Therapeutic Cannabis Medical Oversight Board
February 3, 2021, Remote Meeting (Zoom)
Meeting Minutes

Members Present: Heather Brown, Corey Burchman, Jerry Knirk (Chair), Jill MacGregor, Richard Morse, Molly Rossignol, Seddon Savage, Lisa Withrow

Members Absent: Jonathan Ballard, Virginia Brack, Cornel Stanciu

DHHS Staff: Michael Holt, DPHS Program Administrator

Meeting commenced at 5:35 pm

Minutes

Review and approval of minutes from 1/6/21 meeting were not conducted.

SB 29 Discussion

SB 29, relative to the health risks associated with dispensing high-concentration marijuana in alternative treatment centers.

Chair introduces Senator Guida, prime sponsor of SB29, to present his bill.

Sen. Guida

- Has supported therapeutic cannabis, including patient access and ATC expansion.
- Does not need the Board to vote on this until their March meeting; will provide proposed amendment language to the Board, via Holt, as soon as possible.
- Introduced this bill due to the former US Surgeon General's report. Report expresses concerns about use, particularly use of high potency cannabis by youth; describes harm of high-potency cannabis use for people under age 26. Such use has been expressly stated as hazardous.
- Wants the certifying provider to be required to sign a statement that the use of cannabis products with a potency greater than 10% by a person under the age of 21 is indicated or necessary.
- This 10% number should be considered a "threshold," not a "potency limit."
- Does not believe this step for providers will deter a provider from certifying a patient.
- Indicates that his amendment language will remove DHHS/TCP from an clinical evaluative role, except to require that a form be developed or updated for this purpose

Discussion

- Concern that additional process and requirement to put in writing will deter providers from indicating that a higher amount is permitted. Any proposed standard should not be "medically necessary."
- Consider impact on patients and families. They may go to the black/gray market in order to get higher potency cannabis if their provider chooses not to indicate in writing that a higher potency is permitted.

- Noted that CDC opioid guidelines, requesting a consultation at 100mg, have had a chilling effect on opioid prescribing. Some providers refuse to do this. This example too is "threshold," not a hard stop.
- Is it necessary to create a new form to do this, or could providers provide the information in their notes or in other ways?
- Noted the law already requires that 2 providers (one of whom must be a pediatrician) issue certifications for people under age 18.
- Instead of protecting this under-21 population, this will cause unintended consequences
- Cannabis certification is not a prescription, so why the need to build in clinical requirements as if this were a prescription?
- Pharma perspective: *Dose* is what's important, not *concentration*. People will use less of higher concentrations and more of lower concentrations to titrate desired effect. Without more evidence, any threshold is arbitrary.
    - Disagreement: Higher concentrations more rapidly cross blood-brain barrier and have more rapid onset of effects, associated with psychosis, reward/addiction, and other challenges.
- Business perspective (Prime ATC and Sanctuary ATC representatives provided comment)
    - Total active ingredient can be grown in less cultivation space if higher potency. Costs more to make lower concentration flower.
    - Higher concentration is less expensive for patients, dose for dose.
    - Currently business is focused on higher concentrations, would have to reformulate many products.
    - Currently one ATC has 40% of products under 10% potency, 60% of products above 10%. Most of the products over 10% are inhalable (flower and concentrates), which is a common route of administration for high speed of onset for fast-acting symptom relief.
    - Very few patients fall into the targeted age group; and many of those patients have serious conditions, generally not just chronic pain.
    - Most CBD-rich products ("low-THC" products) at ratios of 1/1, 2/1, 3/1 CBD:THC currently have higher than 10% THC, and all would need reformulation.
    - Providers are already able to put restrictions on a patient's use, through administrative process that limits an ATC's ability to dispense certain products.
- New Futures (advocacy) perspective:
    - New Futures is monitoring the issue.
    - Reports from Colorado are finding that the 18-20 age group switching to medical program because medical cannabis is not taxed (less expensive) and higher potency is available.
    - It is important that providers provide education
- Primary care and addiction medicine perspective:
    - Appreciate concern with adolescents and cannabis use.
    - How much education about cannabis do certifying providers have? Enough to sign in favor of permitting a higher potency?
    - There doesn't seem to be enough cannabis knowledge for this.

    - If clinicians are required to cross a threshold and approve a higher concentration, they would likely say no.
    - Potential for patients to seek illicit sources is real.
- TCMOB needs to do a deep dive into concentration and harm.
    - Literature is evolving.
    - Cannot say that the concentration doesn't make a difference.
    - Speed of onset and speed of crossing the blood brain barrier are important factors
- TCMOB is between a rock and hard place in terms of this bill.
    - Yes, higher concentrations are a concern.
    - But a threshold will have a chilling effect on those who need it.
- TCMOB struggles with challenge of cannabis as a "medication" vs. cannabis as a "therapy"
    - Is it appropriate to impose medical concepts and standards on what is not an approved medication?
    - Board is not always consistent in its approach.
    - One member offers: if we are calling it "therapeutic" then it is effectively "medicine"

Action
Chair directs Brown, Burchman, Savage, and Withrow to form working group to review the issues discussed related to potency threshold in NH, both clinically and in terms of practical impact, and report back to the Board at its March meeting with information and a recommendation for action. Savage says her workgroup participation will be a literature review only.

Other Legislation
HB 163, relative to cannabis use during pregnancy.
Knirk introduced the bill discussion:

- Bill is a carry-over from the 2020 session (passage was halted due to COVID)
- Board recommended support of the bill last year
- This year's bill adds similar requirements relative to adolescents.
- For both populations, the bill identifies the specific risks to be counseled on and to appear in informational brochures/posters.
    - Knirk asked if the risks should be codified in statute or if the responsibility for identifying (potentially changing) risks should be left to the Board.
    - All agreed that the list should be the purview of the Board.

Discussion
"Counseling" requirement

- Legislation should clarify that the counseling requirement be conducted by the certifying provider.

- Concern raised that requiring certifiers to document that they have counseled women of child-bearing age and individuals under age 25 would be a burden.
    - Suggestion that this counseling should come from the ATCs
    - Greater concern that providing clinical health risks are not the purview of the ATCs, as they are not clinical facilities.
- This may be complicated, regarding pregnancy, for those under age 18, where a parent must be present.
- Department noted that the Written Certification could be easily amended to add documentation of these counseling requirements.
    - Could sub boxes be required for documenting counseling to women of child bearing age and for individuals under age 25?

"Information dissemination" requirement

- It was agreed that everyone should get this information as cannabis might find its way to others in the household.
- Noted that DHHS sends brochures to every patient with their cannabis registry ID card regarding cannabis use in pregnancy, keeping children safe, and accidental poisonings, but no information is provided about risks of adolescent use.
- Noted that medications and potentially harmful substances usually have warnings on them (eg, alcohol and nicotine).
- After discussion it was agreed:
    - Adolescent information should be mailed by the state with cards
    - All information (adolescent, pregnancy, keeping children safe, etc.) should be available at ATCs.
    - Posters on pregnancy and adolescents should be visible in the ATCs as public health notices
        - These should be "informational" posters and not "warning" posters;
        - Board recommends that bill be amended appropriately
    - Suggested DHHS add language on the Written Certification, to the current "counseling box-risk box" saying something like: "including information on pregnancy and adolescent/child use as appropriate"

No vote taken on recommendations to clarify the bill, that certifying providers provide the counseling, and that the posters be "informational" and not "warning" posters.

HB 89, adding qualifying medical conditions to the therapeutic use of cannabis law (insomnia).

- Knirk introduced the bill discussion
- Bill is a carry-over from the 2020 session (passage was halted due to COVID)
- Board recommended support of the bill last year
- Asked if the Board would support adding Autism Spectrum Disorder (ASD) to this bill, as both conditions were recommended by the Board but only insomnia was picked up in this legislation.
- All agreed that Knirk could testify on the Board's findings related to insomnia.

- All agreed that Knirk could testify on the Board's findings related to ASD and could request an amendment that adds ASD to HB 89.
    - Motion: Savage; Second: Withrow. Vote: 7-0 (one abstention).

HB 240, relative to identification of cannabis strain for therapeutic cannabis.

- Bill would permit expanded use of chemovar names (ie, commercial strain names) instead of current TCP requirement to not use these names in a public manner. ATCs are currently using undescriptive letters, numbers, and abbreviations.
- Noted that some chemovar names (Amnesia Haze, Maui Wowie, Blue Haze, etc) are:
    - Evocative of partying and getting high and undermine the identity of dispensaries as therapeutic enterprises.
    - Attractive to adolescents
- It was noted by board and the public that chemovar names are helpful because they:
    - Are easier to remember by patients and providers
    - Are consistent strain names from state to state so are helpful when patients relocate
    - Reduce time of providers, dispensaries, patients in trying to identify what a patient has been dispensed.
    - Easier for providers to document.
    - Dispensaries spend a lot of time converting between the chemovar and the abbreviated names
    - The bill permits dispensaries to use the chemovar names on the website, but not on social media sites.
- Board recommends support of this bill to the Legislature:
    - Motion: Brown; Second: Withrow. Vote: 5-2 (2 abstentions).

Alternate Chairperson

- Brown expressed interest in maintaining role as Alternate Chairperson for 2021.
- There were no objections; and no other nominations
- Board agrees with continuation of position. Motion, second, and vote were not recorded for this decision

2021 Meeting Schedule

- Knirk reported Holt's survey findings on alternate days/time for the Board to meet.
- There was no other day/time identified that was common to all members.
- Choosing a different date/time, while allowing certain members to participate more fully, would result in other currently participating members to not be available to meet.
- Suggested the Board revisit schedules later in the year.

Meeting adjourned after 7:30. Exact time not recorded.