NADC STANDARDS FOR LIVER HEALTH IN DIABETES CARE

nadc
National Association of Diabetes Centres

ads
Australian Diabetes Society

1.0 ROUTINE RISK IDENTIFICATION & SCREENING FOR ANY MAFLD

No.	Criterion	Service Level	Evidence Examples
1.1	All adults with T2DM or prediabetes with increased metabolic risk, or obesity with one other metabolic risk, are screened for MAFLD related fibrosis at diagnosis and at regular intervals (e.g. every 3 years).	Primary; All in follow up	Screening protocol; EMR prompts; recall system; audit reports; patient record review; diabetes annual review templates.
1.2	Screening incorporates liver US, FBE/LFTs for FIB-4 calculation for liver fibrosis risk, with clear documentation in the patient record.	All	Pathology reports, EMR documentation; FIB-4 calculator/template; patient records; audit reports.
1.3	MAFLD risk assessment is incorporated into the standard diabetes complications assessment process	All	Diabetes complications assessment template; clinic workflow; annual review forms; EMR fields.
1.4	Education and support provided to referring clinicians on MAFLD fibrosis risk assessment and identification	Tertiary/ COE	Correspondence to the referrer from the tertiary/COE; education sessions; webinar records; newsletters; presentation slides; attendance records; educational resources.
1.5	People receive clear education on MAFLD and its relationship to diabetes	All	Education handouts; website resources; documented counselling; patient information sheets

* FIB-4 <1.30 (or <2.0 in those aged >65 years) indicates advanced liver fibrosis is unlikely (90% Negative Predictive Value)

2.0 SEVERE FIBROSIS RISK STRATIFICATION USING NON-INVASIVE TOOLS

No.	Criterion	Service Level	Evidence Examples
2.1	FIB-4 is used as the first-line tool for liver fibrosis assessment with standardised thresholds to guide management.	All	Fibrosis risk flowchart; written decision algorithm; clinical protocol; audit reports; EMR workflow. *FIB-4 Ref: https://liver.org.au/health-professionals/fib-4-calculator/
2.2	Patients with indeterminate scores receive timely second-line assessment (e.g., liver elastography, ELF or Hepascore)* and as indicated, and/or referral to hepatology or gastroenterologist with special interest.	All	FibroScan referrals; ELF requests; specialist referrals; referral pathway documentation.
2.3	People with high risk or indeterminate FIB-4 scores receive evidence-based informed counseling - including the need for further fibrosis assessment.	All	Clinical notes; education resources; patient records; counselling templates.
2.4	Clear local pathways define escalation and ensure results are communicated promptly to the referring clinician and relevant care team	All	Referral protocols; care pathways; referral templates; communication records.

*Use FibroScan cautiously in people with a BMI >40, as results are at higher risk of false positives. If available, consider using ELF or referring onward for further assessment. Elevated readings may not accurately reflect true fibrosis.

3.0 MULTIDISCIPLINARY INTERVENTION & MANAGEMENT

No.	Criterion	Service Level	Evidence Examples
3.1	Cardiovascular and renal disease risk management, dietary and physical activity optimaisation, weight management and alcohol avoidance is promoted as first-line care in people with MAFLD, including people with T2DM	All	Patient education materials; care plans; dietitian referrals; exercise referrals; clinical notes; cardiac risk assessment with www.cvdcheck.org.au
3.2	Assess people with elevated liver enzymes and/or fibrosis for other common causes of liver disease including alcohol excess, medications, viral hepatitis and iron overload.	All	Patient records; pathology requests; liver work-up protocols; clinical assessment templates.
3.3	Multi-disciplinary obesity management including consideration for metabolic bariatric surgery are considered in individuals where appropriate	All	Multi-disciplinary case discussions; clinical notes

4.0 SPECIALIST REFERRAL & SHARED CARED

No.	Criterion	Service Level	Evidence Examples
4.1	Formal protocols with referral pathways for all people with high-risk FIB-4 (>2.7) to be referred to a hepatologist or gastroenterologist with special interest*	All	Referral protocol; referral templates; specialist correspondence; audit reports.
4.2	Formal protocols for referral of people with indeterminate FIB-4 scores, based on local factors, availability of liver elastography, ELF or Hepascore	All	Local pathway documents; FibroScan access pathway; referral criteria
4.3	A system for tracking and reviewing patients with advanced fibrosis or cirrhosis in place. Access to timely referral and communication between services, and as able, clinical trial referral.	All	Patient registers; recall systems; tracking spreadsheets; EMR reports.
4.4	Shared care arrangements ensure coordinated management of complex cases.	All	Shared care agreements; co-managed care plans.
4.5	Hepatocellular carcinoma surveillance in people with cirrhosis is in place and coordinated with a liver disease specialist or gastroenterologist with special interest. Shared care arrangements should be arranged where able.	All, combined	HCC surveillance; protocols, ultrasound requests/reports, specialist correspondence, shared care plans

*Where a hepatologist or gastroenterologist is not available, alternative referral pathways may include physicians with an interest and expertise in liver disease.

5.0 PHARMACOLOGICAL THERAPY

No.	Criterion	Service Level	Evidence Examples
5.1	Prescribing aligns with evidence-based guidelines for diabetes, MAFLD and CV risk reduction.	All	Prescribing audits; clinical protocols; medication review documentation.
5.2	Pharmacotherapy for severe liver fibrosis and CVD risk reduction is initiated or continued, where appropriate.	All	Prescribing records; clinical protocols; medication review notes; mulridisciplinary discussions.
5.3	Medication plans are tailored to liver fibrosis status, comorbidities, and weight and diabetes management needs, including cardiovascular risk reduction.	All	Medication review records; care plans; specialist recommendations.

6.0 FOLLOW-UP, EDUCATION & SURVEILLANCE

No.	Criterion	Service Level	Evidence Examples
6.1.1	Processes for follow-up are defined for all people who have been assessed for liver fibrosis appropriate to their risk score.	All	Clinical protocols; patient records; education materials; audit data
6.1.2	People at low risk for advanced liver fibrosis are reassessed at appropriate intervals (e.g. at 3 years) irrespective of normal ALT/AST levels and/or ultrasound findings.	All	Recall systems, EMR reminders; audit reports; patient records

ADS MAFLD Living Guidelines:

The NADC standards for prevention, detection, and management in people with diabetes are adapted from the ADS Living Guidelines. The NADC standards below are drawn from the following recommendations.

NADC Standard	Associated ADS Recommendations
Standard 1: Routine Risk Identification and Screening	R1, R2, R3
Standard 2: Fibrosis Risk Stratification Using Non-Invasive Tools	R2, R3, R5
Standard 3: Multidisciplinary Intervention and Management	R8, R9, R10, R11, R12
Standard 4: Specialist Referral and Shared Care Coordination	R4, R5, R6, R7
Standard 5: Pharmacological Therapy and Monitoring	R11, R13, R14
Standard 6: Follow-up, Education and Surveillance	No direct ADS recommendation - however, included for completeness

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Clinical Advisory Group Disclosures

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