TRANSCRIPT of
FOURTH MEETING: MEDICAL MARIJUANA WORKGROUP

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Workgroup Information and Materials: https://www.maine.gov/dafs/omp/workgroup

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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: Perfect. So, we're live and it's recording, yeah? Beautiful. Alright, so welcome everybody to the fourth working group for the medical marijuana working group. I hope everybody had a nice break. Nice, nice Thanksgiving, relaxing, spent it with family, all that fun stuff. I'm hoping everybody had the opportunity to see the email that went around yesterday afternoon, with today's agenda, and the testing proposal that was asked to be written down, something that we can cover and go through as a group a little bit later in the meeting. But as you can tell from that agenda, we do have a lot of items to talk about, in very short periods of time. Hopefully, we can get a lot of substantive conversation going. But I will approach this much like I did the last meeting. Whereas, we'll try to adhere to the time to make sure that we can at least touch upon all the topics, and then do follow up conversations if individuals do get cut off. And that's part of the brief recap of the third meeting. We did have what I perceived to be a great conversation around patient education, provider education, registrant types and whatnot. And I did have three follow up meetings with Paul, Julie, and Patricia. And those conversations were recorded, and they're online on the working group webpage. So, if you want the opportunity to go and see the conversations between those individuals, that's up there live now is something that we can definitely consider in the work product that this group is going to move forward with at the end of the day. So, still trying to schedule one with Susan. I know she's been having a lot going on. But just give everybody a heads up so they don't think I'm being rude. Trying to get through all this stuff. But, I thought the best place to start today, after reviewing a lot of the conversations that we had in the first few meetings was just a consensus consensus check on a few items. As we're starting to build out what that report back to the legislature is going to look like both in lieu of the rules and in the report for statutory changes in program improvements that really would be a in their wheelhouse for statutory changes are concerned. So, I really wish I had the full group here. But I suppose when they join, we can either circle back as a group or have myself or David circle back to make sure that if they're don't have consensus on some of these items, we can at least get their thoughts to be able to appropriately report those back to the legislature because we want to make sure that everybody is able to have a voice in anything that we produce here. So, I envision this going pretty quickly. Obviously, if somebody has something they want to contribute or speak to, please just raise your hand, I'd be happy to

call on you. And again, this is just – Hey, Susan – this is again, just for us to be able to build out what that work product is going to look like as we move it towards the legislature. But before we get into that, I obviously want to do introductions, looks like we had two more people join us. But Paul, Paul's got his hand up.

Paul T. McCarrier: Well, I guess I want to say when we're talking about trying to have consensus building here is that we should really define what consensus is. Consensus means everyone agrees. It doesn't mean the majority of people think that something should go one way or the other. And, you know, I want to make sure that we also talk about the last draft of the rules that the department suggested, and the reason that we're here. Because those rules were a vast overreach of what was statutorily required. And that's the reason that the legislature passed LD – I think its 1242 and another bill that mandated this type of workgroup and mandated that the, you know, your office work with the stakeholders here. Because what I'm seeing what we're on the agenda here, there's no discussion about how these rules will impact caregivers, small caregivers, patients. There's discussions about policy changes. But that doesn't seem to be the focus of what the legislature wanted us to do. They wanted us to work on the rules. And I find it really disturbing that we're trying to talk about things that the legislature had clearly said they have no interest in doing, such as mandatory testing and using metrc as a mandatory third party tracking system. So I think that's, that's where I'm coming from right here with this meeting. Because if I knew that this workgroup would have been put together just to talk about how we're going to change the law to make mandatory testing and how to reintroduce metrc without having an in depth discussion about the rules that were submitted last session and how they overreach statutorily and how we can work to improve them, I wouldn't have applied to be on this committee.

Erik: Well, thank you for sharing. I will say as far as the rules, we totally understand that that's part of the work that we're doing here. Hence why you see inventory tracking, defining what the different sides of caregivers are, packaging, labeling, local control these are all things that I want to have an open discussion about, that would go into a proposed rule and move forward. As far as testing is concerned, that wasn't something that OMP pushed it was a conversation that started organically. There seems to be a wide array support from the working group here. And I think that's certainly something that we simply wouldn't be doing our job if we didn't move forward and tell the story of the conversations had here to the legislature around that stuff. So certainly, I know what happened in the past around what that specific testing proposal was, I don't think that was an end all be all. But certainly, Paul, I hear where you're coming from the conversations that we're having, are both going into what the proposed rule will look like and also the report back to the legislature. You simply can't have one conversation without the other. And at the end of this meeting, in the fifth meeting, we'll really talk about what that work product is going to look like, how we're going to bring it forward to this group, and how we'll end up and delivering it to the legislature and all those timelines. But I think everything that we've talked about to date really is important in the work that we're doing on both those fronts.

Paul: So will the workgroup have a chance to review what the what the office is planning to do with the rules and then meet as a group again, to give you guys feedback?

Erik: I think what we're going to do after we have this meeting, and this is more or less one of the last agenda items for today, but talking about how that work product is going to move forward. I think everybody can agree 17 individuals trying to work through a 50-60 page document line by line is not really going to work. But I think and like a high level we can go through what we're thinking as far as sections, what we're going to include, or how it's going to look different from the last proposed rules and how it tied into the conversations that we had as this working group. So.

Paul: Thank you.

Erik: Yep. Alright, let's get to introductions. And we'll try to move pretty quickly here. We'll do it in the same fashion we've done before. Just want to make sure everybody live streaming chooses to watch the video knows who we are and what seat we hold. So, I will call you up. And we'll start with Catherine.

Catherine Lewis: Caught me writing notes. I'm Catherine Lewis. I am owner of Homegrown Healthcare. I'm also the board chair for Medical Marijuana Caregivers of Maine Trade Association. And I'm located in Winthrop, Maine.

Erik: Thank you. Paul. You are on mute, Paul.

Paul: Good afternoon. My name is Paul T. McCarrier. I'm here to represent patients, small caregivers, and other interested parties. And I'm from One Mill in Belfast, Maine.

Erik: Thank you. Susan. Oh, she looks like she's way from away from her chair we can come back. Joel is going to join us late. David.

David Vickers: Hi, I'm David Vickers. I'm a caregiver representative and I own origins cannabis company in Manchester.

Erik: Looks like Susan's back. Susan.

Susan Meehan: Hi, Susan Meehan. I own a caregiver operation Mays Mama's and I am the chairperson of Maine Cannabis Coalition and I represent caregivers on this committee.

Erik: Thank you. Heather.

Heather Sullivan: Hey everyone, I'm Heather Sullivan, senior licensing manager for Curaleaf and I'm here as a dispensary representative.

Erik: Josh.

Joshua Quint: Everybody, good afternoon. My name is Josh Quint with Canuvo. Dispensary representative in this group.

Erik: Barry?

Barry Chaffin: Hi, my name is Barry Chaffin. I'm one of the Co-owners of Nova Analytic Labs in Portland and I am representing the testing facilities.

Erik: Alex.

Alex McMahan: Hi everyone, Alex McMahan. MedCo, representing products manufacturers.

Erik: Patricia.

Patricia Callahan: Hi, I'm Patricia Callahan and I'm a patient representative in the workgroup.

Erik: Michelle.

Michelle Caminos: Hi, I'm Michelle Caminos. I am here representing patients.

Erik: I don't think we have Sean yet. We have reached out to him. Jamie?

Jamie Comstock: Hi, my name is Jamie Comstock. I represent relevant health care. I work for Bangor, Public Health and Community Services and I'm the health promotion manager, and in advance I'd like to just say that I need to hop off around 2:30 or 2:40 and join by phone, so apologies for any disruption.

Erik: Julie.

Julie Millikin: Hi, I'm Julie Millikin. I'm a family nurse practitioner. I own Maine Medical Certifications in Augusta. We write medical marijuana certifications for patients. So, representing the patients and their interests in the medical card in the medical program.

Erik: Chris.

Chris Beaumont: Chris Beaumont, work for the City of Portland cannabis, the marijuana compliance coordinator, representing municipalities.

Erik: And, last but not least, Rebecca.

Rebecca McMahon: Hi, I'm Rebecca McMahon. I am an attorney for the Maine Municipal Association. And I am a municipal representative.

Erik: Great. Now, I'm Erik Gundersen, Director of OMP. And as you saw a couple weeks ago, David is out. So, I have a whole team of OMP staff filling in to help facilitate this call and all the technical pieces. Tracy, Gabi, Hannah and Vern. And if it's appropriate to bring them in with any questions, comments, concerns, feedback you folks looking for in our conversations today, I'm also happy to do that as well. Great, thank you. So, as I was saying, I think the best place to start is to put a bow on some of the earlier conversations in regards to what our report back to the legislature is going to look like. So, you can see there as far as the consensus check, and I think Paul brings up a good point, what is consensus? And certainly everything that we report back to, we want to make sure that we are accurately reflecting and making sure everybody's voices are heard. So certainly there will be majority consensus, full consensus, and anybody that is basically against whatever there's consensus of, we'll make sure that they have the opportunity to share their voice, and how they would like that reflected in any work material that goes back to the legislature. So, with that, is it alright, if I just go through and kind of tee these up and see if we can't take some votes so we can accurately report back how this group feels with some of these items?

Paul: Erik, can we can we move the consensus check on the OMP testing protocols up to this one, too? So, the all the consensus checks are in one spot?

Erik: No, because I certainly want to have – I think, I mean, when you talk about testing, there's a lot of other factors at play. I think when you're talking about what registering types should look like how to define caregivers, when we have conversations about tracking, I think that can really be beneficial when we go over the proposal, and ways to reconsider it or redefine it because I'm hoping to have a little bit more of a conversation around the language and the writing that we've proposed here. These other ones are, are kind of teed up. As we gone back and reviewed the video, we thought that we had a pretty good majority consensus and we just really want to formalize that. Does that make sense for everybody? We okay with that? I want to make sure we're okay with that. Okay. All right. So, the first three that I just we can do in a more formal process with a show of hands. So if you're a voting member of the working group, if you could come off or come on the video, it would just be a little bit easier for us to make sure that we accurately report back it looks like everybody is. Okay. So as far as patient access our first meeting and then went into our second meeting, there were certainly three three topics of conversation that I felt moving forward were important for this group to display consensus and majority consensus around to see if the legislature might be working, be willing to make be moving forward with some of those recommendations. And the first one, I think is probably the easiest one. There's a lot of conversation around patient confidentiality and how that's been important since the start of the program and all the work that we do here at OMP and any future changes made. So really, it would just be a

consensus vote that moving forward with any regulations, any statutory changes that patient confidentiality continues to be now and into the future a priority in anything that either the regulatory agency does or the legislature does. And we can report that back accordingly in the in the materials that we prevent, present the legislature. So, I think everybody was agreement that patient confidentiality was a very important piece of this program. And I just wanted to formalize that in our report back. So if you support that being a finding in this working group, and more or less we deliver in a way that I just described, you can raise your hand and vote yes. If not, you can tell us what, what you would like your voice to be and if anybody has any comments to interject before we take take any type of vote, I'm happy to happy to take those now. Paul,

Paul: So, when we're – since this is under patient access, you know, one of the important things that continually comes up during this meeting is cost. Cost to patients. Is that something that we could add into this patient access piece, that the cost to patients needs to be considered paramount?

Erik: I don't see why not. That can be tied into patient access.

Paul: Great. That's, that's just something I just saw that wasn't that was just missing on here, when we're talking about patient access that I know has been a continuing subject during these meetings.

Erik: I think that's an important consideration.

Michelle: I agree. For me, that is a primary consideration.

Erik: Yeah, when we're talking about the, yeah, the vision of this working group is to benefit patients of the state, benefit businesses and the stakeholders around this working group and others, so costs his patients to certainly be something that both of the whatever the regulatory agency is in charge of the programs or the legislature. So, I would definitely entertain that and we can illustrate that back not only patient confidentiality, but access in the form of cost. So, with that, is there anything else? Alex? Oh, sorry, was that you just?

Alex: I was just getting jump on the vote.

Erik: Alright. So, show of hands for that report back?

Michelle: Sorry, can you repeat the question?

Erik: In the report back to the legislature, we're going to have a finding being a commitment to patient confidentiality.

Michelle: Yes, ok. Sorry.

Erik: I take that. All right. Perfect. Nope, we're good. I think we got it. All right. The second one I think we had a consensus, but again, just to formalize it was the digital digital certification. And obviously, there's some details that go into it, but I think what I heard for the most part was still doing the hard card that we typically do or traditionally have done in the program, but allowing some type of digital digital certification to serve as a way to access medicine before you get it, if you misplace it. So, it's kind of have a two-pronged approach with having that patient certification. So, if anybody wants to add to that before I call for a vote on allowing digital certifications in the way that we had discussed in I believe the first meeting. Susan.

Susan: I just, I support digital certifications. However, I want to make sure that we always retain the ability for a patient to just have a paper certification. So, I wouldn't want digital certifications to be mandatory, especially in our rural haphazard WiFi land.

Erik: Yep, it would be both. And that was in line with the conversations that we had was having both those available. Julie.

Julie: Sorry, just to kind of reinforce the validity of that sort of a process if we could just include some language that reminds the legislature that you can use a digital format to go through TSA in order to get onto an airplane. So, it should be perfectly acceptable to use it for your medical certification as well.

Erik: And, Michelle.

Michelle: Sorry, takes a second to unmute. I'm sorry to back up, I just wanted to add back to the patient access. If it's not in there, I just wanted to add a little bullet point about having the appropriate infrastructure to go along with anything that is required. In other words, if we only have a couple of testing facilities in the state, we need to make sure that whatever we're requiring, gives time for that infrastructure to be built up. Just a bullet point. Thank you.

Erik: So, by a show of hands, in the report back from this group, we support and recommend a statutory change, allowing some type of digital certification but also maintaining the hard copy. Just allowing that flexibility for the patient population. So, a raise of hands. That looks like anybody. Oh, hey, Joel. Okay. Perfect. And another one that we talked about I believe it was the first meeting.

Michelle: Erik, I'm sorry, I just wanted to note that Susan raised her hand, but her picture had frozen.

Erik: Got it.

Susan: And then all I could see was my own hand and I thought nobody else for it was their hand.

Erik: I think I caught it on the tail end. No problem. And then finally, I believe it came from the first meeting, the pediatric certification process. How what statutorily required is not really the practice that's in place. So, to basically align that with current practice to make sure that there's actually access for the pediatric patients in a way that makes sense. Susan, I know this is something that we've talked about numerous times over the years, is there any feedback or anything you want to add to that? I certainly think it should be a recommendation to the legislature that we formalize in any report out.

Susan: Think it should look nearly identical to the adult certification. In my opinion, I feel that a follow up to that would be that pediatric patients' doctors, health care providers who are certified in pediatric patients, must provide some way to access the office off hours, after hour, the weekend. It doesn't have to necessarily be free, but patients need to be able to call to ask their questions, especially when they're medicating a person such as a pediatric patient who can't necessarily provide a, "hey, this makes me feel scary, or this makes me feel you know", whatever. So that's the only the only thing that I would offer as an alternative to mirroring the adult certification process is that the office must provide a way to contact the office after hours.

Michelle: I think that's, I think that's a great point. May I add something Erik?

Erik: Yeah.

Michelle: As the mother of a pediatric patient. On a personal note, when my son was first diagnosed with an aggressive malignant brain tumor, it was horrifying to have to wait almost two weeks to get his certification and then be able to start what might be, you know, lifesaving intervention for him. The only intervention we were able to do at that point, because we were also waiting for the other standard interventions that were going to take some time to access. And I just want to raise a point of awareness that, to us anyway, that seemed rather random. The doctor recommended this, we had that recommendation, we had all the records and everything to back it up and to prove he did indeed have this condition. And this was recommended as an intervention. What in the world is a 10 day waiting period going to accomplish? So, I would just like to point that out and have that as a point of awareness that if this is a requirement, why? It seems rather random. And if it doesn't need to be a requirement, get rid of it. And if it does need to be a requirement, then can we make some exceptions for people who have life threatening conditions that are very time sensitive? Thank you.

Erik: Absolutely. And I accidentally muted myself. I don't know if Susan, when I muted it was, you were saying something after hours access. Is that something that is that something that would just fall on the medical provider in their operations?

Susan: Yes, I'll give you an example. I had one meeting with a patient who was certified by an office that didn't have any after hours, and the patient was in crisis over the weekend. And it was very difficult because I was the only person they could reach that had any knowledge of the product in their hands.

And I'm not allowed to give medical advice. So it creates an issue, and also is an issue when a pediatric patient goes to the hospital and the hospital can't get in touch with the recommending provider. So there has to be some sort of process set by the medical office. And most medical offices, like integrate health care or even a doctor's office that you that you go to would have this process in place, but not all recommending doctors who recommend cannabis have this in place. So, and most of them choose not to certify pediatrics for that reason. But I think that the mistake can be made in a doctor's a health care provider can think though this is no different than certifying an adult. But there there is a difference in there's bound to be more questions and more hand holding involved. So, we ended up getting that patient certified through integrate so that integrate good help manage the questions that they were facing.

Erik: I think I understand. What I would like to do if it's alright with the group is take a vote on more or less realigning with the pediatric patient certification process looks like and then follow up with Susan and Michelle, and maybe Julie, about this conversation to see what role OMP has in it, whether there's anything statutory or regulatory that we can do. This is just something that we would need more information about, but really heard. Is that alright with Michelle and Susan, if we follow?

Michelle: Yeah, sure. Thank you.

Erik: Okay, cool. So show of hands, people that support a recommendation from this working group to really redefine what the certification process looks like for pediatric patients more aligned with what actually happens in reality, or with the patient process. Great, thank you. You got that? Okay, great. Another finding and a lot of conversation we've had, especially last meeting was around patient education. And this one, I don't know, necessarily, they would go into a statutory change, or a regulatory change, but it's certainly a finding of this group and it seems like there's broad support around the Office of Marijuana Policy, providing some level of patient education, patient resources on their website, and finding a way to provide that information to patients in a way that's convenient to them. So, I certainly want to put that as a finding in any report back to the legislature, and kind of put timelines and parameters on that. While it's something that we can do internally, I think it's important that we document the conversations that we have with this group and a lot of the stuff that we're going to be doing both at OMP, at the legislature, and in the rules. So by show of hands, unless anybody has additional feedback or comment, we can have that as a finding, as far as, again, patient education, patient resources, something that we can build out on the OMP website and figure out a way to provide access to patients. So, show of hands. Perfect. And then finally, we came up twice, and we spoke to it briefly around the one card caregiver assistants, one card for caregiver assistants. This would certainly help with turnaround times and the administrative of work on our end. It would certainly work on the interest industry time of getting people to, to work as quickly as possible, and hopefully help with a number of issues that we see here at OMP and on the industry side as well. So, we've certainly been supportive before. We've been told that we need statutory change with some of the language that is currently on the books as far as how we issue those cards. But I think the vast majority of people on this call support that basically, if you're a caregiver assistant, and you're an assistant to five different

caregivers, you need five different caregiver system cards, even though a lot of your information has hasn't changed. So, this would allow essentially one universal caregiver assistant cards to allow you to operate as a caregiver assistant within the program, not having to come back and do administrative paperwork for each one of those assistants that you're working with. Is that clear to everybody? Does anybody have any questions that came up? Like I said, briefly, on the second and third call, I believe. Alex?

Alex: Oh, yeah, I would just be wondering if now it'd be a good time to – first of all, I definitely agree with that, support that. But I'm wonder if now would be a good time for us to rope the IICs into that as well. I realized that be a little bit more difficult from a legislative standpoint, because it involves statutory changes on AU, as well as medical. But I'm wondering if we could just have it be like an industry card so if you have an industry card, you could be an employee at an adult use facility or a caregiver assistant. Just wanted to throw that out there. It's seems like a good opportunity to kind of bundle that together.

Erik: That being kind of thrown in the conversation. I mean, that would I would have to spend a certain amount of time vetting that internally, as far as that would have worked with both of our programs and both of our systems. And that's certainly a larger conversation than we're having right now. Although I do appreciate that feedback, Alex and that's certainly something that we can talk about offline. I think as far as moving forward with this proposal to help with just a medical, I think we should likely keep the proposal the way that we we have it laid out right now, but certainly something that we can talk about offline or moving forward. Josh, I want to make sure we get to Josh and Heather.

Joshua: Thank you. Yes. So, Alex, I see what you're saying, and it makes a lot of sense to me. But also, the statutory changes would require, you know, a bunch of time and effort. And so is there a middle ground option there, which is to say that, like, the IIC card operates in the adult use program, if you just had one, you know, registration or or employment or background check whatever card for the medical program that could cover any job in the medical program that you want it to do. And so, if someone's a caregiver assistant, but they also want to become a caregiver themselves, or they want to work part time for a dispensary, or or they want to work for manufacturing or lab license. I don't know if that's a little bit simpler, but still offers some more flexibility for workers.

Heather: I was gonna suggest exactly what Josh suggested.

Paul: So, I think you know, and Josh, this might just be your idea, I might be saying it differently. But would we be able to maybe have like someone who would just register with your office, and then they would be able to have almost like a profile in your office and then have a card that would be designated to what they could do within each program. So, the idea that like, you know, I can be registered as a caregiver. I would be registered with the Office of Marijuana Policy. And then I could be registered as a caregiver, but then I could also be an adult use employee. And so basically, if someone was checking

my profile, they would see I was authorized to do both of those things. Does that? Does that make sense? So, there'd be like, if people would have an individual profile within the Office of Marijuana Policy, and they would basically be designated within that profile of what, what programs they participate in, and then what they could do within those programs.

Erik: Believe me, I understand what you're saying. But just to back to my comments after Alex, these are not insignificant systems changes to be able to bleed, essentially, individual licensing across both programs within our licensing system. I'm not saying that's impossible. But this is something that we would have to spend a lot of time on figuring out how to do with our vendors and how to do it policy wise and in line with both programs. Certainly not something that we have to close the book on today, though. Catherine,

Catherine: I'd like to close the book on it. Immediately, knee jerk reaction is why don't we just merge the two programs together, we don't need two programs? They're asking for two different things in the medical program versus the adult use program, the background checks system is different between the two programs and then you just stay that way. We are treading very dangerous grounds and trying to link these two systems together, and me as a caregiver and me as the president of the trade association, is strongly against any merging of the two programs. Thank you.

David: I feel like I was talking to Catherine. Yes. 100%. I mean, let's just keep it medical. The two programs we do not want to combine. Let's focus on the task at hand, which is just dealing with what we need to deal with on the medical side and keep this one moving, I think for sure. Yep.

Erik: Perfect. And also to Catherine's point, there are different requirements for individuals in adult use that get IICs, and individuals that become caregiver, the caregiver assistants. But Josh, I saw your hand went back up.

Joshua: Yes. So just to clarify, I mean, we're all kind of talking about different versions of the same idea. And I guess what I was talking about previously, was, was giving the program separate to Catherine's point, but mirroring the simplicity of the IIC in the adult use program by only requiring one single, you know, registration or ID card that covers any activity in the medical program. And then from there, we'll drill down to you know, what you're actually licensed to do.

Erik: Yeah. Understood. Again, that, I think from where we're coming from now that would, could we get there? Possibly, yeah. The only difference right now in the medical program are the difference between the caregiver cards in the assistant cards, as the caregivers are allowed to have this authorized activity and basically, the assistant is an extension of the caregiver. I understand what you're totally saying. So, if people want us to try to figure out a way to do a one card that rules them all, we might be able to do that. But in lieu of additional work requirements, system build outs, I think we can at least take one positive step forward in consolidating the assistant cards, but also is this is the group, so I want

to make sure that we have consensus. And if we vote on this and somebody else wants to be a dissenting vote to be able to get that into the report back, then we're happy to do that as well, if that's something that we want to see if the legislature has the appetite to do. Does that make sense? So, if somebody wants to push this issue, push away, and we can make sure that that gets into the report and is reflected appropriately. So, with that, I will take the vote on the original proposal, the original conversation to consolidate into one assistant card. And if there's any dissenting votes, we can make sure that we capture exactly what you're thinking, does that make sense? So, vote for the one assistant card consolidations to the **one assistant** card. No dissenting votes. We are keeping it clean, okay. I think it will be a positive first step. All right. So, with that, only 22 minutes behind schedule. We are doing great. Heather, did you want to say something? Nope. Nope. Okay. So getting into the next conversation or discussion around program enhancements, this is tying back to the end of the third meeting, when we had conversations about basically, scalability within the medical program, a lot of these conversations that we have with policy levers, transparency in certain regulations, it becomes very difficult with one size fits all. And we had a conversation about kind of redefining what a registrant or a caregiver registrant is to make sure that the larger I think the term that was thrown out was more of a commercial caregiver is subject to a certain set of requirements or regulatory oversight than a smaller caregiver operator that might operate more in the traditional way. So, I wanted to make sure that we had the opportunity to have that conversation. And I think if we get to consensus or even majority consensus, I think it might make the conversations later in this meeting, a little easier, a little bit more palatable. But I wanted to throw it out there for anybody that wanted to weigh into this. If as a group, we still feel like that's an appropriate move, to make to kind of redefine what a caregiver is, not redefine what a caregiver is but reclassify what a large caregiver is versus a smaller caregiver. So, I'll just throw it out there to see if people still have the appetite to do that. See if they think that's a smart move. And I can also throw out some thoughts that we've kicked around internally, but I want to hear from you folks. So, Paul.

Paul: So, I guess, you know, for me that it's, it's what, its definition. So, what are we what are we defining, and then how many categories we're going to try to define it into? So, we're going to try to take the caregiver and split it into two categories, three categories, four categories? You see what I'm saying there?

Erik: Yeah, I mean, that's exactly the conversation I want to have. What makes sense. What? Well, one, what's what's, what makes sense from the operators, from the caregiver, from the industry side, what are the different operations? How are they set up? What, yeah, exactly, what would make sense? And I'm hoping this group can have that conversation. Is it two? Is it three? Is it four? Is it, hopefully not 15, but that's, yeah, that's exactly what we're looking for.

Paul: I think I mean, I think from you know, my discussions with people in the industry is there's definitely a desire to be able to have, you know, a caregiver that's going to be able to operate on a larger scale or provide for more patients either directly or through wholesaling to other caregivers or storefronts and dispensaries. So, you know, I kind of see two things about this, like, you know, one,

would it be with caregivers, then what do you increase either the plant count or the square footage that they'd be allowed to cultivate? And that would have to also increase the number of veg plants that they'd be able to have. So those are, those are kind of the two like, I guess, foundational, you know, parts right there. And then would this be something where someone would automatically have to be kind of roped in with having a storefront? Because how would storefronts you know, tie into this? So, would that be kind of like a separate, you know, caregiver category? Or would that be aside from cultivation? And then when we're talking about manufacturing, with manufacturing, you know, still be under, you know, the purview of any sort of caregiver. So, if we're going to have the smallest level caregiver, would that caregiver still be able to do you know, inherently hazardous substance extractions, even though they're not on the larger commercial level? Those are those are kind of my questions, you know, in from my discussions that people are looking at is that, you know (a) you want to determine how much you know, someone can cultivate both vegetative and flowering plants, you know (b) will it gave to be tied to some sort of, you know, retails retail storefront or that'd be almost like a separate license and then (c) how well products manufacturing work into that, will that still fall under any caregiver card? Or will that again be kind of a separate category, or registration, like the storefront that I mentioned earlier?

Chris: I, first, I support kind of splitting into a couple different categories there. You know, I will echo what Paul said about the, you know, you'd have the two means already the plant count and then the the vegetative square foot. I guess the only other piece I'll kind of add to that is potentially the, you know, overall size of facility, square foot or that location of the facility. So, the difference between potentially, you know, working out of your home truly, or working out of an industrial or commercial area, or a commercial property, may be, you know, a line to split on.

Erik: Sorry, I'm on mute. Sorry, sorry. I saw Barry then, Rebecca.

Barry: Yeah, so, just throwing this out as an idea. And I'm, you know, this would be a better answered for Paul and Catherine, some of the caregiver representatives. But, you know, when I'm on these calls, I hear a lot about costs, and how it's going to affect my cost, how it's going to, you know, testing and tracking and things like that. So, would it be would it makes sense to define size with some sort of financial aspect to it, like a revenue limits, tiers that are somehow would lead to exemptions?

Paul: Could I answer that real quick? I don't want to jump my my turn line.

Erik: Yeah, you can respond to that. You were call out and sorry, Barry, I muted you when I tried to unmute myself.

Paul: Yeah. So, I just I guess I'm just I would just be concerned about financial disclosures to the department. I think I see what you're saying, though, is the idea if you're going to do under $50,000 worth of sales a year, then that would, you know, that would exempt you from some of these more commercial things? It it's an enticing idea, but just from the people that I know, in the industry, I think

just sticking to square footage, plant count, and what kind of activities you're engaged in, I think that would be simpler for them. You know, so when we're talking about costs and stuff, too. I'll stop there. I don't want to take up too much more time.

Erik: No. And Paul, what you just shared Paul was the first thing that popped in my head about how to actually do that internally, taking 3100 financials and defining them and this and that, but is it was an interesting thought. Rebecca.

Rebecca: I mean, obviously, this goes without saying that this is coming from a municipal perspective, and it might sort of show my ignorance and how caregivers operate now, but one of the things that we have been hearing from municipalities is given sort of the new statutory authorization for caregivers to sell wholesale and you know, the entirety of their product, wholesale to other caregivers, I'm wondering if maybe a distinction might be that, you know, the degree to which a caregiver is selling wholesale and maybe not selling their product to or distributing their product to other caregivers or dispensaries more than patients. So maybe the degree to which they're actually acts of service serving patients rather than serving, you know, using their product for other caregiver purposes.

Erik: That's an interesting thought. I hadnt thought about that. Susan, Katherine and then David.

Susan: Um, yeah, I also was concerned as to how we define small versus commercial like, is it plant count? Is it location, whether it's a home residence or commercial location? Is it product manufacturing? Is it the size of the facility? or revenue? Revenue, I have concerns about on an administrative basis and a governmental basis is that I – I might sound like I'm playing the wrong side here but I mean, what if you know you're right at the cusp and you intentionally make sure your revenue doesn't go over a certain limit? Revenue, I don't know this a good is a good basis. And like Erik said, analyzing 3100 sets of books might be difficult. So, those are only those are my concerns is definition of what constitutes small versus commercial.

Erik: You. Catherine.

Catherine: Forgot the mute. Um, a couple of things. One on Rebecca's comment: That's pretty much what we just came from. So, we had it that caregivers could sell 75%, wholesale and 25% to the consumer, that was just changed in legislature to 100% wholesale that a caregiver can can sell the product that they harvest. I don't think we want to go backwards on that. Two, I'm not exactly sure what we're trying to redesign on the caregiver platform right now. As it stands, we're limited by the 30 plants we can grow or the 500 square feet. If you want to grow more, then become a caregiver dispensary, and get the next license and then you can cultivate, cultivate more, and you can maintain, like, turning this store into a dispensary if I wanted to. It's open to, to the real people now. It was just the eight dispensaries that had it before. But that license is open to everybody. So, I'm not sure why we're trying to create more confusion because we already have a ton of confusion within the program, and with the

department trying to manage what we have. And I think we're asking for trouble. The municipalities are already confused, crazily confused as to what they can and cannot regulate, what caregivers can and cannot do. Right now, a caregiver can cultivate, sell to patients, wholesale, and manufacture their own products. We don't have to get separate licensing for all that. And it sounds like we're looking to muddy the water by, by going further. Maybe I'm misunderstanding what this conversation is about, but that's what it sounds like to me. Um, as far as whether you have a municipality, like you have a warehouse that you're growing in versus your home, you're a home caregiver, or you're a commercial caregiver that's growing in a commercial building. I mean, it's already there. And we already have the licensing in place for that. So, I think, I'm concerned about confusing the issue.

Erik: Thank you, Catherine. And we've certainly been very public about if you want to grow your business, to move to the dispensary model, which is there. And there's the whole purpose, why they lifted the cap, which comes with the different sets of regulations. I think the conversation comes from both the conversation that was started at the last meeting, understanding that you have a caregiver, maybe much like Susan, who has services, a limited number of pediatric patients, and then you have a caregiver who operates a storefront and wholesales and is just as an enormous operation. And in front of the legislature, we heard from a number of committee members that they wanted a scalable approach that makes sense. So, I'm hoping that we have that conversation so we can possibly capture those larger operators, those caregivers, to where smart regulations make sense with the size of the operator. So, David.

David: Thank you, Erik. So, yeah, just to sort of chat about that. You know, where I sit with it is, of course, you know, we're a larger operator. And when I talked about this at the last meeting, from my perspective, it was more along the lines, Catherine, towards sort of to just try to make sure we separate, you know, maybe some of us that are on this call, and the folks that are, you know, like Erik just mentioned, doing things on a very small scale. And I think what, you know, my senses, and maybe, maybe I'm alone on the panel with this, but it does seem like we're moving in a direction it from from the state, from the state's perspective, where, you know, more regulations will be on the medical side, right? And so when I started talking about that, at the last meeting, for me, it was, okay, that's coming, let's make sure we take care of those that are on a smaller scale, so that they don't get hit with some of these larger, you know, the expenses that can be more challenging when you're growing less plants, you know, you have left less infrastructure for expansion. So from my perspective, you know, I don't know, Erik, if we'd want to get into a situation where we had, you know, eight different levels, or I think you would just right, you just want to make sure that someone who's growing out of their home, right, and servicing, you know, not a ton of patients, you know, has maybe, I don't know, I don't want to throw the number out because somebody will tell me, I'm a fool but 12 plants or I don't even know, I don't know what the number is right? I don't want to I want to be careful about saying it that way. But that is clearly not doing you know, you know, 30-60-90 like grows wholesaling, operating on a commercial level in the medical market. I just want to make sure that those folks who are operating on a much smaller scale are never forgotten about because those folks were probably all of us at one time. And we want to make

sure that that that's like the cottage industry. That's the bread and butter of Maine. And I want to make sure that that doesn't get left aside. So that was my thoughts there.

Erik: Thank you, David. And that's certainly in line with what we're hoping to achieve with this at OMP is, that's what we heard about protecting those small operators making sure there's still space for them in the program, with with regulations that make sense for everybody. So, I'll go to I got Alex, Chris. Catherine just dropped Alex, Chris, Paul.

Alex: So yeah, I agree with David's intuition. It seems like the reason we're discussing, having a split here for caregivers wouldn't be to kind of allow more, it's more to allow, if we're gonna be adding regulations, adding testing, you know, it's more to allow some of the smaller caregivers to continue forward. So, you know, from the document that was sent out for this meeting, or mentioned, the potential registrants that would be affected by the testing proposal is to be determined, that kind of led me to believe that the reason why we're discussing different tiers for commercial caregivers, versus smaller caregivers is to, again, to tie in some of the previous meetings is to potentially allow for some of the smaller caregivers to have less stringent testing requirements and maybe less stringent security requirements. But I do think that, you know, I'm all for that, you know, I think the ideal way our Maine cannabis industry plays out, as you know, we go into the store, and it's similar to, you know, a cooler of Maine craft beer, where you get all these different, small to medium size breweries, and you kind of get to choose from them. So, I think it's important to keep that in mind as we go forward. And also, I do think it's important to think about how the two interact with each other. So, if there is like the smaller caregivers that are exempt from testing requirements, just as an example, and if a larger retailer that would be considered a commercial caregiver, wants to buy their products and put it on the shelves, you know, would it be that they are then in the commercial regulations? And they have to then test the product that the smaller caregiver was exempt from testing? Or would they be able to just put the, you know, this product has not been tested label on it, just because, again, I see that being you know, some of the larger stores maybe might go with people that have already tested it, and then it kind of squeezes out the smaller people anyway, versus, you know, the smaller caregivers are allowed to be exempt from testing requirements. And then anybody is allowed to retail those with just this product is not ingested label, then that seems to be a way that kind of the smaller caregiver and the commercial caregivers are able to merge, not merge but to be able to interact with each other and do business.

Erik: Thanks, Alex, you're certainly right. The TBD was OMP not wanting to come forward with that, wanting to have this conversation first, to make sure that any type of consensus that we have, or majority consensus made sense for the right person, and the TBD, I mean, it has a lot to do with a lot of the conversation. We have the packaging, labeling, maybe, or the tracking or the testing, again, with to what Paul talks about a lot, making sure the cost is there for patients, certainly maintaining the access for patients, and then also protecting the smaller operators. So, I think we're on the same page. I got Chris and Paul.

Chris: Yeah, second time around, I'll be brief. I do think, just kind of a backup point, one of the reasons to make a break between residential and commercial is the code, the building code, and the fire code that we have adopted in the state make a lot of differences between those two occupancies. And it's gonna potentially allow for different uses in residential versus commercial. So, I think it just coming from my perspective on the municipal side and the code enforcement side, it does, it starts to make a clean break. So so to back that point up below.

Paul: I, um, you know, based on everything I've heard from people, I think there's definitely like a desire to have, you know, these different tiers and trying to figure out how to get there. So, I know you said earlier, Erik, that you are going to mention what you guys have been thinking and working on over OMP. So, I'm just really curious about what what that is because I want to be able to give you feedback to those ideas while we're on this topic,

Erik: Kicking it around in our head, as far as what conversation we had in third meeting, commercial versus noncommercial, the first place my went my brain went was, well certainly the dispensary model would be considered a commercial registrant for a certain set of requirements. Then also those that operate a storefront. I mean, that's, that's a commercial establishment there as far as just having a store, store open on Main Street in Maine. And then we talk about manufacturing, we have requirements for even if it was a smaller caregiver operating an IHS manufacturing, they still have to go through certain procedures and get certain certifications for that IHS. So, I don't necessarily think that that would ticket to like a commercial registering with the program. But that's certainly as far as keeping it simple, keeping it clean, trying to capture the real commercial entities versus the smaller I think it's a nice baby step. A step in the right direction just to capture again dispensaries and caregivers who operate storefronts. Obviously, that doesn't mesh as cleanly as we would hope with what Chris is saying from the municipal aspect. But would love feedback on that? I saw not.

Paul: You know, just just from where I'm sitting, I mean, the dispensary that the dispensary model the way that you're presenting it makes sense to me. But I think the problem that you run into that is that that you need to have municipal authorization to operate as a dispensary before you can operate for it before you can get authorization. Is that correct?

Erik: Can you can you say that again?

Paul: You need to have the municipalities to opt in for dispensary cultivation, manufacturing or retail. Right? Before you can.

Erik: Yep.

Paul: So. So the problem that I that I see with you know, as much as I agree with you, and I see where you're coming from the the problem with every caregiver who is operating commercially, being pushed

over to the dispensary, and is that without any sort of grandfathering is that you'd have to have these municipalities opt in to dispense to authorized dispensaries. I know that right now, my municipality, I think it's past time to get something on the town warrant. So, you'd have to get something authorized by the select people or have to go, I think it's actually even too late to gather a petition. So um, so that's, you know, kind of one concern when we're looking at trying to add another category or trying to have the idea of caregivers just being traditional caregivers, whether just directly serving patients, as opposed to being the small businesses that they are today. So when we're, you know, when my feedback to OMP on this idea is being able to, you know, definitely have a separate category of caregiver that is able to be able to cultivate more and operate in a more traditional commercial manner. That will obviously come with more privileges and oversights from the department, but not needing to be able to have to go to the municipal opt in process when it comes down to becoming a dispensary. And I know, I know, that could give some heartburn to probably people in the municipal end. But if some of these caregivers are operating on a commercial scale, and the municipalities want to have more oversight, this is where they'd be able to get more state oversight. I think, you know, I think the idea of having, you know, commercial store, storefronts, caregivers who have storefronts, that being either like a separate registration or something along those lines, that makes sense to me. I see that as more of a tax compliance issue more than anything else, but at the same time, that also has a strong, you know, municipal oversight role because municipalities are required to opt in for anybody wants to operate a storefront. So

Erik: I'm not I'm not sure where you're going with the dispensary. I mean, I understand the limitations there. I'm certainly think if somebody is willing to operate or one operator operates a dispensary who has that, that volume in that scale, and certainly they should be required for a higher standard of regulations, but also those that are currently operating a larger scale as a caregiver, how to make sure that we have proper regulations in place on that that front, and I guess, so, just I mean, we're jumping all over the place and this is a really good conversation. So, the TBD and the testing requirements. So, kind of why we thought internally, it might make sense to kind of, and we're not talking about additional registration fees or additional worth, it would still be the same, they would just be kind of redefined. And then we would hit that scalable approach. Right? So along the lines of testing, if I were to fill in the blanks here with TBD, so anything that would have required testing for limited panels, the only product would be harvested marijuana that's sold on a store shelf, basically a caregiver storefront or dispensary. That way you can scale the different types of regulations that are aimed towards public health, public safety, and working for all the stakeholders around this group, including the municipalities. Does that make sense?

Paul: I mean, that that makes sense to me. But at the same time, it's still we're talking about there's a lot of caregivers out there that operate on a smaller micro level. You know, I'm talking about people that have, you know, maybe one or two employees, where they, their main source of income is wholesaling to choose dispensaries to caregiver storefronts. And so, they are not operating on a truly commercial scale. There's still a smaller micro scale, because they're not growing on that level. Does that make

sense? You know, you see where I'm coming from with that? So, then the idea of making, adding any sort of additional costs and mandatory costs to them is going to be something that will push push them out of business, and it's going to be really hard for not only their families, but also their employees. Because one of the things when we're talking about, you know, testing regulations, any sort of mandatory costs is that those the costs that you're suggesting that will be placed upon the program don't operate in a vacuum. You know, we're talking about electricity rates are going to be doubling for a lot of caregivers, for, for caregivers, especially to have locked in their electricity rate. We're talking about the cost of supply shop supplies, the cost of nutrients, those costs going up, also the cost of transportation, property taxes going up, your rent going up. So, all of those costs are going to factor in to what's going to end up costing the patient. Because those patient does that cost like any business will eventually be will be passed off to the consumer who in this case, is the patient. So with those regulations, and the idea of mandatory testing, I think we have to be careful because anything that's sold on a store shelf, a lot of the things that I'd say the majority of things that are on store shelves, if they're not produced by the operator of that store, they're produced by caregivers who have less than three employees, and by caregivers who operate on a very thin profit margin. So, the idea that they don't operate on a commercial scale, they're not operating the scale of a dispensary, but they're operating on such a small scale that unless they are given an option to be able to expand and be able to cultivate more, if they're able to cultivate more than hopefully they can layer lower their costs by producing more than they will not be able to absorb these costs. Do you see what I'm saying? So right now they'll be

Erik: I would love I would love. I don't want to put anybody on the spot. I'm gonna go to Catherine, David, and I don't know how long you've been waving your hand, Trish. I'll go to you first because you might have been doing it for quite a while. But, Josh, not to put you on the spot, I would love to hear your response to that from the dispensary operator side of things. So, Trish, I feel like you could have been raising your hand for an hour now. So, I'll go to you.

Patricia: I feel bad. No, it wasn't that long. I'm just sort of two points. One we've bantered the word costs around a lot and it isn't difficult time and, and costs are a huge issue. You know, I've been poor most of my adult life so and financing my medicine has always been a problem. On the point of cost one, we always have to remember, first of all, we are so blessed that everyone can grow their own in Maine. And so, the bar for entry to this program is as low as dirt and a pot in some seeds. And that is a wonderful thing. And yes, costs seem to be kept out in the market, to some extent, but there are other costs to consider. Costs for going to the doctor for things that may be side effects of tainted medicine that you don't know, costs, what is the cost of ingesting carcinogens in small amounts over years, and then finding out that may have contributed to some larger big health issue years down the road? You know, there's a lot of, you know, the word cost has a lot of connotations and areas in which it pops up not just caregiver cost. Um, the second thing, from a patient perspective, I've discussed this a few times in a few circles, when it comes to untested medicine, I think obviously, anything coming out of a storefront needs to be tested, but for me, there's a line somewhere, like, when I go to a store, you cannot have an intimate conversation at a store about how has that medicine grown. On the other hand, I've

shopped like with a small caregiver, I don't want to throw a number around either because you get crucified, but perhaps this caregiver was maybe handling 10 to 12 patients, and on a very intimate level. So, I was able to have a conversation with his caregiver about what are your growing practices? What do you use? How does this go? How do you harvest love that, you know, this person harvested? Traditionally, which most folks don't. Um, and so with her I had this conversation where I could build confidence in her medicine without needing a test. That isn't necessarily the case in some, you know, other places where you cannot have that intimate discussion about how was this medicine grown and harvested? So for me, there's a line there, um, you know, and I'm not sure where it is, again, I don't wanna throw numbers, but it's in being able to have that intimate conversation about the medicine you're about to purchase. Thank you.

Erik: Yeah, no, thank you. That's an interesting perspective, which I hadn't even considered but Catherine and David.

Catherine: didn't want to unmute again. I agree to a point. The small home base caregivers should be held to the small base caregiver model and those that have stores or grow in a commercial space or commercial size then that may be maybe two separate thought processes. But again, I, I still think we're playing with Pandora's Box. Right now, a caregiver can cultivate, grow, manufacture, take care of the patients, and be real careful what we asked for because in the past, we've seen changes to this program that were not beneficial to the patient, they were not beneficial to the caregiver model. And if we want something different than the caregiver model, it's there. And then we need to discuss, discuss, like Paul was talking about as far as the municipality piece of that, because that was something that I had not considered as to how that would look and whether different municipalities see dispensaries and caregivers differently. Because it literally can be the same thing, if we choose it to be that way. And the small caregivers need to be, the home base caregivers, a home base caregiver. And the municipalities already have a hard time dealing with this. And we're asking for trouble with it.

David: Thank you, Erik. So, a couple things. There's a lot of pieces moving right now as we talk about this, right? So, the first thing I would say is from as someone who grows and grows, you know, in a pretty good size facility, we have had times when we, so we test everything that we grow. So, let's just start there. So, everything that goes through our facility gets tested. We've had a situation in the past where we would have eight strains in a room, and we would test the entire room each strain independently. Seven of the eight passed with zero microbials and one strain did not. So, I am very confident that we run an incredibly clean operation. You know, the protocol and the SOPs are all there. So, had we not tested that room, right, we would have said, well, you know, have confidence in the schwag team and the Origins team, because clearly, we grow very, very clean medicine. We don't spray, we don't do these things. And historically, we have no issues. But without the test, we would have put on one of my store shelves, medicine, that would have failed a microbial test. I'm sure most people in this room are going to start talking about failing a test. But I'm saying it because it's important to understand that just because you grow clean cannabis does not mean that things don't happen with certain strains,

and don't happen in an environment. Right? So, I don't have a great answer on how this rolls out the State of Maine. But I do say and I think Patricia really hit the nail on the head is that when you really break it down, the cost of testing compared to the cost of putting I mean, I couldn't live with myself if I had put medicine on the shelves that would potentially harm someone right, with a compromised immune system or whatnot. So that's why we always do what we do. But I mean, the state may have a real issue on our hands, right? We may not know. I mean, there may be some wonderful people out there who think they're doing everything right. But if they're not testing every single time, and I mean, we'd never fail the test before like it happened recently. And so I just share that story. Because I think it drives home the point that there's a room eight strains, seven were perfect, one wasn't. And I think that's the reason why probably I mean, Barry can probably talk to this, but there's, it's why there's such a importance to this whole thing and why it's such an important thing for me, because we want to put safe medicine on the shelves in both the recreational and the medical market. It's important. We're trying to help people. Thank you.

Erik: I want to make sure that we kind of recenter refocus on kind of potentially redefining registrants and what would make sense that would be tied to those different types of regs like require testing, certain level of tracking, different levels of packaging and labeling. So, Josh, is it okay, if I put you on on the spot to feedback from Paul's comments, so I can better understand and OMP can better understand that relationship between dispensaries and caregivers and the product that moves through the system?

Joshua: Sure, I can try. It's been a few minutes since Paul spoke, but I'll try to accurately respond to what he was talking about. So, I think a lot of the confusion and difficulty that's come into this particular aspect of the issue is that there's a fairly wide range of operating realities, right, on the caregiver side, you've got all the way from small at home operations, they're dealing with a couple patients and are really not, you know, making tons of money or any real money off of this enterprise, all the way up to a fairly commercial operation, you know, like Dave was talking about his operation, Origins. And that's just within the the caregiver. So, there are caregivers that have operations equivalent to our size as a dispensary, and we're the smallest remaining dispensary, it goes up to, you know, these multi state operators. With that massive range, there's no way to set up a regulatory platform that applies to everybody equally, if you have set definitions and groups, they're always going to be people who are sitting right at those margins. And so I think it's pretty difficult for us to be able to say with authority, you know, home caregivers, any caregiver with two employees or fewer, shouldn't be regulated or shouldn't have anything additional apply to them, a caregiver with a store or a commercial extraction or manufacturing capability and more of a three or more employees needs to then fall under the dispensary side. I'm just making this up as an example. This is not what I'm proposing we need.

Paul: Josh, you said, three, three or more employees?

Joshua: It's just as an example of something. It's really, I'm seeing, it's really difficult for us to set up those boundaries because there's such a wide range of reality in terms of the operators in this medical program. Anywhere you pick the line, you're going to be screwing somebody over. Right? There's no way to do this super cleanly, so that everybody's really happy and everybody's well defined within their group. That's not that's not a realistic outcome. So, how do we make a change, and minimize a negative outcome while trying to create better clarity for regulators like the municipalities? I live in Bridgeton, and in dealing with our municipality, they really didn't understand there to be any differences between caregivers and dispensaries. They just think it's marijuana. They also didn't really consider much difference between medical and adult use. It was just there's marijuana they want to come in, what was the town want to do about it? I think it's very important, and almost everybody has said this, for small operators, and particularly the at home caregivers to essentially maintain the structure then and oversight that they've had since the beginning of the program, which is very, very little, because they're not operating in a way that affects very many people, they're not conducting a massive business operation, they should really be left to their own devices. Having a straight up pick where that line is, is gonna piss somebody off. Again, there's no way to avoid that. And so, I think that it makes sense either for us to start picking some lines, and then go out into the industry and talk to people and see how this works. And that, going back to the example that I said earlier, two employees or fewer, you know, no changes three or more, and a store or and a manufacturing capability within push you into the higher tier, go and talk to a lot of operators and see how many people are getting caught in that gray area. It's also, I think, a reality of any highly regulated industry that if a new rule comes out, people will have to adapt to it. And it may be that number of different operations are forced to get a little bit larger, get a little bit smaller to make it easier for them to comply with these regulations. But I don't know that that's that that's a good enough reason not to do anything. So, I've been a little meandering here, and Paul, I don't think I actually really answered what you were talking about before. So, if there's time, Erik, and we want to let Paul reiterate what he was talking about, and more accurately answer.

Paul: Well, I guess, I guess part of it is like how, you know, and how many, like, you know, how many vendors do you use? And how many of them do you think would fall under a non-home base caregiver or more of a commercial commercial base caregiver? Because that's that's the thing that's that's what I'm seeing over here in my bubble in in rural Maine, is that there are a lot of caregivers out there who are small operators who have you know, much thinner margins, they're not you know, they're not making beaucoup bucks. But what they are doing is they are providing products to local stores. Much like our small farms, much like our craft, alcohol industries. And so, anything that would increase their costs. So that's I guess my question is like, do you encounter a lot of those or you encountering more that are on a commercial level, on a larger commercial level that couldn't look to possibly absorb these costs?

Joshua: So, I definitely interact more with larger operators who, you know, if they're not doing this stuff voluntarily, already, would be able to absorb this cost. And what I'm saying is, even though I don't deal with a majority of these smaller operators, I understand their value to the program. And I'm saying that we need to keep those people around. Because otherwise, it's just a bunch of box stores. And that's

not what this should be. That's what I'm, that's where I'm at. But I don't know how to more effectively draw the lines to start breaking these up into smaller categories. It's just that this is going on for a decade now without, without very much of that definition work happening. And so anywhere we draw the lines is going to be inconvenient for somebody.

Paul: Right, I see what you're saying there. And that's where it's like, I think you made an important point is that over the past decade, and this also, I think speaks to what you said, David, over this past decade, we haven't had any sort of problems with accommodation. We haven't had problems with people getting sick off cannabis products, according to the data that that has come out of the state of Maine. So, any sort of additional regulations, I feel like we that one needs to be drawn, but any sort of additional regulations need to keep those people in mind. And I don't you know, I'm interested to hear what other people have to say about this. But I think we do need to try to figure out if this is going to be a line that we want to draw, and that we want to offer together as a workgroup.

Erik: Michelle, you've had your hand up for a while, certainly want to hear from you and then kick it over to David and Trish.

Michelle: Yeah, so for me when we're talking about testing, I always go back to the question for myself, when we're trying to come up with a solution, before we come up with a solution, and it's beyond the purview of this group, I think, so I'm just putting this out there and asking the question, so that it's like on the record of, you know, is, how can you solve a problem when we haven't agreed on what the problem is? Like? How can we come up with a solution, when we don't know what the problem is? And so I guess what I would just ask is, that's a starting point for me, as far as testing, what is the issue that we're trying to solve? Or what is the anticipated problem, and that could vary depending on how the product is being used. So, for example, with a smokeable product, you might be concerned about certain microbials that could affect the lungs, you know, with product that is being turned into a concentrate? Personally, I would be worried about things like heavy metals or things like pesticides, particularly well, that would be for smokeable product, too, for things like resist residual solvent, okay. So it really like boils down to like, what's the problem you're trying to solve? And then take it a step further, and Paul has addressed this? How would that impact the consumer? If you didn't address that problem? So, like, is it causing issues? Or do we have evidence somewhere to suggest that it could be a problem? So, I am not suggesting anybody, we have to answer all this now, that would be way longer than we could take. But just you know, for me, it kind of boils down to like, what's the problem? What is the potential issue of not addressing this? How do we want to address it? And then as a lot of people have already said, how will that impact cost and people's ability to access? And also, how will it impact really small operators. You know, who everybody's happy, they're happy, their patients that they're working with is happy, there haven't been any problems. And now all of a sudden, we have all of these new regulations that they have to follow, that are going to put them out of business or that that the cost is going to skyrocket so much that the people that they're helping now can't be helped. That's all I don't have

answers necessarily to these things. But I'm just putting that out there as a broader like, this is what we need to be thinking.

Erik: No, and those are all really good consensus building points. I think a lot of what we're trying to do in the vein of protecting public health and safety with these different requirements, is I mean, Paul likes to bring it up, operating off data that we do have and making data driven decisions. So, we have our adult use, and we can get this if we have the opportunity to talk about our testing proposal, but our adult use testing data, figuring out where those fail rates most commonly occur. Firsthand experience from both Trish and Shawn. Certainly what we hear while we're out in the fields. The pesticide data from Barry. What we see with our compliance team. Trying to protect against what's ending up in the hands of Maine patients in lieu of economic gains, essentially. But this whole conversation is walking that fine line of protecting patients, and protecting small businesses, but all completely valid points. David, Joel, Josh. And then then I'll try to figure out a way to wrap this conversation up. Oh, and then Trish, I'm sorry. So we'll go David, Joel, Trish, and then Josh.

David: Thank you, Erik. Just sort of circle back real quickly. Clearly where we are today. And where we were even three years ago, the program is a different program. It's changed. We have storefront. I mean, let's just, we just need to all accept that, right? So, the end of the game really is, let's make sure that the small at home-based operators can continue to do you know, that are just servicing, you know, limited numbers. I'm sure the folks on the municipal level, one of their challenges is when they you know, they hear that there's folks at home operator that they have 55 patients a day coming through there, it's probably hard for you guys, and I'm sure that's one of the challenges that you deal with on that level. But from a proposal standpoint, Erik, I heard you sort of mentioned that the storefront idea might be a good place to start from a testing perspective. I would just like to say I think that's a great idea. Because it might be a slow, a slow, or spot that may, you know, may not hit as many people initially as just an overall, you know, blanket blanket hit. But you know, as a startup writer for myself, you know, we're certainly going to make sure that if something's on our shelves, you know, we test everything that it's going to be tested. So maybe it's a personal decision, I don't know, but I got a feeling there's going to be some legality coming down the road on that one, for the folks that decide that they are not going to have testing out their stores, because someday there's gonna be a problem.

Erik: And I appreciate the positive feedback. It's always nice to hear that stuff. But I mean, that's certainly in line with what we were envisioning; medicine being sold in a commercial fashion through retail store. I mean, there's always the catch 22 of the the qualifying patient that's really in need of this, for whatever their medical condition may be operating with a small caregiver, you would want that to be tested too. But we're talking about scalability here. So, I mean, it's a difficult conversation to have. So, Joel, Trish, Josh, and then we're gonna end with Paul.

Joel Pepin: Thank you. Um, you know, I want to just comment on there not being a problem in the program, resulting from medical marijuana not currently being required from testing. Sure, there haven't

there isn't data acutely from intoxication of tainted products. But as an industry operator, I think in all of us, who are I think we are aware of, of operators who, in lieu of economic gains have used pesticides and bad products, on their plants. And, you know, I just think we don't know what that looks like five years, 10-20 years down the road, like we've talked about on this call today. And I think it's something that we need to acknowledge. Honestly, in my opinion, I come from the background of working in a garden supply store, you know, and there's a lot of gardeners, we're operating on thin margins, you get really close to having a crop, and it gets threatened by some type of pest or mold. And there's some operators that don't operate with integrity or value and will spray bad things on their plants and try to sell it. So that happens. And I don't know exactly how to to implement this. I do think it shouldn't, I don't think any testing requirements that we're talking about here, there should be tiers to the to the class of caregiver involved, it should not be burdensome on the small operators for the back backbone of the program. And it certainly shouldn't look like in my opinion, exactly what it looks like on the adult use side testing products multiple times down the supply chain. That's not that's not feasible in my opinion, either on the medical for the medical program as it exists. But I do think we need to try to figure out some way to implement testing for the larger scale commercial operators. Now one thing I did want to say and I agree with what Paul said about caregivers being commercial in jumping to the dispensary class and I think Erik you you understood his point, but it comes to an issue municipally of towns opting in specifically for that for that license type. So, like in Windham, just to give you a quick example, caregiver storefront is what I have and I'm interested in becoming a dispensary in Windham, right? A lot less assistant cards we pretty much already operate by all the standards in which a dispensary would However, Windham opted in only for one dispensary, and if, for instance, their existing ordinances years ago before caregiver storefronts were even a thing in Windham, and the ordinance reads If you're going to be a dispensary in Windham, and if we were to do it, your, your, your operating hours going to be from 8am to 5pm. You know, currently my store is open from 8am to 8pm. And so it's just it's not as easy as saying, Okay, I want to be a commercial caregiver, I'm going to be a dispensary, it's going to take tremendous time and effort. And these municipalities are short staffed, and there are a lot of them are burnt out quite, quite frankly, a marijuana and all the different moving targets. So that that is a big challenge.

Erik: Thank you. So again, Trish, Josh, Paul, we will get Michelle in. I promise at that point, we'll put a bow on it.

Patricia: Hi, is I'm totally in support of those small home-based caregivers who are directly dealing with patients on a very intimate level and and protecting them. But to answer some of the questions about perspective, you know, when these growers are supplying stores, there used to be growers who didn't have any regulation and had their stuff go to the market regularly. And it was called black market. And it was in existence long before this program. So when we look at how we're deciding growers who are contributing to or selling to stores and stuff, perhaps we should whether or not they're the ones testing it, or the stores are the ones testing it, someone's got to test it because other than that, you know, why have a program, because I could for years before 1999, I was able to get untested weed all time use

it as medicine. Part of for patients, specifically patients who aren't caregivers, part of the reason you become a patient is to get off the black market, and to be able to say, oh my god, I'm treating myself with safe medicine. To me, there's just a minimum standard to separate a medical program from what was a really fairly functional black market back in the day. So if we're not going to, you know, ensure that medicines safe, why not just go back to the days of dealers, because, you know, I knew most of my dealers and could have conversations about where the came from and stuff so, um, you know, that's, that's something to consider when you're trying to defend, you know, having medicine go to the market and a large quantity without being tested. It's no different than a black market at that point. Thank you.

Erik: Thank you Trisha. And I just want to point out into the chat, Susan's having internet troubles and she has posted some comments and we'll make sure to put those into that the actual record in the transcript even though she wouldn't be able to verbally share those so I just want to make sure everybody has a chance to see those as well. Josh

Joshua: Yeah, so just a couple things. So Joel referring back to the like the app the weird hours that are listed in the Windham town ordinance again I think that falls into it like it's a pain in the ass I get that a pain in the butt sorry but at the end of the day that falls into the category of like, you know, ordinances always that weird stuff in them like you have to convince the town to change it or that the rule is nonsensical. You can't you can't make everybody happy. Although having you know just the one license for the town's definitely you know definitely an issue. But but looping back to the kind of entity structure and and alignment of classes or types within the medical program. Um, Catherine I was actually really interested to get your feedback on this since you do so much work with MMCM leading that organization do you know can you tell me offhand ballpark like what what a typical or an average number of employees for the members of your organization would be like three four somewhere in that range? Less more

Catherine: It’s really hard to say I don't have like the data printed out. We don't ask for their employee count. Many of our members are going to the store front model. But they're smaller. And I if I had to guess I would say probably around up to five employees.

Joshua: Okay.

Paul: Josh, to answer just answer your question here here in Waldo Knox and Penobscot counties is generally about one to five. If you're talking about ones that don't that don't have storefronts. Once you have a storefront that that number tends to go up but I just wanted to give you that information.

Joshua: Okay, perfect. So So I guess here's here's what I'm thinking guys. And going back to the conversation about how we might split up the license levels and then Catherine's point about whether that's actually you know, more trouble than it's worth. I didn't know if it might make sense to instead of thinking about breaking up the caregivers into multiple groups and and dispensaries, you know, kind of

staying by themselves, or even being split up themselves. The the medical program has had these two classifications for a long time right caregivers and dispensaries and it's coming it was based on what you were allowed to do. But over time that distinctions gotten more and more arbitrary. And so I'm just throwing out an idea. Would it make sense to, I understand this is a ton of work for OMP and municipalities, but would it make sense to basically reclassify all participants in the medical program into one of two new categories, and pick that dividing line, relatively high up the ladder in terms of size of operation. So to say that if you have, again, like you have a retail store, and an extraction or manufacturing capability, and grow, or if you have more than 12 employees or something, then you are in the upper tier and anything else, you're in the lower tier, just throwing this out as a notion. But if we again, instead of trying to chop up and create a bunch of small groups, that would create tons of little kind of gray areas at the edges, if you just had two larger groups, and you and you have the dividing line be relatively high. Because to Paul's points earlier, any any new proposed rules are going to include additional cost burdens. And if we're able to have those applied to a smaller group at the top, who are the operators who basically are incentivized to continue to try to continue growing basically, forever, at least for a while, then those are operations that can generally accept those costs. And people who are just operating a relatively small or even medium sized business, but plan to kind of stay at that scale, don't have to take any of that makes sense.

Erik: I think it makes sense. And I think I certainly want to hear what Michelle has to say and put a bow on it, make sure that we can talk about one of the three remaining items, but I think this might be something along the lines of, offline OMP talking to a number of people in the working group, see if there's any type of can get people kind of in this area, as opposed to this area, put some bullet points together and propose it to the group in our final meeting. Didn't really want to be in that place, and the final working group before the report back. But look, if there's value there, then that's probably the way we should go. But I'll just jump to Michelle to make sure that she can share your comments.

Michelle: Yeah, thanks. I just wanted to this is my little puppy, my new dog. Sorry. He’s cute though. I just want to circle back to testing for a second, I had a thought that I wanted to add that I felt was very important. I just wanted to put a pin in the idea of exempting donations, because in certain instances from testing requirements, that is I want to put a pin in that as an idea because particularly like for example, you know, Susan could speak to this as well. But when we have like peds questions, need lots of concentrate, for example, and we have like 15-20 different people who are willing to give, you know, one to 10 ml of product or something like that. And then you pull it all together, we always test. It's something that we do, because we choose to do it. But once it becomes like a legal requirement, if it's too burdensome, or you have to test every single one from every single source, you then have this thing – I don't want to ever be in the position of where some illegal Underground Railroad, you know, trying to help people because we're having to skirt requirements. I don't want to ever be in that position. And I can't be in that position, because I'm a licensed professional, and I would lose my you know everything. So, I'm just putting a pin in that that are can we think about certain instances like that that may be accepted? Thank you.

Erik: No, absolutely. And I think somebody in my office that actually brought up the idea about accepting donations for that exact scenario, because you're not the only one that's ever brought that up. And we certainly don't want to put you or anybody else in that position. That's why we're having this conversation. So, I got I got Trisha. And, Paul, if you both can keep it to 60 seconds, I'll make sure that we get your comments, so we don't have to circle back. But we can at least pick up one of these other combos. So, Trish, and then Paul.

Patricia: So just a cautionary tale and if you do exempt donations, I like that idea, but there would have to be some clarification on you know, possibly the size of the donation and or the the person is notified that it isn't tested. Because it's a cautionary tale. We were in a situation where a lot of medicine was being donated to addicts, and three weeks into receiving donations. The addicts get told this medicine got tested and it's got a a high amount of benzene and don't use it if you haven't used it yet. So, you know, telling a bunch of addicts in recovery, that the medicine that they've been given for three weeks is now tested bad, don't use it. Obviously, chances are it's obviously gone and it was gone and it was ingested and it was too late when they found out so I do agree that, you know, sometimes people all pull together to come in on behalf of somebody but on the other side of that there is also donating stuff that you don't want to market yourself. So there's got to be some it's just a cautionary tale. Thank you.

Erik: Thank you. Paul.

Paul: I just want to take this opportunity really quick to to read what Susan has a has said. So Susan Meehan caregiver representative has put in the chat. So for everyone watching. She says I would like to say that there is no big problem with Aspergillus, for example, molds and funguses are in our environment everywhere. There is no crisis of patients with exposure to microbes. Protecting full vertical integration to the market is imperative to protecting access to means program. Michigan is in a $200 million crisis from a change in testing processes from a PCR test to a plated testing plated will fail in Maine because many of these microbes live in the air, soil and water. I would like to protecting vertical integration, access to the market is critical to participation in Maine’s market in my opinion, number of employees as possible criteria five question mark 10 Question mark. Just because this program has no mandatory testing does not make it equivalent to the black market. In the medical there is no reports of fentanyl laced no reports of vitamin E and vapes, etc. This is not a black market operation. Disclosure of whether something has been tested and what isn't and tested and for what is important and perhaps should be mandated. Mandated tests are still a hard no for me. Michigan's $200 million issue right now. Test bottleneck in other states, Oregon, for example, um, have impacted patient access. So, I wanted to make sure Susan's comments were read, you know, to the, to the video and for people watching. I thought, you know, just to kind of wrap this up. You know, Dave, I understand, you know, where you're coming from when you're talking about trying to, you know, have mandatory testing for all caregivers in the medical program. Just like, you know, the adult use program. I think, you know, looking around, there's all, all all, looking around, there's a lot here who have an interest in the adult use

marketplace also. But I think the point is, is that if you're going to try to make the store, do the mandatory testing, is that you're still going to eliminate a lot of these small caregivers from being able to participate in the marketplace. And so that's something that we I think, you know, we want to avoid, I think both you and I want to make sure that small caregivers are still able to, you know, be in this marketplace and still being able to provide for storefronts, and for their patients. I thought Patricia made a really good point when she said about how you know, there was a black market, and there wasn't testing for the black market and that people could eventually go back to it, and that people will get to know their dealers. And that's one of my big concerns is that with some of these additional suggestions of regulations and testing, is that this can lead to people returning to the black market. I think it's really important to mention too, that when we're talking about pharmacies, there's a lot of idea that pharmaceutical medications are tested. But pharmacy comm poundings are not spot tested, and they're not sent to a lab to test when the pharmacist compounds them. There was a big issue with that down in Massachusetts, I think about a decade ago, when you had a compounding facility that was making, you know, compounds for injections that lead to a lot of issues. So even the pharmaceutical industry has a significant issue. And they may seem like they have mandatory testing, but they don't. I like the idea of looking at something like Josh said, from when we're talking about if you have like a storefront or a manufacturing facility, or extra more employees, that that could lead to a higher regulatory burden from the state. I would want to flesh out more details on that. But I think that could be a way to go. But I think that also would need to be incorporated with the idea of having a larger cultivation space, if you want it to fall into those regulations also, but not be defined as a dispensary. And so what I would suggest for the cultivation size tiers would be the largest here would be 2001 square feet of plant canopy or less. The next tier down would be 501 square feet of plant canopy or less. And then a third one could be a 30 plant canopy or less. Or then you can just do the traditional non registered family caregiver which I believe you take care of two or three patients each. But then if you if if you had a storefront, you would automatically fall into the category of additional regulations. If you had a manufacturing facility or were manufacturing products, you would fall into that category. And a another thing that has been brought up to me and I'm not saying that I support this but it has been brought up to me and I think I should mention this to this group is as a way to have additional oversight within the program is having the idea of a wholesale registration with the with the agency. I know on the caregiver application, there is a whole part that says do you wholesale or accept wholesale from other caregivers. But if there was a separate registration for that, maybe that could prioritize the staff time that the Office of Marijuana Policy is spending to make sure that the program is running smoothly, and the operators make compliance. Thank you.

David: Erik, can I just jump in for a quick second? Because let's…

Erik: Yeah, you can you can respond to that. We've, we've gone around the bend here. So, we'll just wrap it up. And then I can dive into the testing proposal, get some initial thoughts and talk about a jam packed with meeting. So, Dave, go for it.

David: No, no, listen, just for the record. To be clear, when I started this conversation, you know, the the main goal is always to make sure that we protect the small farmers in Maine. Right? So, for the blanket statement that you just said that I had made a point about is not true. Right? So, and you know that, and then to bring up the recreational market was also, you know, we know what you're doing. That said, I respect you, Paul, and you know that.

Paul: I respect you, Dave, I just think it's important for, you know, for transparency, that people know that there are people within this workgroup that are caregiver representatives, who also have interests or operators in the adult use field. And I just think that's an important, you know, we it's not mentioned a lot in our introductions. And I know that people again, have

Erik: Yes, just for the sake we you've had the floor for like the last 15 minutes. I just want to make sure Dave can get out what he said. And other people have a fair share to chat here. So

David: Yeah, and I just in so so in fairness, you know, I think I just said even earlier today, when Catherine made a point was like, let's make sure we keep these two programs separate, right. So, I'm very much in support of the caregiver program and to suggest otherwise, it's just not fair. That said, for those who have storefronts and product that's going out to the open market, I think it's very important that we protect the patient, and I'm not gonna back down from that. And I won't be bullied in this setting to make it like I'm saying something other than that, because for sure, I stand behind that. I feel that in the market, at store fronts products should be tested. I will not back down. Thank you very much, Erik.

Erik: Thank you, Dave. And since we're kind of blown this whole thing up, I'll go to Josh and Barry. And then I'd be happy to talk about the testing proposal.

Joshua: I'm so sorry. My hand was left up previously.

Barry: Okay, so yeah, I just wanted to respond. Paul brought up Susan's comment in the chat. Like I said, in my first meeting, my main point here is to be a source of reference. To help out with misinformation and, and correct things are floating around, I hear a lot of them calls. And no disrespect to Susan, I'm sure you're not doing this on purpose. But everything in that post is factually incorrect, regarding testing, and the appearance of between plating and PCR, and microbes being in the air, and I get, that's why I'm here is to correct things like that, and to provide that source. Because a lot of these things do go around. And I'm sure that this is going around out there. And Susan, I'm sure you read this somewhere. And that, you know, wherever they were presenting that information, I'm surely meant well, but it's just it's it's not accurate. Plating versus PCR and not is not what's causing an issue in Michigan. If anything, the plating is more accurate than PCR when you're looking for a large group of yeast and molds. That's why Michigan barred PCR testing for yeast and molds. We've experienced that personally in our own lab, we've done a back to back side by side comparison between the two methodologies. So, I just I just I'm just here again, I mean, no, no disrespect anyone on the panel, I just want to clear up

some things when when things are said that are not factually correct. This is, you know, microbes, yes, are in the air. But that goes for anything. When you do mold testing in your home. Yes, there's mold in the air. But when mold concentrates in place, it becomes worse for you it's it's not just the microbes in the air. It's when I reach a level of dangerous level when they concentrate on a particular substrate, whether it be your drywall in your walls or the product that you're adjusting. It's a it's about a growth level. So I can I can talk forever about this post. And that's why I didn't respond until Paul brought it up. But I just wanted to quickly point out that there are some factual misinformation here and that I'd be happy happy to go into call after this if we needed to, to go over this whole post in detail and talk about, you know, the issues around testing. I just I don't want to talk forever. It would take me literally 30-45 minutes to go through all the issues in this chat. And I don't want to take up the whole call doing that.

Paul McCarrie: Erik, can someone read just Susan's comment in the chat was I think that's appropriate to the testing.

Erik: Last comment?

Barry: You just read it. That's that's why I was responding.

Erik: Is that the one we're talking about one you already read?

Paul: No, it's the one that says pharma testing and criteria would make most of us cringe. And it is not lab lab comparable. When one has a phenol barbital blood plasma level done, it is not comparable lab to lab hospital hospital. People are surprised when their cannabinoid profile does does not compare lab to lab. This is normal results will vary lab to lab. I just want to make sure that Susan doesn't have reliable internet and can't do that, that her comments are being read out for the people who are watching us.

Erik: Yeah. I appreciate that. We were gonna put in the record, but people are watching the live link. And I know Barry just spoke to some of this but the lab comparability I mean, we do have data on the side on the AU side, that shows the variance on different panels is a very small margin. I don't want to step outside of my wheelhouse, Barry if you want to comment on that, or we can just move to the proposal. But is up? No, go for it, Barry.

Barry: Again, this is something that's gonna take up a lot of time. I don't know, how much time do you want to take up? Yes, there are variability from lab to lab. There's, you know, labs have to do several things to validate their methodology. You know, there's, I mentioned earlier call that we should be scrutinized, you know, more heavily than the caregivers. As far as how or how tight our methods are, how accurate and reproducible our own methods are in our in our laboratory. And that will, I think, eventually start bringing labs closer together, the more the higher level that we put restrictions and oversight, and, you know, proficiency testing round robin testing blind testing laboratories, I think you'll start to see that lab to lab variability start to decrease, because, you know, currently, you know, I come

from the clinical, are working the clinical market for a long time, and then in pharmaceuticals, well, under FDA regulation, and there is I can tell you that there's very little lab to lab variability allowed and anything that's regulated by the FDA. This market is new, there's not a whole lot of oversight. There's not a whole lot of, you know, restrictions and testing done to test out labs' precision and accuracy. So I, you know, again, I'm all for more oversight on the lab industry. And I would be happy to help and happy to be part of any any workgroup that's necessary to come up with tools to, you know, kind of move that that range closer from lab to lab.

Erik Gundersen Thank you. Michelle, I see your hands up.

Michelle: And I know we probably need to move on. But I just want to point out once again, that for me a larger concern, and I don't have like, very strong opinions of yes, we need to mandate testing, no, we don't need to mandate testing, I can kind of see both sides. On the other hand, I'm probably leaning more toward I'm a little bit frightened of what mandates could look like. Be, and I value testing very, very much. And I respect and value science and evidence. My bigger concern is again, do we have like industry wide standards about do we have enough evidence to say, these are the cut offs? And these are the concerns if you are smoking this or if you were using this as you know, if you were taking this as a tincture, and you're? And it also, you know, I'm not, I don't know a lot about toxicology, but I do know the dose makes the poison. So, it's like, are you taking two drops of a tincture? sublingually per day? Are you a cancer patient who's taking a full gram of you know, so these things matter. And if we try to, like make a one size fits all, requirement standard, without a lot of evidence to back it up, my real concern is that with the best of intentions, it could be done in a way that is not really based on good data that could negatively impact people who need to access something that now has become more expensive, less available. I'm not again, not making the point that we shouldn't do this or just that. I'd like to see it done in a very thoughtful way of what are the problems we're trying to avoid? What can happen if people ingest XYZ, what is the way that they're ingesting it? You know what I mean? Like all of these things, because because otherwise it's just we're just doing something to say we did it and that doesn't help anybody.

Erik: Right. I mean, good points, and again, in line with both OMP's mission statement and the vision of this group, I think it behooves us again, to protect patient and public health in general. A lot of this work has been done up front. I, if I pulled every single caregiver and dispensary representative on this call, they're all going to say the test. But as soon as we talk about some type of required testing, it becomes a different conversation. So that's where we're trying to find that fine line between testing for those those certain analyte types that we know exist and we see exist, that would have the largest long term or short term public health effects. I mean, this is medicine. And we're selling in a commercial way. We want to make sure we protect against those things. And I guess that dives right into the testing proposal, which we'll go into, and obviously, who's the potential registrant that's affected? That's a TBD. I think that's gonna come with conversations that we have in between this meeting. And next meeting,

we can definitely, we're gonna have to push some of this stuff into our six meeting, because of this conversation, but I didn't want to cut it off, because I thought it was good. But I mean, thank you.

Michelle: Oh, I'm so sorry, Erik. I'm just piggybacking on your comment. To me, it's more like a supplement. You know, maybe we're splitting hairs. But like, supplements are not regulated in the same way. Supplements are kind of a buyer beware market. And I might say, well, this supplement is very important to me, I take it every single day. And I take pretty high doses. So, I'm going to get one that's GMP certified, that I know, you know, but it's not the same thing as buying a pharmaceutical. And just again, that's just, you know, to me, that's an important distinction.

Paul: Erik, I really want to talk about this this document a lot. But I have a pretty hard stop at four, I can try to stretch for like another like, you know, five, maybe 10 minutes. But I, I just you know, I was started, I started to do some numbers and looking up some other stuff. So, I just want to make sure that you know, there's enough time to have a good discussion about the idea of testing.

Erik: If people can run 5-10 minutes over, I would like to at least get it out. And we can do a conversation, we can do follow up calls in the same way that we've done the last ones where we videotape it and have that feedback. We're also happy to take email feedback, which we can put into the record and put on online. So, we can do it a number of different ways. And we still have a lot of conversations for well, what was supposed to happen today. And in our sixth meeting. Our fifth meeting, excuse me, but again, what's tested final form testing. So, before it goes to the patient, different than what's an AU upon transfer. So, I think that streamlines it there. Again, I towards protecting public health and keeping costs down. And then limited panels for the different types of products. So, you're limited panels, or there's written for flower concentrates and edibles with, rolling over time. And then all of those panels that are required on adult use, would be tested through the OMP auditing. So that would help hopefully with cost, but also be able to catch those other important analytes that we would be testing for. But you folks can read this, if I'm hoping some of you had the chance to review it earlier on. I think it just formalizes it, put it into writing to kind of what we talked about at the last meeting. I think the biggest question mark would be again, who would be required to do it? Or if this this group, has the majority are full consensus that you know what? I don't think we would get there. But mandatory testing are required testing, no matter how limited the panels are. I mean, any type of feedback would be helpful. And Paul, since you got to go if you want to throw any type of feedback, happy to take it.

Paul: Yeah, I mean, I guess I'm just I don't know if Barry could help answer this question, but what would be what would what what's the cost for mold and mildew screening, because I have I have this that I was pulling off of. So, I'm trying to I just didn't see mold or mildew on there. As what the cost of the test would be?

Barry: It should be in the column, it's microbials. You'll see it broken down at the end panel. And then there's they're broken down individually a yeast and mold panels, I believe is $30.

Paul: Okay, so So the so the idea with like, harmful microbials to be rolled in 2022 and mold and mildew. It would be like $150 for the whole the whole run. Correct? Yeah. Okay. Um, yeah. Yeah. I mean, I, I'm, I'm really curious to hear what other people you know, have to say about this. Um, you know, I know that Susan has a lot a lot to say about this, Erik. So, I know we don't want to try to punt this till the next meeting. But I feel like, you know, it's for, you know, almost five after for right now. Um, and I could I could get into this, but I'd rather I'd rather save it so we could have I could hear feedback from people because I know I want to hear you know what, what Dave's experience has been with, with testing and other people's and then just how you know how we can we could engauge it in a realistic manner for people who are current operators.

Erik: Josh.

Joshua: Yeah. So, I think that this is a pretty good starting point for this conversation. I think that just a note right off the top is I think we need to change the schedule, to 2023 and 2024 instead of 2022 and 2023, because we're a day or two away from December of 2021. And the whole purpose of breaking this out over a couple of years is so that people who are facing a new requirement can diffuse those costs over a couple years, and it's not hitting them all at once. So, I think that'd be an important thing to do. Obviously, we got to figure out who this applies to. And then I think, you know, even though there's also more to figure out on the audit side, I want to, I guess, I want to commend the department for being willing to take that step, because that's a bunch of work. And it's something that I think, should make it easier for more current operators, to, you know, be able to make this work or to stomach this, if the department is splitting part of that burden. It's a good faith effort. So, I just, yeah.

Erik: Appreciate that. Thank you. I'm being respectful, everybody's time it is 402. So I guess we could take a, we can wrap this up. We can take email feedback on the testing proposal, which I can then share with the group. We can also bring it up at our next meeting and talk about it see if we can't get any path forward. But we also have, to Paul's point, there are topics that are going to have to do with the regulations that also need or the rule that need to be discussed. So, we'll have an action packed, fifth meeting. And we also need time to talk about what the work product is going to look like, and what will be in that. So, we might be able to make that work in the fifth meeting, or we might have to do it via email exchange. But we'll talk about a way to make it work for the entire group, a way that everybody's happy with that and products in the way that it's given to the legislature at that point. Does anybody have anything that they want to share, before we close this meeting, understanding the next meeting will be testing proposal and some of these lingering issues that we need to get to at least have the conversation on the record. We could report back any types of findings, even if they don't come with any type of consensus. Dave

David: Just real quickly, I think it's, as we tackle all these topics, I do think it's very important that we start fresh, like there is no and again, you know, kind of going circling back to a comment made earlier,

that we're not starting from the AU side of things, right? We're starting from a side of a group of panelists who are, you know, in this workgroup to try to move the medical marijuana program forward. And so, I think it's just really important as we do this, you know, to make sure that we're thinking about it from that standpoint, how it affects everybody. And at the end of the day, how it affects the patients. And so, I just want to make sure that that's on the record that this really needs to be driven from that perspective, and not from the other side. Thank you.

Erik: And then

Michelle: May I ask a question?

Erik: Yeah, fire away.

Michelle: Sorry. Um, when you said testing proposal, did you mean that it's going to be a fleshed out a little bit in an email, for example, here are the things that we may be requiring for testing here are the people that it would apply to here is an approximate cost, like those types of details or not that granular?

Erik: Well, you should have that. So, the testing proposal, or you can't see it's fuzzed. out, we sent around, and it's also can be read in tandem with what Barry and his group have sent around as far as costs are concerned.

Michelle: Okay, I'm so sorry, my son has been having like 200 seizures a day. It's been a nightmare. So, and we were just in the hospital last week. So, I'm not caught up with that. Thank you.

Erik: Totally understandable, it's there. And we can send it to you again to make sure that it's top of your inbox. So, before we wrap up this meeting, obviously, this was a much more free flowing meeting. I thought it was a lot of good conversation and a lot for us to consider, review, go back with and find structure for our next meeting. Does anybody have any topics that they want to make sure that we can get you in our fifth meeting? I think it's next week or two weeks. Next week. Two weeks, Catherine? Mute, you are on mute.

Catherine: Damn mute button. I'm getting calls from some caregivers with concerns about the online application process not functioning as intended. And so I don't know if there's anything that we can bring attention to meaning like they fill out their application, they have to send in their background check fee separately, then they send in a different check for the, the designation of whatever level they're picking. And like the background check fee is not being attached to the proper caregiver or employee. We ourselves here at this office had an issue as well as other people coming in calling about it. So slightly different concern.

Erik: Yeah, it just sounds like the new process and the step by step process the new processes on the website, and we we attached the two different payments to make sure that we're not collecting money for people that end up getting rejected and having no mechanism to refund. So same. I'm happy to talk to you about it offline. But we do have the step by step instructions of how to go through that process. It was meant to make it easier for people and…

Catherine: You know, it's unfortunately, it's not because it's like checks are getting lost and are attached to the wrong people

Erik: …are harder. But have you talked to the lic – we can have this conversation offline.

Paul: One, just it's one of the things is, you know, any anything that that your office can substantially provide and where you plan to go with with for with the rules, because I feel like that would give us the best ability to give you feedback of whether you're on the right track or whether we feel like there's going to be a significant issue. Because ideally, I would love for us to all hold my hands, hold hands, sing Kumbaya, and tell the veteran Legal Affairs Committee that we're ready to move forward with an improved program.

Erik: Yeah. And we had planned to do that. Obviously, we didn't have the chance to talk about a lot of sections of what a potential rule may look like. But I think high level we can have some type of document prepared for us to go over understanding that still yet, but I think we can definitely have that. Good. Alright, well, great. Thank you, everybody, a good conversation and you should see communications from us in the coming days.

Michelle: Thank you all. Thank you, Erik, for running a great meeting. Thank you. Bye, everybody.