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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)

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 its Articles of Incorporation to reduce suffering caused by healthcare delivery. With regard to the period covered by our 2022 Annual Benefit Report, January 1, 2021 to December 31, 2021, HBHS pursued the specific benefit purpose as attached.

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 of perjury as set forth in Section 609.48 as if I had signed this document under oath.

Jeanne Huddleston, MD

Corporation's Chief Executive Officer

March 1, 2022

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:

huddleston@hbhealthcaresafety.org

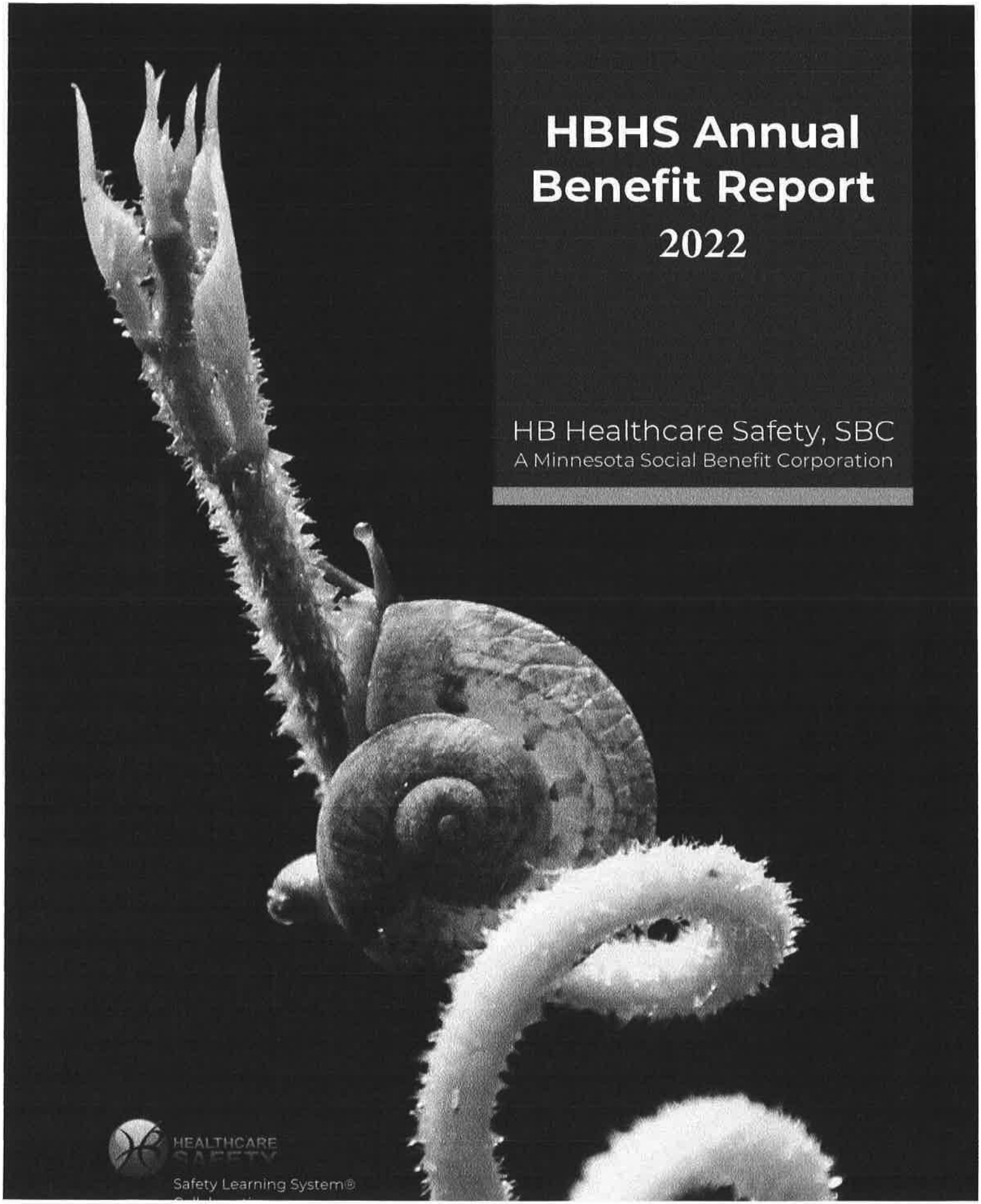
☑ Check here to have your email address excluded from requests for bulk data, to the extent allowed by Minnesota law.

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

Jeanne Huddleston	507-316-1118
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 ☑



HBHS Annual Benefit Report

2022

HB Healthcare Safety, SBC

A Minnesota Social Benefit Corporation

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 Safety Learning System™ methodology paired with our Healthcare Safeware® technology enables healthcare providers to create and implement lasting quality improvements and reliable systems of care.

HBHS was founded through Mayo Clinic ventures by Dr. Jeanne M. Huddleston and Lacey A. Hart. Taking care of people is a part of our DNA & we are dedicated to taking care of those who take care of others. Our commitment is to help organizations design reliable systems that reduce burnout & support teams in delivering excellent care. As founders, we are reinvigorated with the gift of truly tapping into our talents and passions to bring compassion and learning to all aspects of society where humans take care of humans.

Our purpose is to reduce the suffering caused by process failures through research, education, initiatives, and advocacy involving all stakeholders in the healthcare system and beyond. As a Social Benefit Corporation, we have a solid foundation to help human service 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.

We are dedicated to continual learning, improving the provider-patient experience, and innovating healthcare systems on a worldwide scale by learning together & fostering a research community of support.

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, 2021 to December 31, 2021, HBHS pursued the specific benefit purpose as follows.

We have remained steady in our purpose through an array of educational, research, 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, implementation of systems improvement projects and the study of methodology outcomes. HBHS continually improves its teaching and training rubric and its technology offering to best serve the Collaborative and individual needs through our research efforts.

Our SLS Collaborative has come a long way since its founding in 2016 and continues to grow with new members joining in 2021 and renewed social benefit commitments from members.

New Members 2021

- UC Health expansion
  - Colorado
- Valley Health expansion
  - Virginia & West Virginia
- St Lukes Health System
  - Idaho
- Presbyterian Health (end 2021)
  - New Mexico
- Audie L. Murphy Memorial VA Hospital
  - San Antonio, TX

Research and continuous learning are cornerstones of the SLS Collaborative. Our exceptional members have implemented numerous improvement projects and studied dozens of cohorts utilizing the Safety Learning System® and Healthcare Safeware®.

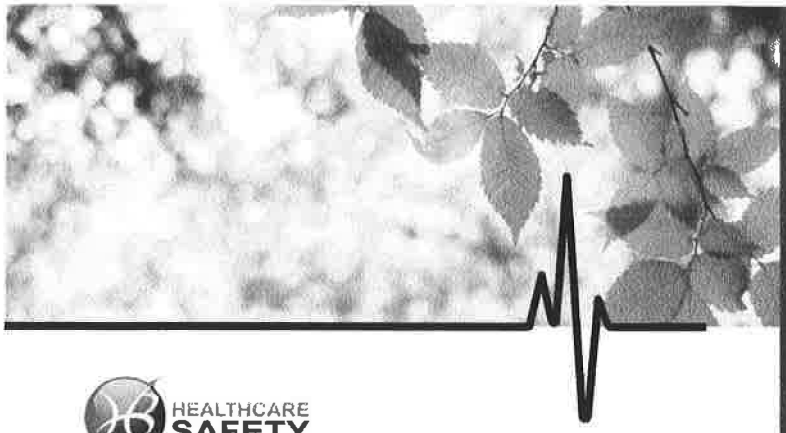
This year HBHS was able to share benchmarking reports to its Collaborative members. Benchmarking is the practice of comparing processes and result performance metrics between organizational units. It is a crucial component of organizational learning, continuous improvement, quality initiatives, high reliability, and Six Sigma. Effective benchmarking practices allow our members to:

Remain Relevant
Remain relevant by keeping up with the latest and greatest improvement projects implemented by Collaborative members.

Boost Resiliency
Recover from any friction or barriers by examining the solutions of other Collaborative members.

Spark Innovation
Experience a competitive cultural shift among your team to become the best in the Collaborative.

Learn Collaboratively
Gain perspective on how well you perform compared to other Collaborative members.



HEALTHCARE SAFETY

ABOUT THE SAFETY LEARNING SYSTEM® COLLABORATIVE

The Safety Learning System® Collaborative is a growing group of Australian, Canadian and USA medical systems moving beyond mortality review and simply counting and trending adverse events.

We are defining, measuring and improving those process of care and system failures that contribute to the suffering and harm of our patients and providers.

"**This Collaborative** allows me to feel like I'm doing my best to help **improve the care of everyone** and it's not just the care of our patients but it's also the **care of our providers.**"

~ Shira Wolf, BSE
Collaborative Participant

This is more than just a research and learning collaborative. This a community of practicing providers and quality staff who seek to create a safe space for healthcare workers to research and create practical, meaningful, and lasting change without reprimands or misaligned incentives.

THE SLS COLLABORATIVE PROVIDES:

Training on proven case review methods and system improvement approaches for implementing change.

Access to the Healthcare Safeware® Web-Based Registry.*

Learning from other Collaborative Member sites through benchmarking reports and monthly webinars.

Improve performance by targeting identified process of care and/of system failures.

Opportunity for scientific publications and presentations with fellow collaborators.

WHAT CAN I GET AS A MEMBER?

Personalized online learning channels

Virtual training for Collaborative members is conducted through the learning management system Thinkific. Members have the option to receive a personalized channel on Thinkific for their site.

Members also have access to recorded monthly Collaborative Conversation webinars every month through Thinkific!

Personalized benchmarking

Members receive an annual benchmarking report outlining current collaborative data, learning & improvements. Occassionally, HBHS will provide a random benchmarking report on a special topic of benefit for members.

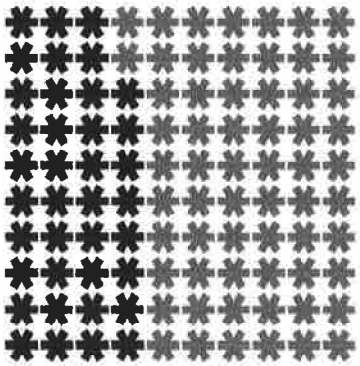
Members also learn how to conduct annual iceberg reports. These reports allow them to highlight the hidden causes of harm that our Safety Learning System identifies to inspire & influence your leadership.

WHAT IS THE SAFETY LEARNING SYSTEM®?

Our Safety Learning System® is a holistic methodology designed to identify the vulnerabilities in the systems and processes of care delivery creating daily challenges for care providers.

Using a continuous loop of organizational innovation and learning, these system vulnerabilities and provider challenges are translated into Opportunities for Improvement (OFIs).

This system creates meaningful (understandable, measurable and improvable) knowledge, which is then used to inspire and influence leadership for lasting change. *HBHS provides further training on how to inspire and influence leadership exclusively for Collaborative members.*



63.8%

One or more opportunities for improvement

SLS Collaborative participants, from the end of 2015 to the middle of July 2021, have honored the lives of 18,740 patients through our unique case review process and our compatible Healthcare Safeware®. 63.8% of these patients had one or more

Our Successes

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

This year marks the 5th year of the, now well tested, modified Delphi approach to identifying, naming, defining, and measuring opportunities for improvement (OFIs) in our healthcare delivery system. This methodology serves as a primary pillar of the Safety Learning System® work at each of the Collaborative sites and aligns with the growing focus on high reliability principles. We have a membership of over 150 hospitals, outpatient and mental health clinics. We have also been joined by the State of California Department of Corrections.

This work is foundational for the organizations aligning with high reliability principles which hold that the people who do the work are best positioned to identify where the processes and systems are broken and participate in the generation of meaningful solutions. So, what have we learned from extensive time commitments made by the SLS Collaborative's teams?

The aggregate cases page from the SLS Healthcare Safeware® registry below represents the hard work from all sites since the end of 2015 through the middle of July 2021. This cases table represents the efforts of the SLS Collaborative sites to **honor the lives of 18,740 patients** cared for in their facilities to date. It also clearly recognizes the efforts of their colleagues who provided the care. This is worth celebrating!!

Reviewing the review data, there is significant variation in the proportion of cases reviewed with opportunities for improvement (17.6% - 100%). There are no easily identifiable facility characteristics that correlate with the proportion of cases with one or more OFIs. Variables evaluated include size of facility, patient demographics, number of cases reviewed, proportions of OFIs in other hospitals of the same healthcare system, teaching status, year joining the Collaborative, etc.). Future SLS Collaborative research will seek to understand the contributing factors to this wide variation in case-based learning outcomes.

Expressions of Gratitude

One hospital leader opened their monthly SLS case discussion group with the following words: "More than 95% of the time, we do very well taking care of our patients. But there are occasions when we could do better. Let's spend some time talking about those opportunities so that can continue to improve the quality of care we provide in our community."

We believe that it's important to begin our work with gratitude. Hence, we applaud the tremendous amount of work completed by our colleagues described in the patient reviews above. We also call out the expressions of gratitude summarized by the Opportunity for Gratitude data. The Opportunity for Gratitude category did not exist at the outset of the SLS Collaborative. As a result of very important early learning, it was added in 2018 and has become one of the most selected OFIs as we continue to discover our aggregate potential.

Opportunities for Improvement (OFIs)

The following sub-categories where within the most common two opportunities for improvement across the Collaborative:

End of Life Care: The top 80% of end-of-life OFIs include: palliative care could have assisted, goals of care uncertain/discussion delayed, excessive/futile care, and expectation management. This underscores the importance of the ongoing work across the Collaborative to ensure reliable open and clear communication with the patient early and often to ensure that their expectations and goals of care are realistic and prioritized. One End-of-Life Category OFI that did not make the Pareto 80% mark is symptom management. Clinical experience tells us that this is likely being under-identified. Given the findings of respiratory symptoms in association with delayed recognition of deteriorating patients, delayed and missed diagnoses there is a high likelihood that at a minimum we may be able to do a better job of respiratory symptom management.

Treatment: Many of the Treatment and Care OFIs are highly correlated with other categories. As more of these OFIs are identified across the Collaborative, we will be able to analyze and understand the contributing factors more deeply. This is crucial to design initiatives that will deliver more timely and reliable care with less burden on frontline teams. As with any OFI category, it is impossible to just "fix treatment problems". Cluster and common thread analyses will create design requirements for right-sized quality initiative targeting the chosen subcategory. Identifying treatment and care opportunities is often difficult for new reviewers. These OFIs were traditionally considered in peer review settings, laying blame at the feet of the frontline

staff. This creates a historic bias when reviewing cases. We see the people on the frontline as doing their best and doing everything they could possibly do to help the patient, so how could there be an OFI? That is a reasonable question, but we all know there are slues of process and system failures that contribute and create the OFIs. It is crucial to provide SLS reviewer training, not only on doing the reviews, but on the clear ethos of identifying the process and system issues that keep the front line from doing their best job at any moment. Consistent reliable reinforcement is needed through time to emphasize the importance of learning to relieve future suffering of patients and front-line teams.

While the Safety Learning System® originated from Mayo Clinic's mortality review process, it has evolved into a broad case review process with the flexibility to review any cohort of interest. A total of 59 different cohorts have been reviewed by hospitals in the Collaborative. We have grouped some similar cohorts into categories and present the results in the table below. Age, length of stay, and OFIs all vary significantly across cohort types.

COVID-19

This past 24 months has been especially challenging for healthcare workers and healthcare systems on the front lines of COVID-19 pandemic. We recognize the strain this has put those within our Collaborative and are impressed that many still found time to continue reviewing cases. The SLS Collaborative work is a unique national dataset representing an incredible opportunity to gain a deeper understanding of the impact of COVID-19 on the quality and safety of healthcare delivery in a system under stress. What is the impact on the safety and reliability of care delivery in these moments of history? In manufacturing settings, systems under stress often reveal process and system weaknesses more visibly. If this is also true in health care, we hypothesize that there will be more OFIs to identify for not only COVID patients, but also in patients with any diagnosis during the pandemic.

The Collaborative data set will only continue to grow as more and more cases from the pandemic are reviewed. Currently, the data tells us that there are statistical differences between COVID-19 hospitalizations compared to all other reasons for hospitalization. COVID-19 patients were similar in age, but had significantly longer lengths of stay, were less likely to be on comfort care when they died. There is a statistically higher proportion of COVID-19 cases with OFIs with more OFIs per case finalized.

Launching COI_2L™

Continuous organizational improvement involves a set of repetitive actions and activities that are consistently reviewed, measured, and acted upon. This process of continuous action acts like a flywheel in which momentum builds over time resulting in greater speed over time.

A flywheel is different than a regular wheel because it uses angular momentum to store rotational energy. As you turn a flywheel, momentum builds quickly over time resulting in greater speed and inertia. Similarly, Safety Learning System® work just gets easier with time.

We have developed our own model of continuous improvement that combines organizational learning methodologies with tactics for achieving innovation and improvement across the Collaborative called COI_2L: Continuous Organizational Innovation, Improvement, and Learning. COI_2L is not a one-size-fits all solution that has a concrete ending. It is a cyclical process that requires continual investment in making the Safety Learning System® successful with every revolution of the COI_2L flywheel.

The Safety Learning System®, along with its Continuous Organizational Innovation, Improvement, and Learning (COI_2L) framework, allows organizations to:

Identify

where we can improve at any point in patient care by discovering Opportunities for Improvement within patient charts.

Learn

from these Opportunities for Improvement to develop meaningful, right-size, and cost-effective quality improvement projects that appeal to hospital leadership.

Share

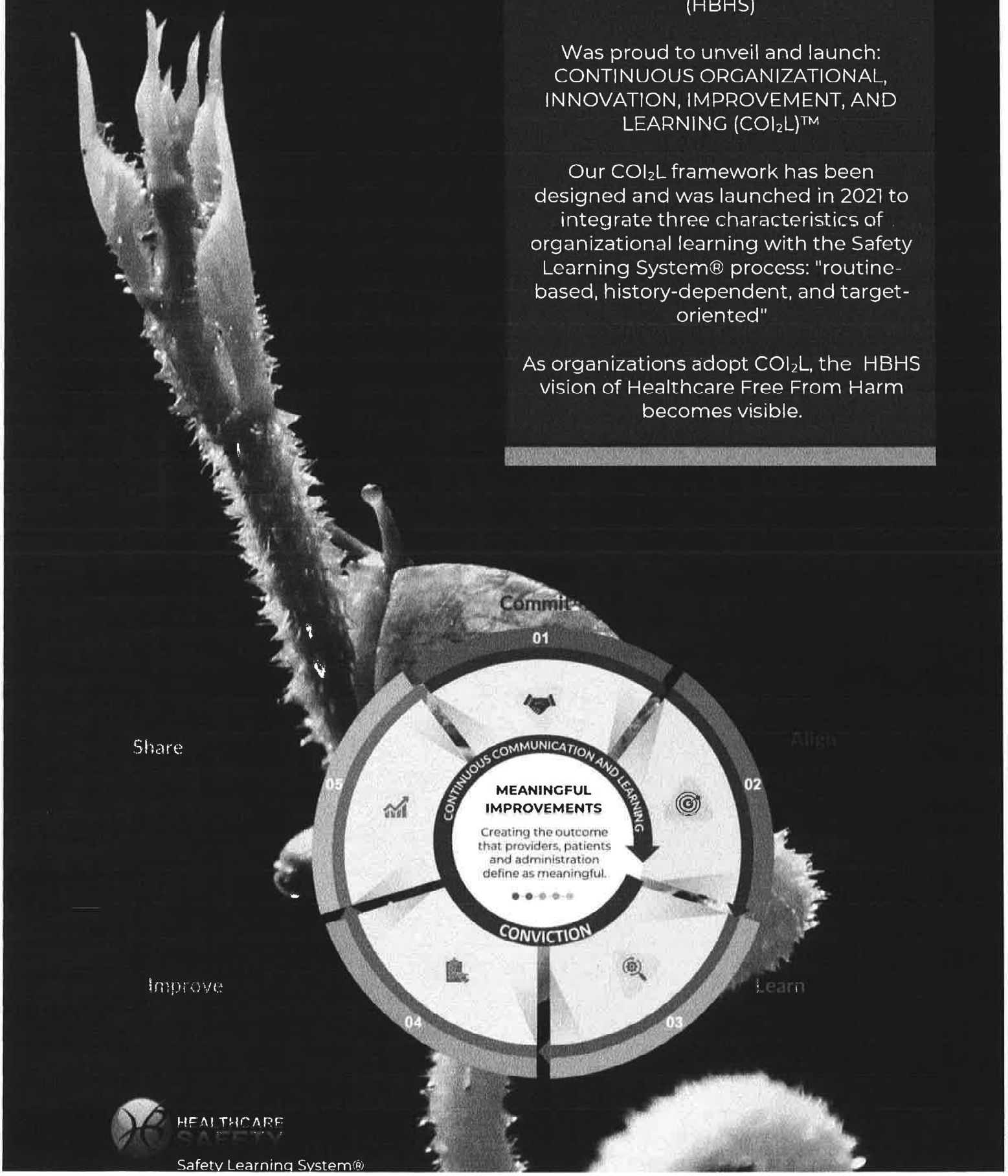
the lessons learned in case review and SLS implementation as broadly as possible to help all providers and other hospitals improve care for thousands of patients.

HB Healthcare Safety, SBC
(HBHS)

Was proud to unveil and launch: CONTINUOUS ORGANIZATIONAL, INNOVATION, IMPROVEMENT, AND LEARNING (COI_2L)™

Our COI_2L framework has been designed and was launched in 2021 to integrate three characteristics of organizational learning with the Safety Learning System® process: "routine-based, history-dependent, and target-oriented"

As organizations adopt COI_2L, the HBHS vision of Healthcare Free From Harm becomes visible.



FEDRAMP

FedRAMP Certification and launching our first commercial product to the Veterans Affairs Health Care system continues to take considerable time and attention but provides a tremendous opportunity to expand this work to touch lives by reducing suffering caused by process and system failures.

Historical Roots

In addressing results of last year's work around the impact of the delivery system on staff mental and physical well-being, we uncovered a precedence for doctors and nurses' altruistic spirit being tied to historical roots. To tie historical lessons to modern desires lends itself to value-based measures. To apply some of the lessons within historical primary sources to our methodology, research and business practices, we engaged an internship model in partnership with the Minnesota State University Mankato where our first graduate student interpreted primary medicine history sources and applied to the real-world applications.

During this internship, Ms. Hart helped to develop new educational curriculums and conducting independent research on Mayo Clinic History. Her research is focused on the early practice of the Mayo Brothers and the influence of the Sisters of St. Francis of Rochester, Minnesota. HB Healthcare Safety's origins come from years of mortality review conducted at the Mayo Clinic. Therefore, Mayo Clinic values have fundamentally influenced our company's approach to learning and patient-centered care. Researching and understanding the historical roots of Mayo Clinic values assisted us to find a richer identity and further help us to articulate regional differences among our clients in approaching care.

- Artifact 1: This essay outlines general trends within modern science and medicine that developed over the nineteenth-century.
- Artifact 2: In Artifact 1, Ms. Hart found that many of the lessons within primary sources could provide company lessons. Especially, as Dr. William J. Mayo was a renowned leader beyond his surgical abilities. This offers the value of a primary source, places the primary sources within their historical context, and provides future recommendations for current business and consulting practices.

Challenges

In order to transform patient care and mitigate harm through systems improvement methodologies, we have to completely change how we think about patient safety. Traditional patient safety, such as peer review, will usually attribute cause to an individual provider. We want to change that and it all starts with changing our language and perspective. As Albert Einstein once said:

> The world as we have created it is a process of our thinking.
> It cannot be changed without changing our thinking.
> Albert Einstein

Changing our perspective starts with talking about the "issues" and "Opportunities for Improvement" (OFIs) in patient care; not the "failures". Issues or OFIs are universal and unintended in that they can happen to *any* provider at any given time without anticipation.

From the outset, every Collaborative member's training included the message that performing reviews does not improve outcomes. We must target the identified opportunities for improvement with process and/or system vulnerabilities to realize meaningful change.

Likely the most challenging work in this is the intentional dissemination of all the knowledge being created through application of the SLS methodology. To drive change, we need to wrap our data in the powerful stories in order to make them memorable and inspirational. Every one who participates in this work becomes a better clinician at the bedside because of the lessons learned from each other through the process of storytelling in the case discussion groups. Transferring that knowledge to all our other interdisciplinary colleagues is crucial to elevating the entire organization's clinical acumen and quality of care.

Culturally in medicine we need more than a directive to encourage active participation in quality improvement initiatives. We need to understand that the changes we are making will make a meaningful improvement in patient care, and even more motivating if the proposed changes will make it easier to provide that care. For the latter to occur, the knowledge created by the SLS methodology must leave the case discussion room and infiltrate the layers of the organization.

Looking Ahead

Continued work will with Veterans Affairs hospitals and prison systems will require dedicated efforts but continues to provide a tremendous opportunity to expand this work to touch lives by reducing suffering caused by process and system failures.

Continued advances in the cybersecurity and modern technology capabilities offer SLS Healthcare Safeware® to disrupt the healthcare quality technology sector changing markets and altering the established rules of competition in this space; changing the measures from purely discreet and defined measures (such as handwashing measures) to include experience and perception (patient and staff experience) qualitative and quantitative understanding.

Disseminating and continued SLS Collaboration growth in the Continuous Organizational Innovation, Improvement, and Learning (COI_2L) framework allows a precedented shift in healthcare delivery and offers staff growth and resiliency.

The impacts of COVID flipping the Healthcare industry on its head now with burnout and labor shortages as well as our conscious pivot towards learning systems offers a perfect storm of opportunities to diversify and potentially become industry agnostic, however, the need for hope & healing from self-help and professional development education continues to grow in the healthcare and first responder sectors at an alarming rate.

Finances & Market

Members of our learning research Collaborative pay an annual fee according to organization or institution size and services rendered to participate in Research. Due to COVID impacts, many members were granted a reprieve and allowed to defer participation fees and granted discounts into 2021. Many collaborative members are still sponsored by development funds of vested patient advocates. While it was projected that 2021 would bring in commercial sales, the reality of continued COVID impacts only allowed HB Healthcare Safety to move just slightly out of red.

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 2021 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

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Original File Number 834974500056

STATE OF MINNESOTA
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Steve Simon
Secretary of State