8349745000S6

9432461

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

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)

HB Healthcare Safety maintained its goal of safety learning activities with significant investment in technology driving continuous safety improvement in healthcare delivery through an iterative approach across 20 US hospitals. See enclosed annual report for a full review of 2016 activities, successes, challenges and a look ahead.

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.

Jeanne M. Huddleston, MD

Signature of Public Benefit Corporation's Chief Executive Officer

02/28/2017

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:

Hart@hbhealthcaresafety.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 A. Hart, COO	507-208-9438
Contact Name	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 ☒

HEALTHCARE SAFETY

2016 ANNUAL BENEFIT REPORT

HB HEALTHCARE SAFETY, SBC

A Minnesota Social Benefit Corporation.

January 2017

HEALTHCARE SAFETY

COMPANY OVERVIEW

HB Healthcare Safety, SBC (HBHS) believes that no one should ever suffer (emotional or physical or mental) or die as a result of process of care or system failures and by no one, we mean patients & families as well as the care teams.

With the mission of HBHS is to **reduce harm associated with healthcare delivery,** a Social Benefit Corporation creates a solid foundation for our long term mission alignment & value creation. It protects our mission through capital raises & leadership changes.

We believe that the pain, harm and death caused by failures of healthcare delivery are a societal issue and public health problem. We have a moral obligation to learn as much as possible about what needs to be fixed to end this suffering caused by healthcare delivery. The expense caused by these failures is prohibitive (more than one billion dollars per year spent treating the infections that hospitals give people).

Our focus is to help healthcare systems pin point the common causes of patient harm in their systems & processes, provide technology that monitors the action and inactions that lead to harm, & develop processes addressing failures of care delivery – dollars and lives saved.

WHAT DOES THE HB STAND FOR?

Honey Badger! That's right, the Honey Badger, that small carnivore that has a reputation for being, pound for pound, Africa's most fearless animal despite its small size. Thank you Dr. Taunya Lowe for accurately capturing the spirit of our Wholly Women Owned & Operated Honey Badger leadership team:

Relentless,
Tenacious,
Determined To Succeed,
and Never Afraid Of Larger Than Life Challenges!

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

Healthcare Delivery

Free from Harm

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

WHAT WE DO (IN SUPPORT OF OUR PURPOSE / MISSION)

HBHS maintained its goal of its safety learning system activities with significant investment in its Health technology, Healthcare Safeware™, driving continuous safety improvement through an iterative approach providing immediate insight into performance against known gaps and their common causes.

HBHS delivers the case for change by working with clients to: 1) identify opportunities for improvement (OFI) in care delivery; 2) aggregate, reconcile, analyze and trend data to create actionable information; and 3) integrate data and patient stories to promote meaningful change.

Safety Learning System™						
Retreat and Conference Engagement	Diagnostic Chart Review Evaluation of Care Delivery Vulnerabilities	Training & Peer Coaching: Engagement & Culture Change	Translation of Lessons Learned into Actionable Information	Benchmarking with Analytics Report Generation	Pilot Projects to Address Shared Opportunities for Improvement	Study and Disseminate Safety Improvement Efforts
Healthcare Safeware™						

PURSUIT OF PURPOSE

With regard to the period covered by this report, January 1, 2016 to December 31, 2016, HBHS pursued the specific benefit purpose stated in its articles of incorporation as follows.

At HBHS, we've brought together clinical expertise and goal of developing an advanced patient surveillance technology to end the suffering caused by healthcare delivery. In 2016, we formed a multi-center collaborative intent to study the identification of healthcare system improvement opportunities and their common causes of process failures. Organized in cooperation with Academic Research led by Mayo Clinic Rochester, participating medical centers:

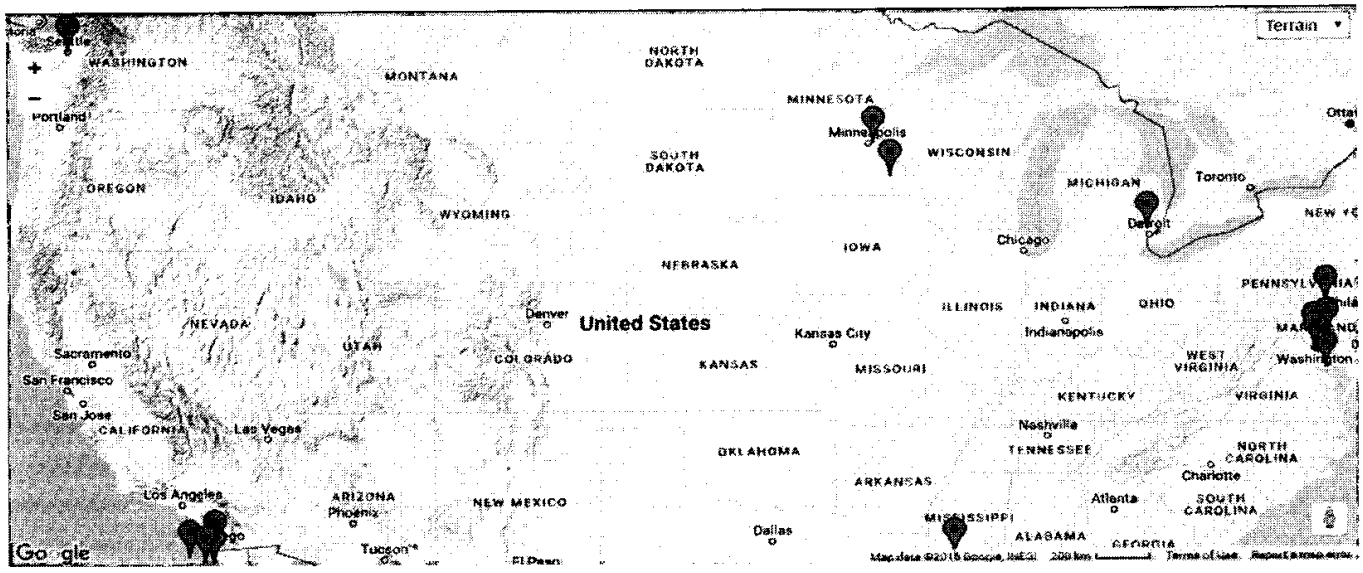
1) Elucidated and categorized types of process of care failures
2) Quantified the prevalence of process of care failures
3) Defined the common causes of process of care failures aims
4) Quantified and described the differences in findings between institutions

After on-site training, each participating hospital reviewed processes of care for consecutive patients from a prior specified cohort (e.g. sepsis, readmissions, recessitation calls, mortalities, surgical events, etc.). The goal for each site was 100 cases with mixed method (qualitative & quantitative) reviews entered into the web-based safety learning system. Monthly multidisciplinary case discussions were held locally for those cases with any findings. De-identified data & descriptive statistics illustrated process of care issues identified along with their common cause failures. Benchmarking reports between sites were distributed with academic publications pending.

OUR SUCCESSES

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

Our approaches for fostering healthcare free from harm leverages "systems thinking"—recognizing that the hospital is a system, and that the system can and must be designed to compensate for the errors that are likely to be made by any of its components. We were pleased to collaborate with 20 hospitals that span across the United States in Multi-Center Collaborative study. Through a combination of data gathering, analytics, interpretation and data visualization, we have been able to provide meaningful insights and knowledge for these participating sites to prioritize their healthcare quality improvement initiatives to make a significant difference in lives of patients.



Beaumont Health	Royal Oak	MI
Mayo Clinic, Methodist Campus	Rochester	MN
Mayo Clinic, St Marys Campus	Rochester	MN
MedStar Franklin Square Medical Center	Baltimore	MD
MedStar Georgetown University Hospital	Washington	DC
MedStar Good Samaritan Hospital	Baltimore	MD
MedStar Harbor Hospital	Baltimore	MD
MedStar Montgomery Medical Center	Olney	MD
MedStar Southern Maryland Hospital Center	Clinton	MD
MedStar St. Mary's Hospital	Leonardtown	MD
MedStar Union Memorial Hospital	Baltimore	MD
MedStar Washington Hospital Center	Washington	DC
Penn State Hershey Medical Center	Hershey	PA
Regions Hospital Health Partners	St Paul	MN
Sharp Chula Vista Medical Center	Chula Vista	CA
Sharp Coronado Hospital & Healthcare Center	Coronado	CA
Sharp Grossmont Hospital	La Mesa	CA
Sharp Memorial Hospital	San Diego	CA
University of Mississippi Medical Center	Jackson	MS
University of Washington Medical Center	Seattle	WA

What is failing - *Where* it is failing - *Why* it is failing

Preliminary data from the collaborative illustrates that of the patient journeys studied, 80% of the Opportunities for Improvement (OFIs) are all "acts of omission" as opposed to the commissions considered to be a more traditional definition of adverse events traditionally reported by healthcare systems. While most think of medical errors as something a care provider did to a patient that caused harm; however, as our data shows, a more common type of medical harm is the error of omission.

Why have these errors been overlooked for so long? With traditional quality monitoring, they are often invisible and hard to recognize, but more important is the culture shift required to no longer view these omissions as just inherent characteristics of our systems of care.

HBHS is spurred by these findings, and will continue to track new OFI learnings, iterate its development and testing of technology support, and leverage our unique and proven "systems thinking" methodology that captures the patient story and their hospital journey resulting in the capture of actionable insights for system improvements in our healthcare delivery.

CHALLENGES

The following is a description of what prevented us from achieving the specific benefit purpose, to the extent that we did not pursue or create the specific benefit purpose in this reporting year.

Healthcare continues to be complex with an unforgiving social and political environment. Addressing hospital safety is a highly multifaceted issue requiring a shift in culture and systems to capture opportunities for improvement in a dynamic landscape. The problem currently is plentiful with little ability to prioritize where to start and rightsizing. Yet, appetite and financial reimbursement for such solutions remains variable in the market. HBHS made significant financial investment into its technology solution to promote efficient opportunity for improvement data capture yet requires sustained academic support to further the culture shift necessary to adopt and demand its solutions.

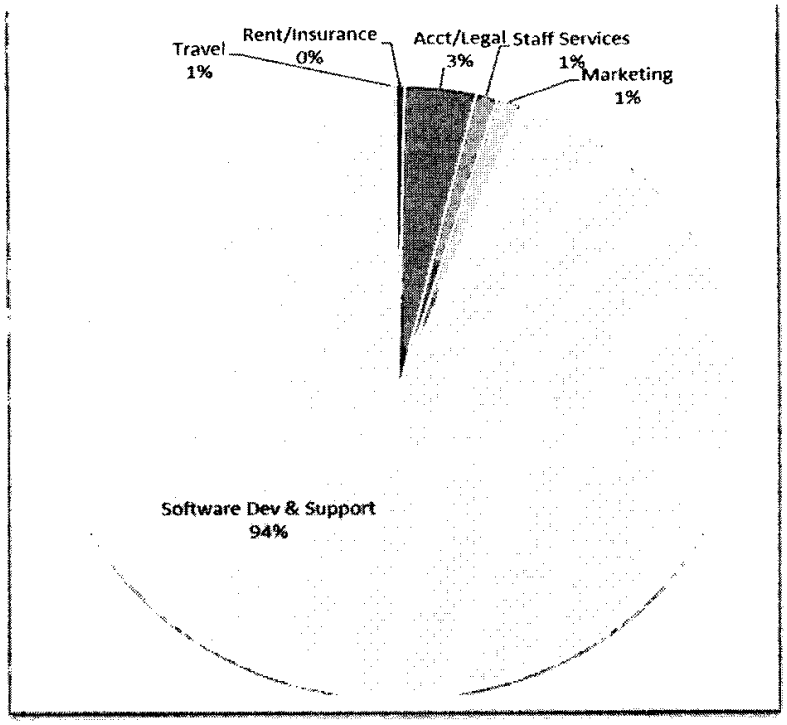
LOOKING AHEAD

HBHS will continue to enlist hospitals across the country & explore internationally in a commitment to implement changes in care that facilitates process improvement through case reviews, recording qualitative and quantitative information, tracking new OFI learnings shared within the hospital and corporate level structures, and creating the ability to track resultant projects and their impact on clinical care. HBHS aims to continue to academically partner with collaborators to explore the system failures causing harm not only potentially or caused to patients but also expand its reach to harm/potential harm inflicted on care providers as secondary victims of system failures.

Partnering with another Minnesota based health IT firm, our tool shall be easily integrated with hospital electronic medical records to allow for automatic entry of demographic and relevant clinical information. In addition, efforts to iteratively develop and test our technology will continue.

FINANCES & MARKET

HBHS received private loans from Bremer Bank and the Rochester Area Economic Development, Inc. fund to its founders to cover expenses for a total of $450,000 whereas 94% of funds were allocated towards Software development and support from IT partner, The Nerdery. Participants in the Multi-Center Collaborative covered nominal expenses for a total of $57,500. Neither founder received remuneration of any kind from HBHS in 2016.



Healthcare Efforts in 2017 are anticipated to continue to be funded by early adopters willing to participate in research studies with the software. The target market for HBHS continues to include multi-facility healthcare systems (hospitals, outpatient and skilled nursing facilities), acute care hospital facilities, and long-term care facilities. Early traction indicates higher cultural readiness in academic medical centers. Additional capital may be sought via social impact investors. Current trends illustrate that Benefit corporations are attractive to a large and growing market for socially responsible and impact investments. As an SBC, we can provide Social investors 1) high social impact; 2) structure to maintain the mission after the next financing or sale and 3) can command higher valuations.

CERTIFICATION BY THE BOARD OF DIRECTORS

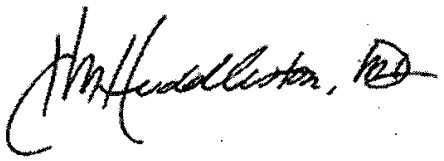
The undersigned, being all the directors of HB Healthcare Safety, SBC, hereby acknowledge and certify that we have reviewed and approved the enclosed 2016 Annual Report.

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

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

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

Work Item 943246100031
Original File Number 834974500056

STATE OF MINNESOTA
OFFICE OF THE SECRETARY OF STATE
FILED
03/29/2017 11:59 PM

Steve Simon
Secretary of State