Patient Access Subcommittee Meeting Minutes

Date: July 16th, 2018

Time: 11:30 am – 1:30 pm

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

Attendees:

OCC Attendees: Anthony Taylor
Subcommittee Members On phone: Kris McAlister, John Sajo, and Todd Dalotto, Sarah Bennett
Subcommittee Members: Clifford Spencer and Anthony Johnson
OMMP/OHA Staff: Shannon McFadden and Margaret Flerchinger
Members of the Public as listed on the Sign in sheet: Michael Rochlin and Lee Burger

Subgroups	Responsible Party
Patient access to care	Anthony Taylor/Andre Ourso (leads)
https://www.dropbox.com/s/xjmzinswt5b6hcr/Patient%20Access%20July%2016%20.MP3?dl=0	Audio recording

Welcome and Introductions by the Oregon Cannabis Commission

Proposed Motion	Proposed by	Outcome
Approval of minutes from June 2018	**Table May and June Meeting minutes until subcommittee members can review.**	
Topic	**Key Discussion**	Responsible
• **Updates** • **Reviewing and discussing the OHA's report on the OMMP released Thursday**	Public comment period is open currently. The day for public comment in person is July 26th here at PSOB. The public comment period is open till the 31st of this month. Please see full Report under meeting materials provided. Clifford states this report depends a lot on one's perspective, and it seems to me the people involved in this were much much more concerned about "diversion" than "patient access". This report was on Operations and Compliance assessment. Anthony's interest in this is how it effects and can help our subcommittee in moving our goals forward. Which is to get cannabis as medicine to as many patients or Oregonian's that want to use it as medicine as possible. This report seems to be heavy in compliance officers and law enforcement. I think we are better off having more education and outreach.	Anthony Taylor

	SB 1544 – rearranged the address issues for medical marijuana grow sites. Patients and their growers are getting letters saying if you have an address that is subdivided and not recognized by the USPS your grow site is no longer valid. The report really lacks that empathy for the patient. Their number one goal is that patients get access and now they are talking about enforcement and compliance and laying it all on the legislature and the patients and not taking much responsibility. John Sajo states that he understands the political context this report is issued in where state officials are getting pressure from the US Attorney and so forth. What troubles me is this narrative that compliance and so forth, lacks under medical marijuana system in comparison to the more comprehensive tracking of the Seed to Sale System (METRC) with absolutely no discussion of whether that is actually effective overall because I think it is not. I think the tracked system to OLCC is probably the now the largest source of diversion from Oregon, not because they aren't trying hard but simply because the nature of the beast is that marijuana is going to be diverted when it is more valuable in other places.	

	Solutions to this must acknowledge that and not just accept this story that if we were only the METRC system then there wouldn't be diversion because there are plenty of stories of OLCC businesses that are completely tracked diverting marijuana. I think it points to the fact that we now have an Oregon in the OLCC system over a million pounds of inventory, and I keep saying the marijuana is there, the medicine is there we just need to get it to the patients. So, I hope we can talk about that aspect of the program we've been talking about creating mechanisms that don't get bogged down in the red tape. But get some of that million pounds of marijuana to the patients that need it who are right now going without. Kris McAllister states there are a couple things not reflected in the report. There is some testing manipulation that's happening on the shop level. Example, having weed A and weed B that isn't' selling and mixing it together to get different results or testing the top part of the product vs the bottom part and getting discrepancies. THC and CBD are the only thing mandated to be searched for but adding other cannabinoids integrated in the tests would help mitigate	

	some of these types of issues. The patient access weed locally in Lane County that is on the shelves has test dates from a year out and is old. Having access and having the medicine people need are not mutually inclusive. There are issues in terms of tracking. I know two issues where the grower died the shop held onto their flower, the widow didn't get paid for the medicine and the medicine has now disappeared…." disposed" of even though you can see the same flower at the shop with a different name and different tracking number. This hasn't been mitigated. And when I tried to go through the process through OHA and OLCC they told me to talk to the OCC. I have even less hope that some of these diversion things and manipulation that are being done by shops in the name of putting "Access" out there are actually real or helpful. Sarah Bennet states – Agrees the report seems disingenuous. There is a lot of work to be done and I feel like, while we talk about all these reasons why and where we are at and the history about everything, this is great. We really need to identify what did we learn and how do we move forward. The CTS METRC system is currently the largest diversion. There is	

	no incentive, I don't know what the solutions are above and beyond CTS, I don't know why they didn't have statutory authority to track seed to sale originally, and METRC has been around for a while so I am just curious why we didn't utilize that in the beginning, why they created their own system. But what system is really out there, who is going to be in charge of overseeing patient access and what does the relationship look like in bringing together the patients and the growers, the OLCC if we need them for their outlet purposes so patients have access, how the OHA OMMP participates in the ultimate oversight. But really how do we expand this so patients have an easy walk into accessing their medicine from start to finish and the product in their hand. It's hard for me sometimes to go down these lengthy rabbit holes and whatnot when I really want to get to the nitty gritty and the nuts and bolts. What are the actual items that it will take to get to the solution. Because our patients are dying. We all want everyone to have access immediately, so how do we do that. There is a lot of information and a lot of overlap in this report. This report is from the perspective of OHA and OMMP so it will be fantastic to get a survey out to the people and participants of OMMP and kind of compared the two and see	

	where the strongest commonalities between the interpretation and understanding of OHA OMMP and what they had to do to administer the program vs what the actual effects were by the growers, caregivers, and patients of the program and see that side by side. Anthony Johnson shares everyone's concerns. This report is done really under the fear of Jeff Sessions administration repealed the Cole Memo and under pressure of the federal government putting pressure on the state of Oregon to crack down on so called diversion. I think it is harmful for patient access to have that be the overriding theme and concern from OHA from how the media plays it, so I think that we should discuss at this subcommittee or maybe the Cannabis Commission as a whole to respond to the issue with a statement illustrating the need to keep a focus on the patients that are without access and the patients do get harmed if there are more and more regulations that push growers out of the system.	

• **Patient Access program** • **Continued discussion and drafting of proposed legislative concept for supplemental patient program**	Wanting to use the OLCC backlog to patients which in turn will create diversion. Clifford doesn't want to rely on solely the OLCC backlog. We need to focus on lessening regulations so growers can produce medicine patients need. Also giving incentives to processors as well as dispensaries to accommodating a low-income patient program. Also likes Kris McAlisters Idea about having small gardens whom would like to offset some of their expenses by making small contributions as well, for lack of a better word a product they could provide for free to patients. If processors would donate 30% of their fair market value that would eliminate their backlog per say and give them a discount on their annual licensing fees dependent on how much they donate. Anthony Taylor - Just because there is access doesn't mean patients can get it. For example, you can buy as much RSO as you want but it will cost you a lot of money. We need to keep affordability in mind and get as much low-cost medicine to patients as possible.	Anthony Taylor

	If you can't produce cannabis for yourself, you can ask someone else to produce it for you. If they agree then you can designate them to do it for you. That means all these people are getting free cannabis. One of our struggles right now is how do we keep that free cannabis flowing. Every time you start talking about free cannabis people start freaking out, well everyone that has a card can get free cannabis so everyone is going to get a card, everyone that is broke and has a card, or some way for the indigents to have access. Free marijuana scares them but it is an important part of the program has been doing for so many years, is providing free medicine. Unless the state wants to step up and start paying for it or start shouldering the costs of the pharmaceuticals that these patients that are being shut out more and more are going to have to switch to they are going to have to make a decision themselves as to whether they are going to be ok with what we are proposing including free cannabis or not so we have to be really careful how we craft this to get the cost down as low as possible even to free in my opinion to make sure the state is ok with it. We have to craft language well enough to settle their fears of diversion and everyone is	

	Oregon having free Marijuana and taking away from their tax revenue. We really do need to switch and advocate from this subcommittee up to the full commission up to the state to advocate that the program is no longer funded by fees from the patients but funded by the revenue generated from the sale of recreational marijuana to adult users. Any revenue generated from the remaining fees of 50 or 35 dollars a year whatever it may settle on is dedicated to funding for research and other patient services. We have got to push the funding of the program be rearranged. If we are down to 39,000 patients how close are we to the tipping point, I would say that without the grow site registration fees that these growers are paying for their patients this program would be upside down right now and we have a big job ahead of ourselves of flipping it back into viability and a legitimate program. Anthony Johnson states OLCC tax revenue is on pace to hit 80 million this year. 20 million the first two quarters. Originally projected to be 40 million this year, so doubled from what was expected. In the City limits of Berkley, they were	

	donating 1% of their cannabis and bumped that up to 2% as a requirement of their licensing. The OLCC surplus is in danger of going bad and entering the black market. We need to find a way to incentivize these dispensaries and processing sites to get this to the patients. Needing a 4 or 5 different pronged avenues approach – whatever patient demographic you happen to fit in. Not every product works for every patient the same way. Something can work better for one person and do nothing for another so something to take into consideration when donations of product happen. Our goal should be every patient has access to every marijuana product available. Need to open the pathway that every producer can transfer to a patient. If they are looking for something specific they could be told what county and store it is in. Anthony Taylor state for shipping you just need to create a manifest and ship the product that way. Need to think about a delivery modality for those patients in Bend needing the product being sold in Southern Oregon.	

	Discussion continued regarding incentives to get donated medicine – free cannabis or subsidized cannabis to patients through other growers, dispensaries, processors, and OLCC * Needing everyone on this subcommittee to bring Anthony Taylor proposed language and bullet points of pathways to patient access should mean. Thoughts on taxing the producers and how that works so we can get the stores to become active and willing participants. Also, send data requests for the survey we are wanting to send out.	
Public Comment	Michael Rochlin A lot of the subcommittees are overlapping in some of their concepts. I am very upset Product Integrity didn't meet this morning because last Product Integrity meeting they mostly talked about diversion and not product testing. Product testing to me is extremely important because part of patient access is safe patient access. We talked about the lack of metals testing, we are practically the only state that doesn't run those tests. I am going to bring that up to the main Cannabis Commission that I strongly urge that we add that to	Anthony Taylor

	all testing. Cannabis is an aggregator and it's going to aggregate things like lead and mercury which would accumulate in people's systems. Since we don't have the evidence and a lot of unknows, the assumption is that it's probably there and we need to prove that it's not. A lot that was talked about today was tax and the basis of using the taxes and the fees. I think tax incentives are appropriate, some sort of rebate against licensed fees. Right now, OLCC has the majority of folks switched to roughly 400 dispensaries. OLCC with the promise to be able to sell back in which is currently very limited. What we don't know is what is the effectiveness of the current tax money and how it's being spent, that needs to be audited. I think that's a really big issue. Schools is there education really go on, I think it's just in the general fund. Or it's the way I am perceiving it. Rehab, that's a big issue. How's that money being spent. I want to see it, return on our tax dollars. This is a big tour industry and I don't think the majority of folks spending money in the summer on tourism really care but people in the state do and	

	if we are going to do something about it we need to find out what's the baseline before we make changes as far as continuing the same amount of tax derivatives. The commercial is not the same as the medical market. We don't have the same kind of customers, we don't have the same needs. I went down the street to find on of the hardest strains to find. I found it for $24 dollars a gram with retail. Which would be $6,000 a pound. Totally unaffordable to my medical patients. That should be donated. I have been looking for that stuff for a long time, very hard to grow and it's very desirable for certain kinds of patients. Just an example of how egregiously out of balance our system is. I am just upset about this for patient access. And I mean safe patient access because the report from OHA looks like it's focused on compliance only which is where I saw this so-called product integrity and diversion subcommittee talking about diversion mainly. The reps were talking about essentially compliance and diversion which is a part of this but in medial in no manner whatsoever should this be the top discussion. This	

	has been in the rhetoric since I have been in the discussion for the past 4 plus years which seems like 20 where I heard people talking about the over production and it's all medical and that's where It came from. We need to do something to get this into people's hands legally. In addition the money that was spent to help the METRC system for the growers should have refused to have been funded. So those are the kinds of things that hurt our patients and as a provider I am really upset about this stuff but the lack of access to medical providers. Our committee is struggling to education medical providers. We have a ton of people within the medical field that are willing to step up but are not allowed by statute to provide the simple card access. Let's allow for equal access for medical. It will be interesting to hear all the subcommittees repour outs at the main Commission meeting on Monday because the bottom line is we all need to do this together. The legal adult system will be hurt by not allowing true proactive research and education so we main stream this. That was the main intent to legalize it. We are 4 years	

	behind essentially. This is an urgent issue and I really look forward to more real solid commonsense regulation coming out of this unifiable industry especially quality assurance and testing. Lee Burger I am really glad to hear the questionnaire part is moving forward. I think that is the most critical component to the mission of this subcommittee. Respectfully John, I don't know which is the more guessy kind of assertion that you make, "There are fewer patients because they don't have access" or that "most of the diversion is coming from the inventory". I don't think either is true but neither of us know. We won't know the answer to the first one without a questionnaire to the first one that addresses that. I think the people that are involved in this committee work as either committee members or observers are the most in tuned with legislative and administrative and agency attack on medical growers. I read the report. I think it was a false equivalency to say that	

	"If cannabis is diverted by a medical grower, that's cannabis that would have gone to a patient." That's just nonsense. Between 1998 and 2013 where patients would make an arrangement with a grower to supply them, patients didn't care where the rest of it went. Patients received what they needed. And there was an implicant understanding about that. That's how it was till 2013. The legislature not withstanding the voter powers efforts in 2003 and 2010 to create regulated supply systems through the ballet initiative and there was an opportunity to provide the access to medical dispensaries but it's just a false equivalence. If we want to save and rescue the medical growers so that they are able to continue to be companionate then we need to continue to up the limits so medical growers are allowed to transfer into the adult use system since there are fewer and fewer medical dispensaries. I am the only one who testified at the hearing about 1544 on Friday about this and I suggested then and would renew the suggestion now that and would urge the subcommittee to recommend to the commission	

	that the legislature to increase the amount that a medical grower can send to the adult use system to 20lbs a year to 20lbs a month. If they are an outdoor harvester that only harvests once a year then that's 240lbs at the end of the year. And to the extent that diversion no kidding is a problem, the solution is to broaden the market. The solution is to end Federal Prohibition at best. At least to allow interstate trade between the coterminous states. The bill in the legislature last session that I think is going to be renewed next session. Certainly the patient access subcommittee can recommend to the commission to endorse the proposal that the governor would be allowed to enter into compacts with the coterminous states Washington, California, and Nevada in the same way she has with the tribes. That was the bill that passed out of said judiciary committee last year and there isn't any reason this group couldn't support the same kind of legislation. Even when it was assigned to DHS, they've always been hostel to medical both as a notion and believed the lies from the federal government. We had a hearing on adding	

	conditions where one of the members of the panel brought the material from the office of national drug control policy. Another way to expand the market is to lower the age for adult use from 21 to 18. On October 17th in Canada, a 7-hour train ride away an 18-year-old can go and buy cannabis. Once consequence of the 9 bills that were discussed in the report and here today is that I am still a criminal lawyer, I've represented people on minor in possession. I represented a woman who is 20 years and 3 months old. She holds a full-time job and working on getting a double major at a prestigious private university and she is a completely responsible person who is completely polite and cooperative with law enforcement. Why, have recourses that apply to folks like that. I know about the brain development stuff, I am married to a lawyer who has used the brain development science to limit when children can be waved into adult court. By presenting evidence in a trial court that untimely the Oregon Supreme Court adopted her argument that essentially brains aren't developed enough to be able to appreciate the	

	consequences of your actions. Because particularly for guys the prefrontal cortex doesn't form. I am not the only one who first used cannabis at the age of 16 and I've won cases in the Oregon Supreme court and I pay taxes. The notion that we should continue to criminalize 18, 19, 20-year old's because we are somehow protecting them when there is this million-lb. surplus should be again something this subcommittee recommends to the commission to recommend to the legislature. I am a little bit concerned about the notion of the surplus going bad because Chris Conrad who is an international cannabis expert based in Elsorida California testified at a trial I had down in Salem some years back about how if it's zip locked and frozen it can last up to 10 years. I've spoken to growers that know this and waited out these kinds of depressions in the market. I disagree about the notion about the surplus. I don't think the focus should be on that, I think the focus should be on identifying which patients have most been harmed by the legislative reaction to ballot measure 91 and how best to create a pipeline where they can	

	have access to medicine but also medicine that they need for a particular condition. Matthew Mendoza I had a grandfathered grow site and I was unable to find a grower for myself and my patients that I grew for at that time couldn't afford cannabis especially at OLCC dispensaries. I gave testimony when asked by OMMP regarding the hardships of 1057 and 2198 and how that has affected us. In part the response I got back from the agency was in addition growers are only able to transfer marijuana to a patient that they are growing for. Growers are unable to give marijuana to anyone other than the patient they grow for. I am asking for the ability in my reporting on my dashboard online on OMMOS to simply report transfers to anyone in the program, patients, growers, and caregivers. I have been going to clinics gathering signatures. I already got 294 signatures so people really agree with this. The common advice I am give is to report the transfer to myself and then go dispense that to	

	patients. Talked to several people who would be willing to do this only if we were provided a legal pathway to do this. Wanting to add onto the survey the question of who should govern the Medical Program. Along with these signatures they still want OHA to govern the OMMP. They do not want to switch to OLCC. According to the snap shot provided by OMMP I have broken up the number of growers and each county has plenty of access to growers who would be able to transfer to any OMMP patient if we were just permitted to. If it's recorded to transfer amongst ourselves then there shouldn't be a reason not to. Number 4 on the documents provided for the subcommittee meeting provides a few reason why patients have left the program.	