



**Medical Marijuana Authorization Practice Guidelines Workgroup
Meeting Minutes
January 25, 2016**

On Monday, January 25, 2016, the Washington State Department of Health's Medical Marijuana Authorization Practice Guidelines Workgroup met at 310 Israel Rd SE, Olympia, Washington. Public notice was provided to individuals requesting notification of meetings related to medical marijuana.

Workgroup Members

Chad Aschtgen, ND, Board of Naturopathy
Juan Acosta, DO, Board of Osteopathic Medicine and Surgery
Louise Kaplan, PhD, ARNP, Nursing Care Quality Commission
William Gotthold, MD, Medical Quality Assurance Commission

Department of Health Staff

Chris Baumgartner, Drug Systems Director, Health Systems Quality Assurance
Brett Cain, Program Manager, Board of Osteopathic Medicine and Surgery
Michael Ellsworth, JD, MPA, Supervising Staff Attorney, Office of Legal Services, Health Systems Quality Assurance
Susan Gragg, Program Manager, Board of Naturopathy
Garr Nielson, Investigator, Nursing Care Quality Assurance Commission
Susan Reynolds, Medical Marijuana Program Operations Manager
Michelle Teed, JD, Director of Legal Services, Medical Quality Assurance Commission
Cathie Tedrick, Medical Marijuana Program Coordinator
Kristi Weeks, JD, Office of the Secretary

Guests

Brian Roberts & Karin Couture, HempZen
Michelle Herman, Sarah Rorick & Carine Stearman, UW Nursing
Rhonda Knight, TVC
Laura Katers, PA-C, WAPA
Jessie Tonani & Kersten Beyer, Verd2Bio
John Kingsbury
Calum Hughes, Green Hygienies Tech
Neomosha Nelson, South Sound P/P
Ezra Eickmeyer, E&A Strategic Consulting

OPEN SESSION – 8:32 a.m.

I. INTRODUCTION

Facilitator Mike Ellsworth introduced the workgroup members and noted the people who signed up to give testimony during the open microphone portion of the meeting. He outlined his goals for the meeting including:

- Learn about what kind of healthcare continuing education (CE) programs related to medical marijuana (MMJ) are currently available.
- Have the workgroup share input in a collaborative manner to begin discussion about continuing education based on the MMJ practice guidelines.
- Give the audience a chance to participate during the time allotted for the open microphone.

Mr. Ellsworth informed the audience that if they want to provide input to the workgroup, they can testify, send emails, or write letters.

Workgroup members introduced themselves to the audience and stated their role on the workgroup.

II. PRESENTATION ON SSB 5052 AND POLITICAL LANDSCAPE – KRISTI WEEKS

Ms. Weeks gave a brief history of marijuana in Washington state from 1998 to current, including I-502, 2SSB 5052 and HB 2136. Ms. Weeks reminded the workgroup while thinking about the CE based on the MMJ practice guidelines to consider the laws: qualifying conditions, how many plants to authorize, etc. A lot of the changes affect the way MMJ is authorized. The department gets a lot of questions about how the authorizing process works. The legislature is trying to ensure patients have terminal or debilitating conditions. MMJ practice guidelines helped clarify standards to licensees and legislators recognize this work. Practitioners who authorize need to take a more in-depth involvement in the care of the MMJ patients.

Q: What happens if there are bad outcomes, side-effects, lawsuit issue?

A: Possibility of specialty clinics – report to Governor. Contraindication with medications is possible. There are some liability issues.

Q: Can you talk about the Authorization Form?

A: DOH was required to develop a new form by July 24, 2015. Old authorizations are still good until July 1, 2016. There are about 200 stores currently licensed. Capped at 556 by Liquor and Cannabis Board. Want to make sure there are enough licensed stores by July 1 to supply MMJ patients.

Q: Is there a cost savings? What is the difference?

A: Excise tax and sales tax - Patients won't have to pay sales tax, but will have to pay excise tax. Prices are coming down to align with recreational marijuana market.

Q: Laws are always evolving, if the CEs are approved by the workgroup, what will the legislature do about this?

A: There aren't any comprehensive bills this year. The LCB might propose changes to the number of stores.

III. PRESENTATION ON CONTINUING EDUCATION DEVELOPED BY THE ANSWER PAGE.COM ABOUT MEDICAL MARIJUANA – STEPHEN CORN, MD

Dr. Corn is the ASA Physician of the Year. He gave a presentation on The Answer Page MMJ continuing education which is used in Massachusetts, Florida, and New York. Proposed creating a Washington specific CE similar to the New York CE course.

Questions asked by workgroup:

Q: How do you determine the level and quality of the references?

A: We are extremely critical of the existing literature and look at what level materials are – moderate, strong, anecdotal. We are reserved in making recommendations.

Q: You do make a point for the clinical use, but how accurate is the rest of the research evidence?

A: We would provide a list of the authors and how we rate them.

Q: Does your course emphasize pieces of the problem, like what the healthcare practitioners (HP) should be authorizing the MMJ use for and how to “take” the medicine?

A: Florida wanted us to include legal aspects. We can easily incorporate your guidelines in the course - it is very relevant. [Showed an example - New York smoking issue.]

Q: The AnswerPage is a very static model; do you ever create interactive webinars that can be viewed at different dates?

A: We are able to update the webpage at any time. Florida asked for video format, but it is difficult to update it. We can do live events around the world.

Q: Is there a mechanism in your course that you can get updates after you have gotten your CE or do you have to sign up again?

A: Yes. The Medical Library holds several topics related to MMJ in the syllabus. As a subscriber, anytime there is an update there will be no additional charge. Physicians get an alert when new topics are available. [Showed the content that is free]. New York for example has 3 syllabus topics. Anytime there is an update, there are no additional charge, and anyone registered will get an email about updates for the course. Limited to 1 year, then they must re-subscribe. We try to make it as friendly as possible - MY CE section shows what you have completed and you can print the certificate of completion.

Q: How many hours are required for New York?

A: Four hours CE credit on MMJ. They can take the core course and then all the disease courses.

Q: Washington is creating a new category called a MMJ Consultant Certificate (MMJCC), I have failed to find evidence-based guidelines on how to select a strain for a specific health problem and dosing instructions. I worry about all the websites that direct patients to do various things.

A: On our website we have no guidelines that are evidence-based on dosing - suggest you start slow with a low dose. We don't make any recommendations on dosing, because we don't have evidence to support it. We reject most of the literature for not being good.

Q: Can you talk about the use of international research? Do you use hypotheticals or what type of information about interacting with patients?

A: Yes we do use international research. Look at our team – international selection of researchers and clinicians. Focused on mixed recreational studies, not a lot of patient scenarios in the literature. Cannabinoid-hyper animus syndrome-vomiting issue, metabolic disturbances - a lot of people come to the ER with this condition. We included a clinical scenario with that information.

Q: Is there a section on how to wean patient off MMJ when treatment is over?

A: Cannabis abuse disorder is addressed in that section. We also have a search function that you can search for specific topics. We also have a daily newsletter to let you know if there is new content relevant to your work.

Q: What is the requirement in NY?

A: Guideline is 4 hour; but they offer more.

IV. PRESENTATION ON CONTINUING EDUCATION DEVELOPED BY THE UNIVERSITY OF WASHINGTON ABOUT MEDICAL MARIJUANA – SHARON GARRETT, MPH, MA

Other Presenters:

Nancy Sutherland, MLE, Associate Director of ADAI

Bia Carlini, PhD, MPH

Megan Brunner, MLIS

Discussed the establishment of the interdisciplinary research center in 1973 with NIH Grant funding. They also received a Gates Foundation conference grant, I-171 (liquor taxes) funds alcohol and drug research and dissemination and then most recently the I-502 (MJ taxes).

Focus:

- SUD treatment disorders
- Opioid overdose prevention
- Tribal based prevention
- Epidemiology on SUD

Use best practice for creating training. [Presents training website]. Training includes transcript and tools for hearing and vision impaired. Interactive –user directed, research based, review, test, toolkit, go to module 2. Has a decision tree. Dosing. Videos. Case study. Now expanding our focus on this and CE training:

- Stop overdose .org
- Healing of the Canoe project
- Toolkits aimed at different audiences
- Medicinal Cannabis and Chronic Pain Project

How they work:

- Learn who the target audience is and then make content specific for the audience.
- Find the most responsible information and maintain a content experts list on the website. Reached out of the country on pharmacological research with resources rated on content, accuracy, credibility and presentation. Not many of them met all the criteria. However, lack of research in the U.S. does not equal lack of research evidence:
 - Emotional issue – A lot of one sided information
 - Autism – Science
 - Research papers discuss endocannabinoid system and autism
 - How our systems respond internally
 - MAMMA – organization for parents of autistic patients.
 - Chronic Pain Project

- Used RedCAP to do a healthcare provider survey and recruited various organizations to disperse the survey. 30 of the 39 counties were represented.

Proposal:

- One year process, apply what we have already learned.

Questions asked by workgroup:

Q: You said lack of evidence is not the same as no research. What method did you use to make this determination?

A: Consulted with professional researchers about research and clinical reviews. There is a lack of randomized trials on pain management, there is no controlled research. Used medication that is more controlled synthetic MJ - outside the U.S. We talk about the limitations that are in the reviews used in the training.

Q: You said the expectation is that you can come up with training modules within a year on more related topics. Can you discuss in more detail about the lack of real evidence? Over time there may be some access to useful information as doctors keep records on authorizing MMJ to their patients. Is there a way to rapidly adapt the modules over time as information becomes available?

A: We are not advocating for MMJ, we can bring what is available and follow what the law allows. We have the ability to update. We are capable of looking at both sides of the topic. Substance abuse and monitoring is part of our project. We do monitor for bias and try to make things as neutral as possible.

Q: What has been the feedback from people who have completed the CE?

A: We don't really get feedback regularly, but when we do it is good. People find it to be a useful training.

Q: Still many HPs are not comfortable writing authorizations. I am curious about which groups you surveyed?

A: It was an anonymous survey, so we don't know who they all were by profession. However, the survey respondents identified themselves as advanced registered nurse practitioners, licensed

practical nurses, medical doctors, naturopath doctors, osteopathic doctors, physician assistants, pharmacists, and registered nurses.

Q: There are no evidence-based dosing studies. How do you anticipate handling the Washington MMJCC to help select products without evidence based guidelines?

A: Make the best possible choices with the knowledge that is available. There are no instructions like other medications. Voters decided they wanted this, so we are trying to do the best possible responsible practices. It would be great if the information the HPs are getting is the same as the MMJCCs.

Q: What process did you use to ensure quality and level of evidence in your two modules? How did you make your decision in what was included and was excluded?

A: Selected quality papers where studies and research from other countries that do research on MMJ. Limitations are clearly in the slides when research is listed.

Q: Do you anticipate discussing that there isn't really hard evidence.

A: We will be updating as things change – it will impact the budget.

Q: Do you think there is a perceived biased?

A: There may be a perception that we are more conservative. Try to give balanced training.

V. LUNCH

VI. OPEN MICROPHONE – 12:17 p.m. – 12:47 p.m.

Public presentations from interested stakeholders to the workgroup:

Katy Baker, ND

Dr. Baker discussed how she offers the authorizations. She has a flat office fee regardless of time spent with patients.

Brian Roberts, Massage Therapist

Getting past the stigma of marijuana and have been using topical oils for skin cancer with good results. Inspired by the people who shared their stories. Science and trying to nail these things down with this plant. Every crop is different. Revolutionary stuff, keep an open mind.

Jessica Tonani, VerdaBio

Goal is to do clinical research on MJ. Emphasize the need for research. I-502 is great if you want to get high, but it is impossible to do research. Discussed research bill (6177) - Baylor, Argon national labs, study of cannabis purchased in Washington. Get away from the strain names, we look at a sample and the quality is lower than dog food. Any research you see on a strain name I would highly question. Please look at the effect on medical professionals and what they are allowed to do.

Q: Will any research ever overcome the Federal Schedule I classification?

A: Working with UW and looking at Oregon State, we can't get around the schedule 1 as a state.

John Kingsbury

MMJ patient. Improved quality of life a lot. I'd like you to consider it. History of surgeries, drug therapy, anti-depressants. My doctor hinted about MMJ, but he wouldn't authorize it because of his DEA license. Neurologist suggested he try MMJ. "It may not work at first, you'll have to talk to other people, try things, trial and error". My narcotics went down to about 1/6 of what I used to take and what was a normal dose. Look at it from quality of life. Highly personal, but practitioners should be aware of the different properties of types – Sativas, Indicas. Very inexact, testing doesn't mean much since there is a lot of testing fraud. It has greatly enhanced the quality of my life. This could be a great thing if we make this scientific.

Ezra Eickmeyer

Six years ago I didn't believe in MMJ. I started meeting people providing MMJ and those taking it. I have helped people get the medicine they need. The difference between having studies and having evidence. Off-label use of pharmaceuticals. Use that flexibility in the guidelines for MMJ as well. I think a lot of the abuses have been cleaned up in the new law. I understand why many practitioners are not comfortable with authorizing. Producers and the industry itself need to understand that inhalation of medicine is not a standard use. I believe we will be moving toward pills and away from joints - oil extract pills that are standardized and dispensed and monitored. Keep the door open, maintain the flexibility they need to authorize. Opiates and chronic pain are serious problem. MMJ has no lethal overdose, unlike opioids. Maybe it should be the first line of defense, instead of a last resort. Would be helpful to let the HPs know that it is okay if they're not rubber-stamping authorizations.

VII. WORKGROUP DISCUSSION ON DEVELOPMENT OF CONTINUING MEDICAL

- Workgroup members were provided a handout of the adopted MMJ practice guidelines to use as a starting point.
- General discussion on what 2SSB 5052, Section 38, requires the boards and commissions develop and approve CE related to the use of MJ for medical purposes that are based on the MMJ practice guidelines.
- General discussion about pros and cons of different options to develop and approve CE; options included:
 - Contract with third party vendor to develop a CE that satisfies state law and MMJ practice guidelines;
 - Develop and approve a summary of the relevant state laws and the MMJ practice guidelines for practitioners and then HP completes third party CE on MMJ to satisfy section 6 of MMJ practice guidelines;
 - Boards and commission develop criteria and then individually approve CE; and
 - Health care associations collaborate to develop CE and then boards and commissions approve.
- Workgroup agreed on next step of identifying gaps between the CEs presented and the MMJ practice guidelines. Gather more information on costs to create CE.

VIII. CLOSING – 3:00 p.m.