**AGENDA**
**COLONIAL BEHAVIORAL HEALTH**
**BOARD OF DIRECTORS**
**MAY 5, 2026**
**3:00 PM**

- **WELCOME AND CALL TO ORDER**

- **ROLL CALL**

- **PUBLIC COMMENT**

- **CONSENT CALENDAR**
  - Approval of the following meeting minutes:
    - April 7, 2026, Board of Directors Meeting
    - April 20, 2026, Executive Committee Meeting

- **INFORMATION/DISCUSSION**
  - Facility Development Update (*K. Cook*)
  - Nominating Committee Report – Proposed FY 27 Officers (*R. Witham*)
  - Annual Board Planning Day (discussion)
  - Evaluation of Executive Director (*R. Ashe*)

- **ACTION ITEMS**
  - A-1 CBH/CCSI FY 2025 Financial Audit (*J. Roller, CPA*) (*Robinson, Farmer, Cox Associates)*
  - A-2 One-Time Payment to Staff – June 2026 (*S. Ousey*)

  <u>Policy Reviews</u> (*M. Obremski*)

  - A-3 Approval – Revisions to Policy 16 *Incident Reporting*
  - A-4 Approval – Retirement of Policy 44 *Serious Incident – Injury and Death*
  - A-5 Approval – Revisions to Policy 87 *Quality Improvement*

- **REPORTS**
  - Recruitment/Hiring/Retention Report (*C. Thomas*)
  - March 2026 Financial Report (*S. Ousey*)

- CBH FY 2027 Operating Budget *(S. Ousey)*
- Executive Director's Report (*D. Coe*)

- **Adjournment**

**Next Meeting:**
Tuesday, June 2, 2026
473 McLaws Circle, Williamsburg
3:00 PM

# COLONIAL BEHAVIORAL HEALTH
# BOARD MEETING

**DATE:** March 3, 2026

**LOCATION:** Colonial Behavioral Health, 473 McLaws Circle, Williamsburg, VA 23185

**WELCOME AND CALL TO ORDER:** 3:00pm

**BOARD MEMBERS PRESENT:**
Mr. Ryan Ashe – James City County
Mr. John Collins – York County
Ms. Lynette Diaz – James City County
Mr. Sean Dunn – Williamsburg
Mr. Jeff Gould – James City County
Mr. Bruce Keener – York County
Ms. Kristen Nelson – York County
Mr. Gerald Patesel – Poquoson
Ms. Amber Richey – York County
Ms. April Thomas – York County
Ms. Donyale Wells – James City County
Mr. Roy Witham – James City County

**BOARD MEMBERS ABSENT:**
Mr. Steven Miller – York County

**CBH STAFF PRESENT:**
David Coe, Marsha Obremski, Kristy Wallace, Katie Leuci, Denise Kirschbaum, Kyra Cook, Patty Hartigan, Linda Butler, and Chaenn Thomas

**GUESTS:** Brandi Strickland – Advisory Council Member

**PUBLIC COMMENT:** None

**CONSENT CALENDAR:**
The consent calendar was presented for approval of the following meeting minutes:

- **February 25, 2026, Services and Evaluation Committee Meeting**
- **March 3, 2026, Board of Directors Meeting**

Kristen Nelson made a motion to approve the consent calendar as presented. Roy Witham seconded this motion.
The motion passed as follows:
Yes – 12
No – 0
Abstain – 0

**INFORMATION/PRESENTATION**

**Appointment of Nominating Committee – *Ryan Ashe***

Ryan Ashe (CBH Board Chair) appointed Roy Witham, Amber Richey and April Thomas as members of the Nominating Committee; Roy Witham will be the Chair of this committee.

**Strategic Plan Quarterly Review - *Kyra Cook***

Kyra Cook presented CBH's Strategic Plan with Quarter 7 updates for each goal:
Services Goal – there is a lot of work being done in this category although we report once it is complete.
Operations Goal – CBH successfully utilized a recruiting firm and is exploring doing so more often for key positions. Mid-Management staff participated in feedback session regarding past and future training using live polling software.
Infrastructure Goal – Henderson, Inc. selected as the design build vendor for Phase 2.
Resources Goal – Capital Campaign Fundraising position has been filled. The Behavioral Health Consultant (CBH employee) embedded at SEVHS resigned.

**William & Mary Study Overview – *Kyra Cook***

CBH engaged the William & Mary Mason School of Business to conduct a strategic and financial review of the planned integrated care facility and expanded campus. The report affirms that the integrated care model presents a strong opportunity to expand access and strengthen CBH's regional role; however, it also identifies significant operational and financial risks if growth, staffing, and revenue diversification are not carefully managed.

**ACTION ITEMS:**

**A-1 Contract with New Day – CSW FF&E (*Kyra Cook*)**

As part of the development of the Center for Support and Wellness, Colonial Behavioral Health (CBH) has undertaken a comprehensive process to procure furniture that aligns with the facility's clinical, operational, and design needs. The furniture selections are intended to support a therapeutic, welcoming, and functional environment for both clients and staff.
Staff recommends that the Board authorize the Executive Director to execute a contract with New Day Office in the amount of $585,272.37 for the purchase and installation of furniture for the Center for Support and Wellness.
Kyra Cook presented a slide show that allowed the CBH Board to see what the furniture will look like in each area of the Center for Support and Wellness. Kyra passed around baskets that contained samples of the colors/finishings of furnishings that have been selected for this building.
Bruce Keener made a motion to authorize the Executive Director to execute a contract with

New Day Office in the amount of $585,272.37 for furniture procurement for the Center for Support and Wellness. John Collins seconded the motion. The motion passed as follows:
Yes – 12
No – 0
Abstain – 0

**A-2 CCSI/CBH Agreement – Phase 2 (*David Coe*)**
Colonial Community Services, Inc. (CCSI) serves as the property holding corporation for all CBH land and office location buildings. CBH pays rent to CCSI to cover the cost of debt service, insurance, etc. CCSI and CBH first entered into an agreement for development of new land and facilities in April 2024 – focusing on the Center for Support and Wellness. Land acquisition is no longer relevant for that property in Phase 2, and resource development strategies are still in very early stages, therefore, a revised agreement will be useful in defining those roles in Phase 2. CBH's attorney Pat McDermott has signed off on the agreement; it is possible that revisions may need to be made as we gain more clarity moving forward.
John Collins made a motion that the Board of Directors authorize the Executive Director to execute the Agency Agreement Between Colonial Community Services, Inc. and Colonial Behavioral Health contingent upon approval by the Colonial Community Services, Inc. Board of Directors. Bruce Keener seconded the motion. The motion passed as follows:
Yes – 12
No – 0
Abstain – 0

**A-3 Contract with Henderson, Inc. – Phase 2 (*Kyra Cook*)**
The purpose of this memorandum is to request Board authorization for the Executive Director to execute a contract with Henderson, Inc. in an amount not to exceed $1,247,000 for Phase 2 design services for Colonial Behavioral Health's new campus project. The contract and attachments are under legal review and will be approved prior to execution by the Executive Director. Authorization to proceed now ensures a campus master plan and project renderings are available to unveil where the Center for Support and Wellness opens this fall. This action also includes a request to amend the FY budget to allocate funding for Stage 1 of this contract. The contract has been divided into two Stages: Stage 1 ($729,000) will be funded by grant received from Williamsburg Health Foundation and CBH's fund balance. Stage 2 ($518,000) will be addressed later once there is greater clarity regarding federal funding availability, available fund balance, and/or additional funds raised.
Roy Witham made a motion that the Board of Directors authorize the Executive Director to execute this Agreement on behalf of Colonial Community Services, Inc. Bruce Keener seconded this motion. The motion passed as follows:
Yes – 12
No – 0
Abstain – 0

**A-4 Approval – Revisions to Policy 15 – Press and Media Release *(Marsha Obremski)***
**A-5 Approval – Revisions to Policy 22 – Ethical Principles *(Marsha Obremski)***

**A-6 Approval – Revisions to Policy 47 – Corporate Compliance *(Marsha Obremski)***
**A-7 Approval – Revisions to Policy 57 – Response to Social Media *(Marsha Obremski)***
**A-8 Approval – Revisions to Policy 84 – ADA Statement & Accessibility *(Marsha Obremski)***
Masha Obremski summarized the proposed changes to Broader Community Group of policies, which consisted of updating pronouns, removing procedures and formatting for the new template.
Kristen Nelson made a motion that the Board approve the revisions to the Broader Community Group of policies as presented. Roy Witham seconded the motion. The motion passed as follows:
Yes – 12
No – 0
Abstain – 0

**REPORTS:**
**Recruitment/Hiring/Retention Report *(Chaenn Thomas)***
For the period of February 12, 2026, through March 10, 2026, Colonial Behavioral Health (CBH) successfully completed 5 hires (all full-time positions). The agency currently has 33 vacant positions that includes 27 full-time positions, 2 part-time positions, and 4 PRN/WAR positions. During the identified period, CBH had a total of 2 resignations, both were full-time positions. Update: As of today, we successfully filled a full-time position, the applicant accepted our offer today. CBH had a few unexpected separations (part-time employees) and 1 separation (FTE) in our DD Services area. HR has secured a contract with Civic Minds – a recruiting firm to assist with higher level positions.

**February 2026 Financial Report (*Sherri Ousey*)**
Sherri Ousey (new Director of Finance) presented the February 2026 Financial Report. Our operating budget remains consistent with previous month.

**Executive Director's Report (*D. Coe*)**
<u>Agency Issues</u>
Sherri Ousey has joined the CBH team as our Director of Finance.
Construction of the Center for Support and Wellness is proceeding well.
The VACSB Annual Training Conference will be held May 6-8, 2026, in Richmond. If you would like to attend, please contact Kristy Wallace to manage your registration. Transportation can be arranged if you would like to carpool.
We are encountering some delays with the $2 million secured by Congressmen Wittman. His office is working with the USDA to resolve the issues.
<u>Community Issues</u>
Our triennial CARF (accreditation) survey will be held onsite June 1-3. SUD Intensive Outpatient Program is CBH's only CARF accredited program – located in Williamsburg and Yorktown).
Our community has been selected for a SAMHSA's GAINS Center for Behavioral Health and Justice Transformation -led Sequential Intercept Model (SIM) workshop for the CBH area June 4-

5, hosted by the Williamsburg Police Department. This marks the first SIM effort in over 15 years.

Public Policy

The General Assembly amended the FY 2026 budget to approve funding for a one-time payment (2%) for CSB and other state-supported local employees in June 2026. We plan to bring an action item to the Board in May to enact this payment.

The General Assembly adjourned without adopting a biennial budget. Language on support for employee salary increases is an important factor in budget development.

DBHDS and DMAS informed us that VA could not be ready to meet with 2026 Federal CCBHC application. We are working with the National Council and with the state to hopefully submit an amendment to Virginia's Medicaid Plan for creation of the CCBHC system. Virginia would not be the first state to do so.

**ADJOURNMENT:**

A motion to adjourn the meeting was made by John Collins and seconded by Bruce Keener. The motion passed as follows:

Yes – 12
No – 0
Abstain – 0

The meeting was adjourned at 4:30pm.

**NEXT MEETING:**

Date: Tuesday, May 5, 2026
Location: 473 McLaws Circle, Williamsburg, VA 23185
Time: 3:00pm

_____ _____

**Ryan Ashe, Board Chair** **Amber Richey, Secretary**

# COLONIAL BEHAVIORAL HEALTH

**EXECUTIVE COMMITTEE MEETING**
**473 McLaws Circle, Williamsburg**
**April 20, 2026, at 2:00pm**

**Call to Order:**
The Executive Committee Meeting was called to order at 2:00pm.

**Committee Members Present:**
Ryan Ashe, Bruce Keener, Amber Richey, Donyale Wells

**Committee Members Absent:**
John Collins

**CBH Staff Present:**
David Coe, Marsha Obremski, Kyra Cook, Sherri Ousey, Chaenn Thomas, Kristy Wallace

**Members of the Public:**
N/A

**UPDATES/DISCUSSION ITEMS**

**Recruitment/Hiring/Turnover Update** **(*Chaenn Thomas*)**

For the period of March 11, 2026, through April 13, 2026, Colonial Behavioral Health (CBH) has successfully completed 4 hires (2 full-time and 2 PRN/WAR which includes a paid intern). The agency currently has thirty (30) vacant positions, this total includes twenty-four (24) full-time positions, two (2) part-time positions and four (4) PRN/WAR positions. During this identified period CBH had a total of four (4) separations (2 full-time and 2 PRN/WAR).
We have interviews scheduled for Friday for four (4) clinical positions that have been vacant for a long period of time. CBH increased the salary for these positions.

**Facility Development Update** **(*Kyra Cook*)**

Phase 1 (CSW)
On time, and we are in the final stretch. The easement issue (Va. Dominion Power) has been settled. Kyra would like to schedule a hard-hat tour of the CSW building and proposed Tuesday, June 2nd prior to the CBH Board meeting. Our CBH Executive Committee agreed to that date and a time of 1:00pm. Kyra will work with Henderson to solidify the date and time, and she hopes to get the invite out this week for that event.
Phase 2
CBH received confirmation that we will receive $2M in funding and should be available in two months. These funds will be based on reimbursement (submit receipts, receive funding). CBH will utilize the funding from the Williamsburg Health Foundation for items that involve moving dirt (storm water).
The Kickoff meeting for Phase 2 will take place tomorrow. CBH will hold four stakeholder meetings:
1. Blossom Bash – May 20th (staff)

2. Afternoon after the SIM Workshop – June 5th (Community Partners)
3. Lived Experience – People's Place – May 13th (Pizza Lunch)
4. Community Stakeholders and CBH Board of Directors – Stryker Center 4:00pm

**March 2026 Financial Report** **(*Sherri Ousey*)**

Sherri reviewed the Financial Report as of 3/31/2026. The recognized total revenue is $18.3M. State revenue ($934K) reflects that both PSH and Crisis drew less this past month. Our total expenditure is largely consumed by personnel. Operating budget is $1.6M.

**First Draft – FY 2027 Operating Budget** **(*Sherri Ousey*)**

Sherri talked through key points related to the FY 2027 Operating Budget; the draft budget will be presented for approval in the coming weeks.

Key Revenue Assumptions

There are a few non-reoccurring revenues from FY26: We will no longer receive GWCAC funding after December 25th; No KOVAR is reflected, and non-recurrent funds for Mobile Crisis.

Key Expense Assumptions

2% COLA, 1% salary increase, increase in employee healthcare costs and 2.5% has been allocated for attrition.

Anticipated Operating Budget Range: $25.9M - $27.6M

**ANTICIPATED ACTION ITEMS – 5/5 BOARD MEETING**

- FY 2025 Audit Report (Robinson, Farmer, & Cox) (*David Coe/Sherri Ousey*)
  The auditors will be present at May 5th CBH Board of Directors meeting to present the budget.
- Approval of One-Time Payment to Staff (2%; June 2026) (*Sherri Ousey/David Coe*)
  Workforce dollars will offset the gap between what is provided by the State.
- Policy Reviews (*Marsha Obremski*)
  - Policy 16 – Incident Reporting
  - Policy 44 – Serious Incident – Injury and Death
    This policy is recommended for retirement. It was wrapped up into Policy 16.
  - Policy 87 – Quality Improvement
- Contract Award: Consolidated Audit Services 2026 – 2029 (*Kisha Young*)
  Purpose: to establish a contract with a qualified independent certified public accountant firm to perform financial audits of Colonial Behavioral Health and its component units for fiscal years ending June 30, 2026, through June 30, 2029.
  Respondents: Two proposals were received in response to the solicitation:
  Roberson, Farmer, Cox Associates
  Brown Edwards & Company, L.L.P.
  Evaluation Process: An evaluation committee reviewed both proposals; each proposal was evaluated and scored independently, with results compiled for comparison. Reference checks were completed and considered as part of evaluation process.
  Recommendation: As of April 17, 2026, the evaluation process has been completed and Brown Edwards & Company, L.L.P, has been selected. Accordingly, staff

recommends that the Executive Committee approve the award of a contract to Brown Edwards & Company, L.L.P., and authorize execution of the agreement.
Motion: Bruce Keener made a motion that the Executive Committee approve the award of a contract to Brown Edwards & Company L.L.P and authorize execution of the agreement. Amber Richey seconded this motion, and all were in favor.

**OTHER ITEMS for 5/5 BOARD**

**Nominating Committee – Proposed Slate of Officers (FY 27)**

The nominating committee consists of Roy Witham, Amber Richey and April Thomas.

**Evaluation of Executive Director**

**Executive Director's Report**

This information will be included in the May Board Meeting packet.

**Items from the Committee**

Bruce Keener asked that the Executive Committee think about the Board Planning Day – look at days that you would be available; possibly have an evening and morning session?

**Adjournment**

Bruce Keener made a motion to adjourn the meeting at 2:34pm. Amber Richey seconded this motion; all were in favor.

**NEXT MEETING**

Monday, May 18, 2026
2:00pm
473 McLaws Circle, Williamsburg, VA 23185

**CBH NOMINATING COMMITTEE**

**PROPOSED SLATE OF OFFICERS**
**CBH Board of Directors**
**Fiscal Year 2027**

| | |
|---|---|
| CHAIR: | To be announced during 5/5 Meeting |
| VICE CHAIR | To be announced during 5/5 Meeting |
| SECRETARY | To be announced during 5/5 Meeting |
| TREASURER | To be announced during 5/5 Meeting |
| MEMBER AT-LARGE | To be announced during 5/5 Meeting |

**Action Item A-1**

## Acceptance of FY 2025 Financial Audit and Governance Letter

**Background**

As a public agency, Colonial Behavioral Health is required to have all funds audited by a licensed accounting firm. CBH contracted with Robinson, Farmer, Cox Associates to perform this audit for Fiscal Year 2025.

Electronic copies of the following documents were distributed previously, with hard copies being made available on location during this meeting:

1. CBH Governance Letter 2025; and
2. The CBH 2025 Consolidated Audit Report.

This report is being presented by Josh Roller, CPA, from the Charlottesville office of Robinson, Farmer, Cox Associates. Mr. Roller served in the lead auditing role for the Fiscal Year 2025 audit.

Many thanks to our Finance team and to the York County Finance Office for their support in this effort during this transitional year in CBH financial leadership.

**Recommended Motion:**

That the CBH Board of Directors accepts the FY 2025 Governance Letter and Audit Report as submitted by Robinson, Farmer, Cox Associates.

ROBINSON, FARMER, COX ASSOCIATES, PLLC
*Certified Public Accountants*

**Communication with Those Charged with Governance**

**To the Board of Directors**
**Colonial Behavioral Health**

We have audited the financial statements of the business-type activities and the aggregate remaining fund information of Colonial Behavioral Health for the year ended June 30, 2025. Professional standards require that we provide you with information about our responsibilities under generally accepted auditing standards, *Government Auditing Standards,* and the Uniform Guidance, as well as certain information related to the planned scope and timing of our audit. We have communicated such information in our engagement letter to you dated July 29, 2025. Professional standards also require that we communicate to you the following information related to our audit.

Significant Audit Findings

*Qualitative Aspects of Accounting Practices*

Management is responsible for the selection and use of appropriate accounting policies. The significant accounting policies used by Colonial Behavioral Health are described in Note 1 to the financial statements. As described in Note 18 to the financial statements, Colonial Behavioral Health changed accounting policies by adopting Statement of Government Accounting Standards (GASB Statement) No. 101, *Compensated Absences*. We noted no transactions entered into by the entity during the year for which there is a lack of authoritative guidance or consensus. All significant transactions have been recognized in the financial statements in the proper period.

Accounting estimates are an integral part of the financial statements prepared by management and are based on management's knowledge and experience about past and current events and assumptions about future events. Certain accounting estimates are particularly sensitive because of their significance to the financial statements and because of the possibility that future events affecting them may differ significantly from those expected. The most sensitive estimates affecting Colonial Behavioral Health's financial statements were:

> Management's estimate of the allowance for uncollectible client fees receivable, useful lives of capital assets and related depreciation expense and accumulated depreciation, the health insurance reserve reported as other current liabilities, and the net pension asset and related items.
>
> Management's estimates are based on historical collection records and specific account analysis for the estimated uncollectible client fees, accounting and other guidelines for the useful lives of capital assets, related depreciation expense and accumulated depreciation, and information from York County that administers the entity's health insurance plan regarding amounts reserved for potential health insurance claims. The net pension asset and related items are based on calculations made by an actuary hired by the State of Virginia Retirement System. We evaluated the methods, assumptions, and data used to develop the above estimates in determining that they are reasonable in relation to the financial statements taken as a whole.

The financial statement disclosures are neutral, consistent, and clear.

*Difficulties Encountered in Performing the Audit*

We encountered no significant difficulties in dealing with management in performing and completing our audit.

*Corrected and Uncorrected Misstatement*

Professional standards require us to accumulate all known and likely misstatements identified during the audit, other than those that are clearly trivial, and communicate them to the appropriate level of management. Management has corrected all such misstatements. There were no material misstatements detected as a result of audit procedures which were required to be corrected by management.

*Disagreements with Management*

For purposes of this letter a disagreement with management is a financial accounting, reporting, or auditing matter, whether or not resolved to our satisfaction, that could be significant to the financial statements or the auditors' report. We are pleased to report that no such disagreements arose during the course of our audit.

*Management Representations*

We have requested certain representations from management that are included in the management representation letter dated January 26, 2026.

*Management Consultations with Other Independent Accountants*

In some cases, management may decide to consult with other accountants about auditing and accounting matters, similar to obtaining a "second opinion" on certain situations. If a consultation involves application of an accounting principle to the entity's financial statements or a determination of the type of auditor's opinion that may be expressed on those statements, our professional standards require the consulting accountant to check with us to determine that the consultant has all the relevant facts. To our knowledge, there were no such consultations with other accountants other than consulting services to convert the internal cash basis financial reports to the accrual basis.

*Other Audit Findings or Issues*

We generally discuss a variety of matters, including the application of accounting principles and auditing standards, with management each year prior to retention as the entity's auditors. However, these discussions occurred in the normal course of our professional relationship and our responses were not a condition to our retention.

Other Matters

We applied certain limited procedures to management's discussion and analysis and the schedules related to pension and OPEB funding, which are required supplementary information (RSI) that supplement the basic financial statements. Our procedures consisted of inquiries of management regarding the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We did not audit the RSI and do not express an opinion or provide any assurance on the RSI.

Other Matters (Continued)

We were engaged to report on the combining financial statements and the schedule of expenditures of federal awards which accompany the financial statements but are not RSI. With respect to this supplementary information, we made certain inquiries of management and evaluated the form, content, and methods of preparing the information to determine that the information complies with accounting principles generally accepted in the United States of America, the method of preparing it has not changed from the prior year, and the information is appropriate and complete in relation to our audit of the financial statements. We compared and reconciled the supplementary information to the underlying accounting records used to prepare the financial statements or to the financial statements themselves.

Restriction on Use

This information is intended solely for the use of the Board of Directors and management of Colonial Behavioral Health and is not intended to be and should not be used by anyone other than these specified parties.

Robinson, Farmer, Cox, Associates

Charlottesville, Virginia
January 26, 2026

**Action Item A-2**

## Approval – One-Time Staff Bonus Payment

**Background:**

The Virginia General Assembly has amended the FY 2026 State Budget (in HB 29) to provide support for a 2% bonus payment to CSB employees. The payment is to be made in June 2026 (House Bill 29, Item 469, Y.1). The new state funding is provided by formula, and generally only supports 30-33% of the cost of such payments. In the event the employer cannot match the state funding to implement the payment, those state funds are forfeited.

However, there are sufficient unspent regional and state funds (with some designated by the state for "workforce") in the FY 2026 budget to support this one-time payment (bonus) to CBH staff. This includes funding allocated by the General Assembly to partially support this payment. CBH proposes the combination of these funding sources to support the following payment plan:

The methodology for this payment was developed with our Human Resources and Finance departments. It is intended to provide a meaningful impact for all employees by creating a "not less than" allocation strategy.

**Methodology:**

Payment is to be made to CBH staff as follows:

- PRN staff will receive $500 ("take home" pay);
- Staff earning $50,000 or less will receive $1,000 ("take home");
- The remaining funds will be distributed to other staff (at "take home" pay levels). This method also provides greater proportionate impact for lower-paid staff.
    - To maximize the benefit to employees, CBH will cover all FICA/fringe costs so employees receive the full amounts detailed above.
    - Payment to be made on employee 6/12/2026 paychecks.

- **COST OF PROPOSAL: $247,282**

**Recommended Motion:**

That the Board approve the one-time bonus payment proposal at a cost not to exceed $250,000.00, to be paid in June 2026.

Action Item A-3

**Revision of Policy 16 – Incident Reporting**

**Background:**

CBH staff have reviewed the CBH Incident Reporting Policy #16 and are pleased to recommend revisions to the Board of Directors for review.

A primary theme of the recommended changes is the movement of several portions of the Policy to the level of procedure. These changes are made without compromising the intent or integrity of the Policy itself.

This policy and accompanying revisions have been reviewed and endorsed by the agency's lawyer, Pat McDermott.

**Summary of Changes: It should be noted that Policy 44 – Serious incident/injury and death was merged with Policy 16 – Incident Reporting.**

**Policy 44 should be deleted and archived.**

| Current Incident Reporting Policy | Proposed Changes to Policy |
|---|---|
| Most of the information remains | Policy statements include statements from policy 44 with some of the sentences revised. |
| Definition of Terms was revised | The definitions were scaled back and removed. There is a reference to the code of Virginia of Virginia which is in the current policy. Also, there are three definitions per the policy of employee related events; serious incidents and serious injury based on DBHDS definition. |
| Individual Incident/Injury | Reporting timeline was added so it reads Individual Incident/Injury Reporting Timeline. |
| Employee Incident/Injury | Reporting Timeline was added to it reads Employee |
| Complete external reporting as required by DBHDS. Where this statement lives is a procedure. | Added a paragraph about external notification to include HL, OHR, MCO, family, guardian, AR, social services, law enforcement etc. when it is appropriate |
| Not in the current policy | Added Types of Incident Levels. This information was in Policy 44. |

Action Item X-#

| | |
|---|---|
| | Recommendation is to move to Policy 16 as policy 44 should be deleted. |
| There are a few sentences that references investigations for human resources and quality management. | There is a section added and titled Incident Investigations. |
| There is one sentence that references root cause analysis. | Root cause analysis section added referring to the policy 85 – root cause analysis. |
| Under QM Staff responsibility | Section added Quality Improvement measures that implies incidents will be compiled and reviewed and report findings will determine if training, procedure changes and risk mitigation plan is needed. |
| Employee Responsibility listed under procedure | This section was modified. |
| Not in the current policy | Compliance section was added. After reading the guidance from DBHDS, there must be a section on enforcement. |
| Not a section in the current policy but throughout the policy | Confidentiality and Incident Report Record Retention section was added. There is a huge change in LVA requirements for individual incidents. In September 2025, the change went from 3 year to 10 years all involved incidents with individuals which aligns with the health records retention. |
| Procedure Section – Employee Section | Most of the information deleted was procedures and only relevant information, that is a policy remains. The information that remained was timelines for reporting, who is responsible, and transportation. |
| Procedure Section – Human Resources Staff Responsibility | Most of the information deleted being it was procedures and only relevant information related to investigations and retention remains in policy. |
| Procedure Section – Quality Management | Most of the information deleted being it was procedures and only relevant information related to investigations, root cause analysis, external reporting and retention remains in policy. |
| Guidelines | Deleted; will become a procedure |
| Guidelines for writing incident report | Deleted; will become a procedure |

Action Item X-#

**Motion from the CBH Executive Committee:**

That the Board approve the revisions to the Incident Reporting policy as presented.

**COLONIAL BEHAVIORAL HEALTH**

**COUNSEL REVIEW OF BOARD POLICY**

**Name of Policy:** Incident Reporting
**Category:** Administration and Operations
**Policy No.:** 16

**Review Date:** April 20, 2026

**Name of Counsel:** Patrick B. McDermott, Esq.

**Comments of Counsel:**

1. **Virginia Code Compliance:** The reference to 12VAC35-115-230 should be retitled to read: "Provider requirements for reporting." Other references are correct.

2. **Federal Law Compliance:** N/A

3. **Grammer and Punctuation:** Acceptable

4. **Comments:** Policy #44 "Serious Injury and Death" will be deleted and archived as its provisions have been merged into this Policy #16.

Patrick B. McDermott, Esq.

Signature of Counsel

## Policy and Procedures

**Category:** Administration and Operations

**Title:** Incident Reporting

**Policy Number:** 16

**Primary Areas Affected:** CBH Organization

## Policy and Procedures

| | |
|---|---|
| **Category:** | Administration and Operations |
| **Title:** | Incident Reporting |
| **Policy Number:** | 16 |
| **Primary Areas Affected:** | CBH Organization |

### Policy Statement

The purpose of this policy is to define the mechanism for documenting and reporting incidents that occur at Colonial Behavioral Health (CBH). It is the policy of CBH to report and document incidents that occur when the individual is supervised by or involved in services or sustains a serious injury, as well as employees, visitors and vendors related incidents or injuries while working.

The reason for reporting and documenting incidents is an ongoing quality improvement effort to ensure compliance, reduce individual injuries, reduce employee injuries, compile data of the various types of incidents to reduce CBH's exposure to litigation, manage risks and implement corrective measures to prevent future incidents. Additionally, information identified in incident reports may also be used to assess the effectiveness of services, as well as the policies and procedures at CBH, with the goal of continuously improving the quality-of-service delivery.

This policy defines what constitutes a serious incident, injury, event and outlines provider responsibilities for categorizing, documenting, reporting, and reviewing incidents.

### Source of Authorization

Board of Directors

### Legal/Regulatory References

12VAC35-105-20 – DBHDS Licensing Definitions

12VAC35-105 – 160 – Required Reporting

12VAC35-115-230 – Human Rights Regulation

8.01-581.17 – Code of Virginia

GS 20 – Series 200904 - Library of Virginia Record Retention and Disposition

## Policy and Procedures

**Category:** Administration and Operations

**Title:** Incident Reporting

**Policy Number:** 16

**Primary Areas Affected:** CBH Organization

**Definitions**

All definitions contained within this policy will be interpreted in accordance with the Virginia Administrative Code 12VAC35-115-30 and 12VAC35-105-20 that governs the Virginia Department of Behavioral Health and Developmental Services (DBHDS) and as defined by Colonial Behavioral Health (CBH).

Employee related events mean any incidents/injuries that occur while performing the duties of their assigned job that may have caused minor or severe injuries or incidents. The injury or incident must have occurred on agency premises, agency vehicles or in the community while providing services to individuals or families or carrying out job related duties.

Serious incidents are any serious injury, incident, event or death that are not consistent with the routine operation of a CBH direct care provider or the routine care of an individual, and that result in or are likely to lead to adverse effects, cause harm or could cause harm upon an individual.

Serious injury means any injury resulting in bodily hurt, damage, harm, or loss that requires medical attention by a licensed physician, Doctor of Osteopathic Medicine, physician assistant, or nurse practitioner.

**Individual Incident/Injury Reporting Timeline**

All employees are required to report and document incidents to the Quality Management and Compliance Department within eight (8) hours of occurrence. In the event of an individual's death or reportable event defined by DBHDS, it is the responsibility of the Primary Provider, Program Coordinator or Program Manager to submit the incident report within eight (8) hours of discovery. Quality Compliance and Management Department will report the incident to the Department of Behavioral Health and Developmental Services within 24 hours of discovery.

## Policy and Procedures

**Category:** Administration and Operations

**Title:** Incident Reporting

**Policy Number:** 16

**Primary Areas Affected:** CBH Organization

**Employee Incident/Injury Reporting Timeline**

Employee related injuries or incident must be reported to Human Resources within 8 hours of the injury, incident or event.

**External Notifications**

External notifications for reportable incidents will be completed timely. The quality management department will notify office of licensure, office of human rights within the designated timeframe in accordance with the regulation. Clinical or designated employee will report the incident within the required timeframe to the individual's designated emergency contact, family member, guardian, and/or authorized representative, department of social services, law enforcement, managed care organizations (MCO) and other community stakeholders as required by state and federal regulations and laws.

**Types of Incidents That Should Be Reported**

The types of incidents to be reported and documented include, but are not limited to the following:

1. Abuse, Neglect, or Exploitation (see Human Rights Policy #3)
2. Biohazard Accidents (see Infection Control Procedure #4)
3. Choking
4. Communicable Diseases (when exposure occurs-internal reporting only)
5. Confidentiality Breach (see Confidentiality Policy #2)
6. Contraband
7. Death

## Policy and Procedures

**Category:** Administration and Operations

**Title:** Incident Reporting

**Policy Number:** 16

**Primary Areas Affected:** CBH Organization

8. Emergency Room Visit
9. Employee Incident (see Human Resources for further guidelines when to report work-related incidents that occur while on duty)
10. Ethical Violation (Policy # 22)
11. Mandated Reporting to Adult Protective Services (APS) and Child Protective Services (CPS) (see Protective Services Policy #17)
12. Medical Related/Medical Emergency to include but not limited to bowel obstruction, pressure wound, urinary tract infection, aspiration pneumonia or ingestion of hazardous substances
13. Medication Error
14. Minor Medical Event
15. Missing Persons/Elopement/Wandering
16. Natural Disaster
17. Peer-on-Peer Aggression (with or without injury)
18. Property Damage
19. Seclusion and/or Restraint
20. Serious Incidents/Injury including bruises, falls, bites, burns, significant scrapes and cuts, ingestion of foreign objects, lacerations, eye injury, self-injurious behavior that requires medical attention, fractures, dislocations, heat exhaustion, etc.
21. Sexual Assault

## Policy and Procedures

**Category:** Administration and Operations

**Title:** Incident Reporting

**Policy Number:** 16

**Primary Areas Affected:** CBH Organization

22. Suicide Attempt
23. Theft
24. Threat – If the threat involves an employee, this incident would be classified as an allegation; complete the human resources incident report.
25. Unplanned medical hospital admission
26. Unplanned psychiatric hospital admission
27. Vehicle Accident- any company vehicle that is involved in an accident or unsafe situation is to be reported as an incident. Refer to the Policy 50 - Transportation Policy.
28. Violence (with or without injury)

**Types of Incident Levels**

Not all reportable incidents are categorized into level types. Level types are assigned based on severity and risk.

- Level I Serious Incident may include minor injuries or potential risks that did not result in injury. Providers must record and review Level I incidents internally as part of quality improvement. Level I incidents do not get reported to DBHDS via Comprehensive Human Rights Information System (CHRIS).
- Level II Serious Incident results in significant harm or threat to health or safety (but does not meet Level III). Includes serious injury, threats to others, significant health risks, or required urgent medical care. Level II is reported to DBHDS via CHRIS.
- Level III Serious Incident include death, sexual assault, suicide attempt, and other critical incidents meeting criteria in regulations. Level III is reported to DBHDS via CHRIS.

## Policy and Procedures

**Category:** Administration and Operations

**Title:** Incident Reporting

**Policy Number:** 16

**Primary Areas Affected:** CBH Organization

### Incident Investigations

Not all reportable incidents will require formal investigation. Investigations are conducted to determine what occurred, why it occurred, and what actions are necessary to prevent similar incidents in the future. Certain incidents, based on their type, frequency, severity, risk level, regulatory requirements, or potential impact on individuals, staff, agency operations, or circumstances of the incident will require a formal investigation.

Internal investigations include review of records, program documentation, corrective action plans, root cause analysis information or any documentation as applicable that will assist the investigation.

The Quality and Compliance Department will complete investigations within ten (10) business days of the incident. The decision to initiate an investigation will be documented, and investigations conducted will follow agency procedures to ensure thorough review, corrective action, and prevention of recurrence.

The Human Resources Department as applicable will conduct investigations of events at a minimum through employee interviews, witness interviews as appropriate, and review of and act upon agency policies and procedures

Investigation reports will be made available to the executive director, program director, and/or coordinator/administrator and the appropriate DBHDS Office as required.

**Root Cause Analysis**

CBH will conduct a root cause analysis for all Level II and Level III incidents within 30 days of discovery. The root cause analysis will be completed by the quality management department. Refer to Policy 85 – Root Cause Analysis (RCA).

**Quality Improvement Measures**

## Policy and Procedures

**Category:** Administration and Operations

**Title:** Incident Reporting

**Policy Number:** 16

**Primary Areas Affected:** CBH Organization

- Data from all incident types and levels will be compiled and reviewed to identify patterns, systemic risks, and opportunities for improvement.
- Report findings will determine the need for employee training, procedural changes, and risk mitigation plans to ensure alignment with CBH risk management plan.

**Employee Responsibilities**

When an employee who observes, is involved in, obtains knowledge of, or is otherwise made aware of a serious incident, injury, reportable event, or death must immediately notify their program manager, coordinator/administrator, and/or program director.

In addition to department notification, the employee is required to complete and submit an incident report through the electronic reporting system (Clarity) to the Quality Management Department in accordance with this policy and applicable DBHDS regulations.

In situations where an incident involves both an individual receiving services and an employee (e.g., injury or other reportable event), the employee may be required to complete two separate reports:

- An Individual Incident Report submitted to the Quality Management and Compliance Department; and
- An Employee Incident Report submitted to the Human Resources Department.

All reports must be completed accurately, thoroughly, and within the required reporting timelines.

**Compliance**

An employee failure to report serious incidents in accordance with CBH policy, DBHDS regulations, state and federal regulations may result in corrective action, citation during audits, inspections, or other administrative actions. Such action may lead to corrective or disciplinary action, including verbal or written warnings, suspension, or termination of employment, depending on the severity of the violation.

CBH will provide complete and accurate information, update information as needed and cooperate with regulatory entities during investigations and corrective action implementation when necessary.

**Confidentiality and Incident Report Record Retention**

## Policy and Procedures

**Category:** Administration and Operations

**Title:** Incident Reporting

**Policy Number:** 16

**Primary Areas Affected:** CBH Organization

All individual and employee incident reports that contain confidential information must be protected by HIPAA and other relevant privacy standards, while ensuring required reporting elements are provided to authorized entities when necessary.

The Quality Management and Compliance Department and Human Resources will retain all incident report documentation for risk management purposes.

- Incident reports and related documentation based on individuals receiving services must be retained for ten (10) years in accordance with the Library of Virginia record retention schedule. Incident reports related to visitors or vendors will be maintained with the quality management department and retained for three (3) years.
- Incident reports related to employees, student interns, will be maintained in the Human Resources designated file. These types of incidents will be retained for three (3) years.

Incident reports in the Quality Management and Human Resources Departments will be destroyed by shredding.

## Policy and Procedures

**Category:** Administration and Operations

**Title:** Incident Reporting

**Policy Number:** 16

**Primary Areas Affected:** CBH Organization

### Diary of Changes

**Date of Origin**

07/01/1997

**Dates of Review**

03/06/2026

06/06/2024 – ADA Compliance | 07/01/2023 | 07/01/2022 | 02/09/2022

12/010/2021 | 10/30/2020 – COVID 19 Protocol | 10/30/2019 | 10/31/2018

10/03/2018 | 08/04/2016 | 03/31/2016 | 09/11/2015 | 08/11/2014

06/05/2013 | 10/01/2010 | 03/01/2010

**Dates of Revision**

03/06/2026 | 10/24/2025 | 4/30/2025

**Approved By**

_____ 5/5/2026_____

Signature | Effective Date

Ryan Ashe_____ CBH Board Chair

Printed Name | Title

Action Item A-4

**Revision of Policy 44 – Serious Incident/Injury and Death**

**Background:**

CBH staff have reviewed the CBH Serious Incident/Injury and Death Policy 44 and are pleased to recommend revisions to the Board of Directors for review.

A primary theme of the recommended changes is the movement of several portions of the Policy to the level of procedure. These changes are made without compromising the intent or integrity of the Policy itself.

This policy and accompanying revisions have been reviewed and endorsed by the agency's lawyer, Pat McDermott.

**Summary of Changes: This policy should be eliminated and archived as the information in this policy speaks to the theme of incident reporting - Policy 16.**

| Current Serious Incident/Injury and Death Policy | Proposed Changes to Policy |
|---|---|
| Policy Statement | Eliminate and archive. The theme of the information is incorporated with the statement in policy 16 – incident reporting. |
| Definitions | Some of the information was moved to Policy 16. |
| Procedures – Employee Responsibility | Some of the information was moved to Policy 16 and procedures will be developed to incorporate the information. |
| Investigation | Moved to Policy 16 |

**Motion from the CBH Executive Committee:**
That the Board approve retiring the Current Serious Incident/Injury and Death policy as presented.

**COLONIAL BEHAVIORAL HEALTH**

**COUNSEL REVIEW OF BOARD POLICY**

**Name of Policy:** **Serious Incident/Injury and Death**
**Category:** **Administration and Operations**
**Policy No.:** **44**

**Review Date:** **April 28, 2026**

**Name of Counsel: Patrick B. McDermott, Esq.**

**Comments of Counsel:**

1. **Virginia Code Compliance: N/A**

2. **Federal Law Compliance: N/A**

3. **Grammar and Punctuation: N/A**

4. **Comments:** **This policy should be deleted and archived. Please see Counsel Review of Policy #16 dated April 20, 2026.**

Patrick B. McDermott, Esq.

**Signature of Counsel**

# Policy and Procedures

**Category:** Administration and Operations

**Title:** Serious Incident/Injury and Death

**Policy Number:** 44

**Primary Areas Affected:** CBH Organization

**Policy and Procedures**

| | |
|---|---|
| **Category:** | Administration and Operations |
| **Title:** | Serious Incident/Injury and Death |
| **Policy Number:** | 44 |
| **Primary Areas Affected:** | CBH Organization |

## Policy Statement

It is the policy of Colonial Behavioral Health to report and document serious incident and/or injuries resulting in bodily damage, harm, or loss that that requires medical attention by a licensed physician, Doctor of Osteopathic Medicine, physician assistant or nurse practitioner while the individual is supervised by or involved in services. Deaths are reported under any circumstance when an individual has an open case with CSB. All employees are responsible to report and document serious incidents, injuries, and deaths immediately upon discovery.

## Source of Authorization

## Legal/Regulatory References

## Definitions

With regard to this policy, the following definitions apply (12VAC35-105-20):

1. Serious incident: any incident which is not consistent with the routine operation of a service provider or the routine care of an individual that is likely to lead to adverse effects, cause harm or could cause harm upon an individual. The term serious incident includes death and serious injury.
    a. Level I serious incident: a serious incident that occurs or originates during the provision of a service or on the premises of the provider and does not meet the definition of a Level II or Level III incident. Level 1 incidents will be reviewed quarterly by the Quality and Compliance Office or designee.

**Policy and Procedures**

**Category:** Administration and Operations

**Title:** Serious Incident/Injury and Death

**Policy Number:** 44

**Primary Areas Affected:** CBH Organization

b. Level II serious incident: a serious incident that occurs or originates during the provision of a service or on the premises of the provider that result in a threat to the health and safety of an individual that does not meet the definition of a Level 1 or Level III incident. Level II serious incidents includes a serious injury caused by another individual or person, an individual who is missing for any period of time, an emergency room, unplanned psychiatric or medical hospital admission, choking incidents, ingestion of hazardous substances, and a diagnosis of a decubitus ulcer, bowel obstruction or aspiration pneumonia. A root cause analysis will be completed by the Quality and Compliance Department staff.

c. Level III serious incident: a serious incident whether or not the incident occurs while in the provision of a service or on the provider's premises and results in any death of an individual, sexual assault of an individual, or any suicide attempt by an individual admitted to services resulting in a hospital admission. A root cause analysis will be completed by the Quality and Compliance Department staff.

2. Serious injury: any injury resulting in bodily hurt, damage, harm, or loss that requires medical attention by a licensed physician, Doctor of Osteopathic Medicine, physician assistant, or nurse practitioner.

## Procedures

### Employee Responsibility

Whenever an employee observes, obtains knowledge of, or is otherwise aware of or involved in a serious incident, injury or death, the employee should:

1. Promptly notify his/her/their respective Supervisor, Coordinator, or Program Director.

## Policy and Procedures

**Category:** Administration and Operations

**Title:** Serious Incident/Injury and Death

**Policy Number:** 44

**Primary Areas Affected:** CBH Organization

2. Promptly notify the individual's guardian or authorized representative and/or emergency contact person that is listed in the record.
3. Document the incident (event), injury or death in the health record.
4. Complete an Incident Reporting Form within 8 hours of the discovery of the serious incident, injury or death and submit through the incident reporting system, that will notify the Quality and Compliance Department that a serious incident, injury or death has occurred. At the time the incident report is submitted via CBH electronic system, the Executive Director, Program Director, Director of Operations, Quality and Compliance Officer, Program Coordinator and Program Manager are notified of the incident.
5. The Quality and Compliance Department staff will submit all serious incidents, injuries and deaths to the Office of Licensing and Office of Human Rights, within 24 hours upon discovery. The information will be entered in the Virginia Department of Behavioral Health and Developmental Services (DBHDS) electronic data base system (CHRIS – Comprehensive Human Rights Information System).
6. The Quality and Compliance Department will retain the incident report that is related to the event for Risk Management purposes and may facilitate investigation of events when applicable. Incident reports will be retained for three years.

## Investigations

1. Internal investigations include review of records, root cause analysis, corrective actions: which includes the development, and implementation of preventative measures. The investigations will be completed by the Quality and Compliance Department employees within 10 business days of a reported death. A Level I serious incidents will be reviewed upon submission of the incident report as well as quarterly. A

## Policy and Procedures

**Category:** Administration and Operations

**Title:** Serious Incident/Injury and Death

**Policy Number:** 44

**Primary Areas Affected:** CBH Organization

root cause analysis will be completed for all Level II and Level III serious incidents to include a detailed description of what happened, an analysis of why it happened, identification of all identifiable underlying causes of the incident that were under the control of the provider and identify solutions to mitigate the reoccurrence of the incident. The report will be available to the Executive Director and DBHDS Office of Licensing.

2. Deaths that occur at or during program services, which are directly or indirectly related to implemented services or are deemed to be the result of a suicide, will be additionally reported to Local Law Enforcement if appropriate and will be internally investigated.

## Policy and Procedures

**Category:** Administration and Operations

**Title:** Serious Incident/Injury and Death

**Policy Number:** 44

**Primary Areas Affected:** CBH Organization

# Diary of Changes

## Date of Origin

03/13/2002

## Dates of Review

06/06/2024 – ADA Compliance | 12/13/2023 | 12/15/2022 | 12/15/2021

12/15/2020 – COVID 19 Protocol | 10/30/2019 | 10/31/2018 | 10/03/2017

08/10/2016 | 09/11/2015 | 0919/2014 | 03/17/2013 | 10/01/2010

03/08/2010

## Dates of Revision

10/24/2025 | 4/30/2025

## Approved By

_____ | 05/05/2026

Signature | Effective Date

Ryan Ashe | CBH Board Chair

Printed Name | Title

Action Item A-5

**Revision of Policy 87 – Quality Improvement Program**

**Background:**

CBH staff have reviewed the CBH Quality Improvement Program Policy 87 and are pleased to recommend revisions to the Board of Directors for review.

A primary theme of the recommended changes is the movement of several portions of the Policy to the level of procedure. These changes are made without compromising the intent or integrity of the Policy itself.

This policy and accompanying revisions have been reviewed and endorsed by the agency's lawyer, Pat McDermott.

**Summary of Changes: This is a somewhat of a new document based on the DBHDS guidance document on a Quality Improvement Program Policy and Technical Assistance with DBHDS. This plan was submitted to DBHDS for reveiw and awaiting a response on the revisions to the QIP policy.**

| Current Quality Improvement Program Policy | Proposed Changes to Policy |
|---|---|
| Purpose | This section is now called "Policy Statement". It has been shortened with the same theme of safe, effective, person-centered and in compliance with regulations. Some of the information was moved to other sections in the policy. |
| Definitions – many of the definition in this policy were deleted. | Definition scaled backed and deleted. Only included definitions on CAP, DBHDS, Incident, PDSA, QI, QIP and RCA. |
| Scope Section – the scope was scaled back and information deleted. Many of the items listed in the current policy will move to another policy or procedure on QIP or corporate compliance. | There is one paragraph that states the policy applies to licensed programs, agency departments, and agency processes with the review timeline and annual update. |
| Leadership and Responsibility | New title – "Governance and Responsibilities". This section was added to include leadership, program directors, coordinators, managers, quality department (same but scaled back because of what is documented moved to |

| | |
|---|---|
| | procedures), Quality Improvement Committee and agency staff. |
| Not in the current policy | A "Guiding Principle" this section was added based on the guidance document from DBHDS. For this section trying to include many areas as it relates to a quality improvement program but feel free to delete some of the items. This section is required. |
| Quality Management Section | This section was deleted and will move to procedures. |
| Not in the current policy | "Quality Improvement Committee" section was added to the policy. This section states the purpose of the committee, how often we meet, review of the program QIP and communication. |
| Not in the current policy | Section added on "Policies and Procedures" that help drive the quality improvement program. |
| Not in the current policy | Section added "Quality Improvement Program Required Elements" This section addressed the program quality improvement plan criteria, what categories will be monitored, plan measurable goals and objectives, ongoing monitoring, evaluation and data analysis. |
| Method of Implementation – for this policy majority of the information was deleted and will be moved to procedures if appropriate. | This section (same theme) was revised and now includes the section titled "Quality Improvement Tools" that will list PDSA and RCA to include the fishbone method for reviewing incidents levels when appropriate. |
| Incident Reporting | This section is deleted. Incident reports are throughout the document. However, there is a new section in the policy that relates to the review of the incident report and risk monitoring. It is called "Incident Report Review and Risk Monitoring. See below. |
| Confidentiality | The title is the same but the content of what is written is more of a general statement related to confidentiality and is inclusive to human resources at it pertains to incident reports. Also the statement on |

| | |
|---|---|
| | Personnel Policy 14 was deleted in this section. |
| Corrective Action Plan | This section is now titles “Corrective Action Plan (CAP)” The section was redefined based on technical assistance from DBHDS. It still have the same theme but the layout of what is written is different and focus on the concept of the CAP. |
| Not in the current policy | This is a new title that was added called “Incident report review and risk monitoring” This section speaks to the review of incidents is an ongoing process and component of the QI program. The focus is on incident trends. |
| Evaluation of the Plan | This section title is deleted and now called “Review of Quality Improvement Plans” |
| Title not in the current policy | New title added “Review of Quality Improvement Plans”. This section speaks to each licensed program plan for improvement. |
| Not in current policy | This section was added and titled “Evaluation of the Quality Improvement Program.” This section speaks to the overall implementation of the QI program. |

**Motion from the CBH Executive Committee:**

That the Board approve the revisions to the Quality Improvement Program policy as presented.

**COLONIAL BEHAVIORAL HEALTH**

**COUNSEL REVIEW OF BOARD POLICY**

**Name of Policy:** Quality Improvement Program
**Category:** Administrative
**Policy No.:** 87

**Review Date:** April 20, 2026

**Name of Counsel:** Patrick B. McDermott, Esq.

**Comments of Counsel:**

1. **Virginia Code Compliance:** The policy references 12VAC105-20 and states that it *Requires a detailed quality improvement work plan to review quality of services provided.* I think that this reference is in error. This section of the Virginia Administrative Code is simply the "Definitions" section and makes no such requirement. I recommend deletion of this reference.
   The other references to the VAC are correct.

2. **Federal Law Compliance:** The references to the Health Insurance Portability and Accountability Act are correct.

3. **Grammar and Punctuation:** Acceptable.

4. **Comments:** This is a broad omnibus rewriting of the CBH Quality Improvement Program Policy. I think that it is well done and should be a useful tool.

Patrick B. McDermott, Esq.

**Signature of Counsel**

## Policy and Procedure

**Category:**

**Administrative**

**Title: Quality**

**Improvement Program**

**Policy Number:87**

**Primary Areas Affected:** All Staff

**Policy and Procedure**

**Category:**

**Administrative**

**Title: Quality**

**Improvement Program**

**Policy Number:87**

**Primary Areas Affected:** All Staff

## Policy Statement

Colonial Behavioral Health (CBH) will implement a quality improvement program. The quality improvement (QI) program ensures CBH services are safe, effective, person-centered, timely, efficient, equitable, and in compliance with state and federal regulations. The program provides a structured system to monitor performance, identify opportunities for improvement, implement changes, monitor and evaluate clinical and service delivery as well as sustain compliance. The program will have continuous and ongoing monitoring of each program's defined quality improvement criteria, incidents, policies, procedures, and outcomes that promote efficiency, effectiveness and improvements in agency operations and service delivery.

## Source of Authorization

Board of Directors

## Legal/Regulatory References

12VAC35-105-20: Requires a detailed quality improvement work plan to review quality of services provided.

12VAC35-105-620: Requires an ongoing, written QI program with measurable goals, monitoring, and annual evaluation.

12VAC35-105-170: Requires a written CAP for systemic non-compliance with monitoring for effectiveness.

45 CFR Parts 160, 162 and 164: Health Insurance Portability and Accountability Act (HIPAA): Requires confidentiality of health information and quality improvement documentation containing individual data.

12VAC35-105: DBHDS Licensing Requirements: Requires programs to demonstrate measurable improvement and compliance with regulations.

**Policy and Procedure**

**Category:**

**Administrative**

**Title: Quality**

**Improvement Program**

**Policy Number:87**

**Primary Areas Affected:** All Staff

## Definitions

Corrective Action Plan (CAP): A documented plan that outlines steps to correct systemic non-compliance or deficiencies, assigns responsible staff, and includes measurable outcomes and timelines.

DBHDS: Department of Behavioral Health and Developmental Services.

Incident: Any event affecting the health, safety, or well-being of individuals served or staff, including events that may lead to a sentinel event. A Sentinel incident is an unexpected event involving death, serious injury, or risk thereof, requiring immediate review that may have occurred on CBH property and/or during the provision of services.

Plan-Do-Study-Act (PDSA): A structured cycle to plan improvements, implement interventions, study outcomes, and act to standardize or revise processes.

Quality Improvement (QI): A systematic process of monitoring, evaluating, and improving services to achieve better outcomes.

Quality Improvement Plan (QIP): is a structured work plan designed to improve performance, efficiency, or quality within CBH.

Root Cause Analysis (RCA): A process to identify the underlying causes of significant incidents or recurring deficiencies to prevent recurrence.

**Policy and Procedure**

**Category:**

**Administrative**

**Title: Quality**

**Improvement Program**

**Policy Number:87**

**Primary Areas Affected:** All Staff

## SCOPE

This policy applies to all licensed CBH programs, agency departments, and with the consideration of operational functions and processes. Each program or department (as appropriate) will maintain a written Quality Improvement Plan (QIP) aligned with this policy. Each quality improvement plan (QIP) will be reviewed at least every three months to assess progress, evaluate outcomes, and make necessary changes throughout the year and updated annually.

## GOVERNANCE AND RESPONSIBILITIES

Leadership: Supports the QI Program, allocates resources, holds middle managers accountable for quality improvement initiatives and reviews the annual report with the Board of Directors - Service and Evaluation Committee.

Program Directors, coordinators/administrators, managers: Develop program-specific QIPs, establish measurable goals, implement improvements, monitor progress, and document outcomes, including trending events in the program.

Quality and Compliance Department: Coordinates the QI Program, completes root cause analysis (RCA) and ensures corrective action plans (CAP) are completed by programs, monitors incident reports, and reports findings to program directors, coordinators/administrators and to the executive leadership when appropriate.

Quality Improvement Committee: The quality improvement committee monitors performance data, identifies, opportunities for improvement, and recommends corrective actions if appropriate.

Agency Staff: Quality is a collective responsibility of every employee and is maintained in adherence to the plan by ensuring that all work is done in an ethical and proper manner.

**Policy and Procedure**

**Category:**

**Administrative**

**Title: Quality**

**Improvement Program**

**Policy Number:87**

**Primary Areas Affected:** All Staff

## GUIDING PRINCIPLES

The quality improvement program at CBH is guided by principles that prioritize individualized person-centered care, ensuring that services are safe, effective, efficient, and responsive to individual needs. The process of continuous evaluation and decision-making are essential to identify gaps, implement best practices, and enhance the overall administrative operations, treatment, service delivery systems. A collaboration among multidisciplinary teams, along with transparency and accountability, promotes a culture of ongoing learning and improvement across the agency.

The guiding principles include but are not limited to:

1. Person-Centered & Recovery-Oriented Care - CBH prioritizes the dignity, preferences, strengths, and recovery goals of individuals served. Services are trauma-informed, culturally responsive, and designed to support hope, empowerment, choice and self-determination.
2. Safety & Risk Reduction - CBH is committed to minimizing harm and promoting physical and psychological safety through proactive risk identification, incident review, and continuous system improvement.
3. Evidence-Based & Best Practices - Clinical and operational decisions are informed by current research, established clinical guidelines, and industry best practices to ensure effective, measurable outcomes.
4. Data-Driven Decision Making - CBH uses reliable data to monitor performance, identify gaps, track outcomes, and guide improvement initiatives. Data transparency supports accountability at all agency levels.
5. Quality Improvement (QI) - Quality improvement is an ongoing, systematic process. We use structured methodologies (e.g., Plan-Do-Study-Act cycles) to test changes, evaluate results, and sustain improvements.
6. Regulatory & Accreditation Compliance - CBH makes every effort to comply with applicable federal, state, and payer requirements and align quality initiatives with accreditation standards.

**Policy and Procedure**

**Category:**

**Administrative**

**Title: Quality**

**Improvement Program**

**Policy Number:87**

**Primary Areas Affected:** All Staff

7. Interdisciplinary Collaboration - CBH supports collaboration among clinical staff, leadership, peers, support staff, and community partners.
8. Stakeholder Engagement - Individuals served, families, staff, and community stakeholders are actively engaged in evaluating services and shaping improvement efforts.
9. Accountability & Transparency - Roles, responsibilities, and performance expectations are clearly defined. Results are communicated internally and used constructively to strengthen services.
10. Workforce Development - CBH supports ongoing staff education, supervision, and competency development to maintain high standards of care and professional growth.
11. Ethical Practice & Confidentiality - CBH upholds professional ethics, protects confidentiality, and ensures compliance with privacy regulations in all quality activities.

## QUALITY IMPROVEMENT COMMITTEE

The purpose of the Quality Improvement Committee (QIC) is to promote continuous improvement by systematically reviewing Level 1 incident report quarterly, identifying trends, and ensuring appropriate follow-up actions. Each program will communicate through multiple avenues, including staff meetings, departmental briefings, and email to ensure employee awareness and engagement of the quality improvement initiatives. The committee reviews quality improvement plans quarterly to determine progress toward identified goals. The committee also oversees quality improvement projects initiated by leadership, providing direction, monitoring progress, and evaluating outcomes to achieve measurable improvements in agency performance and service delivery. The committee meets on a quarterly basis.

The level 2 and level 3 incidents are reviewed by the health and safety committee quarterly.

Program coordinators/administrators, quality and compliance manager, quality and compliance officer, risk management officer, or designated employees as needed are members of the QIC.

**Policy and Procedure**

**Category:**

**Administrative**

**Title: Quality**

**Improvement Program**

**Policy Number:87**

**Primary Areas Affected:** All Staff

## POLICIES AND PROCEDURES

CBH's quality improvement (QI) program includes written policies and procedures that establish standardized guidelines for agency practices, performance measurement, data collection, analysis, incident reporting, risk management, corrective action planning, and ongoing monitoring of outcomes. All policies and procedures are reviewed periodically and revised as necessary to reflect regulatory requirements, accreditation standards, organizational changes, and identified opportunities for improvement. CBH management ensures consistent implementation, oversight, and documentation of all quality improvement activities to support continuous enhancement of behavioral health services. For purposes of the quality improvement program, the following policies and procedures include but are not limited to:

- Policy 02 - Confidentiality
- Policy 03 - Human Rights
- Policy 14 - Personnel
- Policy 16 - Incident Reporting
- Policy 22 - Ethical Principles
- Policy 26 - Behavior Management
- Policy 27 - Health Information Management
- Policy 31 - Medication Management
- Policy 44 - Serious Incident – Injury and Death
- Policy 47 - Corporate Compliance
- Policy 65 - Infection Control

**Policy and Procedure**

**Category:**

**Administrative**

**Title: Quality**

**Improvement Program**

**Policy Number:87**

**Primary Areas Affected:** All Staff

- Policy 85 - Root Cause Analysis
- Risk Management Plan

## QUALITY IMPROVEMENT PROGRAM REQUIRED ELEMENTS

1. Quality Improvement Plan (QIP) Criteria

Each program and department will develop and utilize established approved criteria when identifying and implementing program Quality Improvement (QI) activities.

In determining priorities for Quality Improvement (QI) activities, each program or department will consider input from individuals, guardians, authorized representatives as appropriate, stakeholders through surveys, program director, leadership and employees. Additionally, programs and departments will evaluate and prioritize concerns based on, but not limited to, the following:

- Medication errors reviews.
- Issues impacting a significant number of individuals served or employees.
- Risk concern(s) that affect the health and safety of individuals and employees.
- Organization compliance concerns.
- Service delivery and planning.
- Trends identified through data analysis, performance monitoring, incident reporting, or statewide outcome measures.
- Concerns identified through the annual systemic risk assessment if appropriate.

## Policy and Procedure

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- Any performance or operational measure that is identified through program evaluations that require improvements.

Programs and departments will document the area for improvement and ensure alignment with CBH's strategic goals, regulatory requirements, and continuous performance improvement standards.

All program/department QI program plans are integral components of the agency Quality Improvement (QI) Program. The QI program plans will support and contribute to the agency's wide quality improvement objectives, ensuring coordinated systematic and continuous improvement across all services and departments.

2. Program/Department Measurable Goals and Objectives

Each program/Department (as appropriate) will:

- Identify areas for improvement.
- Establish measurable goals, performance targets, with the responsible staff for implementing program QIP.
- Determine implementation and completion dates.
- Monitor the QIP progress or lack of progress quarterly and update if needed.
- QIP must be signed, at a minimum, by the Program Director, Coordinator, and/or Manager to indicate responsibility for the plan review and implementation.

## Policy and Procedure

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3. Ongoing Monitoring, Evaluation and Data Analysis of Information

CBH collects, reviews and analyzes information on the following:

- Clinical services and documentation
- Service delivery effectiveness and outcomes
- Serious Incident reports on a quarterly basis
- Medication errors on a quarterly basis
- DBHDS Performance measures (review dashboard monthly)
- Satisfaction surveys
- Billing and reimbursement
- Regulatory compliance
- High risk indicators on the risk management plan as appropriate

The analysis of trends identifies patterns over time, identify risks, and opportunities for improvement. Findings are documented and corrective actions plans are implemented as needed.

**Policy and Procedure**

**Category:**

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## QUALITY IMPROVEMENT METHODS

CBH will utilize the following standard quality improvement (QI) tools:

1. Plan-Do-Study-Act (PDSA): Framework used to evaluate QIP and aims to promote efficiency, accountability, and compliance. The process promotes continuous improvement strategies by providing structured evaluation for monitoring and refining agency practices to achieve better outcomes.
2. Root Cause Analysis (RCA): Conducted for serious incidents or sentinel incidents, recurring deficiencies, or significant compliance concerns; includes root causes, contributing factors, corrective recommendations, responsible staff, and timelines for correction. Information is collected using the fishbone method.

## CORRECTIVE ACTION PLAN (CAP)

The intent of this Corrective Action Plan (CAP) is to establish a structured and consistent approach for addressing and resolving instances of systemic non-compliance. The CAP purpose is to ensure that deficiencies are promptly corrected with appropriate corrective measures to ensure sustainable controls are established to prevent recurrence, thereby promoting accountability, regulatory compliance, and continuous quality improvement.

When systemic non-compliance is identified:

- Programs/Departments will develop a written CAP that will include corrective actions, assigned staff, measurable outcomes, and timelines for completion.
- If required, the CAP will be submitted to DBHDS via Connect.

**Policy and Procedure**

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**Policy Number:87**

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- Each program coordinator and manager will monitor the effectiveness of the CAP as required by the timeline listed in the CAP. The purpose of monitoring is to ensure continued compliance with regulations and prevention of repeat events or deficiencies.

## INCIDENT REPORT REVIEW AND RISK MONITORING

Incident report monitoring is an ongoing component of the QI Program. The quality and compliance department reviews incident reports through an electronic reporting system (Clarity).

All incidents are reviewed to:

- Identify trends
- Assess risks to individuals and staff
- Determine if a root cause analysis needs to be completed
- Initiate corrective action when warranted

Trend analysis of incident reports is conducted quarterly to identify patterns, risks, and opportunities for improvement. Findings are documented and corrective actions plans are implemented as needed. If appropriate, findings may be integrated into program QIPs and agency-wide improvement activities to prevent recurrence to enhance workflows, quality of services and/or operations.

**Policy and Procedure**

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**Improvement Program**

**Policy Number:87**

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## CONFIDENTIALITY

Quality improvement records, quality improvement plans, investigations, incident reports, and any internal report findings are maintained confidentially as required by HIPAA and agency policy, while remaining accessible for regulatory review when required.

## REVIEW OF QUALITY IMPROVEMENT PLANS

The Quality Improvement (QI) Plan is designed to guide the continuous assessment and improvement of agency operations, efficiency, effectiveness, and quality of service delivery. To ensure ongoing relevance and effectiveness, the QI program plans will be reviewed quarterly and updated at least annually. If appropriate, revisions to the plans may be based on performance data, identified opportunities for improvement, regulatory changes, or agency priorities.

CBH will conduct a written annual evaluation of the quality improvement plans to assess:

- Achievement of measurable goals and objectives
- Effectiveness of improvement initiatives and CAPs
- Trends in incidents and outcomes
- Barriers to improvement
- Revise program quality improvement plans annually

**Policy and Procedure**

**Category:**

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**Improvement Program**

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**Primary Areas Affected:** All Staff

## EVALUATION OF QUALITY IMPROVEMENT PROGRAM

The Quality Improvement (QI) Program will be evaluated annually to assess its effectiveness, achievement of established goals, performance outcomes, and alignment with organizational priorities and regulatory requirements. The evaluation will include a review of key performance indicators, improvement initiatives, risk and compliance data, that may include external stakeholder feedback. Findings will be documented and used to identify strengths, areas for improvement, and priorities for the upcoming year. The results of the annual evaluation will be reported to leadership and the governing body for review and oversight.

## Policy and Procedure

**Category:**

**Administrative**

**Title: Quality**

**Improvement Program**

**Policy Number:87**

**Primary Areas Affected:** All Staff

# Diary of Changes

## Date of Origin

10/1/2000

## Dates of Review

03/06/2026 10/24/2025 04/30/2025

## Dates of Revision

03/06/2026 10/24/2025 04/30/2025

## Approved By

_____ 5/5/2026_____

Signature Effective Date

Ryan Ashe_____ CBH Board Chair

Printed Name Title

# Recruitment Status
# March 11, 2026 – April 13, 2026

**Recruitment Status Update:**
For the period of March 11, 2026, through April 13, 2026, Colonial Behavioral Health (CBH) has successfully completed 4 hires (2- Full-time and 2 PRN/WAR which includes a paid intern). The agency currently has thirty (30) vacant positions, this total includes twenty-four (24) full-time positions, two (2) part-time positions and four (4) PRN/WAR positions. During the identified period CBH had a total of 4 separations (2 Full-time and 2 PRN/WAR).

Colonial Behavioral Health
Wellness, Support & Recovery Services

**YEAR TO DATE REVENUES AND EXPENDITURES**
**as of**
**March 31, 2026**

## REVENUE

| CATEGORY | TOTAL BUDGET | RECOGNIZED YTD | BUDGET YTD | % RECEIVED | BALANCE |
|---|---|---|---|---|---|
| State | $ 14,274,982 | $ 9,771,939 | $ 10,706,236 | 91% | $ (934,297) |
| Local | $ 4,147,000 | 3,071,250 | 3,110,250 | 99% | $ (39,000) |
| Fees | $ 6,421,285 | 4,691,040 | 4,815,964 | 97% | $ (124,923) |
| Grants/Other | $ 736,943 | 800,132 | 552,707 | 145% | $ 247,425 |
| Total Revenue | $ 25,580,210 | $ 18,334,362 | $ 19,185,157 | 96% | $ (850,796) |

## EXPENDITURES

| CATEGORY | TOTAL BUDGET | EXPENDED YTD | BUDGET YTD | % EXPENDED | BALANCE |
|---|---|---|---|---|---|
| Personnel | $ 19,181,019 | $ 12,876,770 | $ 14,016,898 | 92% | $ 1,140,128 |
| Staff Development | 116,497 | 106,712 | 87,373 | 122% | (19,339) |
| Facility | 1,776,594 | 1,094,702 | 1,332,445 | 82% | 237,743 |
| Equipment and Supplies | 1,509,307 | 782,815 | 1,131,980 | 69% | 349,166 |
| Transportation | 189,408 | 86,858 | 142,056 | 61% | 55,198 |
| Consultant and Contractual | 2,549,955 | 1,552,383 | 1,912,466 | 81% | 360,083 |
| Client Supports | 87,348 | 47,998 | 65,511 | 73% | 17,513 |
| Miscellaneous | 170,083 | 143,819 | 127,562 | 113% | (16,257) |
| Total Expenditures | $ 25,580,210 | $ 16,692,058 | $ 18,816,292 | 89% | $ 2,124,234 |
| Operating Margin | $ - | $ 1,642,304 | | | |

Unless noted otherwise, all amounts are modified cash basis: revenues recognized when earned and received; expenditures upon disbursement

## CRISIS SERVICES CENTER PROJECT

| CATEGORY | PROJECT BUDGET | PROJECT TO DATE |
|---|---|---|
| Total Revenue | $ 12,521,000 | $ 5,425,096 |
| | | |
| Total Expenditures | | $ 4,694,977 |
| Balance: | | $ 730,118 |

## PHASE II - NEW BUILDING

| CATEGORY | PROJECT BUDGET | PROJECT TO DATE |
|---|---|---|
| Total Revenue | $ - | $ 652,500 |
| | | |
| Total Expenditures | | $ 22,923 |
| Balance: | | $ 629,577 |

**COLONIAL BEHAVIORAL HEALTH**
**DRAFT Budget Summary**
**Fiscal Year 2027**

| Account | FY27 Budget | FY26 Revised Budget | 27B v 26RB Better/ (Worse) | 27B v 26RB %Δ |
|---|---|---|---|---|
| **Revenue** | **$ 26,107,325** | **$ 25,530,210** | **$ 577,115** | **2.3%** |
| Fee Revenue | 6,614,257 | 6,421,285 | 192,972 | 3.0% |
| Local Revenue | 4,361,175 | 4,147,000 | 214,175 | 5.2% |
| State Revenue | 1,448,443 | 959,943 | 488,500 | 50.9% |
| Other Revenue | 13,683,450 | 14,001,982 | (318,532) | -2.3% |
| **Expense** | **$ 26,107,325** | **$ 25,530,210** | **$ (577,115)** | **-2.3%** |
| Personnel | 20,115,239 | 19,161,019 | (954,220) | -5.0% |
| All other operating expenses | 5,992,086 | 6,369,191 | 377,105 | 5.9% |
| **Operating Margin** | **$ 0** | **$ -** | **$ 0** | |
| Year over Year | | | | 2.3% |

**FY27 v. FY26 - Key Assumptions**

FY27 Operating budget is projected to be 2.3% over the FY26 Revised Budget (RB).
This current draft does not yet include all Director priority expense requests for FY27.

Revenues:
>FY26 included one-time funding that did not carry over into FY27.
>FY27 includes carry-over funding to support workforce restricted use, increased Medicaid fee schedule and local general funds.

Expenses:
>Assumes 208 FTEs; a 3% pay increase; with 5.7% attrition and a healthcare increase.
>Lower non-recurring expense for MCR, which was supported by 1-time funding in FY26.

**COLONIAL BEHAVIORAL HEALTH**
**Executive Director's Report – May 2026**

## Agency Issues

1. We are pleased to invite the Board to a "hard hat" tour of the Center for Support & Wellness before the June meeting. We will share more details as they are finalized.
2. The CBH Board Member Home Page is live and active tor Board members to access agency policies. We will be expanding content beyond policies over the next few months. The site link is: CBH Board Sharepoint Home Page.
3. The VACSB Annual Training Conference is being held May 6-8 in Richmond. Board member Bruce Keener has registered to attend.
4. The VACSB Public Policy Conference will be held October 7-9 in Roanoke. If you are interested, please contact Kristy Wallace to manage your registration and lodging.
5. We are pleased to report that complications associated with the $2.0 million secured by Congressman Wittman have been resolved. There are some USDA restrictions for use of the funds, but none that will keep CBH from proceeding as needed.

## Community Issues

1. We are hosting four (4) feedback sessions, during the months of May and June, related to Phase 2 of our facility development plan. The four (4) separate sessions will receive focused input from
    a. CBH staff,
    b. Individuals with lived experience and families,
    c. Public/community session – including Board members, and
    d. Agency partners and stakeholders.
2. Our community has been selected for a SAMHSA's GAINS Center for Behavioral Health and Justice Transformation–led Sequential Intercept Mapping (SIM) exercise for local partners on June 4–5, hosted by the Williamsburg Police Department.

## Public Policy

1. As of this writing, the General Assembly has still not adopted a biennial budget. We are proceeding with our budget development process without dependence on new sources of state funding.
2. With Virginia not pursuing the statewide federal CCBHC Demonstration Grant opportunity this year, there remains the opportunity for individual agencies to seek CCBHC status by applying for a SAMHSA CCBHC Expansion grant. We were unsuccessful in our 2024 application, but plan to submit again this summer. The Expansion Grant provides funding for 4 years but does not include an advantageous billing mechanism like the statewide grant. Marsha Obremski leads this project.

Respectfully submitted,
David A. Coe