UW Medicine
UNIVERSITY OF WASHINGTON MEDICAL CENTER

About the Transition Care Program

Moving from pediatric to adult healthcare

This handout explains the Transition Care Program at University of Washington Medical Center (UWMC).

What is the Transition Care Program?

The Transition Care Program (TCP) at UWMC supports young adults with complex medical needs, their families, and healthcare providers as the young adults move from child-centered to adult-centered healthcare services.

What are the program goals?

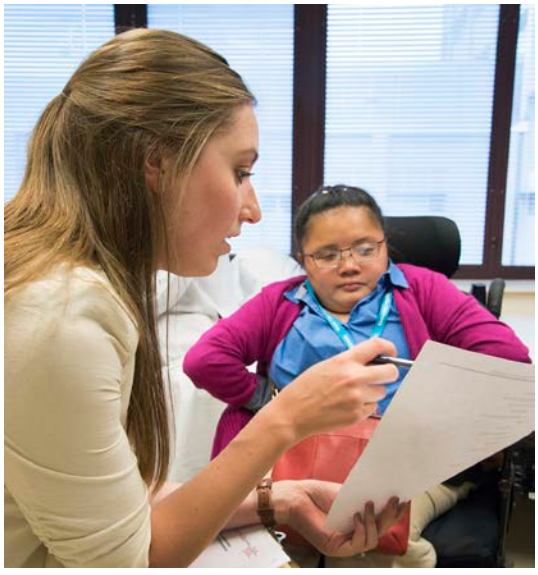
At the TCP, we want to help you:

- Learn how to navigate the adult-centered healthcare system
- Find new adult-centered providers, including primary care and specialty care providers
- Answer your questions and concerns about moving from pediatric to adult care, including insurance issues, home healthcare needs, and community resources

What can I expect?

The TCP uses a step-by-step process to help you and your family make a smooth shift from pediatric to adult care.

As a part of our program, you will have annual clinic visits for many years during the transition period. Through these visits, our healthcare team will get to know you and learn about your health conditions and your life. This way, we will be able to pass along information to your new providers.



We want to help your transition to adult care go smoothly.

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1959 N.E. Pacific St., Seattle, WA 98195 | 206.598.2972

Why should I move to adult-centered care?

Pediatricians provide excellent care for children, but most cannot continue to care for their complex patients as those patients grow older. Most patients are ready to move to adult-centered care at about age 21.

Adult-centered providers can also address new medical issues that arise with age but are less common in younger patients. Young adults with complex medical conditions want to grow up and graduate to adult care, just like their peers do.

I already have a primary care provider (PCP). What does TCP add to my care?

You will continue to receive primary and specialty medical care from your current providers during your transition time. We coordinate your care and identify your needs so that the shift goes smoothly.

- **If you now have a pediatric PCP**, we will help you find an adult-centered PCP and coordinate transition of the specialty care providers you need. We will work with your current providers to make sure information about your healthcare needs is clearly shared with your new adult-care providers.
- **If you already have an adult-centered or family practice PCP**, we will work with you to coordinate transition of the specialty care providers you need.

Your First Clinic Visit

You will meet all members of our team during your first clinic visit. The team will assess your healthcare needs at this visit. You will have follow-up visits with the team members who can best help you meet your healthcare goals.

The TCP Clinic is on the 8th floor of the hospital, in the Department of Rehabilitation Medicine.

To Learn More

Please call our Transition Care Team at 206.598.2972 to learn more about our program, or call our patient scheduler at 206.598.4295 to set up an appointment.

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Transition Care Program: Expected Timeline

Ongoing growth in patient and caregiver awareness, preparedness, confidence, and independence

Age 17 — 18 — 19 — 20 — 21 — 24

Care provided by current pediatric providers
(Seattle Children's Hospital)

Care fully transferred to adult-centered providers by age 24
(UW Medicine)

Age 17	Age 18	Age 19	Age 20	Age 21	Age 24
Pediatric PCP or subspecialist refers patient to TCP	Patient has 1st solo visit to UW Medicine	If needed: UW Medicine visit	UW Medicine visit	Patient has 1st solo visits with UW Medicine PCP and specialists	Check-in at TCP for assessments
• Referral form • Review of records and images • Schedule 1st TCP visit	• More records requested **Meet with:** • TCP doctor or ARNP • RN coordinator • Social worker • PC • PSS	• Records review **Meet with:** • TCP ARNP • RN coordinator • Social worker	**Meet with:** • TCP ARNP • RN coordinator • Social worker **At this visit:** • Care Plan review with family and PCP • 1st PCP and UW Medicine specialist visits scheduled by TCP PSS	• TCP sends Care Plan to providers 1 to 2 weeks before clinic visit • Providers may consult with each other before patient visit • New provider may contact TCP to review patient's health history, if needed	• Review insurance coverage and new social work needs • Time for feedback to let us know how your transition went **Meet with:** • RN coordinator • PC

ARNP = Advanced registered nurse practitioner
PC = Patient coordinator
PCP = Primary care provider
PSS = Patient Services Specialist
RN = Registered nurse
TCP = Transition Care Program

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