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

Hawaii Convention Center
Honolulu, Hawaii
Room 312

Sunday, May 27, 2018
9:30 – 11:30 AM

Chair: James D. Nickman, AAPD President
Parliamentarian: Mario E. Ramos, assisted by Tim Wynn, PRP, President, Perfect Rules Inc.

Dr. Nickman called the meeting to order at 9:32 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 70th Annual Session, National Harbor, Maryland

The Board of Trustees approved the minutes of the 70th Annual Session on December 15, 2017. The president proposed that the Board be authorized to approve the minutes of the 71st Annual Session. There were no objections to the proposal.

3. Appointment of Tellers

Dr. Nickman appointed the following members as tellers:

Scott Cashion, head teller
Sara Filstrup
Jacob Lee

Timothy Wynn of Perfect Rules to serve as Parliamentary Consultant

4. Nominations Committee report

The Nominations Committee presented recommendations for the 2018-19 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: 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

Additionally, Anupama R. Tate was approved by the board of trustees to serve as parliamentarian for 2018-2019.

5. ADA President-elect Jeffrey M. Cole made remarks to the assembly.

6. Informational reports were given by AAPD President James Nickman, HSHC President Neophytos L. Savide, AAPD PAC Steering Committee Chair K. Jean Beauchamp, and AAPD Chief Executive Officer John S. Rutkauskas.

7. Reference Committee Report—Budget and Finance Committee

Budget and Finance Committee Chair Dr. Jessica Y. Lee presented the following figures, which were informational only. She noted that:

- The proposed budget for 2018-19 reflects a negative balance of $932,145.01.
- Estimated income does not reflect unearned/unrealized income (investments).

Core Revenues		Core Expenses	
Dues	$ 4,629,491.00	Headquarters Operations	$ 4,641,622.57
Annual Session	$ 3,200,000.00	Services	$ 5,308,011.69
Education	$ 1,171,726.00	Travel	$ 1,102,232.00
Publications	$ 1,042,000.00	Other	$ 268,495.75
Other	$ 345,000.00	TOTAL	$ 11,320,362.01
TOTAL	$ 10,388,217.00		

8. Reference Committee Report—Oral Health Policies, Clinical Recommendations, 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.

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:

Best Practices on Dental Management of Heritable Dental Developmental Anomalies
The reference committee recommended that this document is no longer needed.

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

Definition of Dental Home
Policy on Minimizing Occupational Health Hazards Associated with Nitrous Oxide
Policy on Patient Safety
Policy on the Role of Pediatric Dentists as Both Primary and Specialty Care Providers
Policy on the Use of Fluoride
Policy on Prevention of Sports-related Orofacial Injuries
Policy on the Dental Home
Best Practices on Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance/Counseling, and Oral Treatment for Infants, Children, and Adolescents
Best Practices on Dental Management of Pediatric Patients Receiving Immunosuppressive Therapy and/or Radiation Therapy
Best Practices on Fluoride Therapy
Best Practice on Use of Nitrous Oxide for Pediatric Dental Patients
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)

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

Best Practices for Pain Management in Infants, Children, Adolescents and Individuals with Special Health Care Needs
Lines 11: Purpose: Begin with: "The American Academy of Pediatric Dentistry (AAPD) recognizes that infants, children, and adolescents can and do experience pain due to dental/orofacial injury, infection, and dental procedures, and that inadequate pain management may have significant physical and psychological consequences for the patient. Appreciation of pediatric pain can help practitioners develop clinical approaches to prevent or substantially relieve dental pain. When pharmacologic intervention is necessary to manage pain, the practitioner must understand the consequences, morbidities, and toxicities associate with the use of specific therapeutic agents."
Then delete "The purpose of this document is" and add "This document is intended" to provide dental professionals and other stakeholders with current best practices for pain management in pediatric dentistry."

Lines 31-2: delete ", and professional and educational requirements are being reviewed at multiple levels." Add "; due to the increased appreciation for pediatric pain and because of the national opioid crisis, recommendations for professional education and approaches for therapeutic management are being reviewed at the national, state, and local levels.[2-5]"

Line 39: reorder "invasive treatment, tissue damage, or infection" to "tissue damage, infection, or invasive treatment" so dental procedures are not listed as the prominent cause of pain.

Line 168: change "good local anesthetic techniques" to "profound local anesthesia" as interpretation of good is unclear

Lines 179-82: Because the AAP recommendation is 17 years past publication, change: "The American Academy of Pediatrics consensus statement on the assessment and management of pain in children recommends acetaminophen, ibuprofen and opioids as the top three medication choices for the treatment of acute pain in children.[3,16]" to "Acetaminophen, ibuprofen, and opioids are common medication choices for the treatment of acute pain in children.[16,76]"

Line 199: Add "acetyl-para-aminophenol" prior to "APA". Change "APA" to the common abbreviation, "APAP", and enclose with brackets.

Lines 211-3: Change "Common use in pediatric patients include: cancer pain, sickle cell crises, osteogenesis imperfecta pain, epidermolysis bullosa pain, and pain related to neuromuscular disease.[83,84,85]" to "Common uses in pediatric patients include pain associated with cancer, sickle cell disease, osteogenesis imperfecta, epidermolysis bullosa, and neuromuscular disease.[83,84,85]"

Lines 226-7: After "specialty provider" insert (e.g., pain medicine practitioner, anesthesiologist)

Line 264: after "prescription" add "because of the increased potential for respiratory depression.

Line 269: "After "individuals.", add citation number 95. Replace "A study also demonstrated a" with "A"

Line 271: after "group", add "also has been demonstrated"

Line 289: delete "standard"

Line 298-9 Change "Most agree some screening should be done for adolescents, however there is no common standard.[77]
Change to "Screening adolescents for opioid abuse or misuse has been suggested; however, a standard assessment has not been identified.[77,104]"

Line 307: change “i.e.,” to “e.g.,”

Lines 295-6: Change “controlled substance prescriptions” to “prescriptions for controlled substances”. Delete “, as well as controlling” and add: “which may also decrease”.

Line 300: At the end of the existing language, add “Furthermore, discussion regarding the proper disposal of unused controlled medications is key to reducing availability/diversion of substances with the potential for abuse or for physical and/or psychological dependence.”

Line 303: Insert before the bulleted list: “Infants, children, and adolescents can and do experience pain due to dental/orofacial injury, infection, and dental procedures. Inadequate pain management may have significant physical and psychological consequences for the patient. Adherence to the following recommendations can help practitioners prevent or substantially relieve pediatric dental pain in a safe and effective manner.”

Line 304: Change “Minimize tissue damage and use careful technique when providing dental treatment.” To “Use careful technique to minimize tissue damage when providing dental treatment.”

Line 309: Delete “of”

Line 311: Change “Screening of parent and patient is recommended when prescribing opioid analgesics” to “To help minimize the risk of opioid abuse, screen pediatric patients and their parents regarding previous/current opioid use before prescribing opioid analgesics.”

Line 312: Change “Proper disposal measures for all medications is recommended” to “To avoid diversion of controlled substances, practitioners should utilize prescription monitoring databases and encourage patients to properly discard any unused medications.”

Additionally, references will be appropriately formatted where needed.

Policy for Selecting Anesthesia Providers for the Delivery of Office-Based Deep Sedation/General Anesthesia
Lines 11-15:
Purpose
~~The purpose of this policy is to guide dental professionals in selecting a qualified anesthesia provider for the delivery of deep sedation/general anesthesia in an office-based setting, specifically for pediatric and special healthcare needs populations. It is not the intent of this policy to suggest that any individual group of anesthesia provider is more qualified than another.~~

The American Academy of Pediatric Dentistry (AAPD) recognizes that it is the exclusive responsibility of dental practitioners, when employing anesthesia providers to administer office-based deep sedation/general anesthesia, to verify and carefully review the credentials and experience of those providers.[1] An understanding of the educational and training requirements of the various anesthesia professions and candid discussions with potential anesthesia providers can assist in the vetting and selection of highly skilled licensed providers in order to help minimize risk to patients.

Lines 22-27:

Background

~~Pediatric patients and patients with special healthcare needs who are unable to accept dental care using a customary approach due to a lack of cooperation may have dental treatment accomplished by deeper forms of sedation or general anesthesia.~~ Historically, ~~these levels of~~ care necessitating deep sedation/general anesthesia was ~~were~~ provided in a surgical center or hospital-based setting by an anesthesiologist selected and vetted by the facility or institution.

Delete lines 32-36 (moved to Purpose and rephrased):

~~In an effort to establish the safest care possible, the American Academy of Pediatric Dentistry (AAPD) wishes to assist its members in screening potential anesthesia providers. The following document shall serve to help guide members during the screening process associated with selecting a competent and experienced anesthesia provider for the delivery of office-based care for the pediatric and special needs populations.~~

After line 40:

Add language from AAPD Best practices on use of anesthesia providers:

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[1].

Lines 40-44:

No other responsibility is more important than identifying an anesthesia provider ~~that is meticulous and~~ who is highly competent. 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. Advanced training in recognition and management of pediatric emergencies is critical in providing safe sedation and anesthetic care.[1] ~~Dentists collaborate closely with mobile~~ Close collaboration between the dentist and the anesthesia providers ~~to expand the field of dental medicine,~~ can provide access to care, establish an enhanced level of patient cooperation, improve surgical quality, and offer an elevated level of patient safety during the delivery of dental care.

Federal, state, and local credentialing and licensure laws, regulations, and codes dictate who legally can provide office-based anesthesia services. Practitioners choosing to use

these modalities must be familiar with the regulatory and professional requirements needed to provide this level of pharmacologic behavior management.[1] The operating dentist must confirm any potential anesthesia provider's compliance with all licensure and regulation requirements. Additional considerations in anesthesia provider selection may include proof of liability insurance and recommendations from professional colleagues. Lastly, dentists must recognize potential liability issues associated with the delivery of deep sedation/general anesthesia within their office.

Lines 48-50:
~~With this, we offer a summary of the advanced training and certifying credentials associated with the anesthesia providers that most commonly provide mobile anesthesia care in an office-based dental setting.~~Table 1 summarizes the educational requirements of various anesthesia professions.

Delete lines 52-163, as this information is now in table form.

Table 1. Anesthesia Education and Training Comparison
Update table with current information from association documents.

Lines 175-183:
Because of the diversity in anesthesia education among potential providers, ~~It is important for~~ operating dentists ~~to appreciate the diversity in anesthesia education among potential providers, and if appropriate,~~ should further investigate an individual's training and experience. A candid discussion with a potential anesthesia provider to establish the individual's comfort and experience with unique patient populations (e.g., patients with development disabilities or medical comorbidities, ~~special needs,~~ infants and toddlers, ~~certain comorbidities, etc~~.) is extremely important, especially if it is anticipated that this will represent a large portion of a dental practice's deep sedation/general anesthesia focus. ~~Lastly, dentists must recognize the additional exposure to potential liability issues associated with the delivery of deep sedation/general anesthesia within their personal office and establish a rigorous vetting strategy to help mitigate this risk.~~ Selection of a skilled and knowledgeable anesthesia provider is paramount in providing patients with the safest and most effective care possible.

Add Policy Statement:
Policy Statement
The AAPD encourages dental practitioners, when employing anesthesia providers to administer office-based deep sedation/general anesthesia, to verify and carefully review the credentials and experience of those providers. In addition to the credentialing process, the AAPD encourages dentists to engage a potential anesthesia provider in a candid discussion to determine expectations, practices, and protocols to minimize risk for patients. Sample questions to assist in this conversation appear below.

Sample questions revised and reordered. Legal disclaimer added:
~~20~~ SAMPLE QUESTIONS TO ASK A POTENTIAL OFFICE-BASED ANESTHESIA PROVIDER

These sample questions, developed by the AAPD, are provided as a practice tool for pediatric dentists and other dentists treating children. They were developed by experts in pediatric dentistry and offered to facilitate excellence in practice. However, this list does not establish or evidence a standard of care. In supplying this list of sample questions, the AAPD is not engaged in rendering legal or other professional advice. If such services are required, competent legal or other professional counsel should be sought.

~~1. What is your experience with providing mobile deep sedation/general anesthesia care?~~

~~2~~1. What is your experience with pediatric patient populations? ...special healthcare needs populations?

2. What is your background/experience in providing office-based deep sedation/general anesthesia care? ...and specifically for pediatric dental patients?

~~3. How did your training prepare you for the delivery of anesthesia on a mobile basis?~~

~~4. What is your experience with providing anesthesia for dental cases?~~

~~5. How long have you provided mobile dental anesthesia care for pediatric patients? ...special needs patients?~~

~~6~~3. ~~Explain how~~ How do you evaluate a dental facility and staff prior to initiating ~~mobile~~ anesthesia services~~.~~? What expectations and requirements do you have for the dentist, auxiliary staff and facility?

~~7. What expectations and requirements do you have for the dentist, auxiliary staff and facility?~~

4. What equipment do you use to administer and monitor deep sedation/general anesthesia in the office, and what is your maintenance protocol for this equipment?

~~8~~5. What equipment and/or medications should be maintained by the dental facility?

~~9. How would you manage a medical emergency?~~

~~10~~6. What are some potential emergencies associated with the delivery of deep sedation/general anesthesia in the pediatric dental office, noting any that may be unique to these clinical circumstances?

7. What is your training/experience in recognition and management of pediatric anesthetic emergencies?

8. In the event of a medical emergency, what is your plan of action? What are the roles of the dentist and auxiliary staff during a medical emergency?

~~11. What is the role of the dentist and auxiliary staff during a medical emergency?~~

~~12. How do you prepare the dentist, auxiliary staff and facility for the possibility of a medical emergency?~~

9. Do you have an affiliation with any area hospitals in case a patient requires transfer?

10. What patient selection criteria (e.g. age, weight, comorbidities) do you use to identify potential candidates for office-based deep sedation/general anesthesia?

~~13. Explain how you prepare a patient for office-based deep sedation/general anesthesia?~~

~~14~~11. When a decision has been made that a patient is a candidate for office-based sedation/general anesthesia, ~~W~~what is the office's role in preparing a patient for office-based deep sedation/general anesthesia? How/when do you prepare the patient for the procedure?

12. What is your protocol for monitoring a patient post-operatively?

~~15~~13. What ~~is~~ are your discharge criteria and follow-up protocols for patients who receive office-based deep sedation/general anesthesia ~~on an outpatient basis~~?
~~16~~14. ~~Explain~~ Would you describe a typical general anesthesia case from start to finish~~.~~?
~~17~~15. What is your protocol for ordering, storing and recording controlled substances for deep sedation/general anesthesia cases?
~~18. Do you have any specific patient criteria (ie: age, weight, comorbidities, etc.) in identifying potential candidates for office-based deep sedation/general anesthesia?~~
~~19~~16. What are the patient ~~costs~~ fees associated with ~~the~~ office-based deep sedation/general anesthesia services?
~~20. What are the long and short-term effects of anesthetic agents on neurologic development in young patients?~~
17. How/where are patients records related to the office-based administration of/recovery from deep sedation/general anesthesia stored?

Additionally, references will be added and appropriately formatted where needed.

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

Dr. Kevin J. Donly, 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 this proposed Constitution and Bylaws change was mailed to the membership more than 60 days prior to the General Assembly. The notice was provided in the March 2018 issue of *PDT*, on pages 8-10. This issue was mailed on March 8, 2018. The proposed Constitution and Bylaws amendment has also been available on the AAPD website. Members were alerted to this information via AAPD E-News. This information is also on the Annual Session itinerary.

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

1. Clarification of recognized chapters to include pediatric dental organizations based in other countries

The Reference Committee recommends one technical correction:
Section 5 B: An application for a recognized foreign chapter shall be submitted to the AAPD Board of Trustees. Chapter status shall be granted by a majority vote of the ~~District~~ Board of Trustees.

2. Clarification of Credentials and Ethics proceedings

The Reference Committee recommends adoption of the proposal with the following amendment (following the addition after line 136):

This provision shall not apply to those individuals who are otherwise duly qualified for membership, but whose current employment does not require a valid license to practice in any state.

3. Technical correction concerning trustee membership requirements

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 that two recent AAPD EBD guidelines were accepted by the National Guideline Clearinghouse, an initiative of the Agency for Healthcare Research and Quality.

- Clinical Practice Guidelines for use of Vital Pulp Therapies in Primary Teeth with Deep Caries; and
- Clinical Practice Guideline on the Use of Silver Diamine Fluoride for Dental Caries Management in Children, Adolescents and Individuals with Special Healthcare Needs.

Our guidelines were accepted because they were produced in accordance with standards created by Institute of Medicine and mandated by the National Guideline Clearinghouse. Acceptance by this clearinghouse guarantees our guidelines will be seen by private and public payers, policy makers and the public. Both guidelines were published electronically in the September-October 2017 issue of Pediatric Dentistry and in print in the 2017-18 Reference Manual.

Patient education materials based on the new guidelines were developed for silver diamine fluoride, pulpotomy and indirect pulp therapy. They are available through the AAPD's online bookstore.

The non-vital pulp systematic review workgroup is preparing in vivo and in vitro protocols that will be registered within the year.

The EBD Committee is forming a new workgroup on behavior guidance for the pediatric dental patient. We expect a new behavior guidance guideline, based on an existing systematic review, to be published in 2019.

10. New Business

Dr. Castellano introduced one item for new business. As indicated at the Reference Committee hearings, the Board of Trustees directed the Council on Clinical Affairs to recommend some amendments to the Policy Statement on Use of Silver Diamine Fluoride for Pediatric Dental Patients that was adopted last year. This request came after the deadline for posting CCA materials for advance review by members. It was brought to the board's attention that many state Medicaid programs and dental boards are misunderstanding the proper use of SDF and appropriate coding, despite AAPD's excellent clinical practice guideline. Some are viewing it as equivalent to fluoride varnish and assuming it can be applied indiscriminately to teeth absent a dental diagnosis and supervision by a dentist. Because this is a hot topic and a fast-moving

issue, the board did not want to wait another year before adopting an updated policy that addresses some of these issues.

An item of New Business requires approval by a two-thirds vote in order to be considered.

A motion was made and seconded to consider the new item of business. The motion carried unanimously.

The Reference Committee recommends approval of existing 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

Following line 13, add:

When SDF is indicated, it is essential that the infants, children, adolescents, or individuals with special health care needs receive a comprehensive dental examination, diagnosis and a plan of ongoing disease management prior to placement of the material.

Lines 20-22:

One of these strategies employs ~~the~~ application of SDF as an antimicrobial and remineralization agent to arrest active ~~carious~~ caries ~~dental~~ lesions after diagnosis and at the direction of a responsible dentist of record.

Following line 70:

~~The use of~~ SDF is safe ~~poses little toxicity or fluorosis risk~~ when used in adults and children.[38-41] Placement of SDF should follow AAPD's Chairside Guide: Silver Diamine Fluoride in the Management of Dental Caries Lesion. [41] ~~manufacturer's recommendations.~~ Delegation of the application of SDF to auxiliary dental personal or other trained health professionals, as permitted by state law, must be by prescription or order of the dentist after a comprehensive oral examination.

The ultimate decision regarding disease management and application of SDF are to be made by the dentist and the patient/parent, acknowledging individuals' differences in disease propensity, lifestyle, and environment.[42] Dentists are "required to provide information about the dental health problems observed, the nature of any proposed treatment, the potential benefits and risks associated with the treatment, any alternatives to the treatment proposed, and potential risks and benefits of alternative treatment, including no treatment." [43] The SDF informed consent, particularly highlighting expected staining of treated lesions, potential staining of skin and clothes, and the need for reapplication for disease control, is recommended. [41] Careful monitoring and behavioral intervention to reduce individual risk factors should be part of a comprehensive caries management program that aims not only to sustain arrest of existing caries lesions, but also to prevent new caries lesion development. [42] Although no severe pulpal damage or reaction to SDF has been reported, SDF should not be placed on exposed pulps.[42] Therefore, teeth with deep caries lesions should be closely monitored clinically and radiographically by a dentist [42]

SDF, when used as a caries arresting agent, is a reimbursable fee through billing to a third- party payor, when submitted with the appropriate dental code recognized by the American Dental Association's Current Dental Terminology. Reimbursement for this procedure varies among states and carriers. Third- party payor's coverage is not consistent on the use of the code per tooth or per visit. [42] Because there is a recommended code for SDF application, billing the procedure using any other code would constitute fraud, as defined by the Federal Code of Regulations. [44] The AAPD supports the education of dental students, residents, other oral health professionals and their staffs to ensure good understanding of the appropriate coding and billing practices to avoid fraud. [45]

Following line 100:

Policy statement

The AAPD:

- Supports the use of SDF as part of an ongoing caries management plan with the aim of optimizing individualized patient care consistent with the goals of a dental home.
- Supports third party reimbursement for fees associated with SDF.
- Supports delegation of application of SDF to auxiliary dental personnel or other trained health professionals according to a state's dental practice act by prescription or order of a dentist after a comprehensive oral examination.
- Supports a consultation with the patient/parent with an informed consent recognizing SDF is a valuable therapy which may be included as part of a caries management plan.
- Supports the education of dental students, residents, other oral health professionals and their staffs to ensure a good understanding of appropriate coding and billing practices.
- Encourages more practice-based research to be conducted on SDF to evaluate its efficacy.

Additionally, references will be appropriately formatted where needed.

11. Awards recognition

The following awardees were recognized or announced:

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**

Vickie Hemann, Indiana University Pediatric Dental Alumni Association President, and Barbara McDonald Dean, Dr. McDonald's daughter, announced the Ralph E. McDonald award, which is sponsored by the Indiana University Pediatric Dentistry Alumni Association.

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

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

3rd place: Shan Girn, University of California–San Francisco, San Francisco, CA—*Functional Remineralization of Dentin using Polymer Induced Liquid Precursors (PILP)*

2nd place: LaToya Jones, University of Florida, Gainesville, FL—*Association of Candida Albicans in Early Childhood Caries (ECC) Relapse*

1st place: Sarah Duchaj, Lurie Children's Hospital, Chicago, IL—*Silver Diamine Fluoride Temporal Effects on Dermal Fibroblast Cells*

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

Dr. Nickman noted the passing of one of the authors of this article, N. Sue Seale Coll. The board of trustees has voted unanimously to name Dr. Seale Coll editor emeritus of the Academy's journals.

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

Dr. Norman Tinanoff

Dr. Nickman noted that the board of trustees has voted unanimously to rename this award the Suzi Seale Coll Evidence-Based Dentistry Service Award.

8. **2018-19 Preventech Samuel D. Harris Research and Policy Fellow**

Dr. Paul Casamassimo, AAPD's Chief Policy Officer, congratulated the 2017-18 Harris Fellow on completing his research:

Wayne E. Stephens, DDS, MBA, Jessi Trice Community Health Center in Miami; Chair of Pediatric Dentistry at the Larkin Community Hospital and Lutheran Hospital—*A profile of the pediatric dental safety net at FQHCs*

The 2018-19 Harris Fellow is:

Dr. Brianna Muñoz, University of Connecticut

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

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

10. **2018-19 Sunstar Research Fellowship Awards:**

Ms. Jackie Sanders, Manager, Professional Relations Marketing at Sunstar Americas, Inc., presented the Sunstar Postdoctoral Research Fellowship. She acknowledged the 2017-2018 award winners, who presented their research at this meeting:

Martin Berger, Boston Children's Hospital/Harvard Medical—*The microbiologic and mechanical effects of caries arrest by Silver Diamine Fluoride.*

Charis Luk, University of British Columbia— *Effect of an audiovisual preoperative intervention in reducing parental anxiety prior to a child's sedation appointment.*

Heidi Steinkamp, Nationwide Children's Hospital/The Ohio State University— *Microbial pioneers- acquisition and establishment of the subgingival microbiome*

The 2018-2019 Postdoctoral Research Fellowship award winners are:

Dr. Suzanne D. Baker, University of North Carolina—*A randomized clinical trial of buffered 1% vs unbuffered 2% Lidocaine in children*

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

11. Other business

The 2018-19 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. Joseph B. Castellano, incoming AAPD president, presented remarks.

The meeting adjourned at 11:17 a.m.

Minutes taken by Margaret A. Bjerklie, Governance and Operations 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 approved by electronic vote July 16, 2018.