M.A.P. (Measure, Act, Partner)

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.

Choose and check what works best for your practice

Step 1: Measure	When	Who	How (draw from AMA-CDC tools)
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 • Use/adapt "Business Associate Agreement" template on AMA's website if needed
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 Refer to "Commonly used CPT and ICD codes"
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 • Discuss program feedback with patient and integrate into care plan	• 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 **www.cdc.gov/physicalactivity**

* These BMI levels reflect eligibility for the National DPP as noted in the CDC Diabetes Prevention Recognition Program Standards and Operating Procedures. The American Diabetes Association (ADA) encourages screening for diabetes at a BMI of ≥23 for Asian Americans and ≥25 for non-Asian Americans, and some programs may use the ADA screening criteria for program eligibility. Please check with your diabetes prevention program provider for their specific BMI eligibility requirements.

** To share patient contact information with a diabetes prevention program, you may need a Business Associate Agreement (BAA).