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FINANCIAL AND OPERATIONAL SUSTAINABILITY

Seasonal patterns of initial domestic health assessment for refugees in New York State, 2013

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Background: Refugee health assessments (RHA) are a crucial milestone that ensure the continuum of refugee healthcare, prevent spread of communicable diseases, and monitor disease prevalence. Refugees should receive an initial RHA upon arrival. In NYS, this is provided by one of NYS Refugee Health Program's (NYSRHP) contracted providers, preferably within 90 days after arrival in the U.S. RHA is designed to ensure that unobserved or developed health conditions after overseas exam are referred to primary and specialty care. Eliminating barriers to complete the initial assessment including transportation, hours of service, wait times, and poor weather is essential for successful resettlement.

Methods: We conducted a retrospective review of NYSRHP data from January 1 to December 31, 2013. Country of origin, arrival date, RHA completion date, season of arrival, county of resettlement, and resettlement agency were analyzed. Data were then evaluated using descriptive analyses.

Findings: In 2013, 3762 refugees resettled in NYS. Overall, 30% of the refugees did not complete the initial RHA within 90 days after arrival. Numbers of incomplete health assessments increased in the fall and winter seasons to reach 47% and 45%, respectively, compared to 24% in spring and 25% in summer. Resettlement agencies were surveyed to assess services provided, 64% provide transportation from office, 27% from central stop, and 9% by taxi and none of them provide any special winter accommodation.

Interpretation: These pilot data suggest seasonal variation in the completion rate of initial domestic refugee health assessments. Limitations of this data include a fiscal federal shutdown in October of 2013, which may have impacted refugee resettlement patterns compared to typical large arrival numbers in the fall season. Further research is needed to address barriers to healthcare that refugees face post-resettlement, including season variation. Rresults suggest a need for additional evaluations and interventions of current services provided to refugees to ensure appropriate resources allocation and better health access.

Abstract #: *2.001_FOS*

The economic burden of noncommunicable diseases on America's youth: an analysis of children's healthcare spending in the United States from 1996-2012

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Background: Over 17 percent of U.S. gross domestic product is spent on health. Little research has focused on spending on children. We produced estimates of healthcare spending of children and youth in the U.S. from 1996 through 2012 across types of goods and services, age groups, sex groups, and causes of illness and healthcare events. We compare spending between noncommunicable disease (NCDs), communicable and neonatal disorders, and injuries. Lastly, we explain changes in healthcare spending among children and youth over time.

Methods: We use National Health Expenditure Accounts (NHEA) data to provide total healthcare spending across different categories of goods or services. We use eight U.S. surveys and administrative data sets to estimate the composition of healthcare spending across age groups, sex groups, and causes of illness or healthcare events within each category. Causes of illness are aggregated across NCDs, communicable and neonatal disorders, or injuries. Healthcare spending estimates are analyzed across levels and changes. A decomposition method is employed to explain changes in healthcare spending across increases in population, prevalence, utilization, and prices.

Results: From 1996 to 2012 children's healthcare spending increased from $161 billion to $259 billion, the most of which was ambulatory care spending. Congenital disorders, skin disorders, neonatal preterm conditions, chronic upper respiratory disorders, endocrine disorders, otitis, attention-deficit/hyperactivity disorder (ADHD), asthma, falls, and depression contribute to the top 36% of all healthcare costs in children. Among these top 10 conditions, 7 are NCDs. In total, NCDs contribute to nearly two-thirds of healthcare spending. Per capita (per child) healthcare spending is greatest for under-1-year-olds and is lowest for 5-9-year-olds. The $98 billion increase in spending was mostly due to increases in prices over the time period.

Interpretations: NCDs contribute to more healthcare spending among children as opposed to conditions traditionally associated with children, such as neonatal disorders and communicable conditions like respiratory infections and otitis. Investments in prevention of NCDs in childhood could help combat increasing prevalence of NCDs and curb future growth in healthcare spending. These findings can aid in more efficient health resource allocation and planning for children.

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Coordinating community healthcare needs to local services in Paraiso, Dominican Republic through strategic assessment strategies

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