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Office of the Minnesota Secretary of State
Minnesota Public Benefit Corporation / Annual Benefit Report
Minnesota Statutes, Chapter 304A



Read the instructions before completing this form
Must be filed by March 31
Filing Fee: \$55 for expedited service in-person, \$35 if submitted by mail

The Annual Benefit Report covers the 12 month period ending on December 31 of the previous year.
Notice: Failure to file this form by March 31 of this year will result in the revocation of the corporation's public benefit status without further notice from the Secretary of State, pursuant to Minnesota Statutes, Section 304A.301

1. Corporate Name: (Required) HB Healthcare Safety, SBC

2. The public benefit corporation's board of directors has reviewed and approved this report.

3. In the field below, enter the information required by section 304A.301 subd. 2 or 3 for the period covered by this report, (see instructions for further information): Note: Use additional sheets if needed. (Required)

See attached annual report for reporting period 11/1/19 - 12/31/19

4. I, the undersigned, certify that I am the chief executive officer of this public benefit corporation. I further certify that I have signed this document no more than 30 days before the document is delivered to the secretary of state for filing, and that this document is current when signed. I further certify that I have completed all required fields, and that the information in this document is true and correct and in compliance with the applicable chapter of Minnesota Statutes. I understand that by signing this document I am subject to the penalties of perjury as set forth in Section 609.48 as if I had signed this document under oath.

[Signature]

Signature of Public Benefit Corporation's Chief Executive Officer

March 26, 2020

Date (Must be dated within 30 days before the report is delivered to the Secretary of State for Filing)

Email Address for Official Notices

Enter an email address to which the Secretary of State can forward official notices required by law and other notices:

~~hbsbc@hbhealthcare.com~~ hart@hbhealthcare.safety.org

Check here to have your email address excluded from requests for bulk data, to the extent allowed by Minnesota law.

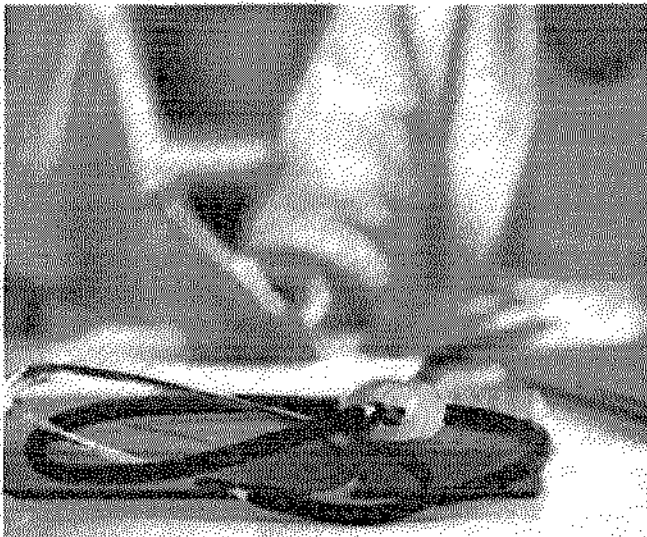
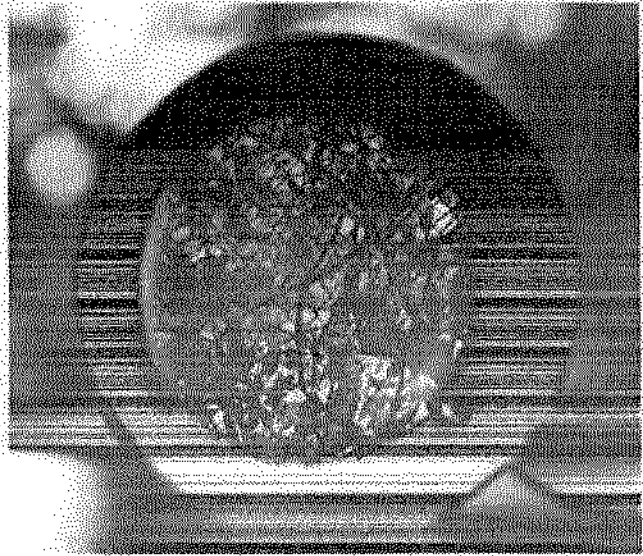
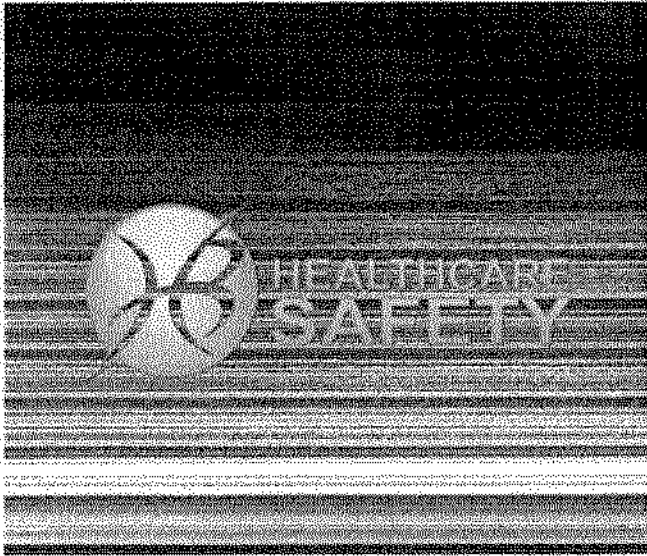
List a name and daytime phone number of a person who can be contacted about this form:

Lacey Hart
Contact Name

507-208-9438
Phone Number

Entities that own, lease, or have any financial interest in agricultural land or land capable of being farmed must register with the MN Dept. of Agriculture's Corporate Farm Program.

Does this entity own, lease, or have any financial interest in agricultural land or land capable of being farmed?
Yes No



2019 Annual Benefit Report

HB Healthcare Safety, SBC

A Minnesota Social Benefit Corporation

March 2020

HB Healthcare Safety was incorporated on July 30, 2015 as a Social Benefit Corporation under Minnesota's Public Benefit Corporation Act. Pursuant to Section 304A.101 of the Act, public benefit purpose as stated in it's Articles of Incorporation to reduce suffering caused by healthcare delivery.

Throughout this report, HB Healthcare Safety will be referred to as HBHS or may refer to itself as "we", or "our" or "us."

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Company Overview

HB Healthcare Safety (HBHS) believes that no one should ever suffer (emotionally or physically) or die as a result of process of care or system failures and by 'no one', we mean patients and families as well as the care teams. Our purpose is to reduce the suffering caused by healthcare delivery through research, education, initiatives, and advocacy involving all stakeholders in the healthcare system.

Our mission is to reduce harm associated with healthcare delivery. As a Social Benefit Corporation, we have a solid foundation for our long-term mission alignment and value creation as it protects our mission through capital raises and leadership changes. Our focus is to help healthcare systems to pin-point the common causes of patient harm in their systems and processes, provide the technology solution that monitors the actions and inactions that lead to harm, and develop processes addressing failures in care delivery – dollars and lives saved.

HBHS has been combating ineffective peer review and other processes of review by broadening our focus to identify omissions (what we don't do to cause harm such as delayed diagnosis or failure to diagnose) and to examine process of care and system failures. Our Safety Learning System™ methodology paired with our Healthcare Safeware® technology enables healthcare providers to create and implement lasting quality improvement initiatives and reliable systems of care.

What does the HB Stand For?

Honey Badger! Our healthcare honey badgers (Collaborative members) are relentless in their pursuit of the mission: healthcare delivery free from harm. They are tenacious advocates for patients and colleagues by working hard to identify and correct omission of care that prevent providers from doing their best job and allow for mistakes to be made.

We believe **NO ONE**
should suffer or die as a
result of healthcare
delivery process or
system failures

VISION

Healthcare Delivery

Free from Harm

PURPOSE

To reduce the suffering
caused by healthcare
delivery through
research, education,
initiatives and advocacy
involving all stakeholders
in the healthcare system.

Pursuit of Purpose

With regard to the period covered by this report, January 1, 2019 to December 31, 2019, HBHS pursued the specific benefit purpose as follows.

We pursue our purpose through an array of educational, consulting, and support services that fall within our Safety Learning System™ methodology. We lend assistance in the identification of harm, training of case reviewers, guidance in change management and leadership strategies, facilitation of culture change, effective use of technology services, and the implementation of systems improvement projects.

SLS Collaborative members are committed to our vision of healthcare free from harm and gaining wisdom in the process. We are dedicated to continual learning, improving the provider-patient experience, and innovating healthcare systems on a worldwide scale by learning together & fostering a community of support. Our Collaborative goes beyond the facts & data to provide a community of support to providers who may be drowning in the chaos of healthcare. We seek to diminish burnout by fostering forgiveness, camaraderie, and empowerment within your hospital & between collaborative member institutions. The first step in this journey is to recognize that individuals are rarely at fault for harm caused.



Shira Wolf is a Senior Consultant at HBHS, where she leads the Safety Learning System (SLS) Collaborative. She has over 20 years of experience in healthcare safety and quality improvement, and is a frequent speaker at national and international conferences. She is also a past president of the American Society for Healthcare Quality.

Shira Wolf



Patty Atkins is a Senior Consultant at HBHS, where she leads the Safety Learning System (SLS) Collaborative. She has over 20 years of experience in healthcare safety and quality improvement, and is a frequent speaker at national and international conferences. She is also a past president of the American Society for Healthcare Quality.

Patty Atkins

Healthcare providers are further encouraged to share experiences with all disciplines and specialties within hospital systems within our Learning Collaborative. Our aim is to lessen secondary victim burden and increase knowledge to enhance physician and hospital system performance leading to better patient experience and more positive outcomes. To achieve this culture shift, HBHS continually improves its teaching and training rubric and its technology offering to best serve clients and their individual needs.



Tony Calabrix is a Senior Consultant at HBHS, where he leads the Safety Learning System (SLS) Collaborative. He has over 20 years of experience in healthcare safety and quality improvement, and is a frequent speaker at national and international conferences. He is also a past president of the American Society for Healthcare Quality.

Tony Calabrix



Valerie Craig is a Senior Consultant at HBHS, where she leads the Safety Learning System (SLS) Collaborative. She has over 20 years of experience in healthcare safety and quality improvement, and is a frequent speaker at national and international conferences. She is also a past president of the American Society for Healthcare Quality.

Valerie Craig

Our Successes

The following is a description of how we believe we succeeded in achieving the goals of our specific benefit purpose.

2019 was a year of expanded learning and gratification in our mission. The Safety Learning System® (SLS) Collaborative is a growing group of American, Australian, Canadian and Saudi Arabian medical systems moving beyond simply counting & trending adverse events. We are defining, measuring, and improving the process of care & system failures that contribute to the suffering & harm caused to our patients & providers. SLS Collaborative members provide guidance to one another throughout the improvement process, help each other to implement solutions & provide second victim support by fostering a community of forgiveness.

Findings

Meaningful prioritization in healthcare is impossible when governments and external entities impose counting exercises that increase workload and distract from the real-world issues facing patients and providers. Healthcare is flooded with patient safety information and quality improvement teams are stranded on an Iceberg. Real change however, is lurking beneath the icy water. To be heard by leadership, people communicate with louder, repetitive demands. Healthcare must begin to shift resources toward fixing what matters:

Rapid Shift in Perspective

Many of our Collaborative members have witnessed a change in culture as a result of our review process. Dr. Aaron Lane-Davies speaks about the rapid culture shift at Bronson Healthcare before any systematic changes have been developed:

<https://youtu.be/FLJH5GXWpJs>

Improving End-of-Life

End-of-life care has consistency become one of largest OFI categories for our Collaborative members. Dr. Vikram Kumar speaks about the changes made at the Eastern Maine Medical Center to improve their end-of-life care opportunities: <https://youtu.be/FLJH5GXWpJs>

Just Get People Exposed

Collaborative members suggest exposing people to the review process. Especially those reluctant few who may be resistant to a new project or method like SLS:

<https://youtu.be/wI7nZiGaxzQ>

Temper Your Expectations

Collaborative members advise future collaborators to temper their expectations on change. Prepare for a marathon and not a sprint. They give tips on how to strategically involve key staff during the on-boarding process for quicker implementation & training.

<https://youtu.be/WN6ZhpTUqU>

Engineering Approach

Our Safety Learning System® (SLS) is a systems-improvement methodology that brings together advanced workflow & analytics technology to promote organizational learning & actionable insights that will significantly reduce the harm & suffering caused by faults in the systems & processes of healthcare delivery. We have expanded our technology services to become more customizable and collaborative. We have also found that this goes beyond healthcare having expanded into the Prison systems with the State of California. HBHS and our Collaborators have taken the fearful dive below the water to discover why harm caused by healthcare is still the third leading cause of death in the United States. We have found that it is the omissions of care (e.g. misdiagnosis or failure to communicate with a patient) that contribute to the majority of patient harm. It is not the provider but the faulty processes and systems of healthcare delivery that allow care teams to cause harm.

"In the past, medical errors were thought to be the result of individuals behaving badly. We blamed the doctor who ordered the wrong treatment, the pharmacist who dispensed the wrong dose, or the nurse who gave the medication to the wrong patient. This idea that adverse events were due to bad people led to a "deny and defend" culture among healthcare professionals and prevented progress on patient safety.

Today, we know better. We know that medical errors are largely the result of bad systems of care delivery, not individual providers."

—Ashish Jha

Why have these errors been overlooked for so long?

With traditional quality monitoring, errors of omission are often invisible and hard to recognize. More importantly, a necessary culture shift needs to be achieved in which hospitals move away from shame-and-blame to taking accountability for omissions in care - to no longer view them as inherent characteristics of care. Errors of omission allow providers to cause unnecessary harm. Under no circumstances is harm justifiable. It is our duty as care providers to reduce any pain and suffering caused to our patients but it is impossible when the system continually works against us. The Safety Learning System® reviews patient journeys through a standardized case review method to "diagnose" process & system failures that allow providers to cause unintentional harm.

Challenges

Our mission of healthcare free from suffering and harm cannot be accomplished without a fundamental shift in hospital culture from adversarial and hierarchal relationships to collaborative learning and teamwork among supporting colleagues. Culture change is dependent on leadership and change management strategies in these key areas:

Over Simplification

All of our guiding principles encourage participants to resist the over simplification of issues so that targeted quality improvement projects can be locally developed & implemented.

Preoccupation with Failure

Patient harm is an everyday occurrence but it is often treated as an anomaly. Our methodology encourages participants to anticipate failures before they happen.

Overlooking Expertise

Deference to expertise is most simply a respect for professional knowledge regardless of hierarchy. We honor this principle throughout the entire process.

Stagnation

High-reliability organizations continually reinvent themselves. We at HBHS believe that the age-old excuse of 'things have always been done this way' is not only obsolete but dangerous and catastrophic.

Provider Burn-out

Care providers are directly involved in this work giving them the opportunity to change the system so it works for them in the hopes of reducing provider burnout.

Looking Ahead

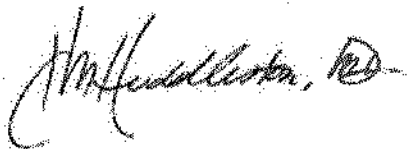
We continue to improve our Healthcare Safeware® according to the needs and convenience of our clients, however, with increased IT security standards across health-care the cost & liability expectations of our clients in relation to their willingness to pay for such services is out of balance. We are investing to move our technology into a government cloud based technology but the increases in hosting and protection costs will lower our abilities to cover enhancement programmer costs moving forward. Healthcare administration has become reactive over time and struggles with putting systems in place for the long haul. The Safety Learning System® is rooted in high reliability engineering. The intent of the Safety Learning System™ is to create reliable systems of care ensuring the four rights of healthcare: right person, right place, right time, right provider.

Finances & Market

Members of our Learning Collaborative pay an annual fee according to organization or institution size and services rendered. Many collaborative members are sponsored by development funds of vested patient advocates. HBHS continues to finance efforts from founder investments yet was able to begin paying back investments from previous years.

CERTIFICATION BY THE BOARD OF DIRECTORS

The undersigned, being all the directors of HB Healthcare Safety, SBC, hereby acknowledge and certify that we have reviewed and approved the enclosed 2018 Annual Report.



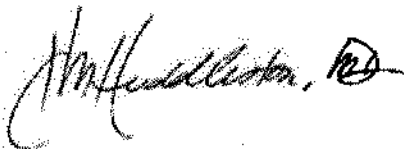
Jeanne M. Huddleston, M.D.
Chief Executive Officer/President and Secretary



Lacey A. Hart, MBA, PMP
Chief Operations and Financial Officer/Treasure

SUBMISSION:

I, the undersigned, certify that I am the President and Secretary of this public benefit corporation. I further certify that I have signed this document no more than 30 days before the document is delivered to the secretary of state for filing, and that this document is current when signed. I further certify that I have completed all required fields, and that the information in this document is true and correct and in compliance with the applicable chapter of Minnesota Statutes. I understand that by signing this document I am subject to the penalties of perjury as set forth in Section 609.48 as if I had signed this document under oath.



Jeanne M. Huddleston, M.D.
Chief Executive Officer/President and Secretary



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STATE OF MINNESOTA
OFFICE OF THE SECRETARY OF STATE
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Steve Simon

Steve Simon
Secretary of State