

Special Issue: Implementation Science in Gerontology: Research Article

# Mandated Caregiver Training in the Veterans Health Administration: Caregiver Inquiry Informs National Dissemination

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## Abstract

**Background and Objectives:** A minority of family caregivers receive training, with implications for their own and their recipient's outcomes. Federal policy has supported the implementation and expansion of caregiver training and support. The Department of Veterans Affairs (VA) has developed a national Caregiver Support Program and collaborated with VA health services researchers to explore caregivers' acceptance of an evidence-based training program in preparation for system-wide dissemination.

**Research Design and Methods:** This approach entailed a convergent mixed-methods design, which involved separate analyses of quantitative and qualitative data. Survey questions based on the Kirkpatrick model for training evaluation measured caregivers' reaction and learning, and interview questions elicited caregivers' reports about the value of the program for them.

**Results:** Most caregivers reported satisfaction with the training when responding to survey questions, although qualitative interviews revealed caveats suggesting need to hone the best timing and specific group of caregivers for maximal benefit.

**Discussion and Implications:** Our findings indicate that understanding program–user fit may be particularly critical when implementing training for caregivers as they come to the program at different points along their caregiving journey, needing differing types and intensities of support. While a general program may appeal to policymakers aiming to scale caregiver training within a large, heterogeneous system, there may be shortcomings in terms of end-user acceptance and subsequent downstream outcomes such as reach and ultimately program effectiveness. Good, iterative communication flow between program developers and policymakers facilitates this understanding and, in turn, decisions about scaling.

**Keywords:** Education and training, Informal caregiving, Qualitative methods, Veterans

## Background and Objectives

Family caregivers provide most home-based long-term care in the United States. However, only about 7% of family caregivers report receiving training in how to support others in their activities of daily living, navigate through a complex health care system, or manage stress from caregiving (Burgdorf et al., 2019; Elkins & Rustin, 2019; Freedman & Wolff, 2020; Van Houtven et al., 2019). These caregivers include those who care for the estimated 4.7 million Veterans across the age spectrum who have a service-connected disability, supporting complex care involving mental health and physical disability in the context of disjointed community-based services that do not always pair well with existing Veteran supports (RAISE Family Caregiving Advisory Council, 2021; Tanielian et al., 2013).

Unmet needs for training among caregivers of persons receiving home health care are associated with substantially higher acute care utilization for the care recipients (Burgdorf et al., 2021). While not all caregivers report a need for training and instead desire supportive services, such as home health aides, to help them perform their role (Van Houtven et al., 2010), four out of ten caregivers report feeling unprepared to function as a family caregiver (Schulz & Eden, 2016). Feeling unprepared can impede the quality of care and increase caregiver depressive symptoms and feelings of burden (Scherbring 2002). The 2018 RAISE Family Caregivers Act, which mandated the development of a national caregiver support strategy drawing from best practices, brought awareness to the need to implement accessible training and education for family caregivers (Cacchione, 2019; RAISE Family Caregiving Advisory Council, 2021; RAISE U.S. Congress, 2018).

This article describes an evaluation conducted by a VA embedded Quality Enhancement Research Initiative (QUERI) team to prepare for dissemination in VA of an evidence-based caregiver training program that they had developed. During this evaluation, the QUERI team elicited caregivers' perspectives about the program and interacted with the VA national Caregiver Support Program (CSP) office, established in 2010, while they explored approaches to refine and expand a system of caregiver support. The objective of this evaluation was to identify influential factors for adoption and areas to adjust in preparation for scaling the training program nationwide (Stetler et al., 2006; Wang et al., 2018). Policymakers who make strategic decisions about implementing caregiver support services can use these findings to help scale training for wider dissemination and use similar approaches to evaluate implementation in their own settings.

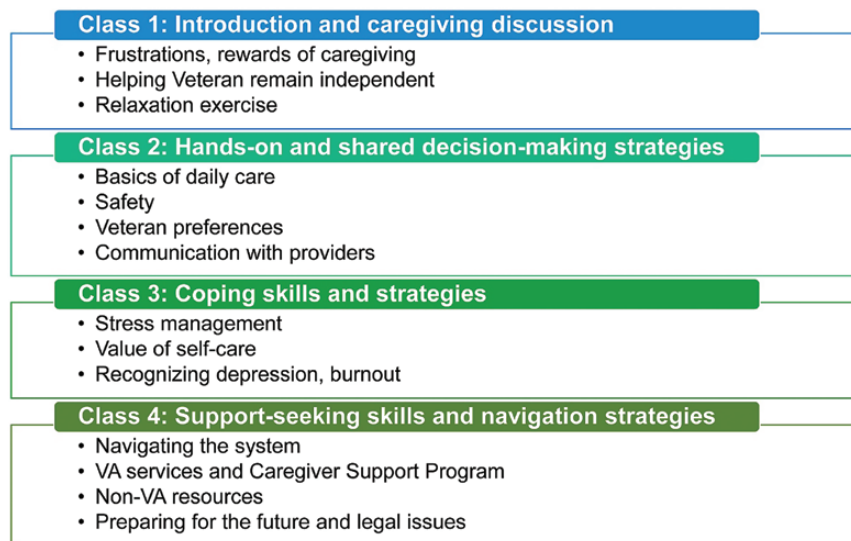
### National Caregiver Support Training in the Veterans Health Administration

The CSP provides skills training and education for caregivers of Veterans across the continuum of care, including counseling, respite care, support groups, peer mentoring, and

a Caregiver Support Line (Bruening et al., 2020; Griffin et al., 2017; Sperber et al., 2018). The CSP differs from the Administration on Community Living's National Family Caregiver Support Program in that it has a much larger scope, receiving more than three times the amount of funding compared to the National Family Caregiver Support Program (Congressional Research Services, 2022; U.S. Department of Health and Human Services, 2022). Participating caregivers, who care for Veterans with a wide array of conditions, have reported high levels of satisfaction with VA care for their Veteran (Shepherd-Banigan et al., 2020). At the same time, they themselves need services for emotional support, engagement with other caregivers, and training due to high reported levels of caregiving intensity, perceived burden, and loneliness, among other factors (Shepherd-Banigan et al., 2020).

In 2018, as part of a larger implementation research study, a VA QUERI team partnered with CSP to disseminate evidence-based caregiver training to eight VA medical centers nationwide and develop implementation tools for wider health system dissemination. This was called Caregivers FIRST (Caregivers Finding Important Resources, Support, and Training), formerly iHI-FIVES (Boucher et al., 2021; Shepherd-Banigan, Kaufman, et al., 2020). Also in 2018, the passage of the VA MISSION Act (PL 115-182) mandated the expansion of VA caregiver services, and thus VA increased staffing to enhance the capacity to provide additional training, psychological support, and peer mentoring programs available to all caregivers (Bruening et al., 2020).

Caregivers FIRST—a pragmatic adaptation of a tested, evidence-based CSP in the VA—consists of a four-module group training that includes an introduction to general caregiving hands-on care, coping, support seeking, and health system navigation skills (Figure 1). The curriculum was delivered at the initial eight voluntarily enrolled sites in 2018–2020 using existing clinical staff. There is flexibility in how Caregivers FIRST is implemented, allowing for alignment with resources available at a site. For example, classes can be delivered by one or multiple facilitators and can be delivered by one or multiple service lines (e.g., CSP, chaplaincy, mental health, and primary care). Classes can be delivered weekly or consolidated over fewer days and can be delivered in-person or using virtual modalities (i.e., phone or video). Classes largely focus on materials delivered to the full group; however, there are also “pair and share” exercises that ask caregivers to identify actions that they could take pertaining to the material to empower themselves in their caregiver role (e.g., for coping, agreeing to go to lunch with a friend or address their feelings of stress with their own provider, identifying a medication system such as a pill box to help manage the Veteran's medications). Subsequent classes follow up on action items by providing the opportunity for reflection by participating caregivers. Participants receive a workbook that includes VA and non-VA resources ranging from descriptions of VA home and community-based services to nonprofit and



**Figure 1.** Class outline and core components of Caregivers FIRST caregiver training program disseminated to eight Department of Veterans Affairs sites, 2018–2020.

affinity group resources, recommendations of books and mobile apps for caregivers, and important VA forms like Advance Directives. Supplementary materials to the core four-module training can be offered via video or phone, delving deeper into some of the topics covered in classes.

## Research Design and Methods

We conducted an evaluation of Caregivers FIRST in preparation for national dissemination, collecting data from family caregivers who had attended training through the eight health care systems that had piloted implementation from 2018 to 2020. Quantitative and qualitative data collection tools included questions to assess to what extent and how the training program met caregivers' needs from their perspectives. We used a convergent mixed-methods design, in which quantitative and qualitative data were collected and analyzed independently and integrated by comparing and merging results (Creswell & Plano, 2018). We report on the quantitative and qualitative methods and findings in separate sections, a "contiguous approach" to integrating by presenting findings in a single report (Fetters et al., 2013). We merge data in our Discussion, using our qualitative results to expand on our survey findings. The quantitative survey was considered Quality Improvement, that is, part of routine health care delivery and monitoring and thus exempt research, as defined in VHA Handbook 1058.05; we received institutional review board approval by the Durham VA Healthcare System for the qualitative interview component (IRB#2040).

### Quantitative Survey

Caregivers who participated in Caregivers FIRST training were invited by the on-site, local program delivery staff to

participate in one posttraining feedback survey collected via paper at the end of the last class (Class 4) for formative purposes. The survey included a limited number of items based on the Kirkpatrick model for training evaluation, which includes different domains, or levels, of questions (reactions, learning, behavior, and results; Kirkpatrick, 1994). This formative evaluation focused on measuring caregivers' reactions to the Caregiver FIRST training experience, with seven questions inquiring about satisfaction and utility (e.g., "I was satisfied with the classes overall" and "This class provided content that is relevant to my role as a caregiver," with four response options from "Strongly agree" to "Strongly disagree"); one additional question included a summative component to assess the extent to which participants believed that they had improved their skills as a result of the training (see Table 1). The feedback survey was mailed or scanned for entry by research study staff into a DatStat Illume, version 6.1 database. Descriptive statistics were analyzed in SAS.

### Qualitative Interviews

Caregivers were invited to participate in an interview if they had participated in at least two of the four curriculum modules, were at least 18 years of age, and had a Veteran loved one who met overall study eligibility criteria, determined by having an eligible referral in the electronic medical record for at least one of the following VA home and community-based care programs: Homemaker and Home Health Aide Care, Home Based Primary Care, Adult Day Health Care, Respite Care, or Veteran-Directed Care. Eligible caregivers were sent a study recruitment and information letter and then contacted by the interviewer (R. Bruening), a trained qualitative methods researcher who had not participated in class facilitation or had any

**Table 1.** Survey Items and Responses ( $n = 124$ ) According to the Kirkpatrick Model for Training Evaluation Used by VA Embedded Researchers for Evaluation of a VA Caregiver Training Program, 2018–2020

Kirkpatrick level	Sublevel	Survey question	Strongly agree (%)	Somewhat agree (%)	Somewhat disagree (%)	Strongly disagree (%)	Do not know (%)	Missing (%)
Reaction	Satisfaction reactions	I was satisfied with the classes overall.	86	9	1	2	1	1
		The balance between lecture and group interaction was just right.	74	18	6	2	0	1
	Utility reactions	The facilitators were knowledgeable about the topic.	92	4	2	2	1	0
		The facilitators were responsive to my questions and input.	91	7	0	2	1	0
		This class provided content that is relevant to my role as a caregiver.	86	10	0	2	2	1
		The class workbook and resource list are beneficial to my success as a caregiver.	90	7	2	2	1	0
Learning	Skills	The gains that I have received from the classes have been worth the time that I invested.	86	11	1	2	1	0
		I learned new skills or strategies in how to approach my role as a caregiver.	72	23	3	2	1	0

relationship with participants, by phone at least 7 days later. The interviewer screened caregivers by phone, excluding any who had difficulty talking or hearing over the phone or who were under 18 years old. Caregivers gave verbal consent by phone for the study and for audio recording of the interview. Interview audio files were transcribed and deidentified.

The overarching goal of the interviews was to understand the overall value of the training program to caregivers from their perspective. The interviewer asked caregivers about their relationship to their Veteran, how they learned about the program, what barriers they encountered in participating, feedback about the program, and any supports and strategies they have used as the program. Interview data were analyzed using directed content analysis, in which a priori topical codes related to interview questions informed the initial codes, and data-derived codes were subsequently added to capture new ideas (Hsieh & Shannon, 2005). See Table 2 for interview questions and analytic codes. One analyst developed the a priori topical codes and iteratively added data-derived codes while reviewing transcripts, with input from a team member trained in qualitative data analysis (N. R. Sperber). For example, responses to the interview question, “What did you hope to gain from Caregivers FIRST?” were topically coded as “anticipating program gains,” and responses to the question, “What was most useful to you about the Caregivers FIRST training sessions?” were coded as “most useful.” Data-derived codes included, “asking for help” and “navigating the VA.” The analyst then identified themes using second-layer codes under the topical and data-derived codes (e.g., “you’re not alone” and “support from facilitators” under “most useful”) until no new a priori or inductive codes or themes could be identified in the data, and refined the themes by writing about them (Eakin & Gladstone, 2020; Saunders et al., 2018). Data were managed with NVivo 12 Plus (QSR International) qualitative data software.

## Results

### Participants

Approximately half (51%, 124/241) of all caregivers who had attended at least one class from all eight sites completed the survey. The majority (84%) of caregivers who responded to the evaluation survey attended Caregivers FIRST at a high-complexity VA Medical Center facility and 15% at a low-complexity facility, with high complexity consisting of higher patient volume, teaching and research, and larger number and breadth of physician specialties. Additionally, a total of 41 caregivers from seven of the eight VA Medical Centers participating in the initial implementation completed interviews (with one VA Medical Center not participating in interviews and one interview involving two caregivers at the same time). Seven caregivers declined to participate in interviews (“too busy”

or “overwhelmed” [ $n = 3$ ], care recipient died [ $n = 2$ ], and “not interested” [ $n = 2$ ]). Interviews ranged from 10 to 35 minutes. Most interview respondents ( $n = 28/41$ ) identified as spouses of their care recipients, eight as parents, two as children, and one each as a partner or sibling; one did not select a role. Interview respondents reported caregiving for 6 months to 19 years, with a median of 4 years.

## Survey Findings

Most (86%) survey respondents reported satisfaction with classes overall, with 72%–92% strongly agreeing with all satisfaction questions. Over 90% strongly endorsed class facilitators, workbook, and resources list: 92% strongly agreed that “the class facilitators were knowledgeable about the topic,” 91% strongly agreed that “the class facilitators were responsive to my questions and input,” and 90% strongly agreed with the statement that “the class workbook and resource list are beneficial to my success as a caregiver.” Table 2 maps survey questions to Kirkpatrick levels and sublevels and includes the resultant scales.

## Interview findings

### Overall satisfaction with training

Nearly all interview participants ( $n = 40/41$ ) expressed that some aspect of the program was useful. Caregivers indicated that they valued support from class facilitators ( $n = 12/41$ ) as well as connection with other caregivers ( $n = 14/41$ ). When caregivers talked about their appreciation of the training facilitators, many mentioned their “accessibility,” being available to help troubleshoot and answer questions with a phone call or in-person chat. Caregivers additionally reported that the program was valuable because they connected with other caregivers, arranging to meet with others in their class after the training had ended. Specifically, caregivers talked about the value of knowing that there are other caregivers experiencing similar challenges and learning from them, though the time for sharing was short.

They [facilitators] were awesome you know because they were like you know if you ever need anything you can call us. Which you know having access to phone numbers and help and they were very helpful in giving us information of other benefits that were available ... The [facilitators] were just, I mean they couldn't have been more supportive. (0101)

To think that I'm not the only caregiver going through the situation and knowing that there's so many out there that kind of going through the same thing, and but we all have the same common goal of being better caregivers. (0602)

Additionally, many ( $n = 15/41$ ) caregivers reported that they referred to their participant resource notebook after completing the program. For example, two caregivers described how they used it for relaxation techniques outside of the classes.

Well, I've looked through it again. And I think that's again why I was reminded about the breathing. (0201)

I have, I actually it's right, I mean practically right by my chair. That's how come I could find it right away. I do, every once in a while, I do go back, and I read. (0414)

### Least useful for specific caregiving needs

Some participants said that aspects of the program did not apply to their situation ( $n = 5/41$ ). While participants generally said that they valued the resources provided by the program, they indicated that the broad-based program fell short of addressing their specific caregiving needs. Caregivers of Veterans who could not easily leave their homes said that the program's focus on respite care and activities outside of the home did not apply to them:

Well there is more [respite] but it's outside the home more. And I have a difficult time getting [name] somewhere else. And ... some of the people that attended they would bring their, whoever they were the caregiver for spouse, or mother, or father or whoever ... to respite right at the VA. Well, I'm not always able to do that with [name]. You know every, each person is a little bit different. Maybe, I don't know, if there was some way to have some questionnaire that you could find people that were more alike in their caregiving? (0401)

One caregiver expressed frustration that the training “turned out to be counseling” (0214) and did not resolve an unmet need for in-home respite, for which the Veteran did not qualify.

### Perceived utility affected by time in caregiving journey

Caregivers ( $n = 4/41$ ) indicated without prompting that their prior experience influenced their perceived usefulness of the program. For example, one caregiver said, “... this was not my first-time taking care of an elderly person with Alzheimer's” (0102), suggesting that the program did not provide new, helpful information for her. Another caregiver said that the program's emphasis on preparing a will and power-of-attorney documents, for example, would have been useful earlier on but that “I had to do all of that on my own ... we didn't have [the training] a year ago” (0402). Conversely, one caregiver noted that although much of the training material was review for her, she appreciated the reinforcement.

It's always good to be reminded of things, especially when you're in the caregiving situation, on the day-to-day things you might not think of something that was brought forward in the class. (0201)

### Additional content requested

Many caregivers suggested adding content to the training program ( $n = 16/41$ ), including additional resources for caregivers ( $n = 7/41$ ), training about dementia care ( $n = 4/41$ ), and general hands-on training ( $n = 3/41$ ). When asked what topics, if any, they would recommend adding

**Table 2.** Interview Questions and Analytic Codes Used in Evaluation by VA Embedded Researchers of a Caregiver Training Program in the Department of Veterans Affairs, 2018–2020

Questions	A priori codes	Data-derived codes
What did you hope to gain from Caregivers FIRST when you decided to join the training program?	Anticipated program gains	<ul style="list-style-type: none"> <li>• Additional contact for support</li> <li>• Camaraderie with other Caregivers</li> <li>• Deal with interactions with Veteran</li> <li>• Help navigating VA</li> <li>• How to handle emergency</li> <li>• Learn how to care for Veteran</li> <li>• Long-term care planning</li> <li>• Respite or in-home care</li> <li>• Self-care</li> </ul>
Was there anything that made it difficult to participate in the Caregivers FIRST training sessions?	Encountering barriers to participation	<ul style="list-style-type: none"> <li>• Bringing Veteran to the VA</li> <li>• Care coverage for another person that was not the Veteran</li> <li>• Care coverage for Veteran</li> <li>• Computer access</li> <li>• Fatigue</li> <li>• Forgot—too busy</li> <li>• Helping Veteran with daily activities</li> <li>• No barriers</li> <li>• Parking</li> <li>• Veteran clinic care conflict</li> <li>• Veteran discomfort or suspicion</li> <li>• Dealing with family members</li> <li>• Dealing with the Veteran</li> <li>• Dementia care</li> <li>• End of life decisions and coping</li> <li>• Forgiveness</li> <li>• Hands on training</li> <li>• The importance of me time</li> <li>• Legal advice</li> <li>• More resources</li> <li>• Respite</li> <li>• Vetting care services</li> </ul>
What topics, if any, would you recommend adding to the training sessions?	Adding topics	<ul style="list-style-type: none"> <li>• Already learned elsewhere</li> <li>• Attempted</li> <li>• Communicating with Veteran</li> <li>• Coping with dementia</li> <li>• Organization or goal setting</li> <li>• Relaxation</li> <li>• Self-care</li> <li>• Advanced planning info</li> <li>• Already knew material</li> <li>• Care for a Veteran during classes</li> <li>• Caregivers sharing information</li> <li>• Hearing from other caregivers</li> <li>• Information about support</li> <li>• Other aspects of curriculum content</li> <li>• Recognition as a caregiver</li> <li>• Relaxation</li> <li>• Support from facilitators</li> <li>• You are not alone</li> </ul>
Do you still use any of the strategies that were covered in the training sessions?	Continuing to use strategies	
What was most useful to you about the Caregivers FIRST training program?	Caregivers FIRST feedback Most useful	

Table 2. Continued

Questions	A priori codes	Data-derived codes
What was least useful to you about the program?	Caregivers FIRST feedback Least useful	<ul style="list-style-type: none"> <li>• Advice about forgiveness</li> <li>• Caregiver venting</li> <li>• Format</li> <li>• Nonrelevant info</li> <li>• Nothing</li> <li>• Timing</li> <li>• Too little time</li> <li>• Video noises</li> </ul>
How does Caregivers FIRST compare to other caregiver training programs you have attended?	Comparing to other Programs	<ul style="list-style-type: none"> <li>• Advertising supportive services</li> <li>• Advocating for the Veteran</li> <li>• Asking for help</li> <li>• Balancing independence and assistance</li> <li>• Becoming burned out</li> <li>• Being able to relate</li> <li>• Caregiver needs</li> <li>• Caregiving experience</li> <li>• Dealing with unpredictability</li> <li>• Navigating billing issues</li> <li>• Navigating the VA</li> <li>• Taking care of oneself</li> <li>• Training format</li> </ul>
As completing the training, could you tell me about any caregiver or other support services you have engaged in to help you as a caregiver?	Engaging in support	<ul style="list-style-type: none"> <li>• Attempted but encountered barriers</li> <li>• Caregiver event</li> <li>• Counseling</li> <li>• Disability program</li> <li>• In-home help</li> <li>• No new engagement</li> <li>• Respite</li> </ul>

to the training sessions, one caregiver who had been caregiving for 13 years said:

Probably more direct resources that you could get. Maybe a question and answer period about things, actual things that could help you. (0205)

Caregivers said that they wanted more information about resources because they found services available through the VA (e.g., home health aides, respite, and equipment) somewhat fragmented and difficult to find and expressed a need for a resource that consolidated information about these services, like a one-stop shop: “Why couldn’t everything be in one spot, you know, all of it?” (0306). Those caring for a Veteran with dementia had specific unmet needs, which they suggested as additional topics, such as how to “deal with agitation in dementia” (0503) or “strategies for how to divert” (0606) a Veteran from asking the same question again and again ( $n = 4/41$ ). Several caregivers ( $n = 3/41$ ) said that they wanted hands-on training for clinical activities, such as how to change a catheter or transfer a Veteran to a wheelchair, in addition to administrative activities, such as how to use the VA patient portal or order supplies through the VA. Caregivers wanted VA resources pertinent to their specific situations.

## Discussion and Implications

This study underscores the importance of considering acceptance by end users, caregivers, when exploring the implementation of a policy of training intended to reach a large, diverse population. Furthermore, there is a growing call to solicit feedback from end users as early as possible in the implementation process and respond to end user feedback iteratively, as a general determinant for implementation outcomes (Bullock et al., 2021; Chen et al., 2021; Greenhalgh et al., 2016). We observed how this determinant of end-user variability may affect the acceptance of a caregiver training program.

Caregivers FIRST had early implementation successes in testing the concept (Van Houtven et al., 2019); however, in preparing for national implementation, we noted differences in how well Caregivers FIRST was received based on the characteristics of individual caregivers. Participants initially reported high rates of satisfaction and found the trainings helpful, many learning new skills as a result, indicating the potential to reach people in a way that other programs have not been able. Subsequent qualitative evaluation that elicited more feedback from end users suggested the need to hone the best timing and specific group of caregivers who will most benefit from the

program and review messaging about who the training is for and what will be covered to manage expectations of Caregivers FIRST. Caregivers consistently report high levels of stress and strain that need to be addressed throughout their caregiver journey, even after they are no longer actively caregiving (Cameron et al., 2013). While addressing a caregiver's levels of stress and strain at any point in their journey would be beneficial, even after they are no longer actively caregiving, our findings suggest that caregivers who seek emotional/social support in their caregiving, strategies for coping with their role and (nonclinical) tips and guides for caring for their Veteran are best poised to benefit from Caregivers FIRST; caregivers who sought more hands-on clinical training expressed an unmet need for such skills after completing Caregivers FIRST and may need another resource, such as training tailored to the condition of their care recipients.

Caregivers have specific needs, some of which are addressed in Caregivers FIRST and some of which are not. Earlier evaluation of general caregiver support and services in VA also revealed the desire by caregivers for more tailored services, supporting findings from this study (Bruening et al., 2020). Prior work involving VA caregivers has shown that caregivers who receive training about heart failure in the VA system benefit from tailoring to learning styles and cultural backgrounds (Slightam et al., 2020). Caregivers could also benefit from disease-specific training: a general caregiver population surveyed about training needs identified knowledge about health issues and resources as their top priorities (Elkins & Rustin, 2019), and Sadavoy et al. (2021) demonstrated that group training that includes psychotherapeutic and problem-solving techniques specifically for caregivers of people with dementia improved caregivers' outcomes, including perceived stress, burden, and depression compared to a control group. Understanding program–user fit may be particularly critical for caregivers.

Although the program was well accepted, results point to areas for improvement for future programming based on our model to improve reach and other downstream outcomes. Policymakers should consider a general training program like Caregivers FIRST as a foundational gateway into a continuum of caregiver support services to caregivers' needs, including needs-specific trainings. Such training includes the Resources for Enhancing Alzheimer's Caregiver Health (REACH) program that provides one-on-one, tailored support and has been implemented in a variety of settings, including VA (Burgio et al., 2009; Nichols et al., 2011; Schulz et al., 2003). The actual needs may or may not include "training" but could include supports and services such as respite, referrals to home and community-based services, or how to plan in terms of getting Power of Attorney. The VA environment is unique in that it offers integrated services for caregivers, whereas other entities may need to rely more on referrals. A practical way to improve a warm hand off for Caregivers FIRST participants could be

having time spent at the last class or one more add-on class to have a brief wrap-up meeting with a member of the CSP team, which would allow caregivers to receive information about the best next steps based on the caregiver's individual needs. An additional strategy would be to guide caregiver expectations via program materials detailing what the program can and cannot do for them as a caregiver. Finally, the VA could leverage an existing caregiver assessment tool, developed as this evaluation, to best match caregivers for whom the general training program could assist in meeting their resource needs or in identifying those for whom more tailored trainings would be helpful (e.g., disease-specific training).

This kind of approach to identify caregivers' unique needs and services has evolved with the development of the VA CSP since its inception in 2010, and the CSP has sought to continually improve services using evidence generated by research partners. In this case, CSP expressed interest in widely disseminating Caregivers FIRST, and this evaluation provided more information about end users' acceptance to help with their exploration of how it would fit into their larger caregiver program and population. Prior to national expansion, the QUERI team shared preliminary evaluation results with the CSP central office and field-based Caregiver Support Coordinators; these suggestions (e.g., extending the recommended length of training sessions) derived from subsequent discussions between the CSP and QUERI.

Additionally, this initial evaluation has helped the CSP understand how to best implement Caregivers FIRST, developed as an introduction to general caregiving skills, among its suite of priorities and services that aim to focus on caregivers' own contexts. As quantitative and qualitative data from this evaluation suggest, general caregiver support services can offer some value for caregivers and, in turn, the CSP. Similarly, an evaluation of the VA Caregiver Support Line found an increase in Veteran utilization of VA resources, regardless of caregivers' reasons for calling, suggesting that a general gateway program focused on training caregivers could, in fact, lead to greater support seeking by caregivers (Griffin et al., 2017). Caregivers FIRST offers another way to reach caregivers and a gateway to services that they need. However, CSP learned that while Caregivers FIRST was generally well accepted and caregivers were engaged with the content; some caregivers expressed limitations. Thus, while a general program may appeal to policymakers aiming to scale caregiver training within a large, heterogeneous system, there may be shortcomings in terms of acceptability (perceived satisfaction with the program) and subsequent outcomes such as reach and ultimately program effectiveness (Proctor et al., 2011; Reilly et al., 2020). This experience demonstrates that active engagement between those who make decisions about disseminating a program and researchers who gather evidence to guide decisions can help to address shortcomings. In this case, the CSP and QUERI team together identified suggestions for improvement and delivery.



Timing matters for the way in which operations and research teams can function together as policy actors (Bullock et al., 2021). The VA policy context within which the initial dissemination of Caregivers FIRST occurred affected dissemination and implementation plans. CSP had identified a need to increase group training opportunities for caregivers of Veterans from all eras of service and had increased capacity from the new MISSION Act legislation, while separately the QUERI team had a caregiver training program, Caregivers FIRST, that had been developed, refined, and tested. A partnership between VA HSR&D and CSP to expand training for caregivers thus gained traction. After initial demonstration of Caregivers FIRST at eight sites, CSP supported wider dissemination by denoting it as one of the three “strong practice” education programs in the fiscal year 2021 that caregiver support staff at VA medical centers could offer to meet annual leadership performance plans. Ninety-six additional medical centers implemented Caregivers FIRST by the end of the fiscal year. Based on ease of uptake and feedback from medical center staff after this wider dissemination, for example, through national calls with field staff about different trainings being delivered nationally, the merit of the toolkit to launch the training, and the value in not having to be certified to deliver the Caregivers FIRST training, CSP recognized Caregivers FIRST in October 2021 as a “minimum standard” or mandated caregiver group support program for all medical centers to hold at least two training series in the fiscal year 2022.

This evaluation also has relevance for policy direction outside of VA according to recommendations from The RAISE Advisory Council in a 2021 report to Congress to adopt strategies to strengthen caregiving in care delivery efforts through public-private partnerships, planning on all levels (e.g., local, state, and territorial), caregiver outreach, and public awareness. To carry out the RAISE Act recommendations, information is needed from end-users, family caregivers themselves, to optimize implementation. Policymakers, who set priorities and make decisions about supports, need guidance on how to meet training requirements of a heterogeneous caregiver population, for example, with different types of care needs and support levels, while disseminating at scale. For implementation efforts to have the greatest acceptability and, in turn, reach, there should be information exchange between policy makers, implementation teams, and end users early and iteratively during the exploration phase of implementation in various settings, when implementers assess needs of a given population, identify appropriate evidence-based practices to meet those needs and decide whether to implement the practices (Aarons et al., 2011; Bullock et al., 2021; Chen et al., 2021; Greenhalgh et al., 2016).

This evaluation has limitations. The quantitative tool had an express purpose of focusing on how participants overall responded to the training for an initial round of quality improvement; to minimize respondent burden, we collected minimal information about participant characteristics.

As such, we lacked the availability of participants’ demographic information beyond their roles. However, caregiver context does matter, and future evaluation of Caregivers FIRST in VA should purposefully measure, and sample, based on caregiver characteristics such as perceived burden or employment status as well as care recipient characteristics such as disease type or care needs. Additionally, survey and interview participants were sampled separately from the same population, and interview respondents may not have contributed to the survey data. Despite these limitations, integration of survey and qualitative data provides an overall picture of acceptance by caregivers

In conclusion, policymakers should assess whether, and how, a program fits with both the problem and context of the implementation setting as well as the program’s or policy’s end users. Findings underscore the need to consider fit for caregivers and additionally illustrate the value of interchange between policy/operations and research/evaluation entities when implementing evidence based practices (EBPs) on a larger scale. Our findings suggest that understanding program-user fit may be particularly critical for caregivers as they come to the program at different points along their caregiving journey, needing differing types and intensities of support. Large-scale efforts to implement caregiver training may be more effective when program leaders and policymakers understand whom a training is most effective for and when. Good communication flow between program leaders and policymakers facilitates this understanding and, in turn, decisions about scaling. Without this multidisciplinary collaboration, attempts to scale caregiver training will likely fall short of reaching those for whom it would benefit.

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## Conflicts of Interest

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