Type 2 diabetes Referral Pathway (aged 17-25 years)

Central Australia Region

Visit with GP / RAN / AHP
May occur in context of:
- Incidental diagnosis when presenting for other reasons
- Symptomatic presentation
- Screening if noted risk factors for T2D (see screening flowchart)
- Annual Health Check

Screen with HbA1c

- **<5.7%** → Repeat HbA1c in 12 months.
- **5.7-6.4%** → Proceed as per screening flowchart.
- **HbA1c ≥6.5% (i.e. Type 2 diabetes is diagnosed)** → Collect diagnostic bloods/urine as per management flowchart.
  As per screening/ management flowcharts, consider whether Type 1 Diabetes is a possibility, if so discuss with endocrine doctor urgently (contact via ASH switch)
  → Screen for (+ manage) complications as per management flowchart.

Collaboration between primary health care team, diabetes educators and endocrinologists

1) Primary carer (GP, AHP, RAN, NP) start **education about diet + lifestyle + start treatment** as per management flowchart.
   a) Discern which family members need to be involved RE: diagnosis & treatment plan & invite early.
   b) Endocrinologists + diabetes educators happy to be involved in these extended discussions to improve "buy in" from the beginning.
   c) Assess psychosocial factors — consider food security, timing of medications for adherence, sleep patterns, mental health, sexual health, school attendance, family structure, support from other agencies (e.g. youth workers).
2) Primary care team to decide on best **referral pathway** depending on circumstances of individual young person.
   Suggest care under paediatric team if aged 17-18 years and either still at school, cognitive impairment, FASD or behavioural concerns. Suggest care under adult team if aged ≥19 years, or if aged 17-18 years and have left school and no developmental issues.

Set up PHC Team

PHC Team
PHC team to decide key person/care coordinator for follow up:
- AHP
- Chronic Disease Nurse
- GP
- PHC Outreach CDN / NP

N.B. Circumstances may change and need flexibility to revisit engagement and follow up plan.

Community support
Consider how support could be maximised to young person/family
- School supervision
- Community services support
- Youth workers
- Social and emotional wellbeing support

Ongoing support
Ongoing reviews with support networks.

Medication

Start metformin
Medication decision is guided by HbA1c and other factors—as per CARPA, APEG and ADS guidelines.

Initial Medication Management
Clinic r/v BGLs + provide support, titrate meds fortnightly.

- **HbA1c < 8.5%**
- **HbA1c ≥8.5%** → **Intensify Management**
  Discuss within 2-5 days with ASH Endocrine doctor on-call RE: intensification of management.

Review
- Clinic review at least weekly post intensification, more frequently if on insulin.
- Titrate medication.
- Involve diabetes educators, endocrinologists and NP.

Three month review
HbA1c - Glycaemia in target?
HbA1c < 6.5%
Fasting BGLs 4-7 mmol/L
Post prandial 5-10 mmol/L

- **No** → **Management**
  Discuss with Endocrine doctor on-call RE: intensifying management.
- **Yes**

Referrals

Diabetes Educator

Endocrinologist
Endocrine doctor on-call available for urgent advice; outpatient referral.

Allied Health

Dietitian

Optometry
Baseline and regular.

Mental health
Based on need & availability.

Exercise Physiologist
Based on need & availability.

Dental
Based on need & availability.

Podiatry
Based on need & availability.

Follow-up

Organisational approach to identify young people requiring follow-up.

- Multidisciplinary team review
- Identify local resources available for follow-up
- Re-refer to ASH Endocrinology if appropriate

Ongoing management
At least monthly clinic reviews for first 6 months.
Review medical management at least 3 monthly.

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