

Identification of facilitators and barriers to home dialysis selection by Canadian adults with ESRD. Osterlund K, Mendelsshon D, Clase C, Guyatt G, Nesrallah G. *Semin Dialy* 2014;27(2):160-172

Towards a better practice: investigate the problems, change the procedures

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Home dialysis, either domiciliary haemodialysis (HHD) or peritoneal dialysis (PD), are associated with more autonomy, quality of life and even survival advantages. Such reported benefits would expectedly increase its prescription with more patients allowed to profit from home therapy modalities.

The authors mention that Canadian prevalent rates for home HD (4%), peritoneal dialysis (17.1%) and Centre haemodialysis (78.9%), represent an underutilization of home dialysis, since in Australia, as an example, that modality reaches 30%. In Portugal, home dialysis (peritoneal dialysis) has increased but still remains as only 8.6% (in incident patients) or 6.25% (in prevalents).

The present study aimed to identify determinants of home dialysis selection/prescription in order to optimize patient management. By using in-depth interviews to nephrologists, including an advanced-practice nurse and administrator, as well as qualitative data collected in a related survey of nephrologist attitudes, the authors constructed taxonomies of barriers and related facilitators that were specific to PD, specific to home HD, and common to both. Medical factors, psychological and cognitive factors, social factors, dialysis units or local hospital and health system variables were investigated.

Disabilities, cognitive impairment or lack of suitable housing were common barriers to home dialysis, but formal or informal caregiver was pointed as a facilitator. Specifically in PD, surmountable barriers were identified: 1) medical conditions – prior abdominal surgery, colostomy, herniae, polycystic kidneys and mechanical back pain; 2) residual renal function loss was not mentioned as a limitation in eligibility; 3) clinicians lack of knowledge and biased attitudes were common but lower physician reimbursement was not considered a major limiting factor; and 4) local wait times and access to PD catheter implantation were pointed as modifiable factors.

In addition, common barriers concerning both HHD and PD are related with: a) in nephrology and dialysis Units – late referral and insufficient patient information, local culture unenthusiastic about home dialysis resulting in inconsistent or negative messaging, lack of physical space for HHD training, lack of human resources, local culture favouring center HD as default modality, home dialysis not included in clinical discussions, lack of standardized information to the patients including non-programmed HD start patients, suboptimal programme size resulting in insufficient resource use, lack of expertise or unsustainability; b) in the health care system: perception that remuneration is insufficient for extra clinic time, lack of

motivation, or even perception that home and centre dialysis offer comparable outcomes so patients are not recruited, lack of funding for assisted PD, lack of support from hospital administration, rapid proliferation of home dialysis resulting in hospital service volumes exceeding local budget.

This laborious survey deserves extended reading, reflection and reproduction in our society. As nephrologists we should investigate, recognize and correct the variables that limit our best performance –the article makes suggestions for improving practices that should be taken into account. On the other

hand, those who legislate and administer urge to invest on nephrologists as pivots of change. Before undesirable changes hit us all –physicians and patients.

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