

Home Sweet Home: A Program Report on Promoting the Uptake of Home Dialysis

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Abstract

Purpose of program: Canada's growing prevalence of people with kidney failure receiving kidney replacement therapy has necessitated the expansion of dialysis programs. Although facility-based hemodialysis is the predominant dialysis modality in Canada, it is substantially costlier than home dialysis (peritoneal or home hemodialysis). Initiatives to increase the uptake of home dialysis typically consist of didactic and experiential education. We describe a novel local initiative, Home Sweet Home (HSH), where individuals with lived experience of home dialysis and kidney health professionals share their experience and knowledge with participants in a clinic setting that has been set up to represent a metaphorical home. The aim of this report is to describe our HSH program and to evaluate its acceptability and reach for future scale and spread. We also explored home dialysis uptake among program participants.

Sources of information: We collected feedback from attendees following each HSH event with anonymized surveys. We obtained clinical and demographic data and modality at follow-up from 2 linked databases, the Canadian Organ Replacement Register (CORR) and a regional clinical database, the Nephrology Information System (NIS).

Methods: Reach was evaluated according to modality (i.e., the proportion of participants who were non-dialysis dependent vs the proportion receiving facility-based maintenance hemodialysis) and the proportion living remotely (defined as greater than 200 km from the event). We examined acceptability as the proportion who were interested in a home therapy (either peritoneal dialysis, home hemodialysis, or both) after attending the event. Demographic data and survey data were summarized with counts and percentages. Free text from surveys was collated and summarized. Participants were followed from the time of program attendance until June 21, 2022 or death.

Key findings: A total of 291 participants attended HSH between 2015 and 2019. At the time of program attendance, 70% of participants had chronic kidney disease (CKD) not requiring dialysis (CKD G4-5ND) and 30% had CKD G5D on facility-based maintenance hemodialysis. Participants were primarily urban dwelling (ie, in Edmonton). After the event, 92% of participants indicated they were interested in a home dialysis modality. From the survey free text, participants commonly expressed that they valued the “first-hand information” and a “real life perspective” from HSH facilitators and the simulation helped to ease anxiety about home dialysis. Participants expressed a desire for longer HSH events with more opportunities to ask questions. At a median follow-up of 858 days (interquartile range = 353-1347), 18% of the cohort remained dialysis independent and 25% died. Of the remaining 167 participants, N = 41 (25%) were receiving a home dialysis modality (either peritoneal dialysis or home hemodialysis), N = 40 (24%) received a kidney transplant, and N = 86 (51%) were dialyzing with facility-based hemodialysis.

Limitations: A more in-depth understanding of how the HSH program influenced decision-making for home dialysis could be attained from interviews and focus groups. No causal inferences can be made regarding the uptake of home therapies and HSH attendance. We did not have data on who received a home therapy prior to the last recorded modality at follow-up, which likely underestimated the use of home therapies.

Implications: The HSH program was highly acceptable with 92% of participants reporting they were interested in a home modality. The reach of HSH could be improved by recruiting more individuals from facility-based hemodialysis and rural and remote locations.

Abrégé

Objectif du programme: Au Canada, la prévalence croissante des personnes atteintes d'insuffisance rénale recevant une thérapie de suppléance rénale a nécessité l'expansion des programmes de dialyse. L'hémodialyse en centre demeure la modalité prédominante au Canada, mais elle est beaucoup plus coûteuse que la dialyse à domicile (dialyse péritonéale



ou hémodialyse à domicile). Les initiatives visant à accroître l'adoption de la dialyse à domicile consistent généralement en de l'éducation didactique et expérientielle. Nous décrivons une nouvelle initiative locale, Home Sweet Home (HSH), où des personnes ayant un vécu expérientiel de la dialyse à domicile et des professionnels de la santé rénale partagent leurs expériences et leurs connaissances avec des participants dans un cadre clinique aménagé de façon à représenter un foyer. Cet article décrit notre programme HSH et l'évaluation de son acceptabilité et de sa portée en vue de sa propagation et de son éventuel déploiement à grande échelle. Nous avons également exploré l'adoption de la dialyse à domicile chez les participants au programme.

Sources de l'information: Les commentaires des participants après chaque événement HSH ont été recueillis par l'entremise de sondages anonymes. Les données cliniques et démographiques, ainsi que les données sur la modalité lors du suivi ont été obtenues à partir de deux bases de données couplées, soit le Registre canadien des insuffisances et des transplantations d'organes (RCITO) et une base de données cliniques régionale, le Nephrology Information System (NIS).

Méthodologie: La portée du programme a été évaluée selon la modalité (c.-à-d. la proportion de participants non dépendants de la dialyse par rapport à la proportion de participants recevant une hémodialyse d'entretien en centre) et la proportion de participants résidant en région éloignée (définie comme résidant à plus de 200 km de l'événement). L'acceptabilité a été déterminée par la proportion de personnes intéressées par une thérapie à domicile (dialyse péritonéale, hémodialyse à domicile ou les deux) après avoir assisté à l'événement. Les données démographiques et les données tirées des sondages ont été résumées en chiffres et pourcentages. Les réponses sous format de texte libre dans les sondages ont été rassemblées et résumées. Les participants ont été suivis du moment de leur participation au programme jusqu'au 21 juin 2022 ou jusqu'à leur décès.

Principales observations: Au total, 291 personnes ont participé à un événement HSH entre 2015 et 2019. Au moment de leur participation au programme, 70 % des personnes souffraient d'insuffisance rénale chronique (IRC) ne nécessitant pas de dialyse (IRC G4-5ND), alors que 30 % étaient atteints d'IRC G5D et recevaient l'hémodialyse d'entretien en centre. Les participants résidaient principalement en milieu urbain (Edmonton). Après avoir assisté à un événement, 92 % des participants ont indiqué être intéressés par la dialyse à domicile. Dans les questions à développement du sondage, plusieurs participants ont mentionné avoir apprécié les « *informations de première main* » et la « *perspective de personnes avec un vécu expérientiel* » données par les animateurs de l'événement HSH, et que la simulation les avait aidés à apaiser leur anxiété à l'égard de la dialyse à domicile. Les participants ont également exprimé le souhait que des événements HSH prolongés soient organisés et qu'ils comportent davantage d'occasions de poser des questions. Après un suivi médian de 858 jours (intervalle interquartile: 353 à 1 347), 18 % des membres de la cohorte étaient toujours non dépendants de la dialyse et 25 % étaient décédés. Des 167 participants restants, 41 (25 %) recevaient la dialyse à domicile (dialyse péritonéale ou hémodialyse à domicile), 40 (24 %) avaient reçu une greffe de rein et 86 (51 %) étaient sous hémodialyse en centre.

Limites: Des entrevues individuelles et des groupes de discussion pourraient permettre de mieux comprendre la façon dont le programme HSH influence la prise de décision pour la dialyse à domicile. Aucune inférence causale ne peut être établie entre l'adoption de thérapies à domicile et la fréquentation du programme HSH. Les données sur les personnes qui avaient déjà reçu une thérapie à domicile avant la dernière modalité enregistrée lors du suivi n'étaient pas disponibles, ce qui a probablement sous-estimé l'utilisation des thérapies à domicile.

Conclusion: L'acceptabilité du programme HSH s'est avérée excellente puisque 92 % des participants ont déclaré être intéressés par une modalité de dialyse à domicile. La portée du programme pourrait être améliorée en recrutant plus de personnes sous hémodialyse en centre et résidant en régions rurales et éloignées.

Keywords

home dialysis, education, uptake

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Introduction

The prevalence of kidney failure is increasing in Canada, necessitating the growth of dialysis programs. In 2022, approximately 30 000 Canadians required maintenance dialysis, a number that has grown by 50% in the past decade.¹ Despite making up less than 0.1% of the adult population, costs associated with maintenance dialysis accounts for up to 5% of annual health care expenditures, with the vast majority of costs attributable to the provision of dialysis care.²⁻⁵ More than three quarters of individuals receiving maintenance dialysis are dialyzing with facility-based hemodialysis—the most expensive treatment option, with an average estimated annual cost of \$50 000 to 60 000 per patient per year.^{1,5-8} Home dialysis, in contrast, is significantly less expensive than facility-based hemodialysis (\$20 000-30 000 less per patient per year for both peritoneal and home hemodialysis) and can offer the advantage of convenience, flexibility, and freedom to make lifestyle choices.^{5,6,8-10} Moreover, individuals performing home dialysis report greater satisfaction with care and quality of life compared with their facility-based counterparts.¹¹⁻¹⁴

Despite the economic and potential individual benefits of home dialysis, only a minority (less than 25%) of people with kidney failure in Canada are receiving a home dialysis modality.⁹ Key reasons for the underutilization of home dialysis include a lack of knowledge and inadequate pre-dialysis education.^{4,7,11} A study by Finkelstein et al¹⁵ brought to attention how almost one third of people with chronic kidney disease (CKD) have limited understanding of their condition and little-to-no awareness of their treatment options. In addition, a substantial proportion of people with kidney failure are referred to nephrologists late in their disease trajectory.^{13,16,17} Inadequate physician training and unfamiliarity with home dialysis modalities are other barriers to the provision of home dialysis.¹¹ Together, all these factors contribute to the perception that people with kidney failure may not be fully informed when deciding about their dialysis modality.^{7,13,18}

In this program report, we describe a novel approach to promoting the uptake of home dialysis for people with non-dialysis CKD (G4-5ND) and those receiving facility-based hemodialysis (HD). Our local program, named “Home Sweet Home” (HSH), is a 4-hour in-person education event facilitated by both individuals receiving home dialysis and kidney health care professionals. Individuals with non-dialysis CKD (G4-5ND), those receiving facility-based HD, and their chosen support person were invited to attend this event. Participants rotate through a number of rooms modified to look like rooms in a home with home dialysis supplies or equipment. In each room, they learn about a different aspect of home dialysis. Our aim is to describe HSH and evaluate its acceptability and reach for future scale and spread. We also explored home dialysis uptake among participants.

Methods

Standard Home Dialysis Education in Alberta Kidney Care North

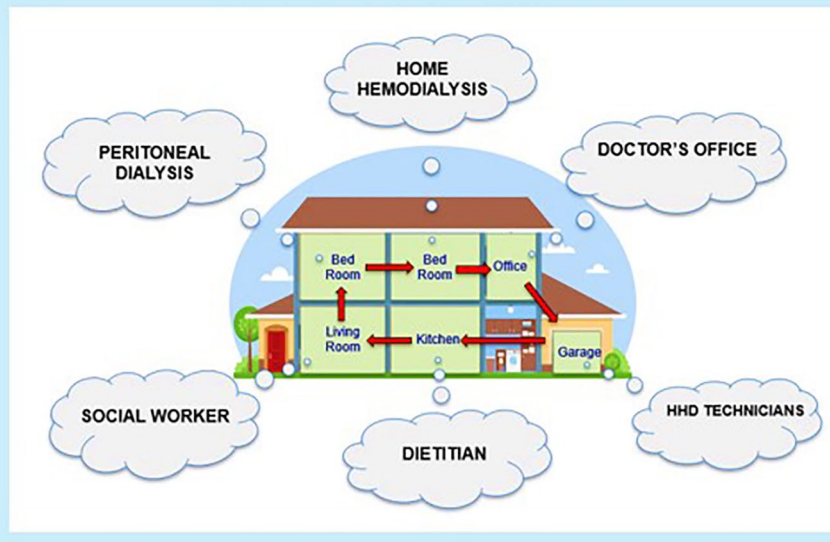
Over the 5-year period during which HSH was delivered, outpatient care delivery in Alberta Kidney Care North (AKC-N) approximated 2,500 people with CKD G4-5ND and 1700 people receiving dialysis. Of those receiving dialysis, 1200 were facility-based HD, 300 were receiving peritoneal dialysis, and 100 were on home HD. Aside from the informal modality education that nephrologists typically provide in our CKD clinic, information on kidney replacement therapy (including conservative care and transplantation) is delivered by registered nurses (RNs) in our multidisciplinary advanced CKD clinic. A provincial standardized education pathway encompasses both group introductory modality education classes and individualized one-on-one modality education, with the option of more advanced education depending on the individual’s modality preference. Educational information is relayed in a didactic format with additional visual and written materials (eg, lectures, leaflets, booklets, educational videos, and web-based content).

The Home Sweet Home Program

The HSH extended from April 2015 until September 2019 and was suspended in 2020 due to the COVID-19 pandemic. The HSH is a regional initiative that was developed by AKC-N stakeholders (managers, nurses, and nephrologists) in response to the growing financial and health care demands of facility-based maintenance HD. In contrast to previous models of dialysis education, the HSH program sought to use peer-to-peer education as a means of empowering individuals and promoting self-care to increase home dialysis uptake. Consistent with the aim of facilitating engagement through peer education, the rooms and sessions held at HSH were led by individuals receiving home dialysis. The HSH was targeted toward people with CKD G4-5ND (eGFR <25 mL/min/1.73 m²) and those who were already receiving facility-based maintenance HD (CKD G5D). Participants were passively recruited using posters and mailouts and actively recruited following discussion with their nursing team and/or nephrologist. The HSH participants were also invited to bring 1 support person.

The HSH consisted of a single, 4-hour workshop held twice a year (spring and fall). The events took place at a dialysis clinic at the University of Alberta Hospital, Edmonton, Alberta. The workshop was organized by the home dialysis team (nurses, nephrologists, managers) 3 months in advance of the event. Each workshop required approximately 12 staff from home therapies (home therapy nurses, multidisciplinary team members, renal technologists, and nephrologists), each paired with an individual with a lived experience of home

- An “office” to discuss the benefits of choosing a home dialysis modality.
- A “bedroom” to explore cyclor-assisted peritoneal dialysis.
- Another “bedroom” to introduce home hemodialysis.
- A “kitchen” to review general principles of diet.
- A “garage” to talk over the technical aspects of home hemodialysis.
- A “living room” to weigh the financial and social implications of dialysis at home.



Box 1. Home Sweet Home rooms.

dialysis. In addition to providing education on a different topic within each of the rooms, these volunteers chaperoned groups through the home and provided logistical support. The clinic rooms were modified to represent the rooms in a house (Box 1). For example, the purpose of the garage was to demonstrate the basic appearance of a home HD dialysis machine and water treatment equipment. This was shown by a biomedical technologist with a peer partner present to explain the operation and maintenance of the dialysis equipment to participants and that the technologists were available 24/7 to provide support for the home HD equipment. The peer volunteers were selected by the home dialysis nursing team on the basis of their willingness to participate, ability to articulate both the advantages and disadvantages of the modality from a lived perspective, and geographic proximity to the workshop. To demonstrate that home therapies are suitable for older individuals who may consider themselves less familiar with technology, we explicitly approached older adults to participate as peers. Peers were provided with general guidelines on what to discuss in each of the rooms.

Examples included their personal story of transitioning to home dialysis, what surprised them, how they fit the therapy into their daily routine, the required storage space, travel options, ability return to work, support from the home dialysis staff, and any other special considerations. Attendees were given time for questions. The HSH participants were given 20 minutes in each room (including time for questions), with 5 minutes to transition between the rooms. The workshop included an hour-long lunch break for participants to socialize and to ask additional questions. At the end of the HSH event, participants were given the contact information of our program’s designated modality educator (RN), and encouraged to contact this person to set up a personalized one-on-one assessment for appropriateness. Wrap-up remarks also included the guidance “Talk to your kidney doctor or nurse, or ask to speak with the modality nurse or manager of your kidney care unit. They will help you to find your pathway to home if that is what you choose.” The budget for each event was approximately \$70 per participant (and their support person).

HOME SWEET HOME
Patient Home Dialysis Education Day
10-2, Saturday, October 16th, 2015

1. How did you hear about the Home Sweet Home Event?

2. Did we provide enough information?

3. Was the length of each session adequate?

4. Do you recommend any changes for future "Home Sweet Home" Events?

5. After today's event, what would most interest you (please circle one)?

Peritoneal Dialysis	Home Hemodialysis	Neither	Both
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Figure 1. Anonymous evaluation form completed by all patient participants who attended a Home Sweet Home event between 2015 and 2019.

Program Evaluation

Anonymized feedback on the HSH program was collected from all participants (not support persons) at the end of each HSH event using a standardized evaluation form consisting of 5 questions (Figure 1). Reach was defined as participant representativeness according to CKD G4-5ND vs CKD G5D. Acceptability was assessed qualitatively with comments on anonymized feedback forms as well as quantitatively as the proportion of participants who were interested in a home dialysis modality after attending HSH. Uptake was explored as the last documented modality at the end of follow-up.

Data Collection

Demographic data for HSH participants were collected from 2 databases linked by personal health number, the Canadian Organ Replacement Register (CORR) and the Nephrology Information System (NIS), our regional clinical database. From those data sources, we extracted the relevant demographic and clinical data. We also extracted the last renal replacement modality for HSH attendees until follow-up ended (June 21, 2022). If modality data were missing, we assumed that the participant remained on the modality that

Table 1. Characteristics of Individuals Who Attended Home Sweet Home Between 2015 and 2019.

Baseline characteristic	Attendees (N = 291)
Mean age (years)	61 ± 14
Sex (%)	
Male	64
Female	36
Ethnicity (%)	
White	74
Non-white	34
Distance from event (%)	
0-50 km	71
50.1-100 km	7
100.1-200 km	9
>200 km	13
Dialysis modality at time of event (%)	
No dialysis (chronic kidney disease)	70
In-center hemodialysis	30
Primary cause for CKD/ESKD (%)	
Diabetic kidney disease	43
Hypertensive or renovascular disease	11
Glomerular disease	27
Other	18
Pre-dialysis education prior to event	28

Note. Plus-minus values are means ± SD. Percentages may not total 100 due to rounding. CKD = chronic kidney disease.

was recorded at the time of HSH. We calculated the driving distance from the postal code centroid of the participant's residence to the event location at the University of Alberta Hospital. A waiver of individual-level consent was obtained from the University of Alberta Research Ethics Board (Pro00107394).

Data Analysis

Demographic data and modality selection after the event are summarized by counts and percentages. Free text was extracted from surveys and categorized.

Key Findings

Baseline Characteristics of Home Sweet Home Participants

A total of 291 participants attended 10 HSH events between April 2015 and September 2019. Participant demographics are shown in Table 1. The majority (70%) of participants had CKD G4/G5ND. The remaining 30% had CKD G5D. The mean participant age was 61 years (standard deviation 13.6 years); 64% of attendees were male and 75% of participants identified their ethnicity as white. The most common cause of kidney disease was diabetes (43%), followed by glomerular disease (27%) and hypertensive/renovascular disease

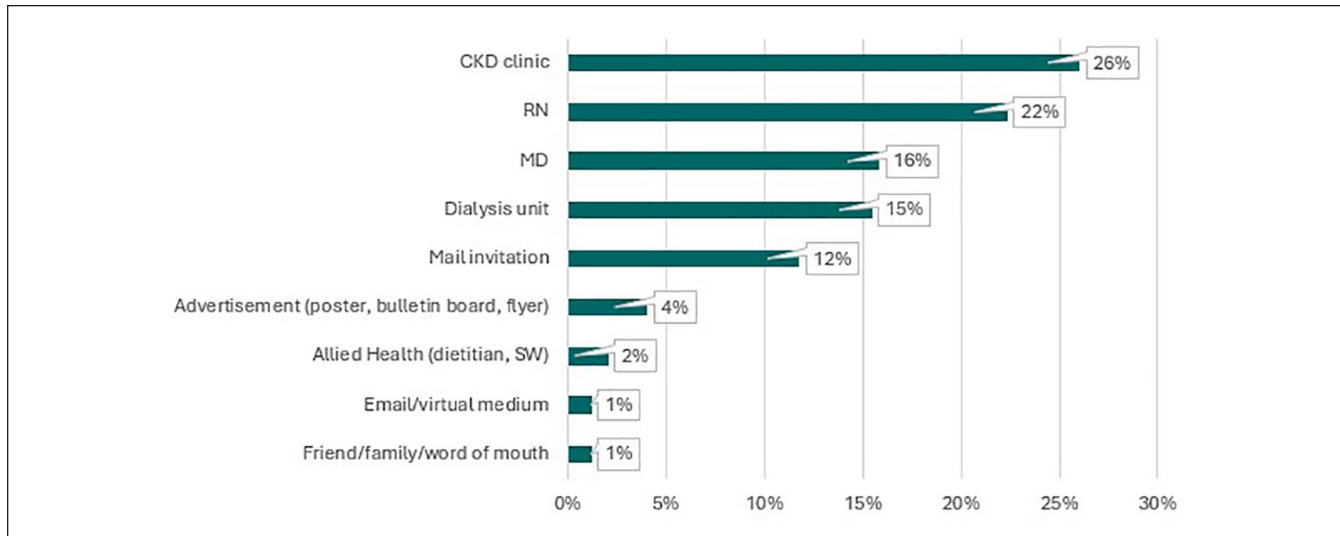


Figure 2. Patient-reported methods of recruitment to HSH program (2015 to 2019). RN denotes registered nurses in both CKD clinic and hemodialysis clinic.

Note. MD = nephrologist; RN = registered nurse; SW = social worker.

(11%). The majority of attendees (72%) lived within 50 km of the event location and 13% lived more than 200 km away. In total, 28% of the participants reported receiving some form of modality education prior to the event.

Attendance

Of HSH participants, 26% reported hearing about HSH at their CKD clinic and 15% at their dialysis unit. Similar proportions recalled having been informed about HSH by a nurse (22%) or physician (16%) directly. Mailed invitations accounted for 12% of recruitment. Emails, phone calls, word of mouth, and advertisements accounted for a minority of recruitment (Figure 2).

Home Sweet Home Program Evaluations

Event participants consistently reported that the HSH experience made a meaningful difference in helping them to choose a dialysis modality (Box 2). Participants frequently commented on how the program was “an invaluable source of information” and that it helped them to make “informed decisions.” They expressed appreciation for the opportunity to have their questions and concerns answered and commented explicitly on the inclusion of patient volunteers, whom they felt provided “first-hand information” and a “real-life perspective” on home dialysis. One attendee remarked, “With very open patients it makes [the process of choosing a dialysis modality] so much easier.” Another participant similarly shared, “My stress level is so reduced.” A third participant disclosed, “It is encouraging to know that I am not alone in the process—[that there are] others with the same condition.”

The most common criticism of the HSH program was that the event was too short. Many participants expressed that the sessions during the day could have been longer and that more time should have been allotted for questions and discussion. There was a collective desire for more information—more handouts, more time for open discussion, more opportunities to connect with patient volunteers, and more frequent HSH events. The information shared would have also helped family members, with 1 attendee remarking, “We have other family members at home (teenage children) who would have benefited from the presentations.” Some attendees also commented on the travel time required to get to the HSH location and that they “had to drive 2 hours.”

Dialysis Modality After Home Sweet Home Attendance

In total, 85% (N = 248) of HSH participants completed an evaluation. From the evaluation forms completed at the end of every event, N = 228 (92%) were interested in a home dialysis modality: N = 102 (41%) were interested in peritoneal dialysis, N = 77 (31%) in home HD, and N = 49 (20%) were interested in both. A minority of participants, N = 16 (6%) remained undecided and N = 5 (2%) expressed a preference for facility-based HD.

A summary of home dialysis uptake at follow-up from the day of HSH attendance (median 858 days, interquartile range = 353-1347 days) is shown in Figure 3. In summary, N = 52 (24%) of the participants remained dialysis independent and 25% died. Of the remaining 167 participants at follow-up, N = 41 (25%) were receiving a home dialysis modality (either peritoneal dialysis or home HD), N = 40 (24%) received a kidney transplant, and N = 86 (51%) were dialyzing with

- ✦ “Everyone should come to this [event] before deciding dialysis choice.”
- ✦ “It was great! We wish we could have come 2 years ago or at GFR of 25 instead of 10. Almost too late.”
- ✦ “Recommend for pre-treatment patients. Earlier education leads to more informed decisions.”
- ✦ “We have other family members at home (teenage children) who would have benefited from the presentation.”
- ✦ “The Q&A period was special. To hear from patients was very good.”
- ✦ “Actual patients provide good ‘real life’ perspective.”
- ✦ “Hold more than 2 [sessions] per year; a great way to educate others.”
- ✦ “I especially liked that there were actual patients to talk to and get first-hand information.”

Box 2. Illustrative responses collected from evaluation forms completed by participants at the end of Home Sweet Home events.

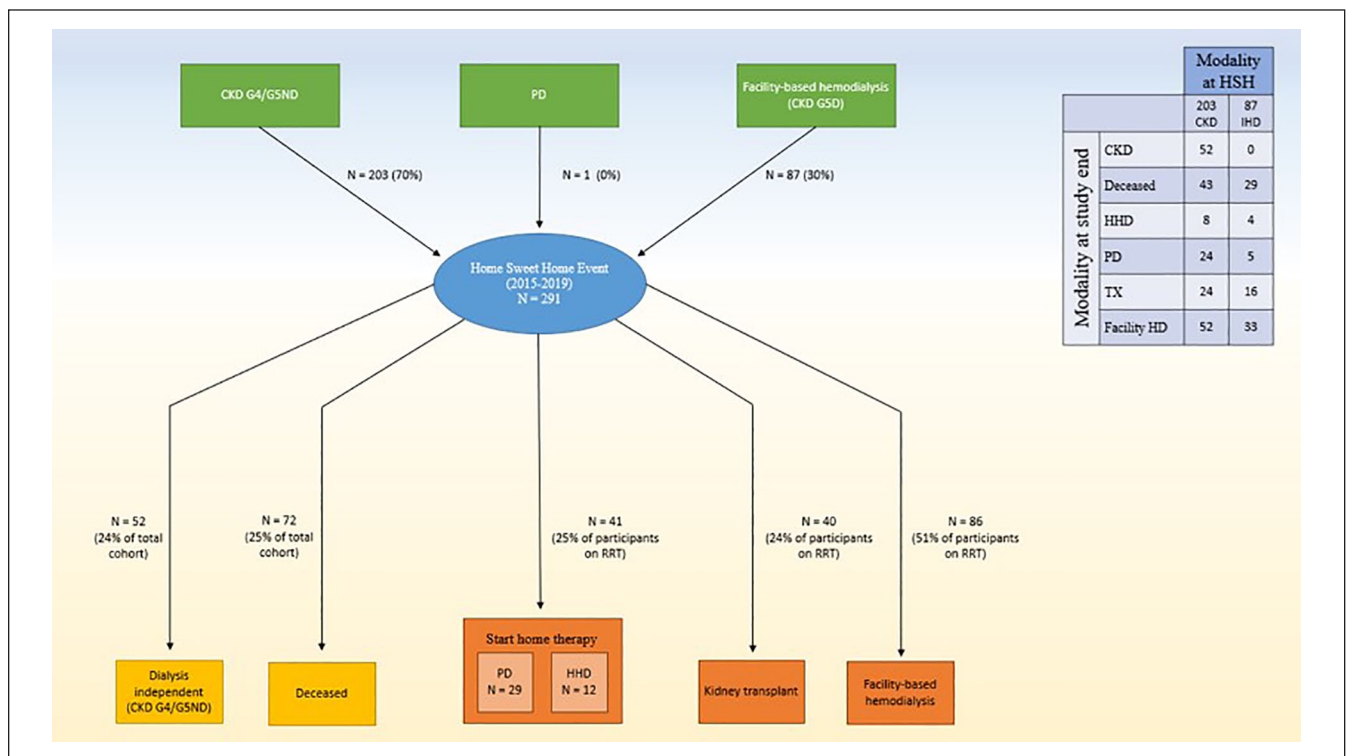


Figure 3. Flow chart depicting kidney replacement modalities of Home Sweet Home participants before and after attendance. Green boxes denote the CKD stage at the time of Home Sweet Home participation. Yellow boxes denote the dialysis modality at the end of the study (June 21, 2022). Subgroup size is listed above the yellow boxes, along with the corresponding percentage of the entire cohort population (N = 291). The insert shows the exact number of individuals in each subgroup, stratified by the initial modality at the time of attendance in Home Sweet Home.

Note. CKD = Chronic kidney disease; HHD = home hemodialysis; HSH = Home Sweet Home; PD = peritoneal dialysis.

facility-based HD. Of those HSH participants who were receiving facility-based HD at the time of attendance and survived to follow-up (N = 58), N = 9 (15%) were receiving a home dialysis modality, whereas N = 33 (59%) remained on facility-based HD at follow-up. Of those HSH participants who non-dialysis dependent at time of attendance and survived to follow-up (N=108), N = 32 (30%) started a home dialysis modality.

Limitations

The main limitation of our program report is that we are unable to make a conclusion regarding whether the interactive, peer-led HSH program resulted in a higher uptake of home therapies compared with more conventional didactic approaches. Although we explored dialysis modality before and after HSH attendance, it is important not to infer any causality from these data. In addition, we did not have data on how many participants may have received a home therapy prior to transitioning to their documented modality at follow-up, which underestimates the use of home therapies. Our main objective was to describe acceptability and reach. Our understanding of how participants perceived the HSH program was restricted to evaluation forms, which were not designed to elicit deeper, more reflective responses. Our understanding of how attendees perceived the HSH program and what components were most helpful would have been enriched by interviews and/or focus groups with HSH participants. We also did not use quantitative measurements in the evaluation of HSH and instead selected to use participants' comments and demographics to understand acceptability and program reach. We acknowledge the characteristics of the population studied may limit generalizability. The HSH participants were mainly male, white, living in an urban setting and English-speaking. Future events should promote the inclusion of non-English-speaking participants, which is feasible with translation service and apps, as well as support for travel.

Implications

In this report, we describe a novel approach to home dialysis education that utilizes peers with lived experience as the primary providers of education, with health care professionals functioning in a supportive capacity. From the evaluations, we found that the HSH program was highly acceptable with 92% of participants reporting they were interested in a home modality. A recurring comment was the value of "first-hand information" and a "real-life perspective" from peers. To improve program reach for future HSH initiatives, recruitment should focus on people receiving facility-based HD and those living outside of a main urban center, as this is where the majority of the people in our CKD program reside. The latter population (those living in rural areas) may find home-based dialysis appealing because of the time saved

from commuting to an in-center facility or having to relocate. We also explored home dialysis uptake in HSH attendees and found it to be of high acceptability. Our estimate of home dialysis uptake among attendees at follow-up is likely an underestimate, as patients may have transitioned to home dialysis prior to kidney transplant or technique failure.

Modality education is associated with a higher uptake of home dialysis.^{7,13,14,16-24} However, even with pre-dialysis education, Ziolkowski and Liebman²⁵ found that a commonly cited reason for not starting home dialysis was fear of personal incompetence. Lack of confidence and concerns about dialyzing without supervision have also been cited as barriers to home dialysis uptake in other studies.^{11,20,23} Providing information alone may reduce some of these concerns, but additional strategies, such as those based on improving self-efficacy for home dialysis, may be more effective. Self-efficacy is defined as one's particular set of beliefs that determine how well one can execute a plan of action in prospective situations.²⁶ Relevant to HSH, Social Cognitive Theory explores how self-efficacy can be cultivated through seeing others (who are perceived as similar) performing specific tasks, termed vicarious experience.²⁶ From HSH surveys, the role of "patient peers" in facilitating these elements was key to its acceptability. Individuals frequently perceive their peers-or those who have "gone through what they are going through" as valuable resources providing real, authentic, and trustworthy knowledge.^{27,28} Through demonstration, individuals with kidney failure can show their peers how home dialysis can be self-managed and, in doing so, inspire other patients to do the same and help to normalize living with kidney failure.^{28,29} Though not extensively evaluated in dialysis modality uptake, the role of peer support and education in general is a potentially useful tool that should be examined further.

Our program's overall rate of home dialysis uptake is approximately 25% per year. As discussed above, our reported rate is likely an underestimate as we did not include transitions before follow-up. Given the high acceptability of the program, it is important to acknowledge that modality selection is complex, with both modifiable (eg, early referral, structured pre-dialysis education, physician training) and non-modifiable factors (eg, cognitive impairment, lack of dexterity or low vision, abdominal adhesions). Non-modifiable factors may explain why uptake among those currently receiving facility-based HD was relatively low. Follow-up with these participants after future HSH events would improve our understanding of barriers for this specific population and would help to inform planning of future HSH events. In addition, only 30% of attendees received any formal modality education prior to attending HSH. Given the limited resources and space within HSH, it may be more efficient to provide some education first along with an assessment for any non-modifiable barriers. Other aspects to consider with future HSH events are the inclusion of people living with CKD and their chosen support person in event

planning. Tailoring future HSH events to the preferences and needs of attendees is not only person-centered but builds on the principle that people with chronic conditions best manage their conditions when they are actively involved in their care.

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Declaration of Conflicting Interests

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Ethics Approval

Ethics approval was obtained through The University of Alberta's Research Ethics Board (Pro00107394).

Consent to Participate

Due to the use of aggregate registry data, a patient consent form was not required and the requirement for individual level consent was waived by the Research Ethical Board (REB).

Consent for Publication

All authors provided their consent for publication of the manuscript.

Availability of Data and Materials

Data may be available on request.

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