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TOOLKIT GUIDE

# Overweight and obesity in adults: 20 key messages to improve practices

Validated by the HAS Board on 11 January 2023

Updated on Feb 2024

## The 20 key messages

### Systematically perform life-long screening for overweight or obesity

1. Calculate BMI, measure waist circumference and monitor their evolution annually.

### Immediately a situation of overweight or obesity has been diagnosed, jointly put together a personalised care plan

2. Conduct a multi-component, multidisciplinary assessment.

3. Identify dietary problems and eating disorders.

4. Systematically assess and provide early support for any psychological difficulties, psychiatric problems and any form of social, family or professional vulnerability

5. Recognise, detect, prevent and support any stigmatisation.

6. Consult user associations throughout the care pathway.

### Scale care and support depending on three complexity situations and adjust them based on the evolution

7. Define care and support priorities based on the impact on health and the person's needs and expectations.

8. Propose personalised patient education from the time of diagnosis of overweight or obesity, continue and consolidate it.

9. Organise time for coordination in all situations, and in complex and highly complex situations, organise a multidisciplinary team meeting and appoint a care pathway coordinator

10. Regularly monitor health over several years in situations of non-complex obesity and for life in situations of complex and highly complex obesity.

11. Reassess the entire situation in the event of difficulties maintaining lifestyle changes and stabilising weight or in the event of resistance to continuation of weight loss.

### Support people before and after bariatric surgery [Updated Feb 2024]

12. The prevention of interruptions of post-bariatric surgery care is key to promoting successful surgery outcomes and preventing complications. The percentage of people receiving regular post-bariatric surgery follow-up is under 50% at 2 year and declines substantially at 5, 10 and 15 years.

13. The surgery plan is accompanied by at least 6 months of bariatric surgery preparation. This period may be longer, the candidate is informed of this.

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14. Surgery preparation helps optimise the person's physical and mental health and concurrently start specific therapeutic education sessions for bariatric surgery with participation from resource patients and user associations.

15. The specific follow-up for bariatric surgery first involves the specialist obesity physician and the surgeon, and then once the person's health has stabilised, the general practitioner or advanced practice nurse in alternation with the multidisciplinary specialist team.

16. After bariatric surgery, therapeutic education sessions targeting one or more endpoints are continued in group or individual settings after an assessment of needs.

17. Sharing information is key to ensuring continuity of care at all stages of bariatric surgery.

**Be attentive to specific populations and situations**

18. Prevent overweight and its progression to obesity in people with disabilities. Support the person before and after bariatric surgery [Updated Feb 2024].

19. In women with obesity, ensure regular gynaecological follow-up, identify any risks before and during pregnancy, be vigilant in the event of bariatric surgery, monitor weight evolution during and before pregnancy and support a return to a healthy weight.

20. Encourage physical activity during the perimenopause and menopause, be vigilant in the event of high waist circumference.

# Systematically perform life-long screening for overweight or obesity

## 1. Calculate BMI, measure waist circumference and monitor their evolution

- Monitoring of BMI is annual to detect overweight or obesity, a cardiovascular risk, and more frequent in the event of a family or personal history, warning signs on the BMI curve, long-term medication inducing weight gain, a situation of disability or a chronic disease potentially exacerbated by obesity.
- Any medical visit can be an opportunity to identify overweight or obesity, to ask permission from the person to address weight, lifestyle habits and life context, to encourage daily physical activity and a reduction in sedentary behaviours, to improve and balance diet, to improve sleep and life rhythms.
- Any healthcare professional, working in a community setting, a healthcare facility, a medico-social service or facility, an occupational, school or university health service, can identify a situation of overweight or obesity and advise the person to talk to their own primary care physician.

# Immediately a situation of overweight or obesity has been diagnosed, jointly put together a personalised care plan

## 2. Conduct a multi-component assessment

- Understand the situation, factors, causes or consequences of overweight or obesity and identify the needs and expectations of the cared-for person.
- Assess the impact and complications of overweight or obesity on overall health.

- Investigate for undernutrition and sarcopenia, particularly in an elderly person.
- Depending on the needs of the situation, seek support from one or more local professionals (health, social, medico-social, occupational health fields) or a specialist obesity physician or team to extend or supplement the assessment, get advice on the diagnostic or care approach to be implemented, get assistance to find the most appropriate local professionals or care team.
- Define the complexity of the situation to formulate the goals to be attained with the person as part of a shared decision-making process.

## 3. Identify dietary problems and eating disorders

- Identify warning signs, explore and treat them as a priority or concomitantly with an improvement in diet.
- Seek the support of a psychologist or psychiatrist specialising in eating disorders and a dietician.

## 4. Systematically assess and provide support for any psychological difficulties, psychiatric problems, and any form of social, family or professional vulnerability

- Identify any physical, psychological or sexual maltreatment (abuse, incest), history of trauma. Refer to a psychologist, and to a social worker if necessary.
- Present the need for the intervention of a psychologist or psychiatrist in the event of anxiety, signs of depression, suicidal thoughts or suicide attempts.
- Assess addictive behaviours, refer individuals wishing to seek treatment or reduce their risky practices to specialised resources.
- Seek solutions with the support of the social worker in the event of difficulties accessing care, a deterioration in social, financial and/or family situation, or de-socialisation.
- Help people to remain in employment and prevent professional exclusion with the assistance of occupational health physicians and their network of players to support the employee and the employer.

## 5. Recognise, detect, prevent and support any stigmatisation

- Recognise stigmatising practices in the person's activity and/or work environment and analyse these. Undergo training, raise awareness, provide training and implement a collective caring approach to patient welfare.
- Prevent stigmatisation thanks to high-quality communication, an environment, care equipment and medical transport that are adapted to the patient's weight and comfortable.
- Be particularly attentive to the identification of signs of self-stigmatisation and provide support to the person without delay. If necessary, propose the support of a psychologist or psychiatrist.
- Refer the person to resource patients or user association representatives, to enable them to share their experiences and obtain support.

## 6. Consult user associations throughout the care pathway

If the person so wishes, contact with a local user association is proposed in order to:

- facilitate their understanding of information and the care plan, encourage and support them in their decision-making and their care pathway, thanks to the support of peers.
- share the experiences of resource patients, particularly during patient education sessions, alongside caregivers.
- prevent self-stigmatisation and help people cope with stigmatising situations or attitudes.

- help ensure the goals of the care plan remain a priority for young adults during the transition from paediatric to adult care.

## Scale care and support depending on three complexity situations and adjust them based on the evolution

- Mobilise and coordinate the professional skills and resources required based on the definition of three complexity situations, which can be fine-tuned on the basis of clinical phenotyping parameters.[1]
- Depending on the evolution: increase or decrease the intensity of care and support, expand or limit the multidisciplinary team, continue investigations and/or tests, as second-line treatment and under certain conditions, consider prescribing medicinal treatment with a GLP1 analogue with a marketing authorisation in obesity, and, as a last resort, bariatric surgery, respecting the indications.
- Continue the transition from paediatric care to adult care to avoid disruption of the care pathway and help young adults to continue to make the goals of their care plan a priority.

**1. A situation of overweight** (BMI between 25 kg/m$^2$ and 29.9 kg/m$^2$) **or obesity** (BMI < 35 kg/m$^2$, class 1) **is considered to be non-complex** in the absence of associated physical complications and/or mental illnesses, OR treated, stabilised and monitored locally, AND without the accumulation of factors promoting overweight or obesity (for example, a related social or psychological problem) OR for which accessible local solutions can be found.

**2. A situation of obesity is considered to be complex** due to the severity of the obesity (BMI ≥ 35 kg/m$^2$, class 2) OR the accumulation of associated factors: physical or psychiatric complications or comorbidities, functional impact, significant impact on daily life and quality of life, eating disorders associated with mental illnesses, social problems, history of failed obesity treatment.

**3. A situation of obesity is considered to be highly complex** if the obesity is exacerbated by a chronic physical and/or psychiatric condition exposing the patient to a major health risk; OR in the event of class 3 obesity (BMI ≥ 40 kg/m2) and the accumulation of associated factors: situation of functional handicap or limited walking distance, impact on professional, social and family life, non-attainment of weight loss goals; OR contraindication to bariatric surgery; OR failure of bariatric surgery.

## 7. Define care and support priorities based on the impact on health and the person's needs and expectations

- Stabilise weight, personalise and support progressive weight loss, maintain a healthy weight, develop a strategy to avoid weight fluctuations.
- Provide support for the consequences of self-stigmatisation: loss of self-esteem, self-confidence, feelings of guilt, withdrawal from social life, avoidance of care, loss of motivation.
- Depending on the situation, at the same time or as a priority, treat functional or painful symptoms, physical or psychological complications, look for medicinal treatments with the least impact on weight gain.

[1] *Haute Autorité de Santé, Fédération française de nutrition. Obésité de l'adulte : prise en charge de 2e et 3e niveaux.* [Obesity in adults: Second and third-level management.] Good practice guideline. Saint-Denis La Plaine: HAS; 2022 (Table 2)

- Facilitate activities of daily living and mobility to improve quality of life.
- Provide support in terms of the person's relationship with their body, the impact on their emotional or sex life.

## 8. Propose personalised patient education from the time of diagnosis of overweight or obesity, continue and consolidate it

- Propose a personalised format for regular patient education sessions, locally if possible, and continued for as long as possible to maintain lifestyle changes over the long term, as well as the other treatment components if applicable.
- Develop strategies with the person to maintain lifestyle changes and the weight goal in the long term. Reinforce the person's motivation and sense of personal self-efficacy, regardless of the evolution of their weight, by continuing the patient education sessions.
- Provide support in the event of deviations from goals: remove guilt, maintain a relationship of trust, help the person re-engage, combat the unrealistic objectives that some people impose on themselves or that are imposed upon them, which are difficult to incorporate into their lifestyle and context and can lead to frustration, a sense of failure or self-stigmatisation.

## 9. Organise time for coordination in all situations, and in complex and highly complex situations, organise a multidisciplinary team meeting and appoint a care pathway coordinator

- Organise time for coordination in accordance with the arrangements jointly defined by the professionals involved in the person's care pathway: regular information-sharing, multidisciplinary team (MDT) meeting, common coordination support.
- A local care pathway coordinator addresses a need for additional coordination. They liaise with and between the professionals and support the person's engagement in their care plan.

## 10. Regularly monitor health over several years in situations of non-complex obesity and for life in situations of complex and highly complex obesity.

- Involve the cared-for person in the evaluation: give them the opportunity to make choices when reformulating new goals; be open to a need for respite, if applicable, arranging to maintain a link with healthcare professionals.
- Draw on the assessments of the professionals involved in the person's care pathway, the local care pathway coordinator and the person's own perceptions to tailor the nature and frequency of the care and support to the evolution of the individual situation.
- Investigate for the development of complications, impacts on health.
- Continue investigations and/or tests, if necessary.
- If necessary, seek the expertise of one or more specialist physicians or a specialised obesity team.

### 11. Reassess the entire situation in the event of difficulties maintaining lifestyle changes and stabilise weight or in the event of resistance to continuation of weight

- In the year following the effective implementation of the care plan, watch out for any weight regain after weight loss, weight stagnation above the negotiated goal and difficulties in continuing the weight loss.
- Be alert to signs of discouragement, psychological distress, a recurrence of dietary problems or eating disorders or addictive behaviours.
- Reassess the whole situation and seek advice from an obesity specialist in order to understand resistance to continuation of weight loss.
- Complete the treatment and continue multidisciplinary patient education sessions and physical activity on a regular basis, adapting the educational goals.
- Following the advice of a specialist obesity physician, a specialised obesity facility or a teaching healthcare facility, consider the initial prescription of second-line medicinal treatment with a GLP1 analogue with a marketing authorisation in obesity under certain conditions.[2]

## Support people before and after bariatric surgery [Updated Feb 2024]

### 12. The prevention of interruptions of post-bariatric surgery care is key to promoting successful surgery outcomes and preventing complications. The percentage of people receiving regular post-bariatric surgery follow-up surgery is under 50% at 2 year and declines substantially at 5, 10 and 15 years [Updated Feb 2024]

In order to support surgery candidates' commitment to their care plan, it is particularly advised to:

- Prepare surgery to optimise the person's physical and mental health, provide specific therapeutic education for bariatric surgery, initiate a shared decision-making process;
- After surgery, offer medico-surgical consultations, general practitioner follow-up and treatment sessions particularly in the first two years and regularly over the long term according to a schedule defined, understood and accepted by the person. Contact them if they miss an appointment;
- Ensure the benefits of surgery and detect any surgical, nutritional, or digestive complications;
- Prevent self-stigma through tailored communication. Explain the need to analyse weight curve evolution at each consultation without making it a priority and central component of the consultation;
- Detect, as early as possible, any problems or disorders that may occur or recur and support and/or treat them without delay: difficult interpersonal relations (social, family, emotional, intimacy), onset or resurgence of mood disorders (anxiety, suicidal ideation), signs of relapse of eating disorder (i.e. loss of control eating), addictions (i.e. tobacco, alcohol, etc.), weight regain, disappointment in relation to surgery outcome;
- Ensure continuity of care: sharing of information and consultation of actors;

[2] *Haute Autorité de Santé*. WEGOVY 0.25 – 0.5 – 1.0 – 1.7 – 2.4 mg solution for injection. First assessment. Saint-Denis La Plaine: HAS; 2022. https://www.has-sante.fr/jcms/p_3398698/fr/wegovy-semaglutide-obesite

- Provide a link to association resources to find support close-by;
- Locate and ensure contact with a specialised obesity team and the future general practitioner if the location of the person's residence or care setting changes.

## 13. The surgery plan is accompanied by at least 6 months of bariatric surgery preparation. This period may be longer, the candidate is informed of this [Updated Feb 2024].

- The specialist obesity physician responsible for the person's follow-up takes the initiative of holding a multidisciplinary team meeting to envisage bariatric surgery.
- They coordinate surgery preparation and continue post-surgery coordination.
- They provide information on the objectives, content and foreseeable duration of surgery preparation and deploy a shared decision-making process.

## 14. Surgery preparation helps optimise the person's physical and mental health and concurrently start specific therapeutic education sessions for bariatric surgery with participation from resource patients and user associations [Updated Feb 2024].

- The specialist obesity physician plans investigations, tests, specialised medical consultations, using teleconsultation and/or tele-expertise if required.
- They treat nutritional and vitamin deficiencies, and any undernourishment. They make sure in conjunction with the general practitioner and other specialist physicians that treatments of obesity-related diseases are adjusted, support for psychological problems is provided, and any psychiatric disorders and/or disorders linked with psychoactive substance use are treated and stabilised.
- They take part in the implementation of therapeutic education with a multidisciplinary team and the participation of trained expert patients to develop or mobilise the specific knowledge and skills in respect of self-care, safety and psychological, social, cognitive, emotional adaptation for bariatric surgery.
- The content of education sessions, sharing of experience with resource patients, linking with user associations support the shared decision-making process around bariatric surgery.
- The specialist obesity physician summarises the data to prepare the multidisciplinary team (MDT) meeting, accounting for the assessment of each professional involved in surgery preparation. They make sure that the person still wants the surgery and feels ready.
- If surgery is not an option selected by the MDT team or needs to be postponed, an alternative care plan is provided.

## 15. The specific follow-up for bariatric surgery first involves the specialist obesity physician and the surgeon, and then once the person's health has stabilised, the general practitioner or advanced practice nurse in alternation with the multidisciplinary specialist team [Updated Feb 2024].

- In the first year, medico-surgical consultations and education sessions (dietitian in particular) are close together: at 1, 3, 6 and 12 months. At regular intervals between specialist consultations, the general practitioner monitors and adjusts the treatment of obesity-related diseases, renews prescriptions for treatments, vitamin and mineral supplements and contraception, identifies surgical, digestive and nutritional complications, and adaptation issues.

- The second year, it is possible to alternate follow-up between the medico-surgical team and the general practitioner or advanced practice nurse with a recommended course of action if the person's health has stabilised. Otherwise, the medico-surgical consultations are continued.
- From the third year if the person's health has stabilised, bariatric surgery-specific follow-up is performed every 6 months by the general practitioner or advanced practice nurse. Specialist follow-up is performed at an interval of 3 years and 5 years post-surgery.
- After the fifth year, specialist follow-up is performed at 3- to 5-year intervals if the person's health is stable with lifelong annual follow-up by the general practitioner or advanced practice nurse.
- Post-surgery follow-up involves other professionals according to the assessed needs, in particular dietitian, tailored exercise programme professional, psychologist, dental surgeon, etc.

### 16. After bariatric surgery, therapeutic education sessions targeting one or more endpoints are continued in group or individual settings after an assessment of needs [Updated Feb 2024].

- For the first 2 years post-surgery, continue therapeutic education sessions by adapting their frequency and involvement of relevant professionals (particularly the dietitian, tailored exercise programme professional, nurse, etc.) for the assessed educational needs, encourage and support the person's commitment.
- The need to consolidate or pick up or develop new skills in respect of self-care, psychological, social, cognitive, emotional adaptation is subsequently assessed annually throughout the person's lifetime and therapeutic education sessions are resumed if needed.

### 17. Sharing information is key to ensuring continuity of care at all stages of bariatric surgery [Updated Feb 2024]

- Information sharing and traceability are required between the specialist obesity physician, the surgeon, the general practitioner, and the professionals involved in the care plan.
- Pre-surgery: date of entry into surgery preparation, handover of hard-copy or digital personalised follow-up record, review of surgery preparation stage, conclusions of multidisciplinary team (MDT) meeting.
- Post-surgery: document given to person operated on at time of discharge for the attention of health professionals tasked with continuing their care; personalised follow-up record completed with at least a medico-surgical follow-up consultation schedule for the first year and therapeutic patient education sessions, an emergency contact; person's record: summaries of medico-surgical consultations, general practitioner or advanced practice nurse consultations, therapeutic education sessions or series of sessions in group or individual settings (dietitian, tailored exercise programme professional, etc.).

## Be attentive to specific situations

### 18. Prevent overweight and its progression to obesity in people with disabilities. Support the person before and after bariatric surgery [Updated Feb 2024]

- Promote access to prevention messages and patient education in order to support lifelong adaptations and lifestyle changes, involving the families and/or healthcare professionals that care for the person if applicable.

- Ensure the early prevention of overweight and its progression to obesity by proposing a multi-component assessment, with additional vigilance and adjustment depending on the disability. Involve families and/or medico-social service or facility professionals.
- Adapt the physical activity recommendations for the general population to the desires, needs and functional capacities of people with disabilities: assess the need for a prescription for adapted physical activity and prescribe it following a medical consultation.
- Seek a specialist opinion in the event of severe obesity associated with eating disorders or clinical signs suggestive of obesity with a rare cause.
- If bariatric surgery is proposed, it is necessary to ensure accessibility for surgery preparation sessions, and their adaptation, and encourage a loved one's presence if the person wishes.
- If the person has a disability with impaired function and adaptive behaviours: assess the person's actual level of autonomy in day-to-day tasks, their organisational skills, their mental flexibility and the scope for effective post-surgery support and care, taking into account the person's expectations and preferences and those of their loved ones.
- If the person has a physical disability: improve the person's function and autonomy in day-to-day tasks, their level of physical activity with assistance from a physical medicine and rehabilitation physician.

## 19. In women with obesity, ensure regular gynaecological follow-up, identify any risks before and during pregnancy, be vigilant in the event of bariatric surgery, monitor weight evolution during and before pregnancy and support a return to a healthy weight

- Address the person's relationship with their body, the impact on their emotional or sex life, the wish for contraception.
- Ensure regular gynaecological and breast examinations and cervical smears, which may take longer or be more difficult to perform: adopt a respectful and non-stigmatising attitude, use adapted equipment, seek the support of a specialised department if necessary.
- Systematically propose a preconception consultation to all women with overweight or obesity planning a pregnancy: screen for cardiovascular risk factors, dyspnoea, diabetes, due to the risk of complications during the pregnancy, delivery and the postpartum period.
- Medically assisted reproduction (MAR) or assisted reproductive technology (ART) should not be delayed or made conditional on an unrealistic weight loss goal.
- Support the weight goals of pregnant women based on their initial BMI.
- Encourage pregnant women to start or continue regular physical activity during their pregnancy, with adaptations if required, and to improve their diet.
- For women with overweight or obesity before pregnancy, or whose BMI has increased during pregnancy or during the postpartum period, without weight loss one year after delivery, propose a personalised care plan based on a multi-component assessment, aimed at stabilising weight and then losing it progressively, at the same time continuing regular physical activity.
- For any woman having had bariatric surgery, systematically organise specialised multidisciplinary monitoring in terms of nutrition and obstetrics as soon as the pregnancy is planned or, failing that, as soon as the pregnancy is confirmed. A laboratory workup should be conducted every three months with personalised correction of deficiencies based on laboratory results.

- In the absence of nutritional follow-up following bariatric surgery: prescribe minimal and systematic supplementation as soon as the pregnancy is planned, step up monitoring with three-monthly laboratory workups (vitamins and minerals, protein status), a physical examination, weight monitoring, a systematic nutritional consultation as soon as the pregnancy is diagnosed, to be repeated at a frequency that will depend on the nutritional status.
- In the postpartum period, the multidisciplinary team responsible for the usual long-term postoperative follow-up of the woman having undergone bariatric surgery, defines a weight goal with her, and continues more frequent nutritional and surgical monitoring, in liaison with the general practitioner.

## 20. Encourage physical activity during the perimenopause and menopause, be vigilant in the event of high waist circumference

- Weight gain during this period is common but not systematic.
- Be vigilant, nonetheless, in the event of overweight combined with high waist circumference promoting cardiovascular risks.
- Encourage women to engage in daily physical activity: alleviation of perimenopausal symptoms, way of maintaining physical fitness, preventing loss of muscle mass and bone loss.
- In the event of overweight or obesity at the menopause: implement a moderate reduction in calorie intake and ensure an adequate protein intake, combined with regular physical activity.

This document presents the main points of the publication: Overweight-obesity in adults: 20 key messages to improve practices - January 2023 **- updated on February 2024**
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