2026

BLUEPRINT FOR ACTION UPDATE

Purpose

The purpose of the 2026 Roanoke Valley Collective Response (RVCR) Blueprint for Action Update is to provide a comprehensive, data-driven roadmap that guides regional partners in addressing the evolving substance use and overdose crisis across the Roanoke Valley–Alleghany region. Building on the foundation of the 2020 Blueprint for Action, this update reflects shifts in the local and national landscape—including the increase of fentanyl in the illicit drug supply, changing patterns of substance use, and new opportunities for cross-sector collaboration.

This report synthesizes insights gathered through a year-long, community-driven process involving stakeholders, subject-matter experts, people with lived experience, and regional leaders. It identifies priority areas, evidence-based and emerging best practices, and actionable recommendations to strengthen prevention, treatment, crisis response, recovery services, and long-term pathways to thriving.

The Blueprint for Action Update is intended to:

- Provide a unified framework that supports coordinated, multisector strategies across the recovery ecosystem.
- Guide decision-makers, funders, service providers, and community partners in aligning efforts to meet the region's most urgent needs.
- Establish clear priorities for the next 3–5 years that enhance the region's capacity to reduce substance-related harms and promote recovery.
- Support the ongoing development, evaluation, and sustainability of the RVCR as a regional backbone organization grounded in the Collective Impact Model.

Ultimately, the purpose of this document is not only to inform—but to empower. This Blueprint serves as a practical tool to help partners mobilize resources, strengthen collaborative practices, and implement solutions that improve the health and well-being of individuals, families, and communities throughout the Roanoke Valley–Alleghany region.

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Acronyms & Definitions

- American Rescue Plan Act (ARPA)
- Blueprint for Action (Blueprint)
- Collective Advisory Committee (CAC)
- Collective Impact Model (CIM)
- Community Services Board (CSB)
- Emergency Department (ED)
- Emergency Medical Services (EMS)
- Framework for Addiction Analysis and Community Transformation (FAACT)
- Neonatal Abstinence Syndrome (NAS)
- Overdose Detection Mapping Application Program (ODMAP)
- People Who Use Drugs (PWUD)
- Recovery-oriented system of care (ROSC)
- Roanoke Valley Alleghany Regional Commission (RVARC)
- Roanoke Valley Collective Response (RVCR)
- Substance Abuse and Mental Health Services Administration (SAMHSA)
- Substance Use Disorder (SUD)
- Vibrant Virginia and Combating Overdose through Community Level Interventions (COCLI)
- Virginia Commonwealth University (VCU)
- Virginia Department of Health (VDH)
- Virginia Opioid Abatement Authority (VOAA)

Executive Summary

The Roanoke Valley Collective Response (RVCR) began in 2018 as a volunteer-led coalition of healthcare providers, law enforcement and criminal justice officers, nonprofit leaders, public officials and concerned citizens to address the region's substance use and overdose crisis. Housed as a quasi-governmental agency under the Roanoke Valley Alleghany Regional Commission (RVARC), the RVCR aims to address the addiction crisis in the Roanoke Valley through activities such as collaborative assessment and planning, addressing root causes of addiction, implementing evidence-based practices, local tailoring of efforts, embracing comprehensive strategies and providing community education and support.
The RVCR serves individuals within the RVARC footprint which includes Alleghany County, Botetourt County, Craig County, Franklin County, Roanoke County, the cities of Covington, Roanoke and Salem; and the towns of Clifton Forge, Rocky Mount and Vinton.

The RVCR's initial collaboration and ongoing deliberation over 18 months resulted in the release of the Blueprint for Action (Blueprint) in September 2020. The Blueprint was intended to be a strategic plan to build a recovery-oriented system of care (ROSC). The RVCR has since evolved into a formally staffed program under the Roanoke Valley-Alleghany Regional Commission (RVARC) with support from the American Rescue Plan Act (ARPA), Substance Abuse and Mental Health Services Administration (SAMHSA), and the Virginia Opioid Abatement Authority (VOAA).

THE RVCR MISSION:
United to build, sustain, and support communities by responding to addiction and promoting recovery and wellness.

As the environment around substance use, addiction and response to these crises have shifted, with the rise of fentanyl and changing partner dynamics, so too did the urgency for an updated plan and expansion of scope and a broader focus. The Blueprint remains critical for guiding strategic priorities, informing policy and identifying funding needs across the region. The RVCR Blueprint for Action is supported by three operational components: RVCR staff, the Collective's Advisory Committee (CAC), and approximately 50 – 60 active members of the stakeholder group.

The 2026 Blueprint for Action Update consists of a full review, scope expansion, and update of the 2020 Blueprint for Action as the guiding document for those working in the SUD space in the region to achieve the RVCR mission. Activities to create the update included (1) review of the current state of the addiction crisis in the RVARC service area, (2) assessment of the impact of the original 2020 Blueprint, evaluating where specific measurable outcomes of the work of the RVCR can be tracked to date, (3) assessment of the current workgroup structure and recommendations for changes, and (4) strategic plan and priority setting to guide the activities of the RVCR over the next 3 years.

The 2026 Blueprint for Action Update prioritized presents **47 community-driven recommendations for priorities across 9 workgroups**. *Of note, these recommendations are not ranked or weighted in any particular order and will henceforth be referred to as Priorities.*

Snapshot of Workgroups

Prevention, Education & Family Support

Purpose: Identifying, communicating, and educating the Roanoke Valley of available resources for individuals with SUD.

Goal: Decreasing mental health challenges that may lead to increased substance use, violence, and decline in the quality of life for individuals with SUD.

Priorities: To increase access to safe and supportive spaces for individuals and families, reducing stigma within the community, and improving awareness of support services available to individuals with SUD.

Crisis Intervention & Public Safety

Purpose: Improving the rapid response to overdose by strengthening response with trauma-informed care, addressing health disparities, and strengthening the referral network to additional services for individuals.

Goal: To decrease the burden of overdose felt by persons who use drugs, their friends and families, and first responders.

Priorities: To provide data driven rapid response to overdoses, increase SUD support in local jails, increase support for Peer Recovery Specialists, and strengthen connections with law enforcement and EMS.

Treatment

Purpose: Services along a continuum of care for individuals with SUD with support during transitions in care and cross-sector coordination.

Goal: Rapid access to treatment at all levels of care to reduce disruptions in care and foster better outcomes for individuals.

Priorities: To integrate evidence-based practices into treatment services, increase collaboration, and strengthen the continuum of care to reduce gaps and barriers to treatment services.

Workforce & Economic Development

Purpose: Development of regional workforce supports for individuals living with SUD.

Goal: Engaging the business sector to become recovery ready to identify workforce needs and support recovery in the workplace.

Priorities: To engage and educate employers on supervision, emotional support, resiliency, and sustainability for individuals in recovery in the workplace.

Recovery Services

Purpose: Integrating peer support services and care coordination across all aspects of recovery, including housing, transportation, and other aspects of the social determinants of health.

Goal: Focusing on supports for individuals, families, and communities affected by SUD for improvement on health and wellness.

Priorities: Discussion with the insurance sector to support recovery services, additional collaboration with other service agencies in the region, practical job training and job readiness, and development of viable recovery housing.

Thriving

Purpose: Supporting individuals in long term recovery including recreation, wellness, and self-development.

Goal: Long-term support for individuals in recovery by maintaining social determinants of health as well as personal purpose, passion, and identity development.

Priorities: Transitional support to independent living, identifying and fostering opportunities for self-sufficiency, and sharing stories of success to encourage and support individuals with SUD and reduce stigma.

Overall Priorities for Workgroups

Purpose: Focus on supporting the workgroups within the RVCR to achieve restructuring, reconvening, and the tracking of progress on identified workgroup priorities.

Goal: Activating the RVCR workgroups in a meaningful and purposeful way to advance progress towards RVCR goals and priorities.

Priorities: Defining roles, identifying workgroup chairs, determining meeting frequency and tracking mechanisms, as well as engaging representatives from sectors not currently involved in the RVCR.

Funding, Policy & Advocacy

Purpose: Cross membership workgroup focused on identifying funding opportunities, policy and advocacy, and engagement with government entities to support aspects of the recovery ecosystem.

Goal: Supporting stakeholder and partner organizations to acquire the resources necessary for effective service delivery and advocacy.

Priorities: Advocating to state and elected officials to sustain and expand services, coordinating for funding opportunities and proposal development, and engagement with government on relevant needs of the SUD community.

Data Collection, Measurement, and Evaluation

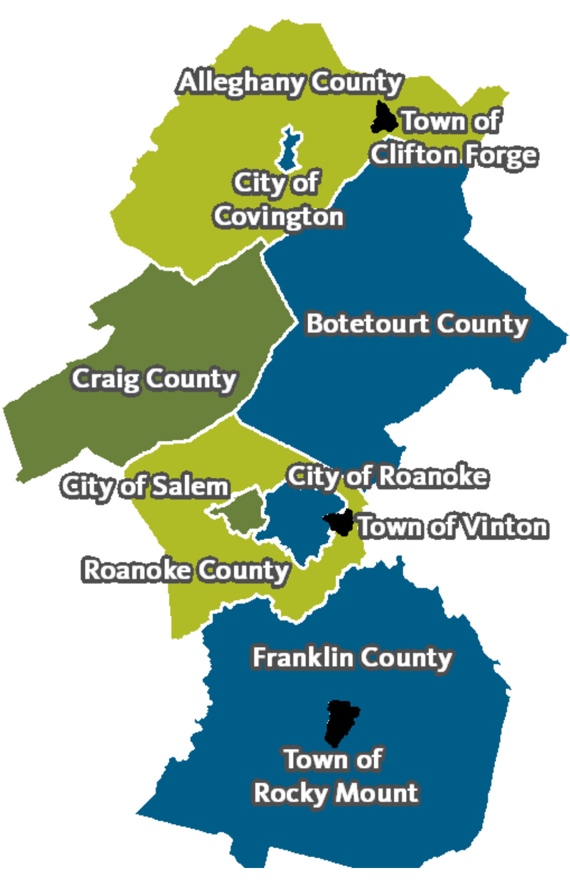
Purpose: The Cross membership workgroup focused on collecting data, measurement, and evaluation of the RVCR in alignment with the Collective Impact Model (CIM).

Goal: To benchmark and track progress of the RVCR goals and workgroup priorities that result in impacted outcomes within the recovery ecosystem.

Priorities: To establish a shared data system with routine data sharing, increase awareness of RVCR goals, priorities, and collective impact model core elements.

Introduction & Background

Geographic Communities of Focus



The Roanoke Valley Alleghany Regional Commission serves residents in 11 geographic areas including Alleghany County, Botetourt County, Craig County, Franklin County, Roanoke County, the cities of Covington, Roanoke and Salem; and the towns of Clifton Forge, Rocky Mount and Vinton. According to the U.S. Census Bureau (2023), among the total population of 351,741 people, 48% are female and 52% are male. Approximately 21% of the MSA's residents are aged 65 years and older, which is a higher rate than both the Virginia and national levels. Within the region, about 12% of residents live in poverty, 3% of whom are children. Median household income ranges from approximately $35,222 to $88,228, with a median of $68,772 in 2025 inflation-adjusted dollars. In terms of educational attainment, among the population aged 25 and over, 58% have attained some college education or more, which is lower than both Virginia and the United States (See Table 1).

Table 1. Demographic, Socioeconomic, and Income Characteristics of the Roanoke Valley–Alleghany Region Compared to Virginia and the United States. (2023)

	Roanoke Valley Alleghany Regional Commission		Virginia		United States	
Total Population	**351,741**		8,657,499		332,387,540	
Gender						
Female	169,608	**48%**	4,278,490	49%	164,545,087	50%
Male	182,133	**52%**	4,379,009	51%	167,842,453	50%
Age						
Under 18 years	72,143	**21%**	1,893,985	22%	73,645,238	22%
18-64 years	205,680	**58%**	5,353,354	62%	202,772,255	61%
65 years and over	73,918	**21%**	1,410,160	16%	55,970,047	17%
Poverty Status in 2023						

Living in poverty under 18	12,245	**3%**	236,443	13%	11,829,878	16%
Living in poverty, 18-64 years	23,547	**7%**	484,270	9%	22,905,636	12%
Living in poverty, 65 years and over	7,011	**2%**	114,153	8%	5,654,531	10%
Total population living in poverty	42,803	**12%**	834,866	30%	40,390,045	38%
Educational Attainment for Population 25 Years and Over						
Population 25 Years and Over	251,799		5,958,915		228,434,661	
Less than High School	21,175	**8%**	516,186	9%	24,230,217	11%
High School Graduate or More (Includes Equivalency)	230,624	**92%**	5,442,729	91%	204,204,444	89%
Some College or More	146,769	**58%**	4,019,027	67%	144,367,955	63%
Median Household Income (In 2025 Inflation-Adjusted Dollars)	**Range: $35,222-$88,228**		$96,785		$83,555	

Source: U.S. Census Bureau, American Community Survey (ACS) 5-Year Estimates (2019–2023)

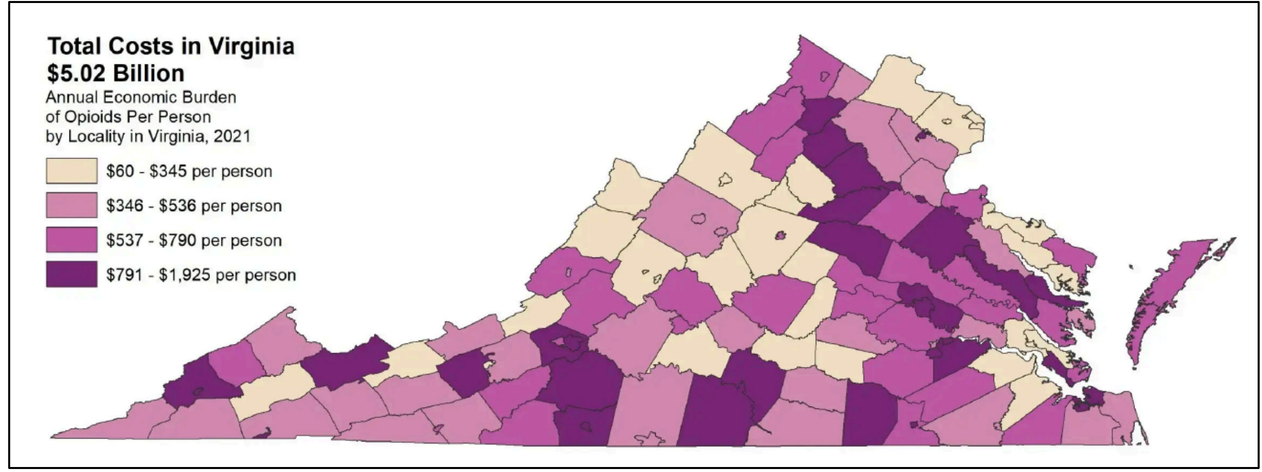
Statement of the Problem

While Virginia has experienced escalated rates of opioid misuse and drug overdose in the past several years, rates are declining ever so slightly among some key indicators. In 2023, there were “2,463 drug overdose deaths among Virginians, a 1% decrease from 2022; drug overdose deaths peaked in 2021 at 2,622 deaths” (Virginia Department of Health, 2024a). However, more than three quarters of drug overdose deaths involved fentanyl, fentanyl analogs, and tramadol, so the threat of fentanyl that spiked during COVID-19 persists (Laing & Donnelly, 2024). Rates of neonatal abstinence syndrome (NAS), which is a developmental condition among newborns exposed to substances in utero, have decreased since 2019 (Virginia Department of Health, 2024b). The decrease in NAS is credited in large part to the increased access to Medication Assisted Treatment (MAT) for pregnant women and greater awareness of providers in the continuum of care for pregnant women.

Impact Indicators

A study by the Virginia Department of Health (VDH) and Virginia Commonwealth University (VCU) reports that the opioid epidemic cost Virginia $5 billion in 2021, with at least 6 Virginians dying of an overdose every day on average (Trani, 2024). Costs are notably higher per capita in the Roanoke Valley compared with the surrounding regions (Figure 1).

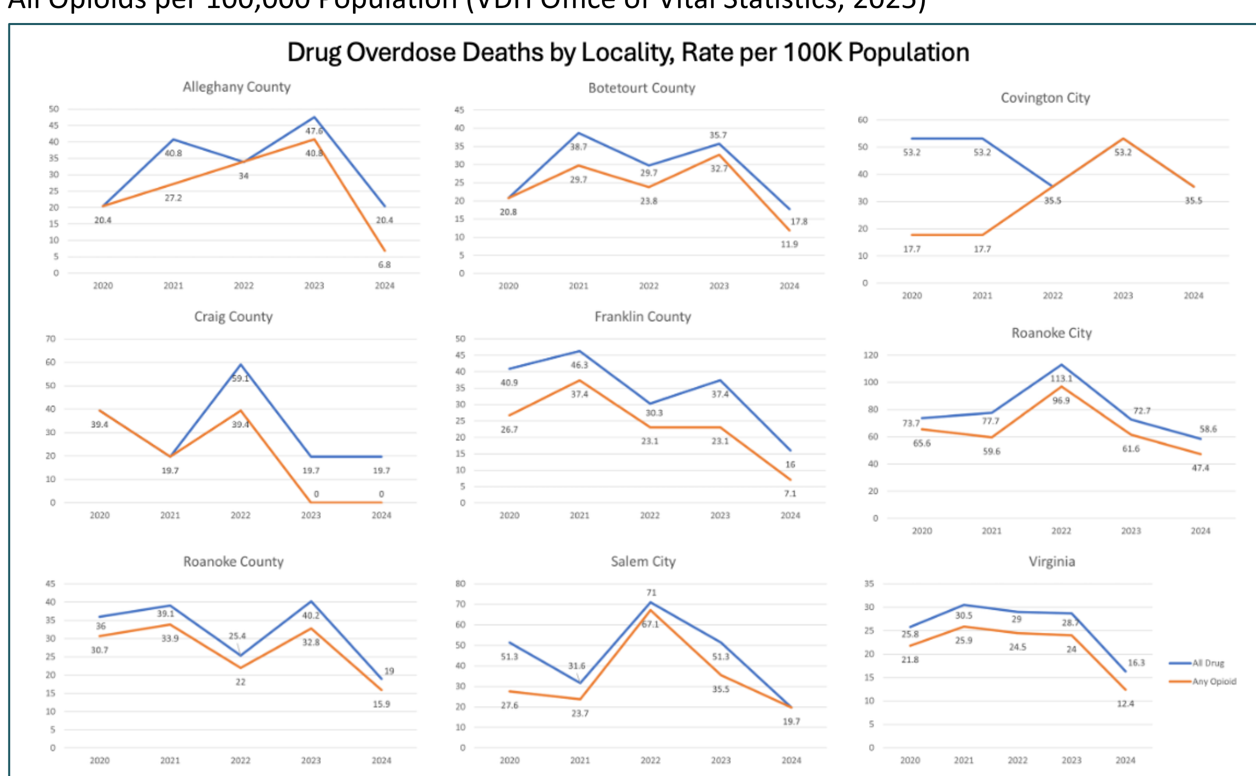
Figure 1. Annual Economic Burden of Opioids per Person by Locality in Virginia (2021) (Trani, 2024)



Trends in Opioid-Related Emergency Department (ED) Visits and Overdose Mortality in Virginia

Virginia is experiencing a persistent opioid crisis, as reflected in the trends of opioid-related emergency department (ED) visits and overdose mortality over the past six years. The data shows fluctuations, but the overall trend indicates a sustained increase in opioid-related health emergencies through 2022. Between 2018 and 2019, ED visit rates remained relatively stable at 86.4 and 88.5 per 100,000, respectively. However, in 2020, there was a sharp increase, with ED visits surging to 117.2 per 100,000, continuing to climb until peaking at 134.8 per 100,000 in 2022, before slightly declining to 132.5 per 100,000 in 2023. When comparing drug-related ED visits in the Roanoke Valley to statewide trends, it is clear that several localities have consistently higher rates than the Virginia average (Figure 2). Roanoke City and Salem City stand out with persistently elevated rates, peaking significantly higher than the state average and showing a sharp increase before slightly declining in recent years. Smaller localities like Covington have also experienced spikes, notably in 2020.

Figure 2. Rate of Fatal Drug Overdoses by Locality of Injury, 2020-2024* for All Substances and All Opioids per 100,000 Population (VDH Office of Vital Statistics, 2025)



*Deaths among residents of each locality, regardless of location at time of death. Does not count non-resident deaths in localities.

Other localities, such as Alleghany and Franklin Counties, have shown relatively stable trends, with moderate fluctuations over time. While their rates have not surged as dramatically as Roanoke's, they have exceeded the statewide average.

Virginia's Office of Data Governance and Analytics Framework for Addiction Analysis and Community Transformation (FAACT) platform[1] tracked a number of indicators related to the opioid and substance use crisis. In January 2025, Virginia experienced an average of 20.9 EMS substance use incident responses per 100,000 population, with 1 a.m. being the most active hour. In contrast, Roanoke City had a per capita rate of 59.5 substance use incident responses. In January 2025, EMS opioid use responses per 100,000 averaged 5.6 incidents per 100,000 population in Virginia, with Craig County being the most impacted locality at 40.8 per capita. Figure 3 shows an overarching trend that EMS incident responses in the Roanoke City and Alleghany Health Districts related to opioids have been decreasing slightly over time since the peak in 2020-2021, however 2025 data is not complete. Several factors could be influencing this trend, including fewer calls to EMS in the event of an overdose, increased access to naloxone among people who use drugs (PWUD), increased harm reduction behaviors among PWUD, a

[1] The FAACT Platform was decommissioned in June of 2025.

less lethal drug supply, or more awareness of what is in the drug supply due to spike alerts and drug checking.

Figure 3. Average Number of Opioid Related EMS Incidents by VDH Health District Per Year (2018-2025) (Virginia Department of Health, 2025)

Average Annual Number of Opioid Related EMS Incidents by VDH Health District (2018-2025)

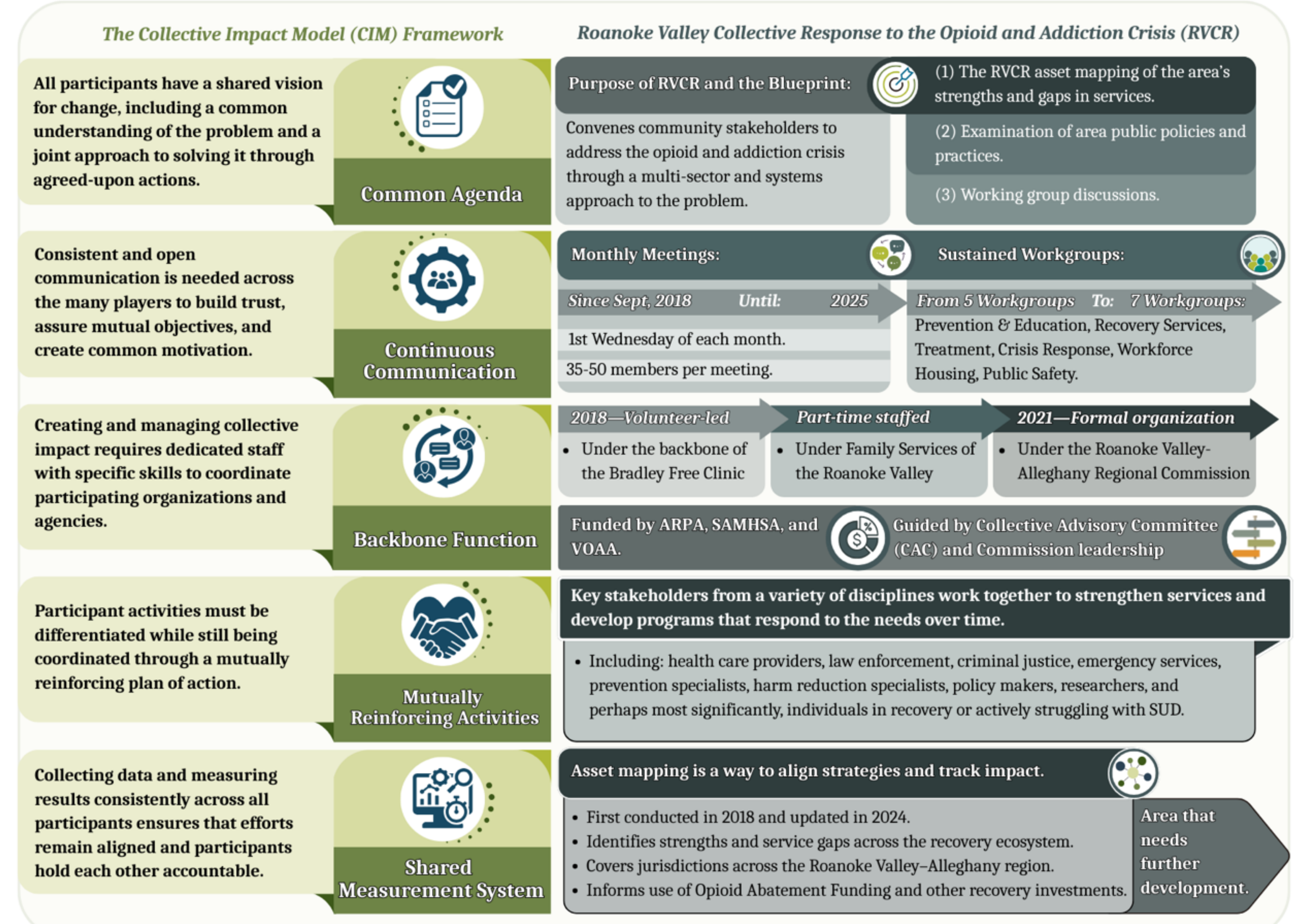
District	2018	2019	2020	2021	2022	2023	2024	2025
Alleghany	37	43	50	56	52	45	38	21
Roanoke City	116	101	118	111	116	108	96	59

Overall, opioid- and all drug-related rates in Southwest Virginia remain higher than the state average, with certain localities experiencing more volatility than others. While some areas show signs of stabilization, the persistent disparities indicate that substance use disorder (SUD) continues to be a major public health challenge in the region.

The Collective Impact Model

The Collective Impact Model (CIM) first emerged from structured collaborative efforts that substantially addressed large-scale social problems. Collective impact initiatives involve a long-term commitment by a group of influential actors from different sectors to a common agenda for solving a specific social problem whose actions are supported by a shared measurement system, mutually reinforcing activities, and ongoing communication and are staffed by an independent backbone organization (Hanleybrown et al., 2012; Kania & Kramer, 2011, 2013). The CIM emphasizes that the challenges of addressing complex issues, such as improving community health, cannot be tackled by a single organization or sector alone and argues that solving such problems requires a shift from isolated efforts to a systemic approach. This framework is built on five core components known as the conditions for achieving alignment and impactful results: (1) common agenda, (2) shared measurement systems, (3) mutually reinforcing activities, (4) continuous communication, and (5) backbone support organization (Hanleybrown et al., 2012).

Figure 4. How the CIM 5 core elements relate to activities of the RVCR.



Successes & Growth

5 → 6 → 9

WORKING GROUPS

Prevention, Education & Family Support
Crisis Intervention & Public Safety
Treatment
Workforce & Economic Development
Recovery Services
Thriving
Workgroups
Funding, Policy, & Advocacy
Data Collection, Measurement, &
Evaluation

ENGAGED STAKEHOLDERS

360 Individual Stakeholders

Average 45 Monthly Meeting Attendance

Integration under the Roanoke Valley Alleghany Regional Commission

11 GEOGRAPHIC AREAS OF SERVICE

10+ SECTORS

250 MEMBERS IN THE PEER RECOVERY NETWORK

Updated Asset Mapping of the Recovery Ecosystem

CONTINUED GRANT SUPPORT

ARPA, SAMHSA, VOAA, COCLI, ETC.

Successes & Growth

There have been many successes throughout the formation and operation of the Roanoke Valley Collective Response, notably the ongoing engagement of stakeholders, active working groups, continuing assessment, and securing grant funding. Some detailed accomplishments are detailed as follows:

1. **Continued commitment from community stakeholders.** The RVCR holds standing monthly meetings (1st Wednesday of each month), averaging **45** members across meetings. Total individual membership is approximately **360** (as of this report).
2. **Sustained and expanded workgroups.** In 2018 the RVCR operationalized 5 workgroups: Prevention, Treatment, Child and Family Support, Crisis Response and Connection to Care, and Recovery. These workgroups were refocused in 2023 in response to updated needs identified and with consideration post-COVID-19 pandemic. The updates were organized into 6 workgroups: Prevention & Education, Treatment, Crisis Intervention, Housing, Workforce, Public Safety, and Recovery Services. Further updates to the workgroups based on current needs have been presented in this Blueprint for Action Update.
3. **Integration under Roanoke Valley Alleghany Regional Commission.** As of December 2021, the RVCR has been a program of the RVARC. The RVARC has a strong history of project management and oversight and serves many of the same localities as the RVCR, with strong relationships with local governments. In the transition to a stand-along 501-C3, the RVARC is serving as a backbone organization, giving the RVCR structure to develop a strategic framework to better work towards its mission.
4. **Development of the Peer Recovery Network**. The Peer Recovery Network is comprised of peer recovery specialists in the Roanoke Valley with a common mission rooted in the principles of cooperation, sharing of valuable resources, and fostering innovation to tackle issues effectively. This group recognizes the critical role of peer support in recovery and acknowledges the importance of holistic approaches to wellness. Total individual membership is approximately **250** (as of this report).
5. **Updated asset mapping.** Asset mapping was first conducted 2018 as the RVCR was launched and was updated in 2024 to understand the current state of the recovery ecosystem to build on regional strengths and resources. *Please see attachment 1 for the Asset Mapping of the Regional Recovery Ecosystem full report.*
6. **Successful grant funding support for RVCR and stakeholder agencies**. The RVCR and stakeholders have been successful in applying for a received several grants supporting activities aligned with the Blueprint for Action priorities. Some sources include, but are not limited to, the American Rescue Plan Act (ARPA), Substance Abuse and Mental Health Services Administration (SAMHSA), Vibrant Virginia and Combating

Overdose through Community Level Interventions (COCLI), and Virginia Opioid Abatement Authority (VOAA).

Process for Blueprint Development and Updates

Following the Collective Impact Forum's (CIF) best practices for learning and evaluating the collective impact context, the Blueprint for Action Update process began with assessment of the current state of the overdose crisis in the Roanoke-Alleghany regions as a foundation to build recommendations to address the identified needs. As shown in Table 2, the Blueprint for Action Update evolved over a one-year timeframe and involved 6 distinct activities.

Table 2. Blueprint Development Process

Breakout Group Discussions with the Roanoke Valley Collective Response (RVCR).		
Description	**Location/Event Where Data Was Gathered**	**Type of Data Analysis**
Thirty-five attendees of the RVCR monthly meeting were randomly assigned to six groups to begin the Blueprint for Action update process by reviewing the current state of the opioid and addiction crisis, as well as recent changes, gaps, and other factors. Each group was facilitated by a member of the VT IPG faculty or a RVCR leadership. Facilitators recorded each group discussion for thematic analysis, as well as took written notes of major themes and discussion points.	This session was held virtually at the monthly RVCR meeting in April 2025.	Basic coding and thematic analysis of responses were completed on the transcripts of each group session. Notes from notetakers and facilitators were also used to triangulate the identification of major themes. *Please see Attachment 2 for the full narrative results of this activity.*
Dot Voting Session with the Roanoke Valley Collective Response (RVCR).		
Description	**Location/Event Where Data Was Gathered**	**Type of Data Analysis**
Approximately 40-50 attendees participated in a structured dot voting session as part of the 2026 Blueprint for Action update process. They represented a broad range of organizations and roles with varied levels of experience and involvement in the Collective Response. The session was organized into four facilitated stations. Each station was dedicated to 2–3 workgroups and their associated priorities. These priorities were drawn from two foundational reports:	The data was collected in-person during the RVCR June 2025 monthly stakeholder meeting.	Votes for each priority were collected and counted. Response counts ranged from 33 to 44 votes per priority. The results were organized into a pivot table and visualized through bar graphs by workgroup. These visuals provided a clear snapshot of perceived implementation levels. The data was then narratively

• The *2020 Blueprint for Action* utilized five strategic workgroups to create strategies and priorities to build a recovery-oriented system of care: Child and Family Support, Crisis Response, Prevention and Education, Recovery, and Treatment. • The second, *Building on Hope* (2023), updated these strategies post COVID-19 pandemic and amid a worsening addiction crisis. The Collective Response expanded to seven workgroups: Crisis Intervention, Housing, Prevention and Education, Public Safety, Recovery Services, Treatment, and Workforce. Stakeholders were divided into four groups and rotated every 10 minutes until they had visited all stations. At each round, participants reviewed the displayed priorities and used voting dots to assess whether priorities had been "Fully," "Partially," or "Not at all" achieved. They could also select "I don't know."		analyzed to highlight major patterns, including perceived strengths, uncertainty, contradictions, and gaps and summarized by workgroup area. *Please see Attachment 3 for the full narrative results of this activity.*
Survey of Stakeholders.		
Description	**Location/Event Where Data Was Gathered**	**Type of Data Analysis**
A survey was distributed to RVCR stakeholder to gather insights on the development, function, and evolution of the RVCR. The survey solicited opinions regarding how the RVCR functions as a collective impact community coalition to address the addiction crisis, along with supporting a continuum from prevention to recovery. Participants represented a diverse range of perspectives and expertise, as well as roles within the RVCR such as stakeholders, staff members, the Collective Advisory Council, and workgroup chairs.	The survey was distributed online in June through the Virginia Tech survey software, Question Pro. After being open for 6 weeks with weekly reminders for completion via email, it was closed in July. A total of 68 responses were recorded, and 23 were fully completed.	All data was analyzed using basic descriptive statistics, and incomplete answers were also retained for analysis. Responses to open-ended questions were organized by theme and summarized into narrative form. *Please see Attachment 4 for the full narrative results of this activity.*

Review of Priorities with RVCR Stakeholders.		
Description	**Location/Event Where Data Was Gathered**	**Type of Data Analysis**
Approximately 45 stakeholders participated in a first-round review of the drafted 2026 Blueprint for Action. Participants left written reviews, feedback, and suggestions on largely printed posters of the priorities. The session was organized into the nine newly proposed workgroups, and participants reviewed the associated priorities in randomized groups in a round-robin style with approximately eight minutes at each station. Each station was facilitated by a VT IPG or RVCR member, to answer questions and guide participants to write down their feedback on the posters.	The review was conducted in-person during the October monthly RVCR stakeholder meeting.	Feedback from the stakeholders was combined and reported exactly as written to project personnel and leadership within the RVCR. *Please see Attachment 5 for the full narrative results of this activity.*
Review of Priorities with the Ad Hoc Committee.		
Description	**Location/Event Where Data Was Gathered**	**Type of Data Analysis**
Six Ad Hoc Committee members participated in a second-round review of the drafted 2026 Blueprint for Action priorities that had been updated based on stakeholder feedback that had been previously gathered. AHC members were also presented the feedback collected at the October RVCR stakeholder meeting to add consider context, changes, or additional guidance.	This review was conducted in two sessions. The first session was held in person on October 27, 2025, as part of the monthly Ad Hoc Committee meeting. Due to thorough discussion and time constraints, a second session was held virtually on October 30.	During the meetings, highlights of previous stakeholder feedback on the priority areas were presented to committee members, and they were asked to add comments or suggest ideas for further revision. The sessions included real-time notetaking. All notes were collected and presented narratively and taken into consideration for review by the Collective Advisory Committee. *Please see Attachment 5 for the full narrative results of this activity.*

Review of Priorities with the Collective Advisory Council (CAC).		
Description	**Location/Event Where Data Was Gathered**	**Type of Data Analysis**
Five CAC members participated in the third and final review of the drafted 2026 Blueprint for Action priorities that had been updated based on all previous feedback and review.	Project leadership attended the CAC regularly scheduled monthly meeting in person on November 19, 2025.	During the meeting, some highlights of previous feedback on the priority areas were presented to committee members, and they were asked to provide detailed feedback via email or tracked changes or comments on the drafted priorities. All notes were collected and presented to RVCR and RVARC in consideration for final revisions to the 2026 Blueprint for Action priorities. *Please see Attachment 5 for the full narrative results of this activity.*

Recommendations

The following **47 recommendations** for the Blueprint for Action Update include priorities identified by stakeholders and leadership as areas of importance to focus the efforts of the RVCR over the next 3-5 years. The recommendations are based in evidence-based, and emerging best practices and have been thoroughly reviewed and revised by RVCR stakeholders, local leaders, and RVCR leadership.

Twenty-five priorities are captured within 6 critical areas of the recovery ecosystem, also referred to as the *"Workgroup(s)"*: **(1) Prevention, Education & Family Support, (2) Crisis Intervention & Public Safety, (3) Treatment, (4) Workforce & Economic Development, (5) Recovery Services, and (6) Thriving.**

Twenty-two priorities are categorized by areas of development and evaluation under the Collective Impact Model to guide, monitor, and assess activity of the workgroup progress towards recommended priorities as well as the overall goals of the RVCR. These areas include: **(1) Overall Priorities for the Workgroups, (2) Funding, Policy & Advocacy, and (3) Data Collection, Measurement, and Evaluation.** These recommendations will be the responsibility of the RVCR staff and leadership to implement.

The workgroups, recommendations, and priorities as they are presented are not weighted or ranked.

2026 Blueprint for Action Update Recommended Priorities

Prevention, Education & Family Support

Priorities:

1. Continue to provide prevention education across a range of sectors emphasizing the need for and benefits of prevention, including prevention efficacy and economic benefit.
2. Apply evidence-based practices to implement new and expand existing prevention programs across the spectrum of severity and diverse populations.
3. Create easy access points for services by increasing awareness and process navigation of services for mental health and/or substance use disorder support and treatment.
4. Establish Family Resource Support Centers with help available to navigate access to care, obtain educational resources, and find support from someone else with a family member struggling with addiction.
5. Improve awareness of complex family support programs, such as kinship care grants and foster funding to strengthen recovery support for families. Promote such services through public information campaigns to support informed decision-making.

Crisis Intervention & Public Safety

Priorities:

1. Provide a rapid response to overdoses and identify spikes utilizing the Overdose Detection Mapping Application Program (ODMAP), and other best-available data. Strive for consistent improvement to overdose response with data-informed decision-making.

2. Increase support for increased SUD treatment in local and regional jails, and connections to link individuals to treatment and other wraparound services upon return to the community. Assuring the continuum of care and support is critical to reducing repeated overdose and legal consequences related to SUD.

3. Following the integration of Peer Recovery Specialists throughout the response and recovery systems, employ supports to hiring barriers, reduce emotional fatigue and burnout in the workplace, and competitive wages.

4. Strengthen connections with law enforcement and EMS and educate them on the resources available for individuals.

Treatment

Priorities:

1. Continuously review and integrate evidence-based practices into treatment services that result in abstinence or clinical reduction in substance use.
2. Increase interagency collaboration to ensure that best treatment practices are available and applied across the continuum of care.
3. Strengthen the continuum of care and transitions in care to reduce gaps and interruptions in treatment and barriers confronting special populations (releases from incarceration, pregnant women, minority populations, youth, physically/medically disabled).

Workforce & Economic Development

Priorities:

1. Engage and educate employers to increase awareness of programs in the area for those seeking recovery and/or second-chance citizens.
2. Create a central repository of resources around recovery and workforce reentry, including a master list of second-chance employers in the RVARC service area.
3. Develop trainings, guidance, and educational materials for employers of people in recovery to set clearer boundaries and provide better supervision and emotional support to prevent burnout. Improve human resource policies to support recovery in the workplace.
4. Adopt counselor-to-counselor models and build support systems for people in recovery to improve resiliency and sustainability in the workforce.

Recovery Services

Priorities:

1. Establish and sustain dialogue with the insurance sector to increase coverage for recovery services.
2. Improve outreach and collaboration with Community Services Boards (CSBs) to strengthen recovery services in rural areas.
3. Develop programs that combine substance use counseling with practical job readiness training, such as trade schools.
4. Conduct a targeted and systematic study to determine specific bed and unit estimates of recovery housing that are needed for the Roanoke Valley.
5. Facilitate regular cross-sectoral conversations with housing developers, operators, and local government to build more recovery housing projects.
6. Seek and leverage funding opportunities from public and private sources to develop innovative and financially viable recovery housing.

Thriving

Priorities:

1. Create innovative recovery models that start with an initial phase of intensive support (housing, treatment, employment supports, medical care, physical rehabilitation, peer support, etc.) and transition gradually to independent living.

2. Foster opportunities for individuals that promote self-sufficiency through regional and local solutions to support successful integration in society, including but not limited to job skills training, professional behavior, emotional regulation, earning a livable wage, food security, regaining custody of children, and transportation.

3. Use storytelling and the voices of peers to help people see how SUD could affect their own families, which can reduce stigma over time and shift attitudes.

Priorities for the Roanoke Valley Collective Response

Overall Priorities for Workgroups

Priorities:

1. Workgroups will be reconfigured into six groups: (1) Prevention, Education & Family Support, (2) Crisis Intervention & Public Safety, (3) Treatment, (4) Workforce & Economic Development, (5) Recovery Services, and (6) Thriving.

2. Create a chair for each workgroup who drives action planning as well as assign a dedicated RVCR staff member for each group to document progress and provide logistical support.
   - Workgroup chairs should meet quarterly with the CAC and each other to present new ideas, progress, and troubleshoot challenges.
   - Workgroups should report out quarterly to RVCR on their progress.

3. Workgroups members should have a clear sense of the goals of their workgroup, timeline of workgroup goals, their role within the workgroup, and ways to collaborate with other workgroups.

4. Engage representatives from sectors not already involved with the Roanoke Valley Collective Response, such as local and state legislators, school boards, business sector, etc.
   - Increase participation from strategic public, private, and non-governmental organizations to enhance cross-sector collaboration.

5. Focus meetings on clear, outcome-driven tasks such as securing funding for stakeholder agencies and collaborations, evaluating programs and advancing Blueprint goals.
   - RVCR staff will develop a logic model for each workgroup to articulate clear goals and tasks of the workgroups.
   - RVCR staff will develop and maintain a tracker to monitor progress towards workgroup priorities.

Priorities for Funding, Policy & Advocacy

Policy & Advocacy

1. Leverage local community service groups to advocate for underserved populations.
2. Prioritize advocacy calls identified by stakeholders.
3. Advocate among local and state elected officials to sustain services within the continuum as well as support public events and speeches to confront stigma and raise awareness.
4. Support public events and speeches to confront stigma and raise awareness.
5. Equip partners for effective advocacy (e.g., relevant discussion during meetings, providing talking points, identifying windows of opportunity for legislative windows, relevant legislative agendas).

Funding

1. Develop and maintain a list of funding opportunities that align with the 2026 Blueprint Update for both the RVCR and its stakeholders.
2. As federal funding remains precarious, partners need to identify and diversify their funding streams to include more corporate, foundation, and community philanthropy. RVCR staff will support searching for diversified funding sources that support multisector collaboration.
3. Stakeholders will submit at least 5 collaborative grant applications with the RVCR as a supportive entity.
4. Track amount of philanthropic and public funding leveraged by stakeholders for the targeted issue area/system through partnerships and collaborative funding efforts.
5. Meet regularly with local government leaders to educate them about funding opportunities and to co-develop proposals.
6. Present innovative solutions, new ideas, and local success stories to funders, policymakers, and local leaders to show how funding and progressive policy can make a difference.

Data Collection, Measurement, and Evaluation

Priorities:

1. Use data-driven approaches to identify at-risk populations within the Roanoke Valley Alleghany Regional Commission service area with greatest service needs.
2. Create a way to highlight data from all community coalitions across the continuum of care of the recovery ecosystem that are included in the coverage areas of the Collective Response.
3. Establish a shared external partner data system that includes a common set of data collection methods and measurements that can provide timely evidence of progress or lack thereof toward the RVCR's initiatives and outcomes.
    - A participatory process is used to determine a common set of indicators and data collection methods.
    - Partners agree to a data sharing agreement that supports ongoing collaboration.
4. Establish routine data sharing from internal RVCR data collection (e.g. monthly meeting attendance, collaborative activities and events, stakeholder demographics, engagement from stakeholder meetings, etc.)
5. Stakeholder awareness of the 5 core elements of the Collective Impact Model has increased by 25%. (5 Core Elements: Common Agenda, Backbone Infrastructure, Mutually Reinforcing Activities, Shared Measurement System, Continuous Communication)
6. Leadership within the RVCR regularly reviews data from an established shared measurement system to determine progress towards goals and to inform strategic decision-making.

While the RVCR and research team have put forth great efforts in developing sustainable recommendations based on the evidence gathered throughout the Blueprint for Action Update process, the RVCR does not have broad authority to implement each individual priority presented. Rather, the intent of the Blueprint for Action Update is to empower those who do have the authority to distribute resources and implement these recommended priorities. The RVCR's purpose is to serve as a place of collaboration and support to stakeholders and entities within the recovery ecosystem that serve individuals in the Roanoke-Alleghany region.

Next Steps and Ongoing Support

Many achievements have already ensued through the development of the Blueprint for Action Update, however, the RVCR stakeholders, RVCR leadership, and the research team have identified several immediate next steps following to the Blueprint release:

1. **Present the Blueprint for Action Update** to the RVCR stakeholders, as well as various community stakeholder groups, regional and state officials, and others identified by RVCR staff and leadership.
2. Continue to **explore information gathered from the Blueprint for Action Update process and asset mapping** as a basis for developing a roadmap of care through the recovery ecosystem.
3. **Convene the workgroups** to begin to make progress towards the recommended priorities presented in this document. Tasks of importance for the first several workgroup meetings include determining strategies and action items for each priority. The research team, along with RVCR staff, will support the workgroups by providing a guidance document for each workgroup that includes, but is not limited to, suggestions for action items, logic model outline and example, and tracking document to monitor progress.
4. **Identify workgroup chairs and/or co-chairs** to work in conjunction with RVCR staff to lead their respective workgroup in convening and organizing immediate tasks.
5. The Institute for Policy & Governance will **develop a Social Impact Assessment** to align with the recommended priorities within the Collective Impact Model to evaluate the social, environmental, and economic impact as a fundamental aspect of sustainability of the RVCR.
6. **Development of an evaluation plan** with RVCR staff and leadership that outlines recommendations for sustainable and measurable action and tracking for each workgroup and priority.
7. The institute for Policy & Governance will provide **ongoing technical assistance** to RVCR staff and stakeholders to advance the Blueprint for Action Update recommended priorities that contribute to the overall goals of the RVCR. This assistance may include, but is not limited to, identification of grant opportunities that align with proposed priorities, grant application support, literature review and/or searches for best practices, development of data collection instruments and/or tracking mechanisms, etc.

ALL OF THESE ACTIONS ARE INTENDED TO ADVANCE THE MISSION OF THE RVCR.

FOR MORE INFORMATION ABOUT THIS BLUEPRINT OR TO PROVIDE COMMENT OR INPUT, PLEASE CONTACT THE RVCR THROUGH THE WEBSITE AT HTTPS://WWW.RVCOLLECTIVERESPONSE.ORG/

Appendices

1. Asset Mapping of the Regional Recovery Ecosystem – August 2024
2. Landscape of the Substance Use and Overdose Crisis, Discussion with Stakeholders, April 2025
3. Review of Past Priorities, Dot Voting Activity with Stakeholders, June 2025
4. Survey of Stakeholders, August 2025
5. Review of Workgroups Priorities and Priorities for the Roanoke Valley Collective Response, October - December 2025

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