EXHIBIT 22

Sheppard Pratt Health System, Inc.
Safety and Performance Improvement Plan

I. Purpose

Sheppard Pratt Health System is dedicated through our mission, core values, and guiding principles to improve the quality of life of individuals and families by compassionately serving their mental health, addiction, special education, and community support needs.

Sheppard Pratt is also committed to achieving excellence in patient care and providing a safe environment for all individuals we serve and our employees. To achieve our goals, the Safety and Performance Improvement Plan outlines the framework for improving patient and employee safety and our organizational performance by

- Establishing and maintaining mechanisms by which employees at all levels, in all departments, and in all disciplines are motivated and encouraged to contribute to improving organizational performance and safety;
- Monitoring and evaluating the quality of care and competency of internal providers and the quality of care provided by contractual clinical services;
- Promoting a culture of safety and quality where employees are empowered to identify, report, and solve quality and safety concerns; and
- Focusing on processes and systems to improve organizational performance via SPIRIT activities. SPIRIT (Sheppard Pratt Improvement Resources Inspired by Toyota) initiatives, implementing Lean methodology, are person centered, outcomes oriented, data driven, and value centric. Problems are embraced as opportunities for improvement.

II. Scope of the Safety and Performance Improvement Plan

The Safety and Performance Improvement Plan encompasses all physicians, employees, patients, and volunteers. Throughout this plan, "patient" refers to any individuals (patients, residents, and students) receiving services at Sheppard Pratt Health System. The plan addresses maintenance and improvement in safety and quality in every department, division, and program throughout the Health System.

III. Authority and Responsibility

The Board of Trustees of the Sheppard and Enoch Pratt Foundation, Inc. has the ultimate authority, accountability, and responsibility for the safety and quality of care provided to our patients. The Board delegates the review of safety and performance improvement initiatives to its Clinical Committee and Risk Management Committees. The Clinical Committee oversees the implementation and ongoing monitoring of performance improvement and compliance with regulatory and accreditation requirements in the Health System. The Quality Council and Medical Executive Committee report performance improvement, safety, and compliance activities and quality of care issues to the Clinical Committee on a semiannual basis. The Risk Management Committee, which oversees the Risk Management Program, provides oversight, management, and general guidance in matters related to risk management, control, and reduction. A report evaluating compliance with the HIPAA Privacy Rule is provided to the Risk Management Committee of the Board annually. The Safety Oversight Committee reports at least semiannually to the Risk Management Committee. In addition, as a way of ensuring Board engagement, the

Board is updated about SPIRIT activities at every meeting; general progress reports on SPIRIT alternate with report outs about specific projects from project leaders.

The Health System Director of Risk Management is also appointed as the Clinical Safety Officer. She reports critical incidents, risk reduction actions taken in response to root cause analyses, and trend data generated from incident reports and root cause analyses to the Medical Executive Committee and Risk Management Committee on a periodic basis. In addition, the Clinical Safety Officer oversees the clinical safety program. At least annually, information is submitted to the Risk Management Committee of the Board which includes system or process failures relating to potential adverse events, the number and type of reportable sentinel events, whether the patient/family was informed of the event, and actions taken to improve safety, proactively and in response to actual events**.**

It is the responsibility of leadership and the medical staff to set expectations for safety and performance improvement, provide the resources and training needed for these activities, assure compliance with regulatory and accreditation requirements, evaluate the competence and performance of clinical providers, and participate personally in safety and improvement activities.

It is the responsibility of each employee to provide a safe environment for patients, visitors, volunteers, and other employees. Physicians and employees receive education and training during their initial orientation process and annually regarding job-related aspects of safety and performance improvement. Physicians and employees are required to report any incident or situation that may compromise the quality of patient care or may pose a safety hazard to patients, employees, visitors, and volunteers. Opportunities are provided to employees to participate in performance improvement initiatives and teams both in their work areas and in organization-wide teams. Various avenues are available to employees to voice concerns or suggest opportunities for improvement: the Concern Line, Safety Alert Line, and safety suggestion boxes.

IV. Reporting Structure

A. The Quality Council, chaired by the President and Chief Executive Officer, provides oversight of performance improvement efforts in the Health System. The Quality Council's main functions include:

- Establishing priorities for safety and performance improvement in conjunction with the SPIRIT Steering Committee;
- Reviewing the progress of safety and performance improvement efforts and ensuring that measurable improvements are achieved;
- Monitoring compliance with regulatory and accreditation requirements;
- Overseeing the implementation of recommendations from root cause analysis teams;
- Reviewing data identified through monitors and audits and external statistical reports for significant trends which impact performance and safety;
- Evaluating the effectiveness of safety and performance improvement initiatives on an annual basis; and
- Monitoring activities of the Safety Oversight Committee. The Safety Oversight Committee reports at least semiannually to the Quality Council.

The Safety Oversight Committee, chaired by the Vice President and Medical Director, monitors and coordinates patient, employee, and environmental safety initiatives and activities

throughout the Health System. Data relating to areas such as aggression, self-injury, medical emergencies are discussed.

In addition, the following committees or individuals report to the Safety Oversight Committee:

1. Environment of Care Committees – Report issues/activities relating to Safety Management, Life Safety, Hazard Communication, Emergency Preparedness, Occupational Safety, Security, Utilities Management, Medical Equipment Management, and environmental safety rounds.
2. Medication Safety Oversight Committee – Reviews and investigates, when needed, medication incident data; activities/issues with the electronic order entry system; and concerns, issues, and performance improvement expectations from contractual pharmacies. In addition, other medication related initiatives or problems may be addressed.
3. Product Standardization Committee - Coordinates the selection of clinical equipment/products to ensure safety and standardization across the Health System.
4. Fall Prevention Team – Reviews fall data, conducts a review of any significant falls that have occurred, and evaluates current fall risk assessments and interventions.
5. Infection Control Coordinator – Reports infection surveillance data and other infection prevention activities.
6. A representative from the Affiliate programs - Reports the Affiliate's safety issues and initiatives.

B. The SPIRIT Steering Committee chaired by the President and Chief Executive Officer, reviews SPIRIT improvement projects prior to their initiation. The Steering Committee has established 5 strategic objectives:

1. Safety – providing an environment free from potential injury and harm for the people we serve, employees, contractors, and visitors.
2. Quality – achieving high reliability by having the right processes and the right outcomes.
3. Service Delivery – providing services efficiently throughout the continuum.
4. Employee Engagement – instilling a sense of purpose and belonging in employees and enhancing their level of pride in their job, their team, and the organization.
5. Customer Satisfaction – meeting or exceeding expectations of services and experience of care.

Any improvement project must be in alignment with at least one of these five major objectives. A SPIRIT project is presented at each Quality Council meeting.

C. The Medical Executive Committee (MEC), on behalf of the Department of Psychiatry and Medicine, is responsible for the overall clinical care rendered to the persons served at Sheppard Pratt. The MEC is responsible for:

- Monitoring and evaluating the performance and clinical competence of individual providers via peer review, privileging review, and performance appraisals;
- Undertaking corrective action, if problems are identified. Corrective actions may include, but are not limited to, educational programs; policy and procedure initiation or revision; staffing changes; ancillary services changes; and adjustment in clinical privileges.
- Reviewing the findings and recommendations from its subcommittees: Infection Control, Pharmacy and Therapeutics, Ethics, Peer Review, and Credentialing;
- Monitoring the quality of care provided by contractual clinical services via semiannual reports

- Approving policies, practices, and protocols that impact treatment and services; and
- Evaluating data from clinical reports such as infection control, medication usage, adverse drug reactions, critical incidents, significant medication errors, seclusion and restraint use, patient complaints related to physician interaction, and medical records.

A report on SPIRIT initiatives/projects is presented at least quarterly.

V. Safety and Performance Improvement Activities

A. Definitions

1. A critical incident or adverse event is an unexpected occurrence related to a patient's medical treatment and not related to the natural course of the patient's illness or underlying disease condition. The following meet criteria as designated by the State of Maryland and/or The Joint Commission:

    a. Near miss or good catch – a situation that could have resulted in a critical incident but did not, whether by chance or timely intervention
    b. Level 3 Adverse Event – a critical incident that does not result in or does not require any medical intervention to prevent death or serious disability. Serious disability means a physical or mental impairment that substantially limits one or more of the major life activities of a patient lasting more than 7 days or still is present at the time of discharge.
    c. Level 2 Adverse Event – a critical incident that requires a medical intervention to prevent death or serious disability
    d. Level 1 Adverse Event – a critical incident that results in death or serious disability
    e. Sentinel Event – an unexpected event involving death or serious physical or psychological injury or the risk thereof. The phrase "risk thereof" includes any process variation for which a recurrence would carry a significant chance of serious adverse outcome. A sentinel event also includes one of the following, even if the outcome was not death or major permanent loss function not related to the natural course of the patient's illness or underlying condition:
        - Suicide of any patient receiving care, treatment and services in a staffed 24 hour care setting or within 72 hours of discharge;
        - Abduction of any patient;
        - Rape, assault (leading to death or permanent loss of function), or homicide of any patient; and
        - Rape assault (leading to death or permanent loss of function), or homicide of a staff member, licensed independent practitioner, visitor, or vendor while on site.

2. A Root Cause Analysis is a medical review committee process to identify the basic or contributing causal factors that underlie variations in performance associated with adverse events or near misses. A root cause analysis shall be conducted for Level 1 and 2 Events and, if warranted, for any other near miss or critical events.

3. A performance improvement team or SPIRIT team/initiative is a team approach to review current systems or processes or to develop new processes. Teams are generated when a current process needs improvement or a problem is identified. Data are analyzed to determine if a system/process is producing the desired results. In accordance with

The Joint Commission requirements, a proactive risk assessment is conducted for one high-risk process every 18 months.

B. Investigation of Critical Incidents

When a critical incident occurs within the Health System, the incident shall be reported to the Clinical Safety Officer. The Clinical Safety Officer shall:

- Confirm that appropriate medical care for the patient and/or employee has been initiated
- Identify any immediate corrective action to prevent reoccurrence
- Report the event to SPHS administration and outside agencies, when indicated
- Coordinate the investigation of the critical incident; determine if a root cause analysis is required; and, if so, designate a root cause analysis team
- Identify and ensure implementation of any immediate corrective actions which would prevent recurrence
- Monitor the root cause analysis team activities and any resulting actions

If SPHS admits a patient with a condition resulting from an adverse event that SPHS perceives may be related to care that was provided at another Maryland hospital and that appears to be unknown to the originating hospital at the time of discharge, SPHS shall, through the Clinical Safety Officer, notify and provide any necessary information to the appropriate medical review committee at the hospital where the adverse event allegedly occurred. The hospital where the event allegedly occurred shall conduct the root cause analysis and provide notice to DHMH in accordance with the reporting requirements, and shall also be responsible to notify the patient or the patient's family. All communication that occurs in accordance with this notification is confidential under Health Occupations Article §1-401 et seq Annotated Code of Maryland.

C. Data Collection and Analysis

Data collection occurs through the incident reporting system, which includes medication incidents, falls, employee or patient injuries, and critical incidents; seclusion and restraint database; client satisfaction surveys; employee surveys; infection control surveillance; complaint database; audits of clinical contractual services; and focused audits. Efforts are made to identify data as it applies to organizations similar in patient characteristics and level of care, e.g. through benchmarking and The Joint Commission's Core Measures. Care provided by physicians (and included in the quality profile for physician performance) is rated by patients in the client satisfaction surveys and this information is used for reappointment and performance reviews. Data are analyzed, reviewed for prevalent trends, and reported to leadership and various committees, including committees of the Board of Trustees. In the hospital program, a compilation of various items are distributed on dashboards to the leadership of each inpatient unit on a monthly basis. Specific data, e.g. the Core Measures, are also reported externally.

VI. Communication with Patients/Consumers

Patients are informed via the patient handbook about avenues available to address any concerns with their treatment, medication, or other health care concerns. In addition, the Grievance Procedure policy is in the patient handbook. The Patient Advocates meet with patients to address complaints and educate them about speaking up about their health care concerns. During the initial assessment and continuing through the course of treatment, clinical staff teaches patients about maintaining safety. Patients and, when appropriate, families/guardians are involved in planning their care. Safety suggestion boxes and the Concern Line are also available to receive feedback from patients and visitors.

Sheppard Pratt shall inform the patient and, if appropriate, the patient's family of any significant unanticipated outcome or event. This disclosure shall occur as soon as reasonably possible. The attending physician or clinician who is responsible for the overall care of the patient should, in most instances, handle the disclosure.

Information about SPHS's services and performance is obtained from patients and, when appropriate, families/guardians by two formal methods: the Grievance Procedure and Client Satisfaction Survey.

1. A complaint process exists for patients, guardians, families, and interested parties who wish to file complaints regarding care or services provided at SPHS. Complaints are investigated and resolved by the Patient Advocates or designee. The data from these complaints are aggregated and compiled into a Complaint Report. Trend data from complaints are reported semiannually to the Quality Council and the Clinical Committee of the Board.

2. The Client Satisfaction Survey is given to patients and, when appropriate, guardians/families upon the patient's discharge and queries them as to care they received specific to the program and more generally with the organization. This data are also aggregated and analyzed into a Client Satisfaction Report. This report is distributed to leadership and managers.

In addition, the Consumer Council, chaired by the President and CEO, meets monthly and consists of consumers, family members of consumers, community members, and employees of both the Health System and Mosaic, Inc. The Consumer Council's focus has been to improve or change communication processes and procedures which are not working at optimum potential with consumers and families.

VII. Communication with Employees, Physicians, and Contractors

Communication of safety issues and performance improvement activities is a vital component in identifying opportunities for improvement and preventing unanticipated outcomes. In addition to the routine flow of information among employees, Sheppard Pratt has various methods to obtain information from employees: the Concern Line, Safety Alert Line, safety suggestion boxes, environmental safety rounds, and an incident reporting system. Information about quality and safety activities is provided to employees, physicians, and independent contractors via departmental/ division/service meetings, Town Hall meetings, Health System leadership meetings, the SP Bulletin, and Grand Rounds presentations.

VIII. Confidentiality of Information

Highly sensitive information and data related to safety and performance improvement activities shall be confidential and protected against disclosure and discoverability (Section 14-501 of the Health Occupation Article of the Annotated Code of Maryland). The following committees are designated as medical review committees, as defined by §1-401 et seq Annotated Code of Maryland, Health Occupations Article and are formed and approved as such by the Board of Trustees:

Clinical Committee of the Board of Trustees
Risk Management Committee of the Board of Trustees
Quality Council
Medical Executive Committee
Pharmacy and Therapeutics Subcommittee
Infection Control Subcommittee
Ethics Committee
Safety Oversight Committee
Medication Safety Oversight Committee

Fall Prevention Team
Product Standardization Committee
All Health System Environment of Care Committees
Emergency Preparedness Committee
Performance Improvement teams
Root Cause Analysis teams

IX. Evaluation of Safety and Performance Improvement Plan

The Safety and Performance Improvement Plan is updated annually by the Quality Council and approved by the Clinical and Risk Management Committees of the Board of Trustees.

X. Analysis of Goals of 2014

1. Expand SPIRIT (Lean methodology/training) throughout the Health System via employee training and organized performance improvement activities. Utilize SPIRIT tools to evaluate and identify prevention strategies for identified high risk areas: suicide and self-injury; medication safety; violence prevention; and fall prevention.

   The following is a summary of results for SPIRIT in 2014. Figure 1 indicates the number of staff participating on a SPIRIT project team. Figure 2 indicates the number of projects completed in 2014.

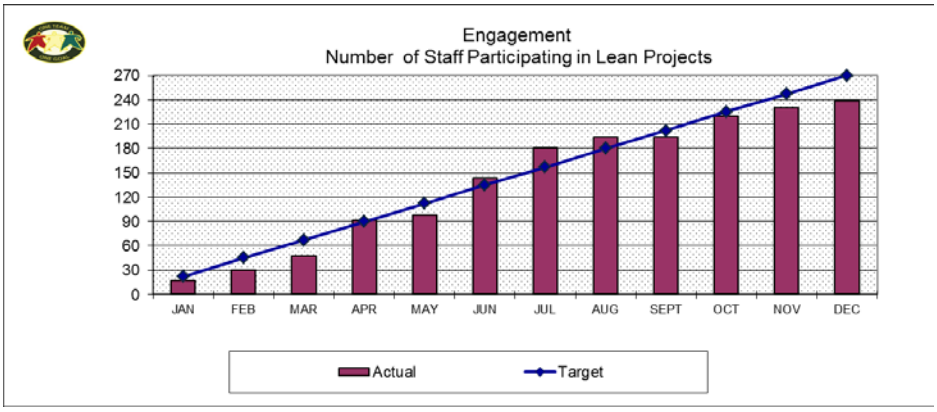

Figure 1: Staff Participation in SPIRIT

The data in figure 1 shows that 238 staff members or 9% of the organization participated in formal improvement activities in 2014. This represents a 4 percentage point improvement over 2013 participation levels (5%). The activities range from engagement in daily improvement huddles to full kaizen events focused on improving safety and quality within our processes. For 2015, a 15% goal was established. To achieve this goal, 10 additional huddles will be rolled out within the year with a continued focus on rapid process improvement events throughout the Health System. We also plan to reach out to our remote locations for training and engagement in the SPIRIT program.

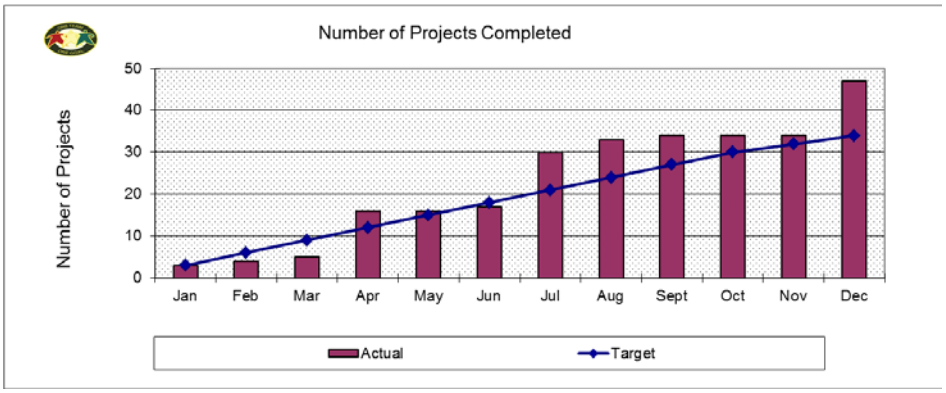

Figure 2: SPIRIT Project Completion

The data in Figure 2 shows that 47 projects were completed during the year. This represents a 176% increase in the number of formal improvement projects throughout the health system over the prior year. The highlights from this year's safety and quality improvement related projects include: reducing seclusion and restraint use by over 40%, reducing the use of antipsychotics within the dementia population by over 10%, completing a violence risk reduction initiative, improving EKG reporting timeliness, improving medication dispensing on the Ellicott City campus, and improving nursing home outpatient delivery of care.

In addition to the aforementioned projects, a pilot study of a new post-discharge courtesy call to confirm patient's understanding of their aftercare plans after re-entering their home environment commenced within the year. This initial response to the pilot study was positive customer service feedback as well as appreciation by patients and staff for offering this service to ensure both post-discharge compliance with aftercare recommendations geared toward patient safety and prevention of readmissions, in addition to the customer service component. The pilot supported a general need for this service, and SPHS is making plans to continue cascading this effort in 2015. Further, the health system addressed the need for a bridge visit in between an inpatient stay and an outpatient psychiatric provider by developing a post discharge "Transitional Aftercare Program" (TAP).

2. Establish outcome measures to evaluate the DBT treatment model in the residential programs. This will be incorporated into the outcome measurement plan and goals for 2015.

3. Expand use of the PHQ-9 scale to other units in order to evaluate the effectiveness of treatment for patients with depressive disorders on those units.
The use of the PHQ-9 scale was implemented in the contractual telepsychiatry program. This also will be incorporated into the outcome measurement plan and goals for 2015.

4. Implement a patient safety champion program encompassing all clinical areas and focusing on prevention of adverse events, better engaging direct care staff and program leadership in proactive patient safety activities and fostering a culture of quality and safety.
Focused committees and performance improvement activities continue to focus on the Health System's high risk areas (e.g. violence, suicide/self-injury, falls, and medication adverse events). The model for moving a formalized clinical safety champion program to the implementation stage is actively being developed.

Goals of 2015

1. Continue to expand SPIRIT (Lean methodology/training) throughout the Health System via employee training and organized performance improvement activities. Utilize SPIRIT tools to evaluate and identify prevention strategies for identified high risk areas: suicide and self-injury; medication safety; violence prevention; and fall prevention. Establish processes to cascade improvements to similar programs/processes. The goal is to increase the number of SPIRIT projects in 2015 by 25% from the previous year.

2. Implement a clinical safety program encompassing all clinical areas and focusing on prevention of adverse events, engaging direct care staff and program leadership in proactive clinical safety activities, and fostering a culture of quality and safety.

3. Improve the timeliness of staff reporting actual and near miss adverse events.

4. Develop and begin implementation of an outcomes measurement strategy focusing on safety, symptom relief, functional recovery, and reducing relapse risk.

5. Improve patient/family communication with clinical staff via initiatives involving the Patient Advocates, Consumer Council, and unit leadership.

6. Reduce injuries, seclusion, and restraint in the hospital and RTC programs by at least 10% compared to 2014 rates.

7. Develop quality related staff recognition and reward programs.