Regional Implementation Integrated Care Approach for Childhood Overweight and Obesity

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Abstract

Background

The child on a healthier weight (KnGG) approach of Youth on a Healthy Weight (JOGG) is a practical translation of the Dutch national model of integrated care for childhood overweight and obesity developed by the Vrije Universiteit (VU) Amsterdam.

Research question

The aim of the study is to support the regional implementation of the KnGG approach by answering the research question: how do regional coordinators, working as part of an integrated care approach for childhood overweight and obesity, perceive their role and the functioning of the regional network they are involved in?

Methods

A qualitative interpretative study design with interviews and a focus group was adopted to answer the research question. The study population consisted of ten regional coordinators and one KnGG expert of the regional implementation of the KnGG approach. The interview guide included questions based on the Collaborative Adaptive Health Networks framework and the needs that were raised at the learning network organized by JOGG. The data collected from the learning network was analyzed as a focus group.

Results

The findings indicated that regions are currently at different stages of implementation of the network approach. Investing in relationships and relatedness were important facilitators for the regional implementation of the approach. Financing appeared to be a significant barrier, as current funds were insufficient and only available until 2026. Other challenges involved monitoring and evaluation, the positioning of the coordinating professional and procurement policies.

Conclusion

Formal agreements of commitment, along with a shared vision, were essential prerequisites for successful implementation. Unmet prerequisites were experienced as a barrier, partly because they are not sufficiently supported at the national level. The study presents a set of recommendations to further support the regional implementation of the KnGG approach and potentially form the basis for a broader regional prevention structure.

Introduction

Childhood obesity is a global health problem with adverse effects on both physical and psychosocial well-being, with over 390 million children and adolescents who are overweight including 160 million with obesity impacted worldwide in 2022 (Dabas & Seth, 2018; Rankin et al., 2016; Sahoo et al., 2015; World Health Organization, 2024). Obesity and overweight can be defined by higher levels of body fat, caused by a chronic state of positive energy balance (Clément & Ferré, 2003; Sahoo et al., 2015). Childhood obesity negatively impacts health-related quality of life and is associated with an elevated risk for metabolic complications, cardiovascular diseases and mental health problems (Lister et al., 2023). Consequences of childhood overweight and obesity extend beyond the individual and include broader societal implications. It is associated with high healthcare expenses, as well as high societal costs (Hecker et al., 2022). Obesity is considered to be a complex health problem, influenced by interacting biological factors (e.g., genetic, hormonal or physiological factors), lifestyle factors (e.g., food consumption, physical activity and sleep behavior), social factors (e.g., socioeconomic position, sociocultural factors and family characteristics) and environmental factors (e.g., school policies, demographics and family characteristics), with the UK Foresight map highlighting its multifaceted nature (Ang et al., 2012; Budd & Hayman, 2006; Jebb et al., 2007, p129; Sahoo et al., 2015).

In 2023, the percentage of children aged between 4 and 17 who are overweight in the Netherlands is 12.7%, of which 4.1% are dealing with obesity, prompting high-priority government action (National Institute for Public Health and the Environment & Statistics Netherlands, 2024; Seidell & Halberstadt, 2020). The National Prevention Agreement, established in 2018, aimed for a reduction in childhood overweight (and obesity) by 2040 through initiatives outlined in the Integrated Care Agreement (IZA) and the Healthy and Active Living Agreement (GALA) (Ministry of Health Welfare and Sport, 2018, 2022, 2023). These agreements describe commitments between the Ministry of Health, Welfare, and Sport and diverse healthcare stakeholders, ensuring future delivery of quality, accessible, and affordable healthcare.

To address childhood overweight and obesity in the Netherlands, the Vrije Universiteit (VU) university team Care for Obesity developed the Dutch national model of integrated care for childhood overweight and obesity (Halberstadt et al., 2023). It is derived from recommendations from the National Comprehensive Obesity Guideline, published in 2008, and the Care Standard Obesity, released in 2010 (Seidell et al., 2008, 2010). The Dutch model provides for a comprehensive documentation of the integrated care approach and additional materials for policymakers and professionals to support implementation for enhanced effectiveness and greater impact. A key professional is the coordinating professional (CP), who guides the child and family and coordinates collaboration between the social and healthcare domains. To the best of our knowledge, there are no studies that analyzed approaches from other countries that resemble the Dutch National model of integrated care for childhood overweight and obesity. However, according to Halberstadt et al. (2023) the Dutch model does align with guidelines from the United States, the UK, New Zealand, Australia, Scotland, Canada and recommendations of the World Health Organization.

The child on a healthier weight (In Dutch: KnGG) approach of Youth on a Healthy Weight (JOGG) is a practical translation of the Dutch national model and based on insights from eight pilot municipalities in the Netherlands (Halberstadt et al., 2023). The national organization JOGG is funded by and operates on behalf of the Ministry of Health, Welfare and Sport to support the nationwide implementation. JOGG assists stakeholders in exploring the feasibility of implementing the KnGG approach, identifying the necessary parties involved and devising strategies to coordinate their efforts.

Due to the variety of different factors and their interconnected influences, complex health problems, such as obesity, require cross-sector collaboration (Calancie et al., 2021). Cross-sector collaboration involves organizations from two or more sectors “linking or sharing information,

resources, activities, and capabilities" to achieve a shared outcome that one sector alone could not accomplish (Bryson et al., 2006, p. 44). A well-known example of cross-sector collaboration is the Health-in-All-Policies (HiAP) approach, which describes public policies across sectors, while considering the health implications of decisions and seeking synergies (World Health Organization, 2014). This implies the need for an approach that extends beyond the healthcare sector and also considers, for example, the social domain. Implementing a HiAP approach requires close collaboration among various organizations and professionals (Hendriks et al., 2013). The KnGG approach involves cross-sector collaboration, bringing together organizations and professionals within both the social domain and healthcare domain.

The integrated care approach contributes to the call for more sustainable healthcare (Steenkamer et al., 2017). In the National Prevention Agreement, it is determined that by 2030, all municipalities must have an integrated care approach in place for children who are overweight or have obesity (Ministry of Health Welfare and Sport, 2018). To achieve this goal, the IZA and GALA agreements have mandated that the Dutch national model integrated care for childhood overweight and obesity is 1 of the 5 integrated care approaches that must be established by January 1, 2025 (Ministry of Health Welfare and Sport, 2022, 2023). Up until now, JOGG has mainly focused on implementing the approach in collaboration with local project leaders. However, given the scale that is currently being targeted, providing guidance to every municipality on a local level is not feasible, and there is a need for regional implementation of the network approach.

Regionalization in health care focuses on aligning resources with local health needs, fostering community involvement, and improving service quality for optimal outcomes (Bywood & Erny-Albrecht, 2016). In theory, regional collaboration potentially offers various advantages for the KnGG approach. JOGG has developed a document discussing several advantages based on experiences from other regions in the Netherlands (JOGG, 2023). Various Public Health Service regions are already implementing the KnGG approach on a regional level. The first advantage is that a more efficient implementation allows for the uniform addressing of shared issues, saving both time and costs. Secondly, regional collaboration provides for opportunities for regional learning, sharing insights, and development. Thirdly, regional intervision also enhances the quality assurance for professionals within the network approach. Fourthly, regional collaboration creates more opportunities for smaller municipalities and enables positioning of the approach as an appealing proposition for new municipalities. Fifthly, agreements with supra-local organizations, such as hospitals and health insurers, can be more effectively structured at both the executive and managerial levels. Regional implementation of the approach aligns with the trend of working on a regional level, as outlined in IZA, in terms of regional perspectives and plans for future healthcare (Ministry of Health Welfare and Sports, 2022).

Although these theoretical advantages are well-documented, empirical evidence regarding the practical realization and required conditions for these benefits remain scarce. This underscores the need for an in-depth understanding of the experiences of regional coordinators of the KnGG approach, the potential barriers and facilitators of the approach and prerequisites for effective regional collaboration. The aim of this study is to support the further regional implementation of the KnGG integrated care approach. This will be done by means of qualitative research by addressing the following research question: how do regional coordinators, working as part of an integrated care approach for childhood overweight and obesity, perceive their role and the functioning of the regional network they are involved in? The study focused on organizational variations in the structure (i.e., involved professionals and their roles, involved organizations, prerequisites) and dynamics within cross-sector collaborations from a policy perspective.

Methods

Study design and setting

The study was conducted over the course of a five-month time period in collaboration with the VU university team Care for Obesity, JOGG and the National Institute for Public Health and the Environment (In Dutch: RIVM). In this study, all criteria outlined in the Consolidated Criteria for Reporting Qualitative Research (COREQ), a 32-item checklist, will be utilized to comprehensively document all aspects of this qualitative study (Tong et al., 2007) (see Appendix C).

Conceptual framework

To explore cross-sector collaboration within the KnGG approach, the Collaborative Adaptive Health Networks (CAHN) framework was utilized (Steenkamer et al., 2020). Bryson et al. (2015) conducted a comprehensive review of theoretical frameworks and empirical studies on cross-sector collaboration. They suggest that due to the inherent complexity of cross-sector collaboration, no singular framework or theory has full explanatory power. By opting for the CAHN framework, a more recent study grounded in various theories and frameworks, an attempt was made to select the most comprehensive framework for cross-sector collaboration. The CAHN framework is a theoretical structure designed to achieve the triple aim (TA) by highlighting the essential components of Population Health Management (PHM) strategies (Steenkamer et al., 2020). PHM is defined as major transformation initiatives needed to reorganize and integrate public health, healthcare, social care, and wider public services to improve population health, enhance care quality, and reduce cost growth (Steenkamer et al., 2017). TA is generally understood to mean enhancing public health, while ensuring high-quality care and reducing healthcare costs (Steenkamer et al., 2017). The CAHN framework is based on a scoping realist review that examined the strategies required for successful PHM development, the necessary conditions during the implementation of this strategy (i.e., context and mechanism), and the theories underlying strategies: (S), context (C), mechanism (M), and outcome (O) configurations (Steenkamer et al., 2020). By working with SCMO configurations, an attempt has been made to identify causality and provide answers to the question: “Which strategy works, and why, and in what context and in what manner should this strategy be implemented to achieve the desired outcome” (Steenkamer et al., 2020, pp. 188-189)? The CAHN framework includes eight key components, each of which is further divided into a total of 38 subcomponents. The primary components are social forces, resources, finance, relationships, regulations, market, leadership, and accountability (Steenkamer et al., 2020) (Figure 1).

The first component, *social forces*, includes institutional elements that offer guidance for management of change: cultural-cognitive, normative, and regulative elements. In order to transform from what generally happens, cultural-cognitive, towards what should happen, regulative, Steenkamer et al. (2020) identified strategies that encompass establishing a shared new vision and goals, providing clear guidance to each stakeholder on the content of this new vision. The second component, *resources*, encompasses both material and institutional resources, consistently enhancing the provided services. The third component, *finance*, refers to financial arrangements and consists of financial strategies (e.g., determining risks that need to be taken to achieve the common goal), contractual relationships, and contractual scope and requirements (e.g., contractual preconditions). The fourth component, *relations*, primarily emphasizes that the relationship between professionals working as a part of a network should be carefully cultivated by investing in interaction, while ensuring mutual trust and respect. The fifth component, *regulations*, is referred to by Steenkamer et al. (2020) as policies regarding health, associated legislation and regulations, items prompting action on the political agenda, and the impact of political influence.

When issues are addressed not only at the local level, but also at the regional level, there is an opportunity to more effectively link regional concerns to national issues and collaborate with more influential allies, such as payors and politicians. The sixth component, *market*, consists of involved

organizations and partnerships within a network. It describes the dynamics within cross-sector collaboration of the regional setting. Additionally, having a history of working together can positively contribute to cross-sector collaboration. The seventh component, *leadership*, involves establishing suitable leadership roles. This entails examining the existing leadership structures and assessing which processes and styles provide for the best PHM development within a network (e.g., distributed leadership as a collective process). The eighth component, *accountability*, addresses the allocation of accountability among organizations and stakeholders. Steenkamer et al., (2020) indicates that with the establishment of clear agreements and the implementation of a governance structure, organizations are more inclined to fulfill their responsibilities.

Figure 1. Visual overview of the components of the CAHN framework (Steenkamer et al., 2020, p. 198).

Study population

The study population consisted of ten regional coordinators of the KnGG approach and one KnGG expert in regional implementation. A total of three regional coordinators participated in a focus group, with one agreeing to participate in an in-depth interview. This resulted in interviews with one KnGG expert and eight regional coordinators. The KnGG approach is integrated into JOGG and includes its own allocation of experts and advisors who support municipalities and professionals. Currently, there are 27 regional coordinators, some of whom have only recently been formally assigned the role of regional coordinator, appointed within 25 regions in the Netherlands. The participants were recruited with the assistance of the KnGG advisors' network via email and the recruitment was based on non-probability sampling, specifically, purposive sampling. The inclusion criteria for the regional coordinators were being familiar with the KnGG approach and working within a regional network where this approach was implemented. For the expert, the inclusion criteria were the same, except that it pertains to an advisory role regarding the regional implementation of the approach. Participants were excluded if they did not fulfill the inclusion criteria. Four regional coordinators who were invited to participate in the study via email refused to participate, due to scheduling conflicts during the period the interviews were conducted. The remainder did not respond to the email. Data saturation was achieved for two themes, the competency profile of regional coordinators and the functioning of the regional network approach, where no new results emerged in the final interviews.

Data collection

The data collection methods included interviews and focus groups. Nine semi-structured interviews and one focus group with three participants were conducted by one researcher (FP, BSc). FP holds a bachelor's degree in Health and Life Sciences and is currently pursuing a master's degree in Health Sciences, with a focus on prevention and public health. Each interview lasted approximately 45-60 minutes and took place via teams. There was no one else present besides the participant and the researcher (FP). The interviews were performed with a semi-structured interview guide. In this process, consideration is given to an iterative data analysis approach, where insights emerging during the analysis were taken into account, and the interview guide was adjusted accordingly if necessary. The interview guide was developed using the CAHN framework and a practical translation of the model in Dutch, developed by the RIVM, has been utilized. The interview guide also included questions based on the needs that were raised at the learning network organized by JOGG. Within this learning network, crucial issues and themes were highlighted, addressing the challenges and success factors that regional coordinators experienced during the regional implementation of the approach. The data collected from the learning network was analyzed as a focus group. The interview guide was revised following the first two interviews and subsequent discussions with JOGG advisors regarding preliminary findings. The interview guide for regional coordinators can be found in Appendix A, and the guide for the KnGG expert in Appendix B.

The interviews were conducted between April 5th and May 7th in 2024 and audio-recorded after informed consent was given. The interviews were transcribed verbatim following automatic transcription via Microsoft Teams. Furthermore, as the interviews were conducted in Dutch, the quotes were subsequently translated into English. To ensure credibility, a member check was performed on the interview transcripts to assure accurate interpretation of the data (Frambach et al., 2013).

Data analysis

An inductive thematic analysis was performed using the MaxQDA 2018 program. Coding was based on a process of open, axial and selective coding (Braun & Clarke, 2013). To ensure credibility and attain investigator triangulation, the first two interviews were coded and analyzed by two researchers (FP and JvA) (Frambach et al., 2013). JvA is currently pursuing a master's degree in Health Sciences, with a focus on prevention and public health. The analysis began with reading and familiarization with the data. After following the coding process, patterns were identified, and themes emerged. To ensure confirmability, the data analysis is discussed with peers and experts during a peer debriefing with multiple researchers, another student (JvA), a post-doc researcher (LK, PhD) and an assistant professor (BvV, MD) (Frambach et al., 2013). LK is a post-doc researcher within health sciences and performed a PhD-thesis on "the development of the Dutch national model of integrated care for childhood overweight and obesity" (Koetsier, 2023). BvV is an assistant professor within the Faculty of Youth and Lifestyle, the National Project Leader and Research Leader Care for Obesity and an obesity physician. Additionally, another peer debriefing was conducted with an independent researcher at the RIVM (NvV, PhD). NvV is a post-doc researcher and performed a PhD-thesis on "the process of cross-sector collaboration" (Van Vooren, 2024). A record of methodological choices was maintained throughout the data collection and analysis phases to ensure transparency (Frambach et al., 2013).

Ethical considerations

This study adhered to the Faculty of Science's Code of Ethics at Vrije Universiteit Amsterdam and complies with the Dutch Medical Research Involving Human Subjects Act (*Research ethics review committee - Vrije Universiteit Amsterdam*, n.d.). As a result, based on the Research Ethics Review Committee's self-check procedure, this study was determined not to necessitate further examination.

Participation in the interviews was entirely voluntary and participants were informed they could withdraw from the study at any point without needing to provide a reason. A detailed explanation of the study was provided in the format of an informational letter for participation via email before the interview. Informed consent was obtained from all participants. Names, regions, and organizations were securely encrypted and accessible only to the research team, with the code key stored securely at VU Amsterdam.

Results

The findings that emerged out of the analysis of the interviews and focus group were divided into seven themes: (a) the complexity of regional collaboration within an integrated care approach, (b) the functioning of the regional KnGG network approach, (c) competency profile regional coordinators, (d) prerequisites of the network, (e) potential facilitators of the network, (f) challenges and potential barriers of the network and (g) resource utilization and support for regional coordinators. Table A, outlines the roles of the regional coordinators, which provides an overview of the name of the assigned role of the coordinator and the organization within which this regional coordinator operates and to whom they are accountable. The results show that the role depends on the structure of the region, the stage of regionalization the region is in, and the extent to which the coordinator is also responsible for other network approaches.

Table A. Demographic characteristics study participants

Participant code	Role	Setting
1	Regional coordinator KnGG[a]	Municipal Health Service
2	Regional coordinator KnGG	Municipal Health Service
3	Regional coordinator KnGG	Municipal Health Service
4	KnGG expert	JOGG
5	Regional coordinator JOGG[b] and KnGG	Municipal Health Service
6	Regional coordinator IZA[c] GALA[d]	Municipal Health Service
7	Regional coordinator KnGG	Municipal Health Service
8	Project leader and regional coordinator network approaches overweight and obesity	Municipality
9	Project leader and regional coordinator five network approaches IZA GALA	Municipality
10	Regional coordinator KnGG	Municipal Health Service
11	Subregional coordinator KnGG and project leader KnGG	Municipal Health Service

a. Child on a Healthier Weight approach
b. Youth on a Healthy Weight
c. Integrated Care Agreement
d. Healthy and Active Living Agreement

(a) The complexity of regional collaboration within an integrated care approach

At the regional level, many different organizations are involved within the KnGG approach, as it is an integrated approach in which healthcare and the social domain work closely together. Regional coordinators indicated that healthcare and the social domain can speak different languages and experience organizational variations, and that it is crucial to clearly distinguish these differences when coordinating the approach at the regional level. These differences can include different funding streams or the contexts within which these professionals and organizations operate. Organizations from these domains have their own interests and goals. Each stakeholder has the right to make their own decisions, as each works for a different organization and must account to their principal.

According to regional coordinators, this occasionally resulted in stakeholders operating in silos.

"They [The regional coordinators] not only have to deal with different parties, but bringing together healthcare and social domain can be quite challenging sometimes, as they really do speak different languages, but additionally they have to navigate the various governing bodies and decision-making structures underlying these domains." (Participant code 4, pos. 65)

Additionally, many of the regional coordinators not only have to consider the implementation of the KnGG approach, but also other network approaches within the prevention structure. As illustrated in Table A, regional coordinators often oversee multiple integrated network approaches. According to the regional coordinators, integrating these network approaches can be more effective, as there is overlap between the approaches. This includes overlap in collaboration partners, allowing the implementation of one network approach to build on the network established by another approach. Collaboration also provides the opportunity to brainstorm with colleagues about the overarching processes described in IZA and GALA. However, implementing multiple network approaches simultaneously can also cause confusion, as there are, apart from overlap, many differences between the approaches. For example, the KnGG approach and the adult approach for overweight and obesity address the same health issue but target different populations. This results in differences not only in collaboration partners, but also in agreements with health insurers and the content of care (e.g., group interventions and program duration).

"I notice through the IZA and GALA plans, within this municipality, but also within other municipalities, that there is a lot of searching in assigning functions, because everything needs to be connected with everything else and yet we also want to have some kind of demarcation. So yes, for me primarily it's about overweight and obesity for both children and adults, but I also connect a lot with the other network approaches because I see a lot of overlap... for example, when it comes to the part of deeper underlying issues, it also touches on, for example, a network approach for promising start or a network approach for social prescription." (Participant code 8, pos. 9)

(b) The functioning of the regional network approach

In numerous instances, the commissioning party was the Municipal Health Service, a choice deemed logical by the coordinators due to the Municipal Health Services substantial expertise in health promotion and its status as a reliable partner devoid of commercial interests. Regions are currently at varying stages of regionalization, ranging from those yet to be formally assigned a regional coordinator role to those that have been implementing the approach on a regional level for over five years and are collaborating at the provincial level with multiple regions. Despite these variations, a few regional coordinators said they possess a clear understanding of the desired final approach, although the pathway to achieving this remains less defined. Additionally, it is important to recognize that while every region involved in the regional implementation of the KnGG approach aims to ensure a well-functioning network approach, each municipality determines the local implementation of their own health policy within the municipality. Consequently, most regional coordinators do not anticipate a clear and concrete assignment description.

"Well, I have a reasonable idea of it myself, just not entirely in detail, because what I notice is that I have a very... clear idea of what KnGG is and what the network approach should look like, as an end product, as a result. And what is needed for that, I have a clear idea of that too, but you just notice that each municipality has its own structure and each municipality has its own health policy in which

certain network approaches must fit... and I find that this really is a puzzle." (Participant code 5, pos. 25)

The organizational structure employed within each region varies. However, common collaboration partners included the municipality, the Municipal Health Service, Youth Health Care, health insurers, hospitals, general practitioners, dietitians and physiotherapists. Typically, regional coordinators mentioned a shared work agenda aimed at creating joint ownership. Regions adopted different approaches in this regard; while some coordinators indicate that regional cooperation is based on local needs, other regional coordinators report that decisions within the region are made from a regional perspective.

(c) Competency profile regional coordinators

The regional coordinator functions as a central figure in the regional implementation of the KnGG approach, acting as the connecting factor among all stakeholders and driver of the regional implementation. The regional coordinator has to navigate the diverse interests of stakeholders and has to consider the complex interrelationships among organizations. Regional coordinators emphasized the importance of distinguishing and recognizing these interests. They must be able to quickly adapt, work strategically, and ask critical questions. Their responsibilities include the initial engagement of these organizations, bringing them together, and facilitating collective decision-making. This role requires not only communication skills, but also sensitivity to the organizational backgrounds. One of the regional coordinators mentioned that experience serves as a facilitator in this context. According to regional coordinators, taking risks, being inventive, and being willing to experiment are essential for making progress. Additionally, networking is crucial, as building connections is necessary to create an effective network.

“Yes, that person [regional coordinator] is constantly dealing with what happens on a relational level, what interests are at play that are productive or counterproductive? The same applies to social forces, legislation, regulation, and finances... they have to continuously keep an eye on that, relate themselves to it, how do I relate to it? ...I strongly believe that if someone learns to develop and grow in that area, then they can also take on the next challenge..." (Participant code 4, pos. 113)

(d) Prerequisites of the network

According to regional coordinators, one of the key prerequisites is creating commitment. This involves making decisions about what should be organized locally and regionally and ensuring that the involved parties take responsibility. The need for a formal assignment is emphasized as crucial for aligning responsibilities. All stakeholders must clearly understand the relevance of the approach, agreements need to be made at the vision level, and there must be energy within the network to actively engage with the approach. The network should consist of individuals with intrinsic motivation to ensure the success of the KnGG approach, people who are committed to driving sustainable change. To enable regional collaboration, it is essential to first invest in these relationships and build collaborative partnerships within the network.

"What I do see is that there is a lot of energy among all these different stakeholders to get started with this network approach for this group of children, because everyone actually sees that, yes, these children just need something extra and at the moment we are not providing that. So, there is a clear shared sense of rolling up our sleeves together." (Participant code 5, pos. 34)

(e) Potential facilitators of regional implementation of the network

To implement the network approach at the regional level, a few of the regional coordinators suggested that aligning the health policy within the region is beneficial. It is also important to stay informed about national developments. A useful tip that regional coordinators mentioned is to look at other network approaches to potentially build on existing relationships. In regional collaboration, an optimal relationship between organizations enhances cooperation. Additionally, having sufficient resources, time, and space for dialogue is crucial. One of the most frequently mentioned facilitators is learning from good practices and the exchange of experiences between regional coordinators.

"We really don't need to keep it to ourselves, this problem is so big, we don't need to be afraid of competition, just share everything you have learned, then other people can benefit from it." (Participant code 9, pos. 184)

(f) Challenges and potential barriers of regional implementation of the network

One of the challenges that regional coordinators experienced in the regional implementation of the KnGG approach is the positioning of the CP. This includes challenges related to procurement policies and the assigning of the CP role. Other challenges mentioned by coordinators include organizing monitoring and evaluation, uncertainties regarding the SPUK IZA and GALA funds, and the fact that the combined lifestyle intervention for children cannot currently be claimed from health insurers, even though policy regulations indicate that this should be possible. Regional coordinators desired a shared responsibility between municipalities and health insurers in addressing these issues. According to regional coordinators, these challenges have partly arisen, because the prerequisites set by the Ministry of Health, Welfare and Sport have not yet been met. The regional implementation is still in its early stages and it is unclear how the intended outcomes will ultimately be achieved. Regional coordinators have also expressed concerns about the fact that currently only one national provider will soon be able to offer the combined lifestyle intervention for children included in the Healthcare Insurance Act.

The financing of the implementation is also presented to be an obstacle, as the current funding from IZA and GALA runs until 2026 and is already insufficient for many municipalities to fund the approach. Unanswered questions and unresolved challenges may lead municipalities to only meet the minimum requirements and administrative agreements described in the IZA and GALA. Regional coordinators indicated that more is needed to convince municipalities to regionalize than just a compelling narrative about the most logical and efficient option. Regional coordinators also stated that municipalities want to be and remain the owners of the implementation of the approach, ultimately deciding on health policy within their own municipality. According to regional coordinators, municipalities are questioning how the financing will be structured in a regional collaboration and who will ultimately make the decisions.

“Yes, and what do you do when 14 out of 16 municipalities want to go left and two do not, can you then force those two to also come on board? Or can those municipalities chart their own course? So then you have to determine together, in what aspects will we really work together and make a decision where the majority rules, and in which aspects can you maintain your local differences? Because that's also a tension field, right? That municipalities don't just want to give everything up, because it is their vision, their money, their residents." (Participant code 4, pos. 75)

The IZA and GALA stipulate that every municipality must start implementing the network approaches by 2025, leading more municipalities to seek to implement the KnGG approach. However, regional coordinators are concerned about this rollout to other municipalities, because there are no known results of scientific studies in controlled settings on the effectiveness of the approach yet.

Additionally, regional coordinators indicated that SPUK GALA does not clearly specify how municipalities should account for the funds.

“There are no results known yet, but we are already going ahead with a rollout to other municipalities, which of course, is also exactly as you are not taught to do it during your bachelor or master. So that's how it's being done now. Or that's how we would like to do it, and you notice that there are municipalities that are very critical of it, because even from the pilot, there are just a number of things that just yes, there are still some teething problems that need to be ironed out. And yes, we haven't arranged that yet, but then we are already, yes already, busy with that rollout..." (Participant code 2, pos. 29)

(g) Resource utilization and support for regional coordinators

Regional coordinators indicated that they utilize various resources. Many coordinators connected with each other to brainstorm and exchange good practices, for example through the learning community of JOGG. They expected the national organization JOGG to keep them informed about national developments, provide advice when needed by using their knowledge of regional and national activities, and facilitate exchanges between regional coordinators. There is a need for an expansion of the 'regionalization guidelines' and a concrete overview of the approach's design by pioneering regions. Regional coordinators noted that in some regions, the regional implementation has progressed to the point where they contributed more to JOGG and the learning network than they received, surpassing JOGG in practical experience, making it more of a brainstorming session than receiving concrete advice. There is a hope that JOGG will use its influence at the national level to address the current challenges and ensure that the prerequisites set by the Ministry of Health, Welfare and Sport are in order.

"It takes a lot of energy while yes.. [region x] has of course set up a whole process that goes beyond municipalities, a whole structure has been set up there and they don't have it on paper... and what they know, how their structure is completely put together? They can't provide that to me so well, while I think, well, those are the examples of, how did you actually organize it throughout your entire region?" (Participant code 11, pos. 118)

Discussion

The aim of this study was to support the regional implementation of the integrated care approach by identifying potential barriers and facilitators encountered by regional coordinators, and understanding how professionals perceived their roles and the functioning of the regional network for childhood overweight and obesity. The findings indicated that regions are at different stages of implementation, facing challenges involving monitoring and evaluation, CP positioning and procurement policies. Financing appeared to be a significant issue, as current funds were insufficient and only available until 2026. However, the study also identified potential facilitators for regional collaboration, such as investing in relationships and partnerships, aligning health policies, learning from other networks, and sharing best practices. Regional coordinators emphasized that commitment, formal assignments, clear stakeholder understanding, and intrinsic motivation were important prerequisites for the KnGG approach. The study also highlighted the competencies required by the regional coordinator to effectively fulfill the role of coordinator as well as the resources and support provided to coordinators, from for example, JOGG.

The study demonstrates that cross-sector collaboration and the implementation of a network approach on a regional level can be complex and involves various factors that potentially influence the process. Hence, most of the components outlined in the CAHN framework used for the interview guide are evident in the findings of this study and recognized by the regional coordinators to be of importance. However, when considering the definition of resources as described by Steenkamer et al. (2020), it can be concluded that a consistent contribution to implementation in terms of institutional and material resources is not adequately described within the study. The complexity also resonates with the literature on cross-sector collaboration (Bryson et al., 2006; Guglielmin et al., 2018). The results indicated that the most important prerequisites of the network were commitment, the formal assignment of the regional coordinator role, a shared vision and energy within the network to actively engage with the approach. These prerequisites align with literature on cross-sector collaboration for promoting well-being and sustainability (Calancie et al., 2021; Simo & Bies, 2007; Van Vooren et al., 2023, p). The Consolidated Framework for Collaboration Research suggests that a strengthened shared vision is one of the key elements for enhancing cross-sector collaboration (Calancie et al., 2021). Also, according to Simo en Bies (2007) formal agreements and commitment are considered to be of importance to support accountability and the absence of formal agreements can complicate collaboration.

The results of the current study revealed that regional coordinators attempt to connect with other network approaches or are required to do so because they oversee multiple network approaches, in order to work more effectively by, for example, potentially building on existing relationships and corresponding collaborative partners. This resonates with the literature, which emphasizes the significance of prior relationships, as partners rely on these relationships to determine the trustworthiness and legitimacy of stakeholders (Bryson et al., 2015). Trusting relationships are, in turn, crucial for enhancing cross-sector collaboration and community engagement (De Leeuw, 2017; Lee et al., 2011; Mundo et al., 2019).

The results of this study also indicated that the competencies required for a regional coordinator included the ability to navigate diverse stakeholder interests, recognize these interests, adapt quickly, work strategically, ask critical questions, network effectively, communicate proficiently, demonstrate sensitivity to organizational backgrounds, and exhibit comfort with being inventive. Additionally, a regional coordinator must be willing to take risks and experiment. Key individual and organizational competencies mentioned by Bryson et al. (2015) are the ability to engage into strategic planning, participate in teamwork and the ability to assess stakeholder perspectives. One of the most frequently mentioned forms of support by regional coordinators is the exchange with other regional coordinators. Fostering knowledge exchange is one of the methods through which JOGG supports the

regional implementation, and it is also recognized in the literature as a facilitator for cross-sector collaboration (Sullivan & Williams, 2012).

There are various strengths and limitations of this study. The primary strength of this study is that it is the first study conducted in the Netherlands that explores the regional implementation of the KnGG approach. The KnGG approach can serve as a base for the establishment of a regional prevention structure for other approaches outlined in the National Prevention Agreement in the Netherlands. Moreover, beyond the Dutch context, this approach may be applicable to childhood overweight and obesity care in other countries. Once established, the prevention framework could potentially expand to address other chronic diseases, mental health issues, and social challenges such as poverty. Another strength of this study is that it was informed by regional coordinators as well as a KnGG expert, which gives the study a broader scope of how the KnGG approach is implemented from the perspective of the expert on a national level, as well as regional coordinators on a regional level. Another strength of the study is the assurance of correct interpretation of results through member checking.

The main limitation of this study is the relatively small sample size, which meant that data saturation was not achieved for all themes, except for two themes, the competency profile of regional coordinators and the functioning of the regional network approach, where no new results emerged in the final interviews. However, it is important to note that there are only 27 regional coordinators in the Netherlands, some of whom coordinate the same regions. Additionally, many regions have not yet started regionalization or are in the early stages of implementation. This implies that despite the limited number of participants, a significant portion of the target group is represented in the study. The initial intention was to collect data until reaching data saturation to ensure dependability. However, the short period of the study did not allow for additional interviews to be conducted. To mitigate this limitation, a focus group was conducted, and an expert was interviewed in addition to the interviews with regional coordinators. Another limitation of the study is that the interviews were conducted solely by one researcher and no field notes were taken. However, the researcher noted that no specific circumstances arose during the interviews that could have influenced the outcomes.

The study identifies several implications for practice and research. Firstly, efforts should be increased to raise awareness of the differences between the social domain and healthcare domain, as well as to highlight where they can support and complement each other. This can be achieved by fostering more dialogue between these sectors. Enhanced mutual understanding and collaboration will help build trust and make stakeholders more aware of the benefits of cross-sector collaboration (Smith & Barnes, 2012). It is crucial for the successful implementation of the approach to continue collecting field experiences by means of qualitative research from regional coordinators, as many regions were in the early stages of implementation at the time of the current study. Over time, regions will gather more insights into facilitators and barriers, leading to an evolving understanding of the regional implementation of the KnGG approach. There is currently only one national provider soon able to offer the combined lifestyle intervention for children. Additionally, there is only one combined lifestyle intervention for children available which is included in the Healthcare Insurance Act, potentially hindering public sector efficiency and limiting healthy competition. Although a single provider can facilitate the sharing of best practices across regions and create a uniform structure, it is crucial for the government to promote effective market functioning by allowing multiple providers to ensure healthy competition and a more effective approach (Hofmann et al., 2019).

The current study also identifies several opportunities for JOGG. Regional coordinating roles within the Municipal Health Service are often already oriented towards integrating multiple network approaches simultaneously. Regional coordinators who oversee multiple network approaches, for example, refer to themselves as coordinators of the IZA and GALA initiatives. By connecting the network approaches, work may be carried out more effectively. An opportunity for JOGG is to provide

overarching advice across the different network approaches on implementing an integrated approach and building a regional prevention infrastructure. Some regional coordinators have a clear understanding of the differences between the approaches and have experienced these in practice, so collaboration with the Municipal Health Service can be sought there. The success of other network approaches can influence municipalities' willingness to implement additional network approaches within their municipality. There is also a demand for a detailed overview of the network of one of the pioneering regions, describing all the steps taken, particularly in the initial phase. Regional coordinators wish for a concrete overview of, for example, all undertaken actions, the structure of the network approach, the involved parties and their responsibilities, how funds are allocated and the positioning of the central care provider. JOGG could respond to this by collaborating with the pioneering regions and evaluating the process.

Lastly, regional coordinators express hope that JOGG, with its influential national position, endeavors to exert more influence on the Ministry of Health, Welfare and Sport to establish the necessary conditions and prerequisites. This thought holds merit, because, according to Steenkamer et al., (2020), SCMO configurations revealed that leaders strategically aligned regional and national health concerns, collaborating with influential allies like insurers, politicians, and academic institutions. By integrating these issues into a unified regional vision and gaining support from stakeholders, including institutional networks and political entities, they enhanced government receptiveness to policy changes. This approach generated urgency, raised awareness, and increased credibility for health issues and policies, ultimately securing political backing and financial resources (Steenkamer et al., 2020).

To conclude, investing in relationships and relatedness are important facilitators for the regional implementation of the network approach. Formal agreements of commitment, along with a shared vision, are essential prerequisites for successful implementation. Unmet prerequisites were experienced as a barrier, partly because they are not sufficiently supported at the national level. The study presented a set of recommendations to further support the regional implementation of the KnGG approach and potentially form the basis for a broader regional prevention structure.

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Appendices

Appendix A: Interview guide regional coordinators

Interviewguide regiocoördinatoren KnGG

Introductie (5 minuten)

Allereerst hartelijk dank dat je bereid bent om aan dit interview deel te nemen. Voordat we beginnen aan het interview zou ik graag willen vragen of je de informatiebrief over het onderzoek al hebt doorgenomen en of alles duidelijk is en of je het informed consent formulier in de docs al hebt ondertekend.

Zo niet, maakt helemaal niet uit en vraag ik de toestemming voor nu mondeling, maar het toestemmingsformulier is wel belangrijk zodat ik het interview ook daadwerkelijk mag analyseren.

Is de opname wat u betreft akkoord?

*[**Start opname**]*

De recorder wordt nu aangezet. Ik werk als stagiair bij de 'care for obesity' onderzoeksgroep van de VU en bij JOGG.

Ik voer zoals je hebt gelezen in de informatiebrief een onderzoeksstage uit naar de regionale implementatie van de ketenaanpak voor zorg en ondersteuning voor kinderen met overgewicht en obesitas. Hierbij wil ik, samen met de VU en JOGG, inzicht krijgen in de ervaringen van regionale partners bij de implementatie van deze ketenaanpak. Ik houd hierbij rekening met de breedte aan variaties in de vormgeving van een ketenaanpak voor kinderen met overgewicht en obesitas en de succes- en knelpunten hierbij. Vanaf nu zal ik als het gaat om de Kind naar Gezonder Gewicht aanpak, KnGG aanpak zeggen.

Er zijn geen goede of foute antwoorden; het is juist fijn als je zo goed mogelijk al je ervaringen beschrijft.

Het interview bestaat uit vijf delen:

1. Wat is jouw rol binnen de organisatie
2. Hoe de ketenaanpak is vormgegeven binnen de regio
3. Starten met regionaliseren
4. Wat jouw ervaringen zijn met de regionale implementatie van de ketenaanpak
5. Jouw aanbevelingen aan JOGG

Het interview zal ongeveer 45 minuten duren. Zijn er nog vragen of onduidelijkheden voordat we beginnen?

Interviewvragen (45 min)

Deel 1: Uw rol binnen de organisatie [10 min]

Kun je vertellen wie je bent en hoe je bent betrokken bij de regionale implementatie van de KnGG aanpak?

- Wat is jouw rol en die van de organisatie waar je werkzaam bent binnen de ketenaanpak?
- Van welke regio ben je regiocoördinator?
- Hoe en sinds wanneer ben je betrokken geraakt bij de implementatie van de ketenaanpak?

- Wat is de opdracht die je hebt gekregen en welke taken horen daarbij?
- Zit er overlap of is het af en toe onduidelijke welke taak de regiocoördinator toebehoort en welke de lokale projectleiders?
- Deel je ook binnen je organisatie je rol en verantwoordelijkheden?

Deel 2: Hoe de aanpak is vormgegeven binnen de regio [5]

Wat is de huidige stand van zaken van de ketenaanpak binnen de regio?

- Hoe lang zijn jullie nu bezig met regionaliseren binnen de regio?
- Wat is de overlegstructuur? Projectgroepen, werkgroepen, stuurgroepen etc.
- Welke organisaties zijn betrokken bij de netwerkaanpak binnen de regio?
- Welke stakeholders/organisaties nemen het initiatief binnen de regio?

Deel 3: Starten met regionaliseren [10 min]

Wat maakt een goede regiocoördinator?

- Welke competenties heb je nodig om een goede regiocoördinator te zijn?

Wat zijn de randvoorwaarden voor het beginnen met een succesvolle regionale implementatie van de aanpak?

- Wat zijn de eerste stappen die zijn ondernomen?
- Wat moet er op orde zijn om te kunnen starten met regionaliseren van de KnGG aanpak?
- Bij welke organisaties is het van belang dat ze betrokken zijn en verantwoordelijkheid nemen?

Wat waren uw eerste ervaringen bij het begin van de regionale implementatie van de ketenaanpak?

- Wat werkte volgens u in het begin bevorderend voor de regionale implementatie van de ketenaanpak?
- Wat werkte volgens u in het begin juist belemmerend voor de regionale implementatie van de ketenaanpak?

Denk hierbij aan (voor doorvragen):

- Wat gebeurde er in deze situatie?
- Wie waren er betrokken?
- Waarom gebeurde het specifiek nu of op deze manier?
- Wat voor gevolgen heeft deze situatie gehad?

Deel 4: Huidige ervaringen met regionale implementatie ketenaanpak [15 min]

Wat zijn momenteel jouw ervaringen bij de regionale implementatie van de ketenaanpak?

- Wat werkt volgens jou bevorderend voor de regionale implementatie van de ketenaanpak?
- Wat werkt volgens jou juist belemmerend voor de regionale implementatie van de ketenaanpak?

Als je kijkt naar deze **'praatplaat' dan ziet u een aantal factoren** die een rol spelen bij complexe samenwerkingen.

Zijn er naar jouw mening nog andere factoren, die niet zijn genoemd, die een rol spelen in de opstart van een ketenaanpak?

Denk hierbij aan:

- Relaties, kennen alle betrokken partijen elkaar al? Zijn er al vertrouwensbanden opgebouwd? Verantwoordelijkheid, wie neemt zijn of haar verantwoordelijk? Is het duidelijk wie 'waarvoor' verantwoordelijk is?
- Marktcontext, hoe is de dynamiek en samenwerking tussen verschillende organisaties?
- Sociale krachten, zit iedereen op één lijn als het gaat om de visie van de KnGG aanpak, is het voor iedereen duidelijk waar 'we' naartoe moeten gaan?
- Financiën, welke contracten lopen er? Wie krijgt financiering, waarvoor en tot wanneer?
- Hulpbronnen, welke hulp krijg jij aangeboden om je functie goed te kunnen uitvoeren? Van welke andere materiële of institutionele hulpbronnen kan gebruikgemaakt worden?
- Regulering, wat is het gezondheidsbeleid? Wat zijn wetten en voorschriften die relevant zijn voor de regionale implementatie? Hoe belangrijk is politieke invloed? In hoeverre staat de regionale implementatie van de KnGG aanpak op de politieke agenda?
- Leiderschap, wie neemt de leiding? Wie heeft er zeggenschap over beslissingen die worden gemaakt?

Deel 5: Aanbevelingen [5 min]

Heb je op basis van je huidige ervaringen met de regionale implementatie van de ketenaanpak aanbevelingen?

- Wat is nog goed voor JOGG om te weten om landelijk gemeenten te kunnen adviseren/ondersteunen?
- Wat zou je andere regio's mee willen geven, zodat zij niet het wiel opnieuw hoeven uit te vinden?

Is er nog iets wat je zou willen toevoegen aan het interview?

- Zijn er relevante onderwerpen nog niet aan bod gekomen tijdens dit interview? Zo ja, welke?

Dan zijn we nu bij het einde van het interview aangekomen. Ik wil je allereerst ontzettend bedanken. Aan het einde van dit onderzoek zal ik alle opgedane, geanonimiseerde inzichten met je delen. Door de gestructureerde wijze van het in kaart brengen van informatie, kun je zelf meer inzicht krijgen in je eigen regionale situatie en hoe die zich verhoudt tot de organisatie in andere regio's. Ook draagt je deelname bij aan algemene kennis over de regionale implementatie van de KnGG aanpak, waardoor ook andere regio's beter ondersteund kunnen worden.

Relaties

Interactie **Historie**

Verantwoordelijkheid

Aansprakelijkheid **Afspraken**

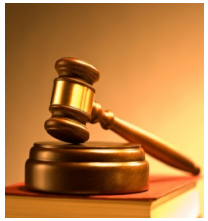
Marktcontext

Vraag/aanbod **Competitie vs. Samenwerking**

Sociale krachten

Cultureel-cognitief **Normatief**

Financiën



Strategie en risico's **Contractuele randvoorwaarden**

Hulpbronnen

Materiële & Institutionele hulpbronnen

Regulering

Wet- en regelgeving **Politieke krachten**

Leiderschap

Representatie **Type leiderschap**

Appendix B: Interview guide JOGG-experts
Interviewguide JOGG-experts KnGG

Introductie
Allereerst heel erg bedankt dat je bereid bent om aan dit interview deel te nemen. Voordat we beginnen aan het interview zou ik graag willen vragen of alles duidelijk is omtrent het onderzoek en of je nog vragen hebt. Het toestemmingsformulier om dit interview op te nemen is akkoord dus ik ga nu de opname starten.

*[**Start opname**]*
We hebben elkaar natuurlijk al is gezien, maar ik werk dus op het moment als stagiair bij de 'care for obesity' onderzoeksgroep van de VU en bij JOGG.

Ik voer zoals je weet een onderzoeksstage uit naar de regionale implementatie van de ketenaanpak voor zorg en ondersteuning voor kinderen met overgewicht en obesitas. Hierbij wil ik, samen met de VU en JOGG, inzicht krijgen in de ervaringen van regionale partners bij de implementatie van deze ketenaanpak. Vanaf nu zal ik als het gaat om de Kind naar Gezonder Gewicht aanpak, KnGG aanpak zeggen.

Er zijn geen goede of foute antwoorden; het is juist fijn als je zo goed mogelijk je ervaringen beschrijft.

Het interview bestaat uit vijf delen:
1. Wat is jouw rol
2. Hoe de ketenaanpak is vormgegeven binnen de regio
3. Starten met regionaliseren
4. Wat zijn jouw ervaringen met de regionale implementatie van de ketenaanpak
5. Jouw aanbevelingen voor regionale implementatie van de ketenaanpak

Het interview zal in totaal dus ongeveer 45 minuten duren. Zijn er nog vragen of onduidelijkheden voordat we beginnen?

Deel 1: Jouw rol [10 min]
Kan je me iets meer vertellen over hoe jouw functie eruitziet en op welke manier je bent betrokken bij de implementatie van de regionale KnGG aanpak?
- Hoe en sinds wanneer bent u betrokken geraakt bij de implementatie van de ketenaanpak?
- Wat is uw rol/ die van de organisatie binnen de ketenaanpak?

Deel 2: Hoe de aanpak is vormgegeven binnen de regio's [5 min]
Wat is de huidige stand van zaken van de ketenaanpak binnen de regio's waar jij mee te maken hebt?
- Op welke manier kunnen regio's van elkaar verschillen?
- Wat is de projectstructuur? Is er sprake van stuurgroepen en/of projectgroepen? Wat is de overlegstructuur?
- Welke organisaties zijn betrokken bij de netwerkaanpak binnen de regio's?
- Welke stakeholders/organisaties nemen het initiatief binnen de regio's?

Hoe is de afbakening van wat het takenpakket is van de lokale projectleider in vergelijking met die van een regionale coördinator? Zit hier verschil in tussen regio's?

Deel 3: Starten met regionaliseren [10 min]

Wat zijn de randvoorwaarden voor het beginnen met een succesvolle regionale implementatie van de aanpak?

- Wat zijn de eerste stappen die ondernomen moeten worden?
- Wat moet er op orde zijn om te kunnen starten met regionaliseren van de KnGG aanpak?
- Bij welke organisaties is het van belang dat ze betrokken zijn en verantwoordelijkheid nemen?

Wat waren je eerste bevindingen bij het begin van de regionale implementatie van de ketenaanpak?

- Wat werkte volgens jou in het begin bevorderend voor de regionale implementatie van de ketenaanpak?
- Wat werkte volgens jou in het begin juist belemmerend voor de regionale implementatie van de ketenaanpak?

Denk hierbij aan (voor doorvragen):

- Wat gebeurde er in deze situatie?
- Wie waren er betrokken?
- Waarom gebeurde het specifiek nu of op deze manier?
- Wat voor gevolgen heeft deze situatie gehad?

Deel 4: Huidige ervaringen met regionale implementatie ketenaanpak [15 min]

Wat zijn momenteel jouw ervaringen bij de regionale implementatie van de ketenaanpak?

- Wat werkt volgens jou bevorderend voor de regionale implementatie van de ketenaanpak?
- Wat werkt volgens jou juist belemmerend voor de regionale implementatie van de ketenaanpak?

Denk hierbij aan (voor doorvragen):

- Wat gebeurde er in deze situatie?
- Wie waren er betrokken?
- Waarom gebeurde het specifiek nu of op deze manier?
- Wat voor gevolgen heeft deze situatie gehad?

Als je kijkt naar deze **'praatplaat' dan ziet u een aantal factoren** die een rol spelen bij complexe samenwerkingen.

Zijn er naar jouw mening nog andere factoren, die nog niet zijn genoemd, die een grote rol spelen in de opstart van een ketenaanpak?

Denk hierbij aan (eventueel toelichting geven per factor van het framework om meer inspiratie te bieden):

- Relaties, kennen alle betrokken partijen elkaar al? Zijn er al vertrouwensbanden opgebouwd? Verantwoordelijkheid, wie neemt zijn of haar verantwoordelijk? Is het duidelijk wie 'waarvoor' verantwoordelijk is?
- Marktcontext, hoe is de dynamiek en samenwerking tussen verschillende organisaties?

- Sociale krachten, zit iedereen op één lijn als het gaat om de visie van de KnGG aanpak, is het voor iedereen duidelijk waar 'we' naartoe moeten gaan?
- Financiën, welke contracten lopen er? Wie krijgt financiering, waarvoor en tot wanneer?
- Hulpbronnen, welke hulp krijg jij aangeboden om je functie goed te kunnen uitvoeren? Van welke andere materiële of institutionele hulpbronnen kan gebruikgemaakt worden?
- Regulering, wat is het gezondheidsbeleid? Wat zijn wetten en voorschriften die relevant zijn voor de regionale implementatie? Hoe belangrijk is politieke invloed? In hoeverre staat de regionale implementatie van de KnGG aanpak op de politieke agenda?
- Leiderschap, wie neemt de leiding? Wie heeft er zeggenschap over beslissingen die worden gemaakt?

Deel 5: Aanbevelingen [5 min]

Heb je op basis van je huidige ervaringen met de regionale implementatie van de ketenaanpak aanbevelingen?

- Wat is nog goed voor JOGG om te weten om landelijk gemeenten te kunnen adviseren/ondersteunen?
- Wat zou je andere regio's mee willen geven, zodat zij niet het wiel opnieuw hoeven uit te vinden?

Is er nog iets wat je zou willen toevoegen aan het interview?

- Zijn er relevante onderwerpen nog niet aan bod gekomen tijdens dit interview? Zo ja, welke?

Dan zijn we nu bij het einde van het interview aangekomen. Ik wil je allereerst ontzettend bedanken. Aan het einde van dit onderzoek zullen wij alle opgedane, geanonimiseerde inzichten met je delen. Door de gestructureerde wijze van het in kaart brengen van informatie, kun je zelf meer inzicht krijgen in je eigen regionale situatie en hoe die zich verhoudt tot de organisatie in andere regio's. Ook draagt je deelname bij aan algemene kennis over de regionale implementatie van de KnGG aanpak, waardoor ook andere regio's beter ondersteund kunnen worden.

Relaties

Historie **Interactie**

Verantwoordelijkheid

Aansprakelijkheid **Afspraken**

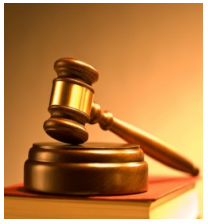
Marktcontext

Vraag/aanbod **Competitie vs. Samenwerking**

Sociale krachten

Cultureel-cognitief **Normatief**

Financiën



Strategie en risico's **Contractuele randvoorwaarden**

Hulpbronnen

Materiële & Institutionele hulpbronnen

Regulering

Wet en regelgeving **Politieke krachten**

Leiderschap

Representatie **Type leiderschap**

Appendix C: Consolidated criteria for reporting qualitative research

Table Consolidated criteria for reporting qualitative studies (COREQ): 32-item checklist

No. Item	Guide questions/description	Reported on page #
Domain 1: Research team and reflexivity		
Personal Characteristics		
1. Interviewer/facilitator	Which author/s conducted the interview or focus group?	Methods, page 8
2. Credentials	What were the researcher's credentials? *e.g., PhD, MD*	Methods, page 8
3. Occupation	What was their occupation at the time of the study?	Methods, page 8
4. Gender	Was the researcher male or female?	Not stated
5. Experience and training	What experience or training did the researcher have?	Methods, page 8
Relationship with participants		
6. Relationship established	Was a relationship established prior to study commencement?	Methods, page 8
7. Participant knowledge of the interviewer	What did the participants know about the researcher? *e.g., personal goals, reasons for doing the research*	Appendices, pages 20 and 24
8. Interviewer characteristics	What characteristics were reported about the interviewer/facilitator? *e.g., Bias, assumptions, reasons, and interests in the research topic*	Not stated
Domain 2: study design		
Theoretical framework		
9. Methodological orientation and Theory	What methodological orientation was stated to underpin the study? *e.g., grounded theory, discourse analysis, ethnography, phenomenology, content analysis*	Not stated
Participant selection		
10. Sampling	How were participants selected? *e.g., purposive, convenience, consecutive, snowball*	Methods, page 8
11. Method of approach	How were participants approached? *e.g., face-to-face, telephone, mail, email*	Methods, page 8
12. Sample size	How many participants were in the study?	Methods, page 8
13. Non-participation	How many people refused to participate or dropped out? Reasons?	Methods, page 8
Setting		
14. Setting of data collection	Where was the data collected? e.g. home, clinic, workplace	Methods, page 8
15. Presence of non-participants	Was anyone else present besides the participants and researchers?	Methods, page 8

16. Description of sample	What are the important characteristics of the sample? e.g. demographic data, date	Results, page 9
Data collection		
17. Interview guide	Were questions, prompts, guides provided by the authors? Was it pilot tested?	Appendices pages, 20-28
18. Repeat interviews	Were repeat interviews carried out? If yes, how many?	No, but not specifically stated
19. Audio/visual recording	Did the research use audio or visual recording to collect the data?	8
20. Field notes	Were field notes made during and/or after the interview or focus group?	No, but not specifically stated
21. Duration	What was the duration of the interviews or focus group?	Methods, page 8
22. Data saturation	Was data saturation discussed?	Methods, page 8
23. Transcripts returned	Were transcripts returned to participants for comment and/or correction?	Methods, page 8
Domain 3: analysis and findings		
Data analysis		
24. Number of data coders	How many data coders coded the data?	Methods, page 8
25. Description of the coding tree	Did authors provide a description of the coding tree?	No, but not specifically stated
26. Derivation of themes	Were themes identified in advance or derived from the data?	Methods, page 8
27. Software	What software, if applicable, was used to manage the data?	Methods, page 8
28. Participant checking	Did participants provide feedback on the findings?	No, but not specifically stated
Reporting		
29. Quotations presented	Were participant quotations presented to illustrate the themes / findings? Was each quotation identified*? e.g. participant number*	Results, page 10
30. Data and findings consistent	Was there consistency between the data presented and the findings?	Yes, but not specifically stated
31. Clarity of major themes	Were major themes clearly presented in the findings?	Results, page 9
32. Clarity of minor themes	Is there a description of diverse cases or discussion of minor themes?	Not stated

Appendix D: List of abbreviations

List of abbreviations

KnGG	Child on a Healthier Weight
IZA	Integrated Care Agreement
GALA	Healthy and Active Living Agreement
HiAP	Health-in-all-policies
CP	Coordinating professional
JOGG	Youth on a Healthy Weight
VU	Vrije Universiteit
RIVM	National Institute for Public Health and the Environment
COREQ	Consolidated Criteria for Reporting Qualitative Research
CAHN	Collaborative Adaptive Health Networks
PHM	Population Health Management
TA	Triple Aim