Journey to No Preventable Risk: The Baylor Health Care System Patient Safety Experience

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Abstract
The patient safety vision at Baylor Health Care System (BHCS) has 3 components: (1) achieving no preventable deaths, (2) ensuring no preventable injuries, and (3) seeking no preventable risk. These goals require strategic efforts in the categories of culture, processes, and technology. Culture focuses on tactics such as teamwork training and quality improvement education. Processes are measured using the percentage adoption of a variety of target clinical processes such as order set use and adherence to National Patient Safety Goals. Technology includes focus areas such as clinical decision support and reliability of the electronic health record. BHCS has also achieved significant systemwide standardization of safety processes and development of the systemwide Office of Patient Safety to facilitate the implementation of evidence-based patient safety practices. Associated with these improvements, BHCS has made significant progress toward reducing hospital-standardized mortality rates and rates of hospital-acquired adverse events.

Keywords
patient safety, mortality reduction, adverse event reduction, patient safety culture

Baylor Health Care System (BHCS) is a not-for-profit integrated health care delivery system in North Texas, comprising 26 owned, operated, ventured, or affiliated hospitals; 21 ambulatory surgery centers; 7 short-stay surgical hospitals; 136 HealthTexas Provider Network (HTPN) locations with 450 physicians; 41 satellite outpatient clinics; 4 senior health centers; 4,575 medical staff members; more than 19,000 employees; and the Baylor Research Institute. BHCS has 125,000 inpatient admissions per year and approximately $5 billion in annual net operating revenue.

The vision of BHCS is “to be trusted as the best place to give and receive safe, quality, compassionate care.” Its mission is “to serve all people through exemplary health care, education, research, and community service.” To achieve this mission, BHCS organizes its strategic objectives (organizational action plans) around 4 pillars of excellence:

people—be the best place to work;
quality—deliver safe, timely, effective, efficient, equitable, and patient-centered care (STEEEP; reflecting the 6 major aims defined by the Institute of Medicine), supported by education and research;
finance—be responsible financial stewards;
service—serve both our patients and our community.

Baylor Health Care System Vision for Safe Care
The BHCS progressive vision for safe care is summarized in Figure 1. This patient safety vision has 3 components: (1) achieving no preventable deaths, as measured by the hospital-standardized mortality ratio; (2) ensuring no preventable injuries, as measured by the actual rate of hospital-acquired adverse events (AEs), with AE rates determined

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The BHCS patient safety vision has 3 components: (1) achieving no preventable deaths, as measured by the hospital-standardized mortality ratio; (2) ensuring no preventable injuries, as measured by the actual rate of hospital-acquired adverse events (AEs), with AE rates determined by random chart audit using the Institute for Healthcare Improvement Global Trigger Tool; and (3) seeking no preventable risk, with the metric for this component to be defined.

### Early Milestones in Baylor’s Journey to Safe Care

Baylor’s journey to safe care began with the realization, in 1999, that systemwide alignment and standardization were critical to improving patient safety and that organizational leadership had to be engaged in safety and quality improvement efforts as a core business strategy. Support from organizational leadership and widespread standardization of improvement processes were the first steps toward ensuring the dissemination of patient safety goals and improvement initiatives across the system with minimal resistance. Thus, a health care improvement strategic plan for the organization was developed based on 3 crucial elements: (1) the alignment of every board member across BHCS, as well as the BHCS senior administrative and medical leadership and frontline employees, toward making quality of care a priority; (2) the introduction of performance management incentives linked to clinical indicators; and (3) the creation of a multidisciplinary health care improvement operations team across all BHCS operating units (the Best Care Committee).

A key component of the prioritization of safety and quality improvement was a resolution from the Board of Trustees in 2000 that affirmed its commitment to improving patient safety throughout BHCS. The resolution states as follows:

> Whereas, maintaining the status quo or achieving quality and safety levels only equal to or slightly better than national, regional, or local norms is not compatible with the BHCS Vision and Mission Statements; and

> Therefore, be it resolved, that the Board of Trustees of Baylor Health Care System hereby challenges itself and everyone involved in providing health care throughout the system to give patient safety and continuous improvement in the quality of patient care the highest priority in the planning, budgeting, and execution of all activities in order to achieve significant, demonstrable, and measurable positive improvement in the quality of patient care and safety.

This organizational, Board-driven commitment to patient safety was the first step in transforming BHCS from a health care system in which each hospital pursued safe care largely on its own (primarily by focusing on regulatory compliance) to one in which strong systemwide integration and alignment of proactive patient safety goals would be achieved.

### Office of Patient Safety

A major milestone in BHCS’s patient safety improvement journey was reached in 2005, with the creation of the systemwide Office of Patient Safety (OPS) to facilitate the implementation of evidence-based patient safety practices throughout the system and to help align BHCS’s efforts with anticipated future national expectations. In line with the recommendation of the Institute of Medicine for “all health care settings to establish comprehensive patient safety programs operated by trained personnel within a culture of safety,” the OPS seeks to intensify existing patient safety programs, promote an organizational culture conducive to recognizing and resolving situations that pose a risk of patient injury, develop patient safety innovations, and guide employees in the adoption of the values of a safety culture. Its systemwide activities include not only hospitals but also the 100+ ambulatory care centers of HealthTexas Provider Network, the ambulatory care subsidiary of BHCS, ensuring widespread standardization of processes and outcomes.

Figure 2 illustrates the operational functions and activities related to patient safety. BHCS also established in 2005 the system-level Patient Safety Committee, with broad professional and institutional representation, which provides guidance to the OPS and receives guidance from the Best Care Committee.

Since 2005, the OPS has expanded to include 9 full-time employees with a range of expertise. The OPS supports hospitals by helping them set goals that are challenging but attainable, using measurement systems to show hospitals their current performance, and providing resources...
such as coaching and training. In addition, a system-level Quantitative Sciences Department has been established to measure and disseminate performance data across the system. The OPS and Quantitative Sciences Department use the DataVision Resource to examine risk-adjusted performance across multiple categories of patient safety and to compare BHCS performance with the performance of other hospitals.

As part of its efforts to measure and improve patient safety across the system, the OPS has introduced biannual site visits to explore facility effectiveness with regard to patient safety. Site visits are akin to a health “checkup.” Their purpose is to identify (1) any unique or special patient safety goals for each hospital, (2) good/best practices for dissemination across the system, and (3) problems regarding patient safety that need to be addressed. Site visits are preceded by a detailed data review by the site visit team and are summarized in a formal document describing opportunities for shared learning. The 2008 site visits, for example, showed that broad and substantial overall progress had been made in the implementation of processes to improve patient safety. Frontline awareness of patient safety goals was much higher than in the past, with more leaders reporting that they understood BHCS and facility goals related to reducing inpatient mortality and AEs and that they knew how BHCS was working to attain these goals through patient safety programs, such as Stop the Line (or speaking up when there is an imminent threat to patient safety) and Teamwork Improves Patient Safety. In addition, widespread structural improvements and leadership engagement had been achieved. For example, the OPS had identified major opportunities for patient safety improvement focused on culture (eg, “Stopping the Line”), specific diseases (eg, catheter-associated urinary tract infections), and processes (eg, the World Health Organization [WHO] Safe Surgery Saves Lives [SSSL] initiative); facilitated adoption of programs to address these health care improvement opportunities; and communicated these programs to the Best Care Committee, the Patient Safety Committee, and throughout the facilities (Figure 2). These site visits also suggested that only limited progress had been achieved in moving from central learning to distributed learning, that improvement was still needed to ensure a more just (and

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**Figure 2.** Functional view of patient safety

Abbreviations: CMS, Centers for Medicare and Medicaid Services; USNWR, U.S. New and World Report; PUDF, Public Use Data File; DFWHC, Dallas-Fort Worth Hospital Council; HCI, health care improvement; WHO, World Health Organization; CAUTI, catheter-associated urinary tract infections; VTE, venous thromboembolism; HF, heart failure.

The Baylor Health Care System (BHCS) governance/leadership draws its patient safety (PS) objectives from the national priority to make patient safety outcome data more transparent, as well as from the BHCS Office of Patient Safety (OPS). The OPS, in turn, performs data analysis and identifies major opportunities for PS improvement based on BHCS’s comparative performance across PS outcomes. The Best Care Committee and Patient Safety Committee collaborate with the OPS and help it define initiatives at the hospital/ambulatory level, the BHCS system level, and the regional level.
less punitive) culture, and that hospital-to-hospital variation in the implementation of patient safety processes still existed. These findings helped BHCS patient safety leaders to define both topics for the 2009 Employee Survey of Attitudes and Practices of Patient Safety and projects (cultural and process-based) for 2009.

Together, the OPS, Patient Safety Committee, Quantitative Sciences Department, and biannual site visit program help ensure systemwide alignment and transparency with regard to patient safety objectives and performance.8

Institute for Healthcare Improvement 100,000 Lives Campaign
Another major patient safety milestone that was reached in 2005 was the development of a board resolution focusing on the IHI 100,000 Lives Campaign and its national efforts to reduce inpatient mortality.12 The resolution reads as follows:

Whereas the Baylor Health Care System Vision is to be trusted as the best place to give and receive safe, quality, compassionate health care and,

Whereas Baylor Health Care System has joined the Institute for Healthcare Improvement national campaign to save 100,000 lives through six hospital-based improvements in quality and patient safety,

Therefore be it resolved that Baylor Health Care System management, medical staffs, and hospitals will commit their attention and necessary resources to rapidly implement the six programs that are part of the Institute for Healthcare Improvement 100K Lives Campaign, and the Baylor Health Care System has, during fiscal year 2006, established a target to reduce the inpatient mortality rate experienced during fiscal year 2005 by at least four percent, in each acute care hospital and in the aggregate across the system.

This Board Resolution reaffirmed BHCS’s organizational commitment to patient safety at the highest level and emphasized the importance of aligning BHCS patient safety goals with national patient safety objectives.

Standardization of Care
In addition to the changes driven by the OPS, the Best Care Committee has led the agenda to achieve greater standardization of care across the system, which contributes to all the domains of STEEEP. Standardization is achieved with the use of order sets, particularly those for common conditions such as heart failure and community-acquired pneumonia. Implementation of the pneumonia order set has been especially successful, with use consistently at or above 75% across all BHCS acute care hospitals since February 2007. We have found reductions in mortality as well as costs associated with order set use.13 Similarly, evaluation of the implementation of an evidence-based order set for heart failure has also been found to improve outcomes for BHCS patients, reduce costs of care, and increase adherence to standard performance and quality measures (David J. Ballard et al, unpublished data, 2009).

BHCS has also driven patient safety and quality improvement through the Best Care Physician Champion model. System-level and hospital-level physician champions are compensated to provide intellectual capital and leadership related to order set design, order set deployment, and clinical process improvement. Using academic detailing principles, these physicians motivate, encourage, and offer medical expertise to collaboratively design solutions to address challenges to quality improvement and to support standardization of evidence-based processes of care.14

In the area of patient safety, Patient Safety Physician Champions work at the hospital level (reporting to the Chief Safety Officer/System Vice President of Patient Safety) to facilitate the alignment of system and hospital patient safety goals and assist with AE review and patient safety rounds, and to represent patient safety to major medical and executive committees.

Patient Safety: Current Strategies and Goals
BHCS’s strategic aims to decrease excess mortality, AEs, and patient risk fall into the categories of culture, processes, and technology (Table 1).

Culture
Reliable industries have long recognized the importance of cultural change to improve safe practices and improve quality.15 In commercial aviation, for example, structured communication is used to achieve clear and focused communication and improve team performance.16 Situational awareness to avoid groupthink, use of a script to mitigate differences in communication styles, and adoption of cross-monitoring or double checking are examples of cultural practices that can facilitate safe outcomes.4,17

To identify and address cultural “potholes” and work toward a culture of safety, BHCS has used a Survey of the Attitudes and Practices of Patient Safety, which was developed using items from a variety of instruments (including the Agency for Healthcare Research and Quality [AHRQ] survey18). The biannual survey, which was begun in 2005, facilitates data-driven conversations about changes that
are needed to improve patient safety across the system. The findings of the survey conducted in 2009 included areas of strong performance such as double-checking before procedures, reporting of errors and near misses, facility leaders’ promotion of patient safety, use of checklists and reminders to reduce errors, dissemination of material about patient safety to patients, and speaking up to peers to prevent harm. Areas that represented opportunities for improvement included cooperation between units and departments; strength of teamwork; existence of a workload that permits safe care; handling of errors in an effective and supportive environment, consistent with a balance of system and individual accountability; managing problem physicians and staff; rounding by leaders on patient safety topics; levels of less-experienced staff; and value of employee retention. Providing perspective is that for 3 of 4 survey items from the AHRQ Hospital Survey on Patient Safety Culture that were incorporated into the BHCS Survey of the Attitudes and Practices of Patient Safety, the BHCS percentile was at or above the national 90th percentile (Figure 3). Comparisons between responses for 5 key questions on the 2009 and 2007 BHCS surveys are displayed in Figure 4.

To address gaps identified by cultural self-assessment, multidisciplinary projects\(^19\) have been established in the following areas:

- encouraging employees to Stop the Line\(^9\);
- teamwork training through the Teamwork Improves Patient Safety program\(^10\);
- quality improvement education through ABC Baylor, a comprehensive educational program that teaches health care leaders the theory and techniques of rapid-cycle quality improvement\(^20\);
- using standardized communication (Situation-Background-Assessment-Recommendation); and
- reduction of disruptive behavior.

### Patient Safety Processes

BHCS’s second major strategic category for patient safety improvement is the area of clinical processes. Goals were

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**Table 1. Baylor Health Care System (BHCS) Current Patient Safety Strategic/Tactical Categories**

<table>
<thead>
<tr>
<th>Strategic Area</th>
<th>Areas of System Focus</th>
<th>Metrics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Culture</td>
<td>Stopping the Line</td>
<td>Survey of Attitudes and Practices of Patient Safety</td>
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<tr>
<td></td>
<td>Teamwork training</td>
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<td></td>
<td>Quality improvement training</td>
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<td>Frontline learning</td>
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<td></td>
<td>More rounding</td>
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<td></td>
<td>Reduce disruptive behavior</td>
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<td></td>
<td>Increase transparency</td>
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<tr>
<td>Processes</td>
<td>Increased order set use</td>
<td>Percentage adoption of target process</td>
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<tr>
<td></td>
<td>World Health Organization</td>
<td>Hospital-standardized mortality ratio (HSMR)</td>
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<td></td>
<td>Safe Surgery Saves Lives</td>
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<td></td>
<td>Reduce adverse drug events</td>
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<td></td>
<td>National patient safety goals</td>
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<td></td>
<td>Reduce catheter-associated urinary tract infections</td>
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<td></td>
<td>Reduce hospital-associated pressure ulcers</td>
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<tr>
<td></td>
<td>Obstetrics excellence</td>
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<tr>
<td></td>
<td>Reduce falls (especially with injury)</td>
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<tr>
<td>Technology</td>
<td>Employee flu vaccination</td>
<td>Specific virtual medical record measures</td>
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<td>Clinical decision support</td>
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<td>Alerts/reminders</td>
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<td>Risk assessment</td>
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<td>Reliability of electronic health record</td>
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<td></td>
<td>Human factors issues</td>
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\(^a\) BHCS’s current strategic aims for patient safety improvement fall into the categories of culture, processes, and technology.
set based on patient benefit, alignment with regulators and payers, alignment with other existing and planned programs, and amount of “leadership capital” needed to effect meaningful change. Processes, which are measured using the percentage adoption of the target practice, include the following:

- order set use\textsuperscript{13};
- use of WHO SSSL processes\textsuperscript{11,21};
- reduction of adverse drug events\textsuperscript{22};
- adherence to National Patient Safety Goals\textsuperscript{23};
- use of National Quality Forum Safe Practices\textsuperscript{24};
- reduction in use of urinary catheters\textsuperscript{25};
- reduction of hospital-acquired pressure ulcers\textsuperscript{26};
- obstetrical excellence;
- reduction of falls\textsuperscript{27}; and
- increased employee flu vaccination\textsuperscript{28}.

**Technology**

The third strategic category for patient safety improvement within BHCS is technology, encompassing the prevention of AEs and improvement of patient safety and patient-centeredness through electronic medical records and clinical decision support\textsuperscript{29,30}, computerized physician order entry\textsuperscript{31}, and bar code medication administration\textsuperscript{32}. Although health information technology has considerable promise to improve patient safety, its complexity can lead to unintended and unforeseen consequences; therefore, it is important for health information technology efforts to be aligned with the maxim to “first do no harm.” This alignment necessitates multidisciplinary coordination between relevant departments to create an integrated systemwide approach to identifying errors, evaluating causes, and taking appropriate actions to improve performance in the future\textsuperscript{22}. Deployment of this portfolio of work is still in its early stages.

**Baylor Health Care System: Outcomes Related to Patient Safety**

**Hospital-Standardized Mortality Rates**

The first goal of the BHCS patient safety vision is to achieve no preventable deaths (Figure 1). Defining a “preventable death,” however, is typically not straightforward\textsuperscript{33}. To measure preventable deaths, BHCS uses risk standardization—HSMR is equal to observed deaths divided by expected deaths. This method is applied to more than 500 hospitals...
that use the MIDAS resource to measure care quality and operational efficiency. Figure 5 displays the BHCS HSMR trend since 2002. BHCS inpatient mortality was, in fiscal year 2009 (July 2008-June 2009), 8% lower than the national average for MIDAS hospitals. Although BHCS HSMR performance has improved faster than HSMR performance in the rest of the United States, BHCS performance has not achieved excellence, standing at approximately the 75th percentile when measured against other hospitals reporting data to MIDAS. The first 4 months of fiscal year 2010 (July-October 2009) suggest an acceleration of mortality reduction that may represent benefit from intensification of organizational focus on reducing inpatient mortality that was subsumed by the formation of a system-level mortality reduction task force in April 2009.

Baylor Health Care System: Hospital-Acquired AEs

The second goal of the BHCS patient safety vision is to achieve “no preventable injuries” (Figure 1). Like preventable deaths, preventable injuries can be challenging to define and measure.\(^2\) Voluntary AE reporting systems have been found to be effective primarily as learning tools and do not accurately measure adverse outcomes.\(^3\) Accordingly, BHCS adopted the broad-based use of the IHI GTT to measure rate of AEs.\(^4\)

**Global Trigger Tool**

The GTT is a validated audit method that retrospectively identifies AEs using standardized review of randomly selected patient records and, as a result, allows measurement of the actual rate (vs the reported rate) of AEs.\(^5\) As described elsewhere,\(^6\) BHCS has attempted to add value to this work by asking nurse reviewers to characterize AEs by severity, type, harm score, preventability, whether the AE was present on admission, and contributing factors to the AE. In addition, BHCS nurse reviewers write a brief structured summary of the AE, which allows BHCS to use the GTT as a systemwide learning and improvement tool focusing primarily on hospital-acquired AEs. From July

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Figure 4. Changes in key patient safety survey items (2009 vs 2007) on Baylor Health Care System Employee Survey of Attitudes and Practices of Patient Safety

*The percentage of respondents who answered each question with the best option (strongly agree) and the top 2 best options (strongly agree or agree) is shown for 2009 and 2007.*
2006 through June 2009, the OPS coordinated a review of approximately 200 charts per month. The OPS applies a severity and preventability “filter” and disseminates this information to hospital-level AE review teams, along with data related to AEs and near misses identified by our voluntary reporting system. The ratio of AE incidence rates is 16:1 favoring use of the GTT.

The rate of all hospital-acquired AEs for all BHCS hospitals has been declining substantially during the last several years. In fiscal year 2007 (July 2006-June 2007), there were 31.1 (±7.4) AEs per 100 discharges; in fiscal year 2008 (July 2007-June 2008), there were 27.3 (±7.1) AEs per 100 discharges; and in fiscal year 2009 (July 2008-June 2009), there were 24.1 (±6.8) AEs per 100 discharges. Although the rate of hospital-acquired AEs has been decreasing, hospital-acquired AEs still occur in nearly 20% of admitted patients with length of stay longer than or equal to 3 days. Whereas 63% of these AEs had minimal patient impact, 37% extended length of stay or caused serious harm to the patient. In addition, reviewers judged 52% of these hospital-acquired AEs to be “possibly” preventable and 20% as either “probably” or “definitely” preventable. Admissions with a hospital-acquired AE were more likely to be associated with adverse financial outcomes. A more detailed description of our findings is forthcoming. This information allows monitoring of system-level performance and patterns and new hospital “best practices”; in addition, hospital-level improvement teams are using the data to facilitate improvements in hospital care. The 23% decrease in AE incidence rate during the last 2 years (31.1 to 24.1 AEs per 100 discharges) is gratifying and felt to be derived, at least in part, from many of the components of our portfolio of patient safety programs.

**Future Challenges in Patient Safety**

The third aim of the BHCS patient safety vision is to seek no preventable risk (Figure 1). Although specific metrics for preventable risk are still under development, BHCS has identified several initiatives to help achieve this aim. In addition to embracing the tenets of high-reliability organizations and reliability in health care,38 a specific initiative is consistent use of the WHO SSSL checklist to improve the reliability of surgical care.11 On September 29, 2009, the Operating Policy and Procedure Board of Directors unanimously adopted a resolution to fully implement the WHO SSSL checklist, affirming its support to surgeons, anesthesia personnel, and staff to facilitate team success in doing all the right things, on all patients, all the time. Current chart documentation indicates bundle performance of 98% in May 2010, exceeding the goal of 95%.

BHCS also plans further improvements in its patient safety culture, including measurement of the implementation effectiveness of “Stop the Line,” clarification of the tenets of a Just Culture, reduced tolerance for disruptive behavior, and growing transparency regarding AEs. Specifically, based on 2009 patient safety culture data, each hospital will select 1 major culture goal for deployment during the next 16 months. Formal goals will be established and deployed to staff, and their progress will be monitored.
In addition, BHCS plans to further improve patient safety processes by intensifying reductions in procedure- and surgery-related AEs (identified by the GTT) and exploring management of fatigue. In the area of technology, BHCS will increase electronic order set deployment, barcoded prescription administration, electronic alerts for prescription and diagnosis interactions, and use of electronic reminders.

Conclusions

Although changes in culture, processes, and technology are recognized as having the potential to improve patient safety and health care quality, the literature lacks accounts of how such changes are related to measurable patient outcomes such as rates of inpatient mortality and AEs. The experience of BHCS shows that specific improvements targeting patient safety culture, processes, and technology have coincided with improvements in the HSMR and the rate of hospital-acquired AEs. Moreover, the patient safety initiatives implemented by BHCS may be considered for adoption by other hospitals and health care systems interested in improving health care safety and quality.

The journey to safe patient care requires a long-term vision, systemwide alignment of strategies and processes, and an understanding from organizational leadership that improved quality and safety are fundamental business objectives. Goals to improve specific aspects of patient safety, such as preventable deaths and injuries, must be carefully and specifically defined, and metrics must be chosen to reliably determine progress, or a lack thereof, toward the outcomes of these aims. In addition, a balance among improvement of patient safety culture, processes, and technology is needed to achieve sustainable patient safety improvements. Although demonstrable progress provides some reassurance of the utility of the BHCS patient safety program, abundant evidence exists for the importance of vigorous and disciplined continuing work. Next steps for BHCS will involve defining metrics to assess preventable risk and developing and implementing initiatives to reduce preventable risk in tandem with continued work to reduce preventable deaths and preventable injuries.

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