Table 1: Coding tree

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| Transition of care |
| Transition of care > Organization of transition of care |
| Transition of care > Organization of transition of care > Available |
| Transition of care > Organization of transition of care > Changes over time |
| Transition of care > Organization of transition of care > Document transfer |
| Transition of care > Organization of transition of care > Criteria for transition |
| Transition of care > Organization of transition of care > Adult specialists |
| Transition of care > Organization of transition of care > Adult specialists > Establishing contact with and informing the adult specialist |
| Transition of care > Organization of transition of care > Adult specialists > Education of the adult specialist |
| Transition of care > Organization of transition of care > Adult specialists > Education of the adult specialist > By pediatric specialist |
| Transition of care > Organization of transition of care > Adult specialists > Education of the adult specialist > By intersex people themselves |
| Transition of care > Organization of transition of care > Which specialties are involved |
| Transition of care > Psychosocial support for adults (lacking?) |
| Transition of care > Hurdles to implementation |
| Transition of care > Hurdles to implementation > Organisation of medical specialities |
| Transition of care > Hurdles to implementation > Lack of related specialists/resources |
| Transition of care > Hurdles to implementation > Access to regional centers |
| Transition of care > Hurdles to implementation > Connection among MDTs and regional centers |
| Transition of care > Hurdles to implementation > Financial costs |
| Transition of care > Hurdles to implementation > Transfer of knowledge |