Priorities for peer support delivery among adults living with chronic kidney disease: a patient-oriented consensus workshop

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Abstract

Background: Peer support can address the informational and emotional needs of people living with chronic kidney disease (CKD) and enable self-management. We aimed to identify preferences and priorities for content, format and processes of peer support delivery for patients with non-dialysis CKD and their loved ones.

Methods: Using a patient-oriented research approach, we conducted a half-day, virtual consensus workshop with stakeholder participants from across Canada, including patients, caregivers, peer mentors and clinicians. Using personas (fictional characters), participants discussed and voted on preferences for delivery of peer support across format, content and process categories. We analyzed transcripts from small- and large-group discussions inductively using content analysis.

Results: Twenty-one stakeholders, including 9 patients and 4 caregivers, participated in the workshop. In the voting exercise on format, participants prioritized peer mentor matching, programming for both patients and caregivers, and flexible scheduling. For content, participants prioritized informational and emotional support focus, and for process, they prioritized leveraging kidney care programs and alternative sources (e.g., social media) for promotion and referral. Analysis of workshop transcripts complemented prioritization results and emphasized tailoring of peer support delivery to accommodate the diversity of people living with CKD and their support needs. This concept was elaborated in 3 themes, namely alignment of program features with needs, inclusive peer support options and multiple access points.

Interpretation: We identified preferences for peer support delivery for people living with CKD and underscore the importance of tailored, flexible programming in this context. Findings could be used to develop, adapt or study CKD-focused peer support interventions.

Plain language summary: In this virtual workshop, patients, caregivers, peer mentors and clinicians across Canada discussed and voted on priorities for delivery of peer support for people with kidney disease. The top identified priorities included matching patients with similar peer mentors, flexible programming, increased program access and distinct caregiver supports.

People living with complex chronic conditions are tasked with self-managing their health.[1,2] For the around 10% of adults in Canada with chronic kidney disease (CKD),[3] unique challenges include balancing dietary guidance, medication burden and lifestyle strategies to slow progression of their disease with other competing priorities.[2,4–6] Although multidisciplinary care models for CKD are well suited to supporting patients' medical and informational needs, particularly among those at high risk of kidney failure,[7–9] support gaps persist owing to factors such as time-constrained clinic visits, the dynamic trajectory of CKD and the care team's lack of lived experience of the condition.[10,11]

Peer support offers a complementary approach to supporting patients' emotional needs, validating their concerns and sharing knowledge through structured interactions with others with similar health-related experiences.[12] Given the national interest in strategies to enhance self-management of

chronic disease and patient-centred care, opportunities to integrate peer support into comprehensive kidney care models are being increasingly sought.[13] Among people with non-dialysis CKD, formalized peer support can establish a sense of community and equip them with knowledge and confidence to face an often-uncertain future.[14–16] However, little is known about the extent to which formalized peer support meets the needs for people living with advanced, non-dialysis CKD, whose disease experiences can differ substantially from those

with kidney failure or those who receive kidney replacement therapy (i.e., dialysis or transplantation). In the context of our broader, patient-oriented research program, the aim of this stakeholder consensus workshop was to identify preferences and priorities related to delivery of peer support for patients with CKD and their caregivers in Canada.

Methods

Study design and setting

We held a half-day virtual workshop in June 2021 using the Zoom online platform to engage stakeholders in a modified nominal group technique. This established, consensus-building approach aims to generate and prioritize ideas by experts in the topic area over a series of group discussions (Appendix 1, Section 1, available at www.cmajopen.ca/content/11/4/E736/suppl/DC1).[17,18] During the workshop we referred to 6 unique personas (i.e., fictitious descriptions of potential users),[19] developed previously in partnership with patients to prompt discussion about needs and preferences related to the content, format and processes of delivery of formalized peer support (Appendix 1, Section 2).[4,20] We reported this work in accordance with the Guidance for Reporting Involvement of Patients and Public (GRIPP2)[21] and the Consolidated Criteria for Reporting Qualitative Research.[22]

Participants

We recruited adult participants aged 18 years or older who were comfortable communicating in English from one of the following stakeholder groups: people living with non-dialysis CKD, informal caregivers (e.g., family members, friends), clinicians and other relevant stakeholders with an understanding of CKD and interest in peer support, and peer mentor volunteers from the Kidney Foundation of Canada. We purposively recruited participants from across Canada using established partnerships with the Canadians Seeking Solutions and Innovations to Overcome Kidney Disease (Can-SOLVE CKD) patient-oriented research network and the Kidney Foundation of Canada.[23] We identified additional participants from previous qualitative work in the non-dialysis CKD population who had consented to be contacted about future research (including those who had progressed to kidney failure).[24] Our organizational contacts and research coordinator distributed email invitations to eligible adults, and those responding with interest were contacted by the research team to discuss the project and obtain consent. We sampled purposively across stakeholder roles to ensure sample diversity and aimed for 20–25 participants, which is acceptable for a virtual, consensus-based exercise.[4,13]

Study procedures

Two weeks before the workshop, we distributed materials by email, including a summary of the topic area, personas and a workshop overview. We asked participants to review the personas, consider how they might access peer support and reflect on how their own experiences may have shaped their views. Research team members were available by email or

telephone for assistance. All participants completed a questionnaire to summarize their demographic characteristics.

At the start of the workshop, the main facilitator (M.J.E.) welcomed participants, provided a program overview and established expectations for respectful interactions. Over a series of 3 small-group sessions (each including 6–8 participants across stakeholder groups),[25] participants discussed needs for delivery of peer support in relation to the personas. Small-group sessions were facilitated by team members (M.D., J.F., N.V.) with advanced training in focus group and workshop methodology and who were skilled in guiding balanced discussion across stakeholder roles. They referred to a topic guide (Appendix 1, Section 3) and prompted participants to assume the perspectives of the personas during discussions on 3 topic categories (content, format, process) identified from previous work and related frameworks of intervention reporting.[15,26] We encouraged participants to contribute perspectives relevant to their role. Facilitators took measures to ensure equitable contributions of workshop participants to the discussion, including inviting individual participants to share their thoughts, probing the group for alternative views, respectfully redirecting the conversation to another participant or issue if anyone was dominating the discourse and ensuring discussions centred on the personas rather than overemphasizing any one participant's perspectives. After each small-group session, facilitators presented a summary of their group's ideas to the larger group and solicited feedback. Before the final prioritization exercise, the research team consolidated and categorized preferences discussed during the workshop. We used cumulative dot voting,[27,28] whereby participants used the annotation feature of Zoom to vote anonymously on 3 individual ideas or suggestions under each of the 3 categories that they considered most important for peer support delivery for people living with advanced CKD (i.e., up to 9 votes per participant). All sessions were audio-recorded and transcribed. After the workshop, we emailed participants a survey assessing their satisfaction with the format and process (Appendix 1, Section 4).

Patient engagement

Two patient partners (N.V., D.S.) with lived experience of kidney disease collaborated on the design, conduct, interpretation and reporting of this project. Both contribute to our group's self-management and peer support–related research initiatives within the Can-SOLVE CKD Network. One patient (N.V.) with qualitative research training and experience facilitated small-group sessions, and one (D.S.) participated in data collection (i.e., workshop participant). Patient partners reviewed final outputs and contributed to manuscript preparation. About 1 month after the workshop, all participants (including patients) had the opportunity to provide feedback and request clarification on a summary of findings circulated by email.

Data analysis

We summarized demographic and workshop data descriptively. To rank preferences within each category, we tallied

the number of votes and ranked results as high (≥ 7 votes), medium (3–6 votes) and low (< 3 votes) priority, established a priori based on the anticipated number of participants and selections available within each topic area.[1] Two research team members reviewed field notes and transcripts to verify that all key features raised during discussions were captured in the voting exercise. We summarized responses from the satisfaction survey descriptively.

We uploaded transcripts from small- and large-group sessions to NVivo 12 (QSR International) to facilitate data organization. Three research team members (M.J.E., S.L., B.B.) reviewed and inductively analyzed deidentified transcripts using conventional content analysis to identify themes related to delivery of peer support that were prioritized by stakeholders.[29–31] Each team member independently reviewed transcripts, highlighted meaningful segments of text and developed initial codes using the first small- and large-group discussion. We discussed, refined and applied final codes to the remaining transcripts, from which we derived themes with representative quotes. We referred to our field notes about the interactions between workshop participants to refine our analysis and ensure that final themes reflected a diversity of participant roles and viewpoints. We ensured methodological rigour through a reflexive approach to data collection and analysis, researcher and data triangulation, and provision of rich descriptions to support our findings.[32]

Ethics approval

This study was approved by the University of Calgary Conjoint Health Research Ethics Board (REB21-0423). All participants provided written informed consent.

Results

The workshop included 21 participants (5 patients, 4 caregivers, 4 peer mentors, 6 clinicians and 2 organizational representatives). Three-quarters of participants were from Alberta (n = 15). Most participants identified as women (n = 16, 76%), were aged 40–64 years (n = 13, 62%) and had a university or professional degree (n = 15, 71%). Patient participants reported a range of CKD causes and disease durations (Table 1). All peer mentors reported having experience of both dialysis and transplantation. Eight participants (4 patients, 2 caregivers and 2 peer mentors) had contributed to previous related qualitative work on kidney disease–related self-management and peer support.

Prioritization results

Within the format area, the most highly prioritized options (≥ 7 votes) included matching peer mentors based on characteristics and need for support, offering peer support to both patients and caregivers and ensuring flexible programming to suit the wide variation in people's needs (Table 2). Conventional formats such as group, one-on-one and telephone sessions were more highly prioritized than virtual, social media or informal activities. With respect to content, participants prioritized informational and emotional support over reassurance and validation (i.e., appraisal support) and assistance with

Table 1 (part 1 of 2): Participant characteristics	
Characteristic	No. of participants
All participants	21
Geographic location	
Alberta	15
Ontario	4
Saskatchewan	1
Manitoba	1
Employment status	
Full-time	14
Retired	4
Part-time	1
Disability, not employed	2
Education	
University degree	11
Professional or graduate degree (e.g., MD)	4
Technical diploma	3
High school	2
Did not respond	1
Age, yr	
< 40	4
40–64	13
≥ 65	4
Ethnicity	
White	18
Asian	2
Latin American	1
Gender	
Woman	16
Man	5
Patients (n = 5) and caregivers (n = 4)*	9
Marital status	
Married	7
Common law	2
Divorced	0
Single	0
Cause of CKD†	
Diabetes	3
High blood pressure	1
Other	1
Time with CKD, yr†	
< 5	2
5–9	2
10–20	1
Self-reported kidney function (eGFR in mL/min/1.73 m²)†	
< 15	2
15–29	0
30–44	0
45–60	1
Did not respond	2

Table 1 (part 2 of 2): Participant characteristics	
Characteristic	No. of participants
Peer mentors	4
Length of time as mentor, yr	
1–4	1
5–10	0
> 10	3
Treatment experience‡	
Kidney transplant	4
Hemodialysis	4
Peritoneal dialysis	2
Non-patient stakeholders	8
Role	
Allied health	2
Nephrologist	2
Nurse/nurse practitioner	2
Peer support program representative	2
Time in current position, yr	
< 10	0
10–15	2
> 15	6
Clinical time in current role, %	
< 25	1
25–50	1
> 50	4
Not applicable	2

Note: CKD = chronic kidney disease, eGFR = estimated glomerular filtration rate, MD = medical doctor.
*Caregivers attended either with (n = 2) or without (n = 2) their loved one with CKD.
†Patient participants only.
‡All peer mentors reported having experience with peritoneal dialysis, hemodialysis or both, in addition to transplantation.

depended on factors such as disease duration, rate of progression and understanding of their prognosis. For example, whereas patients with a recent diagnosis might benefit from emotional and informational support to promote disease acceptance and understanding, those with progressive disease may turn to peers for assistance with treatment decision-making. Stakeholders emphasized matching peer support users with mentors on defined demographic characteristics when facing relatable life challenges, such as matching the young woman persona who had questions about family planning with another young woman with CKD. Matching based on mentor experiences (e.g., dialysis, transplantation) was considered important when people sought information about what to expect from kidney failure and its therapies. Participants suggested a one-on-one delivery format was better suited to interpersonal connection, whereas structured group sessions with peer facilitation could integrate educational information.

Inclusive peer support options
Participants highlighted challenges in the accessibility of peer support related to the geographic and ethnocultural diversity of people living with CKD in Canada. Several clinicians noted inconsistent access to technology and limited options to connect with peers in rural, remote and Indigenous communities. Stakeholders emphasized a need for peer support programming appropriate to the needs of ethnocultural minority populations. They encouraged peer matching with mentors fluent in patients' primary languages, engagement of community or faith-based organizations and support resources that respected cultural traditions. A gap in distinct programming for caregivers was noted, whereby access to peer support, independently from their affected loved one and from trained caregiver mentors, could help normalize their experiences and provide strategies for managing in this role.

Multiple access points
Participants acknowledged individuals' varying levels of disease acceptance and readiness to engage in peer support throughout their illness journey. They prioritized peer support as a complementary strategy to multidisciplinary CKD care at multiple time points and from multiple sources. Although patients may not be ready to access peer support early in their disease course, participants suggested introducing it at diagnosis or upon intake into a multidisciplinary CKD program, revisiting it regularly thereafter and referring patients once they express interest. They also encouraged promotion of peer support by multiple sources, such as care teams and community organizations, and using traditional (e.g., brochures) and nontraditional (e.g., social media) approaches.

Satisfaction survey
Sixteen participants completed a satisfaction survey after the workshop (Appendix 1, Section 4). Although most had a positive workshop experience overall (81%) and appreciated the convenience of the virtual platform (88%), about one-third of respondents suggested that the allotted time was insufficient to comprehensively cover the volume of material.

day-to-day tasks. Within the process category, using social media to raise awareness about peer support and facilitating referrals through kidney clinic staff were highly prioritized.

Thematic findings
Participants identified the need to individualize or tailor delivery of peer support for people with CKD as an overarching concept across sessions and stakeholder roles. Participants suggested the diversity of people with CKD should be reflected through a variety of flexible options across the format, content and process categories. We characterized 3 themes and provide a thematic summary, supporting quotes, and suggestions to enhance peer support delivery in Figure 1.

Alignment of program features with needs
Participants suggested that the "what" and "how" of peer support delivery should match an individual's needs at that moment in time. Perceived need and receptivity for support

Table 2: Peer support in chronic kidney disease (CKD) topic areas with suggested options, corresponding dot counts and priority status

Category	Suggested options	Dot count	Priority*
Peer support format			
Who delivers	Matching peer mentor	11	High
	Knowledgeable and trained peer mentor	6	Medium
	Health care provider involvement in peer support	3	Medium
	Varied mentor experiences	1	Low
Who receives	Combination of persons with CKD and caregivers	8	High
	Person with CKD	3	Medium
	Family members, caregivers	2	Low
	Public	1	Low
How delivered	Small group	3	Medium
	One-on-one	3	Medium
	By telephone	3	Medium
	By email or direct messaging	3	Medium
	In-person	1	Low
	Virtual	1	Low
	Blog or social media	1	Low
	Social activities	1	Low
When delivered	Flexible	8	High
	Scheduled	3	Medium
	Ongoing	1	Low
Peer support content			
Informational support	What to expect with kidney disease	9	High
	Hands-on experience	3	Medium
	Diet	3	Medium
	Travel	2	Low
	Family planning, sexuality	1	Low
Emotional support	Feeling supported and not alone	7	High
	Coping and coaching skills	4	Medium
	Building relationships with peers and others	4	Medium
Appraisal support	Reassurance and validation	4	Medium
Instrumental support	Day-to-day tasks	1	Low
Caregiver support	Dedicated caregiver programming	6	Medium
Peer support processes			
Promotion of peer support	Social media	8	High
	Organizational outreach	6	Medium
	Peer mentors on site	5	Medium
	Brochures, posters	1	Low
	Cultural organizations or avenues	1	Low
Referral to peer support	Clinic-initiated	14	High
	Repeated reminders	10	High
	Self-referral	2	Low
	Mandatory peer support	2	Low

*Priority assignment based on number of votes (i.e., dots), defined as high (≥ 7 dots), medium (3–6 dots) and low (< 3 dots).
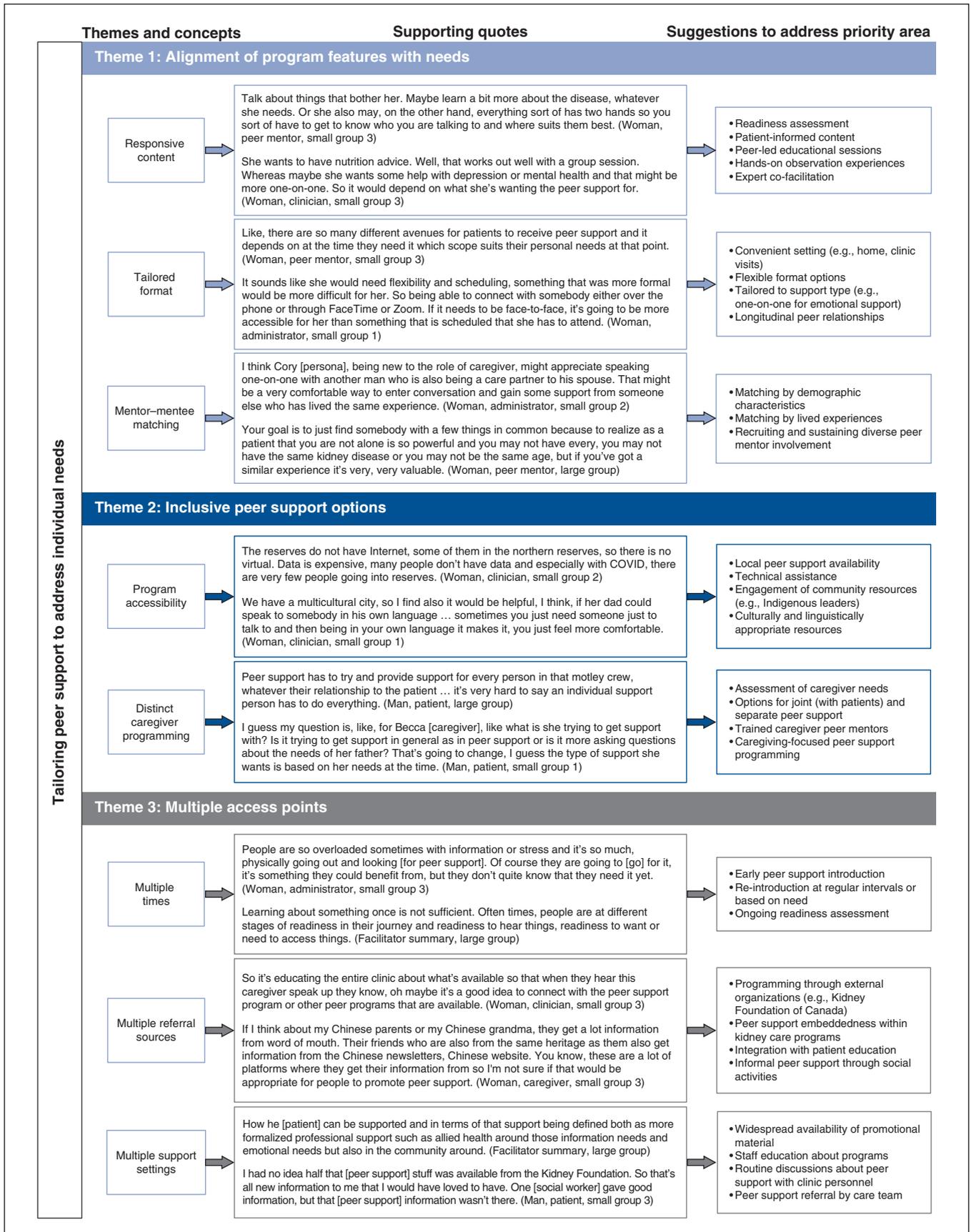
Tailoring peer support to address individual needs

Themes and concepts	Supporting quotes	Suggestions to address priority area

Theme 1: Alignment of program features with needs

Responsive content

Talk about things that bother her. Maybe learn a bit more about the disease, whatever she needs. Or she also may, on the other hand, everything sort of has two hands so you sort of have to get to know who you are talking to and where suits them best. (Woman, peer mentor, small group 3)

She wants to have nutrition advice. Well, that works out well with a group session. Whereas maybe she wants some help with depression or mental health and that might be more one-on-one. So it would depend on what she's wanting the peer support for. (Woman, clinician, small group 3)

- Readiness assessment
- Patient-informed content
- Peer-led educational sessions
- Hands-on observation experiences
- Expert co-facilitation

Tailored format

Like, there are so many different avenues for patients to receive peer support and it depends on at the time they need it which scope suits their personal needs at that point. (Woman, peer mentor, small group 3)

It sounds like she would need flexibility and scheduling, something that was more formal would be more difficult for her. So being able to connect with somebody either over the phone or through FaceTime or Zoom. If it needs to be face-to-face, it's going to be more accessible for her than something that is scheduled that she has to attend. (Woman, administrator, small group 1)

- Convenient setting (e.g., home, clinic visits)
- Flexible format options
- Tailored to support type (e.g., one-on-one for emotional support)
- Longitudinal peer relationships

Mentor–mentee matching

I think Cory [persona], being new to the role of caregiver, might appreciate speaking one-on-one with another man who is also being a care partner to his spouse. That might be a very comfortable way to enter conversation and gain some support from someone else who has lived the same experience. (Woman, administrator, small group 2)

Your goal is to just find somebody with a few things in common because to realize as a patient that you are not alone is so powerful and you may not have every, you may not have the same kidney disease or you may not be the same age, but if you've got a similar experience it's very, very valuable. (Woman, peer mentor, large group)

- Matching by demographic characteristics
- Matching by lived experiences
- Recruiting and sustaining diverse peer mentor involvement

Theme 2: Inclusive peer support options

Program accessibility

The reserves do not have Internet, some of them in the northern reserves, so there is no virtual. Data is expensive, many people don't have data and especially with COVID, there are very few people going into reserves. (Woman, clinician, small group 2)

We have a multicultural city, so I find also it would be helpful, I think, if her dad could speak to somebody in his own language … sometimes you just need someone just to talk to and then being in your own language it makes it, you just feel more comfortable. (Woman, clinician, small group 1)

- Local peer support availability
- Technical assistance
- Engagement of community resources (e.g., Indigenous leaders)
- Culturally and linguistically appropriate resources

Distinct caregiver programming

Peer support has to try and provide support for every person in that motley crew, whatever their relationship to the patient … it's very hard to say an individual support person has to do everything. (Man, patient, large group)

I guess my question is, like, for Becca [caregiver], like what is she trying to get support with? Is it trying to get support in general as in peer support or is it more asking questions about the needs of her father? That's going to change, I guess the type of support she wants is based on her needs at the time. (Man, patient, small group 1)

- Assessment of caregiver needs
- Options for joint (with patients) and separate peer support
- Trained caregiver peer mentors
- Caregiving-focused peer support programming

Theme 3: Multiple access points

Multiple times

People are so overloaded sometimes with information or stress and it's so much, physically going out and looking [for peer support]. Of course they are going to [go] for it, it's something they could benefit from, but they don't quite know that they need it yet. (Woman, administrator, small group 3)

Learning about something once is not sufficient. Often times, people are at different stages of readiness in their journey and readiness to hear things, readiness to want or need to access things. (Facilitator summary, large group)

- Early peer support introduction
- Re-introduction at regular intervals or based on need
- Ongoing readiness assessment

Multiple referral sources

So it's educating the entire clinic about what's available so that when they hear this caregiver speak up they know, oh maybe it's a good idea to connect with the peer support program or other peer programs that are available. (Woman, clinician, small group 3)

If I think about my Chinese parents or my Chinese grandma, they get a lot information from word of mouth. Their friends who are also from the same heritage as them also get information from the Chinese newsletters, Chinese website. You know, these a lot of platforms where they get their information from so I'm not sure if that would be appropriate for people to promote peer support. (Woman, caregiver, small group 3)

- Programming through external organizations (e.g., Kidney Foundation of Canada)
- Peer support embeddedness within kidney care programs
- Integration with patient education
- Informal peer support through social activities

Multiple support settings

How he [patient] can be supported and in terms of that support being defined both as more formalized professional support such as allied health around those information needs and emotional needs but also in the community around. (Facilitator summary, large group)

I had no idea half that [peer support] stuff was available from the Kidney Foundation. So that's all new information to me that I would have loved to have. One [social worker] gave good information, but that [peer support] information wasn't there. (Man, patient, small group 3)

- Widespread availability of promotional material
- Staff education about programs
- Routine discussions about peer support with clinic personnel
- Peer support referral by care team

Figure 1: Thematic summary, supporting quotes and suggestions to address priorities for peer support delivery.

Interpretation

In our patient-oriented consensus workshop, stakeholders collaboratively identified priorities for delivery of peer support in the non-dialysis CKD context. Top priorities across format, content and process categories included mentor–mentee matching, distinct caregiver programming and engagement of kidney care teams in introducing and referring to peer support programs. Our thematic findings highlight a need for tailored, flexible peer support to mirror the dynamic nature of CKD and patients' varied experiences. Participants acknowledged potential accessibility challenges and identified repeated program endorsement as a key driver to enhance uptake.

In Canada, the Kidney Foundation has been the main source of kidney-focused peer support that connects any interested individual affected by kidney disease with trained peer mentors using telephone, in-person and virtual formats (i.e., Kidney Connect, https://kidney.ca/support/).[33] As highlighted by workshop participants, access to such programs can connect patients with peer mentors who have a breadth of transplant- and dialysis-related experiences to help them navigate their kidney disease trajectory. In contrast, few multidisciplinary CKD clinics embed peer support within their care programs.[34] Patients with advanced, non-dialysis CKD often lack overt manifestations yet face challenges related to high symptom burden, metabolic complications, and difficult treatment-related decisions (e.g., choosing among dialysis types).[35] Thus, our findings endorse an inclusive but tailored approach to peer support that purposefully addresses CKD-specific support gaps and connects individuals within the broader kidney community. This includes distinct peer support programming for caregivers who experience high physical, mental and financial burden, yet whose needs are often overlooked.[36,37]

Workshop participants prioritized peer mentor matching based on shared characteristics or circumstances, which can promote bonds and positive social comparisons among people with chronic conditions.[12] Some patients with CKD prefer mentors with more advanced disease (e.g., dialysis, transplantation) to help them navigate their disease trajectory,[14] whereas others prefer matching on factors such as gender, age or ethnicity, depending on context.[38] However, mentor–mentee matching by similarity may not always enhance intervention effectiveness.[39] Some have raised questions about its value and impact on the peer support relationship and emphasize instead finding the right fit based on current needs.[16,40]

Workshop participants highlighted important gaps in access to peer support. Nearly one-fifth of the Canadian population resides in rural or remote areas, among whom recognized disparities in access to kidney-related care exist.[41–43] Findings from a scoping review suggest that peer support programs for other chronic conditions are tailored to address both unique issues faced by people living rurally and barriers to access.[44] Research on existing support structures, preferences for peer support and barriers to program use for rural- or remote-dwelling people with CKD is needed. Other accessibility issues raised during our workshop (e.g., perceived lack of ethnoculturally appropriate peer support resources) draw attention to the need for community engagement to ensure program inclusivity and culturally safe practices. Approaches to integrating peer support across regional and national providers (e.g., CKD programs, external organizations) and evaluating the effectiveness of peer support are additional knowledge gaps requiring further study.

Limitations

Most patients had limited experience with peer support, yet were engaged in the topic and contributed to the discussion. Although all peer mentors had experience of dialysis or transplant, they contributed important perspectives on peer support delivery for people with non-dialysis CKD. To minimize the influence of social desirability on the discussion and final priorities, skilled facilitators encouraged respectful interactions and input from all participants, and voting was anonymous. As we were unable to determine stakeholder role from audio recordings or dot votes, we could not attribute priorities to specific participant groups and thus present integrated findings. The virtual format may have limited interpersonal connection and interaction, and although participants were satisfied with the format, they suggested that additional time to discuss this nuanced topic would have been helpful. Lastly, participants were English speakers, mostly White, and had Internet access, technological proficiency and high educational attainment. Although accessibility issues were raised, it is possible that participants with different characteristics may have identified additional considerations.

Lessons learned from patient engagement

We used a patient-oriented research approach to address a priority area for patients with CKD and learned from the lived experience of our patient partners through their contributions to study design and conduct. In synthesizing and reporting our findings, patient partners provided suggestions to ensure key messages resonate with nonacademic readers. Importantly, our patient partners are deeply invested in this topic and in improving the lives of people with kidney disease, on which we commit to furthering our collaboration through future work.

Conclusion

In our consensus workshop, patients and other stakeholders prioritized flexibility, tailoring and inclusivity of peer support delivery for people with non-dialysis CKD. These program features should be considered when developing and implementing peer support interventions in this context. Findings will inform future work to enhance supports for people with CKD through continued engagement with patient partners.

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Data sharing: This study used potentially identifiable, participant-level data collected from discussions during a consensus workshop. Our deidentified dataset may be made available upon reasonable request in writing to the corresponding author.

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