Drug and Alcohol Planning Council
Meeting Minutes
Microsoft Teams
September 10, 2025

Present: Charles Davis (Chair), Josie Morgano, Fred Quinn, Gabby Warner, Dan Garrigan, Tonisha Wilson, Mario Browne, Leanne Hurney, CCBH; Kathryn Gadd, Administrator, Bureau of Drug and Alcohol Services, OBH; Colleen Sokira, OBH Special Projects Manager; Sarah Bigelow, OBH Special Projects Assistant; Robert Burack, Consultant, DHS

I. Welcome, Attendance, and Minutes Approval

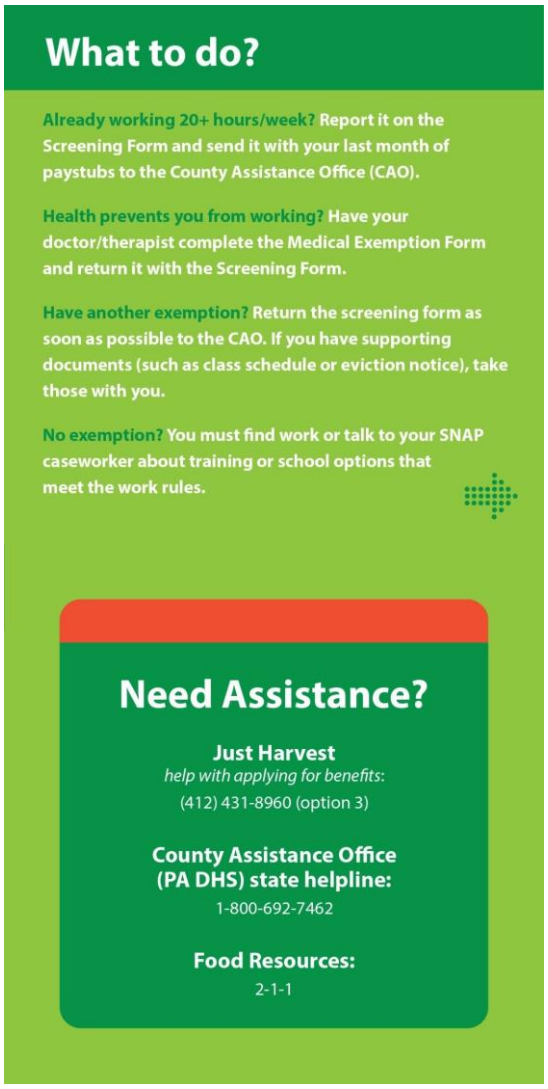
a. Charles Davis called the meeting to order at 4:37.
b. Minutes from July approved

II. Short- and Long-Term Funding and Contracting Challenges and Changes

a. Kathryn Gadd, Administrator, Bureau of Drug and Alcohol Services, OBH
b. Not a lot of new information to bring to you all
c. Short-term
    i. Still have not received scheduled funding or grant agreement from DDAP (state)
        1. Have had to roll over provider contracts for 6 months in the interim
        2. Still have not received word on an updated timeframe – but have received word that it will be in time for the next 6 months of the fiscal year (Jan – June 2026)
        3. Have been told that funding will **not be** decreased
    ii. This issue was happening **before** the current issues with the stalled state budget as well
        1. Hopefully by the end of the month, when state house members return to Harrisburg
        2. Gov. Shapiro sent an updated budget out at the end of August
        3. Human services funding likely to remain flat
d. Long-term
    i. Federal cuts to Medicaid, SNAP, and other services
        1. How to continue to serve vulnerable folks amidst these coming cuts – how to keep the D&A system intact?
            a. Pretty big changes are likely
    ii. D&A providers often receive fewer funds than other human services and serve the most stigmatized populations – it will be difficult, but also means providers have demonstrated resilience for what is to come

e. Questions
    i. JM – Why was DDAP unable to get funding together for providers?
        1. One big reason was dealing with a new (state) administration – grant agreements cover 5 years, though this one will now cover 4.5 years. The changes they wanted to make took a lot of time due to the slow pace of bureaucracy, especially regarding legal and contracting
        2. JM – thank you for explaining, glad to hear it's likely not to be any cuts, because it's always so hard to have to turn away folks
        3. Definitely, DHS is really working cross-office to prepare for these changes
f. SNAP Changes and Resources
    i. Flyer for providers
    ii. Images to share on social media
        1. 

        2.

3. 

4.

iii. We will also send these resources to you all following the meeting, so you can share these with your participants and your networks
iv. When we think about social determinants of health and the stress that it causes folks in the recovery community when you don't have access to basic needs, it's very important to share this information and help connect
v. TW – folks in our residential community have already been receiving information about these cuts, and they don't work 20 hours a week due to the nature of their treatment
    1. It's a big administrative burden to fill out the reaffirmation
vi. The sooner these forms are done the better – the 20 hours/week work requirement went into effect on September 1, so folks will lose their SNAP
vii. GW – at Prevention Point there's a lot of opportunities for volunteerism, which is one way folks can maintain their 20 hours/week
    1. That's one way your org can think about how your folks can keep their benefits as well

g. State Opioid Response funds

i. Have an open solicitation on the county website for programs that prevent or treat opioid addiction
ii. The State has a website where you can see how each SCA has spent its money
    1. Note: not updated in real time – data lag
iii. Allegheny County website

III. Determining Potential Goals

a. DHS is encouraging its advisory councils and boards to establish, on an annual basis, a small number of goals (2-3) to help focus its efforts. We'll review the potential goals surfaced in the July meeting and work collaboratively to determine 2-3 to focus on in the next year.
    i. Hope is to shift from a question and response format to offering recommendations to DHS
    ii. Hope to land on three or so goals to focus on for the next year
b. Possibilities discussed at the July meeting
    i. Information
        1. Goal 1 - Close knowledge gaps about available recovery services
        2. Goal 2 - Recommendations for a pragmatic, honest communication strategy about substance use that balances care for people actively using with prevention efforts, including messaging for parents and teens about substance use risk and support
    ii. Medicaid and Medicare
        1. Goal 3 - Ensuring that all individuals who are eligible for Medicaid are enrolled and stay enrolled, and potentially advocating with the state to ensure there is appropriate funding
        2. Goal 4 - Recommendations to address misalignment of services when clients transition between MA and Medicare
    iii. Youth
        1. Goal 5 - Recommendations to expand support services for families of teens experiencing SUD, including increased service access for youth at the age margins of eligibility
    iv. Treatment and Provider Quality
        1. Goal 6 – Recommendations to standardize approaches to withdrawal management across providers
        2. Goal 7 - Recommendations on how to increase provider understanding of substances like xylazine and medetomidine
        3. Goal 8 - Recommendations focused on implementing sedation observation protocols.
    v. Expanding the Recovery continuum
        1. Goal 9 - Recommendations to improve relapse prevention resources and aftercare/discharge planning, especially for higher levels of care
        2. Goal 10 – Recommendations focused on (free or low-cost) aftercare services
        3. Goal 11– Recommendations focused on strengthening supports for older adults in recovery
c. Discussion

i. GW – I don't know what every person in this group does day-to-day, which may make choosing shared goals difficult
    1. However, I do think Medicaid advocacy is important for all of us (Goal 3 – MH/ID board also working on this)
ii. CD – as someone who helps people get off the street into treatment, I have a love for older addicts. Many places don't want to have anything to do with you when you get older. Often, older folks also have physical disabilities that providers won't accommodate (Goal 10)
    1. GW – I agree. Some of the challenge with that is their enrollment with Medicare and the very limited providers that work with Medicare. The interactions between Medicaid/Medicare gets very complicated very quickly.
    2. DG – I agree, there's certainly a gap in access to care. There are so many hoops that I don't even understand to become a Medicare certified provider
        a. The gaps GW pointed out might be worth honing in on
iii. CD – I've also had people looking for low-cost aftercare services, and everywhere I called was only taking insurance (Goal 11)
    1. Transport to services people can access is also an issue if they're far away (e.g. Erie, Butler)
    2. DG – I agree that aftercare is extremely important, and it's hard to find even insured services, especially if folks have Medicaid
    3. MB – So you're saying that aftercare services don't happen?
        a. DG – they do, but providers don't provide it indefinitely. So if people want to check in every other month, for example, and they've been in recovery for a while, there's a lot of moving parts, especially in Medicaid, for a provider to be able to be reimbursed for that
        b. GW – I agree with what DG said. On top of that, aftercare is already incredibly brief, if a person does receive it. For opioid use, you're looking at like a year plus before that dopamine comes back to you in a natural way, so they need care for longer than they receive it
        c. JM – What kind of after care are we thinking would be useful? That seems really broad to me
            i. GW – That's the thing about D&A services, it's not one size fits all. While AA and NA provide some people with a community, MH support is huge in terms of aftercare. What does it mean to have a peer or CRS follow up with someone for a year after they've left treatment, given how many people they have working for them versus the caseloads?
        d. TW – coming from a level 3.5, finding stable housing for when folks graduate is the biggest barrier we find to aftercare
iv. GW – something that speaks to me that could affect what aftercare looks like is standard withdrawal management (Goals 6&7)

1. It feels like it's possible – these providers and hospitals already exist, but are treating withdrawal and wounds very differently
    a. Patients should receive the gold standard of care wherever they go

v. In chat responses to: "It might be helpful for folks to share a little in the chat re: what their work focuses on, to see if there are areas where there's overlap among several folks in the group?"
    1. GW – "Prevention Point has lowest-barrier medical program that provides care, suboxone scripts for those who need it. As well as mental health support and service navigation. We also have our Syringe service program that gives out Harm Reduction supplies, Overdose Response Supplies, Drug Checking Services and provides training and education on how to use them"

vi. Five goals have been mentioned, which is close to our ideal number of working goals
    1. Use the chat to nominate three goals that you'd prefer to focus on for the year
        a. Goals 6/7 – withdrawal management + provider understanding of substances
        b. Goal 10 – Free or low-cost aftercare
            i. CD – Having trouble thinking of any drop-in centers or places where you get aftercare nowadays. Aftercare is focused on the person more than the group, in my mind
                1. JM – there's Onala and a couple others, but they might not be what you'd typically think of as "drop-in centers"
            ii. GW - Part of it would be defining what we mean by aftercare
            iii. MB – When I was doing treatment a long time ago, it meant that you came back to the treatment center for t
                1. I'm realizing that I didn't notice when it stopped, and don't know why it stopped. Has it been replaced with support services? However, those are two different things
        c. Goal 3 - Ensuring that all individuals who are eligible for Medicaid are enrolled and stay enrolled, and potentially advocating with the state to ensure there is appropriate funding
        d. Goal 11– Recommendations focused on strengthening supports for older adults in recovery
    2. Recommend subcommittees/workgroups that can focus on each of these goals and then report out during bimonthly full council meetings
        a. RB – it may also be possible to bring some of MH/ID board's recommendations regarding Medicaid goal to you

to respond to so you can focus more on the other three goals
        i. JM – could we join up with them?
    b. CD – willing to do research into aftercare and bring to the next meeting
        i. Only familiar on my side of town (the Hill) – not the rest of the city or county
    c. GW – motion to make a subcommittee to focus on the goals identified above
        i. Motion passes
        ii. Please drop your name in the chat or email Colleen if you are interested in participating
        iii. Sarah will work with that group to set up an initial meeting

IV. New Board Business, Announcements, and Public Comments

a. Board leadership positions – it's time for annual elections
    i. Roles to be nominated
        1. Chair
        2. Vice Chair
        3. Member at large
b. Voting will take place November 12th between 9 am and 5 pm via Govenda. Members must be present at the meeting for their vote to be counted
c. Nominations
    i. Chair
        1. Tonisha Wilson
        2. Gabby Warner
    ii. Vice Chair
        1. Jessica Northcott-Brillati
        2. Daniel Garrighan
    iii. Member at large
        1. Fred Quinn
    iv. Sarah will send out an email by the end of the week with these nominations
        1. Nominations will stay open for one week to allow anyone not present to nominate
d. Bylaws workgroup
    i. DG took a first pass at cleaning up basic issues (pronouns, etc.) a few months ago – will redistribute
    ii. Workgroup is meeting October 13 at 4 pm
e. Hope to see many of you on Saturday for the Recovery Walk!
f. TW – Alpha House is expanding its night monitor programming so it can expand its census
    i. Also hiring CRSs and a Clinical Director
    ii. Seeing a surge in admissions
    iii. Please send folks Tonisha's way if you have any recommendations
    iv. GW – do you have part time opportunities?
        1. Yes – for both CRS and night monitor roles

v. FQ – do you have a link to a job posting that you can share?
    1. Yes, can also share job descriptions with you all via email

V. Next Steps and Close

a. Key takeaways
    i. Goals for the coming year
    ii. New subcommittee formation
    iii. Leadership nominations – ready for voting at our November meeting
b. The meeting was adjourned at 5:54

VI. Next Public Meeting

a. The next public Drug and Alcohol Planning Council meeting will be on **Wednesday, November 12** from 4:30 – 6:00 p.m. on Microsoft Teams.
b. Colleen Sokira will send out the Teams invite for this meeting the week before. There is also a link posted on the DHS advisory board webpage.