EXECUTIVE SUMMARY
The opportunity for leaders to collectively and boldly advance evidence-based practice as standard for healthcare is before us. This advisory research-based report and its recommendations provide insights on making this a reality.
AUTHORS

Bernadette Mazurek Melnyk, PhD, RN, CPNP/PMHNP, FNAP, FAANP, FAAN
Associate Vice President for Health Promotion, University Chief Wellness Officer
Dean and Professor, College of Nursing, Professor of Pediatrics and Psychiatry, College of Medicine The Ohio State University
melnyk.15@osu.edu

Lynn Gallagher Ford, PhD, RN, DPFNAP, NE-BC
Director, Center for Transdisciplinary Evidence-based Practice
Clinical Associate Professor, The Ohio State University College of Nursing
gallagher-ford.1@osu.edu

Michelle Troseth MSN, RN, DPNAP, FAAN
Chief Professional Practice Officer
Elsevier Clinical Solutions
m.troseth@elsevier.com
This research-based advisory report provides insights for leaders to collectively and boldly advance evidence-based practice for healthcare

OVERVIEW
This landmark national leadership advisory report is the result of a quest to see evidence-based principles and practices understood, applied, lived and sustained throughout the healthcare system, especially at the point of care. It is the result of an innovation project supported by Elsevier Clinical Solutions in partnership with The Ohio State University College of Nursing to better understand the current reality and perceptions of chief nursing executives on evidence-based practice, demographics and outcomes. Together, we are committed to applying and conducting the work necessary to have evidence-based practice (EBP) be the standard for healthcare and recognize the critical role nursing leadership plays as a partner on this quest to improve healthcare quality and safety as well as to reduce costs through evidence-based care.

Elsevier Care Planning has been on a journey to transform healthcare at the point of care for three decades and today has expanded to a consortium of nearly 400 healthcare settings across North America. The focus is on improving culture and interprofessional practice with lessons learned that transformation work is not a quick fix, nor another project or initiative, and requires a new way of thinking and tools to support the shift in culture and practice. The work has evolved the development of a culture and professional practice framework with actionable models that help healthcare organizations, leaders and point of care providers live new ways of thinking and practice. The Elsevier Care Planning Framework™ and Models are grounded in core beliefs, principles and theories, and provide guidance on the “how” to address the behaviors and tools to transform culture and practice in order to support the patient, family, community and caregiver.

The six integrated clinical practice models are:
- Health and Healing Care Model
- Applied Evidence-based Practice Model
- Health Informatics Model
- Partnership Culture Model
- Interprofessional Integration Model
- International Consortium Model

The Ohio State University College of Nursing (OSU CON) is the world’s preeminent college known for accomplishing what is considered impossible through its transformational leadership and innovation in nursing and health, evidence-based practice and unsurpassed wellness. The CON exists to revolutionize healthcare and promote the highest levels of wellness in diverse individuals and communities throughout the nation and globe through innovative and transformational education, research and evidence-based clinical practice.

The College of Nursing is home to several Centers of Excellence where innovative work is ongoing to explore and provide solutions to important healthcare challenges. One of these Centers is the Center for Transdisciplinary Evidence-based Practice (CTEP), an innovative enterprise that fosters EBP for the purpose of improving health and healthcare. The CTEP is a world renowned center that serves as a model and resource to all disciplines for implementing and sustaining a culture of

“Knowing is not enough; we must apply. Willing is not enough; we must do.”

GOETHE
best practice through transdisciplinary, innovative, evidence-based practices that impact care delivery across the healthcare spectrum.

The CTEP team is comprised of experts in EBP from multiple disciplines, who facilitate the integration of evidence and best practices across settings to improve healthcare outcomes, including the IHI Triple Aims of:

1. Improving the patient experience of care (including quality and satisfaction)
2. Improving the health of populations
3. Reducing the per capita cost of health care

The CTEP is fully dedicated to the promotion of EBP as the foundation of practice and decision-making in healthcare. To that end, the CTEP provides leadership, education and consultation to academic and clinical enterprises across the United States and globe.

BACKGROUND

Evidence-based practice (EBP) is a problem-solving approach to clinical decision-making in healthcare that integrates the best evidence from well-designed studies with a clinician’s expertise, which includes internal evidence from patient assessments and practice data, and a patient’s preferences and values (Sacket, Rosenberg, Gray, Haynes, & Richardson, 1996; Melnyk & Fineout-Overholt, 2011). Findings from research support that the implementation of EBP leads to a higher quality of care, improved patient outcomes and decreased healthcare costs (McGinty & Anderson, 2008; Melnyk, 1994; Williams, 2004). Most importantly, EBP assists organizations in attaining high reliability (i.e., safety) (Melnyk, 2007).

In the landmark summit sponsored by the Institute of Medicine (IOM) on health professions education, it was confirmed the idea previously discussed by Rycoff Malone (Rycoff-Malone, 2008) that leaders who support colleagues and create a vision for EBP in their organizations as well as influence policy to facilitate EBP and incorporate evidence into their own leadership practices have a key impact on EBP implementation.

Findings from research indicate that nurses and other healthcare providers are interested in gaining additional knowledge and skills related to EBP, including a recent study reflecting the current state of EBP where 74% of the U.S. nurses surveyed indicated the need for additional education in EBP (Melnyk, Fineout-Overholt, Gallagher-Ford, & Kaplan, 2012). Studies over the past decades also revealed that when nurses have confidence in their EBP knowledge and skills, they implement EBP more. Further, when nurses’ beliefs in the value and importance of EBP increase, implementation of EBP also increases (Melnyk, Fineout-Overholt, & Mays, 2008; Fineout-Overholt, Melnyk, & Schultz, 2005).

In a recent descriptive survey by Melnyk and colleagues (Melnyk et al., 2012) with a random sample of over 1000 nurses from across the United States (U.S.) who were members of the American Nurses Association (ANA) barriers to EBP were identified. Although several of the barriers named by the nurses were the same barriers that have been reported in previous decades, there were some new developments. Two of the new barriers that nurses reported were resistance to EBP from nurse managers and leaders, and traditional organizational cultures that often upheld the philosophy of “that is the way we do it here.” Respondents to the survey expressed a need for support (as opposed to resistance) from their organizations, managers and interdisciplinary colleagues in order to be able to implement EBP. This recent finding confirmed the idea previously discussed by Rycoff Malone (Rycoff-Malone, 2008) that leaders who support colleagues and create a vision for EBP in their organizations as well as influence policy to facilitate EBP and incorporate evidence into their own leadership practices have a key impact on EBP implementation.
Most recently, Melnyk and colleagues (Melnyk, Gallagher-Ford, Long, & Fineout-Overholt, 2014) published *Evidence-Based Practice Competencies for Practicing Registered Nurses and Advanced Practice Nurses in 2014*. These competencies were developed through a two-round Delphi study and were established to provide healthcare institutions with a set of scientifically derived, essential EBP competencies that can be easily integrated into organizations in their quest to achieve high-performing systems that consistently implement and sustain evidence-based care. Organizations also have viewed the advanced practice nurse competencies as applicable to not only advanced practice clinicians (e.g., nurse practitioners, clinical nurse specialists), but also to nurses in advanced leadership roles as well. The availability of these competencies provides clear language and expectations related to EBP knowledge and skills that can be assessed and implemented in various healthcare settings.

In addition to clear EBP competencies, healthcare organizations have recognized the need for tools and resources to practice EBP at the point of care. There remain large gaps in time, often decades, between the generation of evidence and its translation to practice, which results in suboptimal healthcare quality, inequitable patterns of utilization, poor safety, and unsustainable cost increases. Unfortunately, only a small number of scientific discoveries ever make it into real world practice settings (Wesorick & Doebbeling, 2011). Elsevier Care Planning provides a framework-driven approach to close the gap between evidence and practice via the integrated models, especially the *Applied Evidence-Based Model*. This model is rooted in an understanding of legal, financial, governmental/credentialing, professional standards, and designed to support care providers in evidence-based clinical decision-making and best practice (Hanson, Hoss, & Wesorick, 2008). It provides evidence-based tools (e.g., clinical practice guidelines, risk screens, clinical documentation) that are designed to support interprofessional EBP within the workflow as well as on-going processes and engagement through the Elsevier Care Planning Consortium. The critical contributions of this unique consortium is the shared learning about integrating the evidence-based tools into health information technology (HIT) and electronic health records (EHR) systems so that clinicians can have access to the latest evidence at the point of care. The necessity to leverage HIT to advance EBP has been recognized as critical to achieve sustainable, safe, quality care as well as make it usable in the everyday workflow of nurses and the interprofessional team (Hanson, 2011; Troseth, 2009; Staggers & Troseth, 2011; Wesorick, 2013). The TIGER Initiative Foundation recently published a report, *The Leadership Imperative: TIGER’s Recommendations for Integrating Technology to Transform Practice and Education* where it was identified that over focus by leadership on HIT or technology implementations at the expense of focusing on advancing practice, can result in a lack of evidence-based information and design that lacks integration of EBP (The TIGER Initiative Foundation, 2014). In a time when the nation is calling for EBP as standard of healthcare, leaders must guide and support their organizations and clinicians through this challenge and opportunity. The basic definition of a leader is “one who guides or directs a group” (Dictionary.com 6/24). Evidence-based leaders are individuals who guide or direct a group through integration of the EBP process as a foundational construct of their practice and leadership decision making.

Self-actualization and demonstration of EBP by leaders include embracing EBP in their own practice by attaining EBP knowledge/skills, developing a pro-EBP attitude, role modeling EBP by making evidence-based leadership decisions themselves, publicly navigating EBP barriers, and recognizing EBP achievements. Beyond leaders’ individual responsibilities to embrace EBP, they are by virtue of their position, power and authority, accountable to facilitate the enculturation of EBP throughout their organizations. By embracing and role modeling EBP as well as creating a culture and environment that adopts, values and implements EBP, evidence-based leaders build work environments and context where EBP can not only arrive, but survive and thrive.

The literature clearly indicated that nurse leaders must possess knowledge, skills and a positive attitude about EBP in order to integrate and lead healthcare organizations successfully into the future. However, it was apparent that there was a knowledge gap regarding the current state of EBP from nurse leaders’ viewpoints along with missing data regarding their prioritization and investment in EBP within their own organizations. Therefore, a study was conducted with nurse executives throughout the nation to fill this gap in knowledge and determine appropriate next steps in working with nurse leaders to advance and sustain EBP in healthcare systems to ultimately improve patient care and outcomes. Having a better understanding of the current state of chief nurse executives’ EBP attributes and how they correlate to critical healthcare indices will promote achievement of quality outcomes for the improvement of healthcare. This study focused on determining the EBP beliefs, EBP implementation, and support of an EBP organizational culture as well as how they relate to critical healthcare outcomes.
SURVEY METHODOLOGY

Study Purpose
The purpose of this descriptive correlational study was to:

1. Describe the EBP beliefs, EBP implementation, and perceived organizational culture of EBP in chief nursing executives
2. Determine the major priorities of nurse executives and the amount of investment in EBP
3. Describe NDNQI, core performance measures, and HCAHPS outcomes in the nurse executives’ organizations
4. Determine the relationships among the study variables.

Method
Elsevier provided a chief nursing executive email list. An email was sent to 5100 chief nursing executives to ask for their anonymous participation in the survey. 1,199 emails were returned for a sample size of 3901. The email provided a link to the survey so their responses could be anonymous. The data was analyzed, conclusions were drawn and recommendations are being shared in this Advisory Report.

Research questions:
1. What is the current state of chief nurse executives’ (CNEs) EBP beliefs, EBP implementation, and perceived organizational culture for EBP, and activities that support EBP?
2. What are the major priorities of CNEs and what percent of their budgets do they invest in EBP? What are the relationships among CNEs’ EBP beliefs, EBP implementation, perceived organizational culture for EBP, activities that support EBP, and healthcare system outcomes that include NDNQI, HCAHPS, Core Measures, nurse vacancy rates, BSN rates, certifications, and nursing satisfaction?

Methods: The study was an anonymous online survey of chief nurse executives. The research methodology was a descriptive correlational survey. Participants were provided a cover letter with a description of the study and sent an email inviting them to participate in the online survey.

Sample size, data collection and analysis
Sample size: The sample was 3901 with 327 respondents (8% response rate) and 276 completed surveys (7%).

Procedures: An email was sent to the chief nurse executives with an invitation to complete the anonymous survey. A reminder email was sent one week following first contact and another reminder was sent one day before the survey closed.

The survey participants were offered an incentive to participate in the study; an opportunity to enter a drawing for one of ten $100 gift cards. The gift card recipients were determined using a computer generated random number list. The recipients received their gift card after of the closing of the survey.

Measures: The data collected included:
(a) demographic questions; (b) three valid and reliable instruments that tapped beliefs about EBP, EBP implementation, and perceived organizational culture of EBP; (c) activities that support EBP (e.g., whether the institution had an EBP and a research council, and the effectiveness of the councils); (d) CNE priorities and budget investment in EBP, and (e) core performance measures, NDNQI measures, and HCAHPS data. Three valid and reliable scales developed by Melnyk and Fineout-Overholt were utilized in this study (Melnyk et al., 2008).

The EBP Beliefs Scale measures beliefs about the value of EBP and the ability to implement it (Fineout-Overholt & Melnyk, 2008). This is a 16-item Likert-type scale ranging from 1 (strongly disagree) to 5 (strongly agree). Sample items include: “I am sure that evidence-based guidelines can improve care.” The summed total EBP score with higher scores indicate stronger EBP beliefs. The scale has established face, content and construct validity, with internal consistency reliabilities typically above 0.85 (Fineout-Overholt & Melnyk, 2008).

The Evidence-based Practice Implementation (EBPI) Scale (Fineout-Overholt & Melnyk, 2008) was used to tap the extent to which the CNEs implemented EBP. Participants respond to 18-item Likert-type scale items by answering how often in the last 8 weeks they have performed certain EBP tasks, including (a) generated a PICO question about my practice, (b) used evidence to change my clinical practice, and (c) shared outcome data collected with colleagues. Item scores are summed for a total score range from 0 to 72, with higher scores indicating greater implementation of EBP. The EBPI has established face, content and construct validity with internal consistency reliabilities reported at above 0.85 (Melnyk et al., 2008).

The Organizational Culture and Readiness for System-wide Integration of Evidence-based Practice (OCRSIEP) scale was used to measure organizational culture and readiness for EBP. This instrument measures the extent to which cultural factors that influence system-wide implementation of EBP exist in the environment and the overall perceived readiness for integration of EBP and how it compares to 6 months ago. Respondents are asked to indicate their agreement with...
each item on a 5-point Likert-type scale, with 1 meaning none at all and 5 meaning very much. Examples of items on the 26-item scale include: (a) To what extent is EBP clearly described as central to the mission and philosophy of your institution, (b) To what extent do you believe that EBP is practiced in your institution? Items are summed to create a total score, ranging from 25 to 125, with higher scores reflecting greater organizational readiness for and movement toward a culture of evidence based practice. The scale has established face and content validity, with internal consistency reliabilities reported at above 0.85. (Fineout-Overholt & Melnyk., 2010).

Data Analysis: After data verification and cleaning, descriptive statistics were calculated to assess distributions and examine outliers and used to describe the sample (e.g., age, education, years of experience, type of medical institution). Bivariate analyses (e.g., contingency table analyses, independent t-tests, correlations, and ANOVA models) were conducted to examine differences by CNO demographic characteristics (e.g., biological sex, age, ethnicity, race, and so on) and institutional characteristics (e.g., size, geographic region, etc.) in the EBP beliefs, implementation, perceived organizational culture for EBP, and EBP activities; and determine relationships among the study variables.

KEY FINDINGS

Demographics
- 93% currently in the CNO role
- Ages ranged from 32-68 (M= 55 years)
- Years in practice ranged from 8-47 (M=31 years)
- Years as a CNO ranged from <1- 32 (M= 9 years)
- 92% female; 94% White
- 6% bachelor's degree; 69% master’s degree;
- 8% PhD prepared; 10% DNP prepared
- 45 States and DC represented
- 18% work in Magnet facilities
- 55% reported having clinical ladder systems
- 47% had no ongoing nursing research projects
- Organizations of all sizes and complexity were represented

Summary of Findings
- More than 1/3 of hospitals are not meeting benchmarks for NDNQI performance metrics.
- Almost 1/3 of hospitals are above national benchmarks for core measures (e.g., falls, pressure ulcers).
- Although CNOs believe EBP results in higher quality of care, safety and improved patient outcomes, very little of their budgets are allocated to EBP and EBP is listed as a low priority.
- Although CNOs believe in the value of EBP are strong, their own implementation of EBP is relatively low.
- More than 50% of CNOs believe that EBP is practiced in their organization from “not at all” to “somewhat”.
- There are inadequate numbers of EBP mentors in healthcare systems to work on EBP with direct care staff and create EBP cultures/environments that sustain.
- Although CNOs reported top priorities are quality and safety, EBP is rated as a low priority.

CHIEF NURSE EXECUTIVE NATIONAL FORUM AS A FOLLOW-UP TO THE SURVEY

Based on the key findings from the survey and their implications for nursing leadership, the Chief Executive Officer of the American Organization of Nurse Executives (AONE) was contacted to propose a national forum for CNEs at the annual AONE National Conference to share the study’s findings and strategize action tactics for next steps. The AONE Board enthusiastically approved the proposed idea for a forum, which was held on March 12, 2014 in Orlando Florida. The forum was titled: A National Forum for CNEs/ CNOs on Leveraging Evidence-based Practice to Enhance Healthcare Quality, Reliability, Patient Outcomes and Cost Containment.

This forum was attended by over 150 nurse leaders/executives from across the U.S. Major findings from the national survey, implications for nurse leaders, and a framework to leverage the findings were presented by Drs. Bernadette Melnyk and Lynn Gallagher-Ford from The Ohio State University College of Nursing and Michelle Troseth, Chief Professional Practice Officer for Elsevier Clinical Solutions. The presentations were followed by an “Innovation Workout” that engaged the participants in responding to the following questions:

Based on the data presented from the survey:

1. How have your perceptions of the need to create organizational cultures and environments that support/promote/sustain EBP changed?
2. What tactics do you believe nurse leaders must implement to improve and sustain outcomes?
3. What healthcare policy implications does the data impact?
4. What priorities can be moved or aligned on the organizational agenda to allow EBP to become a priority?
5. What solutions will be necessary in order to create organizational cultures and environments that support/promote/sustain EBP?
6. What do you need, personally, as a nurse leader in order to create an organizational culture and environment that supports/promotes and sustains EBP?
7. What tools would be helpful (toolkit) to you as a nurse leader in order to create an organizational culture and environment that supports/promotes and sustains EBP?

8. What would be the priorities of an AONE sponsored subcommittee to pursue related to these findings and their implications?

9. Who are your key partners within your organization to educate and engage in creating an organizational culture that supports/promotes/sustains EBP?

FORUM INPUT
Innovation Workout Session Participant Feedback
Participants acknowledged that EBP is not an optional initiative or the “difficult to implement endeavor” that some CNEs perceive it to be. EBP needs to be laid as the foundation of care that is delivered as it is the pathway to improved outcomes and sustainable quality care. CNEs must understand EBP to be able to model and implement it successfully, demonstrating their commitment to engage front line care providers. The following recommendations emerged as priorities for a CNE Action Plan to create/support/promote/sustain a culture of EBP:

• Align EBP as a cost effective foundation for patient safety and quality, leveraging data for interprofessional evidence-based planning, decision making, and process improvement.
• Establish a business case, budget, and resources to prioritize EBP as a strategic imperative.
• Focus recruitment/retention and accountability for performance on demonstration of EBP.
• Provide a critical mass of EBP mentors in healthcare systems; integrate EBP into orientation, continuing education, daily interprofessional practice activities such as rounds, patient care conferences, councils and committees.
• Integrate the EBP competencies for practicing professional nurses and advanced practice nurses as an expectation for performance and into clinical ladder systems.
• Provide evidence-based tools and resources at the fingertips of interprofessional team members in the EHR to keep EBP in the forefront of patient care processes.
• Mobilize interprofessional partners in all roles, from the bedside to the board room, to integrate EBP, measure outcomes and celebrate successes.
• Identify and advance healthcare policy to foster vibrant evidence-based practice environments by leveraging collective efforts of multiple disciplines to effect change.
• Explore and partner with AONE to pursue strategies to address the findings and implications of the study, e.g. mentorship program, on-line core curriculum; academic and clinical partnerships for dissemination of EBP, sharing of business cases and ROI strategies.
• Work with AACN, NLN, allied health professional associations and state licensing boards to integrate EBP into curriculum and Continuing Education requirements.

CALL TO ACTION
1. Partner with national leadership organizations to build on this National EBP Report & recent CNE Forum to create a unified voice of EBP Leaders who advocate to fund and create sustainable EBP systems in healthcare.
2. Create a compelling case for integrating and investing in EBP as the foundation for patient safety and quality strategic initiatives, including ROI and data-driven outcomes.
3. Seek out opportunities to develop expertise in EBP in order to model the way for nursing directors, nurse managers and point of care clinicians.
4. Establish sustainable cultures and environments in which EBP can flourish.
5. Advocate for EBP to be integrated seamlessly within the EHR to assure care that is guided by evidence as well as to assure that EBP and informatics competencies co-exist to the future and current workforce.
6. Partner with interprofessional colleagues to assure that EBP is strategically aligned and evidence-based care is provided by the entire healthcare team, which includes patients, families and communities.
7. Work with policy-makers to ensure that EBP is the standard of all healthcare delivered and reimbursed appropriately.
REFERENCES


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