One Care of Southwest Virginia’s Blueprint for Substance Abuse and Misuse Prevention, Treatment and Control

made possible by a grant from The Verizon Foundation

One Care of SWVA, Inc.
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“The Southwest Virginia Health Authority is pleased to have provided encouragement and input to One Care in support of the development of this Blueprint and is pleased now to add its endorsement to its contents and vision.”
One Care of Southwest Virginia, Inc.

Blueprint for Substance Abuse and Misuse Prevention, Treatment and Control
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Letter of Introduction

June 2011

Dear Reader,

There is much to celebrate in Southwestern Virginia. We are a proud, astute and tenacious people with a rich culture that extends back many generations. But the health of our culture and the extraordinary resilience of our families are being threatened by the confluence of poverty, poor health choices regarding diet, exercise and tobacco abuse, limited access to health care and, over the past decade, a persistent increase in substance abuse and misuse, particularly prescription drugs.

It is hard to overstate the problem of substance abuse in Central Appalachia, including the counties of Southwestern Virginia. The facts that you will see in this Blueprint are stark: there is a mounting death rate from the unintentional, fatal overdose of prescription drugs; an escalating number of children in foster care due to substance abuse; and, an increasing level of drug-related crime. Finding solutions to this deepening crisis has been extremely difficult because of the magnitude of the problem across all of Central Appalachia, limited resources, growing but still very limited treatment options and the lack of a coordinated approach.

But there is hope. Thoughtful and dedicated people, agencies and coalitions in our region have been working diligently on improving this situation for a number of years. And over the past year, leaders from health, government, education, law enforcement, and the business and faith communities in our region have come together with the treatment and recovery communities to give birth to a coordinated approach for our area, moving us toward a posture of prevention, a recovery-oriented system of care and other systems-based solutions.

While the region has long welcomed partnership from external sources, we know we cannot merely sit and wait for help as substance abuse ravages our communities. With the leadership of our regional consortium, One Care, and the encouragement of our Southwest Virginia Health Authority, this Blueprint was created to provide a summary of the scope and characteristics of the region’s substance abuse issues. Vision and mission statements were written to unite us in addressing these problems and a set of specific goals and objectives were designed to provide a roadmap for our regional comprehensive response, the opportunity to discover new solutions, and a call to action our internal and external partners can rally around. We welcome your assistance in adopting or implementing any of these needed actions or identifying others and recognize and applaud the many areas where some of this work is already ongoing; in many places and by many hands.

This Blueprint gives testimony to our belief that a committed community is the best solution to significant problems. We believe that all available resources, both within and outside our region must now be garnered for lasting personal, community and policy change involving education, prevention, treatment and control. Because we have some of the most severe challenges in the
nation, we must now strive to become one of the best and healthiest places to live, learn, work and play.

We invite you to engage with this Blueprint, be part of the solutions it offers, and add your voice to transforming our health and securing our future prosperity.

Sincerely,

Senator John S. Edwards

Senator Phillip P. Puckett

Delegate Joseph P. Johnson, Jr

Delegate Ward L. Armstrong

Delegate James M. Shuler

Delegate Charles “Bill” W. Carrico, Sr.

Delegate Charles D. Poindexter

Delegate Clarence E. “Bud” Phillips

Delegate Terry G. Kilgore

Delegate David A. Nutter

Delegate Anne B. Crockett-Stark

Delegate James W. Morefield

The following elected representatives express their support of One Care’s mission:

James H. “Jim” Webb, Jr., U.S. Senator

Mark R. Warner, U.S. Senator

Howard Morgan Griffith, U.S. Congressman
A snowy evening in Southwest Virginia
Introduction: Challenges, Needs and Solutions

If you wish to know the road up the mountain, you must ask the person who goes back and forth on it.
Ancient Proverb

The mission of One Care of Southwest Virginia is to decrease substance abuse and misuse, and related social, economic and health factors through planning, policy, data, and advocacy. In efforts to fulfill its mission, One Care has focused on developing a Blueprint for Substance Abuse and Misuse: Prevention, Treatment and Control. These three components are seen as a logical response to the three prime elements of the ‘drug market’, namely (1) potential users, (2) users, and (3) sellers.

Attention is focused on preventing potential users from entering into substance abuse, treating and assisting drug users in their recovery from drug abuse and addiction, and controlling drug availability and the behavior of those selling drugs. The vision for this Blueprint was developed in response to the Southwest Virginia Health Authority’s goal of addressing substance abuse and addiction in our region and gives direction to achieving that goal. The process of developing this strategic plan involved the review of current research on substance abuse and addiction, including effective evidence-based practices; evaluating and assessing community needs; and holding four community forums in each of our planning districts to incorporate the views of the residents of Southwest Virginia and concerned citizens from beyond our borders. The resulting goals and objectives represent a “roadmap” for moving forward as a region to better address the epidemic of substance abuse and addiction in Southwest Virginia.

The problem of substance abuse and addiction has severely impacted the communities of Southwest Virginia. Increases in accidental overdoses, substance-exposed infants, emergency room visits, drug-related crime, and children entering foster care are all directly related to the increase in rates of substance abuse and addiction. The monetary cost of these problems is enormous, with the State of Virginia conservatively estimating $613 million dollars being spent on the effects of substance abuse in 2006. This figure did not account for many related costs and the actual figure is likely much closer to $1 billion dollars annually, with taxpayers bearing the burden. Beyond the financial expense is the personal and familial cost: broken families, child abuse and neglect, poor health, joblessness, homelessness, isolation, and desperation. The problem of substance abuse and addiction is growing and both our current and previous efforts to prevent, treat, and control it have not yet turned this tragic tide. It is clear that we need to improve our response.

The following goals and objectives provide strategic steps for implementing such a change. They are clear and measurable, and draw upon the ideas expressed from many different perspectives in community forums throughout our region. Implementing these goals and objectives effectively requires an approach that is grounded by documented success. Such an approach is communicated throughout the goals and objectives, but where treatment is concerned it is explicitly identified in the goals to create a Recovery-Oriented System of Care. All of the goals can be best achieved through a collaborative system that works deliberately towards integration and can respond quickly and appropriately to the needs of the individual, the family and the community.

Whether talking about educating the community, developing environmental strategies for prevention, expanding access to treatment, supporting the recovery community, or establishing drug courts, the work is better achieved through an efficient, coordinated response that involves multiple disciplines, agencies, and
individuals. A Recovery-Oriented System of Care moves us forward in combining the strengths of various groups and filling the gaps that currently exist with our separate, and too often poorly aligned or too fragmented, approaches. Research shows that such an integrated, coordinated community response focused on recovery is more effective in preventing, treating, and managing the chronic consequences of substance abuse and addiction than a response that is fragmented or focused primarily on penalties.

A Recovery-Oriented System of Care creates a systematic response, one that is fast, fluid and flexible, meeting needs as they arise and changing throughout the continuum of care. Such a system of care incorporates efforts from all in the community, making the process of recovery more seamless and holistic. A Recovery-Oriented System of Care is created by the community, for the community. It functions and is maintained by agencies, coalitions, groups, and individuals partnering for recovery. As the goals and objectives contained in this document underscore, building and operating a recovery-oriented system of care is our best response to the successful treatment of substance abuse and addiction and addressing the “buyer” side of this tragic market.

As the document also clearly identifies, the market that would sell harmful drugs to potential buyers for profit can also be frustrated by prevention and education efforts. The Blueprint calls for a comprehensive and multilayer sustained campaign aimed at creating wiser more sophisticated individuals less prone to ignorance of the dangers or to the literally poisonous messages and temptations of substance misuse and abuse.

Finally, the seller side—the suppliers of this market must be better controlled. The supplier can take many forms including a ‘friend’ at a party, a family member who leaves pain medicine bottles accessible to children or others, a duped licensed prescriber or a deliberate dealer. There are control opportunities at many points on this supply chain and this Blueprint describes many measurable ways to frustrate and curtail the supply side of this market equation.

As we know from our life experience, seldom is there a single, ‘magic bullet’ solution for problems that have many unintended and serious consequences. Witness the seeming solution of putting pseudoephedrine behind the counter to curtail methamphetamine production. It worked for a time, but the without a solid Recovery-Oriented System of Care for the existing addicts, the demand remained, profit could be made and the market developed other, more pervasive and sometimes more dangerous routes of supply.

Even if we could wave a magic wand and stop every prescription that would ultimately be misused or abused from being written or dispensed, the ‘market’ would respond and we would find that other suppliers would move in to fill the void. As has been the case in other places, we might find such new suppliers to be of the more dangerous, violent and ruthless variety. History and headlines instruct us: this is not easy. The substance abuse market is like the hydra of Greek mythology, cut off one head and two more grow back. Simple fixes or solutions that address only one part of the market, however well intended or logical in their conception, have not been successful long term and are fraught with unintended consequences. The approach for a long-term solution for this epidemic must be multilayered, multifaceted and address all the players in the market including existing users, those at risk for use and those who supply. That is what this Blueprint seeks to do and with the support of our Community, can accomplish.
Efforts to Address Substance Abuse in Southwest Virginia
The Planning Process

In the spring of 2010, One Care of Southwest Virginia, Inc. embarked on a process that would serve as a guide to reducing substance abuse and misuse in Southwest Virginia. Modeled on the work of the Southwest Virginia Health Authority, One Care determined that a comprehensive strategic blueprint was the most effective tool to serve as that guide. One Care worked closely with over 16 substance abuse prevention and treatment coalitions in Southwest Virginia to determine that a series of meetings needed to take place in each of the four planning districts in Southwest Virginia. In order to build the foundation for the Blueprint, a priority was set to be inclusive of treatment providers, employers, human services agencies, local government, legislators, law enforcement, the recovery and faith communities and other concerned citizens. A comprehensive database containing more than 2800 names was developed and One Care extended invitations to a broad range of participants who would offer their perspective on the issues.

Each of the meetings was lead by a professional facilitator who employed a process conducive to frank discussion and maximized the amount of information and perspectives gathered in order to accurately represent the situation in Southwest Virginia. The end product of those meetings was a comprehensive list of strengths, weaknesses, opportunities, threats and potential points of advocacy. Also included in the initial documents were prevention and treatment strategies needed to meet the mission of reducing substance abuse and misuse in Southwest Virginia. After the meetings, a Blueprint writing team was formed to transform the more than 200 action items received into measurable goals and objectives. While the tasks included identifying and eliminating redundancies in the initial documents, a high priority was placed on preserving the integrity and spirit of the ideas and recommendations provided in each of the four planning districts.

The Blueprint writing team grouped the statements by category. Like-minded statements and ideas were combined and, where needed, reworded for measurability. Once this task was completed, the statements were again categorized as goals with corresponding objectives. Additionally, the writing team developed a timeframe that was felt to be realistic to accomplish each objective. The timeframes were identified as Near-term (N) at 0-2 years, Intermediate-term (I) at 3-5 years and Long-term (L) at 6-10 years. Each member of the writing team contributed many hours of professional time in preparing this document, given the extensive amount of information that was received from the regional meetings and the process of organizing and analyzing the data in a manner suitable for publication.
**Vision**
One Care’s vision is to be a model for achieving significant reduction in substance abuse and related social, economic and health factors by building and supporting community partnerships.

**Mission**
One Care of Southwest Virginia is committed to decreasing substance abuse and misuse, and related social, economic and health factors through planning, policy, data, and advocacy.

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**Vision/Mission**

**Inputs**

**Outputs/Outcomes**

**Implementation/Impact**
Cattails by a lake in Southwest Virginia
The Context: Regional Health Data focused on Substance Abuse & Mental Health in Southwest Virginia

Description of the region and data sources

This report contains information on the Virginia Department of Health Southwest (SWVA) Planning Districts (Lenowisco (PD 1), Cumberland Plateau (PD 2), Mount Rogers (PD 3) and New River (PD 4) and the State of Virginia using data that were available by April 2011 from multiple public databases. Some more recent data sources may be available from the State Police using arrest records or from the local Community Service Boards (CSBs) based on information gained via face-to-face evaluation made during emergency mental health crisis evaluations, which typically include a substance abuse assessment. However, those data are not currently available. Available data were analyzed and the results are reported below. Population data is based on the 2010 Census online database.

Population

Based on the most recent data from the U. S. Census, 7.25% (n=579,982) of Virginia’s population of over 8 million people (n=8,001,024) live in the four PDs. According to the most recent census estimates, there is a contrast in population movement trends in the Commonwealth of Virginia as a whole compared to SWVA. Statewide, Virginia by 2010 had an overall increase in residents of about 13%, which compares to the 14% increase in VA reported in 2000. There are 134 counties and cities in the state and 21 are located in SWVA. According to the estimated data, there are 36 counties/cities that were anticipated to have a decline in their population. Of these, 10 were located in SWVA, which indicates that half (47.6%) of the cities/counties in SWVA were estimated to have a decline in their population from 2000 to 2009. The actual results using 2010 census data show that 8 counties in SWVA lost population, 8 counties gained from 0-5% of their population, 4 counties gained from 6-10% of their population and only one county gained 13% of its population, which was the same as the state rate. In summary, considering all 4 PD, the total population increases 3% (n=15,518). The attached PDF file shows the numbers and percentage of population gain/loss by county. Montgomery County showed the largest gain and Grayson & Buchanan showed the greatest loss. PDs

Race & Place of Birth

According the 2010 census, 94% of the residents in SWVA are White and 3.0% are African/American with 3% in other groups compared to 68.6% who are White in VA, 19.4% are AA with 12.0% other groups. The population of Hispanics in SWVA is very small. In SWVA, 69% of the population was born in the state and 29% migrated from other states within US, typically southern states. In Virginia 52% of the population was born in the same state and 38.5% are US migrants [no data available yet]. Other races are lower in frequencies. 5.5% were Asian in Virginia compared to 1.2% in SWVA. Some people in Virginia reported having two or more races, 3.1% in the

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1 http://factfinder.census.gov/home/saff/main.html?_lang=en

State and 1.2% in SWVA. Less than 1% reported “other”; being lower in the proportion in SWVA than in the State.

Figure 1. Weldon Cooper Center Map using non-public data, SWVA is located near/in the oval.

**Education, Poverty & Income**

According to the 2000 Census, the educational attainment for people 25 years and older in Virginia was higher than in SWVA. In SWVA, 29.9% of the population attended school but did not complete high school compared to 17.5% of the population of VA. About half of the population in both the region and the state as a whole completed high school or completed high school plus some college up to an associate degree (52% in SWVA and 54% in VA). However, those in SWVA are significantly less likely to have received a 4-year college degree or higher. In SWVA, 14.4% of the population had a bachelor’s degree or higher college or graduate degree compared to 29.5% of the population of VA who had a bachelor’s degree or higher. From the MATCH County health ranking, 70% of the population within the 4 PDs has reported high school graduation in SWVA compared to 76% in VA and 50% has some college in SWVA compared to 65% in VA. The numbers of people living in poverty is significantly higher in SWVA than in VA. From Census 2000, the per capital income level of this region is 67.1% of the State. On average, the per capital income in SWVA was $16,079 while it was $23,975 for the VA. The 2006-2008 estimated median family income was 1.6 higher in the state than the SWVA ($72,733 in the state vs. $45,340 in SWVA. From the MATCH county health ranking, 24% of the children are in poverty in SWVA compared to 14% on the state.

**Employment and Health Insurance**

The most current data from the Bureau of Labor Statistics, from Jan 2010 to Feb 2011, showed VA had a rate of 6.4% unemployed people while in SWVA, it ranged from 6.9 to 13.4% across counties with 26,350 people without jobs, on average 10.6% of the people in labor force were unemployed. These rates exclude those who are disabled and no longer looking for work. The Small Area Health Insurance Estimates from the Census Bureau provide annual estimates of the adults without health insurance coverage. An estimated 15% of the VA population from 18-64 years old in Virginia is without insurance coverage. The estimated rates in SWVA range from 12 to 26%. These estimations have variability according to the Virginia Department of Health (VDH). VDH
has estimated that 12.6% of the Virginia residents did not have insurance; and 20.5%, 23.5%, 20.3% and 15% of the population between 18 and 64 in planning district 1 to 4, respectively did not have insurance in 2010.

Mortality Rate for All Causes

The crude mortality rate for all causes in VA is 752 deaths per 100,000 people using an average for 2004-2009. The average mortality rate in SWVA is 1,161 deaths per 100,000 (average from 2004-2009).

Overall Mental Health

According to VDH, 9.3% of the adults in Virginia reported frequent poor mental health days, which may be related to untreated psychiatric disorders and/or substance abuse or poor socio-economic conditions. SWVA has two PDs with significantly higher frequency of reports of poor mental health. On average, 16% of the SWVA population reported having poor mental health days. Also, the estimated number of days residents have poor mental health days is higher in SWVA than in the state. From the Centers for Disease Control (CDC) Behavioral Risk Factor Surveillance System (BRFSS), the number of days of poor mental health is estimated using the average number of days that an adult living in the county responded to the question “Thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?” In SWVA, the average was 4.83 days compared to 3.2 days in the state. More people in PD 1 and 2 who presented at a Community Service Board (CSB) displayed overt indication of danger to self than in VA (47.5% in SWVA compared to 37.1% VA).

Estimated Rates of Substance Abuse in SWVA and VA

Drug and Alcohol Abuse

Based on the 2004-2006 data from the National Survey on Drug Use and Health (NSDUH), the created variable for the region of Virginia that included most of SWVA also included 19 counties that were not in SWVA. As such, the information that follows is limited in what it shows specifically about SWVA by PD (Data for specific counties in SWVA is not currently available from the NSDUH). Overall, this snapshot of VA, which includes Danville and Lynchburg, has somewhat higher estimated substance use in almost all categories measured in the survey, alcohol, tobacco, and illegal drug compared to the state. However, the differences are not statistically significant. The survey estimation is among people 12 year-old and over.

Binge Drinking Rates and Tobacco Use

Annually the Center for Disease Control and Prevention (CDC) estimates the Binge Drinking percentage and other risk factors, such as tobacco use, within the population using the Behavioral Risk Factor Surveillance System, which consists on a random-digital dial survey. Responses are biased toward those with telephone and willingness to participate, which may miss the highest users. However, similar resident of Virginia can be compared.
Binge Drinking

Residents in SWVA are less likely to report binge drinking than are those statewide who participate in surveys. Using the 2002-2008 data, it is estimated that 9.12% of the population in SWVA report engaging in binge drinking compared to 14% of the population who report binge drinking in the state as a whole. The binge drinking rate is the population over 18 years-old who consumed more than 4 drinks in a row for women or 5 drinks in a row for men of alcoholic beverages on a single occasion in the past 30 days.

Tobacco Use

The Chronic Disease Prevention and Control Department in Virginia Department of Health has reported the tobacco use by planning district concluding that PD 1 and 3 have the highest current smoking rate in the state (> 29%). PD 3 has the highest percentage of adults reporting smoking allowed in the home (45%) while the state is 24%. Also in PD 3, 45% of the employed adults reported that smoking is allowed in indoor work areas meanwhile the state rate is only 25%.

Negative Consequences Associated with Substance Abuse and/or Mental Health Problems

One study of over 20,000 Medicaid claims from six states found that 52.5% of patients had both high severity of psychiatric and substance use disorders, 19.8% had high severity of substance use disorders and low severity of psychiatric disorders, 19.4% had high severity of psychiatric disorders and low severity of substance use disorders, with only 8.2% having low severity of both suggesting that community providers and policy makers must consider the overlapping conditions in planning (McGovern et al., 2007).  

The problems associated with substance abuse and/or mental illness include unemployment, homelessness, car accidents, children in foster care, violence, unintended injuries, suicide, homicide, and many others. Direct links to substance abuse and the outcomes noted above were made to the fullest extent possible; otherwise rates are stated without respect to documented cause. Rates of unemployment are reported above since it is not possible with the existing data to determine whether or not unemployment was related to substance abuse and/or mental illness.

Rates for a number of health and behavioral problems are higher in this SWVA region than in the state. For example, 11.4% of injury-related deaths occurred in SWVA while one would expect the rate to be in parity with the population at around 7.24% if all things were equal.

Car Accidents

According to the 2009 Fatality Analysis Reporting System, there were 695 car accidents registered in the state. In 32.7% (227) of the accidents, the driver was drunk. For SWVA, in 21% (n=16) of the accidents the driver was drunk compared to 32.7% (277) of the accidents statewide. However, the motor vehicle crash death rate in SWVA is double that of the state. Virginia has a crude rate of 13 deaths per 100,000 and SWVA is 26 deaths

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per 100,000. Statistic on car accidents due to being high or intoxicated or becoming unconscious are not available. These rates were calculated using reports of the National Vital Statistics System from 2000 to 2006 by the National Center for Health Statistics at CDC.

Substance Abuse and Children in Foster Care

According to the Virginia Department of Social Services, approximately 19 percent of children entering foster care in Virginia have an indicator of parent drug abuse and about 6 percent of parent alcohol abuse in the fiscal years 2008-2010. Within each planning district, there was substantial variation among the local departments of social services in indicating both parent drug and alcohol abuse for children entering foster care.

Parent Drug Abuse

All of the planning districts in SWVA exceeded the statewide rate of indication of parent drug abuse associated with children in foster care during this time period. Nearly one-third (32%) of entries into foster care for SWVA indicated parent drug abuse. Within the SWVA entries, over half of the entries (58%) were from PDs 1 and 2. Planning Districts 1 and 4 had the highest rates of parent indicators of drug abuse during this three-year period. The rate in PD 1 (42%) was more than double the rate for the state and in PD 4 (33%) was almost twice the statewide rate.

Parent Alcohol Abuse

All of the planning districts in SWVA exceeded the statewide rate of indication of parent alcohol abuse associated with children in foster care during this time period. However, only the rate in PD 3 appeared substantially higher than the VA rate. In PD 3, 11% of the children in foster care had a parent alcohol abuse indicator compared to the statewide rate of 6%, in other PDs the percentage is around 9.

Injury-Related Deaths

Injury-related deaths include death by any means including suicide and homicide. In Virginia, 37,857 deaths occurred due to injury, which is a rate of 51 deaths per 100,000 people compared to 76 deaths per 100,000 people in SWVA or 11.8% (4,468) of the deaths occurred in SWVA. During 1999-2008, the injury-age-adjusted death rate in PD 2 is twice that of VA.

Overall rates of death by suicide and homicide may result from different mechanisms; such as the use of firearms, poisoning (overdose of any substance such as alcohol, drugs or any other substances). Further examination of suicide by poisoning, which is mostly related to overdose death due to substance abuse, is reported separately. However, these may be under reports since some suicides and homicides may also have involved substance abuse that was not documented.
Deaths by Suicide

Counting only suicides, the age-adjusted death rate in some PDs in SWVA is almost twice the rate of the State. The total number of suicides in Virginia is 8,302, of which 12.13% (n=1,007) of the events were in SWVA. The Virginia-suicide-age-adjusted death rate is 11 deaths per 100,000 and 17 deaths per 100,000 people in SWVA. Most recent annual data show that there were 160 suicide deaths due to poisoning (e.g. drug overdose) in SWVA, or 11.1% of the VA cases (n=1,446). Age-adjusted death rates are higher in the four PDs of SWVA than in VA. It is 2.9 per 100,000 in far SWVA and 1.9 per 100,000 people in the state. Lenowisco rate is more than twice the state rate.

Deaths by Homicide

Counting only homicides, age-adjusted mortality rate is lower in SWVA than in VA. There were 4,243 deaths in Virginia due to homicide of which 226 deaths (5.3%) occurred in far SWVA. Death rates are 4.0 and 5.6 per 100,000 people in SWVA and Virginia, respectively. There were only 11 homicides due to poisoning; however, none of them occurred in SWVA.

Fatal Unintended Drug Overdoses

In 2008, the Virginia Medical Examiner reported the fatal drug overdoses rates in counties in PD 1 and 2 in SWVA. The age-adjusted death rate from fatal drug overdose was 40% compared to 8.3% for the state. The rate in SWVA counties was from 2.5 to 6 times the State rate (8.3 per 100,000).

Crime Data Related to Drugs and Narcotic Offenses

A number of law violations are caused by people who use, produce, or distribute drugs. In 2009, there were 44,952 drug/narcotic offenses in VA. According to the Virginia State Police crime report, the number of drug narcotic offenses is decreasing over time in Virginia after 2007. In 2009, there were 1,163 fewer offenses than in 2008 and 2,837 fewer than in 2007. The 2009 drug/narcotic offense rate for VA is 570 per 100,000 people. It is lower compared with the rate in SWVA. In SWVA, there were 3,623 drug/narcotic offenses for 2009. The SWVA drug/narcotic offenses rate is 629 per 100,000. The chance of occurrence of a drug offense in SWVA is higher than in the state (12.7% vs. 9.11%).

Violence related to Drug Dealing in Virginia

There were 48 cases of aggravated assault where the circumstances was drug dealing. In addition, there were 2,161 violent crime offenses where the offender(s) was suspected of using drugs, including alcohol. In 26 violent crimes, some drugs/narcotics were used as type of weapon. Moreover, there were 6,155 property crimes where the offender(s) were suspected of using alcohol or drugs. Robbery cases (214) were excluded in property crimes given that they are also considered as violent crimes. A total of $1,204,999 in drug/narcotics and $15,688 in equipment were stolen in a burglary or obtained with a fraudulent prescription. In 2009, 73.2 % ($882,201) was recovered for drugs/narcotics and 5.5 ($858) in equipment. On drugs arrests, marijuana ranked the highest with 61.1% of 32,619 arrested. Even children under 10 years of age were arrested for
marijuana use, but no other drug. The month of March consistently showed the highest arrests and offenses reported.

**Arrests and Arrests for Drug Offences**

There are more arrests for crimes in SWVA compared to VA, but not significantly more arrests related to drugs/narcotics. In VA, there were 345,884 arrests, which is an arrest rate of 4,388 per 100,000 people compared to an arrest rate of 5,441 per 100,000 in SWVA. Of all arrests, almost 9% (31,054) occurred in SWVA. In VA, 30,074 cases were registered due to drug/narcotic offenses. Of the total arrests, 2,582 (8.6%) occurred in SWVA. The 2009 drug/narcotic arrest rates were 452/100,000 people in SWVA and 382/100,000 people in the state as a whole. There are two type of crime that are categorized in two groups the group A includes murder, kidnapping, assault, drug/narcotic offences, etc. and the group b includes driving under influence, drunkenness, etc. The incidence of arrest was lower for crimes in categories of group A than group B categories. The arrest rate for group A in SWVA is 2,116/100,000 and 1,747/100,000 in VA.

**Treatment Facilities in Virginia**

**One Care is indebted to the Healthy Appalachia Institute and** M. Leon-Verdin, M.S., Biostatistician and Elizabeth L. McGarvey, EdD, Associate Professor of Public Health Sciences University of Virginia School of Medicine for their work in compiling and summarizing this data.
One of many cultural attractions in Southwest Virginia
RESULTS OF THE PLANNING DISTRICT MEETINGS – GOAL STATEMENTS, OBJECTIVES & RELATIVE TIMELINES

GOALS AND OBJECTIVES: BLUEPRINT FOR SUBSTANCE ABUSE PREVENTION, TREATMENT AND CONTROL

Objectives (lettered) and Objectives (numbered)  
Blueprint Taxonomy  
(N) Near term = 0-2 years  
(I) Intermediate term = 3-5 years  
(L) Long term = 6-10 years

A. Improve Treatment Access for substance abusing offenders to reduce incarceration costs, recidivism and family disruption and return users back to gainful activity.
   1) Advocate for funding of and expansion of existing Drug Court Treatment Programs in 100% of SWVA localities (N/I)  
   2) Double the number of established Drug Courts in SWVA (currently 2) localities by 2013. (N)  
   3) Provide SWVA elected and judicial officials with return on investment information on Drug Courts versus incarceration (N)  
   4) Fund and expand existing Drug Court Treatment Programs in 100% of SWVA localities (I)

B. Encourage and support expansion of Mutual Support/Peer Recovery in SWVA.
   1) Establish at least two Mutual Support /Peer Recovery Groups in 100% of SWVA’s localities (I)  
   2) Support an electronic clearinghouse of information about Mutual Support/Peer Recovery Group meetings, places and times (N)  
   3) Promote Mutual Support/Peer Recovery Promotion in the Community Education Campaign (I)  
   4) Support Peer Recovery Groups geared towards adolescent SA Group Work (I)  
   5) Challenge each faith community with more than 200 members to open their doors to at least one peer recovery group (N)  
   6) Foster at least one AA, NA or similar peer recovery group in 50% of jails in the region (I)

C. Expand treatment options and capacity and promote existing treatment options.
   1) Promote existing treatment resources for tobacco cessation (N)  
   2) Create positive messages about the benefit of locally available treatment options including methadone clinics and residential treatment (L)  
   3) Establish a demonstration project aimed at partnerships between behavioral health (CSB) and primary care clinic (FQHC or private practice) to provide creative collaborative treatment opportunities (N)  
   4) Increase reimbursement for intensive outpatient substance abuse treatment services (I)  
   5) Utilize Southwest VA Mental Health Institute in Marion for new inpatient substance abuse services (N)  
   6) Raise taxes on alcohol and cigarettes to reduce consumption and use additional funds for prevention and treatment activities (I)  
   7) Work toward having 5% of all private practices offering medication assisted therapy for opiate dependence in three years; always in collaboration internally or externally with individual and/or group peer or professional counseling therapy (I)  
   8) Develop at least one long-term residential substance abuse treatment facility in each planning district (L)  
   9) Increase funding for substance abusing adolescent treatment groups (I)  
  10) Establish at least one detoxification facility in each planning district (I)
11) Develop at least one regional women's treatment program geared specifically toward the treatment and prevention/education of women, with a priority toward pregnant women (I)

D. Reduce the incidence of Substance Abuse in SWVA.

1) Assure that at least one professional society (e.g. Medical Society of VA, VA Dental Association, VA Nursing Association, and VA Pharmacists Association) adopts Prescription Drug Abuse mitigation as a priority (I)

2) Require reporting of suspected drug diversion and doctor shopping by Licensed Health Care Provider's (LHCP) and dispensers of Schedule II, III, and IV medication (N)

3) Encourage pharmacists to provide face-to-face verbal counseling for Schedule II controlled substances for new prescriptions or prescription changes (I)

4) Implement “SBIRT” (Screening Brief Intervention Referral and Treatment) in two regional primary care offices, two Emergency departments, three health departments, six Community Health Center sites and eight Community Service Board sites (I)

E. Encourage greater collaboration among Law Enforcement Agencies and others working to control illegal Substance Abuse.

1) Expand ability of local law enforcement to work/augment colleagues in other jurisdictions (I)

2) Reduce sales of alcohol and tobacco to minors by expanding local law enforcement compliance-check partnerships (I)

3) Assist VA State Police in educating Prescribers and Dispensers regarding the role of Drug Diversion Agents (N)

4) Achieve a visible law enforcement educational partnership with 10% of active PTAs/school parent groups (I)

5) Provide initial and semi-annual training for 25% of law enforcement in SA officers regarding substance abuse, use speakers bureau for this purpose (I)

6) Explore the advisability of requiring/allowing immunity for Common Carriers to divulge reasonable suspicion of illegal drug delivery (I)

7) Provide seminars targeted to judges and attorneys regarding physician assisted treatment and monitoring in a drug court context (N)

8) Ensure that at least one drug court will work directly with the support of a physician trained in addiction medicine (I)

9) Create re-entry coalitions to include custodial, treatment and service partners in at least 50% of the localities served by One Care within three years (N)

10) Implement an evidence-based approach to decrease recidivism by 25% in at least two local prison populations in three years (I)

11) Develop a forum to create stronger communication between judges, Commonwealth attorneys and local sheriff departments in effectively using drug courts (N)
Create a culture of responsibility for substance use control at the individual, family and community level.

1. Create and fund a comprehensive communications campaign for deployment in each media market in SWVA (N)
   i. Create community/consumer/patient demand for prescribers and pharmacists to have clear pain management programs for all in their practices and protocols.
   ii. Educate the general public regarding proper storage of medication (see Partnership for a Drug Free America materials)
   iii. Educate the general public regarding not sharing or selling abusable drugs
   iv. Encourage all to be willing to be drug tested
   v. Encourage all to ask family members about drug use
   vi. Host a talk show focusing on substance abuse and interview individual resources
   vii. Create a "getting Clean" show to spotlight successful and the challenges to successful recovery ("shop" to PBS) (17)
   viii. Post information in local papers advising about local treatment services for help – (Pills)
   ix. Provide education regarding proper use of controlled substances
   x. Educate the public regarding the genetic basis for addiction and that addiction is a preventable and treatable disease like Type II diabetes
   xi. Foster public awareness of the dynamics of addiction - Public Awareness of the Dynamics of Addiction – Duke University - Guilford County, NC Model – FACE IT Facing Addiction Community Empowerment Intervention Team and SAY IT – Substance Abuse Youth Intervention Team – all evidence-based activities
   xii. Encourage the avoidance of tobacco which is a gateway drug for youth
   xiii. Increase community awareness of treatment providers and options for Substance Abuse
   xiv. Adopt Celebrate Recovery and support the recovery community
   xv. Work to remove the stigma of addiction; acknowledge pre-use and post-use biochemical differences between addicts and non-addicts
   xvi. Communicate gender differences in vulnerability to addiction
   xvii. Communicate that many behaviors taken to harmful excess are rooted in biochemical and anatomic pathways to addiction (e.g. overeating, drinking, sex, gambling and drug use) Acknowledge almost universal vulnerability
   xviii. Stop or "call out" the sale of drug paraphernalia in convenience stores – engage store owners in limiting this activity
   xix. Provide information and statistical analysis of the SA issues to partner entities like PTAs, churches, schools, parents and make experts available to teach and provide tools and strategies to these groups
   xx. Distribute a DVD or use You-Tube or other means targeted to intermediate students regarding the risks of drug use
   xxi. Partner with early childhood (Pre-K) education (e.g. Smart Beginnings) efforts and elementary education to reach children early at their level regarding all harmful substances including tobacco, alcohol, legal and illegal drugs
   xxii. Involve parents/families in explicit (profile actual cases) educational activities targeted at middle school
   xxiii. Work to include the biology and psychology of addiction into public school curricula and standards of learning (SOL) goals and objectives
   xxiv. Encourage recovery resourcefulness among addicts; “be addicted to recovery”; counter the idea that treatment is expensive. Peer recovery is ‘free’
**xxv.** Work with Senior organizations (e.g. AARP, Area Agencies on Aging) to educate seniors about the risks of misuse, abuse, selling and enabling diversion

**xxvi.** Target physicians and prescribers/staff for specific outreach to assist with implementation and adherence to best practices

**xxvii.** Create a SA/pain management workplace wellness curricula and encourage its use

**xxviii.** Educate the general public about the proper use of methadone and the distinction between use for addiction treatment and use for pain management

**xxix.** Create an ad campaign aimed at highlighting the dangers and excesses of unnecessary prescriptions for benzodiazepines and sleep aids

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**G. Expand Community Treatment Options and support peer recovery (groups).**

1) Create at least two peer recovery groups in the region for Veterans having post-traumatic stress disorder (PTSD) or at risk for PTSD or other mood/anxiety disorder(N)

2) Identify an existing or recruit a regional employer to demonstrate at least one employment based recovery program where the offer and maintenance of employment is conditioned upon staying in recovery(N)

3) Identify or create a source of technical assistance for employers willing to have an employment based recovery program(s), seek advice of existing impaired professional programs (I)

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**H. Expand professional and community SA educational opportunities.**

1) Seek active participation in substance abuse education of at least one major statewide medical professional group and at least one major pharmaceuticals manufacturer (N)

2) Create a speakers bureau that includes both academic or medical experts and recovered persons to speak individually or in team (N)

3) Create a Behavioral Health ASS degree in alcohol and drug counseling as step to Certified Substance Abuse Counselor Licensure (I)

4) Provide coordinated annual educational offerings for SA treatment providers in the region via collaboration among local public and private treatment providers and professionals groups (N)

5) Require prescribers and dispensers of medication to obtain at least one hour of CME on SA and pain management each licensure period (N)

6) Fund an FTE/50,000 population public health educator/community health workers and/or drug educators for SA prevention and outreach to special populations including pregnant women, veterans, and families with multigenerational SA patterns (I)

7) Develop a program targeted at non-professionals to become community drug educators similar to diabetes educators (I)

8) Promote SA as a chronic treatable disease model (as with diabetes) to medical providers and insurers (N)

9) Encourage undergraduate training programs for prescribers, administrators and dispensers of medications (e.g. Physicians, Nurses, Pharmacists) to incorporate at least two hours of didactic education regarding pathophysiology, screening, identification and treatment of addiction (I)

10) Identify or Fund an FTE/100,000 population public health educator/community health workers and/or drug educators for SA counter-detailing and best practice ‘marketing’ towards prescribers (I)
I. Expand SA education opportunities for key community leaders.
   1) engage at least 60 clergy members in actively combating SA in their communities (N)
      i. Provide clergy with resources to educate their congregation and communities
      ii. Provide tools to assist clergy and church leaders to identify signs of SA
      iii. Have engaged clergy members develop and deliver a sermon once a year regarding the
           misuse and or abuse of substances
      iv. Develop a simple sermon template
   2) Hold at least one local and one regional SA coalition meeting annually in the evening to allow care
      providers to more easily attend (N)

J. Expand formal Substance Abuse education in Schools.
   1) Implement age appropriate SA education in K-12 health classes in at least four school districts (I)
   2) Include SA education and medication-related impairment in all driver education classes in high
      school in at least four school districts (I)
   3) Create school health coordinator positions in at least one regional school system to include the
      mandated development of EARLY (K-7th) age appropriate lifetime athletics (e.g., running,
      swimming) and arts (visual, performance) afterschool school-assisted programs and EXPLICITLY
      incorporate stay healthy (eat right, don't smoke, don't use drugs) education and messaging for
      school based wellness (I)
   4) Provide school-based age-appropriate early (K-7) lifetime athletics (running, swimming) and arts
      (visual and performing) opportunities, and explicitly incorporate health and wellness education
      messaging into these activities (I)

K. Advocate for more robust user-level information and control of abuse and overdose prone medications.
   1) Promote Graphic Warning labels using graphic depictions and/or basic elementary reading level
      language (I)
   2) Expand regional "Take Back" activities (N)

L. Support Policy Initiatives geared towards primary prevention of misuse or abuse.
   1) Do not allow for the waiving of pharmacy counseling for Schedule II controlled substances (I)
   2) Require prescribers to complete CME prior to recertification of their Drug Enforcement Agency
      number/State license (I)
   3) Require Prescription Monitoring Program access and periodic review for prescribers and dispensers
      of schedule drugs (N)
   4) Require a PMP profile for any patient prior to prescribing a Schedule II, III, or IV substance (N)
   5) Advocate for the simultaneous multi-state single point of access PMP prescription monitoring
      programs and require physicians to use it as supported by NASPER (I)
   6) Require providers of medication assisted treatment (e.g. methadone and buprenorphine) to
      periodically review PMP on active patients (N)
   7) Advocate for a shall report of suspected drug diversion by patients and prescribers/dispensers of
      potentially addictive medication (N)
   8) Require Pharmaceutical manufacturers to be responsible for products from cradle to grave to
      include pharmacy based take back programs for unused/expired drugs (I)
   9) Ban the sale and marketing of drug paraphernalia and designer drugs in retail establishments (N)
  10) Require periodic saliva, urine or hair based drug screening for any person receiving a Schedule II, II
      or IV medication, the drug screening to include the drug prescribed and other commonly abused
      medications (I)
11) Explore evidence-based programs that use web-based exposure of convicted drug sellers for reducing crime and recidivism (N)
12) Advocate for moving benzodiazepines to Schedule II status (Drug Enforcement Agency) (I)
13) Achieve at least one no-smoking in public places ordinance in at least one of our localities each year, post signs at community events (N)

M. Focus additional effort towards job creation and encouragement for disabled adults and underemployed young adults through education, entrepreneurism and retraining.
   1) Reduce the incidence and prevalence of unnecessary regional disability by two percent in five years (I)
   2) Decrease the unemployment rate for 18-24 year olds by two percentage points in five years (I)

N. Identify gaps in regional research around understanding SA, its impact and best practices.
   1) Identify or initiate a comparative study of the relative costs of any state program that works with substance abusers who use illegal substances (I)
   2) Engage an University to identify a region or locality that has successfully and definitively reduced its SA or overdose death rates and identify the key factors that may be adopted regionally (N)
   3) Encourage a group of engaged community members to study best practices in SA prevention that can be implemented locally (N)

O. Seek additional resources for community and regional level coordination and collaboration activities.
   1) Obtain or retain funding for regional consortium and coalition staff from member entities and other stakeholders (I)
   2) Work to have at least 60% of our counties and cities receiving at least one Drug Free Communities grant by 2013 (N)
   3) Seek state support to develop a “One Stop” initial assessment, referral and care coordination resource for consumers (including infants, pregnant woman) of SA treatment in each locality in an existing agency as an entry point into a Recovery Oriented System of Care (I)

P. Expand the professional SA workforce available in the region.
   1) Identify a source of loan repayment for two licensed SA professionals annually who agree to work for a minimum period in an underserved locality (N)

Q. Implement a Recovery Oriented System of Care regionally.
   1) Work to create a unified, evidence-based and consistent regional treatment SYSTEM that links existing treatment resources, (behavioral, social, community based, faith based, drug offender rehabilitation, private practice and others) into a seamless yet flexible recovery system for abusers that creates measurable superior outcomes in a regional Recovery Oriented System of Care (N)
   2) Develop a rapidly responsive system of SA treatment for parents and children targeted to families whose children are at risk of coming into foster care thru foster care prevention (I)
   3) Assure best practices for the continued availability of pain management services in both primary care and specialty settings (N)
Autumn along the New River Trail in Southwest Virginia
APPENDICES I-VI
A snow covered Gazebo in Southwest Virginia
APPENDIX I

Text of Letter of Invitation to attend Regional Meetings

As a thought leader, stakeholder or citizen concerned about the tragic impact of substance abuse on our economy, our children, our families and our wonderful way of life in Southwest Virginia and central Appalachia, we invite you to contribute your best actionable ideas at one of four planned regional strategic planning sessions. Through this inclusive process, we will create our **Blueprint for Substance Abuse and Misuse: Prevention, Treatment and Control**. To facilitate your participation and contribution, sessions will be held throughout our region. Whether you live, work, learn and play in Southwest Virginia or in a neighboring region or state, we want your input.

While there are scores of public and private agencies, coalitions, faith based communities, business, recovery communities, elected officials, professionals and others who are engaged in vital work to address a problem that has disproportionately impacted our region, we believe there is a need to further collaborate and continue this good work, strategically leveraging our resources and our commitment. Informed by the ground breaking work of the Southwest Virginia Health Authority’s **Blueprint for Health Improvement and Health-Enabled Prosperity** we seek to create a blueprint with shared and measurable goals and objectives that can inform and invigorate our work and spur us to enhance, foster or create opportunities that will dramatically reduce the impact of substance abuse and misuse in our region. Together we can staunch the drain on our region’s reputation, physical, economic and mental vitality caused by substance abuse.

The statistics are all too well known. With over 200 drug-overdose deaths each year in Southwest Virginia since 2003, at rates 3, 4 and 5 times higher in Southwest Virginia communities than in our nation or state, we have lost more than 2000 people to this epidemic in this decade. These are mothers, fathers, brothers, sisters, children, and friends. These losses cannot continue. As terrible and tragic as these deaths are, they do not begin to count the number of lives impacted - the children abandoned and displaced, the jails filled to overflowing, the huge public and private expenses and the economic opportunities we have lost to substance abuse. Unfortunately, this problem is rising rapidly in other parts of our state and nation as well. Fortunately, our region is positioned to be among the leaders in addressing it.

One Care of SWVA is a regional consortium of coalitions committed to develop this “**Blueprint**” in an inclusive process. We understand that “if the problem is in the community, the solution is in the community” and we want you, as a key leader, to be a part of our mutual effort toward solutions. Place matters, and here we have a proud history, a rich culture and a beautiful place to live. We must not allow substance abuse to continue to rob us of prosperity, health and happiness.

Please join us on one of the dates below.

**Thursday, July 8, 2010 – Russell County Conference Center, Lebanon, VA**
**Friday, July 9, 2010 – Dalton-Cantrell Hall, Mountain Empire Community College, Big Stone Gap VA**
**Thursday, July 22, 2010 – Wytheville Meeting Center, Wytheville, VA**
**Friday, July 23, 2010 – New River Valley Competitiveness Center, Fairlawn, VA**
All meetings are 9 a.m. – 1 p.m.

Registration and networking will begin about half an hour before each meeting. Lunch, refreshments and publication of the Blueprint will be provided through a generous grant from The Verizon Foundation. To
Register for the Summit go to: www.onecare.org. On the website you will find links to Virginia’s County Health Rankings, The Blueprint for Health and Health-Enabled Prosperity, and directions to these regional meetings.

This important event is spearheaded and made possible by the agencies and coalitions that make up One Care of SWVA. These include our regions community service boards, departments of health and social services, recovery and faith based communities, businesses, legal and professional communities and other concerned stakeholders. Special assistance and support is provided by the Southwest Virginia Health Authority, Healthy Appalachia Institute, East Tennessee State University and Virginia Economic Bridge.

Sincerely,

Delegate Bud Phillips  
Chairman, SWVA Health Authority

Dr. John Dreyzehner  
Chairman, One Care of SWVA

Marcia Quesenberry  
Co-Director, Healthy Appalachia Institute

Carl Mitchell  
Executive Director, SWVA and President & CEO Virginia Economic Bridge
Wildflowers bloom along a reservoir in Southwest Virginia
# One Care of SWVA’s Blueprint Goals And Objectives With Near, Intermediate And Long-Term Time Frame Characteristics Summarized

<table>
<thead>
<tr>
<th>Goal</th>
<th>Related Objectives</th>
<th>Brief Summary of Blueprint Wording</th>
<th>N</th>
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<tbody>
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<td>A</td>
<td></td>
<td>Improve Treatment Access for substance abusing offenders</td>
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<td></td>
<td>1</td>
<td>Advocate for funding of and expansion of existing Drug Court Treatment Programs in 100% of SWVA localities</td>
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<td>2</td>
<td>Double the number of established Drug Courts in SWVA (currently 2) localities by 2013</td>
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<td>3</td>
<td>Provide SWVA elected and judicial officials with return on investment information on Drug Courts versus incarceration</td>
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<td>4</td>
<td>Fund and expand existing Drug Court Treatment Programs in 100% of SWVA localities</td>
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<td>B</td>
<td></td>
<td>Encourage and support expansion of Mutual Support/Peer Recovery in SWVA</td>
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<td></td>
<td>1</td>
<td>Establish at least two Mutual Support /Peer Recovery Groups in 100% of SWVA’s localities</td>
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<td>2</td>
<td>Support an electronic clearinghouse of information about Mutual Support/Peer Recovery Group meetings, places and times</td>
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<td>3</td>
<td>Promote Mutual Support/Peer Recovery Promotion in the Community Education Campaign</td>
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<td>4</td>
<td>Support Peer Recovery Groups geared towards adolescent SA Group Work</td>
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<td>5</td>
<td>Challenge each faith community with more than 200 members to open their doors to at least one peer recovery group</td>
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<td>6</td>
<td>Foster at least one AA, NA or similar peer recovery group in 50% of jails in the region</td>
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<td>C</td>
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<td>Expand treatment options and capacity and promote existing treatment options</td>
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<td>1</td>
<td>Promote existing treatment resources for tobacco cessation</td>
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<td>2</td>
<td>Create positive messages about the benefit of locally available treatment options including methadone clinics and residential treatment</td>
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<td>3</td>
<td>Establish a demonstration project aimed at partnerships between behavioral health (CSB) and primary care clinic (FQHC or private practice) to provide creative collaborative treatment opportunities</td>
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<td>4</td>
<td>Increase reimbursement for intensive outpatient substance abuse treatment services</td>
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<td>5</td>
<td>Utilize Southwest VA Mental Health Institute in Marion for new</td>
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<td>Raise taxes on alcohol and cigarettes to reduce consumption and use additional funds for prevention and treatment activities</td>
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**F**

Create a culture of responsibility

**G**

Expand Community Treatment Options

1. Create at least two peer recovery groups in the region for Veterans having post-traumatic stress disorder (PTSD) or at risk for PTSD or other mood/anxiety disorder | X |
2. Identify an existing or recruit a regional employer to demonstrate at least one employment based recovery program where the offer and maintenance of employment is conditioned upon staying in recovery | X |
3. Identify or create a source of technical assistance for employers willing to have an employment based recovery program(s), seek advice of existing impaired professional programs | X |

**H**

Expand professional and community SA educational opportunities

1. Seek active participation in substance abuse education of at least one major statewide medical professional group and at least one major pharmaceuticals manufacturer | X |
2. Create a speakers bureau that includes both academic or medical experts and recovered persons to speak individually or in team | X |
3. Create a Behavioral Health ASS degree in alcohol and drug counseling as step to Certified Substance Abuse Counselor Licensure | X |
4. Provide coordinated annual educational offerings for SA treatment providers in the region via collaboration among | X |
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<td>5</td>
<td>Require prescribers and dispensers of medication to obtain at least one hour of CME on SA and pain management each licensure period</td>
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<td>6</td>
<td>Fund an FTE/50,000 population public health educator/community health workers and/or drug educators for SA prevention and outreach to special populations including pregnant women, veterans, and families with multigenerational SA patterns</td>
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<td>7</td>
<td>Develop a program targeted at non-professionals to become community drug educators similar to diabetes educators</td>
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<td>8</td>
<td>Promote SA as a chronic treatable disease model (as with diabetes) to medical providers and insurers</td>
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<td>9</td>
<td>Encourage undergraduate training programs for prescribers, administrators and dispensers of medications (e.g. Physicians, Nurses, Pharmacists) to incorporate at least two hours of didactic education regarding pathophysiology, screening, identification and treatment of addiction</td>
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<td>10</td>
<td>Identify or Fund an FTE/100,000 population public health educator/community health workers and/or drug educators for SA counter-detailing and best practice ‘marketing’ towards prescribers</td>
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<td>I</td>
<td>Expand SA education opportunities for key community leaders</td>
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<td>1</td>
<td>Engage at least 60 clergy members in actively combating SA in their communities</td>
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<td>2</td>
<td>Hold at least one local and one regional SA coalition meeting annually in the evening to allow care providers to more easily attend</td>
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<td>J</td>
<td>Expand formal Substance Abuse education in Schools</td>
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<td>1</td>
<td>Implement age appropriate SA education in K-12 health classes in at least four school districts</td>
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<td>2</td>
<td>Include SA education and medication-related impairment in all driver education classes in high school in at least four school districts</td>
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<td>Create school health coordinator positions in at least one regional school system to include the mandated development of EARLY (K-7th) age appropriate lifetime athletics (e.g., running, swimming) and arts (visual, performance) afterschool school-assisted programs and EXPLICITLY incorporate stay healthy (eat right, don’t smoke, don’t use drugs) education and messaging for school based wellness</td>
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<td>4</td>
<td>Provide school-based age-appropriate early (K-7) lifetime athletics (running, swimming) and arts (visual and performing) opportunities, and explicitly incorporate health and wellness</td>
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<td>Advocate for more robust user-level information and control of abuse and overdose prone medications</td>
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<td>Promote Graphic Warning labels using graphic depictions and/or basic elementary reading level language</td>
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<td>Expand regional “Take Back” activities</td>
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<td>Advocate for more robust user-level information and control of abuse and overdose prone medications</td>
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<td>1</td>
<td>Do not allow for the waiving of pharmacy counseling for Schedule II controlled substances</td>
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<td>2</td>
<td>Require prescribers to complete CME prior to recertification of their Drug Enforcement Agency number/State license</td>
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<td>Require Prescription Monitoring Program access and periodic review for prescribers and dispensers of schedule drugs</td>
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<td>Require a PMP profile for any patient prior to prescribing a Schedule II, III, or IV substance</td>
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<td>5</td>
<td>Advocate for the simultaneous multi-state single point of access PMP prescription monitoring programs and require physicians to use it as supported by NASTER</td>
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<td>6</td>
<td>Require providers of medication assisted treatment (e.g. methadone and buprenorphine) to periodically review PMP on active patients</td>
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<td>7</td>
<td>Advocate for a shall report of suspected drug diversion by patients and prescribers/dispensers of potentially addictive medication</td>
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<td>8</td>
<td>Require Pharmaceutical manufacturers to be responsible for products from cradle to grave to include pharmacy based take back programs for unused/expired drugs</td>
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<td>Ban the sale and marketing of drug paraphernalia and designer drugs in retail establishments</td>
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<td>Require periodic saliva, urine or hair based drug screening for any person receiving a Schedule II, II or IV medication, the drug screening to include the drug prescribed and other commonly abused medications</td>
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<td>11</td>
<td>Explore evidence-based programs that use web-based exposure of convicted drug sellers for reducing crime and recidivism</td>
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<td>12</td>
<td>Advocate for moving benzodiazepines to Schedule II status (Drug Enforcement Agency)</td>
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<td>Achieve at least one no-smoking in public places ordinance in at least one of our localities each year, post signs at community events</td>
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<td>Focus additional effort towards job creation and encouragement for disabled adults and underemployed young adults</td>
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<td>Reduce the incidence and prevalence of unnecessary regional</td>
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<td>Identify gaps in regional research</td>
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<td>1</td>
<td>Identify or initiate a comparative study of the relative costs of any state program that works with substance abusers who use illegal substances</td>
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<td>2</td>
<td>Engage an University to identify a region or locality that has successfully and definitively reduced its SA or overdose death rates and identify the key factors that may be adopted regionally</td>
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<td>3</td>
<td>Encourage a group of engaged community members to study best practices in SA prevention that can be implemented locally</td>
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<td>Seek additional resources</td>
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<td>1</td>
<td>Obtain or retain funding for regional consortium and coalition staff from member entities and other stakeholders</td>
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<td>2</td>
<td>Work to have at least 60% of our counties and cities receiving at least one Drug Free Communities grant by 2013</td>
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<td>3</td>
<td>Seek state support to develop a “One Stop” initial assessment, referral and care coordination resource for consumers (including infants, pregnant woman) of SA treatment in each locality in an existing agency as an entry point into a Recovery Oriented System of Care</td>
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<td>Expand the professional SA workforce</td>
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<td>Identify a source of loan repayment for two licensed SA professionals annually who agree to work for a minimum period in an underserved locality</td>
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<td>Implement a Recovery Oriented System of Care regionally</td>
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<td>Work to create a unified, evidence-based and consistent regional treatment SYSTEM that links existing treatment resources, (behavioral, social, community based, faith based, drug offender rehabilitation, private practice and others) into a seamless yet flexible recovery system for abusers that creates measurable superior outcomes in a regional Recovery Oriented System of Care</td>
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<td>Develop a rapidly responsive system of SA treatment for parents and children targeted to families whose children are at risk of coming into foster care thru foster care prevention</td>
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<td>Assure best practices for the continued availability of pain management services in both primary care and specialty settings</td>
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Sunlight glistens off one of the many historic train stations in Southwest Virginia
APPENDIX III

Thank you!

This strategic planning effort and One Care of SWVA received a generous contribution from the Verizon Foundation for the hosting of the four regional planning meetings and the production of this blueprint. This publication was also made possible through additional effort and support provided by generous in-kind contributions from The Healthy Appalachia Institute at the University of Virginia’s College at Wise, East Tennessee State University and Mountain Empire Community College.

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Dr. Wendy Welch, Community Organizer, Healthy Appalachia Institute

Best Practices - The Impact of Substance Abuse – A Film
Ms. Lori Gates-Addison, LCSW, CPP, Prevention Coordinator, Cumberland Mountain Community Services

Photographs provided by:
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Dr. John Dreyzehner
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Outreach Representative, U.S. Senator Mark R. Warner

Gwyn Dutton
Regional Representative, U.S. Senator Jim Webb

Martin Mash
Field Representative, U.S. Senator Jim Webb

Regina Kinder
Senior Casework Specialist, U.S. Congressman Rick Boucher

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Director, Wythe County Department of Social Services

Rebecca Holmes, LPC, CSAC
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Planner, New River Health District

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Executive Director, Mount Rogers Community Services Board

Donna L. Muncy
Western Region Re-Entry Specialist, Virginia Department of Corrections

Sandra O’Dell, LCSW
Senior Vice President, VA Operations MH/SA Dir

Steve Ray
Executive Director, H.O.P.E./Freedom from Addiction

Regina Sayers
Executive Director, Appalachian Agency for Senior Citizens

Karen Smith
REMOTE Coordinator, Cumberland Mountain Community Services

Aleta Spicer
Executive Director, Occupational Enterprises, Inc.

Ward W. Stevens
Executive Director, OMNEE, Edward Via College of Osteopathic Medicine

Executive Director
Carl Mitchell, MS, CNPM
Executive Director, One Care of Southwest Virginia
President/CEO Virginia Economic Bridge

Advisors/Liaisons/Partners
Gwyn Dutton
Regional Representative, U.S. Senator Jim Webb

Brian Everitt
Constituent Services Director, U.S. Senator Mark R. Warner

L. Thompson “Tom” Hanes, J.D., M.H. A.
Sands Anderson Marks & Miller, P.C.

Louise Arnatt Kadiri
Outreach Representative, U.S. Senator Mark R. Warner

Martin Mash
Field Representative, U.S. Senator Jim Webb

Inputs for this blueprint were also provided by the following individuals who attended the four regional meetings.

Dr. Virginia Acal-Baluyot, Tru-Care Medical Clinic, Physician
Donna Adkins, Appalachian College of Pharmacy, Associate Professor
Pat Arnold, Smyth County DSS, Director
Nick Asbury, Bland County Board of Supervisors
Carl Ayers, Floyd County DSS, Director
J. Baldridge, Virginia State Police
Harvey Barker, NRVCS Ex. Director
Dr. Amor Barongan, MD
Dr. Pablo Barongan, MD
Dr. Roger Bays, General Dentistry
Kristine Bowers, Coalition on Appalachian Substance Abuse Policy, Coordinator
Lester Bowman, Appalachia Police Dept
Chris Boyd, Tazewell County Sheriff’s Office, Chief Deputy
Tonya Noel Buchanan, PharmD, IHC, Appalachian College of Pharmacy, Director of Experiential Education
Derek Burton, SW Va Behavioral Health Board, Project Manager
Thomas J. Cantwell, Highlands Community Services, M.D.
Bill Carrico, Virginia House of Delegates, Delegate
Tommy Casteel, Washington County Dept. of Social Services, Director
Rick Clark, Galax Police Department, Chief of Police
Stephen Clear, Southwest VA Regional Jails, Superintendent
Butch Coleman, Laurel Fork Volunteer Fire Department, Member
Cheryl Coleman, Tri-Area Community Health Center, Director of Case Management
Vicky Collins, Radford City DSS, Director
Chaplain Jim Cox, Wythe County Sheriff’s Office
Anne Crockett-Stark, Virginia House of Delegates, Delegate
Gary Crum, GMEC
Harry Cundiff, Bluefield Va. Police Dept., Chief of Police
David Darden, Clinch Valley Medical Center, CEO
Dr. TP Davis, MD
Jerry L. Davis, Virginia State Police, Lieutenant
Harry Dean, Smyth County IDA, Vice Chairman Smyth Co. IDA
Penny Dean, Twin County Prevention Coalition, President
Rhonda Dotson, Carilion New River Valley Medical Center, LCSW, LSATP, CSAC, ADS
Dr. John Dreyzehner, MD, MPH, Cumberland Plateau Health District, Director
Ron Elkins, Wise County Commonwealth’s Attorney’s Office, Commonwealth’s Attorney
Larry Findley, Virginia Department of State Police, Special Agent
Erika Fischer, Governor’s Office for Substance Abuse Prevention, Director
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Bob Gose, Bristol Va. Dept. Social Services, Director
John Graham, Smyth County Circuit Court, Clerk of Circuit Court
Eve Greene, Frontier Health
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Judy Horne, Noah Horn Well Drilling, Inc., Director of Health and Safety
Ron Houk, Independence Police Dept, Investigator
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Ann Hughes, Medical Society of Virginia, Director of Government Relations
Holly Hurley, Appalachian College of Pharmacy, Assistant Professor of Pharmacy Practice
Mike Hymes, Tazewell County, Board of Supervisors
Michael Jennings, Carroll County Social Services, Director
Sarah Jessee, Wise County CWA Office
Nancy Johnson, RN, Rooker Psychiatric Services, PC, Registered Nurse
Suzanne Kerney-Quillen, Wise County Commonwealth's Attorney's Office, Deputy Commonwealth's Attorney
Debra Kincaid, Dr. Cynthia Southern DDS
Regina Kinder, Congressman Rick Boucher, Senior Casework Specialist
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Mark Larsen, Occupational Enterprises, Inc., LPC
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Deborah May, Life Center of Galax
Alice McDowell, Marion Pediatrics
Dr James McDowell, Smyth County Family Physicians
Linda McGee, PCPC
Shawn Meek, VADOCS - PSCC, Assistant Warden
Sarah Melton, PharmD, BCPP, CGP, Appalachian College of Pharmacy, Director of Addiction Outreach, Associate Professor of Pharmacy Practice
G. Jason Miles, Virginia State Police, Captain
Carl E. Mitchell, President & CEO, Virginia Economic Bridge
Lisa Moore, Mount Rogers Community Service Board, Executive Director
Matthew Mullins, Glade Spring Police Department, Chief of Police
Donna Muncy, VA Department of Corrections, Re-Entry Specialist
Sherri Nipper, Giles County Dept. of Social Services, Director
Sandy O'Dell, Frontier Health, Sr. Vice President VA operations
Jeannie Patrick, Southwest VA Regional Jails, Administrative Lieutenant
Brian Patton, Russell County Commonwealth’s Attorney
Paulette Phillips, Dickenson Behavioral Health
Brittney Powers, Dickenson Behavioral Health
Matthew Puckett, Town of St. Paul, Virginia, Police Officer
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Roger Ramey, Norton City DSS, Director
Sarah Raskin, University of Arizona
The Honorable Radford Ray, Town of Cleveland, Mayor
Willie Richardson, VDEM
Gary Roche, Pulaski Police Dept, Chief of Police
Dr. Gary Rooker, Rooker Psychiatric Services, PC, Psychiatrist
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Kimber Simmons, Virginia Economic Bridge
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Kristy Slone, Appalachian College of Pharmacy, Student Pharmacist
Karen Smith, Cumberland Mountain Community Services Board, REMOTE Coordinator
R.D. Snead, Russell County IDA, Vice Chair-IDA
Kimberly Sobey, Bland Co. DSS, Director
Aleta Spicer, Occupational Enterprises, Inc., Executive Director
Lee Spiegel, Pulaski Community Partners Coalition, Coalition Coordinator
Charles Stapleton, Jr., Wise County Sheriff’s Office, Sgt.
Jonathan Sweet, Grayson County, Administrator
Steve Templeton, Town of Gate City, Town Manager
Rex Tester, Tazewell County DSS, Director
Rita Tipton, Town of Gate City, Vice Mayor
David Vaughn, Family Preservation Services, Counselor
Mike Wade, New River Valley Community Services, Community Relations Specialist
Dr. David Wallace, Dr. David A. Wallace, DDS, MS
Jim Wallis, Pulaski County Dept of Social Services, Director
Cheri Warburton, NRVCS, Director of Adult Clinical and Emergency Services
Kim Watkins, Dr. David A. Wallace, LPN, Oral Surgery Assistant
Susan West-Marmagas, VT Master of Public Health
Lindy White, Smyth County Community Hospital, CEO
Randy Williams, Russell County Commissioner of Rev
J. Bryston Winegar, Holston Medical Group, MD
Mona Woods, USP Lee, Psychology Assistant
Claude Worrell, Va. State Police, Sgt.
Martha Wunsch, Addiction Medicine, MD
Festivals in Southwest Virginia
What’s wrong with this picture?

What’s wrong with this picture? (Office of the Chief Medical Examiner's Annual Report, 2008)

- For the 5th year in a row, the number of drug/poisoning cases increased with an overall increase of 91.4 percent since 1999.
- The overall rate of drug/poison caused deaths for Virginia residents was 9.5 per 100,000 people.
- The majority of cases were accidents (78.1%), males (61.4%), whites (86.1%), and 35-44 year olds (27.2%).
- Narcotics were the most frequently identified (36.2%) followed by anti-anxiety medications (15.6%).
- Twenty-three of the 735 (3.1%) drug/poison deaths were ethanol-only deaths.
- Whites died from prescription drugs 4.5 times that of blacks; blacks died from illegal drugs 1.6 times as whites.
- Western Virginia (PDs 1-4) has 33.5% of all drug-related deaths in Virginia.
- The majority of all drug-related deaths are between ages 25 and 54.
- 450 of 735 drug-related deaths were from prescription drugs (61%).
Office of the Chief Medical Examiner’s Annual Report, 2008 cont’d.

<table>
<thead>
<tr>
<th>FHMO Combination</th>
<th>Total statewide deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oxycodone</td>
<td>87</td>
</tr>
<tr>
<td>Methadone</td>
<td>124</td>
</tr>
<tr>
<td>Fentanyl</td>
<td>50</td>
</tr>
<tr>
<td>Hydrocodone</td>
<td>45</td>
</tr>
<tr>
<td>Oxycodone &amp; Methadone</td>
<td>12</td>
</tr>
<tr>
<td>Oxycodone &amp; Fentanyl</td>
<td>6</td>
</tr>
<tr>
<td>Oxycodone &amp; Hydrocodone</td>
<td>16</td>
</tr>
<tr>
<td>Methadone &amp; Fentanyl</td>
<td>4</td>
</tr>
<tr>
<td>Methadone &amp; Hydrocodone</td>
<td>3</td>
</tr>
<tr>
<td>Fentanyl &amp; Hydrocodone</td>
<td>7</td>
</tr>
<tr>
<td>Oxycodone, Fentanyl &amp; Hydrocodone</td>
<td>1</td>
</tr>
<tr>
<td>Oxycodone, Methadone &amp; Hydrocodone</td>
<td>1</td>
</tr>
<tr>
<td>FHMO Subtotal</td>
<td>356</td>
</tr>
</tbody>
</table>

2008 Deaths by accident, homicide or suicide in PD I

Lee          10 accidental; 2 homicides; 7 suicides - Of these 2 were drug-related, both FHMO

Norton       1 accidental; 0 homicides; 2 suicides - Of these 2 were drug-related, both FHMO

Scott        10 accidental; 1 homicide; 5 suicides - Of these 3 were drug-related, all FHMO

Wise         15 accidental; 0 homicides; 8 suicides - Of these 8 were drug-related, all FHMO

2008 Deaths by accident, homicide or suicide in PD II

Buchanan     19 accidental, 2 homicides, 4 suicides in 2008 - Of these, 10 were drug-related deaths; 7 were FHMO combination,

Dickenson    13 accidental, 1 homicide, 5 suicides - Of these, 11 were drug-related deaths; 8 were FHMO combination

Russell      15 accidental, 1 homicide, 10 suicides - Of these, 5 were drug-related deaths; 4 were FHMO combination

Tazewell     16 accidental, 2 homicides, 4 suicides - Of these, 13 were drug-related deaths; 10 were FHMO combination; 1 was heroin/cocaine.
### 2008 Deaths by accident, homicide or suicide in PD III

<table>
<thead>
<tr>
<th>Location</th>
<th>Accidents</th>
<th>Homicides</th>
<th>Suicides</th>
<th>Drug-Related Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bland</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>Of these 1 was drug-related and was FHMO</td>
</tr>
<tr>
<td>Bristol</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>Of these two were 2 drug-related, both FMHO</td>
</tr>
<tr>
<td>Carroll</td>
<td>19</td>
<td>0</td>
<td>6</td>
<td>Of these, 6 were drug-related, all FHMO</td>
</tr>
<tr>
<td>Galax</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>None were drug-related</td>
</tr>
<tr>
<td>Grayson</td>
<td>2</td>
<td>2</td>
<td>5</td>
<td>None were drug-related</td>
</tr>
<tr>
<td>Smyth</td>
<td>11</td>
<td>3</td>
<td>5</td>
<td>Of these, 5 were drug-related, all FMHO</td>
</tr>
<tr>
<td>Washington</td>
<td>22</td>
<td>0</td>
<td>11</td>
<td>Of these, 10 were drug-related, 9 FMHO, one heroin/cocaine</td>
</tr>
<tr>
<td>Wythe</td>
<td>24</td>
<td>2</td>
<td>8</td>
<td>Of these 11 were drug-related, all FMHO</td>
</tr>
</tbody>
</table>

### 2008 Deaths by accident, homicide or suicide in PD IV

<table>
<thead>
<tr>
<th>Location</th>
<th>Accidents</th>
<th>Homicides</th>
<th>Suicides</th>
<th>Drug-Related Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Floyd</td>
<td>5</td>
<td>2</td>
<td>1</td>
<td>Of these 2 were drug-related, both FMHO</td>
</tr>
<tr>
<td>Giles</td>
<td>9</td>
<td>0</td>
<td>3</td>
<td>Of these 4 were drug-related, all FMHO</td>
</tr>
<tr>
<td>Montgomery</td>
<td>27</td>
<td>3</td>
<td>8</td>
<td>Of these 13 were drug-related, 11 FMHO</td>
</tr>
<tr>
<td>Pulaski</td>
<td>19</td>
<td>2</td>
<td>2</td>
<td>Of these 11 were drug-related, all FMHO</td>
</tr>
<tr>
<td>Radford</td>
<td>11</td>
<td>2</td>
<td>1</td>
<td>Of these 4 were drug-related, 2 FHMO, 1 heroin/cocaine</td>
</tr>
</tbody>
</table>
Emerging Enterprises and Opportunities in Southwest Virginia
APPENDIX V

About One Care

In 2009, One Care of Southwest Virginia, a 501c(3) with roots in substance abuse issues was called upon by community leaders and began to take a focused regional approach and lend a stronger, more unified voice on the substance abuse (SA) issues affecting Virginia’s Great Southwest. That call was embraced by a reinvigorated board and led to a series of meetings where the determination to focus on policy, data and advocacy in the SA arena emerged and coalesced.

Today, One Care of SWVA serves as a consortium of 16 substance abuse coalitions working throughout the 21 counties and cities in the region. The 25 member Board of Directors includes representatives from community service boards, faith based organizations, social services and the health care, higher education, law enforcement and recovery communities. Outreach to business and industry and senior services organization sectors is ongoing. The One Care of SWVA Board operates collaboratively and has is committed to undertaking a broad based strategic planning initiative—a Blueprint for the control and mitigation of substance abuse and misuse in southwest Virginia facilitated by the Healthy Appalachia Institute and with the encouragement of the Southwest Virginia Health Authority, regional partners and elected officials.

One Care Mission, Vision and Values

Mission: One Care of Southwest Virginia is committed to decreasing substance abuse and misuse, and related social, economic and health factors through planning, policy, data, and advocacy.

Vision: One Care’s vision is to be a model for achieving significant reductions in substance abuse and related social, economic and health factors by building and supporting community partnerships.

Values:

• Commitment
• Community
• Compassion
• Dignity
• Inclusiveness
• Integrity
• Openness
• Recovery
• Respect
One Care Strategic Goals

- Build and maintain strategic alliances for the provision of resources.
- Cooperate with strategic and community partners to document and address gaps in service.
- Build and maintain a consortium of service providers for seamless provision of services.
- Ensure people in Southwest Virginia are aware of the available resources provided by One Care and our partners.
- Continuous organizational and process improvement and effective leadership for One Care.
- Build and expand the technological infrastructure to meet the needs of One Care’s stakeholders, partners and the community at large.

One Care Service Region
A scenic view in Southwest Virginia
Adopt a Substance Abuse and Misuse Recommendation

Is your organization helping in the Prevention, Treatment and Control of Substance Abuse and Misuse in Southwest Virginia?

If so, we want to recognize your efforts!

One Care of SWVA’s Blueprint for Substance Abuse and Misuse Prevention, Treatment and Control (OC-SB4RSA) is a 3-5 year strategic plan which tracks progress towards reducing substance abuse and misuse in Virginia’s Great Southwest.

There are several recommendations related to the successful implementation of the OC-SB4RSA. If you are already working on some aspect of one or more of these recommendations, or are considering doing so in any capacity, we need you to sign up!

We want to make sure that your efforts are included. We also want to be able to highlight local, regional and statewide success stories!

Please fill out the form below and check any recommendations that you or your organization is already doing or plans to do, and return your completed form to us table to be entered into a drawing.

Name  
Title  
Agency/Organization  
Email Address  
Phone Number  

A. Improve Treatment Access for Substance Abusing Offenders
- Advocate for funding of and expansion of existing Drug Court Treatment Programs in 100% of SWVA localities
- Double the number of established Drug Courts in SWVA (currently 2) localities by 2013.
- Provide SWVA elected and judicial officials with return on investment information on Drug Courts versus incarceration
- Fund and expand existing Drug Court Treatment Programs in 100% of SWVA localities

B. Encourage and support expansion of Mutual Support/Peer Recovery in SWVA
- Establish at least two Mutual Support /Peer Recovery Groups in 100% of SWVA’s localities
- Support an electronic clearinghouse of information about Mutual Support/Peer Recovery Group meetings, places and times
- Promote Mutual Support/Peer Recovery Promotion in the Community Education Campaign
- Support Peer Recovery Groups geared towards adolescent SA Group Work
- Challenge each faith community with more than 200 members to open their doors to at least one peer recovery group
- Foster at least one AA, NA or similar peer recovery group in 50% of jails in the region

C. Expand treatment options and capacity and promote existing treatment options
- Promote existing treatment resources for tobacco cessation
- Create positive messages about the benefit of locally available treatment options including methadone clinics and residential treatment
- Establish a demonstration project aimed at partnerships between behavioral health (CSB) and primary care clinic (FQHC or private practice) to provide creative collaborative treatment opportunities
- Increase reimbursement for intensive outpatient substance abuse treatment services
- Utilize Southwest VA Mental Health Institute in Marion for new inpatient substance abuse services
- Raise taxes on alcohol and cigarettes to reduce consumption and use additional funds for prevention and treatment activities
- Work toward having 5% of all private practices offering medication assisted therapy for opiate dependence in three years; always in collaboration internally or externally with individual and/or group peer or professional counseling therapy
- Develop at least one long-term residential substance abuse treatment facility in each planning district
- Increase funding for substance abusing adolescent treatment groups
- Establish at least one detoxification facility in each planning district
- Develop at least one regional women’s treatment program geared specifically toward the treatment and prevention/education of women, with a priority toward pregnant women
- Utilize Southwest VA Mental Health Institute in Marion for new inpatient substance abuse services

D. Reduce the incidence of Substance Abuse in SWVA
- Assure that at least one professional society (e.g. Medical Society of VA, VA Dental Association, VA Nursing Association, and VA Pharmacists Association) adopts Prescription Drug Abuse mitigation as a priority
- Require reporting of suspected drug diversion and doctor shopping by Licensed Health Care Provider’s (LHCP) and dispensers of Schedule II, III, and IV medication
- Encourage pharmacists to provide face-to-face verbal counseling for Schedule II controlled substances for new prescriptions or prescription changes
- Implement “SBIRT” (Screening Brief Intervention Referral and Treatment) in two regional primary care offices, two Emergency departments, three health departments, six Community Health Center sites and eight Community Service Board sites

### E. Encourage greater collaboration among Law Enforcement Agencies and others
- Expand ability of local law enforcement to work/augment colleagues in other jurisdictions
- Reduce sales of alcohol and tobacco to minors by expanding local law enforcement compliance-check partnerships
- Assist VA State Police in educating Prescribers and Dispensers regarding the role of Drug Diversion Agents
- Achieve a visible law enforcement educational partnership with 10% of active PTAs/school parent groups
- Provide initial and semi-annual training for 25% of law enforcement in SA officers regarding substance abuse, use speakers bureau for this purpose
- Explore the advisability of requiring/allowing immunity for Common Carriers to divulge reasonable suspicion of illegal drug delivery
- Provide seminars targeted to judges and attorneys regarding physician assisted treatment and monitoring in a drug court context
- Ensure that at least one drug court will work directly with the support of a physician trained in addiction medicine
- Create re-entry coalitions to include custodial, treatment and service partners in at least 50% of the localities served by One Care within three years
- Implement an evidence-based approach to decrease recidivism by 25% in at least two local prison populations in three years
- Develop a forum to create stronger communication between judges, Commonwealth attorneys and local sheriff departments in effectively using drug courts

### F. Create a culture of responsibility
- Create and fund a comprehensive communications campaign

### G. Expand Community Treatment Options
- Create at least two peer recovery groups in the region for Veterans having post-traumatic stress disorder (PTSD) or at risk for PTSD or other mood/anxiety disorder
- Identify an existing or recruit a regional employer to demonstrate at least one employment based recovery program where the offer and maintenance of employment is conditioned upon staying in recovery
- Identify or create a source of technical assistance for employers willing to have an employment based recovery program(s), seek advice of existing impaired professional programs
- Create at least two peer recovery groups in the region for Veterans having post-traumatic stress disorder (PTSD) or at risk for PTSD or other mood/anxiety disorder

### H. Expand professional and community SA educational opportunities
- Seek active participation in substance abuse education of at least one major statewide medical professional group and at least one major pharmaceuticals manufacturer
Create a speakers bureau that includes both academic or medical experts and recovered persons to speak individually or in team

Create a Behavioral Health ASS degree in alcohol and drug counseling as step to Certified Substance Abuse Counselor Licensure

Provide coordinated annual educational offerings for SA treatment providers in the region via collaboration among local public and private treatment providers and professionals groups

Require prescribers and dispensers of medication to obtain at least one hour of CME on SA and pain management each licensure period

Fund an FTE/50,000 population public health educator/community health workers and/or drug educators for SA prevention and outreach to special populations including pregnant women, veterans, and families with multigenerational SA patterns

Develop a program targeted at non-professionals to become community drug educators similar to diabetes educators

Promote SA as a chronic treatable disease model (as with diabetes) to medical providers and insurers

Encourage undergraduate training programs for prescribers, administrators and dispensers of medications (e.g. Physicians, Nurses, Pharmacists) to incorporate at least two hours of didactic education regarding pathophysiology, screening, identification and treatment of addiction

Identify or Fund an FTE/100,000 population public health educator/community health workers and/or drug educators for SA counter-detailing and best practice ‘marketing’ towards prescribers

I. Expand SA education opportunities for key community leaders

☐ Engage at least 60 clergy members in actively combating SA in their communities

☐ Hold at least one local and one regional SA coalition meeting annually in the evening to allow care providers to more easily attend

J. Expand formal Substance Abuse education in Schools

☐ Implement age appropriate SA education in K-12 health classes in at least four school districts

☐ Include SA education and medication-related impairment in all driver education classes in high school in at least four school districts

☐ Create school health coordinator positions in at least one regional school system to include the mandated development of EARLY (K-7th) age-appropriate lifetime athletics (e.g., running, swimming) and arts (visual, performance) afterschool school-assisted programs and EXPLICITLY incorporate stay healthy (eat right, don’t smoke, don’t use drugs) education and messaging for school based wellness

☐ Provide school-based age-appropriate early (K-7) lifetime athletics (running, swimming) and arts (visual and performing) opportunities, and explicitly incorporate health and wellness education messaging into these activities

K. Advocate for more robust user-level information and control of abuse and overdose prone medications

☐ Promote Graphic Warning labels using graphic depictions and/or basic elementary reading level language

☐ Expand regional “Take Back” activities
L. Advocate for more robust user-level information and control of abuse and overdose prone medications
- Do not allow for the waiving of pharmacy counseling for Schedule II controlled substances
- Require prescribers to complete CME prior to recertification of their Drug Enforcement Agency number/State license
- Require Prescription Monitoring Program access and periodic review for prescribers and dispensers of schedule drugs
- Require a PMP profile for any patient prior to prescribing a Schedule II, III, or IV substance
- Advocate for the simultaneous multi-state single point of access PMP prescription monitoring programs and require physicians to use it as supported by NASPER
- Require providers of medication assisted treatment (e.g. methadone and buprenorphine) to periodically review PMP on active patients
- Advocate for a shall report of suspected drug diversion by patients and prescribers/dispensers of potentially addictive medication
- Require Pharmaceutical manufacturers to be responsible for products from cradle to grave to include pharmacy based take back programs for unused/expired drugs
- Ban the sale and marketing of drug paraphernalia and designer drugs in retail establishments
- Require periodic saliva, urine or hair based drug screening for any person receiving a Schedule II, II or IV medication, the drug screening to include the drug prescribed and other commonly abused medications
- Explore evidence-based programs that use web-based exposure of convicted drug sellers for reducing crime and recidivism (59) (N)
- Advocate for moving benzodiazepines to Schedule II status (Drug Enforcement Agency)
- Achieve at least one no-smoking in public places ordinance in at least one of our localities each year, post signs at community events

M. Focus additional effort towards job creation and encouragement for disabled adults and underemployed young adults
- Reduce the incidence and prevalence of unnecessary regional disability by two percent in five years
- Decrease the unemployment rate for 18-24 year olds by two percentage points in five years

N. Identify gaps in regional research
- Identify or initiate a comparative study of the relative costs of any state program that works with substance abusers who use illegal substances
- Engage an University to identify a region or locality that has successfully and definitively reduced its SA or overdose death rates and identify the key factors that may be adopted regionally
- Encourage a group of engaged community members to study best practices in SA prevention that can be implemented locally

O. Seek additional resources
- Obtain or retain funding for regional consortium and coalition staff from member entities and other stakeholders
- Work to have at least 60% of our counties and cities receiving at least one Drug Free Communities grant by 2013
Seek state support to develop a “One Stop” initial assessment, referral and care coordination resource for consumers (including infants, pregnant woman) of SA treatment in each locality in an existing agency as an entry point into a Recovery Oriented System of Care

P. Expand the professional SA workforce

Identify a source of loan repayment for two licensed SA professionals annually who agree to work for a minimum period in an underserved locality

Q. Implement a Recovery Oriented System of Care regionally

Work to create a unified, evidence-based and consistent regional treatment SYSTEM that links existing treatment resources, (behavioral, social, community based, faith based, drug offender rehabilitation, private practice and others) into a seamless yet flexible recovery system for abusers that creates measurable superior outcomes in a regional Recovery Oriented System of Care

Develop a rapidly responsive system of SA treatment for parents and children targeted to families whose children are at risk of coming into foster care thru foster care prevention

Assure best practices for the continued availability of pain management services in both primary care and specialty settings

Work to create a unified, evidence-based and consistent regional treatment SYSTEM that links existing treatment resources, (behavioral, social, community based, faith based, drug offender rehabilitation, private practice and others) into a seamless yet flexible recovery system for abusers that creates measurable superior outcomes in a regional Recovery Oriented System of Care

THANK YOU!

Please return your completed form to One Care of SWVA.
A picture of hope in Southwest Virginia