TRANSCRIPT of
SECOND MEETING: MEDICAL MARIJUANA WORKGROUP

Meeting Date: October 12, 2021
Video Location: https://www.youtube.com/watch?v=b7jTrxQqeHQ
Workgroup Information and Materials: https://www.maine.gov/dafs/omp/workgroup

Please note: The following is a transcript of the second meeting of the Office of Marijuana Policy's (OMP) Medical Marijuana Workgroup. While every effort has been made to ensure the accuracy of the contents of this document, inadvertent transcription errors are likely to appear within this document. OMP will take every effort to correct errors brought to our attention.

The following attempts to be as true to the remarks provided by workgroup members as possible, so reviewers will notice there are repeated words, run-on sentences, and sentence fragments.

Erik Gundersen: Hello, everybody. Welcome back to the second meeting of the medical marijuana working group hope everybody had a nice long holiday weekend. We'll run this a little a little bit like the legislature does considering we do have a live stream going out and people are watching. Go around and do a very brief introduction name, affiliation so everybody watching knows who's on the call and what seat you hold. And to help facilitate that I can just call on individuals and they can give their introductions, so we'll start with John Black

John Black: Hi, I'm John Black. I'm from Earth Keeper Cannabis and I am a caregiver representative.

Erik: Catherine Lewis.

Catherine Lewis: Hi, I'm Catherine Lewis. I'm owner of Homegrown Healthcare. I'm also representative of medical marijuana caregivers trade association and I hold the caregiver seat.

Erik: Paul McCarrier.

Paul T. McCarrier: My name is Paul T. McCarrier. I'm with Maine Craft Cannabis Association. I've worked with medical cannabis since 2010. I'm a caregiver in Belfast Maine with 1 Mill at 1 Mill Lane in Belfast. Thank you.

Erik: Susan Meehan.

Susan Meehan: Good afternoon, Susan Meehan, I am the chairperson of the Maine Cannabis Coalition and I own a small caregiver business that serves pediatric patients, Mae's Mamas and I am serving as a caregiver representative. Thank you.

Erik: Joel Pepin.

Joel Pepin: Joel Pepin, JAR Cannabis Company representing caregivers.

Erik: Dave Vickers.

David (Dave) Vickers: Dave Vickers, owner of ORIGINs Cannabis Company and I'm representing, I'm a caregiver representative.

Erik: Joshua Quint.

Joshua (Josh) Quint: Good afternoon. Josh Quint with Canuvo, out of Bridgton, and I'm a dispensary representative.

Erik: Heather Sullivan. … Heather, I don't believe we can hear you. It looks like you're off mute but…

Heather Sullivan: How about now?

Erik: There we go.

Heather: Awesome, thanks. Heather Sullivan, representing Curaleaf as dispensary representative.

Erik: Barry Chaffin.

Barry Chaffin: Hi, I'm Barry Chaffin, and I am one of the co-owners of Nova Analytic Labs. And I am representing the testing facilities.

Erik: Alex McMahan.

Alex McMahan: Hey. My name is Alex McMahan. I'm with Healing Community MEDCo, and I'm representing product manufacturers.

Erik: Patricia Callahan.

Patricia (Trish) Callahan: Hi. I'm Patricia Callahan, and I'm a patient representative.

Erik: Michelle Caminos.

Michelle Caminos: Hi. I'm Michelle Caminos, and I am the parent of a minor patient. And I am a patient representative.

Erik: Sean McDonough.

Sean McDonough: Hi. I'm Sean McDonough. I'm also a patient representative.

Erik: Jamie Comstock.

Jamie Comstock: Hi I'm Jamie Comstock. I'm with Bangor Public Health and Community Services, and I represent health professionals.

Erik: Julie Milliken.

Julie Milliken: Hi, I'm Julie Milliken, and I'm a nurse practitioner. I own Maine Medical Certifications. We do medical certifications cards and evaluations for medical patients, and I represent the health care community.

Erik: Christopher Beaumont.

Christopher (Chris) Beaumont: Hi, Chris Beaumont. I work for the city of Portland as the cannabis compliance coordinator and I'm sitting as one of the municipal representative positions.

Erik: Rebecca McMahon.

Rebecca McMahon: Hi, I'm Rebecca McMahon. I am a staff attorney at the Maine Municipal Association, and I am municipality representative.

Erik: Perfect, thank you. I am Erik Gundersen, I'm with the Office of Marijuana Policy and again thank you for everybody coming back. It seems like thing went well two weeks ago, nice to see everybody's face again so heading into this conversation today I just wanted to do a brief recap.

First, we want to obviously thank everybody for the candid and thoughtful conversation that we had last week. It was a little bit open ended but after we circled back and reviewed our notes and minutes it really addressed a lot of the information deficit that we are looking to kind of close on how we move forward with both regulations and recommendations to the Maine legislature. So, really helpful and we'll circle back on some of those points later in this meeting but there were certainly a few themes that were consistent throughout that discussion with patient access. And we did have patient education on the agenda which we didn't get to I'm sure you've noticed that it's not on the agenda for this week it is on the agenda for our next meeting. It is a higher priority but again when we went back and kind of reviewed our discussion it led to more questions for us, so I want to make sure we have ample time to have more in depth conversations and some of the agenda items we picked up at the end are also on future agendas. But we are going to get some of them here today, so I think what we are going to talk about today again both with what's on the agenda, most specifically system dynamics which resulted from conversation from our last meeting. I want to dig into some of that and get perspectives from all of our stakeholders here. Certainly patients, caregivers, municipalities, and whatnot. So, before I go into those topics certainly with patient education on the agenda two weeks from now, I know [OMP's] David [Heidrich] had sent around an email. I think for us to kind of tee up that conversation to have the most substantive conversation possible about best practices for patient education what are you doing, what can the state be doing? David did solicit some information and materials that people on this call use of you could sent those to him that would be super helpful heading into the meeting on November 2 but… Paul.

Paul: Did the minutes for the previous meeting go out?

Erik: I don't believe the minutes went but we are currently in the process of transcribing the entire meeting, so there's no chance of it being editorialized for anything and as soon as we have the full transcription it's going to be on the website with all of the other materials and then also the video itself should be archived on the website as well.

Paul: Great and then I guess my other question is, just so I'm clear, how are we defining system dynamics?

Erik: Well we'll get into that conversation. I think a lot of it has to do with some of the topics that were brought up two weeks ago and then we are also going to talk about what you had put

on the agenda as far as data deficiencies and what we can do better on the med side to get the data that you need that you folks are looking for. So, but first and foremost, for the sake of me rambling on and on here obviously the intent of this working group is to identify what's working and what's not. And where the information gaps in the last conversation was incredibly helpful so again when we were reviewing notes there are a few themes that kept coming up and we wanted to get to work as soon as possible to make sure that we can start to move the program froward. And one of them was a conversation around the Office of Marijuana Policy, the state, and municipalities and how there might be a gap there that we can help bridge to help it work more efficiently. Not only for the states, for municipalities, for registrants, and patients and I think that's certainly something that we at the Office of Marijuana Policy (OMP) can do.

I know [OMP's] David [Heidrich] did reach out to Rebecca to start that conversation about things that we can do to help make it more efficient, help make it more streamlined, help make it more clear really with a net benefit being for the patients and for the registrants. So, we've begun those conversations and we're going to form a little sub working group even after this group has finished meeting to make sure we can have those conversations. And even if this group is not together, we're still going to use our website to make whatever progress we make, whatever materials we come up with transparent so everybody can see the work that is being made this fall and into winter. Again, to help benefit the program in totality so that's work that we are going to do with MMA [Maine Municipal Association] and towns across the state.

Does anybody have any input or anything specific that they want to bring up on that front as we begin that work in earnest moving forward? Okay, well while we have those meetings, we'll…

Julie Milliken: I do. I couldn't get there fast enough.

Erik: Oh no, it's okay.

Susan Meehan: Sorry, so are you asking for input on the municipality's thing on the agenda at this time?

Erik: No. So just anything in particular, thoughts that you may have about the conversation that OMP is going to have with Rebecca and her team, MMA. Resources that we can provide to towns so there's a shared understanding and clarity from north, south, east to west.

Susan Meehan: Okay, well I reread the entire statute section on municipality authorities, that's 2429-D—local regulation and I wanted to make sure that I understood it. Because I've had a lot of caregivers as chairperson of the Maine Cannabis Collation, caregivers reaching out to me having issues within their municipalities and the municipalities not understanding what their authority was. So, I reread it to make sure that I understand it, at least per statute and I think it's very clear. And it was very clear as legislative intent back in 2017, when this section was passed that municipalities, while the language states they may regulate caregivers, it very explicitly leaves caregivers out of the equation when it talks about municipalities being able to prohibit or limit caregivers. And it talks about every other category the caregiver retail store fronts and testing facilities and manufacturing facilities are different story. Those municipality authority specifically exists for those, however, it specifically not required for a caregiver who does not

have a retail storefront, they may not prohibit or limit the number of caregivers. And again that very clear both in statue and if you were present in 2017 when this section of the statue was passed it was very clear as legislative intent as well so I wanted to reiterate that on the record and we need to start educating our municipalities on these matters. Thank you.

Erik: Thank you absolutely, Chris I saw your hand up.

Chris: Thank you, Erik. Just to speak to your first point on thoughts or ideas along the municipalities, you know Portland and myself would love to be a part of that other working group if it comes about. I think part of the conversation maybe even in the early stages is on several other state department. There's a delegated review authority that certain municipalities that hit certain parameters can apply for and I just think that would be an interesting piece to add to this conversation. When we are talking about state verses local and where the line is going to be and everything because I think the delegated review program has some benefits too, I think both sides of the house.

Paul: What states are those in Chris?

Chris: In Maine in the Department of Agriculture, the Fire Marshall's Office are two of the programs that come to mind right at the top of my head.

Erik: And Chris I do still have your agenda item about kind of fleshing out the exact role of the municipalities and we'll get to that. And I think it would also bring some clarity, I think everybody around this group would appreciate some clarity around home rule authority as it interacts with the medical program and possibly bringing more clarity to that. Whether its via proposed rule of statutory changes, that's still on the docket and we can delve more into delegated review authority because it's certainly something that I would want to hear more about. And then somebody did have their hand up but it's no longer up. Josh did you have a question or are you all good?

Josh: I'm sorry. I am all good for the moment.

Erik: Okay yeah, no problem. Sorry to put you on the spot.

And then, so we'll have that ongoing work and we'll certainly circle back to you and I think the conversation that we'll have in two weeks is going to help define what that work looks like. But I wanted to let you know that you were heard there and that's certainly something that we can work to improve upon, again, to benefit the program in totality. And the second thing, again, in line with the vision of this working group, does it benefit patients, does it benefit Maine businesses, does it benefit the stakeholders around the group, patient access being of the highest priority, we want to further investigate the digital certifications. Because we think there's a lot of value in that to achieve really the purpose of this working group moving forward, but obviously when you start talking about that internally, what's the best way to do it? How can we improve patient access while making sure that patient privacy has a high priority? There are certainly multiple ways to do it and we certainly want to make some type of recommendation to the legislature to move in that direction. But there again when you start looking at it there are a number of differing ways to do it from very official ways to just your simple print at home. So,

for, I would love to hear from the patients. I would love to hear from the providers particularly, what you were thinking would be the best way to achieve that? Because that's a conversation that we started here, and we want to make sure that when we move a recommendation forward, we're moving one that's going to work for patients but also for the providers themselves. So, I don't know if anybody wants to chime in whether it be Julie, Patricia, Sean? Julie.

Julie: Yeah, I think that there is definitely a place for some digital options for patients in the system. What I kind of envision is a hybrid system where we retain the, you know the formal paper medical card process which requires a wet signature by the provider and records being kept on their medical offices. So, we do have that paper trail to be able to validate make sure that legitimacy of the digital cards existing. There are a lot of patients in the state that don't have access to all of the electronics, elderly patients for example, for whom electronic copies won't work. But to be able to add the option of having either a photocopy or a digital version of the card for patients to use while they're waiting for their physical card to come in the mail and or to be able to have just as a convenience. If they have the physical card, picture or pdf with a signature on it of the actual card with the serial numbers then you know they could have that as an option as opposed to you know little physical paper card which you know are a little bit tough to keep track of. They're kind of flimsy we laminate them often but they're still really hard sometimes. They get lost or misplaced, so to be able to still have access to buy medicine with their legitimate certification while they're waiting for a new paper card or if they don't have the paper card on them when they happen to make it to the storefront. So, some sort of a process for both of those kind of things can work together would be really terrific.

Erik: Okay perfect, Sean.

Sean: Yeah, I would agree that having both of them is a benefit. I have, typically whenever I've gone to the doctor's office, I've left with my card but because of Covid and everything being digital, my next exam coming up here in the next couple weeks will actually be a zoom meeting. So, I'm sure I'll get a card mailed to me, but I agree having something electronic that is official. Currently, with a card there's no reason why can't take a picture and save the copy of the picture same way with a card. But with the weird stuff that goes on now adays, how easy is that to counterfeit or whatever? It would be nice that if there was something more sent by the state or whoever that says that it's a legitimate thing that I can carry on my phone. Because I hate rifling through my wallet and it's like there's my hunting license, there's my pot license, there's my driver's license. Just something else that doesn't have to be in the wallet would be nice. And that is officially accepted by other places not just the paper copy, it has to be 100% accepted in the state so you're not getting turned away because you don't have the paper copy on you.

Erik: Michelle.

Michelle: Yes, thanks. I just wanted to add to that I may be a little behind the times this was a while ago when my son got certified, but he had a malignant brain tumor at the time, which time is really of the essence there in treating. And I also remember having to go through this excruciating waiting period between the time he got certified and we received the card in the mail. And it was really horrific actually, I mean ten days may not seem like that long of a time

but when you're in that situation it feels like an entirety. So that's just another consideration that I wanted to bring to the forefront is that it could, any age, but in at least at the time my son got certified there was that waiting period that was tacked on to it. And I don't know if that is still the case but between that and the time it took to get the card mailed it was little nerve wracking.

So yes, I agree with everything being mentioned about anything that we can do to streamline that process would be you know highly appreciated. And I think there may be, not myself, but there may be, conceivably, some people out there that have privacy concerns about being required to do it electronically. So, I don't know if there is an option where providers could still do the paper if that's what the patient wanted. Thank you.

Erik: Perfect. So, before we go to Julie, I know that Susan had her hand raised, Patricia, and then we'll go to Julie. So, Susan.

Susan: Um, I think Michelle covered it. That's why I put my hand down is just that having the paper option I think is critical because of the state's access to the internet and Wi-Fi. I think some kind of QR code verification would be excellent. But it should we should always maintain the paper copy as well, in my opinion. And that's all thank you.

Erik: Thank you for that feedback. Trish.

Trish: Yes, I wanted to piggyback on that part about if I support the idea of digital, especially in a rural state like ours, but at the same time there are people who most likely are only going to want paper. And so that this isn't system, is it as well you get this in addition too, but do you want to have both? Or do you want just paper kind of a choice would be I think appropriate for a lot of folks.

Erik: Thank you for the feedback. And, Julie.

Julie: Just to reiterate what Shawn was saying, related to the Zoom meetings, we do do a lot of telemedicine in the state, because of the lack of access for folks that live in some of the rural areas. So, the digital copies, you know, would give them a bridge to be able to make purchases and begin that therapy, while they were waiting for the ever-slow US mail to bring them their paper card. So even in the best of circumstances, when we put the cards in the mail the same day, sometimes it's a week or 10 days or longer before they receive them in the mailbox. That's a long time to delay therapy for folks who cards have expired or are new patients.

Erik: Got it, Alex.

Alex: So first, I just want to say I agree with what everybody's saying about having a photo work in addition to the paper copy. But next I want to take it back to you know, kind of 2018 and pre-2018 when there was just the five-patient rule.

You know, I remember the burden being mostly on the caregivers to kind of keep track of it, like caregivers had a binder it had their five patients cards, and you know, they knew who was expired and who wasn't really better than the patients did and kind of reminded somebody, hey, you're a month out, you know, you might want to think about getting a renewal so and really in those days, it was you know, I feel like most people weren't checking the physical card every

time just because they're already on top of it that systems to be able to keep track of it. Almost feel like the law should be more that, you know, we're required to only sell to people that have a valid certification and that of course the burden falls on the people that are doing the retailing if they go out of that but that there should be an allowance for caregivers and businesses to come up with systems for kind of keeping track of that on their own. And again, you know, if you're outside of that compliance, it's the same as if you're outside of that compliance with other way just throw that thought out there.

Erik: Thank you, Alex. And then we'll break for a while Sean bring us home.

Sean: Well, I'm not sure if this brings you home or bounces off the big wall out in the left field but I I didn't mean to confuse anybody I agree with both paper and electronic. I just think that there should be an option. The patient could have one or both. My other thing is I'm probably way out of the loop with this, but why do we have to if I'm going to be dealing with this for the rest of my life With my conditions and using medical marijuana, why do I have to go in for a chronic condition every year? And see somebody every year other than making somebody money? Why am I having to do this, there should be something in place for a two year, a five year a 10 year or lifelong medical marijuana certification for the patient, so that we're not having to make these yearly appointments for something that are obviously chronic on a vast majority of the patients.

Erik: Thank you, Jamie.

Jamie: Hi, sorry, it took me a while to figure out how to raise and lower my hand. So, I just wanted to say, in thinking about all of these things that we've been talking about, I come from a prevention perspective. And I've really tried to kind of draw parallels with this medical marijuana system, along with the regular medical system that we have in place. So, what a pharmacy would do, what, what that kind of system would do. And so in answer to your question, Shawn, I would say that, in order to receive any kind of medicine for any kind of other ailment, or chronic illness that a person has, that's been, that's the system that we have is you, you continue to be seen by your provider so that you can receive the medicine you need to be treated. We talked a lot about the amount of the last time we talked a lot about the amount like raising two and a half ounces to another level to a higher level to account for people being able to get to their provider for their medicine. And I started thinking of that, about that in terms of like controlled substances. And in for pharmaceuticals for controlled substances we have, contracts in place that people, that patients are required to have contracts in place, and they only receive a certain amount of medicine every month, so that so that they aren't in danger of engaging in harmful amounts of use. And then other medicine like cholesterol medicine, you can get in, you know, 90-day quantities. That's an insurance thing. So, I think, just in talking about medical marijuana as a system, we need to just think you need to keep in mind the other medical system that is in place. Yeah.

Erik: No, thank you for that feedback. That's, again, when we're talking about information gap, this is what we're looking for. So, we have about three minutes left on this topic, and I want to make sure that we try to stay on schedule as closely as possible, but we'll go back to Sean.

Sean: Jamie, I would agree. As a nurse, I used to run hospitals and as a chief, nursing officer and risk manager and I've been in pharmaceutical research. So, I'm well aware of what you're talking about. The difference is, there's recreational marijuana, and there's medical marijuana. We do not have recreational laws that allow for opioids to be dealt out with legally as a recreational med. So, what you're saying is I'm required, or any patients required to go in every year versus go by it recreational which is also still legal, we could still get it any other way, legally. So, what we're having to do is go in and see our doctrine. And if we're to be honest, and splitting hairs, recreation, our medical wise, going in and just showing a few pieces of paper about my VA disability, and just saying, yep, literally I sit there and say yep, same thing. Same here. Okay, here's your card. Thank you. Bye. It is not apples to apples. It's not even apples to bananas. It's more like apples to basketballs so it's not really a medical system. It's designed to be but if we were to follow the medical system, a lot of the people out there with medical marijuana cards probably wouldn't have medical marijuana cards because it really is very easy to get a medical marijuana card. If it's that easy, we should be able to at least spread it out. So, it's not so costly for us to get a medical marijuana card, because really? Why? Why do I need to, I know my strains, I can grow my strains, but I keep the medical marijuana card because that's what I'm using it for. So, I guess I'm just asking for financial relief to the patient so that they don't have to keep doing this, when it is obvious that it's a chronic condition. And they again, they can get it legally, any other place outside the medical system.

Erik: All right, so we have Susan, Julian, Heather, and I'll cut off the conversation around that to help get us back on track. So, Susan.

Susan: I agree with what Shawn's saying. And I think that goes back to last week's discussion. That some that it's very important that we preserve affordable telemedicine access to the program, because if we do require that patients renew every year, it should be affordable, especially for renewable renew. And the second thing is on what Heather touched upon the I would love to see a 90-day supply criteria instead of a set amount. Because while two and a half ounces may seem like a lot, for some patients that could be 10 to 12 days if that especially a cancer patient treating it, you know, a couple grams of, of concentrate per day. So those are my thoughts on that. Thank you.

Erik: Thank you, Julie.

Julie: Just very quickly, just one other sort of perspective on the annual review. It's not just an opportunity to you know, collect a fee and write a card for year for renewal. It's a good opportunity to be able to have a conversation with the patient, do some education. How are you using the cannabis? Can I encourage you to switch over from inhalation therapy to you know, edibles and tinctures which would be healthier for you? Do you have any new prescriptions that have been written for you, for example, I had a patient this morning, who has been a medical patient for years, who had a recent health challenge and is now on warfarin therapy had no idea that oral CBD or THC products can impact that medication significantly, in a way that could cause life threatening possible complications with that medicine. And you know, sometimes mainstream medicine providers aren't well versed in cannabis roles. So I think that the providers who are writing the medical cards are doing a disservice to their patient, if they're not taking the

opportunity every year to do some education with their patients, to see whether the cannabis they're using is working for them therapeutically. And to be able to help them understand how they may be able to use the cannabis in a way that is more effective and healthier for them. So, there is some you know, in clearly, Sean, you're very well versed in, in the cannabis world and very experienced, but not everyone is. And so, it's a good opportunity, even for people with chronic conditions to have a good review of their medical situation and for them to get some education and continued support.

Erik: Thank you very much. And then Heather.

Heather: I mean, ultimately, I think you could probably think about splitting the difference and having med cards certify for two years instead of one year, basically cuts the patient's costs in half. Doesn't necessarily address Julie's your consideration. But I would argue that the that if a Medical Cannabis Patient then gets put on a drug after they've been prescribed medical cannabis that's up to their new prescriber to be providing them with the information they need to actually ask the question of whether or not they are a medical cannabis certification holder. But some states do do a two-year med cert timeframe. And that could be a solution. I don't think med certs aren't driving any revenue for the state. Correct? So, the state doesn't get any fees out of it. So, it's not, it's not in the state's best interest, either. To keep it you know, maybe two years is a better fit for folks like Sean.

Erik: Perfect, Thank you. so incredibly helpful information for us. Again, we think there's value in digital certification for those that would utilize it for patient access. glad you brought it up, glad we had this conversation, because I didn't know what direction it was going to go. So that's certainly something that we're going to want to do some work internally and report out, because I think most of us around this table this virtual table, understand that that's going to take a significant statutory change in the way that things are going to do. So, we want to make sure that what we propose is legitimate, has legs, and is going to work for all stakeholders. So, it could be a seamless transition at the legislature, and something that we could operationalize quickly. So Perfect, thank you. So, those are definitely two things that we want to make sure that we're working on. And we'll continue to update this group and the progress that we make on those two fronts and takeaways from our last meeting.

But want to slide into more substantive conversations and discussions. Dave did bring up last week, the thought of us bringing forward some actual policy proposals. So, there could be some reaction in conversation around those. And at the time, I agreed with that. And I'm not saying that we won't do that the next couple meetings, at least some places starting point. But again, as we had conversations internally, reflecting on the first meeting, there's still that information gap for us that we want to make sure that we can get right in order to craft some baseline proposals for the group to react off of, or recommendations to the legislature, or put something in the form of regulations moving forward, which again, will go to the legislature next year as well. One of the things that we continually heard, and we agree with is the need to protect small caregivers, and small caregiver operations that kept resurfacing. And I think that really gets to the heart of the medical program when you're talking about, Well, again, in line with our vision, what benefits Maine businesses and what benefits patients. So, in thinking about that, couldn't agree

more. We also feel like we need to do our best and responsibly make sure that the system works, not only for the small caregivers, but also the patients. Which brings us back to the conversation that we gently touched upon, which was brought up by Sean and others about this conversation about your legitimate and illegitimate caregivers. And the reason I brought it up and wanted to put it back onto this agenda, because in you folks that run this table can correct me if I'm wrong. But in line with our vision, it seems what was described as what potentially might be an illegitimate caregiver works against really the mission of this group, what's going to benefit businesses, what's going to benefit main patients, and what's going to benefit all of the stakeholders around this group.

And from the very short discussion that we had, and what describes me, or to the group here, it certainly works against both of those, those visions. And I just wanted to hear more about well, from the caregivers around here does though, those described as illegitimate caregiver, do those hurt you? Do they not hurt you? Did they hurt the program do not hurt the program? I know, we've heard from Sean and Patricia around this. And it seems to me that that would hurt the patient experience. So, basically, looking for more of a conversation about in your minds, what defines the illegitimate caregiver? Is it beneficial? Or how does it work against the program, and then we can circle back if we have a consensus as far as Okay, they do exist. They're not working in these three ways what can OMP do, as far as policy levers to help build more integrity in the program that benefits the patient experience, benefits the legitimate caregiver, and really what we can do from our perspective and where we sit. So, with that, I have David and I have Sean.

David: Thank you, Erik. You know, the, one of the biggest things that I look at when, you know, looking at the overall situation with our program, is the lack of testing. And when I come to any situation, with any patient in any place that I said, I always sit there and I say, you know, what's the safety? What's the health standards for this person? And it is just very strange to me, that we have testing in one, one division, right, the adult use, and we don't have testing in the medical. And I know there's lots of people that say, Well, you know, potency can be played with, you know, you can dry your buds out, and you'll have a higher potency test for flower. Sure, that's true. There's lots of things people can do. But when it comes to pesticides, heavy metals, microbials I mean, we're in this to help people. And when we talk about, you know, I don't want to get into the you know, who's legitimate and who's illegitimate. I think if we're not testing our product, we're all setting a poor standard for our patients. And that's a piece that's very near and dear to my heart. You know, my family comes from a medical family. And you know, I just really worry that people are consuming products that aren't always clean. And so that would be something I'd like for all of us to discuss. Thank you.

Erik: Sorry about that I was on mute. And I think that's exactly what we're talking about at the end of the day, what can we do that benefits Maine patients. So, thank you for the feedback. And I do have an order here. But testing did get brought up. So, I'm going to go out of order just by one individual and kick it over to Barry who raised his hand. And then after that, in order, I have Sean, Susan, Heather, Paul and Joel.

Barry: Thanks, Erik. And Thanks, David. I chimed in just because I agree 100%. With you, I mean, obviously, I run a testing facility. So, I believe in it, I believe that it's a value. You know,

one of the things I've said from the beginning, not just in the med industry, but in the adult industry is, I feel that testing legitimize the industry. That's just kind of that's, that's my motto, that's my mantra that I believe in it. You got to have, especially in the medical side, you've got to have, you know, I think Sean brought it up two weeks ago, you know, talking about, he made an analogy about apples, you know, you want Maine apples, New York, apples, Canada, apples, you know, you may not get the one you want, but you buy them because you know, they're safe. And they're tested in there, there's a certain degree of quality control there. So, this is, you know, a medical field Medical program. I agree, David, it's really kind of strange that there's no level of testing no level of quality control, as opposed to the rec side. I do have some data I brought, because I saw that there were data and metrics on the agenda. Our lab, I've collected a data dump from the last year of every sample we've run. In the US…

Paul: Could you email that to all of us, please?

Barry: Excuse me?

Paul: Could you email it to all of us? We know what you're looking at please?

Barry: Yeah, I sure can, I'll send to you after the meetings. Okay. So, of globally, if we want to break it down to like the, let's say, the top three, that we're looking at pesticides, heavy metals, and microbes 40% of all samples, we we've tested fail for pesticides. And now granted, we were only testing the eight, the big eight that OMP put in the regulations proposed regulations originally, that's changed, the new proposal have had 60. And the limits, there have been limits to five there were no limits defined before we were going off California and Oregon limits, which were very low. But the new even if you want to factor in the new regs of 60 with higher limits, we started running those in August. So, if you just knock out everything, but August is still a 30% failure rate for pesticides, and everything we've tested. If you look at heavy metals, if you look at globally, the failure rates, that's adult use and medical, it's only a 9% failure rate. But if you drop out the compliance testing samples, and you only look at the QA sample, which is medical and just R&D testing, it's a 30% failure rate. So that tells me that testing works. When there is a program like in all the compliance, if you factor in the compliance samples, you drop from a 27% failure rate to a 9% failure rate. That right there it says everything you need to know, look at microbes is the same way globally It's a 14% failure rate, you pull out the compliance samples, it's a 30% failure rate. So, without testing, you're looking at 30% failing for microbes 27 failing for heavy metals. It's just uh, it's, uh, um, you know, kind of a data driven guy, when I look at this, I think it's, it's concerning. And, you know, if we want to talk about quality control and and legitimizing the industry and safe product and patient care, I think that testing in some way has to be involved some level of baseline. Now I understand the argument is it's expensive. I would counter that it's not as expensive as some of the information flying around out there. We can talk about that later. But we have to find some way to put some level of baseline testing you know, forth for the program. That's just, you know, my two cents, obviously. I am going to feel that way because I believe in testing.

Paul: Barry, when you when you send that data that you know, you just talked about out, could you send us kind of like what your standard is and what the baseline is. So, you know, we have a

better understanding about it is I know that there's been a lot of concerns that there isn't one standard set by the state that's kind of set by every different lab, and there isn't a research lab yet. So that would help me with my, you know, looking at the data.

Barry: Absolutely. When you say standard, do you what do you do to find, like, limits? Because those are…

Paul: Yeah, yeah, it's, you know, but it's the idea of, like, you know, like how the labs testing it, you know, there are people who know more about this than me, that are really concerned about this subject matter, because the state, you know, needs to basically try to look to set the standard. And when we're talking about this being, you know, a plant based item, when you're talking about, like, you know, the idea of apples to apples in New York, apples, Maine apples, we don't test apples, we don't test a lot of our agricultural products. And at the end of the day, cannabis is still an agricultural product. And even though it's still being used therapeutically, you know, for at least me to kind of understand this, and to continue to go down this testing, you know, discussion, being able to understand, you know, how the lab operates, and just those numbers will be very helpful. Yeah.

Erik: Thank you for that feedback. And thank you for that data. I think Paul is certainly right. As far as if you could share that with the group, that would be great. And I think what I think my takeaway from what Paul is asking for are the thresholds, visually action limits and detection limits, that would set that baseline for a pass fail. But thank you for that. So, let's go to Sean.

Sean: Uh, yeah, testing. I agree with David, I agree with Barry, listening to Paul, I semi agree with him, other than the fact, I don't smoke apples for my medical issues. You know, granted, you don't, you don't test for the honey crisp. But I just bought it market basket. But you know, it's coming from a reliable source, not some guy that you meet at the gardener, truck stop, who's willing to give you two and a half ounces above what the state is willing to say, is legal. And he calls himself a caregiver. And he won't show you his testing on it or anything like that. I'm surprised that this is called medical marijuana with caregivers. And anybody would dispute the fact that this stuff needs to be legitimized and tested so that we know what we're smoking or not being poisoned by the stuff that we're seeking to help us. Again, apples to apples, apples are not is to get rid or tamper down, say, my PTSD or somebody's cancer issues or anything like that. And getting back to what Jamie said, if we're to use this across the board, like other medical programs, you look at the medicine that you get at CVS, or Walmart or Walgreens or whatever, that stuff goes through a testing procedure. And my caregiver test is stuff and I get the I get the printout. So, he goes to a local lab, and I see what the results are. And it's very satisfying to know that my stuff has been tested. I would be very shocked that anybody would go to a caregiver and not know that their stuff is tested.

David: Can I just jump in real quick with the dispensary's and if you don't mind maybe Josh what's the situation for testing? I can't fully or Heather what's the testing regulations for you guys? Because you do have to test them; I'm correct in that in my thinking, clearly. No?

Josh: So, we do across the board testing of every batch along the same lines as the adult use standards, but we've done that voluntarily the entire time. It's not a mandated thing. There was if

I'm remembering correctly, I could be wrong about this. There was a provision in the language around yearly inspections where the department was allowed to take soil, leaf, and flower samples from the dispensaries and get them tested. To my knowledge that's never actually occurred. But no, there's not a mandate we just choose to do it.

David: Okay, just the same way we do.

Heather: We test we test all our lots, but it's not mandatory. We choose it.

David: Thank you. I did I did not know that. I thought was, Yep.

Erik: All right. So, let's go to Susan. So, we have Susan Heather Paul Joel and the Michelle raised her hand, make sure that we get to everybody. So, Susan.

Susan: Okay. The conversation started on illegitimate caregivers versus a legitimate caregiver. And I think that the patients who spoke about that last meeting I'm kind of gave us a clue that I simply don't go back to an illegitimate caregiver. I mean, if I have to meet someone in a back alley, and the transaction is shady, and they tell me what illegal things they can offer me, I'm pretty sure I'm not going back to that caregiver. So, I think it's a self-limiting thing. For one, when you get moldy weed from an location, I mean, I would choose not to go back there. And also, to report it to the regulating authority, which I believe Trisha did when this happened. I do think there needs to be some follow up on that. And I had pointed out page 26. And the 2018 rules that were that we're currently sort of operating under, whether it's obsolete or not statute says this is the current set of rules. And I think that page 26 of that offers a beautiful example of how we can have sample collection and testing as part of an inspection.

There are so many concerns I have with some of the things that have just been said, like testing for eight pesticides versus 60. Pesticides, I'd love to know the cost difference. That sounds extraordinary. But I think that when this program, when I first started involvement in this program in 2013, there wasn't even a testing lab in the state that could test a cannabinoid profile. And I think it's wonderful that we do have these options, and that all my concentrates are cleared for pesticides before I formulate pediatric tinctures. But I think that a state research lab that were doing random spot testing and starting to at least accumulate data or starting even if it were not a state research lab, but starting to accumulate data from the labs that are testing in the state like Barry is going to share with us later. I think we need to know those things. But we also need to consider let variations vary with even the medical community, you would be shocked to know the allowed percentage of variation on your pharmaceutical tests when you get for example, phenobarbital, which I have personal experience for my daughter's seizure, seizure diagnosis, those labs at the medical facility won't even compare one lab sample test to another labs when she was brought to the hospital in Portland, they wouldn't compare her blood levels to the levels that were found in Boston, because it's absolutely meaningless to compare.

So, I think we absolutely need to start gathering some data in the medical field. But we also need to consider exactly what do these tests mean, when you burn a pesticide and inhaled the resulting smoke. It's a totally different ballgame than your ingesting it from your apples or from your cannabis. So, I think we also need some data on that. And there seems to be no correlation between

what's used in cannabis and what use tobacco so I, I we need to start gathering data in order to make valuable and meaningful assessments. Thank you.

Erik: Thank you. Heather.

Heather: Yeah, I mean, going back to the question of legitimate versus illegitimate which I think we're kind of glossing over a little bit as we get involved in talking about one of the more one of the issues that I think we have a little bit more differences of opinions on you know, just going back to that when I think of what an illegitimate caregiver is, it's not whether or not they provide detailed explanation of what each strain does some people want that and some people don't want that. So, to me an illegitimate caregiver is someone who's selling outside of the program so selling to people that don't have a med card that is acting in some way outside of the program. So not following certain you know, rules of the program and then selling out of state like those are the three main areas that I would have I have a concern with for using the term illegitimate and I don't even want to use the term illegitimate caregiver because you could be an illegitimate person who doesn't even have a caregiver license and these things still fall in there. So I guess from my perspective, I would want to better understand you know obviously this is you know, OMP has gotten a brand new program off the ground in you know, one year and yay congratulations one year in on Adult Use, by the way, great work. But like what are what does OMP do towards you know, maybe it's not inspection so much as it is, is investigating. So, investigating complaints. When someone says, You know, I know of complaints where I've seen products that were labeled for California on store shelves, like what happens in those situations are we doing Or is the state doing any investigation of individuals or organizations that might be acting outside of the program? That to me is just as much of an issue to Sean's point. And I think, you know, I think maybe Julie, you also said, I'm not sure who who said, you just don't go back to that caregiver. People are creatures of habit, and you're gonna go to the person that's easiest to deal with, or the person that charges you the least. Or you are a different kind of consumer, and you're actually looking for specific things. So, like, I won't buy untested products I'll buy from a caregiver, but I want to see test results with it. But that's my own personal choice. So it's like, figuring out this balance between what as an individual medical patient what each person needs, versus like, to me just trying to figure out like, let's try to get rid of the bad actors, whatever sector they come from.

Erik: Thank you for sharing. Let’s see, we have Paul, Joel, Michelle, Trish, and then I started. Sean and Barry.

Paul: Great. So, I know last time Erik asked about some data from the department concerning complaints. And so far, we, as far as I haven't received anything about that have? Does the department compile complaints?

Erik: So, we were going to talk about I mean, we can jump around. We were going to talk about this in the in the data section, which is the next agenda topic. But yes, we do have inspection data. It's the same data we shared with the legislature. And I don't remember you asking specifically for that you probably did. And we can certainly send we'll have to make sure that we can send that around considering there is confidential information now.

Paul: Yeah, I mean, so well, this really connects to the conversation we're talking about right now. And so I don't, you know, I don't feel like this is a productive use of this workgroups time to discuss things about testing the idea of legitimate or illegitimate caregivers, until we actually have a baseline of the complaints that department has received about this. You know, for example, you know, how many complaints has a department received from patients about quality? You know, how many calls has the department received from other caregivers, about illegitimate caregivers, because right now, I feel like we're operating a lot of basically off of like innuendo off of, you know, analogy, as opposed to operating off of solid data. Because I, you know, I operate Marlo County, is a small county, we see patients from all around the state, but I can't determine what's happening as being a statewide program without having this important data from the department, you know, so being able to have the complaints that came from the department, and being able to have, you know, the data that you're able to provide, well, I think help guide the conversations of what we need to suggest for policy. And what we need to suggest, you know, for these rules, when we're, you know, when we're looking at this, too, is the inspection data is important inspection data is important. But it's still, you know, it's not going to necessarily help us draft really what the rules are. Because when this working group was mandated by the legislature, when it was put together, I thought we were going to be talking a lot more about the rules, and a lot more about how what these rules will look like and how they're going to develop, you know, so one thing that, you know, looking at the time, we only have 28 minutes left. I mean, I was hoping that we could look at what kind of timeline we have for trying to look at any sort of draft rules, or anything that the department could kind of give us and whether you know what they're looking to do, and I know you kind of addressed this earlier. And then if it's needed, do, we need to be able to have additional meetings to be able to draw to draw deeper into this, because with the little bit of time remaining with the seven people whose hands are up, you know, I don't know if we're going to be able to get to the discussion of the data and metrics as has been on the agenda.

Erik: Yeah, and we'll do our best to get to that. And then it sounds like a great agenda topic for the next meeting to talk about regulations and timelines. And just real quickly address the data issue. We do have certain data compliance data, we have our licensing data, we understand what we're seeing and what we're not. And we try to bring that forward again, the same way that we did it the legislature to recommend certain changes. So, two things are happening here. We're having an open and honest conversation with a significant information gap that we need to fill in order to move forward with a program that works for all stakeholders around this meeting. The idea that we sit back and wait for data that most of us know the state doesn't have the tools to get currently, or not to not to listen to the real world advice or experience of the 17 members around this around this table. Basically, as we need data to move forward with any type of policy proposal, I would just push back on that a little bit. We can certainly have the conversation around data, what would you like to see? What type of data can we collect that benefits patient? that benefits the registrants within our program? What data can we start collecting, if we're short of to make sure that the program is working the best that it can, but in lieu of data, hesitant to any changes, again, that are in line with our vision, to what benefits Maine businesses? What benefits patients? I would just push back a little bit on that.

Paul: So, what data is the department collecting?

Erik: Let's wait till we go to the data section. We're still having the conversation about what are we having the conversation about, oh, what's legitimate? What's illegitimate? What can policy levers can we pull again, that benefits the patient experience within the program that benefits everybody around this table that's running a business that benefits all stakeholders? But we'll get to data. So, with…

Paul: That would be that would be something that would help me determine what's a legitimate and illegitimate caregiver and how to best move forward with these policy levers as data?

Erik: Is Data. Okay. Joel?

Joel: Yeah, I mean, I think as much data as we can get on the program, obviously is helpful. So I'm in agreement there, but you know, I think it's, I don't need data to understand like a few of Heather's points, like people care you're selling to patients who don't have cards, adult use delivery services that are advertised publicly, people blatantly selling out of state like we don't need complaints or data like that stuff happens. So you know, for me, it's I got started in this working at a Garden Supply Store and talk to any and that it's been a long time since I've been involved in that setting, but talk to anyone who works at a garden supply store.

And even for me back in 2012 there's a lot of people that move to the state of Maine and I got residents here started as a caregiver and it was obvious that they were selling it back to wherever they came from. And you know, like for all of us here that participate in the industry and work day in and day out trying to compliant business like that's frustrating, you know, that people can just do that and in perpetuity continue to just exploit the program you know, and we get into legitimate caregivers, you know, it's storefronts who, you know, aren't following things that are black and white in the program. And not getting checked up on it does hurt other operators that do their best to follow the letter of the program, the letter of the law, you know, there's, it's, it talked to operators in the Lewiston Auburn area, it seems like it's well understood that like a lot of the medical shops in the Auburn area are kind of quasi noncompliant retail storefronts, like they don't care if you have a card or not. This is secondhand stuff that I hear, I don't know if it's real or not.

You know, in Windham, we'll have patients that will come to us with a digital card from a different state, and we'll deny him and then we'll get a bad review, because so and so down the street did a deal with him. So that hurts my business, but I'm just trying to follow the rules. But the guys down the street want to do a sale. And they do and there's nothing that happens to him about that. So, it does hurt us. And I have a concern. There's some storefronts that you see that have hours from 11am to 3pm. And I know I couldn't run my business with hours like that, and for only a few days a week. And so, a concern I have is you've got some operators that have a storefront out there that in my opinion, probably are being they're supporting the business by what they do out the back door. And I don't know if it's compliant or not what they're doing. But it seems like some of these there's some storefronts that are just sort of like a front for a legitimate operation. And so, it's just interesting.

And I'd say I've been doing this for 10 years as a registered caregiver. And I just had my first state inspection earlier this year. You know, my wife's been in a seasonal ice cream business and she's gotten inspected. She gets inspected once every two years, her once every, you know, once a year,

and it's here, you know, here we are. So, on the weed side, and I just had my first. So, you know, as far as testing goes, I would agree it's medicine. And I think there should be some degree of testing on the medical side, but I will say that my experience on the adult use program, it doesn't I don't think it should be or what adult use is, and I think there's a lot of efficiencies and Erik, we've talked about this and there's a lot of efficiencies on the adult use side that could be made in terms of streamlining the process that ultimately wouldn't put public consumption of final product in jeopardy. I don't know what that looks like medically, but again, Like there's a lot of, there's a lot of quite frankly lazy, unprofessional caregivers that would spray whatever on their plants to save whatever crop they think they're going to have for their own personal financial interests, and not have the morals to second guessed selling that to somebody else. And that's a real thing in our program. And that's not good for all of us who are trying to follow the rules. And again, there's things that we can all do as cultivators as an operator, what do we do?

You know, Barry, you mentioned, testing legitimizes the industry, right? Like being interested in going adult use years ago, we looked at Okay, we know there's testing coming, what are those tests look like? We started testing our product to figure out what is it gonna take to pass these tests, there's a lot of small simple tweaks that we made as an operator along the way, to ensure that we could always produce testable product, you know, so it's, again, I just think it's, there's a lot of unprofessional people that are just, they're lazy, and they'll spray whatever they want on their plants, then it goes out there, and who knows who ends up consuming it. So, I would agree testing in some capacity is important for the program.

Erik: Thank you, Joel. And as Paul pointed out, we are coming up to 330, I want to make sure that we certainly get to everybody. So right now, I have Michelle, Trish, Sean, Catherine, Berry, John, David.

Michelle: I'm gonna be as quick as I can. So, I just want to piggyback on the testing conversation. So, as I said, my son has been a patient for a few years now. We use concentrates with him, and then they get, you know, made into a tincture. And because it's concentrates, you know, I've always been really concerned what is in there, and because he started when he was four, yeah, so you know, pretty concerned about what's in there. So we've always, we work with a caregiver who does tests for cannabinoids, pesticides, mold, mycotoxin, heavy metals, residual solvent, and then sometimes I test again, for certain things like just to make sure it's the right cannabinoid level, and I'm measuring it correctly. That set so I am supportive of that, and I see the importance of it, particularly for certain patients who are really in a position where it's important, they're getting quality. Um, at the same time, I just have concerns about if there are requirements, I want to be sure that it doesn't come down, you know, really hard on people, and then all of a sudden, everybody's clamoring, and we don't really have the infrastructure to do this. And so now people are waiting, and they're not getting what they need, I just want to be sure that we have available labs, you know, that are appropriate for this if we really suddenly up the requirements, so that the cost and turnaround is reasonable.

The other thing is that I would think there should be some exceptions for home grow there. This is a state that has a lot of people under the poverty level, or even people who are middle income, and they're just kind of struggling, and they can't necessarily afford to go to a dispensary, or even

a caregiver for the for the amounts that they need. So, if they're home growing, and then they're going to a reputable processor, and they're getting that done, and they grow it themselves, and they already know what's in there. I personally don't think the state should be telling those folks, you know, before you take that you have to do X, Y and Z with it. So, I think maybe there should be some reasonable exceptions for things like that. And then for caregivers, I would think something like at the batch level would be reasonable if they have a very large batch. And then they can test that once and then spread out that product and you're not talking about every time you then do something else with it. You have to have it tested again and again and again. So that's really all I wanted to say about that to keep costs reasonable.

Erik: No, and that was a good point, though. The latter point that you did make it as far as exceptions, certainly. well taken. And I think certainly any conversation around testing wasn't expecting this conversation to go this way. But yeah, there is the fine balance between what we've heard as far as ensuring patient access and costs with also making sure the product is safe. So, it's not an easy path forward a difficult conversation. But I appreciate all the feedback that we're getting here. So, Sean.

Sean: Yeah. Again, I'm going to piggyback on what's been said and what I said, the illegitimate caregiver, I believe on the one that use that first, and I want to clarify, when I first came to the state of Maine, I know exactly where I could probably get my marijuana from just random marijuana. I didn't take that route. I took the nursing route. I went to a doctor. They told me to look out on the board. There were three names on the board. I called the three names. All of them, according to state law would be considered illegitimate caregivers. None of them. They all got angry when I asked to see their card, they got angry when I asked questions. Every one of them were very upset when I tried as the patient to get a little bit more information to know where my medicine was coming from. And along the process when I came here to Maine and I started out as a patient to actually get clean medicine that was actually going to do what I needed it to do.

I was I was harassed by the caregiver community by other medical marijuana patients, you name it, I was considered I people were actually thinking that I was a police or federal government that I was not from Maine, who am I coming from out of state asking all these questions? I became very scared. I had threats on my life, for the things that I was asking and saying, I kid you not. This is back in 2015 and 2016. And I knew how I could have gotten out of that. But I wanted to go just like somebody probably would my age. First time getting a medical marijuana card. How are you going to do this, you're going to do what the doctor said, you're going to go see who's on their board. And that's what I was confronted with. And I know that happens today because I know other veterans who are trying to get seen. I know other people who are trying to get cards, and they confront the same situation where it's not.

Yeah, there are people that grow marijuana, they disperse marijuana, and they're asked if they're a caregiver, yeah, I'm a caregiver. And it's, it's really difficult if it would be the similar if we're comparing apples to apples, again, it would be similar to going into the doctor's office and seeing rusty tools, lead paint peeling off their walls, and mold down on their carpet. It's like, okay, and I'm here for a flu vaccine. And this is what I'm sitting in, you start to ask questions. And what I go back, no, but I was criticized when I came here from out of state to retire here to start using medical

marijuana, I was criticized for actually doing that, for actually going through the system and trying to see what worked and what didn't work, and three strikes all three off of the board, then I got on other sites. And there were people like, I can't remember I think Joe was saying people falsely advertising you can get on Craigslist, you can get on marketplace, there's so many places where people are squeezing in bud, you name it, where you can get get it delivered. And I made a joke long time ago, I could get an ounce of marijuana delivered to my house quicker than I could get a loaf of bread. And it's still that way here in Maine.

Erik: Well, thank you for sharing your experience, Sean. It certainly is helpful in this conversation. So again, just a time check here, I have Trish, Catherine, John, David and Paul and Barry. And with that, I think we can go into a recap and then looking forward. So, I want to make sure we have the opportunity to get to get to everybody to chime in. So, Trish.

Trish: Hi, thank you, Erik. I wanted to piggyback on the whole testing thing and push back a little bit on this idea of data and first of all, what is the definition of data and data is information and statistics relevant to a certain situation and so as everyone's crying for more data, they're really asking for more statistics where I get confused because I actually was a patient's rights advocate who wrote policy requested policy changes and whatnot and and I've you know, review policy on policy teams and other professional settings but that one in particular I you know, lived patient policy and never did I experience or learn that statistics are the sole driver for or the only measure of sound policy development. So, I find it a, you know, discerning that the idea of waiting for a certain set of statistics to move forward when we have in the set of data, you're actually looking at information and statistics. There's plenty of information about the contaminants and metals that can be in soils that people use, there's plenty of research information available about how cannabis and hemp plants suck up anything from the soil and you can actually use them to clean out your soil so they aren't going to take up anything. There's plenty of research out there about the pesticides and whatnot that some growers have access to and can and will use. There's research we haven't gone there yet but I'm worried about all the hormones that are in some of the nutrients I mean, in my mind, the list could go even longer but where we're at right now is a great place to start. So, if you have all of this research about these available problems in the in the industry, and then you also have some stuff statistical data, like what Barry I believe offered that his company is experiencing. And then you combine that if I was an advocate I would also combine it with Do we have many established cases and immediately come to mind, a patient, a child patient, there was in most of the main media A few years ago, about a main patient who was a child, she was taking a tincture that had a toxic level of a solvent in it. And as the media you know, went through this, I think it was before Roe MV though. In the media, the caregiver didn't contest with this happened. And the processor didn't contest it. This happened, everyone agreed this happened, this child was taking things for with toxic level of solvent in it. So, you have established case, you have plenty of research about how these things could go wrong. And you have some amount of statistical data, statistical data, that's what I consider a good set of information to start making decisions for sound policy. So I would like to very much push back on the idea that statistics are the only driver of sound policy drafting, because that's just, I had a boss who was a lawyer who dealt with high end policy, Legal Affairs for the state for years with the state for years. And she actually advised us to be wary of statistical conversations, because they're conversations that can be easily

manipulated for one perspective or another. And as I worked in that field, I found that to be very true that relying on numbers alone is more of a game than actual sound policy drafting. And I also want to push back on the idea that people will just not go back to a caregiver. I can't tell you how many times I've smelled someone's weed, and oh, my God, that's powdery mildew in it, because I instantly have a reaction to it instantly, and they're like, Oh my god, I didn't even smell that. So people sometimes aren't even aware and have different levels of awareness. They may not know that untested weed might have class pesticide, but when you smoke, it becomes cyanide. So they don't know to not go back to that caregiver. I advise everyone I know there's not a test attached to that batch. Don't touch it. But you know, not every patient in Maine is getting that advice from someone, nor do they follow it. Nor do they know, frankly, to report a problem to OMP. So I see a lot of that is sort of a smoke and mirrors thing that is not necessarily helpful in a patient's right level.

Erik: Thank you Trish for sharing that. Catherine.

Catherine: Hi, thank you. I have a couple points here. One to address the what everyone's been talking about as far as patients not knowing and going back to bed caregivers. If they're illegitimate, they're not part of the program. I don't know if it says anything on the patient card when they get their certification. If not, it should it should refer the patient to OMP for information and on OMP website, it would be very helpful if there was best practices for patients that list interviewing caregivers interviewing dispensaries, what they can look for what they can expect how to report if there's a problem, knowing whether they need their product tested or not, patients can go to a lab and get their own products tested if needed. For a lot of caregivers that are smaller caregivers, they have small batches of products that they make. And so for a full panel of testing, it can be in excess of $750 per test per batch of product made, which could be cost prohibitive for many of the small caregivers. But if the patient needs something specific, they need to know that they can go to the labs. It's not against the law here in Maine, where it is in other states. So if we put a bet patient best practice section on the OMP website, when the practitioner does the certification, they can refer the patient to the OMP website, it should say it right on the card. I I also have several other points, but we don't really have time for them. I'm concerned that we as a group are supposed to be helping work together to produce these rules. And we are not anywhere near close and we only have two meetings left. I would suggest that everybody put together a list of rules going from the proposed rules that we receive last time, go down through itemize your concerns and come back to the next meeting with these itemized things, or we're never going to get this work done. I mean, I think this conversation is good. And I think that this group could meet ongoing for a while to really pull all of our concerns and stuff together. But our purpose from my understanding is to actually help get these rules put together. And we don't have time. January is coming right up and we only have two meetings left. And I while I'm here and I'm happy to be here. I feel like we're really wasting our time going off on tangents. One thing that I do need to bring up that I've been made aware of is that right now, caregiver cards are being withheld asking for operating plans. And that was one of the rules that was postponed with this last batch that we held off. So we need to address that. The other thing is, is we're having trouble getting our caregiver cards or employee cards in a timely fashion. And I'm not sure why. And if there's something that we can do to expediate, that that process would be hugely helpful, anything that we can do to help

OMP in getting this done. I know way back when in years past, there was a problem where OMP did not have the staffing to get things done in a timely manner. But my understanding is that we only have 30 days or so we need to submit our applications 30 days prior to when it's due for renewal. And we are doing that and we're finding that it's taking much longer than the 30 days to receive them back. So that's a concern that that I had. And as far as the there was something back a while ago on the illegitimate caregivers, law enforcement and OMP really needs to look into the investigation process. We have Instagram, Craigslist, like they were saying you can call an order anything that should be really easy for someone to investigate. call one of those numbers and order something, then you'll find out that there's a lot of the illegitimate caregivers don't have caregiver cards, they're not caregivers, that has nothing to do with the caregiver program. There is illegal activity. Big difference. You have dispensaries, you have caregivers that are licensed with the state, those are legitimate. The other pieces they're not they're not they don't have a caregiver card. They're not even going to bother going through that they're completely illegitimate. So that that's all I'm gonna take up my time. So Sorry.

Erik: No, that's fine. Real quickly, Catherine, I can call you later today about I mean, the operating plan. First I've ever heard of it. I don't know where that's coming from, we can talk about turnaround times, I just want to make perfectly clear that we are working towards both recommendations to the legislature and information matters going to help us move forward with a set of regulations that work for all stakeholders, we are sincerely coming to this group with information deficit. And we're asking questions to help formulate it and understand it better. I realize we're all not sitting around a document going line by line. But we've gone through that process already once or twice. So we are taking an honest, sincere approach to try to better understand where we are to inform us to make better policy decisions. 17 people sitting around a document simply is not going to work. That's why we're asking questions like, Alright, these illegitimate caregivers, if they're X, Y, and Z, what policy levers can we pull to help alleviate some of that negative patient interaction, or these that are impacting negatively your business. And we've gotten some good helpful information. And I think your idea about all the best practices or patients is a great resource that we could do. So because we're not going through line by line, having policy line discussions does not mean we're not working towards a better set of regulations. So with that, Catherine, I will call you later because I didn't

Catherine: I didn't mean to be rude on that. My concern is that two meetings is not going to give us enough time

Erik: We're going to talk about. We're going to talk about more meetings as soon as we get to the last couple people here.

Catherine: Okay.

Erik: And it seems like we're going to go a few minutes over if you have to drop off. Totally okay, myself, or [OMP's] David [Heidrich], can circle around and kind of give you the recap of the end. But certainly, going to be more than two minutes, we still have four people that I want to make sure that we get to and talk about additional time and kind of process moving forward. So John.

John: Yes, thanks. And I just want to say Joel basically has hit it right on the head, I want to agree with him 100% that's a major issue in our surrounding areas as well, I think inspections random inspections of some of these facilities. However, OMP wants to handle it, it's I think is in dire need. You know, the honest caregivers that are you know, some of them have metric systems, some of them, you know, have gone to the next level that the cost of doing business is even greater. So by bringing some of these illegitimate caregivers on either they go out of business or you bring them into compliance, it forces them either to go into adult use, which benefits adult use or to force them to get a card and then Get into the medical program as well. So and then it benefits the state as well, hugely, because they generate so much more tax revenue that is not being gathered right now. So, and that in the end for the municipalities, I know right here in our town, they renew our certifications as a medical or adult use, like a liquor license. So, you know, if you get your license June 1, they look at again, June 1, and see if there's any issues in the state with compliance issues and stuff like that. So I would, I would have, you know, throw that out there as well, that, you know, if the state can't cover or can't do these inspections, you know, look to your town to reissue your license, if you know, with local PDs that maybe can look into it as well.

Erik: Thank you. So now we have that was John. So David, Paul, and then Barry, and then we can talk about our next meeting.

David: Thank you, Erick. One of the things I was just going to jump in and you know, I kind of started the conversation on the testing side is, I want to be clear that something that gets people very nervous on the medical side is, you know, are we going to end up looking like the adult use side. And I think it's really important in this group, I'm someone who operates in the adult use side and the medical side, I'm wearing my medical hat, I'm going to be looking out for the small farmers, the people in the medical community, just because adult use does something one way doesn't mean that that way was even right. And let me be very clear, you know, operating in adult use, there's some things there that I give pause to, that said, we follow the regulations, and we do what we're asked to do. But when it comes to testing, I think we can all agree, I think we all can agree that we want to protect people like we wouldn't get in this industry, there's not one of us, I believe for one second, that would do what we've done, how much work this is, it is backbreaking to be doing what we're doing if we didn't have a real care for our patients, and the joy we get from that, you know, I could go on and on about it. And so for me, that's when I talk about testing, I'm not talking about does it have to look like adult use. Does it have to follow this or that? I'm just saying, man, when we all sit there, and we look people across, you know, we look at people that we're giving medicine to right, this is medicine, we should be making sure that those people are safe.

And I feel so strongly about this. And not to give any pushback to a comment that was made earlier, but patients shouldn't have to test the medicine, we should, we should guarantee that that medicine is safe. And, you know, that, to me is a really big deal. The other situation is is you know, the goal should be to set parameters that are easy to follow, that are enforceable. And at the end of the day, it's inclusive for people. And I think one of the big concerns a lot of us have had Erik, is we've seen, you know, municipalities, we've seen this industry get tighter and tighter. And the only people that seem to be able to succeed are those with either a lot of money, or big corporate backings and we don't want that we want to have the the people that really care about this industry.

And I'm not saying those people don't, let me be clear, but I'm just saying that the rules shouldn't be written so that David Vickers can't operate next year. And because if I can't operate, then that means there's other people that can't operate. And so I think it's really, really important that as we look at drafting rules, we look at making safety a parameter very, very high up on the list. And we make sure that the more people that can participate, the better. Because you won't be in this industry, if you don't love it, I'm telling you, you have to be so passionate, I've done many things in my life. And there's been days that I've literally been broken. And I always come back to the fact that I know at the end of the day, I'm doing good. And I know everyone on this panel feels that same way. So all I would ask is when we talk about testing, let's make sure that we think about it from a patient's perspective. Let's make sure we protect the small farmer, but somehow which it needs to be a discussion. And we need to make sure that we allow people who want to be in this industry to be in it and not pushed out. And that to me is a big deal coming from Maine growing up in this state and protecting what you know what we feel so thank you very much.

Erik: Yeah, thanks Dave. And I think we all share that vision so thank you um, we have Paul and then Barry.

Paul: Well, I you know, I think it's important to recognize that Maine is probably the best medical marijuana program in the whole country. And then you could argue actually one of the safest because after operating for since 1999. I don't see there's lines going to the hospital. I don't see there being a bunch of You know, complaints, I don't see there being, you know, any sort of really news articles that are covering this alleged issue. Because you know, we don't have data to back this up, I haven't heard these problems, you know, I'm not seeing any of these problems coming up. And I think it's important that we should recognize that the federal government's been operating a federal cannabis program out of Mississippi for I think, about 20 years now. And so they, I don't know what they use on their products, but I'm guessing that it's not MOFGA certified or anywhere close.

With that being said, it was also brought up to me that they follow these patients, they check these patients for illnesses they check these patients is for, you know, any sort of negative side effects from cannabis. And those are those aren't happening. So when we're talking about this workgroup, I feel like we need to stay focused on the work that was been asked of us, which is trying to figure out suggestions for these rules. As much as we're trying to come up with other policy suggestions. And you know, as you mentioned, Erik, you know, leavers that we can use. If we're, if we don't say focus on trying to focus on rules operating within this nice binder that you gave us within the statute, then all we're going to do is make a bunch of statute, statutory suggestions that will then have us have to come back and write new rules for it. So in the interest of trying to get something actually accomplished in our next two meetings, and more meetings, I hope that you'll have if we need them, I really feel that we need to focus on what's in statute right here, and how that can be developed into a set of operational rules. Because if we go beyond the scope of that, I'm very concerned that we won't necessarily accomplish anything that anybody's looking for in this group. And we will not be able to present a product to the legislature that the legislature will approve of, and we will be back to be doing the same thing again, and still operating under the 2018 rules.

Erik: Thank you, and Barry.

Barry: Thanks, guys, I just wanted to close out and finish with a few thoughts that I heard some people say, mainly addressing some things that Susan and Heather said, One, you know, regarding a state law lab, and Heather mentioning, you know, OMP doing more investigations, I would just like to add that, you know, labs should be on that list of investigations, you know, we should be held to the highest standard of anyone in the industry, I would mention some articles, I could be happy to some of the group I you know, do some research for this, I believe it was Oregon, they put out a, the state actually released the data that the labs were testing, and show which labs were testing and what their data was. And what they were able to do is find illegitimate labs, because the state did that. They found a trend where labs that have always released high potency data, were releasing clean samples for like heavy metals and things like that. So that kind of was a red flag, like these guys always produce high potency and always clean on the contaminants and they went out and did investigation. And, you know, obviously these labs were were not performing properly, and, you know, they were shut down and, you know, had to revamp so I would say that labs we need to we definitely, definitely need to be on there as well, you guys need to monitor us and make that not just monitor us personally, but you know, make that data available to the caregivers and the patients and everyone so they can see, you know, who was testing what and what these results are and help them make judgments for themselves. You know, another article, I'd be happy to give you the group. I came across this in Washington, you know, Washington didn't do any pre release testing of heavy metals and pesticides. They did several others, but wasn't required for that. Well, they were just doing pulling off the shelf and doing spot testing. Well, they found so many samples that were contaminated with heavy metals and pesticides, that they're now going back and writing in heavy metals and pesticides as part of their testing regs. So just something to be aware of I know we don't want to talk about other states. But I know it's helpful to look at what people have done before and learn from those mistakes so that we don't make the same ones. Joel mentioned r&d testing. I think that you know, that's when I mentioned earlier that when you take out compliant samples from our data set, that it looks much worse what's because of r&d testing people, you know, in the in the A use in the adult use program, people are doing r&d testing, to make sure that they have clean product before they do the official test, and it goes out. So that's what I meant by testing works. And one last thing, Catherine mentioned that $750 per test that's a bit high for our lab. I'm not gonna speak to the labs, but if you do just safety testing in our laboratory, which is cannabinoids, pesticides, heavy metals, RSA and micro it's like it's the only $450 tests not $750, but 400 still high. I agree. You know, but it's not, you know, astronomical 400 $750 tests. So just something to keep in mind in ways to lower costs. Michelle, I mentioned earlier about rural areas, having perhaps like a farmers market type of arrangement where that, you know, that's exempt from any type of testing. I think all those are great ideas.

Erik: Thank you Barry, Susan.

Susan: Sorry. I wanted to also indicate that the some of the things we're talking about, like illegitimate caregivers, for example, are people who aren't caregivers. We Well, people who aren't caregivers operating as a caregiver, that's a law enforcement issue. But a illegitimate caregivers are those who are operating. I don't know, in scrupulously, I think that inspection and enforcement of the program are critical. And we have many more inspectors authorized by LD 1242's passage. So I expect that we'll see better enforcement and better compliance, some so those compliance

issues and such should be addressed in the next year or so as those inspectors are brought on board. Thank you.

Erik: Thank you. So that brings us to conclusion only 10 minutes over when we were originally supposed to end I appreciate. Again, one of the most surprising things when you get into the world of cannabis is all the competing interests in the wide array of stakeholders involved. And I can't think this group enough, we're having a respectful dialogue with each other around some sensitive topics. And I'm sure our next few meetings are going to have some more sensitive topics. So I really do appreciate that. And again, I just want to make the point, I understand that we are not going through the rule, line by line. But this is helping inform us because we want to make sure that when we move forward, we have a full picture and full understanding of how to walk a lot of these tight lines these tight I mean, in the proposals that we move forward. And I think we've illustrated a lot of those tightrope acts in the conversations that we just had for an hour and a half. But again, moving forward to the next meeting, which is going to be November 2 at 2pm. I think we can have a conversation here, reflecting back on this meeting, reviewing it, and coming forward with ways that we might be able to move certain topics forward, maybe come up with more substance that some of the people around this table are looking for. And we'll certainly reach out and have those conversations and look for suggestions for the next meeting. Right now we still have a number of outstanding agenda items, the conversation around med data, certainly want to have that understanding what you're looking for what would be helpful around the proper role of municipalities and clarity for all stakeholders on that front. And certainly patient education. And I'm sure as again, we rewatch this, it's going to bring up more questions that may end up on the agenda for November 2, too. So I don't know if anybody has any additional agenda items they want to throw on. I'm happy to keep those in our back pocket. I think we probably have enough to get us through our next meeting. But I'll certainly entertain anything that anybody wants to throw out.

Paul: Could we get the meeting minutes as a as a group, so we can make sure that they're accurate?

Erik: Well, again, that's exactly why we're not doing meeting minutes. We're transcribing the entire meeting.

Paul: Okay. Yep.

Erik: Yes, I we will notify this group and we have accomplished that for the first and second. And then, okay, so no agenda items, like I said, I think we have enough to get us through to the next meeting.

The point of not enough time, I am hoping the meeting on November 2 is only slated for one hour, the conversation that we had got us through 90 minutes pretty quick. Instead of doing any, like formal vote or anything, does anybody have any objections with us extending the November 2 meeting to a full two hours versus an hour, again, trying to be as respectful as possible to everybody's time and I see a bunch of thumbs up. And if that is not doable with somebody's schedule, just let us know. But we are going to make that change. And we'll make sure that's reflected on the materials that are on the website and go out. And we'll send reminders because, again, these are really good conversations when you have so many different parties.

So with that, November 2, 2pm. Two to four. We will send around the agenda as early as possible. We'll send around any relevant information ahead of that meeting. And again, when we get to patient education, any information materials, practices that folks on this call are currently using, if you want to pass that along To help drive that conversation, I think that would be helpful. So with that, does anybody have anything else before we close the second working group meeting?

Alright, I'll just say thank you, everybody, and enjoy the rest of your day.

Paul: Thanks, everyone.

Unclear: Thank you.