In The Matter Of:

Department of Health & Social Services
Revision to DHSS Regulations

Hearing
February 12, 2019

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Min-U-Script® with Word Index

STATE OF DELAWARE

DEPARTMENT OF HEALTH AND SOCIAL SERVICES

In Re:

Revision to DHSS Regulations :
adding Opiate Use Disorder :
to the Qualifying Conditions :
in the Medical Marijuana Program :

Herman Holloway Campus
The Chapel
1901 N. Dupont Highway
New Castle Delaware

Tuesday, February 12, 2019
6:30 p.m.

BEFORE:

ALANNA MOZEIK
HEARING OFFICER

WILCOX & FETZER
Registered Professional Reporters
1330 King Street
Wilmington, Delaware 19801
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1 THE HEARING OFFICER: Good
2 evening, everyone. My name is Alanna
3 Mozeik. I'm the Hearing Officer for this
4 public hearing. At this time, I ask that
5 you please turn off all cellular devices or
6 put them on silent or vibrate.
7 I welcome you to the public
8 hearing to discuss potential revisions to
9 DHSS regulations, specifically adding Opiate
10 Use Disorder, or OUD, to the qualifying
11 conditions in the Medical Marijuana Program.
12 If you wish to speak and haven't
13 yet signed up, please do so now. There is a
14 sign-up sheet right here.
15 Today is Tuesday, February 12th,
16 2019. It is now 6:32 p.m. This hearing is
17 being held in The Chapel on the Herman
18 Holloway Campus.
19 The sequence of events for this
20 public hearing will be:
21 1. A brief opening statement on
22 public hearings;
23 2. Overview of the proposed
24 petition;

1 3. Agency exhibits;
2 4. Ground rules for public
3 hearing;
4 5. Public comments;
5 6. Closing remarks and hearing
6 closure.
7 This public hearing is being
8 held in accordance with the Administrative
9 Procedures Act, which is Title 29, Chapter
10 101, of Delaware law. The purpose is to
11 gather comments on possible changes to DHSS
12 regulations.
13 I would like to emphasize that
14 the Administrative Procedures Act was
15 established so that state agencies have a
16 standard and systematic process to assure
17 that all interested parties that may be
18 impacted by a regulation have an opportunity
19 to provide input.
20 DHSS pledges they will consider
21 your input carefully and thoughtfully and in
22 a responsible way. We ask that your
23 comments be relevant to the matter at hand,
24 which is adding Opiate Use Disorder to the

1 Medical Marijuana Program Qualifying
2 Conditions. While we acknowledge that no
3 public policy serves everyone equally, our
4 goal is to implement regulations that do
5 public good for as many people as possible.
6 Following today's public
7 hearing, the Department will analyze the
8 comments received.
9
10 You will note that a court
11 reporter is present and will type the
12 verbatim transcript of the proceedings.
13 In addition, the Department will
14 analyze comments on the proposed regulations
15 in writing during the official comment
16 period. The official comment period closes
17 on February 28, 2019.
18 According to the Administrative
19 Procedures Act, at the conclusion of this
20 hearing and after the receipt of all written
21 materials, the Department shall determine
22 whether a regulation should be adopted,
23 amended or repealed and shall issue its
24 conclusion in an order which shall include:

1 1. A brief summary of the
2 evidence and the information submitted;
3 2. A brief summary of findings
4 of fact;
5 3. A decision to adopt, amend
6 or repeal a regulation or to take no action;
7 4. The exact text and citation
8 of such regulation adopted, amended or
9 repealed; and
10 5. The effective date of the
11 order.
12 I would now like to introduce
13 Joann Suder, Deputy Attorney General for the
14 Division of Public Health; Paul Hyland from
15 the Office of Medical Marijuana.
16 Now agency exhibits will be
17 entered into the proceeding record.
18 Exhibit No. 1 is a copy of the
19 initial OUD petition.
20 And Exhibit 2 is a copy of the
21 amended OUD petition.
22 (Exhibit 1 and 2 received in
23 evidence.)
24 Now I will review the ground

1 rules for today's proceedings.
2 I would like to emphasize that
3 the primary purpose of this hearing is to
4 seek public comment on the petition as
5 published, and I would ask that you limit
6 your comments to that topic. This is not a
7 debate, so do not expect rebuttal. Because
8 our interest is to know precisely what your
9 concerns and solutions are, you may be asked
10 questions to clarify your comments.
11 We will proceed as follows:
12 You will be called up for
13 comments in the order in which your name
14 appears on the sign-up sheet. As you are
15 called up to provide comments, please
16 clearly state your name and the agency you
17 represent before giving your remarks.
18 So first on our sheet is Richard
19 Jester. If you could please state your name
20 and also spell your name, when you come up,
21 that would be much appreciated.
22 MR. JESTER: My name is Richard
23 Jester. I am the submitter of this
24 petition. This is a prepared statement that

1 I have. I have given a copy of this
2 statement to the hearing officer to help
3 with ensuring my comments are inputted
4 directly as they're said.
5 The opioid overdose epidemic is
6 arguably the worst public health crisis in
7 U.S. history. At the time of this writing,
8 more people are dying than at the peak of
9 the AIDS epidemic or, for the first time,
10 drug overdoses outnumber automobile and
11 handgun deaths.
12 Looking at the data, it's pretty
13 obvious that prescription medications are
14 major fuel for the growing opioid epidemic
15 in our country. In the U.S., over 40
16 percent of overdose deaths are because of
17 prescription drugs. Over 75 percent of
18 heroine addicts start out on prescription
19 drugs.
20 Abstinence-based protocols are
21 mostly ineffective, as 85 percent of
22 individuals relapse within 12 months of the
23 initiation of treatment.
24 In-patient residential treatment

1 do not appear much better. In this
2 paradigm, as high as 80 percent relapse,
3 when measured two years after the treatment
4 initiation.
5 There are three major common
6 medications, Methadone, Suboxone and
7 Naltrexone, that are the most commonly used
8 medication. Unfortunately, all three of
9 those medications are ineffective for at
10 least 40 percent of opioid users.
11 There is currently no
12 established standard for which patients
13 should receive which form of medication-
14 assisted treatment. Only 3 percent of
15 physicians across the country even possess
16 the DEA agency credentials to prescribe
17 these medications, and these physicians also
18 tend to be concentrated in larger cities,
19 leaving 46.8 percent of counties across the
20 United States, especially rural areas with a
21 shortage in convenient access to these
22 treatment options.
23 Many of the barriers that
24 prevent people from accessing traditional

1 OUD treatment do not apply to cannabis
2 therapy, and access to cannabis medicine is
3 rapidly growing as states roll back
4 prohibition. In light of recent evidence,
5 and despite a lack of FDA approval, some
6 U.S. states and private treatment centers
7 have already begun to include cannabis as
8 part of OUD treatment protocols. The States
9 of New Jersey, New Mexico, New York and
10 Pennsylvania recently added Opioid Use
11 Disorder or Opioid Replacement to their List
12 of Qualifying Conditions. Private treatment
13 centers are also citing the benefits of harm
14 reduction, which greatly outweigh the risks
15 of cannabis use during the first 28 days of
16 recovery, a critical time period for patient
17 survival.
18 Many clinicians remain skeptical
19 of cannabis as a viable treatment option
20 either do due to the stigma surrounding it
21 or the belief incorrectly that there is not
22 enough clinical evidence. This is
23 unsurprising considering 85 percent of
24 recent medical graduates still receive no

1 education whatsoever on cannabis. More
2 studies are performed on cannabis than any
3 other drug approved by the FDA and most FDA
4 drugs are approved based on the results of a
5 single study.
6 Addiction isn't something you
7 can attack with more pills or tougher
8 enforcement. If we've learned anything from
9 the war on drugs, we learn that these wars
10 can't be fought against things. Wars are
11 fought against people. It's impossible to
12 win a war on an idea without educating the
13 participants.
14 The argument in favor of
15 recognizing cannabis as a substitute for
16 opioids in the treatment of chronic pain is
17 informed by science, common sense, and
18 simple compassion. If patients never start
19 using opioids, there is no risk their use
20 might progress to dependence or overdose.
21 The most recent version of this
22 petition compiles over 60 pieces of clinical
23 and nonclinical evidence, including peer-
24 reviewed journals, citing key scientific and

1 physiological results in animals and humans
2 that demonstrate how cannabis can ease
3 opioid withdrawal symptoms, reduce opioid
4 consumption, ameliorate cravings, prevent
5 relapse, improve OUD treatment retention,
6 and reduce overdose deaths.
7 Like all consumers of
8 healthcare, patients suffering from
9 addiction will be better served by expanding
10 the variety of treatment options available
11 to them instead of limiting patients to what
12 treatment options their insurance will
13 cover. This growing body of research
14 presented in this petition creates an
15 evidence-based rationale for governments,
16 healthcare providers, and academic
17 researchers to implement cannabis-based
18 intervention as part of a multidimensional
19 approach to addressing the opioid crisis.
20 Doing anything less would be a disservice to
21 all Delawareans.
22 Thank you for your time.
23 THE HEARING OFFICER: Thank you.
24 Next up we have, Cynthia

1 Ferguson.
2 MS. FERGUSON: Cynthia Ferguson.
3 I'm the executive director of Delaware
4 NORML. Today, I came to submit testimony
5 for Delaware Cannabis Advocacy Network.
6 This is in support of the petition to add
7 Opioid Use Disorder to the List of
8 Qualifying Conditions for the Delaware
9 Medical Marijuana Program.
10 Delaware Cannabis Advocacy
11 Network respectfully requests that Opiate
12 Use Disorder be added to the list of
13 Qualifying Conditions. Research shows that
14 cannabis is a safer and more effective
15 opiate-replacement tool than the currently
16 accepted treatments, and legal access to
17 active cannabis dispensaries are associated
18 with a significant decrease in opiate use,
19 abuse and overdose. The State of Delaware
20 already permits medication-assisted
21 treatment and opiate-replacement therapies
22 for opiate use disorder, including
23 Methadone, Suboxone, which are also opiates,
24 as well as opiate blockers.

1 And I could go on and on, but
2 this is written here, so I'm going to give
3 it to you. It's not my testimony. This
4 testimony includes all the citations for
5 what she said. And this is from Zoe
6 Patchell, the President of Delaware Cannabis
7 Advocacy Network.
8 THE HEARING OFFICER: Thank you
9 very much.
10 MS. FERGUSON: You're welcome.
11 THE HEARING OFFICER: Next on
12 the list is Bernadette Plaza.
13 MS. PLAZA: I'm not going to
14 speak. I was signing in for attendance
15 only.
16 THE HEARING OFFICER: Okay. No
17 problem.
18 MS. PLAZA: Sorry.
19 THE HEARING OFFICER: Jude
20 McDonald.
21 MS. McDONALD: I wanted to just
22 say that I support this bill. I work -- I
23 volunteer. Last week we had two fentanyl
24 deaths. What I have found with the homeless

1 and people with drug addictions, they're not
2 that interested in cannabis. They have
3 addiction that's stronger. But I truly
4 think that we must get people off Suboxone
5 and the other two drugs that they constantly
6 have to go to a doctor's office on a daily
7 basis to get that drug, which messes up
8 their work schedules. It's terrible. You
9 see people get off the bus on Kirkwood
10 Highway, and they're all going for the drug
11 they need, but it also interferes with their
12 work life. And I believe cannabis can help
13 this with their pain and help from the
14 Medical Marijuana Department. Thank you
15 very much.
16 THE HEARING OFFICER: Thank you.
17 Next I have Laura Layfield Sharer.
18 MS. LAYFIELD SHARER: I'm a
19 patient with Delaware's Medical Program.
20 I'm also a member of Delaware NORML and
21 Delaware Cannabis Advocacy Network and
22 frequently advocate for additional cannabis
23 access on behalf of medical patients that
24 can't be here. Tonight I wanted to share my

1 personal testimony, my story with opiate
2 withdrawal.
3 Three years and nine days ago, I
4 was taking my final doses. In a last-ditch
5 effort, I convinced my doctor to let me try
6 cannabis first instead of surgery for a
7 gastronomy feeding tube, but to really try
8 cannabis and to stop the other meds. And so
9 the plan was set. Stopping the meds would
10 prove to be another battle. As it turned
11 out, my doctors legally prescribed
12 pharmaceutical medications at levels that
13 created clinical addictions. Even though
14 these medications relieved none of the
15 symptoms they were prescribed for, I
16 literally couldn't stop taking them without
17 getting sicker.
18 The doctor noted that I was
19 improving on cannabis and decided to start
20 weaning me off some of the additional
21 medications. The Percocet went first, and
22 then I tried to stop Dilaudid. That's when
23 I realized that I was clinically addicted.
24 Luckily, at that point, I had my

1 cannabis card, and was able to try different
2 consumption methods. Topicals on my skin to
3 alleviate the pain right where it hurt were
4 very effective for me. Then tinctures and
5 edibles at nighttime to get me through the
6 night sweats and night tremors. Instead of
7 medicating myself to sleep with Valium, I
8 was medicating myself to sleep with
9 cannabis, and I was waking up with an
10 appetite and not a migraine.
11 My baseline from three years
12 ago, I weighed 97 pounds, required full
13 assistance in providing for myself and was
14 on a liquid diet. Malnutrition was causing
15 havoc with my organs, nerve pain in my feet
16 like glass, muscle tremors in my leg,
17 debilitating migraines, constant nausea
18 unrelenting pain, and dozens of time daily
19 vomiting. Three years, nine days later with
20 the help of medical cannabis, I now weigh
21 130 pounds, have established a growing menu
22 of tolerable and healthy foods. My numbers
23 and levels are controlled, healthy and
24 stable. I'm volunteering again, and most

1 importantly, I'm providing for my children,
2 which by far is the best job ever.
3 Cannabis was in fact my exit
4 strategy. At the time, I was granted my
5 card for intractable nausea. I did not
6 realize that I was clinically addicted to
7 the medicines that I was legally prescribed
8 and then went through a six-month battle
9 with opiate withdrawal.
10 So I come today to ask that you
11 please consider adding Opiate Abuse Disorder
12 as a Qualifying Condition because I
13 personally can attest that it works.
14 Thank you for your time. And I
15 just want to note that 36,432 opiate pills
16 were avoided by me personally thanks to
17 cannabis. Thank you.
18 THE HEARING OFFICER: Thank you.
19 Next is Sarah Remp.
20 MS. REMP: Sarah Remp. Thank
21 you for having me here.
22 I'm just really here to share my
23 experience. I drove with LogistiCare for a
24 year. It was really actually quite a trying

1 job. And part of the job was picking up and
2 delivering patients to the clinic at
3 Connections. I've seen a lot of things over
4 that year and a lot of heartbreaking things.
5 I've experienced a lot of heartbreaking
6 stories.
7 Just to start with what I have
8 observed at Connections is that while we all
9 know that Suboxone and Methadone are much
10 worse and harder to get off of. Kind of
11 increases overdoses because once a patient
12 is accepted into the program, a lot of the
13 patients, the doctors, they start to up
14 their doses instead of trying to decrease
15 them. So they're actually keeping them
16 there. So they're actually becoming more
17 dependent.
18 There's been a lot of people
19 I've talked to where they've had problems
20 even getting their doctors to start
21 decreasing it and they have to do it
22 themselves.
23 I see a lot of people that are
24 selling their take-homes. They will sell

1 them, trade them in their cars.
2 They're starting to put up a lot
3 of daycares in the areas of where these
4 clinics are. They're putting daycares in
5 the clinics. This is where people are
6 taking their kids from 7:00 o'clock in the
7 morning till 1:00 o'clock at night. These
8 are becoming high school social groups.
9 People are looking forward to going and
10 seeing their friends because they'll spend
11 all day with their friends after they get
12 their dosages, they'll do their clinic
13 trainings and they'll go through their
14 therapy and they hang out all day. And then
15 they'll go home and they meet up with each
16 other afterwards.
17 They're not really getting
18 anything good out of meeting other addicts,
19 for the most part, because even talking to
20 them, a lot of them that they start to mix
21 together, you know, and they know that even
22 if it took one bite that they would fall
23 back into the addiction.
24 I've seen people from the age of

1 16 to 87 in my car. They have not only
2 just -- most of them have actually become
3 dependent from their doctors and ended up on
4 the street once they were cut off.
5 The average clinic patient that
6 I picked up was between 20 and 45.
7 I had a woman in my car that was
8 widowed by her own overdose. Her four kids
9 have both all have picked up a needle now.
10 Three of those children have OD'd and have
11 been revived.
12 There was a 23-year-old patient
13 in my car that was crying because he
14 couldn't get his life straight because of
15 the way the clinic program was set up. He
16 also had probation, so that took up more
17 time. He could not establish a job.
18 I think these people should be
19 at least given a fair chance, a safe
20 alternative, somewhere that might even be a
21 better option for their family. We've all
22 been touched by this. We have all known
23 people that have either died or they have
24 been through the aggressive period of

1 withdrawal. If they can make it through it,
2 it's more power to them, but it's really,
3 really hard, and most of them can't do it on
4 their own.
5 After speaking to a lot of these
6 people about a cannabis alternative, a lot
7 of them are really in favor of it because
8 they can't take it anymore. They really
9 need an option. Thank you.
10 THE HEARING OFFICER: Thank you.
11 Next is Erica Pukatsch.
12 MS. PUKATSCH: Erica Pukatsch.
13 So it is with much enthusiasm that I express
14 my support for the petition to add Opioid
15 Use Disorder to the list of Qualifying
16 Conditions for access to the Medical
17 Marijuana Program in Delaware. I believe
18 that even if one life is saved by this
19 regulatory change, it would be considered
20 successful.
21 I am aware there is a reluctancy
22 from a lack of federally funded clinical
23 trials to substantiate claims regarding the
24 efficacy of cannabis in patients with

1 substance abuse tendencies. However, I
2 would like to encourage the adaptation of
3 the harm reduction concept.
4 It is my opinion that given
5 reasonable due diligence and an honest
6 attempt to review the studies conducted
7 abroad, correlations of data and empirical
8 data submitted with the original petition,
9 as well as patient testimony today here and
10 all over the Internet widely available
11 pretty much anywhere within chronic pain
12 patients, the evidence will overwhelmingly
13 prove cannabis to be a viable modality to
14 add as a tool to combat the opioid epidemic.
15 Furthermore, the evidence will justify a
16 decision both clinically and ethically sound
17 as no one in the history ever lost their
18 life from the consumption of cannabis.
19 As an advocate for medical
20 cannabis patients and having the
21 opportunities to educate patients one-on-one
22 on a daily basis, I have the unique
23 opportunity to hear individual stories of
24 how vital cannabis was to a patient's

1 quality of life. Although the patients I
2 see now need to utilize backdoor methods to
3 obtain legal access, meaning they are
4 certified by a physician for other
5 conditions, like chronic pain or migraine,
6 which they do suffer from, yet they treat
7 things like anxiety or addiction to their
8 opioid pain medication. And they admit this
9 to the doctor, but they desperately want to
10 discontinue the use of multiple
11 prescriptions.
12 My hope is that adding cannabis
13 as an option for those on medically assisted
14 treatments, those who do not qualify under
15 chronic pain but still are dependent on
16 opiates, can have the same rate of success
17 as chronic pain patients. Although they are
18 treating different mental conditions, they
19 are very much treating the same physical
20 condition.
21 The ever growing body of
22 evidence within the United States
23 surrounding the use of cannabis for
24 conditions ranging in severity is being

1 produced more rapidly than we can
2 comprehend. Locally the patients I
3 encounter in Delaware and Pennsylvania have
4 the distinct similarities, most notable is
5 the desire to reduce their dependence on
6 opiate-based medications.
7 I also know that Pennsylvania
8 and New Jersey have also added these
9 conditions to their list. I've had the
10 opportunity to work with MAT treatment
11 patients or MAT patients in Pennsylvania.
12 And I currently have one that has within six
13 months gotten completely off of their
14 Methadone prescription using cannabis. So.
15 That's pretty much it. Thank
16 you.
17 THE HEARING OFFICER: Thank you.
18 And last is Jessica Andreavich.
19 MS. ANDREAVICH: My name is
20 Jessica Andreavich. And I have been
21 severely impacted in my life over opiates,
22 whether they were prescribed to me or
23 whether they were to people I loved. Many
24 people I loved died over their addictions to

1 opiates.
2 I became an advocate, a very
3 loud one, that caused much trouble. Back in
4 2010, I worked for Christiana Hospital, and
5 I saw firsthand the amount of people with
6 opiate problems and what they were going
7 through. I started advocating in the
8 hospital knowingly with the -- with everyone
9 knowing once the 2011 law went into effect.
10 And there were many people that I met that
11 reached out to me and that were helped
12 through marijuana. Many people got their
13 licenses for pain, which was great because
14 most people who have opiate addictions are
15 coming from a place of pain. So I met a lot
16 of those in the hospital and they were able
17 to get through the program just because of
18 pain.
19 But we have this crisis going
20 on, and we have many people dying, and for
21 whatever reason, they're not able to utilize
22 this program. And I don't understand that
23 considering this is the one option that does
24 not come with a consequence of death. And I

1 believe that everyone who has studied
2 marijuana can say that, that although there
3 are side effects to marijuana, they do not
4 include any kind of death. And that is not
5 what we have with what is given to people
6 today, using Methadone or Suboxone, for
7 their opiate addiction. And this is
8 absolutely uncalled for and inhumane to
9 people who are struggling with real problems
10 that are going to cause them death.
11 So I just want to have it on the
12 record that this is something that is needed
13 and that this is the humane approach to
14 addiction, to offer something that won't
15 kill you and may help you. And maybe it
16 won't, but there are other options. But
17 this should be the first line approach to
18 treating addiction, something that's not
19 going to kill you. That's what I want to
20 vote for. That's what I will continue to
21 push for. When people come and they talk to
22 me and they want to know what will help
23 them, I'm going to say cannabis, this is
24 what will help you, and it won't kill you.

1 And I want everyone to feel that way because
2 it's a very major tragedy that we don't have
3 this option here.
4 That's all I need to say. Thank
5 you.
6 THE HEARING OFFICER: Thank you.
7 Are there any further comments
8 or questions before we close the hearing?
9 Again, a reminder about the
10 public comment period. Written comments
11 will be accepted until 4:30 p.m. on
12 February 28, 2019. Contact information for
13 me, Alanna Mozeik, is available for me on
14 the sign-in table.
15 Finally, let the record reflect
16 this public hearing adjourned at 6:59 p.m.
17 on February 12th, 2019. Thank you.
18 -- -- -- --
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24

1 I N D E X

2 SPEAKERS PAGE

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7 E X H I B I T S

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1 State of Delaware)
)
2 New Castle County)

3

CERTIFICATE OF REPORTER

4

I, Lucinda M. Reeder, Registered
5 Diplomate Reporter, Certified Real-time
Reporter and Notary Public, do hereby
6 certify that the foregoing record is a true
and accurate transcript of my stenographic
7 notes taken on February 12, 2019 in the
above-captioned matter.

8

IN WITNESS WHEREOF, I have hereunto
9 set my hand and seal this 25th day of
February 2019 at Wilmington, Delaware.

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Lucinda M. Reeder, RDR, CRR

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