



Doctors for Cannabis Regulation

Legislative and Administrative Guidelines for Regulating Cannabis Use in Healthcare Facilities

A DFCR White Paper

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Introduction

In 2018, Ryan Bartell, a 41-y/o Coast Guard Veteran with end-stage pancreatic cancer, was admitted for 24-hour hospice care at MarinHealth Medical Center in Greenbrae, California. Due to chronic, unrelenting pain, Bartell was heavily sedated with opioids and unable to communicate with family, friends, and/or caretakers. Because of the opioid-related cognitive impairment, Ryan's father requested that Bartell be allowed to use medical cannabis to lessen his need for opioids and allow increased interaction with his family during his final days. Doctors claimed that the use of medicinal cannabis would threaten the hospital's federal funding (due to the federal prohibition of cannabis) and therefore refused to allow its use [1]. Bartell's family had him transferred to a hospital in Washington State that allowed the use of medical cannabis. After using cannabis, Bartell was able to cease the use of opioids, remain comfortable, and communicate with his loved ones in his final days.

In response to Bartell's situation, California State Senator Ben Hueso publicly stated: "For too long, Californians have been denied access in healthcare facilities to medical cannabis-related treatment methods, despite research demonstrating it to have innumerable benefits...As a result, individuals have been subjugated to unnecessary trials of pain and suffering" [2]. The Senator and California state Governor Gavin Newsom then worked together to enact "Ryan's Law" (Senate Bill 311) in September 2021. While not addressing the issue of federal health reimbursements, Senate Bill 311 supported "the ability of a terminally ill patient to safely use medicinal cannabis within specified health care facilities in compliance with the Compassionate Use Act of 1996..."[3].

Several states and many healthcare organizations have now approved legislation and policies to support the use of cannabis in healthcare facilities. Yet, more than half of medical cannabis states and most healthcare settings still have not addressed this issue. The purpose of this white paper is to present the statute and policy language that has been used to support the use of medical cannabis in healthcare settings, with the hopes that other states and healthcare facilities can utilize similar language. In jurisdictions that have authorized medical cannabis for qualifying patients, the requirements for the storage of medical cannabis, product consumption, patient qualification, and both who can administer the product and how the product is to be administered are described in detail. For this paper, the term "health care facility" can refer to "hospital", "hospice care," "assisted living facility," "medical facility," "nursing/assisted living facilities," and "long-term care facilities."

Dispensing Cannabis in Health Care Settings

In the U.S., medical cannabis has been legalized in 37 states, the District of Columbia, Guam, Puerto Rico, and the U.S. Virgin Islands for pain, nausea, and many other chronic medical conditions. In 2019, there were an estimated 5.5 million individuals with state-issued medical cannabis cards in the US [4].

The need for medical cannabis persists when patients are hospitalized. Yet, most hospitals refuse to either allow cannabis to be dispensed in their facilities or for patients to self-administer their own cannabis, even when purchased under the auspices of a state-approved medical card.

The resistance to cannabis use in health facilities may be due to concerns over the continued federal prohibition of cannabis, the resistance of organized medicine to acknowledge the efficacy of medical cannabis, most physicians' lack of knowledge and inexperience with medical cannabis, and the general conservatism and caution of large corporate medical systems [5, 6]. In addition, although local jurisdictions have legalized the possession and use of cannabis, the federal government continues to identify cannabis as a Schedule I drug (having "no currently accepted medical use and a high potential for abuse") and the use and possession of cannabis remain subject to penalty under federal law. "While cannabis remains a Schedule I drug, for the past 7 years Congress has added restrictions on federal enforcement through the funding bill for the Commerce-Justice-Science (CJS) agencies prohibiting Justice Department funds from being used to prevent states from implementing medical cannabis laws" [7].

However, there is concern within healthcare facilities that, given the continued federal prohibition of cannabis, the Centers for Medicare & Medicaid Services (CMS) may refuse Medicare/Medicaid reimbursement and other agencies may pull federal research funds if cannabis is used in healthcare facilities. Although federal agencies have, to our knowledge, neither threatened nor actively pursued the withholding of reimbursements or funding, these concerns have persisted. In addition, the policy of CMS is as follows (per BA personal communication with CMS):

"Medicare or Medicaid regulations do not address the use of medical marijuana or CBD oil. Surveyors do look at topics such as medication storage, appropriate self-administration of medications, and safe smoking policies, fire safety, etc. – but there is nothing explicitly in the Medicare/Medicaid survey and certification process related to the use of marijuana or CBD oil. CMS regulations generally require compliance with federal, state, and local laws. CMS would not cite this unless that other body (the authority having jurisdiction-in this case the DOJ) has made an adverse finding. We are not aware of a provider that has specifically lost funding or been penalized for permitting the use of marijuana or CBD oil; however, there have been citations cited when there has been non-compliance related to the other areas above (fire safety issues in smoking marijuana in a resident/patient room, safe storage, etc.)."

Given congressional restrictions on the use of Justice Department funds to prevent states from implementing medical cannabis laws, concern regarding CMS withholding reimbursement appears to be unfounded.

In contrast, the Department of Veterans Affairs unequivocally states that all healthcare facilities must follow federal guidelines on all levels of cannabis use, specifically noting that "VA healthcare providers may not recommend it [cannabis] or assist Veterans to obtain it" [8]. Clinicians in these facilities are not allowed to prescribe, complete state paperwork regarding cannabis programs, refill prescriptions, or allow the use or possession of cannabis at VA medical centers.

Optimal Regulations and Policies & Procedures

As of January, 2023, there were 18 states that provide legal guidance for cannabis use in healthcare facilities (Alaska, Arizona, California, Colorado, Connecticut, Florida, Illinois, Maine, Maryland, Massachusetts, Minnesota, Mississippi, New Hampshire, New York, North Dakota, Oregon, South Dakota, Virginia, and West Virginia). Provided below are some examples that represent the language of medical cannabis in healthcare facilities. Using state regulatory statutes and hospital policies and procedures already in place, we propose optimal language for those jurisdictions and healthcare facilities that are considering providing guidance for the allowance of cannabis recommendation, dispensing, and use in healthcare facilities. Commentary regarding language we consider too restrictive will also be noted and discussed.

Who is allowed to use cannabis?

States and organizations permitting medical cannabis in healthcare facilities require certain qualifications to be met for patient use. Some facilities have their own requirements and specified conditions in a provided registry. This is so patients that specify conditions under the policy rules can be recognized for continued use of medical cannabis in healthcare locations. Below are state regulations and specific policies on who can use medical cannabis.

State Statutes

Minnesota created the Minnesota Medical Cannabis Program (MMCP) in 2014, which created a registry through the MDH (Minnesota Department of Health). As long as one is a medical cannabis patient, they are permitted to use medical cannabis as an alternative treatment while admitted to hospital care. Patients must be 18 years old and have an illness that qualifies for a medical cannabis card. In 2015, Minnesota added specific language to include healthcare facilities in allowing medical cannabis treatment methods (state statute H.F No. 1792). This statute (Chapter 144.50 from H.F. No. 1792) describes the definitions and qualifications for licensing and patient registry requirements, with the revised version reading:

“Health care ...facilities owned, controlled, managed, or under common control with hospitals... may adopt reasonable restrictions on the use of medical cannabis by a patient enrolled in the registry program who resides at or is actively receiving treatment or care at the facility” [9].

California Senate Bill 311, noted in the Introduction, is surprisingly limited in that it allows the safe dispensing and use of medical cannabis in the hospital setting *only* for patients who are “terminally ill” (a medical condition resulting in a prognosis of life of one year or less, if the disease follows its natural course” (1649.1, section (e)) and who has a licensed physician’s recommendation or obtainment of a personal medical card from the state of California.

Maine legalized medical cannabis use on their 1999 ballot initiative, and a decade later (2009) passed the Maine Medical Use of Marijuana Act (MMUMA) with a revision recently completed on September 28th of 2022. Taking healthcare facilities and medical cannabis use a step further, section 2430-C covers “legal protection for hospitals and long-term care facilities”. Listed under the section are qualifications for hospital and long-term facility protection according to the MMUMA:

“If the use of a form of harvested cannabis that is not smoked, including but not limited to edible cannabis products and tinctures and salves of cannabis, by an admitted patient who has been certified under section 2423-B occurs in a hospital, that hospital is not subject to prosecution, search, seizure or penalty in any manner, including but not limited to a civil penalty or disciplinary action by an occupational or professional licensing board or entity, and may not be denied any license, registration,

right or privilege solely because the admitted patient lawfully engages in conduct involving the medical use of cannabis authorized under this chapter.” [10]

New York extended Title 10 of the Department of Health part 405 of minimum hospital standards to recently include hospitals as a facility for medical cannabis administration. Under section five of the regulation:

“Hospitals, in accordance with hospital policies and procedures, may authorize a patient to bring in his or her own medications, including prescription medications, non-prescription medications and medical marijuana...”[11].

States address patients’ absolute right to use cannabis in healthcare facilities differently. Of the 18 states mentioned for medical cannabis language, Minnesota [12], Idaho [13] and Mississippi [14] share a similar language that healthcare states facilities (while Idaho shares similarities in language, the law was overturned in 2021 due to unrelated issues):

“..may not unreasonably limit a registered qualifying patient's access to or medical use of medical cannabis authorized under this chapter, unless failing to do so would cause the facility to lose a monetary or licensing-related benefit under federal law or regulations" [14].

While this language appears to provide absolute protection for patient access to medical cannabis in a healthcare facility, the disclaimer “failing to do so would cause the facility to lose a monetary or licensing-related benefit under federal law or regulations” offers a potential loophole for any healthcare facility concerned about losing payments or suffering legal consequences. Missouri leaves the option of allowing or prohibiting cannabis use up to the healthcare facility:

“...A hospital must determine whether it will allow patients to self-administer their own supply of marijuana during inpatient stays, treat the drug as a continuing home medication or ban use in the facility altogether” [15].

Maryland enacted their medical marijuana commission and later medical cannabis law in 2014. A language that slightly differs from previously discussed locations:

“Any of the following persons acting in accordance with the provisions of this subtitle may not be subject to arrest, prosecution, or any civil or administrative penalty, including a civil penalty or disciplinary action by a professional licensing board, or be denied any right or privilege, for the medical use of cannabis.... a hospital, medical facility, or hospice program where a qualifying patient is receiving treatment” [16].

Illinois mentions in the Compassionate Use of Medical Cannabis Program Act that healthcare facilities are not included as a “public place”, which is not a permitted area for medical cannabis use. It is interpreted that healthcare facilities are not included as a location where medical cannabis is not permitted:

“(A) This Act does not permit any person to engage in, and does not prevent the imposition of any civil, criminal, or other penalties for engaging in, the following conduct.... (3) Using cannabis.... (F) .. For the purposes of this subsection, a “public place” does not include a health care facility... a "health care facility" includes, but is not limited to, hospitals, nursing homes, hospice care centers, and long-term care facilities”. [17]

While Idaho has made multiple attempts to legalize medical marijuana, a ballot initiative in 2021 was overturned by their Supreme Court. In Idaho’s planned 2024 planned ballot initiative for legalizing medical cannabis, Idaho offers perhaps the most generous allowance of cannabis use in health care facilities, stating that

“For the purposes of medical care...a registered qualifying patient’s use of marijuana... is considered the equivalent of the authorized use of *any other medication used at the direction of a practitioner* [italics ours] and does not constitute the use of an illicit substance or otherwise disqualify a registered qualifying patient from medical care” [6].

Hospital Policies

The Mayo Clinic variably allows cannabis patients to bring their own cannabis into the healthcare facility. In their Minnesota location, “Mayo Clinic health care providers may certify state residents with qualifying conditions in the Minnesota medical cannabis program...Minnesota residents with a supply of medical cannabis from a Cannabis Patient Center may continue use during their Mayo Clinic visit or hospital stay” [18]. For reasons unexplained, Mayo Clinic campuses in Arizona and Florida do not certify people for medical marijuana or allow its use on campus or in the hospital despite medical cannabis being legal in these states.

Healthcare facilities like Midwest Mental Health Clinic in Minnesota and Sanford Health in North Dakota authorize certified patients to be granted the use of medical cannabis in their facilities [19]. At the Maryland, Washington D.C., and Florida locations of John Hopkins Hospitals, medical cannabis use is only allowed under the auspices of a clinical trial. According to John Hopkins Health Care Senior Vice-President Peter Hill, “If we violate federal law by possessing or dispensing it, we could risk legal action, including withholding of federal funds. We felt that risk was too high to the organization and to our staff” [20].

How is cannabis accessed, administered, and stored?

Regulations vary as to how cannabis can be administered in a healthcare facility. Commonly, state statutes note that healthcare facilities must use their own discretion when applying or creating cannabis-specific regulations. In addition, healthcare facilities are often required to develop and adhere to their policies and procedures for medical cannabis use. Most facilities show similarities in language, optimizing the strength of multiple states in implementing these policies and regulations. In general, these policies require that healthcare facilities note:

- Where the cannabis purchase was obtained
- What staff is qualified to provide patients with the product from its storage placement
- Smoking or vaping policies, e.g. the prohibition of smoking or vaping
- Chart documentation of patient’s use of cannabis
- Storage policies for cannabis

Typical language is that provided in the Idaho Medical Marijuana Act (which, as noted, was overturned in 2021):

“Any ... hospital, or other type of residential care or assisted living facility may adopt reasonable restrictions on the use of marijuana by their residents or a person receiving inpatient services, including: ... (b) That the facility, caregivers, or hospice agencies serving the facility’s residents are not responsible for providing the marijuana for qualifying patients; (c) That marijuana is consumed by a method other than smoking; or (d) That marijuana is consumed only in a place specified by the facility” [13].

New York requires that healthcare staff document a legal source of patient-supplied cannabis, the integrity of the cannabis product, that the patient is qualified to have medical cannabis and the capacity of the patient or their caregiver to administer the cannabis [11].

To protect employees, Minnesota’s program clarifies that staff is not in violation of the state’s law for assisting patients with medical cannabis, which can involve possessing, distributing, and/or administering cannabis [12].

Regulations also may provide language specifying the proper storage of other patients and guests within the vicinity of the hospital. For example, the Idaho Medical Marijuana Act (Section 39-9704) states:

“Any ... hospital, or other type of residential care or assisted living facility may adopt reasonable restrictions on the use of marijuana by their residents or a person receiving inpatient services, including: (a) That the facility will not store or maintain the qualifying patient’s supply of marijuana;” [13].

New York state regulations dictate where cannabis is stored and what happens to the product if the patient passes, including disposal or destruction of the product:

“(vii) if a patient dies in the hospital, any unused prescription medication shall be destroyed or disposed of in accordance with all applicable State and Federal laws and regulations. Such prescription medications may not be turned over to the patient’s caregiver. In the case of medical marijuana, it may be turned over to the deceased patient’s designated caregiver or to appropriate law enforcement for destruction or disposal” [11].

Final Recommendations

After medical cannabis helped Ryan Bartell share his final days with family, other states, families, and medical professionals responded in support of Senate Bill 311. Because medical and adult use of cannabis is becoming more widely accepted nationwide, it is critical to thoughtfully change healthcare facility policies to include storage placement, proof of medical card, proof of purchase, and other aspects of medical cannabis use. Non-smoking policies should be added along with the administration method of medical cannabis (e.g., self-administered vs. health care provider).

To help other states or healthcare properties recreate policies, Americans for Safe Access has created an online, printable guide describing how California’s bill succeeded in becoming law [21]. The guide exemplifies Ryan Bartell’s condition and mission and how to implement it in healthcare facilities including written guidelines for staff, sample medical cards and verifications, waiver documents, and medical professional resources. As one of the largest member-based organizations of not only medical professionals but patients and scientists, the ASA sets an example in advancing a legal and safe approach for cannabis use.

Below we provide a brief summation of language that provide the best options for medical cannabis patients while protecting their providers and healthcare facilities:

Qualifying patients: “For the purposes of medical care...a registered qualifying patient’s use of marijuana... is considered the equivalent of the authorized use of any other medication used at the direction of a practitioner and does not constitute the use of an illicit substance or otherwise disqualify a registered qualifying patient from medical care” [13].

“Hospitals...may authorize a patient to bring in his or her own medications, including prescription medications, non-prescription medications, and medical marijuana” [11].

Limitations on healthcare facilities: A healthcare facility “...may not unreasonably limit a registered qualifying patient’s access to or medical use of medical cannabis authorized under this chapter, unless failing to do so would cause the facility to lose a monetary or licensing-related benefit under federal law or regulations...” [14].

Protections for healthcare facilities: “If the use of a form of harvested cannabis that is not smoked, including but not limited to edible cannabis products and tinctures and salves of cannabis, by an admitted patient who has been certified under section 2423-B occurs in a hospital, that hospital is not subject to prosecution, search, seizure or penalty in any manner, including but not limited to a civil penalty or disciplinary action by an occupational or professional licensing board or entity, and may not be denied any license, registration, right or privilege solely because the admitted patient lawfully engages in conduct involving the medical use of cannabis authorized under this chapter.” [10]

Responsibilities of healthcare facility: A healthcare facility “may adopt reasonable restrictions on the use of marijuana by their residents or a person receiving inpatient services, including: (a) That the facility will not store or maintain the qualifying patient’s supply of marijuana; (b) That the facility, caregivers, or hospice agencies serving the facility’s residents are not responsible for providing the marijuana for qualifying patients; (c) That marijuana is consumed by a method other than smoking; or (d) That marijuana is consumed only in a place specified by the facility” [13].

In conclusion, the use of cannabis in healthcare facilities has the potential to revolutionize the way medical professionals treat a variety of medical conditions. With its proven efficacy in treating chronic pain, reducing anxiety and depression, improving sleep, and providing relief from nausea and vomiting associated with chemotherapy, cannabis has emerged as a viable alternative to traditional medications. The legalization of medical cannabis in many states has made it easier for patients to access this treatment option, and the increasing acceptance of cannabis by the medical community has helped to remove the stigma associated with its use. In light of these developments, it is imperative that states and healthcare facilities adopt policies and protocols that ensure the safe and effective use of cannabis as a form of medical treatment. This will not only benefit patients but will also provide healthcare providers with the necessary tools to provide safe and effective care to their patients. We believe that the responsible integration of cannabis into healthcare practice will have a positive impact on patient outcomes and overall health and wellness.

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