TO THE JOINT COMMITTEE ON MARIJUANA REGULATION 5/2/2017

My name is Clifford Spencer, the founder, and for now 18+ years, the coordinator of a co-op assisting patients in residential care facilities and people on end-of-life care, with implementation of the Oregon Medical Marijuana Act (OMMA).

I write with this perspective, which is not one you have been considering when rewriting the OMMA, and its impact on the patients we serve, in regards to their access to a medicine their doctor recommends.

THE OLCC IS NOT, AND NEVER WILL BE, EQUIPPED TO DEAL WITH MEDICAL.

A vast majority of the patients we have are "low income". Recent changes to the OMMA have been influenced by cannabusiness interests and motivated by money interests. These changes have dramatically negatively impacted access to a medicine their doctor recommends by low income patients disproportionately, compared to those financially able to purchase at dispensaries. The over-regulation and taxes ("fees") imposed by legislation, changing what I and others voted for in 1998, are a direct result in our Co-Op's no longer accepting new patients.

Frankly, legislators, it is heartbreaking knowing that your legislation has made us no longer be able to assist dying patients, and patients in residential care with access to a medicine their doctor recommends.

Our patients are people with advanced MS, quadriplegics, people with traumatic brain injury, "Memory Care" (i.e., Alzheimer's) patients, ALS patients, and people dying from cancers, to name a few.

We have, in the 18 years I have been doing this unpaid work, assisted 83 people with compassionate comfort in death.

Regarding SB 1057, -17 and -18 Amendments: In Support

These amendments will mitigate some of the damage to patient access done by recent legislative changes to the OMMA. The OMMA I voted for in 1998 was to be self funded, NOT a "cash cow" to fund OTHER OHA programs. While working with "Memory Care" patients for the last 15 years, I appreciate the significance of the "- 18 Amendment", and how it could help people with "late stage dementia". We have SO MUCH anecdotal evidence with our "Memory Care" patients with cannabis containing little THC and a significant amount of CBD (a non psychoactive cannabinoid in cannabis), its efficacy regarding anxiety/"agitation", and its calming effect without being sedating.

I DO suggest, however, omitting "late stage", leaving only "dementia".

Regarding SB 1057 -15 Amendment: Support Strongly

Allowing 4 patients' number of plants per address and 18 "immature plants" per patient card returns these limits to pre M-91 for the OMMA. This will significantly improve access for many low income patients, and might influence our co-op to, on a limited basis, consider replacing co-op patients who have passed on (Please see the next entry regarding HB 2198 -7 Amendment for additional aspect of this statement).

Again, as a direct result of recent legislative changes to the OMMA, we are no longer accepting new patients made by nurse and doctor referrals.

Obviously, patients in residential care cannot have a cannabis garden, and almost all their income, typically only Social Security, goes to the residential care facility for the resident's care/room/board. Little is left for clothing, toiletries, etc., and there is just not enough for therapeutic cannabis at a dispensary.

Hospice patients typically do not have the time left here to wait 5 months for cannabis to grow, then wait for testing, it being made into "alternative delivery modalities", and retesting the "alternative delivery modalities".

When the "18 immature plants per card" was established my testimony as an Advisory Committee Member was partly from my experience as an employee at Hugh's Water Gardens, the largest water plant propagator on the West Coast. Standard horticultural practice is to propagate 3 times as many plants as needed...some will not make it, and some do poorly; one may select the 1/3 best prospects for thriving.

HB 2198 -7 Amendment: Strongly Support

Limiting taxes ("fees") for the OMMA patients and those helping them will make access more affordable for low income patients. The OMMA was never meant to be a "cash cow" to fund OTHER OHA programs (even if those programs are needed and important).

Adding the additional expenses of expensive tracking equipment and the added labor of reporting/tracking will make less and less people willing to help patients unless they are paid ("commerce"). I suggest that up to four (4) patient gardens NOT INVOLVED WITH COMMERCE be exempted from being required to cover the costs of expensive tracking equipment and the burdensome reporting requirements.

The person responsible for these 4 (or less) patient gardens should not be required to be "second class citizens", being required to surrender their U.S. and Oregon Constitutional protections (right to privacy in one's home, freedom from warrantless search, etc.) to help patients pro bono, IF they are NOT involved with "commerce", since they are usually in a private residence, one's home, and not in leased space, to limit expenses so "commerce" is not needed.

Low income patients simply cannot afford extra access expenses. They also cannot afford dispensary prices, and over regulating, and making helping overly burdensome will discourage participation from those motivated by compassion, as opposed to "commerce".

Regarding HB 2198 -8 Amendment: Support

While this may not affect the co-op I coordinate, as we prefer to limit the significant work in regards to producing cannabis to produce only enough to support our patient needs, I recognize this may help with low income patient access. Our focus is based upon compassion, not "commerce", but realistically, if patient access costs can be recouped by this approach, many low income patients could potentially benefit, thus helping to minimize some of the damage to low income patient access done by recent legislation.

Remember, based upon OHA information, 40% of OMMP patients are low income (qualify for SNAP, Oregon Health Plan, or SSI OMMP application discounts).

Respectfully,

Clifford Spencer, MA, MS