



## Transition Medicine

**Healthcare Transition:** the process of an adolescent or young adult graduating from the pediatric to the adult healthcare system.

The Transition Medicine team at Cincinnati Children's Hospital Medical Center cares for patients with complex medical problems or developmental disabilities whose healthcare teams have decided they are ready to move from the pediatric to the adult healthcare setting.

### CONTACT US

Contact the program directly:

Phone: **513-803-4348**

Physicians may consult directly with the Transition Medicine team or make patient referrals.

Patients can schedule appointments or speak with a Transition Medicine nurse.

#### Primary Clinic Location

Burnet Campus  
Teen Health Center  
Location C, 2nd Floor  
3333 Burnet Avenue  
Cincinnati, OH 45229

### Why Transition Medicine?

The Transition Medicine team works with patients age 16+ diagnosed with complex medical problems, chronic childhood disease, mental health diagnoses or developmental disabilities who have difficulty finding qualified adult care providers. The current adult healthcare system, with its efficiency requirements and the frequent need for patients to contact the healthcare system, often makes these patients difficult to graduate. General unfamiliarity with pediatric-onset, complex medical conditions also creates a barrier to transition. We assist patients and their families in obtaining uninterrupted, quality and age-appropriate healthcare. We assess each patient's unique needs to determine the appropriate setting for specialty and primary care, such as in these situations:

- For patients who already have primary care, we provide consultation regarding their unique needs, particularly around chronic healthcare problems, such as treating depression or anxiety, or complex behavioral problems in those with developmental disabilities.
- For patients dismissed from a practice due to age, we provide primary care during their transition to appropriate healthcare providers.
- For patients in between primary care providers, we provide bridge care until their adult primary care is established. We recognize more complex patients may require longer term primary care services.
- Patients who may have difficulty finding qualified adult healthcare providers, such as:
  - Patients with developmental disabilities who require complex pharmacologic intervention
  - Patients who are very medically complex – for example, a patient who has public insurance, lives in a healthcare-depleted community, requires multiple subspecialists, or who is technology-dependent.



## TRANSITION MEDICINE TEAM

Our physician team members are board certified in both internal medicine and pediatrics.

Abigail Nye, MD,  
*Director, Transition Medicine*

Darcy L. Thornton, MD

Jennifer M. Shoreman, MD

Jason Woodward, MD, MS

Anne Marraccini, RN, BSN, MSW  
*Program Manager,  
Transition Medicine*

Bridget Kikta, LSW, MSW

## REFERRALS

Primary care providers and specialists may make patient referrals for consultation/ assistance in organizing a patient's complex healthcare needs or for the establishment of primary care in the adult healthcare system by faxing a referral form to **513-803-1111**.

## Patients with Conditions Appropriate for Transition Medicine

We care for patients with chronic, pediatric-onset conditions including, but not limited to:

- Cerebral palsy
- Chronic pediatric rheumatologic conditions such as lupus
- Complex genetic disorders
- Complex needs/special needs
- Developmental disabilities, including but not limited to, autism spectrum disorders and obsessive-compulsive disorder
- Down syndrome
- Mental health diagnoses such as anxiety and depression
- Muscular dystrophy
- Spina bifida

## Goals of the Transition Medicine Program

- Build self-advocacy skills
- Strengthen ability to develop independence
- Assume personal responsibility for managing one's healthcare
- Achieve optimal physical fitness and physical health
- Gain knowledge about the importance of preventive healthcare
- Establish uninterrupted medically and developmentally appropriate healthcare
- Reach attainable levels of self-worth and emotional health

## Timely Access to Care

Patients who are acutely ill can be seen by one of our physicians in a timely manner. We offer one clinic session every weekday. We are able and willing to add on patients outside of normal clinic sessions if needed.

## Collaborative Care

Our team regularly collaborates with community physicians, specialists, social services organizations and providers within the University of Cincinnati Medical Center system for patient care and to help patients transfer to an adult healthcare setting. Our team continues to establish strong working relationships with healthcare providers throughout the tri-state area.

## By the Numbers

**>50%**

Young adults who report that no one has spoken with them about the need to see providers trained in caring for adults

**250+**

Patients in our care since the program began in mid-2013

For physician referrals, fax a referral form to **513-803-1111** or consult with a subspecialist by calling the Physician Priority Link at **1-888-636-7997**. Community agencies may refer by calling **513-803-4348**.

[www.cincinnatichildrens.org](http://www.cincinnatichildrens.org)