

Table A 1. Barriers to Home Dialysis

Patient Related Factors	Health System Related Factors
<ol style="list-style-type: none"> 1. Education[49-51] 2. Emotion and Social Needs/lack of motivation[49, 52] 3. Fear of Incident at home[52] 4. Care giver burnout[53, 54] 5. Fear of self-cannulation (HHD)[27] 6. Fear of isolation at home [55]/ Belief that patients will not be involved in care[52] 7. Lack of awareness/availability of home dialysis [56] 8. Fear of “bringing” their disease home and not being monitored by professionals[56] 	<ol style="list-style-type: none"> 1. Comfort of Physicians[9, 49] 2. Ease of Availability <ol style="list-style-type: none"> a. Mindset: In- Center Hemodialysis is convenient; access placement and patient placement in dialysis units is well oiled. b. Access: suboptimal timely access placement for PD c. Education: Lack of time, and resources to educate patients, especially in the hospital d. Transition of care: lack of LDO support urgent PD starts and home dialysis nurses to support PD starts and home dialysis starts 3. Myths including high BMI[57], low socioeconomic status, risk of mediastinitis[57], and previous abdominal surgery being a contraindication for PD catheter placement[57] 4. Lack of strong clinical evidence supporting the benefits of HHD[56]

Table A 2. Caveats in Pre-Dialysis Education

1. Lack of education[7, 50]
2. Education being very biased towards one modality[5, 6]
3. Education being provided very late[7]
4. Education may be too complex[58]
5. Education provided when patients are very sick[59]
6. Healthcare professionals' bias towards a modality[59]
7. Inadequate attention to individual patient needs[60]
8. Suboptimal involvement in treatment decision making from the patient[6]
9. Imbalanced education material [61, 62]

Table A 3. UAB Urgent PD Protocol	
Patient selection	
<p>Suitable patients</p> <ul style="list-style-type: none"> • Patient well educated about PD • Agreeable • Able to come to clinic for several weeks • *MATCH D criteria reviewed 	<p>Advise Caution</p> <ul style="list-style-type: none"> • Severe electrolyte abnormalities • Uremia affecting mentation • Volume overload affecting oxygenation • Lack of housing/transportation
<p>PD Catheter Placement</p> <p>IR or Surgery place the catheter Placed as an outpatient Can be used within 24-48 hours depending on indications to start dialysis If already inpatient, place catheter and perform low volume, supine exchanges prior to discharge</p>	
<p>Prescription*</p> <p>*All exchanges done with the patient supine for the first 2 weeks *Need a patient exam chair which can recline (LDOs can provide) in home unit</p>	
<p><u>No Residual Renal Function**</u></p> <ul style="list-style-type: none"> • Fill volume of 1000 ml • 4-5 exchanges over 9 hours • 5 days a week • Increase fill volume by 500 ml every 3-5 days <p>**Caution with fluid intake and diet</p>	<p><u>Residual Renal Function >5 ml/min</u></p> <ul style="list-style-type: none"> • Fill volume <ul style="list-style-type: none"> ○ BSA <1.7 M2: 750 ml ○ BSA > 1.7 m2: 1000 ml • 4-5 exchanges over 8-9 hours • 4-5 days a week • Increase fill volume by 500 ml every 5 days
<p>Lab Tests</p> <ul style="list-style-type: none"> • Labs checked on admission, and then weekly • Goal of urgent PD is NOT to achieve a weekly kt/v, but to transition patient to a full prescription without getting into complications • Prescription adjusted based on labs 	
<p>Logistics</p> <ul style="list-style-type: none"> • Hospital nurses need training and in-service on urgent PD • Treat constipation and cough aggressively with new catheter while doing urgent PD • Discharge from hospital needs to be timed appropriately, especially around weekends and holidays (most units do not do urgent PD on the weekends or holidays) • Patient educated that they will spend a significant amount of time in dialysis unit in the first month; we ask them to bring their lunch and a blanket • Training often starts in week 2 of urgent PD; patients are able to go home in 4-5 weeks 	