

Message to writer
please note that this
is an advance
practice nursing
course, so...

[Health & Medicine](#), [Nursing](#)



Discussion Question 2

Discussion Question 2

One family nurse practitioner clinic functioned as a diabetic clinic providing free services to mostly uninsured and homeless patients. Lack of insurance and a more-or-less permanent residence has resulted in fragmented care and noncompliance with medications. As such, the FNP added pharmaceutical counseling specifically for adult diabetics to the range of services the clinic offered in the community (Diggins, 2014). The FNP collaborated with a pharmacist who provided counseling. The pharmacist answered the patients' questions, worked with them to determine the optimum times that multiple medications would be taken by each patient, and suggested combination drugs to reduce the number of medications taken daily. The strengths of this nurse-managed clinic include its provision of free services to a vulnerable and medically-underserved population and its collaborative approach with another discipline, namely pharmacy (Diggins, 2014).

On the other hand, the limitations include the lack of referral to other professionals who can help the patients such as a dietician for nutrition education and a social worker to bridge the patients to resources. In evaluations of nurse practitioner clinics for diabetes managements, albeit for other underserved populations and not the homeless, data collection included the level of patient knowledge about his or her disease, the ability for self-care, empowerment, social support, and the appropriateness of the theoretical framework used in designing services (Carlucci, Arguello & Menon, 2010). In another evaluation, the authors focused on measurable

outcomes including improvements in glycated hemoglobin (HbA1c), blood pressure, blood cholesterol level, weight and BMI, self-efficacy, and depression (Richardson et al., 2014). These studies provide frameworks that can be adapted when evaluating FNP-led diabetic services for uninsured and homeless patients.

Chronic disease management is a highly needed primary care service given the high incidence and prevalence of lifestyle-related non-communicable illnesses, the existence of disparities, and the aging of the population. A clinic that provides chronic disease management services in a family setting is badly needed in my community. It will improve the long-term outcomes among patients and enhance family coping with the chronic illness as well. Therefore, I am considering this as a potential clinic I might be putting up when I become a licensed FNP.

References

- Carlucci, M. A., Arguello, L. E., & Menon, U. (2010). Evaluation of an advanced practice nurse- management diabetes care for veterans. *Journal for Nurse Practitioners*, 6(7), 524-531. doi: 10. 1016/j. nurpra. 2009. 11. 006.
- Diggins, K. (2014). Family nurse practitioner/pharmacist collaborative medication counseling in patients with diabetes. *Journal for Nurse Practitioners*, 10(9), 741-744. doi: <http://dx. doi. org/10. 1016/j. nurpra. 2014. 05. 011>.
- Richardson, G. C., Derouin, A. L., Vorderstrasse, A. A., Hipkens, J., & Thompson, J. A. (2014). Nurse practitioner management of type 2 diabetes. *The Permanente Journal*, 18(2), e134-e140. doi: 10. 7812/TPP/13-108.