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BRIEF REPORT

Clinician attitudes toward referring patients to pharmacists for tobacco cessation services



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ABSTRACT

Background: The role of pharmacists in tobacco cessation has grown substantially in recent years, now including the ability to prescribe medications in many states. Although pharmacists can fill a gap in care by helping patients quit, other clinicians' perceptions regarding referring patients to pharmacists for these services have not been described.

Objective: To characterize clinicians' current referral patterns to pharmacists for tobacco cessation services, intention to refer in the future, and perceived barriers to and facilitators of referrals.

Methods: A cross-sectional survey was administered within a network of federally qualified health centers (FQHCs), which provides care to underserved patients. Guided by the Consolidated Framework for Implementation Research (CFIR), the survey assessed (a) clinicians' sociodemographics, (b) interactions with pharmacists and referral practices, and (c) perceived barriers to and facilitators of patient referrals to network pharmacists for cessation assistance.

Results: Of 51 respondents (80% response), one third ($n = 17$) reported referring one or more patients to a FQHC network pharmacist in the past for help with quitting tobacco. Most (84%) reported willingness to refer patients to pharmacists in the future, and 100% of the 17 clinicians who had previously referred patients strongly agreed that they would refer again in the future. For 8 of 12 CFIR measures (67%), significant differences were observed between clinicians who had previously referred patients to pharmacists and clinicians who had not.

Conclusion: Nonpharmacist clinicians in an FQHC expressed positive views toward a pharmacist-led tobacco cessation service, and prior experience with referrals was consistent with strong intentions for future referrals. Future studies should explore concerns regarding impact on workflow to identify and implement strategies for streamlining referrals for cessation services.

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While significant progress has been made in recent decades to reduce tobacco use, 46.0 million adults in the U.S. used tobacco in 2021.¹ Smoking reduces life expectancy by an estimated 10 years² and results in nearly half a million deaths each year.³ The financial burden of tobacco use is

high, with an estimated \$170 billion spent annually in the U.S. for inpatient services, outpatient services, and prescription drugs to address tobacco-related diseases. Notably, 60% of these associated costs are covered by public sources such as Medicare and Medicaid.³ Although 76.6% of people using tobacco in 2018–2019 reported interest in quitting, few sought professional help to do so; of those who attempted to quit, 31.0% used medication(s), and 10.2% received counseling.⁴

Evidence indicates that pharmacists are effective in helping patients quit,^{5–7} and in 2004, New Mexico became the first U.S. state to permit pharmacists to prescribe tobacco cessation medications to patients through a statewide protocol without a collaborative practice agreement.⁸ As of June 2022, through legislative action, another 16 states had granted pharmacists the ability to prescribe medications to

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Key Points**Background:**

- A total of 46 million U.S. adults reported using tobacco in 2021.
- Pharmacists are effective in helping patients quit tobacco, and in many states can now prescribe medications for tobacco cessation.
- There is a paucity of published literature documenting clinicians' attitudes toward referring patients to pharmacists for tobacco cessation services.

Findings:

- One third of clinicians were actively referring patients to network pharmacists for tobacco cessation services.
- A total of 98% of clinicians agreed that they would be willing to refer to network pharmacists in the future for tobacco cessation services.
- Motivating factors for referring included improving patient quit rates, safety, need for innovation, improving quality measures, convenience, compatibility with workflow, pharmacists' access to medical information, and ease of implementation. A barrier was the concern for additional workload for clinical staff.

help their patients quit,⁹ and since that time several others have passed or have legislation in progress. Prescriptive authority for pharmacists can substantially enhance access to tobacco cessation services, including medications, for patients at the time when they are ready to quit. Research has shown pharmacists' prescribing for tobacco cessation to be effective,^{10,11} producing quit rates that are comparable to other clinicians.¹¹ Furthermore, in a recent study of patients enrolled at a federally-qualified health center (FQHC), 60.5% of 555 people who used tobacco reported that they would be comfortable talking with a pharmacist about quitting, and 43.8% believed a pharmacist would increase their chances of quitting for good.¹²

In a national survey of cessation practices and beliefs, primary care physicians reported commonly asking patients about tobacco use (97.7%) and advising patients to quit (94.9%); however, far fewer assisted patients with quitting and discussed pharmacotherapy (68.5%) or arranged follow-up care (23.1%).¹³ Pharmacists can fill this care gap through referrals from other health-care providers. In a study assessing a standardized referral process to community pharmacists for tobacco cessation prior to joint replacement surgery, patients who received cessation assistance from pharmacists had higher self-reported 30-day point-prevalence abstinence compared to patients who received standard care (20% versus 7%, respectively).¹⁴

Although referral to pharmacists for tobacco cessation services is relatively new, it is worthy of exploration, given their effectiveness and broad accessibility.^{14,15} As such, this study aimed to assess nonpharmacist clinicians' (a) current

referral patterns to pharmacists for tobacco cessation services, (b) intention to refer patients to pharmacists in the future, and (c) perceived barriers and motivators to referrals.

Methods

A cross-sectional study was conducted within a multisite FQHC (HealthLinc), which provides primary care, pharmacy services, and other clinical services to 29,537 underserved patients in Indiana annually. Clinic-based pharmacists at these practice sites provide interprofessional care with nonpharmacist clinicians, routinely prescribe and adjust medications under collaborative drug therapy management protocols, respond to clinicians' drug information questions, and assist with medication accessibility. A physical pharmacy is located with community-based pharmacists at 2 sites. At present, there are no formal health system-wide workflow procedures for referring patients to HealthLinc pharmacists for tobacco cessation services; however, clinicians can refer patients to both the clinic-based and community-based pharmacists for assistance.

Guided by the Consolidated Framework for Implementation Research (CFIR),¹⁶ major categories of survey items were (a) provider-level sociodemographics, (b) providers' interactions with pharmacists and referral practices, including willingness to refer patients to pharmacists in the future, and (c) core constructs of interest from the CFIR to assess providers' perceived barriers and facilitators of patient referrals to network pharmacists (i.e., at HealthLinc) for tobacco cessation.

Survey development and administration to target population

A web-based survey was developed and iteratively reviewed by authors and external content experts prior to pilot-testing with a subset of clinicians at the FQHC. Minor clarification-related revisions were made prior to distribution via email to the full target population of 64 nonpharmacist clinicians. The target population, for which a listing was obtained from the human resources department, included all physicians, nurse practitioners, dentists, optometrists, and behavioral health providers who worked at a health system site at the time of survey administration. Individuals who completed the survey received a \$10 Amazon.com gift card.

Survey measures*Participant sociodemographics*

Clinician respondents reported their gender, age, race, ethnicity, professional discipline, and years in clinical practice.

Clinician interactions with pharmacists and referral practices

Respondents reported the number of times in a typical work week that they interact with a pharmacist for patient care at their practice site, if they had ever referred patients for tobacco cessation services, and how often the latter occurred in the past 30 days. The survey then explained that in Indiana, pharmacists who receive appropriate training can prescribe all tobacco cessation medications under a statewide protocol, and that this "cessation service" requires patient counseling at

Table 1
Respondent population: Clinician characteristics (n = 51)

Characteristic	Category	n (%)
Gender	Male	15 (29.4)
	Female	35 (68.6)
	Prefer not to answer	1 (2.0)
Race	White	38 (74.5)
	Asian	5 (9.8)
	African American/Black	4 (7.8)
	More than one race	2 (3.9)
	Prefer not to answer	2 (3.9)
Hispanic or Latino	No	41 (80.4)
	Yes	8 (15.7)
	Prefer not to answer	2 (3.9)
Clinical profession	Nurse practitioner	24 (47.1)
	Physician	11 (21.6)
	Behavioral health counselor	9 (17.6)
	Dentist	6 (11.8)
	Optometrist	1 (1.9)

intake (medication and behavioral, which could include referral to the Indiana Tobacco Quitline), a 14-day follow-up, and a final contact at end of treatment. Following these statements, respondents were asked, "Based on this information, I would refer patients to a HealthLinc pharmacist in the future for tobacco cessation services (including prescribing for cessation medications)." Response options included 1 = strongly disagree, 2 = somewhat disagree, 3 = neither agree nor disagree, 4 = somewhat agree, and 5 = strongly agree.

Perceived barriers and facilitators of patient referrals to pharmacists for tobacco cessation services

Participants rated their extent of agreement with a series of statements for the various constructs comprising the *Innovation* (evidence-base, relative advantage, complexity, and cost), *Inner Setting* (information technology infrastructure, tension for change, incentive systems, compatibility, and relational connections), and *Outer Setting* (geographical location conditions) domains of the CFIR. Responses were recorded using a 5-point scale (1 = strongly disagree, 2 = somewhat disagree, 3 = neither agree or disagree, 4 = somewhat agree, and 5 = strongly agree).

Statistical analyses

Descriptive statistics were computed to characterize the study population and responses to survey items, and group comparisons were made using Mann-Whitney U tests for independent samples. Data were analyzed using IBM SPSS Statistics, Version 28.0. The study was approved by the Purdue University Committee on Human Research Protection Program.

Results

Participant sociodemographics

Of 64 clinicians who received an invitation to participate in the study, 51 (80%) completed the survey. The response rate across provider types ranged from 50% of optometrists (n = 2) to 100% of behavioral health providers (n = 9). When

examining responses across the 12 FQHC sites, participation ranged from 40% (1 site) to 100% (5 sites), with an average response rate of 82.3%. Most respondents were female (68.6%) and white (74.5%), with 15.7% reporting Hispanic or Latino ethnicity. The average age was 44 years (SD, 10.9; range, 25–76), with an overall average of 12.2 years in practice (SD, 10.8; range, 1–46). Nurse practitioners and physicians comprised just over two thirds of the respondent population (Table 1).

Clinician interactions with pharmacists and referral practices

In a typical work week, the median number of times a clinician reported interacting with a HealthLinc pharmacist for patient care activities was 5 (range, 0–50). One third of respondents (n = 17) reported referring one or more patients to a HealthLinc pharmacist in the past for help with quitting tobacco; among these, the median number of referrals in the past 30 days was 2 (range, 0–40). All but 2 respondents agreed (84% strongly agreed and 14% somewhat agreed) that they would be willing to refer patients to pharmacists for tobacco cessation services in the future. Of the 17 clinicians who had previously referred patients for cessation services, 100% strongly agreed that they would be willing to refer again in the future.

Perceived barriers and facilitators of patient referrals to pharmacists for tobacco cessation services

Overall, 80% or more of clinician respondents either somewhat or strongly agreed with 10 of the 12 statements used to assess the CFIR constructs (Table 2). These included all statements for the Inner Setting (5 items) and Outer Setting (1 item) domains, and all but 2 (of 6) items for the Innovation domain. Respondents were more likely to disagree with workload-related statements assessing whether referring patients to a HealthLinc pharmacist for tobacco cessation services would impact workloads for the provider (Relative Advantage construct) or the clinic staff (Cost construct).

When comparing responses from clinicians who had referred one or more patients to a pharmacist for tobacco cessation services in the past versus those who had not, statistical significance was observed for 8 of 12 statements (Table 2). The *Innovation* domain statements that differed by clinician group pertained to advantages outweighing disadvantages of referrals, lessening of workload, and ease of implementation. For the *Inner Setting* domain, significant differences were observed for items assessing adequacy of pharmacists' access to patient medical information to inform treatment decisions, a need for innovation within the practice site to reduce the number of patients who use tobacco, compatibility with current workflows, and support from clinic staff for referring patients to pharmacists for assistance with quitting. No difference was observed for the *Outer Setting* domain statement. When considering only clinicians who had previously referred patients to pharmacists for tobacco cessation services (n = 17), disagreement was observed for one respondent, for one of the 12 statements: "Referring patients to a HealthLinc pharmacist will not increase workload for the clinic staff" (n = 1, strongly disagreed).

Table 2

Clinicians' (n = 51) perceived motivators and barriers for referring patients to pharmacists for tobacco cessation services [n (%)].

Construct	Statement	Prior history of referring ^a	Strongly Disagree 1	Somewhat Disagree 2	Neither Agree nor Disagree 3	Somewhat Agree 4	Strongly Agree 5	P value ^b
Innovation								
Evidence of Strength and Quality	There is sufficient evidence that pharmacists can increase patients' chance of quitting tobacco use. ^c	Yes	0 (0)	0 (0)	1 (5.9)	1 (5.9)	15 (88.2)	0.06
		No	0 (0)	0 (0)	6 (17.6)	7 (20.6)	21 (61.8)	
		Total	0 (0)	0 (0)	7 (13.7)	8 (15.7)	36 (70.6)	
Relative Advantage	Referring patients to a HealthLinc pharmacist for tobacco cessation services has more advantages than disadvantages. ^c	Yes	0 (0)	0 (0)	0 (0)	0 (0)	17 (100.0)	0.03
		No	0 (0)	0 (0)	1 (2.9)	7 (20.6)	26 (76.5)	
		Total	0 (0)	0 (0)	1 (2.0)	7 (13.7)	43 (84.3)	
Relative Advantage	Referring patients to a HealthLinc pharmacist for tobacco cessation services will help lessen my workload.	Yes	0 (0)	0 (0)	2 (11.8)	4 (23.5)	11 (64.7)	0.05
		No	2 (5.9)	3 (8.8)	6 (17.6)	10 (29.4)	13 (38.2)	
		Total	2 (3.9)	3 (5.9)	8 (15.7)	14 (27.5)	24 (47.1)	
Complexity	A process for referring patients to HealthLinc pharmacists for tobacco cessation services would be easy to implement. ^c	Yes	0 (0)	0 (0)	0 (0)	5 (29.4)	12 (70.6)	0.03
		No	0 (0)	1 (2.9)	7 (20.6)	11 (32.4)	15 (44.1)	
		Total	0 (0)	1 (2.0)	7 (13.7)	16 (31.4)	27 (52.9)	
Cost	Referring patients to a HealthLinc pharmacist will not increase workload for the clinic staff.	Yes	1 (5.9)	0 (0)	1 (5.9)	3 (17.6)	12 (70.6)	0.04
		No	2 (5.9)	5 (14.7)	5 (14.7)	8 (23.5)	14 (41.2)	
		Total	3 (5.9)	5 (9.8)	6 (11.8)	11 (21.6)	26 (51.0)	
Cost	Pharmacists prescribing tobacco cessation medications does not pose a greater safety risk for patients than if I was prescribing. ^c	Yes	0 (0)	0 (0)	1 (5.9)	2 (11.8)	14 (82.4)	0.30
		No	0 (0)	0 (0)	7 (20.6)	3 (8.8)	24 (70.6)	
		Total	0 (0)	0 (0)	8 (15.7)	5 (9.8)	38 (74.5)	
Inner Setting								
Information Technology Infrastructure	Pharmacists at HealthLinc have adequate access to patient medical information to make informed treatment decisions regarding tobacco cessation treatment. ^c	Yes	0 (0)	0 (0)	0 (0)	0 (0)	17 (100.0)	0.05
		No	0 (0)	0 (0)	1 (2.9)	6 (17.6)	27 (79.4)	
		Total	0 (0)	0 (0)	1 (2.0)	6 (11.8)	44 (86.3)	
Tension for Change	There is a need for innovation within my practice site to reduce the number of patients who use tobacco. ^c	Yes	0 (0)	0 (0)	0 (0)	1 (5.9)	16 (94.1)	0.02
		No	0 (0)	0 (0)	1 (2.9)	12 (35.3)	21 (61.8)	
		Total	0 (0)	0 (0)	1 (2.0)	13 (25.5)	37 (72.5)	
Incentive Systems	Working with a pharmacist within HealthLinc will improve patient quit rates and improve my "Tobacco Use: Screening and Cessation" metric. ^c	Yes	0 (0)	0 (0)	0 (0)	3 (17.6)	14 (82.4)	0.07
		No	0 (0)	0 (0)	5 (14.7)	9 (26.5)	20 (58.8)	
		Total	0 (0)	0 (0)	5 (9.8)	12 (23.5)	34 (66.7)	
Compatibility	Referring patients to a HealthLinc pharmacist for tobacco cessation would be compatible with current clinic workflow. ^c	Yes	0 (0)	0 (0)	0 (0)	3 (17.6)	14 (82.4)	0.01
		No	1 (2.9)	2 (5.9)	5 (14.7)	12 (35.3)	14 (41.2)	
		Total	1 (2.0)	2 (3.9)	5 (9.8)	15 (29.4)	28 (54.9)	
Relational Connections	Members of the clinical staff at HealthLinc would be supportive of referring patients to pharmacists for tobacco cessation services. ^c	Yes	0 (0)	0 (0)	0 (0)	1 (5.9)	16 (94.1)	0.02
		No	0 (0)	1 (2.9)	3 (8.8)	8 (23.5)	22 (64.7)	
		Total	0 (0)	1 (2.0)	3 (5.9)	9 (17.6)	38 (74.5)	
Outer Setting								
Local Conditions	It would be convenient for my patients to receive tobacco cessation services from a HealthLinc pharmacist. ^c	Yes	0 (0)	0 (0)	0 (0)	2 (11.8)	15 (88.2)	0.07
		No	0 (0)	0 (0)	2 (5.9)	10 (29.4)	22 (64.7)	
		Total	0 (0)	0 (0)	2 (3.9)	12 (23.5)	37 (72.5)	

All bolded and italicised values equal to or less than 0.05 are statistically significant.

^a Has previously referred one or more patients to a HealthLinc pharmacist for tobacco cessation services.^b P values associated with Mann-Whitney U test for independent samples.^c Items with 80% endorsement (somewhat agree or strongly agree).

Discussion

The results of this study indicate positive attitudes among nonpharmacist clinicians in an FQHC setting for referring patients to pharmacists for tobacco cessation services. Notably, one third of the clinicians who responded to the survey had referred patients to pharmacists in the past for cessation services; of these, all strongly agreed they would be willing to refer again in the future. This suggests positive experiences with referrals in the past, or these providers perceive referring patients to a pharmacist for tobacco cessation services to be generally advantageous.

All but one clinician respondent agreed that innovations are needed within their practice site to reduce the number of patients who use tobacco. Furthermore, most clinicians who had referred patients to pharmacists in the past for cessation services strongly agreed with the need for innovation, which might contribute to their ongoing referrals. This is especially important in FQHC settings, because underserved individuals exhibit a higher prevalence of tobacco use and suffer a disproportionate degree of tobacco-related morbidity and mortality.¹ Enhanced access has the potential to improve patient outcomes—patients who receive assistance from a clinical provider are up to 2.2 times more likely to quit successfully for 5 or more months compared to patients who do not, and those who receive assistance from more than one type of healthcare provider also are more likely to have even greater success with quitting.¹⁷

Of 12 survey statements assessing CFIR constructs, 10 achieved 80% agreement by respondents. Several facilitators of referrals were identified, including evidence of pharmacists' access to information to make treatment decisions, their ability to increase quit rates and improve quality metrics, and the perception that their prescribing will not increase safety risk for patients. Overall, respondents indicated there were more advantages to referring patients than disadvantages and that implementing a new referral process would be easy. Most perceived that a referral process would be compatible with their current workflow, members of the clinical staff would be supportive of referrals, and it would be convenient for patients to receive the tobacco cessation services from pharmacists.

Two workload-related statements did not achieve 80% agreement. With all but 2 clinicians indicating that they would be willing to refer patients to a pharmacist for tobacco cessation services, yet only one third had reportedly done so in the past, it is possible that the lack of a formal health system-wide referral workflow procedure inhibits referrals due to concern about an increase in the associated workload. This is supported by the observed differences between clinicians who had referred in the past versus those who had not for survey items assessing workload, ease of implementation, and compatibility with current workflow.

Because there was some level of disagreement on the extent to which referrals would impact workloads for clinicians and staff, future initiatives should assess clinic workflow processes and explore the potential of automated, default referral systems to FQHC system pharmacists (e.g., embedded within the electronic health record). While there is some support for such an automated referral process in inpatient settings,¹⁸ this has yet to be explored in outpatient settings.

Finally, the between-group differences that were observed related to perceived adequacy of pharmacists' access to patients' medical information and perceptions that other clinical staff would be supportive of referrals suggest potential concerns among clinicians who have not referred to pharmacists in the past. Increasing clinicians' knowledge of what health databases that HealthLinc pharmacists can access, as well as establishing a formalized referral workflow (which would be indicative of health system-wide buy-in), could lead to higher clinician referrals in the future.

While we observed a high response rate across clinic sites and among provider types, the generalizability of the findings is limited by the narrow geographic and clinical population (HealthLinc; one 12-site FQHC network in Indiana) and small numbers of eligible provider types including behavioral health providers, dentists, and optometrists. Despite this, our findings provide potential support for the integration of in-house referrals between clinicians and pharmacists within FQHCs. Results of this study add to the current literature by characterizing nonpharmacist clinicians' perceptions about referrals to pharmacists for tobacco cessation assistance, which thus far has been explored only outside of the United States.¹⁹

Within the setting of a health system that primarily serves under-resourced individuals, most clinicians were willing to refer their patients to pharmacists for tobacco cessation assistance. When considered in combination with published data from the same health system indicating that patients are interested in working with pharmacists for quitting,¹² it is apparent that FQHC pharmacists can play an important and enhanced role. Future research is needed to investigate workflow and procedures, from an implementation science perspective, across various practice sites. Additionally, research is needed to estimate the quit rates and opinions among FQHC patients who participated in pharmacist-led tobacco cessation services, to characterize pharmacist engagement in statewide protocols for prescribing cessation medications, and to estimate the extent to which patients access pharmacy-based cessation services.

Conclusion

The role of pharmacists in tobacco cessation has grown substantially over the past two decades, and this group of healthcare providers can fill an important gap in care for patients who use tobacco products. Within a large multisite FQHC, nonpharmacist providers expressed positive views toward a pharmacist-led tobacco cessation service. Specific concerns expressed by a minority of clinicians pertained to workflow and staff burden. Future studies should further explore these perceptions, conduct studies to assess the actual impact of referrals on workflow and staff burden, and identify strategies for streamlining referrals to FQHC pharmacists for cessation services.

Disclosure

The authors declare no relevant conflicts of interest or financial relationships.

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