IMPLEMENTATION OF THE DUTCH MEETING CENTRES SUPPORT PROGRAM FOR PEOPLE WITH DEMENTIA AND THEIR CARERS IN MILAN: PROCESS EVALUATION OF THE PREPARATION PHASE

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INTRODUCTION

Worldwide, the number of elderly people (aged 60 years and older) with dementia is expected to increase from 46.8 million in 2015, to approximately 131.5 million in 2050.1 Research has shown that people with dementia and their informal caregivers, who are mostly family members (hereinafter carers), are facing numerous difficulties.2-4 For example, people with dementia may have fears and ambivalent feelings regarding the dementia diagnosis. Because of that and of anosognosia tied to the neurodegenerative illness itself they may deny their symptoms and postpone asking for help in the early stages of the disease.4 5 Likewise, Tremont2 found that carers may find it difficult to cope with changing care demands and unexpected problems. Some carers may feel that asking for help is a sign of incompetence to cope with these difficulties, and consequently do not ask for help, especially not in the early stages of dementia.3 However, waiting with asking for help until

Background and Aims. The Meeting Centres Support Programme (MCSP) for people with mild to moderately severe dementia and their carers proved effective in the Netherlands, and is now being implemented in other European countries. This study aimed to compare factors that at the preparation of two meeting centres in Italy were expected and experienced as facilitating or impeding implementation.

Methods. At the start, stakeholders (n = 19) filled in a checklist on expected facilitators and barriers. After opening the centres, experienced facilitators and barriers were inventoried in semi-structured interviews (n = 13) and analysed by two independent researchers, using a Theoretical model on implementation. Additionally, minutes of the initiative group were investigated. Expected and experienced facilitators and barriers were compared.

Results. In contrary to the expectations, the use of existing networks/collaboration between organizations facilitated the preparation phase. As expected, motivated stakeholders were facilitating. Shortening of the original time plan (for pragmatic reasons) was not expected, and made some preparatory tasks difficult to fulfil. Lack of Italian examples and cultural differences in working method made the realization of meeting centres difficult to imagine. Some experienced factors were not foreseen due to unexpected events.

Conclusions. Most aspects of MCSP appeared well implementable in the Italian setting. Many factors were in line with the Dutch implementation study, new influencing factors were also found.

Key words: Meeting centres support programme, Adaptive implementation, Dementia, Carers, Facilitators and barriers
To support either the person with dementia or the carer, numerous Single-component Support Programmes (SSP) are available. Examples of SSP for people with dementia are: psychosocial interventions, such as psychomotor therapy, memory groups and cognitive stimulation therapy. SSP for carers are: support groups and educational programmes. However, many of these SSP do not meet all individual needs and preferences of people with dementia and carers. In contrast, Combined Personalizable Multi-component Support Programmes (CPMSP) offer supportive activities to both the persons with dementia and carers, adjusted to their multiple needs and preferences. CPMSP appear more effective than SSP: the general mental health of both carers and people with dementia is improved and admission to nursing homes is delayed.

An example of a CPMSP is the Meeting Centres Support Programme (MCSP) which was developed more than 20 years ago in the Netherlands. The MCSP is build on a theoretical framework, the Adaptation-Coping model. The programme is meant for people with mild to moderately severe dementia (Global Deterioration Scale-score 4-6) who do not have severe behavioural problems (such as wandering) or movement problems and live at home, and their carers. The MCSP consists of a social club for persons with dementia, which is generally accessible three days a week, where they can participate in recreational and therapeutic activities, such as billiard, cognitive stimulation therapy, creative art, and psychomotor therapy. Furthermore, support is offered to their carers by discussion groups and informative meetings. The staff also helps to coordinate care at home. Also, both people with dementia and carers can participate in social activities, a weekly consultation hour and regular centre meetings in which participants, employees and volunteers share experiences and discuss the support programme. All these supportive activities are adapted to both the people with dementia’s and carers’ needs and preferences.

The Dutch MCSP was compared to psycho-geriatric day care organized in nursing homes, and the effects were in accordance with the positive results which were found in other CPMSP. People with dementia participating in a MCSP showed less mood and behavioural problems and a higher self esteem, and admission to residential care was delayed compared with those receiving regular psychogeriatric day care. Carers felt less burdened and more competent, while lonely carers had fewer psychosomatic complaints. Currently the MCSP is implemented in 144 meeting centres in the Netherlands, but this implementation did not occur spontaneously. According to Grol and Grimshaw, there is still a gap between scientific evidence of innovations and the actual implementation of these innovations in practice. Therefore, Grol proposes a cyclical model which can be used to improve the implementation of care innovations. The model emphasises the importance of identifying obstacles to change and linking these obstacles to the implementation of the intervention. This idea is confirmed by, Meiland, Dröes, De Lange & Vernooij-Dassen who have demonstrated that for a successful implementation of MCSP in the Netherlands, effective implementation strategies which take into account impeding and facilitating factors at various levels (micro, meso, macro) and in various phases (preparation, execution, continuation), are important. Several of these factors include: enthusiastic and active initiators, assessing the need for a meeting centre in the region, finding an accessible social integrated location, collaboration between welfare and care organizations, recruiting funding organizations, and awareness of the meeting centre pioneers about laws and regulations.

Within the framework of a joint European Programme (Joint Programme Neurodegenerative Diseases) the Dutch MCSP is further disseminated and adaptively implemented in three European countries, Italy, Poland and United Kingdom, in the MEETINGDEM project (www.meetingdem.eu). In Milan, Italy, two centres were planned to open in September 2015. These centres were adaptively implemented, taking into account characteristics of the local situation. Local situations between and within countries may differ. For example, the local situation in Milan may differ from local situations in The Netherlands: there are for example differences in organization of healthcare. The Italian healthcare system is mainly based on the Beveridge model and the Dutch on the Bismarck model. Because of these differences, other implementation strategies may be needed in Italy, than in the Netherlands. MCSP was implemented for the first time in Italy. No previous study investigated the implementation process and the used implementation strategies, specifically in an Italian setting. Gaining insight into aspects of the adaptive implementation process is considered to be an important step for successful implementation and further dissemination in Italy and Europe.

This research describes the preparation phase of the implementation of MCSP in two meeting centres in Milan, with the aim of investigating the factors that facilitated and/or impeded this implementation. Special attention is given to possible discrepancies between expected facilitators and barriers on beforehand and those actually experienced during the preparation phase.
MATERIALS AND METHODS

DESIGN
A qualitative descriptive study was conducted in which stakeholders’ expectations of facilitators and barriers at the start of the implementation of MCSP were compared with actual experienced facilitators and barriers during the preparation phase. Approval of the Medical Ethical Committee (MEC) was not required for this process analysis as there were no patients involved.21

STUDY POPULATION AND SETTING
All stakeholders present at the first initiative group (IG) meeting (n = 19), filled in a checklist about foreseen facilitators and barriers. The IG is a multidisciplinary group of representatives of relevant local care and welfare organizations, who were involved in the implementation of the MCSP in Milan. At the end of the preparation phase, stakeholders (n = 13) were interviewed about the experienced facilitators and barriers. These stakeholders were purposively selected based on their role in the project and their profession, ten of them were members of the IG (Table I). The IG was divided into four smaller subgroups with four to five members. Each subgroup worked on one or multiple preparatory tasks and reported results in the full IG: subgroup I worked on the definition of the target group, subgroup II defined the support programme, subgroup III elaborated on the location requirements and financing, and subgroup IV focused on the personnel/volunteers (tasks, function requirements, training). Other interviewed stakeholders were the two project managers of the MEETINGDEM project in Italy, who planned and organized the project and led the IG meetings. Furthermore, both coordinators of the two meeting centres (of which one was also member of the IG) were interviewed.

This study was carried out between March 2015 and September 2015. Both meeting centres opened, during the course of the study in May 2015 and were situated in community centres for elderly people, in zone 4 and 7 of Milan.

DATA COLLECTION METHODS
The data collection methods consisted of administration of questionnaires and semi-structured interviews, and the collection of relevant documents regarding the implementation process. The questionnaire was used to inventory expected facilitators and barriers of implementation of MCSP. This questionnaire was based on the literature about impeding and facilitating factors of implementation of MCSP22 23 and the theoretical model of Meiland et al. (Table II)24 to trace facilitators and barriers of implementation of care innovations. In this model two types of facilitating and impeding factors are distinguished: 1) factors related to preconditions at the start of the implementation and/or during the whole implementation process and 2) factors which are specific for the different phases of implementation, in this study limited to the preparation phase. Preconditions are: characteristics of MCSP, time available for the implementation and operational preconditions, human and financial resources and organizational conditions.

Table I. Characteristics of interviewed stakeholders (n = 13*).

<table>
<thead>
<tr>
<th>Role in MCSP project (number of stakeholders)</th>
<th>Profession (years of experience)</th>
<th>Age (sex)</th>
</tr>
</thead>
<tbody>
<tr>
<td>IG subgroup I (n = 1) Definition of target group</td>
<td>Neurologist in hospital (19)</td>
<td>56 (f)</td>
</tr>
<tr>
<td>IG subgroup II (n = 4) Definition of the support programme</td>
<td>Responsible of hospital volunteer association (10)</td>
<td>49 (f)</td>
</tr>
<tr>
<td></td>
<td>Volunteer of hospital volunteer association (17)</td>
<td>56 (f)</td>
</tr>
<tr>
<td></td>
<td>Physiotherapist in cognitive rehabilitation &amp; counsellor of Alzheimer association (17)*</td>
<td>41 (f)</td>
</tr>
<tr>
<td></td>
<td>Psychologist alzheimer federation (9)</td>
<td>33 (f)</td>
</tr>
<tr>
<td>IG subgroup III (n = 2) Location requirements and Financing</td>
<td>Official of social services Municipality (40)</td>
<td>60 (m)</td>
</tr>
<tr>
<td></td>
<td>District director of social-sanitary organization (36)</td>
<td>60 (f)</td>
</tr>
<tr>
<td>IG subgroup IV (n = 3) Personnel/volunteers</td>
<td>President Alzheimer association (30)</td>
<td>61 (f)</td>
</tr>
<tr>
<td></td>
<td>Psychologist Alzheimer association (2)</td>
<td>26 (f)</td>
</tr>
<tr>
<td></td>
<td>Psychologist in care/welfare cooperation (2)</td>
<td>30 (f)</td>
</tr>
<tr>
<td>Project managers (n = 2)</td>
<td>Psychologist clinical and research in hospital setting (7)</td>
<td>33 (f)</td>
</tr>
<tr>
<td></td>
<td>Neurologist clinical and research setting in hospital (23)</td>
<td>52 (f)</td>
</tr>
<tr>
<td>Coordinators Meeting Centre (n = 2)</td>
<td>Physiotherapist in cognitive rehabilitation &amp; counsellor of Alzheimer association (17)*</td>
<td>41 (f)</td>
</tr>
<tr>
<td></td>
<td>Coordinator of elderly day-care (10)**</td>
<td>46 (f)</td>
</tr>
</tbody>
</table>

* This stakeholder was involved in IG subgroup II and was also a coordinator of one meeting centre, and is listed twice
** This stakeholder did not fill in the checklist
f = female
m = male
Factors specific for the preparation phase are distinguished in three levels: micro level (individual user, personnel, meeting centre level), meso level (organizational and collaboration level) and macro level (healthcare system, legislation and policy level).

The semi-structured interviews were led by a topic guide which was based on this theoretical model, available documents about the project and literature about impeding and facilitating factors of implementation. Furthermore, regarding to the stakeholders’ role in the preparation phase and their area of expertise, different aspects were discussed into more detail. Topics which were not described in the topic guide, but which were mentioned by the stakeholders were also discussed. In this way, the importance of each topic was determined by the information which was given by the participants.

Relevant documents that were collected were minutes of the meetings of the Initiative Group and results of the work in its subgroups.

**PROCEDURE**

The main researcher (MS, Msc Health Sciences Graduate, sufficient knowledge of the Italian language, female) approached all stakeholders by telephone or e-mail with help of the two project managers (EF, neurologist and FS, psychologist), explaining the aim and scope of the research. All contacted stakeholders agreed to participate. They received an information letter and signed a letter of informed consent.

In total eleven semi-structured interviews were conducted with thirteen stakeholders in Italian by MS, principally at the workplace of the stakeholder. Two of the interviews concerned duo interviews, since in both cases a second stakeholder expressed her willingness to participate in the research. After each interview, a methodological memo was written about the execution of the interview.

Privacy of all participants was ensured by replacing private information (i.e. names) with codes. The key to these codes was maintained in a secured safe. The interviews lasted between 26 and 73 minutes (mean duration of 55 minutes), and were transcribed verbatim with Express Scribe Transcription (http://www.nch.com.au/scribe/) by MS.

**DATA ANALYSIS**

Two independent researchers MS and RC (Associate Professor of clinical psychology, male), analyzed the transcripts, combining a deductive and inductive method. First, the Italian transcripts were re-read and an English summary was made by MS. Each transcript was separately (deductively) analyzed in Italian by MS and RC in Excel, by making use of the theoretical model of Meiland et al. New codes were added where necessary (inductive). All codes and their definitions were discussed between the researchers until consensus was reached. Next, MS organized the facilitating and impeding factors in a coding tree with the use of Mindmap (https://www.xmind.net/xmind6/). Per code the fragments of different interviews were collected, which enabled to search for similarities and differences between the interviews. The main findings on facilitators and barriers of the implementation were described (MS) in a short summary and sent to the stakeholders, none of the stakeholders had any comments or extra information to add. Subsequently, MS compared the experienced facilitating and impeding factors with those expected on beforehand in the questionnaire. Meeting minutes of the IG meetings were used to get a better understanding of the implementation process of this preparation phase, including the differences found between the expected and actually experienced facilitators and barriers of implementation. Finally, a description was made of the whole preparation process, and of the factors that had facilitated or impeded this phase of implementation.

**RESULTS**

**Preparation process of the MCSP implementation**

May 2014, all relevant organizations in the Milan area were invited to an information meeting. June 2014, the first IG meeting took place in which an overview of the whole project and the preparation phase was given. At this meeting four subgroups were formed. Each subgroup was dedicated to specific tasks, related to the preparation of the implementation of the meeting.
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centres. These concerned: the target group, the support programme, the location and financing, and personnel. The tasks “communication plan/PR” and “protocol for collaboration” were not specifically allocated to subgroups. Furthermore, in this first meeting the members of the IG filled in a questionnaire (hereinafter checklist) on expected facilitating and impeding factors, and rated the importance of each of these factors (minor, intermediate, major) (Table III). September 2014, in the second meeting the facilitators and barriers were further discussed and possible solutions were identified and discussed. From September 2014 onwards, there was a monthly IG meeting, in which each subgroup worked separately on their own topic. The scheduled time for the actual preparation phase was approximately 16 months, however due to pragmatic reasons (see below result section) this had to be shortened to 12 months. The 5th of May 2015 the first meeting centre opened in Milan, and the second opened the 25th of May 2015. After the opening, the IG was transformed into an advisory committee, however not all members of the IG participated.

EXPECTED AND EXPERIENCED FACILITATING AND IMPEDING FACTORS

For each of the existing preconditions and factors specific to the preparation phase the main expected and experienced facilitators and barriers are described. The main experienced factors are presented in Italic. A complete overview of the factors that facilitated or impeded the preparation of the implementation of the meeting centres is shown in Table III.

PRECONDITIONS

Characteristics of MCSP

In the checklist on expected facilitators and barriers, the stakeholders described they believed this program would have a surplus value for people with dementia and carers compared with other programs for this target group. During the preparation phase, the people with dementia and carers could not yet really experience this surplus value, since the meeting centre was not yet opened. Nevertheless, the stakeholders felt there was a need for this type of innovative program in the Milan area, offering integrated support to people with mild to moderately severe dementia and their carers three days per week. As one of the stakeholders of the meeting centres described:

There was for example a relative, who said to me: “I was waiting for a place like this, where I can talk with a psychologist, but also my wife can do an activity here. There is also a lawyer, in case I have problems related to the administration, or to legal things, I can ask information. So, without having to go to all services of the city”. (R8)

According to the stakeholders, current services were often fragmented, not frequently accessible, and few dementia services were available for this specific target group. They explained that the surplus value of the program compared to existing services amongst other things, motivated them to be involved in the program. Furthermore, the IG expected that studying existing examples of meeting centres would help them adapt the programme to the local situation, as they indicated in the checklist. During the preparation phase they experienced, that the translated Meeting centres guide on existing Dutch meeting centres was indeed useful and helped in guiding the work on the project. However, as the project was new for the stakeholders and no Italian examples of meeting centres were available at that time, in this initial phase some stakeholders found it difficult to imagine how the project could be realized. That is why some stakeholders suggested during the interview, that in order to further facilitate the implementation it would have been better to study the Dutch examples in even more detail in the initial phase, to help them understand what aspects of the MCSP could be used in the Italian setting without changes and what needed to be adapted. As a stakeholder explained:

“I would do something, not really starting from zero, but I would say that this are the experiences, let’s say MCSP in the Netherlands functions like this. And you, how would you do it here in Milan? A greater reference to already implemented models. You always learn from the experiences of others”. (R5)

Time and operational preconditions

In the checklist, the stakeholders emphasized the necessity of having enough time for the preparation phase, in order to explore the opportunities and resources available in the region as well as to enlarge networks. At the start of the project, they expected to have enough time to execute these preparatory tasks. However, the centres had to open four months earlier in order to obtain necessary resources, offered by the Municipality of Milan. Due to this, especially stakeholders with a major role in the project, such as the project managers and the coordinators of the centres, experienced a lack of time and a high workload. According to them, this factor had indeed a great influence on the preparation phase: some preparatory tasks were not done (e.g. signing collaboration protocol), some were not executed as planned (e.g. informal instead of formal needs assessment for a MCSP in the selected districts) and some were postponed to the execution
Table III. Expected and experienced impeding and facilitating factors, according to the stakeholders.

<table>
<thead>
<tr>
<th>Theme’s</th>
<th>Expected factors</th>
<th>Experienced factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preconditions:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Characteristics of</td>
<td>Surplus value for patient as well as carer (MAJOR) (=) Costs and surplus beneficial effects (MAJOR) (N.A.) Project attuned to needs, wishes, values in Milan (MAJOR) (=) Examples of previous services available and availability of a course for personnel (INTERMEDIATE) (=) Scientific research embedding could facilitate tasks of the IG (INTERMEDIATE) (=)</td>
<td>No competition of MCSP with other initiatives could lead to less incentives to improve the project (MINOR) (N.A.)</td>
</tr>
<tr>
<td>MCSP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preconditions:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Time</td>
<td>Enough time will be needed to explore possibilities and perform the tasks of the IG (MAJOR) (X)</td>
<td>Right timing for open centre to maintain enthusiasm</td>
</tr>
<tr>
<td>Preconditions:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Human and financial</td>
<td>Competent project manager and a transparent project plan (MAJOR) (=) Financial resources/ organizational structures available will be crucial for the development of the project but difficult to obtain (MAJOR) (=)</td>
<td>Project managers: motivated IG members to collaborate, were committed to invest time and possessed organization skills. Coordinators of the centre’s: motivated personnel and volunteers and were committed to invest time in preparing the centre. Personnel/volunteers: were qualified, motivated and experienced with dementia.</td>
</tr>
<tr>
<td>financial resources</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preconditions:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Organizational</td>
<td>Enthusiasm of involved parties could motivate participants and give them new idea’s (INTERMEDIATE) (=)</td>
<td>Existing networks and collaborations: helped involving relevant actors to IG, helped obtaining resources and facilitated collaborations in the project. Persons involved with knowledge of laws and regulations.</td>
</tr>
<tr>
<td>conditions</td>
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</tr>
<tr>
<td>Factors of the</td>
<td>Heterogeneous group of personnel/volunteers could give a richer view (MAJOR) (=) Preparation of the location could help to think about concrete aspects of the project (INTERMEDIATE) (=)</td>
<td>Most members of IG were motivated to invest a lot of time. Members of IG: experienced, competent, educated and professional. Two free and adapted locations were offered by the Municipality of Milan. Several organizations offered free personnel and volunteers. Each member of IG spread information about the project and recruited participants. Geographical proximity of the meeting centre to organization involved in the project, facilitated recruitment of personnel/volunteers and people with dementia.</td>
</tr>
<tr>
<td>preparation phase:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Micro level</td>
<td>Presence of enthusiasm among project members could be facilitating, the absence could lead to working in a hasty way (MAJOR) (=) PR strategies/informative meetings could be energy and time consuming in the initial phase, but it is considered to be important in an advanced phase (MINOR) (=)</td>
<td>Difficult to find a suitable location: due to budget constraints and established criteria. Reduction in opening hours of the centre: was thought to impede participation of carers. Difficult to find suitable personnel/volunteers: due to lack of time and professional requirements. Difficult to spread information about the project in a structured way, due to lack of time. Materials for centre lacking at opening of the centres Insufficient communication with potential participants (people with dementia and carers) was thought to lead to confusion with other services, in the future. Difficult collaboration with other users of the location impeded the preparation of one centre.</td>
</tr>
</tbody>
</table>
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<table>
<thead>
<tr>
<th>Theme's</th>
<th>Expected factors</th>
<th>Experienced factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Factors of the preparation phase: 2. Meso level</td>
<td>Initiative group (composition of heterogenous subgroups, frequency, division of responsibilities) could facilitate the preparatory tasks (INTERMEDIATE) (=) Responsible managers could serve as contact persons for the IG members (INTERMEDIATE) (=) Financial support: difficult to understand from where it could be obtained (MAJOR) (=) Collaboration with organisations outside dementia care could be energy/time consuming in the preparation phase. Collaboration with organizations involved in dementia care is considered important from the start of the project. (INTERMEDIATE) (=)</td>
<td>Working in subgroups permitted to work in a focused way. Will to add innovative activities in order to optimize the activity program. Project was supported by the Alzheimer network in Milan. Communication between subgroups was needed to harmonize the work. Planning of monthly meetings guided the work of the IG members. Difficulties regarding the working method, impeded the preparatory tasks of the stakeholders, in multiple ways. Insufficient communication in the big IG gave some members wrong or inadequate ideas about the progress of the project. Heterogeneous IG, gave a more complete view, but also caused conflicting ideas. Checklist: difficult to fill in, but helped to think about implementation of certain aspects of the program.</td>
</tr>
<tr>
<td>Factors of the preparation phase: 3. Macro level</td>
<td>Health insurance regulations and norms are easy to manage if there is one person with knowledge and difficult if knowledge is scattered among members (INTERMEDIATE) (=) Support of national parties: it would be helpful to have a national governmental plan on dementia (approved end 2014) (MINOR) (N.A.)</td>
<td>Laws/regulations issues were facilitated by persons with sufficient knowledge and availability of adapted locations. Difficulties in obtaining financing due to Italian Health care framework. Insecurity about how to finance the meeting centres support programme in the future.</td>
</tr>
</tbody>
</table>

+ Factor is expected/experienced to facilitate the implementation, - Factor is expected/experienced to impede the implementation and ± Factor is expected/experienced to facilitate and impede the implementation.

(MINOR): factor is expected to have a minor impact on the implementation; (INTERMEDIATE): factor is expected to have an intermediate impact on the implementation and (MAJOR): factor is expected to have a major impact on the implementation.

(=): factor is experienced as expected, (>): factors is partially experienced as expected; (X): factor is not experienced as expected and (N.A.): not applicable, not experienced yet. Written in italic: the main experienced factors, which are described in detail in this section.

phase (necessary preparations for the functioning of the centres, such as obtaining materials and developing a network in the district). As one stakeholder explains:

“Also the network of relationships in the district. Right now [execution phase, MS] exactly, I am contacting the Local Health Centres and various centres for elderly. It is something, that probably had to be done a bit before. But there was no time”. (R4)

Even so, generally the stakeholders indicated to be satisfied with the work performed in this short amount of time. Additionally, they considered it to be the right moment to open the centres, in order to profit from the existing enthusiasm of all involved in the project.

Human and financial resources

The stakeholders expected it to be important for the project to have a project manager able to coordinate preparatory tasks. During the preparation phase, the two project managers stated to be very motivated/enthusiastic and they invested a lot of their time in the project in order to finish the work properly. According to other stakeholders they organized the project very well and they guided them in their work. A member of subgroup IV (personnel/volunteers) commented on this as follows:

“The project managers are two really super competent persons. Well, it is their competence obviously which was essential for the realization of this project, obviously their commitment, their competences”. (R7)

Also the coordinators of the meeting centres stated to be very motivated/enthusiastic and they invested a lot more time then the prescribed nine working hours per week. They motivated the personnel/volunteers, for example by organizing a meeting before the centre opened in order to get to know them.

The financial resources are discussed under the sub-heading macro level.

Organizational conditions

At the start, the stakeholders emphasized in the checklist the importance of collaborating with organizations involved in dementia care, while they considered the
collaboration with organizations not involved in dementia care to be too energy and time consuming, especially in the preparation phase. In addition, the use of existing networks was expected to be helpful but not necessary to develop the project. However, during the preparation phase, the stakeholders experienced that the use of existing networks and collaborations with both types of organizations was very important. The main resources were obtained by using the IG members network, such as the two financing organizations (Municipality of Milan and a Swiss foundation), which also offered locations and personnel. As one of the stakeholders explained:

“A key element was the inclusion of a member of the municipality in the project. She was not included immediately, but she was included thanks to a suggestion by one of the members that came to the first initiative group meeting”. (R10)

In addition, existing collaborations between organizations facilitated other collaborations between organizations in the project. For example, the municipality had an existing collaboration with other users of the proposed location, this improved the willingness of these users to collaborate with the MCSP.

Before the project started, collaborations between different care and welfare organizations in the Milan area often did not exist, they were very fragmented and had different visions. Because of this, the project manager found it difficult to identify and involve the relevant actors in the Milan area to the IG. Therefore, some stakeholders missed the first IG meeting.

**Preparation phase**

**Micro level**
The stakeholders expected that the presence of enthusiasm among them would facilitate the preparatory tasks. They felt that absence of enthusiasm would make them execute the work in an impetuous, quickly and hasty way. During the preparation phase many stakeholders experienced that the IG members were indeed very motivated to do something good for people with dementia and therefore they invested a lot of time in the project, mainly for free. However, not all members were able to attend all meetings. One member of subgroup II (support programme) described:

“Well, being there all together for a common purpose, that of being able to improve, wherever possible, the quality of life of the ill person and his family. That was, according to me, the thing which united us a bit, which made it a success, that everybody was there for a single purpose”. (R6)

They considered the members of the IG to be experienced in the field of dementia, educated, competent and professional. Because of that, they knew what people with dementia and carers needed, had many ideas, and could therefore contribute much to the project.

In the checklist, the stakeholders described that the preparation of the location was expected to help them think about the practical aspects of the project. Once the location was found, the project did indeed become more concrete to several stakeholders. However, they found it difficult to find a suitable location, because the choice of location was restricted by the available budget and by the established criteria for the centre. Eventually, two easily accessible locations were offered for free by the municipality of Milan. In one of the centres there was a good collaboration with the other users of the location, because they were already interested in the topic of dementia and therefore they were also interested in the project. However, in the second centre the relationship with other users of the location was difficult and impeded the preparation phase: According to the stakeholders these other users were not interested in the topic of dementia, it might not have been clear to the other users what was needed in order to realize this project and the other users believed that in the end the centre would not be realized. This difficult collaboration delayed the opening of the second centre with three weeks. The stakeholders did not expect to have such a difficult relation with these other users of the centre, as one stakeholder explained:

“A very big difficulty what we had not expected was the hostility by a certain part of the population to the project, because for example in district (...) we have these type of problems”. (R10)

**Meso level**
The stakeholders expected that the IG would profit from the division in smaller heterogeneous subgroups, especially after two to three meetings. They indeed experienced during the preparation phase that the heterogeneous IG gave a more complete overview and competences of the single members were complementary. Only sometimes the different backgrounds and different views seemed to impede the work. As one member of subgroup IV (personnel/volunteers) explained:

“Many different experiences, it’s not easy to make the people work together at the same moment, but in the end you are able to develop a much richer proposal”. (R3)

In addition, the work of the IG was also experienced to be facilitated by the creation of subgroups, each
subgroup was able to focus on one topic without being dispersive. The stakeholders explained that some aspects of the working methodology of the European project were not clear and/or not suitable in the Italian context. For example, initially some of them thought they had to develop the project, which was not the case. In the advanced phase of the preparation, others had preferred to follow the European working methodology of the project less strictly, and to adapt the program more to their own ideas. Furthermore, some explained that they “Italians” were not used to think far ahead about future aspects and to work in a detailed/analytical way, this was especially difficult when the project was not concrete yet and no Italian project examples were available. They experienced these difficulties amongst others, when filling in the checklist on expected facilitators and barriers. As explained by one of the stakeholders:

“The first meetings were a bit difficult, because we had to do all the discussions of the checklist about barriers and facilitators. For us Italians, at least that was absolutely the most difficult thing”. (R1)

They found it very time consuming to fill in the checklist. Even though, they considered the general principal of the checklist as useful. It helped some members to get new insights and to start the preparatory work more informed.

**Macro level**

The stakeholders considered obtaining sufficient financial resources to be a crucial aspect in order to develop the project. At the start they expected difficulties in obtaining financing, but they could not think of possible solutions to solve this problem. Obtaining financing was indeed experienced to be difficult, they explained that their possibilities were limited, due to lack of time and the Italian financial framework for health care. One stakeholder described, that in order to obtain financing by sanitary services, much time was needed to first make an assessment of the activities organized in the centres. In addition, there was not enough time to apply for state or regional financing. As explained by one of the members of subgroup III (financing and location):

“To finance these, new projects, it is a long path. Because you can have financing from the region or the state, but it takes years to obtain this financing”. (R11)

Eventually, they found two funding organizations who each financed one centre. The stakeholders expected that one person with knowledge about health insurance regulations and norms would be more useful than having knowledge scattered amongst members. They were able to involve one person with this knowledge in the project, which saved time in studying laws and regulations. Because the location was already adapted to elderly persons, laws and regulations regarding the location were also less of a concern for the IG.

**DISCUSSION**

The purpose of this study was to investigate the preparation of the adaptive implementation of the proven effective Dutch Meeting Centres Support Program for people with dementia and their carers (MCSP) in Milan. The main focus in our study was to investigate factors that were experienced as facilitating or imped ing the (preparation phase of the) implementation of this support programme. The results of this study show that, several preconditions and factors specific for the preparation phase impeded and/or facilitated (the preparation phase of the) implementation. Some of these factors were expected to be facilitating and/or impeding at the start of the implementation project, while others were not foreseen. One important unexpected facilitating precondition which made it easier to obtain the necessary resources, was the use of existing networks and collaborations. A major impeding unforeseen precondition was lack of time for the preparation phase because the actual opening had to be speeded up with four months because of financing opportunities. An already expected facilitating factor, specific for the preparation phase, was the motivation of IG members. Unexpected impeding factors specific for the preparation phase were: poor collaboration with other users of the selected location for one of the meeting centres, and not being used to aspects of the general working method in the project (working according to a detailed stepped plan) used for the preparation of the implementation.

**FINDINGS IN THE LIGHT OF LITERATURE**

Many different factors were experienced to impede or facilitate the MCSP implementation. This is in agreement with the idea of Grol 28 who described that many factors at social, organizational, financial and professional level can affect implementation, and these cannot be portrayed in one single strategy. During implementation unexpected events can occur even when a solid project plan is available, due to environmental impacts which change the plan 29. This was also experienced in the current study, and therefore some impeding and facilitating factors were not expected by the stakeholders at
the start. For example, lack of time was not expected at the start of the project because there was enough time scheduled for the preparation phase. Other facilitating and impeding factors may not have been foreseen because many stakeholders indicated that they found it difficult to imagine how things would go in practice and found it difficult to think about future potential facilitating or impeding factors.

One of the major success factors for the implementation of this project was the use of existing networks and collaborations. A qualitative study by van Haeften-van Dijk et al. 22 about the transformation of day care centres in nursing homes into community day care centres in the Netherlands, also showed that stakeholders with an existing collaborative network made it easier to create collaborations for the purpose of the implementation of the new community day care centres and united (in principal) different interests of organizations. In our study, for example, it improved the difficult collaboration with other users of the location. In addition, it was crucial in order to obtain the necessary resources and to make the project practically feasible.

Collaboration between stakeholders is a rather complex process, in which different agendas, cultures and priorities can play a role, as shown in a qualitative implementation study of Aarons et al. 30. Also in the current study the collaboration with the other users in one location was found to be difficult, as they had different priorities and views on the project. Due to the complexity of this collaboration, it is expected to remain a delicate topic also in the next phases of implementation: the execution and continuation phase. Furthermore, the collaboration of IG members could have been quite difficult, due to different backgrounds and interests. However, the communal motivation united the members to collaborate as a group.

Shortage of time impeded several preparatory tasks of the current study. The Dutch MCSP implementation study of Meiland et al. 23 emphasizes the importance of taking enough time to prepare the implementation of the meeting centres. For example, to gain support by organizations in the region and to spread information to referral organizations for the recruitment of participants. However, it was no option to take more time for the preparation in the Milan project. As a consequence, several tasks of the preparation phase had to be postponed, which is likely to cause a higher workload in the execution and continuation phase.

A systematic review of Gearing et al. 31 on cross-cultural adaptation and translation of mental health interventions, shows that there can be many difficulties regarding the cultural adaptation and translation of interventions. According to the cross cultural communication model of Lewis 32, the Italian culture is a complete multi-active culture which means that, they only plan the grand outlines and they are flexible in their agenda. In contrast, the Dutch culture is almost a complete linear active culture which means that, they plan ahead step by step and stick to the agenda. Originally, the plan was to have an adaptive implementation of the Dutch MCSP as it was foreseen that for every new implementation it is important to address needs, preferences and characteristics of each local situation. Yet, some Italian stakeholders were not used to aspects of the working method for adaptive implementation, and therefore still experienced difficulties in carrying out the preparatory tasks. This might indicate that the working method needs further adaptation allowing to adopt a methodology that fits to the specific culture, and helps stakeholders to think about detailed, non concrete, and future aspects of the project.

STRENGTHS AND LIMITATIONS

The results of this study were partly obtained by interviewing the majority of the stakeholders (n = 13) involved in the preparation phase. These interviews were double coded by two independent researchers (MS and RC) in order to improve reliability. In addition, the theoretical model of Meiland et al. 24 was used as a guide to trace facilitators and barriers. The validity is increased by sending a summary of the results to the stakeholders and by requesting their comments. However, the interviewed stakeholders also had to evaluate their own work and role in the project which might have influenced their objectivity. Furthermore, the impeding and facilitating factors are not all experienced in the same way by all stakeholders. This may be due to differences in roles and interests in the project or because of a lack of communication. To gain a comprehensive understanding of the different views it would have been interesting to additionally perform a focus group.

IMPLICATIONS FOR RESEARCH AND PRACTICE

The MCSP is in line with the first Italian national plan of dementia (approved in 2014), since it has an integrated approach, it increases the knowledge about dementia and it may improve the quality of life 33. The implementation of MCSP was investigated for the Dutch situation 23, however no implementation study has been performed yet in the Italian context. Moreover, the results of this study on facilitating and impeding factors of implementation can be used for the further dissemination of MCSP in Italy and other European countries. For example, it is recommended to study the content of MCSP
in more detail at the start of the preparation phase, in order to get a better understanding of possible facilitators and barriers of the implementation of MCSP in their own region. In addition, cultural differences regarding the working method for adaptively implementing MCSP need more attention, for example giving more explanation and/or guidance to some existing tasks in the project or adapting the current tasks more to the way of working of the stakeholders (i.e. more concrete examples to help imagine possible facilitators and barriers). Finally, it is crucial for future centres to take enough time to execute all preparatory tasks in an adequate manner, to ensure a successful implementation.

CONCLUSIONS

Overall it can be concluded that the Dutch MCSP is suitable for implementation in an Italian setting. The project can be facilitated even more if the working method for executing some of the different tasks would be further adapted to the Italian way of working. Furthermore, not all experienced facilitators and barriers were foreseen, such as the importance of having a network with also organizations who are not involved in dementia care. Many experienced facilitators and barriers were in line with the findings of the Dutch implementation research into MCSP. However, also new factors appeared to influence the implementation in Milan, such as the collaboration with other users of the location and cultural differences in working method. The knowledge on facilitators and barriers of implementation gained in this study, can be used for the further dissemination of MCSP in other regions of Italy and in other European countries.

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