Advancing Tobacco Prevention and Control in Rural America

EXECUTIVE SUMMARY

PURPOSE

In the United States, rural communities bear a disproportionate burden of health harms related to commercial tobacco use. In response to this persisting public health problem, rural stakeholders have shown energy and creativity in generating and implementing solutions. Through a Cooperative Agreement with the Centers for Disease Control and Prevention (CDC), the National Network of Public Health Institutes (NNPHI) developed a report entitled Advancing Tobacco Prevention and Control in Rural America. Report objectives were to: examine rates and patterns of commercial tobacco use across rural subpopulations; explore aspects of the rural context that may affect tobacco prevention and control efforts; provide an overview of rural tobacco control activities over the past ten years; suggest directions for future research; and offer recommendations for advancing rural tobacco control initiatives.

HIGHLIGHTS FROM KEY FINDINGS

PART I: **The Rural Context for Tobacco Prevention and Control**

Tobacco Use among Rural Subpopulations: Research shows disproportionately high rates of commercial tobacco use in many rural subpopulations. In a national sample of adults, past-month use of tobacco, cigarettes, and smokeless products was higher for rural non-Hispanic Whites, people with any mental illness, people with substance use disorders, and veterans than for their urban counterparts (2015-2016 data). Rural Hispanics, pregnant women, and sexual and gender minorities also showed higher rates than their urban peers on some tobacco use measures (2015-2016 data). Current smoking prevalence for rural adolescents was 7.3%, as compared to 3.8% for their urban peers, and adjusted odds of smoking were 54% higher for rural than for urban youth (2014-2016 data). Relative to other rural racial/ethnic groups, American Indian/Alaska Natives (AI/AN) had the highest rates of current commercial cigarette use (2012-2015 data).

Regional Variations in Tobacco Use: Prevalence and patterns of rural tobacco use varied across regions, with rural-urban disparities appearing in the Northeast, in the South, and among impoverished populations of the Midwest (2012-2013 data). Rural populations showed higher rates of smokeless tobacco use in all four United States Census

Bureau regions (2012-2013 data). Smoking prevalence is elevated in Tobacco Nation, a twelve-state region where rural residents make up over 20% of the population in each state (2015 data).

Sociodemographic Risk Factors for Tobacco Use: Rural-urban differences in tobacco burden are associated with the higher rural prevalence of sociodemographic risk factors, such as non-Hispanic White race/ethnicity and lower levels of educational attainment, employment, and income. However, rural-urban disparities in tobacco use persist even after controlling for sociodemographic characteristics. It is therefore important to consider the potential influences of rural cultures, infrastructure, and policy context on rural tobacco use patterns.

Rural Cultures: Although rural cultures are heterogeneous, some rural communities may share cultural strengths that could support rural tobacco control and prevention. Relevant cultural assets may include strong social networks, high levels of community engagement in mutual aid, and experience in forming cross-sector collaborations to enhance shared quality of life. At the same time, cultural factors in particular rural regions and subpopulations may present obstacles to rural tobacco control efforts. Rural populations, including those in tribal territories, continue to be a target for tobacco industry marketing. Cultural norms favoring tobacco use are prevalent in certain rural areas, including states with historical ties to tobacco cultivation.

Cultural considerations are especially important in addressing commercial tobacco use among tribal populations in rural areas. Experts within the American Indian community recommend an approach to tobacco control that expresses value for the use of sacred traditional tobacco in clearly defined ceremonial contexts, while emphasizing the importance of protecting community members from health harms related to commercial tobacco use.

Rural Infrastructure: Characteristics of rural health infrastructure may pose challenges for tobacco control efforts. For example, recent rural hospital closures could diminish some rural communities' capacity for population health activities including tobacco control. In addition, federal and state formulas for tobacco control funding may disadvantage rural local health departments (LHDs) in relation to their urban peers. Finally, individual rural residents may have greater difficulty accessing tobacco control and prevention services, due to local health care provider shortages, lower incomes, and elevated rates of uninsurance.

Despite the obstacles they face, rural communities can and do mount successful efforts to increase their tobacco control capacity. Rural hospitals, LHDs, Federally Qualified Health Centers (FQHCs), and other stakeholders within and outside the health sector often collaborate closely to conduct community health needs assessments, educate the public about health issues, and lead health improvement initiatives, including tobacco control programs. For example, the Mt. Ascutney Hospital in Windsor, Vermont helped to develop the Mt. Ascutney Preventive Partnership, a community-based public health coalition that uses policy and educational strategies to shift community norms related to tobacco use.

Some rural initiatives have enhanced rural residents' access to tobacco control services through the use of distance technologies such as state quitlines, telemedicine, and mobile phone-based strategies. Innovative, texting-based programs that deliver tobacco cessation support to rural populations include *Every Try Counts*, a campaign of the Food and Drug Administration (FDA), and *This is Quitting*, a program for rural Alaska Native youth sponsored by the Yukon- Kuskokwim Health Corporation, with support from the Truth Initiative.

Tobacco Control Policy Environment: Residents of rural and tribal areas may experience lower levels of tobacco control policy protection than citizens living elsewhere. States with higher proportions of rural residents tend to have less robust smoke-free air and tobacco tax policies, and local tobacco control provisions may be less prevalent in some rural areas. Moreover, state laws regulating commercial tobacco may not apply or be fully enforceable in tribal lands governed by sovereign AI/AN nations. In pursuing policy-oriented tobacco control, rural and tribal stakeholders may confront place-specific challenges, including concerns about disrupting relationships with the tobacco industry and imposing limits on individual freedoms.

In contrast to overall patterns, some predominantly rural states have strong tobacco control policies, and successes in rural tobacco control policy occur at the local level as well. In pursuing local tobacco control policy initiatives, rural stakeholders may advance their aims by engaging youth and ordinary citizens, partnering with local hospitals and LHDs, and presenting stakeholders with data on community members' support for stronger protections. Tribes can help protect their citizens by passing their own commercial tobacco control measures.

PART II: **Tobacco Control and Prevention Interventions in Rural Areas**

Cessation: Successful rural cessation initiatives included policy interventions, media campaigns promoting cessation, and delivery of cessation treatments in both health care and non-clinical settings. Noteworthy countermarketing campaigns with rural and tribal reach included the CDC's *Tips from Former Smokers®* campaign and media initiatives funded by Oklahoma's Tobacco Settlement Endowment Trust (TSET). Rural tobacco cessation interventions were often designed to accommodate their target populations' needs and preferences: Programs were tailored to improve their coordination with other health services and to enhance their cultural appropriateness. Many rural cessation programs addressed obstacles that rural residents sometimes confront in accessing high-quality cessation services. To address geographic access barriers, programs encouraged rural residents' use of quitlines, brought cessation services to rural tobacco users' homes and communities, and employed emerging technologies such as telemedicine, cell phones, and Web-based applications. To mitigate access barriers due to rural workforce shortages, programs employed non-physician providers and lay health advisors to deliver cessation interventions. To address cost barriers faced by some rural residents, programs advocated for improved insurance coverage of cessation, provided free services, and offered financial incentives for quitting tobacco use.

Prevention of Initiation: Successful rural prevention activities used policy strategies and countermarketing campaigns. Policy approaches included restricting tobacco advertising, increasing the unit price of tobacco through taxation, and raising the minimum legal sales age (MLSA). Prevention-oriented policies were adopted in Bethel, Alaska, which raised its excise taxes on cigarettes and smokeless tobacco, and in Chautauqua County, New York, which approved a local 'Tobacco 21' law to raise the MLSA for tobacco use from 18 to 21. Many prevention programs involved cultural tailoring, e.g., incorporating local, rural themes in countermarketing campaigns and working with members of target communities to generate content. Although tailoring was widely used, research suggested that mass media countermarketing campaigns following CDC best practice guidelines could achieve positive results in rural settings even in the absence of extensive adaptation. Countermarketing was effective in preventing initiation among rural youth: Rural adolescents with enhanced exposure to countermarketing were more likely than peers without such exposure to be receptive to anti-tobacco messages. Graphic images of tobacco-related health harms were viewed as highly persuasive by youth in rural areas.

Promotion of Smoke-Free Air: Smoke-free interventions identified in this review were diverse in settings and scope. Many initiatives created smoke-free air policies for particular contexts, such as schools or public parks, whereas others focused more broadly on ordinances covering multiple settings. Many of the smoke-free air interventions included in the report resulted in at least one sustained policy change or recurring smoke-free event, and several ultimately led to multiple smoke-free air policy changes or the eventual passage of a statewide law. Some rural initiatives successfully promoted local smoke-free air policies, even in states that lacked statewide, comprehensive smoke-free laws. Thus, local action helped compensate for weaknesses in state-level protections. Local coalitions made progress in promoting smoke-free air policies even where state law preempted local smoke-free ordinances. Tribes advocated successfully for the passage of smoke-free air protections in tribal communities where state-level smoke free laws did not apply. Rural and tribal communities have built capacity to enact smoke-free policies through participating in state-local collaborations, using technical assistance, and raising community awareness about health harms related to secondhand smoke.

DIRECTIONS FOR FUTURE RESEARCH

- While rural communities may face some similar socioeconomic disadvantages and infrastructure limitations, their tobacco-related social norms and policy climates may vary across states and regions. Therefore, federal and state efforts to support rural tobacco control initiatives should be informed by consultation with rural stakeholders, including leaders of rural hospitals, FQHCs, rural health clinics (RHCs), LHDs, tribal councils, and community-based organizations.
- Community-based participatory research could clarify stakeholders' perspectives on what challenges they face, what strategies they consider productive, and what forms of assistance they need.
- Research is warranted to further explore rural-urban differences in tobacco use within Tobacco Nation.
- More study is needed to determine whether federal health reform and its provisions on tobacco cessation coverage have helped rural people gain access to cessation services.
- Emerging technologies show promise as means for facilitating rural access to cessation services. Further evaluation would be helpful to establish the transferability of these modalities to rural settings.
- Investigators should consider how state-level tobacco control policies including preemption influence local-level policies in rural communities.
- Studies should further examine how state, tribal, and local tobacco control policies affect tobacco use in rural subpopulations.

RECOMMENDATIONS FOR ADVANCING RURAL TOBACCO PREVENTION AND CONTROL

Federal and State Agencies

- Rural hospitals often play key leadership roles in community health improvement initiatives, including tobacco control. The recent wave of rural hospital closures may decrease local capacity for such activities. Federal and state agencies should consider how they can preserve and strengthen health infrastructure in rural communities affected by closures.
- In disbursing tobacco prevention funds to rural health systems and community-based organizations, federal and state agencies should consider allocating resources on the basis of epidemiological burden as well as population impact in order to ensure that rural programs are not systematically underfunded relative to urban ones.
- To increase rural access to cessation services, states could support service provision by non-physicians and lay health advisors, through ensuring that state licensing regulations and Medicaid reimbursement policies accommodate such practices.
- To permit the increased use of emerging technologies in tobacco control and prevention, federal and state agencies should continue to promote the expansion of rural broadband and mobile phone access.
- Given that rural youth respond more strongly to national tobacco countermarketing campaigns as their levels of exposure to campaign messages increase, national campaigns should continue purchasing supplemental advertising in rural television and radio markets, and state tobacco control programs should consider investing in this approach where possible.

Communities, Tribes, and Local Stakeholders

- Given the demonstrated effectiveness of policies such as smoke-free air measures, tobacco excise tax increases, and Tobacco 21 laws in decreasing the prevalence of tobacco use, rural stakeholders may wish to consider advocating for such policies at state, tribal, and local levels.
- Where states preempt the adoption of local tobacco control ordinances, rural programs may achieve progress by educating the public on the adverse impacts of preemption and building community support for the repeal of state preemption laws.
- Tobacco control initiatives may find it useful to leverage rural cultural assets including strong commitments to community engagement and skills in cross-sector collaboration.
- To promote rural communities' involvement in tobacco control and prevention programs, it may be essential to forge partnerships including trusted local leaders from LHDs, health systems, businesses, faith-based organizations, and schools.
- Many communities are more willing to support tobacco control if it is presented as necessary to protect youth. Therefore, young people can be influential tobacco control advocates, and local, rural coalitions should engage their participation.
- To encourage community buy-in, it may also be helpful to involve local stakeholders in developing culturally tailored messages that show how program goals are consistent with core community values.
- Rural health systems can show leadership by implementing evidence-based, system-wide tobacco prevention and control plans. These plans could include:
    - Adopting tobacco-free campus policies
    - Training staff in best practices for the delivery of tobacco cessation services
    - Enhancing linkages to the community by enlisting lay health advisors in service provision
    - Launching quality assurance initiatives that use electronic health records (EHRs) to monitor progress toward tobacco-related population health goals
- As resources permit, rural schools can consider planning and implementing comprehensive tobacco control measures in coordination with their school health programs. Components may include:
    - Adopting 100% tobacco-free campus policies applying to all school facilities and events at all times
    - Linking parents and youth to cessation resources
    - Using evidence-based tobacco prevention curricula
    - Collaborating with LHDs and community agencies to advocate for the adoption of comprehensive tobacco control policies
    - Recruiting youth to lead counter-marketing campaigns targeted to peers
- When rural communities lack resources to tailor their local tobacco prevention campaigns, they can make gains by using existing advertising materials and implementing standard, evidence-based educational programs.
- Given the critical role that parents play in shaping youth norms related to tobacco, rural tobacco control efforts should engage parents as collaborators. Parents could effectively advocate for measures to protect children from secondhand smoke and restrict youth access to tobacco.

To download the full report, including extensive references, please visit www.nnphi.org/ruraltobacco

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