | 67,030 | 70,634 | 68,870 | 65,304 | 61,223 | 51,066 | 58,232 | 56,207 | 60,024 | 66,953 | 68,236 | 68,132 | 64,706 | 66,503 | 68,119 | 64,599 |
| END001 | Thyroid disorders | 65,372 | 71,238 | 68,879 | 69,350 | 60,476 | 36,457 | 62,968 | 58,935 | 58,606 | 64,987 | 63,230 | 61,816 | 61,785 | 65,004 | 66,104 | 64,049 |
| END010 | Disorders of lipid metabolism | 59,757 | 66,729 | 62,656 | 64,103 | 52,382 | 35,220 | 55,088 | 51,148 | 51,758 | 56,588 | 55,590 | 56,645 | 57,732 | 61,943 | 60,963 | 61,169 |
| SYM013 | Respiratory signs and symptoms | 61,710 | 61,167 | 51,142 | 60,043 | 63,183 | 30,218 | 45,727 | 51,648 | 53,274 | 58,697 | 55,536 | 64,125 | 61,670 | 66,247 | 57,106 | 66,867 |
| NEO030 | Breast cancer - all other types | 55,848 | 59,134 | 56,503 | 56,042 | 52,592 | 40,659 | 54,911 | 52,841 | 55,946 | 58,974 | 59,264 | 59,050 | 58,929 | 60,989 | 59,536 | 58,356 |
| MBD002 | Depressive disorders | 79,949 | 82,957 | 76,767 | 76,428 | 67,267 | 21,367 | 30,375 | 33,729 | 36,528 | 46,959 | 46,560 | 42,867 | 41,451 | 44,691 | 45,118 | 45,052 |
| FAC010 | Other aftercare encounter | 58,936 | 62,089 | 59,877 | 59,236 | 49,905 | 24,123 | 44,997 | 48,305 | 47,070 | 53,490 | 52,357 | 48,697 | 44,903 | 50,546 | 50,939 | 50,726 |
| MUS006 | Osteoarthritis | 46,843 | 53,250 | 51,336 | 50,836 | 45,106 | 21,115 | 46,601 | 47,221 | 43,975 | 55,777 | 53,692 | 53,054 | 51,897 | 57,270 | 55,570 | 52,605 |
| CIR017 | Cardiac dysrhythmias | 55,893 | 60,784 | 57,921 | 54,310 | 48,933 | 33,106 | 47,551 | 45,104 | 43,200 | 47,405 | 45,994 | 44,936 | 45,013 | 47,674 | 47,332 | 45,459 |
| GEN003 | Chronic kidney disease | 53,964 | 57,608 | 56,038 | 50,988 | 45,280 | 30,911 | 44,276 | 41,229 | 41,902 | 45,635 | 45,879 | 45,205 | 43,626 | 47,682 | 47,678 | 46,220 |
| MBD018 | Opioid-related disorders | 65,677 | 66,835 | 68,518 | 73,027 | 60,686 | 34,277 | 37,570 | 34,543 | 32,640 | 36,912 | 36,303 | 32,481 | 40,611 | 41,976 | 41,787 | 36,252 |
| MBD001 | Schizophrenia spectrum and other psychotic disorders | 59,080 | 62,086 | 58,589 | 57,533 | 51,947 | 25,321 | 31,178 | 33,587 | 34,820 | 43,063 | 43,419 | 38,042 | 37,043 | 39,400 | 40,862 | 38,967 |
| SYM016 | Other general signs and symptoms | 41,478 | 43,745 | 45,314 | 43,206 | 43,285 | 34,181 | 43,305 | 39,401 | 36,871 | 44,064 | 43,773 | 41,249 | 39,539 | 42,617 | 43,577 | 41,266 |
| FAC006 | Encounter for antineoplastic therapies | 34,108 | 37,366 | 36,657 | 36,772 | 36,717 | 33,482 | 34,226 | 33,048 | 33,257 | 33,720 | 34,659 | 33,833 | 34,620 | 39,450 | 39,106 | 37,223 |
| INF012 | COVID-19 | | | | | | 17,001 | 15,407 | 61,734 | 98,982 | 27,325 | 28,467 | 90,487 | 90,298 | 38,354 | 28,255 | 20,403 |

**Figure 7.1.a. Quarterly Number of Outpatient In-Person Visits by Primary Diagnosis, January 1, 2019-December 31, 2022**

| | | 2019Q1 | 2019Q2 | 2019Q3 | 2019Q4 | 2020Q1 | 2020Q2 | 2020Q3 | 2020Q4 | 2021Q1 | 2021Q2 | 2021Q3 | 2021Q4 | 2022Q1 | 2022Q2 | 2022Q3 | 2022Q4 | Overall |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| FAC016 | Exposure, encounters, screening or contact with infectious disease | 25 | 33 | 24 | 13 | 24 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 2 | 2 | 2 | 1 |
| FAC014 | Medical examination/evaluation | 1 | 1 | 1 | 1 | 1 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 1 | 1 | 1 | 2 |
| FAC008 | Neoplasm-related encounters | 3 | 3 | 3 | 2 | 3 | 5 | 3 | 3 | 3 | 4 | 3 | 3 | 3 | 5 | 4 | 3 | 3 |
| MUS010 | Musculoskeletal pain, not low back pain | 2 | 2 | 2 | 3 | 2 | 4 | 4 | 4 | 4 | 3 | 4 | 4 | 4 | 3 | 3 | 5 | 4 |
| SYM017 | Abnormal findings without diagnosis | 5 | 5 | 4 | 4 | 4 | 3 | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 4 | 5 | 4 | 5 |
| CIR007 | Essential hypertension | 4 | 4 | 5 | 5 | 5 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 |
| MUS011 | Spondylopathies/spondyloarthropathy (including infective) | 7 | 6 | 6 | 6 | 7 | 13 | 7 | 7 | 8 | 7 | 7 | 8 | 8 | 7 | 7 | 7 | 7 |
| END003 | Diabetes mellitus with complication | 6 | 7 | 7 | 7 | 6 | 8 | 8 | 8 | 9 | 8 | 8 | 9 | 9 | 8 | 8 | 8 | 8 |
| SYM006 | Abdominal pain and other digestive/abdomen signs and symptoms | 9 | 9 | 8 | 10 | 8 | 10 | 9 | 9 | 10 | 9 | 9 | 10 | 10 | 9 | 9 | 9 | 9 |
| END002 | Diabetes mellitus without complication | 10 | 10 | 10 | 9 | 10 | 14 | 11 | 11 | 11 | 10 | 11 | 12 | 12 | 10 | 10 | 10 | 10 |
| PRG029 | Uncomplicated pregnancy, delivery or puerperium | 11 | 12 | 12 | 14 | 12 | 7 | 12 | 13 | 12 | 11 | 10 | 11 | 11 | 11 | 11 | 12 | 11 |
| END001 | Thyroid disorders | 13 | 11 | 11 | 12 | 14 | 11 | 10 | 12 | 13 | 12 | 12 | 14 | 13 | 13 | 12 | 13 | 12 |
| END010 | Disorders of lipid metabolism | 15 | 14 | 14 | 15 | 16 | 12 | 13 | 16 | 16 | 15 | 14 | 16 | 16 | 14 | 13 | 14 | 13 |
| SYM013 | Respiratory signs and symptoms | 14 | 17 | 21 | 16 | 11 | 20 | 17 | 15 | 15 | 14 | 15 | 13 | 14 | 12 | 15 | 11 | 14 |
| NEO030 | Breast cancer - all other types | 19 | 19 | 18 | 19 | 15 | 9 | 14 | 14 | 14 | 13 | 13 | 15 | 15 | 15 | 14 | 15 | 15 |
| MBD002 | Depressive disorders | 8 | 8 | 9 | 8 | 9 | 27 | 29 | 24 | 23 | 19 | 18 | 21 | 21 | 20 | 20 | 20 | 16 |
| FAC010 | Other aftercare encounter | 17 | 15 | 15 | 17 | 18 | 24 | 18 | 17 | 17 | 17 | 17 | 18 | 19 | 17 | 17 | 17 | 17 |
| MUS006 | Osteoarthritis | 22 | 21 | 20 | 22 | 21 | 28 | 16 | 18 | 18 | 16 | 16 | 17 | 17 | 16 | 16 | 16 | 18 |
| CIR017 | Cardiac dysrhythmias | 18 | 18 | 17 | 20 | 19 | 18 | 15 | 19 | 19 | 18 | 19 | 20 | 18 | 19 | 19 | 19 | 19 |
| GEN003 | Chronic kidney disease | 20 | 20 | 19 | 21 | 20 | 19 | 19 | 20 | 20 | 20 | 20 | 19 | 20 | 18 | 18 | 18 | 20 |
| MBD018 | Opioid-related disorders | 12 | 13 | 13 | 11 | 13 | 15 | 22 | 23 | 28 | 25 | 27 | 33 | 22 | 22 | 22 | 28 | 21 |
| MBD001 | Schizophrenia spectrum and other psychotic disorders | 16 | 16 | 16 | 18 | 17 | 22 | 28 | 25 | 24 | 22 | 22 | 25 | 27 | 26 | 23 | 24 | 22 |
| SYM016 | Other general signs and symptoms | 23 | 23 | 23 | 24 | 22 | 16 | 20 | 22 | 22 | 21 | 21 | 22 | 24 | 21 | 21 | 21 | 23 |
| FAC006 | Encounter for antineoplastic therapies | 29 | 26 | 26 | 26 | 26 | 17 | 25 | 26 | 27 | 31 | 29 | 28 | 28 | 25 | 28 | 27 | 26 |
| INF012 | COVID-19 | | | | | | 32 | 70 | 10 | 7 | 39 | 38 | 7 | 7 | 28 | 39 | 57 | 29 |

**Figure 7.1.b. Quarterly Rank Order of Outpatient In-Person Visits by Primary Diagnosis, January 1, 2019-December 31, 2022**

| | | 2019 | | | | 2020 | | | | 2021 | | | | 2022 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 |
| FAC016 | Exposure, encounters, screening or contact with infectious disease | -14.8% | -23.3% | -11.4% | 49.5% | -6.0% | 387.1% | 1007.8% | 2167.7% | 3992.5% | 2520.1% | 1931.3% | 2385.7% | 1335.6% | 643.0% | 489.4% | 485.4% |
| FAC014 | Medical examination/evaluation | -4.2% | -1.0% | 4.6% | 0.6% | -16.7% | -43.4% | 20.6% | 28.5% | 22.2% | 27.8% | 22.0% | 25.7% | 23.9% | 23.1% | 26.0% | 20.1% |
| FAC008 | Neoplasm-related encounters | -8.9% | 2.4% | -0.8% | 7.4% | -16.4% | -59.8% | 6.2% | 13.0% | -4.9% | -3.8% | 4.7% | 11.1% | -2.0% | -7.7% | -4.2% | 2.9% |
| MUS010 | Musculoskeletal pain, not low back pain | -5.1% | 5.0% | 2.0% | -2.0% | -15.2% | -60.4% | -17.1% | -19.2% | -17.6% | -1.1% | -4.1% | -8.5% | -9.4% | -1.1% | -4.6% | -11.0% |
| SYM017 | Abnormal findings without diagnosis | -6.2% | 2.9% | 1.4% | 1.9% | -11.2% | -50.8% | -8.0% | -6.9% | -5.0% | 5.1% | 4.2% | 4.5% | 3.9% | 10.8% | 10.6% | 9.1% |
| CIR007 | Essential hypertension | -1.9% | 6.1% | -1.6% | -2.5% | -18.5% | -59.0% | -22.2% | -22.7% | -22.2% | -14.4% | -19.0% | -18.6% | -18.3% | -8.7% | -12.7% | -12.8% |
| MUS011 | Spondylopathies/spondyloarthropathy (including infective) | -5.3% | 4.0% | 1.8% | -0.6% | -13.5% | -59.6% | -16.2% | -13.7% | -14.1% | 1.4% | -0.7% | -5.2% | -6.2% | 1.2% | 1.4% | -5.0% |
| END003 | Diabetes mellitus with complication | -3.4% | 3.9% | 1.5% | -1.9% | -12.2% | -51.6% | -17.3% | -16.0% | -15.4% | -4.2% | -6.8% | -9.6% | -10.4% | -2.9% | -1.9% | -6.8% |
| SYM006 | Abdominal pain and other digestive/abdomen signs and symptoms | -0.7% | 3.8% | -0.4% | -2.7% | -9.9% | -50.8% | -11.5% | -13.9% | -11.0% | -1.3% | -3.8% | -7.1% | -5.5% | -5.9% | -7.6% | -9.8% |
| END002 | Diabetes mellitus without complication | -2.3% | 4.6% | -0.6% | -1.7% | -16.5% | -55.2% | -21.7% | -22.7% | -19.4% | -12.4% | -14.3% | -15.4% | -15.7% | -6.3% | -8.1% | -11.6% |
| PRG029 | Uncomplicated pregnancy, delivery or puerperium | -1.4% | 3.9% | 1.3% | -3.9% | -9.9% | -24.9% | -14.3% | -17.3% | -11.7% | -1.5% | 0.4% | 0.3% | -4.8% | -2.1% | 0.2% | -4.9% |
| END001 | Thyroid disorders | -4.9% | 3.7% | 0.2% | 0.9% | -12.0% | -46.9% | -8.4% | -14.2% | -14.7% | -5.4% | -8.0% | -10.0% | -10.1% | -5.4% | -3.8% | -6.8% |
| END010 | Disorders of lipid metabolism | -5.6% | 5.4% | -1.0% | 1.3% | -17.3% | -44.4% | -13.0% | -19.2% | -18.2% | -10.6% | -12.2% | -10.5% | -8.8% | -2.2% | -3.7% | -3.4% |
| SYM013 | Respiratory signs and symptoms | 5.5% | 4.5% | -12.6% | 2.6% | 8.0% | -48.4% | -21.9% | -11.7% | -9.0% | 0.3% | -5.1% | 9.6% | 5.4% | 13.2% | -2.4% | 14.3% |
| NEO030 | Breast cancer - all other types | -1.8% | 4.0% | -0.7% | -1.5% | -7.5% | -28.5% | -3.5% | -7.1% | -1.6% | 3.7% | 4.2% | 3.8% | 3.6% | 7.2% | 4.7% | 2.6% |
| MBD002 | Depressive disorders | 1.2% | 5.0% | -2.9% | -3.3% | -14.9% | -73.0% | -61.6% | -57.3% | -53.8% | -40.6% | -41.1% | -45.8% | -47.5% | -43.4% | -42.9% | -43.0% |
| FAC010 | Other aftercare encounter | -1.8% | 3.4% | -0.3% | -1.3% | -16.9% | -59.8% | -25.0% | -19.5% | -21.6% | -10.9% | -12.8% | -18.9% | -25.2% | -15.8% | -15.2% | -15.5% |
| MUS006 | Osteoarthritis | -7.4% | 5.3% | 1.5% | 0.5% | -10.8% | -58.2% | -7.8% | -6.6% | -13.0% | 10.3% | 6.2% | 4.9% | 2.6% | 13.3% | 9.9% | 4.0% |
| CIR017 | Cardiac dysrhythmias | -2.3% | 6.2% | 1.2% | -5.1% | -14.5% | -42.1% | -16.9% | -21.2% | -24.5% | -17.2% | -19.6% | -21.5% | -21.3% | -16.7% | -17.3% | -20.6% |
| GEN003 | Chronic kidney disease | -1.3% | 5.4% | 2.5% | -6.7% | -17.1% | -43.4% | -19.0% | -24.6% | -23.3% | -16.5% | -16.0% | -17.3% | -20.2% | -12.7% | -12.8% | -15.4% |
| MBD018 | Opioid-related disorders | -4.1% | -2.5% | 0.0% | 6.6% | -11.4% | -50.0% | -45.2% | -49.6% | -52.4% | -46.1% | -47.0% | -52.6% | -40.7% | -38.7% | -39.0% | -47.1% |
| MBD001 | Schizophrenia spectrum and other psychotic disorders | -0.4% | 4.7% | -1.2% | -3.0% | -12.4% | -57.3% | -47.4% | -43.4% | -41.3% | -27.4% | -26.8% | -35.9% | -37.6% | -33.6% | -31.1% | -34.3% |
| SYM016 | Other general signs and symptoms | -4.5% | 0.7% | 4.3% | -0.5% | -0.3% | -21.3% | -0.3% | -9.3% | -15.1% | 1.4% | 0.8% | -5.0% | -9.0% | -1.9% | 0.3% | -5.0% |
| FAC006 | Encounter for antineoplastic therapies | -5.8% | 3.1% | 1.2% | 1.5% | 1.4% | -7.6% | -5.5% | -8.8% | -8.2% | -6.9% | -4.3% | -6.6% | -4.4% | 8.9% | 8.0% | 2.8% |
| INF012 | COVID-19 | | | | | | | | | | | | | | | | |

**Figure 7.1.c. Outpatient In-Person Visits Volume Change by Primary Diagnosis, January 1, 2019-December 31, 2022**

# Telehealth

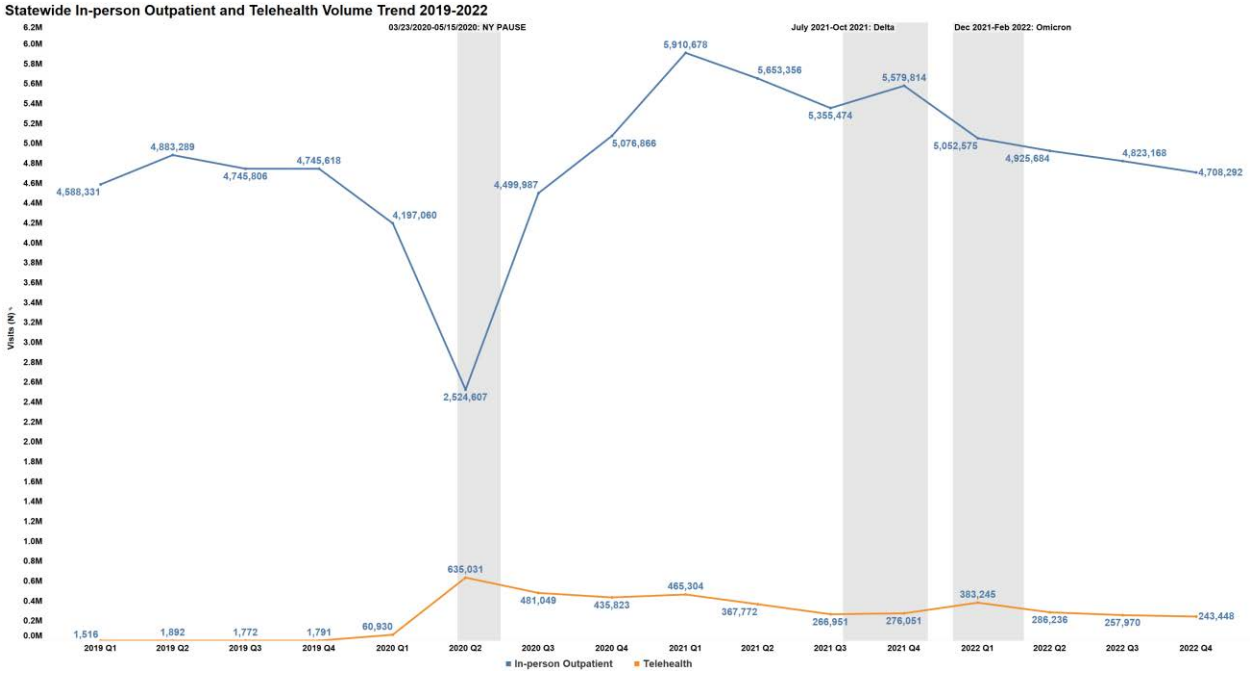


**Figure 8.1.a. Quarterly Number of Visits by Modality Statewide, January 1, 2019-December 31, 2022**

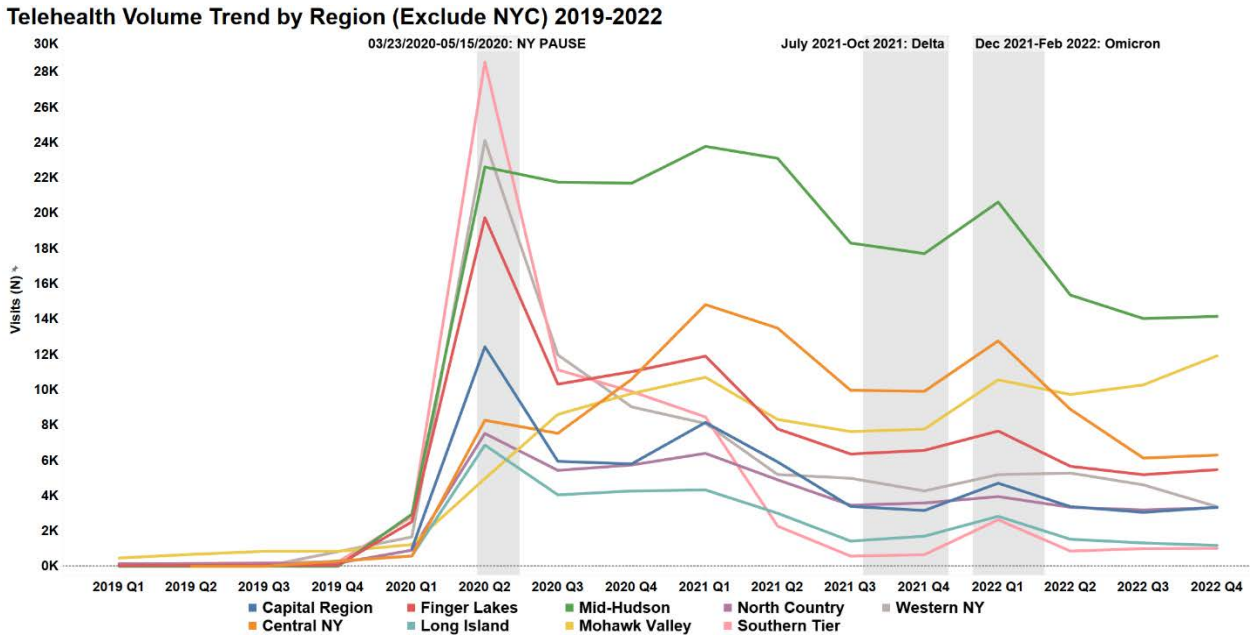


**Figure 8.2.a. Quarterly Number of Telehealth Visits by Region (Excluding NYC), January 1, 2019-December 31, 2022**

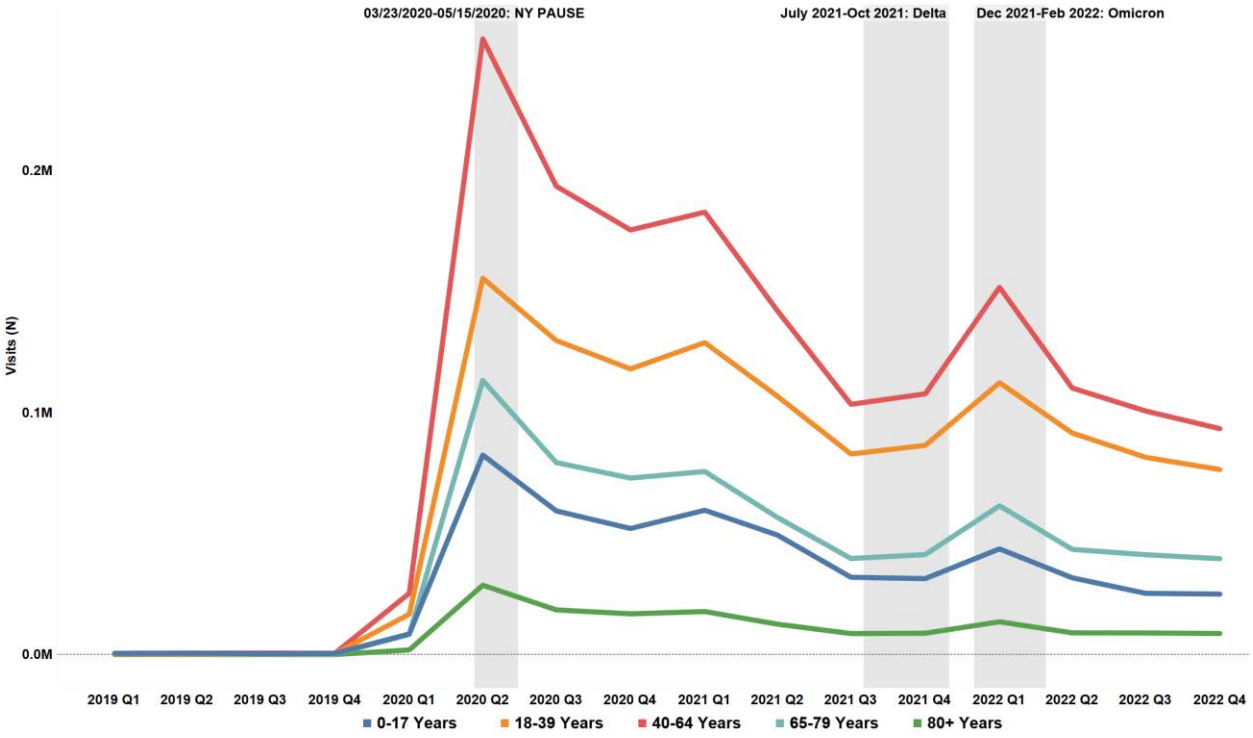


**Figure 10.1.a. Quarterly Number of Telehealth Visits by Age, January 1, 2019-December 31, 2022**

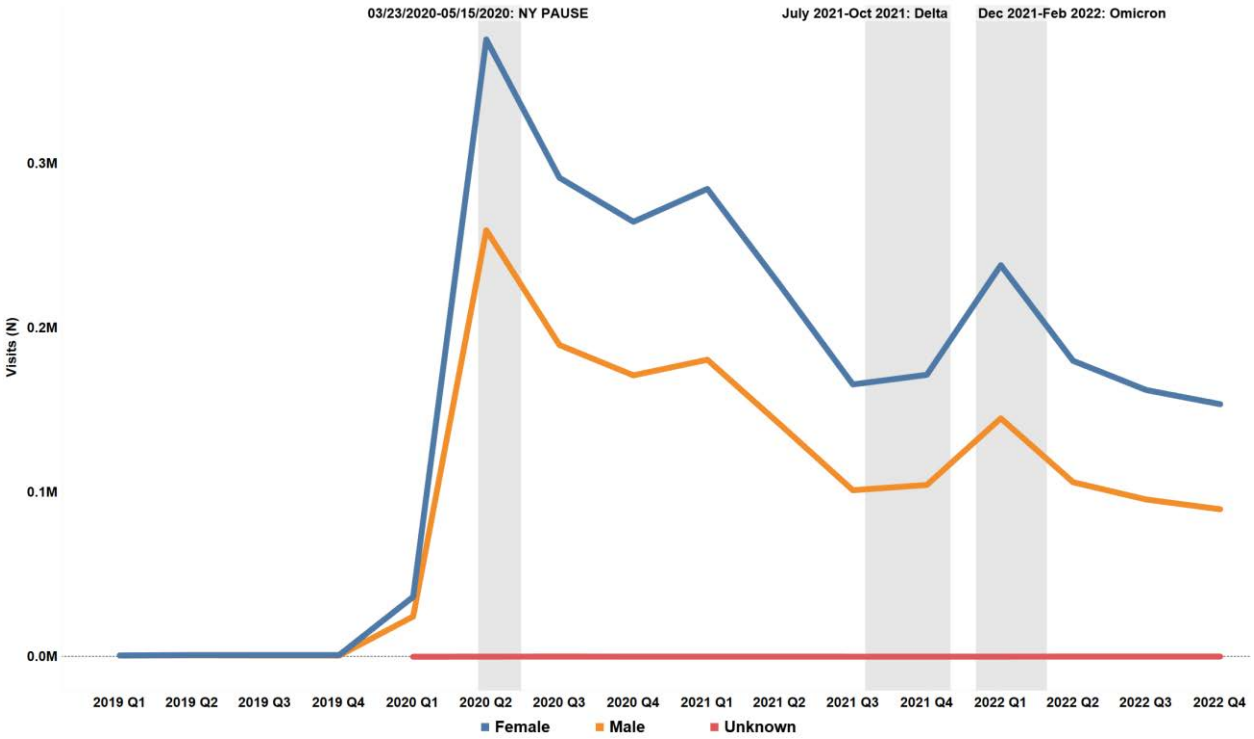


**Figure 10.2.a. Quarterly Number of Telehealth Visits by Sex, January 1, 2019-December 31, 2022**

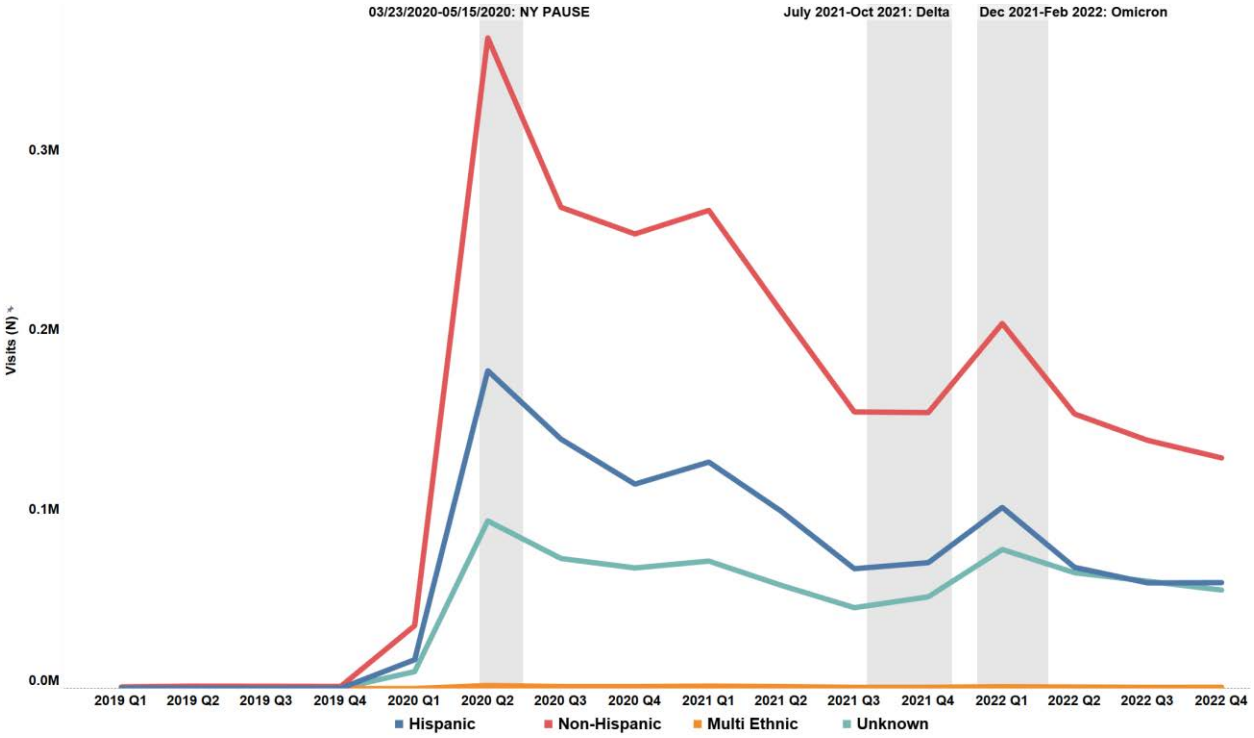


**Figure 10.3.a. Quarterly Number of Telehealth Visits by Ethnicity, January 1, 2019-December 31, 2022**

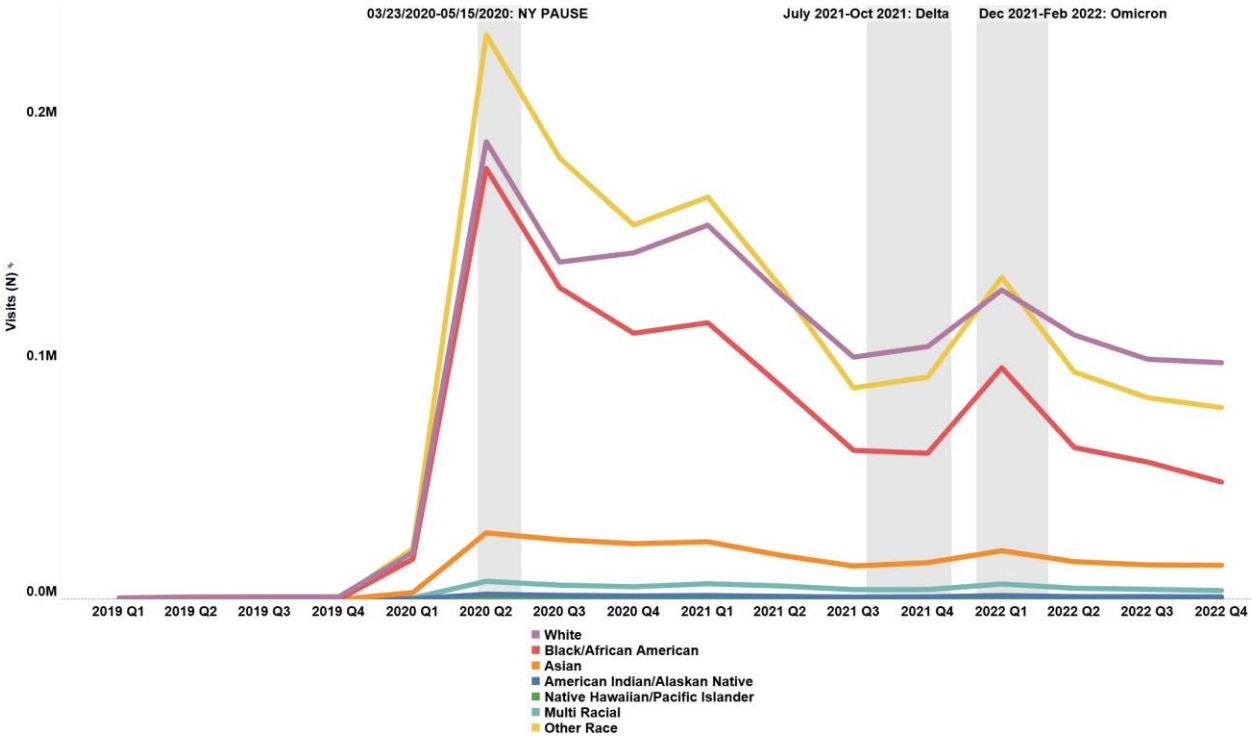


**Figure 10.4.a. Quarterly Number of Telehealth Visits by Race, January 1, 2019-December 31, 2022**