CANNABIS COMMUNITY CARE AND RESEARCH NETWORK℠

Medical Cannabis Policy Recommendations
Submitted to the Massachusetts Cannabis Control Commission
October 29, 2018

The Massachusetts Cannabis Control Commission (CCC) is currently accepting public comments related to the transition of the medical cannabis program from the Department of Public Health (DPH) to the CCC. The following recommendations were prepared by the Cannabis Community Care and Research Network (C3RN), a Massachusetts-based cannabis research, education, and advocacy company.

Executive Summary and Table of Contents

Increase Access for Medical Patients

1. **Remove the Patient Fee:** Remove the $50 patient card fee
2. **Make Patient Registration Immediate:** Remove inefficient waiting times for the card, including issuing a temp card, then the permanent card (Alternative path: allow physicians to issue one-month certification that may be used with a printout of DPH registration to access dispensaries).
3. **Make Physician, Nurse, and Caregiver cannabis recommendation licensing easier and more streamlined.** Develop a educational campaign to increase awareness of the medical cannabis program among the medical community.
4. **Temporary Licencing:** As medical tourism in MA is a big market, mostly from out of state, consider a medical tourism card for 2-3 month temporary certification
5. **Pediatric Certification:** Under DPH regulations, pediatric patients require two clinicians to certify a single patient, only two are licensed to certify in Massachusetts. As this is a high barrier to entry, consider dropping to one pediatrician with parental consent.
6. **Cannabis Delivery:** Allow RMDs to keep the same delivery model for medical patients and expand to include healthcare institutions, assisted living facilities, and other relevant healthcare outlets in addition to home delivery.
7. **Caregiver Model:** Under the current regulations a caregiver is only allowed to have one patient.
    a. We recommend that caregivers be allowed to supply medicine for multiple patients to a minimum of 10 patients to facilitate more patients and ensure no disruption in the regulatory transition. This would bridge the gap between the institutional caregiver model and the single caregiver model as institutions are hesitant to accept that role.
    b. All medical card holders should be allowed hardship on plant counts. Due to the difficulty and barriers to growing in the New England climate. Caregivers and patients should be allowed to grow as many plants as necessary in order to maintain a 60 day supply.
    c. Law enforcement needs to understand that once a medical card is shown there should be no need for prosecution if the patient has more than 6 plants.
    d. Many patients need much higher amount of plants depending on their ailment and means of administration of the medicine. For instance someone that juices the fresh plant needs many more plants to maintain a sufficient supply than someone who only ingests cannabis for say symptomatic conditions.

8. **Health Insurance**
    a. Consider encouraging Mass Health to do a small feasibility study to look at possible mechanisms for medical cannabis to be covered under state health insurance as an alternative to opiates as well as for medically disabled.
    b. Support continuing financial hardship programs and discounts under the medical program, including having special veterans focused discount programs for qualified disabled veterans.
9. **Ensuring equity in the MA Medical Cannabis**
    a. Include Native Americans as one of the focus groups for the social equity program.
10. **Patient Privacy:** Currently patient names are recorded on labels, receipts, and packaging causing risk for patients information to be identified. We recommend removing the name and replacing with a unique ID number on labels, receipts, and the medical card. Ensure this system and ID can be tracked by the police to protect patients.
11. **ADA Compliance:** Medical patient applications forms, website and commission forms should be ADA compliant, and in multiple languages.
12. **Access for Patients:** Strengthen the financial hardship program based on a sliding scale of income and disability status. Continue to promote discounts for veterans and other disabled or low-income populations.
    a. Develop a leadership rating for companies who focus on giving discounts to medical patients for those who qualify with different disabilities.
    b. Ensure disabled Veterans have discounted access to cannabis
13. **Equity for Medical Cannabis Businesses:** It will be critical develop the same license structure and fees in the medical program that mirrors the new adult use program offer incentives for businesses to maintain the medical program. The licensing structure and fees should be non-vertical and allow for the same license types. Consider giving licensing priority for companies that want to implement BOTH medical and recreational, over licenses that only apply for recreational.
    - Mirror the economic empowerment program for medical licenses
    - Positive impact plan (taken from the adult use framework) should be included in the medical program as well
    - Give priority status to Promote medical patient owned businesses and co-ops or micro-licenses for small cultivation or manufacturing for medical patients.

Cannabis Research and Open Data

1. **Form a multi-disciplinary research working group** to ensure transparency and openness in the new research license category. Consider involving patients, clinicians, cannabis industry, citizens, and community members to be part of research setting agenda.
    a. Consider a pediatric working group to look at both youth prevention as well as pediatric medical cannabis patients for autism, cancer, and other pediatric illnesses that are showing promising findings.
2. **Ensure access for small businesses and academics** to actively participate in the research license category. Create expectations for licensees to not require large assets or buildings to participate to encourage small business and researchers to participate.
3. **Publish detailed and transparent research license guidelines** and improve transparency around the research agenda, open data approach, and how stakeholders can meaningfully participate in advancing cannabis research.
4. **Promote collaboration among academia, industry, community, and patients** to advance cannabis science and research through working groups, events and other outlets.
5. **Identify budgets/funding opportunities/mechanisms that promote public and private funding for cannabis research**, particularly for independent academics, universities, schools, private research organizations to implement rigorous studies and trials

Cannabis as a Harm Reduction Alternative to Address the Opioid Epidemic

Massachusetts has one of the leading opioid epidemics in the United States, with alarming rates of overdoses and deaths. Over the last five years, several peer-reviewed studies have documented a reduction in the impact of the opioid epidemic in states with legal medical cannabis. Canada and Israel have integrated the use of cannabis as a treatment into clinical and treatment protocols. Pilot projects in the United States offering cannabis as an alternative treatment during recovery have been promising. Cannabis should not be viewed in isolation as a magic bullet to address opioid addiction and recovery. However, its use as a harm reduction tool, and substitute therapy warrants pilot testing in Massachusetts. The following are related recommendations:

1. **Form a working group** of academics, healthcare providers, public health professionals, community members, and patients to review pilot programs ongoing around the US and internationally that are using cannabis as a harm reduction tool for those suffering from opioid addiction and in recovery. Example programs include:
    - **Illinois**: A person prescribed an opioid can use that script in select cannabis dispensaries to get medical cannabis as an alternative. This program was signed into law in August 2018 (IL Senate Bill 336). The legislation enables doctors to prescribe medical cannabis for patients with conditions that would typically qualify for opioids such as Vicodin, Oxycontin or Percocet. (http://www.medicinemantechnologies.com/illinois-expands-medical-cannabis-with-opioid-alternative-pilot-program/). This bill “While Illinois established a medical cannabis program in 2014, its list of 40 debilitating conditions does not cover every ailment that might qualify for an opioid prescription. SB 336 closes that gap”
        - Key requirement is a previously established relationship between the patient and physician
        - Physician is responsible for ongoing care > including ongoing assessments and treatment
        - Businesses cannot charge patients for assisting in completing the necessary paperwork
        - Application process no longer requires fingerprinting and a background check

- A study that was conducted after this was implemented found that Medicare Part D recipients prescriptions filled for all opioids decreased by 2.11 million daily doses per year if the state offered some type of medical cannabis program
    - For programs that provided dispensaries, versus only home growing, the decrease was 3.742 million daily doses per year.
    - Another report by the RAND Corporation found that states where medical cannabis was allowed and dispensaries were operational, there were lower levels of opioid-related deaths.

2. **Consider developing a pilot program to integrate with needle-exchange cannabis alternatives**
3. **Grant terminal patients permanent access to medical marijuana**
4. **Train police and other first responders on how cannabis and CBD can be a harm reduction tool during overdose and other recovery situations**
    - Take a similar approach to what was used with Narcan (https://www.samhsa.gov/capt/tools-learning-resources/massachusetts-prevention-targets-opioid-overdose)
        - working with doctors and families to improve awareness of opioid painkillers' dangerous interactions with other drugs or alcohol;
        - working with and training users and family members to call 911 when an overdose occurs and conduct rescue breathing until help arrives;
        - training police officers to understand that the use of nasal Narcan, an emergency medication that reverses the physical effects of an opioid overdose, can save lives;
        - educating incarcerated former users about overdose prevention and effective response to overdose;
        - and advocating for public policies to reduce barriers to overdose prevention, such as Good Samaritan Laws that protect people reporting an opioid overdose from criminal prosecution for drug possession.
5. **Implement the 2016 CDC Recommended that all substance recovery programs should not test for cannabis. This should enforced and patients not tested for cannabis as preventing them from being in recovery programs. http://nationalpainreport.com/cdc-says-dont-test-opioid-users-for-marijuana-8829873.html**
6. **Consider programs such as High Sobriety -- in California and NYC. (https://highsobriety.com/supporting-research/)**

7. **Consider working with incarcerated populations as they are much more likely in MA to have an overdose.**
    - Those who are incarcerated get taken off their MAT treatment
    - There is usually no OUD treatment while they are incarcerated
    - Rate of relapse is very high because the addiction is not addressed
    - Rate of overdose is also high because they often do not take their tolerance change into consideration

Monday October 29, 2018

MA Cannabis Control Commision
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IMPORTANCE OF LEGAL PROTECTION OF MEDICAL CANNABIS IN MA

Medical intent creates safer usage guidelines, and promotes research and education

To Whom It May Concern:

My name is Christina Miyabe Shields and I am the Director of Education for C3RN. I received my PhD in Pharmaceutical Sciences from The Center for Drug Discovery at Northeastern University where I studied the system in the brain/body that interacts with *Cannabis* at a molecular level. I believe the state of MA is at a critical point in its *Cannabis* legislature that will decide the future direction of *Cannabis* research and education, which will subsequently drive the entire population of *Cannabis* consumers in the Commonwealth.

Decades of prohibition have made it difficult to separate medical and adult recreational use, but I personally define medical use as a controlled, therapeutically minimal use in order to reduce or eliminate negative symptoms versus recreational use as adding the positive effects of *Cannabis* to enhance an experience. The intent behind the two types of usage are actually completely opposite one another and this fundamental difference creates two very different populations of adult *Cannabis* consumers.

While I have no objection to recreational *Cannabis* in MA, I do not believe it should ever replace medical *Cannabis*. If medical *Cannabis* patients turn to recreational *Cannabis* because it has lower barriers to entry, the entire population of *Cannabis* consumers will suffer. The recreational market will not prioritize research and education for medical usage and, therefore, these patients will receive a lower quality of care. Furthermore, these patients will view the intent of their usage differently as recreational users as opposed to medical patients. In my opinion, a medical patient who is using *Cannabis* recreationally is at the highest risk to develop a substance use disorder as they do not accurately understand the reasons of their use and have decreased accessibility to necessary supports found in the medical *Cannabis* community.

It is essential that policymakers prioritize reducing the barriers to entry for medical *Cannabis* and protecting patients rights at this pivotal time.

Sincerely,

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