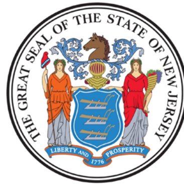

State of New Jersey
CANNABIS REGULATORY COMMISSION
P.O. BOX 216
TRENTON, N.J. 08625-0216

PHILLIP D. MURPHY
Governor

TAHESHA L. WAY
Lt. Governor

DIANNA HOUENOU, *Chair*
SAMUEL DELGADO, *Vice Chair*
KRISTA NASH, *Commissioner*
MARIA DEL CID-KOSSO, *Commissioner*
CHARLES BARKER, *Commissioner*
CHRIS RIGGS, *Acting Executive Director*

1 NEW JERSEY
2 CANNABIS REGULATORY COMMISSION
3 COMMISSION PUBLIC MEETING
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6 VIDEO RECORDING
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10 Date: Monday, June 17, 2024
11 Commencing at 11:00 a.m.
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1 COMMISSION MEMBERS PRESENT:
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3 DIANNA HOUENOU, Chair
4 SAM DELGADO, Vice Chair
5 KRISTA NASH
6 MARIA DEL CID-KOSSO
7 CHARLES BARKER
8 CHRISTOPHER RIGGS
9 WESLEY MCWHITE III
10 DANIEL SAID, Secretary
11
12 INVITED GUEST SPEAKERS PRESENT:
13
14 ELISABETH VAN BOCKSTAELE
15 JENNIFER ROSS
16 ROBERT STERLING
17 KEN WOLSKI
18 GAETANO LARDIERI
19 NICHELLE SANTOS
20 ALEX BEKKER
21 LEO BRIDGEWATER
22 EDWARD LEFTY GRIMES
23 CHRIS GOLDSTEIN
24 HUGH BLUMENFELD
25

1 REGISTERED SPEAKERS PRESENT:
2
3 SAMUEL REICHBART
4 DEANNA ROBINSON
5 ANTHONY CAMPBELL JR.
6 THOMAS NORCIA
7
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1 ROLL CALL:

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3 DIANNA HOUENOU, Chair

4 SAM DELGADO, Vice Chair

5 CHRISTOPHER RIGGS, Acting Executive Director

6 WESLEY MCWHITE III, Director, Office of Diversity and

7 Inclusion

8 KRISTA G. NASH, Commissioner

9 MARIA DEL CID-KOSSO, Commissioner

10 CHARLES BARKER, Commissioner

11 DANIEL SAID, Secretary

12

13 CHAIR: All right. Welcome back,

14 everyone. Thank you for your patience. The time is

15 12:07 p.m. And we will resume the public portion of

16 this meeting. Mr. Said, can you please announce the

17 next item?

18 THE SECRETARY: Next up on the agenda is

19 approving the minutes of both the Commission's open and

20 executive sessions held on May 8th.

21 The minutes have been shared with the

22 members of the Commission prior to this meeting.

23 CHAIR: Thank you. If there are no edits

24 or changes to the meeting minutes. Is there a motion?

25 COMM. NASH: Madam Chair, I motion to

1 approve the minutes.

2 CHAIR: Commissioner Nash moves to approve

3 the meeting minutes.

4 CHAIR: Is there a second?

5 COMM. MARIA DEL CID-KOSSO: Second.

6 CHAIR: Seconded by Commissioner Del Cid-

7 Kosso. Any discussion on this motion?

8 Hearing none, all those in favor of

9 approving the meeting minutes, say aye.

10 COMM. CHARLES BARKER: Aye.

11 VICE CHAIR: Aye.

12 COMM. NASH: Aye.

13 COMM. DEL CID-KOSSO: Aye.

14 CHAIR: Aye. All those opposed, say nay.

15 Any abstentions? Motion passes.

16 THE SECRETARY: The next item on the

17 agenda is the Chair's report.

18 CHAIR: Thank you. Good afternoon,

19 everyone. June -- a couple of -- a couple of items

20 that I wanna raise today. This week is Juneteenth.

21 Juneteenth is just in a couple of days. So as we

22 commemorate the time when the last enslaved people were

23 informed of their emancipation, we must also

24 acknowledge the ways in which the legal system was

25 weaponized against Black people.

1 And this includes the national political
2 efforts that explicitly targeted Black communities for
3 substance use, cannabis among them. Now here in New
4 Jersey, the past disproportionate arrests for marijuana
5 possession left Black communities facing
6 disproportionate collateral consequences for an arrest.
7 And with New Jersey's historical 2020
8 ballot question to legalize cannabis which undoubtedly
9 changed how Black people could engage with cannabis a
10 bit more freely, but Black justice isn't just about
11 criminal justice. The policies implemented by the
12 Cannabis Regulatory Commission prioritizes people with
13 prior marijuana convictions and minority owned
14 businesses for access to the economic opportunities
15 that come with a legal cannabis industry.
16 And as a result of our efforts, nearly one
17 in five licenses awarded by the Commission went to
18 people with a prior marijuana conviction, and 12
19 percent of annual licenses went to Black owned
20 businesses. While undoing the vestiges of race-based
21 slavery certainly requires more than what the New
22 Jersey Cannabis Regulatory Commission can do, the
23 Commission will continue to do its part to advance
24 equity in the cannabis industry.
25 June is also Pride Month, so happy Pride

1 Month to everyone. And I wanna take a moment to
2 acknowledge the intersection of cannabis legalization
3 and LGBTQ+ issues, which goes back decades. Not only
4 did the fight for legal recognition of the two follow
5 similar paths, but the LGBTQ+ community in particular
6 helped advance the availability of medicinal cannabis
7 for patients facing serious conditions.
8 Decades ago, many in the LGBTQ+ community
9 turned to cannabis for relief from medical conditions,
10 notably HIV and AIDS, facing a trifecta of headwinds in
11 the eyes of mainstream society. Their gender or sexual
12 identity, HIV or AIDS positive status, as well as being
13 a cannabis user, brave individuals in this community
14 played leading roles in the national recognition for
15 the medicinal benefits of cannabis.
16 As a result, the federal government
17 recognized medical use -- the benefits of medical use
18 of cannabis when it approved two drugs for treating
19 symptoms of HIV and AIDS in 1992 and in 2016. And New
20 Jersey included HIV and AIDS as qualifying conditions
21 for medical conditions -- I'm sorry, included HIV and
22 AIDS as qualifying medical conditions at the outset of
23 establishing its medicinal cannabis program.
24 Well, even years later, black people,
25 LGBTQ individuals, and cannabis users still face

1 significant negative stigmas in many parts of America,
2 including here in New Jersey. But I wanna take this
3 time to thank all three of these communities for their
4 commitment, courage, and activism in fighting for a
5 stronger, fairer, and more open world, one with even
6 more beauty, color, and culture, and flair.
7 Lastly, I wanna go over a few industry
8 reminders. So our application materials, if you are an
9 applicant, we understand that everyone is eager to get
10 on a board meeting agenda for consideration at a board
11 meeting, but your application materials do need to be
12 submitted at least four weeks in advance. We also --
13 we have a lot of inactive applications just sitting in
14 the application portal and unable to advance through
15 the approval process because the business isn't
16 responding to CRC staff and JCRC staff when we are
17 reaching out to fix their deficiencies in the
18 application.
19 So please, please, please ensure your
20 contact information is up to date and correctly listed
21 in your application, check your spam folders and your
22 voice-mail, and also contact the Office of Diversity
23 and Inclusion, our Office of Licensing, or your
24 assigned investigator, if you have questions about how
25 to fix a deficiency in your application.

1 If you fail to cure or fix your
2 application, you won't be able to move forward. Please
3 note that we also require business individuals who are
4 requesting commission -- commissioners or commission
5 staff to speak at an event, we need you to submit your
6 requests at least four weeks in advance. That allows
7 us the time that we need to process your request, get
8 the -- and get necessary logistics in place for
9 participation.
10 We're thrilled that we have a lot of
11 individuals who are interested in hearing from the
12 Commission, and the Commission is happy to participate
13 in community events and educational events across the
14 state so that we can bring up to date and accurate
15 information to participants.
16 But we do need those requests to be
17 submitted well enough in advance that allows us to
18 prepare for them. And the last thing I'll note is that
19 the Commission will be reviewing the concerns that were
20 raised about the accessibility of some of our licensed
21 facilities. We encourage all of our licensees to
22 ensure that their premises are acceptable -- I'm sorry,
23 accessible for people with disabilities, and I
24 especially hope that our ATCs, which are required to
25 serve patients, are making their premises acceptable --

1 accessible, I'm sorry.
2 So more to come on that front. And that
3 is all that I have for today's Chairs report.
4 THE SECRETARY: Next -- next item on the
5 agenda is the Executive Director's report.
6 CHAIR: Thank you for this. I will turn
7 it over to our now Acting Executive Director
8 Christopher Riggs. The floor is yours.
9 DIR. RIGGS: Thank you, Chairwoman, and
10 thank you for that Chair's report. I echo all of the
11 sentiments that we've raised in that Chair's report.
12 It was very well done. Before I get into the Executive
13 Director's report, I do wanna briefly mention that the
14 CRC is also looking to operationalize a virtual
15 component to our public comment section of our
16 meetings. So our in-person meetings will have --
17 people will have the ability to join virtually and
18 provide comments to the Commission.
19 More to come on that. As soon as we have
20 more information to share, we will share that.
21 I'm gonna update us on dispensary
22 openings. So we have more than 140 medical and
23 recreational dispensaries open in the 21 counties. The
24 good news is that we have at least one licensed
25 cannabis dispensary in every county in the State of New

1 Jersey. That is a good milestone to reach. Each
2 county is now -- has a dispensary that is operational.
3 The new recreational-only dispensaries
4 that have opened since our last meeting, CREAM Cannabis
5 Dispensary in Jersey City, Doobiez in West Milford,
6 Enlighten Health and Wellness in Marlton, The Healing
7 Side in Atlantic City, Moja Life right here in Trenton,
8 One Green Leaf in Gibbsboro, Sea and Leaf in North Cape
9 May, and Twisted Hat in Carneys Point.
10 The next item that I will update on is
11 licensing updates. So this is the recreational
12 licenses that we've received -- that have been approved
13 since June 4th of 2024. We have a little less than
14 1,500 conditionals that have been approved, 338
15 conditional to annual convergence, 176 direct to annual
16 licenses, and 77 expanded ATCs, to have a grand total
17 of 271 total operating licenses in AU and permits
18 medical issued.
19 The -- of those licenses approved in -- as
20 of June 4th of 2024, these are the applications that
21 have been submitted. A little more than 2,500
22 applications have been submitted through our licensing
23 portal. We're just shy of 2,000 of those applications
24 being approved. 108 applications are under review in
25 the Office of Licensing, 312 applications are pending

1 resubmission following a cure, and 145 applications are
2 under review in the Office of Compliance and
3 Investigation.
4 Today what is recommended to the Board,
5 what is up for consideration, we have 15 conditional
6 applications, we have 12 applications that are going
7 from conditional to annual. We have six annual
8 applications. We have one request to be an expanded
9 ATC, and we have 18 annual renewal applications.
10 As always, we'll give a current update to
11 our medical program. Right now as of June, 10th of
12 2024, total active patients are 76,316. We have almost
13 5,000 caregivers and a little over 1,500 doctors
14 enrolled with the program. This is one -- one data
15 point that I wanted to raise here, and this is about
16 Municipal Cannabis Tax Revenue.
17 This is estimated from Quarter 1 of 2024.
18 The first graphic up top, the first chart, shows by
19 region, the cannabis sales and the projected municipal
20 tax revenue that could be gained by a municipality if
21 they opt to have a 2 percent tax on cannabis sales.
22 So as you'll see, you know, in the central
23 region, there was 75,000 -- 75,949,326 in total sales,
24 which would equate to a little over $1.5 million in
25 municipal revenue, and that goes on through the process

1 for a grand total of approximately $4 million in total
2 revenue that a municipality could have -- that all the
3 municipalities could have seen in -- from Quarter 1 of
4 2024. It's also broken down in the bottom here where
5 we broke it down by county in the average for the
6 quarter, and then to the right of -- the other chart
7 here has the municipality.
8 So we also have an average and we broke it
9 down with a median as well, because there are some
10 outliers. But there is a, there is a revenue stream
11 for municipalities to gain by having -- by opting in
12 and allowing cannabis -- cannabis businesses to operate
13 in their locality. And we look forward to having more
14 municipalities opt in so that we can see more cannabis
15 businesses thrive.
16 And that is all for my Executive
17 Director's report. I'll turn it back to you, Madam
18 Chair.
19 THE SECRETARY: Next item on the agenda
20 are the Committee reports.
21 CHAIR: Thank you, and thank you, Director
22 Riggs for their -- your first solo Executive Director's
23 report.
24 For committee reports, I will turn it over
25 to our Permitting and Licensing committee's chair,

1 Commissioner Del Cid-Kosso, to give a readout on that
2 committee's work.
3 COMM. DEL CID-KOSSO: Thank you,
4 Chairwoman. Good afternoon, everyone. Quick update on
5 the conditional extensions for this month -- last
6 month, actually. May 2024 we issued 39 conditional
7 extensions. And I wanted to take this time to brief --
8 to do a recap for not only my fellow commissioners, but
9 the public of what happened during our listening
10 session that took place on May 16th.
11 We had a very good conversation for two
12 hours with the public and I do wanna thank those who
13 registered to speak. We learned a lot from all of you.
14 Your comments were really well received by the, by the
15 Committee. And just a quick recap of what, what were
16 some of those comments. So most of the feedback that
17 we heard were issues concerning things that are
18 happening at the local level.
19 Many of those are out of CRC's purview,
20 but we did hear that municipalities have created long
21 and complicated processes. Real estate continues to be
22 very limited in those communities, and in addition to
23 that, micro businesses are having a hard time finding
24 new locations due to the size and requirements.
25 I do wanna remind folks that we do have a

1 page that was lately created on our website. I don't
2 know if many of you have seen it, but we have a list of
3 the 204 municipalities that have opted in. They are
4 listed under the Government Relations page on our
5 website. So feel free to look, look at that as a
6 resource.
7 There's a continuing ask for additional
8 access to capital funding as another issue that was
9 brought up to the -- during the discussion that we had,
10 and there were a few comments asking the CRC to
11 reevaluate the requirement on keeping two separate
12 inventories for those ATCs that are serving the adult
13 use consumers and medical patients.
14 So what is next for our committee? We are
15 hoping that -- to conduct about two to three focus
16 groups this fall, and we're gonna have more details
17 about that. We're working on the logistics with the
18 Committee, so stay tuned for more details. And the
19 purpose of this Committee -- well, for this listening
20 session and the Committee overall is for us to review
21 and evaluate or aid potential change needed to
22 streamline and improve our application and licensing
23 processes.
24 I think it was very helpful, the comments
25 that we received, and I do have to point out that, you

1 know, some of the comments that were made are -- are
2 things that we can change in regulation and some are
3 things that need to be done by changing the statute.
4 So I think that we need to kind of evaluate those
5 comments and see what we can and cannot do based on --
6 on our regs and statutes.
7 So I think it was -- you know, we had a
8 really good conversation. We're hoping that this is
9 not the last listening session that we'll have with the
10 public on this issue. But again, thank you to everyone
11 who -- who came in and spoke for the two hours that we
12 allocated for this discussion. And that concludes my
13 report on this. If Chairwoman Houenou has anything
14 else to add.
15 CHAIR: Thank you, Commissioner Del Cid-
16 Kosso. So I have nothing further to add. Very -- I
17 echo your sentiments and your gratitude towards the
18 individuals who participated in the listening session,
19 and I look forward to the -- the forthcoming focus
20 groups.
21 THE SECRETARY: Next item on the agenda is
22 the consideration of procurement of customer
23 relationship management services.
24 CHAIR: Thank you. Director Riggs, I'll
25 turn it over to you to provide a summary of this

1 proposed procurement.

2 DIR. RIGGS: Thank you, Chairwoman. We

3 are recommending the procurement of Salesforce, which

4 is a cloud-based customer relationship management

5 platform that staff will use so that we can continue to

6 safely and equitably regulate New Jersey's legal

7 cannabis market by building various workflows and

8 process automation.

9 This will allow our staff to automate the

10 processes across all of our IT systems. It'll bring

11 all of our systems and data sources together into

12 seamless workflows, and it will provide efficient and

13 effective interactions amongst CRC employees, as well

14 as the key internal and external stakeholders. So we

15 are recommending procurement of the Salesforce

16 platform.

17 And I will turn it back over to you,

18 Chairwoman.

19 CHAIR: Thank you, Director Riggs. Are

20 there any questions from the Board for Director Riggs

21 regarding the information presented?

22 Seeing no questions, is there a motion on

23 this item?

24 VICE CHAIR: Madam Chairwoman, I move that

25 we accept Director Riggs' recommendation.

1 COMM. NASH: Madam Chair, I second to
2 approve the resolution for Salesforce software.
3 CHAIR: Thank you. Is there any
4 discussion on this motion?
5 Hearing no discussion, Mr. Said, can you
6 please call the vote?
7 THE SECRETARY: Commissioner Barker?
8 COMM. BARKER: Aye.
9 THE SECRETARY: Commissioner Del Cid-
10 Kosso?
11 COMM. DEL CID-KOSSO: Yes.
12 THE SECRETARY: Commissioner Nash?
13 CHAIR: Yes.
14 THE SECRETARY: Vice Chair Delgado?
15 VICE CHAIR: Yes.
16 THE SECRETARY: Chairwoman Houenou?
17 CHAIR: Yes.
18 THE SECRETARY: The motion passes.
19 Next item on the agenda is the
20 consideration of applications for ownership changes.
21 CHAIR: Thank you. Director Riggs, I'll
22 turn it back over to you to provide a summary of the
23 ownership change applications received.
24 DIR. RIGGS: Thank you, Chairwoman. We
25 have four ownership changes up and for consideration

1 and recommended to the Board to approve today. All the
2 owners and officers have been vetted as required by the
3 law and regulations and have been deemed qualified by
4 staff to hold the positions in the adult use cannabis
5 market.
6 And therefore we recommend that these four
7 ownership changes be approved. Thank you.
8 CHAIR: Thank you. And -- oh, there we
9 go. Thank you, Director McWhite.
10 Are there any questions from the Board
11 regarding the information provided for these four
12 business ownership transfer applications?
13 Hearing none, is there a motion on this
14 matter?
15 VICE CHAIR: Madam Chairwoman, I approve
16 the resolution approving the request for transfer of
17 the four ownership transfers.
18 CHAIR: Moved by Vice Chair Delgado. Is
19 there a second?
20 COMM. DEL CID-KOSSO: Second.
21 CHAIR: Seconded by Commissioner Del Cid-
22 Kosso.
23 CHAIR: Is there any discussion on this
24 motion?
25 DIR. RIGGS: Brief discussion, Madam

1 Chair.

2 CHAIR: Commissioner Barker.

3 DIR. RIGGS: Just wanna stress to the

4 industry to awardees, potential investors, please, we
5 cannot stress this enough, please refrain from
6 predatory practices. To the awardees I would just
7 please stress that you have somebody review any and all
8 agreements before you sign them and enter into them.

9 If you can't afford an attorney or you
10 don't have the privilege of having an attorney review
11 it, please reach out to our office, try to get in touch
12 with the ODI team, or reach out to New Jersey Business
13 Action Center. They can try to provide you some
14 guidance as much as they can, you know, to a limit, but
15 -- but we do wanna make sure somebody is reviewing
16 these agreements, so that way you understand whether or
17 not you're getting fair terms. Thank you very much,
18 Madam chair.

19 CHAIR: One -- thank you, Commissioner
20 Barker. One caveat to what Commissioner Barker said is
21 that the Cannabis Regulatory Commission cannot give
22 business or legal advice. So while the personnel and
23 staff here at the Commission is more than happy to
24 point people in the right direction, give you resources
25 that may aid you in making your business decisions, we

1 cannot tell you -- we cannot advise you on what the
2 decisions you make should be. So just that one little
3 caveat there.
4 Any other -- any further discussion on
5 this motion to approve the ownership transfer
6 applications?
7 Hearing no further discussion, Mr. Said,
8 can you please call the vote?
9 THE SECRETARY: Commissioner Barker?
10 COMM. BARKER: Abstaining.
11 THE SECRETARY: Commissioner Del Cid-
12 Kosso?
13 COMM. DEL CID-KOSSO: Yes.
14 THE SECRETARY: Commissioner Nash.
15 COMM. NASH: Yes.
16 THE SECRETARY: Vice Chair Delgado?
17 VICE CHAIR: Yes.
18 THE SECRETARY: Chairwoman Houenou?
19 CHAIR: Yes.
20 THE SECRETARY: The motion passes.
21 Next item for consideration are the Adult
22 Use Cannabis Business Conditional License Applications.
23 CHAIR: Director Riggs, I will turn the
24 floor to you.
25 DIR. RIGGS: Thank you, Chairwoman. All -

1 - we have 15 conditional licenses that are recommended
2 for approval. There is one cultivator, two
3 manufacturers, two wholesalers, eight retailers, and
4 two delivery licenses that are recommended.
5 All of these licenses have followed our
6 licensing process. They've been given a priority
7 assignment. It's been confirmed that each application
8 was assigned to the appropriate review level. The
9 priority was then verified. We have confirmed that all
10 the appropriate documentation was submitted to the
11 Commission to support the priority designation.
12 There was a completeness -- completeness
13 review check done by our licensing team to confirm that
14 all the required documents are submitted for a
15 conditional license, and then the applications are
16 moved and scored appropriately and then recommended to
17 the Board for approval. These 15 conditional licenses
18 have followed that process and we recommended they be
19 approved. Thank you.
20 CHAIR: Thank you. Are there any
21 questions from the Board?
22 Hearing none, is there a motion on this
23 matter?
24 COMM. NASH: Madam Chair, I move to
25 approve the resolution for conditional license

1 applications.

2 CHAIR: Moved by Commissioner Nash. Is

3 there a second?

4 COMM. DEL CID-KOSSO: Second.

5 CHAIR: Seconded by Commissioner Del Cid-

6 Kosso. Is there any discussion on this motion?

7 Hearing none, Mr. Said, can you please

8 call the vote?

9 THE SECRETARY: Commissioner Barker?

10 COMM. BARKER: Aye.

11 THE SECRETARY: Commissioner Del Cid-

12 Kosso?

13 COMM. DEL CID-KOSSO: Yes.

14 THE SECRETARY: Commissioner Nash?

15 COMM. NASH: Yes.

16 THE SECRETARY: Vice Chair Delgado?

17 VICE CHAIR: Yes.

18 THE SECRETARY: Chairwoman Houenou?

19 CHAIR: Yes.

20 THE SECRETARY: The motion passes.

21 Next item up for consideration are the

22 Adult Use Cannabis Business Conditional License

23 Application Denials.

24 CHAIR: Director Riggs, floor is yours.

25 DIR. RIGGS: Thank you, Chairwoman.

1 Fortunately, we only have two conditionals that we are
2 recommending for denial today. These are for
3 nonpayment. Basically, they've -- they've been
4 provided various notice to make their payment for their
5 license award, and they have not paid, so we would
6 recommend these two conditionals be denied at this
7 time. Thank you.
8 CHAIR: Thank you. Any questions from the
9 Board for Director Riggs?
10 Hearing no questions, is there a motion on
11 this matter?
12 COMM. DEL CID-KOSSO: Madam Chair, I move
13 to adopt the resolution concerning the denial of Class
14 5 and Class 2 annual licenses.
15 CHAIR: Is there a second?
16 VICE CHAIR: I second.
17 CHAIR: Is there any discussion on this
18 motion?
19 Hearing no discussion, Mr. Said, can you
20 please call the vote?
21 THE SECRETARY: Commissioner Barker?
22 COMM. BARKER: Abstain.
23 THE SECRETARY: Commissioner Del Cid-
24 Kosso?
25 COMM. DEL CID-KOSSO: Yes.

1 THE SECRETARY: Commissioner Nash?
2 COMM. NASH: Yes.
3 THE SECRETARY: Vice Chair Delgado?
4 VICE CHAIR: Yes.
5 THE SECRETARY: Chairwoman Houenou?
6 CHAIR: Yes.
7 THE SECRETARY: The motion passes.
8 Next item up for consideration are the
9 adult use cannabis business conversion license
10 applications.
11 CHAIR: Thank you. Director Riggs, I'll
12 turn it back over to you for a summary of these
13 applications.
14 DIR. RIGGS: Thank you, Chairwoman. So
15 these -- these follow the same process. We have 12
16 conditional to annual conversion licenses; two
17 cultivators, one manufacturer, and nine retailers.
18 They follow the same -- similar process to be approved
19 for their conditional license with priority assignment,
20 priority verification, completeness review, and then
21 they were scored.
22 But the additional step here is that there
23 was a qualification review, the individual's financial
24 services -- management services agreements, and any
25 other relevant documents related to the business were

1 reviewed for regulatory compliance. Background checks
2 were conducted on all the individuals and owners to
3 ensure that they meet the statutory standards to
4 operate in the adult use cannabis space.
5 There was quality control conducted by the
6 Office of Licensing and Compliance and our legal
7 office, and we are now recommending that these licenses
8 be approved by the Board.
9 CHAIR: Thank you. And I believe we have
10 a list of those applications. There we are. Great.
11 Thank you.
12 Are there any questions from the Board
13 regarding these applications?
14 Hearing no questions, is there a motion on
15 this matter?
16 COMM. NASH: I move to approve the
17 resolution for applications to convert from conditional
18 to annual.
19 VICE CHAIR: Madam Chairwoman, I second
20 that motion.
21 CHAIR: Moved by Commissioner Nash and
22 seconded by Vice Chair Delgado. Is there any
23 discussion on this motion?
24 Hearing no discussion, Mr. Said, can you
25 please call the vote?

1 THE SECRETARY: Commissioner Barker?
2 COMM. BARKER: Aye.
3 THE SECRETARY: Commissioner Del Cid-
4 Kosso?
5 COMM. DEL CID-KOSSO: Yes.
6 THE SECRETARY: Commissioner Nash?
7 COMM. NASH: Yes.
8 THE SECRETARY: Vice Chair Delgado?
9 VICE CHAIR: Yes.
10 THE SECRETARY: Chairwoman Houenou?
11 CHAIR: Yes.
12 THE SECRETARY: The motion passes.
13 Next item up for consideration are the
14 adult use cannabis business annual license
15 applications.
16 CHAIR: Thank you. Director Riggs, I'll
17 turn it back over to you.
18 DIR. RIGGS: Thank you. We have six
19 annual licenses that are up for consideration today and
20 recommended for approval; one cultivator, one
21 manufacturer, one distributor, and three retailers.
22 These have followed a similar licensing
23 process where priority assignment was given, that
24 priority was verified. They've gone through
25 completeness review. They've been scored, there was a

1 qualification review of the individuals, and to ensure
2 that any other documentation submitted complies with
3 the regulations.
4 We had a quality control done by our
5 Office of Licensing and Office of Compliance and our
6 legal team, and now we are recommending that these
7 licenses be approved by the Board. Thank you.
8 CHAIR: Thank you. Are there any
9 questions from the Board?
10 Hearing no questions, is there a motion on
11 this matter?
12 VICE CHAIR: Madam Chairwoman, I move that
13 we accept the resolution for annual license
14 applications.
15 CHAIR: Is there a second?
16 COMM. NASH: Second.
17 CHAIR: Is there any discussion on this
18 motion to accept the resolution for annual license
19 applications?
20 Hearing no discussion, Mr. Said, can you
21 please call the vote?
22 THE SECRETARY: Commissioner Barker?
23 COMM. BARKER: Abstain.
24 THE SECRETARY: Commissioner Del Cid-
25 Kosso?

1 COMM. DEL CID-KOSSO: Yes.
2 THE SECRETARY: Commissioner Nash?
3 COMM. NASH: Yes.
4 THE SECRETARY: Vice Chair Delgado?
5 VICE CHAIR: Yes.
6 THE SECRETARY: Chairwoman Houenou?
7 CHAIR: Yes.
8 THE SECRETARY: The motion passes.
9 Next item up for consideration is the
10 expanded alternative treatment center certifications.
11 CHAIR: Thank you. Director Riggs, the
12 floor is yours.
13 DIR. RIGGS: Chairwoman. We have one
14 expansion for Theory Wellness of New Jersey, which is a
15 Class 5 Retailer here in Trenton. They requested to be
16 expanded. They have the zoning and municipal
17 approvals. All waiver requirements are met under the
18 law. They are required to certify that they have
19 sufficient quantities of medical cannabis and medical
20 cannabis products available to meet the reason --
21 reasonably anticipated needs of registered qualified
22 qualifying patients, and they have done so.
23 They have met all statutory and regulatory
24 criteria, and therefore we are recommending approval of
25 their expansion into the adult use one. Thank you.

1 CHAIR: Thank you. Are there any
2 questions from the Board?
3 Hearing no questions, is there a motion on
4 this matter?
5 COMM. NASH: Madam Chair, I move to
6 approve the resolution certifying Theory Wellness of
7 New Jersey to expand operations to the AU Cannabis
8 Market.
9 CHAIR: Moved by Commissioner Nash. Is
10 there a second?
11 COMM. DEL CID-KOSSO: Second.
12 CHAIR: Seconded by Commissioner Del Cid-
13 Kosso. Any discussion on this motion?
14 Hearing no discussion, Mr. Said, can you
15 please call the vote?
16 THE SECRETARY: Commissioner Barker.
17 COMM. BARKER: Abstain.
18 THE SECRETARY: Commissioner Del Cid-
19 Kosso.
20 COMM. DEL CID-KOSSO: Yes.
21 THE SECRETARY: Commissioner Nash.
22 COMM. NASH: Yes.
23 THE SECRETARY: Vice Chair Delgado.
24 VICE CHAIR: Yes.
25 THE SECRETARY: Chairwoman Houenou.

1 CHAIR: Yes.

2 THE SECRETARY: The motion passes.

3 The next item up for consideration are the
4 adult use cannabis business annual license renewal
5 applications.

6 CHAIR: Thank you. Director Riggs, floor
7 is yours.

8 DIR. RIGGS: Thank you, Chairwoman. These
9 renewals obviously followed our licensing process and
10 were licensed. Some are -- some are one year of
11 renewal, some are in their second year of renewal.

12 One thing that I do wanna mention on this
13 renewal process is that during the course of the year,
14 these businesses need to ensure that all material
15 changes are reported to the Commission throughout the
16 year. Our regulations require that material changes
17 should not be submitted on a renewal application unless
18 they happen right at the time of renewal.

19 We should have these material changes
20 reported to the Commission and approved as we just did
21 previously with our ownership changes. In this public
22 meeting, I wanted to ensure that all businesses
23 understand that our regulations require that material
24 changes be reported to the Commission, and so that our
25 Office of Compliance can review and process those

1 changes and present them to the Board for approval
2 during the course of the year.
3 The annual renewals are up on -- on the
4 screen right now. And I believe there's one other
5 slide with some other annual renewals. We are
6 recommending that these renewals be approved. They
7 follow the process, they satisfy the statute and
8 regulations, and therefore we recommend approval.
9 Thank you.
10 CHAIR: Thank you. Are there any
11 questions from the Board regarding the annual license
12 renewals?
13 Hearing none, is there a motion on this
14 matter?
15 VICE CHAIR: Madam Chairwoman, I move that
16 we accept the resolution for renewal of adult cannabis
17 business license.
18 CHAIR: Moved by Vice Chair Delgado. Is
19 there a second? Vice Chair Delgado moves that we
20 accept the resolution for the annual license renewals.
21 Is there a second?
22 COMM. DEL CID-KOSSO: Second.
23 CHAIR: Seconded by Commissioner Del Cid-
24 Kosso. Is there any discussion on this motion?
25 Hearing no discussion, Mr. Said, can you

1 please call the vote?

2 THE SECRETARY: Commissioner Barker?

3 COMM. BARKER: Abstain.

4 THE SECRETARY: Commissioner Del Cid-

5 Kosso?

6 COMM. DEL CID-KOSSO: Yes.

7 THE SECRETARY: Commissioner Nash?

8 COMM. NASH: Yes.

9 THE SECRETARY: Vice Chair Delgado?

10 VICE CHAIR: Yes.

11 THE SECRETARY: Chairwoman Houenou?

12 CHAIR: Yes.

13 THE SECRETARY: The motion passes.

14 The next item up for consideration is

15 another annual license renewal that Commissioner Del

16 Cid-Kosso has been recused from.

17 CHAIR: Yes. So Commissioner Del Cid-

18 Kosso has recused herself from the application

19 considering -- concerning Brute's Roots. On account of

20 her recusal, she will remove herself from the Zoom

21 meeting while the Board considers this particular

22 application.

23 Afterwards Commissioner Del Cid-Kosso will

24 rejoin us and will take up the next order of business.

25 So I see that Commissioner Del Cid-Kosso has logged

1 off, so I will now turn it over to Director Riggs to
2 provide a summary of this particular renewal
3 application.
4 DIR. RIGGS: Thank you, Chairwoman.
5 Similar to the 17 others that were just approved by the
6 Board, Brute's Roots has submitted all the renewal
7 documentation as required.
8 And I will echo that material changes need
9 to be reported to the Board when they happen during the
10 course of the year. Not when you're coming up for
11 renewal, when they happen during the course of the
12 year.
13 But we are recommending that Brute's Roots
14 first year of operations annual license be renewed.
15 Thank you, Madam Chair.
16 CHAIR: Thank you, Director Riggs. Are
17 there any questions from the Board?
18 Hearing no questions, is there a motion on
19 this matter as it relates to Brute's Roots?
20 COMM. NASH: Madam Chair, I move to
21 approve the renewal for Brute's Roots.
22 CHAIR: Is there --
23 VICE CHAIR: I --
24 CHAIR: -- a second?
25 VICE CHAIR: I second it.

1 CHAIR: Seconded by Vice Chair Delgado.
2 Thank you. Is there any discussion on this motion?
3 Hearing no discussion, Mr. Said, can you
4 please call the vote?
5 THE SECRETARY: Commissioner Barker.
6 COMM. BARKER: Abstain.
7 THE SECRETARY: Commissioner Del Cid-Kosso
8 is Recused. Commissioner Nash?
9 COMM. NASH: Yes.
10 THE SECRETARY: Vice Chair Delgado.
11 VICE CHAIR: Yes.
12 THE SECRETARY: Chairwoman Houenou.
13 CHAIR: Yes.
14 THE SECRETARY: The motion passes.
15 The next item on the agenda are cases,
16 claims, and petitions.
17 CHAIR: All right. We will give
18 Commissioner Del Cid-Kosso just a quick moment to log
19 back on, and as soon as she does, Director Riggs, I'll
20 turn the floor over to you.
21 We do not have any consideration of adult
22 use of -- application denials -- any additional
23 application denials. Apologies for that slide, folks.
24 All right. So --
25 DIR. RIGGS: Slide, please. Ms. -- is

1 Commissioner Del Cid-Kosso back, Chairwoman?
2 CHAIR: Yes, she is. Go right ahead,
3 Director Riggs.
4 DIR. RIGGS: Thank you very much. We have
5 three ATC employees that have submitted the relevant
6 documentation to show that they are rehabilitated and
7 able to work in the medical cannabis space. They
8 provided the relevant, clear, and convincing evidence
9 to show that they're rehabilitated and able to work in
10 the industry.
11 There are disqualifying convictions in the
12 statute. That is why the rehabilitation was triggered.
13 They have met their burden and provided us with the
14 information necessary to show that they are
15 rehabilitated, and therefore, we are recommending
16 approval of their rehabilitation status. Thank you,
17 Madam Chair.
18 CHAIR: Are there any questions from the
19 Board regarding these -- these claims and petitions?
20 Hearing no questions from the Board, is
21 there a motion on this matter?
22 COMM. NASH: Madam Chair, I move to
23 approve the request for a determination of
24 rehabilitation by ATC employees.
25 VICE CHAIR: And I second that, Madam

1 Chair.

2 CHAIR: Moved by Commissioner Nash and

3 seconded by Vice Chair Delgado. Is there any

4 discussion on this motion?

5 Hearing no discussion, Mr. Said, can you

6 please call the vote?

7 THE SECRETARY: Commissioner Barker?

8 COMM. BARKER: Aye.

9 THE SECRETARY: Commissioner Del Cid-

10 Kosso?

11 COMM. DEL CID-KOSSO: Yes.

12 THE SECRETARY: Commissioner Nash?

13 COMM. NASH: Yes.

14 THE SECRETARY: Vice Chair Delgado?

15 VICE CHAIR: Yes.

16 THE SECRETARY: Chairwoman Houenou?

17 CHAIR: Yes.

18 THE SECRETARY: The motion passes.

19 Next item on the agenda, we have notices

20 of enforcement actions.

21 CHAIR: Director Riggs, I will turn it

22 over to you for a summary of these enforcement actions.

23 DIR. RIGGS: Thank you, Chairwoman. We

24 have two enforcement actions that are up for

25 consideration by the Board today, the QCC Group, which

1 is NOV-90-24, and FullTilt Labs, which is NOV-95-24.
2 These are for violations related to the diversely-owned
3 business status.
4 Our Office of Licensing became aware of these
5 violations through a routine audit of the Division of
6 Revenue and Enterprise Services database. It was
7 determined that they failed to maintain certification
8 indicating that they were diversely owned business as
9 required by our regulations, therefore notice of
10 violation was issued, and we are now at the enforcement
11 stage.
12 We have recommended to the Board that this
13 is a Category 5 violation, and it is their first
14 violation, and I will leave it up to the Board. Thank
15 you.
16 CHAIR: Thank you, Director Riggs. Are
17 there any questions for -- from the Board for Director
18 Riggs?
19 COMM. NASH: Yes. I just wanted to --
20 CHAIR: Commissioner Nash.
21 COMM. NASH: -- clarify that this was --
22 these violations were an administrative oversight, and
23 were not a reflection of any ownership or
24 organizational changes. Is that correct?
25 DIR. RIGGS: That is correct. These were

1 are, you know, an administrative oversight from what we've
2 uncovered, you know, during our investigation.
3 It wasn't any change to the ownership
4 status of these entities that -- that caused them to be in
5 violation of the regulations. That is correct.
6 COMM. NASH: Okay. And they responded by
7 submitting the DORES certificate properly?
8 DIR. RIGGS: Yes, my understanding is that
9 both are now recertified and maintain their diversely-
10 owned business status, have that -- that certification.
11 COMM. NASH: Thank you.
12 DIR. RIGGS: You're welcome.
13 COMM. BARKER: Oh, one follow up question,
14 Acting Director Riggs. Did either of the violations
15 pose a significant risk or threat to public health?
16 DIR. RIGGS: In my opinion, no, they did

17 not pose an immediate concern or any concern related to

18 public health or safety.

19 COMM. BARKER: Thank you.

20 DIR. RIGGS: You're welcome.

21 CHAIR: Thank you. Any other questions from the Board?

22 All right. We'll take these one at a time. So with

23 respect to the first, NOV-90-24, is there a motion on

24 this matter?

25

1 VICE CHAIR: Yes, Madam Chairwoman. I
2 have a motion.
3 CHAIR: Vice Chair Delgado.
4 VICE CHAIR: I move on the -- the action
5 on QCC Group, LLC. I move for a $250 Fine.
6 CHAIR: Vice Chair Delgado has moved to
7 impose a $250 fine. Is there a second?
8 COMM. NASH: Second.
9 COMM. DEL CID-KOSSO: Second.
10 CHAIR: Seconded by Commissioner Nash.
11 Any discussion on this motion to impose a $250 fine?
12 Vice Chair Delgado, if you could please,
13 I'd like to hear your -- your thinking, your rationale
14 for this particular fine.
15 VICE CHAIR: It was a first offense; it
16 was administrative oversight. Very simple. And I just
17 wanna be consistent on what -- on the fines that I
18 believe in. And that's my rationale. First time
19 offense, and it's administrative oversight.
20 CHAIR: I believe that's a reason --
21 (clears throat) excuse me. I believe that that is a
22 reasonable landing place for first offense for an
23 administrative oversight here especially in light of
24 the communication and responsiveness of the business to
25 provide the -- to rectify these -- the situation and

1 get a valid certification for their diversely-owned
2 status.
3 Is there any further discussion on this
4 motion to impose a $250 fine?
5 Hearing no further discussion on the
6 motion to impose a $250 fine in response to NOV-90-24,
7 Mr. Said, can you please call the vote?
8 THE SECRETARY: Commissioner Barker?
9 COMM. BARKER: Aye.
10 THE SECRETARY: Commissioner Del Cid-
11 Kosso?
12 COMM. DEL CID-KOSSO: Yes.
13 THE SECRETARY: Commissioner Nash?
14 COMM. NASH: Yes.
15 THE SECRETARY: Vice Chair Delgado?
16 VICE CHAIR: Yes.
17 THE SECRETARY: Chairwoman Houenou?
18 CHAIR: Yes.
19 THE SECRETARY: The motion passes.
20 CHAIR: So we'll turn now to the second
21 enforcement action item, NOV-95-24. Is there a motion
22 as it relates to this item?
23 VICE CHAIR: Yes, Madam Chairwoman, I have
24 a motion.
25 CHAIR: Vice Chair Delgado.

1 VICE CHAIR: I move that we fine FullTilt
2 Labs, LLC, a $250
3 fine.
4 CHAIR: Is there a second?
5 COMM. DEL CID-KOSSO: Second.
6 CHAIR: Seconded by Commissioner Del Cid-
7 Kosso. Any discussion on this motion?
8 Vice Chair Delgado, same question again,
9 that I'll pose to you here. If you could provide the
10 rationale for the $250 fine.
11 VICE CHAIR: Again, Madam Chairwoman, same
12 rationale, first offense, administrative oversight, and
13 I -- behooves the Commission to be -- to be consistent,
14 and I think the $250 fine is consistent with the
15 previous fine.
16 CHAIR: I tend to agree. Thank you, Vice
17 Chair Delgado. Is there any further discussion?
18 Hearing no further discussion on the
19 motion to impose a $250 fine in response to NOV-95-24,
20 Mr. Said, can you please call the vote?
21 THE SECRETARY: Commissioner Barker?
22 COMM. BARKER: Aye.
23 THE SECRETARY: Commissioner Del Cid-
24 Kosso?
25 COMM. DEL CID-KOSSO: Yes.

1 THE SECRETARY: Commissioner Nash?
2 COMM. NASH: Yes.
3 THE SECRETARY: Vice Chair Delgado?
4 VICE CHAIR: Yes.
5 THE SECRETARY: Chairwoman Houenou?
6 CHAIR: Yes.
7 THE SECRETARY: The motion passes.
8 The next item on the agenda, we have the
9 open public comment period. Actually, we actually --
10 we have invited guests that we are gonna invite first
11 to speak.
12 CHAIR: Yes. Thank you, Mr. Said. So as
13 we open up -- as we prepare for the public comment
14 period, I do want to note, as we do at every board
15 meeting, that members of the public can submit public
16 comments during or after this meeting in writing via
17 our website nj.gov/cannabis/meetings, and the deadline
18 for submitting written comments for today's public
19 meeting is 5 o'clock tomorrow, Tuesday, June, 18th.
20 Written comments will be shared with the
21 Commissioners, and they will be made public. So for
22 today, we have three specific topics that we wanna hear
23 your thoughts on. And as Mr. Said mentioned -- as Mr.
24 Said noted, we will hear first from our invited
25 speakers who will each have five minutes to share their

1 comments, and then we'll open the floor to members of
2 the public who registered to speak, and members of the
3 public will have -- as we usually, in accordance with
4 our standard practice, will have three minutes to share
5 their comments.
6 So on the first, I just wanna highlight
7 for our attendees our three topics that we are
8 particularly highlighting today.
9 Qualifying medical conditions for the
10 medical -- medicinal cannabis program, currently we
11 have 17 medical conditions approved for participation
12 in the program. Should any other medical conditions
13 qualify for the program participation? Why? And how
14 can medicinal cannabis effectively serve people facing
15 other medical conditions?
16 Second item. The second topic is
17 research. How can the Commission support scientific
18 cannabis research efforts? Clinical registrant permits
19 provide one opportunity for institutions to assess
20 patient health and safety in the medical program, but
21 what other pathways should the Commission consider to
22 promote or incentivize appropriate scientific research?
23 And then lastly, our third topic is
24 healthcare provider access. How can health care
25 providers be encouraged to support patients interested

1 in enrolling in the medicinal cannabis program? And
2 how are providers learning about the medicinal benefits
3 of cannabis? So we wanna hear from you. We'll first
4 hear from our invited speakers.
5 When your name -- when you do hear your
6 name called, please raise your hand in the Zoom feature
7 -- in the Zoom platform, apologies, and our staff will
8 be able to unmute you. When we turn to our members of
9 the public, staff will call out our registered
10 commenters in the order in which they registered. When
11 you hear your name called, you please raise your hand
12 in the Zoom platform so that we can unmute you.
13 If your name does not match in the -- if
14 your name in the Zoom platform does not match the name
15 that you used to register to speak, we may not be able
16 to identify you. So it is important that you ensure
17 that your name is accurately spelled in the Zoom
18 platform.
19 If you're not sure what your name looks
20 like on the Zoom platform, log out, immediately log
21 back in where you should -- at which time you should be
22 prompted to enter your name, and from there we will be
23 able to accurately identify you.
24 So with that, I will turn it over to Mr.
25 Said and Director Blake to -- I'm sorry, Director

1 McWhite, to call on our first invited guests.
2 DIR. WESLEY MCWHITE III: All right.
3 Testing, testing, the microphone is on. Yes,
4 wonderful. So I am going to call the first three
5 invited speakers. I ask that you raise your hand.
6 First, Dr. Elisabeth Van Bockstaele, Ken Wolski, and
7 Nichelle Santos, and Gaetano. If you three can raise
8 your hands -- or four can raise your hands, I will
9 allow you to talk one at a time. Thank you so much.
10 And Dr. Elisabeth Van Bockstaele you are
11 first. And please just state your name and your
12 affiliation group or organization before you start.
13 And I do have your slides queued up, Dr. Bockstaele.
14 DR. ELISABETH VAN BOCKSTAELE: Thank you
15 so much. And good afternoon, everyone. Thank you for
16 having us and allowing us to speak with you today. My
17 name is Elizabeth Van Bockstaele. I am a
18 neuroscientist. I work at Drexel University for many
19 years. I've conducted NIH sponsored research on the
20 endocannabinoid system and the body's response to
21 stress.
22 I'm also joined by two of my colleagues,
23 Dr. Robert Sterling, who is a professor and clinical
24 researcher, and has done abundant research on substance
25 use disorder as well as cannabis research, and Dr.

1 Jennifer Ross, who is an assistant professor who
2 initiated her research on cannabis in preclinical
3 models and has transitioned to clinical research to
4 understand how different strains of the marijuana plant
5 affect different medical conditions.
6 We are here today to advocate for more
7 effective education and a clear connection between
8 education and research. If you could go to the next
9 slide. There really is a critical need to introduce
10 effective, comprehensive education for health care
11 providers, at every clinical level, from pharmacists to
12 physician assistants, nurse practitioners, and medical
13 doctors in training.
14 And this research needs to be supporting
15 education, needs to be sound, and really based on
16 representative samples. And to date, there are very
17 few programs which are dedicated to educating these
18 providers on medicinal cannabis. And If I could just
19 turn to my colleague, Dr Jennifer Ross, she was gonna
20 talk through the next slide. And we only have three
21 more slides.
22 Dr. Ross, if you could raise your hand.
23 DR. JENNIFER ROSS: Thank you, Elisabeth.
24 And thank you all for having us speaking here today.
25 Essentially just strictly from a pharmacological

1 perspective, and really to tie together the clinical
2 researchers and their providers that are actually
3 writing the scripts. We need to better understand how
4 much dosing-wise each participant in a clinical study
5 is consuming.
6 So it presents a number of difficulties to
7 both researchers and clinicians to not have sort of a
8 sound idea of really the dosing that is being used by a
9 particular patient, and to try to control for that.
10 One recommendation or idea to just start a conversation
11 about this is to consider expanding the prescription
12 drug monitoring program to include cannabis.
13 In a similar way that any pharmacy that
14 you go to has a record and an identification of your
15 prescription that your doctor wrote you, why not hold
16 dispensaries to the same level of accuracy in
17 dispensing this medicinal drug.
18 Finally from a strictly pharmacology --
19 pharmacological perspective, investing in high
20 resolution drug testing would improve our ability to
21 understand, you know, the various ways that cannabis is
22 consumed, how that drug is actually digested, and how
23 much of it is effectively working through the patient's
24 body.
25 So coming from a very quantitative

1 perspective on trying to operationalize medical
2 cannabis use, these are the things that we would
3 recommend, or at least consider -- invite you to
4 consider. And I'll just turn this over now to our
5 colleague, Dr. Robert Sterling.
6 DR. ROBERT STERLING: Next slide, please.
7 Thank you. My name is Robert Sterling with Drexel
8 University, and I'm very happy to be here this
9 afternoon. You'll hear that there's a common theme
10 throughout our commentary today, and it's about
11 education and research.
12 Before coming to Drexel, I spent over 30
13 years in the Department of Psychiatry, Thomas Jefferson
14 here in Philadelphia, where I conducted both
15 translational and outcomes-based research. And we
16 remain in a situation -- especially as we speak today
17 about medical marijuana, we remain in the situation
18 where limited research today leaves both clinicians and
19 patients alike uncertain about best practices to
20 follow.
21 And so what I'm gonna advocate for, as Dr.
22 Van Bockstaele has and Dr. Ross has, is for more
23 thorough and well considered clinical outcomes
24 research. The idea behind clinical medicine is to
25 deliver the right care to the right person at the right

1 place at the right time. And when we accomplish this,
2 this sort of trifecta of events, ultimately, we improve
3 clinical outcomes, and that's the goal here.
4 Unfortunately, we're not here yet though,
5 when it comes to medical marijuana. Much of what takes
6 place right now is trial and error self-medicating in
7 an attempt to find an efficacious outcome. If we're
8 going to move the science forward, and we are going to
9 move the science forward, we're going to need well-
10 designed research trials that seek to match specific
11 strains, specific clinical indications, and in that way
12 we'll eliminate the trial and error component of it and
13 we'll really create a science behind the diagnostics
14 and the introduction of therapeutics.
15 And in that way, a couple of things will
16 happen. One of the things we'll effectively reduce a
17 stigma around -- around care using medical marijuana,
18 and will result in a -- in a more informed clinical
19 decision-making process, which is something I think we
20 all look forward to. And with that, I will turn the
21 floor back to Dr. Van Bockstaele. Thank you so much.
22 DR. VAN BOCKSTAELE: Thank you. And this
23 is just our last slide, just to reiterate our advocacy
24 for the importance of educating providers broadly
25 defined in a number of different health professions

1 using evidence-based information. And we greatly
2 appreciate your time today. That concludes our
3 comment.
4 CHAIR: Thank you very much to all three
5 of you. I'm very happy that you were able to join us
6 today. I wanna open the floor for any questions from
7 the Board regarding the information that you all
8 presented.
9 And I wanna start by highlighting
10 something that Mr. Sterling, you had -- you had talked
11 about, and that was, you know, the need for well-
12 designed research trials that match specific streams
13 with specific indications.
14 Are there any particular criteria or
15 qualities of research trials that you think the
16 Commission should be paying particular attention to
17 when evaluating whether something is sufficient --
18 sufficiently well designed in your view?
19 DR. STERLING: Thank you very much for the
20 question, the very well-considered question.
21 Ultimately, you know, we, we have kind of
22 landed on the randomized control trial. As the sine
23 qua non of evidence-based research, and I think that's
24 ultimately where we would like to take the science,
25 where we're doing prospective research, where we are

1 employing very carefully considered inclusion and
2 exclusion criteria so that we can eliminate as many
3 extraneous variables in the decision making when we're
4 -- when we -- when we have positive findings.
5 That would -- that would sort of be my
6 answer to the question, Madam Chairwoman.
7 CHAIR: Thank you very much. Any board --
8 any other board members have any questions?
9 COMM. NASH: I'd like to ask --
10 VICE CHAIR: A brief question. Go ahead,
11 Commissioner.
12 COMM. BARKER: (Interposing) I defer to
13 Commissioner Nash and Vice Chair Delgado if they have
14 questions.
15 COMM. NASH: Thank you. Thank you,
16 Commissioner Barker. Dr. Sterling, in the treatment
17 community, and when you talk about opioid use disorder,
18 we've heard on public comments here how Cannabis has
19 helped people who struggled with opioid use disorder,
20 and I've personally spoken to people who have said that
21 cannabis helps them tremendously.
22 And I do find that there is this stigma
23 with the treatment community where they are -- there's
24 -- there's one school of thought that says you must be
25 abstinent and you cannot use cannabis. And then we

1 find this -- this other school of thought where there
2 are people that are saying it's helping them, and I
3 wondered if you could just shed some light on your
4 thoughts on that and your experience.
5 DR. STERLING: Thank you for -- thank you
6 for the question. It's one -- it's -- it's fascinating
7 to me that one of the single most cited articles that
8 Dr. Van Bockstaele and I have collaborated on over our
9 time together doing translational research was a study
10 where we -- where we actually looked at -- in a
11 clinical population. I -- I ran a methadone program --
12 or was associated with running a methadone program, an
13 opioid replacement program for over 30 years.
14 And we saw a very potent and very robust
15 effect with individuals when they were coming into
16 treatment, which is a period of high stress for someone
17 who are making tremendous changes in their life, and we
18 found that individuals who were self-medicating with
19 cannabinoids, and this was by your analysis --
20 confirmed by your analysis, had a much more efficacious
21 process of engaging in treatment, were more likely to
22 still be in treatment at a period of six months later.
23 This is a positive outcome. The problem,
24 of course, is there was no randomization. These were
25 self-selected individuals. So there's a very strong

1 signal there, but we can't definitively say. So this
2 is why I'll -- you know, I'll keep circling back to the
3 point that the degree to which we can conduct well-
4 designed trials, the better off we're gonna be at
5 creating an evidence-based practice around medical
6 marijuana.
7 I hope that answered the question.
8 COMM. NASH: Okay. It does. Thank you so
9 much.
10 CHAIR: Commissioner Barker.
11 COMM. BARKER: Thank you, doctors. Thank
12 you all for your time. We definitely appreciate it and
13 don't take it lightly. Just a few questions, and I'll
14 take my last question for you, Dr. Sterling. And thank
15 you for stressing the need for well-designed trials.
16 I know here in New Jersey we have a
17 clinical registrant component of our industry that
18 we're looking to onboard in the near future. We are
19 the pharma capital. And so part of my -- one of my
20 questions is to your point about the research currently
21 being limited and the need for more well-designed
22 trials. This is for you and any of the other doctors
23 and professors on the call.
24 What does an equitable research trial look
25 like? What -- how do we engage in research, R&D and

1 the like and -- and create these well-designed trials
2 in an equitable and safe and inclusive manner.
3 DR. STERLING: First answer is
4 thoughtfully and usually with the cooperation of an
5 advisory board, and a community engagement strategy
6 which is specifically designed at bringing individuals
7 who are sort of historically misrepresented in these
8 sorts of projects and brings them to the table,
9 overcomes their reticence and reluctance to
10 participate, so that we actually have a picture of
11 efficacy that really is generalizable.
12 Because ultimately, that's what we're
13 looking for in any kind of scientific enterprise, is
14 we're looking for results that are generalizable, that
15 clinicians will actually put into practice.
16 And I'll toss -- I'll toss it off -- off
17 to either Dr. Ross or Dr. Van Bockstaele, if you guys
18 would like to offer a thought.
19 DR. VAN BOCKSTAELE: Nothing to add, Dr.
20 Sterling. Very well said. And thank you for the very
21 thoughtful questions.
22 COMM. BARKER: Absolutely. And just one
23 last question. If Dr. Ross doesn't have a comment on
24 that. It would -- and I think Dr. Van Bockstaele you -
25 - you touched on this earlier in your outro, the need

1 for more effective education and research.

2 And I think you touched on the

3 endocannabinoid system, one of the, you know, basic

4 components of cannabis that's so critical for all of us

5 mammals. And so at a -- at a basic level, I just

6 wanted to ask, and again, any -- any of the -- the

7 three can answer, how can we be better educators on the

8 endocannabinoid system, and what grade or what age

9 should be the cutoff for teaching about the

10 endocannabinoid system so we are properly educated and

11 informed on this?

12 DR. VAN BOCKSTAELE: I can start. I think

13 the earlier the better, in the sense that it's all in

14 the delivery of how this material is presented. I'll

15 just harken back to some of the work that I used to do

16 on a voluntary basis during what is called Brain

17 Awareness Week.

18 And we used to partner with the Franklin

19 Science Museum and basically deliver a lot of content

20 on how the brain functions, and we had a lot of middle

21 schoolers, elementary age kids coming through, and

22 really, you know, these children are, you know,

23 depending on the manner in which you share the topic,

24 are really sponges and really ask such thought-

25 provoking questions.

1 And again, you know, if presented in an
2 engaging and way, because a lot of times with the
3 endocannabinoid system, you know, I parallel it to our
4 endogenous opioid system. So, you know, it's even more
5 abundant in our brains than the opioid system. So
6 trying to explain, you know, how neurons signal one
7 another, you can actually use games in order to show
8 that.
9 I think the sooner we do this, the better
10 for our children to understand. Jen, I don't know if
11 you have anything to add to that.
12 DR. ROSS: Yes. I was just going to say
13 that in terms of the clinicians that we are looking to
14 engage today, I think that there should be an emphasis
15 on, you know, post graduate, or even in college, when
16 individuals are taking their, you know, registered
17 nursing courses, or there needs to be a curriculum kind
18 of baked into their training that includes
19 cannabinoids.
20 Because as Dr. Van Bockstaele was
21 mentioning, the endogenous cannabinoid system is
22 widespread throughout the brain, and in fact, also
23 interacts quite closely with the stress system. And so
24 I guess I wanted to make two separate comments, one on
25 the level of the education for training clinicians, and

1 in doing so would kind of promote and empower and --
2 and increase confidence in the clinicians that are
3 looking to promote cannabis and its beneficial effects.
4 And then the second, I would say in terms
5 of really having an equitable -- an equitably designed
6 research clinical trial, what we have seen in our
7 research relating back to the stress system, it really
8 emphasizes the need to better understand cannabis, its
9 benefits and its uses in underserved populations.
10 So just to kind of reiterate some of the
11 points that have already been made, I think it's
12 extremely important to continue looking at the stress
13 system in relationship with the endogenous cannabinoid
14 system and how that affects society in a systematic way
15 as well. Thank you.
16 COMM. BARKER: Thank you very much. Thank
17 you all very much. Much appreciated.
18 CHAIR: Thank you. And I've got -- I have
19 one more question for I believe it was Dr. Ross. You
20 mentioned -- or you suggested that the state should
21 consider expanding the prescription drug monitoring
22 program to include cannabis. For a practitioner or
23 from a dispensing perspective, what do you think that
24 should look like?
25 DR. ROSS: So, I mean, I think that -- you

1 know, earlier you all were talking about Salesforce.
2 You know, it really needs to be kind of something
3 that's implemented technologically, something that is
4 connecting all the dispensaries, and kind of the
5 prescriptions that are -- are made and -- on file, so
6 to speak, and the filling of those scripts, right?
7 Like, let's treat medicinal marijuana the
8 way we treat any other pharmacological intervention.
9 This would help standardize a few things to start, but
10 I don't know exactly what that, you know,
11 implementation would look like, but I think it would
12 have to be a system through which all dispensaries can
13 kind of log in and be crosschecking for reference how
14 individuals are filling those scripts, how often, what
15 strains they're using, and -- and for what indications.
16 I mean, all of this information can be
17 incredibly helpful from a research perspective.
18 CHAIR: Thank you very much. Are there
19 any other questions?
20 COMM. DEL CID-KOSSO: I have to agree in
21 terms of how important the prescription drug program is
22 for us to include cannabis. And a question that I have
23 is, so I've done some of that work when I was in the
24 Department of Health, and how opioids -- you know, how
25 we track the amount of opioid usage in the state of New

1 Jersey.
Do you have an example of any state or any
2

3 other jurisdiction that is doing this at this point in
4 time that you can point us to?
5 DR. STERLING: Am I muted?
6 COMM. DEL CID-KOSSO: We can hear you.
7 CHAIR: We can hear you.
8 DR. STERLING: Oh, you can? Okay.
9 CHAIR: Yeah.
10 VICE CHAIR: To the best -- yeah, to the
11 best of my knowledge, the answer is no. And it's --
12 it's sort of -- as we were looking over the topical
13 questions in advance of today, it was -- it was sort of
14 a light bulb went over our heads simultaneously that
15 wouldn't this really help standardize the process?
16 So I don't know what it would look like.
17 And, you know, the problem with PDMPs, you know, across
18 the board, is there only as good as the people putting
19 data into the PDMP. So that's -- that's one of the
20 things I think the Board should be considering very
21 carefully, if that's something that the Board thinks
22 might help with the standardization of care, is some
23 sort of, you know, monitoring program is how -- what
24 would it look like.

25 You know, yeah, what would it look like,

1 and who's entering those data? I think that might
2 maybe help a little bit with clinician stigma around
3 involving themselves in delivering medical marijuana
4 care.
5 DR. ROSS: I think if I could just add one
6 more point, that I think ultimately the goal -- anybody
7 that's working in research in -- in cannabinoids, the
8 goal is to really demonstrate with really sound, well-
9 designed clinical research, the benefits of medicinal
10 marijuana, and moreover, to guide patients away from
11 options that may not work as well for them so that, you
12 know, we know exactly what we can, you know, direct
13 someone with, you know, chronic pain or some other
14 stress related disorder, what strain might work best
15 for them.
16 But the goal ultimately is to build up
17 enough evidence to have insurance companies have to pay
18 for such interventions, I mean, by increasing the
19 research and, you know, making it a bit less
20 observational in nature and more intentional, and by
21 building, I think, kind of an arsenal of resources,
22 tools that not just the clinicians can use to increase
23 confidence and direct their attention, but then also
24 providing that incredibly that -- that, I guess,
25 material basis to promote and to argue that this is a

1 medication that is helping people and people may in
2 fact need help paying for such interventions, and that
3 this should be treated on an insurance level as a
4 therapeutic that should be considered covered.
5 So I think that standardizing things in
6 this way would also promote other aspects of patient
7 care as well.
8 CHAIR: Thank you. Last call for any
9 quick questions for this -- our first panel guests.
10 Seeing none, I want to thank the three of
11 you again, Dr. Van Bockstaele, Dr. Ross, Dr. Sterling,
12 for -- for your participation and for your thoughts and
13 insight here.
14 I'll turn it back over to Director McWhite
15 to call on our next invited speakers.
16 DIR. MCWHITE III: Thank you, Madam Chair.
17 The next is Ken Wolski, and I believe you are free to
18 speak.
19 MR. KEN WOLSKI: Thank you. My name is
20 Ken Wolski. I've been a registered nurse here in the
21 State of New Jersey for 48 years, and I'm Executive
22 Director of the Coalition for Medical Marijuana in New
23 Jersey, an organization I co-founded 21 years ago. I
24 appreciate the opportunity to address the CRC on these
25 issues, including qualifying medical conditions for the

1 Medicinal Cannabis Program.
2 Regarding that, I urge the CRC to allow
3 anyone with prescriptive privileges in New Jersey to
4 recommend cannabis therapy for any condition that the
5 prescriber feels may be helped by medical cannabis.
6 Leave this up to the prescriber to act in the best
7 interest of the patient. The State's already approved
8 numerous medical conditions as qualifying for cannabis
9 therapy, so therefore, cannabis should be allowed to be
10 recommended off label, as it is in the case with
11 prescription pharmaceuticals.
12 Adding individual conditions to the
13 Medicinal Cannabis Program is time consuming and
14 inefficient. And also consider rare and orphan
15 diseases. There are over 7, 000 rare and orphan
16 diseases, and one of them, Tourette's syndrome, finally
17 qualifies for medical cannabis in New Jersey, but it
18 took eight years to qualify.
19 But in another level, it really doesn't
20 matter what conditions qualify for medical cannabis
21 therapy if a patient can't get it because of their
22 living situation. Currently, most healthcare
23 facilities forbid the use of medical cannabis in their
24 facility, and this is dangerous, promotes needless
25 suffering, and is potentially a fatal situation.

1 And also it is my sincere hope that the
2 State will recognize its responsibility to
3 institutionalize patients in New Jersey. For 25 years
4 I worked as an RN in state institutions, and I know
5 that many patients in these institutions qualify for
6 medical cannabis, could benefit greatly from it, and --
7 and would reduce the cost of running these programs.
8 The staff is already trained to account
9 for controlled substances, and there is no reason to
10 withhold this important therapy from these patients.
11 Regarding research, there are currently
12 about 80,000 patients and caregivers in New Jersey's
13 medicinal marijuana program, and -- and you've been
14 providing medical cannabis to tens of thousands of
15 patients every month, and it seems like you never ask
16 how they're doing on this medicine.
17 Well-designed clinical trials is a
18 wonderful thing, but it -- it would take years to
19 finally complete, and a simple questionnaire could be
20 developed in the meantime and sent to every patient as
21 part of this program. The questionnaire would be
22 voluntary, of course, and anonymity would be assured,
23 and it would provide great information about what
24 dosages and methods of administration are being used
25 for what conditions and how effective it is.

1 Are the patients experiencing side
2 effects? Have they reduced their use of opiates or
3 other medications? And have they experienced drug
4 interactions? If the CRC doesn't have the resources to
5 conduct this research, perhaps it can be formed out to
6 a local university like Rowan University or Stockton
7 University that -- that have research programs.
8 And finally, with healthcare provider
9 access, with few exceptions, there's a great deal of
10 ignorance and a lack of interest in the -- in the
11 physician community about medical cannabis.
12 The American Medical Association has
13 refused to endorse any of the medical marijuana
14 programs in the 38 states that have these programs, and
15 only about 6 percent of the doctors in -- in New Jersey
16 are taking part in this program, and oftentimes they
17 make no specific recommendations about strains to use
18 or methods of administration, and this information is
19 more reliably obtained from budtenders in the State's
20 alternative treatment centers than from physicians.
21 The CRC should quickly adopt dosing and
22 administration guidelines and educational programs on
23 the endocannabinoid system as recommended by the J.
24 Coney (ph) Law and the Department of Health's Executive
25 Order Report Number 6 -- Order Number 6 Report from

1 2018. Marijuana is mainstream medicine. Even the DEA
2 appears to be on the verge of admitting that marijuana
3 is medicine by reclassifying it to a schedule free
4 drug.
5 So and as more people experience the
6 medical benefits of cannabis through the adult use
7 program, healthcare professional -- professionals in
8 the State must become comfortable incorporating
9 cannabis use into the therapeutic regimens of their
10 patients, and this can be done most efficiently by
11 requiring education on the endocannabinoid system for
12 all healthcare professionals with prescriptive
13 privileges in the State of New Jersey as a condition
14 for continued licensure in the State.
15 That should get their attention. I mean,
16 it is truly remarkable that an entirely new system in
17 the human body was discovered a mere 30 years ago. And
18 this system interacts with all the other systems in the
19 human body, so no -- no -- no -- no one can say that it
20 doesn't affect them. ECS researchers say this system
21 may well play a role in all disease processes affecting
22 humans and animals.
23 So thank you for this opportunity to
24 address the CRC.
25 CHAIR: Thank you, Mr. Wolski. Are there

1 any questions from the Board?

2 I'll start. Mr. Wolski, you talked about
3 the ignorance -- perceived ignorance within the medical
4 community around these issues and around the
5 endocannabinoid system, but -- but participation -- and
6 benefits of participation to benefits that can be
7 realized by patients in the medical -- Medicinal
8 Cannabis Program.

9 Do you have any ideas or suggestions for
10 the Commission to -- to tackle this perceived
11 ignorance?

12 MR. WOLSKI: Well, yes. I mean, my main -
13 - my main suggestion is to require that there is
14 education on the endocannabinoid system for all
15 prescribers as a condition for continued licensure.

16 The -- you know, the -- if the -- if the
17 American Medical Association would be educating itself
18 about this -- this newly discovered system in the human
19 body, there -- and -- and following the science, you
20 know, there -- there would be a great deal of
21 excitement about this.

22 They -- they would be requiring physicians
23 to -- to -- to learn about it, because, you know, here
24 it is, it's -- it's interacting with all the other
25 systems in the human body. I mean, if -- if physicians

1 spend a limited -- who -- who specialize in limited
2 areas of the body say that, you know, this doesn't --
3 this doesn't affect me, that it -- they can -- they can
4 -- they really can't say that because -- because, you
5 know -- you know, it affects every -- every organ of
6 the human body, the endocannabinoid system and
7 receptors for cannabinoids, the -- both the
8 phytocannabinoids in the plant and the endocannabinoids
9 that our own body makes. Receptors for them are in
10 every organ of the human body.
11 So it definitely -- you know, what role
12 you might have in advocating for required education on
13 the endocannabinoid system should certainly be -- you
14 know, be used.
15 CHAIR: Thank you very much. Any other
16 questions from the Board?
17 COMM. BARKER: Yeah. It's just a brief
18 question. Mr. -- Mr. Wolski, thank you very much.
19 Again, thank you for taking time to join us. Thank you
20 for your leadership in this space for the last few
21 decades.
22 I just wanna circle back to the same
23 question that was posed to the previous speakers, and
24 you, you know, being so entrenched in New Jersey,
25 knowing that we are a pharma capital, knowing that our

1 industry is looking to on board a clinical registering
2 component.
3 What does equitable, inclusive and safe
4 research look like in New Jersey? How do we -- how
5 does the pharmaceutical industry enter this space when
6 it comes to research and development in an equitable
7 manner? I would love to hear your thoughts on that.
8 MR. WOLSKI: Well, that's -- that's a
9 really good question, Commissioner Barker. And -- and,
10 you know, part of the problem with doing cannabis
11 research and developing clinical trials if you're --
12 especially if you're -- if you're mimicking the
13 pharmaceutical model, is that they -- they typically go
14 with single -- single substance research.
15 So rather than a complex plant like
16 cannabis that has, you know, hundreds of cannabinoids,
17 or at least a hundred cannabinoids and hundreds of
18 other components to the plant.
19 So to try to put that into -- try to
20 design even clinical research is -- is a difficult
21 research -- is a difficult problem. First of all, it
22 starts with -- it would -- I mean, some -- some small-
23 scale clinical trials have been completed. No -- not a
24 single large-scale clinical trial has ever been
25 completed in the United States on -- on cannabis,

1 partly because the -- the federal -- of the federal
2 government's resistance to this.
3 So, you know, it's -- it's tough to work
4 it into the pharmaceutical model that -- that is --
5 that is the model that we have for approval for drugs.
6 And -- and so I -- I look for other experts on the
7 actual research to give you some more information about
8 this.
9 Gaetano Lardieri is one of the board
10 members of CMM NJ, and he's gonna be talking about this
11 a little more later. So it's -- the -- the research
12 that I suggested was, you know, just, again, a
13 expansion of the observational research. To -- to --
14 to -- to be providing tens of thousands of patients
15 with medical cannabis and not asking them how they're
16 doing is just an -- a wasted opportunity for gathering
17 more information while we wait for the -- the clinical
18 trials to be completed.
19 And if it follows the -- the
20 pharmaceutical model of clinical trials, these clinical
21 trials are gonna take years to complete. So, you know,
22 we can get more information, valid information sooner.
23 And -- and regarding the insurance
24 coverage, you know, insurance coverage is -- you know,
25 the -- these state programs that the state funds, if --

1 they've already passed through some of the -- we have -
2 - we have bills in the legislature right now to provide
3 for insurance coverage for medical cannabis for -- for
4 various -- various programs, and some of them have
5 passed through legislative hearings already.
6 So you know, we can -- we can provide that
7 already here in New Jersey with the information that we
8 have. I hope I answered your question.
9 COMM. BARKER: No, thank you. Yes, you
10 did. Yes, you did. And -- absolutely did, and
11 probably look forward to following up with you down the
12 line for more information. But you did.
13 I think what I gleaned from that, if I
14 may, and correct me if I'm wrong, but the current
15 frameworks -- like a lot of things in cannabis, the
16 current frameworks may not be working, and so it's an
17 opportunity to revisit the status quo and see how we
18 can rework it, or tweak it, or change it for the better
19 to make it more inclusive and more equitable.
20 MR. WOLSKI: Yes, absolutely. Thank you,
21 sir.
22 COMM. BARKER: Thank you.
23 CHAIR: Thank you. Are there any for --
24 any additional questions from the Board for Mr. Wolski?
25 Seeing none, thank you again, Mr. Wolski,

1 for your -- your insight and your experience -- sharing
2 your experience with us here today.
3 MR. WOLSKI: Thank you.
4 DIR. MCWHITE III: All right. I am going
5 to call the next three invited speakers. So if you can
6 raise your hands for us, I am gonna allow you to talk,
7 but please remain on mute until you are called upon to
8 go ahead and start speaking. So I do see Nichelle
9 Santos and Gaetano Lardieri from New Jersey for
10 Minorities for Medical Marijuana.
11 I do see Dr. Alex Bekker, Chairman of
12 Medical Marijuana Review. I also would like Leo
13 Bridgewater for Service Disabled Veterans and Cannabis
14 to please raise his hand, and Edward Lefty Grimes from
15 Sativa Cross to please raise his hand as well. Again,
16 we will start with Nichelle Santos and Gaetano
17 Lardieri, and then Dr. Bekker, and then Mr. Leo
18 Bridgewater.
19 Please -- again, please state your first
20 and last name and your affiliate organization.
21 MR. GAETANO LARDIERI: Hello, can you hear
22 me?
23 DIR. MCWHITE III: Yes.
24 MR. LARDIERI: Hi, this is Gaetano
25 Lardieri. I just want to wish everybody happy pride in

1 Juneteenth. So good afternoon, Chair Houenou, and
2 esteemed commissioners. I am very honored to be
3 invited to speak before you today on a subject that is
4 close to me, both professionally and in my role as a
5 New Jersey state co-director for Minorities for Medical
6 Marijuana.
7 That subject is research. My name is
8 Gaetano Lardieri, co-director for Minorities for
9 Medical Marijuana, New Jersey, M4MM. I -- I've served
10 in this role alongside my colleague and friend,
11 Nichelle Santos. I'm also a board member of the
12 Justice Foundation, Coalition for Medical Marijuana,
13 New Jersey, and UPenn's Affiliate Scholars, all of
14 which are supporters of safe, efficacious, robust
15 cannabis research.
16 Nichelle and I have served in this role
17 for several years now, proudly advocating for social
18 equity in the cannabis industry, and now strongly
19 advocating for the same when it comes to building out a
20 cannabis research program. I've spent 40 years in the
21 medical field, including 26 years in cancer research.
22 I have led teams to significant
23 achievements, such as an FDA approval for a breast
24 cancer drug. For the past 11 years, my focus has
25 shifted to alleviating the stigma around cannabis and

1 psychedelics and advocating for research. I commend
2 the CRC for your outstanding work in fostering social
3 equity within New Jersey's cannabis industry.
4 Now it's time to elevate our efforts to
5 the next level by supporting and building a robust
6 research program. New Jersey has a unique opportunity
7 to lead in cannabis research by leveraging our state's
8 exceptional talent and the strong foundation of
9 framework already established by the CRC for social
10 equity.
11 I propose creating a dedicated division
12 within the CRC for cannabis research. This should be a
13 separate chair led by an expert specifically with
14 experience in cannabis clinical trial research to
15 ensure complexity and safety are managed effectively.
16 This division would include high level professionals
17 and advisors to it to guarantee patient safety and
18 regulatory compliance.
19 The vision should encompass building a
20 state-of-the-art research program that not only
21 advances the scientific understanding of cannabis, but
22 also reinforces the principles of social equity that
23 the CRC has championed. By incorporating scientific
24 advisors, policy experts, and minority and indigenous
25 representatives at all levels of research and clinical

1 trial participation, we can ensure that such programs
2 are inclusive and representative of the fabric of all
3 New Jerseyans.
4 Our medical community in schools must be
5 incentivized to participate, help -- helping to educate
6 and eradicate stigma. This starts by implementing a
7 robust curriculum in our medical schools to include
8 curriculum on the endocannabinoid system. This also
9 extends to developing a vigorous campaign to educate
10 and bring awareness to the general public of the
11 endocannabinoid system.
12 Implementing -- implementing these --
13 these two criteria as soon as possible is crucial in
14 building a strong foundation for research, development,
15 and educational system for cannabis. Imagine New
16 Jersey, a beacon of innovation in cannabis research,
17 setting standards that other states aspire to follow.
18 We have the talent and the resources to make this
19 vision a reality.
20 Our research should address and guarantee
21 safety, efficacy, and accessibility for all,
22 establishing a well-developed and comprehensive
23 clinical registrant application license and guidelines
24 with industry inclusivity in mind that all levels will
25 formalize this process, allowing physicians and other

1 health care professionals to study cannabis for various
2 conditions and lead to many questions being asked and
3 answered.
4 We must also develop protocols for
5 patients using cannabis during hospitalization and
6 explore its potential as breakthrough -- breakthrough
7 therapy for veterans and those who need end-of-life
8 care. To gauge public opinion and healthcare provider
9 perspectives conducting surveys will be beneficial.
10 Additionally, research can and should
11 explore the question of impairment, home grow options,
12 and help create standards. Well-designed clinical
13 trials can provide answers to these and other critical
14 questions. Research must always focus on social equity
15 progress, ensuring transparency and communication about
16 ongoing studies and results.
17 We must implement systems that can measure
18 progress and report the progress to the general public.
19 Data is the new gold. And we in research always say,
20 in G-d we trust, all others bring data. By addressing
21 the legal stigma related barriers, New Jersey can
22 create a state-of-the-art cannabis research program
23 that sets national standards.
24 In conclusion, let's embrace the
25 opportunity to advance cannabis research in New Jersey,

1 ensuring it's -- it's conducted fairly, inclusively,
2 and transparently. Together we can reveal the plants
3 full potential to the benefit of all New Jerseyans and
4 beyond. And I thank you today for this opportunity to
5 speak before you.
6 CHAIR: Thank you very much. And I know
7 we have Nichelle Santos here as well. Ms. Santos, did
8 you have any other remarks that you wanted to share
9 before we open up the question -- for questions room?
10 MS. NICHELLE SANTOS: Yes. (Interposing).
11 CHAIR: Yes, go ahead.
12 MS. SANTOS: Good afternoon. I'm Nichelle
13 Santos, New Jersey State Co-director of Minorities for
14 Medical Marijuana of New Jersey, Board Member of the
15 Coalition of Medical Marijuana of New Jersey, and
16 Founder and CEO of Canna Coverage Insurance Services.
17 We stand on the pillars of social justice, social
18 equity, health equity and creating good policy to
19 alleviate the stigma of medical cannabis.
20 I greatly appreciate the invitation to
21 provide testimony before the New Jersey CRC to develop
22 updated regulations for the expansion of the current
23 list of qualifying medical conditions impacted by the
24 use of medicinal cannabis. This is a historical
25 moment, and the ends of prohibition of cannabis, the

1 14th anniversary of the legalization of the New Jersey
2 Medical Cannabis Program, and now hopeful in the
3 federal reclassification of cannabis from Schedule 1 to
4 Schedule 3.
5 New Jersey can transform healthcare and
6 lead the country with a viable path to achieve health
7 equity in all communities, and especially communities
8 with high levels of conditions and illnesses from
9 social determinants of health by bringing plant-based
10 medicine to healthcare as an alternative to opioids and
11 other highly addictive drugs, of which cannabis has
12 much fewer adverse side effects.
13 Medical cannabis can improve health
14 outcomes, increase workforce productivity, and as the
15 cost of health care continues to rise, medical cannabis
16 benefits is now available to employer-sponsored health
17 plans, bringing substantial cost savings. By expanding
18 the New Jersey Medicinal Cannabis Program, we can bring
19 medicinal cannabis patients back to the declining
20 program to maximize the health and wellness of patients
21 who benefit from the use of medicinal cannabis to
22 include any other chronic or persistent medical
23 condition that is not specifically listed as long as
24 their physician recommends it to provide greater access
25 to this therapeutic option.

1 More patients can experience relief from
2 their symptoms as they do in the state of California.
3 I'm requesting the CRC to consider the following steps
4 for expansion of New Jersey medical cannabis program.
5 Number 1 is to support physician education
6 to build the network of medical cannabis doctors who
7 can properly diagnose and recommend strains and
8 terpenes that may have the ability to effectively
9 replace prescriptions. Education will develop with
10 clinical research for -- with evidence-based data.
11 Number 2 is engage healthcare carriers to
12 increase patient access to medical cannabis with the
13 creation of new CPT billing codes. So current
14 procedure terminology is the language spoken between
15 providers and payers for reimbursement of care and the
16 gateway to increase the network of physician
17 participation for medical cannabis patient visits.
18 So patients pay their copay for doctor
19 visits and the doctor gets paid by the carrier.
20 Number 3 is medical cannabis should be a
21 reimbursable benefit just like any other prescription
22 drug covered under a prescription plan. This plan will
23 be bolted on to core benefits of employer sponsored
24 health plans to increase patient access and
25 affordability.

1 Patients should not have to pay for
2 medicine out of their pocket, including medical
3 cannabis. So patients pay for their copay, for their
4 purchase, and the dispensary gets paid by the Pharmacy
5 Benefits manager.
6 Number 4 is initiate a study of
7 prescription drugs that can be replaced by medical
8 cannabis, such as anticonvulsants, anti-psychotics,
9 anti-migraine, anxiety antidepressants, opioid pain
10 meds, muscle relaxers, ADD-ADHD medication, sleep
11 medication, medicated skin ointments, glaucoma meds,
12 and much more.
13 Bring HIPAA compliant science and
14 innovation to give power to patients. We have DNA test
15 kits to identify biological predispositions of
16 conditions and illnesses to take the guesswork out of
17 diagnosis and increase the efficiency of
18 recommendations of terpenes and strains as well as
19 other prescription drugs.
20 This process will increase health and
21 wellness of patients in New Jersey and across the
22 country. So Canna Coverage Insurance Services is
23 leading with technology, science and innovation and
24 health care. With strategic partners to scale
25 transformation through the masses of group health

1 benefits of both private and public entities, will
2 decode DNA and genetic predispositions for better
3 diagnosis and treatment and transform access to medical
4 cannabis with a national cannabis physician network and
5 dispensary network to integrate medical cannabis into
6 traditional therapeutic healthcare models.
7 And the following are three legislative
8 bills specific to health insurance carriers here in New
9 Jersey for medical cannabis.
10 The first is F-1943, requires workers
11 compensation, personal injury, protection, and health
12 insurance coverage for medical use of cannabis under
13 certain circumstances.
14 Next is A-898, establishes a program to
15 subsidize purchase price of medical cannabis for
16 registered qualifying patients enrolled in Medicaid or
17 New Jersey family care programs.
18 And finally, S-1944 allows costs of
19 medical cannabis to be reimbursed by catastrophic
20 illness and Children Relief Fund, PAAD, and Senior
21 Gold. So I can stop there, or I can keep going.
22 CHAIR: I think -- I think that's a good -
23 - probably a good stopping point for -- for now. Thank
24 you so much, Ms. Santos.
25 Are there any questions from the Board for

1 Mr.
2 Lardieri or Ms. Santos?
3 COMM. BARKER: Just a -- a brief question,
4 Madam Chair, for Mr. Lardieri.
5 CHAIR: Yes, Commissioner Barker.
6 COMM. BARKER: And thank you both, Mr.
7 Lardieri, Ms. Santos, for your comments and your
8 leadership on this front.
9 Mr. Lardieri, you touched on -- and
10 correct me if I'm wrong, but I believe you mentioned
11 that you've been through the FDA process and you've
12 worked in and had a drug approved.
13 Could you go through what that is like,
14 you know, getting FDA approval? If you can, can you
15 speak through -- to the stages of review? I think Mr.
16 Wolski was touching on Stages 1, 2, and 3, which are
17 more observational versus Stage 4 which gives the --
18 the person being tested some input on how the test is
19 going. Would you be able to just touch on that FDA
20 process and your thoughts on how we can make it more
21 equitable or any tweaks that can be considered specific
22 to cannabis?
23 MR. LARDIERI: Yeah. Can you hear me?
24 COMM. BARKER: Yes.
25 MR. LARDIERI: Yeah. Thank you for the

1 question. So the FDA process is very complex and very
2 expensive. How we -- and -- and yes, pharmaceutical
3 companies do concentrate on single molecules, but you
4 know, research encompasses lots and lots of things,
5 right?
6 So real world evidence. I mean, we
7 touched upon a little bit in -- earlier. We can go out
8 there and do surveys and see what's going out on the
9 real world. We can engage one of the universities to
10 do a survey or observational study. Those are very --
11 very important.
12 So other than just single molecules, which
13 -- listen, pharmaceutical is gonna do what
14 pharmaceutical does, and they're like -- they're gonna
15 cut out their lane, but it's not always just single
16 molecules that we focus on. We can do other kinds of
17 studies that focus on social equity and observational
18 studies that are very -- very important.
19 So I would say we can concentrate on those
20 as well and get funding for them and get those through
21 the process as well.
22 COMM. BARKER: Thank you very much for
23 that. And if there's any info or material that you
24 wanna send over, please feel free to share it.
25 MR. LARDIERI: Yeah. The important thing,

1 in my opinion, is the CRC needs to build a division
2 that is inclusive and of experts on all levels,
3 scientists and participants. So that's very important.
4 And hire an expert that can manage that division as
5 well.
6 COMM. BARKER: Okay. Thank you very much
7 for that.
8 MR. LARDIERI: Thank you.
9 CHAIR: Thank you. My question is for Ms.
10 Santos. As an individual who is directly involved in
11 cover -- providing coverage for medical cannabis, I
12 would like to hear a little bit about what barriers or
13 challenges there may be for businesses to -- or -- or
14 health carriers to -- to incorporate medical cannabis
15 into their coverage options.
16 MS. SANTOS: Thank you for that question,
17 Madam Chair. We have engaged with -- conversations
18 with medical carriers, and they are becoming more
19 receptive to the conversation. Of course, we always
20 have to overcome the stigma that cannabis brings
21 leading the charge with medical cannabis and an
22 evidence-based conversation.
23 We are now directed towards conversations
24 where we can discuss the efficiency of replacing
25 prescription drugs with medical cannabis, right? So

1 correlating specific conditions where employers are
2 spending high -- high dollars on those specific claims
3 and then doing a study on the replacement of those
4 prescription drugs is what employers are interested in,
5 what the healthcare carriers are interested in.
6 You know, always follow the data and
7 follow the money. Am I answering your question?
8 CHAIR: Yes, thank you very much.
9 MS. SANTOS: And -- and let me just add
10 that the -- it's -- it's more about the process, the
11 creation of the CPT codes. The doctors have to engage,
12 but they can only engage if there's a way for doctors
13 to be paid for the patient visits.
14 So the development of the CPT codes, and
15 then the -- the development of the process in engaging
16 with the Pharmacy Benefit manager who controls the
17 prescription plans. So that -- those are the plans,
18 the processes that we're currently working on with
19 healthcare carriers. But -- including the CRC in the
20 conversation just gives us more ammunition.
21 So thank you.
22 CHAIR: Thank you. Any other final
23 questions, Commissioner Del Cid?
24 COMM. DEL CID-KOSSO: Yes. Thank you,
25 Madam Chair. Well, thank you to the speakers today,

1 and both of you for your comments. When you said
2 health equity, it was like music to my ears. So thank
3 you for -- for those -- for that feedback.
4 One clarifying question for Ms. Santos.
5 The -- you mentioned HIPAA, but could you elaborate
6 exactly on that? I may have missed what you said on
7 HIPAA related, but it definitely caught my ear.
8 MS. SANTOS: I brought up HIPAA for -- to
9 bring HIPAA compliance, science and innovation to give
10 power to patients, we have HIPAA-compliant DNA test
11 kits to identify biological predispositions of
12 conditions and illnesses to really take the guesswork
13 out of diagnosis and increase the efficiency of
14 recommendations of terpenes and strains, as well as
15 other prescription drugs.
16 And this will -- this process will
17 increase health and wellness of patients in New Jersey
18 and across the country.
19 COMM. DEL CID-KOSSO: Got it.
20 MS. SANTOS: So be HIPAA compliant with
21 those DNA test kits, we can be HIPAA compliant in
22 aggregating data from private entity or public sector
23 entities when we look at high claimant conditions and
24 illnesses and how it can be impacted by medical
25 cannabis. That study will be HIPAA compliant.

1 COMM. DEL CID-KOSSO: Okay. Perfect.
2 Thank you.
3 MS. SANTOS: You're welcome.
4 CHAIR: Any other questions -- oh, Vice
5 Chair Delgado, I believe you're on mute.
6 VICE CHAIR: I need to take myself off
7 mute. So I have a question. So and I'm a simple guy,
8 you know, liberal arts major. I really don't
9 understand all this clinical stuff. But are you saying
10 that if we migrate over to the -- migrate cannabis to
11 insurance, that my insurance policy is gonna be lower?
12 Is that -- is that my -- I'm gonna save on health -- my
13 health benefits?
14 MS. SANTOS: We look forward to the day
15 when your insurance ID card not only includes medical
16 coverage, prescription plan, dental, vision, but also
17 medical cannabis. We will increase the network of
18 cannabis physicians in New Jersey and increase the
19 network of dispensaries, medical dispensaries, so
20 patients can have increased access and affordability.
21 VICE CHAIR: That's not the question I
22 asked. The question I asked is, is it lower -- is it
23 gonna lower my premiums, my medical premiums?
24 MS. SANTOS: You know, that is always the
25 goal because as -- as we all know, insurance increases

1 every year. So we're always striving for cost saving
2 strategies, and by having this alternative to medical
3 cannabis as opposed to very expensive prescription
4 drugs. We do have case studies we can share, and we'll
5 provide that in the written testimony.
6 MR. LARDIERI: And if I can --
7 VICE CHAIR: So those case -- those --
8 those case studies show the lowering of -- of -- and
9 the reason I ask is because I -- I'm a senior citizen.
10 I'm concerned about my --
11 VICE CHAIR: (Interposing) -- you know, my
12 premiums. And so -- so are the -- those studies show
13 that the premiums -- insurance premiums would go down?
14 MS. SANTOS: It doesn't impact the
15 aggregate of the insurance premium, it -- it -- the --
16 the case studies illustrate the cost savings to the
17 employer, right? And if this employer is a member of
18 the public sector, this can have an impact on lowering
19 our -- our taxes here in the State because we're
20 lowering the cost and replacing prescription drugs,
21 expensive prescription drugs with medical cannabis.
22 MR. LARDIERI: And if I may jump in, this
23 is a place where research and a study instead of just
24 case studies, right, we could design a program around
25 to measure. You always wanna measure your progress.

1 So this is a great area where we can measure that
2 progress and then see where the insurance premiums
3 could be lowered.
4 So there's your argument for a research
5 study.
6 VICE CHAIR: Well, I agree on the -- I
7 agree on the research strategy. The only challenge --
8 and again, I'm a little arts major. I'm just a simple
9 guy trying to make sense of this, and I wanna be
10 educated. I understand -- I'm all for the clinical
11 studies. I think that's very important. But you have
12 -- you still have an illicit -- you still have a market
13 out there that's not legal, right?
14 MR. LARDIERI: Right.
15 VICE CHAIR: So how do you capture that in
16 your clinical studies? 'Cause you got -- you got lots
17 of variables here. You -- and in clinical study -- you
18 know, this is the scientific method that I learned in
19 eighth grade.
20 MR. LARDIERI: Yeah.
21 VICE CHAIR: So you still have -- you
22 still have -- you're doing clinical studies with --
23 with the -- with the legal cannabis, but you still have
24 this whole world out there of -- of not legal cannabis.
25 So how do you do studies like -- with

1 that? How do you take care of those variables?

2 MS. SANTOS: Well, we can really transform

3 healthcare by incorporating medical cannabis into your

4 employee health benefits.

5 VICE CHAIR: But that's not the question I

6 asked. That's not the question I asked. I'm talking

7 about how you're gonna incorporate (interposing) --

8 VICE CHAIR: Right now I'm not worried

9 about -- this is a different question. And the other -

10 - the different question I'm asking is, you mentioned

11 clinical. How do you conduct the clinical studies with

12 -- you know, you still have that other marketplace out

13 there, the legacy market?

14 MR. LARDIERI: Well, there are ways of

15 capturing real -- like I said, real world data. You

16 have to go out into the community and collect those

17 data and measure it.

18 So there are ways of capturing that in a

19 well-designed real-world data trial or clinical

20 research.

21 VICE CHAIR: That's challenging, don't you

22 think?

23 MR. LARDIERI: Yeah, of course it's --

24 VICE CHAIR: And I'm not saying -- I'm not

25 against clinical. I'm all for it, believe me.

1 MR. LARDIERI: Right.
2 VICE CHAIR: Yeah. I'm just trying to
3 bring out the -- you know, the challenges that you
4 would have. That's all.
5 MR. LARDIERI: Yeah. It is challenging,
6 but it could be done, right? And -- and with a well-
7 placed program, this could be done. And then as
8 Nichelle said, if -- once we can get this up and
9 running and show good measurement on -- on people
10 coming off of opioids and so on, you know, that'll cut
11 -- that probably would cut into the other markets.
12 You see what I'm saying? Do you
13 understand?
14 VICE CHAIR: It's still -- you haven't
15 sold, but it's still a challenge.
16 MS. SANTOS: Yeah, it's --
17 MR. LARDIERI: Well, it's a challenge, but
18 it's not impossible.
19 MS. SANTOS: Yeah, there's always further
20 engagements.
21 VICE CHAIR: I don't think anything --
22 right, I don't think anything's impossible, but yeah.
23 The other -- the other -- the other -- the other issue
24 I -- well, it's not an issue. It's not -- I guess it's
25 another challenge that I see, and that is if you -- if

1 you -- and I can see this happening because human
2 nature is human nature, right?
3 If you -- if the insurance -- if you allow
4 -- if you do the insurance thing, in other words, if
5 you allow cannabis into the insurance world and insure
6 it, don't you think that -- that people will just
7 gravitate towards, you know, getting insured?
8 MS. SANTOS: Well, we're bringing medical
9 cannabis to employers.
10 VICE CHAIR: Then a lot of people are
11 migrating from the adult use to the medical because
12 they don't have to pay. The insurance covers it.
13 MS. SANTOS: Right, which would be
14 beneficial to the medical program here in --
15 MR. LARDIERI: Right.
16 MS. SANTOS: -- New Jersey. Right now the
17 membership is declining month by month.
18 MR. LARDIERI: Exactly.
19 MS. SANTOS: So by incorporating medical
20 cannabis into employer-sponsored plans is a way to
21 scale patient access and patient affordability, and it
22 gives you a way to track and measure --
23 MR. LARDIERI: Right.
24 MS. SANTOS: -- health programs. So right
25 now we can aggregate data for the -- the high claimant

1 conditions and illnesses and do a cross correlation of
2 how medical cannabis could have replaced specific drugs
3 and do that cost benefit analysis, right? And then as
4 we implement this program --
5 VICE CHAIR: Is there a current cost -- is
6 there a current cost benefit analysis that you just
7 mentioned?
8 MS. SANTOS: There is a cost benefit
9 analysis, hypothetically, but taking real live data
10 from an existing public or private entity --
11 MR. LARDIERI: Exactly.
12 MS. SANTOS: -- and doing that cross
13 correlation can be very beneficial. We're actually
14 talking to a public entity about doing -- conducting
15 that study.
16 MR. LARDIERI: And that's what you wanna
17 show. You wanna show positive health outcomes, right?
18 And then once you start showing those data, now you
19 have some real information you could deal with in
20 programs you can start implementing.
21 VICE CHAIR: Imagine -- for the sake of
22 time, I'll yield the -- my time back to you.
23 MR. LARDIERI: Great -- great questions.
24 VICE CHAIR: Because, you know, this
25 conversation, is -- this is a greater conversation to

1 have. I think everybody agrees.

2 MR. LARDIERI: It's complex, but it could

3 be done.

4 COMM. NASH: Absolutely.

5 DIR. RIGGS: Agreed.

6 MS. SANTOS: Thank you for the questions.

7 MR. LARDIERI: Yeah, thank you.

8 CHAIR: Any last quick questions for these

9 two guests? All right. Hearing none, thank you, Mr.

10 Lardieri and Ms. Santos, for your -- your thoughts,

11 your insights and your recommendations that you've

12 shared with us today.

13 DIR. MCWHITE III: Yes. Excuse me.

14 Sorry. Next on the list of speakers is Dr Alex Bekker,

15 chairman of the Medical Marijuana Review Panel. And

16 the rest of our invited speakers have raised their

17 hands, but Chris Goldstein, I do see you. Can you

18 please raise your hand as well? Thank you so much.

19 Dr. Bekker, it's all yours.

20 DR. ALEX BEKKER: Yes. Can you hear me?

21 DIR. MCWHITE III: Yes.

22 DR. BEKKER: Yes. As previous speaker

23 mentioned, there are well documented evidence that

24 cannabis help people with various conditions. Our

25 panel, which I chaired, approved marijuana or cannabis

1 -- better -- better use the word cannabis, for 17
2 conditions including reduction of harm associated with
3 substances like alcohol, opioid, stimulant, including
4 people with high risk for overdose.
5 So what are the obstacles? And again,
6 previous speakers mentioned in one way or another, I
7 was just to summarize for the sake of time. There are
8 four key themes, lack of medical cannabis education
9 within the healthcare community, misconception and
10 misunderstanding that perpetuates stigma towards
11 medical cannabis, lack of guidelines on cannabis doses
12 for providers indication, and access to medical
13 cannabis.
14 I will just comment on the first two.
15 There are several studies that indicated approximately
16 80 percent of healthcare professionals in training feel
17 that they lack sufficient knowledge to make
18 recommendation regarding medical cannabis, thus
19 incorporating medical cannabis education into medical
20 school curriculum and providing evidence-based
21 guidelines and increase physician confidence and
22 comfort in authorizing medical cannabis.
23 Same applies to other healthcare
24 professionals, of course. This educational gap
25 indicates a need for standardized medical cannabis

1 curricula, and could be aided -- and this is important,
2 would be aided -- aided by acquiring cannabis knowledge
3 in licensing examination. I think Mr. Wolski mentioned
4 this as well.
5 It should be part of licensing exam.
6 Cannabis therapists may also benefit from public
7 education and destigmatizing strategies such as those
8 previously been used in fields like HIV and AIDS. Lack
9 of consensus among healthcare professionals regarding
10 harm reduction with medical cannabis is additional
11 problem.
12 A second major impediment is a lack of
13 guideline and dosages and regimen of cannabis for
14 various medical condition from any professional or
15 governmental body. Again, this point was taken by
16 first three speakers. Thus I believe it's one of the
17 critical step is to -- important -- important step is
18 to establish a registry of current practices and
19 establish group of professionals that will issue best
20 practices guidelines.
21 We do have registry in New Jersey, but
22 it's more administrative registry. This registry,
23 which I propose should include actual time course of a
24 disease, what it was done, and we can create this
25 register by collecting data for -- from currently a lot

1 license professionals. And then you can panel -- some
2 medical panel, which includes other health professional
3 will establish guidelines which again, it's reflects --
4 which reflects points which we brought up before by Dr.
5 Sterling.
6 It should be clear recommendation and
7 expand -- I don't know, right now we have 17 condition
8 in expand, but this is secondary. Even for the 17th
9 condition, we don't -- there're no clear guidelines
10 what to do. And we can -- you know, ideally it's on a
11 national level, but enough information here to put it
12 together in some registry in New Jersey and issue some
13 type of guidelines which will help with all other
14 issues, insurance and everything else. Because
15 guidelines would be critical in this path.
16 So in the sake of time, I -- I will stop
17 right here. If there are any questions, I'll be
18 obviously happy to answer.
19 CHAIR: Thank you so much, Dr. Bekker.
20 Any questions from the board for Dr. Bekker?
21 Commissioner Barker, it looked like you were about to
22 jump in.
23 COMM. BARKER: No -- no, no question right
24 now for Dr. Bekker at this second, but I might change
25 my mind next few seconds. But right now, I don't have

1 any -- I don't have any.

2 CHAIR: All right. Thank you. All right.

3 Hearing no questions for Dr. Bekker, Dr. Bekker, I

4 wanna thank you for taking the time to join us and

5 share your thoughts and recommendations with us today.

6 DR. BEKKER: Thank you. Thank you.

7 DIR. MCWHITE III: Up next is Leo

8 Bridgewater from Service Disabled Veterans and

9 Cannabis. You can go ahead.

10 MR. LEO BRIDGEWATER: Good afternoon,

11 everyone. My name is Leo Bridgewater. I am co-founder

12 of the Service Disabled Veterans and Cannabis. I also

13 sit on the Social Equity Committee for the National

14 Hemp Association, and was a former national director of

15 Veterans Outreach with Minorities for Medical Marijuana

16 and co-founder of Collective 60, New Jersey.

17 I wanted to talk about the expansion --

18 observations and suggestions that I have regarding the

19 New Jersey medical marijuana program. And I have to be

20 honest with you, it was a really good treat to hear Dr.

21 Bekker speak. When he was part of the New Jersey

22 Medical Marijuana Review Board, we actually gave

23 testimony to have PTSD added as a qualifying condition.

24 So it's great to see and hear him speaking today.

25 That being said, on June 4th of 2024, just

1 a couple weeks ago, the House -- the -- the United
2 States -- the United States Congress passed -- I'm --
3 I'm trying to -- I'm sorry, guys, I'm trying to pull
4 this up on my thing here. The house passed a veterans
5 focused marijuana and psychedelics amendments out of
6 committee to go before the Senate.
7 In anticipation of -- of cannabis going
8 from -- going from Schedule 1 to Schedule 3, my
9 recommendation would be for the New Jersey Cannabis
10 Regulatory Commission to start talking to the New
11 Jersey Senate -- Senate Military and Veterans Affairs
12 Committee, which is chaired by Senator Gordon Johnson,
13 and members are Nilsa Cruz-Perez, Raj Mukherji, Parker
14 Space -- Senator Raj Mukherji, Senator Parker Space,
15 Senator Latham Tiver, to talk in anticipation of, you
16 know, cannabis going from Schedule 1 to Schedule 3 so
17 that we can begin that -- that -- that informal
18 educated education process.
19 We often talk about access to the plant --
20 to the medicine as being a -- a -- one of the barriers
21 when it comes to dealing with veteran access. And so I
22 think in having these preliminary conversations, since
23 this is going on, I think it would be very key. I also
24 have traveled all across the country speaking to these
25 types of things when it comes to veterans.

1 And I will tell you that when it comes to
2 the VA, the VA is broken up in a number of different
3 sections. Like, because I live here in New Jersey, I'm
4 in Zone 4 for the VA healthcare system, but I do know
5 that Zone 21 which is the Pacific Southwest, which
6 includes Oakland, California, actually has -- they
7 actually do make recommendations. The VA doctors do
8 because they are much more versed in all things VA when
9 it comes to the cannabis plant, to include yoga and so
10 on and so forth.
11 And so to have uniformity within the VA
12 healthcare system begins with that education and seeing
13 that it goes from Zone 1 all the way into Zone 24,
14 which is what the VA healthcare system is made up of.
15 I also think that -- and from an
16 observatory perspective, especially here on the
17 streets, excuse me, one of the things that we've had
18 here -- I live in the city of Trenton. And so, you
19 know, the crime rate here is pretty high. A couple of
20 summers ago, we had a situation where almost 200 summer
21 jobs were unfulfilled by city -- city teenagers or
22 residents because they could not pass the cannabis --
23 the drug tests and all were testing positive for
24 cannabis.
25 And so my suggestion to the county

1 executive at the time, a man named Samuel Frisby, was
2 to have, you know, these -- these teenagers enroll into
3 the, you know, New Jersey Medical Marijuana Program.
4 It was gonna allow them to be able to continue on with
5 the job for the summer, and also because it offers
6 different types of protection too from, you know,
7 dealing with the police and so on and so forth, and
8 also the counter, some of them, you know, being
9 prescribed opioids.
10 And so from a -- just a bare bones street
11 level perspective, I really think that, you know,
12 having those kinds of conversations with the Senate
13 Military Veterans Affairs Committee, anticipating the
14 Schedule 1, Schedule 3 move, we hope that it will be
15 completely de-scheduled, to be quite honest with you.
16 You know, these are all things that I think that New
17 Jersey can do in terms of taking a proactive approach
18 to, you know, expanding the medical marijuana program
19 and also from a social equity component for
20 stakeholders such as myself and people who look like me
21 or people of color.
22 With that, I'm gonna make it -- I'm -- I
23 wanna retire and make it quick. And that would be all
24 I have. If you have any questions, I am available
25 right now. Thank you.

1 CHAIR: Thank you very much, Mr.
2 Bridgewater. Are there any questions from the Board?
3 COMM. BARKER: One -- one brief question,
4 Madam Chairwoman.
5 CHAIR: Yes, Commissioner Barker.
6 COMM. BARKER: Mr. Bridgewater, thank you
7 for your service, first and foremost, and thank you for
8 your advocacy in this space over the last several
9 years.
10 Just wanna ask you specifically as
11 somebody who has been instrumental in advancing
12 different medicinal conditions to be included for
13 patients, are there any that you think should be added?
14 Are there any conditions that aren't currently being
15 considered?
16 And I do wanna make light of Dr. Wolski's
17 -- Mr. Wolski's comments. I do -- I do remember what
18 he said in terms of just making a blanket for all
19 conditions, but are there any specific conditions that
20 you think should definitely be added in the event we
21 can't do a blanket catch all?
22 MR. BRIDGEWATER: No, you know what? I --
23 I would echo the same sentiments as Ken -- as -- as Ken
24 Wolski has said, which is, you know, all conditions, to
25 be honest with you.

1 COMM. BARKER: Okay.
2 MR. BRIDGEWATER: But what I will tell you
3 is that if you really wanna increase veteran
4 participation, something to think about would be to
5 figure out a way where, you know, you have -- veterans
6 don't have to give up their gun privileges. I know
7 that's beyond your scope, but it is something that
8 needs to be talked about because that is in of itself a
9 very big barrier why you don't have a lot of veteran
10 participation because of that -- because of, you know,
11 firearm privileges.
12 That's something to think about.
13 COMM. BARKER: Okay. Absolutely. Thank
14 you very much for that.
15 MR. BRIDGEWATER: Thank you for your
16 question, and thank you all for your service.
17 COMM. BARKER: Thank you.
18 CHAIR: Any other questions for Mr.
19 Bridgewater? I have one question. With respect to the
20 doctors in the -- the VA program that you set out in
21 the -- on the West Coast who are making cannabis
22 recommendations --
23 MR. BRIDGEWATER: Mm-hm.
24 CHAIR: -- do you happen to know -- or
25 provide any insight on what -- what information, what -

1 - is most compelling for these doctors and these
2 practitioners to make those recommendations, despite
3 some of the challenges that they face at the federal
4 level?
5 MR. BRIDGEWATER: And what's interesting -
6 - and thank you for that question, Chairwoman Houenou.
7 What's interesting is that I was actually working with
8 a colleague of mine by the name of Amber Senter, who's
9 co-founder of Supernova Women, and she actually moved
10 all -- literally all of her healthcare anything
11 strictly to the VA.
12 She's a Coast Guard veteran. And the
13 reason for that was because it was her VA doctor who
14 was suggesting to her that maybe she ought to take a
15 look at the -- looking at the cannabis plant and -- and
16 all that it can serve for her, not knowing who she was.
17 And so Amber did the thing where she just stayed quiet
18 and just wanted to hear what the doctor had to say and
19 let this doctor go on and on about the benefits of
20 cannabis and so on and so forth, which was, you know,
21 something that she had never heard and never thought
22 was going to be a thing until she went -- until she
23 happened to have -- had had that VA appointment and all
24 these things came out.
25 So it taught her that -- because --

1 because she's in Oakland, California, the -- a lot of
2 the medical professionals there by proximity are a
3 little more versed or more well versed than let's say
4 the VA doctors who are here in New Jersey. You
5 understand? So it -- you know, and they're -- and
6 they're -- they -- they took the time to really get to
7 know all the plant, including a lot of them were
8 probably actually consuming cannabis themselves.
9 So they haven't rather intimate -- she --
10 you know, she told me she felt as though they had more
11 of an intimate relationship with the cannabis plant
12 than what I would describe what my experience would be
13 like here in -- on this -- on the East Coast. I
14 actually had to -- I actually came out to my VA doctors
15 back in 2015, that I was actually consuming cannabis so
16 that it was at least documented within my -- within my
17 -- my records and my charts so that should I face any
18 adverse, you know, repercussion from the VA, at least
19 it was documented.
20 And that actually happened to be the case
21 for a lot of people who are in states that don't have
22 comprehensive medical marijuana programs, and doctors
23 who are not really all that well versed. And so if we
24 can get to the point where now you have these -- you
25 know, this is what's happening in -- in Congress and,

1 you know, these bills that's going on.

2 The -- being that the conversation is

3 something that's being talked about a lot, I think this

4 is -- it's like one of those, you know, let's strike

5 while the iron's hot type of things, particularly when

6 it comes to the veterans side of things. And, you

7 know, with veterans, we kinda move mountains when

8 you're talking about our healthcare.

9 CHAIR: Absolutely. You're right. Thank

10 you so much. I appreciate the -- that insight. Last

11 call for some quick questions for Mr. Bridgewater.

12 COMM. BARKER: I have one more and I'm

13 just gonna just piggyback on the same question that

14 I've been asking and just get your specific thoughts on

15 it, if you -- if you may, Mr. Bridgewater.

16 Considering New Jersey is a pharma

17 capital, considering we're working and on the cusp of

18 our clinical registrant guidance and rules, in your

19 opinion, what does -- what does equitable and inclusive

20 and safe research look like in New Jersey?

21 MR. BRIDGEWATER: It looks like you're in

22 my neighborhood talking to me and people who look like

23 me and those who are considered trusted messengers.

24 And so I believe that what you have to do is you have

25 to start naming names like a Ken Wolski, like a, a

1 Keith Da Costa of CareSparc.
2 You know, these are people who are -- are
3 accustomed to being in the -- in the -- in the
4 neighborhoods, you know, on the streets, the frontline
5 sort of say, and actually talking to the people.
6 Because right now, when you talking to
7 regular folks about medical and adult use, they're not
8 making that distinction. They don't know to make that
9 distinction. On top of the fact that you also couple
10 the efficacy of cannabis use along with the illegality
11 or the -- or the reverse of the illegality of the
12 plant, it makes for people to be more welcoming and be
13 more receptive to the conversation.
14 I also think you need to be in the
15 churches talking about the medical efficacy of cannabis
16 as well. You know, there's a massive amount of public,
17 you know, education that still needs to take place
18 despite all of the efforts over the years. If you
19 really wanna know what -- what social equity looks like
20 in the research and advocacy of this plant, go where
21 those people actually are and actually have the
22 conversation.
23 Right now, that's not what you're seeing,
24 or at least hearing folks talk about. They still say
25 gateway drug in a lot of places here in New Jersey, and

1 that's not even the case. And when you say adult use,
2 they still bring up children. You know, so there's a
3 lot of things that are going on particularly -- and
4 from a municipal level as well.
5 You know, so these -- that one
6 conversation can literally spiderweb so many other
7 conversations to include -- that would actually help to
8 educate a municipality. And mind you, it's not just
9 the people, but it's also the municipal governments
10 themselves, like the city councils, like the mayors.
11 You know, these are all -- you know, these are all
12 folks who still say the old things are subscribed to
13 the old way of thinking when it comes to, you know, the
14 cannabis plant.
15 COMM. BARKER: Thank you for that. Thank
16 you very much.
17 MR. BRIDGEWATER: No problem.
18 CHAIR: Thank you. Excellent. Well,
19 thank you again, Mr. Bridgewater. I wanna echo
20 Commissioner Barker's sentiments. Thank you for your
21 service and your dedication to our country and to the
22 issues that you shared with us today.
23 MR. BRIDGEWATER: It is my honor, and
24 thank you for all of your services too. Thank you.
25 CHAIR: I'll turn it back over to Director

1 McWhite to call on our next invited speakers.
2 DIR. MCWHITE III: Yes. The next invited
3 -- invited speaker is Edward Lefty Grimes of Sativa
4 Cross. Lefty, I believe you can speak now.
5 MR. EDWARD LEFTY GRIMES: Good afternoon.
6 This is Edward Lefty Grimes. I'm with sativacross.org.
7 I'm a founding member of Sativa Cross. We're a
8 501(C)(3) fighting for wheelchair accessibility around
9 New Jersey and for cannabis patients' rights.
10 I have four things I'd like to speak about
11 today, and one of them is the Zoom access, which I
12 really appreciate this because I'm in a lot of pain
13 right now. I have horrible sciatic pain. I'm in
14 really no shape to drive an hour and 20 minutes to
15 Trenton. And there's a lot of people in the same shape
16 as me.
17 And we really appreciate this because
18 you're actually relieving my pain and suffering today.
19 I can attend your meeting without the extra pain and
20 suffering that I would normally endure. And Zoom
21 access is very important for disabled people. We've
22 been asking for disabled -- for -- for Zoom access for
23 years for disabled -- access for -- for work, Zoom
24 access for school, for council meetings, for churches.
25 And for 19 months, we were able to get

1 those things. It wasn't done for us, it was done for
2 healthy people so that they wouldn't become disabled.
3 But for 19 months, disabled people enjoyed all those
4 things. And then all of a sudden, after the pandemic
5 was over, a lot of councils took it away. I don't know
6 why they took it away.
7 So I would go to these councils and ask
8 them why they would take it away, and they said, well,
9 we don't have the funds for it anymore. We don't have
10 the people to do it anymore. We don't have the
11 technology to do it anymore. And I'm just like
12 listening, I'm like, wait, we did this for 19 months.
13 Now we can't do it.
14 And it's very important because my friend,
15 Jeff Oakes was able to take part from his deathbed,
16 literally announced he was taking part from his
17 deathbed. And I wanna hear somebody, if they have --
18 if they have something to say from their deathbed, I
19 wanna hear it. And I think you all should hear it too.
20 And I think that's very important.
21 My -- my second point is, I know you're
22 not gonna like this and -- and we don't -- we don't
23 talk about this much anymore because you can't do
24 anything about it, but you actually can and it's home
25 grow. I wanna know why New Jersey is the outlier state

1 and why we can't get an informational hearing since
2 2009.
3 I think that the CRC should have an
4 informational hearing. No voting, but just an
5 informational hearing so that we can set an example and
6 be progressive so that maybe the government will do
7 something about this. Because my next point is gonna
8 bring up about wheelchair access, and I think that the
9 CRC can be progressive in moving the ball forward with
10 things like wheelchair access.
11 Now I've been talking about wheelchair
12 access to the greenhouses of dispensaries for years.
13 If a worker gets hurt, if a worker loses a limb, if a
14 worker gets progressive MS and suddenly can't walk
15 anymore, and they're in a wheelchair, there's no light
16 duty, and they would lose their job. And when I was on
17 the medical advisory board of TerrAscend, I saw how the
18 greenhouses were built and with -- with no -- nothing
19 for disabled people working. And it was just all made
20 for money, as much money as you can possibly make.
21 And I think that should be an issue. But
22 then -- then I saw -- I saw -- I was kinda shocked
23 because I saw there was a bunch of dispensaries opening
24 up without wheelchair access, and this is something
25 I've been fighting for years. I've been all over the

1 state. I've been to hundreds of council meetings,
2 fighting for wheelchair access at police stations and
3 post offices and pharmacies.
4 And Chairwoman Houenou said something
5 about encouraging dispensaries to get wheelchair
6 accessibility. And I like that, but I think it needs
7 to go a lot further than encouraging because we've
8 tried to encourage our government to do these things
9 and they don't listen. We've been to South Amboy
10 police station.
11 We set up a ramp at the South Amboy police
12 station to show them that we can't get in, and nothing
13 was done. We went to the council meeting at South
14 Amboy to tell them that nothing was done, and they told
15 us that it's grandfathered in. We went to Senator
16 Frank Pallone's office and we asked them to help us
17 with South Amboy, and they gave us information on where
18 to get grant money.
19 So there's a disconnect between disabled
20 vets, access, and our government. We wouldn't have
21 these things if it wasn't for disabled vets, but yet
22 there's no access for disabled vets. I don't get it.
23 There's urban enterprise zones in New Jersey, and
24 there's dispensaries opening up in these urban
25 enterprise zones.

1 These urban enterprise zones give you 3.5
2 percent tax benefit. It's a tax break, but if you're
3 in a wheelchair and you can't get into that dispensary
4 in the urban enterprise zone, you can't get the same
5 tax breaks as able-bodied people. And that's ableism.
6 Ableism is just as evil as racism and sexism and we
7 fight this every day.
8 We need to eradicate ableism. We wouldn't
9 have dispensaries if it wasn't for our disabled vets,
10 but yet those dispensaries opening up all over without
11 wheelchair access. We -- there's a dispensary called
12 Mad Hatter. We are consulting with them and we're
13 fixing any issues they have. Now the owners of Mad
14 Hatter have a daughter that's in a wheelchair, so
15 they're proactive with this. They're -- they're on top
16 of this like -- and they wanna donate ramps to other
17 dispensaries, and which we'll get to in a second.
18 We were reached out by -- Liberty City
19 Dispensary reached out to us, and they want us to get -
20 - help them with their wheelchair access. So we went
21 there. I met with Liberty City. And there's a lot of
22 issues because the town's making them open up in the
23 back. Okay. They have a front door that has access,
24 but the town's making them open up in the back where
25 there is no wheelchair access.

1 So they have to put wheelchair access in.
2 And the timing was such that when I was speaking last
3 month, they were actually considering what to do. So
4 when I went there, we had a great conversation. We
5 talked about things. We talked about things such as
6 talking menus for deaf people -- I mean, for -- talking
7 menus for blind people to braille menus for blind
8 people.
9 Things sticking out like a counter space
10 or a standpipe is something that a blind person
11 wouldn't want to walk into, and these are things we
12 have to look for. These are things I was ignorant to
13 until people have reached out to me and said, Lefty,
14 remember this, Lefty, remember that. And I'm like, I
15 didn't know.
16 I'm just as ignorant as everybody else,
17 but I'm trying to create education for everybody else.
18 And I think that if the CRC -- if the CRC mandates, not
19 encourages, but mandates all of these dispensaries to
20 have wheelchair access, you're gonna do more than any
21 government entity that has so far in New Jersey, and
22 hopefully you could set a standard so that these
23 governments can get their police stations access.
24 Because I can't believe it's a thing that
25 there's police stations without access and post

1 offices. So I think the CRC is in a very good position
2 here to make a progressive change and to do something
3 no other entity is doing, and give us -- and I don't
4 know if it's compassion or if it's forced compassion,
5 but if you don't have compassion, you need to have it
6 forced on you, because we need to have access.
7 We need access. I went to a few
8 dispensaries. I wanna thank Baked by the River for
9 having their -- their dispensary accessible. Liberty
10 City wants to donate ramps to people, so there's Baked
11 by the River. And I'll tell you CannaBoy needs a ramp.
12 We went to CannaBoy in South Orange. They have about a
13 six-inch step, they need about a six-inch ramp.
14 They're very open to what we had to say, and they wanna
15 -- they wanna help disabled people.
16 The thing is though, when you put a --
17 when you put a temporary ramp, a portable ramp there,
18 it's accessible, it's a workaround, but if you guys
19 forced these dispensaries to get these things before
20 they open up, it would be a cement ramp, it would be
21 something permanent where you wouldn't have to ask or
22 ring a bell or knock on a window to come in.
23 That's not accessibility. Accessibility
24 is just hitting the button and walking in. That's what
25 we're looking for.

1 So I wanna thank you guys for letting me
2 speak on this. This is a very important issue. It
3 could affect all of us someday. My life was changed in
4 a matter of seconds when I fell at work and I ruined my
5 back, and any one of us can be in a wheelchair at any
6 time. And if you spend a day in a wheelchair, you'll
7 see how bad it is out there.
8 It's -- it's -- it's ugly. And we're
9 trying to do what we can. On July 10th, we have
10 Cannabis Patient Awareness Day. We're trying to do
11 this all over the country. We're trying to create
12 awareness for patients because they're taking over our
13 day on 7/10 and we don't want them to take 7/10 away.
14 7/10 should be about patients.
15 You got 4/20. Take 4/20. 7/10 should be
16 all about the patients and sick and dying people.
17 That's what we want. And just like I said, we wouldn't
18 have these dispensaries without disabled vets fighting
19 for our rights, so they should be allowed to get into
20 every dispensary in New Jersey. And that's pretty much
21 all I had.
22 I appreciate you. Thank you.
23 CHAIR: Thank you, Mr. Grimes. Thank you
24 for sharing your thoughts, your recommendations and
25 your experiences with the -- with the commission today.

1 I want to open the floor to any -- any
2 quick questions we have for Mr. Grimes.
3 COMM. BARKER: I just wanna thank Mr.
4 Grimes. Mr. Grimes definitely comes and speaks from
5 the heart. He lets his concerns be known. Definitely
6 gave us a lot to chew on. And I hope you do stay in
7 touch with us.
8 Please, if you can, Mr. Grimes, submit the
9 comments in writing so we can review them on our end
10 and stay in touch with you to see, you know, where we
11 can weigh in and act on some of the things you
12 mentioned.
13 You know, I hope you strongly consider it.
14 And so something I'm looking to talk to the team about,
15 but again, thank you. Thank you for sharing and
16 letting us know the concerns of the disabled community.
17 Very important -- very important.
18 MR. GRIMES: Can I just say --
19 VICE CHAIR: I think your advocacy is very
20 important. I mean, this is not always on our radar
21 screen, and that's what you do.
22 You keep it on our radar screen. So thank
23 you.
24 COMM. NASH: Mr. Grimes, Commissioner
25 Nash. Thank you for your comments today. You

1 mentioned these portable ramps and I wondered, is -- is
2 that a very costly solution in your opinion?
3 MR. GRIMES: A portable ramp is usually
4 about $100 per foot. Like I said, CannaBoy, they would
5 need a six-foot ramp. That's gonna cost about five --
6 over $500 for that ramp.
7 COMM. NASH: Mm-hm.
8 MR. GRIMES: But it would be worth it. It
9 would definitely be worth it. It's a fold up ramp that
10 could be put inside the front door. We've got a lot of
11 businesses. In -- in Bayonne -- we got 50 ramps in
12 Bayonne by either just asking them, encouraging, or
13 donating. And it's a very simple solution. It's not
14 the best solution, but it is a solution.
15 COMM. NASH: Thank you for that.
16 CHAIR: Thank you. Any final -- any final
17 questions for Mr. Grimes?
18 Seeing no further questions, Mr. Grimes,
19 thank you again for your time and your -- and sharing
20 your experiences with us today.
21 MR. GRIMES: Thank you.
22 DIR. MCWHITE III: Our next invited
23 speaker is Chris Goldstein. You should be allowed to
24 talk now.
25 MR. CHRIS GOLDSTEIN: Good afternoon.

1 Thank you so much for taking time to listen to everyone
2 here today. This has been a really insightful
3 afternoon and the -- and the kind of listening session
4 I think that the patient community and the medical
5 marijuana community we've been working on this so long.
6 I really look forward to.
7 So thanks to you all for listening to us
8 today. My name is Chris Goldstein. I'm a longtime
9 advocate here. You know, Ken mentioned being a nurse
10 for 48 years. I'm 48 years old this year, and I've
11 been working on this issue for 25 years. I was there
12 when the original Compassionate Use Act was passed here
13 in New Jersey, and gosh, almost 14 years ago now.
14 Exactly. And the program was always one
15 of the most restrictive and draconian regulated
16 programs in the country. So the New Jersey Cannabis
17 Commission, in being created to accommodate adult use
18 legalization, you've done a pretty remarkable job
19 trying to keep up medical access and shoehorn one of
20 the most restrictive medical programs in the country
21 into what is a pretty open adult use program.
22 So on the whole, in between, you know, 14
23 years ago and now, there was also the Jake Honig Act,
24 which was sort of an interim fix for what was seen as
25 an interim fix for the -- an expansion of our New

1 Jersey Medical Marijuana Program. It never really
2 worked out. So I have to start out with your original
3 questions, and I wanna address some of those and then
4 get to some of my overall comments.
5 First of all, you asked can there be more
6 conditions added? Absolutely. I back Ken Wolski
7 wholeheartedly. I used to be on the coalition for
8 medical marijuana, New Jersey's board of directors, and
9 Ken and I have spent many hours talking about this.
10 And certainly I agree. There are some states and
11 countries that take the approach of allowing doctors to
12 make the recommendation for cannabis for any condition
13 that they see fit.
14 And that is really how it should be in
15 practice. I will have to point out that the problem
16 here, we've encountered this in some of the talk today.
17 We're in a real catch 22. Doctors are not well
18 educated about cannabis therapy, and they're not well
19 educated about endocannabinoids, and the entire system,
20 yet we are relying on doctors in New Jersey to serve as
21 the access point for patients.
22 Now that is not traditionally how things
23 were done in medical cannabis programs. In fact, New
24 Jersey was the first state to require doctors to be
25 part of a special registry just to make the medical

1 cannabis registration.

2 So now we sort of broke down the barriers

3 on some of that over the years, but the original

4 program created a stigma that still has to be overcome.

5 My recommendation here is that NJCRC and the

6 commissioners yourselves, you have to be the diplomats

7 here for medical cannabis to the wider mainstream

8 medical community, and we have to have more doctors

9 participating.

10 But we also have to consider this. And

11 there has been talk about the Federal Schedule 3. And

12 another interesting side note is that I have a pardon -

13 - a federal pardon from President Biden, and I was

14 invited to the White House in March and again in May.

15 And I've kept up a discussion with the White House and

16 advisors about this whole scheduling thing.

17 It's something I've been involved with at

18 the federal level for almost 20 years as well. Look,

19 Schedule 3 and rescheduling cannabis is an interesting

20 notion, and it is something that keeps physicians from

21 participating in our own state program. We have to

22 recognize that -- and I've heard this here in the

23 discussion, and thank you for bringing up.

24 New Jersey, people talk about it being a

25 pharma state. Well, guess what? There are no full

1 plants that are available for prescription use in
2 Schedule 2, 3, 4, or 5, at all. And that's why
3 marijuana and cannabis, as it's -- should really be
4 called here in this context today, and it's -- is --
5 should not be scheduled at all. It should be de
6 scheduled.
7 So we've run into this big conundrum where
8 we have all these bottlenecks with regulations and
9 stigmas. So why are we trying to continue those
10 forward? I would put the premise forward that cannabis
11 is an over the counter drug, that basically we allow
12 consumers -- adults over 21, to use cannabis however
13 they wish, and they use it over the counter without a
14 doctor's recommendation.
15 And we have had a shrinking medical
16 cannabis program since June of 2022. We are exactly
17 two years away from the peak membership in New Jersey's
18 medical cannabis registration of patients. It's gone
19 down from 124,000 to 76,000 today. That's a dramatic
20 decline. And we'll talk about the -- the price and
21 everything in a moment, hopefully, but I do think that
22 we are -- we must look beyond the restrictions of the
23 patents.
24 There are two things NJCRC could do. We
25 could advocate to get rid of the doctors being the

1 bottleneck, that patients be able to self-register.
2 There is a notion in this because Delaware just passed
3 a bill to allow anyone over age 65 to access medical
4 cannabis dispensaries simply because they're over 65,
5 and we could have a bill coming up for that in New
6 Jersey shortly. But that would allow a certain age
7 group to do that, but I think that all age groups
8 should have that kind of self-registration access.
9 Now, you know, finally, I think NJCRC
10 should strongly consider marijuana with an M is still a
11 Schedule 1 drug at the state level here in New Jersey,
12 and I do believe that there could be barriers removed
13 if we could deal with scheduling at the state level as
14 well as the federal level. On the point of research,
15 Pennsylvania created eight research permits with
16 universities and tried to move forward with a research
17 program there.
18 Drexel's and some of the researchers were
19 here today. That never really launched. I have to say
20 that the concept of researching patient outcomes in
21 some realms of healthcare, it's considered marketing
22 and not really research. I would say that if you want
23 to do an effective research program, it has to bridge
24 the gap of what the federal government can't do, which
25 is somehow get some research on the plant itself.

1 As far as patients themselves, I -- there
2 has been a notion that there needs to be more advisors
3 and patients. Absolutely. This is a medical cannabis
4 program that migrated from the New Jersey Department of
5 Health. You at the CRC need to create a health
6 framework for this program.
7 That must include a board of patient
8 advisors, scientific advisors, and medical advisors in
9 order to make sure that this program proceeds forward,
10 because I think it should. The same operators who are
11 dominating the medical cannabis businesses here in New
12 Jersey operate in Pennsylvania and they charge half as
13 much for products in the state next door.
14 There are 450,000 patients in Pennsylvania
15 who go to about 180 dispensaries served by 32 grow
16 operations. Quite frankly, the states have very
17 similar regulations. And there are some big questions
18 as to why they have so many more registered patients.
19 But I've also heard lobbyists from those companies say
20 that they're willing to give up on the medical program
21 as soon as adult use gets legalized there.
22 So I have to put forward this premise as
23 well. And this is a duty of the NJCRC, I believe.
24 It's your job to make sure that we have fair players in
25 this market. Patients are doing their best. People

1 are willing to register. And -- but if they're not
2 offered fair pricing and options to be -- have true
3 medical access, I think that we'll see a decline in
4 patients continue.
5 And part of it is because the industry has
6 given up on the program, not because the CRC or
7 patients have given up on it, but because when I look
8 at menus in New Jersey, there's only 14 selections of
9 flour. In Pennsylvania, there's 150 and the prices are
10 much lower.
11 So thank you for hearing me out on all
12 this. Thank you for hearing all of us today. And I do
13 welcome any of your questions. But thank you again for
14 making sure that there's an open line of communication
15 here, because I do think that you have a
16 responsibility, maybe as the CRC that the Department of
17 Health took on naturally that the CRC has to take --
18 take forward thoughtfully. So thank you.
19 CHAIR: Thank you very much, Mr. Goldstein
20 for -- for taking the time to -- to share your -- your
21 thoughts and your recommendations with us. Any
22 questions from the Board for Mr. Goldstein?
23 COMM. BARKER: One brief question, Madam
24 Chair.
25 CHAIR: Commissioner Barker.

1 COMM. BARKER: Same question, Mr. -- Mr.
2 Goldstein, and thank you again for your leadership and
3 advocacy not only here in New Jersey but -- especially
4 in New Jersey, but across the country.
5 Just wanna -- just wanna pose the same
6 question to you. New Jersey's position as a pharma
7 capital, you know, the -- the clinical registrant
8 component of the -- of the program here in -- the
9 cannabis program here in New Jersey soon to come. What
10 does equitable research -- research and development,
11 what does equitable and inclusive and safe clinical
12 registrant program look like to you?
13 MR. GOLDSTEIN: That -- that is a great
14 question because New Jersey, as you say, is this pharma
15 capital, and Cannabis doesn't fit into the pharma
16 model. That's why you have such a challenge in
17 creating a better place for public health with a robust
18 medical cannabis program. This really is important to
19 solve. We shouldn't give up on solving this problem.
20 We should not let this program and see the
21 patients diminish off to zero. This is an important
22 part of the fabric of public health. At the very
23 beginning of the meeting, Chairman Houenou mentioned
24 Juneteenth and Pride and the -- the -- the history in
25 the community here. We have to recognize that there is

1 a medicinal use of cannabis that is part of culture.

2 And now it's part of American culture.

3 It's part of New Jersey culture, quite frankly. That

4 there are many more people out there in our society

5 every day utilizing medical cannabis on the daily basis

6 here without interacting with us at all. The medical

7 cannabis program is a sort of exercise in trust between

8 the state and the community.

9 And so what does equitable research look

10 like? It -- I agree with Leo that it has to look like

11 research that is actually in the community. I don't

12 agree with some of the scientists who want to monitor

13 medical cannabis patients with a prescription drug

14 monitoring program. I think that's the opposite of the

15 approach.

16 How are you gonna get people to register

17 if they think that they're just gonna be guinea pigs

18 for the state? That's already what happened with this

19 program, and we should avoid that. I also think

20 Commissioner Del Cid-Kosso, you mentioned HIPAA

21 compliance, and there was some mention of that.

22 One of the real problems with

23 dispensaries, and not just in New Jersey, this is

24 national, is that there is not much privacy for

25 patients once they join. Think about how much data and

1 information you're giving a medical cannabis dispensary
2 and the business behind it. You're telling them your
3 medical conditions and how much cannabis you're using,
4 when, how much you're spending on it.
5 That data should be private. It shouldn't
6 be traded, which sometimes it is. So when we talk
7 about HIPAA compliance for me as a consumer and patient
8 advocate in this space for 20 years, I would love to
9 see the kind of privacy protection that we enjoy every
10 day in mainstream health care come into medical
11 cannabis.
12 When we talk about the insurance bills and
13 things like that, I've worked with Senator Singleton on
14 those bills. I believe in one day having state
15 insurance cover medical cannabis. But again, this is
16 where we have to think outside the box. It will be a
17 long way down the road. No matter how much progress
18 we're making federally right now, the white house and
19 the scheduling review, it will still be a long way down
20 the road, and in between NJCRC and the state of New
21 Jersey has a responsibility to our residents right now
22 for these programs to work, because they can.
23 Back to the center of equity that you
24 asked, how do we center equity on research? We've
25 talked about the equity that is in the businesses, but

1 how do we get equity back to the people? I think that
2 it really comes back to, you know, having people
3 participate in the program and trust the program, trust
4 the laboratory results and trust that they won't be
5 treated like guinea pigs.
6 COMM. BARKER: Thank you very much for
7 that, Mr. Goldstein --Goldstein.
8 CHAIR: Thank you.
9 VICE CHAIR: You mentioned --
10 CHAIR: Can you -- yes --
11 VICE CHAIR: You mentioned over the
12 counter.
13 CHAIR: -- Mr. Delgado.
14 VICE CHAIR: You mentioned over the
15 counter. Can you expand on that a little bit? Are you
16 saying to have it available over the counter in a
17 pharmacy?
18 MR. GOLDSTEIN: Yeah. Okay. So yeah,
19 essentially in Delaware, Governor Carney last week
20 signed a bill that was passed by the Legislature to
21 allow anyone over the age of 65 to access a medical
22 cannabis dispensary without a doctor's recommendation
23 or anything other than a state ID that says they're
24 over 65.
25 They're not the only state to do this.

1 That essentially gives seniors over the counter access
2 to medical cannabis. And that is a great thing in so
3 many ways, right? Other than the fact that when they
4 get to the dispensary, they get scared away by the
5 prices because it's like the most expensive weed
6 they've ever seen in their life.
7 And that's -- that's where we have to get
8 into fair pricing. New Jersey's prices, again, as I'm
9 pointing out, are double what they are in Pennsylvania,
10 and more expensive than they are in Delaware, and in
11 some cases more than New York City. That's a problem.
12 Okay? And that's a problem for access.
13 We were told, you were told, I was there,
14 I was at the meetings, they made promises to y'all like
15 two, three years ago, hours of promises. They tested
16 on -- testified about patient access plans, and their
17 main theme was that prices would go down and they would
18 get more affordable. I look at the menus every two
19 weeks. I do the price studies. The medical and adult
20 use menus are of equal price.
21 They're charging -- 10 years ago, when we
22 first opened dispensaries, it was $60 an eighth. The
23 Star Ledger published articles from the CEOs saying,
24 oh, we'll get more grows open, more competition, prices
25 will go down. Never happened. Now they're selling $60

1 an eighth marijuana. If we want insurance access in
2 New Jersey, and I've talked with Senator Singleton
3 about this, built into that insurance bill is price
4 transparency.
5 Because if consumers and patients aren't
6 getting a fair deal, taxpayers won't get a fair deal
7 from these companies either. And that does come down
8 to your responsibility. Like, how does NJCRC negotiate
9 those prices? Like, this is a conundrum that we're in
10 with other realms of healthcare, but because there's no
11 federal regulations for this, you have the
12 responsibility to be the price negotiators, to be the
13 ones to get the prices down for consumers and patients.
14 And when these same companies are charging
15 double in New Jersey, and charging more in New Jersey
16 than any other dispensary they have in the country, and
17 when they're operating in 12 to 17 states, that really
18 says something. Then it -- I mean, what do you do?
19 You're -- it -- you're going to have to be diplomats
20 that the state needs here to stand in here, and -- and
21 that's tough.
22 But again, you're teaching the lessons
23 that the federal government needs to learn real fast.
24 So the examples that you're setting right now of
25 getting fair prices, of negotiating with this industry,

1 this is something that carries forward at a national
2 level pretty quickly. This is a pharma state. So
3 we've negotiated with pharma companies to get better
4 prices on pharma drugs.
5 This is now your realm to get better
6 prices in this realm of care.
7 VICE CHAIR: Yeah. The only -- the only
8 thing I'm thinking about here, Chris, is that like over
9 the counter drugs are not -- you can't get -- they're
10 not -- you don't get insurance on over the counter
11 drug, right? Like if I go --
12 MR. GOLDSTEIN: That's not -- that's not
13 true. Acetaminophen is -- I mean, again, you can --
14 you can cover over the counter drugs --
15 VICE CHAIR: If I go get Xanax, I can't --
16 I can't -- my insurance company won't pay for my -- my
17 Xanax, right?
18 MR. GOLDSTEIN: But again, your insurance
19 company -- what we would have in New Jersey is a
20 specific insurance program that goes through Family
21 Gold and those programs to pay for. So while Xanax may
22 be cut out of your specific health care plan, we would
23 make available health care plans, especially for -- and
24 this is for people who can't afford these prices.
25 So again, without home cultivation,

1 without price controls, we've got an out of control
2 price model that is not affordable, and we can't even
3 pay for it with state resources. So that's the
4 problem.
5 VICE CHAIR: That would be in the -- that
6 would be in the sausage making of new -- of the
7 legislation, right?
8 MR. GOLDSTEIN: However -- again, it might
9 be in the sausage making of the legislation, but my --
10 my appeal to you is that what you can do is say --
11 Commissioner Delgado, you can look at the menus of
12 these companies in Pennsylvania.
13 You can yourself see that they're charging
14 double in New Jersey. So --
15 VICE CHAIR: No, I know. I know.
16 MR. GOLDSTEIN: So, you know, on a level,
17 there has to be a more transparent to the public
18 approach to these companies on pricing, just like
19 politicians do with the big pharma companies that are
20 based here anyway. Look, if they can negotiate the
21 price of Xanax down, you've got to be able to negotiate
22 the price of a gram of weed down for a medical patient.
23 Okay?
24 And when it's double, I have to say the
25 same lessons -- I mean, the president of the United

1 States, President Biden and members of Congress are
2 talking about corporate greed, price gouging, and how
3 that affects working class people every day. And, you
4 know, that's their role in that realm of pharma care.
5 Your role is medical cannabis care, so
6 you're stuck between these companies and the public.
7 So it's your job to negotiate the better prices.
8 CHAIR: All right. With that, any last
9 questions for Mr. Goldstein? All right. Thank you
10 again, Mr. Goldstein for sharing your -- your thoughts
11 and answering our questions.
12 MR. GOLDSTEIN: I appreciate your time.
13 Thank you all so much.
14 COMM. BARKER: Thank you very much.
15 DIR. MCWHITE III: And last but certainly
16 not least, Dr. Hugh Blumenfeld of Doctors for Drug
17 Policy Reform, formerly DFCR. You should be allowed to
18 talk now.
19 DR. HUGH BLUMENFELD: Hi, everybody. Can
20 you hear me? Hello?
21 CHAIR: We can hear me.
22 DR. BLUMENFELD: You can hear me? Okay.
23 CHAIR: Yeah.
24 DR. BLUMENFELD: Good. Thanks. Hi, thank
25 you for inviting us to -- to speak. I am a member of

1 the Doctors for Drug Policy Reform. I just wanna
2 mention, I'm not speaking officially for them or
3 representing them, I'm just a member and they asked me
4 to speak because my experience with medical cannabis
5 over the years.
6 So just introduce myself. I'm a family
7 physician, and I teach family medicine in Hartford,
8 Connecticut since 2010. I have a full scale -- full
9 scope practice. I -- I do children and adults. I do
10 obstetrics, I do hospice, take care of adolescents, and
11 I have a psych clinic as well. And it's in the middle
12 of Hartford, which is not that different in some ways
13 from Newark, where my mom grew up.
14 I -- I wanted to start with a little story
15 though. Before I became a doctor, my sister-in-law had
16 been diagnosed with MS for a long time, multiple
17 sclerosis. And she told me on the side when I started
18 considering going back into medicine that she wanted to
19 make sure that I learned about medical marijuana
20 because she said that without cannabis, she would
21 certainly have committed suicide. That she had -- you
22 know, she had neurologists -- many -- many neurologists
23 over the years, nobody could really manage her pain,
24 her symptoms, until she was able to get medical
25 cannabis.

1 And she wanted to make sure that, you
2 know, when I became a physician that I would learn
3 about it, which I tried to do.
4 So what I wanted to address for you today
5 is just talk about how we've been doing a medical
6 cannabis in Connecticut, talk a little bit about the
7 qualifying medical conditions and also a little bit
8 about how we've managed healthcare access -- healthcare
9 provider access to make sure that more on board.
10 So, you know, there's a lot that we don't
11 know about the cannabis, how it works. We do know that
12 there are receptors for cannabinoids throughout these -
13 - the -- the brain and the central nervous system, but
14 also through the immune -- throughout the immune system
15 in the body.
16 And so that it makes sense that it, you
17 know, modulates the conduction and perception of pain
18 signals as well as modulating inflammation in the
19 bodies. We know that, you know, THC and CBD are -- are
20 two of the most well-known of the cannabinoids, but
21 then there's also a -- a number of dozens of terpenes,
22 which are smaller chemicals that give marijuana its
23 flavor and taste and -- and, you know, scent, and have
24 therapeutic qualities themselves, which again there's a
25 lot to be learned about the way cannabis works, but we

1 know that it has a -- over a 4,000-year history of use.
2 Medicinally we know that the AMA had it on
3 their pharmacopeia before it was made illegal back in
4 the thirties and protested against it being taken off
5 out of their pharmacopeia. And -- and another thing is
6 that in a lot of conditions, we lack really good
7 alternatives to manage symptoms like the ones that
8 we're trying to treat.
9 And some of those medications that we do
10 use have their own dangers. There's opioids, there's
11 Tylenol, which has many overdoses of Tylenol a year.
12 That's why they don't package it with opioids anymore.
13 NSAIDs cause thousands of complications that end up in
14 the hospitals that I take care of.
15 We have benzodiazepines like Xanax and
16 Valium. Somebody mentioned their Xanax prescription,
17 but these are, you know, highly habit forming, very
18 difficult to get patients off of once they've been on
19 them. Ambien as well. And that's not to mention
20 things that are -- you know, we've tried to make
21 illegal, but, you know, we're not successful like
22 alcohol and cigarettes, which, you know, people have,
23 you know, pretty free -- adults have free access to
24 that are much more dangerous than cannabis.
25 So, you know, from a physician point of

1 view, I've been very interested in the medicinal
2 possibilities of cannabis, but also really interested
3 in harm reduction because the fact of the matter is
4 that working in Hartford, you know, a lot of my
5 patients have access to, or already use cannabis. And
6 so there are advantages to having medical marijuana
7 system -- medical cannabis system.
8 So in Connecticut, we have actually 40 --
9 40 conditions that are listed for adults and 11
10 conditions that are qualifying conditions for children,
11 people under 18. And when I think about the difference
12 between New Jersey's list of 17 conditions and
13 Connecticut's list of 40, it makes me wonder about the
14 usefulness of, you know, trying to find every single
15 condition that there might be evidence for cannabis
16 being effective.
17 So I really wanted to break it down into
18 just a few basic categories that I think all these
19 conditions fall under. One of them is chronic
20 recurrent pain syndromes. Another is neurological
21 disorders. Another one is psychiatric conditions,
22 including substance abuse and PTSD, and in New Jersey -
23 - New Jersey, I think you've included anxiety. There's
24 chronic inflammatory or immunological conditions.
25 A lot of them are autoimmune or some are

1 infectious. These things include, you know, things
2 like MS, but also HIV. And then there's congenital or
3 acquired conditions affecting the musculoskeletal
4 system, a number of those. And then finally, there's
5 some terminal illnesses.
6 And I think -- I'm not sure how much sense
7 it makes to, you know, try to -- there's thousands of
8 conditions that have fallen into any one of these
9 categories, and if you look at the differences, again,
10 between our list and your list, it's just a matter of
11 adding some specific conditions within those major
12 categories.
13 The way that we work it in Connecticut is
14 that this physician is supposed to have a preexisting
15 relationship with the patient, a therapeutic
16 relationship with the patient. We're trying to avoid
17 situations where people just set up shop as, you know,
18 marijuana doctors. But -- but it does mean that more
19 doctors have to get on board with understanding how to
20 use -- how and when to -- cannabis can be used by their
21 patients.
22 But if you have a bonafide therapeutic
23 relationship with a patient, you can certify them for
24 these medical conditions. And the nice thing about the
25 Connecticut system is you don't actually prescribe the

1 cannabis. Basically, once you certify the patient
2 through the Department of Consumer Protection, they
3 have a website, patients are then able to go to the
4 pharmacy, the dispensary, and have a 40 to 60-minute
5 appointment with a pharmacist.
6 And the pharmacists who worked at our
7 dispensaries, our medical dispensaries, are highly
8 knowledgeable in cannabis and the various kinds of
9 cannabis that are available to patients, not only the
10 different blends, which are therapeutic for various
11 conditions, but different modes of -- routes of
12 administration.
13 You know, typically people using adult use
14 marijuana will smoke or vape it, but there's not only
15 ingestible cannabis products that you can eat and then
16 they go through the GI system. They take about 45
17 minutes to an hour to actually -- to start working, but
18 they last longer. And then there's even sublingual
19 products, which, you know, get into the bloodstream
20 much faster, more on the order of -- of smoked or vaped
21 products.
22 So and these things are -- are safer than
23 smoking or vaping. The other thing about the
24 dispensary system that the -- and this is to address --
25 I think Mr. Delgado had questions about, you know, the

1 -- the illegal markets. The kinds of cannabis that are
2 available at the dispensary really can be blended to
3 address medical symptoms.
4 Most of -- most of the cannabis that's
5 available either illegally or for adult, you know, what
6 they call recreational use, the idea is to, you know,
7 get euphoria, to get high. But -- but when you're
8 talking about therapeutics, that can calm PTSD, which
9 is not necessarily an anxiety syndrome anymore, but
10 more thought of as a disorder, the sympathetic nervous
11 system, that fight -- or flight system. You can get
12 products that really address pain, especially
13 neuropathic pain or -- or address inflammation.
14 These -- most of the people I have that
15 are trying to use cannabis medicinally, they wanna stay
16 functional. They don't really wanna be high, and
17 therapeutic plants really address that need for
18 patients to be able to -- to ameliorate their symptoms
19 without getting that -- that euphoria that can make
20 them unable to function.
21 And I think -- and -- and because we have
22 the -- these dispensary pharmacists to have these one-
23 on-one conversations with patients, you know,
24 physicians don't have to be as knowledgeable about
25 cannabis. They need -- they simply need to know if

1 their patients have a condition that would benefit from
2 it, and then it -- it's basically -- it's like a
3 specialist referral.
4 So I think I probably used your three
5 minutes, and I think I'll stop there and see if there's
6 any questions or things that I could address more fully
7 for you.
8 CHAIR: Thank you so much, Mr. -- Dr.
9 Blumenfeld. Really appreciate the time. Commissioner
10 Nash, do you have a question for Dr. Blumenfeld?
11 COMM. NASH: Yes. Hi, Dr. Blumenfeld.
12 Thank you for your time today and your comments.
13 Really appreciate it. So I just wanna understand, are
14 there -- are there pharmacists in every dispensary?
15 DR. BLUMENFELD: Yes.
16 COMM. NASH: Okay. And is -- are they
17 there daily? I mean, in general, I'm just trying to
18 understand really.
19 DR. BLUMENFELD: Yeah. Yeah, no, there's
20 a -- in Connecticut's dispensary, my understanding is
21 that there's a full-time pharmacist in each one.
22 And I visited -- I have visited the one in
23 Hartford. It's -- it's quite amazing to go back and
24 look at it. It looks like the pharmacy in Walmart. It
25 literally has the same shelves with the same kind of,

1 you know, packaging and bottles with -- you know, very
2 -- everything's very formal in terms of -- you know,
3 one of the advantages is -- of medicinal cannabis is
4 you really can break out the percentages of THC, the
5 percentage of CBD, the percentage of specific
6 therapeutic terpenes that are in any given blend and
7 the exact number of milligrams that a patient will be
8 consuming.
9 COMM. NASH: Well, thank you for that
10 answer.
11 CHAIR: Thank you. Any other -- any
12 further questions for Dr. Blumenfeld?
13 COMM. DEL CID-KOSSO: One, just a quick
14 clarifying question. You mentioned that -- and I could
15 have confused you with another speaker, but did you say
16 that you've had some experience working in long-term
17 care facilities?
18 DR. BLUMENFELD: Not new facilities, but
19 I'm a medical director in the hospice program.
20 COMM. DEL CID-KOSSO: In a hospice
21 program.
22 DR. BLUMENFELD: And the nurses and social
23 workers that I supervise, they go into a lot of
24 facilities, including inpatient units to take care of
25 patients there.

1 And -- but a large number of those
2 patients are at home.
3 COMM. DEL CID-KOSSO: And yeah
4 (interposing) --
5 DR. BLUMENFELD: And again, the long-term
6 care facilities don't -- don't allow us to -- to give
7 patients medical marijuana there.
8 COMM. DEL CID-KOSSO: Okay. I was just
9 going to ask that question. Because I'm thinking about
10 institutional caregivers here in New Jersey and how --
11 you know, I wanted to ask if you had some wisdom to
12 share with -- with us in terms of how hospice cares are
13 addressing that issue, but thank you for your -- for
14 your short and quick answer.
15 DR. BLUMENFELD: You're welcome.
16 CHAIR: All right. Great. Well, thank
17 you so much, Dr. Blumenfeld. Really appreciate you
18 taking the time to share your experiences and -- and
19 insights, especially on what's happening in our
20 regional neighbor up in Connecticut.
21 DR. BLUMENFELD: Thanks for having me
22 again.
23 CHAIR: Mm-hm. I believe that is it for
24 our invited guests. I wanna thank everyone again for
25 sharing their -- their thoughts and their expertise

1 with us. And so now we will turn over to the members
2 of the public who have signed up to speak. So we will
3 have, I believe Mr. Said or Director McWhite call out
4 our registered speakers.
5 Members of the public who are registered
6 to speak, you will be limited to three minutes. When
7 it is your turn to -- when you hear your name called,
8 please use the raise your hand feature in the Zoom
9 platform so that our staff can identify you and unmute
10 you.
11 VICE CHAIR: Madam Chair, one. Before --
12 before the speaker start, if I could just correct the
13 record real quick. When we were talking -- when Chris
14 and I were talking about over the counter earlier, I
15 said Xanax and that's -- that is a prescription. I
16 meant Zantac.
17 In my Bronx accent, I said Xanax by
18 mistake. So I wanna correct the record. Thank you
19 very much.
20 CHAIR: Thank you. No problems, Vice
21 Chair Delgado. And trust there will be no judgment
22 from us, whether you have -- whether -- for either
23 medication.
24 VICE CHAIR: There better not be.
25 CHAIR: All right. We'll turn it over to

1 Mr. Said to call out our registered speakers.

2 THE SECRETARY: Thank you, Chairwoman. As
3 a reminder, public speakers during this afternoon's
4 public comment period will be limited to three minutes.
5 Please be respectful and concise during your comments.
6 I'm gonna call out three at a time. Velvet Howell,
7 James from STEMS Inc., and Ronald Sykes. If you're in
8 the Zoom meeting, please raise your hand.

9 The next three I'm gonna call are Deanna
10 Robinson, David Feder, and Margarita Tsalyuk. As
11 a reminder, please raise your hand so that I can allow
12 you access to speak.

13 The next three are Haider Rizvi, Samuel
14 Reichbart, and R.H. Robinson. Okay. I see Samuel
15 Reichbart. Just give me one second. Samuel, you have
16 the floor.

17 MR. SAMUEL REICHBART: Hi, just give me
18 one second. All right. I just wanted to say, first
19 off, thank you guys for implementing virtual testimony
20 for future meetings. This is a great step towards
21 patient accessibility, along with steps towards fixing
22 in-person accessibility issues at newly opened
23 dispensaries. Seeing patients pushed to the side at
24 places they're supposed to be able to access relieving
25 therapies is quite disappointing.

1 I'm glad to hear that the Commission will
2 be taking steps to right some of these wrongs. I also
3 very much appreciate that you guys asked an educated
4 group of doctors and professionals to come and give
5 testimony on some issues that the Commission and the
6 program have been experiencing. It does not go over
7 mine or anyone else's heads though that you guys still
8 refuse to speak to the patients directly affected by
9 these issues.
10 We have valuable voices and suggestions
11 that could help to ease some of the tension and to help
12 this program to continue to grow into what it's
13 supposed to be as well as foster trust with -- between
14 the public and to foster growth in this industry. I
15 would also like to pair a couple of points. Ken Wolski
16 was absolutely correct in his recommendation that any
17 doctor with prescriptive power should be able to
18 recommend or authorize cannabis for any patient for a
19 condition that they deem it will be therapeutic for.
20 You guys are not exactly doctors, and I
21 don't know why you guys would task yourselves with
22 coming up with this list of conditions, not being
23 doctors. I just -- it's too complicated, and there's
24 too many things to potentially think about that need to
25 involve doctors in that decision-making process.

1 I think that would be made a lot easier if
2 you were to hire them internally as a scientific or
3 medical advisory board. Patients have been waiting for
4 this step to be taken as well because many of the
5 decisions that you guys are tasked with making are
6 scientific and medical decisions. They need to be
7 weighed in on by people that truly understand the
8 things that you guys are making the decisions on in
9 order to, you know, make sure that patients have the
10 best outcomes possible.
11 Additionally, the group of doctors that
12 spoke first had an excellent point in that clinical
13 education is going to be of utmost important over the
14 next few years. We have been -- we have gone for too
15 long with doctors that are unable to help and answer
16 our questions. Patients will seek out real science-
17 backed information from real -- from very genuine
18 resources, and we currently struggle with that, and so
19 do the doctors that we would get that advice from.
20 Someone mentioned it earlier that the best
21 place to get that information is currently inside of
22 the dispensaries, but inside dispensaries, we have our
23 hands tied. I work in a dispensary.
24 I'm not able to give medical
25 recommendations, even though I have a deeper

1 understanding than probably most of these people's
2 doctors. I'm not allowed to -- I have to be very
3 careful about the words I use and what I say, and that
4 doesn't really help anyone because they're coming to me
5 because they've been told that I'm the person that can
6 give them advice.
7 They know that their doctor doesn't have
8 the information that they need, and it just doesn't
9 really help anybody for us to not have this knowledge
10 and not have any professional to go to in order to ask
11 these questions.
12 Additionally, we -- while it's great to
13 hear from these professionals --
14 COMM. BARKER: One second, Sam.
15 MR. REICHBART: -- there are still quite a
16 few things we are waiting for. We're still waiting for
17 testing batch size, hospital access, requiring CoAs to
18 be posted online by producers. All of these changes
19 would help to foster accessibility and trust for the
20 program, producers and the commission.
21 And finally, patients are still waiting
22 for solid -- solvent transparency on packaging.
23 Patients are at risk because of your woeful lack of
24 knowledge and failure to properly define and regulate
25 RSO, which is a highly unique product. My efforts to

1 solve this issue have been going on for over six
2 months.
3 COMM. BARKER: Sam.
4 MR. REICHBART: You guys need to take
5 steps to work on this issue. The effect -- this
6 affects sick people. You regulate our medicine --
7 COMM. BARKER: Sam, thank you so. Thank
8 you so much, Sam.
9 MR. REICHBART: -- because of your lack of
10 understanding.
11 THE SECRETARY: Next up on the list is
12 Deanna Robinson. Deanna, please speak.
13 MS. DEANNA ROBINSON: Can you see me now?
14 THE SECRETARY: Yes, we can hear you,
15 Deanna.
16 MS. ROBINSON: Oh. Listen, first of all,
17 I wanna thank you so much for the special guests that
18 you had and also for extending --
19 MR. REICHBART: Very rude of you guys to
20 cut me off instead of letting me finish. I had
21 literally 30 seconds. You can't take the time to
22 listen to patients and it's disappointing. This
23 commission --
24 CHAIR: Mr. Reichbart.
25 MR. REICHBART: -- needs to step up and do

1 --

2 CHAIR: Mr. Reichbart. Mr. Reichbart, I

3 wanna interject here for a second. Apologies, Mr.

4 Reichbart, for the -- the technical -- the technical

5 cutting off. You are out of time, and we will make

6 sure that we highlight for folks. Unfortunately, our

7 counter -- our clock timer is not working with us right

8 now.

9 We've had some technical difficulties for

10 this, but I want to thank you, Mr. Reichbart, for

11 sharing your thoughts, and leave -- and encourage you

12 to -- I want to invite you to submit written comments

13 for anything that you weren't able to get to. I know

14 we do have a lot of --

15 MR. REICHBART: You regulate our medicine.

16 You need to act like it. Your lack of understanding --

17 CHAIR: Excuse me, Mr. Reichbart. Mr.

18 Reichbart, I'm sorry. We're gonna have to ask you to

19 submit your comments, the remainder of your comments in

20 writing so that we can get to the rest of our

21 registered speakers.

22 And I want to take this time to apologize

23 to Ms. Robinson, and also remind all of our registered

24 speakers that you are limited to -- to three minutes.

25 We do have several folks who have signed up to register

1 -- I'm sorry, who have signed up to speak, and we want
2 to be able to give all of those individuals an
3 opportunity to share their thoughts.
4 So I ask that everybody remain cognizant
5 of the -- their -- the time limit. Please feel free to
6 provide any additional comments in writing to us, which
7 is -- and those comments are shared with commissioners,
8 and they are posted online so that your -- your
9 comments will be publicly noted.
10 With that, I wanna turn back to Ms.
11 Robinson. And your three minutes starts now.
12 Apologies, Mrs. Robinson to you.
13 MS. ROBINSON: Oh, that's okay. I
14 understand. He's very passionate, but I am very
15 passionate about thanking you and thanking Mr. Glenn
16 Walker for being a great coordinator. And you guys are
17 wonderful. I enjoyed my ride down to Atlantic city,
18 listening to all your guest speakers.
19 Now there are a couple of comments I'd
20 like to make. Number 1 is if the schedule changes from
21 one to three, how does that affect dispensaries, and
22 will pharmacies like CVS and everything else figure
23 that they can make more money, you know, giving out
24 cannabis -- medical cannabis? That's one thought.
25 Okay. And I know that's way down the

1 line, but it is a thought because a lot of dispensaries
2 are going to expend a great deal of money and possibly
3 lose money.
4 Number 2 is that I'm having a very hard
5 time finding a location, that's why I asked for an
6 extension. It's really tough out there. And I was
7 wondering if -- if some of the people that are out
8 there, such as myself can volunteer and help you guys
9 talk to other townships to maybe get more people to opt
10 in, you know, because it's -- it's -- I've been out
11 here for a minute, you know, and I have two realtors
12 that are trying, but every time I get there, either the
13 licenses have been taken or the townships don't want
14 it.
15 Okay. So then the third thing too is
16 because the gangs have been running the streets for so
17 long, are you setting up a roundtable to discuss their
18 territories that are gonna be invaded by legal
19 dispensaries?
20 You realize that before the -- the
21 dispensaries or the retail stores that are opening,
22 that the gangs were selling the drugs. So, you know,
23 I'm wondering about some of the backlash from that,
24 like in Kansas and Newark and other areas like that.
25 Are there round tables that are being set up to discuss

1 this with the leaders?

2 Just questions. All right. So could you
3 take that into advisement or get back? Mostly the list
4 of the locations. I really need to know what new
5 townships are opting in. All right. Can you guys hear
6 me?

7 CHAIR: Yes. Thank you very much, Ms.
8 Robinson for --

9 MS. ROBINSON: I was short, right? Was
10 that three minutes?

11 CHAIR: You were short. I thank you. I
12 appreciate -- I appreciate the conciseness.

13 MS. ROBINSON: All right. So listen, have
14 a great weekend. And hopefully if I'm here still
15 tomorrow, if I don't go busted, I'll come and visit
16 your place in Atlantic City. All right. Bye-bye,
17 guys.

18 CHAIR: Thank you.

19 MS. ROBINSON: Bye.

20 THE SECRETARY: The next three speakers on
21 the list are John -- John De Los Santos, Carlos
22 Almanzar, and Anthony Campbell Jr. All right. I see
23 Anthony Campbell. Anthony, you have the floor.

24 MR. ANTHONY CAMPBELL JR.: All right. Can
25 you hear me?

1 THE SECRETARY: Yes.

2 MR. CAMPBELL JR.: Hi, Commission, and
3 thank you for your time. My name is Anthony Campbell.
4 I am the founder and CEO of Culture Craft Cannabis
5 Collective. We started this journey years ago, and we
6 are happy to have finally completed our initial
7 investigation phase with the CSE.

8 So thank you again for your comments
9 earlier about the four weeks for review before being on
10 an agenda. That is very helpful. And we've submitted
11 our follow up documents in time to meet the July
12 meeting. We know that you guys have been working extra
13 hard to push applicants through, so I just wanna thank
14 you for all that you do, and hope that, you know,
15 before you guys goes on -- go on break in July, as many
16 of us who have been waiting can hopefully get on that
17 list, because as you know, every month can come with
18 its new set of challenges, and every month counts.

19 A little bit about myself. I went to --
20 I'm a Jersey boy, went to Bergen Academies for science
21 and technology in Hackensack before going to Michigan
22 for chemical engineering. Then I went to work in
23 industry for L'Oréal, Johnson & Johnson, and the Pharma
24 Capital in New Jersey, as we talked about earlier, for
25 over a decade before I went to study health sector

1 management at Duke.

2 So today's conversation I found extremely

3 interesting and beautiful. My team and I cannot wait

4 to bring our decades of formulation and product

5 development experience to the market. We truly are

6 homegrown, 100 percent local, and our goal is to simply

7 have the chance to build a quality cannabis brand and

8 help supply ourselves and other micro cultivators with

9 quality genetics.

10 And I'm a science guy, through and

11 through, so I'm curious to see the role that, you know,

12 we could potentially play in the future as, you know,

13 collectively we unlock all the benefits of the cannabis

14 plant. We're unlocking new uses every day. I've been

15 researching this in the endocannabinoid system.

16 In fact just from my experience in

17 industry, I've had a -- I think the research

18 cannabinoids and personal care products and topicals.

19 So I'm excited to see where the industry takes us and

20 how we could all play a part in an equitable manner.

21 But just wanted to introduce myself, our company

22 Culture Craft Cannabis Collective and say thank you.

23 We are 100 percent minority-owned Class 1,

24 Class 2, micro business, and we are excited to see

25 where the industry goes, and to play a part. So once

1 again, thank you for your support, your time and
2 consideration now and in the future. Thank you.
3 THE SECRETARY: The next three on the list
4 are Andrea Raible, Jesse Marie Villars, and Daniel
5 Vargas. If you're in the room, please raise your hand
6 so I can allow you to speak.
7 I don't see those names. I'm just gonna
8 go over the names one more time just to give everyone
9 an opportunity. Velvet Howell, James from STEMS, Inc.,
10 Ronald Sykes, David Feder, Margarita Tsalyuk, Haider
11 Rizvi, R.H. Robinson III, John De Los Santos, Carlos
12 Almanzar, Thomas Norcia. Okay, I see you, Thomas.
13 Okay, Thomas, you have the floor.
14 MR. THOMAS NORCIA: Hello?
15 THE SECRETARY: Yes, we can hear you,
16 Thomas?
17 MR. NORCIA: You can hear me? Yes.
18 THE SECRETARY: Yes.
19 MR. NORCIA: I'm Thomas Norcia. I'm the
20 owner and operator of Grow Works. I'm a small cannabis
21 business in Sussex County. I'm licensed through the
22 New Jersey Department of Agriculture. I've been
23 growing in Manhattan.
24 THE SECRETARY: Thomas.
25 MR. NORCIA: Yes.

1 THE SECRETARY: Go ahead. You were muted
2 for a second, but go ahead.
3 MR. NORCIA: Sorry. I --
4 THE SECRETARY: Thomas, you're muted
5 again.
6 MR. NORCIA: I have products and
7 dispensary in North Jersey. Recently, an inspector
8 came in and told them that they were no longer to sell
9 the products until they were put into metric. So today
10 my one thing is just seeing if we could start the
11 conversation how we could create a gateway to allow
12 cannabis businesses that are licensed through the
13 Department of Agriculture to have access to measure.
14 So that's really it for today. Just want
15 to see if we could get that a topic on how I could get
16 products into dispensaries.
17 THE SECRETARY: Thank you so much, Thomas.
18 MR. NORCIA: If there's any questions,
19 anyone wants to ask questions, I'm still here.
20 THE SECRETARY: I don't think we're gonna
21 -- we're gonna ask questions --
22 MR. NORCIA: Okay.
23 THE SECRETARY: -- of the public, but
24 thank you so much.
25 MR. NORCIA: Okay. All right. Thank you.

1 THE SECRETARY: Next is Andrea Raible,
2 Jesse Marie Villars, and Daniel Vargas.
3 Okay. I don't see any of those names.
4 Chairwoman Houenou, this will conclude the registered
5 speakers we have for today's public meeting.
6 CHAIR: Thank you, Mr. Said, and thank
7 you to everyone who shared their thoughts,
8 recommendations, and their experiences with us. Again,
9 anyone who was not able to finish their thoughts can
10 submit their comments in writing to the CRC at our
11 website nj.gov/cannabis/meetings, and the deadline for
12 submitting comments for today's board meeting is 5
13 o'clock tomorrow, Tuesday, June 18th.
14 So this considers the -- I'm sorry, this
15 concludes the business that we have before us today,
16 and with that, I move that we adjourn.
17 VICE CHAIR: Madam Chairwoman, I move that
18 we adjourn.
19 COMM. NASH: I second.
20 CHAIR: All right. So we'll say that Vice
21 Chair Delgado has moved to adjourn, and Commissioner
22 Nash seconded.
23 Any discussion on this motion to adjourn?
24 Hearing none, all those in favor of adjourning say aye.
25 VICE CHAIR: Aye.

1 COMM. BARKER: Aye.

2 COMM. DEL CID-KOSSO: Aye.

3 COMM. NASH: Aye.

4 CHAIR: Aye. All those opposed say nay.

5 Any abstentions?

6 Motion passes. The time is 3:29, and we

7 are adjourned. Thank you everyone, and have a great

8 rest of your day.

9 VICE CHAIR: Thank you.

10 (Meeting concluded at 3:29 p.m.)

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