CONTINUOUS QUALITY IMPROVEMENT MONTHLY RESULTS REPORT

PROJECT DETAILS

Name	Alameda County Sheriff Office – Medical Operations Consulting: Continuous Quality Improvement Program Review		
Sponsor	Lieutenant Joseph Atienza, Contracts Lieutenant	**Project Manager**	Tami Bond
Project Summary	To provide expanded Medical Quality Assurance (QA) services for the Alameda County Sheriff Office (ACSO) through the performance of Continuous Quality Improvement (CQI) program review and support to evaluate ongoing CQI monitoring activities, performance improvement strategies, and change implementation effectiveness. Additionally, to provide focused CQI observations and recommendations to help assure appropriate access, timeliness, and continuity of care delivery.		
Methodology	To provide CQI program and study review for the reporting period, Mazars performed medical record review of 30 incarcerated individual (patient) files against Wellpath's CQI criteria for the defined study outlined in the 2023 CQI calendar. Consistent with the Plan-Do-Study-Act (PDSA) model, Mazars performed medical record review after Wellpath's initial audit, subsequent implementation of related Improvement Plan and re-evaluation, to measure long-term performance of the improvement strategy. A compliance score of less than 90-95% threshold warrants a corrective action plan (CAP). *(See Appendix for additional Methodology and CQI program standard details)*		
Report Date	12/20/2023	**Reporting Period**	9/1 – 11/15/2023
CQI Studies	Receiving Screening and Medication Verification		

SUMMARY

For the reporting period of 9/1 – 11/15/2023, Mazars CQI program and study review of the Receiving Screening and Medication Verification* processes to determine recent change implementation effectiveness, identified additional opportunities for improvement (Observations) for the Clinical Team (Wellpath) to help assure appropriate access, timeliness, and continuity of care delivery. A total of eight criteria (Questions) for the Receiving Screening and Medication Verification were measured.

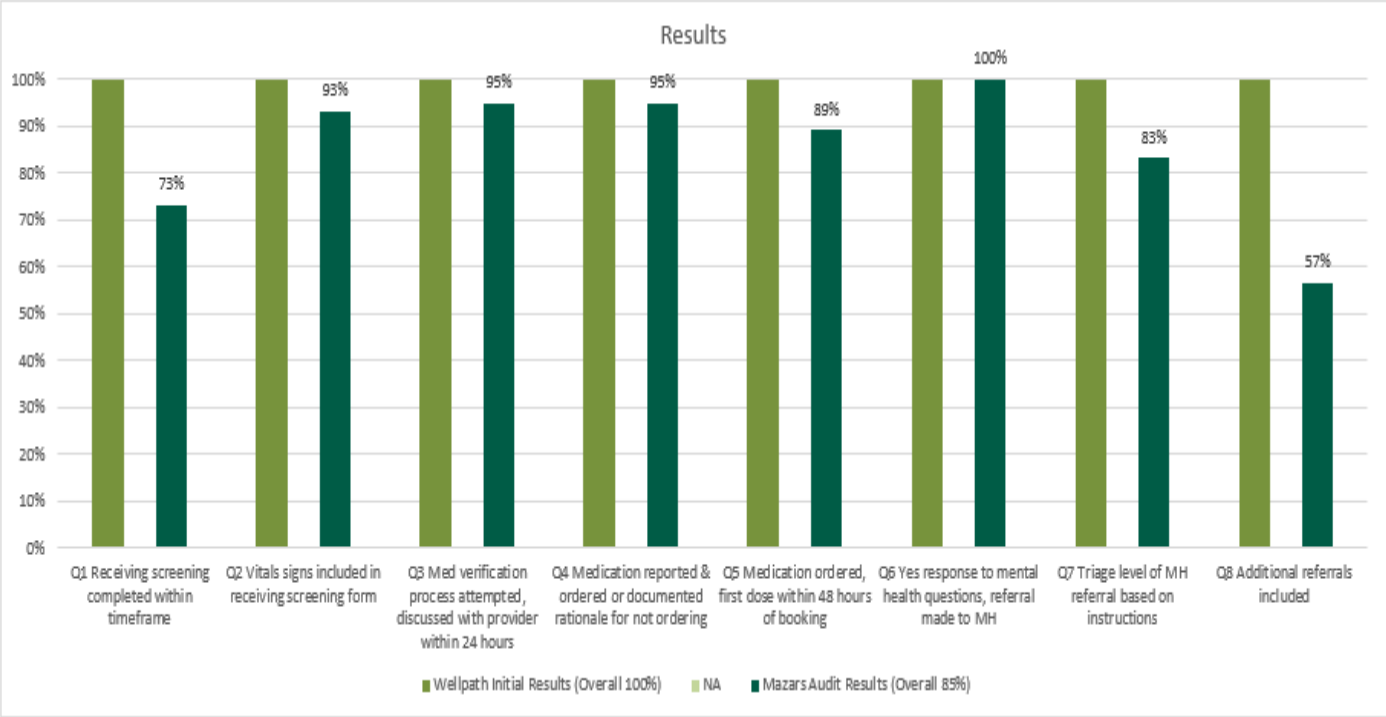
As shown in the Results graph below, Wellpath scored a compliance rate of 100% for Receiving Screening and Medication Verification. Based on the Wellpath Initial Review total compliance score of 100%, a Re-evaluation Review was not required. Notwithstanding, Mazars performed a medical record review that resulted in a compliance rate of 85%. Due to yielding a score less than the 90-95% threshold, consistent with the Act stage of the PDSA cycle, Mazars recommends a CAP to include enhanced action steps that incorporates the observations and recommendations provided, as well as incorporate Mazars' findings into a subsequent re-evaluation within six months or more to demonstrate long-term change implementation effectiveness.

Areas of Risk:
Areas at risk for non-compliance that are identified to require clinical staffing management to ensure prescriber and nursing time is adequate to meet patient care delivery needs include: Timely Receiving Screening at intake, Adequate baseline vital signs

Areas at risk for non-compliance that are identified to require collaborative management and information sharing across different teams and systems include: Referral submitted to Mental Health, Mental Health referral and triage

**Reviewed in Medical QA reports section 2.10 Intake/Admission Screening and section 2.2 Specialty Referrals.*

Receiving Screening and Medication Verification



CONTINUOUS QUALITY IMPROVEMENT MONTHLY RESULTS REPORT

MEDICAL RECORD REVIEW: RESULTS

	Wellpath Initial Review	*Wellpath Re-Evaluation Review*	***Mazars CQI Review Reporting Period Month***	
Date	*7/2023*	*N/A*	***10/2023***	
PDSA Model	Plan-Do	Study	**Act**	**Details for Non-Compliant Files**
Criteria	Percentage Compliant	Percentage Compliant	**Percentage Compliant**	
	goal 90-95% (# compliant/# total applicable)			
1. The receiving screening was completed within the time frame outlined by site policy?	100% (17/17)	*N/A*	73% (22/30)	8 of 30 files non-compliant: Patients 1, 4, 6, 14, 18, 20, 25: Receiving Screening assessment completed beyond 8-hours from applicable Book-In time Patient 12: Untimely Receiving Screening assessment completed contributing to man-down emergency resulting in adverse event Risk for non-compliance: *Requires clinical staffing management to ensure prescriber and nursing time adequate to meet patient care delivery needs
2. The receiving screening includes vital signs as required on the standardized form?	100% (17/17)	*N/A*	93% (28/30)	2 of 30 files non-compliant: Patients 8, 25: No baseline vital signs documented Risk for non-compliance: *Requires clinical staffing management to ensure prescriber and nursing time adequate to meet patient care delivery needs
3. If the patient was on medication, was the med verification process attempted and all medications reported by the patient discussed with the provider within 24 hours?	100% (3/3)	*N/A*	95% (19/20)	1 of 20 files non-compliant: Patient 13: No evidence of order and verification of anticonvulsant medication (Gabapentin)
4. For each medication reported, was medication ordered OR does the documentation reflect the rationale for not ordering the medication?	100% (3/3)	*N/A*	95% (19/20)	1 of 20 files non-compliant: Patients 13: No evidence of order and verification of anticonvulsant medication (Gabapentin)
5. If the medication was ordered, was the first dose	100% (3/3)	*N/A*	89% (25/28)	3 of 28 files non-compliant: Patient 13: No evidence anticonvulsant medication (Gabapentin) verified and ordered without rationale for medication omission

MEDICAL RECORD REVIEW: RESULTS				
	Wellpath Initial Review	*Wellpath Re-Evaluation Review*	***Mazars CQI Review Reporting Period Month***	
Date	*7/2023*	*N/A*	***10/2023***	
PDSA Model	Plan-Do	Study	**Act**	**Details for Non-Compliant Files**
Criteria	Percentage Compliant	Percentage Compliant	**Percentage Compliant**	
	goal 90-95% (# compliant/# total applicable)			
administered within 48 hours of booking?				Patient 23, 29: Delayed order of multiple medications beyond 48 hours of booking without rationale for delay
6. If the patient gave YES answers to any mental health questions, was a referral submitted to mental health?	100% (6/6)	*N/A*	100% (30/30)	Compliant Risk for non-compliance: *Requires collaborative management and information sharing across different teams and systems
7. If referred to MH, was the triage level of the referral submitted based upon the instructions listed in the receiving screening?	100% (6/6)	*N/A*	83% (25/30)	5 of 30 files non-compliant: Patients 8, 16: No evidence Mental Health referral screen completed during applicable Book-In period Patients 21, 22, 27: No evidence Mental Health referral screen completed and notable delayed start of new psychiatric medications during applicable Book-In period Risk for non-compliance: *Requires collaborative management and information sharing across different teams and systems
8. The receiving screening includes a referral when additional care is needed? (other than behavioral health referrals as addressed above)	100% (17/17)	*N/A*	57% (17/30)	13 of 30 files non-compliant: Patients 1, 2, 4, 9, 10, 11, 14, 16, 20, 25, 26, 29, 30: Inconsistent documentation requesting referrals when additional specialty care is medically necessary

CQI MEDICAL RECORD REVIEW: OBSERVATIONS AND RECOMMENDATIONS	
1. The receiving screening was completed within the time frame outlined by site policy?	Observation: Some of the patient files reviewed showed delayed Receiving Screening completion beyond the required 8-hours from applicable Book-In time. Site policy requires the Receiving Screening is performed *upon arrival at booking* to ensure that emergent and urgent health needs are met (HCD-110_E-02). NCCHC standards require the Receiving Screening to take place *as soon as possible upon acceptance into custody.* The Consent Decree mandates that patients are processed through intake *within 8-hours.* For one patient file reviewed, the Receiving Screening assessment was completed within minutes of the 8-hour timeframe, rather than upon arrival or sooner, which contributed to a man-down emergency. The man-down emergency resulted in an adverse event, where patient harm could have been avoided. Delayed Receiving Screening and corresponding intake orders caused an unintentional barrier to the patient receiving the medically necessary rescue respiratory treatment and management interventions. Recommendation: • Identify and address current challenges preventing timely and adequate assessment for each patient • Hold Nursing staff accountable for the timely completion and accuracy of the Receiving Screening assessment • Continue to perform ongoing auditing and monitoring of Receiving Screening assessment form. Report results of auditing and monitoring to the ACSO • Reassess clinical staffing plan to ensure nursing time sufficient to meet patient care delivery needs
2. The receiving screening includes vital signs as required on the standardized form?	Observation: Two of the patient files reviewed showed no evidence of documentation of baseline vital signs on the Receiving Screening form; instead, the vital signs were inconsistently documented in Sick Call. Documentation in Sick Call was created as a result of Receiving Screening completion. Without accessible baseline vital signs, the Clinical Teams cannot readily establish an appropriate and individualized care plan to responsibly care for the patient and appropriately identify and assure patient health care needs are met. Recommendation: • Hold Nursing staff accountable for accurate Receiving Screening assessment • Continue to perform ongoing auditing and monitoring of Receiving Screening assessment form. Report results of auditing and monitoring to the ACSO • Reassess clinical staffing plan to ensure nursing time sufficient to meet patient care delivery needs
3. If the patient was on medication, was the med verification process attempted and all medications reported by the patient discussed with the provider within 24 hours?	Criteria met. Observation: However, for one of the patient files reviewed, there was no evidence of the anticonvulsant medication (Gabapentin) verified or discussed with the provider within 24 hours. Without complete and accurate medication verification documentation, the Clinical Teams cannot responsibly initiate adequate care for the patient and ensure that the patient's immediate health care needs are met. Recommendation: • Hold applicable staff accountable for medication verification, and appropriate medication order entry • Continue to perform ongoing staff auditing and monitoring. Report results of auditing and monitoring to the ACSO • Reassess clinical staffing plan to ensure nursing time sufficient to meet patient care delivery needs
4. For each medication reported, was medication ordered OR does the documentation reflect the rationale for not ordering the medication?	Criteria met. Observation: However, for one of the patient files reviewed, there was no evidence of the rationale for not ordering the anticonvulsant medication (Gabapentin). Without complete and accurate medication reconciliation or supporting rationale documentation, the Clinical Teams cannot responsibly initiate adequate care for the patient and assure that the patient's immediate health care needs are met. Recommendation: • Hold applicable staff accountable for adequate medication reconciliation documentation, including rationale for not ordering the medication and appropriate medication order entry

CQI MEDICAL RECORD REVIEW: OBSERVATIONS AND RECOMMENDATIONS	
	• Continue to perform ongoing staff auditing and monitoring. Report results of auditing and monitoring to the ACSO • Reassess clinical staffing plan to ensure nursing time sufficient to meet patient care delivery needs
5. If the medication was ordered, was the first dose administered within 48 hours of booking?	Observation: Mazars observed some patient files where medications were not ordered or there was a delay in medication order entry thereby resulting in medication administration occurring beyond 48 hours of booking. For one of the patient files reviewed the anticonvulsant medication (Gabapentin) was not verified and ordered, and there was no supporting rationale documentation for not ordering the medication. For some of the patient files reviewed, there was a delay in multiple medication order entry. More specifically, one patient file showed a delay of an antipsychotic medication substitution from Olanzapine to Aripiprazole. This medication substitution delay resulted in the patient not receiving antipsychotic medication for seven days from the applicable Book-In date. Another patient file showed a delay in ordering HIV medication related to failed request for information records and delay in the patient being seen by the infectious disease provider. The absence of a medication order and/or delay in administration puts the patient at an increased risk for inadequate care, inappropriate care, and can result in patient injury and/or harm Recommendation: • Identify and address current challenges preventing adequate assessment and supporting documentation for each patient • Hold responsible Clinicians accountable for ordering medications in a timely manner • Continue to perform ongoing auditing and monitoring of medication verification and ordering. Report results of auditing and monitoring to the ACSO
6. If the patient gave YES answers to any mental health questions, was a referral submitted to mental health?	Criteria met. Observation: For all applicable patient files reviewed, Mental Health referrals were present, however, while there is evidence of Mental Health referrals in CorEMR, there is no visibility of consultation completion and related outcomes. Recommendation: • Continue to hold Clinicians accountable for the appropriate identification and documentation of the required Mental Health Referral(s) • Continue to perform ongoing auditing and monitoring of appropriate selection(s) and documentation of Mental Health Referrals. Report results of auditing and monitoring to the ACSO • Continue multi-disciplinary partnerships to improve care coordination: Wellpath medical, ACSO corrections, and AFBH behavioral health, to uniformly manage and share information across teams and systems • Implement enhanced data integration solution(s) for bidirectional information sharing across applicable systems beyond current interfaces, between Wellpath medical (CorEMR), ACSO corrections (ATIMS), and AFBH behavioral health (Gateway)
7. If referred to MH, was the triage level of the referral submitted based upon the instructions listed in the receiving screening?	Observation: For two of the patient files reviewed, there was no evidence of the Mental Health referral screen completed with the Receiving Screening during the applicable Book-In period. Additionally, there was no evidence of the AFBH Screener completed and scanned in the patient record. For other patient files reviewed, there was a notable delay in starting new psychiatric medications, ranging from six to eleven days, despite multiple patient Sick Call requests. While there is evidence of Mental Health referrals in CorEMR, there is no visibility of consultation completion and related outcomes. Recommendation: • Continue to hold Clinicians accountable for the appropriate identification and documentation of the required Mental Health Referral(s) • Continue to perform ongoing auditing and monitoring of appropriate selection(s) and documentation of Mental Health Referrals. Report results of auditing and monitoring to the ACSO • Continue multi-disciplinary partnerships to improve care coordination: Wellpath medical, ACSO corrections, and AFBH behavioral health, to uniformly manage and share information across teams and systems

CQI MEDICAL RECORD REVIEW: OBSERVATIONS AND RECOMMENDATIONS	
	• Implement enhanced data integration solution(s) for bidirectional information sharing across applicable systems beyond current interfaces, between Wellpath medical (CorEMR), ACSO corrections (ATIMS), and AFBH behavioral health (Gateway)
8. The receiving screening includes a referral when additional care is needed? (other than behavioral health referrals as addressed above)	Observation: For all of the patient files reviewed, Mazars observed inconsistent documentation requesting Specialty Referrals during the Receiving Screening assessment. For some of the patient files reviewed, there was no evidence of Chronic Care referrals for those patients requiring chronic disease management. Additionally, there was no evidence of Discharge Planning referrals for those patients requiring discharge planning and care coordination support. Inconsistent Specialty Referral documentation increases the risk for inadequate care, inappropriate care, delayed care, and/or uncoordinated care, which could negatively impact patient outcome(s), and re-entry into the community, and result in patient injury and/or harm. Recommendation: • Develop and/or update clinical decision tree, including referral triage/prioritization • Continue to provide additional focused staff training and education to assure the appropriate services are provided • Continue to hold Clinicians accountable for the appropriate identification and prioritization of Specialty Referral(s) • Continue to perform ongoing auditing and monitoring of appropriate selection(s) and documentation of Specialty Referrals. Report results of auditing and monitoring to the ACSO

APPENDIX

PROJECT DETAILS

Project Scope	Assess and evidence ACSO compliance with requirements applicable to Alameda County's Santa Rita Jail (SRJ) adult correctional facility, specifically Continuous Quality Improvement (CQI) activities by Wellpath. Additionally, evaluate the County's compliance with applicable laws, rules, and regulations of applicable government authorities regarding the ambulatory medical care provided to incarcerated individuals (patients) at SRJ and required by the ACSO. Project scope excludes the provision of any direct patient medical care.

METHODOLOGY

A. CONTINUOUS QUALITY IMPROVEMENT STUDY REVIEW

As described in the Project Details section, to provide expanded Medical Quality Assurance (QA) services for the ACSO, Mazars performed CQI program review and support to evaluate ongoing CQI monitoring activities, performance improvement strategies, and change implementation effectiveness. Mazars provided focused CQI recommendations to help assure appropriate access, timeliness, and continuity of care delivery.

For the CQI study reporting period*, Mazars conducted medical record review of 30 incarcerated individual (patient) files against Wellpath's CQI criteria for the defined studies outlined in the 2023 CQI calendar and guidance. Mazars performed medical record review after Wellpath's scheduled initial audit and implementation of a related Improvement Plan. Wellpath's subsequent re-evaluation is pending completion. Mazars performed the review to examine change implementation effectiveness and long-term performance of the improvement strategy, consistent with the widely used Plan-Do-Study-Act (PDSA) model:

- Plan – Plan a change or test aimed at an identified problem:
  - Wellpath CQI study calendar by month, date range for data collection, and criteria questions specific to plan details
- Do – Carry out the change or test:
  - Initial Wellpath CQI study audit and evaluation
- Study – Analyze the results of the CQI study to learn opportunities of improvement:
  - Wellpath Improvement Plan development, implementation, and re-evaluation for initial overall compliance performance of less than 90-95% compliance threshold
- Act – Run through the cycle again to determine adopt or abandon change:
  - Mazars CQI review to identify additional risks for non-compliance and need for corrective action plan (CAP)

The compliance threshold of 90% or 95% is determined by Wellpath's CQI study guidance. A compliance score less than a 90-95% threshold warrants a CAP. The CAP includes enhanced action steps consistent with the observations and recommendations provided, including re-evaluation within six months or more to demonstrate long-term change implementation effectiveness, as applicable.

<u>October 2023 CQI Study – Receiving Screening and Medication Verification:</u>

- **Plan-Do** – Wellpath performed the following activities:
  - Audited 17 patient records during the 6/1 – 6/30/2023 date range, against the following criteria:
    1. The receiving screening completed within the time frame outlines by site policy?
    2. The receiving screening includes vital signs as required on the standardized form?
    3. If the patient was on medication, was the med verification process attempted and all medications reported by the patient discussed with the provider within 24 hours?
    4. For each medication reported, was medication ordered OR does the documentation reflect the rationale for not ordering the medication?
    5. If the medication was ordered, was the first dose administered within 48 hours of booking Was the HCP called or consulted per protocol?
    6. If the patient gave YES answers to any mental health questions, was a referral submitted to mental health?
    7. If referred to MH, was the triage level of the referral submitted based upon the instructions listed in the receiving screening?
    8. The receiving screening includes a referral when additional care is needed?
  - Established compliance threshold of 90 - 95%
  - No Improvement Plan required based on Wellpath's initial audit score of 100%
- **Study** – No re-evaluation was required based on Wellpath's initial audit score of 100%.
- **Act** – For this October 2023 reporting period*, Mazars performed the following activities:
  - Evaluated 30 patient files against the Receiving Screening and Medication Verification criteria during the 9/1/2023 – 11/15/2023 reporting period, to evaluate continued compliance
  - Provided focused CQI observations and recommendations for a CAP, including enhanced action steps and re-evaluation

METHODOLOGY

**The "reporting period" refers to the month included in the timeframe that patient files were selected for the specified CQI study noted above*

B. CONTINUOUS QUALITY IMPROVEMENT PROGRAM GUIDANCE

A continuous quality improvement (CQI) program monitors and improves health care delivered in the facility (NCCHC essential standard J-A-06)

- Compliance Indicators:
  1. The responsible health authority establishes a CQI program that includes a quality improvement committee consisting of health staff from various disciplines. Additional participants may be included, depending on the issues being addressed
     a. The CQI committee should meet at least quarterly to establish objective criteria for use in monitoring quality of care, develop plans for improvement based on monitoring findings, and assess effectiveness of these plans after implementation
  2. CQI meeting minutes or summaries are made and retained for reference, and copies are available and reviewed by all appropriate personnel. CQI meeting minutes should provide sufficient detail to guide future decisions
  3. Health record reviews are done under the guidance of the responsible physician or designee to ensure appropriate care is ordered and implemented and that care is coordinated by all health staff, including medical, dental, mental health, and nursing
  4. Beyond chart reviews, the responsible physician is involved in the CQI process
  5. When the CQI committee identifies a site-specific health care concern from its monitoring, a process and/or outcome quality improvement study is initiated and documented
     a. Process quality improvement studies examine the effectiveness of the health care delivery process
     b. Outcome quality improvement studies examine whether the expected outcomes of patient care were achieved
  6. At least one process and/or outcome quality improvement study is completed per year
  7. The CQI committee documents a written annual review of the effectiveness of the CQI program by reviewing CQI studies and minutes of CQI, administrative, and/or staff meetings, or other pertinent written materials
  8. All aspects of the standard are addressed by written policy and defined procedures
- One essential element of quality improvement is the monitoring of high-risk, high-volume, or problem-prone aspects of health care provided to patients
- Recommended areas to study can be consistent with regularly monitored statistical reports (NCCHC essential standard A-04):
  - Service volume
  - Referral to specialists
  - Deaths
  - Incidence of certain illnesses
  - Infectious disease monitoring
  - Emergency services and hospital admissions provided
  - Access, timeliness of health services, and follow-up
  - Missed appointments
  - Grievance statistics
- Success of compliance with CQI program standards is measured by the relevance of the studies and effectiveness of the improvement strategies and corrective action
- The CQI program should use one or more of these quality performance measures when designing studies:
  - Accessibility
  - Appropriateness of clinical decision making
  - Continuity
  - Timeliness
  - Effectiveness
  - Efficiency
  - Prescriber-patient interaction
  - Safety
- The CQI program should measure one or more of the following major service areas annually:
  - Intake processing
  - Acute care
  - Medication services
  - Chronic care services
  - Intra-system transfer services
  - Scheduled off-site services
  - Unscheduled on-site and off-site services
  - Mental health services
  - Dental services
  - Ancillary services
  - Dietary services

METHODOLOGY

- Infirmary services

As part of a continuous quality improvement (CQI) Program, patient Receiving Screening is performed on all patients upon arrival at the facility to ensure that emergent and urgent health care needs are met as aligned with evidence-based standards (NCCHC essential standard J-E-02)

- Compliance Indicators:
  1. Reception personnel ensure that patients who are unconscious, semiconscious, bleeding, mentally unstable, severely intoxicated, exhibiting symptoms of alcohol or drug withdrawal, or otherwise urgently in need of medical attention are referred immediately for care and medical clearance into the facility
     a. If they are referred to a community hospital and then returned, admission to the facility is predicated on written medical clearance from the hospital
  2. A receiving and screening takes places as soon as possible upon acceptance into custody
  3. The Receiving Screening form is approved by the responsible health authority (RHA) and inquires as to the patient's:
     a. Current and past illnesses, health conditions, or special heath requirements
     b. Past infectious disease
     c. Recent communicable illness symptoms
     d. Past or current mental illness, including hospitalization
     e. History of or current suicidal ideation
     f. Dental problems
     g. Allergies
     h. Dietary needs
     i. Prescription medications
     j. Legal and illegal drug use
     k. Current or prior withdrawal symptoms
     l. Possible, current, or recent pregnancy
     m. Other health problems as specified by the responsible physician
  4. The form also records reception personnel's observations of the patient
     a. Appearance
     b. Behavior
     c. State of consciousness
     d. Ease of movement
     e. Breathing
     f. Skin
  5. The disposition of the patient is appropriate to the findings of the Receiving Screening and is indicated on the Receiving Screening form
  6. Receiving Screening forms are dated and timed immediately on completion and include the name, signature, and title of the person completing the form
  7. All immediate health needs are identified through the screening and properly addressed by qualified health care professionals
  8. Potentially infectious patients are isolated from the general patient population
  9. If a woman is pregnant, an opioid history is obtained
  10. If a woman reports current opioid use, she is immediately offered a test for pregnancy to avoid opioid withdrawal risks to fetus
  11. Health staff regularly monitor Receiving Screenings to determine the safety and effectiveness of this process
  12. All aspects of the standard are addressed by written policy and defined procedures

C. APPLICABLE POLICY AND PROCEDURE

NCCHC standards require Receiving Screening to take place as soon as possible upon acceptance into custody.

The *Babu Consent Decree Case No. 5:18-CV-07677* mandates patients are processed through intake within 8-hours. Referral timeframes to medical and mental health providers following assessment at intake dictate Emergent within 4-hours of referral; Urgent within 2-hours of referral, and Routine within five (5) business days or seven (7) calendar days of referral.

Wellpath Policy and Procedure HCD-110_E-02 Receiving Screening-Alameda CA require patients, including transfers to be questioned during Receiving Screening/Intake process immediately upon arrival at the facility, prior to housing, in order to identify health conditions requiring immediate or ongoing interventions, including separation from the rest of the population because of communicable disease and/or active substance withdrawal.

Wellpath Policy and Procedure HCD-110_E-09A Medication Verification-Alameda CA requires reported medications, both those verified and unable to be verified excluding High Priority Medications, be discussed with the provider within one day for decision to either continue the verified order, not continue the verified order, substitute another medication, start medication that was unable to be verified, modify the dosage of a verified order, or not start an (un)verified order. The provider can use the information presented by the nurse from the medication verification process, or if the medication was unable to be verified, can continue the medication

METHODOLOGY

verification process for up to two additional business days. The qualified health provider shall invoke the option to decline whenever a medication is thought to be unnecessary or inappropriate based on diagnosis, usage, drug type, drug indication, dosage, etc. The decision must be documented in the health record. Routine medications will generally be attempted to be verified within 24 hours, or sooner, and administered within 48 hours of notification of the medication to health care staff, when ordered by a Wellpath prescriber or authorized prescriber.