# M.A.P. (Measure, Act, Partner) to Prevent Type 2 Diabetes

The M.A.P. (Measure, Act, Partner) to prevent type 2 diabetes—physicians and care teams can use this document to determine roles and responsibilities for identifying adult patients with prediabetes and referring to community-based diabetes prevention programs. “Point-of-Care” and “Retrospective” methods may be used together or alone.

## Step 1: Measure

### Point-of-Care Method
- Assess risk for prediabetes during routine office visit
- Test and evaluate blood glucose level based on risk status
- During vital signs
  - Medical assistant
  - Nurse
  - Physician
  - Other _______
- Provide “Are you at risk for prediabetes?” patient education handout in waiting area
- Use/adapt “Patient flow process” tool
- Use CDC or ADA risk assessment questionnaire at check-in
- Display 8 x 11” patient-facing poster promoting prediabetes awareness to your patients
- Use/adapt “Point-of-care algorithm”

### Retrospective Method
- Query EHR to identify patients with BMI ≥24; ≥22 if Asian* and blood glucose level in the prediabetes range
- Every 6–12 months
- Health IT staff
- Other _______
- Use/adapt “Retrospective algorithm”

## Step 2: Act

### Point-of-Care Method
- Counsel patient re: prediabetes and treatment options during office visit
- Refer patient to diabetes prevention program
- Share patient contact info with program provider**
- During the visit
  - Medical assistant
  - Nurse
  - Physician
  - Other _______
- Advise patient using “So you have prediabetes … now what?” handout
- Use/adapt “Health care practitioner referral form”
- Refer to “Commonly used CPT and ICD codes”

### Retrospective Method
- Inform patient of prediabetes status via mail, email or phone call
- Make patient aware of referral and info sharing with program provider
- Refer patient to diabetes prevention program
- Share patient contact info with program provider**
- Contact patient soon after EHR query
  - Health IT staff
  - Medical assistant (for phone calls)
  - Other _______
- Use/adapt “Patient letter/phone call” template
- Use/adapt “Health care practitioner referral form” for making individual referrals
- Refer to “Commonly used CPT and ICD codes”

## Step 3: Partner

### With Diabetes Prevention Programs
- Engage and communicate with your local diabetes prevention program
- Establish process to receive feedback from program about your patients’ participation
- Establish contact before making 1st referral
  - Office manager
  - Other _______
- Use/adapt “Business Associate Agreement” template on AMA’s website if needed

### With Patients
- Explore motivating factors important to the patient
- At follow-up visit, order/review blood tests to determine impact of program and reinforce continued program participation
- During office visit
  - Other _______
- Medical assistant
- Nurse
- Physician
- Other _______
- Advise patient using “So you have prediabetes … now what?” handout and provide CDC physical activity fact sheet

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* These BMI levels reflect eligibility for the National DPP as noted in the CDC Diabetes Prevention Recognition Program Standards and Operating Procedures.

** To share patient contact information with a diabetes prevention program, you may need a business associate agreement (BAA).