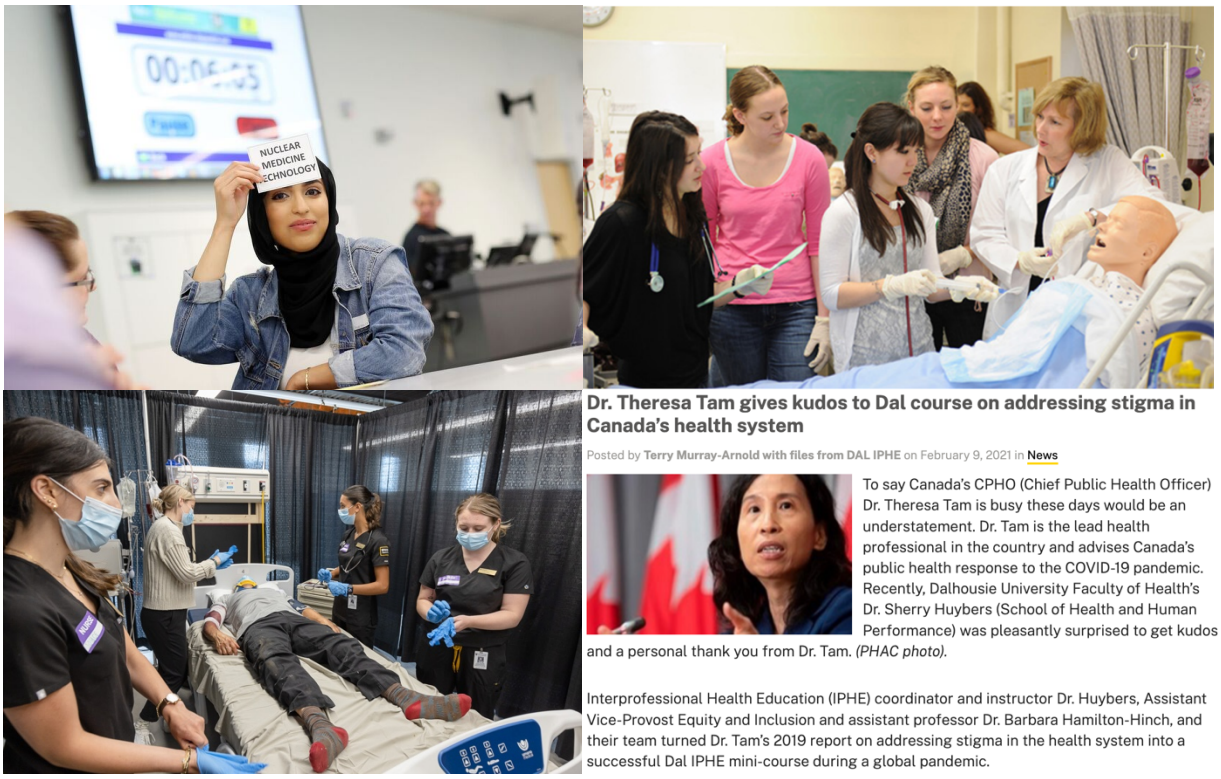
HPJ HEALTHY POPULATIONS JOURNAL

Volume 5 | No. 1
2025

ISSN: 2816-2536

Special Issue on Interprofessional Health Education and Collaborative Practice



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HPJ HEALTHY POPULATIONS JOURNAL

Table of Contents

HPJ HEALTHY POPULATIONS JOURNAL

Welcome from the Co-Editors-in-Chief

We would like to welcome you to volume 5, issue 1 of the *Healthy Populations Journal* (HPJ), a special issue on Interprofessional Health Education and Collaborative Practice (IPHECP) sponsored by the Centre for Learning and Teaching (CLT) at Dalhousie University. As a student-run, open-access, peer-reviewed journal, this issue brings together IPHEC both in content and in practice where an interprofessional guest editorial board learned about the peer review process during the publishing of this issue. You can read more about the editorial experience in CLT's blog FOCUS.

Articles in this issue are written from student perspectives and experiences working in interprofessional settings as student healthcare professionals, present original results from interprofessional research and outline review protocols as a common research methodology used to bring together large bodies of knowledge that can inform interprofessional research and practice. Developed in a community based, interprofessional setting, Liepert et al. infographic increases the accessibility of research findings for healthcare providers, frontline shelter workers and community members with diabetes understand and manage symptoms and health impacts. Two commentaries raise awareness about the role of community-based interprofessional teams that also support student training. Ayoub et al. highlight the Halifax Outreach Prevention Education Support (HOPES) clinic, a student-run clinic offering services from 8 different health disciplines to populations who may otherwise not have access to such care. Dunbar Wilson et al. show how community efforts can lead the way for access to diagnoses support for individuals with FASD in rural Newfoundland. This issue presents three review protocols aimed at advancing IPHECP. Valuing IPHECP as a pedagogical tool, Van Dam & Price outline a protocol aimed at exploring the role of IPHECP in training pre-licensure dentistry and dental hygiene students to understand their professional role and identity. The ways in which the presence of an interprofessional healthcare team influences caregivers of pediatric patients to present to an emergency department is an important question that can inform the structure of pediatric healthcare teams in general (Devereaux et al.). McConnell et al. connect a scoping review on evidence-based interventions in kidney transplantation care to principles of IPHECP to assist interprofessional teams in understanding the roles of different professionals. Yusuf et al. engage love letter writing as a post-qualitative framework to evaluate their experiences as PhD candidates/teaching assistants in an asynchronous, online interprofessional course on allyship.

HPJ would not be possible without support from the Healthy Populations Institute and the guidance from the HPJ Editorial Board Members. Particular to this issue, funding through an Anne Marie Ryan Teaching & Learning Enhancement Grant from the CLT. In addition to base issue costs, this grant permitted HPJ to offer guest editors a modest honorarium for their work. A special thank you to the leadership of Dr. Sara Kirk and Dr. Diane MacKenzie, OT Reg. (NS).

We truly hope you enjoy reading volume 5, issue 1.

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HPJ HEALTHY POPULATIONS JOURNAL

Infographic

Use of an Infographic to Understand Barriers to Diabetes Care for People with Lived Experience of Homelessness in Shelters and Increase Diabetes Awareness Among Shelter Staff and Interprofessional Health Teams

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DOI: 10.15273/hpj.v5i1.12238

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Abstract

Introduction/Objective: Diabetes mellitus is a chronic medical condition that is considered to be a global health emergency (International Diabetes Federation, 2021). Managing diabetes is challenging and requires a multi-disciplinary approach while also demanding a significant degree of patient engagement and self-management. People with lived experience of homelessness (PWLEH) universally face barriers to accessing diabetes care, engaging in self-management and are consequently more likely to have chronic hyperglycemia (Hwang et al., 2000) and adverse outcomes (Sharan et al., 2023). A study discovered that PWLEH and diabetes experience myriad unique barriers to diabetes self-management in shelters (Grewal et al., 2021). A community- based prioritization exercise identified that this group's main priority was to increase the diabetes-related knowledge and awareness of those living and working in emergency shelters. We sought to co-create an infographic with PWLEH to address some of this knowledge and understanding gaps for those in the sector. **Methods:** The infographic was created through a focus group discussion with PWLEH and diabetes, with consultation from clinical experts. The infographic addresses identified knowledge

gaps by presenting accessible and user-friendly information about diabetes, including its definition and general management principles such as blood glucose monitoring and insulin administration. We also outline key symptoms and management principles of hypoglycemia and hyperglycemia and highlight that both conditions can mimic intoxication. **Conclusion:** The infographic will be disseminated in shelters with a goal of increasing knowledge regarding diabetes and its management among shelter staff with the hopes of improving the experiences of those living with the condition in shelters. This will foster education among and between interprofessional healthcare providers working in shelters and community health centres, and frontline shelter staff who are involved in the care of people with diabetes. We also aim to evaluate its efficacy in achieving this outcome.

Keywords: diabetes, homelessness, community-based, health education

What is Diabetes?

Diabetes is a medical condition that impacts the body's ability to regulate blood sugar levels.

Type 1 diabetes

The pancreas does not produce insulin and always requires treatment with insulin.

Type 2 diabetes

Resistance to the body's insulin and usually treated with medications +/- insulin.

Insulin is the hormone that helps lower blood sugar.

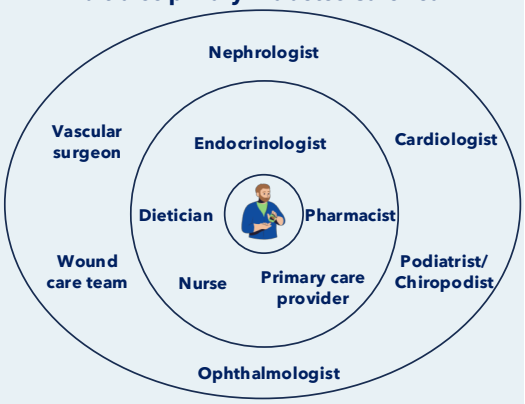
Some people **poke** their finger to **check their blood** sugar. Others wear a **monitor** on their skin.

Insulin usually comes in pre-filled pens. There are two different types.

1) Short-acting insulin is taken just before a meal.

2) Long-acting insulin is taken once a day, in the morning or at bedtime.

Multidisciplinary Diabetes Care Team



People with diabetes can have both low and high blood sugar, depending on their treatments and food intake.

Both low and high blood sugar can make people seem like they are intoxicated when they are not.

Symptoms of Low Blood Sugar:

- Shaking, sweating, chills, feeling dizzy or hungry
- Confusion, fatigue
- Seizure, coma

Symptoms of High Blood Sugar:

- Feeling very thirsty, blurry vision
- Fruity or sweet-smelling breath
- Weakness, fatigue
- Nausea, vomiting, stomach pain

If you see someone with these symptoms, **ask if they need help** - they may have a Medical Alert bracelet or tattoo indicating that they have diabetes.

How to help if someone is low (<4 on a glucose meter):

- If awake and talking, find them something sweet to eat (juice, candy, honey, etc.)
- Ask if they have glucagon (an injection which raises blood sugar).

How to help if someone is high (>15 on a glucose meter):

- Encourage them to drink lots of water.
- Ask them if they have insulin with them, and if they need to take an extra dose.

If they are drowsy or unconscious, call 911.

2024 Calgary Diabetes Advocacy Committee

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HPJ HEALTHY POPULATIONS JOURNAL

Commentary

Halifax Outreach Prevention Education Support (HOPES) Student-Run Clinic: Bridging Community Health and Interprofessional Health Education

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DOI: 10.15273/hpj.v5i1.12318

Abstract

This commentary explores the Halifax Outreach Prevention Education Support (HOPES) clinic, an interprofessional student-run clinic in Halifax, Nova Scotia, which unites students from eight different health disciplines. HOPES provides essential health care services to underserved communities while offering students valuable training in interprofessional collaboration, communication, and cultural competence. By fostering teamwork across disciplines, HOPES aligns with interprofessional health education principles, allowing students to develop skills critical to addressing health disparities. Notable initiatives include a vaccine clinic run in partnership with the North End Community Health Centre, which enhances access to immunizations for underserved populations, and health promotion pop-up events focused on community engagement. These projects underscore HOPES's commitment to reducing health care inequities and promoting health literacy. By integrating diverse health professions, HOPES prepares students to become leaders in inclusive, patient-centred care, ultimately advancing health equity and well-being in the communities they serve.

Keywords: community health, student-led clinics, collaborative practice, practicum

Introduction

Interprofessional student-run clinics (SRCs) allow students to hone discipline-specific skills while simultaneously cultivating essential interprofessional competencies critical for future practice (Briggs & Fronek, 2020). Located in Halifax, Nova Scotia, the Halifax Outreach Prevention Education Support (HOPES) clinic is an interprofessional SRC encompassing eight health-based academic

programs from Dalhousie University and Mount Saint Vincent University. These programs include dental hygiene, dentistry, dietetics, health promotion, health administration, medicine, nursing, and pharmacy. The objectives of HOPES are twofold. First, the clinic aims to offer accessible and sustainable interprofessional health and social services to the community, focusing on underserved populations. Second, through participation in HOPES, students can develop and refine their interprofessional collaboration skills while positively impacting underserved communities' health.

Interprofessional Health Education and the Role of HOPES

Interprofessional Health Education (IPHE) equips students with the essential competencies—teamwork, communication, problem-solving, and collaboration—required to succeed in the health workforce. International health organizations and universities have embraced IPHE as part of a health care system revitalization to promote interprofessional teamwork, enhance patient care, and improve health outcomes (van Diggele et al., 2020). The World Health Organization (WHO) emphasizes that "Interprofessional education occurs when two or more professionals learn about, from, and with each other to enable effective collaboration and improve health outcomes" (WHO, 2010, p. 13). By bringing together students from different health professions, IPHE fosters insight, respect, and teamwork, leading to high-quality, patient-centred care—the foundation of effective health care.

HOPES serves as a hub for IPHE, offering students from the eight disciplines an opportunity to learn from one another in a socialized, professional context. Through peer teaching, students share knowledge from their respective fields, deepening their understanding of each profession's role and responsibilities. This exposure enhances their ability to communicate and collaborate effectively across disciplines. Additionally, assessment and feedback are integral to the IPHE experience at HOPES. Receiving feedback from peers in other disciplines promotes self-reflection, strengthens communication skills, and encourages appropriate professional language, fostering a holistic approach to health care. At HOPES, preceptors from each health profession guide students through challenges like interdisciplinary conflicts, helping them build team cohesion and develop problem-solving skills.

Facilitating interprofessional teams comes with challenges. A significant challenge in establishing HOPES involved navigating conflicting regulations between faculties and regulatory bodies. Balancing the diverse requirements of each profession proved difficult. Moreover, common barriers—such as communication issues, different professional cultures, traditional hierarchies, and role blurring—complicated teamwork. Despite these obstacles, the experience has helped students strengthen their collaborative skills and appreciate the unique contributions of each profession.

Impact on Underserved Populations

HOPES plays a crucial role in addressing health disparities within underserved communities by offering accessible health care services tailored to meet their unique needs. Involvement with HOPES highlights how privilege influences access to health care, as many individuals face systemic barriers such as language differences and socio-economic challenges. HOPES has had a meaningful impact on the individuals and communities it serves by fostering trust and providing culturally sensitive care. This approach enhances individual health outcomes and empowers communities by promoting health literacy and self-advocacy. The work at HOPES underscores the importance of cultural competence in health care, demonstrating that actively listening to and engaging with underserved populations is essential to understanding their perspectives. These insights reinforce the need for health care providers to adapt their practices to better serve the diverse needs of patients. By prioritizing cultural competence, a more equitable health care system can be created—

one that values and respects all individuals, ultimately leading to improved health outcomes and reduced disparities in care.

Looking at HOPES in the 2024–25 Academic Year

In Fall 2024, HOPES partnered with the North End Community Health Centre to allow students to participate in delivering their vaccine campaign. The vaccine campaign addresses health disparities within underserved communities by providing accessible immunization services to individuals facing barriers to traditional health care settings, including newcomers, low-income families, and racial minorities (Aylsworth et al., 2022). The significance of this work lies in its role in promoting health equity. Many underserved groups experience higher rates of preventable diseases due to limited access and availability of health care resources (Baah et al., 2019). By improving vaccine access, clinics can reduce long-standing health disparities in health care access and outcomes.

Nursing and medical students collaborate in the vaccine clinic to administer vaccines to North End Community Health Centre clients. This initiative aligns with IPHE objectives by fostering effective collaboration in a safe, supportive environment. Through this experience, students become better equipped to address the diverse needs of the populations they serve, promoting a coordinated and inclusive approach to health care. Efforts to vaccinate underserved communities are essential for achieving public health goals and reducing health disparities across different socio-economic groups. Overall, the vaccine clinic exemplifies HOPES's commitment to improving health outcomes and promoting equity in health care access.

Projects for HOPES in Winter 2025 have included pop-up events focused on health promotion. These events involve students from all eight health disciplines. The pop-up events feature booths at partnering organizations where clients can learn about various health promotion activities. For example, at interactive booths, dietetics students lead sessions on nutrition and healthy eating habits, while dental hygiene and dentistry students demonstrate proper oral care techniques and offer practical advice for maintaining oral health. Nursing and medicine students provide information on managing chronic conditions such as diabetes, including guidance on monitoring blood glucose levels and recognizing complications. Pharmacy students help clients navigate available resources and provide guidance on accessing the full range of services pharmacists can offer. Students from different disciplines also have the opportunity to observe each other's practice, gaining insight into their peers' roles and approaches to care. These booths serve to engage clients in personalized, informative discussions, empowering them to make informed health decisions. By engaging clients through accessible and informative pop-up events, HOPES aims to educate and empower individuals to take charge of their health, ultimately enhancing health literacy within the community.

Conclusion

HOPES is critical in reducing health inequities and delivering treatment to underserved populations. The SRC supports individuals in need and prepares aspiring health professionals for collaborative practice through its innovative approach to IPHE. Its various initiatives, such as the vaccination clinic and winter pop-up events, demonstrate how effective student-led efforts can improve public health. HOPES gives students invaluable competencies and insights that will influence their future professions in health care by promoting cultural competency and highlighting the significance of accessible health care.

At its core, HOPES is built on a holistic, interprofessional approach that integrates various health professions, including those often overlooked in conventional health care discussions. Guided by the principles of inclusion, HOPES provides dignified care to all community members and embraces various health professions, from physicians and nurses to dietetics and health

administration professionals. This collaborative model offers invaluable experience in interdisciplinary health care, fostering a deeper appreciation for patient-centred care and the importance of accessible health services. Through this experience, participants develop a passion for health care and gain clarity on how to become leaders who drive meaningful change and advocate for the well-being of underserved communities.

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HPJ HEALTHY POPULATIONS JOURNAL

Commentary

Transforming FASD Diagnosis in Newfoundland and Labrador: A Community Collaborative Approach for Capacity Building and Network Development

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DOI: 10.15273/hpj.v5i1.12341

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Abstract

This commentary delves into fasdNL's innovative work in establishing a comprehensive diagnostic network for fetal alcohol spectrum disorder (FASD) in Newfoundland and Labrador (NL). Although unparalleled in its complexity, FASD remains a persistently underdiagnosed and under-resourced lifelong condition. fasdNL, a community-based non-profit organization in NL, has significantly enhanced diagnostic capabilities and training for healthcare professionals, streamlined referral assessments, and addressed persistent gaps in FASD evaluation. The creation of fasdNL's Diagnostic Network represents a significant step forward in improving FASD diagnosis and support within the province. fasdNL's training program is grounded in the principles of Inter-Professional Health Education (IPHE), designed to foster collaboration among diverse health professionals. By emphasizing the importance of a multi-disciplinary approach to FASD diagnosis, the initiative enhances clinicians' capacity to work collaboratively in line with the Canadian FASD Diagnostic Guidelines. This training model not only improves diagnostic capacity but also promotes inter-professional practice by encouraging knowledge exchange and collaborative decision-making among healthcare providers. Further, it underscores the crucial role and potential of community organizations in addressing collaborative assessment and diagnostic processes by building on existing capacities within their regions.

Keywords: fetal alcohol spectrum disorder; diagnosis; community innovation; interprofessional health education

Introduction

Fetal alcohol spectrum disorder (FASD) is a lifelong neurodevelopmental disability caused by prenatal alcohol exposure (Cook et al., 2016). FASD affects individuals throughout life and poses a public health challenge. With an estimated prevalence rate of 4% among the general Canadian population, with higher rates in child welfare and justice systems that often lack appropriate services, the need for effective FASD diagnosis and support in both urban and rural areas is critical (Popova et al., 2019). The connection to alcohol use during pregnancy and its stigma complicates access to support and diagnosis (Bell et al., 2016; Choate & Badry, 2018; Dunbar Winsor, 2021).

Individuals with FASD often face challenges with motor skills, physical health, learning, memory, attention, communication, emotional regulation, and social skills (Cook et al., 2016). Individuals with FASD are at increased risk of mental health challenges (Wilhoit et al., 2017). Unique strengths and variability among how FASD presents across individuals makes accurate diagnosis essential but difficult. Therefore, enhancing diagnostic capacity and providing early assessments enable timely interventions and support, crucial for individuals with FASD (Doak et al., 2019; Reid et al., 2015). Additionally, specialized training for healthcare professionals improves the provision of care for those with FASD.

fasdNL, a pan-provincial non-profit organization, has been at the forefront of FASD work in Newfoundland and Labrador since 2013. Focused on increasing awareness through education, networking, knowledge mobilization, and resource development, fasdNL has made significant strides in developing FASD diagnostic training and a provincial diagnostic network.

Rationale for Initiative

Newfoundland and Labrador, with 510,550 residents (Statistics Canada, 2021), has faced challenges in FASD diagnosis, including limited training, low awareness, minimal funding, and inadequate diagnostic capacities (Dunbar Winsor & Morton-Ninomiya, 2018). This has led to underdiagnosis, long waitlists, and high costs for private evaluations, leaving many individuals and families without timely and affordable diagnoses. Since 2013, fasdNL has been developing and delivering FASD training, resources, providing family supports, and engaging in community-based research (fasdNL, 2025). Recognizing gaps in FASD assessment, fasdNL launched an initiative to improve diagnosis across the province. For example, access to FASD assessments for adults has been a persistent challenge as some geographic regions face limited access due to provincial health zone requirements.

Central to this effort was the creation of a collaborative training course for healthcare professionals involved in FASD assessment and diagnosis. Leveraging its internal expertise and network of knowledgeable researchers and clinicians in the province, fasdNL developed a comprehensive training program to train clinicians in a multi-disciplinary team approach in line with the Canadian FASD Diagnostic Guidelines (Cook et al., 2016). This training, delivered via Zoom at minimum cost[1] to ensure accessibility across NL, targeted active clinical practitioners, including physicians, speech-language pathologists, occupational therapists, and psychologists. To be eligible to register for the training, clinicians had to conduct diagnostic assessments as part of their professional duties and sought to add FASD assessments into the scope of their existing practice. The initiative evolved beyond training to create a provincial diagnostic network as planned. By collecting information from trained individuals who consented to be part of a diagnostic network database

[1] Historically, obtaining diagnostic training has been an expensive endeavour paid for by provincial governments and health authorities, mainly relying on expertise from western Canada.

(such as location, population served, cost of assessment, etc.), fasdNL created a system to connect professionals to individuals seeking FASD assessments or support.

The initial training delivery equipped 75 professionals with the necessary skills and resources to diagnose FASD, a first step to accessing supports and services and formed the basis of the fasdNL Diagnostic Network database. These professionals committed to being part of the network for at least a year, permitting the creation of diagnostic team assessments as recommended by Canadian guidelines. Clinicians or individuals who wish to seek an FASD assessment contact fasdNL who compile information such as region and age and assemble a diagnostic team. The network, maintained by fasdNL, enables coordinated diagnostic efforts and provides a centralized resource repository for continuous professional development. The creation of fasdNL's diagnostic network exemplifies Inter-Professional Collaborative Practice (ICP) by enabling healthcare professionals from different fields to work together in diagnosing FASD. Through this network, clinicians from diverse disciplines form diagnostic teams that function in alignment with ICP principles. By centralizing resources and facilitating communication across professions, this network bridges gaps in diagnosis

Implications and Future Directions

fasdNL's Diagnostic Network represents a transformative approach to FASD diagnosis in NL. The network works collaboratively with existing public and private assessment options to fill FASD gaps in more rural regions, provide alternates to lengthy waitlists, and increase assessment options province wide for adults. fasdNL targets underserved populations, including isolated areas, by improving access to FASD assessments. This addresses long-standing disparities in diagnostic services, particularly for adults who have historically faced challenges in receiving timely and affordable evaluations. By enhancing training and creating a network, fasdNL has improved access to FASD assessments and support. This model demonstrates the potential for similar community-based approaches to the assessment of other neurodevelopmental disorders, such as ADHD and autism, particularly in regions with limited healthcare capacities.

The network also offers valuable data-sharing opportunities, providing insights into the number of individuals seeking assessments, wait times, and barriers to diagnosis and support. This information can guide future organizational strategies and funding priorities, ensuring that community needs are met effectively.

Conclusion

fasdNL's innovative initiative represents a shift in the healthcare landscape of Newfoundland and Labrador. By addressing longstanding gaps in FASD diagnosis and support, this community-driven approach offers a blueprint for enhancing diagnostic capacities for various neurodevelopmental conditions. Ongoing evaluations of fasdNL's Diagnostic Network and training program will provide valuable insights into the effectiveness of this inter-professional approach. Data on the number of individuals trained, wait times for assessments, and regional diagnostic capacity will inform future improvements. These evaluations are critical for understanding how inter-professional collaborative models can be scaled and adapted to other neurodevelopmental disorders, such as ADHD and autism, in resource-limited settings. The success of this model underscores the importance of professional training, collaborative networks, and community engagement in improving healthcare outcomes.

Declarations

The authors have no conflict of interest or funding to declare. No research involving humans or animals was conducted. Ethics clearance was not sought.

Author Contributions

KDW drafted this commentary manuscript. HCP and LSW reviewed and provided input on the commentary manuscript. KDW, HCP and LSW are involved in fasdNL as staff or board members and worked collaboratively to develop fasdNL's Diagnostic Network as described in the commentary.

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HPJ HEALTHY POPULATIONS JOURNAL

Review Protocol

Exploring Interprofessional Education for Collaborative Practice (IPECP) in Oral Health Education for Professional and Interprofessional Socialization and Identity Development: A Scoping Review Protocol

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DOI: 10.15273/hpj.v5i1.12156

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Abstract

Introduction: Interprofessional collaboration between health professionals supports enhanced patient care and outcomes. IPECP in pre-licensure education supports professional and interprofessional socialization. Within IPECP students develop an understanding of their professional role and identity. IPECP experiences also contribute to interprofessional identity formation, where collaborative attitudes, behaviours, and skills are developed that support collaboration in practice. IPECP literature in oral health education for dentistry(DDS) and dental hygiene (DH) students is limited. It is not well understood how DDS and DH students are educated in IPECP and prepared for collaborative practice. **Inclusion criteria:** This review will consider studies specific to IPECP models used in the pre-licensure education of DDS and/or DH students and IPECP models used in health professions education that include at minimum one (1) cohort of DDS or DH students. **Methods:** A pilot search of CINAHL and DOSS was conducted to identify keywords and indexed terms. Databases searched will include CINAHL, MEDLINE, DOSS, and APA PsycInfo. Peer-reviewed articles satisfying inclusion criteria will be sourced and bibliographies searched for additional literature. Articles will be independently screened for title and abstract, followed by full-

text review by two reviewers. A modified JBI-tool will be used for data extraction. Data will be presented in table and diagram forms, accompanied by a narrative summary.

Keywords: collaborative practice, dental hygiene, dentistry, interprofessional identity development, interprofessional education

Introduction

Interprofessional collaborative practice (IPC) among the health professions has been widely recognized as a foundational component of comprehensive health care delivery and effective health systems (Reeves et al., 2013; World Health Organization, 2010). A need to educate health professionals to work interprofessionally has been acknowledged across health systems and organizations globally, and targeted strategies include the integration of interprofessional education into the pre-licensure curriculum of health professions programs (World Health Organization, 2010). Interprofessional education (IPE) is defined as "two or more professions learning with, from and about each other" (Centre for the Advancement of Interprofessional Education, 2019). There is growing evidence in support of interprofessional education for collaborative practice (IPECP) in pre-licensure education to promote students' ability to work and communicate across disciplines, enhancing collaboration and quality of care (Azzam et al., 2022; Khalili et al., 2013; Price et al., 2021a, 2021b). Within IPECP experiences, students begin to develop an understanding of their professional role, the roles of other professions, and how to practise collaboratively as a team (Brandt et al., 2023; Khalili & Orchard, 2020; Reeves et al., 2013).

The exploration of IPECP experiences for professional socialization and their contributions to the development of a professional and interprofessional identity is growing in the literature (Khalili & Price, 2022; Price et al., 2021b; Reeves et al., 2013). Professional socialization is a process through which individuals learn and embody the responsibilities, attitudes, and social behaviours of their chosen profession (Sadeghi Avval Shahr et al., 2019). The foundations of professional identity formation are laid out within students' professional education programs and pre-licensure education (Frenk et al., 2010; Khalili et al., 2013; Price et al., 2021a, 2021b). IPECP experiences are identified as a catalyst for both developing professional identity and promoting socialization between professions (Khalili et al., 2013; Reeves et al., 2013). IPECP experiences have also been found to promote interprofessional socialization in which values and behaviours conducive to effective teamwork are developed (Khalili et al., 2013; Khalili & Orchard, 2020). Through collaborative experiences and exposure to other professions, individuals come to develop a dual professional and interprofessional identity that is integral to interprofessional teams in practice (Khalili & Orchard, 2020; Khalili & Price, 2022).

Research on IPECP for developing a dual professional and interprofessional identity is growing in the health education literature. However, a scan of the evidence reveals that the oral health professions (dentistry and dental hygiene) have been largely excluded (Hamil, 2017; McComas et al., 2019; Morison et al., 2008). Dentists and dental hygienists are experts in the oral-systemic health link, and their professional knowledge and skills are essential to effective management and prevention of oral and systemic disease (Levy et al., 2023; Watt et al., 2019). However, oral health professions have been traditionally educated in silos and have historically followed profession-specific curricula and pre-licensure clinical training models (Hamil, 2017). Enacting comprehensive oral health care requires interprofessional approaches in which oral health professionals are working with and alongside others in collaborative interprofessional teams in care delivery (Levy et al., 2023; Prasad et al., 2019; Watt et al., 2019). There is a gap in knowledge and a need to understand

how future dentists and dental hygienists are educated in, and socialized to, interprofessional practice—and how they are equipped with the knowledge and skills to assume roles within interprofessional care teams in future practice (McComas et al., 2019).

The purpose of this scoping review is to better understand how IPECP is currently occurring in dentistry and dental hygiene pre-licensure education and how the characteristics of IPECP experiences enable professional and interprofessional socialization and interprofessional identity development in students. A preliminary search of CINAHL (EBSCOhost) and DOSS (Dentistry and Oral Sciences Source; EBSCOhost) was conducted, and no current systematic reviews or scoping reviews were identified on this topic. A scoping review was selected as the most appropriate approach to assess the extent of the literature relevant to current IPECP programming within pre-licensure education programs for dentistry and dental hygiene students and to identify models and characteristics of IPECP for professional and interprofessional socialization and identity development. The research team plans to use these findings to inform gaps in current pedagogical approaches and curriculum for IPECP in oral and health education and to direct future research and curricular reform that can support and strengthen IPC and health care teams in practice.

Objectives

The aim of this review is to assess the extent of the literature relevant to current IPECP experiences for dentistry and dental hygiene students during pre-licensure education:

1. What models and characteristics of IPECP are identified to enable professional and interprofessional socialization and interprofessional identity development among dentistry and/or dental hygiene students?

2. What IPECP experiences are identified to enable development of collaborative skills, attitudes, behaviours, and readiness for collaborative practice among dentistry and/or dental hygiene students?

Methods

Eligibility Criteria

The target population of this scoping review are dentistry and/or dental hygiene students within IPECP during their pre-licensure education. The professions of dentistry and dental hygiene, while distinct, are often categorized together under the umbrella term of "oral health professions," which may also be extended to include additional oral health care providers such as dental assistants, therapists, and others (Hamil, 2017). For the purposes of this review, sources of evidence specific to dentistry and dental hygiene within IPECP will be included.

Studies on IPECP for professional and interprofessional socialization in health professions pre-licensure education broadly, which include at minimum one cohort of dentistry or dental hygiene students in an IPECP model, will be included in this review. Rationale for this inclusion criteria is to source the best evidence available on IPECP and the characteristics of experiences supporting professional and interprofessional socialization, identity development, and perceived readiness of dentistry and/or dental hygiene students to work within collaborative interprofessional care teams upon program completion.

Concept

This review will identify IPECP experiences currently used in the context of pre-licensure education for dentistry and/or dental hygiene students. IPECP programming is inclusive of exposure

events and experiences across online, classroom, clinical, community-based, and hybrid settings in which students from two or more professions learn with, from, and about each other to develop mutual understanding and the skills, attitudes, and behaviours that support effective interprofessional health care practice (Azzam et al., 2022). In addition, this review will explore the evidence of IPECP experiences for professional and interprofessional socialization enabling students' development of an interprofessional identity and perceived readiness for IPC in future practice.

Context

This review will be confined to exploring studies relevant to IPECP experiences during pre-licensure education that include dentistry and/or dental hygiene students. As these are both oral health professions, the terms "intraprofessional" and "interprofessional" are often used interchangeably in the literature to describe IPECP experiences between dentistry and dental hygiene, and both terms will be included in this review and search strategy (American Dental Education Association, 2016; Hamil, 2017).

Types of Sources

This scoping review will consider quantitative studies on IPECP that use both experimental and quasi-experimental designs, including before and after (pre-test/post-test) studies and interrupted time-series studies. In addition, descriptive observational studies will be considered for inclusion. Qualitative studies on IPECP will also be considered when they focus on qualitative data sourced from, but not limited to, methodologies such as phenomenology, narrative inquiry, grounded theory, ethnography, and qualitative description. Mixed-methods studies designed to generate quantitative and qualitative data from a combined approach of the research methods/methodologies described will be considered.

Study Design

The proposed scoping review will be guided by JBI methodology for scoping reviews (Aromataris & Munn, 2020) and the Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) Checklist. This protocol is registered in Open Science Framework (Van Dam & Price, 2024).

Search Strategy

The search strategy will aim to locate published, peer-reviewed studies on the topic of IPECP in dentistry and/or dental hygiene education and professional and interprofessional socialization and students' interprofessional identity development. An initial limited search of CINAHL (EBSCOhost) and DOSS (EBSCOhost) was undertaken to identify articles on the topic with the assistance of a subject specialist research librarian. The text words contained in the titles and abstracts of relevant articles, as well as the indexed terms used to describe the articles, were used to develop a full search strategy for CINAHL (EBSCOhost), DOSS (EBSCOhost), MEDLINE (PubMed), and APA PsycInfo. An example search strategy is provided (Appendix B). The search strategy, including all identified keywords and index terms, will be adapted for each database. The reference lists of all included sources of evidence will also be screened for additional studies.

The boundaries of this review will be defined by inclusion and exclusion agreed upon by the reviewers and will be applied across all databases. Studies that satisfy inclusion criteria and will be included in this scoping review are as follows: peer-reviewed studies pertinent to IPECP models used in pre-licensure education of dentistry and/or dental hygiene students published in the past 10 years (January 2014–May 2024) in English. The date filter coincides with the publication of seminal literature related to the topic (American Dental Education Association, 2016; Khalili & Orchard, 2020;

Khalili & Price, 2022). Studies are limited to English because qualified language interpreters are not readily available and no authors are fluent in languages other than English.

Non-peer reviewed sources such as grey literature, unpublished studies, and commentaries will be excluded due to potential risk of reporting bias or conclusion bias on IPECP experiences and their contributions to professional and interprofessional socialization and interprofessional identity development for oral health students.

Studies will be deemed eligible for inclusion if they are found to evaluate or explore IPECP experiences used in dentistry and/or dental hygiene pre-licensure education or in pre-licensure health education programs broadly, inclusive of at minimum one (1) cohort of dentistry or dental hygiene students. Studies specific to the topic of IPECP for professional and interprofessional socialization and interprofessional identity development will be included only if a sampling of dentistry or dental hygiene students was used, to maintain closeness and specificity to the research questions. Full inclusion and exclusion criteria are outlined in Appendix A.

Study/Source of Evidence Selection

Following the search, all identified article citations will be collated and uploaded into online article tracking software, Covidence (www.covidence.org), and duplicates removed. Following a pilot test, titles and abstracts will then be screened by two independent reviewers for assessment against the inclusion criteria for the review. Sources deemed potentially relevant to the topic of IPECP in dentistry and/or dental hygiene education will be retrieved in full text. Full text review of sources retrieved will be assessed in detail against the inclusion criteria by two independent reviewers. Reasons for exclusion of sources of evidence at full text that do not meet the inclusion criteria will be recorded and reported in the scoping review. Any disagreements that arise between reviewers at each stage of the selection process will be resolved through discussion, or with an additional reviewer, until a consensus is reached regarding eligibility for inclusion. The results of the search and the study inclusion process will be reported in full in the final scoping review and presented in a Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) flow diagram (Tricco et al., 2018).

Data Extraction

A modified version of the JBI extraction tool for source of evidence details, characteristics, and results (Peters et al., 2020) will be piloted to extract data from a subset of articles deemed eligible for inclusion in the scoping review by a single independent reviewer. The data extracted will include specific details about article authors, publication year, country of origin, study aims, participants, IPECP model used, duration of IPECP experience, study design/methods, and key findings or gaps in literature noted relevant to the review questions. All team members have approved the data extraction tool design. A draft of the extraction tool is provided (Appendix C). Data extracted will be subsequently reviewed by all team members prior to extracting data from all articles identified as eligible for inclusion. Any queries or disagreements that arise pertaining to data extraction will be discussed and reconciled among the team. The draft data extraction tool will be modified and revised as necessary during the process of extracting data from each included evidence source. Any modifications to the tool will be detailed in the scoping review. If appropriate, authors of papers will be contacted to request missing or additional data where required.

Data Analysis and Presentation

Data analysis in this scoping review will involve initial independent review of extracted data by a single independent reviewer for preliminary identification of IPECP models used in dentistry and/or dental hygiene education and to identify findings and emergent themes that inform the research questions. Independent analysis will be followed by group discussion among all reviewers

of preliminary findings. All reviewers will review the extracted data in order to confirm rigour in the data interpretation and to thematically categorize findings pertinent to the research questions as appropriate. Any disagreements that arise during data analysis and interpretation will be resolved through group discussion, until consensus is reached.

The evidence will be presented in both table and diagram formats, and a narrative summary will accompany the charted results describing their relation to the scoping review objective and research questions. This scoping review will also present the authors' recommendations for IPECP development in oral health education and directions for future research to support IPC and interprofessional health care teams in practice.

Limitations

A limitation to this review is that sources retrieved will be limited to peer-reviewed articles pertaining to IPECP in oral health education published in English, as translation services are unavailable. Resultingly, the authors acknowledge that additional sources relevant to this review published in non-peer reviewed journals or in languages other than English may be excluded. However, the authors confirm that results of preliminary database searches confirm the appropriateness of these limiters to produce sufficient evidence to inform the topic. As the intentions of a scoping review are to synthesize a broad scope of the current literature to inform future research, policy, and practice development, the authors confirm the rigour of this review protocol to inform future needs.

Ethics and Dissemination

Ethics approval for this study was not required, as it is a scoping review of the literature, and data is derived from previously published and publicly available studies. This review protocol is registered on Open Science Framework (Van Dam & Price, 2024). The findings of this review will be synthesized and used to inform and advance innovative IPECP development in oral and health professions education.

Acknowledgements

The authors acknowledge Shelley McKibbon, Health Sciences Research Librarian and health and dentistry subject specialist at Dalhousie University, for her expertise and guidance in database review.

Conflict of Interest

There is no conflict of interest in this project.

Author Note

LVD and SP conceptualized the study and designed, reviewed, and approved the final manuscript. This scoping review will contribute to a Doctor of Philosophy (PhD) for LVD.

Funding

This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

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Appendices

Appendix A: Inclusion and Exclusion Criteria for a Scoping Review on Interprofessional Education for Collaborative Practice (IPECP) in Oral Health Education

Inclusion	• Peer-reviewed journal articles • Published in the past 10 years (2014–present) • English language • IPECP models used in pre-licensure education of dentistry and dental hygiene students • IPECP models used in pre-licensure education of health professions students that include at minimum one (1) cohort of dentistry or dental hygiene students
Exclusion	• Non-peer reviewed articles, grey literature • > 10 years since publication • Studies exploring IPECP models in health professions pre-licensure education that do not include a cohort of dentistry or dental hygiene students. • Studies exploring IPECP models used among practising oral/health professionals • Studies reporting on IPECP models from the perspective of educators/program administrators/institutional quality assessment

Appendix B: Database Search Strategy

CINAHL (EBSCOhost)

Date Searched: Jan 26, 2024

	Search	Record Retrieved
1	Dentistry OR dental hygiene	35,992
2	(inter-disciplinary OR interdisciplinary) OR (multi-disciplinary OR multidisciplinary) OR (interprofessional OR inter-professional) OR (intra-professional OR intraprofessional) OR collaborat*	257,296
3	"professional identity" OR social*	478,427
4	S1 AND S2 AND S3 Limiters- abstract available; 2014-01-01-current; Scholarly (Peer Reviewed)	100

Appendix C: Modified-JBI Template for Source of Evidence Details, Characteristics and Results Extraction Tool[a]

Study Details	
Title/Authors/Year of Publication/Country	
Aims/Objectives	
Research Questions	
Inclusion/Exclusion Criteria	
Student Population/Sample Size	
Concept/Design	
Type of study (qual/quant/mixed-methods)	
IPECP Model	
Duration of IPECP	
Details/Results Extracted	
Key Findings of IPECP Experience	
Gaps Identified	

[a] Adapted from: Aromataris E, Munn Z. Appendix 11.1 JBI template source of evidence details, characteristics and results extraction instrument. JBI Manual for Evidence Synthesis. JBI. 2020.

HPJ HEALTHY POPULATIONS JOURNAL

Review Protocol

Identifying Factors That Influence How Pediatric Patients or Their Caregivers Decide to Present to an Emergency Department: A Scoping Review Protocol

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DOI: 10.15273/hpj.v5i1.12297

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Abstract

Objective: To map and describe the extent and type of evidence in relation to factors that influence how pediatric patients or their caregivers decide to present to an emergency department (ED). **Introduction:** Studies in countries with universal health care systems have suggested that while patients may consider using services outside of the hospital for care, they often end up presenting to an ED. Understanding how pediatric patients and caregivers decide to present to an ED can inform future health care design to mediate decisions before an ED presentation. **Inclusion criteria:** Literature will be included if it assesses patients between zero and 17 years who present to the ED and reports findings from the patient's or caregiver's perspectives. Studies eligible for inclusion are those that focus on ED presentations in a country with universal health care, Organisation for Economic Co-operation and Development (OECD) membership, and classification as a high-income country. Studies that focus on patients transferred to the ED from a residential or correctional facility will be excluded. **Methods:** A scoping review using JBI methodology will be conducted. A preliminary search indicated no scoping reviews in this field have been carried out. CINAHL, MEDLINE ALL, PsycInfo, and Embase will be searched with no date limits. No language restrictions will be applied. Data will be extracted using a standardized form. Articles will be screened and data extracted by two independent reviews, with conflicts resolved by a third reviewer or through discussion. Data will be analyzed through tables with an accompanying narrative summary and PRISMA-ScR.

Keywords: decision making, choice behaviour, emergency medicine, pediatric, universal health care

Introduction

Emergency departments (EDs) are designed to provide treatment for those experiencing severe illness or injuries, operating 24 hours a day and seven days a week (Government of Ontario, 2014). Such departments employ health care providers from a variety of backgrounds, as well as hosting trainees for learning experiences. As workers from various professional backgrounds contribute to patient care in an ED, this setting is considered an interprofessional practice setting (World Health Organization, 2010). In a community setting, health care providers of various professional backgrounds provide comprehensive services for patients by working together with patients, families, caregivers, and communities to deliver high quality care, and this concept is referred to as collaborative practice (World Health Organization, 2010). Collaborative practice can occur among health care providers from settings such as community health clinics, pharmacies, in-patient hospital units, or EDs. Among these settings, interactions with health care providers in the community may play a role in influencing a patient's or caregiver's decision to attend an ED.

Worldwide, EDs are facing challenges of overcrowding, with increased volume and increasing acuity of patients (Canadian Agency for Drugs and Technologies in Health, 2023; Canadian Institute for Health Information, 2024). In Canada, the frequency of ED visits has increased by over one million visits between 2021–2022 and 2022–2023, with the largest increase in visits being observed among those aged 0–4 years (Canadian Institute for Health Information, 2024). While young patients are seeing the greatest increase in ED use, it is also important to note that in a pediatric population, a substantial proportion of presentations are classified as non-urgent, suggesting that these patients may be better treated in a primary care setting (Simpson et al., 2022). Understanding why patients and their caregivers decide to come to the ED can be important for informing future practice and service designs both in the hospital and in the community.

We know that increased numbers of patients are deciding to present to an ED (Canadian Institute for Health Information, 2024). Though scoping and systematic reviews are available in this area, they have largely included studies from the United States, a country without a universal health care system, where decisions to come to an ED have been influenced by payment methods and copayments available in EDs as opposed to other services (Uscher-Pines et al., 2013; Vogel et al., 2019). Studies in countries with universal health care systems have suggested that patients may initially consider using services outside of the hospital for care, but ultimately decide to present to an ED (Agarwal et al., 2012; Truter et al., 2024). If we can understand how patients and their caregivers come to the decision to present to an ED, there is potential to intervene and mediate their decisions before they come to an ED. For example, if patients or their caregivers consider accessing care in the community but feel that shortcomings exist in that service, future interventions that aim to strengthen such community care and promote interprofessional collaborative practice could be implemented.

To understand the context in Canada and other countries with universal health care, we propose a scoping review, using JBI methodologies, to better understand why pediatric patients and/or their caregivers decide to present to the ED. Further information regarding the study context will be described later in this paper. The information generated from this scoping review protocol and subsequent scoping review has the potential to explore existing collaboration among health care professionals from various disciplines and the factors that influence a pediatric patient or their caregiver's decision to present to an ED based on these collaborations. Various literature sources have reported that pediatric patients often present to an ED on the advice of health care providers like family physicians or telephone advice lines (Haasz et al., 2018; Löflath et al., 2021). If health care professionals from a variety of backgrounds are aware of the role they play in an ED attendance, they can work together, directly or through open lines of communication, to provide the most comprehensive care for patients in the most appropriate setting.

The objective of this scoping review is to assess the extent of the literature that discusses aspects of how patients and/or their caregivers decide to present to an ED. This study will map the available literature in an effort to better understand what factors influence a pediatric patient's or caregiver's decision to present to an ED.

Review Question

Primary Question

What is known about the factors that influence a pediatric patient's or caregiver's decision to present to an ED in a universal health care setting? (See Table 1 for population, concept, context [PCC] framework.)

Sub questions

1. Are there any frameworks that outline or guide how patients make the decision to come to an ED in a universal health care setting?
2. What are the commonly reported barriers and enablers to decision-making regarding pediatric ED attendance?

Methods

Eligibility Criteria

This scoping review will consider studies that include pediatric patients or their caregivers who presented to an ED in a setting with universal health care. Studies can include patients of any age but must report data specific to a pediatric population. Perspectives of both patients and caregivers are eligible for inclusion.

Specifics to the ED visit are not limited, and this review will include literature where ED patients had any level of urgency or presenting complaint. Studies involving patients transferred from a residential care or correctional facility to an ED will be excluded, as the decision to attend an ED is presumably not capturing the patient's or caregiver's choice to attend (instead being a choice from the facility).

Concept

The concept examined by this scoping review will include factors and considerations that influence the patient's or caregiver's decision to come to the ED. Literature reporting factors based on triage score alone, or those that exclude patient perspectives, will not be considered for inclusion into the review (e.g., health care provider perceptions of why the patient presented). Patients in the included literature will be able to present to the ED by any means, but studies that focused on the decisions to call an ambulance or emergency services alone will not be included.

Context

This scoping review will consider studies that were conducted in EDs in countries with universal health care, who are a member of the Organisation for Economic Co-operation and Development (OECD), and who are classified as a "high-income country" by the World Bank (Moir & Barua, 2023). This inclusion criteria was selected because these countries were thought to be comparable to the Canadian context—the country of interest—and have been used in past publications to draw comparisons between health care systems comparable to that of Canada. Comparability is assumed based on health system structure and economic status. Using these criteria, the following countries will be included: Australia, Austria, Belgium, Canada, Chile, the Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Iceland, Ireland, Israel, Italy, Japan,

Latvia, Lithuania, Luxembourg, the Netherlands, New Zealand, Norway, Portugal, Slovenia, South Korea, Spain, Sweden, Switzerland, and the United Kingdom.

Table 1

Population, Concept, Context (PCC) Framework

PCC Element	Definition
Population	• Emergency department patients between zero and 17 years of age with presentations of any severity for any presenting complaint.
Concept	• Factors that influenced the patient's or caregiver's decision to come to the emergency department. • Considerations made by the patient or caregiver that led them to the emergency department.
Context	• Studies carried out in countries with universal health coverage who are a member of the OECD and who are also classified as a "high income country" by the World Bank.

Types of Sources

This scoping review will assess published studies that utilize quantitative, qualitative, and mixed-method design. Specific study designs eligible for inclusion are as per recommendations of JBI methodology (Aromataris et al., 2024).

Experimental and quasi-experimental study designs including randomized controlled trials, non-randomized controlled trials, before and after studies, and interrupted time-series studies will be eligible for inclusion. In addition, analytical observational studies including prospective and retrospective cohort studies, case-control studies, and analytical cross-sectional studies will be considered for inclusion. This review will also consider descriptive observational study designs including case series, individual case reports, and descriptive cross-sectional studies for inclusion.

Qualitative studies will also be considered when they focus on qualitative data including, but not limited to, designs such as phenomenology, grounded theory, ethnography, qualitative description, action research, and feminist research.

Systematic reviews will be excluded; however, reference lists of potentially relevant reviews will be mined for potential inclusion in this scoping review. Text and opinion papers will not be considered for inclusion in this scoping review, as these sources are unlikely to provide the patient or caregiver voice or perspective that is of interest to this review.

Grey literature in the form of websites of pediatric hospitals from Canada, Australia, and the United Kingdom will be evaluated. Here, a targeted grey literature search will be carried out to seek information from the hospital that provides messaging directed at patients and families to help support their decision to come to the ED or not. Further, information will be gathered in relation to how easily that messaging was found and whether external sources were linked. Messaging found on the respective websites will be subject to content analysis.

Study Design

The proposed scoping review will be conducted in accordance with the JBI methodology for scoping reviews (Aromataris et al., 2024). The lead author and other members of the study team are trained in JBI methodology.

Search Strategy

The search strategy will aim to locate published studies. A health librarian was consulted for the development of the search strategy. The search strategy was then peer-reviewed by a librarian

using Peer Review of Electronic Search Strategies (PRESS). An initial limited search of MEDLINE ALL (Ovid) was undertaken to identify articles on the topic. The text words contained in titles and abstracts of relevant articles and the index terms used to describe the articles were used to develop a full search strategy for MEDLINE ALL, Embase (Embase.com), CINAHL with Full Text (EBSCOhost), and PsycInfo (EBSCOhost; Appendix A). The search strategy, including keywords and index terms related to the ED, ambulance, and decision-making, will be adapted for each included database. The reference list of all included sources of evidence and relevant literature reviews will be screened for additional studies. Studies published in any language will be included, as long as translation to English is possible using the AI translation software DeepL, further discussed below. The search strategy will apply no date limits to the search.

Study/Source of Evidence Selection

Following the search, all identified citations will be collated and uploaded into Covidence (www.covidence.org) and duplicates removed. Studies published in a language other than English will be translated using the AI translation software DeepL Translator (https://www.deepl.com). If translation using this software is not possible then the study will be excluded.

Pilot testing of inclusion and exclusion criteria will be completed for the title and abstract and full-text screening before each phase to ensure consistency and understanding of inclusion and exclusion criteria among reviewers. Following a pilot test, titles and abstracts will then be screened by two independent reviewers for assessment against the inclusion criteria for the review. Potentially relevant sources will be retrieved in full.

The full text of selected citations will be assessed in detail against the inclusion criteria by two or more independent reviewers. Reasons for exclusion of sources of evidence in full text that do not meet the inclusion criteria will be recorded and reported in the scoping review. Any conflicts that arise between the reviewers at each stage of the selection process will be resolved through a tiebreak by a third reviewer or through discussion. The results of the search and the study inclusion process will be reported in full in the final scoping review and presented in a Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Review (PRISMA-ScR) flow diagram (Tricco et al., 2018).

As per JBI methodologies for scoping reviews, an assessment of the strength of the body of evidence or individual study risk of bias assessment will not be carried out. This decision is supported by JBI methodologies as the intention of a scoping review is to evaluate the extent of evidence available, not necessarily the quality (Aromataris et al., 2024).

Data Extraction

Data will be extracted from papers included in the scoping review by two or more independent reviewers using a data extraction tool developed by the reviewers (Appendix B). Data will be extracted into Covidence. The data extracted will include specific details about the participants, concept, context, study methods, and key findings relevant to the review question. Data points will focus on key findings to each paper that are specific to a pediatric population (e.g., if a study uses a population from one to 40 years, only results of those 17 and under will be extracted). Further data will be collected, if applicable, regarding patient and caregiver contact with a health care provider before ED presentation, attachment to primary care in the community, preferences of health care provider types to see, what profession they typically see, and past use of health care services in the community if reported.

The draft data extraction tool will be piloted prior to the beginning of data extraction to ensure consistency and understanding among reviewers. If needed, the data extraction tool will be modified and revised during the pilot testing process of extracting data from each included evidence

source. Modifications will be detailed in the scoping review. Any conflicts that arise between the reviewers will be resolved through discussion or with an additional reviewer. If appropriate, authors of papers will be contacted to request missing or additional data where required.

Conclusion

The proposed scoping review aims to understand factors that influence the decision to present to an ED in a universal health care setting by pediatric patients or their caregivers. Results from this scoping review will provide further knowledge about how patients and caregivers make decisions and utilize EDs. Understanding how pediatric patients present to an ED can inform future health care design and potentially strengthen health care programs by mediating decisions made before an ED presentation. This understanding could act to strengthen existing health care services or create fit-for-purpose services in hospital and community settings.

Among other data, this study will extract information regarding preferences and health care use prior to an ED visit in a pediatric population from the perspective of the patient or their caregiver. Reporting of such data is beneficial to interprofessional practice and subsequent interprofessional collaboration, as the role that specific professionals play in advising patients to attend an ED may be better understood as a result. Subsequently publishing such information will allow professionals to reflect on their personal practice and how they contribute to the flow of patients to EDs. The results of this scoping review have the potential to contribute to interprofessional collaborative practice among numerous practice settings. Results and reflection by health care providers can strengthen health systems through increased collaborative practice and aid in illuminating areas of need regarding interprofessional education and its place in a formal education setting.

Protocol Registration

Protocol is registered with Open Science Framework (OSF; Devereaux & Curran, 2024).

Funding Statement

This project did not receive any funding.

Conflict of Interest

The authors have no conflict of interest to declare.

Declaration of Ethics

Ethical approval was not required for this review protocol.

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Appendices

Appendix A: MEDLINE ALL (Ovid) Search Strategy

Line	Concept	Results
1	exp Emergency Service, Hospital/	103,409
2	exp Emergency Medicine/	15,966
3	(emergency adj2 (department* or room* or unit* or ward* or service*)).ti,ab,kf.	184,565
4	("accident and emergency" or "a and e" or "accident & emergency" or "a & e" or "a&e").ti,ab,kf.	75,368
5	(trauma center* or trauma centre* or trauma unit*).ti,ab,kf.	24,380
6	or/1-5	314,067
7	((decision* or decid* or motivat* or reason* or cause* or causing) adj3 (present* or attend* or visit* or seek* or "go to" or "going to" or "went to")).ti,ab,kf.	31,932
8	6 and 7	2,966
9	Ambulances/	7,123
10	(ambulance* or emergency mobile unit* or mobile emergency unit*).ti,ab,kf.	14,018
11	or/9-10	16,562
12	((decision* or decid* or motivat* or reason* or cause* or causing) adj3 (call* or dispatch* or request*)).ti,ab,kf.	4,959
13	11 and 12	150
14	((decision* or decid* or motivat* or reason* or cause* or causing) adj3 (emergency department* or emergency room* or emergency unit* or emergency ward* or emergency service* or "accident and emergency" or "a and e" or "accident & emergency" or "a & e" or "a&e" or trauma center* or trauma centre* or trauma unit*)).ti,ab,kf.	2,689
15	((decision* or decid* or motivat* or reason* or cause* or causing) adj3 (ambulance* or emergency mobile unit* or mobile emergency unit*)).ti,ab,kf.	139
16	8 or 13 or 14 or 15	5,581
17	exp Infant/ or (baby or babies or neonate* or neo-nate* or newborn* or new-born* or infant*).ti,ab,kf.	1,537,889
18	exp Child/ or exp Pediatrics/ or (child* or kid or kids or girl or girls or boy or boys or toddler* or preschool* or pre-school* or kindergarten* or school* or juvenile* or minors or p?ediatric?).ti,ab,kf.	3,250,676
19	Adolescent/ or Young Adult/ or (teen* or youth* or adolescen* or juvenile* or (young adj2 (adult* or person* or individual* or people* or population*)) or youngster* or highschool* or ((secondary or high*) adj2 (school* or education))).ti,ab,kf.	3,053,854
20	exp Parents/ or (parent* or mother* or father* or guardian*).ti,ab,kf.	792,457
21	or/17-20	5,835,584
22	16 and 21	1,954

Appendix B: Draft Data Extraction Form

Study Description	Author
	Year of Publication
	Study Objective
	Study Design
	Data Collection Methods (i.e., survey, interview, chart review)
	Date range of data collection
	Inclusion/Exclusion criteria
	Sample size
	Theoretical framework that underpins study (if applicable)
Population	Presenting complaint of interest (i.e., those with vomiting, those with head injury, etc.)
	Severity of complaint if specified (i.e., now acuity, urgent)
	Population age range
	Did patient, caregiver, or both report outcomes
Concept	Caregiver- or patient-reported factors that influenced their decision to attend the ED (in the pediatric study population)
	Considerations made by the patient or caregiver that led them to the ED (in the pediatric study population)
	Did the study evaluate a shared decision-making tool, if so what were the findings of this evaluation
	Have health equity frameworks or associated measures been used in the study
Context	Country
	Location of ED (rural, urban)
	ED setting (pediatric or mixed ages ED)
	Did a health care provider refer the patient(s) to the ED?
	Did a handoff, or communication between the ED and community provider occur prior to transfer? (specify type of provider)
	ED provider perceptions of appropriateness of visit
	Health care provider type contacted before ED visit
	Health care provider type that referred patient to the ED
	Frequency of patients who reported having and not having a regular primary care provider
	Caregiver- or patient-reported health care provider type preferences and health care provider typically seen

HPJ HEALTHY POPULATIONS JOURNAL

Review Protocol

Implementation Strategies for Evidence-Based Interventions in Kidney Transplant Care: A Scoping Review Protocol

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DOI: 10.15273/hpj.v5i1.12310

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Abstract

Introduction: Kidney transplantation represents a significant period of transition, presenting numerous challenges for kidney transplant recipients and their families as they adjust to post-transplant life. To ensure kidney transplant recipients achieve optimal health outcomes, it is essential to provide evidence-based interventions (EBIs) in kidney care that encompass prevention, treatment, and long-term maintenance. Therefore, developing effective implementation strategies is crucial to support the execution, adoption, and integration of these EBIs into routine care. **Objective:** This scoping review aims to understand the extent and type of evidence on strategies used to implement EBIs into kidney transplantation care. **Methods:** This scoping review will follow the JBI methodology for scoping reviews. Included sources from databases and grey literature must discuss implementation strategies to support the implementation of EBIs into in-patient adult kidney transplant recipient care. Two independent reviewers will screen titles, abstracts, and full articles and extract data with conflict resolution through discussion or a third reviewer. Directed content analysis will guide the coding of implementation strategies to the clustered Expert Recommendations for Implementing Change (ERIC) taxonomy and barriers and facilitators to the Consolidated Framework for Implementation Research (CFIR). Finally, the ERIC-CFIR mapping tool will be employed to understand whether the appropriate strategies were selected to address the identified barriers and facilitators. Findings will be presented in tabular and visual format, accompanied by text. **Anticipated Results and Conclusion**: The proposed scoping review will illuminate current implementation science gaps and opportunities in kidney transplant. The results will provide insight for health care professionals caring for kidney transplant recipients and guide their selection of implementation strategies to support the uptake of EBIs.

Keywords: nephrology, healthcare, implementation frameworks, implementation taxonomies, JBI

Introduction and Background

In Canada, thousands of individuals are living with end-stage kidney disease (ESRD), where their only treatment options are dialysis or kidney transplantation (Kitzler & Chun, 2023). In 2021, over 18,000 Canadians were living with a functioning kidney transplant (Canadian Institute for Health Information., n.d.). Kidney transplantation is often the preferred treatment for ESRD as it is associated with increased survival and quality of life over dialysis (Nielsen et al., 2019). Kidney transplantation also reduces health care system costs overall (Ferguson et al., 2021).

While kidney transplant is typically associated with improved outcomes over other kidney replacement therapies, transplantation presents challenges for kidney transplant recipients and their caregivers. After transplantation, transplant recipients must follow strict recommendations related to medications and lifestyle modifications to mitigate these risks and preserve health (Jobst et al., 2023; Tang et al., 2020; Tong et al., 2011; Yang et al., 2020). Additionally, kidney transplant recipients are at heightened risk of complications post-operatively, which can ultimately lead to graft loss or death (Hamed et al., 2015; Lubetzky et al., 2016). Evidence-based interventions (EBIs) are needed to support this vulnerable population during the initial post-operative period and beyond in order to optimize health and well-being and to limit risk of graft loss or death. Kidney transplant is a precarious time for recipients and their families, and evidence-based practices are necessary to ensure health care providers are providing optimal care.

Many standard post-op treatments in kidney transplant are evidence-based. Common examples include triple therapy immunosuppression (Kasiske et al., 2010; Szumilas et al., 2023), cytomegalovirus prophylaxis (Vernooij et al., 2024), antihypertensive treatment (Natale et al., 2024), addressing increased skin cancer risk (Granata et al., 2023), vaccinations (Danziger-Isakov & Kumar, 2013), and exercise training (Wilkinson et al., 2022). Ensuring that practice is rooted in evidence helps clinicians provide the care that maximizes health outcomes and minimizes health risk to kidney transplant recipients. However, not all research evidence is integrated into clinical settings.

Gaps

There is a well-known gap between EBIs and their integration into health care. According to Braithwaite and colleagues (2020), the ongoing 60-30-10 Challenge in health care states that 60% of care agrees with best evidence, 30% is unnecessary or inefficient, and the remaining 10% of care results in harm. The gaps illustrated in the 60-30-10 Challenge hinder health care providers' ability to provide care that optimizes patient and health system outcomes. Gaps have been identified between best practices and implementation into practice in the nephrology setting (Jardine et al., 2017). Gaps include failure to detect chronic kidney disease (CKD) early and initiate therapeutic treatment (Luyckx et al., 2024; Padiyar et al., 2024), arrange timely access to replacement therapy (Jardine et al., 2017; Yohanna et al., 2021), and address transplant medication behaviour (Gokoel et al., 2020; Mellon et al., 2022).

Barriers and Facilitators

There are several factors that negatively or positively affect changes in health care practice, also referred to as barriers or facilitators (Flottorp et al., 2013). Examples of these barriers or facilitators to evidence-based practice for clinicians include knowledge, education, or workplace culture (Duff et al., 2020). Considering these contextual factors when discussing implementation efforts is vital, as a determinant to implementing an EBI may be a barrier in one setting or an enabler (or have no impact) in another. Determinant frameworks, such as the Consolidated Framework for Implementation Research (CFIR), are often used to assess contextual barriers and facilitators (Damschroder et al., 2009, 2022). Using the CFIR will identify and classify barriers and facilitators to EBI in the kidney transplant setting.

Implementation Strategies

Implementation strategies can help close the evidence-to-practice gap by addressing identified barriers and facilitators to EBI implementation in health care. Implementation strategies are "methods or techniques to enhance the adoption, implementation, and sustainability of a clinical program or practice" (Proctor et al., 2013, p. 2). Examples of implementation strategies include educational meetings or materials, audit and feedback, and policy changes (Proctor et al., 2013). There is a call to increase implementation science use and understanding in nephrology, including enhancing implementation science capacity among practitioners, contextual considerations, and evaluation of implementation strategies (Jardine et al., 2017). Taxonomies of strategies, such as the Expert Recommendations for Implementing Change (ERIC), can be used to identify and report implementation strategies. Using ERIC will characterize current use of implementation strategies in the kidney transplant setting.

A mapping tool was developed by Waltz and colleagues (2019) that matches CFIR barriers to strategies in the ERIC taxonomy. This helps ensure that implementation barriers are addressed by appropriate strategies. As the tool was recently created, its application and evaluation are limited, yet growing (Bouma et al., 2023; Delaforce et al., 2023; Howell et al., 2022; Rommerskirch-Manietta et al., 2023; Waltz et al., 2019; Weir et al., 2021). The tool has yet to be used in the renal care setting. However, the narrow use and evaluation completed thus far suggest the tool's promise for identifying appropriate strategies (Yakovchenko et al., 2023). Applying the mapping tool to the kidney transplant setting will help ensure identified implementation barriers are addressed with appropriate strategies. Further use of the tool will strengthen the knowledge base on mapping barriers and facilitators to implementation strategies to facilitate successful implementation of evidence into practice.

Initial Literature Search

There is a need to understand which strategies can address barriers in real-life health care settings (Waltz et al., 2019). An initial search of the literature using the words implementation strategies, implementation interventions, and kidney or renal revealed that while reviews have been completed, they are focused on primary care interventions in CKD patients with limited focus on specialized populations such as transplant recipients (Elliott et al., 2017; Galbraith et al., 2018; Silver et al., 2017; Tsang et al., 2016). A review of implementation strategies in renal replacement therapy has been completed; however, the search was completed over 14 years ago (van der Veer et al., 2011). There is more recent interest in renal care implementation strategies, evidenced by the publication of a systematic review protocol on clinician-focused implementation strategies in CKD primary care (Kamath et al., 2019). Further, there is a need to understand implementation processes in renal care. Implementation theories, models, and frameworks help to guide a better understanding of the implementation process (Nilsen, 2015). Additionally, clarity is needed regarding which outcome measures are focused on the implementation process (Proctor et al., 2013, 2023).

A scoping review was selected as the most appropriate method to examine the use of implementation strategies for EBIs in kidney transplant care, as it is often used to map the available evidence on a topic (Munn et al., 2018; Tricco et al., 2016). Scoping reviews also help explore reported outcomes and how they are measured (Pollock et al., 2023). Finally, scoping reviews are beneficial when there is heterogeneity in the literature (Peters, Marnie, et al., 2020), such as with implementation strategies.

A preliminary search of CINAHL, the Cochrane Database of Systematic Reviews, and *JBI Evidence Synthesis* was conducted, and no current or underway systematic reviews or scoping reviews on the topic were identified. This scoping review aims to assess the extent of the literature on the implementation process to bring EBIs into kidney transplant care, focusing on the

implementation strategies. The review will identify barriers and facilitators to EBIs in the kidney transplant setting. Finally, the review will explore whether the selected strategies are appropriate to address the identified barriers and facilitators.

Review Question

The primary review question is as follows: What implementation strategies are used to implement evidence-based interventions in post-kidney transplant care? The sub-questions are as follows:

1. What theories, models, and frameworks were used to guide implementation?
2. What barriers and facilitators have been identified for implementing evidence-based practice?
3. What strategies have been used specifically for adoption, sustainability, and de-implementation?
4. Are the identified barriers and facilitators in alignment with the selected implementation strategies?
5. What are the reported implementation process and outcome measures?

For data analysis, sub-question 2 will use the CFIR, sub-question 3 will use the ERIC taxonomy, and sub-question 4 will used the CFIR-ERIC mapping tool.

Methodology

The proposed scoping review will follow the JBI methodology for scoping reviews published in the *2020 JBI Manual of Evidence Synthesis* (Peters, Godfrey, et al., 2020).

Eligibility Criteria

Following the *JBI Manual of Evidence Synthesis*, the eligibility criteria will be discussed using population (participant), concept, context, and the types of studies to be included (Table 1).

Search Strategy

A preliminary search of CINAHL was completed to identify articles on the topic. The text words in the titles and abstracts of relevant articles and the index terms used to describe the articles were used to develop a complete search strategy for CINAHL in collaboration with a health sciences librarian (Appendix A). The search strategy, including all identified keywords and index terms, will be adapted for each included database. The reference list of all included sources of evidence will be screened for additional studies.

The databases to be searched include CINAHL, Embase, PubMed, Nursing and Allied Health Database, Cochrane Library, and JBI EBP Database. Sources of unpublished studies/grey literature to be searched include ProQuest Dissertations and Theses. There will be no limitations on the geographical location. Studies published in English will be included from the publication date of 1954 onwards, the year of the first successful human kidney transplantation (Tantisattamo et al., 2022). The full search will be conducted with the assistance of the health sciences librarian, who is experienced in scoping reviews.

Evidence Selection

Following the search, all identified citations will be organized and uploaded into systematic review software Covidence (https://www.covidence.org) for removing duplicates and screening. Two independent reviewers will screen the citation titles and abstracts for assessment against the

outlined eligibility criteria. A third independent reviewer will resolve any conflicts. Citations included at the title and abstract stage will be accessed as full texts and uploaded to Covidence to facilitate screening. Two independent reviewers will critically assess the full text of included

Table 1

Eligibility Criteria

Eligibility Criteria	Inclusion	Exclusion
Population	Papers focused on kidney transplantation recipients or health care providers of kidney transplantation recipients will be included in the study. Papers focused on all recipients of all ages, whether de novo (new) or repeat transplant recipients, will be included in the review.	Papers do not include kidney transplant recipients or health care providers of kidney transplant recipients.
Concept	Papers discussing implementation strategies for facilitating the adoption, implementation, sustainability, or de-implementation of EBIs for kidney transplant recipients.	Papers do not discuss implementation strategies related to adoption, implementation, sustainability, or de-implementation of EBIs for kidney transplant recipients.
Context	All settings delivering post-operative solid-organ transplant recipient care (e.g., in-patient [e.g., transplant unit] and outpatient [e.g., post-transplant clinic] settings).	Papers focused on care unrelated to the transplantation (e.g., transplant recipients admitted for surgical intervention unrelated to their transplant).
Types of Studies	• Experimental and quasi-experimental study designs (including randomized controlled trials, non-randomized controlled trials, before and after studies, and interrupted time-series studies) • Analytical observational studies (including prospective and retrospective cohort studies, case-control studies, and analytical cross-sectional studies) • Descriptive observational study designs (e.g., case series, individual case reports, and descriptive cross-sectional studies) • Qualitative studies • Mixed methods studies	• Text and opinion papers • Conference abstracts • Dissertations • Systematic reviews (however, if they otherwise fit the eligibility criteria, their references will be scanned for individual studies that are appropriate for inclusion)

citations against the eligibility criteria. At the full-text stage, the rationale for citation exclusion will be noted and documented in the scoping review. Again, any conflicts will be resolved by a third reviewer. Ongoing discussion among the review team will occur to ensure all reviewers understand the eligibility criteria. A screening guidance sheet will be provided to reviewers. The search results and the study inclusion process will be comprehensively reported in the scoping review and presented visually in a Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) flow diagram (Tricco et al., 2018).

Data Extraction

Data will be extracted from sources included in the scoping review by two independent reviewers using a data extraction tool developed by the review team. The data extracted will include specific details about the author, publication year, country of origin, study design, study setting, implementation intervention, implementation strategies, and identified barriers and facilitators to the EBI. Strategies will be identified by their target (patient, health care provider, health system) and their purpose (implementation, de-implementation, or sustainability of the EBI). Barriers and facilitators will be further divided into patient-, provider-, and researcher-identified barriers and facilitators. The extraction process will also note whether an implementation theory, model, or framework (and if so, which one) guided the implementation. Acknowledging the increasing focus in implementation science on integrated knowledge translation (Graham et al., 2018; Nguyen et al., 2020), the presence and level of knowledge-user engagement in the implementation process will be captured. Equity, diversity, and inclusion considerations will be extracted to advance these principles in the implementation of EBIs (Baumann et al., 2023; Baumann & Cabassa, 2020; Rodrigues et al., 2023). Finally, included outcomes will be extracted and classified as implementation, clinical, and service system outcomes (Proctor et al., 2011).

A draft data extraction tool was created (Appendix B). The drafted tool will be collaboratively revised throughout the data extraction process. All revisions will be described in the scoping review manuscript. Similarly to screening, a data extraction guidance sheet will also be created to clarify the extraction process. A team approach to communication will be prioritized throughout the review process, from screening to data analysis and presentation. All differences that arise during data extraction will be resolved through a third reviewer and discussion where necessary. If required, authors of included papers will be contacted in pursuit of missing or additional data.

Data Analysis

After the data extraction, the data will be coded to address the objectives of the review fully. Coding will be completed by two independent reviewers who have received training on the included frameworks and taxonomies. Conflicts in the coding process will be resolved through discussion and a third trained reviewer where necessary. A deductive content analysis approach (Hsieh & Shannon, 2005) will be used to code the strategies, determinants, and outcomes. Deductive content analysis is useful when coding data using implementation taxonomies, as the results will be more easily applied to other settings (Delaforce et al., 2023).

Barriers and Facilitators

The CFIR will be used to code barriers to and facilitators for implementing the EBIs in the kidney transplant setting. The CFIR was developed by Damschroder and colleagues (2009) to address the issue of implementation of many similar constructs with slightly different definitions. The original CFIR comprises 39 constructs further categorized into five domains: (a) intervention characteristics, (b) outer setting, (c) inner setting, (d) characteristics of individuals, and (e)

implementation process (Damschroder et al., 2009, 2022). The barriers and facilitators will be coded to constructs within these five domains.

Implementation Strategies

The ERIC taxonomy will be used to code the identified implementation strategies. The ERIC taxonomy was developed by Powell and colleagues (2015) through a modified Delphi process to produce a compilation of 73 discrete strategies and their definitions. Since its conception, it has been further categorized into nine thematic clusters (Waltz et al., 2015). The ERIC taxonomy has also been considered explicitly for de-implementation (Ingvarsson et al., 2022) and sustainability strategies (Nathan et al., 2022). Coders will initially map each strategy to one of the nine thematic clusters: (a) engage consumers, (b) use evaluative and iterative strategies, (c) change infrastructure, (d) adapt and tailor to the context, (e) develop stakeholder interrelationships, (f) utilize financial strategies, (g) support clinicians, (h) provide interactive assistance, and (i) train and educate stakeholders (Waltz et al., 2015).

Alignment of Implementation Strategies with Contextual Determinants

After coding the strategies and contextual determinants, the CFIR-ERIC mapping tool developed by Waltz and colleagues (2019) will be used to determine whether the appropriate strategy was selected to address the identified barriers. The tool was developed by expert consensus and uses barriers identified using the CFIR, prioritizes them, and matches them to strategies in the ERIC taxonomy (Waltz et al., 2019). The mapping tool is downloadable as an Excel file into which barriers categorized by the CFIR can be entered, and a prioritized list of ERIC taxonomy implementation strategies will be produced. The strategies all include a percentage representing the number of experts who felt the strategy to be among the top seven best to address a particular barrier (Waltz et al., 2019). The tool will be used to enter the coded barriers. The output of the strategies will then be used in a comparison matrix to compare to the included literature to determine if the appropriate strategy was selected.

Implementation Outcomes

Given their importance to understanding both the implementation success and how the implementation process drives clinical and health system outcomes, implementation outcomes will be coded using the Outcomes for Implementation Research (Proctor et al., 2023). These eight outcomes were developed from narrative review and through iterative discussion in an expert working group. The eight outcomes include acceptability, adoption, appropriateness, feasibility, fidelity, implementation cost, penetration, and sustainability (Proctor et al., 2023).

Presentation of Results

Results will be presented numerically through frequency counts and percentages, in addition to tabular format where possible. Figures will be created to visualize how the strategies map to the clustered ERIC taxonomy and how barriers and facilitators map to the CFIR. The alignment of the strategy with the identified barriers and facilitators (using the ERIC-CFIR mapping tool) will be displayed in tabular form. Narrative summaries will accompany all data to describe how it relates to the identified objectives of the review.

Scoping review findings will be shared with health care professionals to provide insight into caring for kidney transplant recipients and guide their selection of implementation strategies to support the uptake of evidence-based interventions for improved patient outcomes. The scoping review protocol has been presented at multiple national conferences and meetings. The scoping review findings will be shared at a knowledge translation (KT) implementation research conference.

Locally, results will be disseminated through seminar series or lunch-and-learn events to reach academics and clinicians. The review findings will uncover evidence gaps to inform future implementation research efforts in this area as part of a multi-phase study supporting evidence-based interventions in kidney care. Finally, documented use of the CFIR-ERIC will add to the evidence on determinant-strategy mapping, an area of implementation science requiring further exploration.

Interprofessional Health Education (IPHE) Implications and Conclusion

Implementing EBIs often involves collaboration between several health disciplines to ensure adoption and sustainability of the intervention in practice. Understanding the role and scope of each profession is critical to understanding how health professionals can work together to improve health outcomes. Implementation science is often used by researchers and health care professionals from varied clinical backgrounds. Further, the frameworks and taxonomies employed in this scoping review are useful for supporting interprofessional practice. The CFIR domains and constructs have been used to map barriers and facilitators to interprofessional practice in primary care (Grant et al., 2024). The ERIC taxonomy provides several implementation strategies that can be used in interprofessional practice, such as conducting local consensus discussions or education meetings, creating new clinical teams, or promoting network weaving (Powell et al., 2015). This review will capture current interprofessional practice involving implementation strategies, providing insight into future directions. Integrating implementation science into IPHE provides students with pragmatic ideas and tools to collaboratively improve patient and health system outcomes.

The proposed scoping review will reveal implementation science gaps and opportunities in kidney transplant. The findings will support health care professionals in collaboratively caring for kidney transplant recipients. Firstly, it will characterize current barriers to and facilitators for implementing EBIs into practice, which health care professionals can consider for their local context. Second, it will describe implementation strategies currently used across kidney transplant care. Finally, it will consider the appropriateness of implementation strategies in addressing identified EBI implementation barriers. Overall, the review findings will support the selection of implementation strategies to support the uptake of EBIs across kidney transplant care and beyond.

Acknowledgements

We would like to thank Melissa Rothfus for help with the search strategy development.

Conflict of Interest

No conflict of interest.

Funding Statement

No funding connected specifically to this work.

Declaration of Ethics

Ethics not needed for scoping review protocol.

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Appendices

Appendix A: CINAHL Search Strategy – January 2025

Search	Query	Results
S1	(MH "Kidney Transplantation")	13,159
S2	TI ("kidney transplant*" OR "renal transplant*") OR AB ("kidney transplant*" OR "renal transplant*")	12,204
S3	S1 OR S2	17,193
S4	TI (implement* OR intervention OR adopt* OR adapt* OR uptake OR integrat* OR embed* OR innovation OR translat* OR program OR strateg* OR “evidence-based-practice” OR “evidence-based-intervention” OR disseminat* OR support* OR encourag* OR foster OR enforc* OR incentiv* OR enable* OR facilitat* OR advance* OR promot* OR de-implement* OR sustain* OR abandon* OR deadopt* OR deimplement* OR replace* OR change) OR AB (implement* OR intervention OR adopt* OR adapt* OR uptake OR integrat* OR embed* OR innovation OR translat* OR program OR strateg* OR “evidence-based-practice” OR “evidence-based-intervention” OR disseminat* OR support* OR encourag* OR foster OR enforc* OR incentiv* OR enable* OR facilitat* OR advance* OR promot* OR de-implement* OR sustain* OR abandon* OR deadopt* OR deimplement* OR replace* OR change)	2,652,334
S5	TI (“evidence-based-practice” OR “evidence-based-intervention” OR treat* OR prescrib* OR procedure* OR intervention* OR therap* OR technolog* OR care) OR AB (“evidence-based-practice” OR “evidence-based-intervention” OR treat* OR prescrib* OR procedure* OR intervention* OR therap* OR technolog* OR care)	2,905,124
S6	S3 AND S4 AND S5	3,734

Appendix B: Data Extraction Instrument

Study Characteristics/Demographics							Implementation Strategies			
Author	Publication Year	Country of Origin	Study Citation	Study Design	Study Setting	Implementation Intervention (summary)	Implementation Strategy	Target (patient, health care professional [define role e.g., nurse, pharmacist, doctor.], health system)	Purpose (adoption, implementation, sustainability, de-implementation)	Coding—clustered ERIC taxonomy

Contextual Determinants				TMF		Outcomes	
Patient-identified barriers or facilitators	Provider-identified barriers or facilitators	Study Research Team-identified barriers or facilitators	Coding—CFIR	Informed by Implementation Theory, Model, or Framework (TMF)	Which TMF?	Study Outcomes—Implementation, Clinical, or Service System Outcome(s)	Coding—Proctors Outcomes

Knowledge-User Engagement		Equity, Diversity, Inclusion	
Presence (Yes/No)	Summarize engagement	Was EDI Considered?	Summarize considerations

HPJ HEALTHY POPULATIONS JOURNAL

Research Article

You Were Selected for Your Lived Experience: A Love-Centered Evaluation from the Perspective of Teaching Assistants in an IPE Course in Higher Education

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DOI: 10.15273/hpj.v5i1.12352

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Abstract

Introduction. While teaching assistants with diverse backgrounds are subject to biased evaluations and perceptions of capacity due to race and gender, academic perspectives and emotional and psychological impacts of teaching on diverse teaching assistants is lacking. **Objective**. Applying post-qualitative methods of writing and autoethnography, three PhD level teaching assistants applied a love-centered program evaluation to assess whether they have what they need to facilitate an online asynchronous IPE on allyship. **Methods**. Over the course of five weeks, the teaching assistants met to discuss a need for this work, designed, and completed the program evaluation. Core evaluation activities included writing a series of self-addressed love letters and meeting for group reflections on the teaching experience and the content of the love letters. **What Emerged.** Systemic barriers to engaging left the teaching assistants feeling less effective than they had desired. The lack of training and ongoing support systems led to experiences of unanticipated harm. **Conclusion**. This evaluation aligns with research that suggests that structurally marginalized teaching assistants may require additional support to do their work without harm. Hiring and fairly compensating a small group of teaching assistants to design and deliver a curriculum that aligns with their values and is structured according to realistic learning outcomes may be one way to reduce the harm experienced by teaching assistants facilitating an allyship course.

Keywords: post-secondary, writing as method, post-structural, program evaluation, allyship

It is impossible to teach without the courage to love, without the courage to try a thousand times before giving in. In short it is impossible to teach without a forged, invented, and well-thought-out capacity to love.

- Paulo Freire, Teachers as Cultural Workers: Letters to Those who Dare to Teach, 1998

Introduction and Background

Most often, teaching assistants (TAs [plural]; TA [singular]) are themselves graduate students in need of additional sources of income and teaching experience to build their academic resumes "yet their academic perspectives are underrepresented in current literature" (Tindell et al., 2016, p. 158), with existing evaluations of TA experiences lacking "a deep understanding of individual experiences and contextual factors" (Xu, Lei, & Sexaki, 2024, p 4092). While teaching can be a rewarding learning experience, the majority of literature exploring TAs' experiences focuses on understanding the connections between training and performance with little exploration of the psychological or emotional impacts of teaching (McDonald et al., 2023). With a "consistent bias toward instructors based on race and gender", graduate-level TAs from BIPOC and LGBTQAI groups are at increased risk of harm and/or unfounded negative evaluations from their students while performing their teaching duties (Guffin, 2024, p. 14). For instance, it has been noted that students may perceive TAs teaching social justice courses "who hold minoritized identities as having an agenda to advocate for their own groups," which may introduce an unfair bias towards TAs, leading to their teaching being disregarded (Guffin, 2024, p. 23). Considered to be a different relationship than friendship or intergroup/shared identity relations, allies have been defined as an individual from a dominant group who "work to end prejudice" and group-based privilege in their personal and professional lives by supporting individuals from non-dominant groups (Brown, 2014, p. 713). To the authors' knowledge, the experiences of TAs who may need an ally (e.g., being from a non-dominant group) while simultaneously teaching an interprofessional education (IPE) course on allyship, have not been explored.

IPE is a term used to describe a learning environment where students from two or more professions engage in learning with, from, and about each other (Ford & Gray, 2021; Rutherford-Hemming & Lioce, 2018). Shared goals of improving the quality of care and services to enhance patient outcomes and experiences guide learning situations designed to prepare students to engage in interprofessional collaborative practice (Canadian Interprofessional Health Collaborative, 2024; Khalili et al., 2021). The design, implementation, evaluation, and intended goals of an IPE experience must consider the available resources at the organization, faculty, and learner levels.

With a lengthy history of IPE, Dalhousie University provides accredited training for over 20 health professions across the faculties of Health, Medicine, and Dentistry. While the quantity and diversity of programs are fertile ground for the designing and delivering of IPE across the continuum of care, it also presents challenges ensuring those delivering IPE curriculum are well supported and have access to necessary training and resources to meet varied accreditation standards (MacKenzie, Sponagle, & Sibbald, 2024a). A recently released Open Educational Resource at Dalhousie outlines the need to plan for evaluation of IPE experiences. Despite TAs being frequently tasked with overseeing the implementation of the IPE curriculum, the need to include teaching assistants in the evaluation plan is not mentioned (MacKenzie, Sponagle, & Sibbald, 2024b).

To centre the internal psychological and emotional experiences of diverse TAs teaching an IPE on allyship in a way that recognized the inherent difficulties of being a TA, three PhD-level TAs completed a love-centered program evaluation drawing on autoethnographic writing methods in a post-qualitative paradigm. Thus, the purpose of this evaluation is to assess whether 3 PhD-level TAs

selected in part due to their markers of diversity (e.g., skin colour, sexual orientation, gender), have what they need to facilitate an online asynchronous IPE on allyship. Resting on the premise that not only is it impossible to teach without the courage to love, but to do so, one requires a well-thought-out-capacity (hooks, 1994), the evaluation question "Do we have what we need to be a TA in an online asynchronous IPE on allyship?" is an evocative one. Rooted in care for the self, the evaluation question prompts reflections deeper than logistics, trainings, and self-efficacy to get at the emotional and psychological needs and thus the well-being of structurally marginalized PhD students tasked with teaching how to work towards allyship.

Guiding Theories and Methodology

Grounded in the post-qualitative paradigm, this program evaluation uses autoethnography and Richardson's and St Pierre's 'writing as a method of inquiry' (2000) to assist the TAs in reflecting on and thinking through their experiences. Inquiry in a post-qualitative paradigm resists well-known qualitative methodologies of data collection (e.g., focus groups, interviews, observations), analysis (e.g., coding, generating themes), validity (e.g., member checking, objectivity) and field (e.g., participant observation, ethnography) (St. Pierre, 2021; 2023). Typically undertaken by researchers trained in qualitative research who recognize when their training may not align with the questions they are invested in, the post-qualitative paradigm is not another version of qualitative research.

As a method and form of research that aims to be evocative and personal, autoethnography uses writing to "draw upon the experience of the author/researcher to extend sociological understanding" of a concept or phenomenon (Denshire, 2014, p. 832). Thus, in autoethnography, the researcher and participant are the same person and employing 'writing as a method of inquiry' is one way for the researcher to disrupt an established way of writing common in and thus move beyond a qualitative paradigm (Richardson & St. Pierre, 2000).

The 3 PhD Teaching Assistants

Born Canadian, raised Australian, with Guyanese heritage - a daily sentence alongside "the accent is Australian". I am Joshua (he/him), not Joseph. Ambiguously racialized and large, for the longest time my sense of belonging was fractured by my daily interactions. I'm on a long journey of learning and resisting the anecdotal positive correlation between age and mental rigidity.

My name is Arezoo, and I see myself as someone who lives in the in-between spaces where identity, culture, and experience come together in ways that don't always fit into labels. As a woman and an international student from Iran, my journey has been exploring new places, learning, and growing. When people ask who I am, I'm a curious thinker who wants to make healthcare fairer and more inclusive, especially for those whose voices are often overlooked. My view of the world is shaped by feminism, and I'm committed to being an ally by listening, learning, and staying open to change. I use she/her pronouns and welcome moments that help others think about language and identity. My journey is to understand myself and my place in the world, guided by my hope for a kinder, more compassionate world.

"I like to think of myself as a testosterone addicted lesbian which would I guess, by default, place me into the category of trans. In answer to the question 'gender?' I say, 'oh no, none for me thanks' and claim the sought after status of a mentally ill, chronically pained, queer killjoy feminist living with the invisible disablement of gendered and sexual trauma" says ivan. In recognition of others' need for language and thus, pronouns, ivan leaves that choice up to the speaker in hopes it serves as an opportunity for the other to examine their choices. It is a gentle, ongoing process.

Description of IPE: Setting and Expectations

The purpose of the IPE allyship course is to assist students with a future working in health and health-related fields in learning about what it takes to be a good ally. The course takes the form of an online, asynchronous 3-week course, where each week covered a different module introducing the students to concepts they were asked to critically reflect on. Students were tasked with reading a curated list of materials and engaging in discussions using online discussion board posts in response to learning materials and to each other. As TAs, we were tasked with setting up groups and monitoring the student engagement. Tracking the number of discussion posts and checking whether students had opened/clicked on material in the online portal were the main measures of accountability that TAs were tasked with collecting to ensure students were completing the work. Student groups in the IPE were kept to 4-5 members to maximize engagement.

The initial meeting amongst the TAs and the main supervisor for the course provided an overview of the online portal along with an explanation of expected tasks and responsibilities. The main responsibilities tasked to the TAs were monitoring student interactions in a discussion forum intended to support engagement with a pre-existing curriculum on allyship. The supervisor articulated how the TAs had been curated as part of a roster of teaching assistants with "lived experiences about the topics at hand." It was noted by the supervisor that historically, comments that perpetuated racism, ableism, sexism, classism, or other stigmas, 'isms' or 'obias' were not observed in this course, but should something come up, the TA could bring it to the supervisor's attention for discussion and/or action. Training such as the provision of examples or case studies that might help the TAs identify such comments as opposed to general education to support the development of an ally were not offered. Lacking were strategies or resources on how the TAs, members of equity seeking groups themselves, might care for themselves should comments touch on past negative experiences or trauma were also not offered. The idea for this evaluation emerged after this introductory meeting.

Designing a Love-Centered Program Evaluation

As a program evaluation, research ethics board approval was not required (Dalhousie Research Ethics, 2024). A love ethic in teaching is rooted in the pedagogical praxis of Paulo Freire (1970) and bell hooks (2000) and, for the purposes of this program evaluation, can best be understood as (1) finding "the strength, faith, and humility to establish solidarity and struggle together to transform the oppressive ideologies and practices of public education" (Darder, 2002 p. 91); and (2) acknowledging that to engage in the work of loving others we must, as a first task, do the work needed to love oneself (hooks, 1994). This understanding was used to design an evaluation process that uses the act of love letter writing intended to identify unmet needs, assist with communicating such needs, and evaluate the experience of TAs recruited to teach an IPE course on allyship. To account for the varying level of familiarity that each TA has with engaging in a love ethic as a pedagogical practice, a semi-structured letter-writing guide was developed in advance (Appendix A). The intention is to focus writings on what the TA might have needed to feel supported to do their work. The letter-writing guide served as a reminder for TA to extend the practice of love inwards and, in the face of multiple demands, avoid a situation where the evaluation might be reduced to another task on a long list of 'to dos.' Whatever the TA was able to articulate in the letter would be considered sufficient for the purposes of the evaluation and the exercise itself was noted as a powerful starting point to learn to live differently and perhaps, how to love (Lorde, 1997). Table 1 summarizes the evaluation design.

After the first meeting with the course supervisor, the three TAs met two additional times to discuss initial challenges and offer each other support. During these two meetings, the TAs: decided

to design a program evaluation, outlined the framework for the evaluation, and set up future meeting times to collectively complete the work. The group decided that they would write at least two love letters each: One prior to the start of the course to assess what it was that they might have needed at that time and one at the end/completion of the three-week course that would allow for the TAs to reflect on whether their pre-course needs were met while reflecting on their experience overall. A timepoint for a third letter during the second week of the course was discussed as a midpoint check-in after TAs would have met all students and engaged with their week 1 responses and was identified as optional, being based on the needs and capacity of the TAs. Strict adherence to the letter template was not required and the aim was to make this process generative and supportive. There was no limit on the number of letters that they could write. As TAs were not expected to know what their needs were in advance of writing (consistent with 'writing as a method of inquiry'), permission was given during the writing process to allow meaning to emerge. To remove any fear of judgement, there were no expectations of sharing the contents of our letters. This meant that the analysis would be primarily done orally, in group discussions, allowing each TA to share as much or as little as they felt able to. Discussions were centered around (a) the process of the program evaluation and the experience of writing love letters as a way to evaluate a program and (b) the content of the letters themselves by way of reflecting on the question "Do we have what we need to be a TA in an online asynchronous IPE on allyship?" Each TA took a turn sharing. The two listening TAs took notes during this time. Point form notes were then put into a shared document and used to structure the writing of the results.

Table 1.
Evaluation Design

Pre-Course	**During Course**	**Post-Course**
First meeting with course supervisor	Optional love letter	Writing at least one love letter each
Two 90-minute meetings amongst 3 TAs	Weekly email check-in from ivan and reminder to reflect and/or write a letter	Three 90-minute meetings amongst 3 TAs to discuss and write results
Writing at least one love letter each		Email communication and live document sharing to write results

Recognizing our place in a hierarchical institution, certain methodological decisions were collectively made amongst the three PhD TAs in advance of the evaluation to create a situation where vulnerability and honesty could be first had in private without any forced sharing as such. Thus, letters written to oneself were determined to be first our inner workings, a journey on the page and second-data. The decision to conduct this evaluation independent of the TAs' supervisors was done to maximize privacy and confidentiality of the TAs who could be sharing vulnerable and personal information about their experiences. The intention was to invite the course supervisors to read/engage with this program evaluation as a starting point for further discussion about potential change. Such an approach values relationships and differs from evaluations that may provide recommendations from a position of expert. The TAs acknowledge that providing recommendations for change in a program or an aspect of a program may be insufficient but nonetheless, is a place to begin.

What Emerged

Table 2 summarizes the number of letters each TA wrote per week/time-period and throughout the course. Collectively, the three TAs wrote 8 letters and reached the goal of two letters each at the pre-determined pre/post time points.

Table 2.
Number of Letters per TA per week

	Pre oct 14	Week 1 oct 14-20	Week 2 oct 21-27	Week 3 oct 28-nov 3	Total per TA
ivan	1	1	1	1	4
Arezoo	1	0	0	1	2
Joshua	1	0	0	1	2
Total per week	3	1	1	3	8

On the Process of Love Letter Writing as Program Evaluation
What did the letters allow us to do? How did they do it?

Collectively, the TAs noted that none of them had prior experience engaging in a love letter writing process to evaluate a program or to assess their experience as a TA. Joshua shared how his past experiences with meditation had often left him feeling less grounded or frustrated, but with the additional prompts to ground the reflection process in a praxis of love, he noticed a sense of peace and a slight reduction in tension and stress with the activities. Arezoo appreciated the opportunity to write in a kind manner, to herself, in a way that created space to not just consider but validate her needs and experiences. She found the process to be open and honest.

Holding a regular writing practice, ivan felt at ease with the process of writing love letters and was surprised at how many letters they felt compelled to write throughout the course, taking this as an indication that the course had a stronger, more negative impact on their well-being than ivan had ever thought it might. For ivan, love letter writing with the prompts in the writing guide was structured enough to settle into a letter without dictating what emerged from their writing or what types of things they had to write about. As such, writing the letters allowed pre-existing feelings of despair and helplessness that would have otherwise been dissociated from or perhaps not asked about, to surface.

Through an embodied, love-centred praxis, writing the letters helped the TAs to sit with difficult emotions and experiences during the course long enough to be able to identify and name structural aspects of the course that made it challenging for them to engage as a TA. While questions that might get at what the TAs would change or do differently may also evoke similar responses, a love praxis validates the real emotional impact that asking 'what could be done differently' approach does not necessarily invite into the reflection.

On Whether we Felt Our Needs were Met
What did a love-centred program evaluation reveal about our needs as TA? What did it reveal about the course?

Overall, the TAs acknowledged that the concept of allyship and who was/was not or who could/could not be an ally was difficult to define. While it was understood that the process of 'working towards allyship' could not be standardized or achieved in a static, all-or-none fashion, no training was provided to the TAs before the course to help them understand the concept of allyship within the course. The TAs felt as though it was assumed, by the course coordinators, that, based on their structurally marginalized identities, they would have a working knowledge of what would be required of an ally and thus were best positioned to act as a TA for this course. The positioning of the TAs as lived experts in discrimination and thus knowledge holders of what is required of someone to be an ally contradicted with the lack of agency the TAs felt in the course. Overall, the TAs did not have an opportunity to structure the course or design the curriculum and noted situations where the practice of allyship could not be realized within the course itself. That students were not required to engage with or respond to TA comments meant that students did not have to do so to pass the course.

This lack of requirement led to it being TAs who were typing into the void, limiting the influence of the TAs to one of monitoring and surveillance to ensure that students completed the pre-determined number of engagements (e.g., posts and responses to others' posts), and did not say anything offensive. What was considered offensive or could be determined as requiring deeper engagement with a student was, like the concept of allyship, not defined or discussed in advance of the course. The simultaneous acknowledgement of lived expertise of what it is like to be discriminated against on account of structural marginalization was positioned as sufficient training to deliver a course on allyship. In a sense, this love-centred program evaluation emerged in response to a series of unmet needs revealing that recruiting TAs based on social identities may lead to additional harms, even if unintentional.

For the Teaching Assistants

For Joshua

A hexadecimal colour code, #C9A38F, is the title of my first love letter and reflects a sense of value prescribed to me in an initial meeting about the course. Similar to how the Eye Dropper extension on an internet browser assigns a value to an area of a picture, the eye of the instructors assigned a value to the teaching assistants. Knowing that the teaching assistants had been purposefully selected based on our appearances or outward identity markers, not necessarily what it is we could do, I was left with mixed feelings. I was left with a sense of having a certain level of lived expertise while also carrying a burden of not knowing all there is to know about allyship, exactly what my limits were and how this mix might lead to potential harm.

While I wrote two reflections, I spent much more time thinking about the course, how it operated, and whether my needs were met so that I could participate as a TA in this course. The reflections acted as a protected time for me to assess my capacities in general. Sitting down to reflect, I found that I "mapped out" all the extra labour that felt necessary for me to fit in, be valued, and producing enough to feel secure. This mapping helped me think about how my role as a TA in this course felt like another extra, something that was not in line with my interests, desires, skills, experiences, or needs but that I took on because I felt I had to or else I would lose out in the future.

As the course progressed, I began to question how the germination process of supporting the growth of healthcare professionals who value allyship was sown. The short time frame of three weeks may have unintentionally simplified the concept of allyship, and the linear nature of the course made me question the potential harm of valuing quantity over depth and meaningful engagement. Engaging in reflexive letter writing provided an avenue of expression for whether I thought my needs were being met and how the course may be influencing interprofessional learning on allyship. Existing alongside an increasing sense of burnout and fatigue, these deliberate reflections prompted broader investigation into the commitments and roles I had assumed during the academic term.

For Arezoo

Through this love-centered program evaluation, I found it challenging to articulate what I needed to effectively support student learning. For example, the concept of "privilege" was new to me, and while the materials provided an introduction, I struggled to fully understand its meaning and implications within the context of the course. I felt I needed more in-depth training to confidently moderate discussions and engage with the topic empathetically, which left me feeling less effective in supporting students than I had hoped. The short three-week duration of the course further compounded this, making it difficult to grasp complex concepts like privilege and allyship. I came to realize that allyship is not just a task to check off but a continuous process of learning and engagement, yet the course structure did not fully support this perspective, leaving me uncertain about how to navigate these challenges.

One example of this disconnect was the mandatory video introductions, which offered no alternatives for students who felt uncomfortable participating in this way. This lack of accommodation seemed at odds with the principles of allyship and left me disappointed that I didn't have the tools or agency to better support students in finding approaches that worked for them. It felt counterintuitive to require participation in ways that didn't meet all students' needs, and as a TA, I wished for more opportunities to foster genuine connections and co-learning. By the end of the course, I still felt unclear about how to meaningfully define and teach concepts like privilege and allyship. Moving forward, I believe that more preparation, training, and structural changes in the course would better equip TAs and students to engage deeply and meaningfully with these important topics.

For ivan

Re-visiting my love letters, I noticed an evolution of emotion that shifted throughout my experience of being a TA in this course. Before the start of the course, I was uncertain about how my role might surpass that of tallying student responses and remained open to the possibility that I might be able to draw from some of the expertise that I had been told I was recruited for (first letter). As I continued to engage with the material and student responses to it, feelings of deception and anger surfaced in my second and third letters. I felt deceived about the reason for my recruitment and started to wonder if it was the inclusion of my own structurally marginalized identity, not me, that became a marker of allyship, of a well-run course. I pinpointed the anger as coming from a feeling of being used in primarily two ways. First, I felt as though my identity had been positioned as a level of lived expertise that served to demonstrate the institution's commitment to allyship while second, this positioning could absolve the institution's need to offer training and support in the concept of allyship and/or what might be a problematic viewpoint and how to deal with it. It was my third love letter, during the second week of the course where I came to understand that the course was structured in a way that actually discouraged students from engaging with my comments. Because I would be commenting at the end of a week, once students had completed a module, and they were only required to engage with their peers, not the TA, students would have to complete additional, non-required labour by returning to a completed week to interact with my comments after other requirements were complete.

A re-emerging contradiction was the lack of pre-course training and assurance that students are generally respectful left me unprepared for the level of discomfort that I experienced at the student responses. Regardless of a student's experience or the program they were in, they were tasked with engaging with and responding to the same materials. Course material pointed students towards reflecting on their social location and privileges before evoking reflections on what it means to be an ally. In addition to this structure supporting a thinking that to be a professional means you are inherently privileged, markers of identity became aligned with a lack of privilege suggesting that to be disabled or to be queer (for example) is to suffer and that a well-meaning ally can avoid further harm. That it is systems of domination and oppression that, through assigning value to certain types of humans or ways of being, create inequities and bestow privileges was not a focus of discussion. And so, while true, no one outwardly used slurs or made jokes at the expense of any one group, that students were encouraged to think about how they could, through individual, short-term (e.g., one-on-one client) interactions not continue to benefit from their privileges or how this might excuse them from solidarity work to enact material changes to the lives of people they will be working with filled me with sadness. That I was unable to engage with these students in meaningful conversations about these dynamics led to despair. Without having reached out to the other two TAs to debrief and engage in a shared experience of love letter writing, the harm I encountered from this experience would have been worsened by isolation.

Conclusion

In some ways, this program evaluation emerged as an opportunity for the TAs to create a circle of care while also engaging in a real-time experience of allyship that dismantles misconceptions that allies must always or most often come from positions of privilege. By engaging in a love-centered program evaluation, three TAs tasked with facilitating an asynchronous online course on allyship were afforded an opportunity to reflect on whether the course curriculum and structure aligned with their values and met their needs. Such reflections can help understand and encourage program evaluation metrics that extend beyond learning outcomes to include unintended consequences such as harm to those expected to teach.

In courses on concepts of allyship where the courses rest on an assumption that structurally marginalized folks are subjected to higher levels of inequity, through the sharing of unmet needs by the TAs this evaluation suggests that it may not be fair to expect that such negative experiences dissipate once a person enters the role of TA or other position deemed to be one of privilege. Current teaching structures may be inadequate to meet the needs of diverse TAs selected in part due to their markers of diversity. Hiring and fairly compensating a small group of TAs to design and deliver a curriculum that aligns with their values and is structured according to realistic learning outcomes may be one way to reduce the harm experienced by TAs facilitating an allyship course. Such a move would offer the TAs more agency, value their lived expertise through action, not just words, and establish a circle of support amongst the TAs as they navigate topics of discussion that may evoke feelings of discomfort or cause harm to learners and educators alike. Fostering less reactive spaces that allow for practicing skills of conflict resolution and critical thinking about our role in systems of oppression and domination are noble roles that academic institutions can play.

Conflict of Interest

The authors have no conflict of interest to declare.

Funding Statement

This project did not receive any funding.

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Appendices

Appendix A: Letter Writing Guide

Please take a moment to begin with a short meditation that can look like one of the following:

1. Engage in a meditation practice that you might already have
2. Choose one of the following guided meditations from Rhonda V Magee
3. Listen to one of these songs by renowned Michi Saagiig Nishnaabeg scholar, writer and artist, Leanne Betasamosake Simpson
4. Read some of your favourite poetry
5. Engage in a breath meditation either using an app or from the list offered by The Free Mindfulness Project

Take a moment and reflect on bell hooks' definition of love. Were any of the components missing from your experience of being a TA? For instance, were there times that you did not feel cared for or like there was a lack of respect or responsibility towards you? If so, can you identify (a) how you knew this/what brought your attention to this lack and (b) what you may have needed instead?

Definition of love

bell hooks defines love as a: combination of care, commitment, trust, knowledge, respect, and responsibility, must inform the act of extending "oneself for the purpose of nurturing one's own or another's spiritual growth" (hooks, 2001, p. 6).

Component	Brief Description
Care	Does not equate to love, can exist without love. It is the act of doing what one can to meet the needs of another person.
Commitment	Consistency in showing up, being present, being honest; including communicating when your capacity to commit shifts.
Trust	Essential for justice and intimacy, trust requires a degree of vulnerability and courage.
Knowledge	Learning about and with the self and others. This type of knowledge is a way of knowing, a form of recognition and an acknowledgement of the self and others.
Responsibility	A way to hold ourselves and others to account without blame, shame, or judgement. Also essential to justice, we pledge to do what we can to steward our connections to ourselves and others.
Respect	An honouring of our own inherent dignity and humanity and that of others. A relinquishing of all that serves to humiliate.

Letter Writing

You may write a love letter to yourself (e.g., a letter of self-compassion, link to example) or to someone else (e.g., the author of a post, the TA supervisor, Dalhousie as a whole) articulating what brought your attention to a 'lack' or a difficult experience and what you may have needed in that moment. Please know that this letter can take whatever form you wish. Handwritten, typed, an audio

journal, a series of bullet points, a poem, a drawing, a collage, a series of photographs. Please let it be as easy as possible. It should not add burden or distress to your day.

Question reminder: “do we have what we need to be a TA in an online asynchronous IPE on allyship?”

Acknowledgements

Thank you to all the reviewers, authors, and readers of HPJ!

A special thank you to Dr. Sara Kirk and Dr. Diane MacKenzie for their support with this issue.

Funding Support

Healthy Populations Institute

Anne Marie Ryan Teaching and Learning Enhancement Grant from the Centre for Learning and Teaching at Dalhousie University

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