

To: Members of the Joint Committee on Marijuana Legalization

Public Testimony Regarding HB 4014 and SB 1511

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Thank you for the opportunity to comment on HB 4014 and SB 1511. Most of my testimony will advocate changes to these, in the interest of time. I hope to provide a perspective you have not considered.

My name is Clifford Spencer. I am founder, and now almost 17 years later, the coordinator of a co-op assisting patients in residential care facilities and people on end-of-life (hospice, palliative) care with implementation of the Oregon Medical Marijuana Act (OMMA). Because Therapeutic cannabis is not taught in medical schools or graduate schools, I have been asked to present classes to large groups of doctors and family nurse practitioners, social worker organizations, placement counselor organizations, and Memory Care organizations.

Our patients have challenges to implementing the Act you and I might not have. One is that in residential care, typically a patient's income is Social Security, almost all of which goes to the residential care facility for their care/room/board; what little is left is supposed to be used for clothing, toiletries, etc. Our end-of-life patients are typically bankrupt, not able to work, and have been devastated by copays (for chemo, radiation, office visits, other treatments, etc.), and incurred expenses like transportation, a wig, etc. These patients, the sickest of the sick, THE most physically challenged (like our quadriplegic patients), and dying (we have eased suffering in death of 79 patients to date), simply cannot afford to buy the therapeutic cannabis their doctor recommends at dispensaries or OLCC stores. These patients cannot even afford to reimburse my colleagues and I for "utilities and supplies" to produce their medicine. Our approach back 17 years ago is what it is now: "How do we make the OMMA work well for those who would, otherwise, fall through the cracks?" I strongly feel that, if this should be treated like the medicine it truly is, insurance companies like those on the Oregon Health Plan should not only cover the costs of the therapeutic cannabis, they should also be paying my colleagues and I for what we do. We work closely with the patients, their care providers, nurses, social workers, etc. to assess what conditions these patients have that might benefit from therapeutic cannabis. We develop a treatment recommendation of different delivery modalities of therapeutic cannabis, long acting (medicated candies, cookies, tinctures, cannabis oil capsules, etc.) and short acting (vaporizing cannabis flowers, sublingually or buccally administered tinctures, etc.) to address symptoms. Each week, when we see the patient and staff, we document exactly what is being dispensed, with our recommendations for use, the severity of each symptom

during the previous week, and the efficacy of the therapeutic cannabis and delivery modality for each symptom, as well as any other mitigating information (like changes in prescribed meds). We are a part of the team, and after each follow up, the team reassess. What we do is SO MUCH more than simply giving a patient some cannabis flowers every month or once a year! It is also a LOT more time consuming, especially given the logistics. During the past few years we have made remarkable breakthrough success in treating "agitation from Alzheimer's" and pain issues with CBD, one of the estimated 50 different cannabinoids (active ingredients) in cannabis, one of which is THC. We also now know that THC Delta 9, while therapeutic and psychoactive, THC-A is also therapeutic, effective for pain, and NOT psychoactive. CBD is also not psychoactive. A large percentage of the cannabis plants we now produce simply will NOT "get one high", but are, when processed into cannabis oil capsules (bonded with coconut oil). Rather than making the breakthrough work our co-op has done easier, this legislation will make it no longer possible.

My colleagues and I have no interest in "commerce". It seems the legislators have attempted broad brush strokes to ease concerns, and have impacted patients in a VERY negative way by doing so. Like treating MY 250 sq. foot MEDICAL garden the same way as a 40,000 sq. foot production OLCC garden. MY garden cannot recoup the added expenses of tracking (equipment), pay someone (I am not computer savvy) to report monthly, security, inspections, etc., etc., all at MY expense. My patients and I simply cannot afford these unnecessary over reaches. My small home garden that provided free therapeutic cannabis to the most physically challenged should not necessitate my surrendering my U.S. and Oregon Constitutional protections of privacy and unreasonable search in my home...to do what I do not involving commerce. It means, shortly, we will terminate, as will many more. Was your intent to take away a medicine from Oregon's most physically challenged (like our quadriplegic patients)? Oregon's sickest (ALS, MS, advanced AIDS, etc.)? And dying? My time and focus should be on the work I do with patients in end-of-life care and residential care facilities, not cumbersome, unnecessary paperwork, burdensome reporting, intrusive home inspections, and I should not be burdened with more expenses my patients and I simply cannot afford. While I can understand these for large OLCC gardens, or medical gardens involved with commerce, co-op gardens, and one or 2 patient gardens NOT involved with commerce should NOT have these requirements. I wonder if your perspectives have been influenced by (well paid) lobbyists representing people with financial incentives, instead of humanitarian interests. Realistically, our patients simply cannot afford to buy cannabis at dispensaries or OLCC stores, so they will use more pharmaceuticals (increased costs to the Oregon Health Plan) and suffer with less symptom control.

Typical of the lack of real "boots on the ground" insight into working with severely physically challenged (like our quadriplegics) and dying patients are the unrealistic limitations of "THC concentrates". Again, with broad brush strokes, so uninformed they do not differentiate between THC Delta 9 and THC-A, which has medicinal properties, but NO psychoactive properties. MANY of our patients utilize very large doses of THC-A, which would not be allowed, or the packaging and frequency of delivery would be unworkable. The OMMP patients (and their caregivers) should be exempt from these unrealistic (for medical patients) limitations.

It is disheartening that the OHA took a legislative directive of not imposing the same requirements on one and 2 patient gardens as large commercial OLCC gardens, but the leadership of the OHA took things a step further and imposed the same unreasonable requirements upon the one and 2 patient gardens (in the Administrative Rules). Moreover, the OHA got greedy and imposed even more unnecessary fees (taxes?). When "We The People"

(remember us, the voters?!) passed the OMMA (which recent polls indicate has the support of more than 80% of "likely Oregon Voters"), it was supposed to be self funded, NOT a cash cow to fund OTHER OHA programs. The annual application fee needed to fund the OMMP is \$25. There should be no added "fees" (taxes). Expecting the OHA to implement the changes in these bills immediately is unrealistic at best. Given the OHA has, since the OMMA passed in Nov., 1998, been directed to issue the registration cards within one month of receipt of an application, and the actual time is usually 2 to 4 months, given this track record, expecting implementation of such over reaching requirements is unrealistic. What is the rush?! While M-91 directed a deadline for the OLCC program , it also directed *******(in three places!) ******* that its passage would NOT impact the OMMA. I ask that patients, their growers, and caregivers and the OHA be given until at least January, 2017 to comply.

Some zoning ordinances, like aspects of Clackamas County's, go WAY beyond "time, place and manner", basically ordinanceing our ability to provide free therapeutic cannabis to our patients. Some seem like an attempt to make equipment requirements cost prohibitive, and imposing the same requirements/restrictions on a 250 square foot medical garden as a 40,000 OLCC production garden. Limiting new local ordinances which seek to, effectively, bar cultivation through zoning and "time, place, and manner" restrictions will protect patients who rely upon these growers. I suggest local ordinances passed after January, 2015, do not apply to OMMA garden sites registered as of January 1, 2015.

Respectfully Submitted,
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"The Co-Op" Coordinator, OMMP Caregiver and Patient