

**STATEMENT OF UNIVERSAL HEALTH SERVICES  
367 SOUTH GULPH ROAD, KING OF PRUSSIA, PA 19406  
FOR INCLUSION IN THE RECORD OF THE SENATE FINANCE COMMITTEE HEARING TITLED  
"YOUTH RESIDENTIAL TREATMENT FACILITIES: EXAMINING FAILURES AND EVALUATING SOLUTIONS."  
JUNE 12, 2024**

Universal Health Services, Inc. ("UHS" or the "Company")<sup>1</sup> submits this statement for the record of the June 12, 2024 Senate Committee on Finance ("SFC" or "Committee") hearing titled "Youth Residential Treatment Facilities: Examining Failures and Evaluating Solutions." UHS appreciates the Committee's focus on Residential Treatment Facilities ("RTFs"), how they are regulated and ensuring a safe environment for the residents.

We regret that, in spite of our cooperation with the Committee throughout the course of a two-year investigation of RTFs,<sup>2</sup> the report is incomplete and misleading and provides an inaccurate depiction of the care and treatment provided at UHS RTFs, as well as the safety of the residents at those facilities. While we recognize the importance of the Committee's work in this area and share its concern over any incidents at any RTFs that cause harm to residents, the Committee's report does not present an accurate picture of UHS RTFs. Further it fails to recognize the thousands of children helped by our facilities over the years; children whose lives have been greatly enhanced as a result of their stay and the treatment they received at one of our RTFs.

Our network of subsidiary facilities serving this challenging juvenile population aims to provide high-quality, compassionate, effective treatment and care to each and every individual served. UHS RTFs offer behavioral and mental health services, academic instruction and life-skills training to help residents reach their therapeutic and academic goals, then successfully step-down to outpatient treatment or community-based care. This care setting comes at a time when these youth need intervention, redirecting them from counterproductive and dangerous behaviors. Many individuals are prepared to rejoin and be successful in their schools and communities as a direct result of the care and education they received at a UHS RTF.

We are proud of the positive clinical outcomes consistently achieved by our RTFs, the strong ties that we have developed and maintained with the communities we serve, and our good standing with the regulatory and administrative entities that oversee us. Our Behavioral Health Division resources along with facility leadership and staff work tirelessly to ensure we uphold the high standards we set for ourselves. Any deviation from our high

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<sup>1</sup> UHS is a registered trademark of UHS of Delaware, Inc., the administrative services company for Universal Health Services, Inc. and a wholly owned subsidiary of Universal Health Services, Inc. Universal Health Services, Inc. is a holding company and operates through its subsidiaries including its administrative services company, UHS of Delaware, Inc. All healthcare and management operations are conducted by subsidiaries of Universal Health Services, Inc. Any reference to "UHS" or "UHS facilities" or "UHS RTFs" in this document relates to healthcare or management operations of the subsidiaries of Universal Health Services, Inc., including UHS of Delaware, Inc. For ease of reference only, we may use the term "UHS" or "UHS RTFs" in this document, but such use does not diminish the individual operational responsibilities of the subsidiary facilities. The terms "we," "us," "our" or "the company" in such context similarly refer to the operations of the subsidiaries of Universal Health Services, Inc., including UHS of Delaware, Inc. Further, any reference to employees, staff or UHS employees refers to employees of subsidiaries of Universal Health Services, Inc.

<sup>2</sup> UHS has continuously cooperated with the Committee over the course of its investigation. UHS has voluntarily made nine separate productions, totaling more than 12,000 pages of documents, relating to numerous requests for information regarding the policies, practices and clinical operations of UHS RTFs and provided multiple briefings to Committee staff to answer questions following these voluntary productions. In addition, UHS' senior leaders have spent hundreds of hours responding to the Committee's requests, including a culminating meeting with Committee staff that lasted more than four and a half hours. At every step of the investigation, UHS has provided thorough and transparent responses to every question posed by Committee staff. Despite this good-faith cooperation, the Committee's report is unfortunately riddled with misleading and incomplete allegations of substandard care.

standards is one too many. Additionally, we value the review and feedback of our regulators and seek to continuously improve when opportunities are identified.

We dispute the contention of the report and at the hearing that UHS places financial gain over resident treatment and safety. The care and safety of our residents is our top priority. UHS does not sacrifice those elements for financial benefit.

We would welcome the opportunity to work with the Senate Committee on Finance as well as other committees of jurisdiction on the development of potential legislation for the nation's RTF programs.

### **UHS Response to the Committee Report**

We acknowledge that there have been incidents over the years at some of our facilities where residents have suffered harm. Such incidents are unacceptable and are contrary to the goals and expectations of our facilities. Any harm perpetrated by any staff member is unacceptable, not tolerated and directly contradicts the expectations of employment, the extensive training provided as well as the policies, procedures and protocols of the facility.

Per UHS' policies and practices, allegations from individuals and survey findings from regulators are promptly investigated and, when appropriate, action is taken. Deviation from our high standards is not tolerated, and in most cases, non-compliant behavior by staff results in termination, along with an action plan to drive continuous improvement (e.g., retraining, refinement of protocols, changes to future hiring practices, etc.).

That being said, the Committee Report is incomplete, misleading and provides an inaccurate depiction of the care and treatment at UHS RTFs as well as the safety of the environment at the facilities. None of the Committee staff involved in the investigation of this matter visited any UHS RTF despite being invited prior to publication of the report.

We are deeply committed to providing young people with effective treatment, compassionate care, and a nurturing environment, but are well aware that no organization, including our own, is perfect. We are always looking to improve the care and safety of the patients entrusted to us, which is why the incomplete and misleading Committee Report represents such a missed opportunity to actually improve patient care.

The following attempts to address and respond to the major themes and issues raised in the Committee Report relating to UHS RTFs. Due to space limitations of this submission per Committee rules, we will not address each and every matter, incident or survey cited in the report.<sup>3</sup>

#### ***Regulatory/Accreditation Surveys***

The Committee Report cites various regulatory and accreditation surveys of UHS RTFs over several years. All healthcare facilities are subject to surveys (essentially inspections) by state and federal regulatory agencies as well as accreditation bodies in the ordinary course. The job of every regulator conducting a survey is to identify areas for improvement at a facility and UHS RTFs greatly benefit from their careful review. The Committee Report assumes that the existence of a report and all allegations and findings therein are evidence of deficient care – they are not.

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<sup>3</sup> Our complete response can be found at [www.uhs.com/rtf](http://www.uhs.com/rtf).

**Merely aggregating survey findings across 59 facilities over a multi-year period without regard to severity does not equate to a finding of poor quality of care at those facilities or across the UHS RTF spectrum.** Further, the report references many TJC surveys but does not indicate that with each report where issues were referenced, the facility remedied those and maintained full accreditation. The same is true of state licensing and other regulatory reviews received by the Committee. No corresponding plan of correction is mentioned in the report, nor is any resolution of the identified issues mentioned.

**All UHS RTFs are fully accredited by either The Joint Commission (TJC) or the Commission on Accreditation of Rehabilitation Facilities (CARF) and are in good standing with all regulatory agencies.** All 59 facilities are Medicaid providers for in-state residents as well as out-of-state residents. Each Medicaid plan has its own requirements which vary from state to state. Additionally, all facilities are in compliance with the Federal Regulations (42 C.F.R. §§ 483.350-483.376) governing restraint and seclusion as well as emergency preparedness at RTFs. Further, all 59 UHS RTFs are in good standing with their licensing bodies in their respective states.<sup>4</sup>

As one example of a misguided attempt to impugn the regulatory compliance of one of UHS' RTFs, the Committee Report references a letter received by a Division VP of UHS indicating that there were incomplete behavioral treatment plans and crisis plans for children at the facility. It failed to mention that the facility "continues to MEET the family first requirements for QRTP (Qualified Residential Treatment Program) and did not require a plan of correction". That same letter closes with "DCFS [Department of Children & Family Services] is grateful for your partnership in our collective efforts to improve outcomes for Illinois' most vulnerable children and families." This is an example of failing to provide full context to a regulatory matter and drawing an erroneous conclusion based upon an incomplete review of the document.

Notwithstanding, we view all external agency and accrediting surveys as an opportunity to enhance the quality of care at our facilities as well as improve our operations. In addition, we have engaged our own external consultants at times to assess our facilities and provide recommendations on quality enhancement initiatives and to improve regulatory compliance.

### ***Staff Incidents***

The Committee Report cites isolated incidents over a several-year period of inappropriate sexual contact between staff and residents. To be clear – UHS' position is that one substantiated case of sexual relations or assault as well as any physical abuse by a staff member towards a patient is one too many. UHS has a zero-tolerance policy for such behavior and those incidents have no place in any treatment facility. In all of the instances cited in the report where the allegations were substantiated, those staff members were ultimately terminated.<sup>5</sup> Notwithstanding, context to

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<sup>4</sup> As of the time of submitting this response, Benchmark Behavioral Health in Utah is currently under a Conditional License but is expected to be returned to full license standing by the end of June 2024. Benchmark has had three visits by their state agency in the last few months and there have been no identified concerns raised.

<sup>5</sup> The report incorrectly highlights one matter at Cedar Ridge where a staff member was alleged to be engaging in sexual activity with a resident, but the facility transferred the staff to another unit in lieu of termination. This reference is incomplete and inaccurate. The facts of this matter are more complex. A staff member at Cedar Ridge initially thought there may be boundary issues involving the alleged staff member and reported that to facility management. However, there were no allegations of inappropriate sexual contact between the staff member and resident, and no evidence to support such behavior at that time. Notwithstanding, despite the lack of evidence present at that point in time, the facility transferred the employee to another unit pending a fuller investigation and re-trained and re-educated the employee regarding the facility policies on therapeutic boundaries. Subsequently, information became known to the facility that there may have been inappropriate sexual contact between the staff member and resident. At that point, Cedar Ridge immediately contacted the Oklahoma Health Care Authority who

these incidents is also relevant when viewing UHS as whole in relation to the safety of our RTFs. The Committee Report referenced five incidents at three facilities over a 6-year period (2017-2022) of inappropriate sexual contact with residents while at the facility. During that 6-year period, UHS RTFs treated approximately 19,000 patients spanning approximately 7 million patient days. Internal data for the past 4 years on these types of incidents establishes that the patient risk rate<sup>6</sup> for this type of harm was 0.003.<sup>7</sup> Again, while even one such incident is one too many and UHS' expectations are zero, such a risk rate does not equate to the narrative of a pervasive problem and/or an unsafe environment for residents at our facilities.

As to the incidents of staff physically harming residents at any of our facilities, the report once again identified a small number of isolated incidents to create the narrative of unsafe environments at UHS RTFs without any context as to the number of patients treated across the UHS RTF spectrum during that time. Over the past three years, based upon the number of patients treated during this time period, the patient risk rate of physical harm from staff was 0.015. Again, while even one such incident is too many and UHS' goals and expectations are zero, such a risk rate does not equate to the narrative of an unsafe environment for residents at our facilities due to staff harm since 99.985% of our residents across the UHS RTF continuum never encounter this conduct.

As referenced, through its Patient Safety Organization (PSO) process, UHS tracks the number of serious incidents per year where our staff has acted in a manner inconsistent with our training, policies and procedures, and protocols with respect to interactions with residents that result in harm. With almost 13,000 employees working at various UHS RTFs, the average annual rate of staff involved with serious incidents with patients is 0.005% of the staff. In all these instances, disciplinary action was taken, including and up to, immediate termination dependent on the circumstances and actions involved. Once again, our expectations are that there should be ZERO incidents. However, this data contravenes the false narrative, depicted in the Committee Report, that UHS RTFs are unsafe environments for our residents based upon staff interactions. In fact, this data supports the efforts of UHS to hire, train and evaluate our employees' actions in accordance with our expectations for the safety and well-being of our residents.

As described and provided in detail to the Committee staff during the course of their investigation, UHS facilities utilize an extensive hiring and training regimen for all employees – especially those that will interact directly with our residents. All employees go through screening prior to hiring that includes background checks by a third party. Every new employee undergoes a minimum of 40 hours of initial training. This training includes therapeutic boundaries with patients, physical management techniques, patient observation rounding and verbal de-escalation, to name a few. Employees in training will then be proctored on the patient care floor for a period of time before they are allowed to work independently with the residents. There is annual training required for all employees on a myriad of quality, clinical and resident safety issues.

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conducted an investigation which substantiated the allegations. The facility then immediately terminated the employee and notified law enforcement. This occurred over a course of 2 days. The Committee Report completely failed to include this context.

<sup>6</sup> The patient/resident risk rate is the percentage of patients that encounter this type of conduct or incident during a time period. If the resident risk rate is .003, that equates to .003% of all patients at UHS RTFs encountering this conduct. Conversely, 99.997% of the residents at UHS RTFs during this time period did not encounter or experience such an event. The same is true for other patient/resident risk rates referenced in this response.

<sup>7</sup> Some of these sexual encounters between staff and patients happened outside of the facility after the resident was discharged. Our incident tracking process does not separate the two as such contact and conduct violates our policies and procedures and the training our staff receive on boundary issues with residents (present and former). However, the rate of sexual contact among residents under our care would be even lower if we were to only account for contact within the facility.

### ***Patient-on-Patient Abuse***

The Committee Report attempts to portray pervasive patient-on-patient violence (sexual and physical) based on incidents cited in the report over several years. Once again, greater context will provide a more accurate picture of the state of the patient environment at UHS RTFs. Over the past 5 years, the average rate of patient-on-patient incidents resulting in serious harm across the UHS RTF spectrum was 0.1 per 1,000 patient days. Further, when assessing from a resident risk rate, the resident risk rate for significant physical harm was 0.01. The resident risk rate for sexual contact or acting out was 0.027.<sup>8</sup>

To be clear, even one substantiated incident is one too many. All UHS RTFs have protocols and practices in place to minimize the chance of sexual encounters or assaults between residents. We acknowledge that when the protocols and safety measures put in place are not followed by our staff, these types of isolated and unfortunate incidents can occur. Further, when an incident is reported and investigated, the facility promptly acts to remediate any deficiencies and enact measures to prevent recurrence. The primary focus, in the event of an allegation, is patient safety and protection against any harm. While there are not national benchmarks for this type of conduct, we believe that our rate would compare favorably to similar RTFs in similar locations treating a similar patient population. This is an area where greater data reporting may be of benefit to the industry, our residents and their families.

### ***Restraints and Seclusion***

The Committee Report inaccurately depicts UHS RTFs as overutilizing restraint and seclusion techniques to manage residents. This, again, is an incomplete and misleading characterization of the usage of restraint and seclusion at UHS RTFs. The report also references instances of improper restraint techniques being used. In fact, in UHS RTFs, restraint and seclusion are only for limited circumstances when a resident is in danger of harming themselves or others and in need of greater support. In those circumstances, the use of each intervention is carefully monitored and documented.

The restraint usage at issue is staff members physically holding or restricting a resident's movement in order to help the resident regain self-control when they are dysregulated and are a danger to themselves or others. To be clear, UHS does not use mechanical restraints. While UHS RTFs focus extensively on reducing and minimizing the use of restraints, it is necessary at times to utilize these techniques to protect the patients. As stated, if our staff is found to have utilized inappropriate restraint techniques or utilized restraint in inappropriate circumstances, disciplinary action will be taken, including immediate termination, if warranted. Re-training may also be provided as appropriate.

UHS RTFs have comprehensive policies and procedures regarding the use of restraints and seclusion. Consistent with federal guidelines allowing restraint and seclusion at RTFs in certain circumstances (42 C.F.R §§ 483.350-483.376), UHS has standardized policies and procedures in place pertaining to restraint and seclusion practices, which are required at each UHS RTF. Some individual states have additional regulations that govern these procedures that are implemented by the facilities as well.

Consistent with these policies and other applicable regulations, we require a number of trainings on restraint and seclusion to relevant staff as needed. Training includes instruction on verbal de-escalation and physical management techniques, ongoing monitoring of the patient's health and safety, and properly choosing the least restrictive

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<sup>8</sup> UHS includes both consensual sexual activity as well as non-consensual activity in its data without distinction. While consensual activity between residents is inappropriate and efforts are taken to prevent such conduct, the rate of non-consensual sexual activity would be even lower than the 0.027% rate referenced above if the data were segregated.

intervention among many others. UHS policy requires clinical and nursing staff, upon hire (and semi-annually thereafter), to receive mandatory training on the proper use and monitoring of physical and chemical restraints and seclusion. The training includes an 8-hour training class on verbal de-escalation techniques, followed by a 6-8 hour class on physical management techniques. Direct care staff are required to be certified in a nationally recognized physical management program and show evidence of competency related to application of restraints, and the monitoring, assessment and care of a resident in restraint or seclusion. In order to minimize the use of restraint/seclusion, staff involved in the use of restraint/seclusion must demonstrate an understanding of the causes of threatening behaviors, the impact of staff behaviors, the use de-escalation techniques, the signs of physical and emotional distress during restraint usage, including first aid techniques, and the processes for challenging inappropriate restraint interventions.

While we acknowledge there are instances when inappropriate restraint techniques are utilized (sometimes resulting in harm to a resident), the Committee Report presents a false narrative that such incidents are commonplace at UHS RTFs. The reality is that such incidents are rare. Through its PSO, UHS tracks the use of restraints as a mechanism to enhance our clinical operations and reduce their utilization. We provided data to the Committee staff on restraint usage at the RTFs in accordance with the Patient Safety Quality Improvement Act (PSQIA). In describing this data, the Committee Report made misleading and unsubstantiated claims and failed to provide the larger context for the data. The Committee Report stated that in 2022 there were 35 facilities with “double digit” restraint rates as if to indicate that was excessive. However, there is no nationally established standard or rate at which restraint usage per 1,000 patient days is deemed excessive at RTFs. Based upon our years of experience in the industry, our internal benchmark rate for restraint usage is 16 per 1,000 patient days. The average restraint rate for all UHS RTFs for 2022 was 15.63 --below the benchmark. In 2022, 39 of the 59 facilities (66%) had restraint rates below that benchmark. Further, 44 out of 59 facilities (75%) had restraint usage rates below 20 in 2022.

Additionally, UHS has undertaken a concerted effort over the past few years to significantly reduce the usage of restraints in our facilities. In fact, for 2022, 36 out of the 59 RTFs referenced by the report saw a decrease in restraint rate/usage (some being substantial decreases). UHS has utilized an evidence-based approach to overall restraint use by adopting the principles developed by the National Association of State Mental Health Program Directors’ (NASMHPD) Six Core Strategies for Reducing Seclusion and Restraint Use<sup>9</sup>. By implementing to these guiding principles throughout the UHS Behavioral Health Division, we have seen significant results.

The use of medication as restraint (commonly referred to as chemical restraint) is governed by the same set of rules as physical restraints (holds) and seclusion. All medications, regardless of their use, are ordered by a physician or a nurse practitioner. When less-restrictive interventions do not support the patient in regaining self-control, medications may be an option to assist. There are states that do not allow the utilization of medication as restraint and UHS facilities comply with that requirement. UHS RTFs have policies and procedures regarding the use of chemical restraints to ensure appropriate utilization, management and oversight.<sup>9</sup> As with other restraints, chemical

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<sup>9</sup> The report inaccurately states that during an interview with UHS Leadership, we stated that we believed there were circumstances in which it might be necessary to both chemically restrain and seclude a resident. That is not an accurate representation of the interview nor a statement made by UHS Leadership. Committee staff asked whether there were circumstances where it would be necessary to use a chemical restraint in conjunction with a **physical restraint**, to which we replied there would and which is allowed by federal regulations. We were not asked about chemical restraint in conjunction **with seclusion** as the report incorrectly states. As such, the statement in the report attributed to UHS Leadership on this issue is inaccurate.

restraints are never to be used as a form of punishment or for staff convenience. In any circumstance where lack of compliance is identified, the RTF creates a plan of correction and resolves the concern.

The seclusion data we provided the Committee staff is even more compelling. The Committee Report merely states that in 2022 one UHS RTF had a seclusion rate of 12.63 per 1,000 patient days with no other context around this statement. **However, the report does indicate that 36 of the 59 RTFs (61%) had a seclusion rate of 0.** What the report failed to mention was that of the remaining 23 facilities, 13 had a rate of less than 1. That means 83% of UHS RTFs had a seclusion usage rate of less than 1 per 1,000 patient days.

While UHS is focused on reducing seclusion usage, it is a necessary intervention utilized to protect residents and to help them regain composure and emotional control. Staff are trained never to use seclusion as a punishment or for staff convenience. The requirements for staff monitoring of a patient in restraint and/or seclusion are significant which is counter to any suggestion that seclusion is utilized to address staffing concerns.

There are variances amongst the facilities as to the usage of restraints and/or seclusion. The variances are due to the patient populations at those facilities and the mental health pathologies of those residents as opposed to failures of the staff or lack of appropriate policies and procedures at the facilities.

This is an area where greater industry benchmarks may help establish standardized rate targets to assist all RTFs in reducing and managing restraint and seclusion usage. A national metric exists for restraint and seclusion utilization in inpatient psychiatric settings, however it does not exist for the RTF level of care. UHS would support efforts in identifying an appropriate metric that would provide greater understanding of its utilization. Currently, there is no reliable way to interpret the utilization of restraint and seclusion across RTFs without insights such as patient populations, among others. As the Committee Report is written, it provides the reader with information that is meaningless without this appropriate context.

Many of the issues raised in the report by the Committee staff around restraints dealt with documentation failures as opposed to improper use of restraints. As will be addressed in more detail below, documentation errors or omissions do not indicate the appropriate treatment was not rendered or that protocols were not followed.

### ***Suicide and Ligature Risk***

The report describes survey citations around suicide risk assessment documentation, protocols and ligature risks.<sup>10</sup> The Committee Report once again attempts to create a false narrative that UHS RTFs fail to take appropriate clinical and environmental actions to prevent suicides in our facilities. As part of the review of each facility's physical environment, a ligature risk assessment is completed and issues are addressed based upon that assessment. Our staff are trained on assessing ligature risks and notifying the appropriate individuals to remove such risks when identified.

The Committee Report also references certain instances where surveyors have pointed out ligature risks. In each of those circumstances, the facility promptly mitigated those risks – sometimes while the surveyors were on site. Further, as was described to the Committee staff, we have environmental services staff at all facilities who constantly assess and remediate anything in the facility that could reasonably present a ligature risk.

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<sup>10</sup> Ligature is defined as "a thing used for tying or binding something tightly" and in this circumstance largely means tied to a fixed point in a physical environment.

Patients are assessed regularly throughout the course of their care at an RTF. Those residents who are assessed as a high suicide risk should not be treated in an RTF setting. Those individuals require a higher level of care and should be in an acute inpatient facility. Notwithstanding, our RTF facilities have policies and procedures to assess suicide risk in our patients as well as interventions and safety measures to prevent suicides in the facility. We also provide training to all staff on assessing suicidality and maintaining vigilance in looking for any signs of suicidal behavior or ideation via the use of standardized industry developed and endorsed tools. As mentioned in our prior responses and our interview with Committee staff, one additional intervention at all UHS facilities is the 15-minute observation checks done 24-hours a day, 7 days a week for all residents, regardless of assessed suicide risk.

The Committee Report mainly references documentation errors or omissions regarding suicide assessments which does not mean that our residents are in an unsafe environment.

### ***Staffing***

The report attempts to create the false narrative that UHS RTFs are systemically understaffed. UHS RTFs comply with all state regulations that provide for specific staffing ratios. In addition, in those states that do not have required ratios, UHS RTFs ensure that staffing numbers meet the requirements for effective treatment and a safe environment. Our facilities utilize a multi-level assessment process that takes into account a large number of clinical and operational factors to determine appropriate staffing levels. These staffing levels are then regularly and routinely reassessed and updated to ensure the appropriate staffing levels are utilized. We acknowledge that due to sudden and unforeseen circumstances, staffing numbers may be below ratio or less than what a facility staffing plan requires for a limited time period on a particular unit. This can happen when there are unexpected call-outs by staff without giving sufficient time for the facility to fill the vacancy. We have processes in place to limit the occurrence of those situations, including closing beds or stopping admissions to ensure that the staff available can provide the necessary care and ensure a safe environment for each resident. However, there is no systemic or endemic understaffing at UHS RTFs.

### ***Medical Record Documentation***

Many of the survey issues noted in the Committee Report involve medical record documentation errors or omissions by facility personnel on a variety of issues. First, it is not uncommon for all health care providers and facilities to have documentation lapses, errors and omissions. Second, while there may be omissions in various aspects of the medical records, that does not mean that the appropriate treatment, intervention or care was not provided. The report attempts to aggregate documentation errors and omissions in medical records at select facilities to improperly draw conclusions regarding the quality of care or patient safety at those facilities. While we acknowledge the failure of technical record documentation at some of the facilities referenced in the report, we dispute the narrative of deficient care or safety due to record errors or omissions.

The Committee Report discusses treatment interventions as missing or incomplete as reflected in the medical records. While we acknowledge documentation errors and omissions at selected facilities, we dispute the narrative that our residents are not getting the requisite level of care during their treatment stay from admission through discharge.

UHS spends significant effort and resources training our staff on proper and thorough medical record documentation. We also conduct regular audits of medical records to ensure compliance with record-keeping



requirements, including those required for documentation of the use of restraint and seclusion. UHS has also begun implementing electronic medical records (EMR) at our facilities. With respect to the RTFs, we have installed EMR systems at 15 facilities to date, with more planned. We are confident that this investment will enhance the quality and completeness of our medical record documentation to fully reflect the care and treatment provided.

### ***Length of Stay***

Length of stay at a UHS RTF is dependent on a number of factors and ultimately determined by the attending physician in consultation with the treatment team. Length of stay is a metric that is clinical in nature and focuses on the individual needs of each patient meeting appropriate medical necessity criteria. In addition, others outside the treatment team are also involved in length of stay determinations including family members, guardians, social workers and outside clinicians who will oversee the patient's transition back into the community.

Each RTF has a different average length of stay that is driven by the patient population served. There are occasions where there are not resources available in the child's home state for follow up care and there is no other location that can safely treat the child. At no time would a UHS RTF discharge a patient without a discharge plan in place. On average, the length of stay at our RTFs for children and adolescents is 137 days and has been fairly steady across the last several years. There are outliers based upon clinical presentation and program structure. The Committee requested the minimum and maximum length of stay, which is not a standard metric used in this industry, and it did not request information about the corresponding circumstances that would explain the lengths of stay for those patients.

### ***Education***

The Committee Report incorrectly states that UHS RTFs failed to provide adequate and appropriate education to our residents. UHS facilities' educational services teams are committed to preparing every learner for a successful transition back to their traditional school setting and post-secondary opportunities.

- UHS partners with the appropriate state and local education agencies to thoughtfully plan and allocate educational resources at our RTFs. Educational services may be provided by a local education agency (LEA), or by a charter school or non-public school authorized to operate by the state.
  - Programs typically use state-specific curriculum frameworks, designed to offer transferrable course credit and grades and to meet the special education needs of children with individualized education plans (IEPs).
- UHS facilities comply with all applicable state education requirements for compliance reviews and are staffed by credentialed teachers as well as non-licensed support staff as required by the individualized needs of each school program.
- Many of our academic programs are nationally accredited by Cognia, one of the nation's leading accreditation bodies for K-12 education.
- The "UHS Best in Class Academic Accountability System" measures and reports on academic achievement at UHS RTFs for continuous performance improvement. This system consists of a set of national education standards, an annual school improvement plan and outcome measurement tools.

In the 2023-2024 school year, UHS academic programs had more than 138 students complete their high school requirements; almost 30% are headed to post-secondary school, while others plan to enter the workforce.

***Grievance Reporting***

The Committee raised concerns that staff and patients failed to report their concerns due to fear of retribution. UHS employees who want to report a problem or concern about inappropriate or unethical actions, not related to fraud, are encouraged to submit their concern through the Compliance Hotline (which can be done anonymously) or reach out to their supervisors, to management, to Facility Compliance Officers, or the UHS Compliance Office. UHS prohibits any form of retaliation against anyone who reports, in good faith, potential acts of misconduct or wrongdoing. For employees, anyone retaliating against someone for expressing a concern is subject to disciplinary action.

Patients are also able to report their concerns via the UHS Compliance Hotline/platform. In addition, patients are able to submit complaints or grievances to their Patient Advocate – which is the way most patients report concerns. Patients and families are provided information at the time of admission on how to report concerns internally to the facility and externally to all of the appropriate authorities.

***Conclusion***

We acknowledge that there have been incidents over the years at some of our facilities where residents have suffered harm. These unfortunate, isolated incidents are completely at odds with our deep commitment to provide a safe and therapeutic environment as well as inconsistent with the policies, procedures, protocols and training for our facilities. There is no place for any conduct that is inconsistent with the high standards we set for ourselves in our facilities and we remain committed to ensuring such events are reduced with a goal of zero.

Notwithstanding, and as stated numerous times above, the Committee Report paints an inaccurate, incomplete and misguided picture of the quality of care and safety at UHS RTFs. The report also wholly fails to recognize the thousands of adolescents that have been successfully treated in our facilities over the years whose lives have been dramatically enhanced and quite possibly saved as a result of the care provided. The incidents and references cited in the report are not representative of the hard work of our dedicated staff whose only mission is to improve the lives of the residents they care for.

UHS remains committed to ensuring that the youth who require this level of care have safe and high-quality options that provide hope and recovery. This work is challenging, and it is a high calling, one that each member of our UHS team takes very seriously. Our facility staff are dedicated to the mission of taking care of youth and work tirelessly to ensure that each resident is treated with dignity in a safe environment. Patients come to us after a broad variety of negative experiences – they need very specialized care and treatment. Incidents of staff failing to follow our training, policies, procedures and protocols are an extreme exception and not the norm. Patient and family success stories are our motivation. We have been providing behavioral health care for more than 40 years and our consistent goal is to continue to be a valued resource in each individual community.