

Frequently Asked Questions: Caregiving PAR Webinar, August 17, 2017

Q. Are new applicants who have not had prior NIH funding before encouraged to apply?

A. Yes, we welcome applications from new and early stage investigators. However, if you are new to the NIH application process, we strongly encourage you to consider working with someone who has experience with the NIH grants process, such as a colleague or expert at your institution. Additionally, we encourage you to speak with the scientific contact listed on the FOA.

Q. Are these applications being reviewed by a special emphasis panel?

A. Yes. Review falls under the purview of the Center for Scientific Review (CSR) at NIH. The goal is to convene a special emphasis panel (SEP) with the relevant expertise necessary for comprehensive review. Program Directors advise CSR on appropriate disciplines that should be represented on the SEP. Because this announcement focuses on informal cancer caregiving interventions, the panel will likely have expertise in nursing science, behavioral interventions, health services research, palliative care, and psychosocial oncology. Investigators can assist CSR and Program by submitting letters of intent and by writing cover letters that specify the expertise you think necessary to evaluate your proposal.

Q. Why are the standard NIH receipt dates not included in the application?

A. Because these applications are going to a special review panel rather than a standing study section, there are unique receipt dates for this Program Announcement (PAR).

Q. What is the review process after the scientific review panel? For example, to what extent does the percentile versus other considerations impact this program announcement?

A. Applications reviewed by study sections receive a percentile score and a priority score. New or early-stage investigators may receive special consideration.

Q. Are applications welcome across all cancer sites, and phases of care?

A. Yes, applications that include patients with all cancer sites are welcome, provided patients are over 21 at diagnosis, and all phases of care from diagnosis onward.

Q. Do applications need to target all 3 types of outcomes (patient, caregiver, healthcare utilization)?

A. Yes. It is up to the applicant to decide how to prioritize, but outcomes should be targeted and measured in all three areas.

Q. Do R21s need to propose at least a two-arm RCT?

A. R21s may, but are not *required to*, propose a two-arm RCT. The R21 is an exploratory mechanism, and as such applicants can propose an acceptability/ feasibility study with the intention of designing a larger study to test the intervention in development.

Q. How do you balance the three outcomes of caregiver well-being, patient health, and healthcare utilization. Can one be primary over another?

A. One of the three could be primary, though in most cases patient and/or caregiver health should be considered primary. Prioritization should depend on the overall goal of the research, specific aims specified, and targeted clinical population included. It is always best to consult with a program director if uncertain.

Q. Are there suggestions for how specifically to measure healthcare utilization outcomes in applications to this FOA?

A. There are many possible measures of healthcare utilization and health system measures. Having expertise in health services research represented on the study team is beneficial and is also included as study review criteria specific to this FOA. One might also consider seeking input from healthcare system or hospital administrative leaders to discuss a proposed intervention and additional measures that if collected might foster and facilitate implementation of caregiving interventions. In addition, partnering with community-based organizations can help identify relevant measures of healthcare utilization that might ultimately improve implementation of caregiving interventions. Examining prior literature, preliminary evidence, and letting theory guide the choice of constructs and measures are other useful approaches. An important consideration is that the FOA states *optimized* healthcare utilization as opposed to reduced healthcare utilization. For example, better support of caregivers might lead to increased preventive healthcare visits, which would mean increased but perhaps ultimately more optimal utilization.

Q. Can the intervention or assessment improve outcomes for the patient and the caregiver?

A. The application requires that the intervention must be delivered to at least the caregiver. It can also target the care recipient/patient, but this is not required.

Q. Given that interactions with caregivers often occur outside the healthcare system, is it appropriate to include these settings in an application??

A. Caregiving occurs in many different settings, both inside and outside formal healthcare system settings. It is important both to consider scalability of the intervention and also include reliable and relevant measures of healthcare utilization. It is best to consult a Program Officer to determine if a particular topic and setting is responsive to the FOA.