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Practice-Changing Research in Complex Care at the AACPDM Annual Meeting 2025

In this special Complex Care Journal Club podcast episode, host Dr. Kilby Mann interviews presenters of posters and oral abstracts relevant to the care of children with medical complexity at the American Academy for Cerebral Palsy and Developmental Medicine (AACPDM) 79th Annual Meeting, October 15-18 2025, in New Orleans, Louisiana. Speakers describe their study findings and implications for practice. Dr. Francisco Valencia also discusses the role of the Complex Care Committee and the profound impact of mentorship in the field of complex care.

SPEAKERS:

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Western University School of Physical Therapy

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Western University School of Health Sciences

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Kilby Mann *00:03*
Hello and welcome to the Complex Care Journal Club podcast. My name is Kilby Mann. I am a pediatric rehabilitation medicine physician at Children's Hospital Colorado, and your host for this episode. In this podcast series, we seek to discuss emerging evidence in the care of children with medical complexity and its implications for practice. I'm delighted to be recording from the American Academy for Cerebral Palsy and Developmental Medicine Annual Meeting in New Orleans, Louisiana. I had the chance to talk with a few people about the work that are presenting in the field of complex care.

Kilby Mann *00:35*
Alright, I'm excited to have here Karen Pratt, Laura Brunton and Caitlin Cassidy to talk about their work, the co-design of a peer support program for adults with special care needs. Thank you so much all three of you for taking the time to talk with me. Tell me a little bit about this project and this program.

Karen Pratt *00:53*
Sure. So my name is Karen. I'm a PhD student. This was part of my PhD work, so we were very interested in designing a peer support program, because we heard repeatedly from patients in our program that this was something that they were seeking, and it is something that is lacking within our social support structures in Canada. So we focused on adults with special care needs, very varied population. We really wanted to prioritize participatory methods and involvement of the patients and caregivers and their healthcare providers in the co-design of this project so that it would be meaningful for them.

Kilby Mann *01:34*
I think it's exciting to see more work focused on adults here at the Academy.

Laura Brunton *01:39*
Caitlin does a really wonderful job within the program of really capturing the medical components of the needs adults with childhood-onset disabilities face, but where the services really tend to fall apart is that social support, that participation, that inclusion piece, and just feeling like they're supported in all aspects of your life, which is a huge driver behind some of this research.

Caitlin Cassidy *01:58*
We hear a lot from our patients and their families that in the pediatric system, at least in our geographic location, there are sort of natural peer support opportunities that develop and that are supported by some of the formal structures in the pediatric care world that just don't really exist in an equal way on the adult side, and as we're developing transition and long term care programs for people who have childhood-onset disabilities, it seems like it's something that's maybe been forgotten as we've been so focused on figuring out a medical care plan.

Kilby Mann *02:31*
And what did you find is, some of the most important aspects of this work?

Laura Brunton *02:37*
I think I'll highlight the variability first, right? So you know, whenever you do research like this, where you've got multiple people contributing opinions, there is no clear answer, but I think what came from this was the ability for us to start to think about how to start to design a peer support program that's going to need evolution over time.

Karen Pratt *02:54*
Yeah. So I think some of the things that were really interesting, we were able to run focus groups, which allowed people with disabilities to participate in research and share their perspectives, share their goals, what they wanted to achieve from the program. So we were able to come up with some tangible program goals. The program that we have designed will prioritize flexibility, having hybrid options for participation, so people can participate in ways that work best for them. Kind of having some different opportunities too, such as like going to different locations in the community as well as meeting in person was mentioned a lot of times by the patients. So that's really exciting. And aligns with some of the work that we did, an environmental scan of peer support programs in Ontario as well.

Kilby Mann *03:44*
That is all super exciting to hear more about it here at the AACPDM annual meeting. Is there a session you've been to so far that you've really enjoyed, or one that you're looking forward to in the next couple of days?

Caitlin Cassidy *03:57*
I'm continually interested in learning more about the underlying muscular abnormalities that exist in people with cerebral palsy, and how it's not just sort of a brain-based disability, the way we've always thought about it, but that there are these sort of more peripheral differences that maybe are underpinning things in a way that we hadn't really thought of in the past. And so thinking about how that should change our treatment ideas and paradigms is really fascinating to me. So there's been a good session about contractures already this morning. The general session later today is going to, I think, continue that conversation. So I'm looking forward to that.

Karen Pratt *04:30*
I attended one this morning on Patient and Family Voices and reflecting on priority setting and shared decision making. So this was really exciting because they touched on things like participatory research, as well as involving patients throughout all levels of care. They also touched on a really interesting discussion of like disability identity and how care providers can promote or hinder that, and how that changes across the lifespan as well. So that was a really exciting one.

Kilby Mann *04:30*
I especially love both this work that you're doing and what you just highlighted about getting that caregiver experience and voice, I think is so important, especially as people are figuring out what are the questions that need to be asked that are going to be meaningful to our patients and their families. Thank you again for taking the time with me.

Kilby Mann *05:15*
All right, I'm here with Simran Prakash, who's a fourth year medical student. I think the AACPDM annual meeting is a great time for trainees to get involved and have the support of their mentors. So Simran I would love to talk to you about your free paper on medical student perception of disability healthcare needs. So love to hear what got you interested in this and some of the things you found as you were doing it?

Simran Prakash *05:36*
I chose to focus on disability healthcare needs because I have my history in disability advocacy. I've been doing that for about seven years, and when I went to medical school, I realized that that was a big gap. I noticed that there just wasn't enough training at all in medical school. So I figured, why not see what medical students really think about people with disabilities right now and what's already there, figure out what the gaps are, and that's why I tried to go forward with the study to understand it at a more large scale.

Kilby Mann *06:05*

I think there's a lot coming out right now about the education piece and how we can become better providers for everyone by being better providers with people with disability. So what are some of the things you found?

Simran Prakash *06:16*
A lot of the research that I had done prior to this, I found that people already knew that education was not enough. You know, it's the whole analogy of you have to try to tackle things more like up the stream. Figure out what the source of the issue is, right? So education was the source of the issue because a lot of these people felt like they couldn't treat patients with disabilities. They had a general perception of what they would provide, but it was more so that they didn't have the knowledge on how to accommodate. They didn't have their own confidence in being able to provide the care equally, more equitably. And so it was really interesting to see that while medical students didn't have a general idea of how to provide accommodations, they knew that they wanted to provide accommodations in the first place. We asked them about their knowledge, their self rated proficiency, and then we asked them about perceptions on what kind of accommodations to provide. And for the most part, they knew what kind of accommodations had to be provided, but their knowledge and their self rated proficiencies were not there, they didn't know how to accommodate. And so that's where the gap really [lay].

Kilby Mann *07:20*
Do you have any next steps that you're thinking about based on what you found?

Simran Prakash *07:24*
Yes. So we haven't published the paper yet, but we are drafting that so definitely trying to get this knowledge out to everyone, but I do a lot of medical education work at the University of Miami, and we're trying to reform the curriculum based on the findings. So next steps are to change aspects of medical curriculum to incorporate disability. There are a lot of programs we found that actually do teach about disability, but even if they do, it's more like one class, not an actual curriculum about it. So we are hoping to see if we can influence medical education and incorporate disability education into that as a core foundation.

Kilby Mann *08:00*
I'm excited to read your paper when it comes out. We were talking before we started recording that this is your this is your first time at the AACPDM annual meeting. So is there a session you've been to thus far that really got you excited or thinking, or one that you're looking forward to before the end of the conference?

Simran Prakash *08:14*
Yes. So one session that I am really interested in is a bunch of discussions about adults with cerebral palsy or developmental disabilities. I feel like it's a very untouched part of this community. A lot of the work is very focused on the pediatrics. And then when these patients go into the adult world, there aren't enough providers that really focus on that. So I'm interested to see what kind of work is being done in that realm.

Kilby Mann *08:36*
Thank you so much for taking the time to sit down and chat with me, and best of luck with your upcoming interviews for residency.

Simran Prakash *08:41*
Of course. Thank you.

Kilby Mann *08:45*
Hi. I'm here with Claire Wallace, who is a psychologist in St Louis, and I am really excited to hear her talk a little bit more about the paper she's presenting, which is a multidisciplinary initiative to reduce medical device pulling. So tell me a little bit more about kind of why this and what was successful and what worked.

Claire Wallace *09:03*
Yeah, our institution is a pediatric post acute care hospital, and so we're getting kids when they're, you know, not sick enough to need acute care stays anymore, but not quite ready to go home yet. And what we find in that setting is, I would guess, a much higher incidence of medical device pulling, especially patient driven. You know, self removal of medical devices so common. So it was a pretty well established problem in our setting. And then we implemented an intervention about something else that accidentally skyrocketed the medical device pulling numbers.

Kilby Mann *09:39*
Oh, interesting.

Claire Wallace *09:40*
Which is that we implemented an in house group developmental program for our zero to five year olds, sort of mimicking, almost like a daycare or preschool type of a setting, because that was just missing in their day. And as it turned out, they really liked that, and they did not, in fact, like being returned to their beds, where they then pulled out their trachs.

Kilby Mann *10:00*
Then they know that brings people into their room, right?

Claire Wallace *10:03*
100% it was the it's the clearest graph you'll ever see. Whoa, what happened there? And we said, oh, we know exactly what happened here. So we knew even before that happened, that it needed attention. And then it got to be a really significant problem. It needed much more attention. So we formed a multidisciplinary work group that's called the tube dislodgement work group. It's one of the funniest meetings of my of my week and of my month now, but it really required a huge all hands on deck approach to problem solve. What can we do for these kids? Because in our setting, I think in the acute care setting, you often say, Okay, well, they need a one to one. In our setting, we don't do that. We don't have one to ones for our patients. And so we had to get way creative about what else we can do. There are really, like, five distinct interventions over the course of probably a year and a half that we rolled out, you know, one at a time, just to see if we could make a dent in it. So the first intervention was bedside event debriefs. So, I mean, this is pretty heavy handed, but every time a tube comes out, everyone involved, like, has a little huddle at the bedside or wherever the patient is to say, like, what has happened here? Are there any changes we can make, literally in the moment to help prevent this from happening again. The second thing that we rolled out was actually a new role, a new position called a patient play associate. Oh, I love that. It is beautiful, like a dream job. It's really, really fun. I mean, their job is to play with the kids, and they get some respiratory training now so that they're comfortable supervising patients away from their physical bed space. I mean, we created intermittent one to one and just like a really beautiful, developmentally stimulating pairing, so that kids just got more attention. Because mostly this is happening when they're bored and mad.

Kilby Mann *12:00*
Yeah, yeah, I would assume everyone listening knows what kid pulls out their tube for attention, especially trachs.

Claire Wallace *12:08*
Oh yeah. You can see their face.

Kilby Mann *12:11*
They’re thinking of pulling it out.

Claire *12:13*

Oh 100%. So that was sort of creating one to one, and also creating something that was just globally good for kids. The third thing that we did was implemented a tier system. So that was a way for us to identify the pullers primarily, or the alligator rollers who were popping themselves off their ventilators all the time. And we really put them essentially into risk categories. And then each tier comes with a whole sort of set of guidelines about what, like, what is the bedside staff need to be thinking about. So there's a medical section, there's a behavioral section, and then there's a whole environmental section, and the behavioral section is the longest, because, you know, I have a lot to say.

Kilby Mann *12:57*
Yeah, things to say.

Claire Wallace *12:58*
So a huge part of the tier system was really me and others teaching bedside staff and caregivers how to avoid reinforcing those behaviors with attention. Because what we saw anecdotally was that we were sort of creating bigger problems. Kids get their trachs out in lots of different ways, and their G tubes and J tubes out in different ways. But when we respond with a whole crowd of people and lots of stuff going on, it does not take kids super long to figure out that that's kind of fun and nice.

Kilby Mann *13:32*
That's just parenting in general. We all have to learn how we respond to things.

Claire Wallace *13:41*
Oh 100%. So the tier system was pretty effective. We now have it like flagged in the banner bar of the chart, and we talk about it in daily rounds. And then the fourth intervention that we did was really minor, but ended up being really effective. We use feeding backpacks, even in the hospital setting, because we want our kids to be as mobile as possible. But the kids were, like, routinely stepping on their slack and popping their buttons out. And so we realized that we were actually not feeding the tubing through the right way. And there's this special little loop at the top that, like, prevents the slack from being so bad. So we just pushed out, like quick education to everyone, and did some audits about how the backpacks were being used to make sure that everybody was threading the tubing through in the right way. You know, take the extra 10 seconds to do it the right way, and that ended up being a super effective intervention.

Kilby Mann *14:30*
I love that it's something so simple.

Claire Wallace *14:32*
We tried to make it really complicated, and then we're like, what in fact is this little loop for yes. And then the last thing that we did, which was not targeted at medical device pulling, but had a big impact on it, was we replaced the on unit nurses stations with play corrals.

Kilby Mann *14:51*
Oh, nice.

Claire Wallace *14:52*
So we just took out the nurses stations, put all the computers on wheels, and then made these little, you know, half wall, semi enclosed play spaces. The intention really being to give kids a space to land that's not in their beds. And that, combined with the patient play associate role, I think, has created like, a really beautiful site when you walk onto the unit, which is that the kids aren't in their beds nearly as often as they were before. I love that. And it turns out like when you're free to move about the cabin, and you can crawl and stand and, you know, watch the world go by, you're not nearly as concerned with your, you know, your trach or your G Tube.

Kilby Mann *15:26*
Oh, I think that is so beautiful. I hope you publish all of this at some point. So we can all say, look at this group that did it. I think for me personally, our new rehab unit at Children's Hospital Colorado is shared with our trach program, which is kind of doing similar things, like building up a developmental program for the young kids with trach vent dependents who stay in the hospital longer. And I love the idea that they can be out of their beds more. Since we're here at the annual meeting for the AACPDM, what is a session you've been to that you really enjoyed, or one that you're looking forward to?

Claire Wallace *15:58*
You know I loved your session, talking about resilience and talking about burnout in like, more of a real way, not such a hand wavy kind of way. I I think was a pretty nice call to action, and made me think, not only think about how to implement it, just for myself and for my small team, but really for larger groups. You know, at our institution, I think it really stuck with me when you all said that hospitals haven't figured out how to do this yet, you know, on a large scale, and that makes a lot of sense to me, because the need is so individualized, so that that just it just really got my wheels turning, honestly about how to do this, how to make this work for different groups of professionals in our setting.

Kilby Mann *16:39*
Yeah, for people who are not here and listening, the opening speaker talked about resiliency and burnout. Then I led a co session with Heather Menken about a very specific communication strategy. And then there was another session in the afternoon with our friend Nancy Murphy from the University of Utah and one of the coaches there, again, about like, coaching as a strategy. So I feel like we're all leaving with, like, a lot of tools to consider. Well, thank you so much for taking the time. Claire and I look forward to hearing more about it later today during the session.

Claire Wallace *17:07*
Thanks so much.

Kilby Mann *17:11*
All right, I am here with Esther Yap and Susie Gibb to talk about their poster keeping children with medical complexity at home, improvising emergency care for children supported by a complex care program in Australia. Thank you both so much for taking the time to talk with me.

Esther Yap *17:26*
Absolutely, it's an honor. Thank you for having us and giving us a spotlight to chat about complex care in Australia. We might give you a bit of a background as to what complex care is like in Australia?

Kilby Mann *17:35*
Yes, that'd be great.

Susie Gibb *17:36*
Thanks for having us. So I guess one thing to highlight that is different in pediatrics in Australia compared to the US, is pediatrics is not a primary care specialty in Australia, so we are consultants, and our children will have a general practitioner providing their primary care. And so that influences the way the programs have developed. And then the second thing that is different about our program, to many programs, is that we are not the treating physicians for the children that we support. We're a care coordination, family support and sort of integration service for the children with medical complexity. So the children enrolled in our program will have a primary, generalist physician who is what we term their medical case manager, and our team are the support team that

work with the medical case manager and the child and family to provide timely and coordinated care for their children.

Kilby Mann *18:40*
Thank you. I think that's important for us all to understand the background of information. So do you tell me a little bit more about this project, specifically within your program?

Esther Yap *18:50*
Yeah. So the program supports about 300 kids currently in and they have certain criteria which are very similar to the American complex care as to how they get into the program. The main one being that they have complex chronic disability, and I think we they've started collecting data from quite a while. I think we've got about five years worth of data of kids presenting into the emergency department. And what really kind of struck my interest, because we have monthly meetings with the quite close task of the emergency department at our hospital each time these kids come in, they're flagged as being a complex care kid with a set of recommended plans. They contact us, we give recommendations, but not all the time. And I kept seeing these kids often. It's the same kid that comes back in five or six times. And in my head, I was thinking, how do we keep them at home? And it was quite nice to see the data over the five years. And then we looked at the reasons why they were able to go home versus staying in hospital, and three things that we highlighted as most common reasons. Was one that was seen by someone in ED, they were managed, and then they were sent home. So didn't really necessarily need to come into ED, or they needed some short sort of treatment before they could go home. But my point is that they got home instead of coming into hospital. The other reason, I think that made up 40, 42% of discharges. I should mention before that about half of the kids could go home from ED, which is nice.

Kilby Mann *20:21*
That is, yeah.

Esther Yap *20:22*
And I was like, Oh, is there a way that it could even avoid coming into the ED? Because it's stressful experience coming into ED, and then out of the other two groups that were able to go home, the second one was jejunal and kids that were tube fed, and they came in because the tube fell out, jejunal or gastric tubes. Half the time we were able to kind of get them done in radiology same day. But that sounds hard, challenging, and then oftentimes they were just changed by someone in an ED because the parents were either not confident to do them themselves, or it was a little bit more complex, or there were things that they wanted to get checked out. And the other group that were able to get home were kids that were seen by someone that knew them. So either their treating team like, what Sue mentioned, they've got their own kind of team that knows them the best, or, I think a couple of cases, someone from complex care actually went down and saw them and be like, Oh, you're good. We know what you're like, because it's scary, right? When you see the kid come in with multiple tubes and things hanging out, and you just the tendency is to admit them, yes. So then I think, following on from that, we kind of looked into what can we do as a complex care service to keep them at home when they're a little bit unwell, and when parents are worried, and I think that's really the next part of this kind of project, improvement study that we did.

Kilby Mann *21:50*
That's great any like big lessons you learned for someone who wants to think about the same sort of work in the field of complex care?

Susie Gibb *21:58*
I think the thing that really is highlighted in the data is that even though our whole program is designed around trying to keep children at home and not to come to emergency, there's still a big group that are coming to emergency unnecessarily. And I think our biggest lesson is, how can we make ourselves, insert ourselves in that

process better so that they don't end up in emergency? Because the care that was provided to them in emergency is not that special. It could be provided to them in a drop in clinic or just by being seen by the person who knows them well. And I think that the biggest lesson for our team, I think, is we need to utilize all the resources that we've got to keep those children at home. We need to use telemedicine more to actually visualize the child and give more appropriate advice about actually, maybe you don't need to come to emergency. We feel satisfied with looking at you on the screen, that we could organize a very timely, quick turnaround outpatient review rather than an ED presentation. So that's one thing, and then the second thing is actually the real value for the ED clinicians in being able to connect directly with the person who knows that child well, and that doesn't necessarily need to be their physician. That could be their complex care clinical nurse consultant who really does know them well, knows their baseline, and can really speak to that in avoiding an admission.

Kilby Mann *23:52*
Yeah, that all sounds so fascinating. I also want to highlight that we are at the AACPDM annual meeting, and just ask if there's a session you've been to that was really exciting, that had you thinking, or one that you're looking forward to in the next couple of days.

Esther Yap *24:05*
We attended a talk right before this about another complex care program in Texas, and how what they were doing, and how they were utilizing telemedicine, how the program was quite similar to ours. And I really enjoyed hearing the comparison of American and Australian services, and took some little kind of [inaudible] as to, oh, what can we do about our service to improve keeping them at home. So it was quite nice to see that parallel.

Susie Gibb *24:34*
I agree. It's lovely to hear about other people passionate about the same work and doing the same things. Another session that I really enjoyed was a session looking at legacy, but it was legacy, not in the way that we necessarily always think about legacy, but actually about legacy throughout the life of a child with medical complexity, and really meaning making during the life of a child with medical complexity. And that session was very thought provoking, because actually, when they asked families about, you know, what legacy meant to them and what was important to them in their life, of their child with medical complexity, it was exactly the same things as we think are important in actually, not just legacy, but in quality service provision for children and young people with medical complexity. So the things that come up are the same things that come up all of the time. Communication is so important make sure that people actually understand what it is that you're asking and respectful communication involving the child or young person in the discussion and celebrating the small wins with families along the way. And so those things that families highlighted as important for their child's legacy, they're actually important for us to think about every day in everything we do with the children. So I found that session really thought provoking, too.

Kilby Mann *26:10*
Oh yeah, that sounds super interesting. Thank you both so much for taking the time to talk about your work.

Kilby Mann *26:15*
I'm here with Francisco Valencia, who is a member of the AACPDM complex care committee. It is a great committee, and we wanted to highlight some of the great work that the committee has accomplished. So Francisco, tell me about a couple of opportunities for more people that want to be here at this meeting and connect with more people in the field of complex care.

Francisco Valencia *26:34*
The committee has been a little bit of an eye opener for me. I'm an orthopedic surgeon, and I have been looking for ways how to expand my horizons, and not just go in with the orthopedic blinders, so to speak, and you realize that when you come to this organization, the beautiful thing of having your colleagues in the collaborative effort

that goes into the common good, one of the big obstacles is getting people to know who we are and get them interested. I firmly believe that when people come, and I hear this story repeatedly, that people attend an Academy session, or they have some sort of interaction with one of the members of the Academy. And it can be a life changer from a professional standpoint and sometimes from a personal standpoint. And it certainly was for me, because I grew up in Arizona and in a small town called Nogales, it sits right on the border with Mexico. So growing up my life was very much a bi-national, bicultural experience, and one of the experiences was that I got involved with a group of physicians or professionals who were providing medical care for children with disabilities living in Mexico, and it was a amazing story, because it started with a group of moms in Mexico who realized that they weren't getting enough services for their children. So they started just as the topic of this conference has been resiliency, they were looking for ways to do something for their children and to better their lives, and they hit upon working with a physical therapist from the United States who came down to visit. And then she, in turn, cajoled more professionals, other therapists and orthopedic surgeons to come down. And I happened to meet one of the orthopedic surgeons and said, Oh, you live on the border and you're bilingual, maybe you'd like to be part of this. And it really was a life changer for me, because that was my introduction to science, to medicine, to orthopedics and to the field of children with disabilities. So I firmly believe in being able to have a vehicle where we can attract the next generation, our younger colleagues, and help them, as other people have helped us, right? So getting back to your question, one of the topics that has been of interest to me, has been to help develop an award that would be specific for complex care to be dedicated for a young investigator. So for people who are listening to the podcast, I would hope that you know that they would go back, and there are always students looking for an opportunity. And if you can get them to be involved in a project and be the first author, or do something, so you can qualify for this award, and hopefully get them involved, because it really is that one-to-one relationship that people remember, certainly I do because I met someone who made an effort to reach out to me. And I think it's just part of what we do in medicine, in general and specifically in this field.

Kilby Mann *30:10*
Yeah, my involvement in AACPDM is because someone mentored me and told me this would be a good home for what I do. And one of the things I love about being at this meeting is all the mentoring you see in action. That people are, like, mentoring their trainees, and they're presenting the paper, but they've got their like, key mentor there with them. And I just think it's great.

Francisco Valencia *30:27*
It's generational. It really is like a family, because you can see and with the awards that when you with their mentor, is identified and acknowledged for their all their service, and you can see sort of the generation other people they train. And it's pretty amazing, and it's also very inspiring and very uplifting when you hear the stories, and it invigorates me, you know, to say, Okay, I'm going to go back and take some of this knowledge back and see how I can apply it. I mean, one of the things I learned today was the work that's being done here by the group in New Orleans that that they are using 3D printing to make general items of use for children with disabilities and more specific items, they can tailor it. Yeah, and this is something that I am going to use for my volunteer clinic, and I'm going to put a plug in for it, St Andrews Children's Clinic, and we're in Nogales, Arizona, and we are dedicated to children with disabilities, and that's the same clinic that I mentioned earlier.

Kilby Mann *31:31*
That's awesome.

Francisco Valencia *31:32*
And it goes back 50 years, and it's just an amazing journey for me. But again, I like how we are able to learn things that hopefully are going to be able to be translated to a country, Mexico that's a middle income and in some areas in their country, low income resource areas within their country. So we're trying to use things that are going to be of use to them, and not just provide something that's electronic, and because they don't have batteries or

some transistor breaks down that you've lost any intended benefit. So this is going to be very practical, and that's something that we can keep reusing.

Kilby Mann *32:14*
I really enjoyed that one as well, and was just thinking about so my primary work is on the inpatient rehab unit at Children's Hospital Colorado, and as these kids are, like, changing constantly. Like, is this a method for where you are right now, with your function, with the 3D printing, we can get you what you need, and then as you recover more, and your function changes, then it's like, okay, well, let's meet with them again and figure out what you need now. That one also had me thinking a lot. If anyone is interested in that early career complex care award that is given every year at the annual assembly for AACPDM. Abstracts are due in January, usually. So keep an eye out for that on the website.

Francisco Valencia *32:47*
Yes, please look at the website. You would go about just submitting an abstract that you normally would, and then the committees will be involved as far as selecting but there'll be a designation where you can say, this is an early career participant.

Kilby Mann *33:04*
Thank you so much. Francisco.

Francisco Valencia *33:05*
Thank you.

Kilby Mann *33:06*
I want to thank everyone here who took the time to talk with me during the AACPDM annual meeting. Thanks for listening to the Complex Care Journal Club podcast. We aim to highlight research that has the potential to be practice changing, that values patient, family engagement as relevant across disciplines and diagnoses and uses high quality or novel research methods. We invite you to join the conversation by suggesting an article that you would like to see discussed in this podcast using the form provided on the OPENPediatrics YouTube channel. Thank you for joining us.

Other Resources

American Academy for Cerebral Palsy and Developmental Medicine (AACPDM) 29th Annual Meeting, October 15-18th 2025, New Orleans LA. https://www.aacpdm.org/events/2025/program

American Academy for Cerebral Palsy and Developmental Medicine (AACPDM), www.aacpdm.org/

AACPDM Complex Care Committee (www.aacpdm.org/about-us/committees/complex-care)