ILLINOIS DEPARTMENT OF PUBLIC HEALTH

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In Re the Matter of: :
Public hearing to review :
petitions requesting the :
addition of debilitating :
conditions to the :
medical cannabis :
registry program. :
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ADVISORY BOARD MEETING
Countryside, Illinois
Wednesday, October 7, 2015
9:13 a.m.

Reported By: Paula Quetsch, CSR

Report of Proceedings held at the location of:

HOLIDAY INN
6201 Joliet Road
Countryside, Illinois 60525
(708) 354-4200

Pursuant to notice, before Paula Quetsch, CSR, and Notary Public in and for the State of Illinois.

A P P E A R A N C E S

PRESENT:
LESLIE MENDOZA TEMPLE, Chairperson
MICHAEL FINE, Vice Chairman
JAMES CHAMPION, Member
ERIC CHRISTOFF, Member
JACQUELINE LESKOVEC, Member
DAVID MC CURDY, Member
THERESA MILLER, Member
JYOTIN PARIKH, Member
NESTOR RAMIREZ, Member
ALLISON WEATHERS, Member

ALSO PRESENT:
CONNY MOODY
MALLORY SINNER

C O N T E N T S

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P R O C E E D I N G S

CHAIRPERSON MENDOZA TEMPLE: I'd like to call this meeting to order for the Illinois Department of Public Health's public hearing to review petitions requesting the addition of debilitating conditions to the medical cannabis registry program.

So with that in mind, we open this meeting and we'll start with introductions. Why don't we start with and just go down the table with Conny.

MS. MOODY: And I'd also like to introduce today our -- I'd also like to introduce our court reporter Paula today. So I would ask everyone on our Board and our speakers to speak very clearly and slowly, and our speakers later, we'll ask them to introduce themselves and spell their name.

My name is Conny Moody, and I'm the deputy director for the Illinois Department of Public Health Office of Health Promotion.

MEMBER LESKOVEC: Jacqueline Leskovec. I'm here to represent the Board as a registered nurse, as well as an information specialist.

MEMBER WEATHERS: Allison Weathers. I am an academic general neurologist from Rush University Medical Center in Chicago.

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VICE CHAIRMAN FINE: Michael Fine, F-i-n-e, and I am a patient advocate.

CHAIRPERSON MENDOZA TEMPLE: Leslie Mendoza Temple, MD. I'm a board-certified family physician and a clinical assistant professor of family medicine at the University of Chicago Pritzker School of Medicine and medical director of the Integrative Medicine program at the NorthShore University Health System, and I'm the chairperson of this Board.

MEMBER MILLER: Theresa Miller and I'm an associate professor, and I represent a registered nurse.

MEMBER MC CURDY: I'm David McCurdy, a retired health care ethicist and teaching as an adjunct faculty member in religious studies. I teach courses in ethics and healthcare at Elmhurst College.

MEMBER CHRISTOFF: Dr. Christoff. I practice general internal medicine at Northwestern. I also have an HIV practice, and I'm an appointed member of this Board.

MEMBER RAMIREZ: Nestor Ramirez. I'm a neonatologist here in Chicago, Illinois.

MEMBER CHAMPION: My name is Jim Champion. I'm the veteran's rep on the Advisory Board. I'm a 100 percent service-connected disabled veteran, and I've had MS for 27 years.

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CHAIRPERSON MENDOZA TEMPLE: Thank you everyone for those introductions.

I have the list of also the housekeeping things. I could go over some of that.

So we are convening this meeting, this public hearing for the sole purpose of reviewing petitions from the residents of Illinois for the addition of debilitating conditions or diseases that would benefit from the use of cannabis, and this Board will make recommendations on each condition to the director of the Department of Public Health based upon the collective expertise of the members of this Board.

So, first of all, all persons must sign in at the registration table at the entrance to the room. So if you have not done that, please do so.

All participants shall refrain from interrupting the proceedings of the Advisory Board and conduct themselves in a civil and courteous manner, and audience members should refrain if they can from clapping, cheering, and other loud noises. Any participant that disrupts the proceeding will be asked to leave the hearing.

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For the presentation of technical evidence, the persons who submitted an intent to present technical evidence about a petition being reviewed which was accepted by the Department will be recognized to speak at the appropriate time. Persons who have not filed a statement of intent will not be able to present technical evidence at the hearing.

After being recognized to speak by the Board, persons will begin by giving their first and last names and, if applicable, identifying the organization or group they're representing. Speakers are asked to spell their first and last name so our court reporter can make an accurate record of the attendees and their questions.

Persons must limit their presentations to no more than three minutes, and persons who exceed the time limit will be advised to conclude their presentation to ensure that all presenters will have the opportunity to participate, and Conny will be giving time cues to the speakers who will be sitting in that chair giving their presentations. As the time winds down, you will get a cue to start wrapping your comments up. It's very important that we keep to that time frame because we have 29 speakers and four closed

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sessions.
So the way that this meeting is going to run is we're going to go through each petition and present the technical evidence, have the petitioner speak. If there's anything closed, we ask everyone except for the speaker to leave the room. It will be about five minutes, you can take your bathroom breaks, the speaker will finish, you'll be summoned to come back into the room, and then we will hear the rest of the petitioners speak. Following that we will have discussion amongst the Board regarding questions that need clarification, and then we will put the condition to a vote.
And what will happen is that we submit our votes on paper so that we can make our votes in confidence and in privacy, and then the tallies will be read. We have 9 members present, and a quorum will be 6. So if 6 votes approve a condition, then the condition will pass and I will announce those.
So is there anything else?
MS. MOODY: Yes. Leslie, we had another Board member join us, so our actual number is actually 10 now.
CHAIRPERSON MENDOZA TEMPLE: Great.

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MS. MOODY: If you'd like to have Dr. Parikh introduce himself, that would be great.
CHAIRPERSON MENDOZA TEMPLE: So 7 out of 10 then is a quorum?
MS. MOODY: So it would be 6.
CHAIRPERSON MENDOZA TEMPLE: It's still 6 out of 10.
So please introduce yourself.
MEMBER PARIKH: I came from Washington, DC, sorry about that. My name is Jyotin Parikh.
CHAIRPERSON MENDOZA TEMPLE: And if you can give a background and your organization.
MEMBER PARIKH: I'm a pharmacist by profession.
CHAIRPERSON MENDOZA TEMPLE: Thank you very much everyone for coming. First of all --
MS. MOODY: Madam Chair, may I also make a welcome and an introduction from our statewide program coordinator?
So our statewide program coordinator for the medical cannabis program is Joseph Wright with the office of the governor, and he will be here later today, but he did ask that I welcome the Board on behalf of the governor.

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And, also, the Department of Public Health. Dr. Nirav Shah, the director of public health, also sends his greetings to the Board and also thanks the Board for the important work that you're about to do today.
And we want to make sure that as far as the Board goes, from the department, from our director, Director Shah, and also from myself that we believe that the work that you do is very, very important. This is a pilot program, the Compassionate Use of Medical Cannabis pilot program, and we believe that all of the stories, the testimony that we hear today, the comments from the Board based on their research of these issues, and their consideration of the petitions today will contribute immensely to the evaluation of this program and our ability to move forward with this program.
So please do know that our department thanks you for your service and for all of the work that you put in in preparation of this meeting, of this hearing and, also, to all of our speakers today who are going to present comments and present and do some storytelling about how this program and how the debilitating conditions affect their lives. So thank you very much.

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CHAIRPERSON MENDOZA TEMPLE: Thank you for noting that, and I would love to know when he comes. What is his name again?
MS. MOODY: His name is Joseph Wright. And we can certainly -- Tina and Mallory, who are department staff and who are manning the registration table will be able to give the Board some information when he comes, and then you're welcome to introduce him at that time.
CHAIRPERSON MENDOZA TEMPLE: That would be great. Do you know approximately when he's coming?
MS. MOODY: I don't know. I understand he's caught up in another meeting, and he's trying to get here as quickly as possible.
CHAIRPERSON MENDOZA TEMPLE: Okay. Great.
So with that I would like to go through the review and approval of the May 4th, 2015, petition hearing minutes. We have reviewed this as a board, but we are also opening it up for any corrections that Board members would like to make to the transcript that were discussed.
MEMBER CHAMPION: On the May 4th transcript, in fact, on page 71 when we were speaking of neuropathy, it has me saying that, "Research shows that narcotics

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are not effective in treating neuropathic pain. I found this to be untrue myself." What I actually said was that I found this to be true myself. I have given testimony under oath that narcotics are ineffective in treating my neuropathic pain, while cannabis provides me unparalleled relief from this misery.

On page 126 under anorexia, it says that I say, "There is nothing we can do for these people." What I actually say is that I know there is something we can do for these people, as I have come close to having a feeding tube myself. Cannabis helps me keep a regular diet.

Finally, I'd like the record to reflect that any errors from this petition hearing transcript will be corrected at our next petition hearing, as well. Also, I will not -- also, I will be voting against approving any further minutes with inaccuracies even if we are allowed to address the errors at a later time.

Thank you.

CHAIRPERSON MENDOZA TEMPLE: Thank you, Jim.

Any other corrections from the Board to the minutes as they stood in May so that we can make proper corrections?

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(No response.)

CHAIRPERSON MENDOZA TEMPLE: Okay. So I move to approve the corrections that Mr. Champion has recommended to the Board so that they be incorporated into corrections for the minutes, I believe on a separate document for the minutes of this meeting.

VICE CHAIRMAN FINE: Second.

CHAIRPERSON MENDOZA TEMPLE: All those in favor.

(Ayes heard.)

CHAIRPERSON MENDOZA TEMPLE: Thank you. The motion is passed.

Okay. We're going to get down to it. The ordering of the conditions that -- we decided to use the conditions, the ordering of that based on our petitioners' comfort level. So we chose the chronic pain conditions to go first so that they have an opportunity to speak first and then be able to go if they wish, but we invite everyone to stay to hear all of the testimonies today.

And we are going to open up with chronic pain due to trauma. And that first -- am I missing something?

MS. MOODY: No. You're doing great. We

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have had a request to present testimony in closed session. I would need the Board to move and to approve the closed session.

VICE CHAIRMAN FINE: So pursuant 5 ILCS 120/2(c)(4) I hereby motion to close the session to address this first condition.

MEMBER MILLER: Second.

CHAIRPERSON MENDOZA TEMPLE: All those in favor.

(Ayes heard.)

CHAIRPERSON MENDOZA TEMPLE: Following this closed session there will be an open session also regarding chronic pain due to trauma -- oh, the closed session person is not here.

VICE CHAIRMAN FINE: Oh, sorry. Psych.

CHAIRPERSON MENDOZA TEMPLE: That was just a practice.

MS. MOODY: That was our practice run.

MEMBER WEATHERS: Everybody did a very nice job of getting up.

MS. MOODY: So, Michael, we are actually going to have to entertain -- because we've closed session.

MEMBER WEATHERS: I move to reopen the

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session.

VICE CHAIRMAN FINE: Second.

MS. MOODY: All right. So we are back in open session now. I want to make sure that Paula is good with this.

THE COURT REPORTER: Okay. I haven't closed.

CHAIRPERSON MENDOZA TEMPLE: So I call Dr. Marc Sloan to speak regarding chronic pain due to trauma, and you have three minutes.

MS. MOODY: And if you will kindly -- yes, your mic should be live. As Chairman Mendoza Temple indicated, please state your name, your organization, spell your name, please, both first name and last name, and then I'm going to -- at the one-minute mark and at the 30-second mark I'm going to hold up a sign so that you know where you are at in your three allotted minutes.

DR. SLOAN: Just as a point of order, I have been asked to speak --

CHAIRPERSON MENDOZA TEMPLE: Can you bring the mic closer to you?

DR. SLOAN: Sure, sure, sure. I requested to speak at, I think there's three for pain, and there will be overlap from what I'm saying. So rather than

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just continue, I would just, if possible, present once for all three or four conditions. Is that possible?

CHAIRPERSON MENDOZA TEMPLE: Can you do it in three minutes, though?

DR. SLOAN: I can do it in three minutes. I worked hard to try to do it in three minutes.

MEMBER WEATHERS: Can we apply the testimony to the other conditions in the record?

MS. MOODY: If the Board so chooses, yes.

MEMBER WEATHERS: I make a motion to apply his testimony to the -- it will be the exact wording, obviously, but it will be reflected in the minutes that it applies.

VICE CHAIRMAN FINE: Second.

CHAIRPERSON MENDOZA TEMPLE: All those in favor.

(Ayes heard.)

CHAIRPERSON MENDOZA TEMPLE: Please.

DR. SLOAN: Good morning. My name is Marc, M-a-r-c; Sloan, MD. I am a board-certified physician in anesthesia and pain medicine. I've been practicing pain medicine since 1984, and I'm the director of Pain Management Consultants since 1987. I would like to thank the Advisory Board for allowing me to speak for

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the use of medical marijuana in the treatment of chronic pain conditions.

The International Association for the Study of Pain and the NAH define chronic pain as any, any painful condition lasting three months or more. The World Health Organization defines chronic pain as any painful condition lasting six months or more.

Chronic pain, furthermore, is any pain that persists beyond the expected normal healing time. Chronic pain can be associated with diseases such as rheumatoid arthritis, osteoarthritis, spinal stenosis, nerve entrapment syndromes, and metastatic disease. Chronic pain can be a result of surgery, trauma, or infection.

We know as physicians chronic pain is associated with changes in the central nervous system, and it's felt that these changes are responsible for the continued symptom complexes. These predominant changes occur in the cortex, thalamus, amygdala, and periaqueductal gray areas.

In 2011 the Institute of Medicine postulated that 100 million Americans experience chronic pain at a cost of $600 billion a year in medical treatments and lost productivity. This represents approximately

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one-third of the U.S. population and is more than the associated patients afflicted with heart disease, diabetes, and cancer combined. Opioids, narcotics remain as the primary drugs in the treatment of chronic pain. 2014 the Institute of Medicine noted that Hydrocodone was the number two medication prescribed in the United States, second only to thyroid supplement with 119 million prescriptions. Average opioid sale per U.S. citizens have increased from 1997 of 74 milligrams to 369 milligrams as noted by Pain Physician 2010. It is estimated that 16,000 to 18,000 deaths per year occur due to opioid poisoning. We know dosage increases, side-effects increase, deaths increase.

Cannabinoids have a role in treating pain. Cannabinoids have been shown to be anti-inflammatory, neuroprotective in ischemia, hypoxemia, and also act as an anxiolytic. Analgesics that the cannabinoids provide have minimal toxicity with essentially no risk of lethal overdose. Cannabinoids have central effects but are only associated with mild withdrawal effects.

MS. MOODY: Thank you for your comments today, Dr. Sloan.

DR. SLOAN: All finished.

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CHAIRPERSON MENDOZA TEMPLE: Thank you. You actually could use the opportunity again since you are slated to speak at the other conditions if you have more to say.

DR. SLOAN: Okay.

CHAIRPERSON MENDOZA TEMPLE: Thank you for your testimony.

So we open it up to the Board for conversation about chronic pain due to trauma.

Comments from the Board?

MEMBER CHRISTOFF: I will just make a comment that I think as an alternative to addictive opioids --

MS. MOODY: Could you pull your microphone a little bit closer, Dr. Christoff?

MEMBER CHRISTOFF: I think that because addictive opiate narcotics are not always a solution to chronic pain as a result of trauma that many other options such as cannabis should be made available in the treatment algorithm of various chronic pain approaches that we attempt to deploy in situations like this. So I strongly agree with this proposal.

VICE CHAIRMAN FINE: As a patient and someone who was severely addicted to opioid narcotics

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that ranged the gamut from Norco, Vicodin, methadone, OxyContin, morphine, et cetera, et cetera, et cetera, to the point of a suicide attempt, I have to agree wholeheartedly with Dr. Christoff and recommend this strongly for approval.

MEMBER MILLER: I just had a question because when reading the petitions, particularly with this first one, I didn't see any trauma stated in this particular petition. It was more related to musculoskeletal. So then I questioned what the difference is between all these.

So do we -- do we approve chronic pain in its generality or is it too broad? But I'm seeing a lot of overlap with the chronic pain petitions. This particular petition really I felt was more in the general chronic pain category.

CHAIRPERSON MENDOZA TEMPLE: Jim?

MEMBER CHAMPION: I was going to say first off, as a person who took 59 pills a day, to include methadone, morphine, Vicodin all at the same time, I agree totally with the doctor.

But, also, I'd like to say that studies have shown, and I personally know that cannabis is highly effective for treating pain due to inflammation,

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neuropathic pain, and arthritis, and many of those conditions were approved by this Board previously, neuropathic pain and some of the others. So I urge a yes vote.

MEMBER WEATHERS: Theresa does seem to have -- because I had the same concern when I was reading through this, purely not in any way from the medical standpoint, purely from one of the things that we've been tasked with has been to look at the specificity of the request being accurate or to ensure that we're approving specific conditions and not a generalized category.

Chronic pain due to trauma does have its own ICD 10-code. I think it's probably shared with many. It's G89.21. So I think it is actually its own category and diagnosis, which was reassuring to me.

CHAIRPERSON MENDOZA TEMPLE: I think as a board we also have to look at do we look -- I mean, many of the conditions that are already eligible like fibromyalgia, which is on the list of the 39 conditions -- I've already recommended this to my patients with fibromyalgia. This is all pain to me.

So whether -- what's the cause? I think it helps for clinicians who really need that level of

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definition, makes them feel more comfortable that this is specific to that. I think it's good to pass as trauma. Pain is pain and to me it's a deficit in the endocannabinoid system where you need to establish balance again. I looked at the evidence base regarding pain not specifically to trauma but pain from different comers. It can be from neuropathy or, like you said, inflammation, infection, and whatnot.

But as a board we've got a unique set of chronic pain conditions that all say chronic pain. Chronic pain due to trauma, chronic pain syndrome which is the catch-all, and it's a challenge to the Board to see are we at a place where we can say let's do the blanket chronic pain and not have the clinician have to decide if that patient has -- what is the cause; what's the etiology? Etiology means cause.

When I looked at the petition specifically on paper from chronic pain due to trauma, it was actually noted that the trauma was from a slipped disc. Yes, that's an internal trauma and a physiologic or pathologic accident that happened, but it wasn't like a car accident like Michael went through, which to me is an external trauma.

So we can talk about specific causes all day

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but do we -- and I don't know how the rest of the Board feels about the specificity in sticking with the ICD-10 codes to make it more user friendly for the clinicians who are the gatekeepers to this system. They want, they need to see something more specific.

But from a -- to me from a compassion, common sense point of view, I don't really need to see, is it from trauma, is it from diabetes. We've already passed various shades of pain control through the Pilot Act as it stands. So to me this is just more specificity that might help some. And I don't particularly need it, but we're going to be moving on after this to chronic pain syndrome, chronic post-op pain which we already approved anyway last time, and then intractable pain, which is pain that is not responding to anything.

So whether that's -- chronic is a time thing. It's six months of no pain relief. But intractable is a higher shade of intensity and to me that is -- you know, and we'll get to that piece, but I want to talk about this on a global level because we have to approve the conditions as they are stated here. It's the paperwork we received.

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They are different codes, which is why to the public it might not really make a lot of sense why we have all these specific pain syndromes with different causes, but why didn't they talk about chronic pain due to -- I don't know, it's not on here -- neuropathy again. It's because we can only talk about what was sent to us.

So anyway, when I looked at the different states that have chronic pain without a cause associated, there are a few states, I don't remember exactly which ones, but we would not be the first state to approve chronic pain or chronic intractable pain as a medically eligible condition. So that's nice to know I think from a national landscape.

So I would be in support of this as a specific condition, chronic pain due to trauma.

Other comments?

MEMBER PARIKH: I see the condition chronic pain syndrome as one of the conditions listed here, and what I feel like is last meeting we also discussed why don't we just approve chronic pain syndrome as a general blanket situation for all types of patients. That will eliminate future time wasting for all the different types of pain syndromes. One blanketly

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covers everything, all kind of pain which is chronic. And chronic means it's not just pain for short-term. And there is a situation where it says chronic pain syndrome and that's it. Basically, we are covering everything else.

CHAIRPERSON MENDOZA TEMPLE: I was thinking about that common sense approach, but on the flip side I was wondering if -- we have to send this to IDPH, and I don't know, we don't know what the thinking is, the rationale, do they want the specific conditions.

So from a playing your odds kind of point of view, then yes, I do like the blanket term, but if that gets rejected flat out, you know, we have to be able to rely on these more specific pain-related causes. So trying to increase our chances.

MEMBER WEATHERS: Exactly. Going back, they are -- seem to be separate ICD-10 codes, and I would just hate for depending on how this is interpreted and the work we do and what's eventually approved is if a provider were to put one down and not the other, because of the increased specificity around ICD-10 to have something not approved when we obviously intended it to be.

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So that would be my only argument about addressing them as listed because we're approving very specific conditions that correspond to very specific codes, which increases people's chances of actually --

MEMBER PARIKH: If you have an ICD-10 code for chronic pain syndrome, it's automatically covered. You don't have to go into a specific ICD-10 code for those things.

CHAIRPERSON MENDOZA TEMPLE: Well, there's codes for just chronic pain syndrome and intractable pain. So if they all pass, then we have a pretty good shot, but what we don't know is what IDPH down the road --

MEMBER PARIKH: That we don't know, yes.

THE COURT REPORTER: Okay. One at a time.

CHAIRPERSON MENDOZA TEMPLE: They might only pick two.

MEMBER MC CURDY: I guess my only other comment is in light of the fact that this is still a pilot program and part of I think the approach the State has made in general is to proceed cautiously, this is also part of that. So I would think as much as some of it may not make a lot of sense to have to sort of do each individual condition the way we do it,

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at this stage of the game it may be most appropriate in terms of building a base for whatever comes in the future, if that makes sense.

MEMBER MILLER: Then I just have one follow-up because I'm okay with doing it each separately, as well as generic overall, but how are we then defining trauma? Because in this particular petition it was more musculoskeletal internal trauma rather than how I see trauma defined. So how are we going to separate out that specificity then with this petition?

MEMBER WEATHERS: It looks like -- again, just trying to go back to the coding database that I'm using, coding due to injury or trauma both mapped to G89.21. So I think we're okay. It seems to catch that whether -- so either in this petition if the trauma were an injury versus true external.

CHAIRPERSON MENDOZA TEMPLE: Dr. Ramirez.

MEMBER RAMIREZ: I was just thinking of all the things that were said, I realize that since we're an experimental pilot program, it is better for us to separate things now. If we later on, as time goes by, we can engulf them all into one thing, then it'll be easier to handle. But for now if we incorporate it

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and we get into trouble, it's hard to separate them at that time.

The other thing is I'm not quite clear if we're approving the petitioner's issue or the specific symptom or syndrome or issue.

CHAIRPERSON MENDOZA TEMPLE: I look at it we're looking at the syndrome, the condition. The petitioner adds their story, their testimony, and we add Dr. Sloan's discussion. Is that clear?

Other comments?

(No response.)

MS. MOODY: Madam Chair, if I may. I'm reading from the Illinois Administrative Code 946, which is the compassionate use of medical cannabis code for the Department. And with regard to the petitions themselves, G2 states that, "Each petition shall be a specific description of the medical condition or disease that is the subject of the petition, and the petitioners shall not submit broad categories. For example, all of mental illnesses. Each petition shall be limited to a single condition or disease."

So if that provides any sort of guidance for the Board.

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CHAIRPERSON MENDOZA TEMPLE: Well, the fact that -- okay. That helps a lot because all mental disease would be rejected. I would say, all pain from anything will be -- you know, I think that is well defined, and the fact that there is an ICD-10 code for all of these conditions already defines them as discrete conditions.

So I think that we're on -- we're okay with judging these as they are written.

Other comments?

MEMBER PARIKH: My point is that all conditions -- chronic pain only, chronic pain due to trauma, chronic pain syndrome, intractable pain, like this. So if we have conditions that we keep approving, in the future it's going to have different chronic pain for this, chronic pain for this, chronic pain for this. We are subjecting ourselves to all kinds of reasons for that. Might as well just do one chronic pain syndrome and just call it everything. It's not a blanket like all mental illness. It's chronic pain specifically. Syndrome is just a name for any kind of chronic pain.

So I think that would be a suggestion that we can approve only one condition. You know, you're

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going to have lots of chronic pain patients filing. Whether we approve it or not it would be a different kind of situation, but we would be subject to a lot of persons coming in.

VICE CHAIRMAN FINE: So I would suggest that we move forward with what we have and maybe -- hint, hint -- in the future somebody will submit a petition suggesting chronic pain syndrome.

CHAIRPERSON MENDOZA TEMPLE: It did.

VICE CHAIRMAN FINE: Okay. Then we're good.

CHAIRPERSON MENDOZA TEMPLE: Do we have another comment on the floor?

MS. MOODY: How about Dr. McCurdy.

CHAIRPERSON MENDOZA TEMPLE: Did you have one?

MEMBER MC CURDY: I did not.

CHAIRPERSON MENDOZA TEMPLE: Oh, okay.

All right. My last comment is that we have -- this is going -- we make recommendations. So what gets approved is unknown. So I want to keep that in mind, too, makes total common sense. If we end up getting petitions in the future and we see that the flavor of the approvals from above say we need specifics, I'm worried that if we disapprove chronic

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pain due to trauma and we just say let's just go for chronic pain syndrome and disapprove everything else so that we go comprehensive, if that gets shut down, then we've got nothing.

So I would say just let's just keep taking them as they come. And if it's chronic pain due to I got a paper cut, we'd reject that, and then we just take them as they come.

MEMBER MC CURDY: And I would say apropos kind of reading from the holy text of the regulations, the reality is we need to follow the regulations, and what the rule says is that we need to work within that framework. It would seem to me, therefore, that even though it's cumbersome, at this stage of the game this is the best we can do, and at some point some of that may change. But a list of 39 conditions already is pretty lengthy. Heaven only knows how many there could be as we went along.

CHAIRPERSON MENDOZA TEMPLE: Many of which cause chronic pain.

I make a motion to vote.

MEMBER WEATHERS: I did. He seconded it.

CHAIRPERSON MENDOZA TEMPLE: Michael seconded it. So let's vote.

While we're tallying the votes, the next condition is chronic pain syndrome, and we have four speakers.

Dr. Sloan, are you going to speak again? Yes? Okay.

So we'll start with Zach Cutrara, Jessie Fosdick, Dr. Marc Sloan, and Jared Taylor, we'll do it in that order. So if you can kind of prepare yourselves, they're all open sessions.

Okay. The condition for chronic pain due to trauma has passed with a vote of 10 yes, 0 no.

Thank you.

(Discussion off the record.)

CHAIRPERSON MENDOZA TEMPLE: So like we discussed at our last meeting if we have petitioners who say they are going to be here to give public comment, please show up. So those who are not here, that was for you.

Okay. So I will make a call out to -- we're ready to move on to chronic pain syndrome. What's the ICD-10 for that?

MEMBER WEATHERS: G89.4.

CHAIRPERSON MENDOZA TEMPLE: G89.4.

Zach Cutrara, who I did not see sign in, is

he here?

(No response.)

CHAIRPERSON MENDOZA TEMPLE: Okay. Then we'll move on to our second speaker, Jessie Fosdick. Did I pronounce that correctly? Thank you. Thank you for coming.

MR. FOSDICK: My name is Jessie Fosdick, F-o-s-d-i-c-k. I am speaking in favor of chronic pain syndrome.

I am speaking today on behalf of millions of individuals affected by chronic pain syndrome, which the Institute of Medicine of the National Academies estimates nearly 100 million Americans suffer from a form of chronic pain.

When I originally began my application process a year and a half ago, I did so with the intent of qualifying under chronic pain. Due to the overlap of symptoms, it was not until later that I was diagnosed with fibromyalgia. Also, due to the unknown nature of the condition, it makes it difficult to effectively manage the condition, which often results in long-term opioid use and has been considered one of the leading causes of opioid dependencies.

The National Institute of Drug Abuse

estimated that nearly 10,000 Americans died of opiate-related prescription deaths in 2013 alone. It was the fear of becoming one of these statistics and the intense debilitating pain that resulted from my condition, to the point at which I could -- to the point that it impacted myself and my family's quality of life to the point to which I can no longer be a proper father that led me in the pursuit of medical cannabis.

I have effectively managed my condition with medical cannabis and feel that others suffering from similar conditions should be presented with the same opportunity to have safe and effective relief.

That is all. Thank you for your time.

CHAIRPERSON MENDOZA TEMPLE: Thank you for your testimony.

Dr. Marc Sloan.

DR. SLOAN: Reintroduce myself?

MS. MOODY: That would be appropriate, please.

DR. SLOAN: Good morning. My name is Marc Sloan; M-a-r-c, S-l-o-a-n, MD, board-certified anesthesiologist, pain medicine, practicing pain medicine since 1984, and director of Pain Management Consultants since 1987.

In the June issue of the Journal of American Medical Association of 2015 in an article titled "Cannabinoids for Medical Use," this article reported that there was a 30 percent reduction of pain with the use of cannabinoids. These patients reported a decrease in the use of narcotic analgesics, and when they did take their narcotic analgesics while using cannabinoids, there was some proved analgesia.

Yes, it is true that these studies were classified as moderate using the grade classification. However, as we know in the world of pain medicine, high-quality ratings require randomization and double-blind observation. It's not going to happen with pain patients. A moderate study is about the highest a pain study can ever get. Studies involving pain patients cannot be randomized and double-blinded.

2012 Clinical Journal of Pain Cannabinergic Pain Medicine describes that 71 percent of the studies found that cannabinoids were associated with demonstrable pain relieving effects. Additional studies have found that there is an improvement in quality of life, improved sleep, and greater productivity. Quality of life, improved sleep, and greater productivity in my mind is the goal of

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management of patients with chronic pain.
Like all of our present medication, cannabinoids are not the panacea for patients suffering from chronic pain. However, with cannabis being available to chronic pain patients, it is reasonable to expect pain is improved, improvement of quality of life, a decrease in the number of pain prescriptions, followed by a decrease in the associated side effects, and, ultimately, a decrease in accidental opioid poisoning and associated deaths.
Thank you.
CHAIRPERSON MENDOZA TEMPLE: Thank you, Dr. Sloan, for your testimony.
And our last speaker for chronic pain syndrome is Jared Taylor.
MR. TAYLOR: Good morning my name is Jared Taylor. That's J-a-r-e-d, T-a-y-l-o-r. I'm here this morning to urge the Illinois Medical Cannabis Advisory Board to recommend chronic pain syndrome as a qualifying condition for the medical cannabis pilot program.
Chronic pain syndrome (also known as CPS) is a common problem that presents a major challenge to healthcare providers because of its complex history,

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unknown causes, and poor response to therapy. CPS is poorly defined, yet many medical professionals consider ongoing pain that lasts more than six months as a qualifying criterion. Other professionals have used three months of chronic pain as the minimum criterion. However, with chronic pain, a demarcation of time is arbitrary.
Chronic pain syndrome is a conglomeration of syndromes that do not typically respond to medical treatments. CPS is best managed by combining a variety of approaches, including bad posture, exercising regularly, practicing good sleeping habits, and having balanced meals. Approximately 35 percent of Americans have some element of chronic pain, and approximately 50 million Americans are partially or totally disabled due to chronic pain. As well, chronic pain is reported more commonly in women.
CPS affects suffers on a daily basis. Patients are affected by depressed mood, poor-quality/ nonrestorative sleep, being fatigued, a lack or reduction in libido, and experience disability out of proportion with impairment. Chronic pain may lead to prolonged physical suffering, marital or family problems, loss of employment, and may cause adverse

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medical reactions to long-term treatments.
I myself experienced chronic pain for approximately 2 1/2 years. While I now know that my pain is due to my osteoarthritis, many patients with CPS do not know the underlying cause, and as I can personally attest, chronic pain makes daily life much more difficult. It is hard sometimes to see the proverbial silver lining in dark clouds when one has chronic pain, as chronic pain causes sufferers to have gray skies on a daily basis. Mundane activities such as going to work, doing household chores, caring for dependents, and other normal day-to-day activities are difficult with chronic pain.
Cannabis is a proven medicine that effectively inhibits pain signals from being transferred from the brain to the point of origin. Pain is subjective and what may be painful to me may not be painful for others. I realize that the Advisory Board has proceeded carefully with blanket conditions, and I can admit that chronic pain is a very broad condition. However, I myself suffered for nearly 2 1/2 years in silence from chronic pain on a daily basis which was caused by my osteoarthritis. It affected me heavily and, fortunately, I now have a

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diagnosis and can better manage my symptoms. Other patients are not so fortunate to have a diagnosis, yet they continue to live with chronic pain on a daily basis.
Because chronic pain syndrome is a disease that affects every facet of a patient's life, it is truly a debilitating condition. As such, I urge the Advisory Board to recommend chronic pain syndrome as a qualifying condition to the Medical Cannabis Pilot Program.
Thank you for your time, and God bless the State of Illinois.
CHAIRPERSON MENDOZA TEMPLE: Thank you for your testimony. And thank you for everyone who has come up so far. I know that it takes a lot.
So we open up the conversation through the Board for comments.
MEMBER CHAMPION: I'm just going to say our state -- our state is the only state in the medical cannabis states that requires an ongoing doctor-patient relationship. If a doctor can recommend opiates and narcotics and things like that, I see nothing holding them back from recommending cannabis.
As well, in September the Illinois

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Department of Public Health recognized chronic pain, at least chronic pain in the month of September, so I recommend we as a board recognize and approve this condition, as well.

Thank you.

CHAIRPERSON MENDOZA TEMPLE: Other comments?

(No response.)

CHAIRPERSON MENDOZA TEMPLE: We had a conversation about this already regarding that this condition doesn't have any causes attached to it. So we really need to think about yes, it is its own discrete condition, with its own ICD-10 code, but we are now traveling into sort of an overall general condition area.

But I also am reassured that we don't have to be the first state to do that. And, also, from the evidence base that I had reviewed in the literature provided, as well as my own research outside of this, I see enough evidence base regarding medical cannabis for chronic pain with respect to how the brain interprets pain with the CB1 and CB2 receptors and the potential for this medicine to help ameliorate a dysfunction in that signaling and a deficit of the endogenous, meaning our own homemade cannabinoids.

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We actually make our own chemicals that look like marijuana so that we can relax, eat, sleep, protect, and forget pain when we're trying to defend ourselves of the so we have this system is already in place. We now have a medicine that mimics those cannabinoids that we make ourselves, but if individuals have trouble making them in a robust, balanced way, then getting it externally is something that can be helpful.

So from a just purely scientific basis, I feel that this is a valid condition regardless of the etiology or the cause. So I just want to put an asterisk out there, though, that we have to acknowledge this is still a pretty general condition. But I think it will also help us -- if it gets approved by IDPH, it might help us reduce the need to have other petitions for every other cause there is, and we'll find out how that all goes.

MEMBER PARIKH: In Mr. Jared Taylor the underlying condition is osteoarthritis, but the previous finding was for chronic pain syndrome. So basically, it boils down to one condition of the same petition. So it would be nice to say if it is approved, then we don't have to have further witnesses

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on the stand.

MEMBER MC CURDY: I'm looking at the face sheet in the petition itself, and I note two things. One is -- and what I wonder, for those of you who are in the clinical field, if these come from the -- from the DSM or ICD manual or if these are somebody's interpretation. But the third paragraph says, "A person may have two or more coexisting pain conditions," et cetera. And it also says, "This condition is managed best with a multidisciplinary approach. Unlike pain due acute physical injury, chronic pain syndrome is not generally well controlled by opioids alone and shows nearly no response to anti-inflammatory agents." And the bullet point below that says, "CPS is different from the term 'chronic pain.'"

So I guess the question I'm asking is, is this straight from the manual, and, if so, is this a formal statement of what's distinctive about both the condition and its treatment, for those of you who may know?

MEMBER WEATHERS: When you say "manual," there is no one set -- I don't know where -- what source they're using for that. The only manual that really would list something out would be kind of for

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psychiatry, the DSM-V. I don't believe it's in there. I don't know that for sure, though. I can try to look that up.

But I agree with most of what they -- whatever the source was, that was accurate in that anti-inflammatories don't work, it is a multidisciplinary approach. The remainder of that I felt was an accurate statement.

CHAIRPERSON MENDOZA TEMPLE: Yes, Michael.

VICE CHAIRMAN FINE: I suffer from chronic residual limb pain syndrome, so I could fall under this catch-all, as well, but fortunately, limb pain syndrome is already an approved condition.

From a practical standpoint I understand exactly what the concern is, but I think that, you know, assuming, you know, that there is a condition worthy of being added to the gospel list that has already passed, this could be denied while we'll have all the specific conditions already articulated and to be articulated after this one just in case that occurs.

But I don't see any problem with throwing this out there and approving it and having, you know -- in a perfect world this one being denied and

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the other ones being approved. So I strongly recommend passage.
MEMBER MC CURDY: I would be willing to move approval of this condition at this point.
MEMBER MILLER: I'll second it.
MEMBER PARIKH: As an advisory board, if we somehow can put this emphasis in the minutes that the Board as a whole has approved this chronic pain syndrome as a blanket condition, and I don't know if that would put any weight on the Department or not, but if we can put somewhere in the minutes that this is a condition we all think that this is a blanket condition.
MEMBER RAMIREZ: Madam Chair, I'm sort of confused. I think we discussed that chronic pain syndrome was an entity unto itself and is not a blanket description of anything; it's a specific condition. So I think we need to clear the air so we say we're voting on a specific condition.
CHAIRPERSON MENDOZA TEMPLE: Well, I think the fact that it has its own code and is billable through insurance through various -- all the multidisciplinary -- physical therapy can get coded with it, I believe, the pharmaceutical medications --

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it is a condition in and of itself, but common sense tells me it's a blanket condition. We know that; we're pretty intelligent here.
But as a condition itself, I move that we start to vote on this and make sure that we differentiate that this is a specific condition. How it will be interpreted by those who are going to look at this whole list is unknown us. So if we look at it purely as the condition itself, chronic pain syndrome in and of itself, I think that we ought to move to a vote unless you have any further clarification.
MEMBER RAMIREZ: A little aside from a great Spanish philosopher that once said that common sense is the least common of all senses.
CHAIRPERSON MENDOZA TEMPLE: Thank you.
VICE CHAIRMAN FINE: Second.
CHAIRPERSON MENDOZA TEMPLE: Are you seconding the vote?
MS. MOODY: Madam Chair --
CHAIRPERSON MENDOZA TEMPLE: Yes.
MS. MOODY: -- you can make very clear in your motion what exactly -- what condition specifically, including the ICD-10 code, that the Board wishes to now take a vote on. You can be very specific about that.

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CHAIRPERSON MENDOZA TEMPLE: What was that code again?
MEMBER WEATHERS: G89.4.
CHAIRPERSON MENDOZA TEMPLE: G89.4. Okay.
So I move that we vote on approval or disapproval for chronic pain syndrome, which is ICD-10 Code G89.4, a condition specific -- a specific condition for pain.
MEMBER MILLER: I'll second.
VICE CHAIRMAN FINE: Okay.
CHAIRPERSON MENDOZA TEMPLE: All right. Let's vote.
While those votes are being collected and tallied, our next topic is chronic postoperative pain. I don't know if Dr. Sloan you need to -- okay. So we will not have a speaker for that.
This is a condition that was discussed at the May petition meeting, and I believe it passed in a vote of -- from my notes, chronic postoperative pain passed, but I did not recall the vote tally. But it passed.
VICE CHAIRMAN FINE: We're beating a dead horse now, and it's really dead and I'd certainly welcome any comments from anybody, but I'd motion for

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a vote.
MEMBER WEATHERS: Second.
CHAIRPERSON MENDOZA TEMPLE: Oh, we need to hear the tally first.
MEMBER WEATHERS: Do we?
CHAIRPERSON MENDOZA TEMPLE: Don't we before we move on to chronic postoperative?
Okay. The condition chronic pain syndrome Code G89.4 in the ICD-10 passed with a vote of 10 yes, 0 no. Thank you.
Now, chronic postoperative pain officially. Comments from the Board in addition to Michael's comments?
MEMBER LESKOVEC: Yes. I want to compliment petitioners on the quality of the petitions in citing research for -- so far of the conditions that we've already reviewed. So thank you very much.
CHAIRPERSON MENDOZA TEMPLE: Thank you. I know that also requires a lot of work and research, as well.
Jim, did you have a comment?
MEMBER CHAMPION: No, I was just going to say --
THE COURT REPORTER: I can't hear him.

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MEMBER MC CURDY: I tend to agree but I wanted to say I particularly appreciated the research that was included with this petition. It seemed to make the case, if anything, more strongly than even some of the other ones we've seen just in that regard.
CHAIRPERSON MENDOZA TEMPLE: So without any comments from the Board, I move to vote for the condition chronic postoperative pain. Do you have an ICD-10 code for that?
MEMBER WEATHERS: G89.28.
CHAIRPERSON MENDOZA TEMPLE: G89.28.
MEMBER WEATHERS: And this one is -- I'm sorry; I had it up -- other chronic postprocedural pain. So chronic postop, chronic postoperative pain, painful chronic postoperative. So G89.28 and G89.29 is also painful chronic postoperative not otherwise classified.
CHAIRPERSON MENDOZA TEMPLE: So maybe amend that to include chronic postoperative pain within both codes G89.28 and G89.29.
MEMBER MC CURDY: Are we permitted to do that if the .29 is not on the petition?
MEMBER WEATHERS: Was the .28 on the petition?
MEMBER MC CURDY: Yes.

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CHAIRPERSON MENDOZA TEMPLE: I would interpret the .29 as the same --
MEMBER WEATHERS: As I search through the code, it looks like that's abdominal pain chronic, chronic abdominal pain. So that's why they're linking them together. I would think -- yeah, G89.28 is the one that's really called out as chronic postprocedural pain, so I think we're okay. G89.22 is chronic postthoracotomy pain. I don't know why that gets called out separately.
CHAIRPERSON MENDOZA TEMPLE: Way too specific. That just means pain --
MEMBER WEATHERS: I think as a board we have it in our right to say we're encompassing all of the diagnostic codes that reference postoperative or postprocedural pain.
CHAIRPERSON MENDOZA TEMPLE: I think it is within our rights, too, to make any corrections to codes that might not be capturing what the materials of the petition say. Given the expertise of the Board, I think that we can amend that. So is it G89.28?
MEMBER WEATHERS: And G89.22.
CHAIRPERSON MENDOZA TEMPLE: And G89.22.

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MEMBER PARIKH: Is it all -- 22, 28, and 29?
CHAIRPERSON MENDOZA TEMPLE: All three?
MEMBER WEATHERS: I think that's fine.
CHAIRPERSON MENDOZA TEMPLE: Yes. All three.
VICE CHAIRMAN FINE: Second.
MS. MOODY: Madam Chair, could you restate the motion clearly for the court reporter?
CHAIRPERSON MENDOZA TEMPLE: I will.
MS. MOODY: Thank you.
CHAIRPERSON MENDOZA TEMPLE: I move that we vote on the condition chronic postoperative pain encompassing the ICD-10 codes G89.22, G89.28 and G89.29.
VICE CHAIRMAN FINE: Second.
CHAIRPERSON MENDOZA TEMPLE: Please vote.
While the votes are being collected and tallied, the next condition is intractable pain, and our speakers -- we have one who is closed, and then we have five speakers. So I'm going to check the attendance list first before I fake close the meeting again.
So the closed petitioner whose name I cannot mention has not signed in. So we will not close that, and we will not go through that again. We will just

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open it up to the following speakers, Jonathan Byrne who also has not checked in, Karen Freese, who has not checked in, Jessica Harshbarger, who has also not signed in, Dr. Sloan, who has declined, and Jared Taylor.
So we really only have one speaker, one speaker for intractable pain. So if I called your name and you just didn't sign in, would you raise your hand?
(No response.)
CHAIRPERSON MENDOZA TEMPLE: And then is Jared Taylor -- do you want to speak on it? Okay. We'll wait for the vote first, and then we'll proceed with your testimony.
Okay. The condition of chronic postoperative pain with ICD-10 code G89.22, G89.28, and G89.29 passed with a vote of 10 yes, 0 no.
So moving on to intractable pain, we have Mr. Jared Taylor providing testimony.
MR. TAYLOR: Well, good morning again. My name is Jared Taylor, and I come before the Medical Cannabis Advisory Board to urge that it recommend intractable pain as a qualifying condition to the Illinois Medical Cannabis Pilot Program.
Because of the lack of knowledge of its cause, only a few states (such as California,

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Colorado, Florida, New Jersey, and Texas) have defined what intractable pain means. However, the State of Minnesota is currently considering intractable pain as a qualifying condition to their launching and fledgling medical cannabis pilot program.

Now, according to the Minnesota Department of Public Health, intractable pain means "a pain state in which the cause of the pain cannot be removed or otherwise treated, no relief or cure of the cause of pain is possible, or none has been found after reasonable efforts." To put it simply, intractable pain is severe pain that has no known cause and does not respond to conventional therapies.

While I myself suffer from chronic pain caused by the osteoarthritis that I have, this is different from the intractable pain that I'm talking to you about today because intractable pain causes adverse biological effects on the body's cardiovascular, hormone, and neurologic systems. Individuals that suffer from IP experience changes in testosterone, estrogen, cortisol (which is a stress hormone), thyroid hormones, and/or pituitary hormones.

Intractable also causes patients to be bed- or housebound. So these are not people that are

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walking around; these are people that are in their bed, or they're in their home.

Intractable pain is not curable and, left untreated, can cause death. Conventional therapies for IP include using a TENS unit, taking methadone, as well as using opioid medications.

Now, cannabis is a proven medicine that blocks the transmission of pain signals. Because of this, I believe that patients who have intractable pain could greatly benefit from the use of cannabis. Similar to the State of Illinois, the State of Minnesota, like I mentioned, is considering adding IP to its list of qualifying conditions for their medical cannabis program. While what Minnesota does does not change what Illinois will do, it is important to note that intractable pain is a very real condition and that other states are seriously considering adding this condition to their medical cannabis programs.

There's no doubt in my mind that intractable pain would be a horrific disease to have. Intractable pain it has no cure; it has no known reason for its cause, and the pain experienced by patients is constant and severe. While I know that cannabis will not cure intractable pain, I believe that cannabis is an

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effective medicine that can and will inhibit and disrupt the pain that IP patients face on a daily basis.

As such, I urge the Medical Cannabis Advisory Board to recommend intractable pain as a qualifying condition to the Illinois Medical Cannabis Pilot Program. Intractable pain is a truly debilitating condition, and Illinois patients with this disease should have access to this medicine.

Thank you for your time. God bless the State of Illinois.

CHAIRPERSON MENDOZA TEMPLE: Thank you, Mr. Taylor.

Okay. Comments regarding intractable pain.

Do we have a code for that?

MEMBER WEATHERS: So that's the problem with this one. It really does fall under -- the way the ICD-9 works is it's significantly increased specificity -- to ICD-10 over ICD-9.

CHAIRPERSON MENDOZA TEMPLE: Can you explain actually what the code means?

MEMBER WEATHERS: Sure. It's the international classification of diseases, and it started out in the 1800s as a way -- it was actually --

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they were initially death codes, frankly, a way to capture why patients were dying. And over time these have been through -- and this is used worldwide, and it's how we as providers not -- it's not anything to do with how we code what we're charging for but how we code for what we're seeing, so what is the exact diagnosis. And this has specific implications for public health, for reporting, for vocational scores, how sick you are, how sick are the patients that we're seeing, are we accurately capturing the conditions that they have.

So we have been using in the United States an outdated code system for many years called ICD-9, and as of October 1st, last week we transitioned about 11 years behind the rest of the world to ICD-10. The difference is that ICD-10, as I keep saying, has many, many more codes.

So about 25 percent are just what we call laterality, are you dealing with the right or left. So it used to say ear infection. Well, now it's specifically what's the ear infection, which ear, and if you know, what's the organism or what's the bacteria that's causing the infection.

There's a lot more codes about site, about

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whether it's acute or chronic. That's why we're getting into the specific discussions. So acute or chronic is now differentiated. The episode, is it the first time somebody is coming in for a problem, or is it a long-standing impact due to the problem.

And as providers we're now obligated to be very, very specific in our coding, and it has specific implications for reimbursement, for our vocational scores, for public health, part of why we're all here today and allows us to better capture the conditions that our patients have.

Intractable is oftentimes what we call a modifier. So if somebody comes in, in my world, migraines, one of the things that we need to say about the specific migraine code in order to get to the very specific ICD-10 code is is it intractable or not.

I don't believe -- and that's what I'm having trouble finding. There doesn't seem to be an actual simple diagnosis of just intractable pain. It's the underlying pain syndrome. So the osteoarthritis with intractable pain or chronic pain syndrome and then intractable or not.

That doesn't say it's not a condition, and we can still vote on it, but it's implied -- it's

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almost not necessary because it's implied in the other conditions that have been discussed today.

Just to clarify, though, my only -- to finish my statement, I'm concerned, though -- and again, it gets into how are we really tasked with getting into specific ICD-10 codes, and I don't know if we are. Because I'm concerned that if we were to vote it down, I don't want the perception to be that we don't want medical cannabis to be used for intractable pain. It would be more on a technicality rather than the actual intent of what we're trying to do here and that concerns me.

So I think we need to, obviously, take all of this with a grain of salt.

VICE CHAIRMAN FINE: So there's not a necessity to have a code to approve this condition or any condition; correct? It doesn't need to have a specific code? I'm asking as a layperson. We don't need an ICD-10 code to approve something. I know it's helpful from a clinical standpoint when you docs, you know, approve someone for a cannabis permit or license, but is it necessary to have a specific code?

MEMBER CHAMPION: Do all of our current conditions have a code?

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MS. MOODY: Currently the Act lists 39 different conditions and diseases and simply lists the name of those conditions and diseases. It does not attach any sort of specific framework for the physician to specify an ICD-9 or -10 code.

The application gives the opportunity for the physician to check one or more debilitating conditions in the certification that they provide to the Department attesting that a qualifying patient has a specific condition or disease that meets the requirements of the Act and the code.

MEMBER MC CURDY: And the petition form that you all have created for people to use says that people must include any applicable diagnostic codes. So it's expected by the Department as part of your review. Am I right?

MS. MOODY: So that is requested in the administrative rule making, that information, and that information was requested and specified in the administrative rulemaking to help the Board in considering the specificity of a particular petition to give you as much information as possible from the petitioner to allow you to make consideration of that petition.

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MEMBER WEATHERS: And I know we heard about this last time but we're -- how much are we allowed to use our medical knowledge to say, "We think you meant this, as well"?

So, for example, one of the ones here is that -- you know, nobody included chronic complex regional pain syndrome or reflex sympathetic dystrophy to their own very specific diagnoses but obviously are chronic pain syndromes in the limb, oftentimes postprocedural or posttraumatic. So they get into some of the categories just approved. Would those need specific separate petitions?

MS. MOODY: Those are already part of the debilitating conditions. I believe the precedent that the Board set at the May 4th petition hearing was to consider the recommendation made by the petitioner. So, specifically, for this it is the intractable pain that is cited here in this petition.

However, when the Board makes its recommendations, if you should choose to qualify that information to the Department then --

CHAIRPERSON MENDOZA TEMPLE: Like we did with neuropathy; we split it into groups?

MS. MOODY: Exactly. Exactly.

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CHAIRPERSON MENDOZA TEMPLE: If I may. This may answer -- I found a code for intractable pain. It's R52.

MEMBER WEATHERS: I think that's --

CHAIRPERSON MENDOZA TEMPLE: So I actually am doing litmus test as I went into our medical record, and I looked for the diagnosis in there, and there's actually quite a few. There's intractable pain, intractable abdominal pain, intractable back pain, intractable neuropathic pain of foot left, and then right, or unspecified laterality.

MEMBER WEATHERS: So, yeah, it's coming up as pain unspecified.

CHAIRPERSON MENDOZA TEMPLE: So this is looking at -- I mean, if we were to go with -- this is an Epic system. So this is used in my hospital system, and if I saw that, I would use that code. I don't -- other than getting out my manual and trying to really prove that that wasn't the code, I don't know how else -- I would say that's okay.

MEMBER MC CURDY: So the fact that we have an ICD-9 code in these conditions for intractable pain, how does that matter?

MEMBER WEATHERS: Actually, that's fine.

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Again, these conditions were submitted before we converted.

MEMBER RAMIREZ: My question is, the words "intractable pain" came from where? From the petitioner? From the Department? From whom? The exact word intractable pain, where does it come from?

Because semantically speaking -- and I apologize, but English is my second language, so I'm very strict in meanings -- intractable means you can't treat it. So maybe it should be called analgesic resistant pain, and then you can say we can use cannabis for that. Otherwise, if it's intractable, intractable period. Because if you're dead, you're dead; if you're alive, you're alive. I apologize for that but semantically, intractable pain that you can treat with something else is not intractable.

MEMBER CHRISTOFF: I don't know if anyone -- I don't know if anyone knows this, but don't these codes in this ICD-10 -- like, aren't they defined to some degree? Are these just words that are attached to a code, and then there's no definition? Like that could be true. I don't know how -- like is there even like a sentence or description, or are clinicians just supposed to know what the words mean?

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MEMBER WEATHERS: They're supposed to know what the words mean.

MEMBER RAMIREZ: People who are coders have manuals about 7- or 800 pages big in which they specify and explain what each code means.

MEMBER CHRISTOFF: None of this would necessarily be written down as an agreed upon diagnostic description, I guess, for this or any other descriptive code that's used?

MEMBER WEATHERS: So R52 maps to pretty generalized pain, pain disorder, pain generalized, pain I mean just by itself. So that's what's coming up for all of that. G89.29 is chronic generalized pain disorder and chronic generalized pain, but the R52 is all the very, very generic. And, actually, acute is in there.

MEMBER PARIKH: I think that ICD-10, when there is no decimal point after, then it's a generalized category.

CHAIRPERSON MENDOZA TEMPLE: I found another one.

MEMBER PARIKH: After the decimal points are more specific codes.

CHAIRPERSON MENDOZA TEMPLE: Okay. There is

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a -- so in my system here they've a chronic intractable pain. The code is G89.29 which we just voted to approve. So I mean, always thought chronic --

MEMBER WEATHERS: Exactly. So you could argue, have we already approved this? It's redundant. It's looped into the other. I don't see any value.

CHAIRPERSON MENDOZA TEMPLE: Then I would not use the R52 code if that's what's coming up on yours. Then it would just make --

MEMBER WEATHERS: Mine is G89.29.

CHAIRPERSON MENDOZA TEMPLE: We may need to amend our previous approval where we called it chronic pain syndrome because it's also called chronic intractable pain in other systems, which is the same code. I always thought common sense --

MEMBER RAMIREZ: You've got remember that some of those systems like the Epics, the MedTeks, and all these, what they have done is they've taken the codes and adapted them to people's everyday language so they can code easily, but that does not mean that the ICD-10 is specifically going to say -- they're trying to code them and group them so you can use them in your everyday life.

MEMBER WEATHERS: So I would like to make a

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motion to include the previously approved chronic pain syndrome to also include the diagnosis of chronic intractable pain.
MEMBER MC CURDY: Second.
VICE CHAIRMAN FINE: Second.
MEMBER MC CURDY: All in favor.
CHAIRPERSON MENDOZA TEMPLE: We will need to vote, but on the sheets, then, we're just going to call that one condition. We're just saying that we're going to amend our previously approved -- so the name of that will be chronic intractable pain syndrome.
MEMBER WEATHERS: I would separate them out. I would say chronic pain syndrome and chronic intractable pain.
MEMBER PARIKH: And I think in the future we should stay away from the ICD-10 code.
CHAIRPERSON MENDOZA TEMPLE: I know. I'm a worried about -- okay. So say that one more time.
MEMBER WEATHERS: Chronic pain syndrome and chronic intractable pain.
And, again, the intent of this was never that we were approving necessarily specific ICD-10. It's just one of the things we've been tasked with is to ensure that we're not approving the entire world of

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mental health disorders, and by going with the code, it just lets us as a board be reassured that we are talking about very specific conditions.
I think that was the only intent of even bringing them up, not saying that we're getting into specificity of ICD-10 code despite my really fascinating ICD-10 lecture. I have more. If anybody afterwards would like to hear it, I have slides.
CHAIRPERSON MENDOZA TEMPLE: Michael, do you have a comment?
VICE CHAIRMAN FINE: Maybe the thought process here would be to make a motion that the ICD-9 and -10 codes are offered purely as additional data that would be helpful for clinicians in issuing, you know, their approvals for their patients and are not dispositive of a condition.
MEMBER RAMIREZ: Point of order, Madam Chairman. Mike's motion is out of order right now because we already have a motion on the floor, we have seconded it, and now we need to vote on it.
CHAIRPERSON MENDOZA TEMPLE: Was it seconded to amend our previously approved conditions to reflect it to say chronic pain syndrome and chronic intractable pain?

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MEMBER MC CURDY: Second.
CHAIRPERSON MENDOZA TEMPLE: Now we vote.
MEMBER PARIKH: Does that mean intractable means chronic? Because if you've tried for a longer term to treat that pain --
MEMBER LESKOVEC: My understanding of intractable is not that it is not treatable but that is not being able to be resolved by --
MEMBER PARIKH: Yeah, but that means that you have tried it for a certain period of time to relieve chronic pain. If you have tried it only for four months, then you have not tried all the options. So when you say it is not a helpful means of treatment, meaning that we have tried over a certain period of time, which is probably three months or six months. Obviously, it has to be a certain period of time to be tried. So there is no sense of putting chronic in front of this that is already there.
CHAIRPERSON MENDOZA TEMPLE: So are you proposing chronic pain syndrome and intractable pain and take the chronic out to remove the time?
MEMBER PARIKH: Yeah. It wasn't there to begin with, so we just leave it as it is.
CHAIRPERSON MENDOZA TEMPLE: Okay. Let me

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amend that again. I move to amend our previously approved condition to state chronic pain syndrome and intractable pain.
VICE CHAIRMAN FINE: Second.
CHAIRPERSON MENDOZA TEMPLE: Do we need a paper vote?
MS. MOODY: You can just proceed.
CHAIRPERSON MENDOZA TEMPLE: All those in favor.
(Ayes heard.)
CHAIRPERSON MENDOZA TEMPLE: Any opposed?
(No response.)
CHAIRPERSON MENDOZA TEMPLE: Okay. The motion passes 10 to 0.
We are now at osteoarthritis, which our closed petitioner is still not here. Okay. Then we have Jared Taylor again, and I think following this -- let's see, it is now 10:40. I think we could probably use a restroom break. And is there anything else?
MR. TAYLOR: I was the only person for osteoarthritis in May, as well.
MEMBER WEATHERS: Which we approved.
MR. TAYLOR: You'll remember my face from the repeat coming up here.

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MEMBER WEATHERS: It's nice of you to keep doing that.

Okay. Mr. Taylor, please proceed.

MR. TAYLOR: So good morning. My name is Jared Taylor. I feel like a really familiar face up here. I have osteoarthritis, OA. Some of you may remember me from earlier this year when I was the only individual who spoke in favor of adding osteoarthritis at the May 4th public petition period here in Chicago.

Unfortunately, it's unfortunate I have to join you all today, as this condition should have been approved by DPH as a qualifying condition of the program. Since osteoarthritis has no cure, my disease has not miraculously cured itself since I spoke in front of you five months ago.

To be clear, however, I am not upset with the Advisory Board. Each and every one of you has done your due diligence to the state's residents and the patients of Illinois.

According to Mayo Clinic, osteoarthritis is the most common form of arthritis, affecting millions of people worldwide. It occurs when protective cartilage on the ends of your bones wear down over time. While OA can appear in any joint, commonly

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affected areas are the hands, the knees, the hips, and the spine.

I myself was diagnosed with osteoarthritis earlier this year. It is in the facet joints of my spine which are directly above my tailbone. This makes it difficult and painful for me to sit, to exercise, and to do chores around the house. Overall, not only does this disease limits activities that I enjoy, it limits tasks that I must do on a daily basis.

Commonly used therapies for treating osteoarthritis include taking acetaminophen, also known as Tylenol, chiropractic therapy, attending a chronic pain class, receiving injections in the joint to increase flexibility, and other pain management-based options. While varied, all of these therapies have one thing in common; they are merely treating the symptoms of osteoarthritis. As there is no cure, patients like myself who have OA must merely juggle various treatments in order to get to a manageable level of pain.

Today I'm introducing a study by the University of Nottingham titled "Cannabinoid CB2 Receptors Regulate Central Sensitization and Pain Responses Associated with Osteoarthritis of the Knee

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Joint." In this study, it basically discovered that when we use medical cannabis, it activates the CB2 receptors in our brain, which inhibits the transmission of chronic pain signals from our brain to the area that we're in pain.

Now, I myself, I know that medical cannabis is not going to cure my osteoarthritis. However, I believe that this medicine is another tool to manage the symptoms that this disease causes which limit my ability to live a happy, productive life. I do not intend to only use medical cannabis to manage my chronic pain. I've been to a physical therapist; I've seen a pain specialist, and I visited a rheumatologist, which is a doctor that specializes in arthritis. On a twice daily basis I do stretching exercise; I take acetaminophen and naproxen (also known as Aleve) on an as-needed basis, and I've even started taking a yoga class twice a week. Again, all of these therapies are to manage my symptoms. I know that medical cannabis would be a beneficial medicine to help me manage my arthritis.

In short, I urge the Medical Cannabis Advisory Board to affirm its May recommendation for adding OA to the list of qualifying conditions. The

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osteoarthritis that I and millions of Illinois patients suffer from on a daily basis isn't going to go away. We demand access to this medicine which will help us lead a life with as little pain as possible. As such, I will come to this Advisory Board at every petition period hearing until Illinois osteoarthritis patients are given access to the treatment that we deserve.

Thank you for your time. God bless Illinois.

CHAIRPERSON MENDOZA TEMPLE: Thank you.

So that's all for the speakers on osteoarthritis. So comments from the Board?

VICE CHAIRMAN FINE: Jared, thank you so very much for your testimony today. It's been moving and it's unbelievably explicit and detailed and backed up by tons of research, and you point out again, and again, and again that cannabis doesn't need to be a cure. It's a weapon in the arsenal that you have to fight chronic pain.

I, too, practice yoga six or seven days a week, have acupuncture twice a week, raki, craniosacral therapy, sensory deprivation, flotation. Every single one of these things are different items in the arsenal that I use to function, and if this is

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something that can help you function better, it doesn't need to be the cure-all. Because there is no magic bullet, as you, and many other people, and myself have discovered. It's a complex regime of many different things used together in unison to survive and to live and function. So thank you so very much for your testimony.

MEMBER CHAMPION: I was going to say, I myself have osteoarthritis in several joints, my hips and my knees. Cannabis is effective for treating my arthritic pain. If our program covers rheumatoid arthritis, I don't see how it can be any less effective for osteoarthritis. If it covers one form, I believe it should cover all. And I'm not going to get into a comparison match with somebody with rheumatoid arthritis, but my osteo was pretty, pretty doggone painful.

CHAIRPERSON MENDOZA TEMPLE: I would like to differentiate rheumatoid arthritis, which is a covered condition, versus osteoarthritis.

Rheumatoid arthritis is an inflammation of the joints where they start to lose their symmetry, and people start getting -- their hands start deviating. It's a deformative arthritis, as is osteoarthritis,

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but not as much as rheumatoid arthritis, which is also extremely inflammatory and an autoimmune-type condition that is mediated a lot by the gut but which we have plenty of CB2 receptors that modulate that.

Osteoarthritis is a wear-and-tear type of phenomenon. So in your runners, or overuse injuries, or poor alignment of the spine, and over time things just start wearing away the cartilage, that causes pain and then we're back to the conversation about pain. So this is where I would look at osteoarthritis as another subtype of chronic pain.

Although, having -- and affirming our May vote I don't think should be very difficult, but I want to differentiate between the two, as well as to add a little more caveat that this is a much more common condition. If you get to a certain age, you're going to have it.

So this is where we discussed last time how do we define -- I was proposing why don't we say severe osteoarthritis, and then we had a long discussion about differentiating it and that it should be the clinician. And I was convinced of that after our discussion that it's going to be the clinician who is going to determine with the patient how severe it

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is, how resistant has it been to conventional medications and treatments, and acupuncture, yoga, all of those things that I use for my patients, as well.

So I would like it reflected in our minutes or in our public record that these conditions, albeit very common -- osteoarthritis is like everybody has got it pretty much -- well, I won't say that, but probably half the people in this room have it after a certain age, that it is going to be physician, provider discretion. That is where the relationship comes in and determines whether the person in front of me is a candidate to be certified under the pilot act.

So I think that's very important to emphasize. Because on the face of it, when I talk to my colleagues and they say, "You guys approved arthritis? Everybody has that, osteoarthritis. Come on," I want it known that this is not a blank check type of group over here. We recognize it is a difficult condition to treat for which joint replacement pretty much is getting rid of the bad joint. It seems to be the main definitive treatment other than symptom management or laying off the joint and not using it anymore, which means limiting activities.

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So it can be very debilitating, but it can also be very mild, and as physicians we are there to determine how severe and debilitating these conditions are and whether our patients should be certified for it.

MEMBER PARIKH: As a practicing pharmacist for over 30 years, I haven't seen too many osteoarthritis patients using high doses of oxycodone, or morphine, or hydrocodone, or anything like that, more the Tylenol. So it's a condition that we have to be careful in thinking about it. I don't know if I know patients using too much oxycodone or morphine or pain medication.

CHAIRPERSON MENDOZA TEMPLE: You had a question for me? I'm sorry.

MEMBER PARIKH: These kinds of patients for arthritis, they don't use too much of oxycodone, or narcotics, or high doses of those because that's not helpful to them compared to plain Tylenol, basically.

CHAIRPERSON MENDOZA TEMPLE: Other comments from the Board?

MEMBER MILLER: I'd just like to say I struggled with this in the May meeting because of the -- some of the evidence that was presented. I do appreciate having more current research there today

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and looking over it -- having the ability to look that over.

I'm very much focused on making sure we do the right thing based upon the evidence that's out there, and I know that there's limited evidence, but to go back 5, 7, 10 years makes it really difficult as a board member to approve some of those diagnoses.

CHAIRPERSON MENDOZA TEMPLE: So adding onto the evidence base. Because the research on medical cannabis for medical conditions and not for drug abuse reasons is very restricted, I want to qualify Michael's statement that there were tons of -- you know, there's tons of research for a certain condition. I wish I could say that about all of these conditions. There will not be tons of research. What myself as an evidence-based clinician was raised to look for randomized controlled trials and in humans, I want to see that, but we're just not going to see that at this stage. So it's compassion that's going to be guiding a lot, as well as clinical experience regarding our votes for yay or nay for this particular condition.

So I want to also make a note that if we looked purely at the research and just said, "Okay. This is a research-based, evidence-based treatment,"

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many of the conditions may not really meet the muster of other conditions we might say, yeah, we've got gold standard evidence for that treatment, why don't you try that.

So that's known. And until we get more -- the bottleneck released on medical cannabis research, we are going to be in this same position over and over getting evidence base from smaller studies, or animal-based, or lab studies. I've had to recognize that as a board member am I going to be satisfied with that.

What satisfies me is the safety data is pretty good. From a clinician "do no harm" perspective or "do least harm," this is where I put rubber to the road. Because in the practice where I have patients going to acupuncture, trying some herbal therapies, or nutritional therapies, I don't have a lot of evidence base for that, either. But if it's overall safer than the alternative or there is no alternative, then we go with it with monitoring and supervision.

And that patient-physician relationship is very important in knowing that these patients when they come back -- they have to come back once a year.

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They don't just get their card and run forever and never see you again. They really have to come back and see you in a year or they don't get it. So I think that's a very good safety that was built into this system. Onerous as it can be, it's very important.

So let's put the motion out to the vote for the condition of osteoarthritis.

VICE CHAIRMAN FINE: Second.

MEMBER PARIKH: Same.

MS. MOODY: And, Madam Chair, while the Board is taking its time to deliberate and will tally votes, I would like to introduce to the Board a member of our team, our statewide medical cannabis program coordinator Joseph Wright has joined us, and he works with the entire medical cannabis program across all of the agencies that are responsible for implementation of the program.

CHAIRPERSON MENDOZA TEMPLE: Thank you for coming. And so I wanted to share this statement, waiting for Mr. Wright -- Mr. Wright to come. You probably hear a lot of that.

I just wanted to publicly thank our wonderful staff at the IDPH for their relentless

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commitment, passion, just can-do attitude and openness for putting all of these proceedings together, vetting the patient applications, all the phone calls, all of our inquiries. I think we need to publicly acknowledge them over and over again for the work that they do. So thank you, Conny and team, Mallory -- I know I'm missing somebody, so I'll just say those two names. I know I'm going to forget somebody.

Also, thank you to the Board for your expertise and passion, and to the audience for bringing your testimonies and witness to these proceedings.

I wanted to go over while we're on this break to talk about the official veto message from the governor, which I want to state so we're all clear on what happened, which rejected all of the Board's recommendations from the May 2015 meeting to set a proper stage and dispel any myths about it, and I'm going to read the quote.

The veto message for SB33 to the Illinois Senate, 99th General Assembly is as follows, and I quote, "The pilot program is moving forward but remains in its early stage. Cultivation centers are just beginning to grow their crops, and the first

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dispensary was licensed at the end of August. No patients have yet been served, and consequently the State has not had the opportunity to evaluate the benefit and cost of the pilot program, or determine areas for improvement, or even whether to extend the program beyond its pilot period. It is therefore premature to expand the pilot program before any patient has been served and before we have had the chance to evaluate it. Therefore, pursuant Section 9(b) of Article 4 of the Illinois Constitution of 1970, I hereby return Senate Bill 33 entitled 'An Act Concerning Health' with the foregoing objections: Vetoed in its entirety. Sincerely, Bruce Rauner, Governor."

So I wanted to clarify some things that as a board we are doing what we can to help this pilot act in a balanced, scientific, compassionate manner. I think we have to put our politics and social agenda aside and boil it down to what matters most, which is easing human suffering with appropriately vetted, stringently cultivated, strictly monitored dispensing and properly dosed medical marijuana from our state sanctioned growing centers and dispensaries.

As we did in May this year, we will evaluate

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all these conditions as we have been using the evidence base but also using our common sense and our clinical experience, taking to heart our petitioners' presentations and combine that all with compassion.

This is a volunteer board composed of physicians, of pharmacists, an ethicist, nurses, patients, and patient caregivers. We bring a high level of education to this table, and we ask that our recommendations be taken seriously as the pilot act moves very soon into its implementation stage, which is the request of that letter that we see cannabis start getting into the hands of patients.

So now that we are vetting and making recommendations, I'm hoping to receive feedback from the Governor, we are hoping to get feedback regarding our recommendations today, as well as what we recommended in May. Because the deadline for our recommendations today should hopefully fall within the cracks of dispensaries opening and having product available to patients.

And I'd love to know a timeline for when we are going to get some feedback regarding the petitions in May because that's what we're waiting for. We want to see that the pilot act is working, patients are

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being helped, the bugs are worked out. I would like to know when we're going to hear about our May recommendations, as well as the ones we make today, and to get some guidance on how to go about that.

Do we need to repetition everything all over again from May like we are for some of the conditions today, or do we have to -- are they just going to be looked at again three months into the pilot when people are getting cannabis at the dispensaries.

So that is an open question. I'm speaking for myself but I do think that these are issues pertinent to the Board.

So I thank you for letting me take that opportunity, but these are questions that have come up because of the blanket veto of our petition recommendations in May.

So that being said, we still have to read the results of the vote for osteoarthritis.

MS. MOODY: So there was a problem with one of the ballots that Tina and I could not decipher it properly. So we would like to ask dispensation of the Board to take another paper vote if that would be all right. We have another set of ballots that we will pass out.

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MEMBER WEATHERS: Given that there's two check boxes, I'm not sure how we screwed that up -- I'm sure we did. Can we clarify?

MS. MOODY: So there is a yay -- a yes, that "I agree with the motion being made" and on the right side of the ballot a nay or no and there was a -- one of the ballots confused, or scratched out, or rewrote those, and Tina and I had difficulty deciphering what the voter actually intended.

So I'm sorry for that, but we want to make sure that we do it correctly.

CHAIRPERSON MENDOZA TEMPLE: Thank you for ensuring that process.

Following the announcement of the vote we'll take a short break, a restroom break, and then convene. We have a petitioner who is on her way, and I think we're going to move autism to the end to give her a chance to settle in. So our first condition following the break will be irritable bowel syndrome.

So it's 11:00. So would you say 10, 15 minutes?

MS. MOODY: That would be fine.

CHAIRPERSON MENDOZA TEMPLE: So let's say at 11:15 we come back to the room after we announce

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our vote.
So I'm going to also look at who has signed in. Has there been anyone who has not signed in yet that is slated to be a speaker?
(No response.)
CHAIRPERSON MENDOZA TEMPLE: Okay. We have two closed sessions, of which one I know is not here -- actually, both closed session petitioners are not here.
AUDIENCE MEMBER: I am here.
CHAIRPERSON MENDOZA TEMPLE: You are here, okay. So we're actually going to close the first session and then we'll -- after the break and the announcement. Is Liana Bran here and Kalee Hooghkirk, as well as Jared Taylor? Okay.
The condition of osteoarthritis passed with a vote of 8 yes, 2 no. Thank you.
Okay. So we take a break and we convene at 11:15. Thank you.
(Recess taken, 11:01 a.m. to 11:31 a.m.)
CHAIRPERSON MENDOZA TEMPLE: So if we could get the proceeding in order, we're going to start again reopening our session.
So based on my comments earlier, I wanted to

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ask for a clarification and -- regarding what happens with the May petitions that were made and rejected in total. And Conny is going to go over how that works.
MS. MOODY: All right. So thank you for that question, Leslie.
So the -- again, the Department's administrative rules on the petition process and on adding debilitating conditions -- and this is in the Illinois Administrative Code. It's Part 946 and Section 30 deals with the addition of debilitating medical conditions, and it spells out the process that we're following here today for petitioners to submit petitions to the Department twice a year for the Medical Cannabis Advisory Board to consider those petitions, for the Advisory Board to make a recommendation to the Department, and then, also, for the director of public health to render a final decision regarding the acceptance or denial of the proposed debilitating medical conditions or diseases. And I'm reading straight from the administrative code.
So once that final decision is made, and the director did not approve any of the recommendations made by the Medical Cannabis Advisory Board, those petitions from -- that were heard at the May 4th

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hearing are no longer valid for consideration by the Department.
So what does that mean? That means that under both the Act and under the rules, petitioners can submit petitions for those same conditions to the Board again during one of the open petition periods, and there's one every July for 30 days and one in January of every year for 30 days.
So those -- and that's why, for example, osteoarthritis, that petition, although it was considered at the May 4th petition hearing, it was submitted again during the July petition period, open petition period. We reviewed that petition for whether or not it met all of the criteria and the rules. Those did and they were submitted then to the Board for consideration again at this petition hearing.
MEMBER WEATHERS: Can I ask a clarifying point? I guess -- and it depends on how you interpret what you just read -- that I understand those are off the table. As a Board, are we forced to only wait and respond to petitions, or as a Board can we in addition to what we say today also say we additionally approve or we additionally recommend to the director of public health and provide a list based on those conditions

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that we've approved previously? Can we reiterate that at each meeting without necessarily having somebody come to us first?
MS. MOODY: So the way that the rules are written, it requires a petition to be submitted to the Department, reviewed for whether or not it meets the criteria and the Act and rules, and then pass it along to the Board for consideration.
So we must -- you must as a board act upon those petitions for those conditions that are submitted to you for consideration. Does that answer your question?
MEMBER RAMIREZ: So there is no automatic resubmission?
MS. MOODY: Correct. There is no automatic resubmission. It must be -- your action, your consideration during the petition hearings must be triggered by a petition for a specific condition which results in your review, your consideration, and your recommendation.
MEMBER WEATHERS: Follow-up question. Are we being, then, very clear on the website about which condition -- did people understand that and understand which conditions would need to be resubmitted? I

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know, obviously, osteoarthritis was done today, posttraumatic stress disorder, but in the future, just so people aren't under the impression that they did the work -- that people would know specifically they need to resubmit that?

MS. MOODY: So the directors' denial of the petition recommendations was posted on both the Department's website and also the general medical cannabis statewide website, the mcpp.Illinois.gov website, which is where all of the departments post information, updates, and announcements. This was posted in both of those places.

When we opened the July one, the 30-day petition period, we did not specifically call out any specific conditions. We simply opened up the petition period and provided the appropriate forms for submission.

Now, we talk to a lot of people who call us and ask questions, and we do respond and clarify. But if you remember, the decision by the director was not made until after the petition period was actually closed, after June 30th.

VICE CHAIRMAN FINE: Is there a way that we can amend that? Because right now then everybody is

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kind of hostage to whether the director makes a decision in a time frame that is necessary for them to file a petition.

So is there a way that we can make that date fluid so people don't have to go through the trouble of reapplying for the same exact thing they did before because the director didn't decide in the time frame that -- could we make it coincide to whenever that date is, or is there a way to tie those together to save people the aggravation of going through this an additional time for no reason?

MS. MOODY: So what that would require would be for the Department to seek an administrative change through the State's policies or rules.

VICE CHAIRMAN FINE: JCAR?

MS. MOODY: The JCAR process.

VICE CHAIRMAN FINE: Okay. Forget it.

MEMBER WEATHERS: Is there any advice that we can -- because to serve the members, and the patients, and the public, is there advice we can give people from a purely technical standpoint, you know, save your work as a PDF or a Word file so it can be transposed --

MS. MOODY: I think you're doing that now.

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VICE CHAIRMAN FINE: Can we post it on the website?

MEMBER WEATHERS: Or spread the word among your colleagues. Are they able to save it as a PDF and resubmit that exact same thing, or do they need to update the dates and incorporate that?

MS. MOODY: So the petition documents do require signature and dates on them, but certainly, as with any sort of public comment document. The -- it is a writable PDF form. So if a petitioner were to retain their research, the verbiage that they have put together, they would be able to fill those forms in again.

MEMBER WEATHERS: And the letter of medical support, is there a date on that where we would expect to see a new letter, or is it as long as there's one on file at some point?

MS. MOODY: Well, it would have to be a letter that is submitted with the submission documents. So we do not keep those on file and say, oh, look we still have it. We don't do that. So it must be a full petition package.

As we move on into future petition periods, I think that we would be remiss if we didn't look at a

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letter and say, oh, this is dated two years ago, something like that. So current is good.

CHAIRPERSON MENDOZA TEMPLE: The definition of current will be -- because then these petitioners will be, "Well, I did it three months ago."

MS. MOODY: And three months is different than three years.

CHAIRPERSON MENDOZA TEMPLE: Okay.

MEMBER RAMIREZ: Did the Department strive in any way to notify the individual petitioners who had been approved or disapproved in May of the fact of the veto? Individually were they notified or it was just a collective thing on the website?

MS. MOODY: So the -- I do want to correct that it wasn't a veto. It was just for technicalities -- you and I both like words, Nestor. So it wasn't a veto; it was just the recommendations were not approved.

MEMBER RAMIREZ: The nonapproval.

MS. MOODY: And the Department is working on that notification of those individuals.

We do notify individuals who submit petitions that do not meet the criteria in the Act and rules that their petition did not meet, and we also

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give them some background information about why it did not meet the requirements for submission to the Board.

So we're working on improving all of those processes. Because, as you are aware, we are learning this, also.

CHAIRPERSON MENDOZA TEMPLE: I also want to call attention to the many inquiries that IDPH gets. They do much more than what she's saying. They're probably kind of a therapy session group, as well. So they are to be very highly commended about the many calls -- I'm sure you got some pretty upset calls, as well, and handling them professionally and with grace is really -- that is so important to the success of this pilot. So I thank you for that. It's not an easy job, I'm sure.

MS. MOODY: Well, on behalf of my very dedicated staff, I thank you for those comments.

MEMBER RAMIREZ: Who would be upset?

CHAIRPERSON MENDOZA TEMPLE: We're not upset. We're fine.

Okay. So we have a slight change in the order because of one of the speakers who had to arrange some childcare, and we were going to put -- we're going to put autism at the end, and I hope that

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that works. Is our petition here for autism? Is Patricia here yet?

(No response.)

CHAIRPERSON MENDOZA TEMPLE: Perfect. So it's good to put her at the end. So I apologize for any inconvenience this causes in the reordering of our agenda.

So we'll start with irritable bowel syndrome, and we have two closed petitioners.

VICE CHAIRMAN FINE: Pursuant to 5 ILCS 120/2 back/2(c)(4), I hereby motion to close this hearing for closed session.

MEMBER LESKOVEC: Second.

VICE CHAIRMAN FINE: All in favor.

(Ayes heard.)

MS. MOODY: So I would ask everyone to exit the room, and Mallory and Tina will indicate to the first speaker for closed session to remain in the room, please. If everyone else will exit, and then we will request that you return to session.

CHAIRPERSON MENDOZA TEMPLE: Actually, we have two closed sessions.

VICE CHAIRMAN FINE: Joe, you can stay.

MS. MOODY: Staff, absolutely.

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CHAIRPERSON MENDOZA TEMPLE: So we actually have two closed sessions. Do we call them back in and then send them back out?

MS. MOODY: Mallory and Tina are going to work with the speakers to ensure that they each have an opportunity for closed session.

MEMBER WEATHERS: But procedurally do we need to reopen and reclose?

MS. MOODY: No. We will just move from one closed session to the next, and Paula is going to also capture the audio because according to the Open Meetings Act for closed session we do need to have an audio transcript, also. So while the general session under the Open Meetings Act does not need to be verbatim, for a closed session, for closed proceedings we do need a verbatim transcript. So she is going to set up the audio, and she's going to let us know when she's ready to proceed.

MEMBER CHAMPION: Is that then available on the Freedom of Information Act, the closed session?

MS. MOODY: No.

MEMBER CHAMPION: So anyone --

MS. MOODY: Closed means actually closed. However, we do have to have that transcript on file in

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case there was a legal proceeding.

MEMBER CHAMPION: Someone asked me about that because they said they were worried about giving testimony because of their job, and I told them I thought they should request a closed meeting.

MS. MOODY: Yes. That would be accurate. I do -- and, again, I'm not a lawyer so I cannot speak specifically. I believe that there are some court actions whereby a closed session testimony could potentially be released, but they're highly specific.

MR. WRIGHT: And if someone is worried, those can be sealed for lawyer's eyes only.

MEMBER CHAMPION: It can't be used against the person?

MR. WRIGHT: Right.

MS. MOODY: Now, the transcript, the general transcript -- so when we work with our court reporter, we have a general transcript of the open portion of the meeting and then the closed session transcript, and audio is sent to the Department in a separate file so that those two pieces are never together.

MEMBER RAMIREZ: Now, does the public get access to the general transcript before it gets approved by the Board as official minutes?

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MS. MOODY: No. We do not post that because you need to as a board take action on the minutes, which would be the transcript or general minutes of the hearing or the meeting that we have with you. So I will work with our legal counsel to ensure that when we do post -- now that you have approved the minutes for the May 4th hearing with corrections and with a statement from -- I believe Jim was the only individual who actually made a statement. I'll work with our legal counsel on how to properly showcase that when we move to post those minutes officially.

(Whereupon, at 11:46 a.m., the Board adjourned into executive session, after which the following proceedings were had in public session commencing at 12:12 p.m.)

CHAIRPERSON MENDOZA TEMPLE: If we could take our seats, we're going to proceed with the open session of irritable bowel syndrome. I think we've got almost everyone in the room, if you could take your seats, and we heard two closed sessions, now we're going to open it up to the next scheduled petitioners.

Am I missing anything?

MS. MOODY: And Paula is ready.

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CHAIRPERSON MENDOZA TEMPLE: Sorry, I didn't ask if you were ready.

THE COURT REPORTER: It's okay.

CHAIRPERSON MENDOZA TEMPLE: So we are going to hear from -- so if everyone would kindly take their seats, I promise lunch is after this. Liana Bran please come up.

MS. MOODY: Just as a reminder to the speakers, I am going to hold up timing signs. So when the one-minute sign goes up, that means you have one minute left to present testimony, 30 seconds at the last 30 seconds.

MS. BRAN: I just wanted to share some of the references I provided so you have it in front of you. Is that okay?

CHAIRPERSON MENDOZA TEMPLE: Yes. We'll add it to our paperwork for this petition. And, again, this is for irritable bowel syndrome.

And thank you to the audience for your patience in waiting for us through the closed session.

MS. BRAN: Good afternoon -- I guess we're there.

So I also want to thank the members of the --

MS. MOODY: Would you please first state your full name and spell it for the court reporter, please.

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MS. BRAN: My name is Liana Bran. That's L-i-a-n-a, B-r-a-n.

So I do want to thank the Board for allowing me to submit testimony today. To address the proposal that irritable bowel syndrome should be added to the current list of conditions, I must begin by saying that, unfortunately, like many of the conditions presented today, the causes and exact mechanism of irritable bowel syndrome, or IBS, are not well understood.

While, again, there may, of course, be a possibility for future application of specific cannabinoids in the marijuana plant to treat this condition, I provided an article in Practical Gastroenterology, which is a peer-reviewed professional clinical medical journal which maintains that studies on the effect of smoked cannabis on IBS are lacking, as I'm sure you know, and they also add that the overall effects of THC on GI motility in IBS are veritable, and its effect on abdominal pain and visceral sensation is not promising.

Another thing I wanted to point out is that

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the effects of marijuana on the GI system overall are not well understood, and that's evidenced by one of the paradoxical outcomes of hyperemesis that has emerged in some chronic marijuana users, which is cannabis-induced cyclical vomiting syndrome.

I think what most troubles me here is the fact that IBS in practice requires a diagnosis of exclusion. In other words, diagnostic criteria has not been standardized over time, and so there is a potential for a margin of error in their application. As such, there lies the potential for diversion of what is intended to be medical marijuana for personal use.

IBS also ranges in severity and is much too broad to be included as is into the list of chronic conditions. While most people currently are accessing medical marijuana cards for genuine medical purposes, that may quickly change if a fairly common ailment is introduced that lacks robust diagnostic criteria.

And, of course -- I think I have a little bit more time. The intent, of course, of this initiative is around compassion, but I think an important part of the implementation of the program in order to maintain the integrity of the purpose here is

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to make sure it's going to who it's intended to go to. And I think it can be problematic in circumstances such as these where -- and other ones where there are more broad conditions or it's more subjective and it's harder for the physician to be able to determine if there is a cause, and, unfortunately, that's been the case in some other states.

So, again, for the integrity of the program I think that's very important. I think of the 3,000 cards that have been distributed, one note, I believe about 1,000 of those were given out by one doctor, and I question whether he could maintain a relationship with all those patients and make sure they're all using it appropriately.

CHAIRPERSON MENDOZA TEMPLE: Thank you for your testimony.

We have next on the list -- I'm sorry if I mispronounce your name -- Kalee Hooghkirk.

MS. HOOGHKIRK: Hi. My name is Kalee Hooghkirk; K-e-l-e-e, last name H-o-o-g-h-k-i-r-k.

I want to thank the Advisory Board for allowing me to speak on behalf of the irritable bowel syndrome. I've suffered with IBS and IBD since birth. As you may know IBS is a chronic inflammatory disease

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which can cause unpredictable and debilitating symptoms. The cause is IBS is unknown and can oftentimes be difficult to treat due to a wide range of uncomfortable and overlapping symptoms that it shares with IBD, such as colitis and the already approved condition of Crohn's disease.

Not only can IBS be difficult to pinpoint due to the shared symptoms, but treatments are extremely unreliable and do not work equally for each individual.

Due to its debilitating nature, I've suffered in school and in my work life. Bouts of nausea and severe acid reflux make eating unbearable and extreme weight fluctuations inevitable. Spontaneous and rapid cramping of my colon often leaves me paralyzed in pain. Random and painful, itchy rashes plagued my body and have caused permanent scarring. Frequent and sometimes uncontrollable urges to use the bathroom has caused me to miss so many days from school that my attendance was once reported to the district officials. And even as an adult with proper treatments and recommendations from my GI, it still causes me to force cancellations with my clients on a regular basis and even once a visit to the ER.

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According to ibs.org the cost to society in terms of direct medical expenses due to the costs associated with loss of productivity is considerable, and estimates range to $21 billion or more annually. I've tried many medications and fad diets over the years, and while some provide relief over time, there is absolutely nothing that is able to give me immediate relief from my symptoms.

There's extensive evidence from patients with IBS and Crohn's disease and other painful GI disorders that cannabis eases cramping and helps to modulate diarrhea, constipation, and acid reflux. Recent laboratory research on the endogenous cannabinoid system in humans has identified that there are many cannabinoid receptors located both in the large and small intensities.

Cannabis and new cannabinoid drugs are ideal for GI treatments because they can address a number of symptoms almost immediately with no side-effects. Cannabinoids alter how the gut feels and affects signals to the brain, send back and forth a gut modulating action that sends information to the GI tract itself.

I'm currently taking four separate

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medications to treat my variety of systems, and while there are little to no side-effects from cannabis, some of the medications I've been prescribed cause various musculoskeletal, gastrointestinal, and neurological and endocrine disrupting side-effects, including loss of muscle, appetite, osteoporosis, peptic ulcers, pancreatitis, and convulsions, and even glaucoma, which is an already approved condition.

I've been prescribed Bentyl, which causes my heart to race and for some can cause seizures and confusion, vomiting, and blurred vision. Others cause ulcers, vomiting, and stomach pain, which are all symptoms people with my condition already face. We deserve a safer alternative, and we need another option. I urge you to continue your support for IBS and continue recognizing this condition.

Thank you.

CHAIRPERSON MENDOZA TEMPLE: Thank you for your testimony.

Okay. Mr. Taylor, Jared Taylor.

MR. TAYLOR: Please, Jared.

CHAIRPERSON MENDOZA TEMPLE: Okay. We know you now.

MR. TAYLOR: I don't have a watch on, but

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good afternoon everyone. My name is Jared Taylor. I come before you to urge your recommendation of the irritable bowel syndrome, IBS, as a qualifying condition to the Medical Cannabis Pilot Program.

According to the Mayo Clinic, IBS is a common disorder that affects the large intestine. IBS commonly causes cramping, abdominal pain, bloating, gas, diarrhea, and constipation. It affects between 25 and 45 million Americans, and it's estimated to affect 1 in 10 people worldwide. IBS is a chronic condition that will require long-term management.

There's no known cause of IBS. In a normal functioning adult an individual's intestines contract and relax in coordinated rhythm as food is moved from the stomach, through the intestinal tract, to the rectum. With IBS the contractions may be stronger and last longer, causing gas, bloating, and diarrhea. It is also possible that the contractions may be weaker, which will slow food passage.

These poorly coordinated signals between the brain and the intestines can make the body over react to normal changes in the digestive process. The overreaction can cause pain, diarrhea, or constipation.

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While many people have signs and symptoms of IBS, there are four distinct groups that have a higher risk of IBS, those under the age of 45, females who are twice as likely to have the condition, those with a family history of IBS, and those who have a mental health problem such as anxiety, depression, or personality disorders.

While it's not clear as to what causes IBS, treatment options focus on the relief of symptoms. Dietary changes that alleviated symptoms of individuals with IBS include eliminating high-gas foods such as broccoli, cabbage, and cauliflower, and eliminating gluten. There are few medications that are currently approved for IBS: Alosetron and Amitiza. Alosetron relaxes the colon to slow the movement of waste. It can only be prescribed by doctors enrolled in a special program, and it is not approved for use by men. Amitiza works by increasing fluid secretion in the small intestine to help with the passage of stool. Its effectiveness in men is not proven, and its side-effects include nausea, diarrhea, and abdominal pain (which are the symptoms of IBS that this medication is trying to prevent).

In 2004 the University of Naples conducted a

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study titled "Cannabinoids and Intestinal Motility: Welcome to CB2 Receptors." This study found that cannabinoids which are found in cannabis inhibit gastric and intestinal motility through the activation of enteric CB1 receptors. In plain English, the use of cannabis slows down the digestion process for those with IBS by activating receptors in the intestine.

IBS has no cure and modern medicine does not have an explanation for its occurrence. The symptoms that this disease causes are painful and inconvenient for those afflicted with IBS. Cannabis is a proven medicine that can help to better regulate the digestive process for those with IBS, and it is effective in managing the pain IBS causes.

I must add, however, that there is no such thing as marijuana, only the cannabis sativa plant exists, and there are other ways to ingest cannabis other than smoking, such as edibles, tinctures, and oils.

While I myself do not have irritable bowel syndrome, I urge the Illinois Medical Cannabis Advisory Board to recommend IBS for addition to the Medical Cannabis Pilot Program. This is truly a debilitating and should be a qualifying condition.

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Thank you for your time. And God bless the State of Illinois.

CHAIRPERSON MENDOZA TEMPLE: Thank you, Mr. Taylor, and thank you to all of you who have had the courage to come tell us your personal stories. We appreciate that and take that to heart.

So we open up the comments from the Board regarding IBS.

MEMBER WEATHERS: I would like to make a comment about Ms. Brown's testimony. I recognize her concerns that it is a difficult diagnosis to make; it is a diagnosis of exclusion. However, just to point out that most of the time what is in the differential is IBD, irritable bowel disorders --

CHAIRPERSON MENDOZA TEMPLE: Inflammatory.

MEMBER WEATHERS: Inflammatory. Thank you -- which are already approved conditions. So either way the diagnostic dilemma would be between IBS, which is under discussion, versus something that is already approved.

MEMBER MC CURDY: I would like to raise some questions about the sources that we were given just because --

CHAIRPERSON MENDOZA TEMPLE: Could you turn

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your mic on?
MEMBER MC CURDY: Is it on now?
The first article we had, as I'm recalling it, was about inflammatory bowel disease. But, also, all of the articles seemed to be either about studies done on mice on studies done that looked at the physiological or pharmacological mechanisms within people but no trials on humans that I saw.
So I guess I would wonder if any of you has other sources or if I misread some of the sources that we have.
MEMBER MILLER: I just want to raise some concerns, as well. The disease process on the table is irritable bowel syndrome, and there's a difference between irritable bowel syndrome and the inflammatory processes that Allison has already mentioned were already approved.
Irritable bowel syndrome does not usually occur with the inflammatory process that Crohn's and ulcerative colitis, and IBD has, and that is defined by Mayo Clinic and several other clinical resources that are based on evidence.
The other issue I have is with the articles that we were provided. The articles -- the first

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article, "Beneficial Effect of the Nonpsychotropic Plant Cannabinoid," that study was placed on IBD, not IBS. So it was looking at Crohn's and ulcerative colitis, that disease process that has the inflammatory process, which is not IBS.
That also then leads to my other question or concern is the other study was on rats, animals and not people.
MEMBER WEATHERS: Can I clarify my point? I guess the point that I was making is to address that one of the concerns that the speaker brought up was that this could be misdiagnosed.
My point is if it's -- the only other really big diagnostic category is IBD. So I'm not as concerned as a physician even if I misdiagnose IBS as IBD that's still approved. I actually feel that this should be approved. I guess my point is by just saying, okay it's IBS are you missing something more serious. Well, if I'm missing something more serious, that's on me, and that's something that we've approved anyway.
I know we discussed this at length last time and voted for it. I agree this is a very -- although, we don't see inflammatory changes, we know that this

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is a very hard-to-treat condition. As people have spoken to, there are very limited treatments which can be quite debilitating, meaning sometimes more frustrating for people because there isn't a way to diagnostically confirm it. So I still feel there's significant value.
I know we're concerned about the lack of evidence, but, again, it goes back to the fact of this being a Category I. It's a little bit we kind of get into a spiral where we know that there's not going to be sufficient evidence. For all of us in what we do, we believe very strongly, the clinicians on the Board, about the need for evidence that's based in studies. Kind of what comes first, until this is approved, we're not going to be able to have the data that we want.
So I think at some point we're saying it's compassionate use and we still feel that there could be significant benefit, and I do think there could be absolutely with this drug.
MEMBER LESKOVEC: Yes, I have a question about the material that was provided by the speaker. I'm unable to find the citation for this document, Practical Gastroenterology.

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MS. BRAN: Yes. I apologize. I provided the link on the original statement of intent, but this was produced I think in 2014.
CHAIRPERSON MENDOZA TEMPLE: Anything else, Jacqueline?
MEMBER LESKOVEC: No.
CHAIRPERSON MENDOZA TEMPLE: Jim?
MEMBER CHAMPION: I was just going to say that I know firsthand how cannabis can help stomach problems, as I have a multitude of them. As a matter of fact, I'm dealing with a very serious stomach ailment right now.
Cannabis allows me to maintain -- cannabis relaxes my digestive tract and allows me to maintain a healthy diet. Often I know this to be true when I'm in the hospital at Hines, and I'm there a week or two without my cannabis, I actually lose weight on a regular basis. I don't know if it's spinal cord injury or disease or what it is, but food is just not appetizing for me.
And like I said, I have a multitude of stomach problems, and I'm having one now, but cannabis gives me unparalleled relief that I've yet to find in a medication that comes near to relaxing the digestive

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tract as cannabis does.
CHAIRPERSON MENDOZA TEMPLE: I appreciate that. And I know, Jim, I know you're not feeling well. So I acknowledge he's going through a challenging time. And let us know you if you need anything, and thank you for being here.
I, also, hear Ms. Bran's concerns, and from my evidence-based mind, and my compassionate mind, my common sense clinician, what's going to work and make my patient happy, and I have to balance all of that out.
I did want to point to, yes, there is a cannabis -- the hyperemesis syndrome where people throw up because of cannabis, and I want to point out this is not some freebie medicine that doesn't have side-effects. It does have a lower risk of addiction but it's there; it's not zero. We recognize that.
I think we have to call out that there are risks to everything we do, but you put that scale of risk and compare it to the other alternatives. Then I turn to this medicine for a select group of patients I see with IBS, and the fact that there is CBD, Cannabidiol available, which is primarily focused on your CB2 receptors, should not affect the brain.

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There are actually no or maybe a minimal amount of cannabinoid receptors in the brain stem which causes respiratory depression. That's why people can die of not breathing anymore from opioids. Cannabis doesn't have that.
So when I start looking at the microbiology of all of this, I did see in one of the articles provided from a symptoms perspective, there is good evidence base on nausea and vomiting, which was one of the features of one of our speakers up here that it works on your 5-HT3 receptor antagonists.
So do I call that, well, that's good for cancer-related anorexia and vomiting due to chemotherapy and just say it's only good for that? How come it can't be useful for nausea from other causes, i.e., ulcerative colitis, Crohn's disease, irritable bowel syndrome.
So we have to also take a broader view of all of these conditions. Yes, they are difficult to prove. Like I said before, you're not going to get the kind of research that I want to see as an astute academic clinician. I have learned to accept that -- do you want to close the doors -- it's okay.
So I want to point out that there is an

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evidence base for the symptoms that do lead to irritable bowel syndrome, but no, we probably don't have a ton of -- I didn't see human studies on IBS. So, well, then how come fibromyalgia is on the list, too? There are 39 other conditions that if we were to put a microscope on them and reevaluate everything, there's going to be some stuff on there we're going to cross off, and I don't think that's a good idea at all. So we're putting a microscope on these new conditions because they weren't there before.
So I wanted to see if there are any other comments.
MEMBER WEATHERS: Can I make one more -- I don't know what got me on this one. But just to add on, one of the other concerns that was raised was about the incidence of this condition compared to some of the others, and the volume of people, and now the clinicians. And I think as a Board we still need to be very clear in the work we're doing that -- and we said this last time, but just reiterate that we still expect -- this is still a medical decision between the patient and their provider, and we expect each case to be carefully evaluated on its own merits.
Every patient is different. We're just

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giving people the potential to have that conversation. I know -- and I have the same concern about some of the names, physicians names, but I don't think the Board is here to make a decision based on the concern about some individual physicians not practicing appropriately. I think that's a really dangerous path to go down. I mean, we're giving tools and we expect people to practice responsibly and ethically and on the merits of what they feel each patient is appropriate for.
MEMBER RAMIREZ: I have a comment on the lack of evidence. Part of the fact that we don't have evidence is it's very hard to obtain legitimately. There's a lot of FDA problems and paperwork. So part of the lack of evidence is not because there's no patients or no marijuana; it's the fact that we cannot obtain it legally for research purposes.
CHAIRPERSON MENDOZA TEMPLE: David.
MEMBER MC CURDY: I think all these points are well taken. And I want to make a distinction related to something that Dr. Mendoza Temple said.
I am inclined to take the word of my clinical colleague who knows a lot more about this stuff than I do in terms of practice that there are

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reasons why physicians should be able to recommend -- I guess you can't prescribe but to recommend this for their patients.

So I'd be inclined to vote for the condition on that basis. But I do think that it's a little touchy to be making -- the criteria that, well, you know, other conditions are in the law for which there may not be a lot of evidence either, but the statute has already anointed them as acceptable conditions.

I don't know that that means that we should lower the standard that we apply because the law includes some conditions that we might actually question more than some of these. I think we still need to try to keep to a standard that we establish that may be apart from what we think might have been in the drafters of the statute.

CHAIRPERSON MENDOZA TEMPLE: Other comments?

(No response.)

CHAIRPERSON MENDOZA TEMPLE: I suggest we make a motion.

MEMBER RAMIREZ: I move that we vote.

VICE CHAIRMAN FINE: Second.

CHAIRPERSON MENDOZA TEMPLE: Conny, did you want to go over some of the discussion that we had, or

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do you want to wait until lunch?

MS. MOODY: That would be fine. Whatever your preference would be.

CHAIRPERSON MENDOZA TEMPLE: Why don't we do it while most people are here.

MS. MOODY: Okay. So one of the issues that was brought up was the need for an explicit and detailed justification for the decision made by the Department for the fact that the director did not approve the May 4th -- the petitions recommended by the Board at the May 4th petition hearing.

And I wanted to point out for the Board -- because that was one of your questions -- and I wanted to point out that both the rules and the Act simply state that the director will render a final decision regarding the acceptance or denial of the proposed debilitating medical conditions or diseases, and that's both in statute and also in our rules.

So I believe a comment was made that there was a requirement, a statutory requirement for justification, but neither in the Act or in the administrative rules is that found to be true.

MEMBER WEATHERS: Is the time period, though, stated?

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MS. MOODY: So the time period is indeed stated and that's actually -- what the Act says is the Department will approve or deny a petition within 180 days after its submission, and then what we've added as part of the rule is during the biannual petition period.

And we strive to meet those deadlines, but as you all know, we move in the real world.

MEMBER WEATHERS: I still -- going back to the earlier discussion, and I defer to Dr. Wright, but given the fact that it wasn't on the merits of each -- the decision made on each condition but under the overall directive of the veto, does that allow for kind of interpretation or room for saying that once that decision is changed, the previous recommendations of the committee will be reconsidered given that it wasn't that, you know -- I think it was an unusual situation in the way that it was denied because of the veto rather than the individual merits of each one.

MS. MOODY: And the Act itself states -- and I'm going to quote from Section 45 within the Act. So that's statutory language, not the Department's procedural rules but statutory language. Section 45, "Addition of Debilitating Medical Conditions" states

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that, "The approval or denial of any petition is a final decision of the Department."

So that does lead us then to look at our administrative rules as the submission of a new petition during an open petition period is required even if -- there is no limitation in our rules to how many times a petition can be submitted for a specific medical condition.

Does that answer your question?

MEMBER WEATHERS: It does. Thank you.

VICE CHAIRMAN FINE: So, Conny, do you think it's a good time now to tell people that if this same thing happens again that everybody filing a petition should maintain copies of their petitions? They are going to need to be refiled, but if it's not decided by the time that the deadline arises for the petition to be refiled, it would make sense to submit it. And then if the condition approved, it will be disregarded. But if the condition is denied, it will be back in line again to be approved.

Unfortunately, you'll probably have to come back and testify again, and we'll all have to sit here and say the same thing again. But the point is, that's the only way to maintain the integrity of this process

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and to keep your space in line for it to keep being heard again. And hopefully at some point somebody will hear us, and we can go forward from there.

MS. MOODY: What's very important, though, for petitioners to note is that we would be looking for a petition to be filed during that 30-day open petition period.

So if a petition is filed with the Department, submitted to the Department during, for example, the July 1 to July 30th time frame, and it is dated 2014, for example -- and I'm using that as an example only -- we would have to deny that petition outright because it was not submitted --

VICE CHAIRMAN FINE: So it needs to be current dated at that point. So, in other words, you don't have to start from scratch. It's simply whiting out the date, putting in a new date, and signing it, and that would bring it to the place it needs to be.

MS. MOODY: No whiting out, no crossing out. We would like a clean, new petition to be submitted.

VICE CHAIRMAN FINE: So clean, new petition to be resubmitted.

MEMBER WEATHERS: And one more point of clarification. If the conditions are approved, they

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don't need to -- the condition is already -- we don't need to rehear it.

MS. MOODY: So what we would do is we would discuss that with the Board, and we would indicate we have received these valid petitions, and we are going to recommend that since they are already approved, if that were the case, that they not be added to our agenda. And we would notify the petitioner of that.

VICE CHAIRMAN FINE: Fabulous. Thank you.

CHAIRPERSON MENDOZA TEMPLE: Jacqueline.

MEMBER LESKOVEC: We don't see the petitions that have been rejected. So, basically, they don't meet the criteria that's been set forth by the Department. But for those of you who have been with us since the last time we met, what I've seen here is quite an improved documentation provided with the diseases and disorders. And although I haven't done a formal study, I would suspect that we're seeing a lot more research being done in the area.

So even if your condition has been approved by -- has been recommended by the Board to move forward, you also have the opportunity to increase your support for your disease or disorder and to improve your documentation, and, therefore, either for

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those who have not been approved or those which have been approved, you've got a second chance.

MEMBER MC CURDY: So petitioners or would-be petitioners should please note that we've become an advisory board in a second sense, advising petitioners as well as the Director. So I think it will work.

MEMBER CHAMPION: I think the petitioners have done a very good job themselves.

CHAIRPERSON MENDOZA TEMPLE: I have a question, too, after you tally the votes, Conny.

What would be the process as we are collecting patient's stories and we want to make a great case that the pilot act is working and everyone is getting what they need? How would they direct that information? Is it a letter written to IDPH? And I know she's tallying.

MEMBER WEATHERS: Sorry. We can repeat that in a minute.

MS. MOODY: If you'll let me do my math first.

CHAIRPERSON MENDOZA TEMPLE: Do your math first, but maybe for the group, the more stories and testimonies you can provide, that's what's going to help propel this project forward. Because if nobody says it's great, or they only hear bad things, then

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the evaluation for the success of the pilot act is really going to hinge on what's the feedback.

MEMBER WEATHERS: To form it another way -- and I know that's not what we're tasked with -- what are the metrics for the program?

CHAIRPERSON MENDOZA TEMPLE: I can announce the vote first, and then we'll go to that subject.

So for the condition of the irritable bowel syndrome, the vote was 8 yes and 2 no. So it passes.

VICE CHAIRMAN FINE: Again.

CHAIRPERSON MENDOZA TEMPLE: Again. So we should probably give Conny a chance to hear the questions.

We were talking about collecting the patient's -- what's the best way for the public to give their feedback that, "This is working now; the pilot act is working; I went to my dispensary; I had a great experience; my pain is better," et cetera, et cetera?

MS. MOODY: So I think that that is a very good question.

As you know, the data that the Department is collecting is primarily their data on the number of patients, the types of conditions, the locations where

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those patients reside in the State of Illinois. There is not a true mechanism to collect effectiveness data.

So I think that we would encourage patients to continue to tell their stories at hearings such as this, to reach out to our department, to reach out to their legislators, to reach out to the policy and decision makers, the advocacy groups here in the state to tell their stories about the benefits that they feel they are receiving from medical cannabis as the program continues to move forward with its implementation.

But I mean, telling the story. I mean, that's something that we do in public health all the time because a lot of the programs that we implement, at the very beginning they're just a kernel of an idea in somebody's mind that it might be effective. We rely on the evidence base, and building that evidence base is predicated on hearing those stories, learning that.

And, also, professionals, clinicians like yourselves -- and it's not just the State of Illinois, but the Federal government needs to hear these stories, also. You have talked a lot today about the need for more research, and as you know, in order for us in the United States to obtain an opportunity to research medical cannabis, we will require changes in

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Federal law, also. So it's really not just here at the State of Illinois but also at the Federal level that the voices need to be heard.

CHAIRPERSON MENDOZA TEMPLE: Okay. So thank you for your patience. I hope you're not getting too hypoglycemic.

MEMBER WEATHERS: Make a motion we adjourn for lunch.

VICE CHAIRMAN FINE: Second.

CHAIRPERSON MENDOZA TEMPLE: All right. Let's adjourn for lunch. We're going to try to power through it and come back in 30 minutes, which I know means different things for different people, but at 1:30 we'll come back here with posttraumatic stress disorder and then autism.

(Recess taken, 12:51 p.m. to 1:35 p.m.)

CHAIRPERSON MENDOZA TEMPLE: If we could kindly take our seats. We have two more conditions to discuss, so we'll take a moment while we settle in.

We're going to talk about posttraumatic stress disorder, a condition we discussed in May. We have four signed-in speakers -- is that correct -- five. They're all open; correct?

MS. MOODY: Yes.

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MEMBER PARIKH: Six.

CHAIRPERSON MENDOZA TEMPLE: The names I have for this condition are Jonathan Byrne, Zach Cutrara -- is Jonathan here?

MR. BYRNE: That's me right here.

CHAIRPERSON MENDOZA TEMPLE: And Zach, okay. Joel Erickson, Jared Taylor, Liana Bran.

Am I missing anyone else?

MEMBER WEATHERS: Christopher Amos?

CHAIRPERSON MENDOZA TEMPLE: Did I get everyone who is signed in? Because I have another speaker who wishes to come forward.

MEMBER WEATHERS: I don't think they can do that.

MS. MOODY: So it would be at the discretion of the chairpersons if they wish to allow public comment at the end of the hearing. But for the conditions -- for the petitions we're hearing we can only accept those who submitted a request to provide technical evidence.

CHAIRPERSON MENDOZA TEMPLE: Okay.

MS. MOODY: So at the very end.

CHAIRPERSON MENDOZA TEMPLE: Okay. At the very end of the hearing, after we hear autism, we will

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open up time for additional public comments because I know there are some people who would like to present.

Why don't we go ahead and start with Jonathan Byrne.

MS. MOODY: And, Jonathan, while you're setting up, you remember the drill that I'll hold up one minute -- after you have one minute left to speak and at 30 seconds left.

MR. BYRNE: Okay. Good afternoon. My name is Jonathan Byrne. I did two combat tours in Iraq. I conducted operations out of Djibouti, Africa, for the Marine Corps. I conducted training and humanitarian missions in a dozen other countries.

I'm not here to discuss what you guys can do. I think that would be insulting. I'm here to tell you what I have to offer you in experience and what I've seen.

I have 33 pages worth of medications that the VA has prescribed to me in the last six years since I've been in Chicago. It's had a lot of detrimental illnesses and things to my health, you know. I've had four ultrasounds done on my liver due to being overdosed on Tylenol-based medications or aspirin-based medications, mostly hydrocodone 10/325.

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I was up to eight a day for almost eight years.
During that time I constantly cut myself off and supplemented most of the time illegally with marijuana, and I found a lot of relief from the pain symptoms. But a lot of this ties together with -- I have multiple symptoms for PTSD, IBS, chronic pain. So a lot of this is going to overlap, and I hope that that's okay with you guys. Do you want me to specifically focus on PTSD, or can I kind of run everything together?
CHAIRPERSON MENDOZA TEMPLE: However it works for you.
MR. BYRNE: All right. Because there's a whole slew. I could go specifically with PTSD, but all the medications kind of blend together in this one.
Due to one of my PTSD medications, the VA prescribed me a 10 milligram pill when I was supposed to be taking a 1 milligram pill. I was taking two of those a day, and due to the overdose, I had aseptic meningitis. I spent three days on the couch face down; all I could do was lay on my stomach with my hands to my side, felt like I had a vice grip on the back of my neck. I actually figured that out.
I've had stomach ulcers. This is six years

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worth of my treatment records. You know, I got alcohol abuse mixed in with my medications. So it burned my stomach up, caused a lot of erratic behavior and got me in a lot of trouble. It's had a lot of effect on my family. I've had to explain to my 5- and 7-year-old kids why Daddy's got to go and take his walkabouts and go out with his friends and get away from the family sometimes because I can't control my symptoms based off the medications that the VA prescribes me.
So, in turn, what it comes down to is medicinal marijuana alleviates a lot of these symptoms and a lot of the things that these medications do to your body, and I think that that should be offered to the veterans. Because all the VA medications do is they break down your body even further and shorten your life span.
So I appreciate the time and thank you guys.
CHAIRPERSON MENDOZA TEMPLE: Thank you.
VICE CHAIRMAN FINE: Thanks for your service.
CHAIRPERSON MENDOZA TEMPLE: Thank you for your service.
Zach Cutrara.
MR. CUTRARA: Hello everybody. Thank you

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for your service, by the way.
Anyway, I'm Zach Cutrara. I'm an entrepreneur trying to get into the industry.
CHAIRPERSON MENDOZA TEMPLE: Can you spell your name for the reporter?
MR. CUTRARA: Yeah. Sorry. Zach, Z-a-c-h, and Cutrara, C-u-t-r-a-r-a.
So I've been getting my foot in the door and more often been trying to pursue my passion as much as I can, so that's why I'm here today. And it's all about the patients and all about the health and to really help them as much as you can with any kinds of alternative medication, especially, obviously, medicinal marijuana.
Anyway, so I found some medical journals and articles online that have been conducted by certain types of like investigations and trials and stuff. So I found one online that was a study for oil THC for PTSD. So the method to do it was they had 10 patients with chronic PTSD. You know, the things that they've seen are severe and they needed -- they needed to have some kind of alternative medication. And as the person said before me, you know, pills have severely taken an effect on him. So the possibility is there.

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So anyway, the method for that was they had 10 patients take 5 milligrams of THC twice a day as an add-on treatment. So the results for that were -- had three -- there were mild adverse effects to three patients. So 70 percent were affected, but none of this led to treatment discontinuation and has not had a severe impact on them.
So it says on here the intervention caused significant improvement in global symptom severity, sleep quality, frequency of nightmares, and PTSD-type symptoms. So if this can improve pain, and if this can have the possibility of reducing nightmares that these people have -- you know, the things that they've seen affects them for their whole life. So if they can prevent, you know, the pain and suffering through sleep quality or lack of nightmares, that'd be great.
And the conclusion was just, once again, it was safe and it helped.
I got another journal on here and --
MS. MOODY: I'm sorry. But that's the end of your three-minute time frame.
MR. CUTRARA: Okay. Thank you.
CHAIRPERSON MENDOZA TEMPLE: Thank you for your testimony.

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Joel Erickson.
MR. ERICKSON: Good afternoon. It's Joel Erickson; J-o-e-l, E-r-i-c-k-s-o-n.
Good afternoon. I'm Joel Erickson. I'm an 80 percent disabled Air Force veteran with service-connected PTSD due to a TBI with postconcussion syndrome.
I have tried prescription treatments for my symptoms. I spent a week in the hospital to deal with suicidal ideation I did not have prior to taking Zoloft and have not had since I stopped taking it, and I continue to refuse taking it each time it is offered to me, along with other SSRIs I have had significant adverse side-effects to.
Let me be clear. PTSD affects civilians as well as members of the military. But for veterans who could benefit from cannabis and who rely on the VA for their healthcare, the Federal interference that keeps doctors from having honest and open conversations with their patients continues.
I'm thankful that the Medical Cannabis Pilot Program delivers on Illinois' promise of "State Sovereignty, National Union" when it comes to taking care of its veterans when Federal policies fail,

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especially when conservative estimates are that 22 veterans take their lives each day. Giving vets the ability to legally choose cannabis instead of pills for relief is commendable, and I see other states looking at Illinois' example for veterans when crafting their medical cannabis programs.
If I can ask you for a moment to imagine a Venn diagram. Over in this circle is TBI with postconcussion syndrome. Over in the circle is PTSD. There is a frequent but not quite understood connection between the two, and it's not uncommon for some overlap in terms of symptoms.
In my case, as far as the VA is concerned, there's almost complete overlap between the two. Meaning it's difficult to tell the difference between the two based on symptoms, so it's possible to have PTSD without a TBI. This is important because PTSD is not a condition that only affects military members. It also affects civilians who have never stepped foot into combat, but their struggles are the result of the most personal kinds of terrorism that include rape, domestic violence, and other forms of abuse, and the outcomes in terms of symptoms are the same.
A very concise overview of the currently

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available science is that PTSD is caused due to an endocannabinoid deficiency. Please consider the study entitled "PTSD Symptom Reports of Patients Evaluated for the New Mexico Cannabis Program" which states that patients reported over a 75 percent reduction in three areas of PTSD symptoms, which were reexperiencing, avoidance, and arousal while using cannabis. The symptoms covered by these three categories include anxiety, difficulty obtaining restorative sleep due to nightmares, persistent avoidance of reminders of trauma, and an exaggerated startle response.
A 75 percent reduction in all of these areas isn't a 75 percent increase in quality of life, but it would go a long way to helping treat the invisible wounds of PTSD and reducing the number of Illinois veterans who take their lives.
Thank you.
CHAIRPERSON MENDOZA TEMPLE: Jared.
VICE CHAIRMAN FINE: There's a sandwich back there with your name on it.
MR. TAYLOR: Good afternoon. My named is Jared Taylor. I'm here to urge the Medical Cannabis Advisory Board to recommend posttraumatic stress disorder, PTSD, as a qualifying condition for the

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Medical Cannabis Pilot Program.
The Mayo Clinic defines PTSD as a mental health condition that is triggered by a terrifying event, either experiencing it or witnessing it. Symptoms of PTSD may include flashbacks, nightmares, and severe anxiety, as well as uncontrollable thoughts about the event.
PTSD is not limited to members of the military, although, this topic gets heavy exposure in the media. PTSD can affect anyone, and according to the US Department of Veterans' Affairs, about 7 or 8 out of every 100 people will have PTSD at some point in the their lives. Also, according to the VA, about 8 million adults have PTSD during a given year, and about 1 out of every 100 women develop PTSD sometime during life their lifetime in comparison to roughly 4 out of every 100 men.
According to the VA, 11 to 20 out of every 100 veterans served in Operations Iraqi Freedom and Endurance Freedom have PTSD, as well as approximately 12 percent of Gulf War and 15 percent of Vietnam War veterans experience PTSD during their lifetime. The VA currently reports that 721,575 veterans reside in the state of Illinois out of a population of

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12.8 million residents. That's approximately 5 percent of the population of the state of Illinois.

Now, Dr. Raphael Mechoulam is an Israeli scientist who first discovered THC as the active psychoactive compound in cannabis. Decades later Dr. Mechoulam discovered the human brain's endocannabinoid system and the endogenous neurotransmitter anandamide. Dr. Mechoulam believed that the cannabinoid system is integrally related to memory, including memory distinction, which is the normal, healthy process of removing associations from stimuli. Cannabis can therefore help to aid memory extinction by reducing association with an individual's association with stimuli such as loud noises or PTSD.

I just want to let everyone know that all today's petitioners, whether PTSD or not, were received by the Department of Public Health on August 5th, 2015. The Department of Public Health, according to the Compassionate Use of Medical Cannabis Pilot Program Act 410 ILCS 130, under Subsection 40, "The Department shall approve or deny a petition within 180 days of its submission."

The Illinois Department of Public Health failed to meet this deadline earlier this year, and

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this is both frustrating and disrespectful to patients, especially Illinois veterans. While PTSD can affect anyone who has experienced a traumatic event, PTSD disproportionately affects our veterans.

Because of the debilitating conditions that PTSD causes, I urge the Advisory Aboard to affirm its May 4th recommendation of PTSD as a qualifying condition to the Medical Cannabis Pilot Program. The State of Illinois and its administration should recognize, respect, and honor the service that Illinois veterans have given to our nation with regard to their personal safety.

Thank you for your time. God bless the State of Illinois.

CHAIRPERSON MENDOZA TEMPLE: Thank you. And we have Liana Bran.

MS. BRAN: Hello again. I am Liana Bran; L-i-a-n-a, B-r-a-n. Forgive me. I last time forgot to properly introduce myself. I just want to give a bit more background.

While not a medical expert, I have the benefit of directing a substance through workplace program which has given me the benefit of working with a lot of substance abuse treatment providers, as well

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as substance abuse professionals. So my goal today is to share with you some perspectives on medical marijuana and some of these conditions that I feel represent a pretty wide consensus in this field.

So a lot of the testimony I've been providing is based on what I feel are reliable sources of informational studies, but I also want to pause for a moment to give some personal experience, as well, related to mental illness and the use of medical marijuana.

So a close family member of mine does have schizophrenia. He started using marijuana at a very young age, and while no one can say for sure that was the cause of his mental illness, there is very good evidence that would suggest that schizophrenia and marijuana use, as well as some other mental illness are linked.

Even after he was diagnosed, he continued like so many others to self-medicate, and it wasn't until his mental health provider found out and told him to stop that he really did better. At that time, when he was abusing marijuana is when he was hearing the most voices, and since then he has progressed significantly. So for me it really makes no sense

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that we should be recommending that people experiencing mental illness should be relying upon this treatment that has been shown to produce short- and long-term effects on mental health outcomes.

I have to return again to PTSD and echo what the American Psychological Association and numerous mental health professionals are saying, which is that there is insufficient research to support the use of medical marijuana for PTSD. Other studies have also since produced evidence that actually suggests potential for harm, finding that the initiation of marijuana use after treatment was actually associated with worse PTSD systems, more violent behavior, and more alcohol use. Marijuana may actually worsen PTSD symptoms or nullify the benefits of proven specialized intensive treatment. So we're not just talking about whether it's effective; we're actually coming to the point where we're seeing that it has the potential to cause harm.

Department of Veteran Affairs also acknowledges that PTSD -- I'm sorry -- that they also back this position that there's insufficient evidence to support using medical marijuana to treat PTSD and also demonstrate a greater risks for individuals with

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PTSD to abuse marijuana and also have difficulty recovering from addiction. And I provided some statistics about the increasing number of individuals with PTSD and cannabis use -- symptoms related to use of cannabis.

Unfortunately, the state of science means that a lot of the medical applications are not yet ready, but we really have no concept of the long-term effects of this even if it may alleviate some short-term effects, and I don't feel we should be experimenting with some of our most vulnerable and respected members of society to see the outcomes.

MS. MOODY: Thank you for your testimony.

CHAIRPERSON MENDOZA TEMPLE: Thank you for everyone's testimony on PTSD. So we open up comments to the Board.

MEMBER CHAMPION: If the military can give a person a discharge for PTSD, I feel it should be recognized and covered by our program. The evidence in support of cannabis as an effective treatment for PTSD is overwhelming, as stated by some of our witness veterans who assign suicide rates due to PTSD as high as 22 per day or 8,000 per year. That's more people than we lost in the war itself.

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PTSD affects -- my data shows over 30 percent of all Vietnam, Iraq, and Afghanistan veterans. PTSD in all forms should be approved, but we especially owe it to our veterans.

Also, I'd like to attest that, as Jonathan was speaking to the over- and under-prescribing medications from the Hines VA, the Federal government. I have more than a handful of horror stories myself where they have messed up the medications. I've actually overdosed on methadone twice not by my own fault.

So I can certainly attest to the overprescribing of opiates and the reckless way they do it. In fact, sometimes when they should be giving you one dose, they give you another dose, and they don't find it until, you know, you're all crimped up in a corner. So I have more than a handful of stories, so I can attest to that, Jonathan.

That's all.

CHAIRPERSON MENDOZA TEMPLE: Thank you. Other comments from the Board?

MEMBER WEATHERS: Motion to vote.

VICE CHAIRMAN FINE: Second.

CHAIRPERSON MENDOZA TEMPLE: Okay.

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We'll vote.

For our last topic, the last condition to evaluate is autism and we have three -- no, we have three speakers present for that. Just one last call for Mark Brouwer.

(No response.)

CHAIRPERSON MENDOZA TEMPLE: Okay. So there are open petitions from Liana Bran and Patricia Ihm.

So we'll wait for the vote.

MEMBER CHAMPION: I'm pleased to once again announce that PTSD has once again passed by a unanimous vote of 10 to nothing. Thank you.

(Applause.)

CHAIRPERSON MENDOZA TEMPLE: Okay. With that, we are switching gears to a condition that we have not entertained before, autism, and we will start with Ms. Liana Bran.

MS. BRAN: Thank you for letting me present my testimony today. As concerns the proposal of adding autism to the list of debilitating conditions, I again want to begin by reminding the Board that the American Psychiatric Association does not support the use of marijuana for the treatment of any psychiatric disorder. In fact, in an official statement from the

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APA they assert that current evidence supports at minimum a strong association of cannabis use with the onset of psychiatric disorders, and adolescents are particularly vulnerable to harm, given the effects on neurological development. And I think that that is the most important part of that because I'm assuming the addition of this particular condition is going to include a lot of young folks whose minds, whose brains have not had the opportunity to develop.

A recent study I provided in the Journal of Developmental and Behavioral Pediatrics also reviewed the available research and concluded given the scarcity of data cannabis cannot be safely recommended for the treatment of developmental or behavioral disorders at this time. It cites, also, a growing body of research that points to the role of marijuana use contributing to abnormal brain development.

Again, this is coming -- this initiative is coming from a point of compassion, but there's also that kind of landmark study that showed that young people who were chronic marijuana users actually had a significant increase in -- significant and irreversible decrease in IQ actually. So, again, as a complex developmental disorder, does it make sense that with

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so little evidence we should incorporate a treatment that has been shown to actually produce altered brain development?

Furthermore, autism spectrum disorder is now defined by the American Psychiatric Association DSM-V as a single disorder that includes disorders that were previously considered separate. So it's therefore characterized by a wide range of symptoms and severity that should be considered separately.

Again, I want to conclude that by suggesting that potential applications for medical use of marijuana do exist, and according to clinicaltrials.gov, which is a resource provided by the NIH, there are over 197 studies being conducted on THC alone, many of which are examining the benefits. So the answers are being researched, and the practice of safe, responsible medicine requires that we do wait for some more results.

In the meantime, given the further implications for brain development that marijuana entails and the fact that the causes of autism are not well understood, there's just too great a risk of actually exacerbating the conditions for individuals with autism.

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Last point. No other state has included this in their list of debilitating conditions. So we would be the first.

Thank you.

CHAIRPERSON MENDOZA TEMPLE: Thank you. Ms. Patricia Ihm.

MS. IHM: Good afternoon. My name is Patricia Ihm. The last name is I-h-m. I'm a mom to nine, and one of my children has autism. This is Ethan right here.

I'm learning more on this parenting journey than I ever expected to learn. Honestly I really don't want to learn all this stuff. I don't want to know the side-effects of Risperdal. I don't want to have a reason to need to know that.

I don't want others to treat my sweet boy with any less dignity than he deserves. The grip of autism is not selective. This child is only trying to make sense of his world and his emotional kaleidoscope. I want him to eat lemon knots. I want him to be able to be able to walk across the train tracks without being gripped by fear. I want him to enjoy the Christmas lights with the rest of us. I want him to know that he's a treasure and a great blessing every

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single day.

We know that people with autism are often in a state of sensory overload. Experiences are more intense, louder, scarier, more painful, often intolerable. I've seen anecdotal studies of children close in age to my son with similar behaviors who seem to get better almost overnight when allowed the chance to have medical cannabis.

With Ethan, there are extraordinary swings of angst, fear, and aggression, and in the other direction flashes of brilliance and uncanny cleverness to outsmart a university scholar on a good day. The days where the brilliance outweighs the angst, those are the days we relish. We adore him. We're exhausted on all the days, but he's brought to us intangible things that we didn't even know we needed.

Ethan at 7 has been through two psychiatric hospitalizations when the behaviors became too overwhelming. His therapeutic day school has now brought on a behavioral analyst to help with his programming. I learned yesterday at his IP meeting that my son had more restraints, physical restraints during the last calendar year than anyone else at the school.

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I'm sorry for everything. I'm sorry for the railroad tracks, the thunder, the bees, the wind, and for all the other things that invade your head and stir your fears. We don't want him to have go back to where he's not understood, where nobody sits with him as he falls asleep, and where he's presented with trays of brown things with gravy. We don't want him to go back to a place where the outcome will be no different than the last time.

Then the moments come and there's knowing we can do. My little boy at 7 has been on at least 15 different medications. We've never been sure if any medications have had any positive effects, though the negative side-effects have certainly presented themselves. Many children in states with the more sensible laws have recovered the ability to function in everyday life by using edible cannabis.

I will never give up trying to help my son. I feel that it is our ethical responsibility to offer the same opportunity to children in Illinois, the chance at a childhood that's governed by states of calm and joy. Please offer this chance to my son and to countless others with autism who may not have words to express but feel so very deeply every day.

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Thank you.
(Applause.)
CHAIRPERSON MENDOZA TEMPLE: Thank you very much. So now we open up to comments from the Board.
MEMBER WEATHERS: So my comment back and in response to Ms. Bran's testimony, I think there was emphasis on the point that cannabis could impair normal brain development during adolescents. While we certainly are seeing studies with that, I think it's important for the Board to note, although we're still learning exactly how, we know that these children's brain development is not normal. So I don't think that we can necessarily use that as a reason to not approve this condition.
I think, again, the thought of having a 7-year-old on Risperdal is horrifying to me. I don't like using it on my 67-year-olds, much less a 7-year-old, and if there's an alternative, given the urgency of these symptoms and the concern for how severe, I think that needs to be weighed against potential future risk. You obviously would never think of giving cannabis to a 7-year-old with normal brain development. So I just think it should be considered.

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MEMBER CHAMPION: In my opinion, autism should have been added along with the other conditions for children. The medicines they are forced to take are not only debilitating but the side-effects are horrific. I think it's time for Illinois to once again set an example for other states and approve autism.
MEMBER MC CURDY: I have to ask on the basis of the research materials that we were provided with the petition -- and I haven't look at anything else or found anything else I must say -- so far -- I mean, I'd like to hear from others what evidence for effectiveness with humans we actually have here. The only thing I actually saw was one case study of an individual child. So I'd like to hear more about what makes us think that there's a good chance even that this -- well, maybe more than a good chance, but do we have some basis in evidence to approve this?
MEMBER WEATHERS: I think we're going to be back in that same circle of the studies have never been done in children with a substance, let alone drug. So I just don't think we're ever going to get it, just how we know it works, the potential for calming, the way we see efficacy in other mood

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disorders, the basis we used to approve PTSD. I think there's a lot of similar pathophysiology at play and given, again, that -- you know, I keep going back to, you're right, I don't know. But if there's -- if we feel like it's unlikely that the adverse effects will be significantly harmful in the short-term, at least if there's something we could closely monitor, see the impact, stop if needed but that the potential -- given that the significant potential is there with somewhat of a -- as a clinician what I feel would be a tolerable risk, that's what I'm basing it on.
And I think we -- it kind of goes back to some of the other things we've heard about. We certainly understand that this is not -- there's nothing that we do in medicine that is without risk. I mean, people -- we joke about it -- if you drink too much water, that could kill you. There's nothing we do in medicine that does not have a potential for adverse effects.
I keep emphasizing that's why the critical relationship is no key, that this isn't in a vacuum. It's not like people are going to be getting access to this -- it is a medication. People are not going to be getting access to this medication and going off on

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their own without significant close follow-ups, surveillance, and monitoring.
Even for the conditions we just approved. If things are clearly worsening, just like any medication, people have spoken to multiple times today, not every medication is tolerated by every person. It's assessed and then it would be stopped, and alternative therapy would be tried.
So our approval is not the same as us saying that we think this is going to work for everybody or that people won't experience some adverse effects; it's just that this needs to be an option.
MEMBER MC CURDY: Let me just add on that to the question I asked earlier, and that would be, is it possible that there may be some parallel maybe remote with the fact that people have begun to have some success apparently with seizure disorder with children?
MEMBER WEATHERS: I think there could be. I know it is in the DSM-V, but we were discussing earlier it is also considered -- it's a neurologic disorder; it's diagnosed and managed by pediatric neurologists. A lot of children with autism do also suffer from epilepsy, and we are starting to see

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studies because people are doing studies in children with epilepsy, but we are starting to see increase anecdotal evidence of efficacy.

CHAIRPERSON MENDOZA TEMPLE: As a family physician I see -- we say cradle to grave. We deliver babies; we see kids; we take care of adults; we see people at the end of life. So in my pediatric experience, when I look for research on pediatric trials, in general you can pretty much count on there not being as much as you'd like to see. Because, first of all, from an ethical standpoint how are you going to get a child signed up? You've got to get parental consent. This is big time experimental, risky stuff.

So in terms of trying to do trials that I would like to see even on just standard medications, you're just not going to see it. Just like we have with the bottleneck regarding medical cannabis and all the regulation, really I'd like to do research, but there's so much paperwork and so much money involved, I don't want to do it. I have a lot of other things I need to do.

So until we get that, at this point I go back to the argument of compassion and the fact that

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the medications that you had described, that this mother has described are -- I'd like to study the effects of brain damage on that from a long-term use.

So let us not forget and take the microscope off of the convention medications that we use for patients that cause damage as well, well-documented damage. Yet we're handing it out like candy I guess you would say -- not really. I would say that a good physician is not going to hand out anything like candy.

And with respect to the way the pilot act was set up, which I think was smart, with the pediatric patients, whether they have autism, seizures, Crohn's disease, and they are eligible for all of the conditions listed forth, you have to have two physicians sign off on their certification letter. So -- which I also think makes it challenging, but at the same time there is going to be even more oversight and protection for the children who are going to be signed up.

And as far as I know from the recent report there were maybe -- I forgot how many -- 10 children were granted licenses. So this isn't -- I'm not too worried about people slipping through the cracks and having two attending physicians just sign something

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recklessly.

The other thing, too, to Dr. Weathers' point and to address Ms. Bran's concern about long-term cognitive loss of IQ, that is true. When a person before their brain is fully formed going into adolescence becomes a chronic recreational user or just a chronic user for whatever reason, you can lose IQ points. That goes back to my argument that yes, this is not a drug with no side-effects, no addiction. I think this room is smarter than that.

But we have to also look at the fact that people who have seizures or children who have autism, they're not in that category where I'm worried about them losing a few IQ points when they become 17. I want them to stop hitting themselves in the face; I want them to stop thrashing themselves, hurting themselves, and causing very visible damage to their physical bodies, the damage that it creates to their families trying to care for and just wait out a tantrum or wait out a rage.

I mean, that's damage, too. We have to weight out what's theoretical, what could happen -- yes, that's good; that's bad -- and what's happening right in front of us right now on the floor and we've

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got nothing. So I really think that we need to offer this option knowing that it's not going to be irresponsibly handled.

So anyway, that is my view.

MEMBER WEATHERS: Can I have one more? I know I've had the floor a lot.

Adding onto what you said, I mean, I think even anecdotally, if we can by making this available as an option keeps one child in their home and not have to be placed, I think that alone justifies it.

CHAIRPERSON MENDOZA TEMPLE: One more point I wanted to add. There are strains that are most likely child friendly, with THC -- CBD, like I said before, does not have affect on the cognitive -- doesn't affect the brain as much. It affects primarily the gut, the muscles, there's receptors there, but predominantly not affecting the brain, and there is a lot of evidence documenting the lack of psychoactivity.

MEMBER CHAMPION: I believe a lot of those are taken from hemp, as well.

CHAIRPERSON MENDOZA TEMPLE: So products derived from hemp are what I believe are legal to obtain because they are from industrial hemp from

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people who grow this and have licenses to do this.
So the THC is where I want to call out a little more sophisticated knowledge about what is cannabis; what's marijuana; we're just giving it to our kids; it's going to make a nation of stoners and people who are dropping out of schools. Hey, you know what? Yes, that could happen. It has happened to people, but we're talking about a different category here. We're talking about a debilitating condition, as well as the other debilitating conditions for which there are not a whole lot of great treatments for.
Dr. Ramirez.
MEMBER RAMIREZ: I hate to sound uncompassionate, inconsiderate, whatever you want to call it, but it seems to me like sometimes we talk out of both sides of our mouths. A couple hours ago we were talking about scientific evidence, science-based, and evidence-based. Now we're talking about anecdotal evidence and giving it the same weight and same value.
There must be some reason why the American Academy of Psychiatry and the American Academy of Neurology both have recommended not using cannabis in children. So there must be some reason for those two big bodies of knowledge and science to pronounce

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themselves that way.
If we're going to go for this anecdotal evidence, then let's go, but then let's not demand evidence-based for other conditions.
CHAIRPERSON MENDOZA TEMPLE: I think I made -- maybe I'll clarify a point that yes, I want medical evidence. We do want that research base, but where it doesn't exist, we have to combine it with other factors, clinical experience, common sense, how many other options do you have.
So I think it's impossible to say we're going to hold everything to the exact same scientific standard. Like I said, we can go back and look at all of the approved conditions, the 39 that exist and dissect those away, and several of the conditions that we discussed today, we're going to have a hard time having a consistent level of scientific evidence.
So I do respect what you say. There are reasons but we're also faced with these patients who are -- they have nothing. So I bring in the compassion hat to this discussion with some evidence but not much.
MEMBER MILLER: I don't know that I can add to the clinical evidence of it because it certainly is

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limited. Because as has been said, these are children, and ethically we would not subject children to this type of study.
However, I can speak from a parental side. I do have a little bit of passion for this topic. Both in what Ms. Bran has said from an adolescent view, I do have a family member who has as an adolescent used cannabis since the age of 13 and does have cognitive impairment.
However, I also have a daughter who has epilepsy -- sorry. I'm very passionate about this because one is my child. And my daughter has epilepsy. She does not qualify for this but I have seen it work in children with epilepsy, and I am glad that that opportunity is there for parents who need it.
With that being said, I know a family member who has been on Risperdal as a 12-year-old. That medication is not recommended for children. That is an adult antipsychotic that many of the adult physicians have trouble prescribing to adults.
So while I know there isn't a lot of clinical evidence, I do have to think about what I know from an epilepsy standpoint and some of the neurological development that occurs. My daughter has

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had six grand mal seizures in her life. She's 24. And with each grand mal seizure they lose cognitive development. She's fortunately not in that category, but there are other children that do.
The other family member with the marijuana use, that was a choice that he made, and he will have to live with the consequences of that. Some of these children do not have the ability to make that decision, so as adults we have to make that decision to help them.
So that's all I'll say.
CHAIRPERSON MENDOZA TEMPLE: Thank you.
MEMBER MILLER: Sorry. I just get very passionate when it's my child.
CHAIRPERSON MENDOZA TEMPLE: Any other comments?
(No response.)
CHAIRPERSON MENDOZA TEMPLE: I recommend somebody make a motion.
MEMBER MILLER: I'll make a motion.
MEMBER LESKOVEC: Second.
CHAIRPERSON MENDOZA TEMPLE: So we will vote.
VICE CHAIRMAN FINE: The condition of autism has passed, 8 yes, 2 no.

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So this has been a long day, and I really appreciate the passion everyone has brought forth. The discussion has been excellent and excellent points raised. I think everyone has the same goal of doing right by people and to help the state of our health as -- Illinois and the country.

So I appreciate the passion you've brought. We now have time for public comments, and we'll again limit it to a three-minute session for that person.

Please raise your hand if you'd like to make public comments.

Okay. I would point to the gentleman in the back with his service animal because he asked early on, and if you would kindly spell your name.

MR. BLEESINGHODGE: Lonnie Bleesinghodge; L-o-n-n-i-e, B-l-e-e-s-i-n-g-h-o-d-g-e, and this is Gander.

I'm a 100 percent disabled veteran, Vietnam. I was -- prior to developing PTSD I was a professor for University of Maryland, and I was an adjunct graduate professor in the specialty program on alcohol and drug abuse at Western Michigan University. I was also clinical director of Amethyst Hospital in Charlotte, North Carolina, which at the time was the

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second largest drug and alcohol hospital in America. I was a senior trainer of trainers for the alcohol and drug abuse division in the state of Colorado.

I wasn't able to leave my house. I was having panic attacks -- when PTSD had its onset, panic attacks would last from 5 minutes up to 20 minutes, and I'd have up to five or six of those per day.

The military in their infinite wisdom put me on benzodiazepines and a number of other drugs that the iatrogenic problems associated with those were far worse than the disease itself sometimes. I carried suicide in my pocket like a can of Valium. I was a National Endowment for the Arts fellow in literature, and after taking those medications, I ended up in a creative lobotomy for a decade. One decade and I didn't write, or teach, or do anything because of the medications.

For the last 2 1/2 years, I've made frequent trips to Colorado where I've experimented with different strains of marijuana and different edibles. The early strains caused great dysfunction sometimes. The THC contents were too high. There were a lot of things that caused me to know exactly what real psychosis may well feel like. That's changed.

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In reaction to the thing about the Veterans' Administration, the Veterans' Administration, of course, doesn't find it to be efficacious. They haven't done any research on it; they're just beginning to do that. They also don't think service dogs are efficacious, but I can tell you that this dog saved my life.

I can tell you that marijuana used in high-CBD, low-THC dosages in Colorado, in the 100 interviews I've done with veterans there and the 30 people who have inputted information to me over the course of the last three years tell me that symptomology has been reduced by almost 50 percent in those people that have used it for PTSD correctly and under some sort of supervision. So I applaud you for what you've done.

Thank you.

CHAIRPERSON MENDOZA TEMPLE: Thank you very much.

(Applause.)

CHAIRPERSON MENDOZA TEMPLE: Sandy Champion.

MS. CHAMPION: I am Sandy Champion. I'm a patient advocate for the medical cannabis program, and I am Jim's wife. So because most of you know I shoot from the hip, and I only have three minutes, I will be reading notes.

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First of all, I want to say thank you to Conny and everyone on the staff. I know we've given you quite the runaround, and we've been tense, stressful, and you guys have probably had many conversations about us behind our backs. With that said, thank you.

Earlier it was noted that the director does not have to give any information as to why he denied the conditions. With that said, I also think if we're going to follow the rules, he must, absolutely must follow the 180-day rule, as well. There is no excuse. It's a double standard and I think if he reads this, he needs to know that we expect him to do his job if he expects us to do ours.

Secondly, Conny, you and I have spoken about this, and I have a real huge concern about patients and dispensaries. At startup we're only going to have four or five dispensaries at a time. So that means when you guys send out the forms and the cards, they're going to have to choose a dispensary. Are you guys going to provide information to them so they know which dispensaries are open? Because it we don't, we're going to have an onslaught of calls to IDPH when they change, and we know they're going to change.

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I've been told by our sponsor and a former IDPH employee who will go unnamed that there is a software program that's supposed to be implemented, and it has not been implemented, that would allow realtime dispensary changes on the spot at a dispensary. I know quite a few dispensary owners who are unaware of this, as well, but it's in our rules and in our law. And I've been told you guys are going to implement this in a couple months.

MS. MOODY: I'll let you finish your comments first.

MS. CHAMPION: With that I would encourage you guys to get that implemented ASAP because no patient should have to wait any longer to get their medicine.

Thank you.

CHAIRPERSON MENDOZA TEMPLE: Thank you. And I think Mr. Taylor had -- Jared had a public comment.

MR. TAYLOR: So by now you all know me. My name is Jared Taylor.

As I mentioned earlier, I only have osteoarthritis out of the five conditions that I've petitioned for. However, I do believe that all of these conditions, they are debilitating; they're not

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fun diseases to have.

I heard a comment from one individual to another of, "Oh, I didn't like what this person had to say during their speech, and I wish they had this condition so they would know the effects of this." I vehemently disagree with that because none of these conditions are fun to have. I will have osteoarthritis until I die, and that's not a very fun thing to know at age 26. As Leslie had mentioned, the incidence of osteoarthritis greatly increases as you get old, and I'm sure that there are certain people in the state of Illinois that are approaching a certain age where that incidence of osteoarthritis is very likely to happen upon them, and it's not a very fun disease to have. None of these are pleasurable or enjoyable diseases to have.

I am, however, concerned about the state of which -- the forward future making process of this whole medical cannabis program. As you all know, the osteoarthritis, as well as other conditions, were petitioned back in January, and, unfortunately, they were rejected. These were rejected after that 180-day time frame. It is very unfortunate that the Department of Public Health not only rejected these

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but took so long to reject them.

To be honest with you, I can determine what I'm going to eat for the day earlier in the day, but there are other times where it takes longer where I will have to form an opinion over a much longer period of time. I do not honestly see how the Department of Public Health could take six months -- that is 180 days -- six months at 24 hours a day to determine whether or not these conditions will be approved.

In addition, for conditions that were petitioned and rejected back in January, in the hope that say, for example, osteoarthritis is approved at this moment, there is no guarantee as to when we will actually be able to apply to the medical cannabis program. We are hoping and the deadline basically states February 1st, 2016, for the 180-day time frame.

However, the JCAR process is very lengthy. I've talked to JCAR; they said it's six to eight months. So I'm looking at right now, if we do get approved by February 1st, that we may not even be able to apply as osteoarthritis patients or any of these other approved conditions until August of next year.

So I really wish and hope that the Department of Public Health takes true consideration

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of the valuable testimony not only of patients but also all these medical professionals. I myself am a very, I wouldn't said an uneducated person, but I have a bachelor's degree in science and history, and I'm not a medical professional. However, I rely on the testimony, the recommendations of these medical professionals, and I hope the Department of Public Health does, as well.

At this point we have 3100 patients out of 12.8 million citizens in the state of Illinois. So in order for this program to be successful, we need to add more conditions; there needs to be accountability in terms of why these conditions were rejected, and we need to get this up and going. Because, otherwise, my fear is that we will either have limited time to utilize this medicine, or we will not be able to utilize this medicine at all.

Thank you for your time.

CHAIRPERSON MENDOZA TEMPLE: Thank you.

Any other last housekeeping comments or clarification?

Conny, I think you wanted to share something that Sandy had brought up.

MS. MOODY: So I'm actually -- one of the

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questions that Sandy raised was with regard to the notification of a patient about the dispensaries that are currently licensed by the Department of Financial and Professional Regulation and once product is available will be open to patients for selection.

There are four dispensaries at this point in time that have been licensed by the Department of Financial and Professional Regulation, which we call FPR, and those are posted on the DFPR website, and, also, that listing of dispensaries is available through the statewide medical website, which is the mppp.illinois.gov website.

So what we are getting ready to do now as a department, we're on two tracks and we are -- first of all, we are preparing to issue registry identification cards to those patients that have been approved for participation in the program. And we are -- we still remain hopeful that we will be able to start mailing the first cards at the end of this month, the month of October. That is the goal of the department, and that's what we are pushing for.

At the same time we are going to be reaching out to all of the patients who have been approved to provide them with information about which dispensaries

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are open, how they can go about selecting a dispensary. They will be able to do that to the Department either through an e-mail to us, and we're in the process of establishing a special mailbox that will be accessible to those patients who have been approved for the program to submit their dispensary request to us.

We're also going to be urging patients to take their time in making those selections because, as I stated, only four dispensaries are going to be open at this point in time. And because patients have a one-to-one relationship with a dispensary and must select a dispensary, and that information must be input into our system -- patients can change their dispensary selection, and what we would not like to see is 3100 patients select Dispensary A and then in a few weeks when another dispensary opens we get 3,000 patients who decide to select Dispensary B, and then other one opens --

MS. CHAMPION: That's exactly my point.

MS. MOODY: -- because that is very cumbersome both for the limited staff that we have on board right now and the patients themselves.

So what we are going to urge folks in the communication to them is, if you do not see a

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dispensary that you wish to work with right now, take the time to wait. The Department of Professional Regulation is licensing dispensaries on a rolling basis, and you may want to wait. Now, of course that's the patient's choice if they wish to do that or not.

That process of changing -- once a patient has selected their initial selection of a dispensary and they wish to make a change in that dispensary selection, that is going to be -- that is the department's responsibility to put that into our database, and then we will push that information out to the dispensaries on a nightly basis.

So if I'm a patient, and I call the Department of Public Health or e-mail them at 9:00 a.m. tomorrow on Thursday and indicate I wish to change my dispensary, that information will be -- once we have our system in place, and are still working on programming for this; this is a gigantic IT infrastructure that we are working on here -- once that is in place -- and, again, we're hopeful -- the goal is for the end of this month for all this to come together, all these moving parts, that information by the patient shall be pushed out to the dispensary

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overnight in our nightly upload to that system.

One of the reasons for that is our system, our patient registry system is highly confidential. It is protected by law as a confidential system. We cannot have anyone reach into that system to extract data. We can only push data out to those entities that are statutorily allowed to receive data from us.

So it will be a nightly upload. So although it will not be real time, it will be fast as the State of Illinois can possibly manage to get that information, that change information into the hands of dispensaries.

MS. CHAMPION: Okay. And so I understand that at the startup, but what about the software program that was supposed to be implemented that was in real time so a patient could walk into any dispensary and change on the spot? They would not be identified by their name, address, or anything except for a number, and it was supposed to be real time.

MS. MOODY: So, again --

MS. CHAMPION: And this has been verified by one of our legislators, which happens to be a sponsor of the bill and someone who used to work for you guys.

So it's not like I'm pulling this out of my hat. I'm actually giving you factual information

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given to me, and many of the dispensaries are not even aware that this was supposed to happen.

So I think we need to push for this because the patients, you know, they shouldn't have to go through that many steps just to change a dispensary in the future. I understand at the startup it's not ready and all that, but when is the software going to be implemented so that they have real time?

MS. MOODY: Well, not at this point in time.

MS. CHAMPION: So the three to four months is incorrect, what I was given? I was told that it should be up and running in three or four months.

MS. MOODY: I'm not sure where that information was coming from, and perhaps we can talk later.

MS. CHAMPION: I'm not making it up. I'm just telling you -- you know I've been in this for a long time, and I was there when this stuff was written into the bill, and this was information that was given to me, and I inquired months ago about it.

MS. MOODY: Right. The information that I'm giving today is what I told you several months ago, in that our system is protected; there's no entity out there, dispensaries, anyone who can reach into our

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system.

MS. CHAMPION: Exactly. And the software that was supposed to be implemented would be able to do that. That's my point I'm making.

So can you talk to the powers that be, the IT department or something? Because somebody needs to get into the language of the bill and see that it did say that they're supposed to be able to do real time.

MS. MOODY: Well, and that has not been my understanding from the Department's program implementation. So I will definitely take that up.

MS. CHAMPION: Yeah. Let's do that.

MS. MOODY: But I think that there is -- you know, one of the important things here is that to make a dispensary change should be something that is a -- should be -- and these are my words, this is my opinion.

MS. CHAMPION: I understand.

MS. MOODY: It should not be something where I decide, oh, you know at 9:00 a.m. I want to drive down to southern Illinois and appear at a dispensary at 5:00 that evening. I think what we were trying to do is, again, preserve this program as a model for other states in terms of how we approach this. We

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have -- we want to make sure that patients are getting good access and good service --

MS. CHAMPION: Right. That's our goal, too.

MS. MOODY: -- wherever they see that they need to get their product. I think we're going to learn a lot over time about what types of products are available at different dispensaries.

So right now we have -- we have huge programming efforts. We have -- we're trying to get something as simple -- it may seem as simple as getting photographs right for our patients that is taking us hours, and hours, and hours of time because of the limitations of our system.

Quite frankly, I'm in a situation where the State of Illinois has told me that I must rebid my IT system through the State of Illinois procurement system, which takes months. We've been so focused on getting registry cards out and ensuring that patients are -- that their applications are processed in a timely manner and that we answer phone calls that I don't even have time to write that procurement.

MS. CHAMPION: Hey, listen, I totally understand. But with all due respect, this was signed and put into law in 2013. So here we are at the end

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of 2015, and so we've had a lot of time.

I'm not telling you -- I don't know what goes on internally, but you know I've been involved internally. So I just think that we need to focus on the patients and make sure that they're able to make this as easy as possible for them.

MS. MOODY: And that's why, Sandy, we have tried to put an enormously simple process in place. You can fill out a form, send it to us; you can call us and my staff will pick up the phone and talk to you as a patient and input that information directly into the system right away. So we are trying to --

MS. CHAMPION: So are you guaranteeing the 24 hours?

MS. MOODY: It will be a nightly upload, yes. If somebody contacts us between the hours of 8:30 and 5:00, the State's normal operating time frame, and because you've given us a call, we input that information, it will be part of that nightly upload when the system does that. We do the same thing with the Secretary of State's records.

MS. CHAMPION: And we can talk about the other software program that I've been talking about later, but as long as we make sure the patient is a

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24-hour -- because we were hearing it can be more than 24 hours. Especially in an onslaught. Because like you said, a lot of patients may not heed your warning, and they go and sign up for four dispensaries, and you've got 3,000 or 3100 patients in four dispensaries, and the next thing you know your phones are going to be slammed. So I have a hard time believing that the 24-hour turnaround is going to happen if that happens.

MS. MOODY: And like I said, my -- the caveat that I provided is those folks that we actually talk to before 5:00 p.m. Because if you fax something -- you know, if we do get slammed with 3,000 faxes or 3,000 e-mails, then there's no way humanly possible that -- even if I had every single program staff in our department be able to upload that kind of information, we couldn't humanly do that. So there is that human factor, also.

MS. CHAMPION: Thank you for clearing that up, and we'll talk after about the other stuff. Thank you.

MS. HOOGHKIRK: I do have one more concern along the lines of dispensary designation.

So you said it wouldn't be humanly possible to do that in that amount of time, but you are planning

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on sending the cards at the end of the month. So dispensaries who are planning on opening November 1st, first, how do you expect to deal with the influx of patients who will be designating those dispensaries at this time, and what do you suggest to those patients if you do not send those cards out in that timely manner; what are going to be their options for purchasing product if the dispensaries are opened before that information is sent to them?

MS. MOODY: That's a very good question, and we are doing our best humanly possible to have all of these things come together.

This is an enormous effort by the State of Illinois for multiple agencies to work together across not only their different responsibilities -- because while IDPH is responsible for the patient program, agricultural for cultivation centers, they're working on their parts of the program; DFPR working on the licensure of dispensaries; we have the State police who have a role; we have the Secretary of State; we have revenue. So it really is -- and I've been in State government for more than 20 years, and to me it's a very unprecedented level of cooperation across agency lines.

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But this is enormous. I mean, the type of IT system that we are building here, the processes and procedures that we are all putting into play.

So those are our goals that I have presented, and we have our staff working tremendous amounts of hours to make this all happen. But in the end all I can say is, you know, we are still human. And it's like a domino that if something doesn't work on the IT system that helps us take patient applications, and that system can't speak to the new system that dispensaries and cultivation systems are using, it just takes one glitch in the system to shift those timelines. Not because we're trying to be disrespectful, not because we're not trying to do our jobs, but because these things happen when we're depending on other vendors, on other contractors, and on multiple agencies to do their jobs. So we are doing the best that we can.

And the one other thing that I would add to this, also, is that right now the -- we still are working on a budget in the State of Illinois, and that -- I'm sure you've heard the news -- and that impacts all of the work and all of the efforts that are ongoing. So our vendors continue to work without

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having bills paid; our staff continue to work.

We're doing all of these things -- and I'm not saying these things to complain or anything, but I just want you to understand the enormity of this effort and the way that I truly believe that the folks that we have working on this project are collaborating, are working together, and are doing their best, their darn best to make this all happen. But in the end we're all human, and it's real life that we're talking about here.

So not to be disrespectful and not to -- I mean, my first order of the day, every day my staff and I say, you know, our biggest goal is to be compassionate. So not to discount that but this really is something that is unprecedented in anything that I've ever worked on in the State of Illinois.

MS. HOOGHKIRK: Sure. I understand you have all these technicalities and moving parts, but as far as going forward, if we are opening and have product November 1st, are patients going to be able to access it, yes or no plain and simple, if they do not have their cards?

MS. MOODY: So my understanding from the DFPR rules, the administrative rules for dispensaries is

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that in order for a patient to enter into a dispensary, they must have a card, a registry identification card, and that's why that is our first and foremost goal right now.

The card is going to allow them access to those dispensaries. So that's really our first and foremost goal.

MS. HOOGHKIRK: So, technically, we could be sitting open for months and months or even a few months with product on the shelves and no patients? That's a possibility?

MS. MOODY: We have been told that we have to focus on this effort so that cards will be mailed by the end of this month.

MS. HOOGHKIRK: Thank you.

MS. MOODY: You're welcome.

CHAIRPERSON MENDOZA TEMPLE: We have until 3:00, so we do have time for another public comment, and we will limit the time, as well.

MS. BRAN: Sure. I thank you all again for your patience in letting me contribute my comments.

Please be clear, I'm not trying to seem cold or callus. I think that this sort of thing demands compassion, and there are certainly some conditions

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that will require that. I think my main concern -- and I know this may not be your role or your responsibility, but I would hope that you could also make recommendations about the implementation.

Because as the State of Illinois, we do have the most debilitating conditions on our list, and I think that's honestly because of an effort to be specific about the conditions so as not to make a lot of catch-all conditions. Because there are states that -- we're not the first who are going through this, and in a lot of ways it's not theoretical anymore. They're seeing some negative outcomes.

So my fear is that it would become some sort of de facto recreational marijuana law. And that is not the intention. I can very clearly see that, but, again, I think it is a slippery slope, especially on some of these more broad conditions and especially the fact that people can access 2 1/2 ounces every two weeks, that's 150 in two weeks. That is a lot of product to be able to access plenty for people, frankly, to share with others. And, again, that would be an unintended consequence, and I think most people are not accessing it for that reason, but I think it is possible, and this is being seen in some other

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states who are going through this.

Also, I think it's hard to expect some physicians to kind of except the onus of all this responsibility. Again, I hope that they're doing their best to execute this responsibility responsibly, but I think that there is a lot of education that is still needed for even physicians. This is not something I would assume you learn in medical school how to prescribe marijuana. That's not something at this point that's being done, so I should hope that there's also some kind of education around that piece, as well.

And I again have to reference that point, it may not be the intention, but of the 3,000 cards that are out there, a third of those, 1,000 of those came from one physician. So that troubles me, again, in the implementation piece, as well as the fact that I think the State is doing its best to regulate this, I think all states are doing their best to regulate this, but THC levels, implementation, all of these things, I don't know how well monitored they will be.

I have to reference that point of PTSD. If there are effective treatments that have low THC levels, higher CBD, yes, let's use that. But is that being offered, or are patients just going in there and

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not having access to that knowledge, or is it possible for them to be getting the wrong product, especially when the individuals who are staffing these businesses may not have all the training required.

My last point is research I think is promising, but to be safe and responsible I think that we have to look at these exciting new studies and all this research, but I think if we are going to hold it to the standards that normally they should be or they would be, we also have to look at those studies that maybe they are also finding negative outcomes and hold those as seriously as much as you want them to work.

MS. MOODY: Thank you very much.

MS. BRAN: Thank you so much.

CHAIRPERSON MENDOZA TEMPLE: This one is the last comment and we'll be right at 3:00.

MR. REDIGER: My name is Ben Rediger. I'm the CEO of CBD Education Services. I want to thank all of you for the work that you've done. I was at the hearing in May and again am here today, and I know that it's time out of your day to do this. I appreciate the due diligence in which you've done it.

I would like to talk a little bit about what we need to do from our end as an industry representing

the patients to show the governor what he needs to see in order move these conditions forward.

We all know that this is not about whether or not the governor and the director think it is medicine. It is about what's going on behind the scenes. And in order for us to have the program taken seriously, we need to show progress.

My organization does mass-infused education for dispensaries and cultivators here in Illinois and, specifically, in Rolling Meadows area of Chicago. In our net there's 750,000 people that we touch when we talk up there. 50,000 of them have an existing condition that is not on these new conditions on the list.

There are people in Illinois that qualify for this medication, and until we can prove that we are touching all of them, and that we are not just having one doctor who is recommending 1,000 patients, but we have 1,000 doctors recommending to every one of their patients, we're not going to see a lot of progress.

So it's on us to be able to mass-infuse the market to allow you guys to see the corollary studies you're discussing. Because we can't do clinical information -- or we can't do clinical studies right

now -- right? -- but corollary information would certainly help that.

So it is on the onus of my organization and the people that we work closely with to deliver that for you so you can stand behind the governor and say, look, we have taken this program seriously, and to this point we have thousands of veterans who have Parkinson's, Alzheimer's, epilepsy that are participating, and they are seeing progress with these different medications.

And we are missing the point when we're not discussing dosage and injection method when we talk, and I think that highlighting publically will help change this. Because you are all more interested in the dosage of cannabis, THC, CBD, CBG, and how it might affect an autistic child, as opposed to just having cannabis recommended.

And I believe if we take that approach that we will get what we need from the governor in the long run, but until we've shown progress, nothing is going to happen. So it is on us as part of the industry to deliver all of that for you so you've got the information that you need.

And I know it hits close to home. Every

person in this room, every person at the Tribune, every person in the governor's office has a relative with one of these conditions. And the reason these conditions were added is that there is information out there that proves that it helps. It may not be American scientific clinical information because we're not allowed to study it, but that's in Israel, it's in Europe, and now we have access to it. So we need to utilize that while we can to deliver the amount of patients using it to give you guys the information you need to request research.

So please keep an eye on us, keep an eye on our district. We're informing the governor's office of every move we make when we talk to the public. We will give him the progress and the proof that needs to approve these conditions. Thank you.

CHAIRPERSON MENDOZA TEMPLE: Thank you very much everyone and for your time spent today.

MEMBER PARIKH: Move to adjourn.

VICE CHAIRMAN FINE: Second.

CHAIRPERSON MENDOZA TEMPLE: Yes. All those in favor.

(Ayes heard.)

(Off the record at 2:59 p.m.)

CERTIFICATE OF SHORTHAND REPORTER

I, Paula M. Quetsch, Certified Shorthand Reporter No. 084-003733, CSR, and a Notary Public in and for the County of Kane, State of Illinois, the officer before whom the foregoing proceedings were taken, do certify that the foregoing transcript is a true and correct record of the proceedings, that said proceedings were taken by me stenographically and thereafter reduced to typewriting under my supervision, and that I am neither counsel for, related to, nor employed by any of the parties to this case and have no interest, financial or otherwise, in its outcome.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my notarial seal this 14th day of October, 2015.

My commission expires: October 16, 2017

_____

Notary Public in and for the
State of Illinois

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