Oregon Cannabis Commission Meeting Minutes

Date: May 21st, 2018

Time: 1:00 pm – 4:00 pm

Location: Portland State Office Building, 800 NE Oregon St., Portland, Oregon

Attendees:

OCC Attendees: Katrina Hedberg, Jesse Sweet, Andre Ourso, Esther Choo, Rachel Knox, Anthony Taylor, Jeff Kuhns
On phone: Patrick Luedtke
OMMP/OHA Staff: Carole Yann, Margaret Flerchinger, and Shannon McFadden
DOJ Staff: Shannon O'Fallon
Members of the Public as listed on the Sign in sheet: Mike Rochlin, Chris Nelsen, John Sajo, Erich Berkouitz, Carla Kay, Kathryn Cannon, Dov Judd, Smantha Slaughter, Kassi Roosth, Sam Barber, Kris McAllister, Dana C, Kevin C, Dale Petersdorf, Sunnie Sanchez

Subgroups	Responsible Party
Product Integrity	Andre Ourso and Jesse Sweet and Jeff Kuhns (leads)
Research	Esther Choo and Katrina Hedberg (leads)
Training subgroup	Rachel Knox (lead)
Access to patient care	Anthony Taylor (lead)

Summary of Meeting Motions:

Proposed Motion	Proposed by	Outcome
Approval of Minutes from March 2018	Jesse Sweet motioned; Jeff Kuhn seconded	All approved

Welcome and Introductions by the Oregon Cannabis Commission

Topic	Key Discussion	Responsible
Commission Objective • **Governor's Office Updates**	Esther Choo meets with the Governor's office monthly to provide updates from the meetings. We are advised to be focused on the feasible and not to be too pie in the sky because they would like recommendations that we can implement that will move us forward. Making sure they aren't so lofty even though it may be wonderful but nothing will change. They want us to evaluate the framework of the Oregon Medical Marijuana Program and make recommendations specifically about that framework. The framework piece doesn't fall under our 4 subcommittees but we do have a separate section under the individual subcommittee reports. Also, the governor's office would like to have another patient join one of the subcommittees – please consider adding. Anthony Taylor – Patient Access has added 3 Medical Patients to his subcommittee. 2198 – Mission for Cannabis Commission • A possible framework for the future governance of the Oregon Medical Marijuana Program, including:	Esther Choo

	• (A) Proper oversight and regulation of each of the following: (i) Registry identification cardholders and designated primary caregivers, as those terms are defined in ORS 475B.410; (ii) Attending physicians, as defined in ORS 475B.410; (iii) Marijuana grow sites, as defined in ORS 475B.410; (iv) Marijuana processing sites, as defined in ORS 475B.410; and (v) Medical marijuana dispensaries, as defined in ORS 475B.410; • Steps that the state must take, whether administrative or legislative in nature, to ensure that research on cannabis and cannabis-derived products is being conducted for public purposes, including the advancement of: (A) Public health policy and public safety policy; (B) Agronomic and horticultural best practices; and (C) Medical and pharmacopoeia best practices • The commission shall submit a report in the manner prescribed by ORS 192.245 to the interim committees of the Legislative Assembly related to health and judiciary on the findings and determinations made by the commission under subsection (1) of	

	this section. As part of the report, the commission may make recommendations for legislation. Please see Memorandum - PRIORITIES IN ENFORCEMENT OF FEDERAL LAWS INVOLVING MARIJUANA IN THE DISTRICT OF OREGON - with meeting materials provided	
Reports from Subcommittees • **Summary of Progress** • **Legislative Recommendations from each subcommittee** • **Feedback from Subgroups** • **Possibility of combining some recommendations** **Feasible recommendations for year one**	**Anthony Taylor – Patient Access** **Report to Full Commission-Proposed Rules – SB 1544.** To date the final draft of the proposed rules to implement SB 1544 has not been released so it is not yet known what OHA will propose for final rules relating to immature plants limits under 24". During the first meeting the issue of how many immature plants under 24", OHA proposed a 3:1 ratio of immature plants for every mature plant allowed. This was unworkable for most growers and the discussion soon centered around what the workgroup for SB 1544 had decided before the bill was sent to Legislative Counsel for drafting. According to notes from the meeting this was a 15:1 ratio. After lengthy discussion OHA told the members they would come back with something based on the discussion at the first meeting. They came back with the same proposal – 3:1 ratio. During the second meeting and after another lengthy discussion with pictures and other information provided regarding what is done in OLCC with immatures under 24", OHA left us hanging as to what to expect in the final draft.	

	As noted, we are expecting the final draft to be available any day now and hope that the numbers of immature plants under 24" is decided in favor of the growers and not the agency. The Commission should consider meeting to discuss overriding the OHA should this prove not to be the case. **Patient Access Subcommittee Status Report to Full Commission** The Subcommittee has met twice with its main focus to date on what is needed to increase access for patients and secondarily to analyze the need for changes at the program level. The subcommittee has elected to address patient access first and streamlining the program second. The members are working on suggested survey questions and you will find attached a pretty comprehensive draft of survey questions provided by Sarah Bennett. Patient Survey: • Target date for completion of survey to be years end • What method by which the survey would be conducted whether by email, phone or via USPS • If it should be for existing patients or patients that have left The general consensus was that it be for those that have left the program but consideration be given to ability to contact those patients that have left the program. The method for	

	conducting the survey is still being discussed as it relates to costs and ability to maintain anonymity as primary considerations. Patient Access: Members discussed various approaches to who would qualify for reduced cost and/or free medicines and how to get the medicines to those that need it. Subsets of patients. • Those already receiving a reduced fee for their patient card • Those already in the Oregon Health Plan • Those that need medical grade products with no interest in growing, processing or selling. • Those unable to meet financial cost of being in program/fallen through the cracks. Other things considered: • Growers able to give away to any patient • Expanding list of those than can sign APS • Non- profit dispensaries • How to incentivize OLCC retail outlets to participate Costs:	

	• Ability of state to subsidize. **Esther Choo - DRAFT Legislative Proposal for Research** I. **Background.** There is a need for research that expands our understanding of the health effects of cannabis with greater specificity of products. The state of Oregon will establish a Cannabis Research Center (CRC) devoted to advancing science related to the health effects of cannabis consumption. According to the Senate Bill 844 Task Force report, such a body "will be capable of driving forward critical research at a much faster pace than other similar attempts have been able to…No other single initiative could do as much to strengthen the Oregon cannabis industry and to support the needs of Oregon medical marijuana patients." II. **Goals**. The CRC will develop lines of inquiry within three general priority areas defined by the state (in HB 2198): cannabis-related public health policy and public safety policy; agricultural and horticultural best practices; and medical and pharmaceutical best practices. Within those areas, priority topics may include (as outlined within SB 844): a. *Basic plant and agricultural research*. Studies on the cannabis plant to fully understand the medicinal properties of the plant, define means of insuring product safety, and determining the health impact of product integrity and safety efforts. b. *Public health research*. Research projects designed to assess impacts of policies (such as those relating to time, place and manner of sale) on use, attitudes, and health effects critical to developing policies and procedures for cannabis retail and medical distribution systems, as well as to inform interventions to mitigate potential negative impacts of cannabis legalization; public health questions around cannabis involving toxicology and contamination issues relating to cannabis grown in Oregon.	

	c. *Observational studies* related to the medical benefits of cannabis, which will provide evidence of the likely medical and public health benefits of cannabis and preliminary information for the development of clinical research studies. d. *Pre-clinical research*. Research establishing the safety and efficacy of cannabis and its components necessary to obtain FDA approval to conduct clinical (human) research. e. *Clinical research* (meeting FDA standards). Rigorous clinical trials meeting FDA standards necessary to develop the evidence base for use of cannabis use in Oregon and lead to products FDA approved for medical use. 2. **Structure**. The CRC is conceived as a collaboration across academic institutions and with the Oregon Health Authority, potentially housed within Oregon Health & Science University (OHSU), given its focus on health effects, and with potential co-leadership by OHSU and Oregon State University (OSU). Member investigators will have established experience in cannabis research relevant to public health and medical care. 3. **Funding**. Oregon legislature will allocate cannabis excise tax receipts (??) and OMMP fees to support the CRC, to a total of $10 million over 3 years. A portion of the funds will provide administrative support for the Center. The remainder of the funds would establish a grants program. Although Center investigators will pursue federal and other sources of support, a foundation of sustained support from the state will ensure the long-term success and effectiveness of such a program. 4. **Grant administration.** The CRC grants program could support both internal grants, which would be awarded to Center investigators, and external grants, which would be awarded to investigators from public and private entities outside the Center. Both programs would be	

	administered through a competitive process with a rigorous external peer review process, similar to an NIH grant program, and with input from the Oregon Health Authority. This process will be designed to maximize support for research that will be of the highest possible impact in the scientific community; that will answer critical questions necessary to promote the health and safety of Oregonians; and that will support best practices and policies for the Oregon Medical Marijuana Program (OMMP). Grants would focus on innovative early stage research that will generate the data necessary to obtain external federal grant funding. The funds could also be used to support critical areas of cannabis research that are not likely to be funded by NIH or other federal agencies. Grants may be awarded to investigators outside the state, but should include at least one in-state team member to ensure the focus on addressing the needs of Oregon citizens. 5. **Oversight.** The peer review process will be designed to guard against funding research that is biased in favor of or against particular outcomes, or that brings up potential conflicts of interest, including commercial, personal, and political interests. 6. **Other functions.** With sustained funding, the Center has great potential to develop a workforce for innovative, dynamic, state-of-the-art research related to cannabis. Resources and activities may include: a. A centralized, secure, web-based research participant registry for OMMP members or other citizens who want to learn about getting involved in IRB-approved research studies involving medical cannabis. b. Creation of partnerships and data-sharing arrangements with other institutions and relevant state agencies in order to assemble, organize, and make available as much collected data as possible on the use of cannabis in the state of Oregon.	

	c. Standardized administrative, educational, training, and structural support for university-based researchers in Oregon working on cannabis-related issues in order to expedite the process of obtaining institutional and federal approvals for research using cannabinoids d. In-depth understanding of policy and other barriers to cannabis research, establishment of appropriate recommendations to state agencies in addressing those barriers, and creation of internal or collaborative routes toward completing research that is hindered by such barriers e. Partnerships, collaborations, or contractual relationships with public and/or private entities within the U.S. and other countries in furtherance of the Institute's objectives f. A repository of current literature related to medical cannabis for clinicians and scientists g. Expertise in medical cannabis-related policy and a resource for state and local policymakers h. A potential future site for production of FDA-approved cannabis preparations i. Supporting and examining the impact of education and training efforts **Rachel Knox - DRAFT Legislative Proposal for Attending Physician Training** **Background.** The viability of the Oregon Medical Marijuana Program hinges upon meaningful and effective patient outcomes. These outcomes extend beyond the ability of a patient to access medical cannabis, which has been identified as a significant limitation of the current OMMP structure by which Attending Physicians (i.e. MDs and DOs) currently act in the capacity of gatekeepers, approving access to cannabis to consumers as an elective	

	therapeutic option. While OMMP Attending Physicians (APs) are required to abide by established standards of care and other expectations as outlined in HB 4014, the Clinical Guidelines Work Group's 'Guidelines for Attending Physicians When Recommending the Medical Use of Marijuana,' there remains a need for minimum training requirements. Standardized AP training in cannabis medicine will ensure that OMMP patients are receiving, at minimum, uniform instruction and oversight across all AP encounters. As such, the OMMP will adopt training minimums by way of sourcing instruction from established and credible training programs, or developing a novel training program of its own. **Goals.** AP Training will satisfy multiple priority areas defined by the state as outlined in HB 2198. These priority areas are as follows: *Proper oversight and regulation of Attending Physicians*. APs will receive minimal training to ensure uniformity in the assessment, consultation and management of consumers considering OMMP enrollment or renewal. Training will reaffirm the basis for ORS 475B.916, prohibiting the Oregon Medical Board (OMB) from imposing civil penalties or taking other disciplinary action against an AP who is abiding by the standard of care established by HB 4014 and expanded by the Oregon Cannabis Commission through minimal training requirements. The AP training program will be kept current and in compliance with the established standards of the American Medical Association and Accreditation Council for Continuing Education, a standard recognized by the OMB. AP training will award certifications for completion and require recurrent renewal to ensure that OMMP APs remain up-to-date with respect to advancing clinical principles in cannabis medicine. Certified APs will not be required to submit clinical records with their APS forms in an effort to better protect patient information.	

	Advancing medical and pharmacopoeia best practices. Standardized AP training promotes medical and pharmacologic best practices through measuring key performance indicators (KPIs). This is particularly important in the current absence of rigorous scientific evidence, standing to be fulfilled by the proposed Cannabis Research Center (CRC). Through measuring performance indicators such as provider preparedness and competency, as well as patient outcomes, product use, and satisfaction, training will be subjected to a feedback loop that is critical to advancing and refining training objectives. *Advancing Agronomic and horticultural best practices*. In much the same way, standardized clinical methods being controlled, measuring patient outcomes and product use will identify needs and trends that will inform agronomic, horticultural and processing practices, refining product development to better serve patient, clinical and research needs. *Advancing public health and safety policy*. Standardized AP training provides a uniformity to clinical assessment, consultation and management that inherently controls and protects the narrative of and use of cannabis as medicine. *Identifying (and mitigating) potential factors that could prevent access and affordability of cannabis for medical use*. Access to cannabis for medical use has as much to do with consistent quality care and physical access to care as it does to the availability of consistently high quality and affordable cannabis product. AP training satisfies both by equipping OMMP APs with a consistent and high quality education that can benefit all patients across all AP encounters, and by establishing a means through which more Oregon providers feel comfortable integrating cannabis medicine into their current practices.	

	AP training will improve the level of clinical oversight patients can expect, and in an equitable way. AP training will make clinical directives more precise, helping patients use their cannabis medicine with increased intentionality and efficiency, thereby improving the patient experience and reducing product waste, translating into significant cost savings at dispensaries. AP training is also expected to increase the number of providers participating in the OMMP, limiting patients' need to spend money travelling to clinics, often outside of their cities and towns, to seek evaluation by an OMMP AP. *Addressing the impact of federal laws, regulations and policies on the possible framework*. A rising area of interest is medical malpractice for providers evaluating consumers for cannabis use as medicine. Establishing an AP training program prepares Oregon APs for satisfying future coverage requirements. *Developing a long-term strategic plan for ensuring that cannabis will remain a therapeutic option for persons with debilitating medical conditions as defined in ORS 475B.410*. As described in Section 2, subsection e, AP training will improve the therapeutic efficacy of cannabis use as medicine for our most fragile medical patients, as cannabis remaining a viable and effective option for this group depends, in part, on provider OMMP participation, preparedness and competency. *Addressing necessary amendments to the laws of the state pertaining to cannabis, including any necessary amendments to ORS 475B.010 to 475B.395 and 475B.400 to 475B.525*. AP training will establish the common use of the latin name, *cannabis*, referring to the plant by its taxonomic name, and avoiding the pejorative and racially propagandized term, 'marijuana.' In doing so, it is found necessary by legislative action to change the word	

	'marijuana' to 'cannabis' in statute, in an attempt to unify the common language of the industry. With respect to the AP training's role in establishing medical and pharmacopoeia best practices, it is found necessary by legislative action to amend ORS 475B.035 to grant *limited* authority to the Oregon Liquor Control Commission (OLCC) to determine the quantity of cannabis transferred to a consumer when a quantity of cannabis has been determined necessary by an AP. In accordance with scientific definition as will be reflected in the AP training, it is found necessary by legislation action to amend the definition of cannabinoids as defined in ORS 457B.015 to "A class of diverse chemical compounds found in cannabis that act on cannabinoid receptors of the Endocannabinoid System." Lastly, it is found necessary by legislative action to remove ORS 475B.946, requiring a petition process for a disease or condition to be included as debilitating medical condition of the OMMP, and instead establish in statute the autonomy of trained and certified APs to, according to their professional judgement, to grant access to cannabis use as medicine to any patient and for any condition the AP believes can be mitigated with cannabis. *Addressing the future role of the commission with respect to the possible framework*. AP training is paramount to the effectiveness of the OMMP. In conjunction with the CRC, Oregon stands to lead the rest of the United States in developing a sustainable, scalable, and productive medical cannabis program. As such, the Oregon Cannabis Commission, as a formal agency, would be well positioned to oversee the AP training, CRC, and OMMP into the future.	

	Structure. Attending Physician training will be disseminated through a web-based portal, consisting of modular training and examination on the following: Plant Science (Taxonomy and botany) Endocannabinoid System (Function and dysfunction) Pharmacology (Pharmacodynamics and pharmacokinetics) Cultivation, Processing & Distribution (Familiarizing the clinician with the industry and dispensary model through which patients procure their medicine or homegrow) Clinical Application (i.e. evaluating the patient, determining appropriateness of cannabis as a suitable treatment option, formulating a treatment plan, filling out the APS, follow up and ongoing management expectations) Legal Considerations (i.e. rules, regulations, protections, privileges, etc.) Content will comply with AMA PRA Category 1 Continuing Medical Education standards as set by the American Medical Association and Accreditation Council for Continuing Education - the current standard in clinical education. As such it is required to be rooted in up-to-date scientific evidence. The benefit of modular training is the ability to amend module content as often as necessary to keep up with scientific and clinical trends, and as standards of care advance in cannabis medicine.	

	The benefit of examination is the ability to assess passing rates as a KPI as it relates to provider preparedness, competency, as well as patient outcomes, product use and satisfaction. **Funding.** Unless oversight is granted to the OCC, Oregon legislature will allocate funds to the OMMP, to a total of $___ over ___ years. Funds will be used to either purchase or develop a novel training program, as well as provide administrative support to OMMP in disseminating training, certifying and recertifying APs, and tracking KPIs. **Oversight.** Unless oversight is granted to the OCC, the OMMP will oversee the procurement or development, and implementation of the AP training program. Lessons or information that is biased in favor of or against particular philosophies, or that bring up potential conflicts of interest, including commercial, personal, and political interests will be prohibited. This will be mitigated through abiding by AMA PRA Category 1 CME standards, which is compliant with professional and ethical codes of conduct in medical education. **Other Functions.** With sustained funding, oversight, and process improvements, the AP training program has great potential to become a training standard across the clinical cannabis field and cannabis industry at large. Future activities may include: AP training KPIs will become an important data set for the CRC, helping to refine research objectives and inform the public on the use of cannabis in Oregon. In a similar fashion, CRC reports and literary repository will be assets to improving and advancing the AP training program over time.	

	Through data sharing in relationship with the CRC, training is expected to expand into options ranging from the minimum educational requirements for authorizing medical cannabis use to the clinical mastery, and to even subspecialty-based training. Training KPIs will inform and reform guidelines regarding the adjunct use of cannabis with opioids, the treatment of chronic pain with cannabis during opioid reduction, or treatment of chronic pain with cannabis as a result of opioid discontinuation. Training guidelines will expand HB 4014's recommendation that "clinicians should assess for contraindications and precautions to the concurrent use of [cannabis] and opioids" to additionally address how one should implement concurrent use when necessary. The training of allied health professionals will be necessary in advancing clinical cannabis medicine. Inclusion is critical as myriad providers are involved in the counsel, management and coordination of care in a variety of specialties. Training should be available to all health professionals who want to participate in cannabis medical care, and to the degree determined relevant to their role. standardized administrative, educational, training and structural support for all allied health professionals engaging with patients who use cannabis or involved in the clinical management of patients using cannabis Share clinical outcomes data with the CRC in order to improve state-based product development and focus clinical research efforts To improve best clinical practices, identify regional trends, and outcomes. Set precedent in the advancement of the fields of Endocannabinology and Cannabinology.	

	Establish referral guidelines for patients who can benefit from providers with specialty training in Endocannabinology & Cannabinology. Identify training requirements for industry preparedness (i.e. cultivators, processors, dispensaries, retailers and budtenders) and uniformity when communicating with consumers in addressing HB 2198's directive on the *proper oversight and regulation of Medical Dispensaries* (and all dispensaries). Training will cover liabilities, what cultivators/processors/budtenders should know vs. what they can/cannot discuss with consumers without a medical license, when a budtender needs to refer a consumer to a medical professional, etc.) **Andre Ourso-Product Integrity Subcommittee** The Product Integrity Subcommittee met on June 18, 2018, to discuss possible recommendations for the Oregon Cannabis Commission to include in its report to the Legislature. Topics of discussion included a compliance program for cannabis testing labs and cannabis product testing and diversion of cannabis outside of the medical and recreational (adult use) regulatory systems. **Cannabis laboratory compliance program and audit testing of cannabis products:** ORELAP is a program under the Center for Public Health Practice at the Oregon Public Health Laboratory and accredits qualified laboratories for testing under the Clean Air Act, Clean Water Act, Resource Conservation and Recovery Act, Safe Drinking Water Act and Cannabis testing under ORS 475B.550 to 475B.590. ORELAP is recognized by The NELAC Institute's (TNI) National Environmental Laboratory Accreditation Program. ORELAP's primary role in cannabis is to oversee the accreditation of testing laboratories to ensure they meet testing standards and proficiencies. Through on-site assessments performed, ORELAP ensures that laboratories meet TNI accreditation standards.	

	How Accreditation Works A laboratory seeking accreditation applies with ORELAP for each testing method, analyte and matrix combination it wants to have the ability to perform. These include testing for moisture content/water quality, potency, pesticides, solvents and biological contaminant. The lab submits an online application, a quality control manual, standard operating procedures, method validation and performance testing data to ORELAP. Once the application is approved ORELAP conducts an initial on-site assessment. ORELAP assessors will review the laboratory on how closely they follow their submitted documentation, review equipment calibrations, how data review and analysis is performed and review how data reporting is performed. Once a laboratory meets the accreditation standards it will be granted accreditation approval and may apply for licensure with the OLCC. The laboratory must also participate in a Proficiency Testing (PT) program to show the lab is proficient at testing for a particular analyte or method. Laboratories must pass two out of the last three PT studies for every matrix and method-analyte for which they are requesting accreditation. These PT studies are to be done approximately six months apart. Results of the PT studies are reviewed by ORELAP and are required for a laboratory to maintain accreditation. **Testing Requirements** Marijuana items must be tested to standards adopted in OAR by OMMP. Marijuana items must receive passing compliance test results for pesticides, water activity/moisture content, solvents, and meet potency requirements, as applicable, before being transferred to a dispensary or retail shop. The product type and the intended next transfer destination for the item determines what test will be performed at which stage. Only one compliance test may be ordered for the same marijuana item. Laboratories are required to enter testing result data in the Cannabis Tracking System (CTS) for licensees and starting July 1,	

	2018 for qualifying medical marijuana growers. For medical marijuana growers not required to use CTS, a laboratory only needs to report failed test results to OMMP. **Proposed Legislative Concept and Policy Option Package for Cannabis Testing:** Accreditation is just a snapshot in time and does not continuously ensure that a laboratory is not performing outside its accredited parameters or not violating testing regulations. The establishment of a state reference lab would be a way to objectively audit laboratories and randomly test cannabis products to ensure testing accuracy, consistency and laboratory integrity on a regular basis. OHA and OLCC have received complaints from licensees and registrants that there is inconsistency in lab results between laboratories, especially for potency results, and that labs are manipulating results. Currently the state has very limited capacity to investigate these complaints to ensure the integrity of the testing process by private cannabis labs and whether cannabis products are mislabeled or adulterated. Cannabis lab compliance and random/audit testing programs would further ensure Oregon's cannabis is reasonable safe and cannabis testing laboratories are held to legal and ethical conduct. Such a program would be able to investigate laboratory compliance issues, potential lab shopping on the part of producers and wholesalers, manipulation of testing results, serve as a reference for legal and compliance disputes related to testing, and establish standard reference methods for testing cannabis and cannabis products. After discussing the establishment of a reference lab and a random/audit testing program the state agencies responsible for the regulation of cannabis (OHS, OLCC, ODA) concluded that a state reference lab would be best housed within the Oregon Department of Agriculture (ODA). ODA already has expertise in testing agricultural products for pesticides, particularly cannabis and could be an objective agency without the appearance of a conflict of interest	

	related to OREALP accreditation, which is conducted by OHA. Administrative, legislative and funding recommendations include: • Funding for laboratory equipment and instrumentation to test for potency, water quality/moisture content, solvents, pesticides and biological contaminants • Approximately 3 FTE chemists and an admin lab staff to perform testing, establish reference methods and perform administrative duties • Additional FTE at the laboratory or funding to train OLCC and OHA compliance staff to sample cannabis products and utilize chain of custody procedures **Control of Diversion** On June 18, 2018, the Product Integrity Subcommittee heard testimony from representatives from Oregon State Police (OSP) on data related to the illegal diversion of cannabis. While there is diversion from the medical cannabis and recreational markets as well as significant black-market activity, there isn't data to quantify exactly and in what proportion how much illegal diversion is occurring in each market. Data challenges exist with knowing how much illegal cannabis is seized. Due to various law enforcement jurisdictions having different reporting requirements and the lack of a central data reporting repository for illegal cannabis seizures the exact magnitude of the diversion issue with medical cannabis is unknown. However, there are recommendations from the subcommittee to better understand and control cannabis diversion within Oregon. • OMMP should continue enrolling applicable growers and grow sites into the OLCC Cannabis Tracking System (CTS)	

	• OMMP should implement a compliance and enforcement plan to follow up on applicable grow sites that are not participating in CTS when they are required to do so and to inspect larger grow sites that have recently indicated a reduction in growers and plants. • Funding for additional OSP resources to investigate and develop enhanced data systems around cannabis diversion activities. • Additional FTE to support OMMP in compliance and enforcement, particularly to inspect grow sites and investigate complaints of violating the Oregon Medical Marijuana Act.	
Structure of the OMMP • **Models from other states where Recreational is legalized and they have Medical Marijuana**	**Introduction** Recreational marijuana is legal in nine states and in the District of Columbia. Each of these jurisdictions also has a medical marijuana program, and the following report summarizes the way each one regulates the two different systems of marijuana. <u>Key Findings</u> • All US jurisdictions that currently have legalized recreational, adult-use marijuana had already implemented medical marijuana programs before full legalization occurred • Five states have two separate regulatory bodies overseeing their medical and recreational programs	

	• Two states have or plan to have one body overseeing both programs • In both states with one regulator for both programs, there remains a registry of medical participants that is administered separate from the regulator, and in each case by that state's public health body • Two states and the District of Columbia merely decriminalized recreational marijuana, and so essentially do not have regulators of their recreational "programs" **Multiple Agencies** • Alaska • Colorado • Massachusetts • Oregon • Washington Like Oregon, most legal markets currently keep the administration of their recreational and medical marijuana programs separate. In each of the states for which this is true, the medical program predates recreational legalization, often by more than a decade.	

	Alaska's medical program is overseen by their Division of Public Health, and was approved by 69 percent of voters in 1998. Its recreational market was approved by voters in 2014, and is regulated by Alaska's Alcohol & Marijuana Control Office. It does not appear that participants in Alaska's medical program have to report any inventory or transfer activity, and medical marijuana is not subject to tax. Colorado voters approved its medical marijuana program in November 2000; the Colorado Department of Public Health & Environment implemented that program in 2001, and continues to regulate the program. In 2012, Colorado became one of the first two states to legalize recreational marijuana, a market which came online in 2014, and which is regulated by the Marijuana Enforcement Division – an arm of the state's Department of Revenue. Medical marijuana is subject to Colorado's normal 2.9% sales tax. As such, any business that sells medical marijuana must report these transactions as any retailer would report sales. There is no reporting requirement for medical participants. Of all the states discussed in this report, Massachusetts has the youngest medical marijuana program. It was approved by a ballot passed in 2012, and is administered by the state's Department of Public Health. The state voted for non-medical (recreational) legalization in 2016, and their recreational market is overseen by its newly formed Cannabis Control Commission. A registered marijuana dispensary (RMD) in Massachusetts is subject to reporting to the Department of Public Health, but medical participants are not subject to reporting requirements, and medical marijuana is untaxed. Oregon voters approved of medical marijuana in 1998, and the resulting program continues to be administered by the Public Health Division of the Oregon Health Authority. In 2014, the state's recreational market was approved by voters, and is currently regulated by the	

	Oregon Liquor Control Commission. Medical marijuana is also untaxed in Oregon, and some growers are required to report inventory and transfer activity.[1] Like Oregon, Washington State voters approved their medical marijuana program in 1998. This program is overseen by the state's Department of Health. In 2012, Washington joined Colorado as the first two states to legalize recreational marijuana. Its rec market is regulated by the Washington State Liquor & Cannabis Board. Medical marijuana is subject to a 37 percent excise tax in Washington, but registered patients are exempt from paying the 8 percent sales tax. Medical program participants are not required to report on inventory or transfers. **One Agency** • California (planned) • Nevada California's medical marijuana program was the first in the US, starting in 1996, and it was previously administered by the California Department of Public Health (CDPH). In 2017, California passed comprehensive legislation known collectively as the Medicinal and Adult Use Cannabis Regulation and Safety Act (MAUCRSA), which moved regulation of both medical and recreational cannabis under one body, the new Bureau of Cannabis Control. Implementation of this legislation is ongoing, but even after it is complete, "CDPH will	

	continue to print identification cards and maintain a registry database for verification of qualified patients and their primary caregivers."[2] Medical marijuana is exempt from California's standard 7.25 percent sales tax and its 15 percent excise tax. Medical program registrants are not required to track inventory and transfers. Currently only Nevada claims to have moved administration of both its recreational and medical programs under one authority, the Department of Taxation. According to its website, the medical program, which voters approved in 1998, had previously been administered by the Division of Public and Behavioral Health, which still does administer the state's Medical Marijuana Patient Cardholder Registry.[3] Nevada voters approved of recreational marijuana in 2016, but the relevant initiative did not include provisions for regulation beyond taxation, which likely explains the authority currently responsible for its oversight.[4] In Nevada, medical marijuana is subject to a 2 percent excise tax, and while medical dispensaries must use the state's reporting system, program participants themselves are not subject to tracking and reporting. No True Recreational Market • Maine • Vermont • Washington, D.C.	

	Maine legalized medical marijuana in 1999 by voter approval, and its medical program is administered by the state's Department of Health & Human Services. In 2016, the state's voters approved of a full recreational market – including production and retail sales – however, Governor Paul LePage vetoed the state legislature's bill to tax and regulate recreational sales in 2017. The veto was very recently overturned, on May 2, 2018, and so the bill has become law, but has not yet been implemented. The regulatory body overseeing Maine's recreational market is referred to in law as the "state licensing authority," but remains as yet an unnamed body. Medical marijuana is untaxed in Maine, but new rules passed in November 2017 will require a patient's caregiver to document the transport of product between their grow site and where they dispense the product.[5] The rules went into effect February 2018. Vermont's legislature legalized medical marijuana in 2004, and the body responsible for its medical program is the state's Department of Public Safety. In January 2018, Vermont became the first state to legalize recreational marijuana through legislative action (as opposed to direct voter approval), but the relevant legislation approved personal possession, use, and cultivation, but not commercial sales.[6] As such, there is no true recreational "market," in Vermont, yet there has been discussion among some legislators regarding future plans for a taxed, regulated market.[7] Medical marijuana in Vermont is not subject to taxation, and participants in its program are not required to report on inventory or transfers.	

In Washington, D.C., medical marijuana was approved by ballot measure in 1998, but its implementation was effectively blocked by the US Congress until 2009. The Council of the District of Columbia legalized a full medical program in 2010, and the program began the next year. It is overseen by the District's Health Regulation & Licensing Administration. In 2014, voters approved a measure that legalized possession, cultivation, and transfers of recreational marijuana, but the sale and purchase of non-medical marijuana remains illicit. Therefore, as in Vermont, there is no true recreational "market" in D.C. Medical marijuana is untaxed in the District, and while patients and caregivers are not required to track, they must "register" to a specific dispensary, and can only purchase from that location.

Summary Table

Jurisdiction	One agency?	Med passed	Governance of medical	Rec passed	Governance of recreational
Alaska	No	1998	Division of Public Health	2014	Alcohol & Marijuana Control Office
California	Yes (planned)	1996	Department of Public Health (current)	2016	Bureau of Cannabis Control (future)
Colorado	No	2000	Department of Public Health & Environment	2012	Dept of Revenue (MJ Enforcement Div)
Maine	N/A	1999	Department of Health & Human Services	2016	TBD - "State Licensing Authority"
Massachusetts	No	2012	Department of Public Health	2016	Cannabis Control Commission
Nevada	Yes	2000	Div of Pub Health & Behaviorial Health (formerly)	2016	Dept of Taxation
Oregon	No	1998	Public Health Division of Health Authority	2014	Oregon Liquor Control Commission
Vermont	N/A	2004	Department of Public Safety	2018	Legalization of possession only
Washington	No	1998	Department of Health	2012	Washington State Liquor & Cannabis Board
Washington D.C.	N/A	2010	Health Regulation & Licensing Admin	2014	Legalization of possession only

Oregon Medical Marijuana Biennial Budget	Please see meeting materials provided– 17-19 Actuals with Projections Year to date through March 2018.	
Discuss Survey to OMMP Patients	**Rachel Knox – wants to survey the OMMP providers and do it in the first year ask to legislator.** **Anthony Taylor – Patient Access - Survey to serve multiple purposes:** • patient access assessment • establish baseline for statistics & data collection • determine why there is enrollment deduction • basis for future of program aka patient access to medical cannabis • community engagement surrounding safe access **Recommended Questions:** What is the reason that you did not renew? Cost of Doctor Visits for Chart Note and Attending Physician Statement requirements Cost of OMMP Registration Application	

	Cost: Other_____ Application Process: Cost Paperwork Time to Submit Other_____ Local Jurisdiction Restrictions of growing Restrictions of access Restrictions other_____ Could not grow or find grower Inability to get a grower Handled poorly by grower Did not get medicine Grower wanted to charge fees or reimbursement	

	Other_____ Physician Recommendation, Medical System Previous Physician refused to sign APS New Physician refused to sign APS Not enough Doctor Visits to submit Life Long Illness Terminal Illness No Longer interested in Medical Marijuana No longer in need of Medical Marijuana You obtain your medicine as OTC through OLCC Dispensary Other reason you did not renew: _____ When you first registered with OMMP was it: Easy Moderately easy Very Difficult	

	Other Have you ever renewed your card? How Many times have you renewed What year did you enter? Did you ever let your card expire and not renew? At any time during your OMMP enrollment period did you ever feel uncomfortable about obtaining your medical marijuana? Reasons why you did not renew? Cost Hassle Time Other Did you grow your own medical marijuana? At your own residence At a location, not your residence	

	Other Do you now grow your own recreational marijuana and use for your medicinal needs? Was it easy to find a Grower for your medical marijuana? Where did you find your grower: Family Member Friend Work School General Community Craigslist or other online Other Do you feel you received enough medicine from your grower? Were you ever out of medicine? Are you out of medicine now? Do you feel that you received quality medicine from your grower?	

	In what forms do you take your medicine (select all that apply): Smoking pipe Smoking Cigarette Smoking Water Pipe or Filtration Vaporizing Capsule Tincture Edible Topical Suppository RSO Other Are the fees to the program Too High Too low	

	just right other What would get you to come back to the OMMP Program? Lower Fee It doesn't matter because I use Recreational Dispensaries It doesn't matter because I grow my own Recreational Plants and use it as medicine Easier Application Process to Register as a Patient Do you obtain your medicine from an OLCC licensed dispensary? Would you rather obtain your medicine from a Medical Dispensary if provided the choice between a recreational dispensary and a medical dispensary at the same time? Or does it matter? Are medical dispensaries needed in the state of Oregon? Is it appropriate to obtain your medicine from an OLCC Recreational Dispensary? Did you discuss your medical cannabis therapy with your physician?	
Listening Tour – next steps	We will revisit this in Fall after we have a draft of our legislative recommendations.	

Public Comment	**Michael Rochlin** Many changes have happened since legalization in only 2 years and it seems like 10. Right now, retail is the main focus and the main focus with OLCC. The OMMP has been pretty much decimated. I think there was an expectation and the retail industry at least one group OCBC admitted they made a mistake in the lobbying they were doing. So that fact itself Don Morse said that to the public or at least in the meeting told me that we were on the wrong track over a year ago. My concern is there is two major needs for funding right now. One is research at the top of the list, get some staff to at least start working on this structure in a very aggressive manor. We lost two years essentially in the state. And the other thing is testing. We need to have a robust quality assurance program for testing and I know of at least one layout who is very credible in the state that could do that which is a contract lab. I think that is what we need to move towards immediately. We've gone too long and we don't test for metals which makes me concerned for medical patients, so this is a real high priority. As far as the medical program goes, that should be different from legal adult use because adult use is a consumer product and medicine is not and therefore the way their managed in terms of product and product safety labeling should be done differently, it's a higher standard. The use of the word grade which is significant because when I was testifying at the legislature grade means purity and quality. It does not mean strength. Medical grade in the state has been misused to mean strength so this needs to be changed immediately. Patient access is critical, there are a lot of patients fending for themselves because of cost, on fixed income, on the Oregon Health Plan. They don't have a choice. The policies right now are very prohibited because their either opioid or cannabis. The funding is critical and some short-term needs are really pertinent.	

	Sarah Duff Owner of Duff Johnson Consulting - I consult with Patients, growers, caregivers and clinics. I've worked in 5 different clinics around Oregon. So, I am going to try and make it to the Training Subcommittee because I think that would be good information but I wanted to give a little bit of information I was able to look up pretty easily. These are the stats we keep for the Oregon Medical Marijuana Program. 2005 we had 2,000 patients (fee was only 100 or 20 for the reduced fee), 2011 we increased the fee up to 200 for the maximum application costs with 39,000 patients at the time. I have nothing but respect for Anthony Taylor, I just have a hard time believing there is no way to sustain the program with less patients than we had now. I feel like we should be able to if we had 12,000 patients or even less than that and if not then we have to do whatever we have to do to make that work. I don't think increasing the cost makes sense. Back in 2012 when they increased the costs to 200, we had the highest fee and I think we still do for a registry program for Medical marijuana anywhere in the nation. The cost at the time were 25 dollars to 150 in any other state. So, I think we should think about decreasing the maximum cost of our application fee so that more people participate. A lot of people who would be patients who can't afford to be a participate any longer. I was one of those people for a few years but luckily, I've been able to recently. So, I hope that continues. I also wanted to point out, I mentioned this in last Monday's subcommittee for Patient Access that we have a $4,000 dispensary license fee. And that is an insanely high cost. That is why we don't have nonprofit dispensaries. If we could decrease that down that would greatly increase the possibility to having those. I looked up the OLCC license fee for a brewery and it seems to be $500 dollars. And a distillery is $100. How is it we can't make our program less costly. This is a nontoxic herbal remedy and it is important to train our budtenders to not give medical advice. However, I feel like we should be giving the more tools to be able to offer science that may be could be	

	offered. Since it is over the counter medicine that is being bought because they can't afford to be a patient and can't afford to go and speak to a doctor. I appreciate you all being here and if I can be of any assistance in any way I would love to help. **Sunnie Sanchez** I appreciate you all taking the time to come here and address the issues before the Cannabis Commission. I just want to say good job. I am looking forward to seeing the draft that you're presenting before the legislature. I am a strong supporter of the OMMP. I would like to leave you all with one thought. That is regarding recreational forces, I want to know if OLCC recreational forces are so compassionate where are their medical bump up canopies for patients. So please don't stream line patients into consumers and into recreational consumerisms. Please do everything you can to preserve the OMMP. **Missy Hoffer** I am here as a witness as a patient. I was diagnosed at 11 which was 30 years ago with a very rare brain tumor. I've had countless numbers of surgeries and chemo and radiation and a variety of different things throughout my lifetime and I would say cannabis has helped to save me and it's also given me my quality of life back. It's because my best friend is my personal grower. I went from 30 medications to 3, now that has to be a big savings funding wise for the state of Oregon because I am on Oregon Healthcare. If I didn't' have my friend growing for me as my personal grower I would not be able to go into a dispensary because I am using cannabis to stop vomiting that no medication could ever control. I would go to the hospital multiple times a year with vomiting that took hours and sometimes hospitalizations to get under control. My best friend growing for me just by chance, I was having cannabis in place of my anti-nausea medication which I had 3 or 4	

	different kinds that never worked. And we started noticing the cannabis is controlling my vomiting. For a decade now, I have not been to the emergency room. For hours upon hours and money spent just trying to stop vomiting, and the vomiting can lead to other things like I've had bone issues, kidney failure, kidney issues, liver issues, I've just had a number of multiple things. If It wasn't for my personal grower growing for me I wouldn't be off all those meds. I wouldn't be avoiding surgery after surgery after surgery which again is saving the state a ton of money. And I could not go into a dispensary because we do not have research developed to the point where I can say I need something to stop my nausea. And we also found something that stops headaches. I've had headaches my whole life and everything under the sun. When I was taking 30 medications, I could have very easily overdosed. There is just so many aspects to having a personal grower who grows for you able to test different plants and not restrict it to a small number of plants where they can't even find out whether these things can control the pain, control the nausea, and control the headaches. So, I am here as a patient saying the state would save a lot of money in the long run if they understand that giving people information about medicine because most of our prescription medication leads to other problems and other issues and other diseases. You can tell I am very clear, I couldn't have this conversation with you 8 years ago. I was on way too much medication and I didn't have quality of life. I have a quality of life and I am living it 41 years old plus we were able to get rid of my tumor. And I am willing and ready to speak to anyone who wants to speak to me about how we come to where I've gotten. **Matthew Mendoza** Collecting signatures from Medical Patients, Caregivers, and Growers to be able to transfer marijuana to anyone in the Medical program.	

	This commission is housed under 2198 to stabilize and expand the program. 1544 forced growers over to the OLCC tracking. And about 3 months ago there were about 4500 expected to transfer. I heard today that only 700 went over. If we continue down the road to combining these programs having agency's overlap you are going to decimate the whole program in my opinion. Don't forget OMMP growers out number OLCC producers. In every single county we way out number OLCC producers. Why don't we get OLCC to give cannabis to the OMMP dispensaries that are left? I think that would increase more OMMP dispensaries and it would go into the medical aspect that every bodies been speaking to. Clifford, Dr. Knox talks about it. I envision an OMMP dispensary that focuses on the health we are all talking about. In a very specific manor not in a recreational form. Processors and dispensaries are already with the CTS tracking system so if that's the case there is already a way to transfer the OLCC cannabis over. Once this would happen more businesses would open. We are forgetting all the testing facilities. They are sitting on all kinds of samples that are already been tested clean. They had to destroy it under the OLCC rule, why don't we approach them and get them to donate to patients. And again, back to donating to dispensaries and processors and then again, we can get them to OMMP dispensaries for medicine cannabis. **Pete Kramer – Mercy Center Salem Oregon** I've been with the program for a couple decades. I've seen a lot of changes happen, we were being used as a cash cow for the health department. Fee's, they're ridiculous. A lot of patients are low income patients and they can't possibly come up with these fees. I've talked to a friend a lawyer Brad Shipman. He found the state has been violating our	

	constitutional right, section 20. Everyone should be treated equally. I don't think the patients are being treated equally. When 91 was proposed and that they said in writing they would not touch the medical program, look at what happened to the medical program. Growers had to sign up because of all the restrictions and fees. Patients can't grow for themselves. I hope you do a better job than the other organization. We were asking for research about the cannabis but we never got any information back. We were talking to a wall. Thank you for being here and have fun and go fly a kite. **Eric King** Former OMMP patient and grower. Expired 4/20 of this year. Last year I paid $600 to be a grower for someone else and myself. That is just something I can't do. The black market is not really something I look into either but I am just going to continue growing for myself because that's all I can really do. I don't know what avenue we should go towards because there is always going to be someone wanting money. I can't sell extra to 11 dispensaries in Oregon if I have it. So, I can't come up with 600 bucks every year. I'd like to be a grower but I live in a residential area and can't have more than 12 anyways. I am going to keep it either at 6 and be an OMMP patient and grower or just do the 4 per year and I can't see paying $400 for just myself to get 2 extra plants but I want to be back in the OMMP and I think it was a great program and it should be again. And thanks everyone for being a part of this especially Sarah Duff, I met her 10 years ago. **Morgan Delaney** Missy is my brother's patient. We've survived since this program went into effect. We went over a decade where you can't receive anything in compensation, everything is donation. We survived where we can only receive compensation for your resources but you couldn't	

	receive compensation for your labor. They're about to lose their house, lose everything. These are disabled people that this is their only lively hood not able to get out of the house. To have the recreational program come in and them able to sue to get the 2-year residency removed, to get mold testing removed, to have people bend over backwards to give them as big of canopies so they flood their own market. This isn't about the Oregon Medical growers flooding the market. They flooded the market, the 20lbs, we are a commercial site and we can have 54 plants. We could max that out in 14 plants a year. At 20lbs to survive at a commercial site is not feasible, so this is not a sustainable thing. I think there needs to be a way where medical production sites that are given a different category then this whole patient thing you're going to donate based on how many patients. We are a commercial site so we can have up to 8 patients. So, we can have up to 54 plants. We are being capped out artificially in fear by our lobbyist because they don't want us to mess up their supply amount but they are the one's throwing everything else out of balance because of their growers over producing down south and it's not medical quality. So, if you want us to be able to put in the resources to create medical quality and the diversity of strains needed for a variety of medical alignments then this needs to be looked at in a totally different manner because this isn't sustainable.	