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Community Mental Health Services

New York State Budget Fiscal Year 2001

A Briefing Book

February, 2000

Actions Needed

G Trended Adjustment on All Mental Health Funding ($41.12 million)

Permanent Trend Factor for all Mental Health Rates, Grants and Fees $36.9 million
Institute a mechanism to ensure that mental health reimbursements keep pace with inflation. For this year provide an increase of 3.9% to keep pace with the Consumer Price Index since the most recent adjustment of under 2.5% in 1997.

Parity Adjustment for Non-Contract Agencies $4.22 million
Provide a $15 per visit rate adjustment for Non-Contract agencies, whose only funding stream is Medicaid, to preserve their viability.

G Presumptive Medicaid Eligibility

Presumptive Medicaid Eligibility
End the practice of forcing people coming out of jails, prisons and inpatient psychiatric facilities to wait 45-90 days for Medicaid eligibility.

G Co-Occurring Psychiatric and Addictive Disorders ($4.6 million)

Comprehensive Support Team for People in Dual Recovery $2.7 million
Establish six pilot teams to provide direct treatment services and case management to a selected group of "heavy users" of mental health and substance abuse services.

MICA Case Management Teams $900,000
Establish six pilot teams of two case managers to enable clients with co-occurring disorders to successfully navigate both the mental health and substance abuse systems.

Cross-Discipline Training and Technical Assistance Program $1.0 million
Mental health and substance abuse providers will be jointly cross-trained to establish competency in working with dually-diagnosed clients.

G Vocational Services for People with Mental Illness ($3 million)

Ongoing, As-Needed Employment Supports $3 million
Allow mental health services providers flexibility in applying resources to help recipients of services develop a continuous attachment to the labor force.

G Expanded Treatment Services ($10 million)

Add treatment services for adults, children and adolescents $10 million

Additional Actions Needed

- Authorization of the mental health Special Needs Plan should be contingent upon:
  - The review of an independent actuarial study that assures that the SNP benefit package can be supported by the premiums offered by the Office of Mental Health (OMH);
  - The inclusion of transitional funding to support computer, reporting, and accountability measures required by the SNP and start-up funding for the expected alternative programs not funded by the premium;
  - The inclusion of a permanent Medicaid trend factor;
  - A relaxation of the extraordinarily high level of regulation in favor of the insurance model;
  - A recalculation and adjustment of COPs revenue to respond to volume adjustments in the number of visits provided during the first two years of SNP operation; and
  - The inclusion of a specific expiration date in the authorizing legislation.

- Lift the OMH Medicaid neutrality cap on outpatient mental health services.

- Extend the Community Reinvestment Act indefinitely and engage in a planning process with the stakeholders in the mental health community to identify a successor funding stream.

- Mandate mental health insurance parity.

- Restore the still-missing 149 State shared staff positions cut in the Fiscal Year 2000 budget.

- Pass a technical amendment to the MTA Half Fare Fairness Bill to preclude a lengthy battle with the MTA over implementation in New York City.

Trended Adjustment on All Mental Health Funding

Mental health rates, grants and fees are the only healthcare rates in the State that do not keep pace with inflation. Absent a trending mechanism, mental health reimbursements are effectively cut every year as providers are asked to furnish the same services with fewer real dollars. It has reached the point where some providers ***lose*** money on every unit of service they provide (see attached chart). We therefore request the establishment of a permanent trending mechanism that will tie increases in reimbursements to the Consumer Price Index. For this year, provide the entire mental health service delivery system with a 3.9% trended increase on all personal and non-personal services for all rates, grants and fees to keep pace with the rate of inflation since 1997 when programs received less than a 2.5% adjustment.

While other Medicaid providers in New York State have received trend factors amounting to an average of 3.4 percent each year for 10 years, mental health providers have received less than four percent through sporadic cost-of-living adjustments over the last decade. (See attached chart)

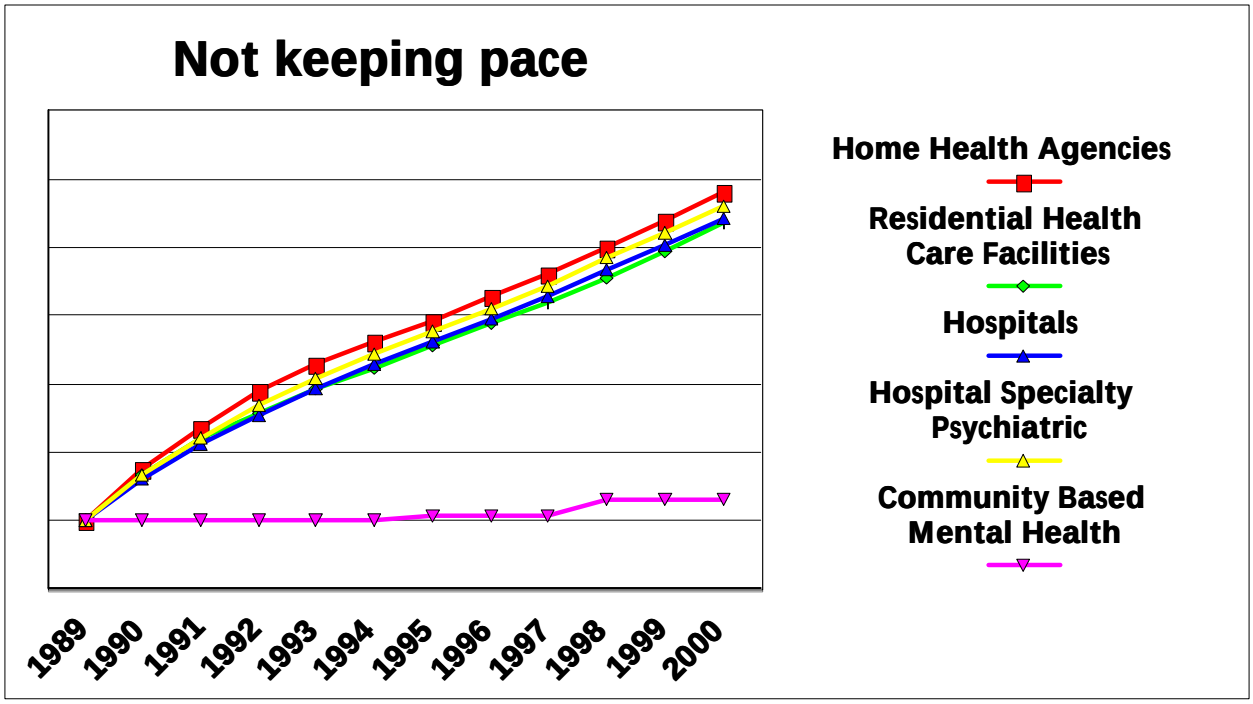
Furthermore, some agencies—those whose only funding stream is Medicaid—were left out of the 1997 and earlier adjustments entirely. Some of these agencies have not had a rate adjustment in over a decade and therefore require an additional one-time $15 per visit adjustment to ensure their viability into the future. If they do not receive it, many of them will be forced out of business.

The lack of trended increases has contributed to the crisis in community-based mental health services characterized by the lack of continuity in, and coordination of, outpatient services and reliance upon fortuitous responsiveness to the individual needs of those with mental illnesses. Client care and agency operations are affected daily by numerous impediments, including:

- Agencies cannot compete with the salaries of State and local government jobs, which pay an average of $10,000 more per year for the same position;
- Staff morale is at an all-time low;
- Turnover rates exceed 27% in many agencies;
- Vacancies go unfilled for months because salaries are uncompetitive;
- Every time a direct care worker leaves, the continuity of care for his or her clients is disrupted, and a key component of the recovery process is destroyed, resulting in treatment setbacks and the need for additional services;
- Agencies have to incur the cost of replacing qualified staff by: placing ads, interviewing, training, and interrupting the routine of staff and clients;
- Improvements to the physical plant get delayed year after year due to lack of trended increases for inflationary Other Than Personal Service (OTPS) costs.

An immediate 3.9 percent trend factor is warranted to stabilize the service delivery system before it is expanded. In addition to the need for increases in staff salaries the costs of rent, equipment, heating oil transportation, communications, supplies, postage are all increasing, but voluntary agencies are not receiving increases to cover those costs.

If this problem is not addressed, some agencies will be forced to shut their doors for lack of money to pay the rent. Trend factors for mental health providers would go a long way toward correcting years of inequities and would finally stabilize our community mental health system into the future, enabling it to meet the accessibility and responsiveness shortcomings which the Governor identified in his budget proposal.


Not keeping pace
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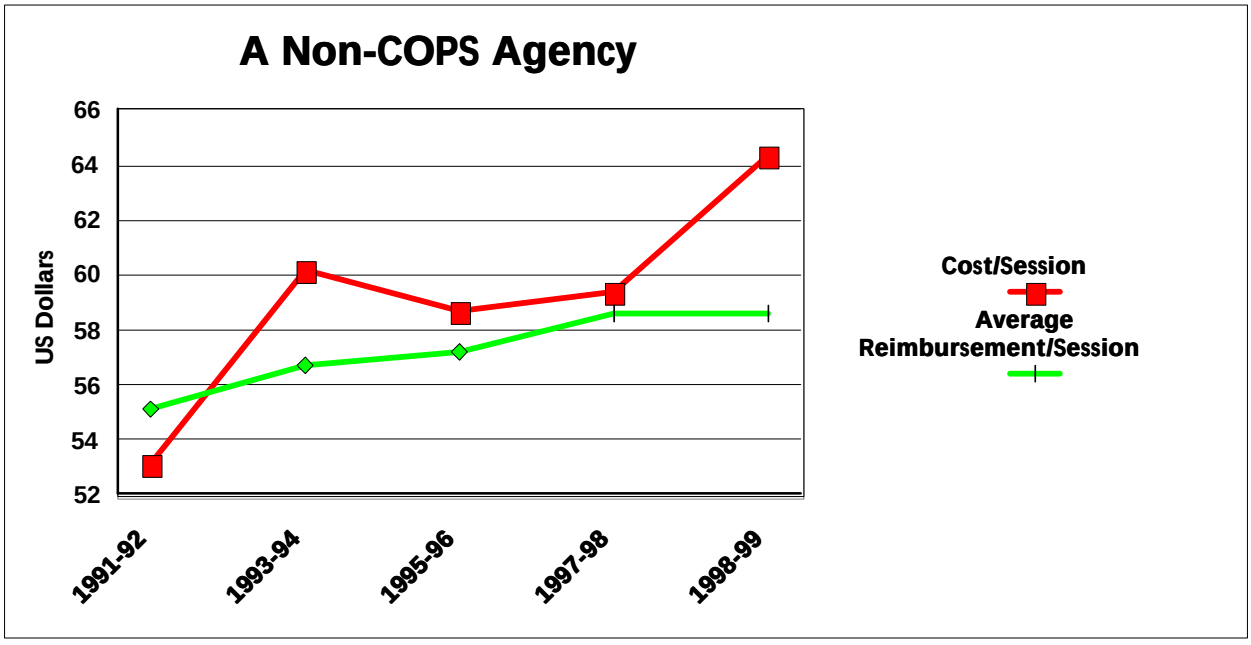
Home Health Agencies
Residential Health Care Facilities
Hospitals
Hospital Specialty Psychiatric
Community Based Mental Health


A Non-COPS Agency
US Dollars
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54
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1991-92
1993-94
1995-96
1997-98
1998-99
Cost/Session
Average Reimbursement/Session

Presumptive Medicaid Eligibility

Mentally ill individuals returning to the community from stays in jails, prisons or hospitals need immediate access to psychiatric care and medication. In order to transition from these settings back into the community, they must have access to medication, case management, treatment services and appropriate housing. Immediate access to these services is the best way to guarantee a safe return to the community for this population.

Most hospitals give patients a two weeks' supply of medication upon discharge, but beyond that, the patient must rely on his/her own ability to negotiate the system to obtain medication and services without insurance coverage. The situation is worse for mentally ill prisoners leaving prison and jail, for they are given little or no medication upon release, and are seldom referred to mental health treatment in the community. Without immediate access to Medicaid insurance even good discharge plans fail, leading to a senseless waste of human potential and money: a revolving door of homelessness, hospitalization, incarceration and tragedy.

An individual discharged into the community without Medicaid must take it upon him/herself to apply for Medicaid, most often without the help of hospital, jail or prison staff. It takes between 45 and 90 days for the Department of Social Services to determine eligibility according to State Social Service law. This means that if an individual applies for Medicaid on the day s/he enters the community, at best Medicaid eligibility will be granted in a month and a half. Presumptive eligibility eliminates the waiting period that occurs while Medicaid eligibility is verified by local Social Services district staff and replaces it with a 90-day assumed eligibility period.

This program should replace the county-operated medication management program proposed in the Executive Budget. First and foremost, medication is not treatment. Providing a person with pills alone is a stopgap and ineffective way to treat a serious mental illness. It is safer and more efficient to allow access to all Medicaid services for this population than to guarantee access to medication unaccompanied by any other Medicaid treatment.

Additionally, presumptive eligibility maximizes the impact of the State's dollars. The proposed medication management program relies entirely on State funds, while presumptive eligibility will draw down Federal subsidies. Furthermore, the medication grant program is proposed to be implemented on a county-by-county basis. In counties that choose not to participate, consumers will be excluded from the program. In order to participate, counties must set up an entirely new layer of bureaucracy, drawing scarce resources away from the consumers who need them.

Also, once a determination of eligibility is made, Medicaid will reimburse for services up to 3½ months prior to the date of initial application. This means that for consumers who are ultimately deemed eligible, no general fund dollars will be necessary. The provision of presumptive eligibility will maximize the benefit of State dollars to people with mental illness and provide the continuity of care that they so desperately need.

Co-occurring Psychiatric and Addictive Disorders

A dually diagnosed client needs a coordinated, seamless service system for both of his/her disorders. We lack that system in New York State, so we must provide the training and regulatory relief necessary to create it. In the meantime, we must fill in the gaps in the system and enable two separate systems to transition to one which is seamless.

In order to transform the care delivery system cross-training is needed. Care that treats both disorders as primary can only be provided effectively by someone who understands both disorders. A training curriculum around people with co-occurring psychiatric and addictive disorders that addresses the needs of providers in both systems is crucial to keep current the knowledge and skill base of service providers. This is being done more today than ever before, but treatment quality will be further enhanced by continued cross-training, the development of dual-competencies, and consultation to provide comprehensive services.

Because we lack a truly integrated care system, clients are faced with barriers (geographic, financial, informational) between the different types of mental hygiene care that they need. MICA Case Management Teams would be an inexpensive way to help consumers and their families overcome these gaps. The lack of integrated treatment places the burden of integrating the two systems on consumers and their families, depriving them of appropriately combined interventions.

All clients identified with co-occurring disorders should have a case management team. These teams would consist of two case managers, one with a specialization in substance abuse treatment and the other with a specialization in mental health treatment. These teams could handle more clients than a single case manager and, for a relatively low cost, help consumers navigate both systems. People in recovery would be excellent candidates for MICA case management roles. As valuable as case management is for navigating the mental health or addiction treatment systems, it is more valuable for consumers who must navigate both.

For clients with the most intensive need Comprehensive Support Teams for People in Dual Recovery (CSTPDR) would be necessary. CSTPDR would be an aggressive outreach team that would see clients in their natural environments (work, home, clubhouse, etc.) on a regular or semi-regular basis. Team members may include a recovering addictions counselor, social worker, peer advocate, psychiatrist and psychiatric nurse. The team would follow the client and enable him/her to access the appropriate treatment from the right sector at the correct time. They would intervene during times of crisis and regularly check on the client to ensure, during times of relapse, that the client would not back-slide too far before receiving treatment. CSTPDR's case loads would not remain in place for life. As clients become more stable and are better equipped to function in the community, they will be moved to less intensive types of case management, like MICA case management teams.

We propose that the State implement six pilot programs for both of these proposed case management teams. After a period of time sufficient for a full implementation, the legislature should review the outcomes and consider more comprehensive program funding.

Vocational Services for People with Mental Illness

The goal of rehabilitation and treatment for people with mental illness is the reintegration of those individuals into the society from which their disability has separated them. Integration is the involvement or opportunity for involvement in the normative activities of the community. Yet, the State Office of Mental Health (SOMH) reports that only between five and fifteen percent of people with mental illness in are involved in the single most normative activity for adults between the ages of 18 and 65: work.

Several steps must be taken to improve employment outcomes if we are to succeed in our goal of community and social integration.

- Benefits – The state should establish a Medicaid buy-in option for people with psychiatric disabilities to enable them to continue to take medication and receive supportive services while they are working. The citizens of New York should never have to make the choice between taking their rightful place as taxpaying citizens and keeping the symptoms of their disability under control.

- Services – HCFA specifically excludes activities such as job development and job coaching from payment though Medicaid. The Governor's budget proposal allocates $880,000 for Supported Employment slots. Although that funding is welcome, it supports only one aspect of the return to work for a limited number of people. A continuous attachment to the labor force is dependent on the presence of post-employment supports that are available throughout a worker's career. We are requesting that the legislature allocate an additional $3 million to allow providers to provide ongoing, as-needed employment supports. This funding will allow mental health services providers a range of flexibility in applying resources to help the recipient of services move beyond entry level positions and develop a continuous attachment to the labor force.

Employment provides a measurable and mutual benefit for both the person and the State. People with psychiatric disabilities who are working are more compliant with their medical regimen and less likely to need expensive hospitalization, crisis intervention services and court orders. For the State, when people with psychiatric disabilities join the labor force, their status changes from tax users to tax payers. In addition, with the potential for an income that rises above simple subsistence levels these working people also become consumers of goods and services, making their own positive impact on the economy.

The allocations that we are requesting will set the cornerstone for the State's efforts to ensure that New Yorkers with psychiatric disabilities have the opportunity for self determination that employment provides.

Expanded Treatment Services

The Governor's proposal to increase the capacity of the community-based mental health system is a welcome recognition of the desperate need to increase access to care for people with psychiatric disabilities. His suggestion to add $125 million in enhanced services will breathe new life into a system long starved for resources.

The need for additional case management is dire and the proposal recognizes this with over $50 million in new funding for different types of case management services. Case management, however, is not treatment. It helps consumers and their families navigate a complex system and ensures that they do not fall through the interstices, but it does not lessen their symptoms. Case management, simply put, cannot be effective unless there are treatment services for consumers to be case managed into. Case management coordinates care, but unless the treatment system for children, adolescents and adults is also expanded, the capacity crisis remains unsolved.

Expanded children's treatment services are especially crucial. Untreated childhood emotional disturbances become severe adult mental illnesses. If these children receive the treatment they so desperately need, it will reduce the burden on the adult mental system in the future. Money invested in children's treatment will pay both human and monetary dividends.

In order to create a comprehensive, coordinated care system we propose an expansion of the treatment systems for children, adolescents and adults. This expansion would maximize the benefit of the proposal the Governor has made and improve the level and quality of care for all New Yorkers with mental illness.

Special Needs Plan Reauthorization

In 1996, when the New York State legislature authorized the implementation of mandatory Medicaid managed care enrollment as proposed by the "Partnership Plan," it also authorized the development and implementation of six adult mental health Special Needs Plans (SNPs). On June 30, 2000, authorization for mandatory Medicaid managed care enrollment and the SNPs expires and the New York State legislature must renew the legislation if this process is to continue. As currently constructed, the SNPs are not viable. We recommend that the SNPs be reauthorized only if the following conditions are included in such reauthorization:

- **The review of an independent actuarial study that assures that the SNP benefit package can be supported by the premiums offered by the Office of Mental Health (OMH).**
  The SNP benefit package developed by OMH is too broad for the SNP premium to support. The legislature must be sure the benefit package can be supported by the premium. The legislature should commission and review independent actuarial data.
- **The inclusion of transitional funding to support computer, reporting and accountability measures and alternative services start-up required by the SNP but not funded by the premium;**
  If the premiums are insufficient to support the benefit package, then clearly they do not adequately support the investments required for computer software, hardware, reporting systems and accountability measures also required by the RFP. The legislature must authorize additional transitional funding to cover the increased costs to providers of re-engineering and infrastructure development.
- **A permanent Medicaid trend factor in the SNP rates**;
  The SNP rates offered by OMH do not include a permanent Medicaid trend factor. The HIV SNP rates and mainstream managed care plans offered by the State Department of Health do include an annual trended increase. An increase in mental health SNP rates that is trended for inflation is permitted by the agreement between New York and HCFA, the Partnership Plan.
- **An easing of the extraordinarily high level of regulation in favor of the insurance model**
  The RFP goes beyond mandating levels of service to include regulations about staffing ratios, alternative therapies and lengths of treatment. The HIV SNPs are based on the insurance model and the mental health SNPs should be as well.
- **A recalculation and adjustment of COPs revenue to respond to volume adjustments in the number of visits provided during the first two years of SNP operation;**
  When New York State reduced its General Fund commitment to mental health care during the early 1990's, Medicaid providers began to receive Comprehensive Outpatient Program (COPs) payments to replace their old net deficit (General Fund) funding. These COPs payments have been the stabilizing force for those community mental health care providers who receive it. If SNPs work as planned certain types of Medicaid visits will decline, reducing the amount of COPs funding available to communities. Unless COPs payments are recalculated and adjusted regularly during the first SNP procurement, this stabilizing funding stream will be lost and SNP development will jeopardize the existing community mental health system.
- **A time-limit on the extension**
  An extension in perpetuity would deprive the legislature of its ability, prerogative and responsibility to review such profound changes to our system of care delivery.

Community Reinvestment

We are pleased that the Governor fulfilled Reinvestment Year VI in his budget proposal. The funding he proposes indicates his recognition of the importance and value of this funding stream and the new services it has enabled in communities across the State. We would like the Community Reinvestment Act to be extended indefinitely. The principle that the money used to keep people in inpatient psychiatric facilities should follow them to the community is an exceptionally important one that should be forever preserved. Moreover, revenue from the consolidation and sale of State psychiatric campuses should be added to the Reinvestment funding stream.

We recognize, however, that there is a limit to the number of additional beds that can be closed in New York State. We therefore encourage the legislature to engage in a planning process with the stakeholders in the mental health community to identify a successor funding stream to expand cutting-edge therapeutic and rehabilitation services that are controlled by a local planning process. These services are so important they require a new source of funding.

Shared Staff

Last year the Governor proposed cutting 215 State shared staff. The legislature provided sufficient funding to restore 66. 149 positions are still missing. This reduction of a commitment made to communities more than 20 years ago has already begun to harm our capacity to serve seriously mentally ill adults and seriously emotionally disturbed children. In many localities these positions form the backbone of county and voluntary agencies' professional staff. Our preference is to retain these shared staff under the current arrangement. The Intensive Case Manager shared staff positions were retained in the Governor's proposal and so should the remaining 149 direct care positions which are of no less value in our communities. We urge the legislature to allocate funding to restore the missing 149 State shared staff.

Mental Health Parity

28 of the 50 United States now mandate some form of mental health insurance parity. It is a shame on our State that we are so far behind the curve in ending one of the most insidious forms of discrimination with which people with mental illness are faced. The continued discrimination against people with mental illness by the insurance industry, and the continued tacit approval of the New York State government, further stigmatizes people with mental illness.

The provision of mental health parity is congruent with Federal policy. The U.S. Surgeon General has urged all States to mandate mental health insurance parity as a way to get effective treatment to the people who need it. In the past year over 9 million Federal employees were granted mental health insurance parity. The Federal Employees Health Benefits Plan, the nation's largest private insurer, must now include only plans that provide full mental health and substance abuse parity.

Why should a person with Alzheimer's, diabetes or heart disease get full insurance coverage when a person with schizophrenia gets severely limited coverage? The costs associated with mental health insurance parity are minimal or non-existent.[1] Furthermore, 91% of New Yorkers want to see an end to discrimination in health insurance and well over half are willing to pay increased premiums for it. In the long run, continuation of this inequity will cost uncountable dollars in emergency room visits, psychiatric hospital re-admittances and lost labor, not to mention the human cost in lost lives. We urge both houses of the legislature to agree upon a bill that will end discriminatory insurance practices for those with mental illness.

Medicaid Neutrality Cap

The OMH Medicaid cost neutrality provision and spending cap must be lifted. Enacted as part of an agreement between former OMH Commissioner Surles and the Department of Budget, the cap artificially restricts expansion of community mental health services to meet the actual need. There is no such cap for Department of Health, Office of Alcoholism and Substance Abuse Services or Office of Mental Retardation and Developmental Disabilities services. The cap may well be a violation of both State and Federal law. We urge the legislature to eliminate this malignant form of discrimination that prohibits people with mental illness from receiving the services they need, and to which they are entitled.

[1] Maryland reported a .2% cost decrease after full parity implementation. Rhode Island reported an increase of .33% after implementing statewide parity. New Hampshire insurance providers reported no cost increases as a result of severe mental illness health parity. According to a study published in the Journal of the American Medical Association, insurance equality would cost $1 a year per employee under managed care.

MTA Half Fare Fairness

People with mental illness suffer countless forms of discrimination every day. In housing, employment, transportation, insurance coverage and in the funding of treatment services they are treated as second-class citizens. Every day they experience the effects of stigma–the negative attitude that attaches to mental illness in our society. People living with mental illness are waging a two-sided struggle–one with the illness with which they were born and one with the society that holds them less worthy because of it. For the past fifteen years the half fare benefit for people with disabilities has been yet another of these discriminatory practices.

Last year the New York State legislature responded to our pleas by passing, with a remarkable degree of unanimity, the MTA Half Fare Fairness Bill of 1999 to close the legal loophole that had cultivated discrimination in New York City's public transportation system. The Governor, recognizing that his proposal for nearly $200 million in new mental health funding will make a greater difference in people's lives if they are able to reach their appointments and go to the services available to them, signed the bill into law.

At no point during the debate over this bill did the MTA step forward to warn that there was a 'technical deficiency' in the bill language that would prohibit them from extending half fare benefits to New York City residents. Yet, now that the law has passed, that is exactly what is claimed. Although we feel the bill passed is a legally binding mandate on the MTA, we urge the legislature to pass a technical amendment to preclude a lengthy battle over implementation. End the discrimination against people with psychiatric disabilities in the New York City Transit system once and for all.

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Coalition 2000 Member Agencies

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Advanced Center for Psychotherapy
AIDS Center of Queens County
Association for Rehabilitative Case Management and Housing
Astor Child Guidance Center
Barrier Free Living
Beacon of Hope House
Bedford-Stuyvesant CMHC
Bensonhurst Guidance Center
Bergen Street SRO
Black Veterans for Social Justice, Inc.
Blanton-Peale Counseling Center
Bleuler Psychotherapy Center, Inc.
Bowery Residents' Committee, Inc.
Boys Harbor
Bronx-Lebanon Medical Center
Brooklyn AIDS Task Force
Brooklyn Bureau of Community Service
Brooklyn Center for Families in Crisis
Brooklyn Community Housing Services
Brooklyn Psychiatric Center, Inc.
Builders for the Family and Youth
C.A.P.E. Samuel Field YM-YWHA
Canarsie Aware
Catholic Charities Counseling Service of New York
Center for Children and Families, Inc.
Center for Urban Community Services
Children's Aid Society
CIS Counseling Center
Columbia University - Harlem Rehabilitation Center
Community Access, Inc.
Community Counseling & Mediation
Community Healthcare Network
Educational Alliance
F.E.G.S.
Fordham-Tremont CMHC
Fountain House
Gateway Counseling Center
Gay Men's Health Crisis
Goddard Riverside
Graham-Windham Services
H.I.R.E.
Hamilton-Madison House
Harlem Dowling West Side Center for Children and Family Services
Harlem Interfaith Counseling Services, Inc.
Henry Street Settlement
Hudson Guild
Institute for Community Living
International Center for the Disabled
Jewish Association of Services for the Aged
Jewish Board of Family & Children's Services
Jewish Child Care Association
Jewish Guild for the Blind
John Heuss House
Joseph P. Addabbo Family Health Center, Inc.
Karen Horney Clinic, Inc.
League Treatment Center
Lenox Hill Neighborhood Association
Lexington Center for Mental Health Services
Lifeline Center for Child Development
Lower East Side Service Center
Lutheran Medical Center- Mental Health Clinic
Mental Health Providers of Western Queens
Metropolitan Center for Mental Health
Montefiore Medical Center
Mount Sinai Medical Center
Neighborhood Care Team
New York Psychotherapy & Counseling Center
New York Society for the Deaf
Northside Center for Child Development
Ohel Children's Home and Family Services
Park Slope Center for Mental Health
Partnership for the Homeless
Paul J. Cooper Center for Human Services
Pesach Tikvah - Door of Hope
Project Hospitality
Project Renewal
PSCH
Puerto Rican Family Institute
Queens Child Guidance Center
Riverdale Mental Health Association
Service Program for Older People/SPOP
Services for the Underserved
Sky Light Center
Spanish Speaking Elderly Council-RAICES
St. Francis Friends of the Poor

St. John's Episcopal Hospital Center
St. Vincent's Services
Staten Island Mental Health Society, Inc.
Steinway Child & Family Services, Inc.
Summit House of Brooklyn, Inc.
The Bridge, Inc.
Union Settlement Association
University Consultation & Treatment Center
University Settlement House
Upper Manhattan Mental Health Center, Inc.
Urban Pathways
Venture House
Victim Services Agency
Visiting Nurse Services of New York
Volunteers of America -Greater New York
Weston United Community Renewal, Inc.
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Women In Need, Inc.

New York State Council 2000 Member Agencies

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Bronx-Lebanon Hospital Center
Brookdale Hospital CMHC
Cayuga Counseling Services, Inc.
Cayuga County CMHC
Central Nassau Guidance & Counseling Center
Central New York Services
Child & Adolescent Treatment Services
Child & Family Services
Clifton Springs Hospital & Clinic
CMHC of Glens Falls Hospital
Crestwood Children's Center
The Dale Association
Dutchess County Department of Mental Hygiene
Family and Children's Association
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Kaleida Health
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Mid-Erie Health Services
Multi-County Community Development Corporation
Niagara Falls Memorial Hospital CMHC/Health Systems Niagara
North Star Behavioral Health Services
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Northwest CMHC
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St. Mary's Hospital CMHAC
St. Vincent's Hospital and Medical Center
Staten Island Mental Health Society, Inc.
Steuben County CMHC
Sunrise Psychiatric Clinic
Transitional Living Services of Onondaga County, Inc.
United Health Services Hospitals
Unity Health System
University of Rochester CMHC
VIAHEALTH The Genesee Hospital
VIAHEALTH Rochester Mental Health Center