

Quality Care Improvements Bowel Protocol



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Setting the standard in bowel care

Bowel Care Protocol Introduction:

Title: Bowel Care Assessment and Protocol Tools

Suggested Practice Guidelines for the management of constipation or neurogenic bowel in adults

Submitted by: Alliance Labs, L.L.C.

Quality Care is paramount in every aspect of the healthcare field. However, over the last ten years very little attention has been paid to the consequences of an ineffective bowel care protocol within the hospital inpatient setting. Secondary patient complications from incontinence and fiscal overages are many times overlooked or unknown. Please find enclosed quality care improvement measures for inpatient bowel protocols that will not only provide for enhanced patient care but cost reductions at the facility level.

Consideration Purpose:

Constipation is the most common gastrointestinal complaint in primary, acute and long-term care settings in the United States. An estimated 4.4 million individuals in the United States have bowel issues of constipation and an estimated one million have incontinence. As the United States grows older, the costs and quality of life issues related to constipation and incontinence of individuals will only increase. Further information and recommendations are needed in this area. Very few healthcare institutions have current bowel protocols in place and the growing need is evident. Studies show that patients placed on a regimented bowel care program, receiving both oral and rectal therapies to achieve complete rectal emptying had 35% fewer episodes of fecal incontinence and 42% fewer incidents of soiled laundry. (Age & Ageing 2000; 29: 159- 1(4) The referenced research into secondary complications of incontinence is included in this packet.

Outline:

1. Patient Assessment Form
2. Predictive Care Path
3. Bowel Intervention Protocol

Constipation:

The highest reported incidences of constipation in specific populations were 45% of all patients with cancer (McMillan & Williams, 1989), 45% of all frail elders (Wolfsen, et al., 1993), and 46% of all hospitalized elders (Wright, 1984). The incidence of constipation increases in people with diminished functional and cognitive ability and in the frail elderly (Campbell et al., 1993). Chronic idiopathic constipation has both physical and psychological impacts (Dykes et al., 2001). Persistent stretching of the pudendal nerves may ultimately result in complications such as hemorrhoids, rectal prolapse, or incontinence. The psychological impact of constipation is often the result of changes in activity levels that often leads to increased isolation (Koch & Hudson, 2000). Situations that place people at risk for acute constipation include imposed immobility, a change in toileting habits, dietary changes (whether self-imposed by dieting or for medical reasons), medications and stress. The most common predisposing factors for chronic constipation include advanced age, being female, poor fluid and dietary intake, cognitive or functional impairment, ongoing privacy issues, and polypharmacy. Opioids are among the major medications that predispose patients to constipation (Levy, 1991; McMillan & Williams, 1989; Sykes, 1996).

Constipation is a common cause of morbidity in palliative care persons. It affects up to 95% of the people who are taking opioids (Driver LC, Bruera E., 2000). Even in the absence of oral intake, the body continues to produce 1-2 ounces of stool per day (Capital Health Regional Palliative Care Program, 2003). The bowel lining is continually renewing itself and sloughed cells, along with bacteria and digestive juices, comprise much of the stool (Chase, D. G. & Erlandsen, S. L. 1976). Hence, individuals can easily become constipated even when they are not eating.

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Complications of Constipation:

- Abdominal pain and increased cancer pain in people with abdominal or retroperitoneal malignancy
- Abdominal distention/discomfort
- Nausea, vomiting and anorexia
- Overflow diarrhea
- Hemorrhoids/anal fissures
- Bowel obstruction
- Urinary retention
- Anxiety and restlessness
- Autonomic dysreflexia

Facts Related to Secondary Complications of Incontinence:

- Incontinent patients have a 22-30% higher risk of developing pressure ulcers.¹
- Odds of having a pressure ulcer were 22 times greater for adult patients with fecal incontinence.²
- Data highlighted that fecal incontinence can damage the skin's integrity, leading to skin breakdown and possible wound contamination, giving rise to major healthcare costs.³
- Nursing Home residents at higher risk for developing ulcers are those who have limited ability to reposition themselves, cannot sense the need to reposition, have fecal incontinence, or cannot feed themselves.⁴
- Both fecal and urinary incontinence increase moisture, but fecal incontinence is hypothesized to act as a more potent risk factor for skin breakdown than urinary incontinence.⁵
- Fecal incontinence represents a major risk to perianal skin integrity and healing of perineal wounds.⁶
- Fecal incontinence can lead to wound contamination, as well as creating a challenge for practical management, giving rise to major healthcare costs.⁷
- Pressure ulcers were more prevalent (12%) among residents who had any recent bowel or bladder incontinence than among continent residents (7%).⁸

Alliance Labs, L.L.C. has set forth the following model to provide better patient outcomes from a dependable bowel care protocol within the facility setting as well as assist in patient compliance at home. The outlined protocol should overcome challenges that facilities face when trying to reach clinician consensus and should provide greater ease for physician and nursing involvement. We appreciate your organization's review.

Neurogenic Bowel Disease Overview:

Spinal cord disorders and the associated neurological damage results in impaired voluntary and reflex activity with altered bowel transit and impaired storage/evacuation mechanisms. Spinal cord disorders are classified by neurological level (anatomic level) and by the degree of intactness of ascending and descending spinal cord pathways ("complete" or "incomplete"). Bowel function varies depending upon the level and, to some degree, the completeness of the spinal cord injury.

Populations/Diagnostic Groups at Risk: Spinal Cord Injury (SCI), Multiple Sclerosis (MS), Spina Bifida, Long Term Care and Traumatic Brain Injury (TBI). All persons with complete SCI have neurogenic bowel. Most persons with incomplete SCI have some manifestation of bowel dysfunction (Stiens, Bierner-Bergman, & Goetz, 1997). Excluding bladder dysfunction, gastrointestinal disorders are the most common complication of patients with spinal cord injuries. 95% of SCI patients require at least one therapeutic intervention to initiate defecation. 54% of SCI patients report bowel and bladder dysfunction as a major life-limiting problem (Higgins, Johanson, 2004).

Source: 1. Foxley & Baadjies, 2009. 2. Maklebust&Magnan. 1994. 3. Using fecal collectors to reduce wound contamination, Karen Ousey, Warren Gillibrand, Wounds uk, 2010, Vol 6, No 1, page 86-91. 4. Pressure Ulcers in the Nursing Home; David M. Smith, MD; Copyright© 2004 by the American College of Physicians. 5. Shannon ML, Skorga P Pressure ulcer prevalence in two general hospitals. Decubitus. 1989;2:38-43. 6. Norton, 2009. 7. Echols et al. 2007. 8. HCHS Data Brief, No. 14 February 2009. Pressure Ulcers Among Nursing Home Residents: United States, 2004 Eurice Park-Lee, PHD., and Christine Caffrey, PhD., Division of Health Care Statistics.

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Neurogenic Bowel Disease Caused by Spinal Cord Disorders is Distinguished into Two Types:

Voluntary-control is lost with both UM/LM lesions; whereas, reflex-control via spinal reflexes is lost with LMN lesions, but retained with UMN lesions. Stool transit is slowed in both upper-motor neuron and lower-motor neuron injuries, and the longer transit time allows for more absorption of fluid from the stool resulting in drier, harder stool with associated constipation and/or impaction (mechanical bowel blockage by immobile stool mass). Rectal storage and evacuation in neurogenic bowel disease are similar in appearance when comparing UMN and LMN bowel dysfunction. In both situations, protracted storage with fecal retention and associated unpredictable evacuation are the typical bowel dysfunctions observed, but for differing reasons.

Upper-Motor-Neuron (UMN) Neurogenic Bowel (nerve damage above the conus):

In upper-motor-neuron neurogenic bowel disease, the unregulated spinal reflexes cause a hyper-reflexic rectal wall, and the PFM and IAS will relax reflexively, but evacuation does not occur as expected due to the absence of coordinated reflex/voluntary relaxation of the "spastic" EAS. Unfortunately, the EAS will relax unpredictably and an incontinent bowel movement will occur.

Lower-Motor-Neuron (LMN) Neurogenic Bowel (nerve damage at the conus or cauda equine. i.e., Conus Medullaris Syndrome, Cauda Equina Syndrome, and Spina Bifida):

In lower-motor-neuron neurogenic bowel disease, the absent spinal reflexes cause a flaccid, areflexic rectal wall, and the reflex relaxation of the PFM and IAS is lost. The EAS is also flaccid, but solid stool will remain within the rectum, as the remaining intrinsic-nerve propulsion is insufficient for evacuation. In this situation, bowel incontinence will occur if the stool is loose (liquid or semi-solid).

A bowel program for a patient with neurogenic bowel should be designed to take into account attendant care, personal goals, life schedules, role obligations of the individual, and self-rated quality of life. Bowel programs should be initiated during acute care and continued throughout life, unless full recovery of bowel function returns. Careful measures must be taken to avoid pressure ulcers and falls. Adequate social and emotional support should be available to help individuals manage actual or potential disabilities and handicaps associated with neurogenic bowel. All aspects of a bowel management program should be designed to be easily replicated in the individual's home and community setting. Effective treatment of common neurogenic bowel complications, including fecal impaction, constipation, and hemorrhoids, necessary to minimize potential long-term morbidities.

Numerous Complications and Evacuation Problems Associated with Neurogenic Bowel:

- Obstruction
- Delayed or unplanned evacuation
- Abdominal distention
- Aspiration and pneumonia
- Hemorrhoids
- Impaction
- Autonomic dysreflexia
- Ability to defecate
- Abdominal pain
- Diverticulosis
- Nausea and vomiting
- Gastric ulcers
- Constipation
- Appetite loss
- Dehydration
- Sensory loss

How the Colon Works:

The colon absorbs water and electrolytes from the chyme, and stores fecal matter until it can be eliminated (Guyton & Hall, 1996). The colon is approximately 1.2m long and is bounded by the ileocecal sphincter at its origin and by the anal sphincter at the perineum (Rothenberger & Orrom, 1991). It consists of the following segments: cecum; ascending, transverse, and descending colon ; sigmoid colon; rectum; and anus. The role of the proximal half of the colon is absorption and the role of the distal half is storage (Guyton & Hall, 1996). The colon wall has several layers: the inner mucosal lining, the submucosa, and an outer layer of muscle that has two divisions- the inner layer, which is a continuous sheath of circular smooth muscle, and the outer longitudinal layer (Rothenberger & Orrom, 1991). The nerve supply to the colon has intrinsic and extrinsic components. The colon wall contains the intrinsic components that include Auerbach's plexus and Meissner's plexus.

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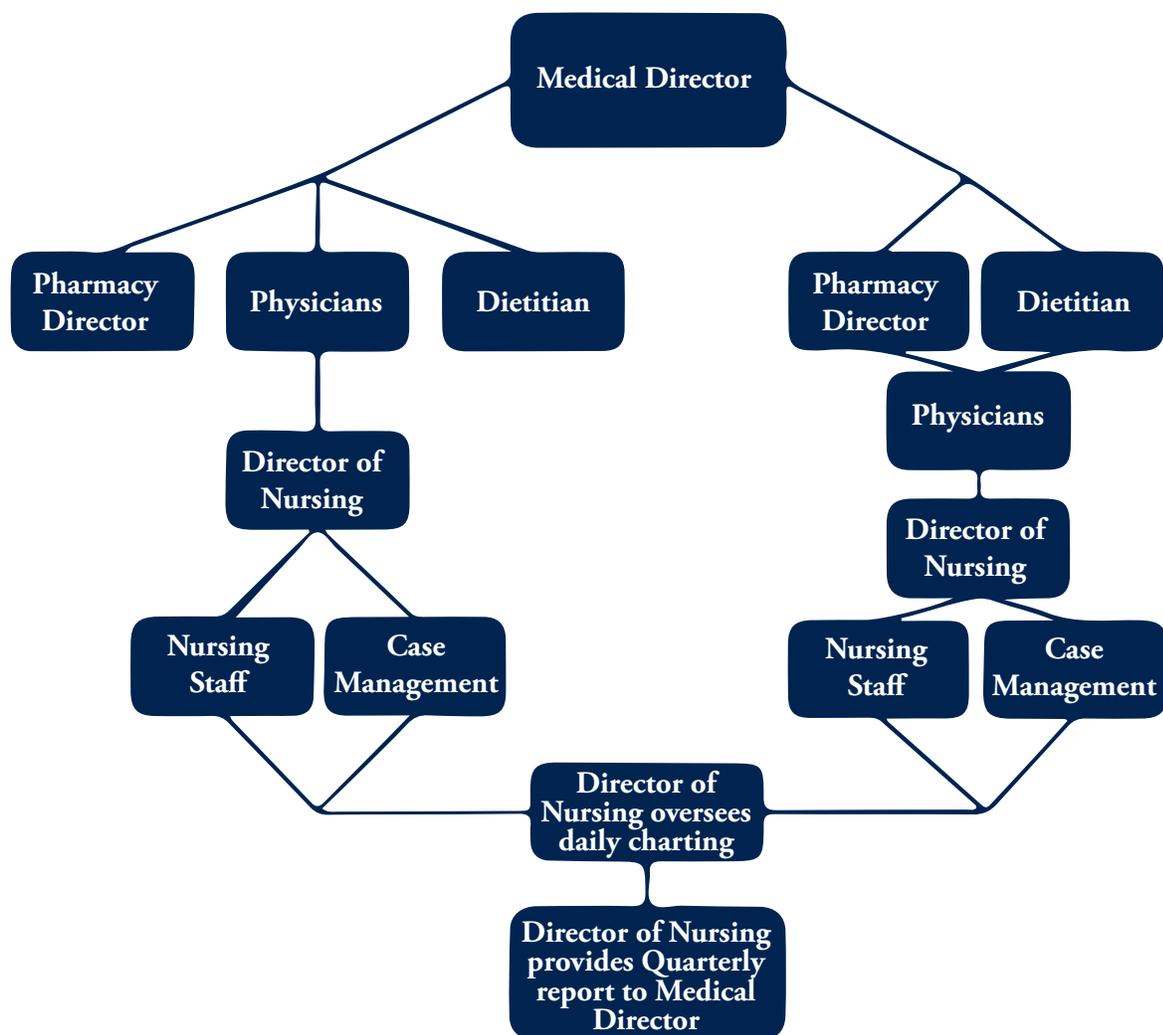
Timing of a Natural Bowel Movement:

At the transverse colon and through the sigmoid colon, mass movements take over the propulsive function. Mass movements usually occur only 1 to 3 times a day, usually after a meal. They are facilitated by the gastrocolic and duodenocolic reflexes, and are strongest for about 15 minutes in the first hour after breakfast. These mass movements are initiated when a constrictive ring forms in response to distension or irritation at a point along the colon, most frequently the transverse colon. This causes 20 cm or more of colon distal to the constrictive ring to lose its haustral contractions and contract instead as a unit. This action forces the fecal material in that segment down the colon. The series of mass movements persists for only 10 to 30 minutes, then returns in 12 hours, or even a day later. When the mass movements have forced the feces into the rectum the need to defecate is felt (Guyton & Hall, 1996).

Most Common Complications that Effect Transit Time:

- Slowed transit times - lack of physical activity, opiates
- Altered fecal composition from fiber intake or lack of fiber intake
- Decreased ability to expel feces - neurogenic bowel
- Altered ability to acknowledge the urge to defecate - Dementia

Bowel Care Protocol Implementation Chart:



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A bowel management program will be implemented for the individual who experiences or is at risk of experiencing bowel incontinence or retention/constipation. The Bowel Program of Choice will be individualized for each patient, requiring the least amount of intervention (i.e.: high fiber diet and dietary supplements, medications, mini-enemas, digital stimulation*, etc) to achieve acceptable results as identified by the patient and the Rehabilitation Team.

Procedure:

1. Assessment. Complete Bowel Assessment Chart
 - a. Identify the patient's pre-morbid bowel elimination pattern and use of laxatives or chemical rectal stimulants.
Identify potential risk for and/or existing bowel elimination problems.
2. Follow recommended nutrition and fluid requirements
3. Establish a daily predictable bowel care time
4. Pharmacological Constipation Intervention-Step Therapy Protocol
5. Documentation
6. Patient assessment and team protocol execution

Fiber Intake:

Fiber is an important part of maintaining a normal bowel function. Individuals should be encouraged to eat fiber from a variety of sources. The diet should include whole grains, fruits, vegetables, legumes, seeds, and nuts. Tolerance of gradual increases in fiber content should be evaluated. Two liters of daily fluid intake is recommended based on the patients tolerance. The benefits of fiber and fluid intake may not be noted for several weeks, so it is important not to discontinue their inclusion in a bowel program prematurely.

- Suggestions that will assist in developing and maintaining a healthy bowel movement regime include:
- Consume at least five fruits and vegetables each day.
- Incorporate 2-3 servings of whole grains as part of the 6-11 recommended servings in the Food Guide Pyramid.
- Vary and complement whole grains, nuts and seeds, legumes and fruits and vegetables to obtain all fiber components in the diet.
- Select whole fresh and dried fruits rather than fruit juices.

Fluid Intake:

Water comprises approximately 80% of the human body at birth and decreases with age to about 60%. In addition to its role in transporting nutrients, oxygen, drugs, and waste products in the blood, and in regulating body temperature, an important function of water is to prevent constipation. Factors that increase fluid needs include exercise, high temperatures, low humidity, high altitude, high fiber diet, and increased fluid losses often related to caffeine and alcohol consumption (Kleiner, 1999). Although requirements vary widely among people, generally humans should consume at least 2 liters per day of liquids in the form of non-caffeinated, nonalcoholic beverages, soups, and other fluids (Kleiner, 1999). Kleiner recommends a fluid intake of 2,900 ml per day for the average-sized man (70 kg) and 2,200 ml per day for women using a guideline of 1 ml/kcal of energy needs. Solid foods provide about 1,000 ml per day and an additional 250 ml is derived from water resulting from oxidation. A pregnant woman requires 300 ml of extra fluid per day and a lactating woman requires 750-1,000 ml above the basic requirement (Food and Nutrition Board, 1989). Additional factors to consider in regards to overall fluid intake is the time of the year, regional location of the patient, activity level and urinary output. Total water and fluid intake should be included in any diet record. Future studies that measure dietary fiber intake should also closely measure fluid intake.

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Constipation is one indication that an older adult may be dehydrated. Dehydration is not easily detected in the elderly because chronic dehydration can result from less than adequate replenishment of water over time. There is no uniform definition of dehydration, but rapid weight loss of greater than 2%- 3% is a generally accepted definition (Weinberg & Minaker, 1995). Regular monitoring of fluid intake is recommended for the elderly. The estimated amount required at baseline for adults more than 65 is 30 ml/kg of body weight. A minimum of 1,500-2,500 ml is the daily water intake required to replace urinary and fecal losses and insensible losses for older adults (Weinberg & Minaker, 1996).

Establishing the Timing of Bowel Care:

Mass movements usually occur only 1 to 3 times a day, usually after a meal. They are facilitated by the gastrocolic and duodenocolic reflexes, and are strongest for about 15 minutes in the first hour after breakfast. An established morning bowel protocol is recommended.

General Constipation:

- Transfer to the toilet/commode at the consistent scheduled time for complete evacuation.

Neurological Disorders:

- A regular bowel pattern - Frequency needs to be established with consideration to the type of neurogenic bowel and the whole person.

Upper-Motor-Neuron (UMN) Neurogenic Bowel (nerve damage above the conus):

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Pharmacological Constipation Intervention:

Pharmacological treatment is appropriate for an acute episode of constipation. Otherwise, there is consensus among experts that pharmacological treatment should be considered only after non-pharmacological interventions, such as diet and exercise, have been tried (Yabbowich, 1990; Harari et al., 1993; Tedesco & DiPiro, 1985). However, this is not true with patients with a Neurogenic Bowel. **Alliance Labs, L.L.C. does not recommend usage of all products listed. Product usage and dosing should be at the discretion of the healthcare facility.**

General Constipation Dosage Orders:

Orders for pharmacological agents in the health care setting should be written as PRN rather than as scheduled medications, to encourage nurses to assess and evaluate the needs of their patients on an on-going basis. Noting that patients with a prior history or high score on the Constipation Assessment Scale (CAS) should be evaluated for scheduled bowel care medication usage as well as patients with a neurogenic bowel.

Neurogenic Bowel Dosage Orders:

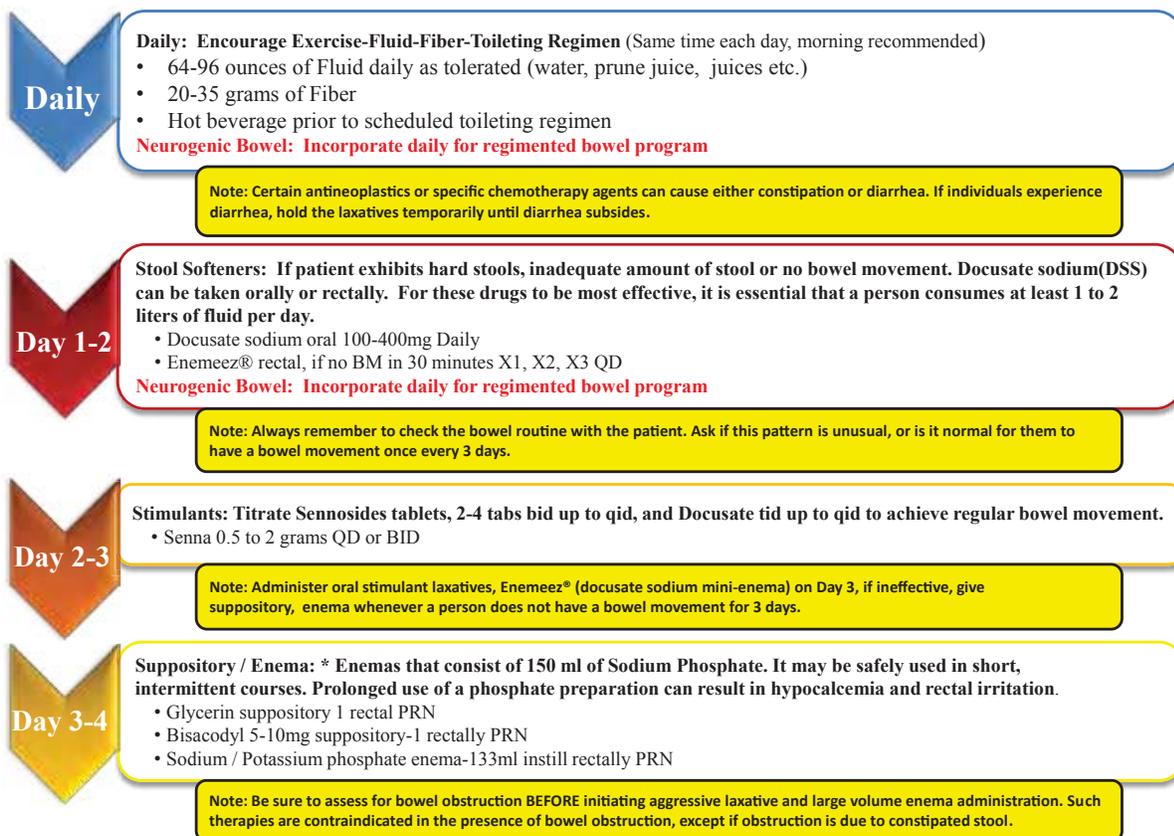
Enemeez[®], if no BM in 30 minutes **Enemeez**[®] X1, X2, or X3. One to three units rectally as needed or as directed by a physician. This process can be administered safely up to 3 times during a bowel care session or per day. Do not exceed physician's recommendations.

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Stepwise Approach to Management of Constipation: (Adapted from Sanburg McGuire & Lee, 1996*)

Taking a least evasive approach or a stepwise approach to management of a neurogenic bowel or constipation is recommended, keeping in mind the most natural form of elimination is the best long term approach. Consideration of maintaining healthy rectal mucosa is paramount to patient quality control measures when using rectal stimulant remedies i.e. bisacodyl.

*Note: Docusate sodium (DSS) can be taken orally or rectally. For these drugs to be most effective, it is essential that a person consumes at least 1 to 2 liters of fluid per day. Glycerin has minimal side effects and is one of the few laxatives that has been recommended as being safe for periodic use with children and infants.



Documentation:

A daily bowel care chart shall be completed for each patient receiving constipation intervention and should be reviewed as part of the predictive care team pathway weekly.

Date	Time of Evacuation	Total Time for Bowel Care	Fluid in ml	Fiber in Grams	Stool Consistency Bristol Stool chart Type 1-7	# of Incontinence Episodes	Time Spent on Digital Stimulation	Bowel Medication(s) Used

Monitor and Assess Team Program:

Taking measures like these will ensure that your organization's team members gain ownership of the program and will extend past the development and implementation of the predictive care bowel protocol and well into their ongoing use and continued improvement.

Director of Nursing to Review the Following:

- Improvements in patient outcomes
- Improvements in FIM scores
- Nursing feedback
- Unit floor costs including hard and soft costs at facility

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Note:

This form is offered as a sample only and criteria for assessment should be determined by staff members at your facility. A listing of assessment areas is offered. It is important to determine that diarrhea is not overflow due to constipation. A three day food and fluid intake history should be a practical approach for assessment.

A. Description of bowel patterns:

Exact time of daily evacuation: _____

Number of incontinent stools daily: _____

Number of mucosal discharge episodes daily: _____

Stool Consistency:

- Type 1: Separate hard lumps like nuts (hard to pass)
- Type 2: Sausage-shaped but lumpy
- Type 3: Like a sausage but with cracks on its surface
- Type 4: Like a sausage or snake smooth and soft
- Type 5: Soft blobs with clear-cut edges (passed easily)
- Type 6: Fluffy pieces with ragged edges a mushy stool
- Type 7: Watery, no solid pieces (entirely liquid)

B. Cognitive and functional ability:

The following general assessment is to be performed on patients that present with a good degree of cognitive ability. A more complete assessment may be required for those patients that present with some forms of brain injury or disease states.

ORIENTATION IN TIME:

- What is the year? _____
- What is the season? _____
- What is the month? _____
- What is the day? _____
- What is the day of the month? _____

ORIENTATION IN SPACE:

- In which state are we in? _____
- In which city are we in? _____
- What is this building we are in? _____
- Which floor are we on? _____

FUNCTIONAL ABILITY:

- Change in activity in the last two weeks? Yes or No
- Change in privacy or accessibility to the toilet? Yes or No

Explain:

C. Altered ability to defecate:

- | | | |
|---|---|--|
| <ul style="list-style-type: none"> <input type="checkbox"/> Neuromuscular <input type="checkbox"/> Hirschsprung's Disease <input type="checkbox"/> Autonomic Neuropathy <input type="checkbox"/> Chagas Disease <input type="checkbox"/> Intestinal Pseudo Obstruction <input type="checkbox"/> Cerebral Tumors <input type="checkbox"/> Meningoceles <input type="checkbox"/> Tabes Dorsalis <input type="checkbox"/> Shy-Dragar Syndrome | <ul style="list-style-type: none"> <input type="checkbox"/> Dermatomyositis <input type="checkbox"/> Progressive Systemic Sclerosis <input type="checkbox"/> Diabetic Neuropathy <input type="checkbox"/> Parkinson's Disease <input type="checkbox"/> Spinal Cord Injury <input type="checkbox"/> CVA <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Traumatic Brain Injury <input type="checkbox"/> Dementia | <ul style="list-style-type: none"> <input type="checkbox"/> Sedation <input type="checkbox"/> Autonomic Failure <input type="checkbox"/> Hypothyroidism <input type="checkbox"/> Opioid Use <input type="checkbox"/> Post-Operative Complications <input type="checkbox"/> Coma <input type="checkbox"/> Vegetative State <input type="checkbox"/> Other |
|---|---|--|

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Additional Comments:

D. Constipation Assessment Scale

	No Problem	Some Problem	Severe Problem
1. Abdominal distention or bloating			
2. Change in amount of gas passed rectally			
3. Less frequent bowel movements			
4. Oozing liquid stool			
5. Rectal fullness or pressure			
6. Rectal pain with bowel movement			
7. Small volume of stool			
8. Unable to pass stool			

Scoring: Add symptom score for a total score that ranges between 0 and 16. **Total Score:** _____

Results:

- 2-6 = mild to moderate constipation
- 7-10 = moderately severe constipation
- 11+ = severe constipation

Source: McMillan SC, Williams FA. Validity and reliability of the Constipation Assessment scale. Cancer Nurs. 1969;12:163-168.

E. Diet and Fluid:

Fluid per day in ounces: _____

Fiber intake in grams: _____

F. Medications:

- Opioids
- Drugs with anticholinergic action:
 - Anticholinergics
 - Antidepressants
 - Phenothiazines
 - Haloperidol
 - Antacids
 - Antispasmodics
- Antiemetics-5HT₃ Antagonists
- Diuretics
- Anticonvulsants
- Iron
- Antihypertensives
- Chemotherapy Agents - Vince Alkaloids, 5-Flourouracil, Mitomycin
- Antibiotics
- NSAIDs - Diciofenac Indomethacin
- Iron Preparations
- Disaccharide Containing Elixirs

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G. Physical Issues:

- Advanced age
- Immobility
- New spinal cord injury
- Lack of exercise
- Poor dietary and fluid intake
- Changes in life routine
- Ignoring the urge to defecate
- Dementia
- Abnormal toileting position
- Inconsistent and insufficient toileting time
- Lack of privacy

H. Abdominal:

- Distention
- Visible peristalsis
- Bowel sounds
- Masses
- Rigidity
- Tenderness

I. Rectal: *Perform on patients in the left lateral position**Perform anal test, appearances of:**

- Fissures
- Hemorrhoids
- Masses
- Stool
- Prostate size
- Perianal ulceration
- Anal sphincter tone
- Anterior mucosal prolapsed
- Anal stenosis

Suggested Testing: (*patients with ongoing constipation issues)

- **Laboratory:** Fecal occult blood testing (FOBT); thyroid function studies; serum electrolytes; serum glucose; and complete blood count (CBC).
- **Radiographic diagnostic testing:** Such testing of the kidney, ureter, and bladder (KUB) may be indicated to rule out an organic cause of constipation. (Constipation may present with clumps of rounded masses with entrapped gas and varying degrees of dilated bowel)
- Additional evaluation is indicated if there is a positive occult blood test, weight loss, anemia, and an onset of constipation that cannot be attributed to lifestyle changes. Appropriate tests include a barium enema, a colonoscopy, and sigmoidoscopy.
- Cognitive Testing (Patient presenting with some degree of impaired cognitive ability.) The provided links are for reference only:

http://www.alz.org/professionals_and_researchers_14306.asp

<http://www.mybraintest.org/2011/04/cognitive-assessment-and-rehabilitation-for-traumatic-brain-injury-tbi/>

Patient Diagnostic Codes:

Quad:	344.00
Para:	344.1
MS:	340
Old SCI Injuries:	907.20
Spina Bifida	740
Stroke	434 or 436

National Drug Code Numbers:

<i>Enemeez</i>[®] must be billed as a drug	
<i>Enemeez</i> [®]	17433-9876-03
<i>Enemeez</i> [®] Plus	17433-9877-03

Wholesale Item Numbers:

	<i>Enemeez</i> [®]	<i>Enemeez</i> [®] Plus
McKesson:	2732121	1163252
Cardinal:	3401650	3419884
Amerisource:	845279	669554

- **Medical Coverage:** *Enemeez*[®] is covered in 60% of the United States by Medicaid, requiring little to no out of pocket cost to the patient.

- **Patient Assistance Program:** For states that do not cover *Enemeez*[®], we have developed a Patient Assistance Program. Our commitment to our patient community is to make sure that all patients shall not be denied *Enemeez*[®] as an option for bowel care because of cost. Please contact us for additional information.

- **Private Insurance:** Many private insurance plans cover the cost of *Enemeez*[®]. We recommend that individuals contact their insurance companies and inquire if *Enemeez*[®] is on their formulary plans. If it is not, request the prior authorization form, which should be completed and submitted to the insurance company by the prescribing physician

- **Group Purchasing Organization:** *Enemeez*[®] is contracted with most major Group Purchasing Organizations.

- **VA Federal Supply Schedule:** *Enemeez*[®] is available on the Federal Supply Schedule and must be requested by name.



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