

LOCAL HEALTH DEPARTMENT (LHD) CLINICAL SERVICE DELIVERY ALONG THE URBAN/RURAL CONTINUUM

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Background

- Rural communities face numerous health disparities related to risky health behaviors, health outcomes, and access to medical care compared to urban communities.
- LHDs serving rural communities have lower levels of staffing and funding to meet their community needs.
- The number and types of community organizations (hospitals, health clinics, not-for-profits), available to partner with may be limited based on geographical isolation.
- These factors may affect the availability of clinical services in rural communities.

Purpose

- Assess LHD clinical service delivery levels based on rurality.

Methods

Data Set: Data were obtained from the NACCHO 2013 National Profile of Local Health Departments Study.

Rural/Urban Status: LHDs were coded as “urban”, “micropolitan”, or “rural” based on Rural/Urban Commuting Area (RUCA) codes for their zip code.

- “Micropolitan” includes census tracts with towns of between 10,000 and 49,999 population and census tracts tied to these towns through commuting.
- “Rural” includes census tracts with small towns of fewer than 10,000 population, tracts tied to small towns, and isolated census tracts.
- Both “micropolitan” and “rural” categories are considered rural by the Federal Office of Rural Health Policy.

Analysis:

- Bivariate analysis for 25 clinical services offered by rural/urban status of the LHD jurisdiction.
- Clinical services included: immunizations; screenings; treatment for communicable diseases; maternal and child health; and other services.

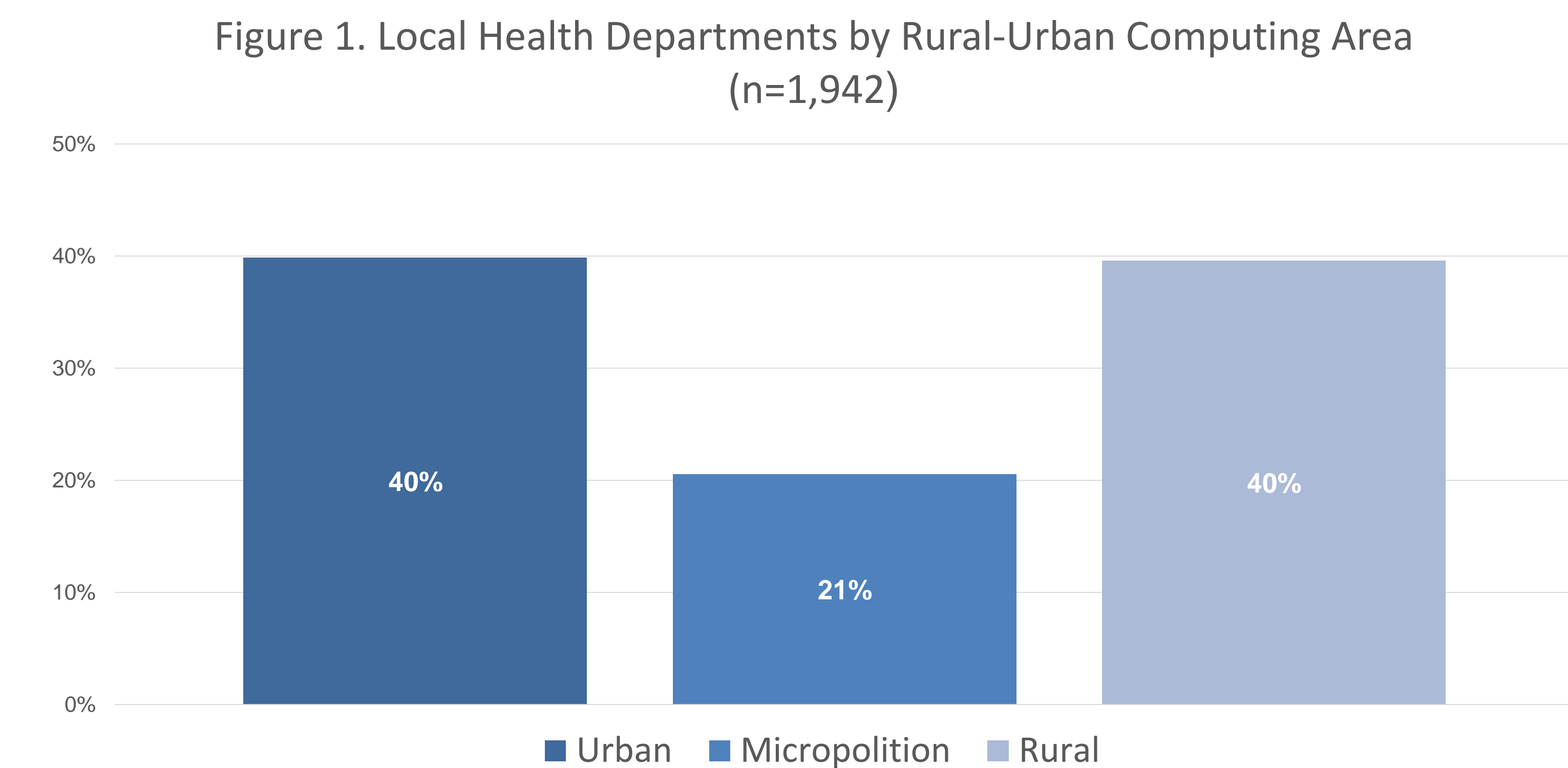
- For each service, we compared the proportions of rural, micropolitan and urban LHDs that:
 - 1) Directly performed the service,
 - 2) Contracted with other organizations to provide the service, and
 - 3) Reported that the service was provided independent of the LHD by organizations in the community.

Results

Table 1. Local Health Department Clinical Service Provision by Rurality

Service	Performed by LHD directly			Provided by others in community			Contracted by LHD		
	Urban	Micropolitan	Rural	Urban	Micropolitan	Rural	Urban	Micropolitan	Rural
Immunizations									
Adult	84.5	96.1	93.0**	55.5	51.5	50.1	6.3	1.4	0.5**
Childhood	80.2	96.3	93.3**	59.1	52.6	45.4**	7.2	0	1.2**
Screenings									
HIV/AIDS	60.9	69.4	54.4**	70.1	59.3	54.7**	10	4.8	4.1**
Other STDs	57.6	73.1	62.0**	64.9	56.4	58.1**	9.4	2.7	3.7**
Tuberculosis	77.1	89.3	87.5**	51.6	53.0	38.1**	6.6	1.2	1.9**
Cancer	31.3	45.6	33.7**	85.9	79.6	78.6**	5.0	4.4	1.4**
Cardiovascular disease	25.4	31.8	27.1*	82.1	88.3	81.1*	3.4	0	1.4**
Diabetes	33.1	35.6	31.2	78.1	81.2	80.6	4.3	0	0.7**
Blood lead	52.7	67.9	62.0**	64.5	62.5	51.5**	6.5	2.2	1.3**
Maternal and Child Health									
Family planning	38.1	70.5	57.7**	77.0	65.5	59.4**	5.1	4.7	6.6
Prenatal care	27.2	27.5	25.6**	82.1	87.2	67.8**	5.2	4.3	2.9**
WIC	54.6	72.7	68.4**	40.6	33.9	29.3**	4.4	2.0	2.9
Other Health Services									
Comprehensive primary care	9.7	14.0	7.5**	89.2	90.7	93.0*	3.7	1.3	0.3**
Mental health services	10.5	13.3	8.5*	90.5	94.7	88.2**	6.5	2.6	2.0**
Substance abuse services	9.2	8.2	3.9**	90.1	96.7	85.0**	5.3	1.0	1.9**

*p<0.05; **p<0.001



Discussion & Conclusions

- For many services, rural LHDs are less likely to offer, contract or have services provided by another organization in the community, whereas larger rural (i.e., micropolitan) jurisdictions are more likely to directly provide these services.
- Lower levels of clinical service delivery by rural LHDs may contribute to the access issues facing rural communities.
- Micropolitan LHDs may have greater infrastructure and capacity to deliver clinical services than those serving smaller jurisdictions. Health care reform brings threats and opportunities for LHD clinical service delivery.
- Further analyses to assess impacts on rural LHDs and identify strategies to help ensure access to clinical services is encouraged