ADVANCING RURAL TOBACCO PREVENTION

2025 THOUGHT LEADERS' SUMMIT

Summit Summary

On November 6-7, 2025, Rural Initiatives Strengthening Equity (RISE), a project of the California Health Collaborative, along with the Tobacco-Related Disease Research Program (TRDRP), convened tobacco prevention and treatment professionals from throughout California for a summit on how to support rural communities as they strategize advocacy toward Endgame, the worldwide effort to end the sale of tobacco and nicotine products that is encouraged and supported by the California Tobacco Prevention Program (CTPP). Participants included researchers, tobacco treatment and cessation leadership staff, senior state-level tobacco prevention program staff, evaluators, county-level public health staff, rural policy experts, and health equity experts. Over the course of two days, the group explored the current landscape of rural prevention efforts with the intention to develop actionable steps and plans to accelerate efforts to reduce rural tobacco use. This document is a summary of this meeting.

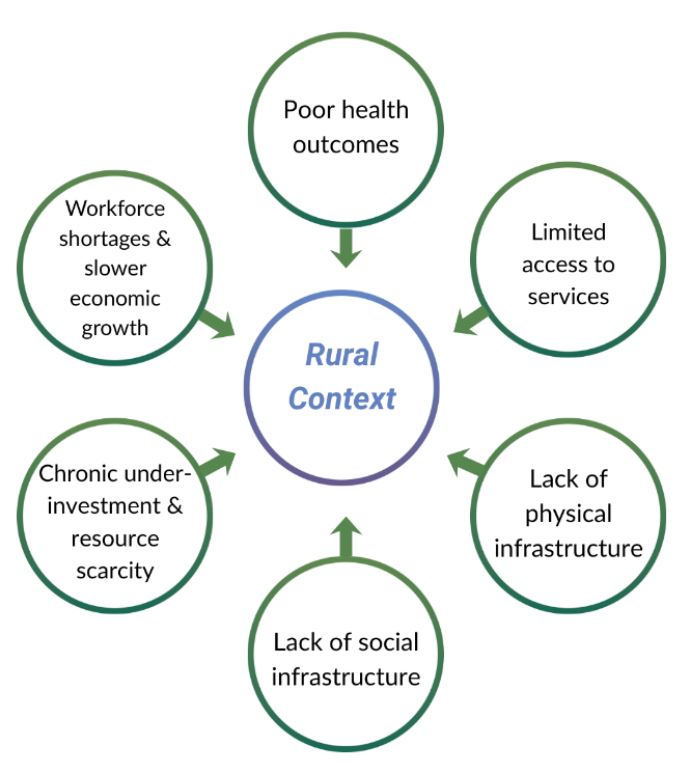
RISE
Rural Initiatives Strengthening Equity

CALIFORNIA HEALTH COLLABORATIVE
changing lives by improving health and wellness

TOBACCO-RELATED DISEASE RESEARCH PROGRAM

Rural Context

The conveners held the summit in a remote area of Northern California, a location touched by issues that affect rural areas throughout the state. The rural north has a high ratio of land mass to population (21.6% of California's total land area and only about 2% (~700,000) of the total population)[1]. Additionally, the rural north has higher poverty rates, higher percentages of residents enrolled in Medi-Cal, and higher percentages of students enrolled in free and reduced meal programs compared to the state average. The rural north has a higher percentage of individuals over the age of 60 and a higher percentage of residents who are white (78.6%) than California as a whole (52.1%).[1] Rural north counties rank below most other counties in the state on key health outcome measures related to length and quality of life.[1] Evidence strongly suggests that deaths associated with behavioral health, substance use, and tobacco use contribute to significantly elevated mortality rates in the region.[2]



California's rural communities are disproportionately burdened by tobacco. Adults living in rural areas of the state are more likely to use tobacco products than those in urban areas (14.5% rural vs. 10.9% urban).[3] Rural 10th and 12th grade students use tobacco products at higher rates compared to their urban and suburban counterparts (9.8% rural; 6.0% suburban; 6.1% urban) and report significantly higher vape use (7.6% rural; 4.8% suburban; 4.4% city).[4] Rural counties have more stores that sell tobacco per 100,000 residents than counties in general (90.6 vs. 74.8).[5] California's rural counties reflect the national trend[6] of fewer past year quit attempts than urban residents (52.5% vs. 54.7%).[7] Yet, rural residents in the state are more likely to report the intent to quit (63.3% vs. 58.4%) than their urban counterparts.[7] (For more information on tobacco treatment in rural communities, see RISE's 2025 Reducing the Impact of Tobacco on Rural California Communities.)

Complex Factors May Lead to Poor Rural Health Outcomes

- **Social, economic, and environmental conditions -** Higher rates of poverty, unemployment, lower educational attainment, and multiple adverse childhood experiences individually predict worse health and shorter life expectancy.[8] [9] [10] [11] Rural residents experience higher rates of chronic diseases[12] that can cause pain, functional limits and distress.
- **Limited access to services -** Nationwide, rural residents live an average of 10.5 miles from the nearest hospital, roughly twice as far as urban and suburban residents.[13] Rural populations are more likely to have to travel long distances to access healthcare services, particularly subspecialist services,[13] [14] which can make it difficult to find tobacco treatment and cessation services.
- **Lack of physical infrastructure -** Not only is it harder to reach in-person care, but poor cellular service and insufficient or non-existent broadband also limit access to telehealth. Rural residents are more likely to lack basic needs, such as safe water, transportation, and emergency services, and contend with delayed care, unmanaged chronic diseases, and communities more vulnerable to large-scale disasters.
- **Lack of social infrastructure -** Increased isolation and weakened support networks compound existing economic and geographic barriers, especially for older adults, farm workers, tribal communities, and low-income families. There are fewer community coalitions, lower outreach capacity, and fewer embedded community health workers in many rural northern California counties, reducing capacity to respond to local needs.[15]
- **Healthcare workforce shortages and underinvestment -** Many rural regions in northern California and the Central Valley are designated as Health Professional Shortage Areas. This means residents contend with longer wait times, fewer available appointments, and reduced access to specialty care and screenings.[16] Heavily burdened rural healthcare staff experience more burnout and

higher turnover. Underinvestment in training pipelines, incentives, and support for rural clinicians leads to persistent staff shortages in rural regions.[17]

- **Slower economic growth and resource scarcity –** Rural public and nonprofit services that provide essential health, social, and economic support are especially vulnerable to cuts, closures, or overload. Fewer services, unstable health care capacity, and fragile safety nets drive higher rates of preventable illness, disability, and premature death, especially among older adults and low-income residents.[17] Slower economic growth means fewer high-paying jobs, higher poverty rates, and increased housing and food insecurity, all of which are strong predictors of poor health outcomes. Chronic economic stress contributes to higher rates of depression, substance use, and chronic disease.[18] Further, when the local economy is weak, the tax base is smaller and philanthropic resources may be thinner, there is less support for health and social services.

Tobacco-Related Impacts

National[19] and local[20] research suggests that the accumulation of these circumstances, called "cumulative disadvantage," contributes to rural health and tobacco-related inequities, including higher rates of tobacco use. When it comes to tobacco treatment, access is more limited in rural regions.[21] Provider shortages make it harder to find primary care (14.7% of rural residents report difficulty accessing primary care, compared to 12.2% of all California residents[22], further limiting opportunities for referrals to tobacco treatment. Compared to the overall state population, rural residents are less likely to have smokefree policy protections (63.6% vs. 88.7%).[23] Smokefree policy protections are shown to encourage quit attempts.[24] Also, there are significantly fewer tobacco retail policies in rural areas (10.7% vs. 46.9%),[25] which can hinder efforts to shift social norms and reduce environmental triggers for tobacco use.[26] [27] Contributing factors to lack of policy protections in rural communities may include the tendency of rural residents and governing bodies skewing politically conservative[28] and resistant to perceived restrictions on personal behavior. As well, rural communities must often weigh competing priorities due to scarcity of resources.

Summit Take Aways & Conclusions

The summit sparked new connections and collaboration ideas. In addition to wanting to lean into efforts to support tobacco treatment, participants identified numerous opportunities to accelerate the reduction of rural tobacco use, including:

- Continue to value rural community wisdom and expertise when designing programs, policies, research and services.
- Continue to foster collaboration among all programs that serve rural communities.
- Provide strategic planning opportunities for rural leaders.
- Continue to prioritize rural counties and focus on needs-based (vs. population-based) funding and technical assistance, keeping in mind the additional challenges rural communities face, such as geography, large-scale disasters, and workforce availability.
- When designing funding opportunities for rural areas, review and adapt guidelines taking into account staff shortages, geographic barriers, and lack of CBO capacity.
- Continue to leverage community partners at market-rate compensation to help do the work; when not available, shore up compensation for adequate project staffing.
- Foster rural workforce development with programs that place medical pathway students in rural settings for training.
- Recognize rural-adjacent sub/urban areas may have different needs and capacities.
- Appreciate standardized workplans and support customization for local community needs.
- Continue rural leadership development; expand opportunities with on-demand trainings.
- Continue public-health pipeline internship opportunities.
- Expand partnerships for local data gathering (e.g. TUPE, LLAs, and researchers).
- Build research partnerships between programs and community partners to share data broadly, including implementing a shared repository of rural data and a means for partners to share available resources and needs.
- Support and elevate qualitative and lived-experience[28] data collection.
- Improve cross-dissemination of treatment resources and expand tailored options that bridge the gaps in rural communities, engaging pharmacies, hospitals, community health workers, and behavioral health entities.
- Engage with community health workers for tobacco treatment training, screening, and referrals.
- Expand focus to link youth to online and in person tobacco treatment options.

At the conclusion of the summit, many recognized the need to build on momentum and nurture new relationships. A core group committed to meet quarterly.

Summit Participants

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