AMERICA'S PEDIATRIC DENTISTS
THE BIG AUTHORITY on little teeth®

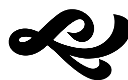
American Academy of Pediatric Dentistry
71st Annual Session

Honolulu, Hawai'i

General Assembly and Awards Recognition

Sunday, May 27, 2018
9:30 – 11:30 a.m.

Hawai'i Convention Center
Room 312



AMERICA'S PEDIATRIC DENTISTS
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Procedural Information

2018 General Assembly Agenda

2017 General Assembly Minutes

REFERENCE COMMITTEE HEARINGS AND REPORTS

Constitution and Bylaws amendments, proposed changes/additions to oral health policies and clinical recommendations of the American Academy of Pediatric Dentistry will be the subject matter for the Reference Committee hearings at the Annual Session.

In accordance with the AAPD Bylaws, notice of these Bylaws amendments was mailed to the membership no later than 60 days prior to the first day of the annual session. The notice was provided in the March 2018 issue of *PDT*, pp. 8-10. This PDT issue was mailed on March 8, 2018. Recommendations from the Council on Clinical Affairs concerning oral health policies and clinical recommendations were posted as a Members-only document on the AAPD website (www.aapd.org) on March 28, at least sixty (60) days prior to the General Assembly. All members were alerted to this availability via AAPD *E-News*.

The Reference Committee hearing will take place on Saturday, May 26, 2018 from 10:00 to 11:00 a.m. in Rooms 308AB at the Hawai'i Convention Center. Members are strongly encouraged to attend. Non-members may attend, but will be polled and asked to identify themselves by the chair, and are not allowed to comment. The Reference Committees are intended to be the venue for member discussion on any formal resolutions that will be proposed before the General Assembly. This is an opportunity for members to present testimony on proposed oral health policies and clinical guidelines, and other business to come before the General Assembly.

Reference Committee Reports will be available in the back of **Room 312 at the Hawai'i Convention Center** beginning at 8:30 a.m. on Sunday morning May 27, 2018 prior to the beginning of the General Assembly and Awards Recognition at 9:30 a.m. If available in time, copies will also be provided at District Caucuses on Saturday, May 26, 2018 from 1:00 to 2:00 p.m.

GENERAL ASSEMBLY AND AWARDS RECOGNITION

The Awards Recognition and General Assembly will take place on Sunday, May 27, 2018 from 9:30 to 11:30 a.m. in Room 312 of the Hawai'i Convention Center. The General Assembly is a meeting of Active and Life members for the purposes of conducting the business of the AAPD. Final action on recommendations from Reference Committees takes place at the General Assembly. An agenda for the General Assembly meeting was posted under "Latest News" in the Members-Only section of the AAPD Web site (www.aapd.org) approximately one month prior to the meeting. All members were alerted to this availability via AAPD *E-News*.

American Academy of Pediatric Dentistry
General Assembly of the 71st Annual Session

Hawai'i Convention Center
Honolulu

Rooms 312

Sunday, May 27, 2018
9:30 – 11:30 AM

1.	Call to Order	President, James D. Nickman
2.	Call to Attention of Minutes of 70th Annual Session, Washington, DC (attached)	President, James D. Nickman
3.	Nominations Committee (additional nominations from the floor) <u>Nominees</u> President-Elect: Kevin J. Donly Vice President: Jessica Y. Lee Secretary-Treasurer: Jeannie Beauchamp Academic At-Large Trustee: Homa Amini American Board of Pediatric Dentistry Director: Gregory M. Olson	Immediate Past President, Jade Miller
4.	Announcement of Tellers and Distribution of Election Ballots	President, James D. Nickman
5.	Report from the ADA President-elect	Jeffrey M. Cole
6.	Report of the AAPD President	James D. Nickman
7.	Report of the HSHC/AAPD Foundation President	Ned Savide
8.	Report of the AAPD PAC Steering Committee Chair	Jeannie Beauchamp
9.	Report of the Chief Executive Officer	John S. Rutkauskas
10.	Reports of Reference Committees	

A. Budget and Finance Committee — Chair, Jessica Y. Lee
   1. Informational report on FY 2018-19 budget

B. Council on Clinical Affairs — Chair, Edward L. Rick

Approve/Reaffirm Existing Definitions, Oral Health Policies and Best Practices as Presented:

a) Definition of Dental Home
b) Policy on Minimizing Occupational Health Hazards Associated with Nitrous Oxide
c) Policy on Patient Safety
d) Policy on the Role of Pediatric Dentists as Both Primary and Specialty Care Providers
e) Policy on the Use of Fluoride
f) Policy on Prevention of Sports-related Orofacial Injuries
g) Policy on the Dental Home
h) Best Practices on Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance/Counseling, and Oral Treatment for Infants, Children, and Adolescents
i) Best Practices on Dental Management of Pediatric Patients Receiving Immunosuppressive Therapy and/or Radiation Therapy
j) Best Practices on Fluoride Therapy
k) Best Practice on Use of Nitrous Oxide for Pediatric Dental Patients
l) Best Practices on Use of Anesthesia Providers in the Administration of Office-based Deep sedation/general Anesthesia to the Pediatric Dental Patient (revision limited to Personnel section)

Delete Existing Definitions, Oral Health Policies and/or Best Practices:

a) Best Practices on Dental Management of Heritable Dental Developmental Anomalies

Approve new Definitions, Oral Health Policies, Best Practices, or Endorsements on the following topics:

a) Best Practices for Pain Management in Infants, Children, Adolescents and Individuals with Special Health Care Needs
b) Policy for Selecting Anesthesia Providers for the Delivery of Office-Based General Anesthesia

C. Constitution and Bylaws Committee[1] — Chair, Kevin J. Donly

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[1] Per the AAPD Bylaws, Chapter XVII. Amendment of Bylaws: "Minor revisions that do not change the basic subject matter or intent of a proposed amendment as mailed to the members can be made upon recommendation by the Constitution and Bylaws Committee Reference Committee of the General Assembly. A majority vote of the General Assembly will be required to accept the changes, but a two-thirds (2/3) vote will be required by the General Assembly to approve the main motion/bylaws amendment."

1. **Clarification of recognized chapters to include pediatric dental organizations based in other countries.**
2. **Clarification of Credentials and Ethics proceedings.**
3. **Technical correction concerning Trustee membership requirements.**

11. Report of the Evidence-Based Dentistry Committee — Board liaison, Kerry Maguire

12. Election Results (if necessary) — President, James D. Nickman

13. Unfinished Business — President, James D. Nickman

14. New Business — President, James D. Nickman

A. Awards recognition

1. Merle C. Hunter Leadership Award: Dr. Edward L. Rick

2. NuSmile Graduate Student Research Awards (GSRA):

Tariq Ghazal, BDS, MS, PhD, DABDPH – University of Alabama at Birmingham, Birmingham, AL
An innovative two-step process to predict future permanent tooth caries incidence

Joshua Cline, DMD, MS – University of Florida College of Dentistry, Gainesville, FL
Association of Streptococcus mutans and Candida albicans in ECC Relapse.

Jennifer E. Tung, DDS, MS – USC Herman Ostrow School of Dentistry, Los Angeles. CA
Clinical Performance of the DentalVibe ® Injection System on Pain Perception During Local Anesthesia In Children

Kelly M. Lipp, DDS, MS – OSU / Nationwide Children's Hospital, Columbus, OH
Comparing Post-Operative Comfort following Dental Treatment under General Anesthesia

Shan Girn, DMD – University of California - San Francisco, San Francisco, CA
Functional Remineralization of Dentin using Polymer Induced Liquid Precursors (PILP)

Ruth Alvarez, DDS, PhD – University of California at Los Angeles, Los Angeles, CA
Relationship Between Salivary Biomarkers and Caries Experience in Hispanic Children

Salam Alsadiq, BDS, MS – Boston University, Boston, MA
Sleep Disturbances and Upper Airway Size among Children 3-18 years

Martin Berger, DMD – Boston Children's Hospital/Harvard School of Dental Medicine, Boston, MA
The Microbiological and Microstructural Effects of SDF on Caries Arrest

3. Ralph E. McDonald Award: to be announced

4. My Kids Dentist Research Poster Competition winners: to be announced

5. Paul P. Taylor Award:
   JA Coll, NS Seale, K Vargas, AA Marghalani, S. Al Shamali, L. Graham. Primary Tooth Vital Pulp Therapy: A Systematic Review and Meta-analysis. *Pediatric Dentistry 2017;39(1):16-27, E15-E110.*

6. Evidence-Based Dentistry Service Award: Dr. Norman Tinanoff

7. 2018-19 Preventech Samuel D. Harris Research and Policy Fellow: to be announced

8. Pediatric Dental Residents Committee Resident Recognition Awards:

   Dr. Sara Ehsani – University of Connecticut
   Dr. Brianna Munoz – University of Connecticut
   Dr. Gail Silveira – University of Tennessee

9. 2018-19 Sunstar Research Fellowship Awards:

   Suzanne D. Baker, DDS
   University of North Carolina
   A Randomized Clinical Trial of Buffered 1% vs Unbuffered 2% Lidocaine in Children

   Joseph DePalo, DMD
   Nationwide Children's Hospital
   The effectiveness of silver diamine fluoride treatment on interproximal dental caries.

B. Installation of 2018-19 officers and trustees for AAPD, HSHC, and ABPD: Jerome B. Miller

C. Presentation of plaques to outgoing officers, board members, and chairs of councils and committees:

   a. Mario E. Ramos, Parliamentarian
   b. Amr M. Moursi, Academic At-Large Trustee
   c. Bruce H. Weiner, Southwestern District Trustee
   d. John L. Gibbons, Western District Trustee
   e. Kevin J. Donly, Council on Annual Session, Chair
   f. Lynn Fujimoto, Council on Annual Session, Local Arrangements Committee,

Chair

g. Rebecca L. Slayton, Council on Annual Session, Scientific Program Committee
h. Edward L. Rick, Council on Clinical Affairs Chair, Chair
i. Homa Amini, Council on Continuing Education, Journal-Based Continuing Education Committee
j. Shari C. Kohn, Council on Membership and Membership Services
k. K. Jean Beauchamp, Council on Membership and Membership Services, Committee on Interprofessional Relations
l. Nidhi Taneja, Council on Membership and Membership Services, Pediatric Dental Resident Committee
m. Anupama R. Tate, Evidence Based Dentistry Committee
n. Jeannie Beauchamp, PAC Steering Committee, Chair
o. Warren Brill, PAC Steering Committee, Vice Chair
p. Cliff Hartmann, PAC Steering Committee, Assistant Treasurer
q. Stephen C. Mills, PAC Steering Committee, Northeastern District Representative
r. Philip Hunke, PAC Steering Committee, Southwestern District Representative
s. Jade Miller, PAC Steering Committee, Western District Representative

15. Remarks from Incoming President — Joseph B. Castellano

16. Adjournment

Minutes of the American Academy of Pediatric Dentistry General Assembly of the 70th Annual Session

Gaylord National Harbor Resort and Convention Center
National Harbor, Maryland
National Harbor Rooms 2/3

Sunday, May 28, 2017
9:30 – 11:30 AM

Chair: Jade Miller, AAPD President
Parliamentarian: David A. Tesini, assisted by Tim Wynn, PRP, President, Perfect Rules Inc.

Dr. Miller called the meeting to order at 9:34 a.m.

1. Rules of debate

In the interest of saving time and to allow more members an opportunity to speak, any debate shall be limited to one speech of two minutes per member, per motion, unless extended by a two-thirds vote without debate. There were no objections to these rules.

2. Minutes of 69th Annual Session, San Antonio, Texas

The Board of Trustees approved the minutes of the 69th Annual Session on July 5, 2016. The president proposed that the Board be authorized to approve the minutes of the 70th Annual Session. There were no objections to the proposal.

3. Appointment of Tellers

Dr. Miller appointed the following members as tellers:
- Santos Cortez, head teller
- Oariana Lowe
- Janice Townsend

Timothy Wynn of Perfect Rules to serve as Parliamentary Consultant

4. Nominations Committee report

The Nominations Committee presented recommendations for the 2017-18 slate of officers/directors. There were no nominations from the floor. Therefore, the General Assembly considered the slate as presented by the Nominations Committee.

Action

Hearing no objection, the nominees were elected as follows:

President-Elect: Joseph B. Castellano
Vice President: Kevin J. Donly
Secretary-Treasurer: Jessica Y. Lee
Trustee At-Large: Tegwyn H. Brickhouse
American Board of Pediatric Dentistry Director: Dorothy T. Pang

Additionally, Mario E. Ramos was approved by the board of trustees to serve as parliamentarian for 2017-2018.

5. ADA President-elect Joseph Crowley made remarks to the assembly.

6. Informational reports were given by AAPD President Jade Miller, HSHC President Neophytos L. Savide, AAPD PAC Steering Committee Chair Reneida Reyes. Dr. Miller called attention to the CEO's Report.

7. Reference Committee Report - Budget and Finance Committee

Budget and Finance Committee Chair Dr. Kevin J. Donly presented the following figures, which were informational only. He noted that:

- The proposed budget for 2017-18 reflects a negative balance of $433,591.63.
- Estimated income does not reflect unearned/unrealized income (investments).

Core Revenues		Core Expenses	
Dues	$4,243,702.00	Headquarters Operations	$ 4,249,721.60
Annual Session	$2,500,000.00	Services	$ 4,338,026.62
Education	$ 971,837.00	Travel	$ 843,360.00
Publications	$ 735,000.00	Other	$ 228,622.41
Other	$ 775,600.00	TOTAL	$9,659,730.63
TOTAL	$9,226,139.00		

8. Reference Committee Report – Oral Health Policies, Clinical Guidelines, or Endorsements as presented by the Council on Clinical Affairs Reference Committee.

Dr. Edward L. Rick, chair of the Council on Clinical Affairs Reference Committee, presented the report. A motion was made and seconded to approve the entire report as a consent agenda (that is, that the entire agenda be considered as a whole without debate as a time saving mechanism). The chair noted that any member had the right to remove any of the recommendation of the reference committee to be considered individually.

The *Guideline on Use of Anesthesia Personnel in the Administration of Office-Based Deep Sedation/General Anesthesia to the Pediatric Dental Patient* was removed for discussion.

Action

The oral health policies, clinical guidelines, and endorsements as presented by the Council on Clinical Affairs Reference Committee were approved as presented. For the record, changes from the drafts presented in the Council on Clinical Affairs' annual report as presented at the Reference Committee hearings are noted below for each document title.

The Reference Committee recommends deletion of the following existing Definitions, Oral Health Policies, or Clinical Guidelines:

Policy on the Use of Deep Sedation and General Anesthesia in the Pediatric Dental Office

The information is contained in the joint AAP/AAPD guideline, making the policy redundant.

The Reference Committee recommends approval/reaffirmation of existing Definitions, Oral Health Policies, Clinical Guidelines, or Endorsements as Presented:

Definition of Dental Disability
Policy on Child Identification Programs
Policy on Emergency Oral Care for Infants, Children, Adolescents, and Persons with Special Health Care Needs
Policy on the Role of Dental Prophylaxis in Pediatric Dentistry
Policy on Third Party Fee Capping of Non-Covered Services
Policy on Mandatory School-entrance Oral Health Examinations
Policy on Snacks and Beverages Sold in Schools
Policy on Interim Therapeutic Restorations (ITR)
Policy on Model Dental Benefits for Infants, Children, Adolescents, and Individuals with Special Health Care Needs
Policy on the Use of Lasers for Pediatric Dental Patients
Guideline on Record-keeping

The Reference Committee recommends approval/reaffirmation of existing Endorsements as Presented:

Guideline on Oral/Dental Aspects of Child Abuse and Neglect (Joint document with AAP)
Guideline on Prescribing Dental Radiographs for Infants, Children, Adolescents, and Persons with Special Health Care Needs

The Reference Committee recommends approval of new Definitions, Oral Health Policies, Clinical Guidelines, or Endorsements as Presented:

Policy on Third-party Reimbursement for Management of Patients with Special Health Care Needs
Policy on Social Determinants of Children's Oral Health and Health Disparities
Policy on Human Papilloma Virus Vaccinations

The Reference Committee recommends approval of existing Definitions, Oral Health Policies, Clinical Guidelines, or Endorsements with the changes as noted:

Policy on Dietary Recommendations for Infants, Children, and Adolescents

Delete lines 171-175:

The AAP has recommended children one through six years of age consume no more than four to six ounces of fruit juice per day, from a cup (i.e., not a bottle or covered cup) and as part of a meal or snack.[15] Night time bottle-feeding with juice, repeated use of a sippy or no-spill cup, and frequent in between meal consumption of sugar-containing snacks or drinks (e.g., juice, formula, soda) increase the risk of caries.[16]

Replace with:

A June 2017 recommendation of the Committee on Nutrition of the American Academy of Pediatrics has reconfirmed that 100 percent juice and juice drinks have no essential role in a healthy diet for children, and contribute to excessive calorie intake and risk of dental caries in children. Their recommendations include: juice should not be introduced to infants before 1 year of age; intake of juice should be limited to 4 ounces a day for children ages 1-3 years of age; 4-6 ounces for children 4-6 years of age; 8 ounces for children 7-18 years of age; toddlers should not be given juice in containers that foster easy consumption; and toddlers should not be given juice at bedtime (Heyman and Abrams 2017).

Delete the following references:

15. American Academy of Pediatrics Committee on Nutrition. Policy statement: The use and misuse of fruit juices in pediatrics. Pediatrics 2001;107(5):1210-3. Reaffirmed October, 2006.
16. Tinanoff N, Kanellis MJ, Vargas CM. Current understanding of the epidemiology, mechanisms, and prevention of dental caries in preschool children. Pediatr Dent 2002;24(6):543-51.

Add:

Heyman MB, Abrams SA. Fruit juice in infants, children, and adolescents: Current recommendations. Pediatrics 2017;139(6):e967

Line 295: add: "The AAPD endorses the AAP recommendations on fruit juice in infants, children, and adolescents."

Policy on Acute Pediatric Dental Pain Assessment and Management

Move lines 134-136 and 146-147 to paragraph at line 105:

Practitioners may be hesitant to prescribe opioid analgesics for pediatric patients for fear of addiction. Because opioid use for dental pain should be of short duration, physical dependence is unlikely and its use should be considered.[12] Opioid analgesics are effective for moderate to severe postoperative pain but have potential for diversion and adverse effects including nausea, emesis, constipation, sedation, and respiratory depression.[15,16,17] Parental anxiety associated with postoperative pain may influence home administration of analgesics.[6] Educating parents about anticipated postoperative discomfort and benefits of pain medication could be associated with decreased reports of pain in pediatric patients. Parental education, expectation management, and effective use of non-opioid analgesics are keys reducing adverse effects of opioid analgesics. Opioid analgesics such as hydrocodone and oxycodone are often combined with acetaminophen. Concomitant or alternating opioid administration with ibuprofen can reduce opioid consumption.[6]

Policy Statement:
(The statement begins "… the AAPD encourages health care professionals to:")

Move lines 167-168 to line 165:

- Consider simultaneous use of analgesics with different mechanisms of action to optimize pain management. Combining opioid analgesics with NSAIDs or acetaminophen for moderate to severe pain may decrease overall opioid consumption.

Line 166: Delete:

- ~~Discontinue the use of codeine in pediatric patients due to safety concerns~~.

Add:

- Support additional clinical research to extend the understanding of the risks and benefits of both opioid and nonopioid alternatives for orally administered, effective agents for acute and chronic pain[19].

The AAPD supports the FDA's April 2017 safety communication which states that codeine or tramadol are contraindicated for treatment of pain in children younger than 12 (FDA Drug Safety Communication 2017).

Add reference:
FDA Drug Safety Communication: FDA restricts use of prescription codeine pain and cough medicines and tramadol pain medicines in children; recommends against use in breastfeeding women. Available at: https://www.fda.gov/Drugs/DrugSafety/ucm549679.htm . Accessed May 26, 2017.

Policy on Using Harvested Dental Stem Cells

Policy Statement:
Lines 63-66: Delete the second bullet point, as it is now redundant:

- While there are currently no treatments available using harvested dental stem cells in humans, the AAPD recognizes that this is an emerging science which may have application for oral health care.
- ~~The AAPD does not endorse the storage or use of harvest dental stem cells as there are no treatments available using harvested dental stem cells in humans~~.

Guideline on Protective Stabilization for Pediatric Dental Patients

Lines 283-284: Patients placed on a rigid stabilization board may overheat during the dental procedure~~; therefore, their temperature should be monitored.[31]~~

Lines 240-251: Because protective stabilization may benefit some patients who don't meet the conditions listed in the indications section, we modified the suggestion forwarded at the Reference Committee hearing to add:
"Protective stabilization is indicated when:…

- An uncooperative patient requires limited treatment (e.g., quadrant) and

sedation or general anesthesia may not be an option because the patient does not meet sedation criteria, there is a long OR wait time, financial considerations, and/or parental preferences after other options have been discussed."

The Reference Committee recommends approval of new Definitions, Oral Health Policies, Clinical Guidelines, or Endorsements with the changes as noted:

Policy on the Use of Silver Diamine Fluoride for Pediatric Dental Patients

Lines 11-13: Rephrase, as the purpose of a policy is not to educate. Delete reference to silver nitrate, as it is not discussed in this policy statement.

This policy ~~intends to educate professionals, parents and patients about~~ addresses the use of silver diamine fluoride **(SDF)** ~~or silver nitrate **(SN)**~~ as part of an ongoing caries management plan with the aim of optimizing individualized patient care consistent with the goals of a dental home**.**

Line 17: Delete "or silver nitrate (SN)"

Line 43: Delete "begun": During the past decade many other countries such as Australia and China have ~~begun~~ been using this compound with similar success.

Lines 57-59: Delete "many", explain bias, delete "and because there is no method to accurately determine caries arrest":
Many clinical trials have evaluated the efficacy of SDF on caries arrest and/or prevention,[6,9-11,13-33] although clinical trials ~~many~~ have ~~risk of~~ inherent bias; because of the staining the difference between control and treated teeth is obvious to the researcher. ~~and because there is no method to accurately determine caries arrest~~.

The General Assembly then considered the removed document, *Guideline on Use of Anesthesia Personnel in the Administration of Office-Based Deep Sedation/General Anesthesia to the Pediatric Dental Patient.*
Concerning the following recommendation:

Lines 170-173: Change "The facility is" to "The licensed practitioners are"; delete or when succinylcholine is present for use in the event of an emergency":
"The ~~treatment facility should~~ licensed practitioners are ~~is~~ responsible for ensuring that ~~have~~ medications, equipment, and protocols are available to treat malignant hyperthermia when triggering volatile inhalation anesthetic agents are used ~~or when succinylcholine is present for use in the event of an emergency~~.[4, 9]."

A motion was made and seconded to strike "volatile inhalation anesthetic". The motion was carried unanimously.

Lines 170-173 now read:

"The licensed practitioners are responsible for ensuring that medications, equipment, and protocols are available to treat malignant hyperthermia when triggering agents are used.[4, 9]."

A motion was made and seconded to approve the amended document, *Guideline on Use of Anesthesia Personnel in the Administration of Office-Based Deep Sedation/General Anesthesia*

to the Pediatric Dental Patient, with the changes recommended by the Reference Committee. The motion was carried unanimously.

For the record, the Reference Committee recommendations for this document are noted below.

Line 1 (and throughout document): Change "Anesthesia Personnel" to "Anesthesia Providers": *Guideline on Use of Anesthesia ~~Personnel~~ Providers in the Administration of Office-Based Deep Sedation/General Anesthesia to the Pediatric Dental Patient*

Line 18: Change "anesthesia personnel" to "a licensed anesthesia provider": the dental practitioner who elects to use ~~anesthesia personnel~~ a licensed anesthesia provider…

Line 25: delete "systematic": …including a ~~systematic~~ literature search…

Lines 40-43: Delete "There are" and begin the sentence with "Some"; change "special needs patients" to "individuals with special care needs"
~~There are some~~ Some children and individuals with special care needs ~~patients with~~ who have extensive ~~treatment~~ oral health care needs, acute situational anxiety, uncooperative age-appropriate behavior, immature cognitive functioning, disabilities, or medical conditions ~~who~~ require deep sedation/general anesthesia to receive dental treatment in a safe and humane fashion (Glassman et al 2009; AAPD Policy on Reimbursement of Sedation/GA Fees).

Line 46: Delete "individuals" and insert "and currently licensed anesthesia providers":
"…by utilizing properly trained ~~individuals~~ and currently licensed anesthesia providers in their offices…"

Line 49: Begin sentence with "Office-based", change D to d, and delete "in the dental office":
"Office-based deep ~~Deep~~ sedation/general anesthesia ~~in the dental office~~…"

Lines 50-55: After "dental team," rework the next few sentences into a bulleted list: "Deep sedation/general anesthesia in the dental office can provide benefits for the patient and the dental team. ~~Access to care may be improved. The treatment may be scheduled more easily and efficiently. Facility charges and administrative procedures may be less than those associated with a surgical center. Complex or lengthy treatment can be provided comfortably while minimizing patient memory of the dental procedure. Movement by the patient is decreased, and the quality of care may be improved. The dentist can use his/her customary in-office delivery system with access to trained auxiliary personnel, supplemental equipment, instrumentation, or supplies should the need arise.~~ Such benefits may include:

- improved access to care,
- improved ease and efficiency of scheduling,
- decreased administrative procedures and facility fees when compared to a surgical center or hospital,
- minimized likelihood of patient's recall of procedures
- decreased patient movement which may optimize quality of care, and

- use of traditional dental delivery systems with access to a full complement of dental equipment, instrumentation, supplies, and auxiliary personnel."

Line 56: Change "anesthesia personnel" to "licensed anesthesia providers":
"The use of licensed anesthesia ~~personnel~~ providers to administer deep sedation/general anesthesia…"

Line 57 (after "The use of ~~anesthesia personnel~~ licensed anesthesia providers to administer deep sedation/general anesthesia in the pediatric dental population is an accepted treatment modality [3-6]."), add (from the deleted Policy on the use of deep sedation and general anesthesia in the dental office):
Extreme caution must be used in patients younger than 2 years of age. Practitioners must always be mindful of the increased risk associated with office-based deep sedation/general anesthesia in the infant and toddler populations. This level of pharmacologic behavioral modification should only be used when the risk of orofacial disease outweighs the benefits of monitoring, interim therapeutic restoration, or arresting medicaments to slow or stop the progression of caries[7,8,9].

7. U.S. Food and Drug Administration. FDA Drug Safety Communication: FDA review results in new warnings about using general anesthetics and sedation drugs in young children and pregnant women. Posted December 14, 2016. Available at: "http://www.fda.gov/Drugs/DrugSafety/ucm532356.htm". Accessed March 22, 2017. (Archived by WebCite® at "http://www.webcitation.org/6p9d3TZ4S")
8. Cravero JP, Beach ML, Blike GT, Gallagher SM, Hertzog JH. Pediatric sedation research consortium. The incidence and nature of adverse events during pediatric sedation/anesthesia with propofol for procedures outside the operating room; a report from thr Pediatric Sedation Research Consortium. Anesth Analg. 2009;108(3):795-804.
9. Creeley CE. From drug-induced developmental neuroapoptosis to pediatric anesthetic neurotoxicity – Where are we now? *Brain Sci.* 2016, 6(3) 32; doi:10.3390/brainsci6030032.

Line 61: change "are not necessary" to "may not be deemed necessary for delivering routine oral health care":
"the extensive medical resources of a hospital ~~are not~~ may not be deemed necessary for delivering routine health care."

Line 66: between "and" and "emergency" insert "trained in rescue":
"…their patient's medical history and trained in rescue emergency procedures…"

Line 72: Delete "Office based" and after "techniques", insert "in the dental office", and add list:
~~Office-based deep~~ Deep sedation/general anesthesia techniques in the dental office require at least three individuals:

- independently practicing and currently licensed anesthesia provider
- operating dentist
- support personnel."

Line 74: Change "observe constantly" to "continuously monitor":
"…to ~~observe constantly~~ continuously monitor the patient's vital signs…"

Line 79: Delete “deep vein thrombosis” and replace with “peripheral neuropathy”, since DVTs are rare in children: “to avoid the possibility of complications secondary to prolonged immobility (e.g., ~~deep vein thrombosis~~ peripheral neuropathy).

Lines 82-96:

Line 82: "practitioners”

Line 83: change "personnel" to "providers”; after "verify", change “scrutinize” to “carefully evaluate"

Line 84: Add a period after experience. Begin the next sentence with "Significant pediatric training, including anesthesia care of the very young, and experience in a dental setting are important considerations,”

Lines 85-86: Add as a preamble to the bullet list: “In order to provide anesthesia services in an office-based setting:” On line 86: delete "appropriate and"; change "for" to "to independently administer"; and at the end of the sentence, add "in a dental office. He/She must be in compliance with state and local laws regarding anesthesia practices. Laws vary from state to state and may supersede any portion of this document."

Lines 87-89: Delete. Issues of which training program someone attended should not matter if the practitioner is licensed and state certified.

Lines 90-91 - Delete. This information is now included in the first bullet point.

Lines 93-96: Revert to original language with modifications and additions

Lines 82-96 now read:

It is the exclusive responsibility of treating practitioners, when employing anesthesia ~~personnel~~ providers to administer deep sedation/general anesthesia, to verify and carefully review their credentials and experience~~,~~. Significant pediatric training, including anesthesia care of the very young, and experience in a dental setting are important considerations, especially when caring for young pediatric and special needs populations.

In order to provide anesthesia services in an office-based setting:

- The anesthesia ~~care~~ provider must be a licensed dental and/or medical practitioner with ~~appropriate and~~ current state certification to independently administer ~~for~~ deep sedation/general anesthesia in a dental office. He/She must be in compliance with state and local laws regarding anesthesia practices. Laws vary from state to state and may supersede any portion of this document.
- ~~The anesthesia care provider must have completed a one- or two-year dental anesthesia residency or its equivalent, as approved by the American Dental Association (ADA), and/or medical anesthesia residency, as approved by the American Medical Association (AMA).~~
- ~~The anesthesia care provider currently must be licensed by and in compliance with the laws of the state in which he/she practices. Laws vary from state to~~

~~state and may supersede any portion of this document.~~

- If state law permits a certified registered nurse anesthetist (CRNA) or anesthesia assistant (AA) to function under the direct supervision of a dentist, the dentist is required to have completed training in deep sedation/general anesthesia and be licensed or permitted for that level of pharmacologic management, ~~as~~ appropriate to state law. Furthermore, to maximize patient safety, the dentist supervising the CRNA or AA would not simultaneously be providing dental treatment. The CRNA or AA must be licensed with current state certification to administer deep sedation/general anesthesia in a dental office. He/She must be in compliance with state and local laws regarding anesthesia practices. Laws vary from state to state and may supersede any portion of this document.

Line 101: change "ADA, AMA, and their recognized specialties" to read "American Dental Association, American Society of Anesthesiologists (ASA), and other organizations with recognized professional expertise and stature"; after "safety and", add "/or is superseded by state law" and delete the remaining verbiage:
"…or other appropriate guideline(s) of the ~~ADA, AMA, and their recognized specialties~~ American Dental Association, American Society of Anesthesiologists (ASA), and other organizations with recognized professional expertise and stature. The recommendations in this document may be exceeded at any time if the change involves improved safety and/or is ~~supported by currently-accepted practice and/or is evidence-based~~ superseded by state law."

Line 105: Change "anesthesia personnel" to "licensed anesthesia provider": "The dentist and licensed anesthesia ~~personnel~~ provider must collaborate ~~work together~~ to enhance patient safety."

Line 106: delete "is" and add "and appropriately timed interventions are": "Continuous and effective perioperative communication ~~is~~ and appropriately timed interventions are essential in mitigating adverse events or outcomes."

Line 113: add "roles and": "Office staff should understand their additional roles and responsibilities…"

Lines 117-134:
Advanced training in recognition and management of pediatric emergencies is critical in providing safe sedation and anesthetic care. During deep sedation/general anesthesia, there ~~There~~ must be one person ~~present~~ ~~available~~ whose only responsibilit~~y~~es ~~is~~ are to ~~constantly observe~~ continuously monitor the patient's vital signs, airway patency, and adequacy of ventilation and to either administer drugs or direct their administration.[4] ~~At least one In addition to this caregiver, there must be a second individual who is certified trained in and capable of providing advanced pediatric life support (PALS) and who is skilled in airway management, basic life support (BLS), and cardiopulmonary resuscitation must be present at all times throughout the delivery of deep sedation/general anesthesia [3].; training in pediatric advanced life support is required. An individual experienced in post-anesthetic recovery care must be in attendance in the recovery facility until the patient, through continual monitoring, exhibits respiratory and cardiovascular cardiopulmonary stability and appropriate discharge criteria [3] have been met.~~ An independent

anesthesiologist often assumes this role. However, if this individual is not an anesthesiologist but is functioning under the supervision of a licensed and legally-permitted practitioner, then this individual, at a minimum, must be trained in advanced pediatric life support (e.g., PALS) and capable of assisting with any emergency event. The supervisor must be physically present during the intraoperative period, free from surgical responsibilities, trained in and capable of providing advanced pediatric life support, and skilled to rescue a child with apnea, laryngospasm, and/or airway obstruction. This provider must have the skills and the ability to open the airway, suction secretions, provide continuous positive airway pressure (CPAP), insert supraglottic devices (oral airway, nasal trumpet, laryngeal mask airway [LMA]), and perform successful bag-valve-mask ventilation, tracheal intubation, and cardiopulmonary resuscitation.[3] Furthermore, at least one practitioner skilled in obtaining vascular access in children must be immediately available.

Personnel experienced in post anesthetic recovery care and trained in advanced resuscitative techniques (e.g., PALS) must be in attendance and provide continuous respiratory and cardiovascular monitoring during the recovery period. The supervising anesthesia provider, not the operating dentist, shall determine when the patient exhibits respiratory and cardiovascular stability and appropriate discharge criteria[3] have been met.

The operating dentist and his/her clinical staff must be well-versed in emergency recognition, rescue, and emergency protocols including maintaining cardiopulmonary resuscitation certification for healthcare providers. In addition, it is highly recommended that the operating dentist be trained in advanced resuscitative techniques. ~~In addition, the staff of the treating dentist must be well-versed in rescue and emergency protocols (including cardiopulmonary resuscitation) In addition to the anesthesia care provider, the operating dentist and all clinical staff must be trained in emergency office procedures [3] and maintain current basic life support credentials.~~ ~~and have~~ Contact numbers for local emergency medical ~~services~~ and ambulance services~~.~~ must be readily available and a protocol for immediate access to back-up emergency services must be clearly outlined [3]. Emergency preparedness must be updated and practiced on a regular basis (e.g., semi-annually), so as to keep all staff members up-to-date on established protocols.[7]

Line 139: Change "between" to "among": Often these levels are not easily differentiated, and patients may drift ~~through~~ ~~between~~ among them.

Line 143: "Facilities ~~also should comply~~ must be in compliance with applicable laws…"

Lines 156 -165: To align language with the joint AAP/AAPD Sedation Guideline: "For deep sedation/general anesthesia, there ~~shall~~ must be continuous monitoring of ~~oxygen saturation, respiratory rate, heart rhythm and rate, blood pressure and heart rate and with intermittent time-based recording of each. respiratory rate and blood pressure.~~ the patient's level of consciousness and responsiveness, heart rate, blood pressure, respiratory rate, expired carbon dioxide values, and oxygen saturation. ~~Continuous end-tidal carbon dioxide (E_tCO_2) monitoring during deep sedation/general anesthesia is also mandatory [3, 4].~~ When adequacy of ventilation is difficult to observe using capnography, use of an amplified, audible precordial

stethoscope (e.g., Bluetooth technology) [3] ~~or capnograph~~ is encouraged ~~(AAP/AAPD Sedation Guideline)~~. ~~An electrocardiographic monitor should be readily available for patients undergoing deep sedation~~. In addition, ~~to the monitors previously mentioned, a temperature monitor~~ an electrocardiographic monitor and ~~pediatric~~ a defibrillator capable of delivering an attenuated pediatric dose are required for deep sedation/general anesthesia.[3]"

Line 166: "Yankauer suction"

Lines 185: Delete "heart rhythm" as this is not in the joint document:
"Vital signs: Pulse and respiratory rates, blood pressure, ~~heart rhythm,~~ ~~and~~ oxygen saturation, and expired CO_2 must be monitored continuously…"

Line 187: Add "on a time-based record". Add "initially every five minutes then". Change "during the recovery phase" to "as the patient awakens" to be consistent with the joint document:

"…and recorded ~~at least every 5 minutes~~ on a time-based record throughout the procedure, initially every five minutes ~~and~~ then, as the patient awakens, at ~~specific~~ 10-15 minute intervals ~~during the recovery phase~~ until the patient has met documented discharge criteria.[3]

Line 189: "and patient effects,", add "(e.g., level of consciousness, patient responsiveness)":

- **Drugs**: Name, dose, route, site, time of administration, and patient effects (e.g., level of consciousness, patient responsiveness) of all drugs, including local anesthesia, must be documented.

Line 208: after "evaluation", add "by an appropriate and currently licensed medical or anesthesia provider": "…the patient must undergo a preoperative health evaluation by an appropriate and currently licensed medical or anesthesia provider."

Line 209: after "equipped", add "and staffed": "High-risk patients should be treated in a facility properly equipped and staffed to provide for their care."

Line 214: after "be", add "documented and": Untoward and unexpected outcomes must be documented and reviewed to monitor the quality of services provided.

Update references

8. Reference Committee Report – Amendments to the AAPD Bylaws as presented by the Constitution and Bylaws Committee Reference Committee.

Dr. Joseph B. Castellano, Chair of the Constitution and Bylaws Committee Reference Committee, presented the report. A motion was made and seconded that the recommendations of the committee report be considered as a consent agenda (that is, that the entire agenda be considered as a whole without debate as a time saving mechanism). The chair noted that any member had the right to remove any of the recommendation of the reference committee to be considered individually. There were no comments.

Please note that in accordance with the AAPD Constitution and Bylaws, notice of these proposed Constitution and Bylaw changes was mailed to the membership more than 60 days prior to the General Assembly. The notice was provided in the March 2017 issue of PDT, on page 11. This issue was mailed on March 13, 2017. The proposed Constitution and Bylaw amendments have also been available on the AAPD website. Members were alerted to this information via AAPD E-News.

Action

The amendments to the Bylaws as presented by the Constitution and Bylaws Committee were approved as presented:

1. **Modification of Leadership Development Committee of the Board of Trustees**

   The Reference Committee recommends adoption of the proposal as submitted.

9. Dr. Kerry Maguire presented an informational report on the Academy's Evidence-Based Dentistry activities.

Dr. Maguire noted the terminology changes for the 2017 *Reference Manual*. There will be two subcategories of recommendations: Clinical Practice Guidelines and Best Practices. Essentially, Clinical Practice Guidelines are based on published systematic reviews, whereas Best Practices are based on the best available evidence and expert consensus. These changes are in response to evolving guideline standards in the larger health care community.

What was previously called Clinical Practice Guidelines, as produced by the Council on Clinical Affairs with assistance from the Council on Scientific Affairs, will now be called Best Practices. Best Practices, as defined by the Centers for Disease Control and Prevention, are "the best clinical or administrative practice or approach at the moment, given the situation, the consumer's or community's needs and desires, the evidence about what works for this situation/need/desire, and the resources available." Best Practices will also cover issues peripherally related to clinical care such as informed consent and record-keeping procedures. Best Practices will continue to be reviewed and voted on by the General Assembly.

The end product of any AAPD EBD process will be called Clinical Practice Guidelines. Clinical Practice Guidelines, as defined by the Institute of Medicine, are: "statements that include recommendations intended to optimize patient care that are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options." Because of the rigorous review process which includes opportunity for input from all stakeholders, these guidelines will not be voted on by the General Assembly.

Dr. Maguire highlighted two new AAPD evidence-based guidelines that will appear in the 2017 *Reference Manual*: Vital pulp therapy and Silver Diamine Fluoride. Because these guidelines are produced in accordance with standards created by Institute of Medicine and mandated by the National Guideline Clearinghouse, an initiative of the Agency for Healthcare Research and Quality, they will be eligible to be included in the National Guideline Clearinghouse. Inclusion in this clearinghouse guarantees our guidelines will be seen by private and public payers, policy makers and the public.

10. Awards recognition

The following awardees were recognized or announced:

1. **Merle C. Hunter Leadership Award**: Dr. Anupama Rao Tate

2. **NuSmile Graduate Student Research Awards (GSRA)**

   Annapurna Bondalapati, BDS, Nova Southeastern University, Davie, FL – *BMP2 Enhances Osteogenesis of Gingival Stem Cells in Peptide Hydrogel*

   Michael Hong, DDS, Boston Children's Hospital / Harvard School of Dental Medicine, Boston, MA – *Association Between Sealant Placement and Caries Development in Primary Molars*

   June Chu-Chun Hsiao, DDS, MS, University of Michigan School of Dentistry, Ann Arbor, MI – *A Novel Material for Pulpal Regeneration After Direct Pulp Therapy*

   Alexandra Katsantoni, DDS, Rutgers School of Dental Medicine, Newark, NJ – *Association of Polymorphisms in Genes Involved in Enamel Formation with Childhood Caries*

   Beau Meyer, DDS, University of North Carolina, Chapel Hill, NC – *Dental Treatment and Expenditures Under General Anesthesia for Medicaid-Enrolled Children*

   Christopher Goodell, DMD, Boston Children's Hospital / Harvard School of Dental Medicine, Boston, MA – *Silver Diamine Fluoride Has Little Effect on the Oral Microbiota*

   Dylan S. Hamilton, DMD, New York University, New York, NY – *Parental Perceptions of Silver Diamine Fluoride Staining*

   Sara Beth Goldberg, DDS, Children's Hospital of Philadelphia / University of Pennsylvania, Philadelphia, PA – *Longitudinal Association of Thrush in Infancy With Early Childhood Caries*

3. **Ralph E. McDonald Award**

   Jeffrey Dean, Ralph McDonald Professor of Pediatric Dentistry at Indiana University, presented the Ralph E. McDonald Award.

   Christopher Goodell, DMD, Boston Children's Hospital / Harvard School of Dental Medicine, Boston, MA – *Silver Diamine Fluoride Has Little Effect on the Oral Microbiota*

4. **My Kids Dentist Research Poster Competition**

   3rd place: Heidi Steinkamp, The Ohio State University, Columbus, OH - *Acquisition of the Oral Microbiome*

   2nd place: John Warner, Oregon Health and Science University Portland, Oregon - *Childhood Caries and Polymorphisms in Sensory Receptors and Energy Homeostasis*

   1st place: Patrick Gilbert, Indiana University, Bloomington, IN - *The Inhibitory Effects of Silver Diamine Fluoride (SDF) With and Without KI (Potassium Iodide) on Streptococcus mutans Biofilm*

5. **Paul P. Taylor Award**

   Wright JT, Tampi MP, Graham L, Estrich C, Crall JJ, Fontana M, Gillette EJ, Nový BB, Dhar V, Donly K, Hewlett ER, Quinonez RB, Chaffin J, Crespin M, Iafolla T, Siegal MD, Carrasco-Labra A. Sealants for preventing and arresting pit-and-fissure occlusal caries in primary and permanent molars. *Pediat Dent* 2016;38(4):282-308.

7. **Evidence-Based Dentistry Service Award**

   Drs. James Coll and Suzi Seale Coll

8. **2017-18 Preventech Samuel D. Harris Research and Policy Fellow**

   Al King, CEO of Preventech, which sponsors the fellowship, congratulated the 2016-17 Harris Fellow on completing her research:

   Erica Caffrey, Children's National Medical Center, Washington, D.C. - *Evaluation of Current State Coverage for Select CDT Codes*

   The 2017-18 Harris Fellow is:

   Wayne E. Stephens, DDS, MBA, Jessi Trice Community Health Center in Miami; Chair of Pediatric Dentistry at the Larkin Community Hospital and Lutheran Hospital

9. **Pediatric Dental Residents Committee Resident Recognition Award**:

   David Anderson – Cincinnati Children's Hospital
   Karina Miller – University of Florida
   Nidhi Taneja – University of Connecticut
   Norman Chen – University of Southern California

10. **2017-18 Sunstar Research Fellowship Awards:**

   Martin Berger, Boston Children's Hospital/Harvard Medical
   Charis Luk, University of British Columbia
   Heidi Steinkamp, Nationwide Children's Hospital/The Ohio State University

11. Other business

The 2017-18 AAPD Board of Trustees, HSHC Board, and ABPD Directors were installed by AAPD Past President, Dr. Jerome Miller. Plaques were presented to retiring officers, trustees, and chairs. Dr. James Nickman, incoming AAPD president, presented remarks.

The meeting adjourned at 11:17 a.m.

Minutes taken by Margaret A. Bjerklie, Executive Assistant and Office Manager, American Academy of Pediatric Dentistry

Approval: Minutes will be reviewed and approved by the AAPD Board of Trustees and posted on the AAPD website.

Minutes were approved by electronic vote of the AAPD Board of Trustees on December 15, 2017.