

Barriers and Facilitators in the Implementation of Family-based Overweight and obesity Care, as perceived by municipalities and healthcare professionals: A Qualitative Analysis Using CFIR

Noa Bominaar
2822601

Master Thesis
Number of ECs: 27
Word count: 8681

VU Amsterdam, Care for Obesity (C4O)
Bibian van der Voorn, b.van.der.voorn@vu.nl (VU-supervisor) & Renée IJzerman,
r.v.h.ijzerman@vu.nl (on-site supervisor)

Master Health Sciences
Specialisation: Prevention and Public Health
Faculty of Science
Vrije Universiteit Amsterdam

July 25, 2025

Abstract

Introduction

Overweight and obesity represent significant public health challenges worldwide, affecting both children and adults. In the Netherlands, two integrated care models have been developed. While these models are primarily designed to target either children or adults and operate in parallel, many families require simultaneous, cross-generational support. Integrating these care models within the family context remains challenging. This study aims to systematically identify the barriers and facilitators experienced by policy makers and healthcare professionals in implementing a combined approach to integrated care for overweight and obesity in both children and adults within the family context.

Methods

A qualitative case study design was employed, incorporating focus groups, semi-structured interviews, and Learning Community sessions. Participants included five project leaders and eleven central healthcare professionals from five pilot municipalities, who were involved in developing and implementing the combined approach. Transcripts were analysed using the Consolidated Framework for Implementation Research.

Results

Key facilitators included the adaptability and substantive added value of the combined approach, a family-centred care culture within local teams, the dedication of healthcare professionals, and structured reflection. Key barriers included a lack of structural clarity and complexity of the combined approach, fragmented policy and insecure funding, privacy regulations, limited information technology integration, a lack of structural embedding and commitment, and insufficient capacity. Professionals also reported low self-efficacy for co-managing child and adult care, discussing weight, and a lack of an integrated family intake strategy.

Conclusion

Implementing a combined approach to integrated care for both adults and children within the family context is perceived as complex and vulnerable. Findings highlight the need for comprehensive implementation strategies that address systemic and structural barriers in policy and funding, strengthen interdisciplinary collaboration, foster cross-sector connections, and support healthcare professionals in delivering coordinated, family-centered care that meets the needs of both children and adults.

Keywords: Integrated care, overweight, obesity, family-based care, implementation, CFIR, healthcare professionals, policymakers, Public health

Introduction

Overweight (defined as a body mass index (BMI) of 25 kg/m² or greater) and obesity (defined as a BMI of 30 kg/m² or greater) are recognized as growing global public health concerns (1,2). Based on WHO evaluations, the global prevalence of obesity reached one in eight people in 2022, amounting to approximately 890 million people worldwide (2,3). In the Netherlands, 14.7% of children and 50% of adults were classified as overweight in 2024, with 2.5% and 14% respectively suffering from obesity (4). These conditions are associated with a range of short- and long-term physical and psychosocial health problems, such as type 2 diabetes mellitus, cardiovascular disease, and depression (5,6). The development of overweight and obesity is multifactorial, driven by a complex interplay of biological, psychological, social, and environmental factors (7,8). Within these factors, the family environment plays a particularly influential role. Parental attitudes, behaviours, and weight status significantly influence the likelihood of children developing overweight or obesity (9–11). Moreover, obesity often occurs across multiple family members simultaneously, due to both genetic predisposition and shared behavioural patterns (12,13).

Given the multifactorial and family-influenced nature of overweight and obesity, effective interventions require integrated care (14). Integrated care, also known as network care, involves collaborative efforts among various professionals and organisations, coordinated around the needs of a specific target group, with the proper support provided at the right time by the right professionals (14,15). In the Netherlands, two national models have been developed to operationalize integrated care for overweight and obesity: the National Model for Integrated Care for Childhood Overweight and Obesity (2018) (16) and the Basic Model Network Approach for Adults with Overweight and Obesity (2023) (17). Both models are structured around a shared six-step trajectory comprising: (1) early identification, (2) comprehensive assessment, (3) care planning, (4) role allocation, (5) intervention, and (6) long-term follow-up (18). They adopt a multidisciplinary and cross-sectoral approach, fostering collaboration between professionals from both the healthcare and social domains. Each care trajectory is coordinated by a designated professional (e.g., Health Care Professional [HCP]), who ensures continuity and coherence of care. In the child model, this role is typically fulfilled by a Central Care Provider (CCP), whereas in the adult model, coordination is assigned to a Central Care Coordinator (CCC). Across both models, the process begins with a broad, multidisciplinary assessment to explore medical, psychosocial, and lifestyle-related factors. The results inform a personalized care plan, with lifestyle intervention forming the cornerstone of the treatment (15,18). Both models align with the Dutch national public health initiatives, such as the Dutch government's Gezond en Actief Leven Akkoord (Healthy and Active Living Agreement [GALA]) and the Integraal Zorgakkoord (Integrated Care Agreement [IZA]), which aim to achieve nationwide implementation of integrated care models for children and adults by 2025 (19,20).

Despite structural similarities, the two models differ in terms of entry point, target group, and system organisation. The child model focuses on the child–parent unit, with initial identification

occurring through routine Youth Health Care (YHC) screenings. A broad psychosocial and lifestyle assessment typically precedes any medical examination. Coordination is provided by a CCP, typically embedded within YHC, and funding is ensured through the Youth Act, resulting in no direct costs for families. In contrast, the adult model targets individual adults who usually enter care through their General Practitioner (GP) after obesity-related symptoms have emerged. Intake often begins with a medical or risk-factor evaluation, sometimes accompanied by a psychosocial assessment. Care coordination is assigned to a CCC, such as a GP or practice nurse. Still, it lacks a uniform reimbursement structure, which may result in patients having to pay part of the costs themselves. Moreover, whereas the child model emphasizes parenting and family dynamics early in the process, the adult model foregrounds societal context and personal responsibility, with environmental support addressed later (18).

Although the two integrated care models for children and adults primarily operate in parallel, in practice, many families require simultaneous, cross-generational support for overweight and obesity. The child model is often described as family-centred due to its emphasis on the family context. However, both models are primarily designed to target either children or adults, and thus, are insufficiently addressed by families in which both the child and the adult require support. Additionally, the shortage of HCPs and high care demands within the population highlight the need for a practical, collaborative, and combined approach to integrated care that addresses the needs of both children and adults within a family (hereafter referred to as the combined approach). This need has been acknowledged by Dutch municipalities, project leaders, and professionals across the medical and social domains. Yet, to the best of our knowledge, no practical tools currently exist to facilitate the implementation of such a combined approach in practice.

To explore the practical implementation and substantive application of the models, a nationwide pilot is currently underway. Participating municipalities are exploring how to integrate one or both models and are involved in a Learning Community (LC), where professionals from policy and practice exchange experiences. Previous literature has identified common barriers to implementing integrated care in various healthcare settings, such as limited organisational engagement, conflicting stakeholder priorities, inadequate resources, fragmented technical systems, financial misalignment, unclear roles, and insufficient coordination between care providers (21). Although these barriers are well-documented in general terms, systematic research specifically addressing the implementation barriers and facilitators relevant to a combined child- and adult-focused approach within one family remains scarce. Therefore, a comprehensive investigation is necessary to determine which factors most significantly influence the integration of care models, such as those examined in the current study.

Implementation science provides a systematic approach to integrating evidence-based interventions into routine healthcare and public health settings, addressing the complexity of real-world challenges (22,23). In the context of integrated care within families, implementation science can provide practical strategies to ensure that healthcare providers deliver more effective and efficient support to

families dealing with overweight and obesity (23,24). A widely utilized framework in implementation science is the Consolidated Framework for Implementation Research (CFIR) (25,26), designed to identify and explain the barriers and facilitators that influence implementation success. CFIR categorizes these determinants into five domains: Innovation, Inner Setting, Outer Setting, Individuals, and Implementation Process (26). Evidence has shown that the determinants included in each domain are key factors that affect implementation effectiveness (27). By applying the CFIR framework, this study aims to systematically identify the barriers and facilitators specific to this combined approach as experienced by key stakeholders such as municipal project leaders (MPLs) and HCPs involved in both adult and paediatric care. This study seeks to uncover practical implementation strategies to strengthen interdisciplinary collaboration, facilitate connections between disciplines and organisations, and provide actionable insights for implementing care models effectively to better address individual needs within a family approach. The central research question is: *What barriers and facilitating factors influence the implementation of a combined approach to integrated care for overweight and obesity for both children and adults within the family context, as perceived by municipalities and healthcare professionals?*

Methods

Study Design

This study employed a qualitative, exploratory case study design to gain an in-depth understanding of how the combined approach is implemented in practice. The study adopted an interpretivist perspective, grounded in a constructivist epistemology, which assumes that knowledge is socially constructed and developed subjectively through interaction between the researcher and participants (28,29). Participants' interpretations were shaped by their professional roles, organisational settings, and broader policy environments. This perspective aligns with the study's aim to explore how HCPs and policy stakeholders perceive and interpret the implementation of the combined approach across different municipal contexts.

National pilot project

This study was embedded in a national implementation pilot project, initiated by Dutch municipalities, in collaboration with 'Jeugd op Gezond Gewicht' (JOGG), the 'Partnerschap Overgewicht Nederland (PON), and 'Care for Obesity' (C4O). This pilot project, which runs from January 2024 to December 2025, explores how two existing care models, one for children (2018) and one for adults (2023), can be integrated into a combined approach to integrated care for overweight and obesity for both children and adults within the family context.

The pilot project served as a real-world implementation setting in which the combined approach was tested and adapted. At the time of data collection, the combined approach was being piloted in three municipalities. Initially, five municipalities were involved in early 2024, but participation changed during the implementation process due to contextual challenges. Participating municipalities are among those taking a leading role, with relatively advanced experience and ambitions regarding the implementation of integrated care. They vary in their implementation stage, ranging from early exploration to the practical application of child and/or adult models, allowing for diversity and an understanding of implementation across different local contexts. As part of the pilot, a LC was established to support the implementation of the combined approach. The LC is a structured collaborative platform led by the national project leaders from JOGG and the PON, bringing together the MPLs of participating municipalities. Monthly sessions were organised to facilitate inter-municipal learning, share knowledge, and reflect on implementation challenges. The pilot was funded through a national grant provided by the Dutch Ministry of Health, Welfare and Sport (30).

Study population and recruitment

The study population consisted of five municipalities involved in the national implementation pilot, including both those actively participating at the time of data collection and those that had withdrawn earlier in the process. Each municipality included professionals from both policy and practice. Typically, this involved an MPL, responsible for local coordination, as well as one or more HCPs providing direct care to families, such as CCPs for children and CCCs for adults. Municipalities

were initially approached in early 2024 through purposive sampling via the professional networks of JOGG and PON. Each municipality received a formal invitation via email, which included detailed information on the pilot's objectives, requirements, and intended research activities. When a municipality agreed to participate, a follow-up information letter specifically about the research study was sent (Appendix 1), detailing the study's aim, data collection procedures, duration, and use of data. Subsequently, professionals were asked to provide written informed consent (Appendix 2) for the confidential use of project data for research purposes. Informed consent was obtained digitally after participants had sufficient time to review the materials and ask questions.

In line with implementation science recommendations (31), and the embedded nature of this study within an ongoing pilot project, the sample reflected all key actors involved in implementation. All included professionals had at least six months of experience in delivering integrated care for overweight and obesity. Exclusion criteria included an inability to communicate in Dutch and/or understand Dutch materials, and a lack of consent from their employer to invest extra time in this pilot, beyond their regular job responsibilities. To facilitate participation, travel and logistical costs were reimbursed where applicable. No additional financial compensation will be provided.

Data collection

Data collection consisted of both retrospective and prospective components. Retrospective data included previously conducted focus group discussions, while prospective data were collected through new one-on-one semistructured interviews, LC sessions, and additional focus groups initiated during the study. This combination allowed for a comprehensive understanding of stakeholder experiences across diverse local municipal contexts. The CFIR was applied as an analytical framework to systematically identify barriers and facilitators across five domains (26).

Procedure

First, focus groups were conducted prospectively between February 2024 and early 2025, involving MPLs from each municipality with their respective CHPs, who participated in the pilot. These sessions aimed to explore early experiences with implementing the combined approach and included structured reflection on the model's six-step trajectory. The focus groups were conducted by a senior researcher in childhood obesity at Vrije Universiteit Amsterdam. Based on insights from the focus groups, a semistructured interview guide was developed using the CFIR (26). This guide structured the interviews across CFIR's five domains: (i) Innovation: how the combined care approach is perceived, such as design features, perceived advantages and potential adaptations within the family context; (ii) Outer setting: the setting in which the inner setting exists, such as a healthcare policies, healthcare system and funding; (iii) Inner setting: organisational structures, including collaboration, communication, culture and available resources; (iv) Individuals: the roles and motivations, capability and readiness of professionals in care delivery; (v) Implementation process: the strategies and activities

used to implement the combined approach. This approach enabled the systematic identification of facilitators and barriers influencing the implementation process across various municipal contexts (26). Barriers refer to factors that hinder the implementation of the combined approach, while facilitators are those that enable or support it. Building on CFIR research (27,32), and a previous CFIR-based study in implementation research (33), an interview guide was developed (Appendix 3) and refined in collaboration with the research team, including a postdoctoral supervisor experienced in qualitative and implementation research (R.V.H.IJ.) and a research intern (L.L.). Interviews were conducted in May 2025 by the primary researcher (N.M.B.), a female research intern and Master student with prior experience in qualitative interviewing, under close supervision of R.V.H.IJ.

The interview was divided into three parts, starting with an explanation of the study's objectives and a brief overview of the interview structure (Appendix 4). In the second part, participants were asked general questions about their role within the organisation, their assigned responsibilities, and their perspectives on the conditions necessary for the successful implementation of the combined approach. The third part included questions structured around the five CFIR domains (26), aiming to systematically identify barriers and facilitators in the implementation of the combined approach. To support this process and structure the conversation, a PowerPoint presentation was used to display a detailed overview of all CFIR constructs for each domain on screen, and they were reviewed together at the start of the discussion. Each domain was discussed separately, with participants encouraged to reflect on their implementation experiences, including both successes and challenges. Open-ended questions were used to facilitate reflection, followed by additional follow-up questions to ensure that all relevant CFIR constructs were covered. The interview guide was revised after the first three interviews to better align with initial insights from the field. In interviews with project leaders whose municipalities had discontinued their participation in the pilot, the questions were phrased in the past tense and tailored to reflect their specific implementation context.

Additionally, the researcher participated in three LC sessions as a participant-observer, adopting an insider-outsider role to gain a deeper contextual understanding of MPLs' interactions, collaboration processes, and implementation dynamics (34). During these sessions, field notes were collected to capture observations of group discussions. These notes were not analysed as primary data but served as supplementary contextual material to support interpretation and reflexive analysis throughout the study (35). All semistructured interviews, LC sessions, and focus groups lasted approximately 60-90 minutes, were audio recorded, and transcribed verbatim using Amberscript. Interviews and LC were conducted online via Microsoft Teams, while focus groups took place either face-to-face or via Microsoft Teams, based on participant preference. All interviews were scheduled and, if necessary, rescheduled via email. Participants received a secure link upon confirmation to access the online interview platform. All transcripts were pseudonymized, and field notes were taken to capture contextual observations.

Data analysis

Data collection and analysis were conducted concurrently. The collected data were analysed using the template analysis method, following the qualitative data analysis software program MAXQDA 2024 (36). This is a specific variant of thematic analysis, which emphasizes hierarchical coding and provides a structured approach to analysing textual data, while also offering the flexibility needed for specific research needs (37). The initial coding framework was grounded in five CFIR domains overarching 48 constructs and subconstructs of the CFIR. During the analysis, two additional codes emerged inductively from the data: ‘Design clarity’, which was placed under the domain of ‘Innovation’ to reflect participants’ emphasis on the need for structural clarity and a coherent design; and ‘structural characteristics’ from the Inner Setting domain, which was positioned under ‘Implementation Process’ to capture aspects related to the organisation structure of the national pilot-project. An overview of the final coding structure is provided in Appendix 5, Fig. A1.

The interviews, LC sessions, and focus groups were analysed by the primary researcher using a structured four-step procedure, supported by regular feedback and substantive consultation with the research team. First, all transcripts were carefully read in full to ensure familiarity with the data and its context. In the second step, all data fragments were coded using the CFIR framework. This coding was independently reviewed by L.L. Any discrepancies in construct or domain assignment were discussed until consensus was reached. Additionally, R.V.H.IJ. independently reviewed the coding of one full transcript and discussed the coding and interpretation with the primary researcher. In the third step, the primary researcher drafted summaries for each construct, which L.L. reviewed. R.V.H.IJ. also reviewed and provided feedback on the construct summaries within one CFIR domain. Any remaining differences in interpretation were discussed until a consensus was reached. Finally, all construct summaries were ultimately collected according to the CFIR domain and classified as either facilitating or barrier based.

Ethical approval and consent to participate

At the start of the national pilot project, in September 2024, all participating professionals provided written informed consent for both their participation in the pilot’s implementation activities and the related research components. Participation was explicitly described as voluntary, and it was clearly communicated that withdrawal at any time would have no negative consequences for participants or their municipality. Re-consent was not required for additional interviews or data collection moments. However, verbal reaffirmation of consent was requested at the start of each interview. Throughout the study, ongoing consent was monitored by regularly checking participants’ comfort. If a participant withdrew, a joint decision was made about whether already collected pseudonymised data could still be used or should be deleted. To ensure confidentiality, audio recordings were transcribed and pseudonymised immediately, after which the original files were securely deleted. Identifiable personal data were excluded from analysis and reporting. A secure code key linking pseudonyms to participant identities was stored on an encrypted research drive at Vrije Universiteit

Amsterdam, accessible only to the primary researcher and direct team members. Before participation, written informed consent was obtained from all participants. Audio recordings were securely stored, and transcripts were pseudonymized to protect participants' privacy.

Furthermore, this study adheres to the Faculty of Science's Code of Ethics at Vrije Universiteit Amsterdam. It complies with the ethical guidelines outlined in the Dutch Medical Research Involving Human Subjects Act (38). The Medical Ethics Review Committee (METC) reviewed the pilot study. It concluded that the Medical Research Involving Human Subjects Act (Wet maatschappelijke ondersteuning [WMO]) does not apply to this research and that an official approval by their committee is not required.

Methodological rigour

To ensure methodological rigour, several strategies were employed. The interview guide was designed based on CFIR (26) and previous research within the research group, enhancing the credibility and dependability of the qualitative research findings (33,39). The guide was iteratively refined after initial interviews, allowing for contextual sensitivity and emerging insights (40). Peer debriefing was used throughout the coding process, and member checks were conducted by sending participants a summary of their interview shortly after data collection. This allowed them to validate the researcher's interpretation, provide corrections, or add clarifications, thereby strengthening the accuracy and credibility of the findings (41,42). Researcher triangulation was employed throughout the process to minimize interpretive bias and enhance the validity and reliability of the results (43). Coding was performed systematically using MAXQDA (36), based on a pre-established CFIR template, with independent review and consensus discussions to enhance analytical reliability. Credibility and consistency of the findings by enabling a structured yet flexible exploration of relevant CFIR constructs. Finally, this study is reported by the Consolidated Criteria for Reporting Qualitative Research checklist (COREQ) (Appendix 6), which was used to enhance the rigor and transparency of both the study's conduct and its subsequent description (44).

Results

Participants' characteristics

A total of sixteen participants were included in the study: five MPLs and eleven HCPs. Of the participants, thirteen were female and one was male. Participants represented five different pilot municipalities, encompassing the local setting and variation in the implementation phase and organisational structure. The sample included various implementation roles, as outlined by the CFIR, along with tasks that supported the implementation of the combined approach. All five MPLs acted as implementation leads, often combining these roles with responsibilities across governance levels (e.g., local and provincial) and domains (child and adult care). They also fulfilled the role of mid-level leaders (e.g., coordinating programs, managing networks) and implementation facilitators, supporting frontline professionals and contextualizing the model within their municipality. This combination of strategic and operational responsibilities provided a rich insight into the implementation dynamics of the combined approach. The HCPs acted as innovation deliverers, providing direct care within the combined approach and collaborating with professionals from both the medical and social domains. At the same time, they fulfilled the role of implementation facilitators, using their substantive expertise to support implementation efforts. In addition, they were part of the implementation team, working closely with the national project team and MPLs to implement the combined approach. They contributed to aligning care trajectories, strengthening frontline collaboration, and actively incorporating families' needs into the development and delivery of care.

Overview of influencing factors

To present the factors influencing the implementation of the combined approach in a clear and structured way, the findings are organised according to the CFIR domains. For each domain, the influencing factors are presented in tables. Factors that were frequently mentioned by participants or perceived to have a substantial impact on the implementation process are designated as 'key barriers' or 'key facilitators'. Other, less dominant but still relevant factors are categorised as 'barriers' or 'facilitators' (Appendix 7). To contextualise participants' perspectives, all quotes include the speaker's role and the data source from which they were derived (e.g., interview, focus group, LC session).

CFIR Domain 1. Innovation influencing implementation

Table I below provides an overview of two key facilitators and two barriers related to the innovation. Supporting quotes illustrate how these factors influenced the implementation of the combined approach.

Table I

Overview of identified themes within the CFIR domain ‘Innovation influencing implementation’

Theme	Quotes
Key facilitators	
Adaptability of the combined approach	‘One of the major strengths, in my view, is the degree of autonomy we have. While we operate within municipal frameworks, I am given the space to determine what would work best for our context. It’s essentially: try it out and make it work. I consider that a very positive aspect of this pilot.’ [MPL - Interview]
Substantive added value of the combined approach	We increasingly see that you can’t really separate the child from the parents when addressing overweight. Of course, parents are already being supported, but it’s strange that we’re still working with two separate approaches.’ [MPL - Interview]
Key barriers	
Lack of clarity in structure and implementation	‘We’re really pioneering here. Is it clear what you’re supposed to do, with whom and when? The answer is no.’ [MPL - Interview]
Complexity of the combined approach	‘Combining care for child and parent requires intensive coordination, time, and engagement across a complex system and vulnerable family situations that involve more than just obesity. And that’s really challenging.’ [HCP - Focus groups]

MPL: municipal project leader; HCP: healthcare professional

A key facilitator was the ‘adaptability of the combined approach’. It was perceived as flexible and capable of being tailored to different local systems, organisational structures, and family needs. Several HCPs noted that strict parallel execution of the child and adult trajectories did not reflect how families engage with care in practice. Instead, they emphasised the importance of allowing phased entry and tailored guidance, aligned with the motivation and readiness of each family member. This

highlighted the importance of adaptability in aligning the combined approach to real-life family needs. It was seen as essential, ensuring the relevance and feasibility of simultaneously guiding both child and adult across diverse municipal contexts. Another key facilitator was the perceived ‘substantive added value of the combined approach’. Participants noted that separate care trajectories often fell short in practice. By combining both models into one coherent pathway, the approach was viewed as more effective and better aligned with families’ needs than existing practices.

A key barrier within the innovation domain concerned the ‘lack of clarity in structure and implementation’ of the combined approach. At the start of the pilot, both MPLs and HCPs reported ambiguity about what the approach entailed, who was responsible for what, and how to organise care trajectories. MPLs noted that, in the absence of concrete protocols or frameworks, municipalities and professionals essentially had to determine locally how to shape the combined approach. Particularly in the initial phase, they were searching for structure, role delineation, and practical guidance for HCPs involved in family-based delivery. Despite supportive input from national partners, the process was widely described as exploratory and cognitively demanding, with MPLs referring to it as a pioneering phase. While the open-ended nature of the pilot allowed for local adaptation, it also contributed to ongoing uncertainty around appropriate execution. The experienced ambiguity and sense of searching within the implementation did not stand alone. Still, they were closely connected, according to MPLs and HCPs, to a second key barrier: ‘the complexity of the combined approach’. This term was frequently mentioned across interviews, focus groups, and LC sessions. The implementation of the combined approach requires intensive coordination across various domains and organisations, operating within a fragmented and complex care system. One MPL referred to this as a ‘complex care landscape’. Furthermore, the complexity of the target group significantly contributes to these challenges. Families in which both children and parents are affected by overweight or obesity often live in vulnerable circumstances. HCPs noted that these families regularly deal with broader psychosocial issues such as financial stress, parenting difficulties, or mental health problems. As a result, care provision is not solely focused on obesity, but must address the broader family dynamics and the underlying social determinants of health.

CFIR Domain 2. Outer setting influencing implementation

Table II summarises three key barriers identified within the outer setting. Quotes highlight how external factors influenced the implementation process.

Table II

Overview of identified themes within the CFIR domain ‘Outer setting influencing implementation’

Theme	Quotes
Key barriers	
• Misaligned and insecure funding structures	• ‘There’s major uncertainty about funding beyond 2026. We call it the fiscal cliff year. That affects our ability to plan or structurally embed anything.’ [MPL - Interview] • ‘The reimbursement structures for the child and adult approaches are not aligned. The role of the CCP will only become clear in November, whether it will be continued in 2026. We expect that continuation may be possible through health insurer funding, but perhaps not through municipal funding for adults. So how will you shape this after 2026? That really touches on the structural embedding of the combined approach within municipalities, and also on the division of roles you aim to establish.’ [MPL - Interview]
• Fragmentation of national policy streams	• ‘Fragmented policy streams create structural complexity. The political conditions were unfavourable. The IZA and GALA policies were under pressure, and the funding for adult overweight and obesity care was not well arranged.’ [MPL – Interview]
• Privacy regulations hindering cross-domain collaboration	• ‘Because of the GDPR, everyone ends up working in silos, even though you want to present yourself to families as one coordinated network. Within such a network, being able to share information should be the norm, not a dilemma.’ [HCP - Interview]

MPL: municipal project leader; CCP: central care provider; HCP: healthcare professional; GDPR: General Data Protection Regulation

A key barrier within this domain was the ‘misalignment and insecurity of funding structures’. In nearly all municipalities, participants reported considerable uncertainty about the future of financing, particularly beyond 2026, the so-called fiscal cliff year (in Dutch: Ravijnjaar) (45). Municipalities and professionals were unsure whether, and in what form, national support for the approach would continue. Additionally, the reimbursement systems for children (typically funded by health insurers) and adults (funded by municipal budgets) were not aligned. This discrepancy created challenges for role division, coordination, and long-term integration of the approach into local policy and practice. As the MPLs

noted, this directly impacted the structural anchoring of the combined approach within municipal systems. Another frequently cited barrier was the ‘fragmentation of national policy streams’. Participants referred to a multitude of national programs (e.g., IZA, GALA, and the Specific Grant for Public Health Tasks [SPUK]) that operate in parallel but are often uncoordinated or even contradictory in practice. Although these programs have separate objectives, their cumulative effect was perceived as increasing organisational complexity. The MPLs noted that they usually had to search for local workarounds, as a lack of overarching clarity at the national level made this task difficult. In addition, HCPs described ‘privacy regulations’ as a structural key barrier to cross-domain collaboration. While aiming to provide families with coherent support, participants noted that strict interpretations of the General Data Protection Regulation (GDPR), a European privacy law governing the processing and sharing of personal data, often limit information sharing across sectors. As a result, professionals supporting children and those supporting adults frequently operated in parallel, with limited opportunity for collaboration.

CFIR Domain 3. Inner setting influencing implementation

Table III presents an overview of key facilitators and barriers identified within the inner setting. Quotes provide insight into how organisational conditions influenced implementation.

Table III

Overview of identified themes within the CFIR domain ‘Inner setting influencing implementation’

Theme	Quotes
Key facilitator	
Relational, family-centred culture	‘Standing alongside families and attuning to their needs fosters trust, openness, and engagement in care.’ [HCP - Focus groups] ‘Healthcare professionals recognise the shame, taboo, and stigma often surrounding overweight and obesity. They are aware of potential judgment and cultural sensitivities and strive to adopt a respectful and non-judgemental communication style.’ [MPL - LC]
Key barriers	
Poor IT-integration	‘The organisations involved use different systems that are not interoperable. This results in duplicate data-entry, frustration among care providers, and inefficient working processes.’ [MPL- Interview]
Capacity and widespread staff shortages	‘Capacity issues were noted both at the municipal level and among municipalities and implementing organisations. Personnel shortages, long-term staff absences, and unfilled vacancies led to delays in decision-making and limited execution capacity’. [MPL - Interview]
Lack of structural embedding and commitment	‘Maintaining commitment is often more difficult than creating it.’ [MPL - Interview]

IT: information technology; MPL: municipal project leader; HCP: healthcare professional

A key facilitator described by HCPs was the presence of ‘relational, family-centred culture’ within organisations. Although still developing, this culture was seen as essential for effective family-based care. Professionals emphasised the importance of first establishing trust and psychological safety, often through a home visit or follow-up phone call, before addressing care content. Culturally sensitive practice was also considered crucial: factors such as respectful communication, language use, timing, privacy norms, and family dynamics influenced openness. Standing alongside families, rather than opposite them, was regarded as fundamental to respectful and effective engagement.

A key barrier reported by multiple municipalities was the ‘poor IT-integration’. MPLs noted that the involved organisations used different digital systems that were not interoperable. This lack of integration resulted in duplicate data entry, inefficiencies, and frustration among HCPs. In some cases, data still had to be entered manually into Excel files. MPLs described this as a frequent and time-consuming obstacle. The absence of structural system linkages, combined with the complexity of privacy regulations, further complicated the secure and efficient exchange of client information between organisations. Another reported key barrier was organisational ‘capacity and widespread staff shortages’. Across all participating municipalities, shortages within general practices, YHC, mental health services, and community teams were described as constraining implementation. Participants cited high workload, long-term absenteeism, and open vacancies as contributing factors to delays in decision-making and reduced implementation capacity. These challenges affected both municipal actors and service providers and were reported to place pressure on the availability of HCPs. A third key barrier identified across municipalities was ‘the lack of structural embedding and commitment’ of local implementation structures, which were often highly dependent on one or two individual stakeholders, such as a project leader or a policymaker. When these individuals changed roles or left, implementation frequently stalled or lost momentum. This vulnerability was attributed not only to staff turnover but also to the absence of structurally embedded roles and clearly defined responsibilities. In some cases, coordination was transferred to another organisation without explicit agreements, leading to confusion about leadership and a lack of oversight. Furthermore, sustaining organisational commitment required ongoing effort, as new colleagues and managers had to be repeatedly informed about the project’s aims, scope, and procedures. This recurring need for onboarding placed a considerable burden on local teams, particularly in municipalities where the combined approach had not yet been formally integrated into routine organisational workflows.

CFIR Domain 4. Individuals influencing implementation

Table IV outlines one key facilitator and barrier at the individual level. Supporting quotes illustrate how these factors influenced the implementation of the combined approach.

Table IV

Overview of identified themes within the CFIR domain ‘Individuals influencing implementation’

Theme	Quotes
Key facilitator	
Dedicated and motivated HCPs	‘I really appreciate that we have two very enthusiastic care providers involved here in the municipality. So, make sure to involve people in this pilot who are truly motivated and willing to fully commit. You really need that, because when challenges arise, it’s those people who will keep things going. [MPL - LC]
Key barriers	
Professionals’ low self-efficacy for co-managing child and adult overweight within the same family	‘Providing support to adults myself was not an option. I don’t have that expertise. You’re stepping into a new area for which you’re simply not trained.’ [CCP – Focus groups]
Limited confidence and capability to address weight-related topics	‘Across different municipalities and among care providers, the question keeps coming up: How do we talk about weight? Even the youth nurse finds this very difficult. They want to refer someone to themselves, but struggle to bring it up, also because of the relationship they’ve built with the family.’ [MPL - Interview]

HCP: healthcare professional; MPL: municipal project leader; CCP: central care provider; LC: learning community

A key facilitator identified by several participants was the presence of ‘dedicated and motivated HCPs’, who played a crucial role in implementing the combined approach in practice. CCPs reported feeling personally engaged with the goals of the combined approach and described themselves, often implicitly, as ambassadors for integrated family care. Their enthusiasm was said to contribute not only to continuity but also to the engagement of colleagues. As a result, family-centred thinking was increasingly introduced in regular care processes. In some municipalities, professionals began to discuss the whole family more explicitly during multidisciplinary meetings, case reviews, and parent consultations. Although this did not always lead to immediate action, it fostered a growing shared awareness that overweight in both child and parent requires a joint response. MPLs confirmed this,

noting that motivated care providers played a central role in driving implementation forward. At the same time, they expressed concerns that maintaining this motivation was difficult when structural support, time, or clear procedures were lacking.

A key barrier was the ‘professionals’ low self-efficacy for co-managing child and adult overweight within the same family’. Several CCPs reported low confidence in addressing adult-related issues, particularly in the medical domain. They described not being trained for this type of care and emphasised that adult support requires fundamentally different expertise. While some were open to additional training, they indicated that the necessary knowledge and skills go beyond what can be covered in short courses. As a result, CCPs experienced hesitation and uncertainty when adult needs emerged. Participants expressed the need for structural support, including clear referral pathways, designated points of contact, and accessible professional back-up. Another key barrier was the ‘limited confidence and perceived capability to address weight-related topics’ among care providers. Across municipalities, both CCPs and project leaders described the topic as sensitive and complex. Providers reported hesitation due to uncertainty about how to approach the issue respectfully and effectively, fear of defensive responses, and concern about undermining the therapeutic relationship, particularly when rapport with the child had already been established. Cultural norms further complicated these interactions, with some families perceiving it as inappropriate to discuss adult health in the presence of children. Several professionals also reflected on the role of weight stigma, noting that addressing parental weight risked reinforcing appearance-based assumptions they explicitly aimed to avoid.

CFIR Domain 5. Implementation process

Table V summarises two key facilitators and one barrier related to the implementation process. Quotes show how these themes are illustrated through the experience of implementing the combined approach.

Table V

Overview of identified themes within the CFIR domain ‘Implementation process influencing implementation’

Theme	Quotes
Key facilitators	
Structured reflection and cross-site learning via the LC	‘The learning community was very valuable in this regard. It provided recognition and practical examples, especially for project leaders who were carrying the load on their own.’ [MPL - Interview]
Case-based reflection to support implementation of the combined approach.	‘During the meetings with CCPs and the medical expert, we discuss case studies using the six steps. This helps us reflect together on what works and where the bottlenecks are. We are currently mainly in steps 1 and 2 of the care trajectories, exploring questions such as: how do you gain insight into the whole family, and how do you involve the parent in an appropriate way during the conversation? It is very valuable to support and encourage care providers in this way’ [MPL – LC]
Key barrier	
Misalignment of integrated family intake strategy	‘A recurring obstacle is the way families enter the system. This is truly a bottleneck that calls for a different referral structure.’ [MPL – LC]

LC: learning community; MPL: municipal project leader

A key facilitator was the support provided through the ‘structured reflection and cross-site learning via the LC’. The MPLs described the monthly LC sessions and national pilot support as valuable components of the implementation process. The LC provided a structured space for shared reflection, exchange of experiences, and the development of new insights. During these sessions, municipalities discussed how the existing child and adult trajectories were organised in their local context and engaged in an initial orientation and/or further development of what the combined approach could entail at the local level. Participation fostered a sense of recognition, encouragement, and inspiration, particularly among project leaders who felt they were working in isolation. Contact with other municipalities, each at a different stage of development, was found to be enriching. Participants reported gaining both practical ideas and renewed energy, even in cases where the combined approach

was not ultimately implemented. Another key facilitator was the use of ‘case-based reflection to support implementation of the combined approach’. Across municipalities, structured case discussions were organised with MPLs, HCPs, and a medical expert familiar with the national model. By applying the whole trajectory in practice, step by step, using real-life cases, care providers developed a clearer understanding of the six process steps and how to apply them in daily work. These sessions enabled participants to identify what worked well, recognise barriers, and jointly explore possible solutions. The opportunity to reflect together on practical experiences strengthened mutual trust within teams and helped clarify roles, particularly for providers who were still defining their position within the combined approach.

A key barrier was the ‘misalignment of integrated family intake strategy’. HCPs reported that current intake structures are typically designed around individual trajectories, often starting with the child. Parents are usually involved at a later stage, which can lead to a lack of perceived relevance or ownership. HCPs observed that parents do not always view themselves as part of the target group and may resist participation, stating, for example, “I’m here for my child, not for myself.” According to participants, simultaneous engagement of the entire family from the outset could strengthen both involvement and the effectiveness of care. The role of GPs was also noted as critical; however, their familiarity with the approach and willingness to refer families as a whole varied considerably between municipalities. Even when GPs successfully accessed the adult care pathway, they were often unfamiliar with referring children to CCPs, limiting the potential for integrated family support.

Discussion

This study aimed to identify barriers and facilitating factors influencing the implementation of a combined approach to integrated care for overweight and obesity for both children and adults within the family context. By applying the CFIR, this study identified barriers and facilitators across five domains. Key facilitators included the adaptability and substantive added value of the combined approach, the development of a relational, family-centred culture within local teams, dedicated and motivated HCPs and structured reflection through cross-site collaboration and case-based learning to support the implementation of the combined approach. Key barriers were identified based on their substantial impact on the implementation process and the frequency with which they were mentioned. These included a lack of clarity in structure and complexity of the combined approach, misaligned and insecure funding structures, fragmented national policy streams, and privacy regulations that hindered cross-domain collaboration. Other frequently mentioned key barriers concerned poor IT integration, capacity (widespread staff shortages), lack of structural embedding, and commitment. Finally, professionals reported low self-efficacy (for co-managing child and adult overweight within the same family), limited confidence and capability to address weight-related topics, and the misalignment of integrated family intake strategy. These insights form the basis for the recommendations that follow, as this study also seeks to uncover practical implementation strategies. Particular attention is given to the most significant and frequently mentioned influencing key barriers. Examining these challenges provides insights into the systemic conditions that require attention to advance the combined approach to integrated, family-based care for overweight and obesity, while offering implementation implications for both policy and practice.

Two of the most impactful and consistently cited barriers to the structural and sustainable implementation of the combined approach concerned the misalignment and insecurity of funding structures, and the fragmentation of national policy streams, which was also perceived as a key barrier to implementation. Both MPLs and HCPs noted that they had to operate within a fragmented landscape of temporary national programmes (such as GALA, IZA and SPUK), short-term funding schemes, and separate financing regimes for youth and adult care. This environment was perceived as limiting their ability to coordinate efforts, allocate responsibilities, and invest in long-term collaboration. These systemic challenges became particularly apparent throughout the course of the pilot. Although five municipalities initially joined, only two remained active by the time of data collection. All project leaders attributed this dropout primarily to financial uncertainty and the absence of overarching policy coherence, often in combination with limited internal capacity within local teams. Even in the remaining municipalities, the lack of structural financial embedding was mentioned as a critical barrier to continuity and scale-up. Taken together, these findings point to a central theme in this study: the implementation of integrated, family-centred obesity care is significantly constrained by systemic misalignments within the current financing and policy landscape.

These findings are consistent with broader literature on the implementation of integrated care. A recent report confirms that other promising regional pilots from Dutch municipalities also struggle to scale up due to systemic limitations in national funding structures and policy frameworks (46). The pilot municipalities in the current study face similar challenges, including fragmented financing, weak cross-sector accountability, and a lack of integrated governance. Dutch studies on integrated youth care likewise highlight these systemic issues (47). Another international study further supports these findings, showing that the scale-up of integrated care is hindered not only by local implementation challenges, but more fundamentally by macro-level system barriers, such as fragmented funding, unclear responsibilities, and limited policy alignment (48). These findings show that the barriers observed in this study reflect broader systemic issues in cross-sectoral care integration.

To enable the sustainable implementation of integrated, family-centred obesity care, it is essential to address the current fragmentation in national financing and policy structures. Various implementation studies have formally demonstrated that policy context significantly affects the adoption and success of innovations (49). A strong “policy push” in the early stages of implementation, especially through the provision of a dedicated funding stream, has been shown to increase the likelihood of successful uptake (49,50). This policy support must occur at the national level. Without structural alignment between financing schemes and policy frameworks, municipalities remain unable to embed integrated care approaches in a lasting way. According to Expert Recommendations for Implementing Change (ERIC) (51), national implementation efforts should involve existing governance structures, such as boards of directors or intersectoral steering groups, to ensure coordinated oversight and continuous evaluation of implementation processes. Additionally, governments and funding bodies are advised to adopt contracting mechanisms that incentivise innovation delivery, for example by issuing targeted calls for proposals and developing new financing models that increase the likelihood of sustained implementation. These ERIC strategies can help reduce fragmentation and foster long-term commitment among local stakeholders. Lastly, the development of meso-level integration mechanisms has been proposed to bridge structures that connect macro-level policy goals with local delivery realities. Rather than focusing solely on micro-level practice change or top-down system reform, sustainable implementation requires this ‘missing middle’: mechanisms that enable cross-sector coordination, align incentives, and foster shared accountability (52). Particularly in the Dutch context, where municipalities operate at the intersection of multiple domains (health, youth care, social policy), such structures could be essential for embedding integrated, family-based care into routine practice.

Another key barrier identified in this study and frequently mentioned by both HCPs and MPLs concerns the capacity and widespread staff shortages within primary and community-based care, such as GP, YHC, mental health services, and community teams. According to MPLs, in a field already characterised by high workload, long-term staff absences and unfilled vacancies further reduced the available implementation capacity. These findings are consistent with international literature that identifies workforce shortages, insufficient staff capacity, high turnover, and staffing instability as

common delivery structure barriers in integrated care interventions (53). In the current study, the limited capacity can be partly explained by the combination of existing workforce shortages in primary and community-based care and the additional demands of delivering integrated, family-centred obesity care. This approach requires HCPs to collaborate across domains while addressing the needs of both children and adults within the same family. It demands additional competencies, time, and coordination, yet lacks structural support and clearly defined roles. As a result, the already strained capacity for implementation is further challenged. Recent research highlights that addressing workforce shortages in integrated care requires more than simply increasing the number of professionals (54). Previous research suggests that sustainable improvement in access to care depends on the development of effective, well-supported interprofessional teams. These teams must consist of professionals who understand their own roles, appreciate each other's expertise, and navigate the broader health and social care systems collaboratively. A fundamental shift is needed away from siloed models of professional training and care delivery towards integrated communities of interprofessional learning, research, and practice. Supportive work environments, shared decision-making, and system-informed design and technology are seen as essential conditions for implementing integrated care successfully (54). For policy and practice, this implies the need to invest in team development, joint training programmes, and organisational structures that foster interprofessional collaboration and shared responsibility. National stakeholders can support this by creating targeted funding instruments, strengthening practice-based education, and developing practical tools to support sustainable team-based care delivery within family-centred obesity care. In line with ERIC recommendations, this also requires active strengthening of existing professional relationships and networks, both within and across organisations, to promote collaborative problem-solving and build a shared vision for implementation ('promote network weaving') (51).

The third key barrier identified in this study was the limited integration of IT systems across care domains, which significantly impeded collaboration between professionals in youth and adult care. Participants described working with separate digital systems that were not interoperable, leading to duplicate data entry, inefficiencies, and frustration in everyday practice. These findings are consistent with international literature, which identifies incompatible IT infrastructures across healthcare, social services, and general practice as a major barrier to integrated working (55–57). In this study, the issue was further exacerbated by a second structural barrier: privacy regulations that hindered cross-domain collaboration. Participants frequently referred to strict interpretations of the General Data Protection Regulation (GDPR), which constrained the exchange of client information between services. Particularly the legal uncertainty around sharing identifiable data caused professionals to adopt a cautious approach. As a result, youth and adult care providers often operated in parallel, without the ability to coordinate support for the same family. These observations align with prior studies that highlight how the GDPR can function both as a facilitator and a barrier for data sharing, depending on the clarity and consistency of national implementation (33).

From an implementation science perspective, IT infrastructure is increasingly recognised as a core component of successful integrated care. A recent systematic review identified integrated IT-systems as essential infrastructure that enables professionals to manage risk, share clinical information accurately, and support change processes across teams (58). The ERIC also emphasise the need for interoperable IT systems, clear data governance protocols, and cross-sector collaboration agreements to enable shared accountability and care coordination (51). To overcome this structural barrier identified in this study, it is crucial that national policymakers invest in an interoperable, cross-domain digital infrastructure that enables secure, real-time data sharing. At the same time, clear national guidance is needed on what is permitted under the GDPR, accompanied by practical protocols for shared responsibility and the use of information within family-centred care.

This study also identified a key barrier in the limited confidence and hesitancy of professionals to address weight-related topics within families. In particular, youth health care nurses reported feeling insufficiently equipped to discuss parental weight, fearing defensive responses and potential harm to the trust relationship with parents. This finding aligns with previous studies showing that health professionals often find it difficult to talk about overweight. They frequently feel unqualified, experience discomfort, and tend to avoid the topic or address it only indirectly, indicating low self-efficacy (59). In addition, literature shows that nurses are often reluctant to raise concerns about a child's weight, precisely because they worry it may undermine parental trust. A lack of knowledge about how to support families and limited confidence in their communication skills were also identified as additional barriers (60). In the current study, this professional hesitancy was further amplified in families with a migration background, where cultural norms could hinder open dialogue. In some cases, discussing adult health in the presence of children was considered inappropriate. Previous studies confirm that cultural factors, such as language barriers, parental beliefs, and healthcare professionals' limited awareness of specific cultural practices, can constrain their ability to address weight-related health issues with parents effectively (59). Another study further highlights that not only health professionals but also patients often underestimate the seriousness of obesity. Only 50% of patients acknowledged that excess weight could negatively impact their future health. This knowledge gap may hinder the effectiveness of care and guidance (61).

For practice, this implies the need for sustained investment in the development of knowledge, including education in obesity biology, communication skills, and professional confidence to address weight in a respectful and effective manner (61). Additionally, other studies emphasize the importance of stigma-sensitive communication and training in motivational interviewing and narrative listening. These approaches can support professionals in overcoming this barrier, with reflective tools and structured communication frameworks helping to build trust and strengthen the relationship with parents (57,59). According to ERIC (51), this requires dynamic and ongoing training trajectories tailored to different learning styles, accessible educational materials, regular expert consultation ('ongoing consultation'), and the strengthening of existing networks ('promote network weaving').

Joint case discussions, peer reflection sessions, and the development of clear working instructions can further support shared responsibility in practice. National organisations can play a supporting role by developing training modules, practical toolkits, and evidence-based communication techniques for intergenerational dialogue. At the same time, the findings and literature call for greater attention to the knowledge and role of families themselves. Building on these recommendations, ERIC also highlights the strategy ‘Prepare patients/consumers to be active participants’, by actively involving families in their own care, informing them about scientific insights, and supporting them in asking informed questions and making deliberate decisions. Investing in shared knowledge and communication thus promotes joint responsibility in delivering family-centred care (51).

Strengths and limitations

A key strength of this study lies in its methodological design, which employed data triangulation through interviews, focus groups, and observations during LC sessions. This enabled the implementation of the combined approach to be explored from multiple perspectives and embedded within the real-world context of municipal practice, thereby enhancing the study’s validity. Additionally, the diversity of participants (MPLs and HCPs from different municipalities and implementation phases) offered valuable insight into context-specific barriers and facilitators. The use of the CFIR provided a structured, theoretically grounded framework that enabled the systematic identification of barriers and facilitators across municipalities. It is among the first study in the Netherlands to explore the practical integration of child- and adult-oriented obesity care within families and stands out by integrating perspectives from both policy and practice. Due to the close involvement of participants in the actual delivery of the pilot, the findings offer practice-based insights into the systemic complexity of combined implementation, including the influence of policy structures, funding mechanisms, and inter-organisational collaboration. Additionally, municipalities that withdrew from the pilot were also included, which enabled the study to explore not only success factors but also reflect on why implementation failed in specific contexts, thereby offering a deeper understanding of contextual barriers. Finally, the researcher maintained an independent position throughout the research process, which contributed to reflexivity and analytical rigour.

At the same time, this study has several limitations. Participating municipalities were predominantly frontrunners, which may limit generalisability to less advanced contexts. At the time of data collection, only three municipalities were actively implementing the combined approach, significantly constraining the number of settings in which actual experimentation and learning occurred. One of these municipalities began implementation concurrently with the study’s onset, meaning that their experiences were still in an early phase. Another municipality withdrew from the study halfway through the study period. These dynamics impacted the depth and comparability of insights across sites. In interviews with municipalities that discontinued participation, there may have been retrospective bias, including selective memory or coloured reflections. Furthermore, this study focused exclusively

on professionals; the perspectives of families, who are the direct recipients of care, were not included, despite being essential to a complete understanding of implementation in practice. In addition, the analysis only briefly addressed the individual learning processes and reflective development of project leaders as implementation actors. Lastly, while the CFIR framework supported structured analysis, its use may have reduced sensitivity to emerging factors that fall outside this theoretical model.

Implications for further research

To our knowledge, this is the first empirical study in the Netherlands to provide a systematic analysis of the implementation of a combined approach to integrated care for overweight and obesity for both children and adults within the family context, incorporating perspectives from both HCPs and municipal stakeholders. To further strengthen the implementation of the combined approach, several areas of follow-up research are recommended. First, qualitative studies with families are needed to understand how the approach is experienced by those receiving care, including relevance, engagement, and barriers. Second, cross-case comparisons between municipalities may reveal context-specific success factors and explain variation in implementation. Third, a longitudinal study is essential to track changes in health outcomes, care coordination, and sustainability over time. Fourth, to support sustainable policy and funding decisions, an economic evaluation is necessary to assess the long-term value of the combined approach in terms of improved family outcomes, enhanced care coordination, and health benefits. Lastly, research into the prevalence of overweight individuals within families could raise awareness and support policy prioritization.

Conclusion

This case study provides insight into the implementation barriers and facilitators of a combined approach to integrated care for overweight and obesity within families, as perceived by municipalities and healthcare professionals. The findings highlight the complexity of implementing combined care models in routine healthcare practice and provide insights to inform future implementation efforts. Key facilitators included the adaptability and substantive added value of the combined approach, the development of a relational, family-centred culture within local teams, dedicated and motivated HCPs and structured reflection through cross-site collaboration and case-based learning to support the implementation of the combined approach. These factors were essential in supporting the implementation process and addressing challenges related to the combined approach. The study also identified key barriers that challenged the implementation. These included a lack of clarity in structure and the complexity of the combined approach, misaligned and insecure funding structures, fragmented national policy streams, and privacy regulations that hindered cross-domain collaboration. Organisational barriers involved poor IT integration, capacity and widespread staff shortages, and a lack of structural embedding and commitment. On the individual level, professionals reported low self-efficacy (for co-managing child and adult overweight within the same family) and limited confidence and capability to address weight-related topics. Finally, the misalignment of integrated family intake strategy emerged as a key barrier within the implementation process. These findings highlight the systemic and operational complexity of embedding such combined care models in practice. Moving from a pilot to sustainable implementation, coordinated national support is essential. This requires precise policy alignment, stable financing structures, and investment in interprofessional teams. In the context of integrated, family-based overweight and obesity care, implementation science can provide practical strategies to strengthen interdisciplinary collaboration, foster cross-sector connections, and support professionals across domains. To sustain such efforts, continuous training and education are needed to equip healthcare professionals with the knowledge, skills, and confidence required to deliver family-centred care. Future efforts must be grounded in a long-term vision from central government, ensuring municipalities can continue building on clarity and structural support. Such conditions are crucial for healthcare professionals to deliver coherent, family-centred care that meets the needs of both children and adults.

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Appendix 1

Informed consent form (in Dutch)

**Project samenkomst van de netwerkaanpak voor overgewicht en obesitas
van kind en volwassene binnen één gezin**

- Ik heb de informatiebrief gelezen. Ook kon ik vragen stellen. Mijn vragen zijn voldoende beantwoord. Ik had genoeg tijd om te beslissen of ik meedoe.
- Ik weet dat meedoen vrijwillig is. Ook weet ik dat ik op ieder moment kan beslissen om toch niet mee te doen of te stoppen met het onderzoek. Daarvoor hoef ik geen reden te geven.
- Ik geef toestemming voor het verzamelen en gebruiken van mijn gegevens op de manier en voor de doelen die in de informatiebrief staan.
- Ik geef toestemming om mijn gegevens nog 10 jaar na dit onderzoek te bewaren binnen de Vrije Universiteit van Amsterdam.
- Ik wil meedoen aan dit onderzoek.

Wilt u hieronder ja of nee aankruisen:

- Ik geef toestemming voor het verzamelen en gebruiken van geluidsopnames van de overleggen betreffende samenkomst van de netwerkaanpak voor overgewicht en obesitas van kind en volwassene binnen één gezin. Deze opnames zullen na te zijn uitgeschreven/einde studie vernietigd worden.
O ja
O nee
- Ik geef toestemming om mij na dit onderzoek opnieuw te benaderen voor een vervolgonderzoek
O ja
O nee

Naam proefpersoon:

Handtekening:

Datum : __ / __ / __

Ik verklaar dat ik deze deelnemer volledig heb geïnformeerd over het genoemde onderzoek. Als er tijdens het onderzoek informatie bekend wordt die de toestemming van de deelnemer zou kunnen beïnvloeden, dan breng ik hem/haar daarvan tijdig op de hoogte.

Naam onderzoeker:

Handtekening:

Datum: __ / __ / __

De deelnemer krijgt een volledige informatiebrief mee, samen met een kopie van het getekende toestemmingsformulier.

Appendix 2

Participant information letters (in Dutch)

Informatie voor deelname aan het onderzoek:

Project samenkost van de netwerkaanpak voor overgewicht en obesitas
van kind en volwassene binnen één gezin

Geachte lezer,

U krijgt deze brief omdat u werkzaam bent binnen de netwerkaanpak voor mensen met overgewicht en obesitas en deelneemt aan de pilot “samenkomst van de netwerkaanpak voor overgewicht en obesitas van kind en volwassene binnen één gezin”, aangeboden door JOGG, PON en Care for Obesity (VU). Met deze informatiebrief willen we u vragen of u wilt meedoen aan gezondheidswetenschappelijk onderzoek, welke uit wordt gevoerd door Care for Obesity (Vrije Universiteit Amsterdam) tezamen met JOGG en PON. Meedoen is vrijwillig.

U leest hier om wat voor onderzoek het gaat, wat het voor u betekent en wat er van u verwacht wordt, wanneer u besluit om deel te nemen.

Heeft u interesse?

Lees deze brief dan aandachtig door.

En stel vragen aan de onderzoeker die u deze informatie geeft of benader rechtstreeks Care for Obesity via careforobesity@vu.nl.

Wilt u meedoen?

Vul dan het formulier in de bijlage in.

Bij voorbaat dank!

Met hartelijke groet,

Dr. Bibian van der Voorn
Landelijk projectleider Care for Obesity
Universitair docent kinderobesitas en arts



1. Algemene informatie

Het onderzoek is opgezet door de Vrije Universiteit van Amsterdam (VU), afdeling Gezondheidswetenschappen in samenwerking met JOGG en PON.

2. Wat is het doel van het onderzoek?

Het doel van het onderzoek is inzicht krijgen in zowel de uitdagingen als de succesfactoren die beleidsmakers en praktijkprofessionals ervaren bij de samenkomst van de netwerkaanpak voor een volwassene én een kind met overgewicht en obesitas binnen één gezin. Deze input vormt de basis voor de doorontwikkelingen van effectieve ondersteuning vanuit JOGG, team Kind naar Gezonder Gewicht (KnGG), en PON.

3. Wat gebeurt er als u meedoet in het onderzoek?

Bij dit onderzoek wordt er om informatie te verzamelen gebruikgemaakt van geluidsopnames van groepsdiscussies tijdens het leernetwerk en daarnaast van verdiepende interviews met lokale

teamleden. Geluidsopnames hiervan worden heel vertrouwelijk behandeld en alleen in het kader van onderzoek geanalyseerd door het betrokken team van onderzoekers. De focusgroepen zullen de deelnemer geen extra tijd kosten, eventuele aanvullende interviews wel. Dit zal ongeveer 45 minuten tijd kosten, waarna nog een membercheck kan volgen. Bij een membercheck wordt een korte samenvatting van de geanalyseerde data gedeeld met de deelnemer om te verifiëren of de interpretatie en conclusies van de onderzoeker correct zijn. Bij het onderzoek worden nog wat aanvullende gegevens van de deelnemers verzameld, dit zijn de functie van de deelnemer en de organisatie en regio welke de deelnemer representeert. Deze gegevens zullen versleuteld opgeslagen worden en alleen voor het onderzoeksteam toegankelijk (zie de tekst onder het kopje "*Hoe beschermen we uw privacy?*").

4. Wat betekent deelname voor u?

Door de gestructureerde wijze van het in kaart brengen van informatie, kunt u zelf meer inzicht krijgen in de organisatie en het aanbod van ondersteuning en zorg van twee of meer leden binnen één gezin binnen uw regio en geleerde lessen uit andere regio's. Uw deelname draagt ook bij aan algemene implementatiekennis over de verschillen en overeenkomsten tussen het basismodel netwerkaanpak voor volwassenen en het landelijk model voor kinderen met overgewicht en obesitas, waardoor ook andere regio's beter ondersteund kunnen worden. De tijd die de deelnemer hierin investeert, zal indien er een aanvullend interview wordt ingepland ongeveer 1 uur extra tijd kosten.

5. Als u niet mee wilt doen of wilt stoppen met het onderzoek.

Deelname aan het onderzoek is geheel vrijwillig en heeft geen consequenties voor de deelname van u en uw gemeente aan de pilot. U mag tijdens het onderzoek ook zelf beslissen om te stoppen. U hoeft niet te zeggen waarom u stopt. Wel moet u dit direct melden aan de onderzoeker.

De gegevens die tot dat moment zijn verzameld, worden dan nog wel gebruikt voor het onderzoek.

6. Wat doen we met uw gegevens?

Doet u mee met het onderzoek? Dan geeft u toestemming om uw gegevens te verzamelen, gebruiken en bewaren.

Waarom verzamelen, gebruiken en bewaren we uw gegevens?

We verzamelen, gebruiken en bewaren uw gegevens om de vragen van dit onderzoek te kunnen beantwoorden. Uw functie, regio en organisatie zullen versleuteld opgeslagen worden en alleen voor het onderzoeksteam toegankelijk (zie de tekst onder het kopje "*Hoe beschermen we uw privacy?*"). De informatie die u deelt tijdens de opgenomen groeps gesprekken zullen zo anoniem mogelijk worden geanalyseerd en bewaard.

Wat doen we met geluidsopnames?

Tijdens het onderzoek zullen wij geluidsopnames van u maken. De geluidsopnames typen we uit en zullen we zo anoniem mogelijk maken. Hierna zal de opname zelf vernietigd worden.

Hoe beschermen we uw privacy?

Om uw privacy te beschermen geven wij uw gegevens een code. Op al uw gegevens zetten we alleen deze code. Daarna worden naam en andere identificerende gegevens niet meer gebruikt.

De gegevens die direct naar u verwijzen zullen versleuteld opgeslagen worden. De sleutel van de code bewaren we op een beveiligde plek op de VU Amsterdam. Alleen leden van het onderzoeksteam weten welke code u heeft. Hier is dus ook sprake van geheimhouding richting de organisaties JOGG en PON. Als we uw gegevens verwerken of delen, gebruiken we steeds alleen die code. We streven ernaar dat in rapporten en publicaties over het onderzoek niemand kan terughalen dat het over u ging.

Hoe lang bewaren we uw gegevens?

We bewaren uw gegevens 10 jaar op de VU Amsterdam, conform de verplichte bewaartermijn voor niet-WMO studies.

Mogen wij u na dit onderzoek opnieuw benaderen voor een vervolgonderzoek?

Wanneer dit onderzoek is afgelopen, doen we misschien een vervolgonderzoek. We willen u dan benaderen met de vraag of u weer deel wilt nemen. Op het toestemmingsformulier kunt u aangeven of u ons daar toestemming voor geeft.

Wilt u meer weten over uw privacy?

Misschien wilt u graag een elektronische kopie ontvangen van gegevens van u die voor het onderzoek gebruikt zijn. Dat kan. U kunt de onderzoeker hierom vragen.

Wilt u meer weten over uw rechten bij de verwerking van persoonsgegevens? Kijk dan op

<https://www.autoriteitpersoonsgegevens.nl/nl/over-privacy/persoonsgegevens>

Heeft u vragen over uw rechten? Of heeft u een klacht over uw privacy? Neem dan contact op met degene die verantwoordelijk is voor de verwerking van uw persoonsgegevens.

Als u klachten heeft over uw privacy, raden we u aan om deze eerst te bespreken met het onderzoeksteam. U kunt ook naar de Functionaris Gegevensbescherming van de Vrije Universiteit Amsterdam, functionarisgegevensbescherming@vu.nl gaan. Of u dient een klacht in bij de Autoriteit Persoonsgegevens.

Waar vindt u meer informatie over het onderzoek?

Op de volgende website(s) vindt u meer informatie over het onderzoek:

<https://kindnaargezondengewicht.nl/>

<https://vu.nl/nl/over-de-vu/onderzoeksinstituten/care-for-obesity>

7. Heeft u vragen?

Bij vragen over dit onderzoek kunt u contact opnemen met stagiair-onderzoeker Frédérique Putting of benader rechtstreeks Care for Obesity via careforobesity@vu.nl.

Dank voor uw aandacht.

Bibian van der Voorn, Landelijk projectleider Care for Obesity

b.van.der.voorn@vu.nl ; 06-25120290



Appendix 3

Interview questions (in Dutch) on the implementation of a combined approach to integrated care for overweight and obesity in both children and adults within the family context.

A: Algemene en implementatie-gerelateerde rollen, verantwoordelijkheden en taken

Projectleiders

1. Wat is uw huidige rol binnen de gemeente of organisatie?
2. Wat zijn uw gebruikelijke verantwoordelijkheden binnen deze rol?
3. Wat was uw taak bij de implementatie van de gecombineerde gezinsgerichte aanpak voor obesitaszorg?
4. Heeft u taken op zich genomen buiten uw reguliere rol?
5. Waren er andere implementatie-gerelateerde verantwoordelijkheden aan u toegewezen?
6. Wat was vanuit organisatorisch oogpunt uw hoofddoel bij het piloten van deze aanpak?
7. Wat beschouwt u als een "succesvolle" implementatie? Welke voorwaarden zijn hiervoor nodig?

B: Implementatie-ervaring: Barrières & Faciliterende factoren

Innovatiedomein

1. Wat zijn de belangrijkste successen geweest met betrekking tot de innovatie?
2. Wat waren de grootste uitdagingen die u bent tegengekomen met betrekking tot de innovatie?
3. Met betrekking tot uw rol:
 - a. Kunt u aangeven wat mede dankzij uw bijdrage is geslaagd?
 - b. Kunt u hiervoor redenen geven?
 - c. Wat ging minder goed en waarom?

Externe omgeving

1. Wat zijn de belangrijkste successen geweest met betrekking tot de externe omgeving?
2. Wat waren de grootste uitdagingen die u bent tegengekomen met betrekking tot de externe omgeving?
3. Met betrekking tot uw rol:
 - a. Kunt u aangeven wat mede dankzij uw bijdrage is geslaagd?
 - b. Kunt u hiervoor redenen geven?
 - c. Wat ging minder goed en waarom?

Interne omgeving

1. Wat zijn de belangrijkste successen geweest met betrekking tot de interne omgeving?
2. Wat waren de grootste uitdagingen die u bent tegengekomen met betrekking tot de interne omgeving?
3. Met betrekking tot uw rol:
 - a. Kunt u aangeven wat mede dankzij uw bijdrage is geslaagd?
 - b. Kunt u hiervoor redenen geven?
 - c. Wat ging minder goed en waarom?

Individen

1. Wat zijn de belangrijkste persoonlijke successen geweest voor u? En voor het team?
2. Wat waren de grootste persoonlijke uitdagingen voor u? En voor het team?
3. Met betrekking tot uw rol:
 - a. Kunt u aangeven wat mede dankzij uw bijdrage is geslaagd?
 - b. Kunt u hiervoor redenen geven?
 - c. Wat ging minder goed en waarom?

Implementatieproces

1. Wat zijn de belangrijkste successen geweest met betrekking tot het implementatieproces?
2. Wat waren de grootste uitdagingen die u bent tegengekomen tijdens het implementatieproces?
3. Met betrekking tot uw rol:
 - a. Kunt u aangeven wat mede dankzij uw bijdrage is geslaagd?
 - b. Kunt u hiervoor redenen geven?
 - c. Wat ging minder goed en waarom?

Appendix 4

Interview introduction (in Dutch)

Mijn naam is Noa en ik doe onderzoek naar de ontwikkeling en implementatie van de pilot gelijktijdige begeleiding voor zowel kinderen als volwassenen met overgewicht, waarbij de gezinscontext centraal staat. In dit interview wil ik graag van u horen wat goed gaat en wat beter kan bij deze ontwikkeling vanuit uw rol als projectleider binnen de gemeente waar je werkzaam bent.

Het gesprek duurt ongeveer 60 minuten. Er zijn geen goede of foute antwoorden; ik ben vooral benieuwd naar uw ervaringen en inzichten.

Zoals u ook hebt kunnen lezen in de informatiebrief, wordt het interview opgenomen en maak ik daarnaast aantekeningen op mijn laptop. De audio-opname wordt uitsluitend gebruikt voor het uitwerken van het gesprek en wordt daarna direct verwijderd. Alles wat je vertelt wordt vertrouwelijk behandeld. De uitgewerkte tekst wordt gepseudonimiseerd (en alleen op groepsniveau en objectief gerapporteerd), zodat uw naam en alle andere mogelijk identificeerbare, zoals namen van collega's, gemeenten, regio's, of bijvoorbeeld organisaties, niet herkenbaar of herleidbaar zullen zijn. Spreek dus gerust open.

Na 2 werkdagen stuur ik je een samenvatting toe, zodat je kunt controleren of alles klopt. Is dat oké voor jou?

We bespreken straks een aantal onderwerpen aan de hand van het **CFIR-model**. Dit model helpt om op een gestructureerde manier te kijken naar wat de ontwikkeling van gelijktijdige begeleiding tot nu toe heeft geholpen of juist heeft belemmerd.

Ik heb een aantal slides gemaakt waarop het model visueel wordt weergegeven, zodat u er ook wat meer beeld bij hebt.

Zoals u ziet, bestaat het CFIR-model uit vijf domeinen:

1. **De innovatie zelf** (de gelijktijdige begeleiding),
2. **De externe omgeving** (zoals beleid en samenwerking buiten de betrokken organisatie(s))
3. **De interne omgeving** (de betrokken organisaties en omgeving waarin GB wordt ontwikkelt)
4. **Individueen** (zoals motivatie, kennis en ruimte van betrokkenen om hun rol goed te kunnen uitvoeren),
5. **Het implementatieproces** (zoals planning, evaluatie en uitvoering).

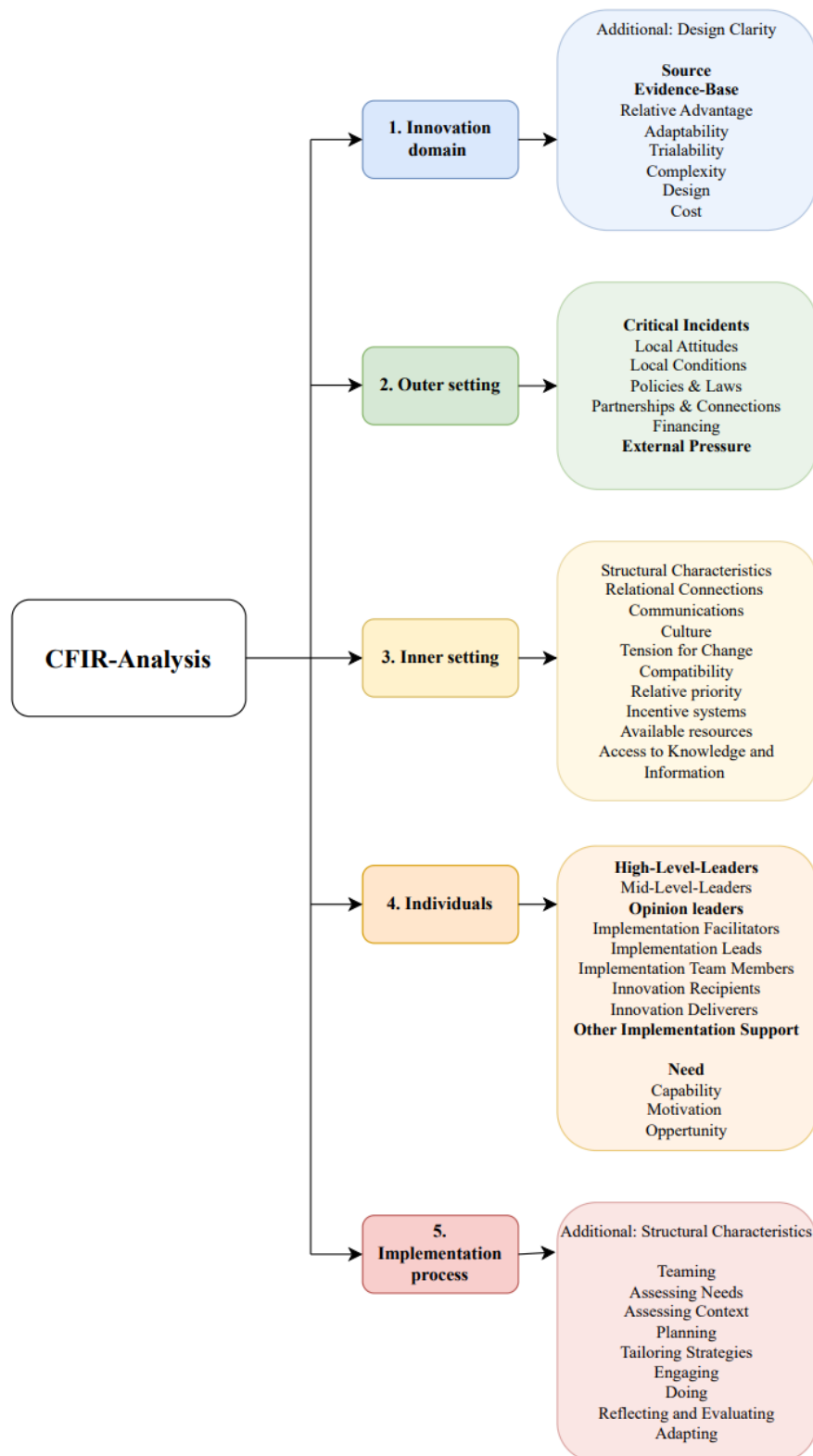
Tijdens het gesprek houden we slides per domein erbij. We gebruiken deze domeinen (met daaronder wat onderwerpen) als leidraad voor ons gesprek, maar het hoeft niet zo te zijn dat we ze allemaal bespreken. We richten ons op de domeinen waar u iets over kunt en wilt delen.

We proberen ongeveer evenveel tijd per domein te besteden, maar als bepaalde onderwerpen korter of langer aandacht vragen, stemmen we dat gewoon samen af.

Appendix 5

Fig. A1. Coding tree

This coding tree is based on the CFIR domains and constructs. The non-bolded codes represent all codes that emerged during the analysis. The bolded codes did not emerge during the analysis.



Appendix 6

Consolidated criteria for reporting qualitative studies: 32-item checklist

No. Item	Guide questions/description	Reported on page #
Domain 1: Research team and reflexivity		
<i>Personal characteristics</i>		
1. Interview	Which author(s) conducted the interviews?	P. 8
2. Credentials	What were the researchers' credentials?	Research intern & MSc student P. 8
3. Occupation	What was their occupation at the time of the study?	P. 8
4. Gender	Was the researcher male or female?	P. 8
5. Experience and training	What experience or training did the researcher have?	P. 8
<i>Relationship with Participants</i>		
6. Relationship established	Was a relationship established prior to study commencement?	P. 8
7. Participant knowledge of the interviewer	What did the participant know about the researcher?	P. 8
8. Interviewer characteristics	What characteristics were reported about the interviewer?	P. 8
Domain 2: Study design		
<i>Theoretical Framework</i>		
9. Methodological orientation	What methodological orientation was stated to underpin the study?	P. 6
<i>Participant Selection</i>		
10. Sampling	How were participants selected?	P. 7
11. Method of approach	How were participants approached?	P. 7
12. Sample size	How many participants were in the study?	P. 11
13. Non-participation	How many people refused to participate or dropped out? Reasons?	P. 8
<i>Setting</i>		
14. Setting of data collection	Where was the data collected?	P. 8
15. Presence of non-participants	Was anyone else present besides the participants and researchers?	P. 8
16. Description of sample	What are important characteristics of the sample?	P. 6,7,11
<i>Data collection</i>		
17. Interview guide	Were questions, prompts, guides, provided by the authors? Was it pilot tested?	P.8 and Appendix 3
18. Repeat interviews	Were repeat interviews carried out?	P. 8
19. Audio/visual recording	Did the researcher use audio or visual recording to collect the data?	P. 8
20. Field notes	Were field notes made during and/or after the interviews/	P. 8
21. Duration	What was the duration of the interviews?	P. 8
22. Data saturation	Was data saturation discussed?	P. 7
23. Transcripts returned	Were transcripts returned to participants for comment or correction?	P. 10

Domain 3: Analysis and Findings		
Data Analysis		
24. Number of data coders	How many coders coded the data?	P.9
25. Description of the coding tree	Did authors provide a description of the coding tree?	P. 9 and Appendix 5
26. Derivation of themes	Were themes identified in advance or derived from the data?	P. 9
27. Software	What software, if applicable, was used to manage the data?	P. 9
28. Participant checking	Did participants provide feedback on the findings?	P.9
Reporting		
29. Quotations presented	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified?	PP. 11-21 + Tables DI-DV and Appendix 7
30. Data and findings consistent	Was there consistency between the data presented and the findings?	PP. 11-21 + Tables DI-DV
31. Clarity of major themes	Were major themes clearly presented in the findings?	PP. 11-21 + Tables DI-DV
32. Clarity of minor themes	Is there a description of diverse cases or discussion of minor themes?	PP. 11-21 + Tables DI-DV and Appendix 7

Appendix 7

Other factors influencing the implementation of a combined approach

The tables below summarise other barriers and facilitators influencing the implementation of a combined approach, categorized per CFIR domain. Each theme is supported by illustrative quotes from HCPs and MPLs, along with the data source (interview, focus group, LC session) noted for context.

Table DI

Overview of Themes and Quotes within the CFIR domain ‘Innovation influencing implementation’

Theme	Quotes
Facilitator	
• Trialability	• ‘What I find valuable is that we are truly experimenting at the local level. It's not about delivering full trajectories right away but about exploring how this approach resonates within families. Piloting on a small scale allows us to test and refine processes, so we can better support families in the future.’ [MPL - Interview]
Barrier	
• Limited applicability of central coordination in family-based care	• ‘It sounds great: a coordinator who arranges everything for everyone, but in practice, you really need additional expertise.’ [HCP - focus groups]
• Unclear terminology	• ‘The term ‘CCP’ is confusing. Families don’t understand or recognise it, and neither do some professionals.’ [HCP - focus groups]

HCP: healthcare professional; MPL: municipal project leader; CCP: central care provider (youth nurse)

Table DII.

Overview of Themes and Quotes within the CFIR domain ‘Outer Setting influencing implementation’

Theme	Quotes
Facilitator	
• Support for the combined approach	• ‘There’s strong support for the idea of combining child and adult care within the family context. Many municipalities show genuine interest, and professionals, including from hospitals, are eager to contribute.’ [MPL - Interview]

HCP: healthcare professional; MPL: municipal project leader

Table DIII

Overview of Themes and Quotes within the CFIR domain 'Inner Setting influencing implementation'

Theme	Quotes
Facilitator	
Learning-centred culture within local teams	'The team culture is characterised by a shared mindset of figuring things out together. This creates a psychologically safe environment in which team members feel encouraged to experiment, give feedback when something doesn't work, and engage in continuous learning with and from each other.' [HCP - Focus groups]
Barrier	
Integration of the combined approach within existing work structures	'We had already established two separate care trajectories. What I'm noticing now is that bringing together two existing pathways is more difficult than expected. Everyone has their own way of working firmly in place, and it's not easy to change that.' [MPL - Interview]
Relatively low priority assigned by GPs to the combined approach	'Also known as the "law of the inhibiting lead.' [MPL - Interview] 'When you ask general practitioners to actively engage in the development of a combined approach, the response is often: not for now. And I understand that. They simply have many other responsibilities. While overweight is important to them, it competes with numerous other healthcare demand.' [MPL - Interview]

HCP: healthcare professional; CCPs: central care providers (youth nurse); GP: general practitioner

Table DIV

Overview of Themes and Quotes within the CFIR domain 'Individuals influencing implementation'

Theme	Quotes
Facilitator	
Having municipal project leaders	'We needed someone to take the lead, otherwise everyone just stays on their own island. The project leader was really the one who kept bringing stakeholders together, fuelling the momentum, and putting the next step on the agenda, especially during this early phase when things don't yet run smoothly.' [MPL - Interview]
Involvement of expert roles providing implementation support	'Her [O1] involvement in the national model, combined with her practical experience as a [B16] and her intrinsic motivation, gives her a great deal of credibility and helps care providers overcome initial hesitation.' [MPL - LC]

MPL: municipal project leader; LC: learning community

Table DV

Overview of Themes and Quotes within the CFIR domain 'Implementation process influencing implementation'

Theme	Quotes
Barrier	
Unclear referral structure and identification process for adults	'It wasn't always clear where adults could be referred to. There was confusion and limited support about which organisation should coordinate the adult approach. You really need specific parties to set up and maintain an effective referral structure.' [HCP - Focus groups]
Lack of expectation management for families	'Referrals sometimes happen without any explanation, which means care providers show up unexpectedly and first must clarify why they're there. People either have no idea, or they do, but their expectations don't match what we offer. This hinders a low-threshold and effective starting point.' [MPL - LC]
limited substantive support and shared ownership in shaping local implementation'	'A challenge was that there was no one available who could think along with me (MPL) at a substantive level and who understood the local context for in-depth questions. As a result, discussions with the national project leaders often remained at a surface level.' [MPL - Interviews]

HCP: healthcare professional; MPL: municipal project leader; LC: learning community; GP: general practitioner

CFIR Domain 1. Innovation influencing implementation

A facilitator was the 'trialability of the combined approach'. Professionals valued the opportunity to experiment on a small scale, exploring what the combined approach looks like in practice before broader implementation. A barrier concerned the use of unclear terminology. The term 'CCP' was perceived as confusing by both families and professionals, who struggled to identify with the role and were unsure what to expect. HCPs noted that in many municipalities, the term failed to resonate; parents often did not understand where they were being referred or what the role entailed.

A barrier concerned the 'limited applicability of central coordination in family-based care'. While the idea of a single healthcare coordinator responsible for both child and adult trajectories was appealing in theory, it proved insufficient in practice. Participants emphasized that the role of one central coordinator often lacked the scope and expertise to address both medical and psychosocial issues across age groups. According to both HCPs and MPLs, additional knowledge and collaboration were required to coordinate complex family dynamics and dual care needs effectively. Another barrier was the use of unclear terminology, particularly the designation of roles such as 'CCP'. The term was

perceived as ambiguous by both families and some professionals, who reported confusion about what the role entailed and to whom it referred.

CFIR Domain 2. Outer setting influencing implementation

A facilitator was the broad conceptual ‘support for the combined approach’, especially among frontrunner municipalities and committed HCPs. The idea of integrating child and adult care within families was widely supported and rarely questioned. In municipalities where both care structures already existed, stakeholders saw clear opportunities to align efforts. Professionals across sectors, including hospital-based specialists, expressed enthusiasm and a willingness to contribute. This shared conviction helped build early momentum, particularly in settings with existing collaboration and supportive infrastructure.

CFIR Domain 3. Inner setting influencing implementation

A facilitator within the inner setting was the presence of a ‘learning-centred culture within local teams’. Both HCPs and MPLs described how teams made deliberate efforts to reflect on practice by sharing experiences and jointly exploring what worked, what did not, and why. This reflective mindset created an environment in which team members felt safe to experiment, provide feedback, and engage in continuous learning with and from one another. As one participant described, the team culture was characterised by “figuring things out together”. In addition to internal team learning, participants also emphasised the importance of structured, smaller reflection groups within larger collaborative settings. For instance, some municipalities established core teams of representatives who regularly discussed practical experiences, identified lessons learned, and shared these insights back with their wider teams. This approach was perceived as more effective than large-group discussions and ensured that learning remained connected to local organisational contexts.

A barrier was the ‘integration of the combined approach within existing work structures’. In several municipalities, only one of the two care models (either child- or adult-focused) had been implemented, making it difficult to align both trajectories. According to project leaders, meaningful integration requires that both models are sufficiently established. Without this foundation, coordination between the two becomes fragmented and unfeasible. At the same time, municipalities that had already embedded both models described a different kind of challenge. In these settings, professionals were accustomed to separate routines, systems, and ways of working, making integration even more complex. One MPL referred to this as “the law of the inhibiting lead” (In Dutch: ‘de wet van de remmende voorsprong’), indicating that the strong institutionalisation of both pathways had created rigidity rather than flexibility. Moreover, differences in the developmental stage and structure of the child and adult models often made combining them feel illogical or forced, further complicating implementation efforts. Another barrier is the ‘relatively low priority assigned by GPs to the combined approach’. Although GPs consider overweight and obesity important, other healthcare demands often take

precedence in daily practice. As one MPL noted, this makes it difficult to actively involve GPs in the further development of the approach, as they face high workloads and a broad range of responsibilities. This is particularly notable given that both MPL and HCPs identified GPs as one of the few professionals with an overview of the entire family. However, their limited availability makes it challenging to co-develop integrated care pathways for children and adults with overweight.

CFIR Domain 4. Individuals influencing implementation

A facilitator was the ‘presence of MPLs’ who actively guided and coordinated the implementation process. Their role was repeatedly described as essential for creating momentum and ensuring local follow-through. MPLs were seen as ‘drivers’ who took ownership, brought stakeholders together, clarified responsibilities, and provided direction, particularly during the early and more fragile stages of implementation. In municipalities where such leadership was lacking, implementation often stalled or became fragmented. Several participants noted that having both municipal commitment and a dedicated project leader was not merely helpful, but a prerequisite for practical local implementation. Another facilitator is the ‘involvement of a medical expert roles providing implementation support’, with in-depth knowledge of the national model, experienced by both MPLs and HCPs. Participants indicated that this role helped increase the credibility of the trajectory, strengthened trust within teams, and provided substantive guidance to CCPs as they navigated their responsibilities within the combined approach. Particularly in teams where professionals were still defining their roles, the presence of an external expert was valued for offering reassurance and practical guidance.

CFIR Domain 5. Implementation process influencing implementation

A barrier in the implementation process was the ‘unclear referral structure and identification process for adults’. Both HCPs and MPLs noted uncertainty about which organisation was responsible for setting up and coordinating the adult care approach. This caused confusion and limited support for execution. Several participants indicated there was insufficient support and a lack of a sparring partner with expertise in adult obesity care to assist CCPs with medical questions or in developing the referral structure. As a result, integrated support for parents could not be adequately realised. Additionally, referral pathways for adults were seen as less accessible than those for children. Within YHC, any professional could refer patients to services such as the lifestyle counter. However, for adults, a formal referral from a GP was required, creating a higher threshold for access. Another barrier in the implementation process was the ‘lack of clear expectation management towards families’. Both HCPs and MPLs noted that parents were often insufficiently informed about what the combined approach entailed, who it was intended for, and what they could expect. This frequently resulted in confusion and a mismatch between the provided support and family expectations, hindering a smooth and accessible start of the care trajectory. Moreover, the absence of clear explanations early on sometimes led to hesitation or even resistance among parents to participate. A third barrier, particularly among MPLs who operated alone, was the ‘limited substantive support and shared ownership in shaping local implementation’. Several MPLs reported that developing the implementation plan for the combined approach felt like a solitary process, with few opportunities to reflect together or co-create a shared strategy. Some indicated that this lack of support contributed to the plan of approach receiving low priority at the time. Additionally, the absence of a local sparring partner made it more challenging to engage in in-depth dialogue with national project leaders, resulting in those conversations remaining at a surface level. In contrast, MPLs working in pairs highlighted the added value of collaboration, which enabled joint reflection, idea exchange, and a more balanced distribution of responsibilities.

Appendix 8

Data Management Plan

	Which types of data will you handle?	How sensitive is the data?	Where will the data be stored?	Who has access?	Who is responsible after completion of your internship?
1	Informed consent forms	High: Personal identifiers	Secure file on the research drive at Vrije Universiteit Amsterdam	B.v.d.V., N.M.B., R.V.H.IJ.	BvdV (Principal Investigator)
2	Audio recordings of interviews and focus groups (semistructured)	High (personal/pseudo-anonymous data). Data includes potentially identifiable information shared during interviews.	Secure file on the research drive at Vrije Universiteit Amsterdam and deleted after transcription and pseudonymization. (password-protected, access-controlled).	B.v.d.V., N.M.B.,	Data will be deleted after completion of the internship
3	Field notes interviews	Moderate Identifiers removed; indirect identifiers possible.	Secure file on the research drive at Vrije Universiteit Amsterdam, (password-protected, access-controlled).	B.v.d.V., N.M.B.,	BvdV (Principal Investigator)
3	Transcribed interview data (pseudonymized).	Low moderate (pseudo-anonymous data). Direct identifiers removed; indirect identifiers possible.	Secure file on the research drive at Vrije Universiteit Amsterdam, (password-protected, access-controlled).	B.v.d.V., N.M.B., L.L., R.V.H.IJ.	BvdV (Principal Investigator)
4	Key file (linking pseudonyms to real identities).	High (personal data).	Secure file on the research drive at Vrije Universiteit Amsterdam, separately stored from transcripts. (password-protected, access-controlled).	B.v.d.V., N.M.B.	BvdV (Principal Investigator)
5	Summaries for member checking and reporting (fully anonymized).	Low (anonymized data). No personal identifiers included	Secure file on the research drive at Vrije Universiteit Amsterdam, (password-protected, access-controlled).	B.v.d.V., N.M.B., L.L., R.V.H.IJ.	BvdV (Principal Investigator)