Oregon Cannabis Commission Meeting Minutes

Date: March 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 Jan. 30 2018	Esther Choo motioned; Anthony Taylor seconded	All approved

Welcome and Introductions by the Oregon Cannabis Commission

Topic	Key Discussion	Responsible
Overview of subgroup communication	Just a reminder to not email each other information about the meetings as you would have started a group conversation which constitutes a public meeting. Send questions, needs or communications through Shannon McFadden.	Carole Yann

OMMP bills passed during legislative session	SB 1544 passed and it modified. Some areas had housekeeping items and added some new elements to both the OHA and OLCC Marijuana Act. A processor who is licensed by OLCC had the ability to create items and process items for a patient or a patient's caregiver, but it wasn't outlined clearly in statue that it could be done without adhering to all the labeling and testing laws. Language outlining this was added in the bill. Processors still must adhere to the dosing laws. It also added that a producer with OLCC can transfer immature plants to our grower, patients and caregivers as well. Requires a grow site provide a physical USPS address. If they don't have a physical address then they need to include an assessors map with the exact location, city, county, zip code and either longitude and latitude or tax lot. Allows us to track where that location is. Rules will still need to be written for these changes but this requirement is effective 7/1/2018. A grower may grow for 8 patients rather than 4 this means at a location for 48 plants; there could be 1 grower for the site. Requires in rule that OHA determine the number of immature plants that a location may have.	Carole Yann

	Made changes to grandfathered sites, if OHA has either suspended or revoked a grower at a location then if that is a grandfathered location they will revert to the standard zoning. More oversight has been added to this area. OHA is working on implementing the seed to sale tracking system with OLCC for 7/1/2018. They have modified the requirement of who needs to track. One of the big changes is that a location that has more than 2 medical growers at it or more than 2 patients must use the seed to sale tracking. For the commission specifically, we did get permission to extend the due date for the reports, which is now due 2/1/2019. Legislative concepts can be submitted by 2/1/2019. And then the sunsetting of the provision where this commission will make determinations on OMMP and how it is run is extended to 1/2/2020. This provides more time for the commission and to learn about the work of OMMP before decisions must be made. Another component that was added was creating an illegal marijuana enforcement grant for rural counties. $375,000 every quarter for 6 years is going to be allocated for this fund. It is coming from the tax dollars and it is	

	to help the rural counties with law enforcement and the district attorneys in those areas with unlawful cultivation and distribution. It will be administered by the Oregon Criminal Justice Commission. We also received confirmation regarding the commissions legislative concepts. This commission does not need to follow OHA's legislative process, it is independent and works directly with the legislative council.	
Subgroups discussion and next steps	Subgroups are open to public. If there are 2 commissioners on a subcommittee then it needs to be treated as a public meeting. Subgroup leaders will select members for their subcommittee. Will either post to GovSpace or send a list to Carole Yann and/or Shannon McFadden and they will send out the notices to the commission for review.	Esther Choo
Priority focus areas, scope, and action items Based on legislative dates	Will work on the Commission report to the legislature that is technically due 2/1/2019 and try and get a draft by 9/2018. We can go through and assign it to each subgroup. Will go through this and assign in the next meeting 5/2018. If something does not fall under a subgroup then we will work on it with a group consensus.	Esther Choo

Format and meeting schedule-subgroups	Looking to schedule the 3rd week of every month; Monday and Tuesday or Monday and Friday of that 3rd week. 2 subcommittees each day one following the other. Not every committee member needs to attend each subgroup. The public can attend any or all subgroups they are interested in. Will send out doodle poll to commission to schedule out through 9/2018.	Esther Choo
Listening Tour Future Meeting Dates for Commission	Let subcommittee have their first meeting and one of the agenda items could be how could the subcommittee benefit from the listening tour and then we can come back at the next meeting and decide who they want to hear from, where and make sure the people from that subcommittee are present and we can schedule around them and target for some time in the summer. If commissioners are careful to not engage in a bunch of side conversations then these listening tours don't need to be constituted as public meetings.	Esther Choo
Public Comment	Michael Rochlin I really like what the Cannabis Commission is doing to be able to resolve clear goals and issues and stay on task. The stigma is still alive amongst health professionals as well as our patients for many reasons. I really feel honored and appreciate Dr.	

	Knox mentioning my name as interested in the education of health professionals. I think that is what we are working towards, trying to understand how they use cannabis which can be an edge up therapy as well as a primary care but it takes medical professionals to understand that as a main stream treatment. That will be one of the biggest issues we will have. Best practices, especially things as far as not just education but evidence in terms of science. It's the human studies that have not been well documented or dispersed. The diversity of this commission as well as where you're going forward are important and thank you very much for what you are doing. John Sajo I want to thank you all for your service on the committee. I am glad the legislature did this. From my perspective as an advocate for Medical Marijuana and Marijuana law reform for almost 40 years I think we have a lot of problems. I was very involved in drafting and passing the Oregon Medical Marijuana Act originally in 1998, worked on prop 215 in California, helped draft measure 91, I was very happy that we included in it repeatedly provisions that said it would not affect Medical Marijuana and it has. It's gutted Medical Marijuana. A few weeks ago, on the same day I found out my friend Dennis Peron died in California, I found out the latest statistics indicated that the number of patients registered with the program had dropped from 77,000 to	

	50,000 in just 2 years. That's a patient in critical condition. I think we will need to look at that and figure out what that means. Those numbers could be interpreted in different ways. Maybe things are so good that patients can use dispensaries now so they can go buy marijuana at the store, so they don't need that card anymore. Or I can grow my 4 plants who needs all that red tape and extra work. But that is not what I am seeing in my life. What I am seeing in my life is that layer after layer of rule and regulation has basically destroyed the system we have created where patients that need Medical Marijuana designates someone to grow it for them and over the last 20 years the system has provided mostly free marijuana to 10s of thousands of people. I personally have given away over a thousand pounds of marijuana to many thousands of individual patients myself and it's been very gratifying for me to do it and it's deeply troubling that it's getting harder and harder for me to do it. And a lot of the good people that I enlisted in this effort have had to drop out because it is just too hard to do it or people don't want to give up their right from search and seizure just to help sick people get their medicine. A few years ago, after we tried several times to legalize dispensaries with the initiative process and we failed with that, the legislature did it and we got to where we have licensed processors and access to a wider variety of Medical Marijuana products than were available to an individual grower and I was able to take my trim to a licensed	

	processor and get back extracts and concentrates that my patients have really benefited from and now I can't do that anymore. I have a little bit of inventory left and looking at literally in a few weeks I will no longer be able to supply my patients with RSO that many of them believe cure their cancer and keeps them alive. Even though great products are available in the stores they simply are way too expensive for any of the patients to buy and there will be many faced with go without or go underground. What I see is a lot of rules being created to solve a problem that aren't solving it and instead are driving people underground. I hope we can get that one fixed. In the bigger picture I think the system of a patient designating someone to produce their medicine for them was a pretty crazy system and yes there was diversion but it really, I think the diversion was vastly over rated. Marijuana was Oregon's biggest cash crop in the 80s. Pegged as a billion-dollar crop in 1986. Marijuana being exported from Oregon was nothing new and making patients go without because we were afraid is unfortunate. One of my patients was going to Florida to help her daughter with her new baby and was going to be gone for several months and she mailed herself a pound of Marijuana to Florida and got busted and now she is a felon and diversion is stuff like that too. A patient that just must be in another state for a few months. I would also point out to everyone that some people didn't divert Marijuana or patients in Texas and Oklahoma and New Jersey and places where	

	they don't have Medical Marijuana programs or has one that doesn't really work, more patients in those states will suffer. Diversion itself is a complicated picture. Oregon will produce more marijuana now and diversion will be larger than it's ever been. The biggest source will be the highly tracked OLCC system. Meanwhile what we are not tracking is what we should be looking at which is patient outcomes. For years I dreamed of when we would have consistent quality control products that would make it possible to do research with patients by simple starting with asking them if it is working or not. Now we have thousands of patients using RSO and similar products to treat their cancer, first their doctor can't advise them about dosages, no one can tell them which cancer should take this variation of the treatment. No one is even taking notes on if they even live or die. So, we are in this crazy situation where we are literally spending tens of millions of dollars on tracking and let me tell you as a medical grower it's a nightmare and I don't have the money to figure it out and the system itself is filled with flaws like if your patient allowed their card to expire then you can no longer report that. Hopefully it will be better with the CTS and moving to Metric and I look forward to doing my best to learn it but I really implore you, if we are going to spend 10 million tracking every marijuana plant then can we spend a few million dollars tracking the medical outcomes of people who are experimenting with their lives. So much that we could be doing with the research. As far as	

	access to patients, I think the system of designating medical growers is being phased out and I have no problem with that since it should be phased out if you are replacing it with a better system. But we haven't replaced it with a better system. We've replaced it with nothing. I am certain that most of those 27,000 patients that dropped out of OMMP did so because they can't get medicine anymore because they can't afford it. I hope someone would ask them at least what it would cost to do a survey to those 27,000 people and ask why did you drop out if things are so good or because things are so bad? I am afraid it would be the later. We have a solution. We have a huge over production of product in the OLCC side and this year we have a million pounds over what will be sold in stores so if we want to stop diversion can we start by giving that excess marijuana to the people who need because they are going to suffer if they don't get it. There is a lot of steps to that but it seems crazy to me that we have thousands of patients going without medicine while we have way too much product on the inventory shelves of producers. It will stop diversion if you give it to the patients. Eric I am a medical patient, grower and recently the PRP and owner of one of the last medical processing sites. 100 milligrams in an edible is nothing, we know patients that need 2 or 3 thousand milligrams a day	

	and they can't afford it with our medical system being completely gutted as a patient, grower and a processor. Karla K Thank you so much for the opportunity and I really appreciate the job you're all doing. I am an electrical engineer by education and the founder of many companies. I am also in an organization trying to help with the access for the patient and my main comment is I've listen to you all talk about everyone you want on the committee which is great and a lot of diversity regarding who you are putting on the subcommittees but I didn't see one person list a patient. That is the whole reason we're here. I am a patient, grower and processor and that's the main thing that I see. We are not addressing the patient directly and I would hope that every single committee adds a patient. And not just any patient but someone who is conscientious, well-educated whether they are college educated or not but someone who is well versed. I'd really like to see that in every subcommittee. Dave So, I come from the world of pediatrics on the East Coast and the reason why I came here was for cannabis. I left my practice and everything behind for it and then when I came here I see the same exact problems that I thought would be answered in Oregon. I lived in	

	DC and Maryland. This is supposed to be so far ahead and I came here and it's not. There are the same problems with a cost for patients and the dispensary don't have the answer. Because it's not a one-year thing it's a 20 30-year thing. I am a medical patient myself now. And I am going to have to afford cannabis the rest of my life and it is hard to think even 60 a month for the next 30 years of my life. Compound that times 12 and compound that times 30. That right there, that's a house. Think of a parent with a child with autism who works to pay for their medical cannabis now. Who's going to pay them to get cannabis when they are in their 70s and their parents are no longer alive. There must be a better system. Thank you so much for trying to make it work. Kris McAlliser Madam Chair, Esteemed Commissioners, and Members of the Public, For the record, my name is Kris McAlister, of Springfield, Oregon, and I am a patient, caregiver, and now a personal grower, within the OMMP. I come before you, with some remarks, and a question. My comments come as we meet just after the closing of our short legislative session. I received a mailer, from the OHA, that reaffirmed that under the current structure, I have been reduced to having 12	

	mature plants, on my property, from 24 originally, prior to the passing of Measure 91, without permission to grow 4, permitted through the aforementioned, as to help retain flower from the black market. Persons who grossly broke the numbers and could profit off it, have been rewarded with special privilege, by being able to utilize their resources to pay the state for their acts, whereas those who struggled, while following in the spirit of the law, often to the detriment of their credit and finances, have been removed almost entirely from the equation. Many of the people I serve, are on Medicare, including myself. After the Affordable Care Act passed, a deadline was set in motion, and our state, while supportive of the effort, failed to make it and subsequently found our indigent poor placed on federal insurance rosters. This led to the cutting of hundreds of approved services to some of our sickest, to allow for the increased spending brought about with the poor, uninsured being put in the same spending pool that was struggling to cover its Medicaid/Medicare load. I am sure the doctors and medical staff present are familiar with wraparound payments, and how they play into scheduling and new patient procedures, but for those whom are not…	

	When I go see my doctor, using Medicare, the federal government has up to six months to pay the system back, for my care. So, I am essentially being seen on credit. One can only do so much and keep the lights on. I can understand that. With that said, part of the cut services, is what is deemed experimental procedures. Makes sense, if you don't know something can work, probably don't want to pay for an "I don't know". However, the devil is in the details. You see, the only time I have been pain free in the past 13 or so years, was when I was taking part in an experimental procedure, with a non-experimental procedure; 5 days led to 2 hours of no pain. You see… The item that made it experimental, was me. Lidocaine has been used in medicine for over 6 decades. It hasn't been used for my condition, in the past, and as such, is a banned item from my personal formulary. Ironically, 1 of the 4 living medical cannabis patients in the federal cannabis program, has and does use cannabis for our shared genetic disorder, and the scientific data there is on the federal level, speaking to its use, though it is harder to access, than the cannabis in DC. I am allergic to morphine but that same formulary approved a pump to be installed in my back... Go figure...	

	So, in the past 5 or so years, our sickest of the sick have lost both access to qualified medical care, and access to a compassionate and accessible alternative for when the former failed them, time and time again. As with the former, both decisions revolved around monies and cost to implement within the letter of the law, regardless of how thought through some of the changes implemented are. We need the ability to provide for our patients, without restrictive regulations or fees from agencies who didn't care about the level or quality of care of our patients before tax revenues were involved, so long as they collected their papers and fees. We need safe places to medicate, to try new modalities without markets driving the accessibility. It is cheaper to get some items, with tests, outside of the market, than accurate and accessible options inside. 90% of the stores in my community do not differentiate between a patient and a rec user, and their guidance from shop owners is upsell, and keep the lines moving. My patients and those like them, deserve knowledgeable and accurate information. I have many ideas about how we can restore integrity back into our OMMP, but as it stands, I feel like we are just tax-exempt commodities for the state and the recreational industry.	

	Which leads me to my question. After Measure 91 passed, and the deadline to allow access to markets came about; the OHA ran dispensary program, which took fees to serve the Oregon sick, who paid fees to be served, gave that space, to OLCC, and collected a 25% tax, which was 5% more than the max allotted in the measure, and 8% more than the state's portion of that 20%. Patients had their side of the shops sometimes closed, their flower moved to the recreational side, and access to program approved venues were restricted, in the pursuit of launching the recreational market. With this in mind, I am told that before communities can get their tax dollars back, from cannabis revenues, OLCC has to be paid back, for all the support it gave to the OHA, in launching a program that ultimately led to the decimation of the program that was used to host it. Has this 8% collected in first 6 months been accounted for, and if so, why is it not going back to the patient side of the OHA services, as it was taken at their expense? If it cannot be put into such a fund, as to help serve the gaps faced by our indigent and health challenged citizens, then perhaps it could be returned directly, to those who paid fees for a year of access and accountability, and to this day, are still on the outside, looking in, as the program continues to be parted out, and parceled to the vice industry.	

	There can be common ground, with similar systems, but as it stands, it appears to be zero sum coming from the compliant patient. I ask this group to bring some much-needed compassionate care from this Oregon rulemaking body, and in a manner, that reflects a time frame dignified for our sick and dying. Respectfully, Kris McAlister Springfield “ Kevin Wilson Good afternoon madam chair, members of the commission. I am honored to be invited to the education committee with Dr. Knox. I didn’t come prepared to say anything but I had a comment about the word diversion regarding cannabis and it seems peculiar to me as a mid-level prescriber of controlled substances that normally diversion means taking a legally prescribed thing and using it in an illegal way. And it’s peculiar that cannabis, while there maybe diversion is being diverted potentially into a legal market because it is legally recreationally usable. I feel like we need a	

	language change there or a concept change because as you all know cannabis is a unique substance with pharmacology and pharma code dynamics. And the diversion idea just needs to be addressed a little more thoroughly somehow. Thank you for your work. Sunnie Sanches I am a resident of Benton Co. I am a PRMG in Linn Co. We have a farm that is considered a category 3 by the OMMP and we can grow up to 48 mature plants. I am not here to give you a history lesson, many of you have been along for the ride of legalization. I know just as much as you because that's when I jumped in. I did have some concerns about somethings I heard today in our conference. I also have a language suggestion, which is can we not refer to people behind the counter as bud tenders. I think that is misleading. Is a liquor store clerk a bartender? I think we should refer to them as store clerks really and that's just my opinion. As far as key meetings of the commission, you mentioned being able to participate via conference calling. Conference calling has been brought up prior at OHA through the ACMM, I	

	again am opposed to conference calling because I think that you're dealing with Marijuana and all attention should be at 100% and that's just my opinion. Another thing I must suggest or support is vetting of subcommittee members, I do also agree that is a very good idea considering that this commission is an extension of Governor Brown. Also as a 2nd generation OMMP participant, we are not all the same and there seems to be this conversation or implication of having trouble educating the 2nd generation OMMP participants such as myself and so I just want to say that and also, I was wondering if further down the line considering HB 2198 and the possible transfer of cannabis from the OMMP program into CTS and into the OLCC stream. Will water rights be enforced or do growers even know they must have a lawful source or water which is my concern is getting that clarified. And as far as I can tell for some research that I have been doing. We have a lot of grow sites still there particularly in Jackson Co. 2 out of 3 grow sites is an OLCC production site. That's up to 40,000 sq. ft. I did the math, 2 out of 3 of all production sites is over 5 million sq. ft. of canopy. I realize there is an over production of marijuana and I hope that doesn't	

	sway or push this commission to penalize growers for patients or patients themselves.	