

# Medical Cannabinoids: What Clinicians in Long-Term Care Should Know

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To date, older adults are consuming cannabinoids at a higher (no pun intended) rate than ever before. Chronic pain, cancer-related pain, back and neck issues, arthritis, insomnia, post-traumatic stress disorder, and anxiety are the most common conditions that lend to the use of medical cannabis — and all are common conditions among the older adult population.

It is likely that the prevalence of post-acute and long-term care (PALTC) residents who desire to continue, restart, or initiate cannabinoid use will continue to rise. The aging of the baby boomer generation, public opinion shifting toward normalization, expansion of state-based medical programs, and the growing availability of over-the-counter cannabinoid products make this trend unsurprising, yet still unsettling, for many PALTC providers.

## Assessing the Current Laws

State-regulated programs that permit primary or comprehensive cannabinoid care exist in every state except Nebraska and Kansas. Publicly available medical cannabis programs to treat chronic pain, arthritis, and other conditions that affect the older adult population exist in 36 states and four territories. It is important to note that nearly half the states with medical cannabis programs list Alzheimer's disease/dementia as a qualifying condition ("State Medical Cannabis Laws," National Conference of State Legislatures, updated June 6, 2022, <https://bit.ly/3OgSL3j>; "Medical Cannabis States and Their Qualifying Conditions," updated Jan. 1, 2021, <https://bit.ly/3Hojt7W>).

Despite a growing body of evidence surrounding the therapeutic benefits of cannabis products, at the federal level the cannabis plant and most products produced from it remain schedule I controlled substances, subject to the U.S. Controlled Substances Act. Consequently, PALTC providers who receive Medicare or Medicaid funding cannot store or permit direct care staff to

assist in the administration of medicines that meet schedule I criteria.

However, several states do allow assisted living providers to aide residents in obtaining medical certification, storing the product, and assisting the resident to administer it. So medical cannabis may become an integral part of a resident's assisted living plan of care, but it may be forbidden later if skilled nursing care becomes warranted.

Federally legal products also are becoming widely available for over-the-counter sales in retail outlets, dispensaries, or online stores. Two cannabinoids exempt from the Controlled Substances Act include cannabidiol (CBD) and hemp-sourced products with a delta-9-tetrahydrocannabinol (THC) concentration of less than 0.3% on a dry weight basis [21 C.F.R. § 1308.11(d)(23)].

## Understanding the Next Steps

Most clinicians theoretically support medical cannabis use, and popular opinion on the subject continues to improve. Unfortunately, the confidence to promote cannabinoids as a therapeutic intervention is often overridden by knowledge gaps, conflicting evidence, regulatory citation concerns, societal stigmas, and other barriers. Approaches may range from "just say no" or "don't ask, don't tell" to "giving the green light." However, whether clinicians feel ready or not, cannabis is here to stay. So it is essential to obtain the basic knowledge needed to aid residents in making informed choices about using or abstaining from cannabinoids for symptom relief or pleasure.

The variability in qualifying conditions, provider-patient relationships, patient certification, and more make understanding the laws within your state a great place to start. The previously mentioned resource from the National Conference of State Legislatures is comprehensive and routinely updated.

If your organization does not already have an established policy, consider curating one that addresses medical cannabis and the therapeutic or recreational use of cannabinoids that are not included in a state cannabis program. Regardless of organizational policy, clinicians should include assessment questions about the current and historical use of cannabinoids to evaluate their safety and provide comprehensive care.

## Evaluating Available Products

It is easy to assume that all of the more than 100 cannabinoids are equivalent in legality and euphoric effects to the mainstream perception of "marijuana" or "pot," but this is far from accurate. Unlike many pharmaceuticals, cannabis is a whole-plant medicine that can simultaneously have a positive impact on more than one body system or target symptoms. Each cannabinoid has a terpene

and flavonoid profile that uniquely interacts with the human endocannabinoid system — the body's largest neuroregulatory system — to maintain homeostasis.

For example, both CBD and THC have analgesic, antiemetic, anxiolytic, and antispasmodic benefits. But, unlike THC, CBD does not induce intoxication or euphoria. In fact, CBD is able to mitigate the euphoria while prolonging the therapeutic effects associated with THC. Other cannabinoids gaining prevalence for therapeutic use include cannabinol (CBN), cannabigerol (CBG), and tetrahydrocannabinolic acid (THC-A).

As normalization progresses from taboo to mainstream, the products continue to evolve in both creativity and the complexity of cannabinoid profile. The most commonly known route of administration is still inhalation, but topicals, sublingual tinctures, edibles, and suppositories make one's choice to use cannabinoids more discrete than ever. If nothing else, both consumers and PALTC providers must be aware of the need to evaluate a product's label and Certificate of Analysis (CoA). The product should be clearly labeled and contain recommended dosing instructions. The CoA is proof of third-party testing and defines the cannabinoid profile and purity.

Understanding the cannabinoid composition will inform the clinician and resident of the cannabinoid profile's intended effects, their duration, and potential side effects. Unless otherwise approved in your state, the concentration of delta-9-tetrahydrocannabinol listed in the CoA should be validated as less than 0.3%. And if the CoA does not confirm the absence or presence of solvents, pesticides, heavy metals, and microbials, this may indicate a product to steer clear of.

## Starting Low, Going Slow

Cannabinoids are biphasic, meaning what is therapeutic at a certain quantity may not achieve the desired effect in a different quantity. Luckily, therapeutic effects may be achieved through various routes of administration and titration of quantities that are unique to each individual.

Dosing should "start low, go slow, and stay low." Why? Higher doses may have diminishing returns with increased risks or unintended effects, such as the symptoms of paranoia, anxiety, or tachycardia more commonly associated with being too "high." Conversely, the product may be unsuccessful in palliating the targeted condition if attention to the cannabinoid profile and its related evidence are not taken into consideration.

Because cannabinoid care is individualized, target symptom and side-effect monitoring should be recorded to evaluate the product's effectiveness. These evaluations should occur at routine

intervals as it may take time to achieve the intended effects or find the right product.

## Anticipating Drug Interactions

Drug interactions with cannabinoids are still being studied, but there are a few known interactions that providers should be aware of. For instance, CYP3A4 inhibitors (macrolides and verapamil) and CYP2C9 inhibitors (cotrimoxazole, fluoxetine, and amiodarone) may increase the psychoactive effects (*CMAJ* 2020;192:E206, <https://bit.ly/3OiP7WM>). Other flagged drugs include warfarin, clobazam, central nervous system depressants and sympathomimetics, theophylline, clozapine, and olanzapine.

## Key Recommendations

The National Council of State Boards of Nursing recommends these elements to consider when performing a clinical encounter to evaluate cannabinoid treatment (*J Nurs Regul* 2018;9[Suppl]:S1-S60, <https://bit.ly/3AbBLrA>):

- Scientific evidence related to the qualifying condition
- Current treatment plan and the resident's response
- Medication reconciliation and prescription drug program review
- Health history and risk factors
- Current and previous use of cannabinoids
- Knowledge level about risks and benefits
- Potential side effects

## Further Information

Several organizations offer information about cannabinoids in health care:

- American Cannabis Nurses Association: <https://www.cannabis-nurses.org/>
- Center for Medical Cannabis Research: <https://www.cmcr.ucsd.edu/>
- Doctors for Cannabis Regulation: <https://www.dfcr.org/>
- National Conference of State Legislatures- State Cannabis Laws: <https://bit.ly/3OgSL3j>
- Society of Cannabis Clinicians: <https://www.cannabisclinicians.org/>

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And importantly, he said that early data have "started to suggest that vaccination is helpful" in preventing PASC.

In PALTC, prevention is on Dr. Mithani's longer-term research agenda. "Do the therapeutics we have available right now have any impact on long COVID? Have the people who have potential for rehabilitation received some level of treatment? In this population, and in any population, actually, we don't have any idea." 

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