

FIDELITY BEHAVIORAL HEALTH

# Meeting People at the Intersection

*Competency restoration, recovery, and the legislative work still ahead.*

Presented by Frank Nally • Fidelity Behavioral Health

WHERE THIS WORK LIVES

# The intersection of mental health and the criminal justice system



## Severe and persistent mental illness

Untreated, under-medicated, often co-occurring with cognitive impairment and trauma.



## Charges, custody, and competency

Clients in jail, deemed incompetent to stand trial, cycling between booking, ER, and the street.

*Fidelity Behavioral Health was built for the people sitting at this intersection — and for the system that has not yet built enough for them.*

# Who we are

**Fidelity Behavioral Health was founded on competency restoration.**

The large majority of our clients come to us out of incarceration, having been deemed incompetent to stand trial because of severe and persistent mental illness, cognitive impairment, or both.



## OUR MISSION

*Create a path of recovery, wellness, and long-term success for people living with severe and persistent mental illness.*

# Take the at-risk client before the first arrest

## TODAY

### Restoration after the system has already failed

By the time we receive a competency client, the person has typically been arrested multiple times, has lost housing, has lost benefits, and has decompensated significantly.

## WHAT WE COULD DO

### Stabilize at-risk clients before the first felony

Catching the person who is obviously headed into the system — by diagnosis, history, and acuity — is dramatically cheaper, and dramatically more humane, than restoring them after the fourth arrest.

HOW WE BEGIN

# Understanding & treating the whole person

*Recovery requires stabilizing four domains in parallel. Gains in one collapse when another fails.*



## MENTAL HEALTH

Consistent medication management.  
Medication education.



## PHYSICAL HEALTH

Primary care.  
Specialists. Dental.



## SOCIAL & SERVICES

Family. Documents. SSI.  
Housing. Employment.



## LEGAL

Working relationships with courts, attorneys, liaisons.

*If one domain fails, the others follow. Integration is the entire point.*

AND CRITICALLY

# Supportive housing — under our roof



**Fidelity offers supportive housing for our clients.**

The gap between clinical stabilization and a living environment that can sustain it is one of the most consistent failure points in the system. We bridge that gap inside our own program where we can.

*But we cannot scale supportive housing on our own. The state has to come to the table.*

# The cornerstone: medication management & establishing a baseline

**24h**

First prescriber visit  
within 24 hours of admission

**Qmap**

All operations staff is capable of  
dispensing medications

**PRN**

Stabilizing antipsychotics  
ready at intake

*The first 72 hours determine whether a client can engage with the rest of treatment at all.*

INTENSIVE OUTPATIENT

# Case Management

*Concrete clinical goals — delivered through a trauma-informed lens.*



**Vital documents**



**Court liaison**



**SSI and HCBS Waivers**



**Employment**



**Housing and discharge planning**

# Four evidence-based modalities, one relationship

## ACT

### Acceptance & Commitment Therapy

Accept what has happened. Commit to actions that move life forward.

## CBT

### Cognitive Behavioral Therapy

Challenge maladaptive thoughts. Connect thought, feeling, and behavior — gently, especially with psychosis.

## DBT

### Dialectical Behavior Therapy

Reduce harmful behaviors. Build emotional regulation and distress tolerance.

## MI

### Motivational Interviewing

Surface the change the client wants. Treat resistance as information, not opposition.

*Used together. Sequenced to where the client actually is.*

# First, hold space.



*The best thing we can do is hold space and be a container — providing safety and a corrective relationship to the negative experiences and unsafe places that have shaped our clients' lives.*

Before any modality lands, the relationship has to be the thing that is true.

*Without that, no worksheet, no skill, and no medication adjustment can do its work.*

# Treating the trauma is treating the illness

**TREM**

## Trauma Recovery and Empowerment Model

An evidence-based group intervention designed for survivors of complex trauma — built directly into our IOP.

**For our population, complex trauma is the rule, not the exception.**

*Treating the trauma is not separate from treating the mental illness — it is the same work, and trying to do one without the other is why so many people relapse.*

# What IOP is for

*Concrete clinical goals — delivered through a trauma-informed lens.*



**Address co-occurring SUD and mental health**



**Drive behavioral change**



**Build coping skills**



**Develop emotional awareness and regulation**



**Improve interpersonal functioning**

# Three jobs, all happening at once



## ADVOCACY

Self-determination and choice.  
Connect to resources. Teach  
clients to advocate for  
themselves.



## ETHICS & SAFETY

Respond to risk appropriately.  
Assess safety. Know how to  
respond inside a crisis instead of  
being swept into it.



## WELLNESS & RECOVERY

Build relationships. Share lived  
experience. Model recovery. Set  
goals. Teach the skills that sustain  
it.

# What independent living actually looks like

*Groups and one-on-one. The work that makes everything else stick.*

**Anger management**

**Creative expression (art & music)**

**Interpersonal relationships**

**Financial literacy**

**Medication education**

**Relapse prevention**

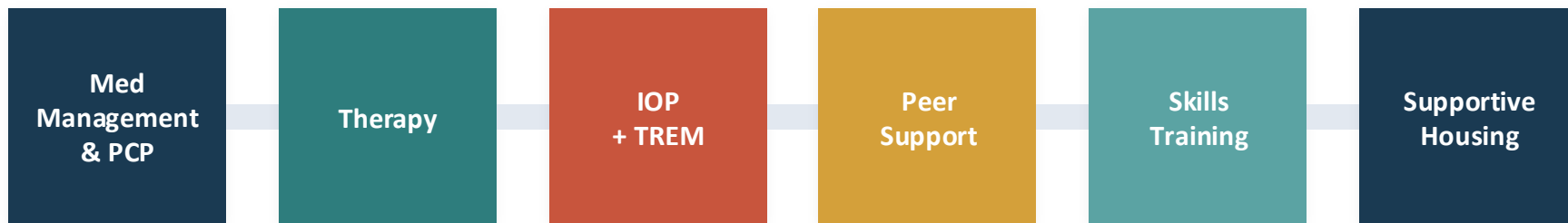
**Cooking and food budgeting classes**

**Activities of daily living**

*Confidence to provide for themselves. Reduced impulses. Preparation for a real life outside.*

HOW IT ALL CONNECTS

# Integration is the differentiator



## Information moves with the client.

Med management talks to primary care. Therapy talks to the case manager. The case manager talks to housing, the SSI advocate, and the court. Nothing is dropped at a transition.

# Two years of outcomes

~150

clients served

*by our main program over the last two years*

41%

completed successfully

*minimum IOP, in good standing, with a transition plan*

1

Legal charges remained

*of every client who completed the entire program, only one did not have legal charges dropped*

*Most of these clients had their court issues resolved and competency restoration completed.*

PART FOUR

# Roadblocks to care for SMPI Clients on Medicaid

*Constitutional, regulatory, administrative, and fiscal barriers compound to delay, dilute, or deny care altogether.*

THE POPULATION AT STAKE

# 1.2 million Coloradans on Health First Colorado

1.2M+

Coloradans enrolled in Medicaid

*Health First Colorado*

FOR THESE COLORADANS, ACCESS ISN'T  
JUST FINDING A PROVIDER

It is navigating a system in which constitutional, regulatory, administrative, and fiscal barriers compound to delay, dilute, or deny care altogether.

**What we see daily:**

*Clients deteriorating while waiting for a bed. Facilities that cannot open on time. Treatment plans constrained by what the system will reimburse — not what the client needs.*

# TABOR



## The Taxpayer's Bill of Rights

Caps state revenue growth. Refunds surpluses to taxpayers rather than reinvesting in public services.

## THE RESULT

- Medicaid starved of flexibility to expand provider rates
- No funding for innovative service models
- No ability to respond to surges in demand
- Federal Medicaid match dollars left on the table

# HCPF oversight of the RAEs

HCPF contracts with 4 Regional Accountable Entities to manage Medicaid behavioral health benefits across the state.

## IN PRACTICE

- Authorization denials with limited transparency
- Inconsistent credentialing timelines
- Opaque rate-setting that providers must build around
- Network adequacy decisions made with little enforcement

**Without active state oversight,**

*the entities entrusted to serve Medicaid members are accountable largely to themselves.*

# Barrier to entry: a Goldilocks problem

## TOO LOW

### Operators may take advantage

When entry is easy and reimbursement is attractive, you draw operators who are not really there to do the work. Peer support is the cautionary example — quality issues across the field.

## TOO HIGH

### Care stagnates

When entry is too costly or too uncertain, operators walk away from the opportunity altogether. DFPC clearance for transitional living facilities is a perfect example.

# Licensure Requirements & Clearance



Opening a Mental Health Transitional Living facility requires clearance from the Division of Fire Prevention and Control.

## THE BOTTLENECK

### Months to years

Approval timelines stretch unpredictably

### Backlogged reviews

Plan reviews queued behind every other application

### Inconsistent codes

Code interpretations vary across regions

### Empty buildings

Beds the state needs sit offline

# No state surplus and minimal notice for big financial changes

90

DAYS

*Roughly the time providers are given to pivot an entire operation when RAE rates change dramatically.*

## WHY IT BREAKS PROVIDERS

Behavioral health business models are built around RAE rates — staffing ratios, facility footprints, clinical programming, the whole cost structure of care.

**With TABOR in place, there is no surplus to:**

- Raise Medicaid rates
- Streamline licensure
- Provide transitional funding to absorb shocks

PART FIVE

# Operational barriers we run into daily

*Where someone, somewhere, can choose to make a different decision tomorrow.*

AND ON THE GROUND EVERY WEEK

# Housing, benefits, and handoffs



## High-acuity housing

We stabilize over months, then discharge into housing with no on-site med admin or management.



## HCBS waivers

One access point, repeated failures. Clients reported as 'no record' even after assessment.



## SSI processing

Full documentation submitted, automatic denials. One client has obtained SSI in our care.

# What is the cost of doing nothing differently?



## Emergency response

Repeat dispatches for psychiatric crises



## ER admissions

Crisis preventable with consistent meds



## Court & jail

Bookings, public defenders, custody days



## The cycle

Repeats. And the bill grows.

*Counties, hospitals, families, and clients are paying for the most expensive, least effective version of care — right now, every day.*

# Why legislative reform is the lever



*These barriers were built by policy. Only policy can dismantle them.*

## COLORADANS DESERVE A MEDICAID SYSTEM IN WHICH:

1

TABOR does not prevent the state from responding to a behavioral health crisis.

2

HCPF actively holds the RAEs accountable for the members they serve.

3

Licensure pathways like DFPC clearance move at the speed of the need.

4

Providers have the rate stability required to maintain care and stay operable

# What needs to change

1

## Reform the funding architecture

Address TABOR's impact on behavioral health. Stop leaving federal match dollars on the table.

2

## Make HCPF accountable for the RAEs

Transparency, network adequacy, authorization standards — enforced, not delegated.

3

## Streamline licensure

Beds the state needs cannot sit idle for a year because of a paperwork queue.

4

## Open the FST pipeline

Restore staffing. Pay evaluators in line with the market. Allow services in jail.

5

## Fund transition care & high-acuity housing

On-site med admin. Custody-to-community handoffs that don't drop clients.

6

## Streamline HCBS & SSI;

Stop automatic denials. Take at-risk clients before the first felony.

THE PEOPLE WE SERVE ARE NOT LOST CAUSES.

*They are people whose entire trajectory bends when somebody finally builds a system around them — and around the policy environment that lets that system function.*

More partners at the table — clinical, legal, governmental, legislative, and community — means more lives changed and more public dollars redirected from crisis into care.

**Thank you.**