

Examples of Funded Grants in Healthcare Delivery Research

Overview

The National Cancer Institute (NCI) frequently receives requests for examples of funded grant applications. Several investigators and their organizations agreed to let the Healthcare Delivery Research Program (HDRP) post excerpts of their healthcare delivery research grant applications online.

About

We are grateful to the investigators and their institutions for allowing us to provide this important resource to the community. We only include a copy of the SF 424 R&R Face Page, Project Summary/Abstract (Description), Project Narrative, Specific Aims, and Research Strategy; we do not include other SF 424 (R&R) forms or requisite information found in the full grant application (e.g., performance sites, key personnel, biographical sketches). To maintain confidentiality, we have redacted some information from these documents (e.g., budgets, social security numbers, home addresses, introduction to revised application).

Copyright Information

The text of the grant applications is copyrighted. Text from these applications can only be used for nonprofit, educational purposes. When using text from these applications for nonprofit, educational purposes, the text cannot be changed and the respective Principal Investigator, institution, and NCI must be appropriately cited and credited.

Accessibility

Individuals using assistive technology (e.g., screen reader, Braille reader) who experience difficulty accessing any information should send an email to the Healthcare Delivery Research Program (NCIHDRP@mail.nih.gov).

424 R&R and PHS-398 Specific Table Of Contents

| | |
|---|----|
| Examples of Funded Grants in Healthcare Delivery Research | 1 |
| Table Of Contents | 2 |
| SF 424 R&R Face Page | 3 |
| Project Summary/Abstract | 4 |
| Project Narrative | 5 |
| Specific Aims | 6 |
| A. SIGNIFICANCE | 7 |
| B. INNOVATION | 8 |
| C. APPROACH | 8 |
| Bibliography & References Cited | 14 |

SF 424 R&R Face Page

PI: Devine, Katie A

Grant Number: 1 R21 CA222936-01A1

Title: Improving Transition Readiness in Adolescent and Young Adult (AYA) Survivors of Childhood Cancer

FOA: PAR16-278

FOA Title: STIMULATING INNOVATIONS IN BEHAVIORAL INTERVENTION RESEARCH FOR CANCER PREVENTION AND CONTROL (R21)

Organization: RBHS -CANCER INSTITUTE OF NEW JERSEY

Department: Rutgers Cancer Institute of NJ

Senior/Key Personnel: Katie Devine

Organization: Rutgers, The State University of New Jersey

Role Category: PD/PI

Project Summary/Abstract

Adolescent and young adult (AYA) survivors of pediatric cancers require lifelong “risk-based” follow-up care tailored to their treatment exposures, including routine medical appointments, monitoring for late effects, and regular cancer screenings. In addition to normal developmental tasks of pursuing higher education, initiating careers, living independently, and forming intimate relationships, AYA survivors must also assume primary responsibility for the management of their long-term follow-up care. This transition from parent-guided management to self-management of medical care can be challenging for the AYA and his or her family, resulting in lapses in care and potentially preventable health problems. Only a minority of young adult cancer survivors obtain risk-based follow-up care; one major contributor to non-adherence is a lack of preparation or low “transition readiness” to transfer to adult-oriented care.

The goal of this project is to pilot test a self-management + peer mentoring intervention to improve AYA cancer survivor transition readiness. Based on the Social-Ecological Model of AYA Readiness for Transition and interviews with AYA cancer survivors, parents, and providers, we created the content for the self-management intervention that focuses on overcoming survivor barriers to self-management such as lack of knowledge, low self-efficacy, and poor communication skills. Peer mentors are a novel component of the intervention and serve to provide credible specialized information, empathy, and advice, capitalizing on shared experience and meeting a psychosocial need for AYA survivors. We conducted a small pilot with AYA survivors to gain feedback on the content and infrastructure of the peer mentor component. AYA survivors found the content, online delivery, and peer mentor contact acceptable, but highlighted a need for engaging online tools. This project will utilize AYA survivor input to build the online intervention with interactive tools such as personalized feedback, animated videos, and games to encourage engagement with the intervention. Then we will conduct a randomized pilot test of the intervention to evaluate feasibility, acceptance, and preliminary effects on AYA transition readiness.

Project Narrative

A lack of preparation to transition from pediatric to adult-oriented healthcare can result in lapses in care and adverse health effects for adolescent and young adult (AYA) cancer survivors who are at-risk for negative health effects due to their cancer treatment history. The proposed innovative intervention is highly responsive to NCI's call for behavioral interventions to improve cancer-related health behaviors across the cancer continuum. This project is intended to empower AYA cancer survivors to become strong advocates of lifelong follow-up care, leading to increased adherence to survivorship medical recommendations and reductions in healthcare costs through prevention or early detection of late effects for survivors of childhood cancers.

Specific Aims

Childhood cancer survivors are a growing population (>379,000 in the US)³ who are at risk for adverse late health effects from treatment. Between 67-95% of childhood cancer survivors develop chronic health conditions such as cardiovascular disease.⁴⁻⁶ Survivors require lifelong “risk-based” follow-up care based on the treatment they received to identify and treat late health effects.⁷ Unfortunately, less than 1 in 5 adult survivors of childhood cancer obtain risk-based follow-up care.⁸ The transition from pediatric to adult follow-up care is a critical period when many survivors are lost to follow-up.⁹ One reason for this loss to follow-up is a lack of preparation or low “transition readiness” for adult-oriented healthcare, which relies on the young adult to assume responsibility for medical decision-making (vs. parent responsibility).¹⁰ Transition readiness is defined as having the skills, motivation, and resources to move from pediatric-oriented to adult-oriented care.¹¹ This transition involves shifting from parent-management of care to young adult self-management of care, and may also involve changing physical location and providers of care. Transition readiness has been linked to engagement in adult-oriented care.¹² However, very few medical centers have programs to prepare adolescent and young adult (AYA) survivors for successful transfer to adult care. Further, this transition in responsibility for care occurs within the broader developmental transition from adolescence to young adulthood, which is characterized by exploration and striving for autonomy in multiple life domains (e.g., education, career, intimate relationships).¹³ These competing developmental tasks often take priority over healthcare transition.¹⁰

To address this important unmet need among childhood cancer survivors, we developed the *content* of “Managing Your Health,” a self-management skills + peer mentoring intervention that focuses on overcoming survivor barriers to self-management of care. The intervention is guided by the Social-Ecological Model of AYA Readiness for Transition,¹ and it is informed by a series of interviews with AYA cancer survivors, parents, and providers. It consists of two components: (1) online educational modules to improve self-management skills and (2) a peer mentor to provide support and facilitate engagement with the modules. We focus on improving survivors’ transition readiness so they have the skills, motivation, and resources to navigate the healthcare system and overcome barriers to obtaining care. Key barriers addressed by the self-management modules include: lack of knowledge of treatment history and late effect risks, lack of self-management skills for handling healthcare logistics, low self-efficacy for managing care, concern about impersonal relationships with adult (vs. pediatric) providers, and poor communication about medical care with parents and providers.^{9,10,14,15} The use of peer mentoring with other AYA cancer survivors is a novel intervention component designed to provide support regarding emotional and practical barriers to transition and to facilitate AYA survivors’ engagement with the online modules. Because of their shared cancer experience, peer mentors can validate AYAs’ concerns about healthcare self-management and address emotional and practical barriers to transition. AYA survivors prioritize opportunities to interact with other AYA survivors¹⁶ and information from trusted peers with similar health experiences may be perceived as more credible,¹⁷ offering an advantage over provider-delivered interventions.

To fill this gap in transitional care, we conducted a series of small studies with AYA survivors to develop and evaluate the basic content of the five self-guided self-management modules and infrastructure of the peer component. The next step is to add interactive components to increase usability and engagement with the material. The goal of this project is to evaluate the feasibility of the “Managing Your Health” intervention. We will use AYA survivor interviews and usability testing to develop interactive tools to create more engaging self-management modules. We will then conduct a randomized controlled pilot test of the intervention versus usual care with 50 AYA survivors ages 18-25 years who have low transition readiness.

Primary Aim: Evaluate the feasibility of intervention.

We will examine feasibility through study enrollment rates, reasons for refusal, retention rates, usability of and engagement with the intervention components, and reasons for study drop out.

Hypothesis 1: Based on literature, we expect >50% enrollment of eligible patients and \geq 80% retention.

Hypothesis 2: Participants will complete >75% of online modules and >75% of scheduled contacts with mentor.

Secondary Aim: Assess preliminary efficacy of the intervention.

Hypothesis 3: Participants in the self-management + peer mentor intervention will demonstrate greater improvement in transition readiness than participants in the usual care group.

The proposed research seeks to address gaps in the long-term healthcare of pediatric cancer survivors by evaluating an innovative theory-based intervention to improve transition readiness of AYA survivors. Results of the proposed research will provide evidence of feasibility and yield an intervention that will be ready for efficacy testing in a large randomized trial.

A. SIGNIFICANCE

A.1. The transition to adult self-management of health is critical but often poorly planned.

AYA cancer survivors are expected to assume primary responsibility for their healthcare when they reach adulthood. Poor readiness to transition to adult self-management of care can lead to inadequate follow-up care or disengagement from care.¹⁸ Given that 67-95% of survivors of childhood cancer develop a chronic health condition by age 45,^{5,6} lapses in care present both a personal and societal risk. The personal risk is that late effects are undetected, misdiagnosed, or mistreated. The societal risk is that a lack of monitoring leads to increased preventable healthcare costs. Unfortunately only a minority (<18%) of adult childhood cancer survivors obtain risk-based follow-up care.⁸ Current guidelines recommend at least an annual surveillance visit in addition to general preventive health behaviors.¹⁹ Results from the Childhood Cancer Survivor Study and our prior work show that even survivors at greatest risk for late effects demonstrate low rates of cancer screening and follow-up.^{2,8,20,21} The transition to adulthood is a particularly challenging time when AYAs are lost to follow-up due to competing developmental demands that take priority (e.g., moving out of parents' home, pursuing a career).^{7,22} Although there has been attention to medical models of transition care for AYA survivors,¹⁰ very few pediatric cancer centers have transition programs to prepare AYAs to move to adult-oriented healthcare.^{9,18,23}

A.2. Improving transition readiness can improve engagement in adult healthcare.

Transition readiness is defined as having the skills, motivation, and resources to move from pediatric-oriented to adult-oriented care.¹¹ Survivor-related barriers to transition readiness include inadequate knowledge of cancer treatment and late effect risks, lack of self-management skills, low self-efficacy for managing care, concern about impersonal relationships with adult (vs. pediatric) providers, poor communication with parents and providers, and lower perceived priority of health compared with competing developmental pursuits (e.g., education, career).^{10,14,16,22} Transition readiness is a critical precursor to adult self-management of care,¹⁸ and adult self-management improves health status and reduces healthcare utilization.²⁴ To date, little work has evaluated transition readiness as a predictor of adult adherence and outcomes in AYA survivors. One study linked components of transition readiness, including survivor motivation, comfort speaking with providers about health concerns, and parental support in healthcare decision-making, to AYA survivor engagement in adult-oriented care.¹² A growing body of research in other populations has generally shown positive associations between transition readiness and adherence to adult care and better health outcomes.²⁵⁻³²

A.3. Theoretically-driven interventions to improve AYA transition readiness are needed.

Until recently, the lack of transition-related theoretical frameworks hindered the development of theory-based interventions to improve transition readiness.¹ However, the recent Social-Ecological Model of AYA Readiness for Transition (SMART; Figure 1)¹ outlines modifiable treatment targets: knowledge of health history and future risks; self-management skills and self-efficacy for managing care; beliefs and expectations regarding adult-oriented care (e.g., belief that adult providers will not understand unique AYA survivors' needs); health transition goals; relationships/communication with parents and providers; and psychosocial functioning of patients, parents, and providers.¹ To date, research has primarily focused on defining and measuring transition readiness;³³ the proposed project will be one of the first to apply transition theory to intervention development. Published survivor-focused interventions have been education-based, using in-person speaker series³⁴ and/or one-day conferences³⁵ to improve knowledge. Although important, knowledge is only one aspect of transition readiness. The proposed intervention will target multiple aspects of transition readiness to prepare AYA survivors for adult-oriented healthcare.

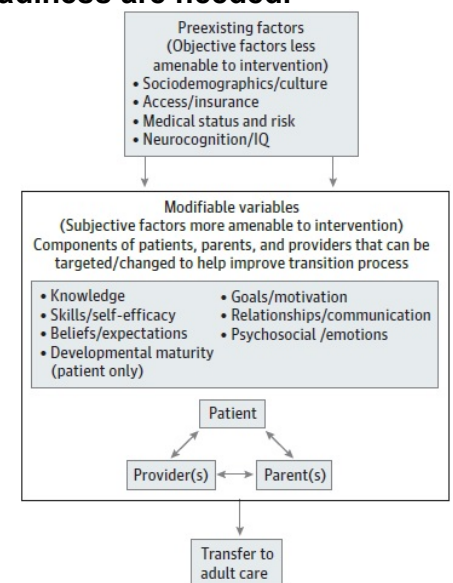


Figure 1. SMART conceptual

A.4. Peer mentors offer specialized support that addresses an unmet need for AYA survivors.

Providing skills to manage their health is necessary for an effective transition to adult-oriented care, but

does not address a common unmet need of AYA survivors to connect with other AYA survivors. Our preliminary work and other studies show that AYA survivors have an unmet need to discuss their healthcare with other AYA survivors who “get it,” as healthy peers do not share the same healthcare demands.^{9,16,36} This aligns with functional specificity theory of social networks, which proposes that individuals receive specific types of support (e.g., informational, emotional, logistical) from different people or ties in their network.³⁷ Social network ties who have direct personal experience with a life event or “experiential similarity” are more likely to offer specialized health-related informational support (e.g., symptom management tips) and emotional support (e.g., empathy).³⁸ Because of their experiential similarity, peer survivors can offer informational and emotional support, serve as role models, and provide advice as AYAs take greater responsibility for managing their healthcare.³⁹ AYA survivors prioritize information from other AYA survivors¹⁶ and such information is likely to be perceived as more credible,¹⁷ giving peer mentoring an advantage over provider-delivered interventions. Peer mentoring using weekly video calls improved self-management skills for adolescents with other chronic conditions,^{40,41} but has not yet been tested for AYA survivors. The only published peer-delivered intervention for survivors focused on smoking cessation. It was effective, suggesting peer-to-peer interventions can change health behaviors in this population.⁴²

A.5. Internet interventions are particularly relevant for AYA and overcome barriers to engaging AYA.

AYA survivors are digital natives and express a desire for Internet interventions that offer trustworthy information, psychological support, and peer support.⁴³⁻⁴⁵ Delivery via the Internet overcomes geographical barriers to participation common among AYA survivors.⁴⁶ The small but growing body of research using Internet interventions has demonstrated feasibility and acceptability among AYA survivors,⁴⁷⁻⁴⁹ but more work is needed regarding the efficacy of these interventions. Studies with other populations suggest that interfaces that are efficient (i.e., easy to understand and use) and those that increase user engagement are more effective.^{50,51} Elements that increase engagement include prompts, gamification, and tailoring of content.⁵²⁻⁵⁴

A.6. Summary of Scientific Premise.

In summary, there is strong evidence demonstrating that the transition to adult-oriented healthcare is critical but there are few formal transition programs available, and no theoretically driven survivor-focused interventions.^{1,9,10,18} Current survivor-focused interventions have focused on knowledge and required in-person attendance, limiting the reach of such interventions. The use of engaging online delivery and a peer mentor to improve self-management of care shows promise for this population.

B. INNOVATION

This study of a novel intervention will advance AYA survivorship care research in the following ways:

1. **Theoretical Approach:** The application of the SMART theory¹ to guide intervention development moves the field from measure development to intervention. The use of theory also shifts current research from single component interventions (i.e., in-person speakers or conferences targeting knowledge improvement) to interventions that target multiple components of healthcare self-management for this unique age group.
2. **Intervention Approach:** The use of peer mentors meets the unique social needs of AYA survivors^{16,36} and capitalizes on the “experiential similarity” of peers to provide specialized health-related informational and emotional support unlikely to be offered by family and friends in the survivors’ social network.⁵⁵ The use of technology overcomes logistical barriers of in-person interventions and can be scaled for dissemination.
3. **Addresses unmet need among AYA survivors:** There are no efficacious interventions for AYA survivors transitioning to adult healthcare. AYA survivors have unique psychological and social needs¹⁰ and must navigate survivorship care in the midst of normative life transitions. This calls for an intervention developed specifically for this population, accounting for the developmental transitions occurring in multiple domains.

C. APPROACH

C.1. Preliminary Studies. The study team has expertise in AYA survivorship and transition (Devine^{21,45,56}), interventions for cancer survivors and caregivers (Manne⁵⁷⁻⁵⁹), AYA medical follow-up care (Masterson), social networks/peer health-related support (Gage Bouchard^{38,60,61}), eHealth (Palermo), and statistics (Ohman-

Strickland). This proposal builds from a series of preliminary studies to identify AYA survivors' unmet needs, illuminate intervention topics relevant to the SMART theoretical model, identify optimal delivery approaches, and demonstrate feasibility of the peer mentorship model and online modules. First, we conducted a qualitative study of barriers and facilitators to risk-based follow-up care with 19 AYA survivors of pediatric cancer (recruited locally and using Twitter and stupidcancer.org) to identify unmet needs to target. We found that poor knowledge, a lack of preparation to take charge of their health, and difficulty negotiating parental involvement in care were barriers to transition to adult-oriented care. One third of the sample spontaneously suggested that it would be helpful to seek advice from a peer who had successfully navigated the transition. These findings demonstrated a need for skills-based self-management interventions that incorporate peer social support.

Next, we conducted interviews with 10 AYA survivors, parents, and providers (recruited locally) regarding specific components of a self-management + peer mentoring intervention to improve transition readiness. Survivors expressed preference for talking with a peer mentor via videoconference or phone and text message rather than social media. Informed by the SMART model and these initial interviews, we developed the basic content of the intervention (in PowerPoint) to address five major themes from preliminary work and the literature⁷ (see Table 1). Initial feedback from 4 AYA survivors indicated that online delivery was preferred and content was relevant, but lacked engaging interactive elements. Participants suggested videos, narrated presentations, and tailored feedback, in line with the broader literature on user engagement.⁵²⁻⁵⁴

Since the last submission, we conducted a small pilot of the intervention, which has allowed us to reduce the amount of development work in this proposal. The intervention modules were built in Powerpoint and delivered via Canvas, an online learning system; participants connected with a peer mentor using HIPAA-compliant text-messaging (TigerText) and videoconferencing (Doxy.me). We trained 10 peer mentors and enrolled 19 participants (6 completed, 10 in progress, 3 dropped). Participants' overall satisfaction and satisfaction with the modules were high (4.7 and 3.8 out of 5). Qualitative feedback indicated module content was relevant and guided peer mentor discussions. Based on participant and mentor feedback, we added new information to modules (e.g., communicating with significant others, support resources) and obtained design ideas (e.g., videos, quizzes). In sum, we have evidence of interest in a self-management + peer mentoring intervention, relevance of the content, and feasibility of the infrastructure of the peer mentoring and modules, but need to enhance interactive components to improve usability and engagement with the online materials.

C.2. Research Design and Methods

C.2.1. Overall Study Design. Usability testing will occur in months 1-9. We will recruit 50 AYA survivors and 10 mentors to participate in the pilot in months 10-18. Participants will complete surveys at baseline, post-intervention (~6 weeks), and follow-up (~4.5 months). Data collection and analyses will occur in months 11-24.

C.2.2. Phase 1: Usability Testing of Self-Management + Peer Mentoring Intervention

In preliminary work we developed useful *content* of the self-management educational modules but identified a need for a more user-friendly and engaging website. The first phase will build a more engaging mobile responsive website with AYA survivor stakeholder input, following processes of user-centered design.

Patient Eligibility & Recruitment. We will recruit up to 20 AYA survivors of childhood cancers through the New Jersey State Cancer Registry (NJSCR) using the same eligibility criteria as the pilot trial (see C.2.3).

Usability Testing. ITX Corporation, an experienced technology firm with whom Dr. Devine has worked (K07174728), will create wireframes or mock-ups of the mobile-responsive website based on functionality requirements defined in preliminary work. We chose responsive web design to optimize viewing on any device and provide flexibility with future technology developments. AYA survivors will complete 1-hour long usability sessions where they are asked to move through standardized features of the site, commenting on any difficulties they encounter. Research staff will record each session, observe participants completing tasks, including time to complete tasks and errors.⁶² At the end of the session, staff will use a semi-structured interview to solicit additional feedback on layout, navigation, and expectations for use of the site. AYA survivors will also provide standard ratings of acceptability (e.g., attractiveness) and usability (e.g., ease of use).⁶³ Usability tests are completed using a rapid iterative procedure, in which design changes are identified and made after receipt of a small group of user feedback (~2-4 people) and

the revised interface tested in the next cycle until no major issues are found. The research team and user design/interaction experts from ITX will discuss conflicting suggestions to form a consensus on proposed changes. We have planned for up to 3 iterative design changes. We also build resources into Phase 2 for maintenance and upgrades.

Proposed Analyses/Intervention Refinement. Notes will be taken and comments transcribed for qualitative analysis. The research team will discuss user experience difficulties with the ITX design team for changes during the iterative cycles of usability testing. Comments on intervention materials will be analyzed using content analysis, guided by our theoretical framework.⁶⁴ Using NVivo qualitative analysis software, Dr. Devine and the research assistant will independently identify themes regarding intervention content and bring to the research team for discussion of refinement. Given the preliminary work already conducted, we expect 12-20 sessions will achieve data saturation (i.e., no new issues emerge according to pre-specified stopping criteria).⁶⁵ We will field-test the live website to identify any technical issues prior to moving to the pilot RCT.

C.2.3. Phase 2: Pilot RCT of Self-Management + Peer Mentoring Program vs. Usual Care

AYA Survivor Eligibility & Recruitment. AYA survivors will be recruited through the New Jersey State Cancer Registry. Eligibility includes: (1) age 18-25, (2) at least 2 years from treatment completion (the typical time for transfer to long-term follow-up care), (3) no documented or self-reported cognitive delay to prevent self-management of healthcare, and (4) low self-reported transition readiness as indicated by report of *not at all ready* or *somewhat ready* (vs. *mostly* or *completely ready*) to assume complete responsibility for healthcare on the Readiness for Transition Questionnaire overall readiness item.⁶⁶ A screener identifies patients in need of intervention.⁶⁷ Recent survey studies show 61-67% of AYA survivors will meet the low readiness criteria.^{66,68}

Procedures for AYA Survivors. After informed consent, participants will complete an online baseline survey using DatStat, a HIPAA-compliant electronic data capture system. Next, participants will be randomly assigned to the intervention or usual care group. Dr. Ohman-Strickland will determine a randomization scheme using an undisclosed varying block size of 4 to 6 to ensure balance in sample size between groups.⁶⁹ We will not stratify randomization by any variable, as there is no evidence to suggest that any variable would influence response to intervention. Research staff will notify survivors of assignment via phone and/or email. All participants will be asked to complete a post-intervention survey at 6 weeks and a follow-up survey 3 months after that (~4.5 months after baseline). Participants will receive \$25 for completion of each survey.

Self-Management + Peer Mentoring Intervention. The “Managing Your Health” intervention consists of: (1) online self-management educational modules and (2) weekly peer mentor calls to facilitate engagement with the modules and offer specialized support. Table 1 shows the content of the calls and online modules based on preliminary work. Phase 1 of this project will build the website and add engagement tools, including tailored feedback on transition readiness, personalized assignments, animated videos, and interactive games. Each module takes 20-30 minutes to complete and ends with a personalized assignment for the participant to complete (e.g., obtain survivorship care plan, make appointment, practice communication skills).

Participants will be matched with a peer mentor of the same sex and cancer type to the extent possible.^{40,41} Peer mentors will introduce themselves via secure text-message (TigerText⁷⁰) prior to the initial videoconference (using HIPAA-compliant Doxy.me⁷¹). The first call is to build rapport, exchange survivor stories regarding follow-up care, and identify the participant’s self-management strengths, weaknesses, and goals. Mentor-participant pairs then complete five additional weekly calls, each aligned with one module, which the mentee is expected to complete prior to their scheduled call. The dose was chosen based on other peer mentoring programs that employed weekly videocalls.^{40,41} Prompts to complete modules will be generated if there is no user activity within five days of the previous log-in. In addition to weekly calls, the mentor will offer support and relevant resources through weekly secure text message. Mentor-mentee calls will be recorded and text messages will be archived for fidelity checks, supervision, and content analysis.

Table 1. Theoretically informed content of self-management modules

| Call | Module | Proposed Content | Transition Readiness Construct |
|------|--------|--|---|
| 1 | N/A | Getting to Know Each Other – rapport building, exchanging survivor stories | N/A |
| 2 | 1 | Understanding Treatment History and Survivorship Care Plan <ul style="list-style-type: none"> • Name diagnosis, treatments received, risks for late health effects • Obtain (if needed) Survivorship Care Plan; Identify necessary health screenings | Knowledge Goals/motivation |
| 3 | 2 | Managing Your Health Care <ul style="list-style-type: none"> • Review self-management tasks (e.g., make appointments, obtain screenings) • Logistics of insurance and healthcare tasks, problem-solving barriers to care | Self-Management Skills Self-efficacy Goals/motivation |
| 4 | 3 | Negotiating Family Involvement in Your Care <ul style="list-style-type: none"> • Challenges of parents who do not relinquish control; communication skills • Discuss supportive ways to include family & significant others | Relationships/communication |
| 5 | 4 | Dealing with Emotions about Your Health and Follow-Up Care <ul style="list-style-type: none"> • Coping with uncertainty of future health • Communicating with providers & families about adult-oriented healthcare | Self-Management Skills Relationships/communication |
| 6 | 5 | Staying Healthy in the Context of Life Transitions <ul style="list-style-type: none"> • Maintaining health in midst of other transitions (education, career, relationships) • Skills & resources for healthy diet, exercise, stress management, sexual health | Goals/motivation Self-Management Skills Self-efficacy |

Peer Mentor Recruitment, Training, and Supervision. Peer mentors will be recruited in year 1 via advertisements at the Rutgers Cancer Institute of New Jersey and online via AYA cancer forums and social media, such as Twitter and stupidcancer.org (used in preliminary interview study). Following guidelines from the National Mentoring Research Center⁷² and the Children’s Oncology Group (personal communication with Patient Advocacy Committee Chair), potential mentors will complete an application with one letter of recommendation. The PI or study staff will interview candidates to assess interpersonal communication skills, level of commitment, and related experience. Peer mentor eligibility is (1) age 21-29, (2) at least 2 years from treatment, and (3) self-reported primary responsibility using the Readiness for Transition Questionnaire overall readiness question (maximum score of 4, *completely ready*).⁶⁶ We successfully used this method in the pilot and will recruit 10 peer mentors (assigned 2-3 mentees each).

Peer mentors will attend a one-day training workshop conducted by the PI and study staff (similar to other peer mentor programs^{41,73}). Peer mentors will be given the Peer Mentor Handbook, a manual detailing their roles, responsibilities, and the outline for each mentor call (developed in preliminary work). Presentations, interactive discussions, and role plays are used to teach mentors how to provide informational and emotional support to their mentees. Ethical issues, including confidentiality and setting boundaries with peers, are discussed. Peer mentors will have regular weekly supervision with the PI or trained study staff once assigned mentees. Peer mentors will record phone/video calls with their mentees and all secure text messages exchanged between participants will be archived for use in fidelity checks, supervision, and content analysis. Peer mentors will be compensated \$75 for time and travel to the training workshop and per mentee completed.

Usual Care Comparison. The Usual Care group will complete surveys only. To select an appropriate comparison, we reviewed the literature of advantages/disadvantages of different designs.⁷⁴⁻⁷⁷ This study can be characterized as a phase IIb feasibility pilot focused on feasibility and acceptability, as well as detecting a clinically significant signal over noise.⁷⁶ A usual care comparison group is recommended for initial evaluations of such interventions,⁷⁴ as it maximizes statistical power and protects against falsely concluding that the intervention lacks efficacy. We considered an attention condition (e.g., nonspecific peer support), but because our intervention targets skills and adherence outcomes, not psychological outcomes, we would not expect attention to change behavior.⁷⁷ Further, nonspecific peer support would be difficult to implement with a credible expectancy for participant benefit if peers are limited in discussion topics to avoid contamination of groups. If the intervention demonstrates a clinically significant signal, a larger future trial can determine if comparable outcomes could be achieved with a less intensive or less expensive intervention.⁷⁵ The few published studies evaluating transition interventions have used non-randomized designs or usual care comparisons.^{25,27,29,30}

C.2.4. Feasibility Measures.

Treatment Fidelity. Mentor-participant weekly calls will be recorded and text messages will be archived via administrative aspects of TigerText; these will be used for weekly supervision with the PI or trained research staff. Additionally, 20% of interactions will be randomly selected for treatment fidelity

checklist review.

Usability/Engagement with Self-Management Modules. Participants will complete three standard measures of internet-based interventions immediately post-intervention:^{63,78} 1) Utility Questionnaire (perceived enjoyment, ease of use); 2) Impact Questionnaire (perceived effectiveness in improving skills); 3) Adherence Questionnaire (barriers to engagement). Objective user data (i.e., log-ins, session duration, modules completed, assignments completed, and use of interactive components) will be obtained unobtrusively.

Acceptance/Engagement with Peer Mentor. Acceptance will be evaluated by mentors' and participants' report on perceived alliance with each other using the Working Alliance Inventory – Short Form,⁷⁹ a validated measure of the quality and strength of the relationship immediately post-intervention. Engagement will be measured via number of contacts (video/phone calls, text), length of video/phone calls, and content discussed.

C.2.5. Outcome Measures.

Demographic/medical history will be gathered at baseline. Transition readiness will be assessed at baseline, immediate post-intervention (6 weeks), and 3-months post-intervention (~4.5 months):

Transition Readiness. There is no gold standard measure assessing transition readiness.³³ Therefore, we will use two complementary measures of transition readiness. The Readiness for Transition Questionnaire – Survivor Version (RTQ)⁶⁶ assesses the degree to which survivors are *responsible for 10 healthcare behaviors*, including knowing their survivorship care plan, scheduling annual visits, scheduling specialist appointments, taking and filling medications (if prescribed), explaining medical history to others, knowing insurance coverage, attending appointments, communicating with providers, and calling providers, on a scale from 1 (*not responsible at all*) to 4 (*almost always responsible*). The RTQ yields a total Adolescent Responsibility score and has demonstrated good reliability ($\alpha = .89$) and construct validity.^{66,68} The RTQ also has one item evaluating “overall readiness to assume complete responsibility for healthcare” with response options of *Not at all ready, somewhat ready, mostly ready, or completely ready*. This item correlates highly with total Adolescent Responsibility ($r = .63$)⁶⁸ and will be used as a screener (see C.2.4. eligibility).

The Transition Readiness Inventory (TRI), developed using the SMART framework,⁸⁰ is a comprehensive measure of multiple components of transition readiness. The TRI differs from the RTQ in its focus on behaviors *and knowledge, attitudes, and beliefs*. Specifically, the TRI yields a total score and provides scales for these targets of our intervention: knowledge, self-management skills, self-efficacy for managing care, goals/motivation, and communication with family and providers around survivorship care. The TRI has shown good reliability ($\alpha = .86$) and content validity,^{80,81} as well as predictive validity with engagement in adult healthcare among AYA survivors.¹² We will use the total TRI score.

Follow-up Care Adherence (exploratory outcome). At baseline and 3-months post-intervention, participants will report on cancer-specific and general medical appointments, cancer screenings, and detection of new comorbidities using the Follow-Up Care Use Among Survivors (FOCUS) survey developed by NCI.⁸² Items are generally considered separately and traditional psychometrics (e.g., reliability) are not relevant.

C.2.6. Proposed Analyses.

Aim 1: We will examine feasibility through study enrollment rates, retention rates, usability/engagement with online modules and peer mentor, barriers to engagement, and reasons for study drop out. Descriptive analyses (frequencies, means, confidence intervals) will be used to evaluate hypotheses regarding enrollment (>50%), retention ($\geq 80\%$ complete all surveys), and intervention completion (>75% modules/mentor calls).

Aim 2: Multilevel modeling (MLM) will be used to examine differences between the intervention and usual care groups over time on transition readiness (RTQ Adolescent Responsibility and TRI total scores). Our primary analysis will consider both time and treatment to be categorical with an interaction between the two. The interaction will be assessed to determine whether change in transition readiness differs between the two groups. The MLM approach assumes any missing observations are missing at random but includes all observed data. Exploratory analyses of additional outcomes (e.g., adherence and comorbidity detection) will use the identity link or the logit link as appropriate for continuous or binary outcomes.

Sample Size and Power. We chose the sample size and decision rules so that the probability of

declaring feasibility would be approximately 5% under unacceptable rates of acceptance/completion and exceed 95% under acceptable rates. If true acceptance and completion rates were 41% and 70%, respectively, which we consider too low to move to an efficacy trial, then the probability of declaring feasibility would be 5%.

Table 2. Feasibility decision rules.

| Feasibility | Unacceptable Rate | Acceptable Rate | Decision rule for claiming Feasibility | Prob. Declare Feasible under Unacceptable Rates | Prob. Declare Feasible under Acceptable Rates |
|-------------|-------------------|-----------------|--|---|---|
| Acceptance | 41% | 50% | If 50 recruited by the 100th eligible | 5% | 97% |
| Retention | 70% | 80% | 40 people complete the follow-up | 5% | 94% |

Sample size was based on the primary feasibility aim, but we also calculated detectable group difference in the primary outcome of the RTQ Adolescent Responsibility total score at the 6-week post-intervention time. Based on survey data,⁶⁸ we expect AYA survivors to score an average of 2.57 (SD = 0.83) at baseline. Using an independent t-test assuming the control group remains at baseline levels and two-sided alpha of .05, we have 80% power to detect a group difference of 0.66 in the outcome. This would represent the intervention group increasing from “sometimes” to “often” being responsible, which we consider clinically meaningful.

C.3. Sex as biological variable. We attend to sex by: 1) recruiting both sexes, 2) matching peer mentors and participants by sex, and 3) exploring any differences in outcomes by sex.

C.4. Design Considerations, Potential Problems, & Alternative Strategies.

Design Considerations. We chose AYA survivors ages 18-25 given legal responsibility for healthcare at age 18. The survivor-focused intervention includes skills to communicate effectively with parents and providers to address provider and system level barriers to transition readiness.⁸³ We set the “dose” of one weekly call based on peer mentoring interventions in other populations.⁴¹ We chose in-person training for peer mentors now but future iterations could use technology to reach mentors in widespread geographic locations. With any technology, there is a risk of becoming outdated prior to wide dissemination; we mitigate this risk by using a mobile responsive website that optimizes delivery across devices and allocate some resources for upgrades.

Potential Problems & Alternative Strategies. Recruitment of AYAs can be challenging,⁴⁶ but the New Jersey State Cancer Registry has a large database (>1000 AYA survivors) and the team has experience and resources, including staff to make calls during evening and weekend hours.⁸⁴ We demonstrated initial success in our small pilot for this revision. Web, phone, and text delivery provide flexibility for participating. If we are not meeting recruitment goals, we will expand recruitment to online (e.g., stupidcancer.org) and local sites from which we have successfully recruited in prior studies (e.g., Rutgers, Hackensack University Medical Center).

C.5. Scientific Rigor. We are taking steps to ensure a robust and reproducible approach: 1) random assignment, 2) validated measures, 3) objective engagement data through website monitoring, 4) a peer mentor manual with guidelines for weekly contacts, 5) treatment fidelity checklists for peer contacts, 6) use of online modules to deliver content uniformly, and 7) adherence to CONSORT guidelines in reporting results.⁸⁵

Bibliography & References Cited

1. Schwartz LA, Tuchman LK, Hobbie WL, Ginsberg JP. A social-ecological model of readiness for transition to adult-oriented care for adolescents and young adults with chronic health conditions. *Child: care, health and development*. 2011;37(6):883-895.
2. Yeazel MW, Oeffinger KC, Gurney JG, et al. The cancer screening practices of adult survivors of childhood cancer. *Cancer*. 2004;100(3):631-640.
3. Ward E, DeSantis C, Robbins A, Kohler B, Jemal A. Childhood and adolescent cancer statistics, 2014. *CA: A Cancer Journal for Clinicians*. 2014;64(2):83-103.
4. Lipshultz SE, Colan SD. Cardiovascular trials in long-term survivors of childhood cancer. *Journal of Clinical Oncology*. 2004;22(5):769-773.
5. Oeffinger K, Mertens A, Sklar C, et al. Chronic health conditions in adult survivors of childhood cancer. *New England Journal of Medicine*. 2006;355(15):1572-1582.
6. Hudson MM, Ness KK, Gurney JG, et al. Clinical ascertainment of health outcomes among adults treated for childhood cancer. *Jama*. 2013;309(22):2371-2381.
7. Nathan PC, Hayes-Lattin B, Sisler JJ, Hudson MM. Critical issues in transition and survivorship for adolescents and young adults with cancers. *Cancer*. 2011;117(S10):2335-2341.
8. Nathan P, Greenberg M, Ness K, et al. Medical care in long-term survivors of childhood cancer: a report from the childhood cancer survivor study. *Journal of Clinical Oncology*. 2008;26(27):4401-4409.
9. Rosenberg-Yunger ZRS, Klassen AF, Amin L, et al. Barriers and Facilitators of Transition from Pediatric to Adult Long-Term Follow-Up Care in Childhood Cancer Survivors. *Journal of Adolescent and Young Adult Oncology*. 2013;2(3):104-111.
10. Freyer DR. Transition of care for young adult survivors of childhood and adolescent cancer: Rationale and approaches. *Journal of Clinical Oncology*. 2010;28(32):4810-4818.
11. Betz CL, Ferris ME, Woodward JF, xOkumura JF, Jan S, Wood DL. The health care transition research consortium health care transition model: A framework for research and practice. *Journal of pediatric rehabilitation medicine*. 2014;7(1):3-15.
12. Szalda D, Piece L, Brumley L, et al. Associates of Engagement in Adult-Oriented Follow-Up Care for Childhood Cancer Survivors. *Journal of Adolescent Health*. 2017;60(2):147-153.
13. Zebrack B, Isaacson S. Psychosocial Care of Adolescent and Young Adult Patients With Cancer and Survivors. *Journal of Clinical Oncology*. 2012;30(11):1221-1226.
14. Kadan-Lottick NS, Robison LL, Gurney JG, et al. Childhood cancer survivors' knowledge about their past diagnosis and treatment: Childhood Cancer Survivor Study. *Jama*. 2002;287(14):1832-1839.
15. Zebrack BJ, Eshelman DA, Hudson MM, et al. Health care for childhood cancer survivors. *Cancer*. 2004;100(4):843-850.
16. Zebrack B, Bleyer A, Albritton K, Medearis S, Tang J. Assessing the health care needs of adolescent and young adult cancer patients and survivors. *Cancer*. 2006;107(12):2915-2923.
17. Eysenbach G. Credibility of health information and digital media: new perspectives and implications for youth. In: Metzger MJ, Flanagin AJ, eds. *Digital Media, Youth, and Credibility*. MacArthur Foundation Series on Digital Media and Learning. Cambridge, MA: MIT Press; 2008:123-154.
18. Mulder R, van der Pal H, Levitt G, et al. Transition guidelines: An important step in the future care for childhood cancer survivors. A comprehensive definition as groundwork. *European Journal of Cancer*. 2016;54:64-68.
19. Skinner R, Wallace WHB, Levitt G. Long-term follow-up of children treated for cancer: why is it necessary, by whom, where and how? *Archives of disease in childhood*. 2007;92(3):257-260.
20. Oeffinger KC, Ford JS, Moskowitz CS, et al. Breast cancer surveillance practices among women previously treated with chest radiation for a childhood cancer. *Jama*. 2009;301(4):404-414.
21. Devine KA, Viola A, Capucilli P, Sahler OJZ, Andolina JR. Factors Associated With Noncompliance With Long-term Follow-up Care Among Pediatric Cancer Survivors. *Journal of Pediatric Hematology/Oncology*. 2017;39(3):167-173.
22. Freyer DR, Brugieres L. Adolescent and young adult oncology: Transition of care. *Pediatric Blood & Cancer*. 2008;50(S5):1116-1119.
23. Szalda D, Pierce L, Hobbie W, et al. Engagement and experience with cancer-related follow-up care among young adult survivors of childhood cancer after transfer to adult care. *Journal of Cancer Survivorship*. 2016;10(2):342-350.

24. Lorig KR, Ritter P, Stewart AL, et al. Chronic Disease Self-Management Program: 2-Year Health Status and Health Care Utilization Outcomes. *Medical Care*. 2001;39(11):1217-1223.
25. Chu PY, Maslow GR, von Isenburg M, Chung RJ. Systematic Review of the Impact of Transition Interventions for Adolescents With Chronic Illness on Transfer From Pediatric to Adult Healthcare. *Journal of Pediatric Nursing*. 2015;30(5):e19-e27.
26. Schmidt S, Herrmann-Garitz C, Bomba F, Thyen U. A multicenter prospective quasi-experimental study on the impact of a transition-oriented generic patient education program on health service participation and quality of life in adolescents and young adults. *Patient education and counseling*. 2016;99(3):421- 428.
27. Hankins JS, Osarogiagbon R, Adams-Graves P, et al. A transition pilot program for adolescents with sickle cell disease. *Journal of Pediatric Health Care*. 2012;26(6):e45-e49.
28. Cole R, Ashok D, Razack A, Azaz A, Sebastian S. Evaluation of outcomes in adolescent inflammatory bowel disease patients following transfer from pediatric to adult health care services: case for transition. *Journal of Adolescent Health*. 2015;57(2):212-217.
29. Sequeira PA, Pyatak EA, Weigensberg MJ, et al. Let's Empower and Prepare (LEAP): Evaluation of a Structured Transition Program for Young Adults With Type 1 Diabetes. *Diabetes Care*. 2015;38(8):1412-1419.
30. Okumura MJ, Ong T, Dawson D, et al. Improving transition from paediatric to adult cystic fibrosis care: programme implementation and evaluation. *BMJ quality & safety*. 2014;23:i64-i72.
31. Rosen D, Annunziato R, Colombel JF, Dubinsky M, Benkov K. Transition of Inflammatory Bowel Disease Care: Assessment of Transition Readiness Factors and Disease Outcomes in a Young Adult Population. *Inflammatory bowel diseases*. 2016;22(3):702-708.
32. Steinbeck KS, Shrewsbury VA, Harvey V, et al. A pilot randomized controlled trial of a post-discharge program to support emerging adults with type 1 diabetes mellitus transition from pediatric to adult care. *Pediatric Diabetes*. 2015;16(8):634-639.
33. Schwartz LA, Daniel LC, Brumley LD, Barakat LP, Wesley KM, Tuchman LK. Measures of Readiness to Transition to Adult Health Care for Youth With Chronic Physical Health Conditions: A Systematic Review and Recommendations for Measurement Testing and Development. *Journal of Pediatric Psychology*. 2014;39(6):588-601.
34. Bingen K, Kupst MJ. Evaluation of a survivorship educational program for adolescent and young adult survivors of childhood cancer. *Journal of Cancer Education*. 2010;25(4):530-537.
35. Sadak KT, Connor C, DeLuca H. Innovative educational approaches to engage and empower the adolescent and young adult childhood cancer survivor. *Pediatric blood & cancer*. 2013;60(12):1919- 1921.
36. Granek L, Nathan PC, Rosenberg-Yunger ZRS, et al. Psychological factors impacting transition from paediatric to adult care by childhood cancer survivors. *Journal of Cancer Survivorship*. 2012;6(3):260- 269.
37. Wellman B, Wortley S. Brothers' keepers: Situating kinship relations in broader networks of social support. *Sociological perspectives*. 1989;32(3):273-306.
38. Gage-Bouchard EA, LaValley S, Mollica M, Beaupin LK. Communication and exchange of specialized health-related support among people with experiential similarity on facebook. *Health Communication*. 2017;32(10):1233-1240.
39. Thoits PA. Mechanisms linking social ties and support to physical and mental health. *Journal of health and social behavior*. 2011;52(2):145-161.
40. Stinson J, Kohut SA, Forgeron P, et al. The iPeer2Peer Program: a pilot randomized controlled trial in adolescents with Juvenile Idiopathic Arthritis. *Pediatric Rheumatology*. 2016;14:48(1):1-10.
41. Kohut SA, Stinson JN, Ruskin D, et al. iPeer2Peer program: a pilot feasibility study in adolescents with chronic pain. *Pain*. 2016;157(5):1146-1155.
42. Emmons KM, Butterfield RM, Puleo E, et al. Smoking among participants in the childhood cancer survivors cohort: The Partnership for Health Study. *Journal of Clinical Oncology*. 2003;21(2):189-196.
43. Barakat LP, Galtieri LR, Szalda D, Schwartz LA. Assessing the psychosocial needs and program preferences of adolescents and young adults with cancer. *Supportive Care in Cancer*. 2016;24(2):823- 832.
44. Abrol E, Groszmann M, Pitman A, Hough R, Taylor RM, Aref-Adib G. Exploring the digital technology preferences of teenagers and young adults (TYA) with cancer and survivors: a cross-sectional service evaluation questionnaire. *Journal of Cancer Survivorship*. 2017;11(6):670-682.
45. Mooney R, Samhoury M, Holton A, et al. Adolescent and Young Adult Cancer Survivors' Perspectives on Their Internet Use for Seeking Information on Healthy Eating and Exercise. *J Adolesc Young Adult Oncol*. 2017;6(2):367-371.

46. Rabin C, Horowitz S, Marcus B. Recruiting young adult cancer survivors for behavioral research. *Journal of clinical psychology in medical settings*. 2013;20(1):33-36.
47. Rabin C, Dunsiger S, Ness KK, Marcus BH. Internet-Based Physical Activity Intervention Targeting Young Adult Cancer Survivors. *J Adolesc Young Adult Oncol*. 2011;1(4):188-194.
48. Casillas J, Goyal A, Bryman J, et al. Development of a text messaging system to improve receipt of survivorship care in adolescent and young adult survivors of childhood cancer. *J Cancer Surviv*. 2017;11(4):505-516.
49. Stinson J, Gupta A, Dupuis F, et al. Usability testing of an online self-management program for adolescents with cancer. *J Pediatr Oncol Nurs*. 2015;32(2):70-82.
50. Perski O, Blandford A, West R, Michie S. Conceptualising engagement with digital behaviour change interventions: a systematic review using principles from critical interpretive synthesis. *Transl Behav Med*. 2017;7(2):254-267.
51. van Genugten L, Dusseldorp E, Webb TL, van Empelen P. Which combinations of techniques and modes of delivery in internet-based interventions effectively change health behavior? A meta-analysis. *Journal of medical Internet research*. 2016;18(6).
52. Schubart JR, Stuckey HL, Ganeshamoorthy A, Sciamanna CN. Chronic health conditions and internet behavioral interventions: a review of factors to enhance user engagement. *Comput Inform Nurs*. 2011;29(2):81-92.
53. Alkhalidi G, Hamilton FL, Lau R, Webster R, Michie S, Murray E. The Effectiveness of Prompts to Promote Engagement With Digital Interventions: A Systematic Review. *J Med Internet Res*. 2016;18(1):e6.
54. Looyestyn J, Kernot J, Boshoff K, Ryan J, Edney S, Maher C. Does gamification increase engagement with online programs? A systematic review. *PLoS One*. 2017;12(3):e0173403.
55. Gage-Bouchard EA, LaValley S, Panagakis C, Shelton RC. The architecture of support: The activation of preexisting ties and formation of new ties for tailored support. *Social Science & Medicine*. 2015;134:59-65.
56. Devine KA, Monaghan M, Schwartz L. Transition in pediatric psychology: Adolescents and young adults. In: Roberts MC, Steele RG, eds. *Handbook of Pediatric Psychology*. 5th ed. New York, NY: Guilford Press, Inc.; 2017:620-631.
57. Manne S, Mee L, Bartell A, Sands S, Kashy DA. A randomized clinical trial of a parent-focused social-cognitive processing intervention for caregivers of children undergoing hematopoietic stem cell transplantation. *Journal of consulting and clinical psychology*. 2016;84(5):389-401.
58. Manne SL, Rubin S, Edelson M, et al. Coping and communication-enhancing intervention versus supportive counseling for women diagnosed with gynecological cancers. *Journal of consulting and clinical psychology*. 2007;75(4):615-628.
59. Manne SL, Kissane DW, Nelson CJ, Mulhall JP, Winkel G, Zaider T. Intimacy-enhancing psychological intervention for men diagnosed with prostate cancer and their partners: A pilot study. *The journal of sexual medicine*. 2011;8(4):1197-1209.
60. LaValley SA, Gage-Bouchard EA, Mollica M, Beaupin L. Examining social media use among parents of children with cancer. *Proceedings of the Association for Information Science and Technology*. 2015;52(1):1-3.
61. LaValley SA, Kiviniemi MT, Gage-Bouchard EA. Where people look for online health information. *Health Information & Libraries Journal*. 2017;34(2):146-155.
62. Zhang D, Adipat B. Challenges, methodologies, and issues in the usability testing of mobile applications. *International Journal of Human-Computer Interaction*. 2005;18(3):293-308.
63. Ritterband LM, Ardan K, Thorndike FP, et al. Real world use of an Internet intervention for pediatric encopresis. *J Med Internet Res*. 2008;10(2):e16.
64. Pope C, Ziebland S, Mays N. Analysing qualitative data. *BMJ*. 2000;320(7227):114-116.
65. Francis JJ, Johnston M, Robertson C, et al. What is an adequate sample size? Operationalising data saturation for theory-based interview studies. *Psychology and Health*. 2010;25(10):1229-1245.
66. Gilleland J, Lee JL, Vangile K, et al. Assessment of transition readiness among survivors of childhood cancer. National Conference in Pediatric Psychology; 2013; New Orleans, LA.
67. Kazak AE. Pediatric Psychosocial Preventative Health Model (PPPHM): Research, practice, and collaboration in pediatric family systems medicine. *Families, Systems, & Health*. 2006;24(4):381-395.
68. Gilleland J, Lee JL, Vangile K, et al. AYA and parent perceptions of transition readiness and healthcare responsibility among survivors of childhood cancer. Society for Pediatric Psychology Annual Conference; 2014; Philadelphia, PA.
69. Suresh KP. An overview of randomization techniques: An unbiased assessment of outcome in clinical

- research. *Journal of Human Reproductive Sciences*. 2011;4(1):8-11.
70. TigerText. <https://www.tigertext.com/>. Accessed January 2, 2017.
 71. Doxy.me. [website]. <https://doxy.me/>. Accessed October 25, 2017.
 72. Garringer M. Effective Mentor Recruitment: Getting Organized, Getting Results. Folsom, CA: Mentoring Resource Center, U.S. Department of Education; 2006; <http://www.nationalmentoringresourcecenter.org/index.php/what-works-in-mentoring/resources-for-mentoring-programs.html?id=89>. Accessed January 9, 2017.
 73. Jerson B, D'urso C, Arnon R, et al. Adolescent transplant recipients as peer mentors: A program to improve self-management and health-related quality of life. *Pediatric transplantation*. 2013;17(7):612- 620.
 74. Mohr DC, Spring B, Freedland KE, et al. The selection and design of control conditions for randomized controlled trials of psychological interventions. *Psychotherapy and psychosomatics*. 2009;78(5):275- 284.
 75. Freedland KE, Mohr DC, Davidson KW, Schwartz JE. Usual and Unusual Care: Existing Practice Control Groups In Randomized Controlled Trials of Behavioral Interventions. *Psychosomatic medicine*. 2011;73(4):323-335.
 76. Czajkowski SM, Powell LH, Adler N, et al. From ideas to efficacy: the ORBIT model for developing behavioral treatments for chronic diseases. *Health Psychol*. 2015;34(10):971-982.
 77. Pagoto S, McDermott MM, Reed G, et al. Can attention control conditions have detrimental effects in behavioral medicine randomized trials? *Psychosomatic medicine*. 2013;75(2):137-143.
 78. Thorndike FP, Saylor DK, Bailey ET, Gonder-Frederick L, Morin CM, Ritterband LM. Development and perceived utility and impact of an Internet intervention for insomnia. *E-journal of applied psychology: clinical and social issues*. 2008;4(2):32-42.
 79. Hatcher RL, Gillaspay JA. Development and validation of a revised short version of the Working Alliance Inventory. *Psychotherapy Research*. 2006;16(1):12-25.
 80. Schwartz LA, Brumley LD, Tuchman LK, et al. Stakeholder validation of a model of readiness for transition to adult care. *JAMA pediatrics*. 2013;167(10):939-946.
 81. Schwartz LA, Hamilton J, Brumley L, et al. Development and Content Validation of the Transition Readiness Inventory Item Pool for Adolescent and Young Adult Survivors of Childhood Cancer. *Journal of Pediatric Psychology*. 2017;42(9):983-994.
 82. National Cancer Institute. <https://cancercontrol.cancer.gov/ocs/resources/focus.html>. Accessed January 10, 2017.
 83. Oeffinger K. Longitudinal risk-based health care for adult survivors of childhood cancer. *Current problems in cancer*. 2003;27(3):143-167.
 84. Kirchoff AC, Montenegro RE, Warner EL, et al. Childhood cancer survivors' primary care and follow-up experiences. *Supportive Care in Cancer*. 2014;22(6):1629-1635.
 85. Eysenbach G, Group C-E. CONSORT-EHEALTH: improving and standardizing evaluation reports of Web-based and mobile health interventions. *Journal of medical Internet research*. 2011;13(4):e126.