Supplemental Information

SUPPLEMENTAL TABLE 5 Comparison of Usual Care, Enhanced Usual Care, and HCT CC

Clinical CC Activity	Usual Care	Enhanced Usual Care	Intervention (HCT Care Coordinator)
Developmentally appropriate adolescent-focused primary care medical home within a dedicated academic setting	X	X	X
Verbal notification in a routine practice setting of an expectation to transfer to adult care provider by age 22 y	X	X	X
Guidance on locating an adult medical provider	X	X	X
Written information on advanced directives	X	X	X
Personalized assistance in establishing advanced directive	—	—	X
Written generic insurance information	—	X	X
Written guardianship information	—	X	X
HSCSN case management for all youth who were covered under an insurance plan (eg, assistance with appointments, referrals, transportation, linkage to community resources)	—	X	X
Exposure to practice-based AAP–AAFP–ACP recommended core elements			
Transition policy in writing (core element 1)	X	X	X
Enrollment in AHC transition registry (core element 2)	—	X	X
Written transition readiness assessment (core element 3)	—	X	X
Transition planning (core element 4)			
Portable medical summary	—	—	X
In-person consultation with HCT clinical care coordinator who addressed strengths and gaps in transition readiness assessment	—	—	X
Scheduled monthly phone calls with HCT care coordinator leading up to transfer to discuss progress and problem solve as needed	—	—	X
Identify and notify adult primary care practice of pending transfer of care date for youth and arrange for individualized introduction	—	—	X
Transition and transfer of care (core element 5)			
Direct communication with adult PCP and team (e-mail, phone, in-person “handshake”)	—	—	X
HCT summary and transfer of care checklist	—	—	X
Send “transition package” containing transfer cover letter and other items named above and in transfer of care checklist	—	—	X
Transition completion (core element 6)			
HCT care coordinator acts as a resource for each transferred patient and his or her adult care PCP and/or team after transfer	—	—	X
HCT care coordinator contacts adult PCP and/or team posttransfer to ensure success and continuity of care	—	—	X
Transition and transfer declared complete	—	—	X

AHC, adolescent health center; HSCSN, Health Services for Children with Special Needs; PCP, primary care physician; —, not applicable.