
# 2012-2013
# Reports of the Officers, Trustees, Boards, Councils, Committees and Task Forces of the American Academy of Pediatric Dentistry

66th Annual Session
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*Orlando, Florida*

# Reports of the Officers, Trustees, Boards, Councils, Committees and Task Forces of the American Academy of Pediatric Dentistry

# 2012-2013

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# 2012-2013 Report of the President

Joel H. Berg
AAPD President

I am honored and proud to have been selected to be your president, and to have served as president of the American Academy of Pediatric Dentistry over the past year. There is no organization like ours. The market share of pediatric dentists we continue to be rewarded with is as a result of the great member value placed before each and every pediatric dentist who has selected to maintain their membership over many years. (Please see the May 2013 PDT report of our CEO on member value).

I want to thank all my colleagues on the Board of Trustees, on the Executive Committee, on all the councils and committees along with their chairs, and each and every member who supported me during the past year. Our central office staff, who is the best that exists anywhere, has helped me and all of us lead the way to continued growth of this amazing organization we are all proud of. You can be assured that the future of the AAPD is strong, and that we are maintaining a path of sustained growth for many years to come. We are financially strong, we are structurally strong, and we are indeed representative of the voice of children and their oral health. We are respected by our colleagues in the dental profession, in the health sciences, in the academic community and in other related of those improving the oral health of children.

I want to take a few minutes to explain some of the fantastic work I'm very proud of that are members and volunteers have created over the past year, all of which will help to sustain the continued growth of the organization for years to come.

Being present of the AAPD takes time away from one's office. For the majority of presidents who have volunteered their time to fill this role coming out of their own private practice, this duty has been enormous in terms of its time commitment and its potential and actual effects on their practices. In my case, being employed in full-time academics, the time commitment has been challenging because of my recently acquired new position as Dean of the University of Washington School of Dentistry. Yet, I could not be more pleased with the opportunity I was given, and I have been rewarded on a daily basis with the outstanding support of the community of colleagues who have a common goal of improving your health of children, and sustaining the efforts of each and every one of our members toward that end. I am exceptionally proud to have served and have loved every minute of it.

I look forward to continued involvement in the AAPD next year, as a member of the Executive Committee as immediate past president and beyond, as I am called upon to assist in any way I am able. I ask each and every one of you to consider what your own individual desires and skill set might bring to the organization. Each of you has a unique capability to help improve our organization even further. Please take a look at the many opportunities around us, now more

than ever as we have grown, and identify (via consultation with your district trustee or with any of the officers) where your expertise and passion might assist in the continued growth of the AAPD.

This year we created several new task forces. First, the task force on talent pool development. This group, chaired by Drs. Charles Czerepak and Rebecca Slayton, has begun the process of creating a structure to identify areas where future talent for the American Academy of Pediatric Dentistry will be needed. Additionally, they have developed a framework of mechanisms whereby we can populate a database of potential experts, including the identification of additional training they may need to fulfill those roles, to sustain the continued growth of the AAPD. Without such a proactive effort, we cannot be certain that we will have the necessary workforce of expert volunteers before us that are the most suited and qualified to be in leadership positions in the future. Please look for further reports from this task force and its ultimate significant impact on the organization over the years to come. We are excited about its continued development.

We also created a task force on global oral health connections and pediatric dentistry. This task force was organized in headed by Dr. Amr Moursi. Dr. Moursi and his team have developed a structured way of looking at how we in the American Academy of Pediatric Dentistry might interact with our pediatric dentistry colleagues around the world. They also will examine how the AAPD might interact with other pediatric dental organizations in other countries on the various continents. There are many groups which have a lot of science expertise, clinical excellence and other aspects of pediatric dental care which are important for us to interact with. Additionally, for the sustained growth of the organization we need to reach out and invite international colleagues to join our organization to share their experience, their expertise, and their passion for caring for children. I'm excited about the outstanding work this task force has already created and the excellent work they will continue to create going forward. I look for a significant increase both in the size and quality of the AAPD by virtue of the multitude of interactions the task force on pediatric oral global health will identify over the years to come. Look for more detailed information at the annual session and beyond regarding the work of this task force.

Finally we created a task force on project management. With the sophistication of the American Academy of Pediatric Dentistry, we need to have an improved method of looking at all the activities of the AAPD, of which there are many. We need to look at these activities in a structured and comprehensive way, and over a multiyear period. We need to be able to allocate resources, measure milestones, and prompt individual volunteers who are involved in the creation of processes and programs, to remain up-to-date in various stages of project management. We cannot continue to rely upon a year-to-year management system; rather, we must create a system which allows us to develop a dashboard which can examine exactly how we are doing in completing the various projects, tasks, charges and other aspects of our work, examining all of this over a one-year period and over a multiyear period. Look for announcements about software and other implementations the task force on project management will recommend going forward.

This year we also completed the first cohort of the advanced leadership Institute at the Wharton school. The outstanding work developed by the various teams who worked with faculty from

the Wharton school over period of over one year, will certainly benefit the Academy in our interest in being the sustained recognized voice of dentistry for children. The work from the Wharton school in this first cohort will certainly bring forward many changes in a very positive way.

We've begun the work with Weber-Shandwick on a public relations campaign. The multi-year effort we have recently contracted with this agency (selected after a very sophisticated process of interviewing many different contenders) will undertake a rebranding effort for the AAPD, as well as demonstrating to the public the great work we do every day in each of our offices, as well as the collective work we do in advocating for improved oral health of children. You will see excitement and results from this comprehensive effort over the next several years. Please look for announcements at this year's annual session and beyond, and stay tuned as we ask you to interface with us to gather information on the best methods and tactics going forward.

I urge you to read the annual report of our CEO Dr. John Rutkauskas. He leads a team of outstanding professionals that keeps us focused on our mission as organization grows and expands its efforts. In his report, you will see a detailed review of some of the things I have discussed here, as well as many other aspects of the great work of our central office staff does each day along with our volunteer leadership.

Again, I thank everyone for all the great things you do each day. I thank you for your friendship, for your support, and for your encouragement, as each of us tries to make a difference by creating opportunities for growth. We hope that these creations will influence our successors for many years to come to allow the sustained growth of the American Academy of Pediatric Dentistry.

# 2012-2013 Report of the President-Elect

Warren A. Brill
AAPD President-Elect

The responsibilities of the President-Elect are the Strategic Planning Committee, hosting the Winter Planning Meeting, selecting appointees to the various AAPD councils and committees to be voted on by the Board of Trustees.

I attended the ADEA meeting as the representative of the AAPD March 16-17, 2013 held in Seattle. The report on this meeting is below. This was a very well attended meeting with not only academicians, but dental students, residents from many disciplines and observers from professional organizations. There were many concurrent educational and policy sessions covering a wide variety of topics. One session was specific for pediatric dentistry, which I will discuss further. I also attended a section meeting for pediatric dentistry.

Following is a list of activities for 2012-2013:

1. May 27, 2012: Sworn in as President-Elect & attended the first Executive Committee and Board of Trustees meeting of the 2012-2013 AAPD year.
2. June 29-30, 2012: Attended Media Training session conducted by Robin Wright held in Chicago.
3. July 6-8. Attended the Executive Committee meeting in Seattle, WA.
4. July 20-22, 2012: Attended the Multi-Cultural Oral Health Summit sponsored by the National Dental Association, Hispanic Dental Association & Society of American Indian Dentists in Boca Raton, Florida. Met with the officers of each organization and discussed areas of mutual interest.
5. August 9-10, 2012. Attended the meeting of the Dental Specialty Groups (DSG) and the Commission on Dental Accreditation (CODA) in Chicago, IL.
6. August 15, 2012 Interviewed and filmed for television treating patients by the Voice of America; subject was pediatric dentistry and prevention for children
7. September 6-8, 2012. Attended the annual meeting of the Canadian Academy of Pediatric Dentistry, Niagara-on-the-Lakes, Ontario, CA. Met with the CAPD leadership and discussed areas of mutual interest.
8. September 28-29, 2012. Attended and participated in the final session of the AAPD Advanced Leadership Institute at the Wharton School of the University of Pennsylvania, Philadelphia, PA.
9. October 18, 2012. Attended the Ad-Interim Executive Committee Meeting, San Francisco.
10. October 19, 2012. Attended the AAPD Ad-Interim Board of Trustees Meeting, San Francisco.
11. October 20-12, 2012. Attended the ADA Meeting, San Francisco.

12. October 26, 2012. Attended the annual all-day continuing education course presented by the Maryland Academy of Pediatric Dentistry. Brought greetings of the AAPD, Columbia, MD.
13. November 5, 2012. Along with President Berg and CEO Rutkauskas, met with the president and other leaders of the American Academy of Pediatrics and the Section on Oral Health. Discussed issues of relevance to both organizations. Chicago, IL.
14. November 9-10, 2012. Attended the joint AAE/AAPD course on trauma. Attended the joint dinner with the Executive Committees of the AAE and AAPD and speakers for the symposium. Scottsdale, AZ.
15. November 29, 2012. Filmed treating patients and interviewed by NBC News for a piece to be shown on the Today Show and posted in the NBC website. Topic: behavior management and access to care.
16. December 6-7, 2012. Attended the ABPD Ad-Interim Board meeting as a guest representing the AAPD. San Juan, Puerto Rico.
17. December 13, 2012. Filmed at work on patients and interviewed by NBC News for the Today Show. Segment was not on air, but a 3.5 minute video of the interview was posted to the NBC News/Today web-page. Subject: managing patient behavior, delivery of care models and positive approaches to oral health for children.
18. Attended the Winter meeting of the Executive Committee and Board of Trustees, January 10-12, 2103, Phoenix, AZ.
19. Presided over the Strategic Planning Session at the Winter Planning meeting, January 12, 2013, Phoenix, Az.
20. Attended the Ad-Hoc Task Force Meetings for Globalization and Talent Pool Development, January 18-19, 2013, Chicago, Il.
21. Attended the meeting of the Dental Specialty Groups. January 31, 2013, Chicago.
22. Attended the Board of Trustees meeting of Healthy Smiles Healthy Children-the Foundation of the AAPD, February 22-23, 2013. Chicago, IL.
23. Attended Executive Committee, Council on Government Affairs and AAPD PAC meetings March 10, 2013; Washington, DC.
24. Attended Public Policy Week lobbying legislators in Washington, DC, March 12, 2013.

**Report on the ADEA Meeting**

The equivalent of our opening session was very well attended. It also included some votes by their House of Delegates. The keynote speaker was Dr. John Medina, a developmental molecular biologist and author of the bestselling book, "Brain Rules". He discussed theories of memory and its implications for learning. His talk was well received and applicable to dental education. We have had similar type speakers and subjects who also have been well received.

One thing they do, which is also done by the ADA, is to have a daily newsletter for the convention. It was a 4 page, full color glossy publication that did include reports of daily activities. For example, Dr. Berg arranged a tour of the University of Washington Center for Pediatric Dentistry. An ADEA staff person was on the tour and wrote an article for

the newsletter that was published the following day. While this is a labor intensive and likely expensive project, I recommend consideration of this for our annual sessions.

I attended several of the seminars. One was entitled, "Unnecessary Teachers: The Art of Clinical Instruction", that was designed for academicians with 0-3 years in academics. It was presented by two dental hygiene program directors, Joyce Hudson from Ivy Tech Community College and Lorinda Coan from Indiana University. It was very well done with excellent audience participation. I don't know the curriculum for our Master Clinician seminars, but contacting them for participation might be a fruitful consideration.

I also attended a very timely session entitled, "Integrating Children's Oral Health and Access to Care into Multiple Educational Settings" presented by Dr. Joan Kowolik, pre-doctoral program director at Indiana University and Dr. Lisa Mruz, pre-doctoral program director at the University of Buffalo. Lisa is also the president of the AAPD Society of Pre-Doctoral Program Directors. The audience was quite varied and included dental school faculty, other pre-doctoral program directors, pre-doctoral dental students and dentists from other disciplines. This seminar was of particular interest to me as one of my intentions for next year is to address how pre-doctoral dental students can get the education needed to adequately treat children.

In a nutshell, the problem for an extremely large number of programs is lack of patient availability due to the siphoning off of these patients by corporate dental chains such as Kool Smiles and Small Smiles.

I attended, as a representative of the AAPD, the Section on Pediatric Dentistry. This was a governance meeting attended by many program directors and faculty. They highlighted the AAPD Academic Day for the annual session and when I brought greetings from the Academy, I reiterated how important we feel this endeavor is for education and for the Academy.

I had several private talks during the meeting. I touched base with ADEA Executive Director and AAPD member, Rick Valachovic. As you know, I hope to establish a task force to address pre-doctoral education in clinical pediatric dentistry. ADEA is also working on this topic and Rick will send me a copy of their report, which will be ready in April. We talked about not re-inventing the wheel and later discussing what we might do together once we see their thoughts. I also mentioned that POHRPC is also developing a white paper on this topic and it will be part of the discussion.

I had an interesting conversation with Dr. John Sauk, dean of the dental school at Louisville and former associate dean at Maryland. The topics were wide ranging, but two stand out: again, the effect of corporate chains on patient availability and the mid-level provider. He was vehemently against mid-levels and their effect on quality of care.

Members of the East Carolina University faculty were in force at the meeting. They, and others from both new and established dental schools were lobbying for program

directors, faculty and department chairs. This was also the case with several other new institutions.

One interesting topic that was of great concern to deans was the new model that these schools have, i.e., a non-research model emphasizing clinical service. They are worried what this effect will have on the scholarly basis of dentistry and evidence based approaches. Huw Thomas was one who expressed this to me.

I must thank the Academy for the opportunity to represent the members at this interesting and worthwhile meeting.

# 2012-2013 Report of the Vice President

Edward H. Moody, Jr.
AAPD Vice President

Per the AAPD Constitution and Bylaws, the Vice President acts as chair of the following Councils and Committees:

**Council on Annual Session**
Summary of report – the Council completed its assigned tasks on schedule and within budget and continues to work toward making the Orlando Annual Session an outstanding experience for all who attend. Initial planning has already begun for the Boston (2014) and Seattle (2015) Annual Sessions.

**Credentials & Ethics Committee**
One case came before the Committee this past year and it has been resolved to the satisfaction of the Committee and Board of Trustees. No additional cases are active or pending at this time.

**Constitution & Bylaws Committee**
Summary of report – the Committee was tasked by the Board of Trustees to develop proposed changes to the Constitution and Bylaws relating to a technical correction, addition of an International Student membership category, and in response to a final report from the Task Force on Governance.

Detailed reports from each of these bodies are included elsewhere in the 2012-13 report to the membership.

There have been no issues placed before the Credentials and Ethics Committee this past year.

# 2012-2013 Report of the Secretary-Treasurer

Robert L. Delarosa
AAPD Secretary-Treasurer

The Budget and Finance Committee met in October in San Francisco in conjunction with the ADA Meeting and again in March in Washington, DC prior to the AAPD Lobby Days. The approved minutes of the October meeting are contained in the report of the Budget and Finance Committee and the draft minutes for the March meeting will be included in the report to the Board of Trustees in May at the AAPD Annual Session in Orlando.

The committee continues to closely monitor the AAPD's income and expenditures as well as the performance and allocation of the investment portfolio.

Current financial statements at the time of this report were reviewed and indicate that we are operating well within our FY 2012-2013 budget while maintaining reserves approximating one year's operating expenses. The AAPD is financially in a very solid, liquid and stable position moving forward.

# 2012-2013 Report of the Immediate Past President

Rhea M. Haugseth
AAPD Immediate Past President

The AAPD immediate past-president is responsible for an annual performance review of the appointed officers of the AAPD Board of Trustees. These were completed for:

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| Dr. Sue Seale – Editor-in-Chief | February 15, 2013 |
| Dr. Jim Crall – Child Advocate | March 10, 2013 |
| Dr. Heber Simmons, Jr. – Congressional Liaison | March 10, 2013 |

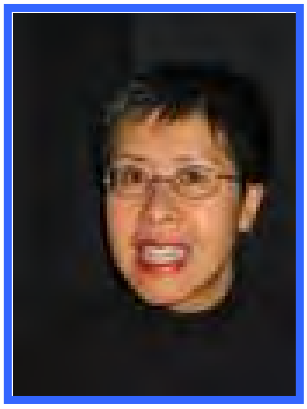
Also in attendance for these reviews was AAPD President Dr. Joel Berg.

AAPD has extended the contract for Editor-in-Chief Dr. Sue Seale for an additional 3 year term beginning January 1, 2013.

# 2012-2013 Reports of the Trustees

## Man Wai Ng
## District I Trustee

### Trustee Activities



At the annual session in Orlando, I will conclude my term as District I trustee. David Tesini will be the incoming District trustee. It has been a distinct pleasure to serve the district and the AAPD.

There are proposed governance changes to the AAPD as recommended by a convened Task Force on Governance. The proposals will be addressed at the **Reference Committee** hearing on **Saturday, May 25th** and will be voted on at the **General Assembly** on **Sunday, May 26th** at the AAPD Annual Session in Orlando. I encourage everyone to attend these meetings as well as the **District Caucus** meeting. If you would like additional information or if I may bring comments about the proposed changes to the reference committee hearing, please let me know.

This past year, I served on the Budget and Finance Committee of the AAPD and served as liaison to the following committees:

- Committee on Behavior Guidance
- Committee on Sedation and Anesthesia
- Pediatric Dental Residents Committee

The Committee on Sedation and Anesthesia, chaired by Bobby Thikkurissy, has had a productive year. The committee developed a core reading list on sedation and anesthesia and will have a narrower list for the Core Reading List to be presented to the Council on Postdoctoral Education by the Annual Session.

The Pediatric Dental Residents Committee, chaired by Maria Cordero, has successfully worked with Headquarters to launch the Residents' page on the new AAPD website. The Resident webpage went "live" in January. It is available for review at: http://www.aapd.org/resources/residents/. The new Residents' page will have available information pertinent to residents currently in training programs. In addition, the committee has begun monthly E-blasts to current residents and program directors.

New this year, the AAPD Pediatric Dental Resident Committee has the "Resident Recognition Award" to recognize pediatric dental residents doing innovative and interesting activities in their training programs. This Award was developed to garner interest in the AAPD among pediatric dental residents, who will become future active

members and potential leaders of the Academy. Nominations or self-nominations were accepted to recognize activities of residents which contribute to one or more of the following fields: pediatric dentistry, teaching, research and public service. Originality of activities and significance of service to others will be the main factors considered for selection. Selected residents will be awarded with $100, featured on the AAPD website, and featured in Pediatric Dentistry Today (PDT). 20 submissions have been received.

This past year, I have served as an ad hoc reviewer to multiple journals including *Pediatric Dentistry*. I am a member of the Examination Committee (serving as a Part Leader for the Qualifying Exam Subcommittee) of the American Board of Pediatric Dentistry. I am also serving on the American Dental Association, Dental Quality Alliance Committee on Implementation, Maintenance and Outcomes Assessment and the National Oral Health Quality Improvement Committee.

Regionally, I am a member of the Massachusetts Academy of Pediatric Dentistry, Massachusetts Early Childhood Oral Health Consortium, and MassHealth Dental Advisory Committee.

This year, I have given various lectures locally and regionally and I have attended or will attend the following meetings:

- AAPD Ad Interim Meeting in October 2012
- AAPD Strategic Planning meeting in January 2013
- AAPD Mid-Winter Meeting and Planning Session in January 2013
- AAPD Budget and Finance Committee meeting in March 2013
- AAPD Advocacy Conference in March 2013
- AAPD Annual Session
- International Academy of Pediatric Dentistry June 2013

## District Organization Activities

Bob Moreau, President of North East Society of Pediatric Dentistry (District I), has been working with Headquarters to update the NESPD website.

The Northeast Society of Pediatric Dentistry sponsored a successful lecture at the Greater New York Dental Meeting in November 2012 given by Dr. Joseph McManus titled ***New Dental Practice Models—they are not like your father's.***

The Northeast Society of Pediatric Dentistry and the Massachusetts Academy of Pediatric Dentistry sponsored a successful full day symposium on behavior management at the Yankee Dental Congress in January 2013. Drs. Marvin Berman and John Rosemond captivated the audience with their years of experience. Over 150 attended the symposium.

## District I Trustee's Report, 2012-2013

Bob Moreau and Craig Elice are excited to be serving as co-chairs of the local arrangements committee to the 2014 AAPD Annual session, which will be in Boston. It promises to be a great meeting!

# State Unit Reports

### Connecticut Society of Pediatric Dentists

*Raven Henderson, President of the Connecticut Society of Pediatric Dentists*
No report received

### Maine Society of Pediatric Dentistry

*Gary L Creisher, President of the Maine Society of Pediatric Dentistry*
There is a hearing scheduled for April 11, 2013 regarding a dental midlevel provider bill before the state legislate.

### Massachusetts Academy of Pediatric Dentistry

*Charlene Pirner, President of the Massachusetts Academy of Pediatric Dentistry*
*Lisa Campanella-Cash, Vice President*
The MAPD Fall meeting was a lecture given by Dr. Fred Margolis on "Clinical Applications of Lasers in Pediatric Dentistry." The Spring meeting lecture will be given by Dr. Andrew Sonis on "Malocclusion management: who, what, when, and how for the pediatric dentist."

Massachusetts has introduced a bill before its legislature to support allowing advanced dental hygienists to perform surgical procedures such as restorations and extractions. To become an advanced dental hygienist would require 12-18 months of study in a master's level program, along with 500 hours of practice under the direct supervision of a dentist and other requirements.

### New Hampshire Academy of Pediatric Dentistry

*Nancy Jun, President of the New Hampshire Academy of Pediatric Dentistry*
The New Hampshire Academy of Pediatric Dentistry meets two to three times per year and members discuss relevant issues that arise. They plan to discuss the proposals by the Task Force on Governance at their meeting in April.

### New York State Association of Pediatric Dentists

*Lois A. Jackson, President of the New York State Association of Pediatric Dentists*
The NYSAPD Fall Meeting was held at the Greater New York Dental Meeting in November 2012. Dr. Joseph McManus presented "New Dental Practice Models—They are not like your Father's."

The Second Annual Dr. Silvia Perez-Speiss Lecture is scheduled for April 17, 2013. Dr. Catherine M. Flaitz will present "A Round-up of New Oral Diseases and Drugs for Tots and Teens" at this NYSAPD Spring Meeting. In conjunction with this meeting, a symposium for all the New York area Pediatric Dental Residents will be given the same

afternoon at the Columbia University College of Dental Medicine. More than 110 residents and faculty have registered to attend.

NYSAPD and the NYU College of Dentistry co-sponsored the Second Annual NYU Pediatric Dentistry Alumni Symposium that was held in September 2012.

NYSAPD and Columbia University College of Dental Medicine will co-sponsor a continuing education course on May 10, 2013. Dr. Shantanu Lal will present on "New Dental Technology."

NYSAPD is planning a lecture on dental materials for Fall 2013.

**Rhode Island Academy of Pediatric Dentistry**
*Craig Elice, President of Rhode Island Academy of Pediatric Dentistry*
No report received

**Vermont Society of Pediatric Dentistry**
*Chuck Bookwalter, President of the Vermont Society of Pediatric Dentistry.*
No report received

# 2012-2013 Reports of the Trustees

## Shari C. Kohn
## District II Trustee

### Trustee Activities

This past year has been full of wonderful experiences for me. Following a quiet summer, the academic year (and Raven's football) started in earnest. In Maryland, we started ramping up our plans for our October all day meeting. In early October, I attended an all-day meeting on Pharmacology and Over the Counter Drugs and their interactions with drugs we use commonly in Dentistry entitled Pharmacology: Drugs and Dentistry – Including Herbals and Natural Products. This lecture was given by renowned pharmacologist from University of Maryland Dental School, Dr. Richard Wynn who is the author of the Drug information Handbook for Dentistry. In October, I traveled to San Francisco to the ADA annual meeting and the Ad Interim AAPD Board of Trustee meeting where a lot was accomplished in a very short time. Then back to Maryland for our All Day CE meeting on October 26, 2012 featuring Dr. Jessica Lee. Dr. Lee spoke on "Pediatric Dental Moderate and Minimal Sedation and Trauma Management". Dr. Lee was an amazing and dynamic speaker and with over 200 in attendance, this meeting was a great success for our District.

In November, my office front desk staff and I participated in an AAPD Webinar entitled "Smooth Operator: Mastering the New Patient Phone Call." If you have not participated in a webinar, I highly recommend it. It was easy and informative and we completed it while we ate lunch in our office.

In December I attended the Maryland American College of Dentists annual meeting.

After much holiday celebration (and a Raven's playoff berth) in January 2013, I attended the AAPD Winter Planning Meeting in Arizona. This is where a bulk of our work is completed and in addition to our board meeting, the various councils and committees meet along with the various chairpersons of these groups. Charges are given, some completed, some ongoing and planning is in full gear for the upcoming annual session in May.

January also brought the Maryland MdAPD's evening business and CE Course. Dr. Jim Coll, one of the AAPD's leading pulp specialists spoke on Evidence Based Primary and Immature Permanent Tooth Vital Pulp Treatment.

On February 3, 2013, the Baltimore Ravens WON Superbowl XLVII – Enough said! I could finally truly celebrate with my purple hair extensions!

Later in February, I traveled on a dental mission trip to Ecuador with a group called Ecuadent – www.ecuadent.org. While this was not an AAPD sponsored trip, the children we treated and the work that we completed is essentially at the heart of what the AAPD is all about. First the medical team goes down and completes cleft and facial surgeries. Then, the dental team follows and treats the surgical patients with obturators and other appliances. The surgical kids are a small part of what we do and the main goal is to treat the other children in need of dental care. We were lucky to help these children who were very much in pain. It is truly a personal accomplishment to help these impoverished children who genuinely appreciated our services. The group tries to go to different areas of the country every year and next year I hope to go with this group again – to the jungle area.

I still remain a part time clinical instructor at the University of Maryland Dental School. In April I am scheduled to give the Junior class a lecture on "The Age One Dental Visit." I am able to present to them a realistic view of how this is done in my private practice utilizing slides that are taken on actual patients. I am also presenting the student chapter of the Maryland Academy of Pediatric Dentistry a lecture on "giving back" once they graduate with emphasis and photos from my recent trip to Ecuador.

**Board Liaison to the Council on Membership and Membership Services, New Pediatric Dentist Committee:** This council is extremely well organized by the new chair, Matthew Schieber. Our 66th Annual Session New Dentist course is entitled "Health Care Reform: What it Means for the Pediatric Dentist." Our Panel will consist of: Drs. Louis Kay, Heber Simmons, Jim Crall and our own General Council Mr. Scott Litch.

The committee has a 3-year proposed plan for the next meetings that is still a work in progress. However, to help find the interests and topics for future meetings, the committee created a survey which was administered to better understand the needs of new Pediatric Dentists and Residents. The data is still being collected and interpreted and will help us plan future courses and address the needs of our younger members.

We plan on continuing to have a family friendly event at the annual session in order to encourage family participation and a sense of community within the AAPD. We also will continue to have the new dentist happy hour sponsored by Treloar and Heisel.

At the Ad Interim meeting in October 2012, the board of trustees approved the Committee's proposal for a reduction in registration fees for new graduates attending the annual session. The hope is that this will help new graduates with financial burdens have the ability to attend the annual session. The committee and the board will be monitoring the outcome of this fee reduction to determine if this in fact is beneficial and makes a difference in the number of NEW PEDIATRIC DENTISTS that attend our annual session.

District II Trustee's Report, 2012-2013

## District Organization Activities

On October 26, 2012 the District II All Day meeting - sponsored by the Maryland Academy of Pediatric Dentistry featuring Dr. Jessica Lee.

The October 31, 2012 District meeting - sponsored by the New Jersey Academy of Pediatric Dentistry featuring Dr. John Rosemond, "The well behaved child" was unfortunately cancelled due to Hurricane Sandy. This course has been rescheduled for 10/31/14.

While I don't believe this was an official District sponsored event, many, if not all the district members were invited to the February Morris Kelner Memorial Conference sponsored by the Albert Einstein Medical Center of Philadelphia.

Some members of Pennsylvania have tried to schedule meetings but to no avail.

I have not been invited to, and I am not aware of any other state or district sponsored meetings.

This is, unfortunately, is at the core of the District II problem. District II is simply not an active or organized group. We have tried to gather information from the local states and many e-mails have been sent but few responses were received. We have asked for recommendations for councils and committees from these states to try to get members involved. We received no recommendations except from the Maryland Academy of Pediatric Dentistry and the New Jersey Academy of Pediatric Dentistry.

As you may know, one of the problems is that District I and District II have low membership compared with other districts. A Task Force on Governance was charged with addressing this among other problems. The Task Force consisted of members from each of the various districts with Dr. Edward Ginsberg representing District II. The task force sought input from the leadership of the various districts and each state within. Surveys and questions were compiled and answers obtained by email, phone or in person. Members from the Task Force also attended the District Caucuses at the Annual Meeting in San Diego. (The District II Caucus usually has less than 10 members present.) The Task Force then developed a Survey which was sent out to the membership via Survey-Monkey and an e-blast but only 429 members responded – only 12% of the AAPD membership. One of the findings was that larger districts tend to be more organized and involved. Along with several other recommendations, the Task Force came to the conclusion that, to more evenly distribute the number of members in each district and to form a larger and hopefully more active and cohesive district, District I and District II should be combined.

## District II Trustee's Report, 2012-2013

Presently, the District numbers are as follows:

| | |
|---|---|
| District I | 719 |
| District II | 530 |
| District III | 1135 |
| District IV | 835 |
| District V | 847 |
| District VI | 1299 |

If District I and District II are combined the new numbers will be as follows:

| | |
|---|---|
| District I &II | 1249 |
| District III | 1135 |
| District IV | 835 |
| District V | 847 |
| District VI | 1299 |

Notwithstanding the fact that the merge of District I and District II would, by necessity, potentially eliminate my position, I support this recommendation. It would help improve the district function from the area in which I live and work. It will also help to more evenly distribute the numbers of members throughout the country. Unless and until we grow membership and activity in District II, it is unreasonable to expect that we will remain as is. This is to better the overall AAPD and the recommendations were made based on the evidence gathered by this very hard working Task Force.

While I support this change, I am disappointed that this is to be the case. However, I do understand that if we do not participate, we cannot expect our representation to continue to be the same. I hope that others will see this as an opportunity to get involved in the AAPD in any way that they can. At the very least, attend the annual session and District Caucus. If your state does NOT presently have leadership you can help us start something so that you and your area can truly be a part of the AAPD.

# State Unit Reports

### Delaware
No organized group exists

### District of Columbia Academy of Pediatric Dentistry
No report received

### Maryland Academy of Pediatric Dentistry
The Maryland Academy of Pediatric Dentistry is dedicated to continued growth and making a difference in our pediatric dental community. We are proud to be in a state that is showing such growth in access to care and participation in organized dentistry from its membership.

## District II Trustee's Report, 2012-2013

Of particular note is that in May, our very own Dr. Warren Brill will begin his term as the President of the American Academy of Pediatric Dentistry. We are extremely proud of Warren for this achievement!

Not only has our fall meeting been a continued success, but we attained a record number of attendees at our Winter meeting featuring Dr. Jim Coll's who talked on Primary and Permanent Pulp Therapy. Over 100 pediatric dentists, staff members, residents, and dental students came to the Columbia, Maryland meeting that night. This doubled our attendance from last year. Our fall meeting has been a continued success, thanks to the hard work of the planning committee and the continued support of our members. With our featured speaker, Dr. Jessica Lee, discussing "Pediatric Minimal and Moderate Sedation in the Dental Office and Trauma Management", this meeting was an incredible success. We had over 200 attendees, approximately 40 more than last year.

The primary objective of the MAPD is to make our academy more meaningful for our membership and for the patients we serve. In striving to encourage leadership in our Academy from newer pediatric dentists, the Executive Board has successfully integrated teleconference and electronic communication as a replacement for some of our regular Board meetings. We hope to increase our membership over the next few years as we strive towards full participation of all Maryland pediatric dentists. And as always, we will continue to provide our membership with the highest quality continuing education opportunities available.

On Friday, October, 25, 2013, we will host yet another successful All-Day CE meeting in Columbia, MD. Tentatively, the speaker is Dr. Francisco Ramos-Gomez. So, save the date and cone and join us! We look forward to another great year.

Our Elected Officers:
President: Michael Virts, DDS
President – Elect: Diana Capobianco, DDS
Immediate Past President: Deven Shroff, DMD
Secretary - Treasurer: Wendy Daulat, DDS
Legislative Chair/AAPD President Elect: Warren Brill, DDS
AAPD District II Trustee: Shari Kohn, DDS
AAPD Public Policy Advocate (Maryland): Dr. Stuart Blumenthal
AAP Liaison: David Hasson, DMD
At Large Members: Margaret Barry DDS, Lobna Zada, DDS, Choti Jahnigen, DDS
Newsletter editor: Todd Lyman, DDS

Respectfully submitted,
Michael Virts, DDS

## New Jersey Academy of Pediatric Dentistry

**OFFICERS:**

| | |
|---|---|
| President: | Maxim Sulla |
| Vice President: | Elisa Velazquez |
| Secretary: | Victoria Roeder & Michelle Backhaus |

## District II Trustee's Report, 2012-2013

| | |
|---|---|
| Treasurer: | Gerald Guzy |
| CE Chair: | Mary Flanagan |
| | Jennifer Cully |
| Past President: | Zuhair Sayany |
| AAPD Liaison: | Yasmi Crystal |
| NJ Public Policy Advocate: | Irvin Sherman |

It is my pleasure to report to you that the NJAPD has completed another successful year. We currently have 166 active members and have hosted a myriad of continuing education courses throughout the year that have been well received and attended by our members. Our website (www.NJAPD.org) continues to provide information for our members as well as the community at large; utilizing e-blasts to update our members about upcoming meetings and CE. We have also continued to facilitate new membership within our organization. In line with this, we have maintained ourselves as a close liaison with UMDNJ and its department of Pediatric Dentistry, encouraging the residents to attend our general and CE meetings. In 2012, this included an invitation for them to present their research projects to us at our May meeting for the first time.

As per our custom, we held three general meetings throughout the year. Some of the issues that concerned our membership this year included the following:

1. Access to Care.
    a. The NJAPD has worked closely with the NJDA this year to expand the duties of Registered Dental Assistants (RDA's) in the state. New legislation allows RDA's to place sealants and pumice before sealant placement. They are not however permitted to perform coronal prophies. There is a push for RDA's to be able to perform rubber cup prophies in NJ and the state board is in support of this. Increasing the abilities of RDA's is an attempt to increase access to dental care within the state.
    b. A new law that went into effect in October allows dental hygienists to work with general rather than direct supervision in the state.
2. Water Fluoridation -- the NJDA's Fluoride bill has been passed through the NJ Assembly Health Committee. However there is an uphill climb due to the capital investments into the infrastructure that will need to be made for implementation.

**CONTINUING EDUCATION:**
We continue to have three general business meetings per year that each incorporate two hours of CE credit as well, approved by CERP. The lectures this year were:
February 1, 2012: Dr. Tayna Gluck, "Review of Survey Results of the AAP membership regarding attitudes and knowledge about oral health issues and referrals to a dental home"

May 3, 2012: UMDNJ Pediatric Dental Residents presented their research projects

## District II Trustee's Report, 2012-2013

Our full day CE offerings this year were:
March 14, 2012: Dr. John Featherstone and Dr. Joseph Oxman, "Caries Management and Materials in Caries Management"
October 31, 2012: Dr. John Rosemond, "The well behaved child." This course was cancelled due to Hurricane Sandy. This course has been rescheduled for 10/31/14

Future CE Courses/ Meetings:
January 30, 2013: David Lustbader, Civil Trial Attorney, "Are you ready to avoid litigation? A Malpractice Review" — 1 hr lecture
April 17, 2013: Dr. Robert C. Fazio, "Medicine, Dentistry and Drugs for the Pediatric Dentist and the Pediatric Patient" — 7 hr presentation
May 16, 2013: UMDNJ Pediatric Dental Residents to present their research projects. — 1 hr. CE
October 31, 2013: Lisa Philips, "Practice Management" — 7 hr. CE
October 31, 2014: Dr. John Rosemond, "The well behaved child — 7 hr. CE

The NJAPD is working closely with the NJ Chapter of the AAP in the implementation phase of their DentaQuest grant; focusing on inter-professional relations between pediatricians and dentists to improve oral health care to the underserved children in New Jersey. In addition to that we are proud to recognize the leadership roles our membership has taken at national and local levels, Yasmi Crystal has been representing our ADA district at the CAPIR council and Elisa Velazquez and Sid Whitman are both Active on NJDA committees including the NJ Oral Health Coalition.

We are excited to continue to do the fine work that is part of the tradition of our organization and thank the AAPD for its support.

Respectfully submitted,
Maxim Sulla, President NJAPD

### Pennsylvania Academy of Pediatric Dentistry

No report received

### Federal Services

Members of the Federal Services Society of Pediatric Dentist are Pediatric Dentist serving in the US Army, US Navy, US Air Force and the US Public Health Service Commissioned Corps. The current officers of the FSSPD are as follows:

President: CAPT Craig Bruce USPHS
Secretary: LTC Brett Henson US Army
Past President: LCDR Jordan Buzzell USN

LTC Brett Henson will become the new President and a new secretary will be elected at the 2013 Annual Meeting in Orlando, FL.

In the best interest of the FSSPD, the society determined to dissolve dues paid by its members. The balance of our existing funds was donated to the Healthy Smiles

Foundation. The total donation to the Healthy Smiles Foundation was $1200. There are approximately 75 Pediatric Dentist Officers in the FSSPD.

## Summary

I am proud to represent the members of District II. I am always available to help with whatever I can with respect to your needs. I encourage you to attend the annual meeting, the District II Caucus, Reference Committee Meeting and General Assembly. This is where your voice can be heard among the leadership and other members of the AAPD.

# 2012-2013 Reports of the Trustees

## K Jean Beauchamp
## District III Trustee

### Trustee Activities

Since the first of the year I have attended the Georgia Academy of Pediatric Dentistry meeting in conjunction with the Southeast Society of Pediatric Dentistry in Atlanta. Also, I attended Lobby Day in Washington D.C. in March.

The **Committee on Communication**s is continuing to help the staff with reviewing the brochures. They want all educational materials updated with good evidence based information and current pictures.

The **Council on Government Affairs** met in Washington in March. Their charges were reviewed and the meeting for the state's Public Policy Advocates was discussed. The AAPD PAC Committee also met and evaluated the congressmen that we've supported.

### District Organization Activities

The business meeting of the SSPD was in January. Gaines Thomas is the current President. There is a spring meeting in April in Destin, Florida. There are plans to increase student involvement. They have 439 paying members which is approximately 60%.

### State Unit Reports

#### Alabama Academy of Pediatric Dentists

There was a C.E. meeting in Birmingham on February 15 with Bill Waggoner speaking. The group is still working on the governors committee to evaluate Medicaid.

#### Florida Academy of Pediatric Dentistry

The dentists are recruiting volunteers to help with AAPD's annual session in Orlando, both with the meeting and with our pre-meeting action day.

#### Georgia Academy of Pediatric Dentistry

GaAPD held its business meeting in January. They are working on their CE course for September in Atlanta with Dr. Stanley Malamed.

## District III Trustee's Report, 2012-2013

### Kentucky Academy of Pediatric Dentistry
The Kentucky unit held a meeting in February to re-organize the group. They are planning a CE meeting and want to get dentists from all over the state to get involved.

### Mississippi Association of Pediatric Dentistry
No report received.

### North Carolina Academy of Pediatric Dentistry
North Carolina has a business meeting planned for April 12, 2013. Their agenda includes a report from their public policy advocate and updates on their website, membership directory and future meetings.

### South Carolina Society of Pediatric Dentistry
No report received.

### Tennessee Society of Pediatric Dentistry
The yearly meeting will be held April 13 in Nashville. There has been some dental legislation that the TSPD is following including: a bill to allow dental sealants to be applied by public health dental hygienists without the child first being examined by a dentist. Then 2 negative fluoride bills, one is a verification of additives to make it more difficult to add it to the water and a bill that states the state is "neutral" on public fluoridation where the policy currently states it supports fluoridation.

### Virginia Society of Pediatric Dentistry
No report received.

### West Virginia Academy of Pediatric Dentistry
Sadly Elliott Shulman died recently. He was a passionate pediatric dentist who was very active in West Virginia.

# 2012-2013 Reports of the Trustees

## James D. Nickman
## District IV Trustee

### Trustee Activities

As usual, it has been a pleasure to serve as District IV's trustee. I would like to that all of the efforts from the members of our district to contribute within their states and at a national level. I am continually amazed at the time that is volunteered and also at the level of talent displayed by our members.

This summer, our district has been busy helping with the access to care issue in our region. I was fortunate to attend the Illinois Mission of Mercy event in June held in Libertyville, Illinois. I visited and spent time with the wonderful group of Illinois pediatric dentists who volunteered. I also attended the inaugural Minnesota Mission of Mercy in Mankato, Minnesota. Both events show that we have a wonderful profession and members who go above and beyond to provide the best care possible. I would strongly recommend to anyone to consider participating in one of these fabulous events or donate time in their own communities. I would also encourage our members to donate time to the Healthy Smiles, Healthy Children volunteer event to be held in conjunction with the AAPD annual meeting in Orlando. Please contact the foundation or consult Pediatric Dentistry Today for more information.

The district meeting was held in Scottsdale this year in conjunction with the AAPD/AAE Symposium. Several of the representatives attended in person while the others attended via conference call. Thank you to the AAPD for facilitating this meeting. In years past, the district fall meeting was held in Chicago in conjunction with the AAPD symposium, but it is harder to meet due to distance. In the future, we may look at holding the meeting back in Chicago at the same time as an ISPD meeting. As usual, all district members attending the upcoming annual session in Orlando are encouraged to attend the District IV meeting in May. Please check the annual session schedule for the place and time of the caucus.

I also recently attended the AAPD Winter planning and Board of Trustees meeting. Several significant items were discussed including governance changes. For the full report, please refer to the actual governance recommendations and the Task Force on Governance report (2013 Annual Session Governance Materials). The AAPD sent on February 22nd an AAPD Member E-News special edition with the link. Keep in mind that these are only proposals at this point to be discussed and potentially acted on during the Reference Committee Hearing and General Assembly at the annual meeting in May.

## District IV Trustee's Report, 2012-2013

Significant changes include combining Districts I and II to balance the district membership numbers. Issues raised include breaking out large individual states (e.g. California) or redrawing district boundaries. In the end, combining districts I and II appeared to be a reasonable compromise. If approved, one result will be that the members of the uniformed federal services and international members will each be represented by an at-large non-academic trustee. My impression is that the uniformed federal services are distributed geographically across the Unites States and world and are not necessarily geographic members of District II. If approved, they will still have the ability to caucus and representation at the board level.

Another issue raised was the requirement to belong to state or district units. The data seems to show that most members in District IV belong to the state units. District membership is automatic and no charge. Other districts and states do not have that same luxury. Some members belong only to state units and others belong only to district units. The only real enforcement mechanism to the "tripartite" structure is delegated to either the states or district units. Rather than push down a forced tripartite structure from the top, the AAPD has offered to collect dues for both the district and state units at no charge. The experience of states with automatic dues collection has been positive, likely due to convenience. Alternately, those who chose not to belong to a state or district unit can actively not pay that portion of the dues collected. I agree that this is a controversial provision, but we must recognize and respect that we have members who hold strong feelings on both sides of the issue.

Finally, another issue raised is the requirement that the AAPD require membership in the American Dental Association, Canadian Dental Association, or recognized foreign dental association at the time of membership application. In the past, the AAPD has required membership, but has had no realistic way to verify or enforce that requirement. Of the three other organizations that require ADA membership, two (AAO and AAP) only require membership at the time of application and one (AAE) only passively enforces the membership requirement after initial application. Personally I feel that it is extremely important for our members to also be members of the mother church. Fortunately, we have a very high percentage of AAPD members who have maintained their respective national association memberships. Our working relationship must be in good order with the respective national dental associations and one way for us to provide our input is to be involved at a local, state and national level.

Minutes of the 2012-2013 Board of Trustees meetings are located on the AAPD website. Please feel free to contact me if you have any questions or concerns regarding the activities of the Board of Trustees.

I also recently attended the AAPD's Lobby Days and PPA training in DC. Those who attended can vouch on the value of the programming and the excellent job our Academy Staff are doing to train our members to be an effective voice of pediatric dentistry. I would strongly encourage anyone who has not attended Lobby Day in the past to make a commitment to attend in the future.

## District IV Trustee's Report, 2012-2013

**Council on Dental Benefit Programs:** Mary Essling and I attended the ADA's National Dental Benefit Conference on September 14th in Chicago. Several of the presentations were very informative regarding coding perspectives, health care reform and Medicaid fraud.

I represented the Academy at the ADA Council on Dental Benefit Programs Code Maintenance Committee (CMC) meeting in February. The AAPD was successful with a code request for the Interim Therapeutic Restoration (ITR) which will be included in the CDT-14. Several other codes impacting pediatric dentistry will be included in the latest revision included caries risk assessment. Please consider attending the Council on Dental Benefit Program's session at the AAPD meeting in Orlando.

I am also working with the CDBP to produce a CE meeting in September educating our membership on the impact of the affordable care act on pediatric dentistry. Paul Reggiardo, the CDBP chair, and Mary Essling, AAPD Staff, have contributed greatly to the development of this program and deserve much appreciation.

# State Unit Reports

### Illinois Society of Pediatric Dentists

No report received

### Indiana Society of Pediatric Dentists

Officers: President: Erin Phillips
Vice President: Sean Cook
Secretary: Keith Roberts
Treasurer: Charlie Fuerher
AAPD Liaison: Dr. Sean Cook

Upcoming Meetings:
March 28, 2013: ISPD Executive Meeting
March 29, 2013: General Membership Meeting with Jeff Dean and early interceptive orthodontic treatment.

### Iowa Academy of Pediatric Dentistry

Officers: President: Polly Iben
Vice President:
Secretary: Diane Houk
Treasurer: Michael Shufflebeam
Past President:
AAPD Liaison: Kaaren Vargas

No report received

## District IV Trustee's Report, 2012-2013

### Michigan Academy of Pediatric Dentistry

Officers: President Dr. Kay Wilson
President-elect: Dr. Matthew Mandeville
Immediate Past-president: Dr. Daniel Briskie
Secretary/Treasurer: Dr. Martin Makowski
AAPD Liaison: Gail Molinari

No report received

### Minnesota Academy of Pediatric Dentistry

Officers: President: Wafa Qureshi
Vice President: Brian Grove
Secretary/Treasurer: Laura Kotteman
AAPD Liaison: Jim Nickman

The MAPD is currently working with the MDA to improve access to care in Minnesota. The Minnesota Office of Inspector General recently released a report on the low reimbursement rate and its impact on access to care. We currently have a bill progressing through the legislature attempting to increase the reimbursement and have provided supporting testimony on the impact on our most vulnerable citizens.

### Nebraska Society of Pediatric Dentistry

Officers: President: Gina Waite
Vice President:
Secretary/Treasurer:
Past President:
AAPD Liaison: Eric Hodges

Nebraska is working on expanded scopes of practice for both our assistants and hygienists. They vote Sept 21st at the NDA House of Delegates on the proposed models. These models would serve pediatric dentists very well.

### North Dakota Academy of Pediatric Dentistry

Officers: President: Mike Goebel
Vice President:
Secretary/Treasurer: Chad Hoge
Past President:
AAPD Liaison: Brent Holman

No report received

### Ohio Academy of Pediatric Dentistry

Officers: President: Erwin Su
Vice President: Dan Gindi
Secretary/Treasurer: Jennifer Bryk
AAPD Liaison: Homa Amini

## District IV Trustee's Report, 2012-2013

No report received

### South Dakota Society of Pediatric Dentistry

No report received

### Wisconsin Society of Pediatric Dentistry

Officers: President: Tom Turner (drturner@fidkids.com)
Vice President: Cesar Gonzalez (gonzalez@marquette.edu)
Secretary/Treasurer: Eileen Studders (estudders@chw.org)

No report received

# 2012-2013 Reports of the Trustees

## Joseph B. Castellano
## District V Trustee

### Trustee Activities

Meetings attended:
AAPD Advanced Leadership Institute in Philadelphia, PA, Sept. 28-30, 2012.
AAPD BOT meeting in San Francisco, CA, Oct. 19-20, 2012.
AAPD Ethics Committee Hearing in San Francisco, CA, Oct. 19, 2012.
CCA workshop in Chicago, IL, Nov.2-3, 2012.
AAPD/AAE Joint Symposium on Trauma in Scottsdale, AZ, Nov. 9-10, 2012.
AAPD BOT Meeting in Phoenix, AZ, Jan. 11, 2013.
AAPD Winter Planning Meeting Phoenix, AZ, Jan. 12-13, 2013.
AAPD Foundation Development Committee Meeting in Chicago, IL, Apr. 6, 2013.
AAP Section on Oral Health Spring Meeting in Elk Grove, IL, April 26-27, 2013.

Liaison Reports:
**Council on Clinical Affairs:** CCA has been busy completing their current charges. The CCA workshop, held Nov. 2-3, was very productive and the council accomplished much. Council chair Sara Filstrup has kept the council on their deadlines so as to have completed documents ready for review and approval at the General Assembly in Orlando, Fl.
The documents in the 2012-2013 cycle up for approval are:

1. P. Use of Fluoride Therapy
2. G. Fluoride Therapy
3. P. Interim Therapeutic Restorations (ITR)
4. P. Sports Related Injuries
5. G. Management of Acute Dental Trauma
6. P. Minimizing Occupational Health Hazards Associated with Nitrous Oxide
7. G. Use of Nitrous Oxide for Pediatric Dental Patients
8. P. Model Dental Benefits for Infants, Children, Adolescents, and Individuals with SHCN
9. P. Role of Pediatric Dentists as Both Primary and Specialty Care Providers
10. P. Patient Safety
11. P. Ethical Responsibility to Treat or Refer
12. P. Stem Cells
13. G. Oral Health Care / Dental Management of Heritable Dental Developmental Anomalies
14. G. Dental Management of Pediatric Patients Receiving Chemotherapy, Hematopoietic Cell Transplantation, and/or Radiation
15. G. Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance, and Oral Treatment of Infants, Children, and Adolescents

## District V Trustee's Report, 2012-2013

*Note: The G- . Management of Acute Dental Trauma will be removed from the reference manual and replaced with the endorsement of the International Association of Dental Traumatology's Guidelines for the Management of Traumatic Dental Injuries

The three new documents have also been developed and should be great additions to the Reference Manual. These are: 1) Medical/ Dental history forms, 2) Policy on Lasers, 3) Guideline on use of Protective Stabilization.

All documents are available on the AAPD website for review prior to the Annual Session. The Council on Clinical Affairs is also preparing for the new documents that will be up for review in the 2013-14 cycle, and any new charges that may be assigned at the Annual Session.

**Section on Oral Health of AAP:** The SOOH had their annual meeting in conjunction with the AAP's NCE meeting in October. Highlights from the section's meeting as they relate to AAPD or pediatric dentistry are:

SOOH Structure

The structure of the SOOH Executive Committee will change from a 6 person to a 7 person Committee, with 3 pediatric dentists, 3 pediatricians, and 1 chairperson whom can be either a pediatrician or a dentist. The Section will need to elect 2 pediatricians and 1 pediatric dentist to the EC in the Spring of 2013.

The AAP will continue to work with the Campaign for Dental Health and the ADA to promote adequate fluoride exposure.

The Section wants to work collaboratively with AAPD, not competitively, to improve children's oral health.

### District Organization Activities

The Southwest Society of Pediatric Dentistry (SWSPD) had their annual business meeting and CE course in Dallas, Texas on Nov. 30- Dec. 1, 2012. Speakers included Brian Dodge and Bob Frazier.

New officers were elected at this meeting. The newly elected officers for the SWSPD are:
President – Kevin L. Haney
President-Elect – Steven J. Hernandez
Vice President – Serese M. Cannon
Secretary/Treasurer – Paula VanBuskirk
Past-President – Marvin Cavallino

The 2013 SWSPD Annual Meeting will be held Dec. 5-8, 2013 in Dallas, Texas.

The SWSPD also had their annual ski meeting in Vail, Colorado Feb.10-16, 2013. Speakers for the week included Dick Wicker, Anthony Molina, Sue Seale, James Kessler, Brian Henderson, and Joel Berg. As always, it proved to be a fantastic Ski and Learn event. The 2014 Ski Meeting is scheduled for Feb. 9-14 at Big Sky Resort in Montana.

## State Unit Reports

### Arkansas Society of Pediatric Dentistry
No report received.

### Colorado Academy of Pediatric Dentistry
Colorado is currently working on developing a "dental hub" that helps to connect children in underserved areas of the state with pediatric providers. They are developing a screen and refer system that would involve hygienists and general practitioners. They are seeking grant funding from local organizations.

Colorado is having their spring CE / Business meeting on April 24. At that meeting, new officers will be elected. Until that date current officers are:
President – Autumn Hurd
Secretary/Treasurer – Lisa Carlson-Marks
Past President – Jeff Kahl

### Kansas Association of Pediatric Dentists
No report received.

### Louisiana Academy of Pediatric Dentistry
No report received.

### Missouri Academy of Pediatric Dentists
The Points of Light program in Missouri initiated in 2011 now has upwards to 70 Points of Light dentists. They applied for a Health Child Healthy Smiles grant to help fund the program for postage and printing and is one of the award recipients. They will be receiving a check for $5000.00 this summer. The MOAPD's next annual session will be January 18th. They are hoping to get Dr. Joe Camp to speak to their group. Cape Girardeau, MO is holding a Mission of Mercy event in May 2013, and St. Louis is slated to hold the next one in 2014 or 15.

### New Mexico Association of Pediatric Dentists
No report received.

### Oklahoma Association of Pediatric Dentists
No report received.

### Texas Academy of Pediatric Dentistry
TAPD will be having their Annual CE and Business meeting in San Antonio, Tx. May 2-3 2013. The CE course will feature Dennis McTigue and will focus on Trauma. The election of new officer will take place at the business meeting.

Current officers are:
President – Harold Simpson
President-Elect – Melissa Rozas
Vice President – Lisa Jacobs
Past President – Joe Castellano

# 2012-2013 Reports of the Trustees

## Santos Cortez
## District VI Trustee

It has been a pleasure to have served the AAPD this past year as District VI Trustee. In that capacity, I have communicated with the district leadership while at the WSPD Board of Directors meeting in Seattle, Washington on October 5, 2012. The next meeting of the entire district is scheduled on April 26, 2013 while at the combined CSPD/WSPD Annual Meeting in Rancho Mirage, California.

### Trustee Activities

As the liaison to the **Council on Continuing Education** (CCE), I have had the opportunity to help promote the Comprehensive Review of Pediatric Dentistry for the General Practitioner that meets in San Francisco, California this year. Through the leadership of the CCE Chairman, Brian Beitel and staff members Kristi Casale and others, a full-court press has been attempted to market this course. Multiple dental organizations have been contacted to help in promoting the course within their membership. At the writing of this report, the number of registered dentists was nearing one hundred but is far short of what would have been expected despite the concerted efforts.

The AAPD Public Policy Advocacy Conference in Washington D.C. was a huge success and attendees included states' Public Policy Advocates who received introductory training on Monday, March 11. California's delegation was represented with 11 residents and 6 mentors that arranged for over 28 congressional visits on behalf of the AAPD. Several residents were funded by the UCLA Community Health Advocacy Training program as well as three residents supported by CSPD's Graduate Student Legislative and Advocacy program. AAPD provided housing for attendees. All contributed to the success of the conference.

### District Organization Activities

I have submitted a written report for publication in the WSPD website and have instituted conference calls that include the district leadership, as well as the presidents of each of the state units and Canadian provinces that I represent. This may afford increased communication within the district leadership.

I have also attended each of the CSPD Board of Directors meetings to provide a verbal report as well as a written report.

The big issue in District VI is the recommendations of the board for bylaws changes on governance as published to the membership. The greatest concern is that the bylaws change that would allow for voluntary state unit membership rather than mandatory membership of

both the state and AAPD. As of this writing, it is the consensus in the district that this will dilute the state unit as members may choose to join AAPD but not their state unit. I have provided district and state leadership information from both the Governance Task Force report as well as the reasoning of the board for the decisions.

## State Unit Reports

Having had no state unit reports submitted to me by the deadline of March 29th, this concludes my report.

# 2012-2013 Reports of the Trustees

## Mario E. Ramos
## At-Large Trustee

### Committee Activities

In August 2012, along with AAPD President, Joel Berg, I participated in the launch of the Partnership for Healthy Mouths, Healthy Lives Children Oral Health Campaign. In partnership with the Ad Council and 35 other organizations, the campaign's media launch occurred in New York City. While Dr. Berg addressed the English-speaking media, I addressed the Spanish-speaking media. Along with a spokesperson from the ADA, Dr. Howell, we provided television and radio interviews to stations throughout the United States on the important topics related to the children's oral health campaign developed by the Ad Council.

On August 22, 2012 , I was invited to appear on *Good Afternoon America* on the ABC networks to introduce the Partnership for Healthy Mouths, Healthy Lives campaign. Along with "*Grover*" from Sesame Street Workshop, one of the many partners involved in this campaign, I appeared on the show to promote good oral health habits and the message developed by the Ad Council.

### Committee Activities

As the liaison to the **Council on Membership and Membership Services** I have had the pleasure and honor of working with the new Chair of the Council, Paula Coates. Under the leadership of Paula Coates, the Council has had a very productive and busy year. In meeting with Paula at the Winter Planning meeting and on a conference call with the Council members, the Council has been able to address their charges and to evaluate member benefits and propose new and innovative ideas to grow and to maintain the Academy's strong membership. The Council continues to address the desire of the Academy to grow the Affiliate Member category by addressing their needs and focusing on retention tactics as well as developing new methods of attracting new Affiliate members. The Council recognizes the need to focus on creating relationships with other organizations such as the HDA, NDA, SAID and AGD in order inform general dentist as to benefits of membership in the AAPD. The Council continues to recognize the importance of growing the International Member category and to forging relationships with International organizations in an effort to form collaborative educational forums for the benefit of AAPD members, International members, and to encourage the growth of this membership category. The Council continues to develop and suggest methods that the AAPD can have a presence at International venues and in joint continuing education efforts.

## At Large Trustee's Report-Mario Ramos, 2012-2013

I have continued to represent the AAPD at the ADA CERP committee and am participating as the Chair of the International Provider subcommittee that is developing a program to encourage International Providers of Continuing Dental Education to seek ADA CERP approval.

I would like to thank the AAPD Officers, the Executive Committee of the Board of Trustees, the current and past Trustees, and the Headquarters Staff for all of their assistance, encouragement and most of all their kindness in sharing their knowledge and dedication to the Academy with me during the past three years. I especially wish to thank Suzanne Wester of the Headquarters Staff for all of her hard work and wisdom in working with the Council.

# 2012-2013 Reports of the Trustees

## John A. Hendry
## At-Large Trustee

### Committee Activities

**Committee of the Board**
The **Strategic Planning Committee** met in Phoenix in January at the winter meeting of the Board of Trustees, where the Advanced Leadership Institute program from the Wharton School of the University of Pennsylvania presented detailed reports of their group projects. Details, changes, additions and recommendations will be presented to the Board in May at the Annual Meeting.

**Board Liaison to AAPD Councils and Committees**
The **AAPD Political Action Committee (PAC) Steering Committee** met in March in Washington, D.C., preceding the AAPD Public Policy Advocacy Conference. Chaired by Dr. Lew Kay, this committee is seeing every success hoped for since its inception.

A detailed report of support to individual Senators and Representatives will be presented in Dr. Kay's reports.

Special Thanks to our District Leaders who did a tremendous job of raising our donations for this successful program. This is not an election year but our increased presence in Washington is very much needed and effective.

**Committee on Special Health Care Needs:** Ed Rick chairs this committee. He and his committee have been actively addressing their charges.

The committee has aggressively addressed the timely issue of transitioning Pediatric Dental patients with Special Needs.

**AAPD**
I had the opportunity to represent the Academy along with Jan Silverman, AAPD Oral Health Research and Policy Center Assistant Director, at the U.S. National Oral Health Alliance colloquium in New Orleans on November 15th and 16th.

The stated purpose of the meeting was: Colloquium participants will work together to develop a shared understanding about the complexity of issues surrounding metrics – and how to drive progress for optimal oral health for all people in this country. The format of the meeting included brief presentations followed by tabletop discussion of specific questions. These included:

## At Large Trustee's Report-John Hendry, 2012-2013

1. How do participants use data for decision making an in the work the participants do?
2. Discussion of the impact of the Surgeon General's report and the Pew report on oral health.
3. Ideas for a systematic approach to data collection and availability.
4. The primary benefit of attendance at this meeting is the networking opportunities and to continue to posture AAPD as "The voice of children's oral health."

Ms. Silverman does an outstanding job of representing the AAPD at the Alliance for Oral Heath.

Thank you for allowing me to serve the AAPD in the capacity of Trustee at Large.

# 2012-2013 Reports of the Trustees

## Catherine M. Flaitz
## Academic At-Large Trustee

### Committee Activities

**Committee of the Board**
**Policy and Procedures Committee:** Members reviewed and provided feedback on the new antitrust compliance policy. In addition, several technical corrections and clarifications to the document were reviewed. Details are available in the Committee's report.

**Board Liaison to AAPD Councils and Committees**
**Council on Post-Doctoral Education** is chaired by Erwin Turner
**Post-doctoral In-service Examination Committee** is chaired by Elliot Shulman (deceased) and Eileen Studders (present).
**Council on Pre-doctoral Education** is chaired by Homa Amini

All of the chairs of the above councils and committee were contacted prior to this report to seek their comments for inclusion in this report. Detailed reports will be submitted by the chairs of the respective councils and committees but I have highlighted a couple of items in my report.

Leadership on the Post-doctoral In-service Examination Committee has changed due to the passing of Dr. Shulman who was an active leader on this committee up to the very end of his death. Dr. Studders wanted me to reinforce his accomplishments, especially the fact that the in-service post-doctoral examination was administered for the first time via computer which was attributed to Elliot's leadership, dedication and hard work. This committee is on track to provide the results to the residents with plenty of time for them to use the results when studying for the qualifying exam.

Regarding the other councils, they have been completed or are close to completion of their charges at the time that this report was written. Under the leadership of the Dr. Amini, the council updated the Predoctoral Educational Literature Resource List and refined and expanded the List of Predoctoral Integral Experiences. Dr. Amini should be commended for her inclusive management style and attention to details and deadlines. As the board liaison, I participated in teleconferences and email discussions, made suggestions for the list of integral experiences and provided a list of references for the oral diagnosis section of literature resource list, in particular in diagnostic sciences and oral pathology/medicine.

For the ad interim report, Erwin Turner had suggested that I reinforce the inclusion of the Committee on Special Health Care Needs and the Committee on Sedation and

Anesthesia as consultants/contributors to the Core Curriculum Reading List. A deadline for the middle of January was recommended by Dr. Rick Udin for the completion of the Core Curriculum Reading List from the Council on Post-Doctoral Education. The Committee on Special Health Care Needs reviewed the core reading list and made no suggestions for revision. Following multiple email discussions, it was felt by some of the council members that this section required updating. The task was completed by Dr. Linda Nelson, Dr. Rick Udin and me, who recommended extensive revisions and provided Scott Dalhouse with electronic versions of the articles. The Committee on Sedation and Anesthesia provided the council with new references in their field of expertise. The reading list was finalized in late February. Dr. Turner should be commended for his delegation skills and timely follow-up. Dr. Udin should be recognized for personally reviewing the selected special needs articles for inclusion of the most relevant material under a very tight deadline. Addressing the expectations and importance of those involved in revising the post-doctoral reading list may be indicated so that the best and most up-to-date articles are chosen for residents and pediatric dentists.

Scott Dalhouse has effectively and efficiently overseen these academic committees and compiled and distributed the information to the appropriate responsible parties. His guidance to the councils and to me has been very valuable.

In summary, it has been very rewarding year to work with such a dedicated and well organized group of dental academicians and the AAPD staff.

## Additional Trustee Activities

**AAPD**

**Council on Clinical Affairs:** As a member, my role was to revise and expand the section entitled, Useful Medications for Oral Conditions, for the resource section of the Reference Manual which was completed and approved. In addition, a group of members, led by Jenny Ison Stigers, were asked to review and make recommendations for a pediatric medical history form and age-appropriate social and dental history forms. This form was reviewed by the CCA in November. Additions, including a section on Infants/Toddlers and Adolescents were added to the form. This form was circulated electronically for comments and edits were made in November and December. The final draft form was approved by the BOT during the winter meeting. These forms will be placed in the resource section of the Reference Manual and an approved version was made available to the Axium user group for adaptation into the electronic health record. (This update has been revised since the winter report.)

As a Member of CCA, I also provided input on several documents including:

1. Policy on Model Dental Benefits for Infants, Children, Adolescents, and Individuals with Special Health Care Needs.
2. School-based Pit and Fissure Sealant Delivery Programs for the Prevention of Dental Caries by the Cochrane Group on behalf the CDC.

4. Stabilization Guidelines during Dental Treatment.
5. Oral and Dental Aspects of Child and Family Health, a Joint Statement by the AAP/AAPD.
6. Trauma Guidelines from the Joint AAE/AAPD Symposium

**Editorial Board of Pediatric Dentistry:** As a member of the editorial board of this journal, I receive multiple abstracts and manuscripts for review in the field of oral pathology, genetics and special needs patients.

**Academic Activities**
For Joint Academic Day, Scott Dalhouse and I, along with other academy members have developed an interesting program for dental educators. The focus is on evaluating the undergraduate pediatric dental curriculum with an emphasis on increasing the clinical experiences of these students. These predoctoral clinical educational experiences have important implications for how well students are prepared to meet the challenges of post-doctoral education and treating children in private practice and community health centers. A panel discussion on innovative programs in dental schools that have resulted in successful recruitment of pediatric patients and increased clinical experiences will be included. In addition, new faculty members will discuss why they went into dental education and highlight the rewards and challenges. Following the combined predoctoral and post-doctoral session in the morning, the afternoon session will break-up into 2 programs based on the educational focus of the faculty participants to address pertinent issues. Special acknowledgements are in order for Drs. Moursi, Amini, Kowolik, Mrurz and Slayton for their input and who finalized the program during the ADEA Annual Session. Joint Academic Day was discussed by Dr. Brill during the ADEA Section on Pediatric Dentistry – Member's Forum on March 17, 2013 and all were encouraged to attend.

Scholarly activities based, in part, on 2012 Joint Academic Day, included the 2 presentations that were held at the 2013 American Dental Education Association Annual Session.

1. Amini H, Udin R. Pediatric Availability in Pediatric Dentistry. J Dent Edu 77(2):227, 2013. Poster Presentation at the ADEA Annual Session in Seattle, WA, March 2013.

2. Kowolik J, Mrurz L. Integrating Children's Oral Health and Access to Care into Multiple Educational Settings. Workshop held at the ADEA Annual Session in Seattle, WA, March 17, 2013. (1.5 hrs)

At the invitation of the Pediatric Oral Health Research and Policy Center and under the leadership of Dr. Jane Gillette, I have been working with a team, to develop a technical brief on the adequacy of predoctoral education. We have had a couple of conference calls and meetings to outline the important issues and challenges of the predoctoral curricula, including adequate clinical experiences. This information will be discussed during the Joint Academic Day with the goal of partnering with other organizations, in

particular the American Dental Education Association, to more widely disseminate the critical academic need and address collaborative ways to find effective solutions.

**Continuing Education**
I participated as a speaker in the following continuing education programs of the AAPD:

1. Comprehensive Review Course in Pediatric Dentistry: Oral Pathology, Oral Medicine, Genetics and Special Needs Patients. September 7-9, 2012, Denver, CO and January 24-26, 2013, San Diego, CA.

2. Comprehensive Review Course for the General Dentist: Oral Pathology/Oral Medicine and Dental Pharmacology. April 5-7, 2013, San Francisco, CA.

# 2012-2013 Reports of the Trustees

## Jane Gillette
## Affiliate Trustee

The Affiliate Membership (AM) has recently engaged in several activities that support the goals of increasing Affiliate Membership recruitment, retention and participation.

**AM Survey**
A survey was sent to all AMs with an email address notated within the AAPD system, in an effort to gain understanding on demographics, practice setting, level of connection to other areas organized dentistry, about effective communication strategies, and level of desire to become further engaged in issues related to child and family health and well-being. Results of the survey are being collected and will be used to identify expertise/resources within the AM, develop effective communication methods, and expand and enhance recruitment and retention.

**Outreach to members of the National Network of Oral Health Access (NNOHA)**
NNOHA is the association that represents dental community health centers (CHCs). The majority of dentists practicing in CHCs are general dentists. General dentists working in CHCs often have areas of growth in caring for young children as the dentists staffing the CHCs are frequently recent graduates or late career dentists with minimal experience in caring for young children. Membership in the AAPD provides general dentists who are caring for young children with access to high quality continuing educations and other resources. In an effort to promote AAPD membership and CE, NNOHA partnered with the AAPD by promoting the annual Comprehensive Review Course for General Dentists this past April. The NNOHA sent out notification to their members via e-blast and also printed the notice on their website and printed newsletter as well.

Though historically CHCs have been staffed by general dentists, recent funding streams and an increase in CHC-based pediatric dental residencies have increased the number of pediatric dentists practicing in the CHC setting. CHC pediatric dentists have unique needs compared to private practicing dentists and AAPD pediatric dentists would benefit from the development of a network of CHC pediatric dentists so as to share best practices in addressing those needs. Additionally, pediatric dentists practicing in CHCs could mentor general dentists and promote membership in the AAPD. In an effort to identify pediatric dentists employed in CHCs a letter was sent to the NNOHA board of directors requesting that 1) a survey be sent to members to identify CHC pediatric dentists and that 2) a question be added to their membership application to gather information on specialty status.

## Affiliate Trustee's Report-Jan Gillette, 2012-2013

**Communication and engagement**
A personal invitation to attend the AM district meeting held in conjunction with the Annual Session will be sent out in April to all AM attending the Annual Session. Items to be discussed during the meeting will include ideas on increasing Affiliate Membership recruitment, retention and participation. Specifically the agenda will include a discussion on development of committees and workgroups within the AM and participation of the AM within national AAPD committees and workgroups.

Depending on comprehensive feedback obtained within the AM Survey, the AM is considering developing a Facebook page to facilitate communication.

## Committee Activities

**Council on Scientific Affairs (CSA):** Indru Punwani is currently serving as CSA Chair; Martha Ann Keels will become the CSA chair after the Annual Session.

- **EBD Manager:** Candidate Laurel Graham has staffed the EBD Manager position. Ms. Graham has been employed by the American Dietetic Association (ADA) for 12 years and has served in their evidence-based activities area for over 6. She holds a master's degree in library science and has conducted systematic reviews for the ADA for many years. She has also worked with the Cochrane Collaboration on a number of projects. Ms. Graham and Jan Silverman will be attending the America Dental Association's Evidence-based Dentistry Champions conference in April
- **Cochrane Collaboration:** The Cochrane Collaboration was retained by the CDC to update the CDC Sealant and Water Fluoridation Guidelines. The Cochrane Collaboration reached out to the AAPD to partner in updating these guidelines. The guidelines are currently under review by the AAPD and are due to be updated in 2013.
- **Pediatric Oral Health Research (POHR) group within the International Association of Dental Research (IADR):** The POHR group has been officially recognized by IADR and met for their first meeting at the IADR meeting in March. During that time they elected officers. Dr. Punwani will serve as the inaugural president. The AAPD will communicate with its members who also belong to IADR to remind them to join the POHR group when renewing their IADR membership. AAPD members making research presentations at AADR/IADR will be urged to identify those presentations with the AAPD logo.

# 2012-2013 Report of the Child Advocate

James J. Crall
AAPD Child Advocate

## AAPD Meetings

- Attended AAPD Board of Trustees Ad Interim Meeting (San Francisco / October, 2012), Winter Planning Meeting (Phoenix / January, 2013) and Annual Session (Orlando / May, 2013). Attended Council of Government Affairs (CGA) and Pediatric Oral Health Research and Policy Center Advisory Committee (POHRPC) meetings.

- March 11-13, 2013: Provided presentation on Dental Medicaid Reforms at AAPD State Public Policy Advocate Orientation conference in Washington, DC. Participated in AAPD Advocacy Days activities, including Congressional visits with 6 California House and Senate offices. Attended AAPD CGA and PAC Steering Committee meetings.

## AAPD Representation at National Meetings and Committees

- June 24-26, 2012: Represented AAPD at the Medicaid-CHIP State Dental Association (MSDA) meeting in Washington, DC.

- Represent AAPD on the Bright Futures Implementation Advisory Committee.

## U.S. Department of Health & Human Services (DHHS) and Other Federal Agency Activities

- June 14-15, 2012: Attended Centers for Medicare & Medicaid Services (CMS) Medicaid/CHIP Quality Conference in Baltimore, MD. The focus of this work is to provide technical assistance to participating States as they work to improve the performance of their CHIP programs. I am a consultant for Mathematical Policy Research which received a contract from CMS to carry out this project.

- June 21, 2012: Participated in a National Quality Forum (NQF) Oral Health Expert Panel conference call to finalize recommendations for the Health Resources and Services Administration (HRSA) concerning areas that the Panel concluded would benefit from additional performance measures development.

- June 28-29, 2012: Attended a DHHS Office of Minority Health (OMH) Cultural Competency National Program Advisory Committee meeting in Baltimore, MD, of which I am a member. This group provides guidance to the contractor that is developing e-learning modules on cultural competency for oral health professionals, which are scheduled to be completed in 2013. Similar modules have been developed for physicians, nurses and other types of health professionals.

- January 23, 2013: Served as an invited presenter for a CMS-sponsored webinar on using quality improvement methods to enhance the performance of State Medicaid and CHIP programs. My presentation focused on how the State of Connecticut and Connecticut Voices for Children used ongoing data analysis to redesign their Medicaid/CHIP programs and monitor the impact of program changes.

- February 20-22, 2013: Invited presenter at HRSA Maternal and Child Health (MCHB)-sponsored Life Course Research Network conference in Washington, DC. Provided an overview of invited paper outlining a conceptual framework for relating oral health to the conference theme of life course health development, which has become the new paradigm for MCHB's programs.

- Provided periodic input to representatives of the U.S. General Accountability Office (GAO) for a study they are pursuing on dental costs in the U.S. — specifically, trends in the cost of dental care in the U.S., major factors that contribute to dental care costs in the U.S., and how the costs for dental care in the U.S. compare to the costs in other advanced countries.

## Dental Quality Alliance (DQA)

- July 12-13, 2012: Represented AAPD at the DQA Executive Committee and DQA Committee meetings hosted by ADA in Chicago.

- November 1-2, 2012: Represented AAPD at the DQA Executive Committee and DQA Committee meetings hosted by ADA in Chicago.

- Participated in weekly calls throughout the year with DQA/ADA staff regarding matters concerning the DQA Measures Research & Development Committee that I chair.

- Participated in the development of an RFP, evaluation of applicants' proposals and selection of a contractor for testing of the initial DQA set of pediatric oral health performance measures developed by the DQA Measures Research & Development (R&D) Committee, which I chair. Participated in bi-weekly calls of the DQA R&D Committee and project staff with the selected contractor (U. of Florida) beginning in November, 2012 to address questions and provide guidance regarding pediatric oral health measures testing. The results of this testing will be summarized in a report that is expected to be completed by June, 2013 and submitted along with final recommendations regarding the DQA's pediatric core measures set for approval by the full DQA at its mid-2013 meeting. Once approved, the measures will be submitted to the National Quality Forum for their endorsement.

- Participated in bi-weekly calls, beginning in February, 2013, with DQA/ADA staff and newly organized Pediatric Measures Workgroup which is charged with identifying additional measures for development beyond the DQA pediatric core measures set.

- [Future: June 28-29, 2013] Invited speaker at Agency for Healthcare Research and Quality (AHRQ)-sponsored DQA conference to be held in Chicago, IL.

## Additional Pediatric Oral Health Activities

- October, 1-3, 2012: Attended National Network for Oral Health Access (NNOHA) conference in La Jolla, CA. Of interest to AAPD, is the extent to which the CAMBRA caries-risk assessment approach is being adopted by various organizations/entities and incorporated into electronic dental records, including some that have been certified for meaningful use.

- April 21-24, 2013: Attended National Oral Health Conference in Huntsville, AL.

## Consultant and Advisory Activities

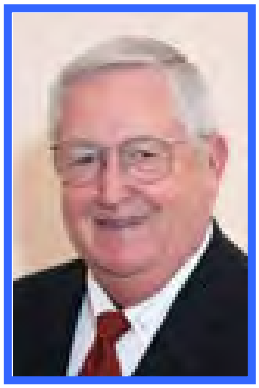
- Served as member of the national advisory committee for State of Iowa DentaQuest-funded project geared toward increasing access to dental services for children enrolled in Iowa Medicaid and CHIP programs.

- Served as national technical advisor for Center for Health Care Strategies DentaQuest-funded project that will work to assist 7 States (AZ, CA, MN, NH, TX, VA, WA) develop and implement plans to improve their Medicaid and CHIP programs and achieve the current objectives of the CMS Oral Health Initiative.

- Attended MetLife Dental Advisory Council meetings in Park City, UT (October 5, 2012) and Minneapolis, MN (April 19, 2013), and presented on States' activities related to formation of State Health Insurance Exchanges and pediatric oral health benefits pursuant to implementation of the Affordable Care Act.

- March 27, 2013: Arranged a call with Jim Eiseman, attorney for the Public Interest Law Center of Philadelphia which has been involved in several federal Medicaid court cases (including the recent FL case), to discuss the implications of recent rulings by the 9th Circuit Court regarding reductions in Medicaid reimbursement for CA dental Medicaid providers. Scott Litch and Paul Reggiardo participated in the call, and discussions about possible AAPD actions are ongoing at the time this report was submitted.

# 2012-2013 Report of the Congressional Liaison



Heber Simmons Jr.
AAPD Congressional Liaison

As I write this report in March of 2013, I reflect back on where we were at this time last year and see a lot of similarities between then and now. Congress and the President are still very divided on ways to solve the budget crisis that we face with the Republicans saying that they are not willing to accept new taxes and spending and the Democrats pushing for spending and new taxes. We have lived through the "Fiscal Cliff" and sequestration is a fact of life today. One truly needs to be an optimist to keep from going slightly crazy! My belief is that Americans of all backgrounds have the ability to be inventive, think "outside of the box" and come up with a solution to a problem. I firmly believe that good old "American ingenuity" will prevail.

Pediatric dentistry's part of Title VII was funded at the $7.563 million level for both 2012 and 2013. Congress had called for funding of "not less than $8 million", but we have never reached that level. We truly need the entire $8 million because we have more programs approved for funding than we have funds available. Sequestration could cut as much as $605,000 from that figure — and that would hurt! When we initiated our efforts in Washington we had 180 first year training slots in the pediatric dentistry training programs around the country. Today, that total stands at 393 — quite a difference. In addition to that increase, Title VII also encompasses a Dental Faculty Loan Forgiveness Program which will allow graduates to pursue a career in academics and have their school expense loans forgiven on a graduated basis. This program is administered through the teaching institutions so that the final decision about who receives the money is determined by the school. Hopefully, this program can grow and help solve the growing dilemma of faculty shortages in our country. Sequestration does not help this process, but I am still hopeful that we will find a way around the sequestration process and see Title VII fully funded. Additionally, there is no funding allotted for Mid-level training.

We have previously discussed the fact that the one constant in Washington is change and that continues today. Old friends in both the Senate and the House choose either to not run for re-election or get defeated and new people take their places. The same is true for staff in both the Congressional offices and the different committee offices. When new people reach leadership positions through their seniority, they want to bring their own people along in the process. Brutal as it is, that is the way of both the jungle and Congress. When a new male lion becomes the leader of a pride of lions by defeating the old leader, he tries to kill all of the cubs sired by the old leader. Call it whatever you wish, but that is the way of nature. Such action has recently taken place in the minority side of the Senate Appropriations Committee and some of our friends have had their jobs terminated in a brutal manner. We have seen this happen before and our job is to

## Congressional Liaison's Report, 2012-2013

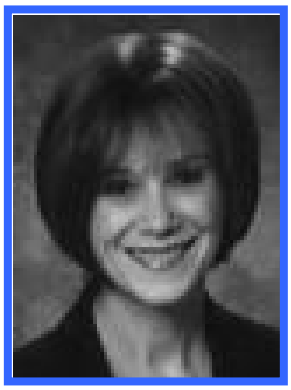
get to know the new people as soon as possible and educate them to the benefits and need for adequate funding in Title VII.

Our most recent Lobby Day in Washington was, in my opinion, the best one we have ever had. The enthusiasm of the participants was palpable and the effect will be beneficial to our efforts. Please realize that a member of Congress will do everything possible to both see and talk with one of their constituents when they are in Washington. However, time will not allow them to speak with every person who wants to see them and especially when that person is not from their state. That is the main problem I face in Washington as I try to spread our story of "help us take care of the children". However, when one of our members asks their member of Congress or their staff to meet with me, I can get in that office to talk with the proper people. There is no substitute for the personal touch. If you know either a member of Congress or one of their staff or are kin to any of them or if they were your patient at one time or if you have any personal connection at all, please utilize it and help me get to talk with them! Our activities on Lobby Day give me that access and I thank you for your help. Official Washington on Capitol Hill is really like any small town in America. Connections and who you know make a difference and getting into one office can lead to another office and on down the line. The Central Office is still compiling the comments from the contact sheets completed by the participants in this year's Lobby Day and I will follow-up with as many as possible as soon as possible. By the time we meet in Orlando in May, I will have been to Washington two more times and will have a better idea of our new friends. If you have any questions or suggestions about the Washington process, please talk with me because I welcome your comments, thoughts and ideas.

As stated in the past, our efforts in Congress are truly a team effort and would not be possible without everyone pulling together without any thought about who gets the credit for our success. I sincerely appreciate the support and encouragement of the Board of Trustees. The Central Office is a key component and ***ALWAYS*** responds to questions that arise from my Hill visits and in coordinating our efforts. Our team at Hogan-Lovells (Mike Gilliland, Kate McAuliffe and John Porter) is unsurpassed in their ability to lead us through the maze of official Washington and are the real professionals in this endeavor. My thanks to each and every one of you for standing ready to help at any time with any situation. Representing the Academy in Washington is a real pleasure and honor for me and I deeply appreciate you allowing me to do this job. Hopefully, we are leaving the woodpile higher than we found it.

Heber Simmons, Jr., D.D.S.,M.S.
Congressional Liaison

# 2012-2013 Report of the Editor-in-Chief



N. Sue Seale
AAPD Editor-in-Chief

I would like to thank the Board of Trustees for their support this year. The following are areas for update or report:

1. We are in the process of scanning 22 back issues of JDC, which will take us back to 1995. Our oldest scanned issue is currently January 2002.
2. Publication of from 7-9 electronic manuscripts along with the 12 printed manuscripts in each issue of Pediatric Dentistry is working well. Acceptance by our readers has been good, and they have had requests to make the website more user friendly for accessing the electronic manuscripts. These requests have been implemented and are working. The backlog of accepted manuscripts has been reduced, and the wait time for publication of printed manuscripts following acceptance has been reduced from 18 months to about 12 months.
3. I want to thank the BOT for supporting my attendance at the Dental Editors Meeting, which met in conjunction with the ADA in October in San Francisco. It was an excellent experience and provided me with an opportunity to network with other dental editors and to learn from them.

## Pediatric Dentistry

**Journal Statistics**

*Pediatric Dentistry* received 611 submissions for the calendar year 2012, of which 562 (Number of Manuscripts by Type Figure) have received action and 49 are being processed for decisions, compared with 399 submissions during the calendar year of 2011. Types of manuscripts were 3 Brief Communications, 146 Case Reports, 131 Clinical Articles, 13 Literature Reviews, 267 Scientific Articles, and 2 Other (see Figure 1 – Pediatric Dentistry – Number of Manuscripts by Type).

The journal statistics for decisions made on manuscripts (Number of Manuscripts by Decision Figure) indicate for 2012 there were: Accept 76, Reject following review 171, Reject inappropriate 162, and Revision 153 (see Figure 2– Pediatric Dentistry – Number of Manuscripts by Decision).

## Editor-in-Chief, 2012-2013

**Statistics for Pediatric Dentistry**

| Journal Statistics | MTD | Prior 12 Months |
|---|---|---|
| Avg. days from submission to first decision | 0.0 | 39.9 |
| Avg. Reviewer turnaround time (days) - **Original** | 9.4 | 21.2 |
| Avg. Reviewer turnaround time (days) - **Resubmission** | 0.0 | 0.0 |
| Avg. Reviewer turnaround time (days) - **Revision** | 2.5 | 17.7 |
| Avg. Time to Assign Reviewer (days) - **Original** | 16.5 | 15.3 |
| Avg. Time to Assign Reviewer (days) - **Resubmission** | 0.0 | 0.0 |
| Avg. Time to Assign Reviewer (days) - **Revision** | 1.7 | 3.3 |
| Avg. days from submission to final decision | 0.0 | 51.8 |

The journal received submissions from 43 countries. The majority of submissions came from: the US (121), Brazil (118), India (83) and Turkey (34). (See Figure 3 – Pediatric Dentistry – Number of Manuscripts by Country).

IngentaConnect, the company that hosts our journals, reported that Pediatric Dentistry made the list of the top 100 of more than 11,000 titles for the period of September 1 to September 30, 2012. The journal ranked 37th for downloads, with 2,359; 63rd for abstract views, with 11,247; and 45th for table of contents views, with 4,609.

For 2011, Pediatric Dentistry made the list of the top 100 and of more than 15,000 titles for the period of November 1 to November 30, 2011. The journal ranked 28th for downloads, with 4,324; 62nd for abstract views, with 13,734; and 26th for table of contents views, with 6,764.

### Editorial Board and Abstract Editors

The following individuals will complete their 4-year terms on the Editorial Board of Pediatric Dentistry as of the 2013 Annual Session. I thank them for their dedication and service to the journal.

Juan Boj
Jorge Castillo
Steven Chussid
Michael Kanellis
Kavita Kohli
Gregory McGann
Alton McWhorter

I am pleased to request that the Board of Trustees approve my nomination of the following individuals as oncoming and returning members of the Editorial Board for a

4-year term beginning immediately after the annual session. Each has accepted my invitation to be nominated for this service.

Rosamund Harrison
Kavita Mathu-Muju
Fouad Salama
George Schuster
Andy Sonis
Kaaren Vargas
Anthenunis Versluis

I would also like to thank the 43 ad hoc reviewers within and outside of our specialty who graciously reviewed manuscripts for the journal. They were publicly acknowledged and named in the Nov/Dec issue of the journal. As in the past, I welcome suggestions from the Board for the names of individuals interested in being on the Editorial Board in the future.

I am pleased to request that the Board of Trustees approve my nomination of the following individuals as oncoming and returning Abstract Editors for a 1-year term beginning immediately after the annual session. Each has accepted my invitation to be nominated for this service.

Christine Hsu
Ronald H. Hsu
Janice G. Jackson
Ari Kupietzky
Robert J. Schroth
Sarat Thikkurissy

## Goals for 2013

The major goals for the coming year are:

1. Shorten the length of time to 6 months between acceptance of manuscripts to publication by publishing between 7-9 electronic manuscripts in each issue until this goal is reached.

2. Formalize the positions of Section Editors who will be responsible for building a cadre of subject matter experts by working with the Editorial Board to identify individuals willing to accept responsibility for the task of ensuring that each manuscript is reviewed by individuals with credentialed expertise in the subject matter represented in the manuscript.

Editor-in-Chief, 2012-2013

## *Journal of Dentistry for Children*

### Journal Statistics

*Journal of Dentistry for Children* received 185 submissions for the calendar year 2012 (Number of Manuscripts by Type Figure) compared with 174 submissions during the calendar year of 2011. Types of manuscripts received were 90 Case Reports, 31 Clinical Articles, 8 Literature Review, 3 Public Health, 52 Scientific Articles, and 1 Other (see Figure 4 – JDC – Number of Manuscripts by Type).

The journal statistics for decisions made on manuscripts (Number of Manuscripts by Decision Figure) indicate for 2012 there were: Accept 26, Reject following review 55, Reject inappropriate 74, and Revision 30 (see Figure 5 – JDC – Number of Manuscripts by Decision).

**Statistics for *Journal of Dentistry for Children***

| **Journal Statistics** | **MTD** | **Prior 12 Months** |
|---|---|---|
| Avg. days from submission to first decision | 0.0 | 40.3 |
| Avg. Reviewer turnaround time (days) - **Original** | 4.0 | 20.8 |
| Avg. Reviewer turnaround time (days) - **Resubmission** | 0.0 | 0.0 |
| Avg. Reviewer turnaround time (days) - **Revision** | 0.0 | 16.3 |
| Avg. Time to Assign Reviewer (days) - **Original** | 5.0 | 18.9 |
| Avg. Time to Assign Reviewer (days) - **Resubmission** | 0.0 | 0.0 |
| Avg. Time to Assign Reviewer (days) - **Revision** | 0.0 | 4.6 |
| Avg. days from submission to final decision | 0.0 | 47.8 |

The journal received submissions from 17 countries. The majority of submissions came from India 85, Brazil 42, and the US 18 (see Figure 6 – JDC – Number of Manuscripts by Country).

IngentaConnect, the company that hosts our journals, reported that JDC again made the list of the top 100 out of more than 11,000 titles for number of full text downloads in 2012. For the period of September 1 to September 30, 2012, JDC ranked 75th with 1153 downloads.

For the period of November 1 to November 30, 2011, JDC ranked 97th , with 1,217 downloads.

## Editor-in-Chief, 2012-2013

### Editorial Board and Abstract Editors

Seven members of the Editorial Board will finish their terms in 2013:

Noel Childers
Kevin Donly
Jeffery Johnson
John Novak
Issa Sasa
Adriana Segura
Rod Vergotine

I would like to thank them and all of our reviewers for their help, which was considerable this year. I would also like to thank the many ad hoc reviewers within and outside our specialty who graciously reviewed manuscripts for the journals. They will be named and acknowledged in the December issue of the journal.

I am pleased to request that the Board of Trustees approve my nomination of the following individuals as oncoming members of the Editorial Board for a 4-year term beginning immediately after the annual session. Each has accepted the invitation to be nominated for this service.

Johan Aps
Donald Chi
Paddy Fleming
Kerrod Hallett
Catherine Hong
Jan Hu
Amr Moursi
Steve Rayes

As a part of my beginning responsibilities, I have added 10 new ad hoc reviewers, and they are:

Martin Curzon
Bernadette Drummond
Monty Duggal
Michael Lloyd
Luc Marks
Philip Monroy
JoAnna Scott
Mark Schubert
Travis Nelson
Richard Welbury

As in the past, I welcome suggestions from the Board for the names of individuals interested in being on the Editorial Board in the future.

### Goals for 2013

The major goals of the Journal of Dentistry for Children for 2013 include:

1. Continue the tight adherence to publication schedule.
2. Increase the number of ad hoc reviewers to expedite the review process.
3. Increase communication with reviewers and establish specific areas of interest of reviewers to expedite the reviewing process.

## Staff

Finally, I wish to acknowledge the dedication and efforts of the AAPD Communications Department:

Cindy Hansen, Publications Manager
Robert Gillmeister, Communication Coordinator
Adriana Loaiza, Publications Coordinator
Jeannette Castillo, Media and Publications Assistant
Thomas McHenry, Magazine and Web Editor

I appreciate all that they do to ensure that our journals are recognized worldwide as quality publications.

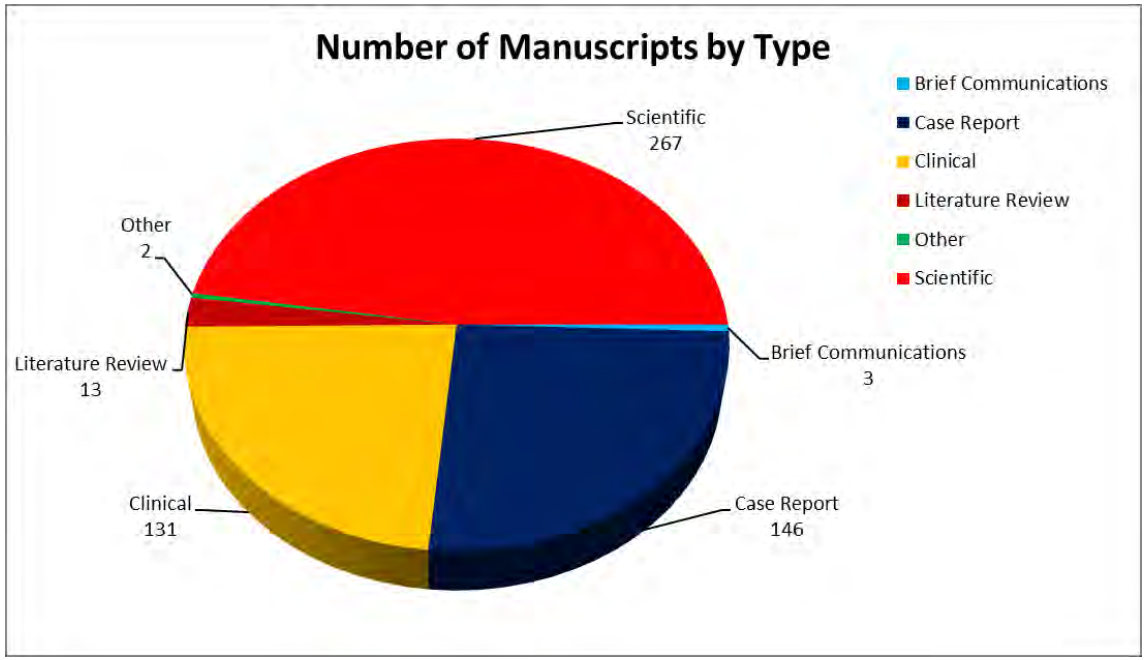
# Figure 1 - Pediatric Dentistry - Number of Manuscripts by Type

## Manuscripts Decided for Pediatric Dentistry

Estimated Data Date: Dec. 3, 2012

Information based on all manuscripts whose submission date is on or after Jan 1, 2012 and decision date is on or after Jan 1, 2012..

**Grouped by: Manuscript Type**




| Manuscript Type | Number of Manuscripts | Percentage of Total |
|---|---|---|
| Brief Communications | 3 | 0.5 |
| Case Report | 146 | 26.0 |
| Clinical | 131 | 23.3 |
| Literature Review | 13 | 2.3 |
| Other | 2 | 0.4 |
| Scientific | 267 | 47.5 |
| **Total** | **562** | **100.0** |

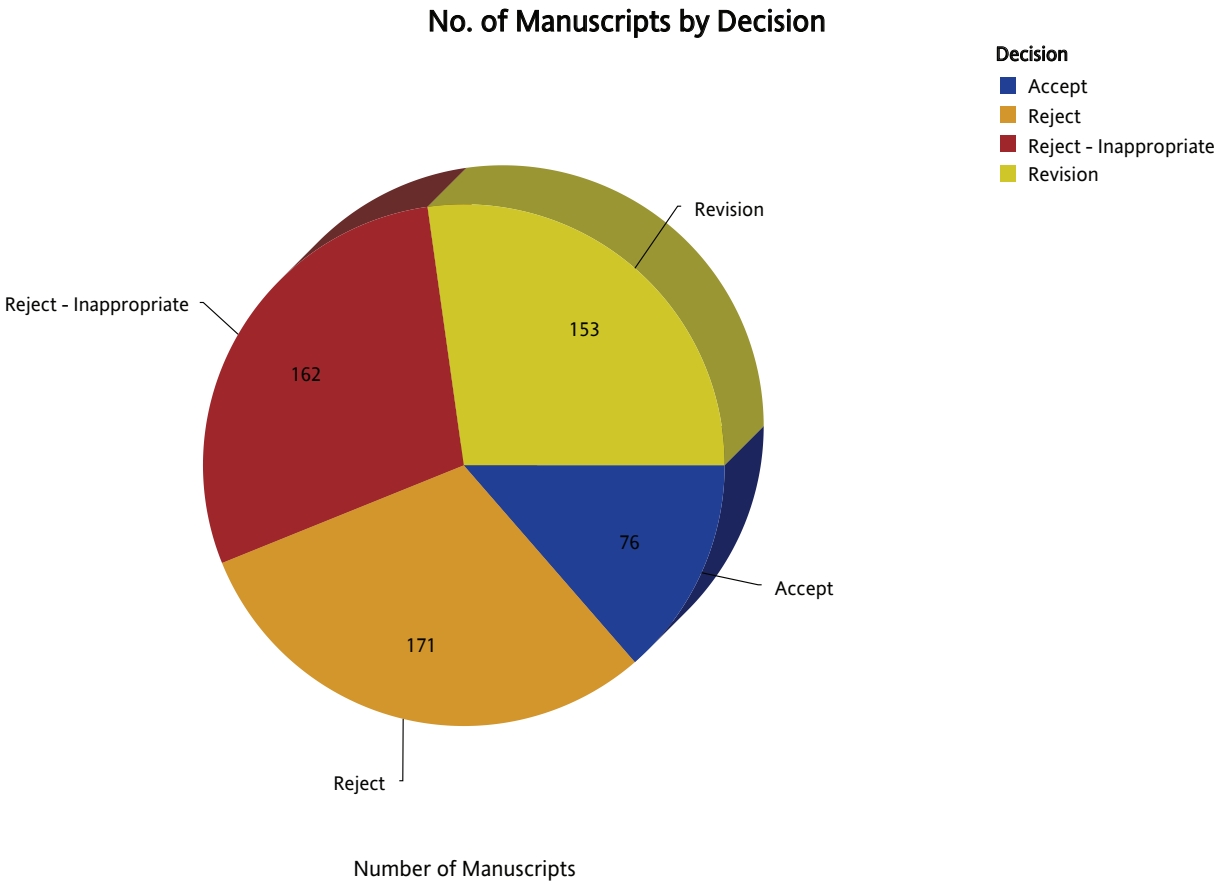
# Figure 2 - Pediatric Dentistry - Number of Manuscripts by Decision

## Manuscripts Decided for Pediatric Dentistry

Estimated Data Date: Dec 3, 2012 10:05:02 AM

Information based on all manuscripts whose submission date is On or after Jan 1, 2012 and decision date is On or after Jan 1, 2012

**Grouped by: Manuscript Decision**




| Manuscript Decision | Number of Manuscripts | Percentage of Total |
|---|---|---|
| **Accept** | **76** | **13.5%** |
| **Reject** | **171** | **30.4%** |
| **Reject - Inappropriate** | **162** | **28.8%** |
| **Revision** | **153** | **27.2%** |
| **Total:** | **562** | **100.0%** |

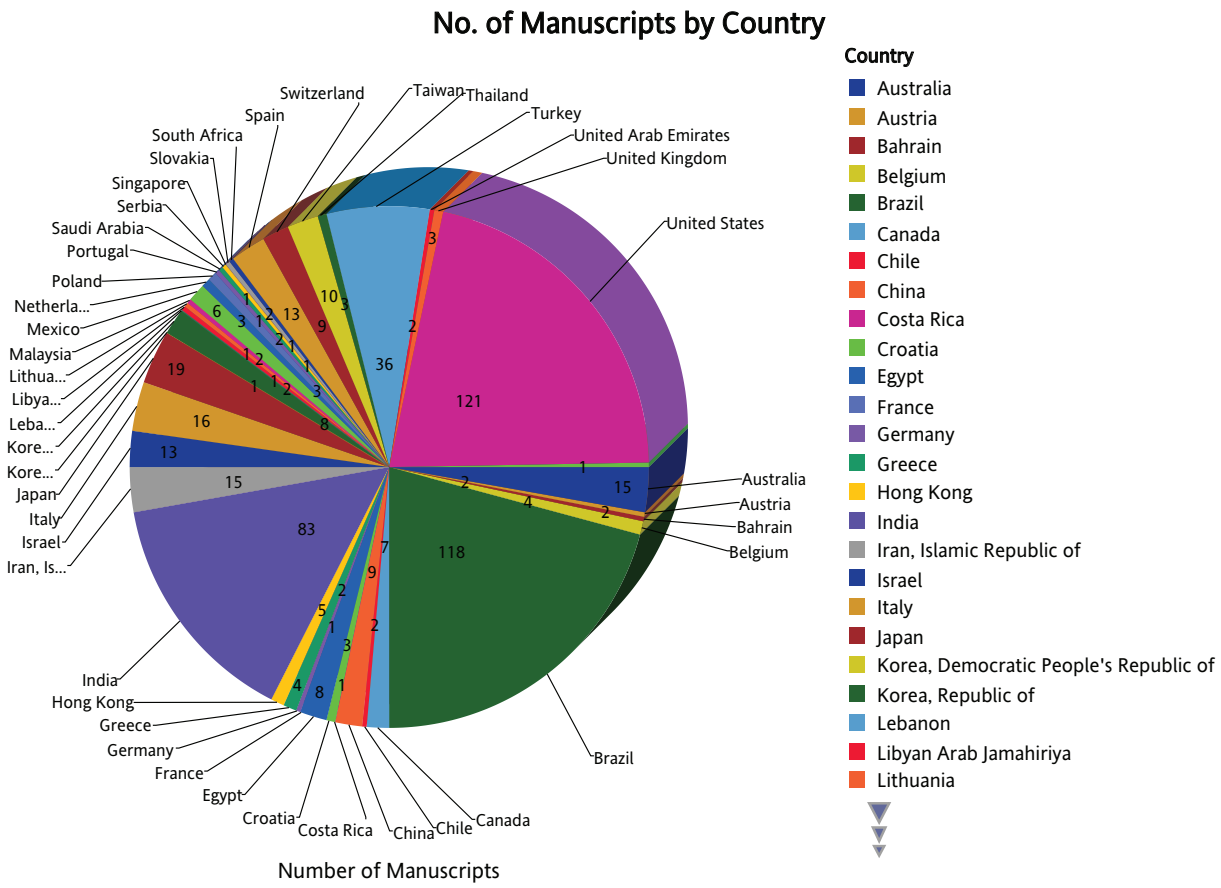
# Figure 3 - Pediatric Dentistry - Number of Manuscripts by Country

## Manuscripts Decided for Pediatric Dentistry

Estimated Data Date: Dec 3, 2012 10:05:02 AM

Information based on all manuscripts whose submission date is On or after Jan 1, 2012 and decision date is On or after Jan 1, 2012

**Grouped by: Country Of Submission**




| Author Country | Number of Manuscripts | Percentage of Total |
|---|---|---|
| **Australia** | **15** | **2.7%** |
| **Austria** | **2** | **0.4%** |
| **Bahrain** | **2** | **0.4%** |
| **Belgium** | **4** | **0.7%** |
| **Brazil** | **118** | **21.0%** |
| **Canada** | **7** | **1.2%** |
| **Chile** | **2** | **0.4%** |
| **China** | **9** | **1.6%** |
| **Costa Rica** | **1** | **0.2%** |
| **Croatia** | **3** | **0.5%** |
| **Egypt** | **8** | **1.4%** |
| **France** | **1** | **0.2%** |
| **Germany** | **2** | **0.4%** |
| **Greece** | **4** | **0.7%** |
| **Hong Kong** | **5** | **0.9%** |
| **India** | **83** | **14.8%** |
| **Iran, Islamic Republic of** | **15** | **2.7%** |
| **Israel** | **13** | **2.3%** |
| **Italy** | **16** | **2.8%** |
| **Japan** | **19** | **3.4%** |
| **Korea, Democratic People's Republic of** | **1** | **0.2%** |
| **Korea, Republic of** | **8** | **1.4%** |

# Manuscripts Decided for Pediatric Dentistry

Estimated Data Date: Dec 3, 2012 10:05:02 AM

Information based on all manuscripts whose submission date is On or after Jan 1, 2012 and decision date is On or after Jan 1, 2012

**Grouped by: Country Of Submission**

| Author Country | Number of Manuscripts | Percentage of Total |
|---|---|---|
| Lebanon | 1 | 0.2% |
| Libyan Arab Jamahiriya | 2 | 0.4% |
| Lithuania | 1 | 0.2% |
| Malaysia | 2 | 0.4% |
| Mexico | 6 | 1.1% |
| Netherlands | 3 | 0.5% |
| Poland | 3 | 0.5% |
| Portugal | 1 | 0.2% |
| Saudi Arabia | 2 | 0.4% |
| Serbia | 1 | 0.2% |
| Singapore | 1 | 0.2% |
| Slovakia | 1 | 0.2% |
| South Africa | 2 | 0.4% |
| Spain | 13 | 2.3% |
| Switzerland | 9 | 1.6% |
| Taiwan | 10 | 1.8% |
| Thailand | 3 | 0.5% |
| Turkey | 36 | 6.4% |
| United Arab Emirates | 2 | 0.4% |
| United Kingdom | 3 | 0.5% |
| United States | 121 | 21.5% |
| | 1 | 0.2% |
| Total: | 562 | 100.0% |

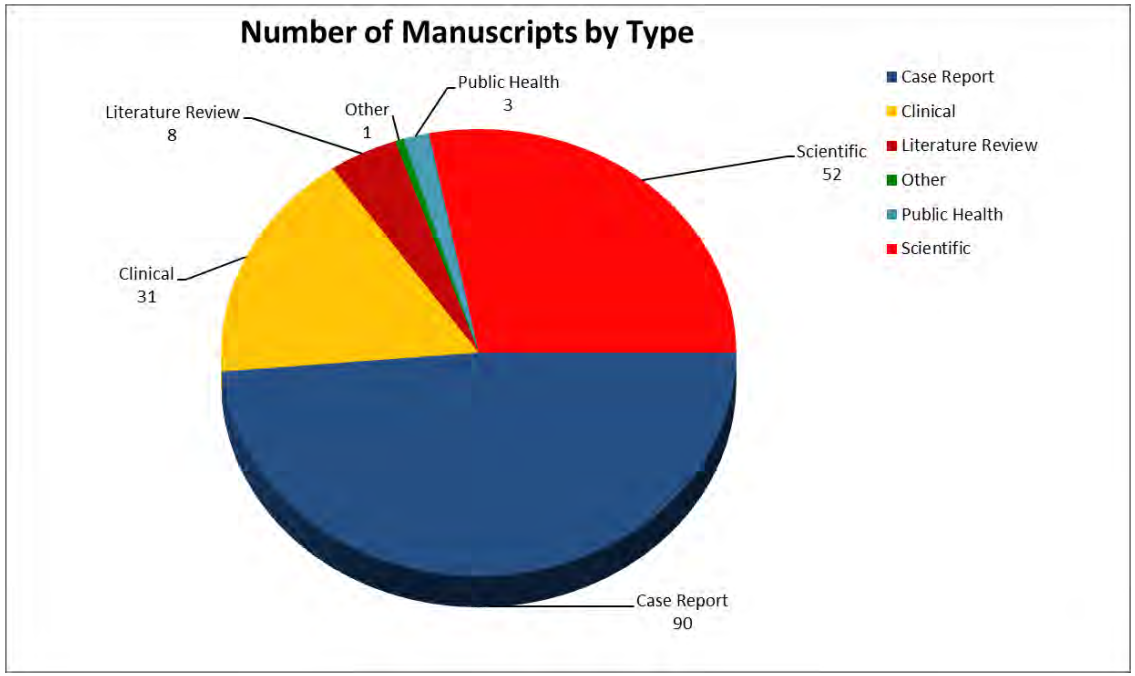
# Figure 4 - JDC - Number of Manuscripts by Type

## Manuscripts Decided for Journal of Dentistry for Children

Estimated Data Date: Dec. 3, 2012

Information based on all manuscripts whose submission date is on or after Jan 1, 2012 and decision date is on or after Jan 1, 2012..

**Grouped by: Manuscript Type**




| Manuscript Type | Number of Manuscripts | Percentage of Total |
|---|---|---|
| Case Report | 90 | 48.6 |
| Clinical | 31 | 16.8 |
| Literature Review | 8 | 4.3 |
| Other | 1 | 0.5 |
| Public Health | 3 | 1.6 |
| Scientific | 52 | 28.1 |
| **Total** | **185** | **100.0** |

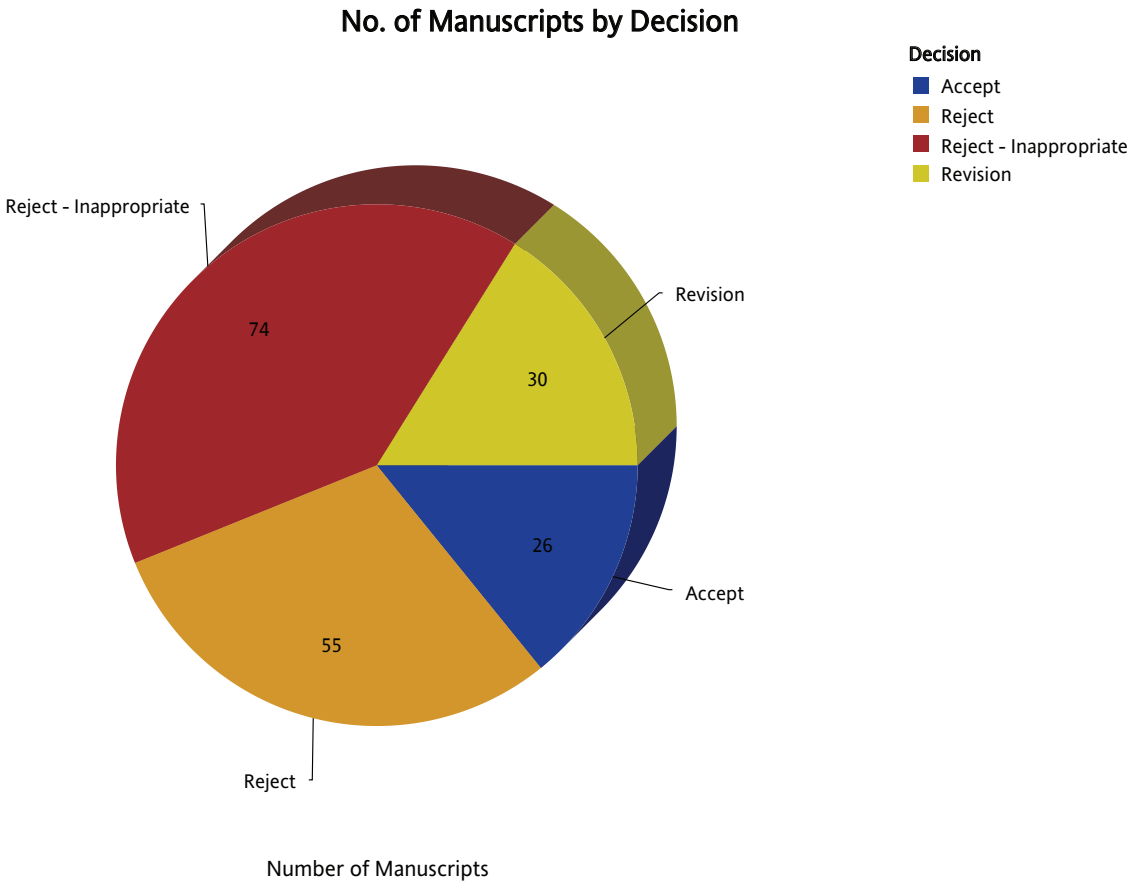
# Figure 5 - JDC - Number of Manuscripts by Decision

## Manuscripts Decided for Journal of Dentistry for Children

Estimated Data Date: Dec 4, 2012 2:35:02 AM

Information based on all manuscripts whose submission date is On or after Jan 1, 2012 and decision date is On or after Jan 1, 2012

**Grouped by: Manuscript Decision**




| Manuscript Decision | Number of Manuscripts | Percentage of Total |
|---|---|---|
| **Accept** | **26** | **14.1%** |
| **Reject** | **55** | **29.7%** |
| **Reject - Inappropriate** | **74** | **40.0%** |
| **Revision** | **30** | **16.2%** |
| **Total:** | **185** | **100.0%** |

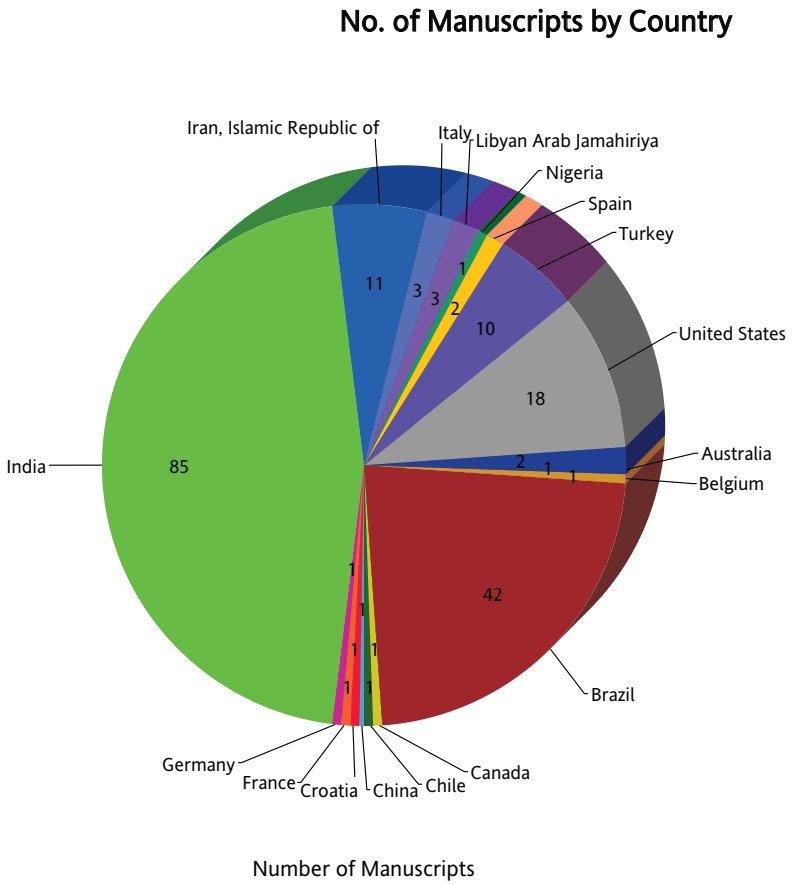
# Figure 6 - JDC - Number of Manuscripts by Country

## Manuscripts Decided for Journal of Dentistry for Children

Estimated Data Date: Dec 4, 2012 2:35:02 AM

Information based on all manuscripts whose submission date is On or after Jan 1, 2012 and decision date is On or after Jan 1, 2012

**Grouped by: Country Of Submission**





| Author Country | Number of Manuscripts | Percentage of Total |
|---|---|---|
| **Australia** | **1** | **0.5%** |
| **Belgium** | **1** | **0.5%** |
| **Brazil** | **42** | **22.7%** |
| **Canada** | **1** | **0.5%** |
| **Chile** | **1** | **0.5%** |
| **China** | **1** | **0.5%** |
| **Croatia** | **1** | **0.5%** |
| **France** | **1** | **0.5%** |
| **Germany** | **1** | **0.5%** |
| **India** | **85** | **45.9%** |
| **Iran, Islamic Republic of** | **11** | **5.9%** |
| **Italy** | **3** | **1.6%** |
| **Libyan Arab Jamahiriya** | **3** | **1.6%** |
| **Nigeria** | **1** | **0.5%** |
| **Spain** | **2** | **1.1%** |
| **Turkey** | **10** | **5.4%** |
| **United States** | **18** | **9.7%** |
| | **2** | **1.1%** |
| **Total:** | **185** | **100.0%** |

# 2012-2013 Report of the Awards Committee

**Warren A. Brill, Chair (Vice President)**
James D. Nickman (Senior Trustee)
K. Jean Beauchamp (Junior Trustee)
Joseph B. Castellano (Freshman Trustee)
John S. Rutkauskas (Chief Executive Officer)

The Awards Committee has selected the following recipients:

**Distinguished Service Award**:
Anna B. Fuks

**Pediatric Dentist of the Year**
John R. Liu

**Jerome B. Miller "For the Kids" Award**
Sara L. Filstrup

**Merle C. Hunter Leadership Award**
Scott W. Cashion

**Manuel M. Album Award**
Sheldon M. Bernick

**Ann Page Griffin Humanitarian Award**
Jerome B. Miller

**Dr. Lewis A. Kay Excellence in Education Award**
Indru C. Punwani

**Paul P. Taylor Award**
B Howley, NS Seale, AG McWhorter, C Kerins, KB Boozer, and D Lindsey. Pulpotomy versus Pulpectomy for Carious Vital Primary Incisors: Randomized Controlled Trial" *Pediatric Dentistry* 2012;34(5): 112-119E

I want to thank the Awards Committee for their suggestions and dedication to evaluating and selecting these wonderful recipients.

# 2012-2013 Report of the Budget and Finance Committee

**Robert L. Delarosa, Chair**
Man Wai Ng, Senior Trustee
K. Jean Beauchamp, Junior Trustee
Santos Cortez, Freshman Trustee
John S. Rutkauskas, Chief Executive Officer

The Budget and Finance Committee met on two occasions during the past year. Those meetings occurred in October 2012 in San Francisco and again in March 2013 in Washington, DC. The minutes of the October meeting are included below and the minutes of the March meeting, along with the proposed budget for FY2013-2014, will be presented to the Board of Trustees at the Annual Meeting in Orlando.

**Minutes of the Regular Meeting of the Budget and Finance Committee**

Date: Thursday, October 18, 2012

Place: Foothill J conference room, San Francisco Marriott Marquis, San Francisco, CA

Presiding officer: Dr. Robert L. Delarosa, AAPD Secretary-Treasurer

Minute taker: Ms. Margaret A. Bjerklie, AAPD Executive Assistant and Office Manager

Budget and Finance Committee members present: Drs. Man Wai Ng, John Hendry, Santos Cortez, Jr., and John S. Rutkauskas, AAPD Chief Executive Officer

AAPD staff present: Mr. C. Scott Litch, Chief Operating Officer and General Counsel

Participating by conference call: Ms. Megan Mulherin, Legacy Partners; Mr. Larry Martin, Martin & Martin CPAs; Ms. Margitta Winkler, AAPD Director of Business Services

Dr. Delarosa called the meeting to order at 10:00 a.m.

I. **Audit Report**

Megan Mulherin of Legacy Partners gave an overview of the audit report for the committee.

- Unqualified opinion – highest level possible
- Recall that there is no A-133 component to the audit this year because the Head Start contract is over
- There is a net decrease in funds because of a slight decrease in investment activities

- Note that the Ad Campaign cost of $500,000 is listed this year, under "Foundation Contribution"; the contributions will be paid over a three year period but will not appear in the income statement
- There were no issues raised by the audit
- Ms. Mulherin said that it was the smoothest audits she's ever been a part of

**MOTION: To accept the audit report.**
Carried

II. **Income statements and balance sheets**

- Question was raised as to how the expense for "Headquarters Office" compares to other organizations of similar size.
    - For the next meeting, Dr. Rutkauskas will attempt to make a comparison, using benchmarks provided by the American Society of Association Executives
    - Note that every organization will have different items considered as "headquarter expenses"; it may not be possible to make a fully equal comparison
- Future financial statements will have a column to compare actual to previous year costs, using a +/- percentage display
- Investment income is equal to or better than other organizations with which Mr. Martin is familiar
- Committee restated the current asset allocation guidelines.

**MOTION: To reaffirm the current asset allocation: 40-65% equity holdings; 30-50% bonds; 0-20% cash equivalents.**
**Carried**

III. **Adoption of Agenda**
**MOTION: The agenda of the October 18, 2012, meeting of the AAPD Budget and Finance Committee was approved as presented.**
Carried

IV. **Approval of Minutes**
**MOTION: The minutes of the March 9, 2012, meeting of the AAPD Budget and Finance Committee were approved as presented.**
Carried

V. **Discussion of Portfolio Management**

- North Star Trust was acquired by BMO Harris one year ago
- Ken Zubeck and Bob Skowronski, who have managed the AAPD account for more than 20 years, made the decision to leave North Star, feeling that the resulting company would be too large to pay as much attention to smaller investors (like AAPD) as they have traditionally done
    - Are now with Associated Bank
    - Associated Bank has a very good reputation
- Note that the investment portfolio of Healthy Smiles, Healthy Children: The Foundation of the AAPD (HSHC) is divided between three asset management firms

    - Part of the HSHC portfolio is with a company that invests entirely in equities
    - The rest is split between North Star and Meritage, which has a similar investment philosophy
- The AAPD's current investment philosophy leans toward liquidity and low risk; ensuring that there is a 100% reserve, as required by our investment policy
    - Do we wish to continue operating under that philosophy?
    - If so, do we need to change our investment firm simply because of a personnel change
        - Note that the AAPD portfolio has followed these two managers through several moves, with significant success
        - Personal relationships carry weight when it comes to how the AAPD is treated by the investment firm
    - Do we wish to keep our investments with one firm?
        - Could be an opportunity to diversify
- Options:
    - Continue with North Star
    - Move to Associated Bank
    - Split the portfolio between the two companies

**ACTION: Drs. Delarosa and Rutkauskas will interview North Star Trust and Associated Bank, to assess each organization's investment philosophy, management fee structure, and other key issues. The Committee will make a recommendation to the Board at its January meeting.**

VI. **2012-13 Approved Budget**
Information. No changes have been made since budget was approved in May.

VII. **Membership Statistics**
Informational.

- Note that Pediatric Dentistry has overtaken periodontics as the 3rd largest specialty.
- Because of member loyalty, AAPD has not had increase our dues in the last 5 years or so, in spite of sponsoring programs like the Ad Campaign.
- AAPD offers more CE than our sister specialties.
- And this allows us to have the conversations we're going to have tomorrow, like the PR campaign Dr. Berg will be proposing, that we will be able to do without a dues increase.

VIII. Proposed **Budget for 2013 Annual Session**
Informational. Modest increases in a couple registration categories, which haven't changed for a number of years.

IX. **Next Budget and Finance Committee Meeting**
Sunday, March 10, 2013, from 9 a.m. to noon in Washington, DC

X. **Future Financial Impacts**

- Running out of space at the headquarters office

- New projects, being discussed at this Board meeting, as well as some prospective grants to the Policy Center, may require hiring new staff, but there is no space for them
- The ADA building will have some space opening up in the next few months, due to the move out of 2 large tenants
    - There have been rumors that physician groups associated with the new Children's Hospital are looking to occupy that space when it becomes available.

**MOTION: The committee directed Drs. Rutkauskas and Delarosa to begin the due diligence process to increase office space.**
Carried.

The meeting was adjourned at 11:58 a.m. on Thursday, October 18, 2012.

Minutes approved March 10, 2013.

# 2012-2013 Report of the Constitution and Bylaws Committee

**Edward H. Moody, Vice President, Chair**
James D. Nickman, Trustee
Tegwyn H. Brickhouse, Member at Large
Beverly A. Largent, Consultant
C. Scott Litch (Chief Operating Officer and General Counsel, non-voting member)

## Constitution and Bylaws Amendments for the 2013 General Assembly

The attached report of the proposed amendments to the AAPD Constitution and Bylaws has been posted on the AAPD website (http://www.aapd.org/assets/1/7/2013_Bylaws_Amendments_with_Governance_Report.pdf) since February 22, 2013. The proposed amendments were mailed to the members on March 6, 2013, in the March 2013 issue of *PDT*.

The website article includes the report of the Task Force on Governance, which appears in Section 3 (**Reports of the Councils, Committees, and Task Forces**) of this compilation of reports.

# NOTICE TO ACTIVE AND LIFE MEMBERS

## Constitution and Bylaws Amendment before the 2013 General Assembly

The following proposed changes to the Constitution and Bylaws were prepared by the Constitution and Bylaws Committee at the request of the Board of Trustees. These will be reviewed at the AAPD Annual Session in Orlando during the Reference Committee hearings and the General Assembly.

*Note to readers: All line numbers reference the current AAPD Constitution and Bylaws as printed in the 2013 Membership Directory.*

~~Strikethrough~~ words are to be removed; **bold underlined** words are to be added to the Bylaws.

### UPDATED PARLIAMENTARY PROCEDURE REFERENCE

*This proposed amendment is based on the 2012 release of an updated code of parliamentary procedure written by the American Institute of Parliamentarians, which essentially replaces the previous editions ("Sturgis") referenced in the AAPD Bylaws.*

1369 **CHAPTER XVI. RULES OF ORDER**
1370 The current edition of ~~Sturgis~~ **American Institute of Parliamentarians** Standard Code of Parliamentary
1371 Procedure shall govern the procedures of the Academy in all
1372 situations not otherwise provided for in these Bylaws or the
1373 adopted policies or administrative procedures of the Academy.

### INTERNATIONAL STUDENT MEMBERSHIP CATEGORY

*This proposed amendment is recommended by the Board of Trustees to create a new membership category of International Student. This reflects the need to accommodate growing interest in AAPD membership from dental students around the world. The Board believes it would be best to create a separate membership category rather than accommodating such individuals under the current Predoctoral or Postdoctoral Student membership categories. The Board also believes that due to higher servicing costs, it is appropriate to charge dues for this membership category.*

114 **CHAPTER I. MEMBERSHIP**
115 Section 1. **CATEGORIES:** There shall be ~~thirteen (13)~~ **fourteen (14)** categories
116 of membership: Active, International, Life, Inactive, Associate,
117 Retired, Predoctoral Student, Postdoctoral Student, **International Student,** Affiliate,
118 Affiliate Life, Allied, Friends of Pediatric Dentistry and Honorary.

119 Section 2. **ELIGIBILITY: . . .**

176 G. **PREDOCTORAL STUDENT:** This category of member-
177 ship is available, upon application, to predoctoral students
178 enrolled in an educational program in dentistry approved by
179 the Commission on Dental Accreditation of the ~~American Den-~~
~~180 tal Association, or its equivalent in a foreign country~~ **U.S. or Canada.**

181 H. **POSTDOCTORAL STUDENT:** This category of member-
182 ship is available, upon formal application, to full and part-time
183 postdoctoral students enrolled in any educational program in
184 pediatric dentistry approved by the Commission on Dental
185 Accreditation of the ~~American Dental Association, or its~~
~~186 equivalent in a foreign country~~ **U.S. or Canada.**

**I. INTERNATIONAL STUDENT: This category of membership is available, upon formal application, to full and part-time students enrolled in any educational program in dentistry or pediatric dentistry, in a country other than the United States or Canada, that is approved by a national accrediting organization comparable to the Commission on Dental Accreditation of the U.S. or Canada.**

Re-letter subsequent paragraphs

*220 Section 3.* **PRIVILEGES: . . .**

**F. INTERNATIONAL STUDENT: Privileges of International Student members shall be to:**

1. **Serve as consultants to councils/committees, but not vote or hold office.**
2. **Attend the annual session of the Academy.**
3. **Receive copies of all general membership communications.**
4. **Be eligible to apply for International membership immediately after satisfactory completion of the required educational program.**
5. **Privileges of International Student members will terminate on the date of completion of the individual's applicable educational program.**

*NOTE: Subsequent paragraphs will be re-lettered.*

*307 Section 4.* **PROCEDURE FOR APPLICATION: . . .**

312 B. APPLICATION REVIEW: Application review will be conduc-
313 ted following receipt of an application for Active, International,
314 Life, Associate, Inactive, Retired, Predoctoral Student,
315 Postdoctoral Student, **International Student,** Affiliate, Allied or Friends of Pediatric
316 Dentistry membership as set forth in Section 2 of this Chapter.
317 Any variance will be reviewed by the Credentials and Ethics
318 Committee and completion of all stipulated requirements, the
319 applicant shall become a member in the appropriate category.

1076 **CHAPTER X. FINANCES**
1077 Section 1. **DUES: . . .**

1094 E. Retired, Inactive, Honorary, and Postdoctoral Student
1095 members shall pay no dues.
1096 F. Predoctoral **and International** Student Members shall pay annual dues in an
1097 amount determined by the Board of Trustees.

1100 Section 2. **ASSESSMENTS: . . .**

1106 B. International, Associate, Inactive, Retired, Postdoc-
1107 toral Student, Predoctoral Student, **International Student,** Affiliate, Allied, Friends,
1108 of Pediatric Dentistry and Honorary members shall be exempt
1109 from the payment of any assessment levied upon the
1110 membership.

## GOVERNANCE

*The following Bylaws amendments are recommended by the AAPD Board of Trustees based on recommendations from the Task Force on Governance.*

## CONSOLIDATION OF DISTRICTS I AND II

*The Board of Trustees recommends that Districts I and II be combined to more evenly distribute the number of members in each district. In the Fall of 2012 the number of Active members by District was: I-719, II-530, III-1135, IV-835, V-847, VI-1299. The Board notes that Districts I and II are not highly organized at present, and believes that a combined district will enhance such efforts. This change will reduce the number of Trustees by one. The Board also believes that members in the federal services and foreign countries (other than Canada) should be removed from District 2 and District 5 and referenced under the duties of At-Large Trustees. Also, the Board believes districts should be referred to be by their geographic terminology rather than numbers.*

**CHAPTER V. BOARD OF TRUSTEES**

Section 1. **COMPOSITION:** The Board of Trustees shall consist of ~~twenty (20)~~ **nineteen (19)** members: the President, President-Elect, Vice-President, Secretary-Treasurer, the immediate past President, one District Trustee elected from each of the ~~six (6)~~ **five (5)** trustee districts, three (3) trustees elected as member at-large, one (1) Affiliate Trustee; and the Editor, Chief Executive Officer, Parliamentarian, Child Advocate and Congressional Liaison, who shall be ex officio members of the Board of Trustees without the right to vote.

Section 2. **TRUSTEE DISTRICTS:** There shall be ~~six (6)~~ **five (5)** trustee districts. A member shall be identified with a trustee district according to the member's primary practice mailing address listed with the Headquarters Office except for Inactive and Retired members or those members employed in the Federal Services ~~(District 2)~~. Inactive and Retired members shall be identified with a trustee district according to the member's mailing address listed with the Headquarters Office. The trustee districts shall be ~~numbered and~~ composed as follows:

**Northeastern District ~~I~~:** Connecticut, Maine, Massachusetts, New Hampshire, New York, Rhode Island, Vermont, and the Canadian provinces of Newfoundland, Nova Scotia, Prince Edward Island, New Brunswick, and Quebec~~;~~ **,**

~~**District II:** Delaware, District of Columbia, Maryland, New Jersey,~~ **and** ~~Pennsylvania, members in the Federal Services, and foreign countries not specifically cited,~~

*NOTE: If adopted, states will be listed in alphabetical order in the final updated version of the Bylaws.*

**Southeastern District ~~III~~:** Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee, Virginia, West Virginia, and the Commonwealth of Puerto Rico;

**NorthCentral District ~~IV~~:** Illinois, Indiana, Iowa, Ohio, Michigan, Minnesota, Nebraska, North Dakota, South Dakota, Wisconsin, and the Canadian provinces of Ontario and Manitoba;

**Southwestern District ~~V~~:** Arkansas, Colorado, Kansas, Louisiana, Missouri, New Mexico, Oklahoma, **and** Texas, ~~and Mexico;~~

**Western District ~~VI~~:** Alaska, Arizona, California, Hawaii, Idaho, Montana, Nevada, Oregon, Utah, Washington, Wyoming, and the Canadian provinces of Saskatchewan, Alberta, British Columbia, Northwest Territories, Nunavut, and Yukon Territory.

Section 3. **TRUSTEE MEMBERS AT-LARGE.** The Board of Trustees shall have three at-large members elected as described in Chapter XI, each for a three (3) year term on a rotating basis of one per year. Starting with the at-large term beginning in 2005 for a three (3) year term, one of the three at-large positions will be designated for and filled by a full time academician. Qualifications of a full time academician for this at-large position include a full time educator who devotes a majority of professional time, in no case less than two days a week, to educational endeavors in a dental school or graduate pediatric dentistry program accredited by the Commission on Dental Accreditation. Interim vacancies in the position of academician trustee at-large will be filled by presidential nomination as described in Chapter V~~I~~. Section ~~8~~**9**. and such appointment shall be limited to full time academicians. **One of the non-academic trustees at-large shall be designated by the President as liaison to members in the uniformed Federal Services, and the other shall be designated as liaison to International members.**

G. **NOMINATIONS COMMITTEE:**

*Composition:*

The Nominations Committee shall be composed of ~~nine (9)~~ **eight (8)** members: the two immediate Past Presidents of the Academy, a board member of the American Board of Pediatric Dentistry as determined by the ABPD and one (1) member elected from each trustee District. Further details on committee member selection and committee procedures are provided in the Administrative Policy and Procedure Manual of the AAPD.

**CHAPTER VI. DISTRICT ORGANIZATION**

Section 1. **ORGANIZATION:**

The trustee districts shall be ~~numbered and~~ composed as set forth in Chapter V, Section 2 of these Bylaws.

**CHAPTER VII. STATE UNIT ORGANIZATIONS**

Section 1. **ORGANIZATION:**

A. The AAPD Trustee Districts shall be organized into State Units representing the Active and Life members of each state, ~~foreign unit, and Federal Dental Services~~ as set forth in Chapter V, Section 2 of these Bylaws.

## AAPD COMPLIMENTARY SERVICE FOR COLLECTING DISTRICT AND STATE DUES

*The Board of Trustees recommends that the AAPD should offer collection of district and state dues at no cost to the district or state. The AAPD has offered this service, at a sliding fee scale depending on number of members, to state unit organizations for four years including 2013-14. 11 states (Alaska, Alabama, Colorado, Connecticut, Indiana, Florida, Massachusetts, Nebraska, Oregon, Pennsylvania, and Wisconsin) currently participate in this service. States that have participated to date have seen an increase in their membership; this is likely due to the convenience of members being able to pay their AAPD and state dues at the same time. The Board believes this is an excellent service and membership benefit that the AAPD can provide to district and state unit organizations, to enhance their finances and scope of activities. This is especially important given the new Public Policy Advocate initiative.*

**876 CHAPTER VI. DISTRICT ORGANIZATION . . .**

**891 Section 3. DUTIES: A District shall: . . .**

898 D. Provide for its financial support. **The AAPD shall provide dues collection service at the district's request, at no cost.**

919 **CHAPTER VII. STATE UNIT ORGANIZATIONS . . .**

935 Section 3. **DUTIES:** A State Unit shall: . . .

942 D. Provide for its financial support. **The AAPD shall provide dues collection service at the state unit's request, at no cost.**

## MODIFICATION OF TRIPARTITE PROVISION

*The Board of Trustees recommends that the requirement for mandatory tripartite membership be deleted. The Board believes it has not been working. It has not been strictly enforced, as doing so would have resulted in a loss of membership in AAPD, districts, and state unit organizations. The Board does not believe mandatory tripartite membership is in the best interests of the AAPD. However, the Board believes the AAPD should take a more active role in helping districts and states. The Board believes the recommended provision on collection of dues for district and state unit organizations will help achieve this goal by providing enhanced and stable finances for these organizations.*

*876* **CHAPTER VI. DISTRICT ORGANIZATION . . .**

911 Section 4: **MEMBERSHIP:**
912 A. AAPD ~~Active and Life~~ members ~~must~~ **are strongly encouraged to**
maintain member-
913 ship in their State Unit and their respective district organiza-
914 tion.
915 ~~B. Members who joined the Academy, or any recognized~~
916 ~~organization related to the Academy, prior to June 30, 1999~~
917 ~~may retain their current membership status and are eligible for~~
918 district organization membership.

## MODIFICATION OF ADA MEMBERHIP PROVISION

*The Board of Trustees recommends that the AAPD should require membership in the American Dental Association (ADA) only at the time of applying for membership to the AAPD. Currently, prospective AAPD members must provide their ADA membership number in their AAPD application. However, the AAPD has no enforcement mechanism or resources to monitor ongoing ADA membership and therefore has never been able to enforce this provision. The Board notes that of the other dental specialty associations that require ADA membership (AAE, AAO, and AAP), two of them (AAO and AAP) only do so at the time of application while the third (AAE) reaches out to lapsed ADA members but does not drop any non-compliant member from their membership. The Board believes this recognizes the importance of maintaining the AAPD's excellent working relationship with the ADA, while avoiding an unmanageable system for the AAPD.*

113 **BYLAWS**
114 **CHAPTER I. MEMBERSHIP . . .**

**119 Section 2. ELIGIBILITY:**

120 A. **ACTIVE:** An ethical dentist may be considered for Active
121 membership provided the applicant:
122 1. Is a member of~~, and maintains membership in,~~ the Ameri-
123 can Dental Association, ~~National Dental Association,~~ **Canadian Dental Association,** or a rec-
124 ognized foreign dental association **at the time of application.**

125 2. Meets the educational requirements of the ~~American Dental~~
126 ~~Association~~ **Commission on Dental Accreditation of the U.S. or Canada** for the announcement of ethical practice in pediat-
127 ric dentistry. An applicant for Active membership who an-

187 I. **AFFILIATE:** This category of membership is available to gen-
188 eral dentists who practice in the United States or Canada and
189 ~~maintain membership in~~ **are members of** the American Dental Association, ~~Na-~~
190 ~~tional Dental Association,~~ or ~~a recognized~~ **the** Canadian Dental As-
191 sociation**, at the time of application.**

## BOARD CERTIFICATION AS ALTERNATIVE CRITERIA FOR ACTIVE MEMBERSHIP

*The Board of Trustees supports an idea suggested by the Task Force on International Issues that board-certified pediatric dentists should be eligible for Active membership even if they do not meet the current educational requirements due to training in a foreign country. The proposed amendment incorporates recommendations from the above proposal for ease of comparison.*

125 2. Meets the educational requirements of the ~~American Dental~~
126 ~~Association~~ **Commission on Dental Accreditation of the U.S. or Canada** for the announcement of ethical practice in pediat-
127 ric dentistry or **has achieved board certification from the American Board of Pediatric Dentistry.**

# 2012-2013 Report of the Credentials and Ethics Committee

**Edward H. Moody, Jr., Chair (Vice President)**
Mario E. Ramos (Trustee)
Joseph B. Castellano (Trustee)
John S. Rutkauskas (Chief Executive Officer)

One case was brought before the Credentials & Ethics Committee during the past year. Following investigation and testimony, the case was subsequently resolved to the satisfaction of the Committee, Board of Trustees, and all other concerned parties.

No additional cases are either active or pending at this time.

# 2012-2013 Report of the Nominations Committee

**John R. Liu, Chair (Past President, AAPD)**
Rhea M. Haugseth (Immediate Past President, AAPD)
Jenny Ison Stigers (President, ABPD)

**Delegates**
Amr M. Moursi (District I)
Anupama Tate (District II)
Joseph Young (District III)
Jessica A. Meeske (District IV)
Philip H. Hunke (District V)
Richard P. Mungo (District VI)

The President of the American Academy of Pediatric Dentistry for the 2013-2014 will be Warren A. Brill (immediate ascension to office).

Joel H. Berg will become Immediate Past President.

The Nominations Committee met prior to the Winter Planning meeting of 2013 to interview candidates for office under the new nominations process. The process went smoothly, with interviews conducted with all the candidates, either in person or by telephone conference.

The Nominations Committee recommends the following slate of candidates for officers, trustee at large, and director of the American Board of Pediatric Dentistry for the year 2013-2014:

President-Elect: Edward H. Moody, Jr.
Vice-President: Robert L. Delarosa, Jr.
Secretary-Treasurer: Jade Miller
Trustee-at- Large, Board of Trustees: Jessica Y. Lee
American Board of Pediatric Dentistry: Jeffrey C. Mabry

# 2012-2013 Report of the Policy and Procedure Committee

**Rhea M. Haugseth, Chair (Immediate Past President)**
Jessica Y. Lee (Parliamentarian)
Mario E. Ramos (Senior Trustee)
Shari C. Kohn (Junior Trustee)
Catherine M. Flaitz (Freshman Trustee)
John S. Rutkauskas (Chief Executive Officer)

The Policy and Procedure Committee responded to several requests by the Board of Trustees during the AAPD year 2012-13. The current edition of the AAPD *Administrative Policy and Procedure Manual* is posted under "Member Resources" in the Members Only section of the AAPD website.

The Board of Trustees approved the following changes to the AAPD *Administrative Policy and Procedure Manual* in 2011-12:

- The addition of Section 13 (General Policies), paragraph M. Antitrust Compliance Policy
- Technical correction to Section 3 (Board of Trustees), C (Policies Governing Recognition of Other Organizations), Paragraph 1, removing the participation of the Society of Post-doctoral Program Directors
- Technical correction to Section 8 (Councils and Committees), A (Appointments), Paragraph 3, as the Annual Session no longer runs through Memorial Day
- Technical correction to Section 8 (Councils and Committees), O (Councils/ committees), Paragraphs 13 and 14, as appointments to the Commission on Dental Accreditation go through the Board, not the Council on Post-Doctoral Education
- Technical correction Section 8 (Councils and Committees).O(Councils/ Committees), Paragraphs 13 and 14, to ensure that there are at least 5 people on the Post-Doctoral Inservice Examination Committee
- Technical correction to Section 8 (Councils and Committees).O (Councils/ Committees), Paragraph 20, regarding the Pediatric Dental Resident Committee, clarifying the requirements and term for the chair

# 2012-2013 Report of the Council on Annual Session

**Edward H. Moody, Jr., Chair and Board Liaison**
Tonya Almond, Staff Liaison

Carlos A. Bertot, Chair, Scientific Program Committee
Rachelle Dermody, Co-Chair, Local Arrangements Committee
John S. Rutkauskas, Ex Officio (Chief Executive Officer)

## VISION AND DUTIES

The duties of the Council on Annual Session, as listed in the AAPD *Administrative Policy and Procedure Manual*, are to supervise and coordinate all aspects of the annual session.

## REPORT

### Charge 1. Status of Charge 1: Completed

Complete planning for the 2013 Annual Session in Orlando and begin planning for the 2014 Annual Session in Boston. The programs and content of the Annual Session should be in conformity with the Strategic Plan of the AAPD and with the information gained from member needs surveys and member evaluations of prior meetings.

*Background and Intent:* The content of the Annual Session should reflect the Academy's Strategic Plan and membership needs.

### Progress Report for Charge 1

Program planning is complete in all respects for 2013 (Orlando) and all associated functions and events are in place. Initial planning has begun for 2014 (Boston) and 2015 (Seattle).

### Charge 2. Status of Charge 2: Completed

In conjunction with the Chief Executive Officer and Headquarters Office staff, prepare a final budget for the 2013 Annual Session to be reviewed by the council chair and presented at the 2012 Ad Interim meeting of the Board of Trustees.

*Background and Intent:* The Annual Session budget should be reviewed and approved by council leadership prior to presentation to the Board of Trustees at the Ad Interim Meeting.

### Progress Report for Charge 2

Budget was presented and approved by Budget & Finance Committee and Board of Trustees at Ad-Interim meeting.

## Council on Annual Session, 2012-2013

### Charge 3. Status of Charge 3: Completed

Review and update the Annual Session Planning Document, as needed. Present a report on the immediate previous Annual Session at the July Pre-Planning Meeting, using information from the annual session debriefing.

*Background and Intent:* Data derived from the Annual Session Debriefing should be used for the planning of the following year's session.

### Progress Report for Charge 3

Discussed and acted upon by the Council at the July 2012 planning meeting for the 2013 (Orlando) Annual Session.

# 2012-2013 Report of the Council on Annual Session, Scientific Program Committee

**Carlos A. Bertot, Chair**
**Edward H. Moody, Jr., Board Liaison**
Tonya Almond, Staff Liaison

*District representative members:*
Kavita Kohli (I)
Rochelle Lindemeyer (II)
Paul B. Andrews (IV)
Janice Townsend (V)
Lynn K. Fujimoto (VI)

*Consultants and Ex-Officio members:*
Ann M. Bynum, Consultant
Steven J. Hernandez, Consultant
Anthea Drew Mazzawi, Consultant
Ricardo A. Perez, Consultant
Rebecca L. Slayton, Expert Consultant
Brian Beitel, Ex-Officio (Chair, Council on Continuing Education)
Indru C. Punwani, Ex-Officio (Chair, Council on Scientific Affairs)

## VISION AND DUTIES

The duties of the Council on Annual Session, Scientific Program Committee, as listed in the *AAPD Administrative Policy and Procedure Manual*, are to propose and develop the scientific program for the annual session.

## REPORT

### Charge 1. Status of Charge 1: Ongoing

Continue scientific program development for the 2013 and 2014 Annual Sessions. Report to the Board of Trustees at the 2012 Ad Interim meeting.
*Background and Intent:* This is a standing charge for the Committee.

### Progress Report for Charge 1

The Scientific Program Committee created a new program to provide a higher level of customer service and appreciation to its speakers. Members of the committee are going to be Speaker Champions to each half day or full day course at the 66th Annual Session. We will also have those Speaker Champions serve as the moderators. The Committee believes this is an important part of the process since they are the group who identifies and invites the speakers to present at the meeting. We have outlined the appropriate communications and staff is working closely with the committee to ensure all the details are conveyed about presentations, bios, etc.

The committee will meet in July to finalize the 2014 Annual Session Program and further discuss 2015.

# 2012-13 Report of the Council on Clinical Affairs

**Sara L. Filstrup, Chair**
**Joseph B. Castellano, Board Liaison**
John Rutkauskas, Mary Essling, and Janice Silverman, Staff Liaisons

*District Representative members:*
Rachael Simon (II)
Noel K. Childers (III)
Edward L. Rick (IV)
Steven P. Hackmyer (V)
Randall K. Lout (VI)

*Consultants and Ex-Officio members:*
Julie D. Anfinson, Consultant
Maria Aslani-Breit, Consultant
Richard S. Chaet, Consultant
Judith R. Chin, Consultant
Maria Regina (Ninna) P. Estrella, Consultant
Catherine M. Flaitz, Consultant
Carolyn A. Kerins, Consultant
Brian J. Sanders, Consultant
Ana Lucia Seminario, Consultant
Anupama R. Tate, Consultant
Ana H. Vazquez, Consultant
Arnold I. Weiss, Consultant
Yoo-Lee Yea, Consultant
Jenny Ison Stigers, Expert Consultant
Norman Tinanoff, Expert Consultant

## VISION AND DUTIES

The vision of the Council on Clinical Affairs (CCA) is to be a critical and vital aspect of American Academy of Pediatric Dentistry continuing as the world leader on children's oral health. Formed from a group of passionate, committed and bright pediatric dentists, this council draws on its long history and responsibility to the organization and the children its members serve. With the common goal of providing the best and most current evidenced based science, documents are drafted that are relevant to healthcare providers and organizations, governmental bodies, and other industry stakeholders. With that bold platform, CCA is an invaluable resource for all of those parties that seek to impact the lives of children by vastly improving their oral health.

Mission: To review, revise and develop the definitions, policies and guidelines using evidence-based dentistry while in congruence with the vision of the AAPD.

The duties of the Council on Clinical Affairs, as listed in the AAPD *Administrative Policy and Procedure Manual*, are to: 1) advise the Board of Trustees on matters concerning the clinical practice of pediatric dentistry; 2) review and develop oral health policies and guidelines regarding the clinical practice of pediatric dentistry and submit recommendations through the Board of Trustees; 3) perform such other duties as assigned by the President or the Board of Trustees.

## Council on Clinical Affairs, 2012-2013

### REPORT

**Charge 1.** **Status of Charge 1: In Progress**

Review all definitions, oral health policies and clinical guidelines at no greater interval than every fifth year. Engage the Council on Scientific Affairs to perform a literature review for scientific validity.

*Background and Intent:* This is a standing charge to the Council. To be effective advocates for infants, children, adolescents, and persons with special health care needs, AAPD oral health policies and clinical guidelines must be supported by the best available evidence. Documents will be reviewed and revised/reaffirmed/retired in a cycle of not more than 5 year intervals. When there is sufficient reason (e.g., publications from a consensus conference), documents will be evaluated in advance of their scheduled review cycle.

Review the following in 2011-2012:

a) Guideline on Fluoride Therapy
b) Policy on Interim Therapeutic Restorations (ITR)
c) Policy on Prevention of Sports-related Orofacial Injuries
d) Policy on Minimizing Occupational Health Hazards Associated With Nitrous Oxide
e) Guideline on Use of Nitrous Oxide for Pediatric Dental Patients
f) Policy on Model Dental Benefits for Infants, Children, Adolescents, and Individuals With Special Health Care Needs
g) Guideline on Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance/Counseling, and Oral Treatment for Infants, Children, and Adolescents
h) Policy on the Role of Pediatric Dentists as Both Primary and Specialty Care Providers
i) Policy on Patient Safety
j) Policy on the Ethical Responsibility to Treat or Refer
k) Guideline on Oral Health Care/Dental Management of Heritable Dental Developmental Anomalies
l) Guideline on Dental Management of Pediatric Patients Receiving Chemotherapy, Hematopoietic Cell Transplantation, and/or Radiation
m) Policy on Stem Cells
n) Policy on Use of Fluoride
o) Guideline on Pediatric Restorative Dentistry
p) Guideline on Management of Acute Dental Trauma

### Progress Report for Charge 1

All revised documents are attached for review.

1. Guideline on Fluoride Therapy: The council is waiting on the ADA Council to release their recommendation regarding the amount of fluoridated toothpaste for young children. Currently the recommendation is a 'smear' of fluoridated toothpaste for children less than 2 years of age and a 'pea-size' amount for children aged 2 through 5 years. The above recommendation may change to 'smear' of fluoridated toothpaste for children less than 3 years of age and a 'pea-size' amount for children aged 3 through 6 years.
2. Guideline on Pediatric Restorative Dentistry: The Council changed title to "Guideline on Preventive and Restorative Materials for Pediatric Dentistry". Extension granted for review: 2013-2014 review cycle. The Council requested an extension to change the format of the guideline to mirror our other guidelines. Currently, the guideline reads more like a text chapter. Also, due to the extensive number of topics covered in the guideline, the Council would like more time to

perform evidence based searches and produce an evidence based guideline. It was also discussed that it may be advantageous to segment the guideline into several separate guidelines.

3. Guideline on Management of Acute Dental Trauma: The Council recommends retirement of the current AAPD Guideline on Management of Acute Dental Trauma. The council recommends endorsement of the International Association of Dental Traumatology's (IADT's) Guidelines. The Council recommends inclusion of the IADT Guidelines in the Endorsements Section of the Reference Manual. Documents for reprints follow:
   - IADT guidelines for the management of traumatic dental injuries: 1. Fractures and luxations of the permanent teeth. Dental Traumatology, Volume 28, Issue 1, pages 2-12, February 2012. (http://onlinelibrary.wiley.com/doi/10.1111/j.1600-9657.2011.01103.x/full)
   - IADT guidelines for the management of traumatic dental injuries: 2. Avulsion of permanent teeth. Dental Traumatology, Volume 28, Issue 2, pages 88-96, April 2012. (http://onlinelibrary.wiley.com/doi/10.1111/j.1600-9657.2012.01125.x/full)
   - IADT guidelines for the management of traumatic dental injuries: 3. Injuries in the primary dentition. Dental Traumatology, Volume 28, Issue 3, pages 174-182, June 2012. (http://onlinelibrary.wiley.com/doi/10.1111/j.1600-9657.2012.01146.x/full)

All the documents stand ready for approval.

## Charge 2. Status of Charge 2: In Progress

Annually review all AAPD-endorsed policies and guidelines developed by other healthcare organizations.

*Background and Intent:* This is a standing charge to the Council to promote optimal standards of care. CCA annually will monitor the policies and guidelines of other dental and medical healthcare organizations to determine when revisions have been made by the authoring group and the appropriateness of AAPD's continued endorsement.

### Progress Report for Charge 2

The Council continues to review and discuss all AAPD-endorsed policies and guidelines developed by other healthcare organizations. No recommendations at this time.

## Charge 3. Status of Charge 3: In Progress

Annually review the tables, charts, graphs and other items found in the resource section of the Reference Manual.

*Background and Intent:* This is a standing charge to the Council to provide contemporary guidance in clinical practice. CCA will maintain a resource section within the Reference Manual that supplements AAPD oral health policies and clinical guidelines. An annual review will determine the accuracy of information and appropriateness for continued inclusion.

## Council on Clinical Affairs, 2012-2013

### Progress Report for Charge 3

The Council continues to review and discuss all tables, charts, graphs and other items found in the resource section of the Reference Manual.
1. Useful Medications for Oral Conditions: The Council recommends review by pharmacist. Status: Council identifying pharmacist with expertise and willingness to assist the Council in this review.

### Charge 4. Status of Charge 4: In Progress

Identify potential topics for new definitions, oral health policies, clinical guidelines, and items for the resource section. Present a list of potential topics and recommendations to the Board of Trustees annually.

*Background and Intent:* This is a standing charge to the Council to anticipate and respond effectively to changes in the clinical and scientific environment.

### Progress Report for Charge 4

The council continues to identify and discuss potential topics for new definitions, oral health policies, clinical guidelines, and items for the resource section.

1. Periodontal Screening / Oral Cancer Screening: The Council recommends the addition of "periodontal screening" and "oral cancer screening" to the Guideline on Adolescent Oral Health Care during the normal review cycle. The guideline's next review cycle is 2015.
2. Sleep apnea: The AAP recommends that physicians ask parents about snoring to screen for obstructive sleep apnea and milder forms of sleep-disordered breathing. Habitual snoring has been associated with cognitive behavior problems in school-aged children, even when polysomnography results are ambiguous or negative. The Council recommends that the Council on Scientific Affairs review the literature on "sleep apnea" to determine merit to develop or endorse a policy.
3. Protective Stabilization Consent Form: The Council recommends discussion to create a consent form for protective stabilization after guideline is approved.

### Charge 5. Status of Charge 5: In Progress

Develop definitions, policies, guidelines or other materials as requested by the Board of Trustees.

*Background and Intent:* This is a standing charge to the Council. To be effective advocates for infants, children, adolescents, and persons with special health care needs, AAPD must delineate the organization's position on new and emerging health issues and translate science into clinical practice.

Develop the following in 2012-2013:

a) Policy on lasers

*Background and Intent:* Although laser usage has been considered for inclusion in other AAPD documents, there has not been an appropriate section in any of the definitions, policies, or guidelines that information on usage could be placed. The need for a policy on laser usage as a viable treatment modality for use in pediatric dentistry has again been brought forward by the membership. The policy should cover safety, efficacy, and usage.

b) Guideline on Passive Restraint

*Background and Intent*: Because passive restraint has come under scrutiny and its use questioned, the Council is directed to develop a guideline on the use of protective stabilization to provide direction on its indications and clinical usage.

c) Pediatric medical history form and age-appropriate social and dental history forms

*Background and Intent*: A request from a member was sent to the Council from the headquarters office, asking if AAPD had a Pediatric Medical History form and if not, is one being developed. The Council has determined that a Pediatric Medical History and an age-appropriate social/dental history would be a benefit for the membership and a good addition to the resource section of the Reference Manual.

**Progress Report for Charge 5**

All new documents are attached for review. The Council changed title of the Guideline on Passive Restraint to "Guideline on Protective Stabilization for Pediatric Dental Patients". The medical history form is in the resource section of the online Reference Manual, at http://www.aapd.org/media/Policies_Guidelines/RS_MedHistoryForm.pdf

## Charge 6. Status of Charge 6: In Progress

At the request of the Committee on Communications, review proposed pamphlets, brochures and other AAPD publications for scientific accuracy and consistency with AAPD Policies and Guidelines.

*Background and Intent:* This is a standing charge to the Council to ensure that the publications and promotional and educational materials offered to our members, other professionals, and the public are scientifically accurate and consistent with our Policies and Guidelines.

**Progress Report for Charge 6**

The Council continues to review and discuss proposed pamphlets, brochures and other AAPD publications for scientific accuracy and consistency with AAPD Policies and Guidelines. No recommendations at this time.

## Charge 7. Status of Charge 7: In Progress

At the request of the Executive Committee of the AAPD, provide timely review of policies, guidelines, and definitions submitted by the AAP Section on Oral Health, with particular attention to conformity with AAPD oral health policies and clinical guidelines.

*Background and Intent:* This is a standing charge to the Council. This mechanism implements the intent of the Memorandum of Understanding with the AAP Section on Oral Health, to review proposed documents for consistency with AAPD policies and guidelines. The Council will review these documents with sensitivity to the embargoed status of the drafts. A summary report will be submitted to the Executive Committee.

## Council on Clinical Affairs, 2012-2013

### Progress Report for Charge 7

The council continues to review policies, guidelines, and definitions submitted by the AAP Section on Oral Health, with particular attention to conformity with AAPD oral health policies and clinical guidelines. No recommendations at this time.

### Charge 8. Status of Charge 8: In Progress

At the request of any council or committee of the AAPD, review proposed definitions, policies, guidelines, or other publications for scientific accuracy and consistency with AAPD Policies and Guidelines.

*Background and Intent:* This is a standing charge to the Council to ensure that any definition, policy, guideline or other publication offered to our members, other professionals, and the public are scientifically accurate and consistent with our Policies and Guidelines.

### Progress Report for Charge 8

The Council continues to review proposed definitions, policies, guidelines, or other publications for scientific accuracy and consistency with AAPD Policies and Guidelines. No recommendations at this time.

**This draft does not constitute an official AAPD health oral policy or clinical guideline until approval by the General Assembly. Circulation is limited to AAPD members.**

# Guideline on Fluoride Therapy

**Originating Committee**

Liaison with Other Groups Committee

**Review Council**

Council on Clinical Affairs

**Adopted**

1967

**Revised**

1978 1979, 1995, 2000, 2003, 2007, 2008, 2013

**Reaffirmed**

1986 1995, 1972, 1977

## Purpose

The American Academy of Pediatric Dentistry (AAPD) intends this guideline to help practitioners and parents make decisions concerning appropriate use of fluoride as part of the comprehensive oral health care for infants, children, adolescents, and persons with special health care needs.

## Methods

A thorough review of the scientific literature in English language pertaining to the use of systemic and topical fluoride was completed to revise and update ~~this~~ the 2008 fluoride guideline. ~~A MEDLINE~~ Database searches were ~~was~~ conducted using the terms "fluoride", "fluoridation", "fluoride gel"~~acidulated phosphate fluoride~~", "fluoride varnish", "fluoride toothpaste", "fluoride therapy", and "topical fluoride". Because there were over two million papers identified through electronic searches, alternate strategies such as appraisal of references from recent evidence-based reviews and metaanalyses, as well as hand searches were performed. This strategy yielded 105 manuscripts, primarily related to randomized clinical trials and evidence-based reviews, that were further evaluated by abstract. Of those 45 manuscripts each had full examination and analysis in order to revise this guideline.

**This draft does not constitute an official AAPD health oral policy or clinical guideline until approval by the General Assembly. Circulation is limited to AAPD members.**

**Background**

Widespread use of fluoride has been a major factor in the decline in the prevalence and severity of dental caries in the United States and other economically developed countries. When used appropriately, fluoride is both safe and effective in preventing and controlling dental caries.[1]

~~Use of fluorides for the prevention and control of caries is documented to be both safe and highly effective.[1-5,1-2]~~ Decisions concerning the administration of fluoride are based on the unique needs of each patient, including the risks and benefits, i.e. risk of mild or moderate fluorosis versus the benefits of decreasing caries increment and in some cases preventing devastating dental disease.

Fluoride has several caries-protective mechanisms of action. ~~including enamel remineralization and altering bacterial metabolism to help prevent caries.[6-2]~~ Topically, low levels of fluoride in plaque and saliva inhibits the demineralization of sound enamel and enhances the remineralization of demineralized enamel. Fluoride also inhibits dental caries by affecting the metabolic activity of cariogenic bacteria. High levels of fluoride, such as topical gels or varnishes, produces a temporary layer of calcium fluoride-like material on the enamel surface. The fluoride is released when the pH drops in response to acid production and is available to remineralize enamel or affect bacterial metabolism.[1]

Initially, it was believed that fluoride's primary action was to inhibit dental caries when incorporated into developing dental enamel ( i.e. the systemic route), but the fluoride concentration in sound enamel does not fully explain the marked reduction in dental caries. However, it is oversimplification to designate fluoride simply as "systemic" or "topical". Fluoride that is swallowed, such as fluoridated water and dietary supplements, may contribute to a topical effect on erupted teeth (before swallowed, as well as a topical effect due to increasing salivary and gingival crevicular fluoride levels). Additionally, elevated plasma fluoride levels can topically treat the outer surface of fully mineralized, but unerupted teeth. Similarly, topical fluoride that is swallowed may have a systemic effect.[2]

**This draft does not constitute an official AAPD health oral policy or clinical guideline until approval by the General Assembly. Circulation is limited to AAPD members.**

Fluoridation of community drinking water is the most equitable and cost-effective method of delivering fluoride to all members of most communities.[3] ~~Optimizing fluoride levels in water supplies is an ideal public health measure because it is effective and inexpensive and does not require conscious daily cooperation from individuals.[4,7-10]~~

~~Daily fluoride exposure through water supplies and monitored use of fluoride toothpaste can be effective preventive procedures.~~ Water fluoridation at the level of 0.7 -1.2 milligrams fluoride ion per liter (ppm F) was introduced in the US in the 1940s. Since fluoride from water supplies is now one of several sources of fluoride, the Department of Health and Human Services has recently proposed to not have a fluoride range, but rather limit the recommendation to the lower limit of 0.7 ppm F. The rationale is to balance the benefits of preventing dental caries while reducing the chance of fluorosis.[4]

Fluoride supplements also are effective in reducing dental caries and should be considered for children at high caries risk who drink fluoride-deficient (<0.6 ppm) water (Table 1).[5] ~~Fluoride supplements should be considered for all children drinking fluoride-deficient (<0.6 ppm) water.~~ Determination of dietary ~~sources of~~ fluoride before prescribing supplements can help reduce intake of excess fluoride. Sources of dietary fluoride may include drinking water from home, day care, and school; beverages such as soda[6], juice[7], and infant formula[8,9], prepared food[10], and toothpaste.

Infant formulas, especially powdered formulas that have been reconstituted with fluoridated water have been associated with an increased risk of fluorosis.[11] Infants may be particularly susceptible because of the large consumption of such liquid in the first year of life, while the infant body weight is relatively low.[2] However, a recent evidence-based review suggests that reducing fluoride intake from reconstituted infant formula alone will not eliminate the risk of fluorosis development.[12] ~~(powdered or liquid) and water bottled specifically for infants have varying concentrations of fluoride.[16-24]~~ Fluorosis is ~~has been~~ associated with cumulative fluoride intake during enamel development, with the severity dependant on the dose, duration, and

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timing of intake.[1] Findings from a U.S. national survey report that 8% of 12-15 year-olds have mild fluorosis and 5% have moderate fluorosis.[13]

Professionally applied topical fluoride treatments also are efficacious in reducing dental caries. ~~in children with moderate or high at caries risk [5,7,8,25-32] Two percent sodium fluoride (NaF; 9000 ppm)[1]~~ The most commonly used agents for professionally-applied fluoride treatments are 5% sodium fluoride varnish (NaFV; 22,500ppm F), and 1.23% acidulated phosphate fluoride (APF; 12,300 ppm F) ~~solution or~~ gel. These products have been shown to be effective in numerous clinical trials in children and adults, although some of the evidence is from studies conducted 20-30 years ago.[14] ~~are the most commonly used agents for professionally-applied fluoride treatments.~~ The efficacy of fluoride varnish in primary teeth when used at least twice a year has been reported in at least four randomized controlled trials. [15,16,17,18] The efficacy of fluoride varnish in permanent teeth, applied at three or six month intervals, also has been reported in at least four randomized controlled trials. [19,20,21,22] Meta analyses of over 14 placebo-controlled trials show that fluoride gels in permanent teeth, applied at three month to one year intervals, are efficacious.[23] Some topical fluoride gel and foam products are marketed with recommended treatment times of less than 4 minutes, but there are no clinical trials showing efficacy of shorter than 4 minute application times.[14] ~~the majority of studies suggest that 4-minute applications are more efficacious.[1,8,36,57,58]~~ Also, there is limited evidence that topical fluoride foams are efficacious.[24,25] ~~Children at higher caries risk may require additional or more frequent fluoride therapies.[7,59,60]~~ Children at caries risk should receive a professional fluoride treatment ~~of a fluoride gel or varnish~~ at least every six months.[14] As the risk categories may change over time, the type and frequency of preventive interventions necessary should be adjusted.[1] ~~If an individual's caries risk level is uncertain, treating this person as high risk is prudent until further experience allows a more accurate assessment.~~

Other topical fluoride products, such as 0. 2% sodium fluoride mouthrinse (900 ppm F), [26,27,28] and brush-on gels/pastes (e.g. 1.1% NaF; 5,000 ppm F) also have been shown to be effective in reducing dental caries in permanent teeth.[29,30]

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Home use of fluoride products for children should focus on regimens that maximize topical contact, in lower-dose, higher-frequency approaches.[31] Meta analyses of over 70 randomized or quasi-randomized controlled clinical trials show that fluoride toothpaste is efficacious in reducing dental caries in permanent teeth, with the effect increased by children with higher baseline level of caries, higher concentration of fluoride in the toothpaste, greater frequency in use, and supervision.[32,33] A meta analyses of eight clinical trials on caries increment in preschool children also show that tooth brushing with fluoridated toothpaste significantly reduces dental caries in the primary dentition.[34] ~~Parents should be counseled on their child's caries risk, dispensing of an appropriate volume of toothpaste onto a soft, age suitable appropriate sized toothbrush, frequency of brushing, and performing/assisting brushing of young children~~. A 'smear' of fluoridated toothpaste ~~(see Figure 1)~~ for children less than 2 years of age at risk for dental caries may decrease risk of fluorosis. A 'pea-size' amount ~~(see Figure 1)~~ of toothpaste is appropriate for children aged 2 through 5 years (see Figure). [35,36] To maximize the beneficial effect of fluoride in the toothpaste, rinsing after brushing should be kept to a minimum or eliminated altogether.[34,37]

**Recommendations**

1. There is confirmation from evidence-based reviews that fluoride use for the prevention and control of caries is both safe and highly effective in reducing dental caries incidence and prevalence.
2. There is evidence from randomized clinical trials and evidence-based reviews that fluoride dietary supplements are effective in reducing dental caries and should be considered for children at caries risk who drink fluoride-deficient (<0.6 ppm) water.
3. There is evidence from randomized controlled trials and meta analyses that professionally-applied topical fluoride treatments as 5% NaF varnish or 1.23% F gel preparations are efficacious in reducing caries in children at caries risk.
4. There is evidence from meta analyses that fluoridated toothpaste is effective in reducing dental caries in children with the effect increased in children with higher baseline level of caries, higher concentration of fluoride in the toothpaste, greater frequency in use, and

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supervision.

5. There is evidence from randomized clinical trials that 0.2% sodium fluoride mouthrinse and 1.1% NaF brush-on gels/pastes also are effective in reducing dental caries in children.

Table 1. DIETARY FLUORIDE SUPPLEMENTATION SCHEDULE

| Age | <0.3 ppm F | 0.3-0.6 ppm F | >0.6 ppm F |
|---|---|---|---|
| **Birth-6 months** | 0 | 0 | 0 |
| **6 mo-3 years** | 0.25 mg | 0 | 0 |
| **3-6 years** | 0.50 mg | 0.25 mg | 0 |
| **6 y up to at least 16 years** | 1.00 mg | 0.50 mg | 0 |

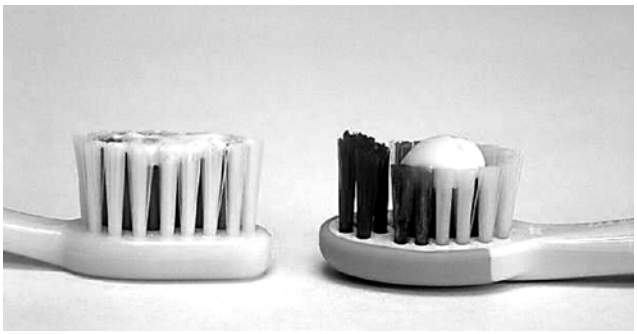

Figure 1. Comparison of a smear (left) with a pea-sized (right) amount of toothpaste.

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~~**Systemically-administered fluoride supplements**~~

~~Fluoride supplements should be considered for all children drinking fluoride-deficient (<0.6 ppm) water. After determining the fluoride level of the water supply or supplies (either through contacting public health officials or water analysis), evaluating other dietary sources of fluoride, and assessing the child's caries risk, the daily fluoride supplement dosage can be determined using the Dietary Fluoride Supplementation Schedule (Table 1). To optimize the topical benefits of systemic fluoride supplements, the child should be encouraged to chew or suck fluoride tablets.[1]~~

~~**Professionally-applied topical fluoride treatment**~~

~~Professional topical fluoride treatments should be based on caries risk assessment.[1,4,5,7,60] A pumice prophylaxis is not an essential prerequisite to this treatment.[61] Appropriate precautionary measures should be taken to prevent swallowing of any professionally-applied topical fluoride. moderate caries risk should receive a professional fluoride treatment at least every 6 months; those with high caries risk should receive greater frequency of professional fluoride applications (ie, every 3-6 months).[7,32,59,62-67] Ideally, this would occur as part of a comprehensive preventive program in a dental home.[68] When a dental home cannot be established for individuals with increased caries risk as determined by caries risk assessment, periodic applications of fluoride varnish by trained non-dental healthcare professionals may be effective in reducing the incidence of early childhood caries.[50-54,69,70]~~

~~**Fluoride-containing products for home use**~~

~~Therapeutic use of fluoride for children should focus on regimens that maximize topical contact, preferably in lower-dose, higher-frequency approaches.[1] Fluoridated toothpaste should be used twice daily as a primary preventive procedure.[1,71] Twice daily use has benefits greater than once daily brushing.[1] Parents should be counseled on their child's caries risk, dispensing of an appropriate volume of toothpaste onto a soft, age-appropriate sized toothbrush, frequency of~~

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~~brushing, and performing/assisting brushing of young children. A 'smear' of fluoridated toothpaste (see Figure 1) for children less than 2 years of age may decrease risk of fluorosis.[72] A 'pea-size' amount (see Figure 1) of toothpaste is appropriate for children aged 2 through 5 years.[72-74] To maximize the beneficial effect of fluoride in the toothpaste, rinsing after brushing should be kept to a minimum or eliminated altogether.[72,75]~~

~~Additional at-home topical fluoride regimens utilizing increased concentrations of fluoride should be considered for children at high risk for caries .[1,4,7,60] These may include over-the-counter or prescription strength formulations. Fluoride fluoride mouth rinses or brush-on gels. may be incorporated into a caries-prevention program for a school-aged child at high risk.~~

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# Policy on Interim Therapeutic Restorations (ITR)

**Originating Council**

Council on Clinical Affairs

**Review Council**

Council on Clinical Affairs

**Adopted**

2001

**Revised**

2004, 2008, 2013

## Purpose

The American Academy of Pediatric Dentistry (**AAPD**) recognizes that unique clinical circumstances can result in challenges in restorative care for infants, children, adolescents, and persons with special health care needs. When circumstances do not permit traditional cavity preparation and/or placement of traditional dental restorations or when caries control is necessary prior to placement of definitive restorations, interim therapeutic restorations (**ITR**)[1] may be beneficial and are best utilized as part of comprehensive care in the dental home.[2,3] This policy will differentiate ITR from atraumatic/alternative techniques (**ART**)[4] and describe the circumstances for its use.

## Methods

This updated policy is based upon a review of current dental literature. ~~A MEDLINE~~Database searches ~~was~~ were performed using key words "dental caries", "cavity", "primary teeth", "deciduous teeth", "atraumatic restorative treatment", "interim therapeutic restoration", and "glass ionomer ~~cement~~", ~~.~~Limiters used were "humans", "children 0-12 years", "Clinical Trial", "Comparative Study", "Controlled Clinical Trial", "Meta-Analysis", "Multicenter Study", "Randomized Controlled Trial", "Systematic Reviews", "Validation Studies".

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**Background**

Atraumatic/alternative restorative technique (ART) has been endorsed by the World Health Organization as a means of restoring and preventing caries in populations with little access to traditional dental care.[4-6] In many countries, practitioners provide treatment in non-traditional settings that restrict restorative care to placement of provisional restorations. Because circumstances do not allow for follow-up care, ART mistakenly has been interpreted as a definitive restoration. ITR utilizes similar techniques but has different therapeutic goals. Interim therapeutic restoration more accurately describes the procedure used in contemporary dental practice in the US.

ITR may be used to restore and prevent further ~~decalcification and~~ caries lesions in young patients, uncooperative patients, or patients with special health care needs, or when traditional cavity preparation and/or placement of traditional dental restorations are not feasible and need to be postponed.[5,7,6,8] Additionally, ITR may be used for step-wise excavation in children with multiple open carious lesions prior to definitive restoration of the teeth, in erupting molars when isolation conditions are not optimal for a definitive restoration, or in patients with active lesions prior to treatment performed under general anesthesia.[9,10,7] The use of ITR has been shown to reduce the levels of cariogenic oral bacteria (eg, mutans streptococci, lactobacilli) in the oral cavity immediately following ~~followed to~~ its placement. However, this drop may rise back in months after ITR placement if no~~not~~ other treatment is provided.[8-10,11-13]

The ITR procedure involves removal of caries using hand or ~~slow speed~~ rotary instruments with caution not to expose the pulp. Leakage of the restoration can be minimized with maximum caries removal from the periphery of the lesion. Following preparation, the tooth is restored with an adhesive restorative material such as glass ionomer ~~self-setting~~ or resin-modified glass ionomer cement.[14,1] ITR has the greatest success when applied to single surface or small 2 surface restorations.[12,13,15,16] Inadequate cavity preparation with subsequent lack of retention and insufficient bulk can lead to failure.[16,17,2] Follow-up care with topical fluorides and oral hygiene instruction may improve the treatment outcome in high caries-risk dental populations, especially when glass ionomers, which have fluoride releasing and recharging properties, are used.~~with the fluoride releasing and recharging properties of the glass ionomer~~

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materials.[18-20]

**Policy statement**

The AAPD recognizes ITR as a beneficial provisional technique in contemporary pediatric restorative dentistry. ITR may be used to restore and prevent the progress of dental caries in young patients, uncooperative patients, patients with special health care needs, and situations in which traditional cavity preparation and/or placement of traditional dental restorations are not feasible. ITR may be used for caries control in children with multiple carious lesions prior to definitive restoration of the teeth.

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# Policy on Prevention of Sports-related Orofacial Injuries

**Originating Committee**

Clinical Affairs Committee

**Review Council**

Council on Clinical Affairs

**Adopted**

1991

**Revised**

1995, 1999, 2002, 2006, 2010, 2013

## Purpose

The American Academy of Pediatric Dentistry (**AAPD**) recognizes the prevalence of sports-related orofacial injuries in our nation's youth and the need for prevention. This policy is intended to educate dental professionals, health care providers, and educational and athletic personnel on the prevention of sports-related orofacial injuries.

## Methods

The revision of this policy is based on a review of current dental and medical literature related to sports-related orofacial injuries as well as the prevention. This policy is an update of the previous document, revised in ~~2006~~2010. ~~The update included an electronic~~ Database searches were performed using ~~the following parameters: Terms:~~ key terms "sports injuries", "injury prevention", "dental injuries", "orofacial injuries", "pediatric dental trauma", and "mouthguard". ~~; Field: all fields; Limits: within the last 10 years humans English clinical trials and literature reviews.~~ The search returned 16,593 articles that matched the criteria. The articles were evaluated by title and \ or abstract, and relevance to pediatric dentistry. ~~The reviewers agreed upon the inclusion of 48~~ 61 ~~articles that met the defined criteria.~~ Sixty-~~three~~ two citations were chosen from this method and from references within selected articles. When data did not appear sufficient or were inconclusive, recommendations were based upon expert and/or

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consensus opinion by experienced researchers and clinicians. The policies, recommendations, and listed references of the Academy of Sports Dentistry (**ASD**) and the International Association of Dental Traumatology (**IADT**) were consulted as valuable resources in preparation of this document.

**Background**

The tremendous popularity of organized youth sports and the high level of competitiveness have resulted in a significant number of dental and facial injuries.[1,2] Over the past decade, approximately 46 million youths in the United States were involved in "some form of sports".[3] It is estimated that 30 million children in the US participate in organized sport programs.[4] All sporting activities have an associated risk of orofacial injuries due to falls, collisions, contact with hard surfaces, and contact from sports-related equipment. Sports accidents reportedly account for 10-39% of all dental injuries in children.[5] A ten-year study of 3,385 craniomaxillofacial trauma cases presenting to an oral and maxillofacial surgery department found 31.8% of injuries in children occurred during sports activities. [~~5~~3] [6] Children are most susceptible to sports-related oral injury between the ages of 7 and 11 years.[5] [~~8,~~56] [,7-10] The administrators of youth, high school, and college football, lacrosse, and ice hockey have demonstrated that dental and facial injuries can be reduced significantly by introducing mandatory protective equipment. Popular sports such as baseball, basketball, soccer, softball, wrestling, volleyball, and gymnastics lag far behind in injury protection for girls and boys. Baseball and basketball have been shown to have the highest incidence of sports-related dental injuries in children 7-17 years of age. [~~5~~6] [10] More specifically, baseball had the highest incidence within the 7-12 year old age group, while basketball was the most frequent sport associated with dental injuries in the 13-17 year age group. [~~5~~6] [10]Youths participating in leisure activities such as skateboarding, inline or roller skating, and bicycling also benefit from appropriate protective equipment.[~~6, 9-11~~] [7,11-13] A large national U.S. survey confirmed the bicycle as the most common consumer sports product related to dental injuries in children. [~~5~~6] [10]

The use of the trampoline provides specialized training for certain sports. However, when used recreationally a significant amount of head and neck injuries occur as a result of falls. [~~6~~3] [14] The

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American Academy of Pediatrics (**AAP**) recommends that practitioners advise their patients and families against recreational trampoline use and discuss that current safety measures have not significantly decreased injury rates. ~~63~~ 14 The **AAP** also states that practitioners "should only endorse use of trampolines as part of a structured training program with appropriate coaching, supervision, and safety measures in place". ~~63~~ 14

Studies of dental and orofacial athletic injuries are reported throughout the medical and dental literature.~~12, 13, 54, 55~~ 15-18 A review of literature published over the past 20 years showed that the injury rate varied greatly depending on the size of the sample, the sample's geographic location, the ages of the participants, and the specific sports involved in the study.~~12,13,54,55~~ 15-18 Traumatic dental injuries also differ in regards to the athlete's gender, level of competition, and time of exposure.~~54~~ 17 The highest incidence of sports-related dental injuries has been demonstrated in 15-18 year old males.~~55~~ 18 Although the statistics vary, many studies reported that dental and orofacial injuries occurred regularly and concluded that participation in sports carries a considerable risk of injury.5,~~12 15~~ 15,16,19,20

Consequences of orofacial trauma for children and their families are substantial because of potential for pain, psychological effects, and economic implications. Children with untreated trauma to permanent teeth exhibit greater impacts on their daily living than those without any traumatic injury.~~16,17~~ 21,22 The yearly costs of all injuries, including orofacial injuries, sustained by young athletes have been estimated to be as high as 1.8 billion dollars.[4] ~~The National Youth Sports Safety Foundation in 2005 estimated the cost to treat an avulsed permanent tooth and provide follow-up care is between $5,000 and $20,000 over a lifetime.~~[18] Significant costs can occur over a patient's lifetime for restorative, endodontic, prosthodontic, implant, or surgical treatment(s) resulting from dentoalveolar trauma experienced during a sporting incident. Traumatic dental injuries have additional indirect costs that include children's hours lost from school and parents' hours lost from work, consequences that disproportionately burden lower income, minority, and non-insured children.~~19 22~~ 23-26

The majority of sport-related dental and orofacial injuries affect the upper lip, maxilla, and

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maxillary incisors, with 50-90% of dental injuries involving the maxillary incisors.[5,~~12,13,23~~] [15,16,27] Use of a mouthguard can protect the upper incisors. However, studies have shown that even with a mouthguard in place, up to 25% of dentoalveolar injuries still can occur.[~~24~~] [28]

Identifying patients who participate in sports and recreational activities allows the healthcare provider to recommend and implement preventive protocols for individuals at risk for orofacial injuries. In 2000, a predictive index was developed to identify the risk factors involved in various sports. This index is based upon a defined set of risk factors that predict the chance of injury including demographic information (age, gender, dental occlusion), protective equipment (type/usage), velocity and intensity of the sport, level of activity and exposure time, level of coaching and type of sports organization, whether the player is a focus of attention in a contact or non-contact sport, history of previous sports-related injury, and the situation (eg, practice vs. game).[~~15,25~~] [20,29] Behavioral risk factors (eg, hyperactivity) also have been associated significantly with injuries affecting the face and/or teeth.[~~26,51~~] [30,31]

The frequency of dental trauma is significantly higher for children with increased overjet and inadequate lip coverage.[~~27,28~~] [32,33] A dental professional may be able to modify these risk factors. Initiating preventive orthodontic treatment in early- to middle-mixed dentition of patients with an overjet >3 mm has the potential to reduce the severity of traumatic injuries to permanent incisors.[~~27~~] [32]

Although some sports-related traumatic injuries are unavoidable, most can be prevented.[~~15,18,29,30~~] [20,34,35] Helmets, facemasks, and mouthguards have been shown to reduce both the frequency and severity of dental and orofacial trauma.[~~15~~] [20] The protective and positive results of wearing a mouthguard has been demonstrated in numerous epidemiological surveys and tests. [~~8,54,57,58,59~~] [9,17,36-38] However, few sports have regulations that require their use. The National Federation of State High School Associations mandate mouthguards for only ~~4 sports:~~ football, ice hockey, lacrosse, ~~and~~ field hockey and wrestlers wearing braces.[~~30~~] [~~52~~] [39] Several states have attempted to increase the number of sports which mandate mouthguard use, with various degrees of success and acceptance. Four New England states have been successful in increasing the number of

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sports requiring mouthguard use to include sports such as soccer, wrestling, and basketball.[30,31] [35,40]

Initially used by professional boxers, the mouthguard has been used as a protective device since the early 1900's.[13,32] [16,41] The mouthguard, also referred to as a gumshield or mouth protector, is defined as a "resilient device or appliance placed inside the mouth to reduce oral injuries, particularly to teeth and surrounding structures."[5] The mouthguard was constructed to "protect the lips and intraoral tissues from bruising and laceration, to protect the teeth from crown fractures, root fractures, luxations, and avulsions, to protect the jaw from fracture and dislocations, and to provide support for edentulous space."[33] [42] The mouthguard works by "absorbing the energy imparted at the site of impact and by dissipating the remaining energy."[34] [43]

The American Society for Testing and Materials (**ASTM**) classifies mouthguards by 3 categories[35] [44]:

1. Type I – Custom-fabricated mouthguards are produced on a dental model of the patient's mouth by either the vacuum-forming or heat-pressure lamination technique.[5,15] [20] The ASTM recommends that for maximum protection, cushioning, and retention, the mouthguard should cover all teeth in at least one arch, customarily the maxillary arch, less the third molar.[35] [44] A mandibular mouthguard is recommended for individuals with a Class III malocclusion. The custom-fabricated type is superior in retention, protection, and comfort.[5,15,34,36,37,50] [20,43,45-47] When this type is not available, the mouth-formed mouthguard is preferable to the stock or preformed mouthguard.[32,38,39] [41,48,49]
2. Type II – Mouth-formed, also known as "boil-and-bite", mouthguards are made from a thermoplastic material adapted to the mouth by finger, tongue, and biting pressure after immersing the appliance in hot water.[5] Available commercially at department and sporting-good stores, these are the most commonly used among athletes but vary greatly in protection, retention, comfort, and cost.[8,15] [9,20]
3. Type III – Stock mouthguards are purchased over-the-counter. They are designed for use without any modification and must be held in place by clenching the teeth together to

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provide a protective benefit.[5,~~15~~ 20] Clenching a stock mouthguard in place can interfere with breathing and speaking and, for this reason, stock mouthguards are considered by many to be less protective.[5,~~8,33,40,50~~ 9,42,47,50] Despite these shortcomings, the stock mouthguard could be the only option possible for patients with particular clinical presentations (eg, use of orthodontic brackets and appliances, periods of rapidly changing occlusion during mixed dentition).

The Academy for Sports Dentistry ~~(ASD)~~ "recommends the use of a properly fitted mouthguard. It encourages the use of a custom fabricated mouthguard made over a dental cast and delivered under the supervision of a dentist. The ASD strongly supports and encourages a mandate for use of a properly fitted mouthguard in all collision and contact sports."[~~41~~ 51] During fabrication of the mouthguard, it is recommended to establish proper anterior occlusion of the maxillary and mandibular arches as this will prevent or reduce injury by better absorbing and distributing the force of impact.[~~41~~ 51] The practitioner also should consider the patient's vertical dimension of occlusion, personal comfort, and breathing ability.[~~39~~ 49] By providing cushioning between the maxilla and mandible, mouthguards also may reduce the incidence or severity of condylar displacement injuries as well as the potential for_concussions.[~~8,42~~ 9,52]

Due to the continual shifting of teeth in orthodontic therapy, the exfoliation of primary teeth, and the eruption of permanent teeth, a custom-fabricated mouthguard may not fit the young athlete soon after the impression is obtained.[~~43~~ 53] Several block-out methods used in both the dental operatory and laboratory may incorporate space to accommodate for future tooth movement and dental development.[~~43~~ 53] By anticipating required space changes, a custom fabricated mouthguard may be made to endure several sports seasons.[~~43~~ 53]

Parents play an important role in the acquisition of a mouthguard for young athletes. In a 2004 national fee survey, custom mouthguards ranged from $60 to $285.44. In a study to determine the acceptance of the 3 types of mouthguards by 7- and 8-year old children playing soccer, only 24% of parents surveyed were willing to pay $25 for a custom mouthguard.[~~45~~ 54] Therefore, cost may be a barrier.[~~44~~[strike through] 55] However, in a study of children receiving mouthguards at no

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cost, 29% never wore the mouthguard, 32% occasionally, 15.9% wore it initially and quit wearing after one month, and only 23.2% wore the mouthguard when needed.[60] [56]

Attitudes of officials, coaches, parents, and players about wearing mouthguards influence their usage.[46] [57] Although coaches are perceived as the individuals with the greatest impact on whether or not players wear mouthguards, parents view themselves as equally responsible for maintaining mouthguard use.[46,47] [57,58] However, surveys of parents regarding the indications for mouthguard usage reveal a lack of complete understanding of the benefits of mouthguard use.[46] [57] Compared to other forms of protective equipment, mouthguard use received only moderate parental support in youth soccer programs. [61] [59] A survey commissioned by the American Association of Orthodontists (**AAO**) reported that 67% ~~percent~~ of parents stated their children do not wear a mouthguard during organized sports. Another finding in the survey was that 84%~~percent~~ do not wear mouthguards while participating in organized sports because it is not required, even though other protective equipment such as helmets and shoulder pads is mandatory. [49] [60] Players' perceptions of mouthguard use and comfort largely determine their compliance and enthusiasm.[34,45,62] [43,54,61] Therefore, the dental profession needs to influence and educate all stakeholders about the risk of sports-related orofacial injuries and available preventive strategies.[32,44,48] [41,55,62] Routine dental visits can be an opportunity to initiate patient/parent education and make appropriate recommendations for use of a properly-fitted athletic mouthguard.[15] [20]

**Policy statement**

The AAPD ~~recommends~~ encourages:

1. dentists to play an active role in educating the public in the use of protective equipment for the prevention of orofacial injuries during sporting and recreational activities;
2. continuation of preventive practices instituted in youth, high school and college football, lacrosse, field hockey, ~~and~~ ice hockey, and wrestling for wrestlers wearing braces;
3. an ASTM-certified face protector be required for youth participating in ~~organized~~ baseball and softball activities~~; an ASTM-certified face protector be required (according to the playing rules of the sport)~~;

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4. mandating the use of properly-fitted mouthguards in other organized sporting activities that carry risk of orofacial injury;

5. ~~prior to initiating practices for a sporting season,~~ coaches/administrators of organized sports to consult a dentist with expertise in orofacial injuries prior to initiating practices for a sporting season, for recommendations for immediate management of sports-related injuries (eg, avulsed teeth);

6. continuation of research in development of a comfortable, efficacious, and cost-effective sports mouthguard to facilitate more widespread use of this proven protective device;

7. dentists of all specialties, including pediatric and general dentists, to provide education to parents and patients regarding prevention of orofacial injuries as part of the anticipatory guidance discussed during dental visits;

8. ~~dentists should prescribe, fabricate, or provide~~ prescription, fabrication, or provision of an appropriate referral for mouthguard protection for patients at increased risk for orofacial trauma;

9. ~~that~~ third party payors to realize ~~realized~~ the benefits of mouthguards for the prevention and protection from orofacial sports-related injuries and, furthermore, encourages them to improve access to these services;

10. pediatric dentists to partner with dentists and other child health professionals, school administrators, legislators, and community sports organizations to promote the broader use of mouthguards;

~~11. endorsement of the **AAP** policy on trampoline safety in childhood and adolescence;~~

~~10~~ ~~12. the ASD and the International Association of Dental Traumatology (**IADT**) be consulted as valuable resources for the professions and public.~~

~~12~~ 11. pediatric dental departments to teach students fabrication of custom fitting mouthguards.

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# Policy on Minimizing Occupational Health Hazards Associated With Nitrous Oxide

**Originating Committee**

Clinical Affairs Committee

**Review Council**

Council on Clinical Affairs

**Adopted**

1987

**Revised**

1993, 1996, 2000, 2003, 2008, 2013

## Purpose

The American Academy of Pediatric Dentistry (**AAPD**) recommends that exposure to ambient nitrous oxide (**$N_2O$**) be minimized to reduce occupational health hazards for dental personnel.

## Methods

This ~~document~~ policy is an update of a previous document revised in 2008 and is based on ~~current dental, medical, and public health literature regarding the potential risks of ambient nitrous oxide exposure. A MEDLINE~~ a systematic literature search of the Pubmed electronic database using the following parameters: ~~search was conducted using the terms~~ "nitrous oxide", "occupational exposure ~~to nitrous oxide~~", and "~~nitrous oxide and~~ dentistry". Fields: all fields; Limits: within the last 10 years and English. Sixteen articles met these criteria and 3 additional papers were reviewed and added to the references from the previous policy statement. Guidelines and recommendations from the National Institute for Occupational Safety and Health (**NIOSH**) also were reviewed.[1-2] Expert opinions and best current practices were relied upon when sufficient scientific data were not available.

## Background

~~Epidemiologic studies provide strong evidence that there are increased general health problems~~

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~~and reproductive difficulties among dental personnel chronically exposed to significant levels of ambient nitrous oxide.[3-7] Nitrous oxide acts by oxidizing vitamin $B_{12}$ from the active, reduced cobalamin to the inactive form. In turn, this inactivates the enzyme methionine synthetase, which requires both the active cobalamin and folate as cofactors. The inactivation of methionine synthetase decreases DNA production, thereby interfering with cell proliferation.[8] Nitrous oxide has been linked epidemiologically to reproductive, hematologic, immunologic, neurologic, hepatic, and renal disorders; symptoms are time and dose dependent.[9] Symptoms are reported most frequently in cases where scavenging has not been used or with chronic (recreational) abuse.[9] Absolute occupational~~ eEffects of occupational exposure to ambient nitrous oxide are ~~still~~ uncertain, especially since the introduction of methods to scavenge $N_2O$ and ventilate operatories.[93] ~~Epidemiologic conclusions~~ Studies that linked increased general health problems and reproductive difficulties among dental personnel to chronic exposure to significant levels of ambient nitrous oxide have been challenged.[310] ~~Adverse neurologic and reproductive outcomes are linked to $B_{12}$ deficient individuals and those exposed to "high nitrous oxide levels".[9]~~ A maximum safe level of ambient nitrous oxide in the dental environment has not been determined.[9-142, 4-6]

Reduction of ambient nitrous oxide through system maintenance, scavenging, ventilation, use of the minimal effective dose, and patient management is ~~critical~~ important to maintaining the lowest practical levels in the dental environment.[1,2,7~~14,15~~] Frequent and regular inspection and maintenance of the nitrous oxide delivery system, together with the use of a scavenging system, can significantly reduce ambient nitrous oxide.[~~16,17~~8] Using a well-fitted mask and an appropriate amount of suction via the scavenging system will minimize leakage, reducing ambient nitrous oxide levels.[~~178~~,9] NIOSH has recommended that the exhaust ventilation of nitrous oxide from the patient's mask be maintained at an air flow rate of 45 L/min and vented outside the building away from fresh air intakes.[2] However, scavenging at this rate has been shown to reduce the level of pyschosedation achieved with nitrous oxide inhalation.[~~20~~10] Where possible, ~~100% clean~~ outdoor air should be used for dental operatory ventilation.[1] Supply and exhaust vents should be well separated to allow good mixing and prevent "short-circuiting".[1]

~~Appropriate p~~Patient selection is an important consideration in reducing ambient nitrous oxide levels.[~~15~~7] Patients who are unwilling or unable to tolerate the nasal hood and those with medical

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conditions (e.g., obstructive respiratory diseases, emotional disturbances, drug dependencies) that contraindicate the use of nitrous oxide should be managed by other behavior guidance techniques.~~15~~7 In the dental environment, patient behaviors such as talking, crying, and moving have been shown to result in significant increases in baseline ambient nitrous oxide levels despite the use of the mask-type scavenging systems.~~19~~11,12 Furthermore, the use of scavenging systems alone cannot lower the ambient nitrous oxide levels to the standards recommended.8,11,13 The ~~U~~use of supplemental measures, ~~including a rubber dam and/or a~~ such as high-volume dental aspirator~~,~~ placed ~~near or within 20 cm of the patient's mouth~~ in proximity to the dental operative site, has been shown to significantly reduce ~~significantly~~ ambient nitrous oxide levels.~~21 23~~ 11,14 During the first 3-5 minutes after terminating nitrous oxide administration, a significant amount of the gas is exhaled by the patient.~~24~~ Once nitrous oxide administration is discontinued, oxygen replaces the nitrous oxide in the gas delivery system ~~should be flushed~~ by administering 100% oxygen to the patient for at least 5 minutes.2,15 This post-procedural oxygenation also decreases the risk of diffusion hypoxia to the patient. Diligent use of the above practices in the pediatric dental environment has allowed for the reduction of ambient nitrous oxide to the levels recommended by NIOSH.~~14,23~~14,16 Measurement of nitrous oxide levels in the dental operatory can be helpful in determining the type and extent of remediation necessary to decrease occupational exposure.

**Policy statement**

The AAPD ~~recommends that~~ encourages dentists and dental auxiliaries ~~minimize their exposure to nitrous oxide by maintaining~~ to maintain the lowest practical levels of nitrous oxide in the dental environment while using nitrous oxide. Adherence to the recommendations below can help minimize occupational exposure to nitrous oxide.

1. Use scavenging systems that remove nitrous oxide during patient's exhalation.
2. Ensure that exhaust systems adequately vent scavenged air and gases to the outside of the building and away from fresh air intake vents.
3. Use, where possible, ~~100% clean~~ outdoor air for dental operatory ventilation.
4. Implement careful, regular inspection and maintenance of the nitrous oxide/oxygen delivery equipment.

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5. Carefully consider patient selection criteria (i.e., indications and contraindications) prior to administering nitrous oxide.
6. Select a properly-fitted mask size for each patient.
7. During administration, visually monitor the patient and titrate the flow/percentage to the minimal effective dose of nitrous oxide.
8. Encourage patients to minimize talking and mouth breathing during nitrous oxide administration.
9. Use rubber dam and high volume ~~oral aspiration~~ dental evacuator when possible.
10. ~~Flush the delivery system of~~ Replace the delivery system's nitrous oxide with oxygen after completion, by administering 100% oxygen to the patient for at least 5 minutes.

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# Guideline on Use of Nitrous Oxide for Pediatric Dental Patients

**Originating Council**

Council on Clinical Affairs

**Review Council**

Council on Clinical Affairs

**Adopted**

2005

**Revised**

~~2009~~ 2013

## Purpose

The American Academy of Pediatric Dentistry (**AAPD**) recognizes nitrous oxide/oxygen inhalation as a safe and effective technique to reduce anxiety, produce analgesia, and enhance effective communication between a patient and health care provider. The need to diagnose and treat, as well as the safety of the patient and practitioner, should be considered before using nitrous oxide. By producing this guideline, the AAPD intends to assist the dental profession in developing appropriate practices in the use of nitrous oxide/oxygen analgesia/anxiolysis for pediatric patients.

## Methods

~~This guideline is based on a review of the current dental and medical literature related to nitrous oxide/oxygen analgesia/anxiolysis in pediatric patients. A MEDLINE search was conducted using the terms "nitrous oxide", "analgesia", "anxiolysis", "behavior management", and "dental treatment".~~

This document is an update of the previous guideline revised in 2009. The update is based on a review of the current dental and medical literature related to nitrous oxide use. An electronic search was conducted using PubMed® with the following parameters: Terms: "nitrous oxide", "analgesia", "anxiolysis", "behavior management", and "dental treatment"; Fields: all; Limits: within the last 10 years, humans, English, and clinical trials. Forty articles met these criteria and

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21 papers were added to the references from the previous document. When data did not appear sufficient or were inconclusive, recommendations were based upon expert and/or consensus opinion by experienced researchers and clinicians.

**Background**

Dentists have expertise in providing anxiety and pain control for their patients. While anxiety and pain can be modified by psychological techniques, in many instances pharmacological approaches are required.[1] Analgesia/anxiolysis is defined as diminution or elimination of pain and anxiety in a conscious patient.[2] The patient responds normally to verbal commands. All vital signs are stable, there is no significant risk of losing protective reflexes, and the patient is able to return to pre-procedure mobility. In children, analgesia/anxiolysis may expedite the delivery of procedures that are not particularly uncomfortable, but require that the patient not move.[2] It also may allow the patient to tolerate unpleasant procedures by reducing or relieving anxiety, discomfort, or pain. The outcome of pharmacological approaches is variable and depends upon each patient's response to various drugs. The clinical effect of nitrous oxide/oxygen inhalation, however, is more predictable among the majority of the population.

Nitrous oxide is a colorless and virtually odorless gas with a faint, sweet smell. It is an effective analgesic/anxiolytic agent causing central nervous system (**CNS)** depression and euphoria with little effect on the respiratory system.[3, 4] Nitrous oxide has multiple mechanisms of action. The analgesic effect of nitrous oxide appears to be initiated by neuronal release of endogeneous opioid peptides with subsequent activation of opioid receptors and descending Gamma-aminobutyric acid type A (**GABAA**) receptors and noradrenergic pathways that modulate nociceptive processing at the spinal level. The anxiolytic effect involves activation of the GABAA receptor either directly or indirectly through the benzodiazepine binding site.[4, 5, 6] Nitrous oxide has rapid uptake, being absorbed quickly from the alveoli and held in a simple solution in the serum. It is relatively insoluble, passing down a gradient into other tissues and cells in the body, such as the CNS. It is excreted quickly from the lungs. As nitrous oxide is 34 times more soluble than nitrogen in blood, diffusion hypoxia may occur. Studies[5-7] [7-9] have shown that children desaturate more rapidly than adolescents, and administering 100% oxygen

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to the patient ~~for 3 to 5 minutes~~ once the nitrous oxide in a closed system has been terminated is important.[5-7] Nitrous oxide causes minor depression in cardiac output while peripheral resistance is slightly increased, thereby maintaining the blood pressure.[3] This is of particular advantage in treating patients with cerebrovascular system disorders.

Nitrous oxide is absorbed rapidly, allowing for both rapid onset and recovery (2-3 minutes). It causes minimal impairment of any reflexes, thus protecting the cough reflex.[3] It exhibits a superior safety profile with no recorded fatalities or cases of serious morbidity when used alone and with recommended concentrations during sedation.[10-13] Although rare, silent regurgitation and subsequent aspiration need to be considered with nitrous oxide/oxygen sedation. The concern lies in whether pharyngeal- laryngeal reflexes remain intact. This problem can be avoided by not allowing the patient to go into an unconscious state.[8-14] It generally is acceptable to children and can be titrated easily. Most children are enthusiastic about the administration of nitrous oxide/oxygen; many children report dreaming or being on a "space-ride".[8-14] For some patients, however, the feeling of "losing control" may be troubling and claustrophobic patients may find the nasal hood confining and unpleasant.[9] [15] Studies have reported negative outcomes associated on $N_2O$ use above 50% and as an anesthetic during major surgery.[16,17] The decision to use nitrous oxide/oxygen analgesia/anxiolysis must take into consideration alternative behavioral guidance modalities, the patient's dental needs, the effect on the quality of dental care, the patient's emotional development, and the patient's physical considerations.

The objectives of nitrous oxide/oxygen inhalation include:

1. reduce or eliminate anxiety;
2. reduce untoward movement and reaction to dental treatment;
3. enhance communication and patient cooperation;
4. raise the pain reaction threshold;
5. increase tolerance for longer appointments;
6. aid in treatment of the mentally/physically disabled or medically compromised patient;
7. reduce gagging;
8. potentiate the effect of sedatives.

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Disadvantages of nitrous oxide/oxygen inhalation may include:[3]

1. lack of potency;
2. dependant largely on psychological reassurance;
3. interference of the nasal hood with injection to anterior maxillary region;
4. patient must be able to breathe through the nose;
5. nitrous oxide pollution and potential occupational exposure health hazards.

**Bioenvironmental Problems of Nitrous Oxide.**

$N_2O$ is emitted naturally by bacteria in soils and oceans. It is produced by humans through the burning of fossil fuels and forests and the agricultural practices of soil cultivation and nitrogen fertilization. Altogether, $N_2O$ contributes about 5% to the greenhouse effect.[18,19] Only a fraction thereof (0.35-2%), however, is actually the result of combined medical and dental applications of $N_2O$ gas.[19]

**Recommendations**

**Patient selection**

Indications for use of nitrous oxide/oxygen analgesia/anxiolysis include:

1. a fearful, anxious, or obstreperous patient;
2. certain patients with special health care needs;
3. a patient whose gag reflex interferes with dental care;
4. a patient for whom profound local anesthesia cannot be obtained;
5. a cooperative child undergoing a lengthy dental procedure.

Review of the patient's medical history should be performed prior to the decision to use nitrous oxide/oxygen analgesia/anxiolysis. This assessment should include:

1. allergies and previous allergic or adverse drug reactions;
2. current medications including dose, time, route, and site of administration;
3. diseases, disorders, or physical abnormalities and pregnancy status;
4. previous hospitalization to include the date and purpose.
5. airway for airway compromised by obstruction (e.g., cold or congestion)

Contraindications for use of nitrous oxide/oxygen inhalation may include:

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1. some chronic obstructive pulmonary diseases; [20]
2. severe emotional disturbances or drug-related dependencies[~~10~~ 21];
3. first trimester of pregnancy[~~11~~ 22];
4. treatment with bleomycin sulfate[~~12~~ 23];
5. methylenetetrahydrofolate reductase deficiency.[~~13~~ 24]
6. cobalamin deficiency[6]

Whenever possible, appropriate medical specialists should be consulted before administering analgesic/anxiolytic agents to patients with significant underlying medical conditions (eg, severe obstructive pulmonary disease, congestive heart failure, sickle cell disease,[~~14~~ 25] acute otitis media, recent tympanic membrane graft[~~15~~ 26], acute severe head injury[~~16~~ 27]).

**Technique of nitrous oxide/oxygen administration**

Nitrous oxide/oxygen must be administered only by appropriately licensed individuals, or under the direct supervision thereof, according to state law. The practitioner responsible for the treatment of the patient and/or the administration of analgesic/anxiolytic agents must be trained in the use of such agents and techniques and appropriate emergency response.

Selection of an appropriately sized nasal hood should be made. A flow rate of 5 to 6 L/min generally is acceptable to most patients. The flow rate can be adjusted after observation of the reservoir bag. The bag should pulsate gently with each breath and should not be either over- or underinflated. Introduction of 100% oxygen for 1 to 2 minutes followed by titration of nitrous oxide in 10% intervals is recommended. During nitrous oxide/oxygen analgesia/anxiolysis, the concentration of nitrous oxide should not routinely exceed 50%. Results from studies have demonstrated that gas concentrations dispensed by the flow meter vary significantly from the end- expired alveolar gas concentrations and it is the later that is responsible for the clinical effects.[28,29] To achieve sedation the scavenging vacuum should not be too strong as to prevent adequate ventilation of the lungs with $N_2O$ .[30] A review of patient records of administration of nitrous oxide-oxygen inhalation sedation demonstrate that the typical inhalation sedation patient requires from 30 percent to 40 percent nitrous oxide to achieve ideal sedation.[31] Nitrous oxide concentration may be decreased during easier procedures (eg, restorations) and increased

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during more stimulating ones (eg, extraction, injection of local anesthetic). Side effects such as nausea and vomiting are more likely to be observed when titration is not employed.[31] During treatment, it is important to continue the visual monitoring of the patient's respiratory rate and level of consciousness. The effects of nitrous oxide largely are dependent on psychological reassurance. Therefore, it is important to continue traditional behavior guidance techniques during treatment. Once the nitrous oxide flow is terminated, 100% oxygen should be delivered for ~~3 to~~ 5 minutes.[3,21] The patient must return to pretreatment responsiveness before discharge.

**Monitoring**

The response of patients to commands during procedures performed with anxiolysis/analgesia serves as a guide to their level of consciousness. Clinical observation of the patient must be done during any dental procedure. During nitrous oxide/oxygen analgesia/anxiolysis, continual clinical observation of the patient's responsiveness, color, and respiratory rate and rhythm must be performed. Spoken responses provide an indication that the patient is breathing.[2] If any other pharmacologic agent is used in addition to nitrous oxide/oxygen and a local anesthetic, monitoring guidelines for the appropriate level of sedation must be followed.[~~17~~ 32]

**Adverse effects of nitrous oxide/oxygen inhalation**

Nitrous oxide/oxygen analgesia/anxiolysis has an excellent safety record. When administered by trained personnel on carefully selected patients with appropriate equipment and technique, nitrous oxide is a safe and effective agent for providing pharmacological guidance of behavior in children. Acute and chronic adverse effects of nitrous oxide on the patient are rare.[~~18~~ 33] Nausea and vomiting are the most common adverse effects, occurring in 0.5% of patients.[~~19~~ 34] A higher incidence is noted with longer administration of nitrous oxide/oxygen, fluctuations in nitrous oxide levels, and increased concentrations of nitrous oxide.[3] Fasting is not required for patients undergoing nitrous oxide analgesia/anxiolysis. The practitioner, however, may recommend that only a light meal be consumed in the ~~2~~ two hours prior to the administration of nitrous oxide.[~~20~~ 35] Diffusion hypoxia can occur as a result of rapid release of nitrous oxide from the blood stream into the alveoli, thereby diluting the concentration of oxygen. This may lead to

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headache and disorientation and can be avoided by administering 100% oxygen after nitrous oxide has been discontinued.[3]

**Documentation**

Informed consent must be obtained from the parent and documented in the patient's record prior to administration of nitrous oxide/oxygen. The practitioner should provide instructions to the parent regarding pretreatment dietary precautions, if indicated. In addition, the patient's record should include indication for use of nitrous oxide/oxygen inhalation, nitrous oxide dosage (ie, percent nitrous oxide/oxygen and/or flow rate), duration of the procedure, and post treatment oxygenation procedure.

**Facilities/personnel/equipment**

All newly installed facilities for delivering nitrous oxide/oxygen must be checked for proper gas delivery and fail-safe function prior to use. Inhalation equipment must have the capacity for delivering 100%, and never less than 30%, oxygen concentration at a flow rate appropriate to the child's size. Additionally, inhalation equipment must have a fail-safe system that is checked and calibrated regularly according to the practitioner's state laws and regulations.~~17~~ 32 If nitrous oxide/oxygen delivery equipment capable of delivering more than 70% nitrous oxide and less than 30% oxygen is used, an in-line oxygen analyzer must be used. The equipment must have an appropriate scavenging system to minimize room air contamination and occupational risk.

The practitioner who utilizes nitrous oxide/oxygen analgesia/anxiolysis for a pediatric dental patient shall possess appropriate training and skills and have available the proper facilities, personnel, and equipment to manage any reasonably foreseeable emergency. Training and certification in basic life support are required for all clinical personnel. These individuals should participate in periodic review of the office's emergency protocol, the emergency drug cart, and simulated exercises to assure proper emergency management response.

An emergency cart (kit) must be readily accessible. Emergency equipment must be able to accommodate children of all ages and sizes. It should include equipment to resuscitate a

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nonbreathing, unconscious patient and provide continuous support until trained emergency personnel arrive. A positive-pressure oxygen delivery system capable of administering >90% oxygen at a 10 L/min flow for at least 60 minutes (650 L, "E" cylinder) must be available. When a self-inflating bag valve mask device is used for delivering positive pressure oxygen, a 15 L/min flow is recommended. There should be documentation that all emergency equipment and drugs are checked and maintained on a regularly scheduled basis.~~17~~ 32 Where state law mandates equipment and facilities, such statutes should supersede this guideline.~~17~~ 32

**Occupational safety**

Long-term exposure of nitrous oxide used as a general anesthetic has been linked to bone marrow suppression and reproductive system disturbances in the medical literature.6, 36-39 In an effort to reduce occupational health hazards associated with nitrous oxide, the AAPD recommends exposure to ambient nitrous oxide be minimized through the use of effective scavenging systems and periodic evaluation and maintenance of the delivery and scavenging systems.~~21~~, 40,41.

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# Policy on Model Dental Benefits for Infants, Children, Adolescents, and Individuals ~~With~~ with Special Health Care Needs

**Originating Councils**

Council on Dental Benefit Programs/Council on Clinical Affairs

**Adopted**

2008

**Revised**

2013

## Purpose

The American Academy of Pediatric Dentistry (**AAPD**) believes that all infants, children, adolescents, and individuals with special health care needs must have access to comprehensive preventive and therapeutic oral health care benefits that contribute to their optimal health and well-being. This policy is intended to assist policy makers, third-party payors, and consumer groups/benefits purchasers to make informed decisions about the appropriateness of oral health care services for these patient populations.

## Methods

This policy is based upon a review of AAPD's systematically-developed oral health policies and clinical practice guidelines as well as clinical practice guidelines that have been developed by other professional organizations and endorsed by the AAPD.

## Background

The AAPD, in accordance with its vision and mission, advocates optimal oral health and health care for all infants, children, adolescents, and individuals with special health care needs. Oral diseases are progressive and cumulative; ignoring oral health problems can lead to needless pain and suffering, infection, loss of function, increased health care costs, and life-long consequences in educational, social, and occupational environments. When oral health care is not accessible, the health implications, effects on quality of life, and societal costs are

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enormous.[1] The AAPD's oral health policies and clinical guidelines[2] encourage the highest possible level of care to children and patients with special health care needs. The AAPD also sponsors a national consensus conference or symposium each year on pediatric oral health care and publishes those proceedings in a special issue of Pediatric Dentistry. Those documents,[2-6] as well as clinical practice guidelines from other organizations with recognized professional expertise and stature,[7-13] serve as the basis for the recommendations below. Such recommendations ideally are evidence based but, in the absence of conclusive evidence, may rely on expert opinion and clinical observations.

**Policy Statement**

The AAPD encourages all policy makers and third party payors to consult the AAPD in the development of benefit plans that best serve the oral health interests of infants, children, adolescents, and individuals with special health care needs. These model services are predicated on establishment of a dental home, defined as the ongoing relationship between the dentist (ie, the primary oral health care provider) and the patient, inclusive of all aspects of oral health care, starting no later than 12 months of age.[14]

A dental benefit plan should be actuarially sound and fiscally capable of delivering plan benefits without suppressing utilization rates or the delivery of services. For both commercial and government programs, when a plan is not actuarially sound and adequately underwritten, access and appropriate care under the plan are placed at risk.

~~Expected benefits of care should outweigh potential risks.~~ Value of services is an important consideration, and all ~~stake-holders~~ stakeholders should recognize that ~~cost-effective care is not necessarily~~ ~~the~~ a least expensive treatment is not necessarily the most beneficial or cost effective plan in the long term for the patient's oral health. ~~Consistent with AAPD clinical guidelines,~~ ~~t~~The following services ~~should be included~~ are essential components in health benefit plans.

A. Preventive services:

(1) Initial and periodic examinations of the dentition and oral cavity, including medical and

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dental histories, furnished in accordance with the attached periodicity schedule~~[15]~~ or when oral screenings by other health care providers indicate a risk of caries or other dental or oral disease~~[15]~~;

(2) Education for the patient and the patient's family on measures that promote oral health as part of initial and periodic well-child assessment;

(3) Age-appropriate anticipatory guidance and counseling on non-nutritive habits, injury prevention, and tobacco use/substance abuse;

(4) Application of topical fluoride at a frequency based upon caries risk factors;

(5) Prescription of dietary fluoride supplement[12] based upon a child's age, caries risk, and fluoride level of the water supply or supplies, and sources of dietary fluoride;

(6) Application of pit and fissure sealants based on caries risk factors, not ~~based upon~~ patient age ~~or time lapsed since eruption~~;[16]

(7) Dental prophylactic services at a frequency based on caries and periodontal risk factors.

B. Diagnostic procedures consistent with guidelines developed by organizations with recognized professional expertise and stature, including radiographs in accordance with recommendations by the US Food and Drug Administration and the American Dental Association.[9]

C. Restorative and endodontic services to relieve pain, resolve infection, restore teeth, and maintain dental function and oral health. This would include interim therapeutic restorations, a beneficial provisional technique in contemporary pediatric restorative dentistry.[17]

D. Orthodontic services including space maintenance and services to diagnose, prevent, intercept, and treat malocclusions, including management of children with cleft lip or palate and/or congenital or developmental defects. These services include, but are not limited to, initial appliance construction and replacement of appliances as the child grows.

E. Dental and oral surgery ~~which shall include~~ including sedation/general anesthesia and related medical services ~~that shall be furnished~~ performed in an office, hospital, or ambulatory

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surgical care setting. ~~on an inpatient basis when medically necessary~~.

F. Periodontal services to resolve gingivitis, periodontitis, and other periodontal diseases or conditions in children.

G. Prosthodontic services, including implants with restorations, to restore oral function.~~, that are consistent with guidelines developed by organizations with recognized professional expertise and stature.~~

H. Diagnostic and therapeutic services related to the management of orofacial trauma. When the injury involves a primary tooth, benefits should cover complications for the developing succedaneous tooth.

I. Drug prescription for preventive services, relief of pain, or treatment of infection.

J. Medically necessary services for preventive and therapeutic care in patients with medical, physical, or behavioral conditions. These services include, but are not limited to, the care of hospitalized patients, sedation, and general anesthesia in outpatient or inpatient hospital facilities.

K. Behavior guidance services necessary for the provision of optimal therapeutic and preventive oral care to patients with medical, physical, or behavioral conditions. These services may include both pharmacologic and non-pharmacologic management techniques.

L. Consultative services provided by a pediatric dentist when the dental home has been established with a general practitioner or when requested by another dental specialist or medical care provider.

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## Recommendations for Pediatric Oral Health Assessment, Preventive Services, and Anticipatory Guidance/Counseling

Since each child is unique, these recommendations are designed for the care of children who have no contributing medical conditions and are developing normally. These recommendations will need to be modified for children with special health care needs or if disease or trauma manifests variations from normal. The American Academy of Pediatric Dentistry (AAPD) emphasizes the importance of very early professional intervention and the continuity of care based on the individualized needs of the child[15]. ~~Refer to the text in the Guideline on Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance, and Oral Treatment for Infants, Children, and Adolescents (www.aapd.org/media/Policies_Guidelines/G_Periodicity.pdf) for supporting information and references.~~

| | AGE | | | | |
|---|---|---|---|---|---|
| | 6 TO 12 MONTHS | 12 TO 24 MONTHS | 2 TO 6 YEARS | 6 TO 12 YEARS | 12 YEARS AND OLDER |
| Clinical oral examination [1] | • | • | • | • | • |
| Assess oral growth and development [2] | • | • | • | • | • |
| Caries-risk assessment [3] | • | • | • | • | • |
| Radiographic assessment [4] | • | • | • | • | • |
| Prophylaxis and topical fluoride [3,4] | • | • | • | • | • |
| Fluoride supplementation [5] | • | • | • | • | • |
| Anticipatory guidance/counseling [6] | • | • | • | • | • |
| Oral hygiene counseling [7] | Parent | Parent | Patient/parent | Patient/parent | Patient |
| Dietary counseling [8] | • | • | • | • | • |
| Injury prevention | • | • | • | • | • |

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| | | | | | |
|---|---|---|---|---|---|
| counseling [9] | | | | | |
| Counseling for nonnutritive habits [10] | • | • | • | • | • |
| Counseling for speech/language development | • | • | • | | |
| Substance abuse counseling | | | | • | • |
| Counseling for intraoral/perioral piercing | | | | • | • |
| Assessment and treatment of developing malocclusion | | | • | • | • |
| Assessment for pit and fissure sealants [11] | | | • | • | • |
| Assessment and/or removal of third molars | | | | | • |
| Transition to adult dental care | | | | | • |

[1] First examination at the eruption of the first tooth and no later than 12 months. Repeat every 6 months or as indicated by child's risk status/susceptibility to disease. Includes assessment of pathology and injuries.

[2] By clinical examination.

[3] Must be repeated regularly and frequently to maximize effectiveness.

[4] Timing, selection, and frequency determined by child's history, clinical findings, and susceptibility to oral disease.

[5] Consider when systemic fluoride exposure is suboptimal. Up to at least 16 years.

[6] Appropriate discussion and counseling should be an integral part of each visit for care.

[7] Initially, responsibility of parent; as child matures, jointly with parent; then, when indicated, only child.

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[8] At every appointment; initially discuss appropriate feeding practices, then the role of refined carbohydrates and frequency of snacking in caries development and childhood obesity.

[9] Initially play objects, pacifiers, car seats; when learning to walk; then with sports and routine playing, including the importance of mouthguards.

[10] ~~At~~ First discuss the need for additional sucking: digits vs pacifiers; then the need to wean from the habit before malocclusion or skeletal dysplasia occurs. For school-aged children and adolescent patients, counsel regarding any existing habits such as fingernail biting, clenching, or bruxism.

[11] For caries-susceptible primary molars, permanent molars, premolars, and anterior teeth with deep pits and fissures; placed as soon as possible after eruption.

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# Guideline on Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance/Counseling, and Oral Treatment for Infants, Children, and Adolescents

**Originating Committee**

Clinical Affairs Committee

**Review Council**

Council on Clinical Affairs

**Adopted**

1991

**Revised**

1992, 1996, 2000, 2003, 2007, 2009, 2013

## Purpose

The American Academy of Pediatric Dentistry (**AAPD**) intends this guideline to help practitioners make clinical decisions concerning preventive oral health interventions, including anticipatory guidance and preventive counseling, for infants, children, and adolescents.

## Methods

This guideline is ~~a compilation of related policies and guidelines developed by the AAPD, in addition to pediatric oral health literature and national reports and recommendations. The related policies and guidelines provide additional references for individual recommendations~~ an update of a previous document adopted in 2009. The update used electronic database and hand searches of articles in the medical and dental literature using the following parameters: Terms: "periodicity of dental exams", "dental recall intervals", "preventive dental services", "anticipatory guidance and dentistry", "caries risk assessment", "early childhood caries", "dental caries prediction", "dental care cost effectiveness children:, "periodontal disease and children and adolescents U.S.", "pit and fissure sealants", "dental sealants", "fluoride supplementation and topical fluoride", "dental trauma", "dental fracture and tooth", "nonnutritive oral habits", "treatment of developing malocclusion", "removal of wisdom teeth",

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"removal of third molars"; Fields: all; Limits: within the last 10 years, humans, English, and clinical trials; birth through age 18. From this search, 3,418 articles matched these criteria and were evaluated by title and/or abstract. Information from 113 articles was chosen for review to update this document. When data did not appear sufficient or were inconclusive, recommendations were based upon expert and/or consensus opinion by experienced researchers and clinicians.

**Background**

Professional dental care is necessary to maintain oral health.[1,2] The AAPD emphasizes the importance of initiating professional oral health intervention in infancy and continuing through adolescence and beyond.[1-3] The periodicity of professional oral health intervention and services is based on a patient's individual needs and risk indicators.[3,4-7] Each age group, as well as each individual child, has distinct developmental needs to be addressed at specific intervals as part of a comprehensive evaluation.[5-7,8-11] Continuity of care is based on the assessed needs of the individual patient and assures appropriate management of all oral conditions, dental disease, and injuries.[8-10,12-19] The early dental visit to establish a dental home provides a foundation upon which a lifetime of preventive education and oral health care can be built.[11,20-22] Anticipatory guidance and counseling are essential components of the dental visit to ensure caregivers have sufficient information and knowledge to change and sustain behaviors that can result in positive oral health outcomes for their families.[5-7,8-10,11-18,20-27]

**Recommendations**

This guideline addresses periodicity and general principles of examination, preventive dental services, anticipatory guidance/counseling, and oral treatment for children who have no contributory medical conditions and are developing normally. An accurate, comprehensive, and up-to-date medical history is necessary for correct diagnosis and effective treatment planning. Recommendations may be modified to meet the unique requirements of patients with special health care needs.[28]

**Clinical oral examination**

The first examination is recommended at the time of the eruption of the first tooth and no later

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than 12 months of age.~~11~~20-22 The developing dentition and occlusion should be monitored throughout eruption at regular clinical examinations.27 ~~Unrecognized dental disease can result in exacerbated problems which lead to more extensive and expensive care,19-20whereas~~ eEarly detection and management of oral conditions can improve a child's oral health, general health and well-being, and school readiness.~~12,22-27~~23,29-32 Delayed diagnosis of dental disease can result in exacerbated problems which lead to more extensive and costly care.~~19-20~~4,7,29,33-36 Early diagnosis of developing malocclusions may allow for timely therapeutic intervention.~~28~~9,27

Components of a comprehensive oral examination include assessment of:

- General health/growth
- Pain
- Extraoral soft tissue
- Temporomandibular joint
- Intraoral soft tissue
- Oral hygiene and periodontal health
- Intraoral hard tissue
- The developing occlusion
- Caries risk
- Behavior of child

Based upon the visual examination, the dentist may employ additional diagnostic aids (eg, radiographs, photographs, pulp vitality testing, laboratory tests, study casts).27,37
The most common interval of examination is 6 months; however, some patients may require examination and preventive services at more or less frequent intervals, based upon historical, clinical, and radiographic findings.~~3,29-34~~4,5,7,17-19,38-43 Caries and its sequelae are among the most prevalent health problems facing infants, children, and adolescents in America.1,44 Carie~~s~~ous lesions are ~~is~~ cumulative and progressive and, in the primary dentition, ~~is~~ are highly predictive of caries occurring in the permanent dentition.~~35,36~~45-47 Reevaluation and reinforcement of preventive activities contribute to improved instruction for the caregiver of the child or adolescent, continuity of evaluation of the patient's health status, and repetitive exposure to

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dental procedures, potentially allaying anxiety and fear for the apprehensive child or adolescent.[48]

**Caries-risk assessment**

Risk assessment is ~~the~~ a key element of contemporary preventive care for infants, children, adolescents, and persons with special health care needs. Its goal is to prevent disease by identifying and minimizing causative factors (eg, microbial burden, dietary habits, plaque accumulation) and optimizing protective factors (eg, fluoride exposure, oral hygiene, sealants).[3749] ~~A~~ Ccaries-risk assessment ~~tool (CAT)~~ forms and management protocols simplify~~ies~~ and clarify~~ies~~ the process.[1324,50,51] Sufficient evidence demonstrates certain groups of children at greater risk for development of early childhood caries (**ECC**) would benefit from early preventive infant oral health care.[1223,2229,38,3952-54,] Infants and young children have unique caries-risk factors such as ongoing establishment of oral flora and host defense systems, susceptibility of newly erupted teeth, and development of dietary habits. Children are most likely to develop caries if mutans streptococci are acquired at an early age.[3952,4055] The characteristics of ECC and the availability of preventive ~~methods~~ approaches support ~~anticipatory guidance/counseling as an important~~ age-based strategy~~ies~~ ~~in~~ addressing this significant pediatric health problem.[55] ECC can be a costly, devastating disease with lasting detrimental effects on the dentition and systemic health.[1219-2723,29-36] Adolescence can be a time of heightened caries activity due to an increased intake of cariogenic substances and inattention to oral hygiene procedures.[41,42,9,56,57] Risk assessment can assure preventive care is tailored to each individual's needs and direct resources to those for whom preventive interventions provide the greatest benefit. Because a child's risk for developing dental disease can change over time due to changes in habits (eg, diet, home care), oral microflora, or physical condition, risk assessment must be documented and repeated regularly and frequently to maximize effectiveness.[11,24]

**Prophylaxis and topical fluoride treatment**

The interval for frequency of professional preventive services is based upon assessed risk for caries and periodontal disease.[4,5,7,11,24,38,50-52] Gingivitis is nearly universal in children and

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adolescents[43~~42~~]; it usually responds to thorough removal of bacterial deposits and improved oral hygiene.[43~~42~~,44~~58~~,59] ~~Self-administered plaque control programs without periodic professional reinforcement are inconsistent in providing long-term inhibition of gingivitis.[44] Many patients lack the skill or motivation to become and remain plaque-free for a significant time.[44]~~ Hormonal fluctuations, including those occurring during the onset of puberty, can modify the gingival inflammatory response to dental plaque.[43~~42~~,43] Children can develop any of the several forms of periodontitis, with aggressive periodontitis occurring more commonly in children and adolescents than adults.[43~~42~~,43,59]

Caries risk may change quickly during active dental eruption phases. Newly erupted teeth may be at higher risk of developing caries, especially during the post-eruption maturation process. Children who exhibit higher risk of developing caries would benefit from recall appointments at greater frequency than every 6 months.[4,5,7,11,24,51] This allows increased professional fluoride therapy application, microbial monitoring, antimicrobial therapy reapplication, and reevaluating behavioral changes for effectiveness.[3~~,45,46~~51,60,61] An individualized preventive plan increases the probability of good oral health by demonstrating proper oral hygiene methods/techniques and removing plaque, stain, and calculus[47~~42~~,43,62]~~, and the factors that influence their build-up.[48-50]~~

Professional topical fluoride treatments should be based on caries risk assessment.[~~13,14,51-53~~24,25,63-65] Plaque and pellicle are not a barrier to fluoride uptake in enamel.[54~~66~~-68] Consequently, there is no evidence of a difference in caries rates or fluoride uptake in patients who receive rubber cup prophylaxis or a toothbrush prophylaxis before fluoride treatment.[54~~66~~,67] ~~A pumice prophylaxis is not an essential prerequisite to this treatment.[54] Appropriate~~ Pprecautionary measures should be taken to prevent swallowing of any professionally-applied topical fluoride. Children at moderate caries risk should receive a professional fluoride treatment at least every 6 months; those with high caries risk should receive greater frequency of professional fluoride applications (eg, every 3-6 months).[~~52,55,56,57-62~~,64,68-73] Ideally, this would occur as part of a comprehensive preventive program in a dental home.[~~11~~20]

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**Fluoride supplementation**

Fluoride contributes to the prevention, inhibition, and reversal of caries.[53,62,63,65,73-75] The AAPD encourages optimal fluoride exposure for every child, recognizing fluoride in the community water supplies as the most beneficial and ~~inexpensive~~ cost-effective preventive intervention. Fluoride supplementation should be considered for children at moderate to high caries risk when fluoride exposure is not optimal.[62,73] Supplementation should be in accordance with the guidelines ~~jointly~~ recommended by the AAPD[62,73], ~~the American Academy of Pediatrics[63],~~ and the American Dental Association (**ADA**).[64,76], ~~and endorsed by the Centers for Disease Control and Prevention.[14]~~

**Anticipatory guidance/counseling**

Anticipatory guidance is the process of providing practical, developmentally-appropriate information about children's health to prepare parents for the significant physical, emotional, and psychological milestones.[65,8,9,20,21,77] ~~Appropriate~~ Individualized discussion and counseling should be an integral part of each visit. Topics to be included are oral hygiene and dietary habits, injury prevention, nonnutritive habits, substance abuse, intraoral/perioral piercing, and speech/language development.[8,9,15,16,20,21,27,77-80]

Oral hygiene counseling involves the parent and patient. Initially, oral hygiene is the responsibility of the parent. As the child develops, home care is performed jointly by parent and child. When a child demonstrates the understanding and ability to perform personal hygiene techniques, the health care professional should counsel the child. The effectiveness of home care should be monitored at every visit and includes a discussion on the consistency of daily preventive activities.[3,4,5,9,24]

~~High risk~~ Caries-conducive dietary practices appear to be established early, probably by 12 months of age, and are maintained throughout early childhood.[66,67,81-83] ~~Frequent bottle feeding at night, breastfeeding on demand, and extended and repetitive use of a no-spill training cup are associated with, but not consistently implicated in, ECC.[68]~~ Dietary practices, including prolonged and/or frequent bottle or training cup with sugar-containing drinks and frequent in

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between meal consumption of sugar-containing snacks or drinks (eg, juice, formula, soda), increase the risk of caries.[68,83,84] The role of carbohydrates in caries initiation is unequivocal. Acids in carbonated beverages and sports drinks can have a deleterious effect (ie, erosion) on enamel.[85-87] Excess consumption of carbohydrates, fats, and sodium contribute to poor systemic health.[88-90] Dietary analysis and the role of dietary choices on oral health, malnutrition, and obesity should be addressed through nutritional and preventive oral health counseling at periodic visits.[15,26] The US Department of Agriculture's Food Plate ~~Pyramid~~[69,91] and Center for Disease Control and Prevention/National Center for Health Statistics' Growth Charts[70,92] provide guidance for parents and their children and promote better understanding of the relationship between healthy diet and development.

Facial trauma that results in fractured, displaced, or lost teeth can have significant negative functional, esthetic, and psychological effects on children.[71,93] Practitioners should provide age-appropriate injury prevention counseling for orofacial trauma.[16,17,15,16] Initially, discussions would include advice regarding play objects, pacifiers, car seats, and electrical cords. As motor coordination develops, the parent/patient should be counseled on additional safety and preventive measures, including use of athletic mouthguards for sporting activities. The greatest incidence of trauma to the primary dentition occurs at 2 to 3 years of age, a time of increased mobility and developing coordination.[72,94] The most common injuries to permanent teeth occur secondary to falls, followed by traffic accidents, violence, and sports.[73-76,95-98] Dental injuries could have improved outcomes if the public were aware of first-aid measures and the need to seek immediate treatment.

Nonnutritive oral habits (eg, digital and pacifier habits, bruxism, abnormal tongue thrusts) may apply forces to teeth and dentoalveolar structures.[18,27] Although early use of pacifiers and digit sucking are considered normal, habits of sufficient frequency, intensity, and duration can contribute to deleterious changes in occlusion and facial development.[27] It is important to discuss the need for early ~~additional~~ pacifier and digit sucking, then the need to wean from the habits before malocclusion or skeletal dysplasias occur.[27] Early dental visits provide an opportunity to encourage parents to help their children stop sucking habits by age 3 years or

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younger. For school-aged children and adolescent patients, counseling regarding any existing habits (eg, fingernail biting, clenching, bruxism) is appropriate.[18]27

Speech and language is an integral component of a child's early development.[77]80 Deficiencies and abnormal delays in speech and language production can be recognized early and referral made to address these concerns ~~appropriately~~. Communication and coordination of appliance therapy with a speech and language professional can assist in the timely treatment of ~~these~~ speech disorders.[80]

Smoking and smokeless tobacco use almost always are initiated and established in adolescence.[78-80]99-101 During this time period, children may be exposed to opportunities to experiment with other substances that negatively impact their health and well-being. Practitioners should provide education regarding the serious health consequences of tobacco use and exposure to second hand smoke.[81]78,100 The practitioner may need to obtain information regarding tobacco use and alcohol/drug abuse confidentially from an adolescent patient.[69] When substance abuse has been identified, referral for appropriate intervention is indicated.[78]

Complications from intraoral/perioral piercings can range from pain, infection, and tooth fracture to life-threatening conditions of bleeding, edema, and airway obstruction.[82]79 Although piercings most commonly are observed in the teenaged pediatric dental patient, education regarding pathologic conditions and sequelae associated with these piercings should be initiated for the preteen child/parent and reinforced during subsequent periodic visits.[79]

**Radiographic assessment**

Appropriate radiographs are a valuable adjunct in the oral health care of infants, children and adolescents.[29,30]39,40 Timing of initial radiographic examination should not be based ~~up~~on the patient's age.[29]40 Rather, after review of an individual's history and clinical findings, judicious determination of radiographic needs and examination can optimize patient care while minimizing radiation exposure.[29,30]39,40 The US Food and Drug Administration/ADA guidelines were developed to assist the dentist in deciding under what circumstances specific radiographs

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are indicated.[~~30~~40]

**Treatment of dental disease/injury**

Healthcare providers who diagnose oral disease or trauma should either provide therapy or refer the patient to an appropriately-trained individual for treatment.[~~83~~103] Immediate intervention is necessary to prevent further dental destruction, as well as more widespread health problems. Postponed treatment can result in exacerbated problems that may lead to the need for more extensive care.[~~19-21~~22,30,31,35] Early intervention could result in savings of healthcare dollars for individuals, community health care programs, and third party payors.[22,30,31,35]

**Treatment of developing malocclusion**

Guidance of eruption and development of the primary, mixed, and permanent dentitions is an integral component of comprehensive oral health care for all pediatric dental patients.[~~28~~27] Early diagnosis and successful treatment of developing malocclusions can have both short-term and long-term benefits, while achieving the goals of occlusal harmony and function and dentofacial esthetics.[~~84-87~~104-108] Early treatment is beneficial for many patients, but ~~may~~ is not ~~be~~ indicated for every patient. When there is a reasonable indication that an oral habit will result in unfavorable sequelae in the developing permanent dentition, any treatment must be appropriate for the child's development, comprehension, and ability to cooperate. Use of an appliance is indicated only when the child wants to stop the habit and would benefit from a reminder.[~~28~~27] At each stage of occlusal development, the objectives of intervention/treatment include: (1) reversing adverse growth; (2) preventing dental and skeletal disharmonies; (3) improving esthetics of the smile; (4) improving self-image; and (5) improving the occlusion.[~~28~~27]

**Sealants**

Sealants reduce the risk of pit and fissure caries in susceptible teeth and are cost-effective when maintained.[~~88,89~~109-113] They are indicated for primary and permanent teeth with pits and fissures that are predisposed to plaque retention.[112] At-risk pits and fissures should be sealed as soon as possible. Because caries risk may increase at any time during a patient's life due to changes in habits (eg, dietary, home care), oral microflora, or physical condition, unsealed teeth

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subsequently might benefit from sealant application.~~[88]~~[109,114] The need for sealant placement should be reassessed at periodic preventive care appointments. Sealants should be monitored and repaired or replaced as needed.[111,112,114]

**Third molars**

Panoramic or periapical radiographic assessment is indicated during late adolescence to assess the presence, position, and development of third molars.~~[29,30]~~[39,40] A decision to remove or retain third molars should be made before the middle of the third decade.[115] Impacted third molars are potentially pathologic. Pathologic conditions are generally more common with an increase in age. Evaluation and treatment may require removal, exposure, and/or repositioning. In selected cases, long-term monitoring may also be needed. Treatment should be provided before pathologic conditions adversely affect the patient's oral and/or systemic health. ~~[90]~~[108,115,116] Consideration should be given to removal when there is a high probability of disease or pathology and/or the risks associated with early removal are less than the risks of later removal.~~[10]~~[14,108,116] Postoperative complications for removal of impacted third molars are low when performed at an early age. A Cochrane review in 2012 reported there was no difference in late lower incisor crowding with removal or retention of asymptomatic impacted third molars.[117]

**Referral for regular and periodic dental care**

As adolescent patients approach the age of majority, it is important to educate the patient and parent on the value of transitioning to a dentist who is knowledgeable in adult oral health care. At the time agreed upon by the patient, parent, and pediatric dentist, the patient should be referred to a specific practitioner in an environment sensitive to the adolescent's individual needs.~~[6,9]~~[1,9,28] Until the new dental home is established, the patient should maintain a relationship with the current care provider and have access to emergency services. Proper communication and records transfer allow for consistent and continuous care for the patient.[37]

**Recommendations by age**

**6 to 12 months**

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1. Complete the clinical oral examination with adjunctive diagnostic tools (eg, radiographs as determined by child's history, clinical findings, and susceptibility to oral disease) to assess oral growth and development, pathology, and/or injuries; provide diagnosis.
2. Provide oral hygiene counseling for parents, including the implications of the oral health of the caregiver.
3. Remove supragingival and subgingival stains or deposits as indicated.
4. Assess the child's systemic and topical fluoride status (including type of infant formula used, if any, and exposure to fluoridated toothpaste) and provide counseling regarding fluoride. Prescribe systemic fluoride supplements, if indicated, following assessment of total fluoride intake from drinking water, diet, and oral hygiene products.
5. Assess appropriateness of feeding practices, including bottle and breast-feeding, and provide counseling as indicated.
6. Provide dietary counseling related to oral health.
7. Provide age-appropriate injury prevention counseling for orofacial trauma.
8. Provide counseling for nonnutritive oral habits (eg, digit, pacifiers).
9. Provide required treatment and/or appropriate referral for any oral diseases or injuries.
10. Provide anticipatory guidance.
11. Consult with the child's physician as needed.
12. Complete a caries risk assessment.
13. Determine the interval for periodic reevaluation.

**12 to 24 months**

1. Repeat 6 to 12-month procedures every 6 months or as indicated by individual patient's risk status/susceptibility to disease.
2. Assess appropriateness of feeding practices (including bottle, breast-feeding, and no-spill training cups) and provide counseling as indicated.
3. Review patient's fluoride status (including any childcare arrangements which may impact systemic fluoride intake)and provide parental counseling.
4. Provide topical fluoride treatments every 6 months or as indicated by the individual patient's needs.

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**2 to 6 years**

1. Repeat 12- to 24-month procedures every 6 months or as indicated by individual patient's risk status/susceptibility to disease. Provide age-appropriate oral hygiene instructions.
2. Scale and clean the teeth every 6 months or as indicated by individual patient's needs.
3. Provide pit and fissure sealants for caries-susceptible primary molars and permanent molars, premolars, and anterior teeth.
4. Provide counseling and services (eg, mouthguards) as needed for orofacial trauma prevention.
5. Provide assessment/treatment or referral of developing malocclusion as indicated by individual patient's needs.
6. Provide required treatment and/or appropriate referral for any oral diseases, habits, or injuries as indicated.
7. Assess speech and language development and provide appropriate referral as indicated.

**6 to 12 years**

1. Repeat 2- to 6-year procedures every 6 months or as indicated by individual patient's risk status/susceptibility to disease.
2. Provide substance abuse counseling (eg, smoking, smoke-less tobacco).
3. Provide counseling on intraoral/perioral piercing.

**12 years and older**

1. Repeat 6- to 12-year procedures every 6 months or as indicated by individual patient's risk status/susceptibility to disease.
2. During late adolescence, assess the presence, position, and development of third molars, giving consideration to removal when there is a high probability of disease or pathology and/or the risks associated with early removal are less than the risks of later removal.
3. At an age determined by patient, parent and pediatric dentist, refer the patient to a general dentist for continuing oral care.

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# Policy on the Role of Pediatric Dentists as Both Primary and Specialty Care Providers

**Originating Council**

Council on Clinical Affairs

**Review Council**

Council on Clinical Affairs

**Adopted**

2003

**Revised**

2008, 2013

## Purpose

The American Academy of Pediatric Dentistry (**AAPD**) emphasizes that health care providers and other interested third parties must recognize the dual role that pediatric dentists play in the provision of professional preventive and therapeutic oral health care, which includes both primary and specialty care services.

## Methods

This document is an update of the previous policy, revised in 2008. ~~This statement~~ and was based on a review of the accreditation standards for advanced specialty training programs in pediatric dentistry and the AAPD position paper on the role of pediatric dentists as primary and specialty care providers.[1,2] A ~~MEDLINE~~ electronic search was conducted using the terms "pediatric dentist", "pediatric specialist", "primary care provider", "dual care provider" and "specialty care provider". Relevant policies and guidelines of the AAPD and the American Dental Association (ADA) are included.

## Background

"Pediatric dentistry is an age-related specialty that provides both primary and comprehensive preventive and therapeutic oral health needs for infants and children through adolescence, including those with special health care needs."[1,3] The American Dental Association, the

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American Academy of General Dentistry, and the AAPD all recognize the pediatric dentist as both a primary care provider and specialty care provider. The dual role of pediatric dentists is similar to that of pediatricians, gynecologists, and internists in medicine. Within the medical profession, clinicians and third-party payors recognize these physicians in a dual role and have designed payment plans to accommodate this situation.

The AAPD respects the rights of employers to negotiate health care benefits for their employees. Unfortunately, third-party payors sometimes do not recognize pediatric dentists as primary care providers. This position restricts access to pediatric dentists for children who have reached a predetermined age.

**Policy statement**

The AAPD recognizes that infants, children, adolescents, and individuals with special health care needs have the right to quality oral health care. The AAPD encourages third party payors to recognize pediatric dentists as both primary and specialty oral health care providers and to refrain from age-related restrictions when a parent or referring clinician desires to utilize the services and expertise of a pediatric dentist to establish a dental home or for limited specialized care.

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# Policy on Patient Safety

**Originating Council**

Council on Clinical Affairs

**Adopted**

2008

**Revised**

2013

## Purpose

The American Academy of Pediatric Dentistry (**AAPD**) recognizes patient safety as an essential component of quality oral health care for infants, children, adolescents, and those with special health care needs. The AAPD encourages dentists to consider thoughtfully the environment in which they deliver healthcare services and to implement practices that decrease a patient's risk of injury or harm during the delivery of care. This policy is not intended to duplicate safety recommendations for medical facilities accredited by national commissions such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or those related to workplace safety such as Occupational Safety & Health Administration (OSHA).

## Methods

~~This guideline is based on a review of the current dental and medical literature related to patient safety. A MEDLINE literature search was conducted using the terms "patient safety", "risk management", "patient's rights", and "dentistry".~~

The policy is based upon a review of current dental and medical literature, including a systematic literature search of the MEDLINE/PubMed® electronic database with the following: TERMS: "patient safety ", AND "dentistry" ; FIELD: All Fields; LIMITS: within the last 10 years; humans; English. Ten articles matched these criteria. Papers for review were chosen from this list and from the references within selected articles.

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**Background**

All health care systems should be designed to promote patient health and protection. Dental practices must be in compliance with federal laws that help protect patients from misuse of personal information [eg, Health Insurance Portability and Accountability Act (**HIPAA**)][1-4] and potential dangers such as the transmission of disease. State and local laws help regulate potential chemical and environmental hazards (eg, radiation) and facilities (eg, fire prevention systems, emergency exits). Furthermore, state dental practice acts are intended to regulate the competency of and provision of services by dental health professionals.

Designing health care systems that focus on preventing errors, being more efficient and more patient–family centered is critical to assuring patient safety.[5,6] Some possible sources of error in the dental office are miscommunication, failure to review the patient's medical history (eg, current drugs and medications), and lack of standardized records, abbreviations, and processes.[5] Standardization helps assure clerical and clinical personnel execute their responsibilities in a safe and effective manner. Policy and procedure manuals that describe each facility's established protocols serve as a valuable training tool for new employees and reinforce a consistent approach for safe, quality patient care. Identifying deviations from such protocols and studying patterns of occurrence can help reduce the likelihood of adverse events.[6,7] Reducing clinical errors requires a careful examination of adverse events , including "near misses", and root cause analysis of how the event could be avoided in the future, so that safety practices can be implemented. Safety demands a culture in which communication does not depend on hierarchy, therefore a non-punitive or "no blame" culture encourages all personnel to report errors.[6,8]

The environment in which dental care is delivered impacts patient safety. In addition to structural issues regulated by state and local laws, other design features should be planned and periodically evaluated for patient safety, especially as they apply to young children. Play structures, games, and toys are possible sources for accidents and infection.

Scientific knowledge and technology continually advance, and patterns of care evolve due, in

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part, to recommendations by organizations with recognized professional expertise and stature. Some recommendations can be based only on suggestive evidence or theoretical rationale (eg, infection control); other concerns of clinical practice remain in flux (eg, materials utilized in restorative dentistry). Consequently, the dental patient would benefit from a practitioner who follows current literature and participates in professional continuing education courses to increase awareness and knowledge of best current practices.

The AAPD emphasizes safe, age-appropriate, nonpharmacological or pharmacological behavior guidance techniques for use with pediatric dental patients. It is important to base behavior guidance on each patient's individual needs with goals of fostering a positive dental attitude, safety, and providing quality dental care.~~7~~9 Appropriate diagnosis of behavior and safe and effective implementation of advanced behavior guidance techniques (ie, protective stabilization, sedation, general anesthesia) necessitate knowledge and experience that generally are beyond the core knowledge that students receive during predoctoral education.~~7~~9,10

**Policy Statement**

To promote patient health and protection, the AAPD ~~recommends~~ encourages:

1. Patient safety instruction in dental curricula to promote safe, patient-centered care.11
~~1.~~2. Professional continuing education by all licensed dental professionals to maintain familiarity with current regulations, technology, and clinical practices.
~~2.~~3. Compliance with federal laws such as HIPAA to protect patients against misuse of information identifiable to them.1
~~3.~~4. Compliance and recognition of the importance of infection control policies, procedures, and practices in dental health care settings in order to prevent disease transmission from patient to care provider, from care provider to patient, and from patient to patient.2-4
~~4.~~5. Routine inspection of physical facility in regards to patient safety. This would include development of office emergency and fire safety protocols and routine inspection and maintenance of clinical equipment.
~~5.~~6. Recognition that informed consent by the parent is essential in the delivery of health care and effective relationship/communication practices can help avoid problems and adverse

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events.~~[8]~~ [12]The parent should be encouraged to be an active participant in the child's care.

~~6.~~7. Accuracy of patient identification with the use of at least 2 patient identifiers, such as name and date of birth, when providing care, treatment, or services.[5,~~9~~]

~~7.~~ 8. An accurate and complete patient chart that can be interpreted by a knowledgeable third party.~~[10]~~[13] Standardizing abbreviations, acronyms, and symbols throughout the record is recommended.

~~8.~~9. An accurate, comprehensive, and up-to-date medical/dental history including medications and allergy list to ensure patient safety during each visit.~~[10]~~[13] Ongoing communication with health care providers, both medical and dental, who manage the child's health helps ensure comprehensive, coordinated care of each patient.

10. A pause before an invasive procedure, to make sure that the correct procedure is done on the correct patient and at the correct site on the patient's body.[5]

~~9.~~11. Appropriate staffing and supervision of patients treated in the dental office.

~~10.~~12. Adherence to AAPD recommendations on behavior guidance, especially as they pertain to use of advanced behavior guidance techniques (ie, protective stabilization, sedation, general anesthesia).~~[7]~~[9,10]

~~11.~~13. Standardization and consistency of processes within the practice. A policies and procedures manual, with ongoing review and revision, could help increase employee aware-ness and decrease the likelihood of untoward events. Dentists should emphasize procedural protocols that protect the patient's airway (eg, rubber dam isolation)~~[11]~~ [14]and minimize opportunity for injury during delivery of care (eg, protective eyewear).

~~12.~~14. Minimizing exposure to nitrous oxide by maintaining the lowest practical levels in the dental environment. This would include routine inspection and maintenance of nitrous oxide delivery equipment as well as adherence to clinical guidelines for patient selection and delivery of inhalation agents.~~[12]~~ [15]

~~13.~~15. Minimizing radiation exposure through adherence to ALARA (as low as reasonably achievable) principle, equipment inspection and maintenance, and patient selection criteria.~~[13]~~[16]

~~14.~~16. All facilities performing sedation for diagnostic and therapeutic procedures to maintain records that track adverse events. Such events then can be examined for assessment of risk

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reduction and improvement in patient safety.~~14~~ 17

~~15.~~17. Dentists who utilize in-office anesthesia care providers take all necessary measures to minimize risk to patients. Prior to delivery of sedation/general anesthesia, appropriate documentation shall address rationale for sedation/general anesthesia, informed consent, instructions to parent, dietary precautions, preoperative health evaluation, and any prescriptions along with the instructions given for their use. The dentist and anesthesia care provider must communicate during treatment to share concerns about the airway or other details of patient safety.~~15~~ 18

~~16.~~18. Ongoing quality improvement strategies. Routine assessment of risk, adverse events, and mistakes with a plan for reduction and improvement in patient safety and satisfaction.[5,6]

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# Policy on the Ethical Responsibility to Treat or Refer

**Originating Council**

Council on Clinical Affairs

**Review Council**

Council on Clinical Affairs

**Adopted**

2003

**Reaffirmed**

200~~8~~13

## Purpose

The American Academy of Pediatric Dentistry (**AAPD**) believes that all infants, children, adolescents, and individuals with special health care needs are entitled to oral health care that meets the treatment and ethical standards set by our specialty. If a dentist is unable to provide or fails to offer treatment for a diagnosed dental disease or condition, he or she has an ethical responsibility to refer the patient to a specific practitioner capable of providing the necessary care.

## Methods

Documents relating to principles of ethics of dental and medical organizations were reviewed. A MEDLINE search using the terms "ethics" and "dentistry" was performed with no new documents found. Experts on dental and medical ethics were consulted.

## Background

Dentists have an obligation to act in an ethical manner in the care of patients. Commonly accepted virtues of ethics include autonomy, beneficence, non-maleficence, and justice.[1, 2] Autonomy reflects the patient's or, if the patient is a minor, the parent's or guardian's right to be involved in treatment decisions. The caregiver must be informed of the problem and that treatment is recommended. Beneficence indicates the dentist has the obligation to act for the

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benefit of the patient in a timely manner, even when there may be conflicts with the dentist's personal self interests. Nonmaleficence dictates that the dentist's care does not result in harm to the patient. In situations where a dentist is not able to meet the patient's needs, referral to a practitioner capable of providing the needed care is indicated. Justice expresses that the dentist should deal fairly with patients, colleagues, and the public.

A patient may suffer progression of his/her oral disease if treatment is not provided because of age, behavior, inability to cooperate, disability, or medical status. Postponement or denial of care can result in unnecessary pain, discomfort, increased treatment needs and costs, unfavorable treatment experiences, and diminished oral health outcomes.

**Policy statement**

Infants, children, and adolescents, including those with special health care needs, have a right to dental care. The AAPD believes it is unethical for a dentist to ignore a disease or condition because of the patient's age, behavior, or disabilities. Dentists have an ethical obligation to provide therapy for patients with oral disease or refer for treatment patients whose needs are beyond the skills of the practitioner.

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# Guideline on ~~Oral Health Care/~~Dental Management of Heritable Dental Developmental Anomalies

**Originating Council**

Council on Clinical Affairs

**Adopted**

2008

**Revised**

2013

## Purpose

The American Academy of Pediatric Dentistry (**AAPD**) recognizes that pediatric dentists are uniquely qualified to manage the oral health care needs of children with heritable dental developmental anomalies. These children have multiple, complex problems as their dental conditions affect both form and function and can have significant psychological impact. These conditions may present early in life and require both immediate intervention and management of a protracted nature, including coordination of multi-disciplinary care. The AAPD's Guideline on Management of Dental Patients with Special Health Care Needs[1] alludes to this patient population but does not make specific treatment recommendations for the oral manifestations of such diagnoses. This guideline is intended to address the diagnosis, principles of management, and objectives of therapy of children with heritable dental developmental anomalies rather than provide specific treatment recommendations. This guideline will focus on the following heritable dental developmental anomalies: amelogenesis imperfecta (**AI**), dentinogenesis imperfecta (**DI**), and dentin dysplasia (**DD**). Ectodermal dysplasia has been thoroughly studied and reported in the National Foundation for Ectodermal Dysplasia's "Parameters of Oral Health Care for Individuals Affected by Ectodermal Dysplasia Syndromes."[2] Refer to that document for care of children with ectodermal dysplasia.

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**Methods**

This guideline is an update of a previous document adopted in 2008. It is based on upon a review of the current dental and medical literature related to heritable dental developmental anomalies. ~~A MEDLINE~~ A systematic literature search of the Pubmed database was conducted using the following ~~terms~~ parameters: Terms:"heritable dental developmental anomalies", "amelogenesis imperfecta", "dentinogenesis imperfecta", "dentinal dysplasia", "dentin dysplasia", "enamel hypoplasia", "enamel hypocalcification", "amelogenin", and "enamelin". Fields: all fields; Limits: within the last 10 years, humans, English, and clinical trials; birth through age 18. One thousand five hundred and twenty one articles matched these criteria. Alternate strategies such as appraisal of references from recent evidence-based reviews and metaanalyses, as well as hand searches were performed. This strategy yielded 131 articles for review were chosen from this list and from the references within selected articles and were evaluated by their abstracts. Of those, 39 articles each had full examination and analysis in order to revise this guideline. When data did not appear sufficient or were inconclusive, recommendations were based upon expert and/or consensus opinion by experienced researchers and clinicians.

**Background**

Anomalies of tooth development are relatively common and may occur as an isolated condition or in association with other anomalies. Developmental dental anomalies often exhibit patterns that reflect the stage of development during which the malformation occurs. For example, disruptions in tooth initiation result in hypodontia or supernumerary teeth, whereas disruptions during morphodifferentiation lead to anomalies of size and shape (eg, macrodontia, microdontia, taurodontism, dens invaginatus).[3] Disruptions occurring during histodifferentiation, apposition, and mineralization result in enamel hypoplasia or hypomineralization[4,5] for AI, DI, and DD.[3]

Heritable dental developmental anomalies can have profound negative consequences for the affected individual and the family. ~~4,5~~ [7] [6,7] Preventive care is of foremost importance. Meticulous

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oral hygiene must be established and maintained.[8] The problems range from esthetic concerns that impact self-esteem to masticatory difficulties, tooth sensitivity, financial burdens, and protracted, complex dental treatment. These emotional and physical strains have been demonstrated ~~in a recent study~~ showing that persons with AI have fewer long-term relationships and children than nonaffected people.[4,6] Due to extensive treatment needs, a patient may require sedation or general anesthesia for restorative care.[7-9]

**Amelogenesis Imperfecta**

Amelogenesis imperfecta is a developmental disturbance that interferes with normal enamel formation in the absence of a systemic disorder.[5,6,7,10] In general, it affects all or nearly all of the teeth in both the primary and permanent dentitions.[3,5-7-11] The estimated frequency of AI ~~in the US population is 1:7,00~~ ranges from 1:718 to 1:14,000 depending on the population studied.[8,9,12,13]

*Genetic etiology:* AI may be inherited by x-linked~~, autosomal dominant or recessive,~~ or sporadic inheritance. The different clinical manifestations of AI have a specific gene anomaly associated with each phenotype. Specific mutations proven to cause AI include: amelogenin (AMELX), enamelin (ENAM), kallikrein4 (KLK4), enamelysis (MMP-20) and FAM83H. [10,14-16 ~~10-12~~]

*Clinical manifestation:* The most widely accepted classification [13] of AI includes 4 types: ~~hypocalcified, hypoplastic pitted, hypoplastic generalized and hypomaturation~~ hypoplastic, hypomaturation, hypocalcified and hypomaturation-hypoplastic with taurodontism (See Figure 1). Each type has subtypes differentiated by mode of inheritance. This classification system takes into consideration 15 subtypes based on clinical features and inheritance pattern. The variability of the appearance of the different types of AI makes identification difficult.[15,9] Some dentitions will appear normal to the untrained eye while other types of AI will be disfiguring. Hypomaturation-hypoplastic with taurodontism type of AI is also associated with tricho-dento-osseous syndrome. [19]

Children with AI can exhibit accelerated tooth eruption compared to the normal population or have late eruption.[20-25~~15,16~~] Other clinical implications of AI - low caries susceptibilty, rapid attrition, excessive calculus deposition and gingival hyperplasia. [25,25] Pathologies associated with AI are enlarged follicles, impacted permanent teeth, ~~and~~ ectopic eruption, congenitally

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missing teeth, crown and/or root resorption and pulp calcification.[21,24-26 16] Agenesis of second molars also has been observed.[22 17] Although uncommon in AI, enamel resorption and ankylosis have been reported.[21 16] In addition, the incidence of anterior open bite is 50% in hypoplastic AI, 31% in hypomaturation AI, and 60% of hypocalcified AI.[20, 23 15,18]

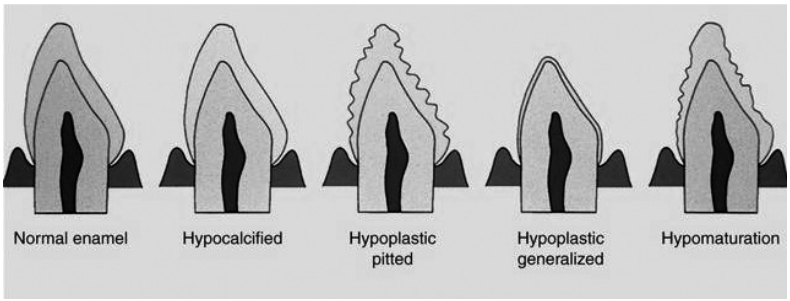


Figure 1. Amelogenesis imperfecta. Diagram of enamel defects of basic types. Hypocalcified - normal thickness, smooth surface, less hardness. Hypoplastic, pitted - normal thickness, pitted surface, normal hardness. Hypoplastic, generalized - reduced thickness, smooth surface, normal hardness. Hypomaturation - normal thickness, chipped surface, less hardness, opaque white coloration.
This figure was published in Contemporary Oral and Maxillofacial Pathology, Sapp J, Eversole L, Wysocki G; Developmental Disturbances of the Oral Region, page 19; Mosby, Inc. 2004.14

*Differential diagnosis:* Other forms of enamel dysmineralization will exhibit a pattern based upon the time of insult, thus affecting the enamel forming at the time. In contrast, AI will affect all teeth similarly and can have a familial history. Fluorosis can mimic AI, but usually the teeth are not affected uniformly, often sparing the premolars and second permanent molars. A history of fluoride intake can aid in the diagnosis.

**Dentinogenesis Imperfecta**

Dentinogenesis imperfecta is a hereditary developmental disturbance of the dentin originating

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during the histodifferentiation stage of tooth development. DI may be seen alone or in conjunction with the systemic hereditary disorder of the bone, osteogenesis imperfecta. Children with unexplained bone fracturing should be evaluated for DI as a possible indicator of an undiagnosed case of OI. This is important in helping delineate child abuse from mild or undiagnosed OI.[27 19] The incidence of DI is about 1 in 8,000.[28 20] Two systems, one by Witkop[28 20] and the other by Shields[29 21], are well accepted classification systems of DI (See Table 1).

*Genetic etiology:* Type I collagen (product of COL1A1 and COL1A2 genes) is the most abundant dentin protein.[30 22] The diverse mutations associated with the COL1A1 and COL1A2 genes can cause the DI phenotype in association with osteogenesis imperfecta (DI type I). DI Type II and Type III are autosomal dominant conditions that have been linked to chromosome 4q12-21, suggesting these may be allelic mutations of the DSPP gene encoding dentin phosphoprotein and dentin sialoprotein.[31, 32 23,24]

*Clinical manifestation:* In all 3 DI types, the teeth have a variable blue-gray to yellow-brown discoloration that appears opalescent due to the defective, abnormally-colored dentin shining through the translucent enamel. Due to the lack of support of the poorly mineralized dentin, enamel frequently fractures from the teeth leading to rapid wear and attrition of the teeth. The severity of discoloration and enamel fracturing in all DI types is highly variable, even within the same family. If left untreated, it is not uncommon to see the entire DI-affected dentition worn to the gingiva.

Shields Type I occurs with osteogenesis imperfecta. All teeth in both dentitions are affected. Primary teeth are affected most severely, followed by the permanent incisors and first molars, with the second and third molars being the least altered. Radiographically, the teeth have bulbous crowns, cervical constriction, thin roots, and early obliteration of the root canal and pulp chambers due to excessive dentin production. Periapical radiolucencies and root fractures are evident. An amber translucent tooth color is common.

Shields Type II is also known as hereditary opalescent dentin. Both primary and permanent dentitions are equally affected, and the characteristics previously described for Type I are the same. Radiographically, pulp chamber obliteration can begin prior to tooth eruption.

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Shields Type III is rare; its predominant characteristic is bell-shaped crowns, especially in the permanent dentition. Unlike Types I and II, Type III involves teeth with shell-like appearance and multiple pulp exposures. Shell teeth demonstrate normal-thickness enamel in association with extremely thin dentin and dramatically enlarged pulps. The thin dentin may involve the entire tooth or be isolated to the root.

*Differential diagnosis:* OI, other collagen disorders, and numerous syndromes have DI-like phenotypes associated with them. DD Type I clinically has normal appearing crowns, but radiographically the teeth have pulpal obliterations and short blunted roots. DD Type II has the same phenotype as DI Type II in the primary dentition but normal to slight blue-gray discoloration in permanent dentition.

**Dentin Dysplasia**

Dentin dysplasia represents another group of inherited dentin disorders resulting in characteristic features involving the dentin and root morphology. DD is rarer than DI, affecting 1:100,000.[5]

*Genetic etiology:* DD exhibits an autosomal dominant pattern of inheritance.[7-9 ~~5-7~~]

*Clinical manifestation:* In 1973, Shields and colleagues proposed a classification system of dentinal dysplasia.[23 ~~21~~]

Dentin Dysplasia Type I (Radicular Dentin Dysplasia; Rootless Teeth):[7-9 ~~5-7~~,33 ~~25~~] The crowns in DD Type I appear mostly normal in color and shape in both the primary and permanent dentitions. Occasionally, an amber translucency is apparent. The roots tend to be short and sharply constricted. DD Type I has been referred to as "rootless teeth" because of the shortened root length due to a loss of organization of root dentin. Wide variation of root formation and pulp formation exists due to the timing of dentinal disorganization. With early disorganization, the roots are extremely short or absent and no pulp can be detected. With later disorganization, the roots are shortened with crescent or chevron-shaped pulp chambers. With late disorganization, typical root lengths exist with pulp stones present in a normal shaped pulp

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chambers. This variability is most profound in the permanent dentition and can vary for each person and from tooth to tooth in a single individual.

Radiographically, the roots of all teeth in the primary and permanent dentitions are either short or abnormally shaped. The primary teeth have obliterated pulps that completely fill in before eruption. The extent of pulp canal and chamber obliteration in the permanent dentition is variable. Both the primary and permanent teeth demonstrate multiple periapical radiolucencies. They represent chronic abscesses, granulomas, or cysts. The inflammatory lesions appear secondary to caries or spontaneous coronal exposure of microscopic threads of pulpal remnants present within the defective dentin.

Dentin Dysplasia Type II (Coronal Dentin Dysplasia):[7-9~~5–7~~,33 ~~25~~] DD Type II demonstrates numerous features of DI. In contrast to DD Type I, root lengths are normal in both dentitions. The primary teeth are amber-colored closely resembling DI. Radiographically, the primary teeth exhibit bulbous crowns, cervical constrictions, thin roots, and early pulp obliteration. The permanent teeth are normal in coloration. Radiographically, they exhibit thistle-tube shaped pulp chambers with multiple pulp stones; periapical radiolucencies are not present.

*Differential diagnosis:* The first differential diagnosis for DD Type II is DI. The differentiation between DD and DI can be challenging because these 2 developmental anomalies form a continuum.[57] Both DD and DI have amber tooth coloration and obliterated or occluded pulp chambers. However, the pulp chambers do not fill in before eruption in DD Type II. A finding of a thistle-tube shaped pulp chamber in a single-rooted tooth increases the likelihood of DD diagnosis. The crowns in DD usually are normal in size, shape, and proportion while the crowns in DI typically are bell-shaped with a cervical constriction. The roots in DD usually are not present or appear normal while the roots in DI typically are short and narrow. Association of periapical radiolucencies with non-carious teeth and without obvious cause is an important characteristic of DD Type I.[7,8~~5,6~~]

An unrelated disorder with pulpal findings similar to DD Type II is pulpal dysplasia.[86] This

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process occurs in teeth that appear clinically normal. Radiographically, pulpal dysplasia exhibits thistle-tube shaped pulp chambers and multiple pulp stones in the both the primary and permanent dentitions.

**Recommendations**

**Amelogenesis Imperfecta**

*General considerations and principles of management:* A primary goal for treatment is to address each concern as it presents but with an overall comprehensive plan that outlines anticipated future treatment needs. Clinicians treating children and adolescents with AI must address the clinical and emotional demands of these disorders with sensitivity. It is important to establish good rapport with the child and family early. Timely intervention is critical to spare the patient from the psychosocial consequences of these potentially disfiguring conditions. A comprehensive and timely approach is reassuring to the patient and family and may help decrease their anxiety.[6]

*Preventive care:* Early identification and preventive interventions are critical for infants and children with AI in order to avoid the negative social and functional consequences of the disorder. [34] Regular periodic examinations can identify teeth needing care as they erupt. Meticulous oral hygiene, calculus removal, and oral rinses can improve periodontal health. Fluoride applications and desensitizing agents may diminish tooth sensitivity.[35, 36, ~~26,27.32~~]

*Restorative care:* The appearance, quality, and amount of affected enamel and dentin will dictate the type of restorations necessary to achieve esthetic, masticatory, and functional health.[35,39,40 ~~26,28,29~~]

When the enamel is intact but discolored, bleaching and/or microabrasion may be used to enhance the appearance.[36, 37 ~~30,31~~] If the enamel is hypocalcified, composite resin or porcelain veneers may be able to be retained with bonding.[28 ~~32~~] If the enamel or dentin cannot be bonded, full coverage restorations will be required.[19, 31-42 ~~17,33-38~~] In order to facilitate veneer or crown placement, periodontal therapy may be necessary when acute/chronic marginal gingivitis along with hyperplastic tissue exists. [41-48 ~~34,39-42~~]

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During the primary dentition, it is important to restore the teeth for adequate function and to maintain adequate arch parameters. Primary teeth may require composite or veneered anterior crowns with posterior full coverage steel or veneered crowns.[44,49,50, ~~35, 43, 44~~]

The permanent dentition usually involves a complex treatment plan with specialists from multiple disciplines.[46, 48,51 ~~38,41,45~~] Periodontics, endodontics, and orthodontics may be necessary and treatment could include orthognathic surgery.[44, 46, 52,53, ~~34,38,42,46,47~~] The prosthetic treatment may require veneers, full coverage crowns, implants, and fixed or removable prostheses.[39,45,48,51-53 ~~28,33,36,37,48-50~~] The fabrication of an occlusal splint ~~is advocated~~ may be needed to reestablish vertical dimension when full mouth rehabilitation is necessary.[22,49-51 ~~17,40,45~~] Therapy will need to be planned carefully in phases as teeth erupt and the need arises.

Behavior guidance, as well as the psychological health of the patient, will need to be addressed in each phase.[6] Counseling for the child or adolescent and his/her family should be recommended when negative psychosocial consequences of the disorder are recognized. ~~Due to extensive treatment needs, a patient may require sedation or general anesthesia for restorative care.[37]~~

**Dentinogenesis Imperfecta**

*General considerations and principles of management:* Providing optimal oral health treatment for DI frequently includes preventing severe attrition associated with enamel loss and rapid wear of the poorly mineralized dentin, rehabilitating dentitions that have undergone severe wear, optimizing esthetics, and preventing caries and periodontal disease. The dental approach for managing DI will vary depending on the severity of the clinical expression.

The clinician must be cautious in treating individuals with OI if performing surgical procedures or other treatment that could transmit forces to the jaws, increasing the risk of bone fracture. Some types of protective stabilization may be contraindicated in the patients with OI.

*Preventive care:* Early identification and preventive interventions are critical for individuals with DI in order to avoid the negative social and functional consequences of the disorder. Regular periodic examinations can identify teeth needing care as they erupt. Meticulous oral hygiene,

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calculus removal, and oral rinses can improve periodontal health. Fluoride applications and desensitizing agents may diminish tooth sensitivity.[35,36] [~~26,27~~]

*Restorative care:* Routine restorative techniques often can be used effectively to treat mild to moderate DI. These treatments more commonly are applied to the permanent teeth, as the permanent dentition frequently is less severely affected than the primary dentition. In more severe cases with significant enamel fracturing and rapid dental wear, the treatment of choice is full coverage restorations in both the primary and permanent dentitions.[49-51] [~~50~~] The success of full coverage is greatest in teeth with crowns and roots that exhibit close to a normal shape and size, minimizing the risk of cervical fracture. [49-51]

Ideally, restorative stabilization of the dentition will be completed before excessive wear and loss of vertical dimension occur[54] [~~51~~] Cases with significant loss of vertical dimension will benefit from reestablishing a more normal vertical dimension during dental rehabilitation. Cases having severe loss of coronal tooth structure and vertical dimension may be considered candidates for overdenture therapy. Overlay dentures placed on teeth that are covered with fluoride-releasing glass ionomer cement have been used with success.[68]

Bleaching has been reported to lighten the color of DI teeth with some success; however, because the discoloration is caused primarily by the underlying yellow-brown dentin, bleaching alone is unlikely to produce normal appearance in cases of significant discoloration. Different types of veneers can be used to improve the esthetics and mask the opalescent blue-gray discoloration of the anterior teeth.

*Endodontic considerations:* Some patients with dentinogenesis imperfecta will suffer from multiple periapical abscesses apparently resulting from pulpal strangulation secondary to pulpal obliteration or from pulp exposure due to extensive coronal wear. The potential for periapical abscesses is an indication for periodic radiographic surveys on individuals with DI. Because of pulpal obliteration, apical surgery may be required to maintain the abscessed teeth. Attempting to negotiate and instrument obliterated canals in DI teeth can result in lateral perforation due to the poorly mineralized dentin.

*Occlusion:* Class III malocclussion with high incidences of posterior crossbites and openbites

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occur in DI Type I and should be evaluated.[55,52] Multidisciplinary approaches are essential in addressing the complex needs of the individuals affected with DI.

**Dentin Dysplasia**

*General considerations and principles of management*[9,7]*:* The goal of treatment is to retain the teeth for as long as possible. However, due to shortened roots and periapical lesions, the prognosis for prolonged tooth retention is poor. Prosthetic replacement including dentures, overdentures, partial dentures, and/or dental implants may be required.

*Preventive care*[6]*:* ~~Preventive care is of foremost importance.~~ Meticulous oral hygiene must be established and maintained. As a result of shortened roots with DD Type I, early tooth loss from periodontitis is frequent.

*Restorative care:* Teeth with DD Type I have such poor crown to root ratios that prosthetic replacement including dentures, overdentures, partial dentures, and/or dental implants are the only practical courses for dental rehabilitation.[5] Teeth with DD Type II that are of normal shape, size, and support can be restored with full coverage restorations if necessary. For esthetics, discolored anterior teeth can be improved with resin bonding, veneering, or full coverage esthetic restorations.

Clinicians should be aware that even shallow occlusal restorations may result in pulpal necrosis due to the pulpal vascular channels that extend close to the dentin-enamel junction.[68] If periapical inflammatory lesions develop, the treatment plan is guided by the root length.[68]

*Endodontic considerations*[6]*:* Endodontic therapy, negotiating around pulp stones and through whorls of tubular dentin, has been successful in teeth without extremely short roots. Periapical curettage and retrograde amalgam seals have demonstrated short-term success in teeth with short roots.

**Ectodermal Dysplasia**

The AAPD endorses the National Foundation for Ectodermal Dysplasia's "Parameters of Oral Health Care for Individuals Affected by Ectodermal Dysplasia Syndromes."[2]

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Table 1. DENTINOGENESIS IMPERFECTA*

| **Shields** | **Clinical Presentation** | **Witkop** |
|---|---|---|
| Dentinogenesis Imperfecta I | Osteogenesis Imperfecta with | Dentinogenesis Imperfecta |

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| | | |
|---|---|---|
| | opalescent teeth | |
| Dentinogenesis Imperfecta II | Isolated Dentinogenesis Imperfecta | Hereditary Opalescent Dentin |
| Dentinogenesis Imperfecta III | Isolated Dentinogenesis Imperfecta | Brandywine Isolate |

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# Guideline on Dental Management of Pediatric Patients Receiving Chemotherapy, Hematopoietic Cell Transplantation, and/or Radiation

**Originating Committee**

Clinical Affairs Committee

**Review Council**

Council on Clinical Affairs

**Adopted**

1986

**Revised**

1991, 1997, 1999, 2001, 2004, 2008, 2013

**Reaffirmed**

1994

## Purpose

The American Academy of Pediatric Dentistry recognizes that the pediatric dental professional plays an important role in the diagnosis, prevention, stabilization, and treatment of oral and dental problems that can compromise the child's quality of life before, during, and after cancer treatment. Dental intervention with certain modifications must be done promptly and efficiently, with attention to the patient's medical history, treatment protocol, and health status. Chemotherapy and/or radiotherapy for the treatment of cancer or in preparation for hematopoietic cell transplantation (**HCT)*** may cause many acute and long-term side effects in the oral cavity. Furthermore, because of the immunosuppression the patients experience, any existing or potential sources of oral/dental infections and/or soft tissue trauma can compromise the medical treatment, leading to morbidity, mortality, and higher hospitalization costs. It is imperative that the pediatric dentist be familiar with the medical history as well as oral manifestations of the patient's underlying condition and the treatment differences for patients undergoing chemotherapy, radiotherapy ~~only~~ and those who will receive a~~n~~ HCT.

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***Footnote:***

**** The term HCT is also referred to as hematopoietic stem cell transplantation (HSCT)***

**Methods**

This guideline is ~~based on~~ an update ~~review~~ of the previous document adopted in 1986, and last revised in 2008. The update included a new ~~current dental and medical literature~~ systematic literature search of the PubMed electronic database with the following: TERMS: ~~related to dental management of pediatric patients receiving chemotherapy, hematopoietic cell transplantation, and/or radiation. A MEDLINE search was conducted using the terms~~ "pediatric cancer", "pediatric oncology", "hematopoietic cell transplantation", "hematopoietic stem cell transplantation", "bone marrow transplantation", "mucositis", "stomatitis", "chemotherapy", "~~radiation therapy~~radiotherapy", "acute effects", "long-term effects", "dental care", "oral health", "pediatric dentistry" ~~, and "clinical practice guidelines".~~ AND "practice guideline"; FIELD: All Fields; LIMITS: within the last 10 years; humans; English; clinical trials; birth through age 18. 61,432 articles matched these criteria. 133 papers for review were chosen from this list and from the references within selected articles. When data did not appear sufficient or were inconclusive, recommendations were based upon expert and/or consensus opinion by experienced researchers and clinicians.~~Expert opinions and best current practices were relied upon when sufficient scientific data were not available.~~

**Background**

A multidisciplinary approach involving oncologists, nurses, social workers, dieticians, dentists and other related health professionals are essential in caring for the child before, during and after any cancer therapy.[1] The oral cavity is highly susceptible to the effects of chemotherapy and radiation, and, is the most frequently documented source of sepsis in the immunosuppressed cancer patient.[1] ~~is the mouth; Therefore~~ For these reasons, early and definitive dental intervention, including comprehensive oral hygiene measures, reduces the risk for oral and associated systemic complications.[1-13] Acute oral sequelae as a result of cancer therapies and HCT regimens are common in children.[2] Oral and associated systemic complications may include: pain, mucositis, oral ulcerations, bleeding, taste dysfunction, secondary infections (i.e. candidiasis, herpes simplex virus), dental caries, salivary gland

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dysfunction (i.e. xerostomia), neurotoxicity, mucosal fibrosis, post-radiation osteonecrosis, soft tissue necrosis, temporomandibular dysfunction (i.e. trismus), craniofacial and dental developmental anomalies and oral graft versus host disease (**GVHD**).[1,2,14] All patients with cancer should have an oral examination ~~before~~ prior to initiation of the oncology therapy.[1]~~, and~~ Prevention and treatment of preexisting or concomitant oral disease is essential to minimize complications in this population.[1] The key to success in maintaining a healthy oral cavity during cancer therapy is patient compliance. The child and the parents should be educated regarding the possible acute side effects and the long-term sequelae of cancer therapies in the oral cavity.[~~1~~2-6,8,15-17~~14-16~~] ~~Younger patients present more oral problems than adults.[2]~~ Because there are many oncology and HCT protocols, every patient should be managed on an individual basis and ~~appropriate~~ consultations with their physicians and other dental specialists should be sought before dental care is instituted.[5]

**Recommendations**

**Dental and oral care before the initiation of cancer therapy**

*Objectives*

The objectives of a dental/oral examination before cancer therapy starts are ~~two~~three-fold[16]:

1. to identify and stabilize or eliminate existing and potential sources of infection and local irritants in the oral cavity—without needlessly delaying the cancer treatment or inducing complications; ~~and~~

2. to communicate with the oncology team regarding the patient's oral health status, plan and timing of treatment; and

3. to educate the patient and parents about the importance of optimal oral care in order to minimize oral problems/discomfort before, during, and after treatment and about the possible acute and long-term effects of the therapy in the oral cavity and the craniofacial complex.

*Initial evaluation*

Medical history review: should include, but not be limited to, ~~type of~~ disease/condition (type, stage, prognosis), treatment protocol (conditioning regimen, surgery, chemotherapy, radiation, transplant), medications (including bisphosphonates), allergies, surgeries, secondary medical diagnoses, hematological status (complete blood count, **CBC**), coagulation status ~~and~~

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immunosuppression status, presence of an indwelling venous access line, and contact of oncology team/primary care physician(s).[1] For HCT patients, include type of transplant, HCT source (bone marrow, peripheral stem cells or cord blood stem cells), matching status, donor, conditioning protocol, date of transplant, and presence of graft versus host disease (GVHD) or signs of transplant rejection.~~prophylaxis~~. The American Heart Association (**AHA**) recommends that antibiotic prophylaxis for nonvalvular devices, including indwelling vascular catheters (eg, central lines) is indicated only at the time of placement of these devices in order to prevent surgical site infections.~~17~~ **18-20**The AHA found no convincing evidence that microorganisms associated with dental procedures cause infection of nonvalvular devices at any time after implantation.~~17~~ **18-20** The infections occurring after device implantation most often are caused by staphyloccal Gram-negative bacteria or other microorganisms associated with surgical implantation or other active infections.[18-19] Due to the risk of antibiotic adverse events, development of drug resistance among oral flora, spectrum of non-oral bacteria causing catheter-related infections and lack of evidence from clinical trials, antibiotic prophylaxis is not necessary for patients with an indwelling central venous catheter who are undergoing dental procedures.[18-19] ~~The AHA further states that i~~Immunosuppression is not an independent risk factor for nonvalvular device infections; immunocompromised hosts who have those devices should receive antibiotic prophylaxis as advocated for immunocompetent hosts.~~17~~[18-22] Consultation with the child's physician is recommended for management of patients with nonvalvular devices.

Dental history review: includes information such as fluoride exposure, habits, trauma, symptomatic teeth, previous care, preventive practices, oral hygiene, and diet assessment. ~~etc~~.

Oral/dental assessment: should include thorough head, neck, and intraoral examinations, oral hygiene assessment and training, and radiographic evaluation based on history and clinical findings.

*Preventive strategies*

Oral hygiene: Oral hygiene includes brushing of the teeth and tongue 2 to 3 times daily with

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regular soft nylon brush or electric toothbrush, regardless of the hematological status[4,5,8,9,13,18,21,27] Ultrasonic brushes and dental floss should be allowed only if the patient is properly trained.[1,8] Patients with poor oral hygiene and/or periodontal disease may use chlorhexidine rinses daily until the tissue health improves or mucositis develops.[4] The high alcohol content of commercially-available chlorhexidine mouthwash may cause discomfort and dehydrate the tissues in patients with mucositis; thus, an alcohol-free chlorhexidine solution is indicated in this situation.

Diet: Dental practitioners should encourage a non-cariogenic diet and advise patients/parents about the high cariogenic potential of dietary supplements rich in carbohydrates and oral pediatric medications rich in sucrose.[4]

Fluoride: Preventive measures include the use of fluoridated toothpaste or gel, fluoride supplements if indicated, neutral fluoride gels/rinses, or applications of fluoride varnish for patients at risk for caries and/or xerostomia.[4,8] A brush-on technique is convenient and may increase the likelihood of patient compliance with topical fluoride therapy.[8]

Trismus prevention/treatment: Patients who receive radiation therapy to the masticatory muscles may develop trismus. Thus, daily oral stretching exercises/physical therapy should start before radiation is initiated and continue throughout treatment. Therapy for trismus may include prosthetic aids to reduce the severity of fibrosis, trigger-point injections, analgesics, muscle-relaxants, and other pain management strategies.[3,5,10]

Reduction of radiation to healthy oral tissues: In cases of radiation to the head and neck, the use of lead-lined stents, prostheses, and shields, as well as salivary gland sparing techniques (eg, 3-dimensional conformal or intensity modulated radiotherapy, concomitant cytoprotectants, surgical transfer of salivary glands), should be discussed with the radiation oncologist.

Education: Patient/parent education includes the importance of optimal oral care in order to minimize oral problems/discomfort before, during, and after treatment and the possible acute

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and long-term effects of the therapy in the craniofacial complex.[1]

*Dental care*

Hematological considerations:[14]

1. Absolute neutrophil count (**ANC**):

• >2,000/mm$^3$: no need for antibiotic prophylaxis.[1,10]

• 1,000 – 2,000/mm$^3$: Use clinical judgement[1] based on the patient's health status and planned procedures. ~~no need for antibiotic prophylaxis.10 However, s~~Some authors[1,5] suggest that antibiotic coverage (dosed per AHA recommendations[19]) may be prescribed when the ANC is between 1,000 and 2,000/mm$^3$. If infection is present or unclear, more aggressive antibiotic therapy may be indicated and should be discussed with the medical team.

• <1,000/mm$^3$: defer elective dental care ~~until the ANC rises~~. In dental emergency cases, discuss antibiotic coverage (antibiotic ~~beyond endocarditis~~ prophylaxis versus antibiotic coverage for a period of time) with medical team before proceeding with treatment. The patient may need hospitalization for dental management.[12]

2. Platelet count[5,14~~10~~]:

• >75,000/mm$^3$: no additional support needed. ~~but the dentist should be prepared to treat prolonged bleeding by using sutures, hemostatic agents, pressure packs, gelatin foams, etc~~.

• 40,000 to 75,000/mm$^3$: platelet transfusions may be considered pre- and 24 hours post-operatively. Localized procedures to manage prolonged bleeding may include sutures, hemostatic agents, pressure packs, and/or gelatin foams.

• <40,000/mm$^3$: defer care. In dental emergency cases, contact the patient's physician to discuss supportive measures (eg, platelet transfusions, bleeding control, hospital admission and care) before proceeding. In addition, localized procedures (i.e. microfibrillar collagen, topical thrombin) and additional medications as recommended by the hematologist/oncologist (i.e. aminocaproic acid, tranexamic acid) may help control bleeding.[1]

3. Other coagulation tests may be in order for individual patients.

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Dental procedures:

1. In general terms, most oncology/hematology protocols (exclusive of HCT, which will be discussed later) are divided into phases (cycles) of chemotherapy, in addition to other therapies (eg, radiotherapy, surgery). The patient's blood counts normally start falling 5 to 7 days after the beginning of each cycle, staying low for approximately 14-21 days, before rising again to normal levels for a few days until the next cycle begins. Ideally, all dental care should be completed before cancer therapy is initiated. When that is not feasible, temporary restorations may be placed and non-acute dental treatment may be delayed until the patient's hematological status is stable.[1,5,8,10,11]
2. Prioritizing procedures: When all dental needs cannot be treated before cancer therapy is initiated, priorities should be infections, extractions, periodontal care (eg, scaling, prophylaxis), and sources of tissue irritation before the treatment of carious teeth, root canal therapy for permanent teeth, and replacement of faulty restorations.[10, 14] The risk for pulpal infection and pain determine which carious lesions should be treated first.[8] Incipient to small carious lesions may be treated with fluorides and/or sealants until definitive care can be accomplished.[5] It is important for the practitioner to be aware that the signs and symptoms of periodontal disease may be decreased in immunosuppressed patients.[5]
3. Pulp therapy in primary teeth: Although there have been no studies to date that address the safety of performing pulp therapy in primary teeth prior to the initiation of chemotherapy and/or radiotherapy, many clinicians choose to provide a more definitive treatment in the form of extraction because pulpal/periapical/furcal infections during immunosuppression periods can have a significant impact on cancer treatment and become life-threatening.[5,8,11, 14] Teeth that already have been treated pulpally and are clinically and radiographically sound should be monitored periodically for signs of internal resoption or failure due to pulpal/periapical/furcal infections. present minimal risk.
4. Endodontic treatment in permanent teeth: Symptomatic non-vital permanent teeth should receive root canal treatment at least 1 week before initiation of cancer therapy to allow sufficient time to assess treatment success before the chemotherapy.[5,10, 14] If that is not possible, extraction is indicated. Extraction is also the treatment of choice for teeth that cannot be treated by definitive endodontic treatment in a single visit. In that case, the

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extraction should be followed by antibiotic therapy (penicillin or for penicillin-allergic patients, clindamycin) for about 1 week.[5,10,12] Endodontic treatment of a~~A~~symptomatic non-vital ~~endodontic needs in~~ permanent teeth may be delayed until the hematological status of the patient is stable.[10,11,~~20,~~ 14,23] It is important that the etiology of periapical lesions associated with previously endodontically treated teeth be determined because they can be due to a number of factors including pulpal infections, inflammatory reactions, apical scars, cysts, and malignancy.[8] If a periapical lesion is associated with an endodontically treated tooth and no signs or symptoms of infection are present, there is no need for retreatment or extraction since the radiolucency likely is due to an apical scar.[~~20~~23]

5. Orthodontic appliances and space maintainers: Poorly-fitting appliances can abrade oral mucosa and increase the risk of microbial invasion into deeper tissues.[5] Appliances should be removed if the patient has poor oral hygiene and/or the treatment protocol or HCT conditioning regimen carries a risk for the development of moderate to severe mucositis.[14] Simple appliances (eg, band and loops, fixed lower lingual arches) that are not irritating to the soft tissues may be left in place in patients who present good oral hygiene.[~~1,~~8, 14] Removable appliances and retainers that fit well may be worn as long as tolerated by the patient who maintains good oral care.[5,8,~~21~~24] Patients should be instructed to clean their ~~changes~~ appliance ~~soaking solutions~~ daily and routinely clean appliance cases with an antimicrobial solution to prevent contamination and reduce the risk of appliance-associated oral infections.[5] If band removal is not possible, vinyl mouth guards or orthodontic wax should be used to decrease tissue trauma.[8]

6. Periodontal considerations: Partially erupted molars can become a source of infection because of pericoronitis. The overlying gingival tissue should be excised if the dentist believes it is a potential risk and if the hematological status permits.[8,10] Patients should have a periodontal assessment and appropriate therapy prior to receiving bisphosphonates as part of cancer treatment.[~~22,23~~25-27] Extraction is also the treatment of choice for teeth with a poor prognosis that cannot be treated by definitive periodontal therapy. If the patient has had bisphosphonates and an invasive periodontal procedure is indicated, risks must be discussed with the patient, parents, and physicians prior to the procedure.

7. Extractions: There are no clear recommendations for the use of prophylactic antibiotics for

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extractions.A Recommendations generally have been empiric or based on anecdotal experience. Surgical procedures must be as atraumatic as possible, with no sharp bony edges remaining and satisfactory closure of the wounds.[5,8,10-12] If there is documented infection associated with the tooth, antibiotics (ideally chosen with the benefit of sensitivity testing)should be administered for about 1 week.[5,8,10,12]

- To minimize the risk of development of osteonecrosis~~,~~ ~~or~~ osteoradionecrosis or bisphosphonate related osteonecrosis of the jaw (BRONJ), patients who will receive ~~bisphosphonates or~~ radiation to the jaws or bisphosphonate treatment as part of the cancer treatment must have all oral surgical procedures completed before those measures are instituted.[~~22,23~~25-27] If the patient has received bisphosphonates or radiation to the jaws and an oral surgical procedure is necessary, risks must be discussed with the patient, parents, and physician prior to the procedure. There is an increased risk of BRONJ after a tooth extraction or periodontal disease in patients undergoing long-term, potent, high-dose intravenous bisphosphonates,[25-27] however, most of the evidence has been described in the adult population.[26] Patients with a high risk of BRONJ are best managed by a dental specialist in coordination with the oncology team in the hospital setting.
- Loose primary teeth should be allowed to exfoliate naturally~~, and the patient should be counseled to not play with them in order to avoid bacteremia. When the patient cannot comply with this recommendation, the teeth should be removed if the hematologic parameters allow~~.
- Nonrestorable teeth, root tips, teeth with periodontal pockets >6 mm, symptomatic impacted teeth, and teeth exhibiting acute infections, significant bone loss, involvement of the furcation, or mobility should be removed ideally 2 weeks (or at least 7 to 10 days) before cancer therapy is initiated to allow adequate healing.[~~1,~~5,8,10,11,14]
- Some practitioners prefer to extract all third molars that are not fully erupted, particularly prior to HCT, while others favor a more conservative approach, recommending extraction of third molars at risk for pulpal infection or those associated with significant pathology, infection, periodontal disease, ~~infection, including~~ pericoronitis, or if the tooth is malpositioned or non-functional.[8,28-29]

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It is vital to communicate the comprehensive oral care plan with the oncology team. Inform them of the severity of dental caries (number of teeth involved and which teeth need immediate treatment), endodontic needs (pulpal versus periapical infection), periodontal status, number of teeth requiring extraction, soft tissue pathology and any other urgent care needed. It is important to discuss with the oncology team how much time is needed for the stabilization of oral disease as this will also affect the timing of the treatment or conditioning protocols.[1]

**Dental and oral care during immunosupression periods**

*Objectives*

The objectives of a dental/oral care during cancer therapy are three-fold:

1. to maintain optimal oral health during cancer therapy;
2. to manage any oral side effects that may develop as a consequence of the cancer therapy; and
3. to reinforce the patient and parents' education regarding the importance of optimal oral care in order to minimize oral problems/discomfort during treatment.

*Preventive strategies*

Oral hygiene: Intensive oral care is of paramount importance because it reduces the risk of developing moderate/severe mucositis without causing an increase in septicemia and infections in the oral cavity.[1-12,13,24] Thrombocytopenia should not be the sole determinant of oral hygiene as patients are able to brush without bleeding at widely different levels of platelet count.[8,9,~~13~~] Patients should use a soft nylon brush 2 to 3 times daily and replace it on a regular (every 2-3 months) basis.[8,13,24] Fluoridated toothpaste may be used but, if the patient does not tolerate it during periods of mucositis due to oral burning or stinging sensations, it may be discontinued and the patient should switch to mild-flavored fluoridated toothpaste.[1]~~brush with water alone.~~ If moderate to severe mucositis develops and the patient cannot tolerate a regular soft nylon toothbrush or an end-tufted brush, foam brushes or super soft brushes soaked in chlorhexidine may be used.[9,17] Otherwise, foam or super soft brushes should be discouraged because they do not allow for effective cleaning.[9,~~19~~22] The use of a regular brush should be resumed as soon as the mucositis improves.[8,13,28] Brushes should be air-dried between uses.[8] Electric or ultrasonic brushes are acceptable if the patient is capable of using them without causing trauma and irritation.[~~1,~~8] If patients are skilled at flossing without traumatizing the tissues, it is reasonable to

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continue flossing throughout treatment.[8] Toothpicks and water irrigation devices should not be used when the patient is pancytopenic to avoid tissue trauma.[8,10]

Diet: Dental practitioners should encourage a non-cariogenic diet and advise patients/parents about the high cariogenic potential of dietary supplements rich in carbohydrate and oral pediatric medications rich in sucrose.[4]

Fluoride: Preventive measures include the use of fluoridated toothpaste or gel, fluoride supplements if indicated, neutral fluoride gels/rinses, or applications of fluoride varnish for patients at risk for caries and/or xerostomia. A brush-on technique is convenient, familiar, and simple and may increase the likelihood of patient compliance with topical fluoride therapy.[8]

Lip care: Lanolin-based creams and ointments are more effective in moisturizing and protecting against damage than petrolatum-based products.[8,11]

Education: Patient/parent education includes reinforcing the importance of optimal oral hygiene and teaching strategies to manage soft tissue changes (eg, mucositis, oral bleeding, xerostomia) in order to minimize oral problems/discomfort during treatment and the possible acute and long-term effects of the therapy in the craniofacial complex.

*Dental care*

During immunosuppression, elective dental care ~~must~~ should not be provided. If a dental emergency arises, the treatment plan should be discussed with the patient's physician who will make recommendations for supportive medical therapies (eg, antibiotics, platelet transfusions, analgesia). The patient should be seen every 6 months (or in shorter intervals if there is a risk of xerostomia, caries, trismus, and/or chronic oral GVHD) for an oral health evaluation during treatment, in times of stable hematological status and always after reviewing the medical history. ~~If a central line is still in place and an invasive dental procedure is planned, consultation with the oncologist is recommended.[17]~~ b

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*Management of oral conditions related to cancer therapies*

Mucositis: Mucositis care remains focused on palliation of symptoms and efforts to reduce the influence of secondary factors on mucositis.[5,10,12,30] The Multinational Association of Supportive Care in Cancer/International Society of Oral Oncology has published guidelines ~~(which are updated regularly)~~ for treatment of mucositis.[~~24~~13, 28] The most common prescriptions for management of mucositis include good oral hygiene, analgesics, non-medicated oral rinses (i.e. 0.9% saline or sodium bicarbonate mouth rinses 4-6 times/day), and parenteral nutrition as needed.[1,7,13] Mucosal coating agents such as Amphojel®, Kaopectate®, hydroxypropylmethylcellulose film-forming agents (e.g.. Zilactin® and Gelclair®) have also been suggested.[1] The use of palifermin, also known as keratinocyte growth factor-1, for prevention of oral mucositis associated with HCT and oral cryotherapy as prophylaxis and treatment to decrease mucositis have recently been recommended.[1,13, 28] Palifermin has been observed to decrease the incidence and duration of severe oral mucositis in patients undergoing conditioning with high-dose chemotherapy, with or without radiotherapy, followed by HCT.[7] The guidelines, however, did not recommend the use of sucralfate, antimicrobial lozenges, pentoxifylline and granulocyte–macrophage-colony stimulating factor mouthwash for oral mucositis.[13,28] In addition to oral care, there is limited evidence of the potential use of low-level laser therapy when applied daily to oral lesions has been shown to decrease the duration of chemotherapy induced oral mucositis.[29-30] Appropriate protocol must be followed when using low-level laser therapy to prevent contamination and occupational risks to the child and dental team. Studies on the use of chlorhexidine for mucositis have given conflicting results. Most studies have not demonstrated a prophylactic impact, although reduced colonization of candidial species has been shown.[7,12,~~24~~28] Chlorhexidine is no longer recommended for preventing oral mucositis in patients undergoing radiotherapy.[13] Patient-controlled analgesia has been helpful in relieving pain associated with mucositis, reducing the requirement for oral analgesics. There is no significant evidence of the effectiveness or tolerability of mixtures containing topical anesthetics (eg, "Philadelphia mouthwash", "magic mouthwash").[~~24~~28] The use of topical anesthetics ~~often is~~ has been recommended for pain management although there are no studies available to assess the benefit and potential for toxicity. Topical anesthetics only provide short term pain relief.[13] Lidocaine use may obtund or diminish taste and the gag reflex

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and/or result in a burning sensation, in addition to possible cardiovsascular and central nervous system effects. ~~Local application may be useful for painful ulcers.[7]~~

Oral mucosal infections: The signs of inflammation and infection may be greatly diminished during neutropenic periods. Thus, the clinical appearance of infections may differ significantly from the normal.~~[1,]~~[10] Close monitoring of the oral cavity allows for timely diagnosis and treatment of fungal, viral, and bacterial infections. Prophylactic nystatin is not effective for the prevention and/or treatment of fungal infections.[5,~~26~~31] Oral cultures and/or biopsies of all suspicious lesions should be performed and prophylactic medications should be initiated until more specific therapy can be prescribed.[1,5,8-12]

Oral bleeding: Oral bleeding occurs due to thrombocytopenia, disturbance of coagulation factors, and/or damaged vascular integrity. Management should consist of local approaches (eg, pressure packs, antifibrinolytic rinses or topical agents, gelatin sponges) and systemic measures (eg, platelet transfusions, aminocaproic acid).[~~5,6~~,8,10]

Dental sensitivity/pain: Tooth sensitivity could be related to decreased secretion of saliva during radiation therapy and the lowered salivary pH.[5,8,10] Patients who are using plant alkaloid chemotherapeutic agents (eg, vincristine, vinblastine) may present with deep, constant pain affecting the mandibular molars with greater frequency, in the absence of odontogenic pathology. The pain usually is transient and generally subsides shortly after dose reduction and/or cessation of chemotherapy.[5,8,10]

Xerostomia: Sugar-free chewing gum or candy, sucking tablets, special dentifrices for oral dryness, saliva substitutes, frequent sipping of water, alcohol-free oral rinses, and/or oral moisturizers are recommended.[8,~~33~~27] Placing a humidifier by bedside at night may be useful.[10] Saliva stimulating drugs are not approved for use in children. Fluoride rinses and gels are recommended highly for caries prevention in these patients.

Trismus: Daily oral stretching exercises/physical therapy must continue during radiation

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treatment. Management of trismus may include prosthetic aids to reduce the severity of fibrosis, trigger-point injections, analgesics, muscle relaxants, and other pain management strategies.[3,5,10]

**Dental and oral care after the cancer therapy is completed (exclusive of HCT)**

*Objectives*

The objectives of a dental/oral examination after cancer therapy ends are ~~two~~three-fold:

1. to maintain optimal oral health; ~~and~~
2. to reinforce to the patient/parents the importance of optimal oral and dental care for life~~.~~
3. to address and/or treat any dental issues that may arise as a result of the long-term effects of cancer therapy.

*Preventive strategies*

Oral hygiene: Patients must brush their teeth 2 to 3 times daily with a soft nylon toothbrush. Brushes should be air-dried between uses.[8] Patients should floss daily.

Diet: Dental practitioners should encourage a non-cariogenic diet and advise patients/parents about the high cariogenic potential of dietary supplements rich in carbohydrate and oral pediatric medications rich in sucrose.

Fluoride: Preventive measures include the use of fluoridated toothpaste or gel, fluoride supplements if indicated, neutral fluoride gels/rinses, or applications of fluoride varnish for patients at risk for caries and/or xerostomia. A brush-on technique is convenient, familiar, and simple and may increase the likelihood of patient compliance with topical fluoride therapy.[8]

Lip care: Lanolin-based creams and ointments are more effective in moisturizing and protecting against damage than petrolatum-based products.[8,11]

Education: The importance of optimal oral and dental care for life must be reinforced. It is also important to emphasize the need for regular follow-ups with a dental professional, especially for patients who are at risk for or have developed GVHD and/or xerostomia and those less than

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6 years of age during treatment due to potential dental developmental problems caused by cancer therapies.

*Dental care*

Periodic evaluation: The patient should be seen at least every 6 months (or in shorter intervals if issues such as chronic oral GVHD, xerostomia, or trismus are present). Patients who have experienced moderate or severe mucositis and/or chronic oral GVHD should be followed closely for malignant transformation of their oral mucosa (eg, oral squamous cell carcinoma).[6,32~~25~~]

Orthodontic treatment: Orthodontic care may start or resume after completion of all therapy and after at least a 2 year disease-free survival when the risk of relapse is decreased and the patient is no longer using immunosuppressive drugs.[~~21~~24] A thorough assessment of any dental developmental disturbances caused by the cancer therapy must be performed before initiating orthodontic treatment. The following strategies should be considered when providing orthodontic care for patients with dental sequelae: (1) use appliances that minimize the riskof root resorption, (2) use lighter forces, (3) terminate treatment earlier than normal, (4) choose the simplest method for the treatment needs, and (5) do not treat the lower jaw.[~~28~~34] However, specific guidelines for orthodontic management, including optimal force and pace, remain undefined. Patients who have used or will be given bisphosphonates in the future present a challenge for orthodontic care. Although bisphosphonate inhibition of tooth movement has been reported in animals, it has not been quantified for any dose or duration of therapy in humans.[~~29~~35] Consultation with the patient's parents and physician regarding the risks and benefits of orthodontic care in this situation is recommended.

Oral surgery: Consultation with an oral surgeon and/or periodontist and the patient's physician is recommended for non-elective oral surgical and invasive periodontal procedures in patients who have used or are using bisphosphonates or those who received radiation therapy to the jaws in order to devise strategies to decrease the risk of osteonecrosis and osteoradio-necrosis, respectively.[25-27] Elective invasive procedures should be avoided in these patients.[~~28~~34]

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Patients with a high risk of BRONJ are best managed by in coordination with the oncology team in the hospital setting.

Xerostomia: Sugar-free chewing gum or candy, special dentifrices for oral dryness, saliva substitutes, frequent sipping of water, alcohol-free oral rinses, and/or oral moisturizers are recommended.[8,~~27~~33] Placing a humidifier by bedside at night may be useful[10]. Saliva stimulating drugs are not approved for use in children. Fluoride rinses and gels are recommended highly for caries prevention in these patients.

Trismus: Daily oral stretching exercises/physical therapy should continue after radiation therapy is finished in order to prevent or ameliorate trismus. Management of trismus may include prosthetic aids to reduce the severity of fibrosis, trigger-point injections, analgesics, muscle-relaxants, and other pain management strategies.[3,5,10]

**Hematopoietic cell transplantation**

Specific oral complications can be correlated with phases of HCT.[1,8,14,15]

*Phase I: ~~Pre-transplantation~~ Preconditioning*

The oral complications are related to the current systemic and oral health, oral manifestations of the underlying condition, and oral complications of recent medical therapy. Oral complications observed include oral infections, gingival leukemic infiltrates, bleeding, ulceration, termporomandibular dysfunction.[1] Most of the principles of dental and oral care before the transplant are similar to those discussed for pediatric cancer.[1~~7~~6] The 2 major differences are: 1) in HCT, the patient receives all the chemotherapy and/or total body irradiation in just a few days before the transplant, and 2) there will be prolonged immunosuppression following the transplant. Elective dentistry will need to be postponed until immunological recovery has occurred, ~~which may take as long as 9 to 12 months after HCT~~at least 100 days following HCT, or longer if chronic GVHD or other complications are present.[5,8] Therefore, all dental treatment ~~must~~ should be completed before the patient becomes immunosuppressed.

*Phase II: Conditioning~~/~~ neutropenic phase*

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In this phase, which encompasses the day the patient is admitted to the hospital to begin the transplant conditioning to 30 days post-HCT, the oral complications are related to the conditioning regimen and supportive medical therapies.[8] Mucositis, xerostomia, oral pain, ~~oral bleeding~~hemorrhage, opportunistic infections, ~~and~~ taste dysfunction, neurotoxicity (including dental pain, muscle tremors), and temporomandibular dysfunction (including jaw pain, headache, joint pain) may be seen, typically with a high prevalence and severity of oral complications.[1] Oral mucositis usually begins 7 to 10 days after initiation of conditioning and symptoms continue approximately 2 weeks after the end of conditioning.[1] Among allogeneic transplant patients, hyperacute GVHD can occur, causing more severe inflammation and severe mucositis symptoms, however its clinical presentation is difficult to diagnose.[1] The patient should be followed closely to monitor and manage the oral changes and to reinforce the importance of optimal oral care. Dental procedures usually are not allowed in this phase due to the patient's severe immunosuppression. If emergency treatment is necessary, consult and coordinate with the attending hematology/oncology team.

*Phase III: ~~Initial e~~Engraftment ~~to~~ hematopoietic recovery~~reconstitution~~*

The intensity and severity of complications begin to decrease normally 3 to 4 weeks after transplantation. Oral fungal infections and herpes simplex virus infection are most notable.[1] ~~Oral~~ Acute GVHD can become a concern for allogeneic graft recipients.[1] Xerostomia, hemorrhage, neurotoxicity, temporomandibular dysfunction and granulomas/papillomas are sometimes observed.[1] A dental /oral examination should be performed and invasive dental procedures, including dental cleanings and soft tissue curettage, should be done only if authorized by the HCT team because of the patient's continued immunosuppression.[8] Patients should be encouraged to optimize oral hygiene and avoid a cariogenic diet. Attention to xerostomia and oral GVHD manifestations is crucial. HCT patients are particularly sensitive to intraoral thermal stimuli between 2 and 4 months post-transplant.[8] The mechanism is not well understood, but the symptoms usually resolve spontaneously within a few months. Topical application of neutral fluoride or desensitizing toothpastes helps reduce the symptoms.[8]

*Phase IV: Immune reconstitution~~/~~ late posttransplantat~~ion~~*

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After day 100 post-HCT, the oral complications predominantly are related to the chronic toxicity associated with the conditioning regimen, including salivary dysfunction, craniofacial growth abnormalities ~~(especially in patients less than 6 years of age at the time of treatment)~~, late viral infections, oral chronic GVHD, and oral squamous cell carcinoma.[1,8] Xerostomia and relapse-related oral lesions may also be observed.[1] Unless the patient is neutropenic or with severe chronic GVHD, mucosal bacterial infections are less frequently seen. Periodic dental examinations with radiographs can be performed, but invasive dental treatment should be avoided in patients with profound impairment of immune function.[8] Consultation with the patient's physician and parents regarding the risks and benefits of orthodontic care is recommended.

*Phase V: Long-term survival*

Craniofacial, skeletal growth and dental developmental issues are some of the complications faced by cancer survivors[1,8,14] and usually develop among children who were less than 6 years of age at the time of their cancer therapy.[8,14] Long term effects of cancer therapy may include tooth agenesis, microdontia, crown disturbances (size shape, enamel hypoplasia, pulp chamber anomalies), root disturbances (early apical closure, blunting, changes in shape or length), reduced mandibular length, and reduced alveolar process height.[14] The severity of the dental developmental anomaly will depend on the age and stage of development during their exposure to cytotoxic agents or ionizing radiation. Patients may experience permanent salivary gland hypofunction/dysfunction or xerostomia.[36] Relapse or secondary malignancies can also develop at this stage.[1] Routine periodic examinations are necessary to provide comprehensive oral health care. Careful examination of extraoral and intraoral tissues (including clinical, radiographic and/or additional diagnostic exams) are integral to diagnosing any secondary malignancies in the head and neck region. Dental treatment may require a multidisciplinary approach, involving a variety of dental specialists to address the treatment needs of each individual. Consultation with the patient's physician is recommended when relapse or the patient's immunologic status declines.

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# Policy on Stem Cells

**Originating Council**

Council on Clinical Affairs

**Adopted**

~~2008~~2012

Stem cells are pluripotential cells that can divide and multiply for an extended period of time, differentiating into a diverse range of specialized cell types and tissues. ~~Adult~~ M~~m~~esenchymal stem cells, of which dental stem cells are a subset, are highly proliferative ~~display inherent plasticity, the ability to proliferate~~ , and have the ability to differentiate into many cell lines[1]. The most familiar application of adult stem cell therapy is bone marrow transplantation to treat hematopoietic cancers, metabolic disorders, and congenital immunodeficiency syndromes. Stem cell therapy is undergoing clinical testing for other conditions such as Parkinson's disease, diabetes, and brain trauma/spinal cord injuries[2,3]. Suggested applications related to oral health care have included wound healing and regeneration of dental and periodontal tissues as well as craniofacial structures (eg, repair of cleft lip/palate)[4].

Parents may elect to preserve umbilical cord blood of their child for future harvesting of stem cells if autologous regenerative therapies are indicated. Pulpal tissue of exfoliating primary teeth and surgically removed third molars may serve as a source of ~~adult~~ mesenchymal stem cells[5]. While sources of dental stem cells are readily accessible, those cells must be secured and stored properly to maintain the potential to proliferate and differentiate[6]. The public is increasingly aware of this emerging science, and more parents are expressing interest in harvesting/banking dental stem cells.

The American Academy of Pediatric Dentistry recognizes the emerging field of regenerative medicine and encourages dentists to follow future evidence-based literature in order to educate parents about the collection, storage, viability, and use of dental stem cells with respect to autologous regenerative therapies. As the technology continues to evolve, the process of

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procurement of dental stems cells should be accomplished only with deliberate integrity and appropriate informed consent to assure the highest ethical standards and quality of outcomes.

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# Policy on Use of Fluoride

**Originating Committee**

Liaison with Other Groups Committee

**Review Council**

Council on Clinical Affairs

**Adopted**

1967

**Revised**

1978, 1995, 2000, 2001, 2003, 2007, 2008, 2013

**Reaffirmed**

1977

## Purpose

The American Academy of Pediatric Dentistry (**AAPD**), affirming that fluoride is a safe and effective adjunct in reducing the risk of caries and reversing enamel demineralization, encourages public health officials, health care providers, and parents/caregivers to optimize fluoride exposure.

## Methods

A ~~MEDLINE~~ electronic database search was conducted using the terms "fluoride", "fluoridation", "acidulated phosphate fluoride", "fluoride varnish", "fluoride therapy", and "topical fluoride" to update this policy. Expert opinions and best current practices also were relied upon for this guideline.

## Background

The adjustment of the fluoride level in community water supplies to optimal concentration is the most beneficial and inexpensive method of reducing the occurrence of caries.[1] Epidemiologic data ~~within~~ in the last half-century indicate reductions in caries of 55 to 60%, and recent data still show caries reduction of approximately 25%, without significant enamel

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fluorosis, when domestic water supplies are fluoridated at an optimal level.[2] Evidence accumulated from long-term use of fluorides has demonstrated that the cost of oral health care for children can be reduced by as much as 50%.[3] These savings in health dollars accrue to private individuals, group purchasers, and government care programs. An even higher caries reduction can be obtained if the proper use of fluorides is combined with other dietary, oral hygiene, and preventive measures[4,5] as prescribed by a dentist familiar with the child's oral health and family history.

A large body of literature supports the incorporation of optimal fluoride levels in drinking water supplies. When fluoridation of drinking water is impossible, effective systemic fluoridation can be achieved through the intake of daily fluoride supplements. Before supplements are prescribed, it is essential to review dietary sources of fluoride (eg, all drinking water sources, consumed beverages, prepared food, toothpaste) to determine the patient's true exposure to fluoride.[1,6,7] Fluoride content of ready to use infant formulas in the US and Canada ranges from 0.1 to 0.3 mg/L[8], which provides only a modest source of fluoride. ~~Non-milk based formulas have higher fluoride content because the calcium that is added to formula contains fluoride.~~ The more important issue, however, is the fluoride content of concentrated or powdered formula when reconstituted with fluoridated water. Considering the potential for mild fluorosis, caution is advised for infants consuming formula that is reconstituted with optimally-fluoridated water.[9]

Significant cariostatic benefits can be achieved by the use of <u>over the counter</u> fluoride-containing preparations such as toothpastes, gels, and rinses, especially in areas without water fluoridation.[1] Monitoring children's use of topical fluoride-containing products, including toothpaste, may prevent ingestion of excessive amounts of fluoride.[10] <u>Also numerous</u> ~~A number of~~ clinical trials have confirmed the anticaries effect of professional topical fluoride treatments, including <u>1.23% acidulated phosphate fluoride</u> and 5% neutral sodium fluoride varnish.[11] ~~Fluoride varnishes can prevent or reverse enamel demineralization.[15] In children with moderate to high caries risk, fluoride varnishes[14,16] and fluoride-releasing restorative and bonding materials have been shown to be beneficial and are best utilized as part of a comprehensive preventive program in the dental home.[17-19]~~

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**Policy statement**

1. The AAPD endorses and encourages the adjustment of fluoride content of domestic community water supplies to optimal levels where feasible.
2. When fluoride levels in community water supplies are suboptimal, and after consideration of sources of dietary fluoride, and the caries risk of the child, the AAPD endorses the supplementation of a child's diet with fluoride according to ~~the~~ established guidelines.[12] ~~jointly recommended by the American Academy of Pediatric Dentistry AAPD[8], the American Academy of Pediatrics[20], and the American Dental Association (**ADA**)[21] and endorsed by the Centers for Disease Control and Prevention.[1]~~
3. The AAPD encourages dental professionals to inform medical peers of the potential of enamel fluorosis when excess fluoride is ingested prior to enamel maturation.
4. ~~The AAPD encourages continued research on the causes of enamel fluorosis.~~
5. ~~The AAPD does not support the use of prenatal fluoride supplements.[19]~~
6. ~~The AAPD recommends an individualized patient caries-risk assessment before prescribing the use of supplemental fluoride-containing products.[8,22]~~

~~7.~~4. The AAPD encourages the continued research on safe and effective fluoride products, ~~including fluoride-releasing restorative materials~~.

~~8.~~5. The AAPD supports the delegation of fluoride application to auxiliary dental personnel, or other trained allied health professionals, by prescription or order of a qualified dentist or physician, after a comprehensive oral examination has been performed.

~~9.~~6. ~~The AAPD endorses ADA 2002 House of Delegates Resolution 67H to encourage labeling of bottled water with the fluoride concentration and company contact information.[23] The resolution also supports including information with each home water treatment system on the system's effects on fluoride levels.~~

~~10.~~7. The AAPD encourages all beverage and infant formula manufacturers to include fluoride concentration with the nutritional content on food labels.

~~11.~~8. The AAPD encourages dentists and other health care providers to educate parents that ~~both~~ infant formula if reconstituted with optimally fluoridated water contains ~~and the water used to reconstitute the formula may contain~~ fluoride. Dentists and other health

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care providers, therefore, should assist parents in determining the infant's fluoride exposure.

~~12.~~9. The AAPD recognizes that drinking fluoridated water and brushing with fluoridated toothpaste at least daily are perhaps the most effective method in reducing dental caries in children.

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# Policy on the Use of Lasers

Originating Council
Council on Clinical Affairs
Review Council
Council on Clinical Affairs
Adopted
2013

## Purpose

The American Academy of Pediatric Dentistry (**AAPD)** recognizes the judicious use of lasers as a beneficial instrument in providing dental restorative and soft tissue procedures for infants, children and adolescents, and persons with special health care needs. This policy is intended to inform and educate dental professionals on the fundamentals, types, diagnostic and clinical applications, ~~advantages~~ benefits, and limitations of laser use in pediatric dentistry.

## Methods

This policy is based on a review of current dental and medical literature related to the use of lasers. This document included ~~and electronic~~ database searches using ~~the following parameters: Terms:~~ key terms "laser dentistry", "dental lasers", "laser pediatric dentistry", "laser soft tissue treatments", and "laser restorative dentistry". The search returned 4,726 articles that matched the criteria. The articles were evaluated by title and \ or abstract, and relevance to dental care for children and adolescents. ~~The reviewers agreed upon the inclusion of articles that met the defined criteria.~~ Twenty-three citations were chosen from this method and from references within selected articles. When data did not appear sufficient or were inconclusive, recommendations were based upon expert and / or consensus opinion by experienced researchers and clinicians.

## Background

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Medicine began integrating lasers in the mid 1970s for soft tissue procedures.[1] Oral and maxillofacial surgeons incorporated the carbon dioxide (**$CO_2$**) laser into practice for removal of oral lesions in the 1980s.[2, 3] The first ~~specified~~ laser specifically for dental use was a neodymium-yttrium-aluminum-garnet (Nd:YAG) laser, developed in 1987 and approved by the Food and Drug Administration (**FDA**) in 1990.[1,4]

The term **LASER** is an acronym for **L**ight **A**mplification by **S**timulated **E**mission of **R**adiation. Within a laser an active medium is stimulated to produce photons of energy that are delivered in a beam with an exact wavelength unique to the active medium.[5] Lasers are typically classified by the active medium that is used to create the energy. The energy radiated by the laser is basically a light of one color (monochromatic) and thus a single wavelength.[5] Oral hard and soft tissues have a distinct affinity for absorbing laser energy of a specific wavelength. The wavelength of a dental laser is the determining factor of the level to which the laser energy is absorbed by the intended tissue. Target or identified tissues differ in their affinity for specific wavelengths of laser energy.[1,5,6,7] For this reason, selecting a specific laser depends on the target tissue the practitioner wishes to treat. The primary effect of a laser within target tissues is photothermal.[1, 8] When the target tissue containing water is raised above 100 degrees C, vaporization of the water occurs, resulting in soft tissue ablation.[1] Since soft tissue is made up of a high percentage of water, excision of soft tissue initiates at this temperature. Hard tissue composed of hydroxyapatite crystals and minerals are not ablated at this temperature, but the water component is vaporized, the resulting steam expands and then ~~explodes~~ disperses the encompassing material into small particles.[1, 7]

Various types of lasers have been used in dentistry. The $CO_2$ laser is well absorbed by water, and therefore effective in incising, excising, and coagulating soft tissue.[1, 9] The $CO_2$ is primarily a soft tissue laser, as its wavelength is poorly absorbed by hydroxyapatite.[10] The diode laser contains a solid active medium and is composed of semiconductor crystals of aluminum or iridium, gallium and arsenic.[1, 10] This laser is effectively absorbed by pigmented tissues and has a good depth of penetration. The diode laser is relatively unable to be absorbed by hard tissue. For this reason, soft tissue surgery can be completed safely without affecting adjacent hard

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tissue structures.[1,9,10] The Nd:YAG laser consists of neodymium ions and crystal of yttrium, aluminum, and garnet.[6] This laser energy is absorbed well by pigmented tissues and only minimally absorbed by hard tissue.[1] Soft tissue surgery can be completed adjacent to the tooth accurately and safely.[10,11] Pigmented surface carious lesions can be removed without affecting healthy tooth structure.[12,13] The Nd:YAG wavelengths are absorbed by hemoglobin, and are effective in coagulation and hemostasis during soft tissue procedures.[1,11] Erbium lasers consist of two separate wavelengths. The Er:YAG which consists of erbium ions and a solid active medium of crystals of yttrium, aluminum, and garnet; and the Er,Cr:YSGG containing erbium, chromium ions and a crystal of yttrium, scandium, gallium, and garnet.[1, 14] In addition to soft tissue procedures; the erbium lasers can effectively remove caries, and prepare enamel, dentin, cementum and bone.[14, 15] Wavelength-specific protective eyewear should be provided and stringently worn at all times by the dental team, patient, and parent(s) during laser use. [1, 3]

*Diagnostic applications*

Laser fluorescence (**LF**) can be used as an additional tool combined with conventional methods for detection of occlusal caries.[16] The portable diode laser-based system interprets the emitted fluorescence on the occlusal surface which correlates with the extent of demineralization in the tooth.[7, 11] Laser digital readings can indicate the proportional amount of caries present. LF ~~is recommended to~~ may be used as a complimentary instrument when diagnosing occlusal caries in cases of questionable findings after visual inspection.[7, 16] LF caries detection is not recommended under dental resins or sealants due to a high probability of unreliable readings as a result of the intrinsic fluorescence from the sealant material.[16]

*Soft tissue clinical applications*

Dental lasers have been used for numerous clinical soft tissue procedures in pediatric dentistry. Clinical applications include maxillary and lingual frenectomies, operculectomies, exposure of teeth for orthodontic purposes, gingival contouring __gingivectomies, removal of mucosal lesions and biopsies, and treatment of aphthous ulcers and herpetic lesions.[7,9,11] $CO_2$, diode, and Nd:YAG lasers all have the capability of incising tissue effectively, coagulating and contouring tissues.[7,9] Erbium lasers also have the capability of providing soft tissue procedures;

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however, the hemostatic ability of these wavelengths is not as effective as $CO_2$, diode, and Nd:YAG wavelengths.[1,10,12]

*Hard tissue clinical applications*

The Nd:YAG, Er:YAG, and Er,Cr:YSGG lasers have all been used successfully for removal of caries and preparation of teeth for restorative procedures in children and adolescents.[11,14-16] Lasers have also been used effectively for indirect and direct pulp capping treatments.[15,16] The erbium lasers are the predominant lasers used for hard tissue procedures.[11,14,15] Dental lasers have been utilized for endodontic procedures such as primary tooth pulpotomies and root canal disinfection.[11,14-16] Success rates of laser pulpotomies have been comparable to those of formocresol pulpotomies.[11,17,18]

*~~Advantages of~~ lLasers in pediatric dentistry*

One of the benefits of laser use in pediatric dentistry is the selective and precise interaction with diseased tissues.[3] Less thermal necrosis of adjacent tissues is produced with lasers than with electrosurgical instruments.[1,11] During soft tissue procedures, ~~good~~ hemostasis can be obtained without the need for sutures in most cases.[3,9] With the benefit of hemostasis during soft tissue treatments, wound healing can occur more rapidly with less post-operative discomfort and a reduced need for analgesics.[7,9,11,16] Little to no local anesthesia is required for most soft-tissue treatments.[7,9,10,11,16] Reduced operator chair time has been observed when soft tissue procedures have been completed using lasers.[9,11,16] Lasers demonstrate decontaminating and bacteriocidal properties on tissues, which requires less prescribing of antibiotics post-operatively.[7,9,11,16] Lasers can provide relief from the pain and inflammation associated with aphthous ulcers and herpetic lesions without pharmacological intervention.[6,9,16] The erbium lasers can effectively remove caries with minimal involvement of surrounding tooth structure because caries have a higher water content than healthy tissue.[1,3.12.] The noise and vibration of the conventional high-speed dental handpiece has been postulated as stimulating discomfort, pain, and anxiety for the pediatric patient during restorative procedures.[7,15,19,20] The non-contact of erbium lasers with hard tissue eliminates the vibratory effects of the conventional high-speed handpiece allowing tooth preparations to be comfortable and less anxiety provoking for children and

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adolescents.[7,11,15,20] Nd:YAG and erbium lasers have been shown to have an analgesic effect on hard tissues, eliminating injections and the use of local anesthesia during tooth preparations.[7,11,14,15,21-23]

*Limitations of lasers in pediatric dentistry*

There are some disadvantages of laser use in pediatric dentistry. Laser use requires additional training and education for the various clinical applications and types of lasers.[3,14,15,16] High start up costs are required to purchase the equipment, implement the technology, and invest in the required education and training.[3,16] Since different wavelengths are necessary for various soft and hard tissue procedures, the practitioner ~~will~~ may need more than one laser ~~to effectively complete the numerous treatments~~.[3] Most dental instruments are both side and end-cutting. When using lasers, modifications in clinical technique along with additional preparation with high-speed dental handpieces may be required to finish tooth preparations.[3, 15] When using dental lasers, it is imperative that the patient, doctor and auxiliaries wear protective glasses, adhere to infection control protocol, and utilizes high-speed suction as the vaporized aerosol may contain infective tissue particles. [3,11,24] The practitioner should exercise good clinical judgment when providing soft tissue treatment of viral lesions in immunocompromised patients; as the potential risk of disease transmission from laser-generated aerosol exists. [25,26] To prevent viral transmission, palliative pharmacological therapies may be more acceptable and appropriate in this group of patients.

Policy statement

The AAPD ~~recommends~~:

1. recognizes the use of lasers as an alternative and complimentary method of providing soft and hard tissue dental procedures for infants, children and adolescents, and persons with special health care needs~~.~~;
2. advocates the dental professional receive additional didactic and experiential education and training on the use of lasers before applying this technology on pediatric dental patients~~.~~;
3. encourages ~~the~~ dental professionals to research, implement, and utilize the appropriate laser specific and optimal for the indicated procedure~~.~~;

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4. endorses use of protective eyewear ~~protective from~~ specific for laser wavelengths during treatment for the dental team, patient, and observers.

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# Guideline on Protective Stabilization for Pediatric Dental Patients

**Originating Council**

Council on Clinical Affairs

**Adopted**

2013

## Purpose

The American Academy of Pediatric Dentistry (**AAPD**) believes that all infants, children, adolescents, and individuals with special health care needs are entitled to receive oral health care that meets the treatment and ethical principles of our specialty. The need for the patient to receive timely diagnosis and treatment, as well as to ensure the safety of the patient, practitioner and staff, should be considered before using protective stabilization. The AAPD has included use of protective stabilization (formerly referred to as physical restraint and medical immobilization) in its guidelines on behavior guidance since 1990.[1-8] This separate guideline specific to protective stabilization provides additional information to assist the dental professional, and other stakeholders, in understanding the indications for and developing appropriate practices in the use of protective stabilization as an advanced behavior guidance technique in contemporary pediatric dentistry. This advanced technique must be integrated into an overall behavior guidance approach that is individualized for each patient, in the context of promoting a positive dental attitude for the patient, while ensuring the highest standards of safety and quality of care.

## Methods

This guideline is based on a review of the current dental and medical literature related to the use of protective stabilization devices and restraint in the treatment of infants, children, adolescents, and patients with special health care needs in the dental office. An electronic search was conducted using PubMed® with the following: Terms: "protective stabilization and dentistry", "protective stabilization and medical procedures", "medical immobilization", "restraint and dentistry", "restraint and medical procedures", "Papoose® board and dentistry",

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"Papoose® board and medical procedures", "patient restraint for treatment"; Fields: all; Limits: within the last 10 years; humans; English; birth through 18. Thirty-four articles matched these criteria and were evaluated by title and/or abstract. Information from 35 articles was used to develop this guideline. When data did not appear sufficient or were inconclusive, recommendations were based upon expert and/or consensus opinion by experienced researchers and clinicians.

**Background**

Pediatric dentists receive formal education and training to gain the knowledge and skills required to manage the various physical challenges, cognitive capacities, and age-defining traits of their patients. A dentist who treats children should be able to assess each child's developmental level, dental attitude, and temperament and also be able to recognize potential barriers to delivery of care (eg, previous unpleasant and/or painful medical or dental experiences) to help predict the child's reaction to treatment.[9] A continuum of non-pharmacological and pharmacological behavior guidance techniques, including protective stabilization, may be employed in providing oral health care for infants, children, adolescents, and individuals with special health care needs.[9] Behavior guidance approaches for each patient who is unable to cooperate should be customized to the individual needs of the child and the desires of the parent and may include sedation, general anesthesia, protective stabilization, or referral to another dentist.[9] The AAPD Guideline on Behavior Guidance[9] should be consulted for additional information regarding the spectrum of behavior guidance techniques.

Protective stabilization is defined as "any manual method, physical or mechanical device, material or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body or head freely."[10] Active immobilization involves restraint by another person, such as the parent, dentist, or dental auxiliary; passive immobilization utilizes a restraining device.[11] When determining whether to recommend use of stabilization or immobilization techniques, the dentist should consider the patient's oral health needs, emotional and cognitive development levels, medical and physical conditions, and parental preferences.[11] Furthermore,

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alternative approaches (eg, treatment deferral, sedation, general anesthesia) and their potential impact on quality of care and the patient's well-being should be included in the deliberation.[11]

**Recommendations**

*Education*

Didactic and clinical experiences vary for pre-doctoral students between and within dental schools. While some schools provide didactic and hands-on training in advanced behavior guidance, others offer limited exposure. A survey of pre-doctoral program directors found a majority of dental schools spend fewer than 5 classroom hours on behavior guidance techniques.[12] Furthermore, 42 percent of institutions reported fewer than 25 percent of students had 1 'hands-on' experience with passive immobilization for non-sedated patients, while 27 percent of programs provided no clinical experiences.[12] Therefore, graduates from dental school may lack knowledge and competency in the use of protective stabilization. Limited training in protective stabilization is not unique to dentistry as other health care disciplines have suggested a need for advanced training and guidelines.[13,14]

Protective stabilization is considered an advanced behavior guidance technique in dentistry.[9] Attempts to restrain or stabilize patients without adequate training can leave not only the patient, but also the practitioner and staff, at risk for physical harm.[15] Both didactic and hands-on mentored education beyond dental school is essential to ensure appropriate, safe, and effective implementation of protective stabilization of a patient unable to cooperate.[9] Advanced training can be attained through an accredited post-doctoral program (eg, advanced education in general dentistry, general practice residency, or pediatric dentistry residency program) or an extensive and focused continuing education course that includes both didactic and mentored hands-on experiences. Formal training will allow the practitioner to acquire the necessary knowledge and skills in patient selection and in the successful use of restraining techniques to prevent or minimize psychological stress and/or decrease risk of physical injury to the patient, the parent, and the staff. Currently, at least one state requires training beyond basic dental education in order for the practitioner to utilize protective stabilization devices.[16]

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*Consent*

Protective stabilization, with or without a restrictive device, performed by the dental team requires informed consent from a parent.[9] A parent's signature on a consent form should not preclude a thorough discussion of the procedure. The practitioner must explain the benefits and risks of protective stabilization, as well as alternative behavior guidance techniques (eg, treatment deferral, sedation, general anesthesia), and assist the parent in determining the most appropriate approach to treat his/her child.[17] Informed consent discussion, when possible, should occur on a day separate from the treatment. Supplements such as informational booklets or videos may be helpful to the parent and/or patient in understanding the proposed procedure. Informed consent must be obtained and documented in the patient's record prior to performing protective stabilization.[16,18,19] If a patient's behavior during treatment necessitates a change in stabilization procedure or technique, further consent must be obtained and documented.[18]

When appropriate, an explanation to the patient regarding the need for restraint, with an opportunity for the patient to respond, should occur.[17,20,21] Although a minor does not have the statutory right to give or refuse consent for treatment, the child's wishes and feelings (assent) should be considered when addressing the issue of consent.[18,22]

Laws governing informed consent vary by state. It is incumbent on the practitioner to be familiar with applicable statutes. Currently most states have adopted the "patient-oriented" standard. Thus, a practitioner may be held liable if a parent has not received all of the information that is essential to his/her decision to accept or reject proposed treatment.[18,23,24]

Written consent before treatment of a patient is mandated by some states.[25] Even if not required by state law, detailed written consent for medical immobilization should be obtained separately from consent for other procedures as it increases the parent's awareness of the procedure.[18]

*Parental presence*

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Parental presence in the operatory may help both the parent and child during a difficult experience.[26] Ninety-two percent of mothers in one study believed they should have been with their child when he/she was placed on a rigid stabilization board to increase the child's security and/or comfort.[26] In addition, 90 percent recognized that immobilization protected the children from harm.[26] Practitioners should consider allowing parental presence in the operatory or direct visual observation of the patient during use of protective stabilization unless the health and safety of the patient, parent, or the dental staff would be at risk.[8] Further, if parents are denied access, they must be informed of the reason with documentation of the explanation in the patient's chart.[16] If parents choose not to be present, they should be encouraged to provide positive nurturing support for the child both before and after the procedure. Ultimately, a parent has the right to terminate use of restraint at any time if he or she believes the child may be experiencing physical or psychological trauma due to immobilization. If termination is requested, the practitioner immediately should complete the necessary steps to bring the procedure to a safe conclusion before ending the appointment.

*Techniques*

Alternative approaches to restricting patient movement during medically necessary dental care should be explored before immobilizing a patient. Protective stabilization should be used only when less restrictive interventions are not effective. It should not be used as a means of discipline, convenience, or retaliation. Furthermore, the use of protective stabilization should not induce pain for the patient.

Active immobilization involves restraint by another person, such as the parent, dentist, or dental auxiliary; examples of active immobilization include head holding, hand guarding, and therapeutic holding. Treatment should first be attempted with communicative behavior guidance without protective stabilization unless there is a history of maladaptive or combative behavior that could be injurious to the patient and/or staff.[27] When mechanical immobilization is indicated, it should be the least restrictive alternative or technique.[28,29]

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An accurate, comprehensive, and up-to-date medical history is necessary for effective treatment. This would include careful review of the patient's medical history to ascertain if there are any conditions (e.g., asthma) which may compromise respiratory function or neuromuscular or bone/skeletal disorders which may require additional positioning aids due to rigid extremities.

Following explanation of the procedures and consent by the parent, protective stabilization of the patient should begin in conjunction with distraction techniques[30] by placing the child, in a manner as comfortable as possible, in a supine position. If restriction of extremity movement is needed, then a dental auxiliary under direct supervision of the dentist might initially employ hand guarding or ask the parent to hold the patient's hands. Full-body protective stabilization, when indicated, may be accomplished in a sequential manner beginning with the mid-abdomen area followed by the trunk, then the arms and the legs.[31] If the stabilization device includes a head hold, that is activated next. At no time should the device be active to the point of restricting blood flow or respiration.[9]

*Equipment*

Numerous devices are available to limit movements by a patient unable to cooperate during dental treatment. The ideal characteristics of a mechanical restraining device to use as an adjunct to dental procedures include the following:

1. Ease of use;
2. Appropriately sized for the patient;
3. Soft and contoured to minimize potential injury to the patient;
4. Specifically designed for patient stabilization (ie, not improvised equipment)[31] ; and
5. Ability to be disinfected.

Stabilization devices indicated for use on the extremities include, but are not limited to, Posey straps®, Velcro® straps, seat belts, and the use of an extra assistant. If hand guarding or hand holding does not deter disruptive movement of a patient's hands, wrist restraints may be utilized.[27,32] If a patient is unable (due to medical diagnosis) or unwilling (due to maladaptive

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behaviors) to control bodily movement, a full body wrap may need to be used. Full-body stabilization devices include, but are not limited to, Papoose Board® and Pedi-Wrap®.[27,32] Stabilization for the head may be accomplished using forearm-body support, a head positioner, or an extra assistant.[32] Although a mouth prop may be used as an immobilization device, the use of a mouth prop in a compliant child is not considered protective stabilization.

*Monitoring*

Tightness of the stabilization device must be monitored and reassessed at regular intervals.[9] Ongoing awareness/assessment of the patient's physical and psychological well-being during the dental procedure should be performed by an additional staff member not directly involved with the procedure. For a patient who is experiencing severe emotional stress or hysterics, protective stabilization must be terminated as soon as possible to prevent possible physical or psychological trauma.[28] At the completion of dental procedures, removal of restraints should be done sequentially with short pauses between stages to assess the patient's level of cooperation.[27] Struggling during removal of restraints may increase the potential for injury to the child, as well as others. When immobilization has been introduced intra-operatively (i.e., unplanned intervention), debriefing is beneficial for the understanding of parent/patient[20] and to discuss management implications for future appointments.

*Indications*

Protective stabilization is indicated when:

1. a patient requires immediate diagnosis and/or urgent limited treatment and cannot cooperate due to emotional and cognitive developmental levels or lack of maturity or medical and physical conditions;
2. emergent care is needed and uncontrolled movements risk the safety of the patient, staff, dentist, or parent without the use of protective stabilization;
3. a previously cooperative patient quickly becomes uncooperative during the appointment in order to protect the patient's safety and help to expedite completion of treatment;
4. a sedated patient who may become uncooperative during treatment;

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5. a patient with special health care needs for whom uncontrolled movements would be harmful or significantly interfere with the quality of care.

*Benefits*

When used correctly and in accordance with this guideline, protective stabilization has the following benefits:[9]

1. reduction or elimination of untoward movements;
2. protection of the patient, staff, dentist, or parent from injury;
3. facilitation of quality dental treatment.

*Contraindications:*

Protective stabilization is contraindicated for:

1. cooperative non-sedated patients;
2. patients who cannot be immobilized safely due to associated medical, psychological, or physical conditions;
3. patients with a history of physical or psychological trauma due to restraint (unless no other alternatives are available);
4. patients with non-emergent treatment needs in order to accomplish full mouth or multiple quadrant dental rehabilitation.

*Risks*

The use of protective stabilization may lead to potential serious consequences, such as physical or psychological harm, loss of dignity, and violation of patient's rights.[9] Research has demonstrated that psychological trauma can have lasting detrimental effects on brain function, and when this trauma is of sufficient intensity, frequency, or duration, subsequent neurodevelopment may be altered and become maladaptive.[33] Parents may also experience distress when their children are restrained.[21]

The majority of restraint-related injuries consist of minor bruises and scratches, although other more serious injuries have been reported.[34] Fewer injuries were incurred due to passive

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stabilization compared to active stabilization, and fewer injuries occurred with the use of planned passive stabilization compared to its use in emergent situations.[34] Patients placed on a rigid stabilization board may overheat during the dental procedure and must never be unattended as the patient and the board may roll out of the chair.[28] A rigid stabilization board may not allow for complete extension of the neck and, therefore, may compromise airway patency, especially in young children or sedated patients.[35] Proper training and use of a neck roll may minimize this risk.

*Documentation*

The patient's record must include:

1. indication for stabilization
2. type of stabilization;
3. informed consent for protective stabilization;
4. reason for parental exclusion during protective stabilization;
5. the duration of application of stabilization;
6. behavior evaluation/rating during stabilization;
7. any untoward outcomes, such as skin markings;
8. management implications for future appointments.

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# 2012-2013 Report of the Council on Clinical Affairs, Committee on Behavior Guidance

**Sara L. Filstrup, Chair**
**Man Wai Ng, Board Liaison**
John S. Rutkauskas, Staff Liaison

## VISION AND DUTIES

The duties of the Council on Clinical Affairs, as listed in the AAPD Administrative Policy and Procedure Manual, are to: 1) respond to requests of the Board of Trustees on issues pertaining to behavior guidance in the dental treatment setting; 2) perform such other duties as assigned by the President or the Board of Trustees.

## REPORT

### Charge 1. Status of Charge 1: Completed

Respond to requests of the Board of Trustees on issues pertaining to behavior guidance in the dental treatment setting.

*Background and Intent:* This is a standing charge to the committee. It is the intent of the Board to maintain a committee capable of advising them on issues pertaining to and surrounding behavioral guidance in the dental environment.

### Progress Report for Charge 1

The Council has developed a "Guideline on Protective Stabilization for Pediatric Dental Patients".

# 2012-2013 Report of the Council on Clinical Affairs, Committee on the Adolescent

**Sara L. Filstrup, Chair**
**James D. Nickman, Board Liaison**
Janice Silverman, Staff Liaison

## VISION AND DUTIES

The duties of the Council on Clinical Affairs, as listed in the AAPD Administrative Policy and Procedure Manual, are to: 1) regularly review all AAPD Policies and Guidelines concerning the adolescent patient; 2) develop appropriate CE sessions on the adolescent patient for AAPD annual sessions; 3) prepare regularly updates for *PDT* on adolescent oral health issues; and 4) perform such other duties as assigned by the President or the Board of Trustees.

## REPORT

### Charge 1. Status of Charge 1: Ongoing

Prepare annually for publication in *Pediatric Dentistry Today* a summary of issues and activities relevant to adolescent oral health, including other health topics that may impact adolescent oral health.

*Background and Intent:* This is a standing charge to the committee. It is the intent of the Board to maintain a committee capable of advising them on issues pertaining to and surrounding adolescent oral health and well-being.

### Progress Report for Charge 1

No recommendations at this time.

# 2012-2013 Report of the Council on Clinical Affairs, Committee on Perinatal Oral Health Care

**Sara L. Filstrup, Chair**
**James D. Nickman, Board Liaison**
Janice Silverman, Staff Liaison

## VISION AND DUTIES

The duties of the Council on Clinical Affairs, as listed in the AAPD Administrative Policy and Procedure Manual, are to: 1) facilitate implementation of the AAPD's *Improving Perinatal Oral Health* project in conjunction with the subcontractor (Children's Dental Health Project); 2) periodically review all AAPD policies and guidelines as they apply to perinatal and infant oral health care; 3) develop appropriate CE sessions on perinatal and infant oral health issues for AAPD annual sessions; and 4) perform such other duties as assigned by the President or the Board of Trustees.

## REPORT

### Charge 1. Status of Charge 1: Ongoing

Participate with the Council on Clinical Affairs in the periodic review of all AAPD Policies and Guidelines as they apply to perinatal and infant oral health care.

*Background and Intent:* This is a standing charge to the Committee. It is the intent of the Board to maintain a committee capable of advising them on issues pertaining to and surrounding the establishment of the dental home by twelve months of age.

### Progress Report for Charge 1

The Council continues to review all AAPD Policies and Guidelines as they apply to perinatal and infant oral health care. No recommendations at this time.

# 2012-2013 Report of the Council on Clinical Affairs, Committee on Sedation and Anesthesia

**Sarat Thikkurissy, Chair**
**Man Wai Ng, Board Liaison**
John S. Rutkauskas, Staff Liaison

*Members:*
Paul Casamassimo
Joseph P. Cravero, MD
Kevin Donly
Keira P. Mason, MD
A. Charles Post
William F. Vann, Jr.

*Consultants:*
Ronald W. Kosinski, Consultant
Richard F. Stafford, Expert Consultant
Stephen Wilson, Consultant

## VISION AND DUTIES

The duties of the Council on Clinical Affairs, Committee on Sedation and Anesthesia, as listed in the *AAPD Administrative Policy and Procedure Manual*, are to: 1) provide technical assistance to state licensing boards drafting or modifying sedation or general anesthesia legislation or regulation; 2) review AAPD Guidelines and Policies on sedation and anesthesia for scientific and clinical accuracy and make recommendations for updates; 3) maintain information on state statutes and regulations concerning the administration of sedation and general anesthesia in the dental office; 4) perform such other duties as assigned by the President or the Board of Trustees.

## REPORT

### Charge 1. Status of Charge 1: In Progress

Assist individual members, state units and district organizations in providing input and expertise to state licensing boards drafting or modifying sedation or general anesthesia legislation or regulation.

*Background and Intent:* This is a standing charge to the committee. State sedation and general anesthesia regulations and statutes impact the delivery and access of oral health care services to infants, young children and patients with special healthcare and developmental needs. It is important such regulations and statutes preserve patient safety, be based upon sound scientific and clinical principles, and not impose unnecessary or false barriers to the delivery of care.

### Progress Report for Charge 1

This is a standing charge to the committee. There have not been any requests for assistance since the 2011-2012 Annual Report.

## Council on Clinical Affairs,
## Committee on Sedation and Anesthesia, 2012-2013

### Charge 2. Status of Charge 2: Completed

Annually review AAPD Guidelines and Policies on sedation and anesthesia for scientific and clinical validity and adherence to best practice principles, supported by current literature, primacy of patient safety, and implications on accessibility of services. Make recommendations to the Board of Trustees and to the Council on Clinical Affairs for modification to our Policies or Guidelines as appropriate.

*Background and Intent:* This is a standing charge to the committee. It is the intent of the Board that a report of the Committee be submitted at least annually, with recommendations for Policy and Guideline modification as appropriate.

### Progress Report for Charge 2

This is a standing charge to the committee. The AAPD Guidelines and Policies on Sedation and Anesthesia were reviewed in 2010 and were approved by the AAPD and the American Academy of Pediatrics. The AAPD guidelines on Nitrous Oxide Use and Occupational Exposure were reviewed in 2012. The AAPD Guidelines and Policies on Sedation and Anesthesia are current.

### Charge 3. Status of Charge 3: In Progress

Maintain liaison, work with, assist, and otherwise be proactive in providing input and expertise in the drafting or modification of guidelines, policies, standards or other parameters of care concerning sedation and general anesthesia of the minor dental patient or dental patient with special healthcare or developmental needs by allied healthcare organizations. Provide at least annually a report to the Board concerning committee efforts in this area, specifically addressing targeted organizations.

*Background and Intent:* This is a standing charge to the committee. As the recognized experts in pharmacologic management of the minor dental patient in the office environment, we should endeavor to provide expertise when other healthcare organizations are attempting to draft parameters of care in this arena. This may be achieved by assuming and maintaining liaison or appointment to appropriate committees or other bodies of such organizations as the American Dental Society of Anesthesiology, American Dental Association, American Academy of Oral and Maxillofacial Surgeons, American Society of Anesthesiologists and the American Academy of Pediatrics..

### Progress Report for Charge 3

This is a standing charge to the committee. The AAPD course on sedation and simulation is done in cooperation with the dental anesthesiologists representing the American Society of Dental Anesthesiologists and the American Dental Society of Anesthesiology.

### Charge 4. Status of Charge 4: In Progress

As needed, identify and train media spokespersons expert and conversant in areas of sedation and anesthesia.

*Background and Intent:* This is a standing charge to the committee. The Academy maintains a cadre of trained spokespersons to address many areas of pediatric dental care, prevention and public education, but these individuals do not possess the expertise to address serious media interest in sedation and general anesthesia of the minor dental

patient or patient with special healthcare or developmental needs in the dental office. In the event of an unexpected and adverse outcome, there may be public and membership benefit in having specific designated spokespersons available to the media.

**Progress Report for Charge 4**

This is a standing charge to the committee. A complete list of current spokespeople with interest and expertise in sedation has been identified. Several new spokespersons have been identified and trained. No additional individuals are required at this time.

Charge 5. Status of Charge 5: In Progress

Review all aspects of the clinical content and organization of the sedation and anesthesia courses provided by the Academy.

*Background and Intent:* This is a standing charge to the committee. The Anesthesia and Sedation Committee developed a course in contemporary sedation for the membership based on the need for education specific to our practices. The content, layout, and organization must be continually updated because of changes in drugs and techniques. Reviews by attendees have been used to modify existing course content.

**Progress Report for Charge 5**

This is a standing charge to the committee. The sedation and anesthesia course is annually reviewed and revised as needed by the course director and faculty. The AAPD Task Force on Sedation Education's recommendations have been forwarded to AAPD Sedation Workgroup. This group is working on revising the AAPD sedation course curriculum to respond to membership needs and state dental board requirements. In the 2013-2014 year, the intent is to bring together members of the Sedation/Anesthesia Committee and Sedation Course to critically review material covered in the Sedation course.

Charge 6. Status of Charge 6: Completed

Based on the findings of the Task Force on Continuing Education in Sedation, develop a plan for assessing and administering sedation education to academicians.

*Background and Intent:* It is the intent of the Board of Trustees that a working group be formed to assess the sedation education needs of both academicians and our membership. This group will review current educational guidelines and advanced education standards. A plan will be developed to implement and coordinate curriculum development.

**Progress Report for Charge 6**

The Task Force on Continuing Education in Sedation has completed their work. The committee has received the final report and is waiting on recommendations from the AAPD Working group on Task Force Recommendation Implementation.

Charge 7. Status of Charge 7: In Progress

Work with the Council on Post-Doctoral Education to review the AAPD Core Curriculum Reading List for the topic "sedation" and make recommendations for

additions and/or deletions to the list. The Committee will provide this information to the Council in time for the Council to report to the Board of Trustees at the Winter Planning Meeting.

*Background and Intent:* The Committee on Sedation and Anesthesia has the knowledge and resources to make the best recommendations for modifications and updates in the Core Curriculum Reading List..

## Progress Report for Charge 7

This is in progress and should be completed by the 2013 Annual Session. To date the committee has reviewed a large collection of articles that was developed by Dr Steve Wilson. Our first review and cut down named 175 articles as candidates for the final list.

The 175 semifinal articles were placed in the following categories:
1. Overview, 2. Pre-sedation evaluation and case selection, 3. Sedation agents, administration, and efficacy, 4. Monitoring, and 5. Risk assessment and adverse events.

# 2012-2013 Report of the Council on Clinical Affairs, Committee on Special Health Care Needs

**Edward L. Rick, Chair**
**John A. Hendry, Board Liaison**
John S. Rutkauskas, Staff Liaison

Maria Aslani-Breit
Sheldon M. Bernick
Jessica R. De Bord
Sanford J. Fenton
Frank J. Foreman
Purnima R. Hernandez
Martha Ann Keels
David A. Tesini
Mark L. Wagner
LaQuia A. Walker
Paul S. Casamassimo, Consultant

## VISION AND DUTIES

The duties of the Council on Clinical Affairs, Committee on Special Health Care Needs, as listed in the AAPD *Administrative Policy and Procedure Manual*, are to: 1) develop recommendations for future AAPD action based on the *Symposium on Lifetime Oral Health Care for Patients with Special Needs*; 2) review AAPD policies and guidelines related to patients with special health care needs, and make recommendations for updates and revisions; 3) regularly review scientific literature in this area; 4) perform such other duties as assigned by the President or the Board of Trustees.

## REPORT

### Charge 1. Status of Charge 1: In Progress

Annually review recent scientific literature that addresses commonly-encountered special needs patient populations requiring unique behavior guidance considerations or other tailored interventions. Examples might include Attention Deficit Hyperactive Disorder, Autism spectrum, and hearing or vision impairment. Identify populations for whom evidenced based recommendations could be developed by the Council on Clinical Affairs. Report to the Board of Trustees no later than the May Board meeting.

*Background and Intent:* In AAPD's Guideline on Behavior Guidance, most basic techniques center on communication and "may be used with any patient". Communication deficits are characteristic of many special needs patient groups. While our guidelines note that voice control is contraindicated for those who are hearing impaired, the only techniques that specifically include indications for SHCN patients are the advanced techniques (i.e., protective stabilization, sedation, and general anesthesia). We do not address behavioral approaches for routine visits for patients with SHCN. This charge is intended to identify special groups of patients with SHCN for whom it is feasible to develop evidence-based guidelines regarding care and management for inclusion in the Reference Manual. The annual report to the BOT should also include a specific request to charge the CCA to develop the suggestion guideline(s), including background and intent statement(s).

## Council on Clinical Affairs, Committee on Special Health Care Needs, 2012-2013

### Progress Report for Charge 1

Work continues in the Committee on SHCN to develop guidelines as needed.

### Charge 2. Status of Charge 2: In Progress

Work with the Council on Post-Doctoral Affairs to review the AAPD Core Curriculum Reading List for the topic "care for special needs patients" and make recommendations for additions and/or deletions to the list. The Committee will provide this information to the Council in time for the Council to report to the Board of Trustees at the Winter Planning Meeting.

*Background and Intent:* The Committee on Special Health Care Needs has the knowledge and resources to make the best recommendations for modifications and updates in the Core Curriculum Reading List.

### Progress Report for Charge 2

Committee on SHCN completed a review of the current AAPD Core Curriculum Reading List. A report was submitted to Council on Post-Doctoral Education. There were no recommendations for change. The Committee will continue to review the literature and make recommendations as needed.

# 2012-2013 Report of the Council on Continuing Education

**Brian Beitel, Chair**
**Santos Cortez, Jr., Board Liaison**
Kristi Turcheck and Tonya Almond, Staff Liaisons

*District Representative members:*
Monica H. Cipes (I)
Maxim Sulla (II)
Kurt Swauger (III)
Robert F. Majewski (IV)
Bruce Weiner (V)
D. Cody Mast (VI)

*Consultants and Ex-Officio members:*
Ann M. Bynum, Consultant
Oshmi Dutta, Consultant

## VISION AND DUTIES

The duties of the Council on Continuing Education, as listed in the AAPD *Administrative Policy and Procedure Manual*, are to: 1) monitor member needs and desires regarding continuing education courses sponsored by AAPD; 2) plan and implement AAPD continuing education courses in collaboration with the Headquarters Office; 3) make recommendations to the Board of Trustees regarding the continuing education activities of AAPD; 4) recommend faculty for continuing education courses; 5) perform such other duties as assigned by the President or the Board of Trustees.

## REPORT

### Charge 1. Status of Charge 1: In Progress

Develop and plan new and unique continuing education courses aligned with the Strategic Plan and the needs and desires of the membership. Propose at least annually to the Board of Trustees such courses. Monitor member and allied dental professional needs and desires regarding AAPD continuing education, on which a report is to be presented to the Board of Trustees, along with the Council's recommendations for specific course offerings, at the Winter meeting of the Board of Trustees.

*Background and Intent:* This is a standing charge to the Council, based on future membership needs assessment surveys. It is the Academy's desire to regularly offer continuing education opportunities of unique content. This is a membership benefit as well as a potential source of non-dues revenue. The Council on Continuing Education will develop questions to be utilized in electronic surveys and other sources to measure the needs and desires of our members.

### Progress Report for Charge 1

Currently the CCE is developing two courses to be presented at the 2014 Annual Session in Boston. One course will be a panel discussion on Dental Service

Organizations. The other course planned will also be a panel discussion but related to Practice Management. There has been positive response in the past to the panel discussion format and it is believed that these courses will be very informative and well attended.

## Charge 2. Status of Charge 2: In Progress

Suggest topics and monitor planning activities as requested to assist the symposium director in the development and execution of the yearly symposiums.

*Background and Intent:* This is an ongoing charge to the Council. The Academy is committed to providing our members with the best evidence-based knowledge on pediatric dental topics. The Council on Continuing Education shall oversee the continuing education aspects of the symposia.

### Progress Report for Charge 2

Symposium topics have been confirmed through 2015 to include 2013: Behavior Management, 2014: Restorative, 2015: Oral Medicine & Pathology, and have tentatively discussed 2016 with Oral Surgery. The CCE is currently discussing possible topics for another joint symposium with the AAO.

## Charge 3. Status of Charge 3: In Progress

Make recommendations to the Board and headquarters office staff for marketing courses to the Affiliate membership and to other general dentists. If appropriate, recommend to the Board of Trustees proposals for courses dedicate solely to the general practitioner.

*Background and Intent:* This is an ongoing charge to the Council. There is a demand for general dentists to obtain evidence-based knowledge of pediatric dentistry. As more general dentists treat children, and increased knowledge of behavior management is needed, it is necessary for the Academy to sponsor CE for the general dentist. Behavior management should be integrated within the comprehensive review course to educate general dentists about our policies and guidelines as they pertain to behavior management, and best practices on behavior management.

### Progress Report for Charge 3

Our current course, Comprehensive Pediatric Dentistry for the General Practitioner, is to be held next month in San Francisco. The CCE believes that with few cost prohibitive exceptions the staff and council have exhausted all marketing ideas and efforts on this course and currently have 93 enrollees. The CCE believes that final attendance outcome of this course will be indicative of the actual desires of the general dentists to learn Pediatric Dentistry in the stand alone course setting.

## Charge 4. Status of Charge 4: In Progress/Completed

Plan and conduct the Pediatric Medicine Update course in May 2014 at the Boston Annual Session Preconference Course. This course will repeat in November 2015 and every two years to follow.

*Background and Intent:* There is a continued need for our members and their staff to obtain evidence-based knowledge and updates on more common disorders and diseases mostly

commonly encountered in a pediatric dental practice. The latest medical treatment in the management of these diseases and disorders is part of the curriculum.

**Progress Report for Charge 4**

Pediatric Medicine Update will be included as the AAPD's Annual Session Preconference Course in May of 2014 and will resume its biannual position in November of 2015.

Charge 5. Status of Charge 5: In Progress

Evaluate the existing behavior guidance education vehicles and content currently available. Results of the evaluation are to be provided to the AAPD Board of Trustees at the 2013 Ad Interim Meeting. Provide a recommendation in the form of a business plan for the AAPD to develop a one-day course to include protective stabilization. The target audience is any dentist who did not receive this training in their residency or who is looking for an update.

*Background and Intent:* There is a demand for general dentists to obtain evidence-based knowledge of pediatric dentistry. As more general dentists treat children, and increased knowledge of behavior management is needed, it is necessary for the Academy to sponsor CE for the general dentist. Behavior management should be integrated within the comprehensive review course to educate general dentists about our policies and guidelines as they pertain to behavior management, and best practices on behavior management.

**Progress Report for Charge 5**

Background efforts have already begun on this charge and it will be presented and discussed with the CCE at this year's Annual Session in Orlando.

Charge 6. Status of Charge 6: In Progress

Create a curriculum designed specifically as a board preparation course for candidates taking the ABPD Qualifying Examination. The curriculum and business plan are to be presented to the AAPD Board of Trustees by the 2014 Winter Planning Meeting. The course would take place in the Fall 2014.

*Background and Intent:* Based on the ABPD requirements for ROC-P and the number of members who are diplomats maintaining their certification, it is important to provide them the tools they need to study for the exam and maintain their Diplomate status. This course is in addition to the existing Comprehensive Review Course which is also a requirement of maintenance in the ROC-P. We may eventually change the number of offers of Comp Review as we evaluate the marketplace.

**Progress Report for Charge 6**

Dialogue has begun with the ABPD. At this point both parties are trying to determine the best possible method to disseminate this information to AAPD members. The early process of addressing this charge has begun and it is believed that as dialogue continues with the ABPD, and as the CCE becomes more involved with this task, we will arrive at a solution that satisfies both the members' needs as well as the desires of the ABPD and BOT.

## Council on Continuing Education, 2012-2013

### Charge 7. Status of Charge 7: In Progress

Work with the Council on Annual Session, Scientific Program Committee, to create a panel discussion on dental service organizations at the 2014 Annual Session.

*Background and Intent:* Based on the increasing number of dental service organizations and those who hire pediatric dentists, we want to embrace the DSO model and provide an educational forum to our members about this growing trend.

### Progress Report for Charge 7

The CCE has already begun dialogue regarding the best possible members of this panel and will continue this discussion through our 2013 Annual Session. We are looking forward to working jointly with the Scientific Program Committee to create a must-see course for the 2014 Annual Session. Many thanks to the BOT and others for their input regarding potential panel members.

### Charge 8. Status of Charge 8: Completed

Plan and conduct a series of webinars on both Practice Management and clinical topics to include:

a) New Patient Phone Call
b) Risk Management
    i) Record Keeping
    ii) Liability
    iii) Consent
    iv) HIPAA
c) OSHA
d) Sterilization
e) Pediatric Antibiotic Update
f) Pain Management
g) Infection Control
h) Recreational Drug Update
i) Trauma
j) Special Needs – autism, patients with allergies
k) Fluoride update
l) GERD max

*Background and Intent:* Currently, a majority of pediatric dental residents receive a portion of their training electronically. Younger dentists communicate electronically for a majority of their professional and non-professional encounters. The Academy needs to be prepared to engage this group professionally through electronic continuing education.

### Progress Report for Charge 8

Steve Wilson's webinar entitled "Pediatric Sedation Emergencies: Can they be Avoided?" has been postponed until June 7. The CCE has been discussing additional webinar topics for some time and will continue prioritizing webinar topics and begin selecting speakers for upcoming topics. The hope is to pick up the pace on this task so as to begin building an online learning library for members.

# 2012-2013 Report of the Council on Continuing Education, Journal-Based Continuing Education Committee

**Homa Amini, Chair**
**Santos Cortez, Jr., Board Liaison**
Kristi Turcheck and Scott Dalhouse, Staff Liaisons

*Members*
Judith R. Chin
Catherine H. Hong
Philip G. Monroy

## VISION AND DUTIES

The duties of the Council on Continuing Education, Journal-Based Continuing Education Committee, as listed in the AAPD *Administrative Policy and Procedure Manual*, are to: 1) develop, monitor, implement and evaluate the Journal-Based Continuing Education Program; 2) promote participation in the Journal-Based Continuing Education Program by AAPD members; 3) perform such other duties as assigned by the President or the Board of Trustees.

## REPORT

### Charge 1. Status of Charge 1: Completed

Develop a mechanism and format for continuing education credit to be made available for doctors and auxiliary personnel via the AAPD newsletter, PDT. Act subsequently at the direction of the Board.

*Background and Intent:* Have one or two articles in each newsletter that have questions to be answered on an answer sheet in paper or electronic format that could be submitted for CE credit. Each article would offer appropriate CE credit. Each article/credit hour would meet DANB/CERP standards. The fee for CE credit submission would be established by the AAPD Board of Trustees.

### Progress Report for Charge 1

PDT is not a peer-reviewed journal. Following discussion, the committee has decided not to pursue this charge as there are other outlets for auxiliaries to earn continuing education credits.

## ADDITIONAL COMMENTS

The Journal-Based Continuing Education Committee reviews articles from each issue of Pediatric Dentistry, and three articles are selected for each issue for the program. Five to seven questions for each of the articles are written and to be answered by subscribers in

## Council on Continuing Education, Journal-Based Continuing Education Committee, 2012-2013

order to earn continuing education credits. To date, 163 members have participated in the Journal-Based CE program.

In 2011, there were 167 subscribers. In 2012 (to date), there are 110 subscribers. The 2011 year saw an increase at the end of the year. The Journal CE program has taken in $8,820 this year (at $60 per subscription). The budgeted income for Journal CE was $6,500, so that's about 35% more than budgeted. Last year, the income for Journal CE was $4,860, so the program has almost doubled. There are no expenses.

# 2012-2013 Report of the Council on Dental Benefit Programs

**Paul A. Reggiardo, Chair**
**James D. Nickman, Board Liaison**
Mary Essling, Staff Liaison

*District Representative members:*
Eli C. Schneider (I)
Katherine Wezmar Poepperling (II)
Brent D. Johnson (IV)
Brynn L. Leroux (V)

*Consultants and Ex-Officio members:*
J. David Crossley, Consultant
Jennifer Hendershot, Consultant
Jessica Y. Lee, Expert Consultant

## VISION AND DUTIES

The vision of the Council on Dental Benefit Programs is that all infants, children, and adolescents have access to meaningful dental benefits, thereby affording them the opportunity of lifetime optimal oral health.

The mission of the Council on Dental Benefit Programs is to maintain and expand access to oral health services for infants, children and adolescents through the support and promotion of robust and equitable third party payment systems. We accomplish this by enabling our members to assist their patients in obtaining dental benefits to which they are entitled and by working with other professional organizations and the dental benefits industry to continually improve dental benefit programs.

The duties of the Council on Dental Benefit Programs as listed in the AAPD *Administrative Policy and Procedure Manual* are to: 1) formulate and recommend policies to the Board of Trustees related to pediatric oral health care in various health care programs and reimbursement mechanisms; 2) monitor and investigate developing trends impacting pediatric oral health in health care programs and reimbursement mechanisms; 3) perform such other duties as assigned by the President or the Board of Trustees.

## REPORT

### Charge 1. Status of Charge 1: Ongoing

Continue to assist state units in achieving universal reimbursement for medically necessary general anesthesia and related facility fees under health care plans and programs when oral health services are provided under general anesthesia. Report annually to the Board on progress in this field. This charge also includes providing education to members concerning the Employee Retirement Income Security Act (ERISA) and its impact on self-funded health plans, including self-funded dental reimbursement plans.

*Background and Intent:* This is a standing charge to the Council. The Academy's goal is to secure the passage of legislation in every state to ensure coverage for medically-necessary anesthesia and related hospital charges when dental treatment is provided under general

anesthesia. The outcome should be that all registered state insurance plans assure reimbursement for dental procedures rendered under general anesthesia.

## Progress Report for Charge 1

- With addition of Pennsylvania last year, thirty-six states now have statute or negotiated settlement establishing reimbursement for general anesthesia as a program benefit under the patient's medical care plan when dental services are provided in a specified setting. Qualifications vary from state to state, but generally apply to pre-school or early elementary school ages and children with special medical or developmental needs.
- The implementation of the Affordable Care Act will make additional state legislation unlikely in the near future. While policies sold inside or outside of the state exchanges must conform to state insurance law and regulation in regards to coverage and services, the premium cost for state mandates placed into effect after December 31, 2011, must be borne by the state to the extent that these policies are underwritten for low-income purchasers. Specifically, for those states that already have general anesthesia laws in place as of 12/3/11, this is a mandated state benefit that has to be offered as part of EHB (essential health benefits) in small and individual group insurance offerings inside and outside of health insurance exchanges. If a state wants to cover some service that is not part of EHB, then the state would have to bear the cost—and by costs here it means the premium subsidies that lower income individuals will receive to purchase EHB. This provision will be in effect in 2014 – 2015, and could be changed by the Department of Health and Human Services beginning in 2016.
- With the launch of the AAPD state level Public Policy Advocates in March of this year, the CDBP will shift in 2013 – 2014 from trying to work directly with state units to effect additional general anesthesia laws to working with the state Public Policy Advocates.

## Charge 2. Status of Charge 2: Ongoing

Act as a liaison between the AAPD and the ADA Council on Dental Benefit Programs and the ADA Code Advisory Committee (CAC). In the ADA procedure code revision process, provide specific pediatric dental benefits perspective as indicated by membership interests and as directed by the Board of Trustees. Act also to monitor the dental benefit program activities and concerns of the other ADA-recognized specialties organizations, and those of other professional organizations, keeping informed the Board of Trustees and interacting as appropriate.

*Background and Intent:* This is a standing charge to the Council. The Academy's goal is to protect and advance patient interests in dental benefit programs. Chief among these activities is full participation in the biannual ADA procedure code revision process.

## Progress Report for Charge 2

- Last year the ADA abolished the joint profession/industry Code Revision Committee (CRC) process and established in its place a 21-member Code Maintenance Committee (CMC) of the ADA Council on Dental Benefit Programs. The CMC is composed of 21 voting representatives from various sectors of the dental community. Dr. James Nickman served as AAPD's representative to the CMC in

2012-2013. The CDT code set will now be revised annually (instead of the previous biannual process).

- The deadline for submission of code change requests for the 2014 cycle was November 1, 2012. The AAPD CDBP posted notice of this deadline to our membership in PDT and through AAPD email alerts. With the approval of the Board, the CDBP submitted a code revision request this year for the Interim Therapeutic Restoration (ITR). Ninety change requests were received and considered by the CMC.
- The CMC met February 28 – Mar 2, 2013, in Chicago. The meeting was attended by Dr. Nickman and Ms. Mary Essling, AAPD Dental Benefits Manager, representing AAPD. Notable changes to the 2014 CDT are listed below:
    - ADD **interim therapeutic restoration – primary dentition,** described as *Placement of an adhesive restorative material following caries debridement by hand or other method for the management of early childhood caries. Not considered a definitive restoration.*
    - ADD **reattachment of tooth fragment, incisal edge or cusp**

Not accepted were requests from the American Society of Dental Anesthesiologists for the addition of codes for (1) preanesthetic evaluation and assessment and (2) postanesthesia management. The Committee commented that while the first had merit and could be reconsidered if modified and resubmitted for the 2015 code set, the elements of the second as submitted were already encompassed in existing codes (D9229 et.al.).

## Charge 3. Status of Charge 3: Ongoing

Respond to membership inquiries and concerns regarding third party reimbursement issues through the Dental Benefits Manager in the Headquarters Office. Support the Dental Benefits Manager in third party issues as appropriate. Report annually to the Board of Trustees on third party reimbursement issues and activities.

*Background and Intent:* This is a standing charge to the Council. The Board desires that the Academy maintain the ability to respond to individual member inquiries regarding third party reimbursement actions or policies. When appropriate, the Council will respond on behalf of the Academy or on behalf of the member on individual issues.

### Progress Report for Charge 3

Mary Essling, Dental Benefits Manager, continues as part of her responsibilities to respond to individual member requests and inquiries concerning dental benefits issues. She reports receiving between 6 to 15 calls per week.

## Charge 4. Status of Charge 4: In Progress/Ongoing

Work with the Dental Benefits Manager to provide and annually review AAPD website content regarding coding and other dental benefits issues.

*Background and Intent:* This is a standing charge to the Council. The Board desires that the membership have a source of relevant, contemporary, and reliable information specific to their interests and needs in this area. The CDBP will continually update CDT code information on the website.

## Progress Report for Charge 4

- Dr. Johnson is charged with working with the Dental Benefits Manager and Website Editor to monitor and modify content and to develop a mechanism for regular review, maintenance, and update of the material contained therein.
- The 2012 revision of the AAPD website now features a distinct and easily located members-only section on Dental Coding and Insurance as a subset of the Practice Management tab under the Resource Center heading. The section contains information on the ADA CDT code set impacting pediatric dental practice, claim submission information, Medicaid compliance issues, and the related activities of the AAPD Council on Dental Benefit Programs.

## Charge 5. Status of Charge 5: In Progress

Coordinate/prepare and present a Code Workshop for the Annual Session in odd-numbered years to coincide with the publication of CDT code revisions. In the even-numbered years (, i.e. non-CDT release years), the council shall prepare and present a provider and staff forum to discuss private and public (i.e. Medicaid and CHIP) sector benefit program issues at the annual session. Should the ADA adopt an annual code revision process, the annual session presentation will reflect this change.

*Background and Intent:* CDT procedure codes are currently revised every two years, which require changes in practice management administration and billing systems to ensure that correct billing codes are submitted to third party payers. The coding workshops will explain the code revision process and delineate the changes taking effect that year. The presentation in years in which no code revisions occur is intended to provide a continuum by the CDBP of dental benefits issues for practitioners and their administrative staffs at the annual session.

## Progress Report for Charge 5

- At the annual session in San Diego, the CDBP presented, in an even-numbered year, a symposium on ***Medicaid Compliance for the Pediatric Dental Professional,*** attended by approximately 150 pediatric dentists and staff. Strategic Health Solutions, the Medicaid integrity education contractor for the Centers for Medicare and Medicaid Services, provided an overview of Medicaid program integrity, common compliance vulnerabilities, and recommendations for developing or improving a practice Medicaid compliance program.
- As noted in an earlier section of this report, CDT Code revisions now occur annually, which dictates a change in the content of the CDBP Annual Session presentations to include each year code revision information as well as a discussion of private and public sector benefit program issues.
- The 2013 Coding and Insurance Workshop in Orlando will cover the changes and revisions in CDT 2013.The course will offer advice by Dental Benefits Manager, Ms. Mary Essling, on claims submission, cross coding dental procedures to medical procedures and medical diagnostic codes, developing effective and meaningful claims narratives, and recommendations for appealing claims denials. CDBP Chair Paul Reggiardo will provide information on the Affordable Care Act, the pediatric oral health components of the Essential Health Benefits (EHB) package, and state insurance exchange information.

## Charge 6. Status of Charge 6: Ongoing

Working with the Dental Benefits Manager, coordinate, oversee, and promote state and regional Coding and Insurance Workshops.

*Background and Intent:* In 2010 the CDBP began offering a Coding and Insurance Workshop developed for AAPD state units and district organizations. These regional workshops, presented by AAPD Benefits Manager Mary Essling, each approximately three hours in length, encompass CDT coding issues, claims processing information, documentation requirement specific to pediatric dentistry, medical cross-coding to CPT procedure codes and ICD-9 diagnostic codes, instructions on developing meaningful narratives, and guidelines for successful appeal of claim denials. Included also was information on state Medicaid reimbursement and 2011-2012 CDT code revisions effective January 1, 2011. The workshops are provided without cost to the AAPD state unit or regional organization, other than reimbursement of the travel expenses of the presenter. It is the intent of the Board of Trustees to encourage and promote these regional workshops as a membership benefit and as service to our state units and regional organizations.

### Progress Report for Charge 6

- Regional Coding and Insurance Workshops were presented in 2010 and 2011 as follows:
  - **Nebraska Society of Pediatric Dentistry** – April 2010
  - **West Virginia Academy of Pediatric Dentistry** – July 2010
  - **Indiana Society of Pediatric Dentistry** – September 2010
  - **Connecticut Society of Pediatric Dentists** – November 2010
  - **Southeast Society of Pediatric Dentistry** --January 2011 (Atlanta, GA)
- The next Regional Coding and Insurance Workshop is scheduled in conjunction with the Annual Meeting of the California Society of Pediatric Dentistry and the Western Society of Pediatric Dentistry April 27 in Rancho Mirage, California.

## Charge 7. Status of Charge 7: In Progress

Assist the Dental Benefits Manager in updating the AAPD Coding and Insurance Assist the Dental Benefits Manager in updating the AAPD Coding and Insurance Manual for the 2013/2014 code revisions so long as the Council and the Board determine the continued publication of the manual.

*Background and Intent:* This manual meets member needs for assistance on coding, claims, and related third party reimbursement issues and can serve as a source of non-dues revenue.

### Progress Report for Charge 7

Under the editorship of the Dental Benefits Manager, Mary Essling, the *AAPD 2013 Pediatric Dentistry Coding and Insurance Manual* was released this year in as an interactive CD ROM. The cost to AAPD members is $19.95 ($29.95 for non-members) and is available for purchase on the website as well as onsite at the Annual Session.

## Council on Dental Benefit Programs, 2012-2013

**Charge 8.** **Status of Charge 8: Ongoing**

Report no less than annually to the Board of Trustees on options and opportunities to communicate with the dental benefits industry and major dental benefit purchasers our perspective on appropriate oral health benefits for children and concerns with third party reimbursement programs. Explore and report to the Board the options, logistics, and feasibility of convening a pediatric dental benefits industry summit meeting on an annual or biannual basis in conjunction with one of the major dental benefits meetings (i.e. the American Association of Dental Consultants, the National Association of Dental Plans, America's Health Insurance Plans, or the annual ADA Dental Benefits Conference in Chicago).

*Background and Intent:* This is an ongoing effort to reflect and resolve member concerns with third party reimbursement coverage This meets members' needs by educating and influencing major insurers concerning pertinent pediatric dentistry issues. In 2010 the CDBP organized and presented an invitational Dental Insurance Summit Conference in conjunction with the Chicago session. This was the second such industry summit attended by dental benefit industry representatives and AAPD elected and volunteer leadership. The first occurred in conjunction with the 2008 annual session in Washington DC. The 2010 summit was attended by nine representatives of the dental benefits industry (26 were invited) and approximately 15 members of AAPD volunteer leadership. In May 2012 AAPD hosted an Insurance Summit/Dental Directors & Consultants Meeting in conjunction with the meeting of the American Association of Dental Consultants.

### Progress Report for Charge 8

- **American Association of Dental Consultants (AADC)**
  - The AADC 2012 Spring Workshop was held in Orlando in May. The workshop is the annual meeting of dentists employed and contracted as administrative and claim consultants to the dental benefits industry. CDBP Chair Paul Reggiardo and Dental Benefits Manager Mary Essling attended and represented ASPD at that meeting. At that meeting, AAPD hosted, for the first time, a luncheon and *Open Forum for Dental Benefits Directors,* an informal meeting with approximately 15 representatives of the major carriers, that allowed an open dialogue on claim and benefit issues concerning pediatric dental care delivery. The American Association of Endodontists shared the luncheon hosting and held a similar *Open Forum* following ours. The session was very productive from our perspective and something we would like to co-host with AAE in future odd-numbered years. In even-numbered years, the Open Forum is conducted by AAP and AAOMS.
  - CDBP Chair, Dr. Paul Reggiardo, and Dental Benefits Manager, Ms. Mary Essling, will represent AAPD the 2013 Spring Workshop May 15-18, 2013 also in Orlando.

- **National Association of Dental Plans (NADP)**
  - The NADP is the largest national trade association focused exclusively on the dental benefits industry (i.e. dental HMOs, dental PPOs, discount dental plans and dental indemnity products). NADP members include major commercial carriers, regional and single state insurance companies, and companies organized as Delta and Blue Cross/Blue Shield. NADP serves as the voice of the dental benefits industry to government, the media, and a

range of organizations including the American Dental Association, the Oral Health Action Partnership, and specification standards organizations HL-7 and X-12.
- The 2012 NADP Annual Conference was held last September in Seattle. Ms. Essling represented AAPD at that meeting. The 2013 conference will be held in Phoenix September 10-13, 2013.

- **America's Health Insurance Plans (AHIP)**
  - AHIP represents nearly 1,300 health benefit companies serving more than 200 million Americans. AHIP's principal purpose is to represent the interests of its members on legislative and regulatory issues at the federal and state levels, and with the media, consumers and employers.
  - AHIP each year convenes a national conference, at which the AHIP Dental Committee meets. Presentations before the Dental Committee are by invitation only. In 2010 Warren Brill and Mary Essling represented the CDBP in Washington DC, at which they presented a code-by-code review of the AAPD Model Dental Benefits Plan. In 2011, CDBP Chair, Dr. Paul Reggiardo, presented the AAPD *Guideline on Caries-risk Assessment and Management for Infants, Children and Adolescents*. CDBP Manager, Mary Essling, also attended the meeting and spoke with AHIP representatives.
  - Ms. Essling and Dr. Reggiardo will determine if we have a presentation request for 2013.

- **American Dental Association National Dental Benefits Conference**
  - CDPB Chair Paul Reggiardo and Benefits Manager Mary Essling represented AAPD at the 2012 ADA National Dental Benefits Conference in Chicago. Attendees at this annual seminar typically include benefits brokers, dental consultants, third-party administrators, constituent and component dental society staff, and dental specialty organization representatives.
  - The ADA has indicated it may not continue the annual National Dental Benefits Conference because of poor attendance and lack of interest by state dental associations.

## Charge 9. Status of Charge 9: Completed

As directed and approved by the Board of Trustees, prepare, coordinate and present, in conjunction with the Dental Benefits Manager and appropriate AAPD staff, a national conference in the fall of 2013 on the impact and implications to pediatric dental patients and providers of the Patient Protection and Affordable Care Act as implemented beginning January 1, 2014. Secure recognized subject experts for each of the conference presentations. Present to the Board of Trustees by the 2013 Annual Session meeting a course outline, speaker list and business plan for the conference.

*Background and Intent:* The Affordable Care Act (ACA) includes in the individual mandate pediatric dental benefits intended to increase access to oral health services for children who obtain health coverage in the individual and small group health insurance markets, including those who will be covered through the new health insurance exchanges. The Act also places certain requirements on dentists as employers. Members need sufficient information on the ACA to make informed delivery choices. Part of the

target audience for this conference are the state public policy advocates, who are expected to assist their state unit members in negotiating the ACA.

## Progress Report for Charge 9

As of the date of this report (3/29/13), a preliminary budget has been submitted and approved by the Board of Trustees. The conference will occur Saturday, September 28, 2013, in Chicago. Tonya Almond and Kristie Casale have submitted RFPs to appropriate hotel venues, a preliminary agenda has been adopted, and potential speakers identified and contacted to ascertain their availability and willingness to participate. A full report will be available to the Board of Trustees in May.

# 2012-2013 Report of the Council on Government Affairs

**Beverly A. Largent, Chair**
**K. Jean Beauchamp, Board Liaison**
John S. Rutkauskas and C. Scott Litch, Staff Liaisons

*District Representative members:*
Robert Moreau (I)
Deven Shroff (II)
James M. Keeton, Jr. (III)
Jessica A. Meeske (IV)
Jason Zimmerman (V)
BJ Larson (VI)

*Consultants and Ex-Officio members:*
John A. Bogert, Consultant
Douglas B. Keck, Consultant
Jessica Y. Lee, Consultant
Jeffery Miles Mazzawi, Consultant
Kara M. Morris, Consultant
Patrice B. Wunsch, Consultant
Scott W. Cashion, Ex-Officio (Chair, PDMCAC)
Joseph. B. Castellano, Ex-Officio (AAPD Liaison to American Academy of Pediatrics)
James J. Crall, Ex-Officio (Child Advocate)
Paul A. Reggiardo, Ex-Officio (Chair, Council on Dental Benefit Programs)
Matthew Schieber, Ex-Officio (Chair, Council on Membership and Membership Services, New Pediatric Dentist Committee)
Heber Simmons, Jr., Ex-Officio (Congressional Liaison)

## VISION AND DUTIES

The vision of the Council on Government Affairs is that all children have access to quality dental care within the dental home. To attain this vision the Council will educate membership and advocate on the national level for fair and equitable treatment for all children.

The duties of the Council on Government Affairs, as listed in the AAPD *Administrative Policy and Procedure Manual*, are to: 1) monitor legislative and regulatory activities at the national level that may affect the health of children and make recommendations to the Board of Trustees regarding AAPD policy on these matters; 2) collaborate with related organizations on legislative and/or regulatory matters of mutual interest, including the ADA's legislative offices in Washington, D.C. and Chicago; 3) provide information to district organizations and state units that would be of benefit in their regional and local legislative and regulatory efforts; 4) make recommendations to the Board of Trustees concerning the Academy's legislative and regulatory priorities and additionally recommend activities related to these priorities; 5) perform such other duties as assigned by the President or the Board of Trustees.

## Council on Government Affairs, 2012-2013

## REPORT

### Charge 1. Status of Charge 1: Completed

Annually develop, and recommend to the Board of Trustees at the Winter Planning Meeting, AAPD Legislative and Regulatory priorities for the ensuing calendar year, and coordinate all elements of advocacy resources to support these priorities.

*Background and Intent:* This is a standing charge to the council.

### Progress Report for Charge 1

CGA met via conference call on December 12, 2012 to develop AAPD Legislative and Regulatory priorities for 2013. These priorities were approved by the board of trustees at the Winter Planning meeting. The 2013 Legislative and Regulatory Priorities are attached, and are posted on the AAPD website at:
http://www.aapd.org/aapd_2013_legislative_and_regulatory_priorities/

### Charge 2. Status of Charge 2: In Progress

Continue workforce expansion and enhancement efforts by promoting funding for pediatric dentistry training through:

a. New primary care dental training authority under health care reform law, which includes faculty loan repayment.
b. Identification and implementation of state faculty loan repayment programs
c. AAPD membership support for workforce efforts, including national, state and local legislative initiatives and collaboration with local dental education programs.
d. Technical assistance for program directors concerning funding of pediatric dental training including Title VII applications and awards, and GME.

*Background and Intent:* This charge recognizes that efforts to grow the pediatric dental workforce require multiple efforts and technical assistance as requested by current and potential training sites.

### Progress Report for Charge 2

This charge is in progress. See the CEO's Annual Report for more details on FY 2013 appropriations for Title VII Pediatric Dentistry.

### Charge 3. Status of Charge 3: Ongoing

Promote and support fair and equitable access to oral health services for all segments of the population by:

a. Promoting enhanced public funding of pediatric oral health services through:
    1. Federal legislators and regulators for Medicaid and CHIP
    2. State legislators and regulators for Medicaid and CHIP, highlighting "model" programs such as the Michigan Healthy Kids Dental Program, and reforms resulting from litigation settlements in Connecticut and Texas.
b. Encouraging federal and state health agencies to remove non-financial barriers to children's oral health care. "Non-financial barriers" mean administrative and regulatory burdens and communications problems that discourage provider and/or patient participation in these programs.
c. Facilitating dissemination of information through the Pediatric Oral Health Research and Policy Center and AAPD website on the status of state dental

Medicaid programs, utilizing expertise of the Council's Pediatric Dental Medicaid and CHIP Advisory Committee.

d. Promoting state adoption of EPSDT dental periodicity schedules based on AAPD guidelines, and disseminating such schedules.
e. Continuing to provide technical assistance on Medicaid pediatric dental reimbursement to states and on-site consulting service on this topic and/or general anesthesia legislation to state units.

*Background and Intent:* The intent is to continue to support efforts to improve Medicaid for kids' oral health and have successful implementation of a pediatric oral health component of CHIP.

## Progress Report for Charge 3

The AAPD's Pediatric Oral Health Research and Policy Center is working on several initiatives in this area. Dr. Jacqueline Hom, the 2011-12 Harris Research and Policy Fellow, co-authored an article in the March 2013 issue of JADA on *State Medicaid Early and Periodic Screening, Diagnosis, and Treatment guidelines: Adherence to professionally recommended best oral health practices*. This examined state adherence to dental periodicity schedule requirements.

CGA, under the leadership of Dr. Paul Reggiardo, developed a model School Entrance Exam document. This document is attached to this report and can be found on the AAPD website under our School Oral Health Entrance Exam toolkit: http://www.aapd.org/advocacy/school_oral_health_entrance_exam_toolkit/

## Charge 4. Status of Charge 4: In Progress

Develop and maintain an effective AAPD advocate structure.

a. Conduct advocacy forums during the annual session, including basic advocacy training refresher courses as appropriate.
   *Background and Intent:* The intent is to continue education and dialogue with our growing "advocacy network".
b. Encourage membership participation in our advocacy and legislative training programs. Utilize the New Pediatric Dentist Committee in recruitment efforts, and encourage these committee members to attend.
   *Background and Intent:* This charge relates to the continuing effectiveness and improvement of AAPD Advocacy Training Workshops.
c. Present an Advanced Legislative Workshop each fall in the Chicago area, focused on a specific advocacy issue.
   *Background and Intent:* This charge builds upon the success of the fall 2010 advanced workshop focused on mid-level/non-dentist provider issues. Moving forward, basic advocacy training will be offered as needed at either the Annual Session or Lobby Days, rather than as a free-standing workshop.
d. Encourage states to develop and increase their advocacy infrastructure, through mechanisms such as a public policy advocate, including liaison and partnership with their state dental association.

## Progress Report for Charge 4

The AAPD conducted the inaugural training of the state Public Policy Advocates (PPAs) on March 11, 2013 prior to the Public Policy Advocacy Conference in Washington D.C.

## Council on Government Affairs, 2012-2013

*32 states have PPAs currently in place*[1]. PPAs were instructed on their duties and expectations. They received an update on state health insurance exchanges and essential health benefits under the Affordable Care Act (ACA). Critical implementation issues at the state level were discussed, as well as strategies for working with state dental associations and oral health coalitions.

CGA is also assisting in an Annual Session Program on health care reform being sponsored by the Committee on the New Pediatric Dentist.

### Charge 5. Status of Charge 5: Completed

Maintain a close collaboration with the AAPD Political Action Committee related to evaluating candidates for AAPD PAC support, taking into account the advice of AAPD's Washington lobbyist. CGA will present a report to the PAC Steering Committee in election years to facilitate recommendations for candidate financial support.

*Background and Intent:* The PAC has two functions: to raise money and to disburse it. This charge creates a formal mechanism for the Academy to identify those seeking office it wishes to support utilizing the Council most familiar with issues that are deemed important for children's oral health. This will include a written CGA report for each Congressional election cycle.

### Progress Report for Charge 5

CGA met with the AAPD PAC Steering Committee on March 10, 2013. A review was conducted of the candidates supported in 2012 and the success rate (as published in the March 2013 PDT). The group also discussed key Senators up for re-election in 2014, and early support opportunities in 2013. The CGA continues to work closely with the AAPD PAC.

### Charge 6. Status of Charge 6: In Progress

Monitor state legislative activities related to AAPD legislative and regulatory priorities. Inform state advocates of important analysis and reports developed by the Pediatric Oral Health Research and Policy Center that will assist in their advocacy efforts. Expand reporting on state legislative news in AAPD publications, including website.

*Background and Intent:* While the CGA deals primarily with national concerns, there are many issues that arise in the states that may influence national legislation. In addition, the same issue may arise in several states and communication between them could be of paramount importance.

By the district members of the Council monitoring activities within their states and reporting back to the Staff Liaison and Board of Trustees, our members will have the opportunity to learn what is happening throughout the country and thus be more efficient and effective within their own locales.

### Progress Report for Charge 6

Additional state legislative news has been included in recent issues of PDT. In addition as the State Public Policy Advocates (PPA) program gets underway, we will collect and disseminate brief legislative updates from the various state PPAs.

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[1] See the CEO's Annual Report for the PPA list.

Appendix 2

# AAPD Model School-Entrance Oral Health Examination Law

**Section ____. School-entrance oral health examination.**

(a) All children in kindergarten of any public, private, or parochial school shall have a dental examination performed no earlier than 12 months prior to the date of the initial enrollment of the pupil or at any time during the school year. The examination shall be performed by a licensed dentist. Parents and guardians of students shall, no later than May 15 of the school year, present proof of having received a dental examination.

(b) The dental examination shall include documentation of oral health history, soft tissue health/pathologic conditions, oral hygiene level, variations from a normal eruption/exfoliation pattern, dental dysmorphology or discoloration, caries (including white-spot lesions), and existing restorations. The child and the parent or guardian should also be informed of age-related caries-risk and caries-protective factors, as well as the benefits of a dental home.

(c) Each public, private, and parochial school must give notice of this dental examination requirement to the parent or legal guardian of a pupil described in subsection (a) concerning the dental examination requirement, no later than thirty (30) days after the start of the school year. The notification shall, at a minimum, consist of a letter that includes all of the following:

(1) An explanation of the requirements of this section.
(2) Information on the importance of primary teeth.
(3) Information on the importance of oral health to overall health and to learning.
(4) A toll-free telephone number to request an application for Medicaid, CHIP, or other government-subsidized health insurance programs.
(5) Contact information for county public health departments.
(6) A statement of privacy applicable under state and federal laws and regulations.

(d) The parent or legal guardian of a pupil may be excused from complying with subsection (a) by indicating on the form described in subsection (d) that the dental examination could not be completed because of one or more of the following reasons:

(1) The examination poses an undue financial burden on the parent or legal guardian.
(2) Lack of access by the parent or legal guardian to a licensed dentist.
(3) The parent or legal guardian does not consent to a dental examination.

(e) In order to ensure uniform data collection, the department of education, in consultation with interested persons, shall develop a standardized form that shall be used by each school district to record the results of the examination or the reason the examination was not conducted. The standardized form shall include all of the following:

(1) A section that can be used by the licensed dentist performing the examination to confirm the date of the completed examination.
(2) A section that can be used by the licensed dentist performing the examination to indicate whether the pupil presented with a history of decay indicated by restored or missing teeth and untreated dental decay or other oral health needs.
(3) A section that can be used by the licensed dentist to indicate treatment recommendations arising from the examination that were communicated to the parent or legal guardian.
(4) A section to indicate if this is the child's first dental examination and, if not, if the child was a patient of record at the time of the examination.
(5) A section in which the parent or legal guardian of a pupil can indicate the reason why an examination could not be completed by marking the box next to the appropriate reason consistent with subsection (c).

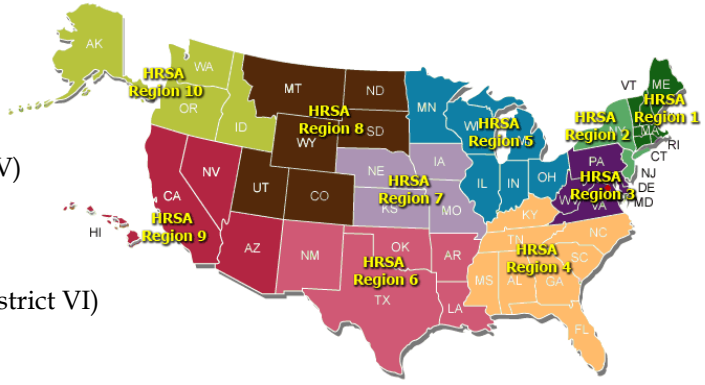
(f) Upon receiving completed standardized forms, all school districts shall, by December 31 of each year, submit a report to the county office of education of the county in which the school district is located conveying in a statistical manner the information derived from the forms. The report will be in a standardized format developed or approved by the state Department of Education and will be available for public inspection and posted on the department's website. The report shall include all of the following:

(1) The total number of pupils in the district, by school, who are subject to the requirement to present proof of having received dental examination pursuant to subsection (a).
(2) The total number of pupils described in paragraph (1) who present proof of an examination.
(3) The total number of pupils described in paragraph (1) who could not complete an examination due to each of the reasons in subsection (c).
(4) The total number of pupils described in paragraph (1) who are examined and found to have (a) a history of decay indicated by restored or missing teeth and (b) untreated dental decay or other oral health needs.
(5) The total number of pupils described in paragraph (1) for whom the examining dentist recommended the treatment options described in paragraph (d)(3).
(6) The total number of pupils described in paragraph (2) for whom this was (a) the child's first dental examination and, if not (b) was the child a patient of record of the examining dentist.
(7) The total number of pupils described in paragraph (1) who did not return the form.

# 2012-2013 Report of the Council on Government Affairs, Pediatric Dental Medicaid and CHIP Advisory Committee

**Scott W. Cashion, Chair**
**K. Jean Beauchamp, Board Liaison**
C. Scott Litch, Staff Liaison

Lawrence I. Lipton (HRSA Region 1, AAPD District I)
Amr M. Moursi (HRSA Region 2, AAPD District I)
Ross M. Wezmar (HRSA Region 3, AAPD District II)
Scott W. Cashion (HRSA Region 4, AAPD District III)
Charles S. Czerepak (HRSA Region 5, AAPD District IV)
Dietmar Kennel (HRSA Region 6, AAPD District V)
Jessica A. Meeske (HRSA Region 7, AAPD District IV)
Brent L. Holman (HRSA Region 8, AAPD District V)
Francisco J. Ramos-Gomez (HRSA Region 9, AAPD District VI)
Dale Ruemping (HRSA Region 10, AAPD District VI)
James J. Crall, Expert Consultant




Since my last annual report the Pediatric Dental Medicaid and CHIP Advisory Committee (PDMCAC) and the Medicaid/CHIP State Dental Association (MSDA) have had a busy year. I sit on the MSDA board of directors and participate in the monthly board calls as well as its meetings representing the AAPD.

The MSDA had its second annual stand-alone symposium June 24- 26, 2012. The meeting was held in Washington DC at the Marriott Wardman Park. I served on the planning committee for the symposium. The focus of this year's symposium was Dental quality. Two of our own were speakers at the symposium, Drs. Anu Tate and Tegwyn Brickhouse. Both of these speakers were very well received.

All of the PDMCAC members and three AAPD staff members were able to attend the meeting. All members were able to network with the state dental Medicaid directors and other state and federal Medicaid officials. The new chief Dental Officer for CMS, Dr. Lynn Mouden, was in attendance as well Laurie Norris from CMS. Many of the members were able to network with both of them during the conference.

The PDMCAC continues to look at ways to be sure that the AAPD is looked as the go to organizations on children's oral health issues. Our presence at this meeting continues to be very valuable. The key stakeholders recognize us and know that we are there to give the perspective on children's oral health.

## Council on Government Affairs, Pediatric Dental Medicaid and CHIP Advisory Committee, 2012-2013

We are able to distribute to all in attendance, a copy of our reference manual. To quote one State Dental Medicaid director "the AAPD reference manual is my go to reference when making decisions concerning pediatric Medicaid codes and reimbursement rates; thanks for giving me an updated version."

The MSDA had its annual planning/Board of Directors meeting on November 11, 2012 in Washington DC. This meeting spent a significant amount of time reviewing the revisions to the constitution and By-laws. The changes will go before the MSDA membership at its annual meeting. Marty Dellapenna gave a report to the board on the MSDA Policy Center. She continues to look for ways in which the AAPD and MSDA can work together. MSDA is looking at modifying the logo to better show that this is a national organization. Each of the partnership groups gave updates. I updated them on the AAPD and that we continue to value the relationship between the two groups. The meeting concluded with some lengthy discussion about the funding and sustainability of MSDA. Mary Foley will focus a good bit of her time on this area.

I continue to be on the monthly conference calls of the MSDA board. These calls are very well organized and productive. Mary Foley, the Executive director and the President Linda Altenhoff keep the calls on time and efficient.

The 2013 MSDA symposium will be June 2-4 at the Marriott Wardman Park in Washington DC. I sit on the planning committee for the symposium this year. The planning is well under way. The topic this year is *Optimizing Program Impact through Innovation and Leadership: Preparing for 2014*. The main focus will be on the Affordable Care Act and how it will affect Medicaid programs and their providers. I have asked the committee to recommend speakers for this year's program.

# 2012-2013 Report of the Council on Membership and Membership Services

**Paul A. Kennedy, III, Chair**
**Mario E. Ramos Board Liaison**
Suzanne Wester, Staff Liaison

*District Representative members:*
Derek S. Zurn (I)
Ricardo A. Perez (II)
Thomas J. Bouwens (IV)
Jason A. Clapp (V)
Ruth W. Bol (VI)

*Consultants and Ex-Officio members:*
Perry Francis, Affiliate Member Consultant
Tanesha M. Francis, Consultant

## VISION AND DUTIES

The vision of the Council on Membership and Membership Services is to evaluate, address and support the needs of the membership and to promote the growth and longevity of the Academy.

The duties of the Council on Membership and Membership Services, as listed in the AAPD *Administrative Policy and Procedure Manual*, are to: 1) monitor membership trends; 2) make recommendations to the Board of Trustees regarding mechanisms for recruiting and retaining members; 3) perform such other duties as assigned by the President or the Board of Trustees.

## REPORT

### Summary

**Pre-Doctoral Chapters of the AAPD**: Over half of the dental schools in the U.S. have registered chapters. We continue to work on recruitment and retention. We will also begin to revisit updating the Handbook for Pre-Doctoral Chapters.

**Affiliate Members**: Continue to have personal contact with existing Affiliate members and focus on retention tactics.

Identify and engage the leaders of other dental organizations like the NDA, HDA, and SAID in order to attain a more diverse membership population.

**Career Fair**: Recognizing that the planning of the annual Career Fair derives mostly from the AAPD Headquarters Office, the Council will be phasing this current charge out in the future.

**International Membership Recruitment and Retention**: Display a poster at the registration booth at the Annual Session advertising the International Reception.

Recommended to the Board that changes should be made to the International Post-Doctoral Student Category. A recommendation for a $25 fee for membership dues was

submitted to the Board of Trustees was accepted. This recommendation led to the need to change the Constitution and Bylaws.

## Charge 1. Status of Charge 1: Completed

Provide an ongoing review and evaluation of AAPD membership benefits and services, including the proposal of new or additional benefits and services, reporting to the Board of Trustees on an annual basis, using the data from the current Member Needs Assessment. Provide an annual report on the current value and benefits of Academy membership along with a statement regarding the anticipated need for any unusual increase in funds necessary to maintain or increase those services.

*Background and Intent:* This is a standing charge to the Council. Recognizing that 92 - 94% of eligible pediatric dentists belong to the Academy, the council should focus on membership retention and maintenance of active status after conversion of student membership. Membership benefits and services are important to this effort. The Council will develop mechanisms for tracking demographics of membership benefits and include this information in its annual report to the Board.

### Progress Report for Charge 1

We had initially planned to create a survey to send to a small random sample of the AAPD membership (approximately 500 members). Our original intentions were to gather data to see if the membership was satisfied with member benefits or if they had any new desires for benefits. Understanding that our membership is constantly being solicited for surveys, we decided to table that plan and focus on gearing up for the 2014 Membership Needs Assessment. Our plan is to review the survey questions used in the past in order to see if any deletions or additions are to be made in order to gather more specific data regarding the membership. Our staff liaison is continuing to collect data from other dental specialty organizations regarding their respective membership benefits. The information collected would be distributed to the council members and reviewed to see if there are any new benefits we would like to recommend to the Board of Trustees for consideration.

## Charge 2. Status of Charge 2: Completed

Encourage and support the development of new pre-doctoral chapters. Report annually to the Board at the May meeting on these pre-doctoral chapters as to their numbers and activities.

*Background and Intent:* This is a standing charge to the Council. Increasing numbers of pediatric dental training positions require an increasing pool of qualified applicants. Pre-doctoral membership in AAPD serves to increase student interest and awareness of the pleasures, rewards and opportunities of treating children, whether as a general dentist or specialist. It also offers opportunities for contact and mentoring with pediatric dentists early in the educational process.

### Progress Report for Charge 2

We continue to support the pre-doctoral chapters through the Academy. Contacts have been made with many pre-doctoral Directors and the chapter representatives contact the

Headquarters office for information and to receive money to offset their meeting costs throughout the year.

More effort should be made in developing solid contacts at more of the dental schools in the Pediatric Dentistry department. A formal letter should be mailed to each school's pediatric department chair at the beginning of the school year requiring their response and explaining/demonstrating the importance of having active faculty at these schools in order to support/increase the number of participating chapters. All dental schools should know about this program, so our efforts should focus on forming relationships with the faculty sponsors of "Pediatric Dental Clubs" as well as the department chair at the various schools. Out of 62 schools in the USA, we have 32 programs registered (~50%) to date. The current Pre-Doctoral Chapter Handbook will need to be updated in the future.

## Charge 3. Status of Charge 3: Completed

Review the marketing plan on an ongoing basis to increase membership in the Affiliate membership category, including strategies to improve retention and attendance at Annual Session by the Affiliate membership category. Report to the Board by May 2013.

*Background and Intent:* Support of general dentists providing care for children is an increasingly important part of our vision that all children receive optimal health and care. Increasing the membership base of general dentists will allow us to be more effective in this arena.

### Progress Report for Charge 3

AAPD staff will continue to call new Affiliate Members that join the Academy to personally welcome them. The Affiliate Member of the AAPD Brochure has been completed and will be available to distribute to potential new Affiliate members at various events like the Comprehensive Review of Pediatric Dentistry for the General Dentist. Suzanne Wester has been attending other large dental meetings to promote the AAPD to other dentists. She usually attends the Greater New York Dental Meeting and Chicago Mid-winter meetings. She also attended the Multi-Cultural Oral Heath Summit sponsored by the National Dental Association, The Hispanic Dental Association and the Society of the American Indian Dentist in July 2012 as well as the ASDA Leadership Conference held in Chicago in November 2012.

In addition to the AAPD staff contacting the affiliate members, it will be worthwhile for there to be increased outreach to Affiliate Members in some form. For example, sending out a special "e-blast" to all Affiliate members on a periodic basis may increase their interest in the Academy; the more they feel included, the more they will feel good about their membership. The council will begin to investigate possible Affiliate Membership-only benefits that may continue to draw new members as well as retain our current Affiliate Members.

Another area that the AAPD should focus on is associating with other cultural dental organizations. The AAPD's Advanced Leadership Institute presented a report during the 2013-2014 Strategic Planning Retreat in January 2013. Within the report, ideas were suggested as how to partner with and recruit new members, especially from the general dentist population. This council expects to receive further instruction from the AAPD Leadership whenever a definitive course of action has been decided upon.

## Charge 4. Status of Charge 4: Completed

Review and coordinate the promotion of pediatric dental career opportunities on the AAPD website with the Annual Session Career Fair including the review from the Residents Committee, print ads, and other venues. Present that plan for the consideration of the Board oat the 2013 Winter Planning Meeting. Act subsequently at the direction of the Board.

*Background and Intent:* This is a standing charge to the Council. Coordinating efforts in advertising career opportunities will result in increased visibility and facilitate greater consistent interactions among those investigating pediatric dental careers.

### Progress Report for Charge 4

The career fair seems to be progressively getting better each year, based on interviews with students and vendors over the last few years. Majority of the work needed to carry out this annual event during the AAPD annual meeting has been completed by the AAPD Headquarters Staff. (i.e. acquiring exhibitors, participant and exhibitor surveys). They continue to do an outstanding job year after year. We anticipate that this charge will not be needed for this council in the future.

## Charge 5. Status of Charge 5: Completed

Review the marketing plan on an ongoing basis to increase membership in the International membership category, including strategies to improve retention and attendance at Annual Session by the International membership category. Report to the Board by May 2013.

*Background and Intent:* Attracting International members to the AAPD will strengthen our pediatric dental organizational representation on a more global level. New leadership of IAPD may be open to developing increased ties to AAPD. This may be the first step to foster this relationship and also increase the international membership of AAPD.

### Progress Report for Charge 5

During the San Diego meeting, the council discussed options on ways to promote the AAPD during the Biannual Session of the International Academy of Pediatric Dentistry (IAPD). The suggestion was made create a poster/flyer that could be displayed during the IAPD meeting in Seoul, South Korea June 2013 promoting the AAPD's 67th Annual Session in Boston. The 3rd Annual International Reception was a great success. Both Immediate Past President Dr. Rhea Haugseth and President Dr. Joel Berg were both in attendance. Dr. Berg welcomed the attendees and expressed that one of his many goals was to promote the IAPD meeting in Seoul.

The AAPD has let International Post-Doctoral students join for free (same as US Post-Doctoral Students) in the past. Initially, the number was relatively small and the AAPD easily absorbed them into that category. However in the past years, there has been a growing number of International Post-Doctoral Student Members. Currently, we have 119, with 89 joining primarily from Mexico. They mostly sign up to attend the Annual Session at no cost to them (Post-Doctoral Students). While it is not the intent of this Council to discourage International student membership or attendance, and as these International Post-Doctoral students rarely convert to Internal Membership Status once

they complete their programs (even when provided with invitations to join and AAPD membership applications), we decided that we needed to address this current trend. The Council had recommended an action item to the Board of Trustees requesting that a minimal fee of $25 be assessed of International Post-Doctoral Students who are attending schools that are not approved by the Commission on Dental Accreditation of the American Dental Association. The purpose of the fee is to help with the additional cost of postage to mail publication. This was agreed upon by the Board of Trustees but has been referred to the Constitution and Bylaws Committee. There will need to be a new membership category created within the Constitution and Bylaws. This will be voted upon during the 2013 Annual Session in Orlando.

# 2012-2013 Report of the Council on Membership and Membership Services, New Pediatric Dentist Committee

**Matthew Schieber, Chair**
**Shari C. Kohn, Board Liaison**
Suzanne Wester, Staff Liaison

*District Representative members:*
Zameera Fida (I)
Jennifer L. Cully (II)
Cara C. DeLeon (III)
Tehemina Gagrat Richardson (IV)
Courtney Alexander (V)
Arminda V. Robles (VI)

*Consultants and Ex-Officio members:*
AnnaMarie DeFeo, Consultant
Todd L. Hillyard, Consultant
Elsa K. Hui-Derksen, Consultant
Paul A. Kennedy, III, Consultant
D. Harvey Lee, Consultant
Patrice B. Wunsch, Consultant
Maria Cordero, Ex-Officio (Chair, Pediatric Dental Residents Committee)

## VISION AND DUTIES

The duties of the Council on Membership and Membership Services, New Pediatric Dentist Committee, as listed in the AAPD *Administrative Policy and Procedure Manual*, are to: 1) encourage the participation of new pediatric dentists in AAPD activities; 2) make recommendations to the Board of Trustees regarding issues of interest to new pediatric dentists; 3) perform such other duties as assigned by the President or the Board of Trustees.

## REPORT

### Charge 1. Status of Charge 1: In Progress

In conjunction with the Councils on the Annual Session and Continuing Education, provide planning and execution for a continuing education course directed to the new pediatric dentist. Present the programming details and proposed speakers for the 2014 Annual Session to the Board of Trustees no later than May 2013. Maintain a three year plan of proposed topics and speakers for future meetings.

*Background and Intent:* This is a standing charge to the Committee. The intent of this charge is to attract young pediatric dentists to the annual session and to AAPD membership. The course and content should address issues relative to new pediatric dental practitioners.

### Progress Report for Charge 1

The committee has liked having several speakers share their perspective in this program. We will always maintain a panel format (2-4 speakers) during the new

pediatric dentist program. Every other year, the committee would like to focus on HR topics such as the business side of building a practice, customer service, practice philosophies. Alternative years can focus on other things such as getting involved in organized dentistry or other various fields of pediatric dentistry (the road after graduation).

The topics for the next 3 annuals sessions are as follows:

66th Annual Session May, 2013
*Topic*: "Health Care Reform: What it means for the Pediatric Dentist."
*Objectives*: To give the new pediatric dentist an idea of how the Affordable Care Act and Health Care Reform will impact Pediatric Dentistry.
*Topics for discussion include:*

1. Explanation of the pediatric dentistry benefit as part of the Affordable Care Act
2. Changes to current regulations and its effect on dentistry
3. The pediatric dentist's role in advocating for oral health care and how to get involved

*Speakers:*
Dr. Louis Kay, Dr. Heber Simmons, Mr. Scott Litch, Dr. Jim Crall

Possible topics for the following two years:
67th Annual Session May, 2014
Customer Service/ Team building

68th Annual Session May, 2015
Insurance- How to code and maximize insurance

Survey
We have created a survey to better understand our new pediatric dentists/residents and what topics they would be interested in learning about at our annual meeting. To encourage participation in the survey, the board has approved a raffle prize of free registration to the AAPD annual session.

Questions to include:

1. What topics would you be interested in learning about at our annual meeting?
   - Corporate Dentistry- Evaluate different models of practices
   - Insurance- How to code and maximize insurance
   - How to communicate with your medical colleagues- Strategies for educating our colleagues and marketing our practices to them.
   - Malpractice
   - Customer Service/ Team Building
   - "Master Pediatric Dentist" panel- Pearls of wisdom
   - Leave a blank for suggestions

2. Did you attend the meeting this year?
   - How long have you been out of residency?
   - What type of practice are you in?

## Council on Membership and Membership Services, New Pediatric Dentist Committee, 2012-2013

See Appendix 1 for details of our results

### Charge 2. Status of Charge 2: In Progress

In conjunction with the Council on the Annual Session, review annually the "New Dentists Reception" and the "Family Friendly" section at the Welcome Reception in conjunction with the Annual meeting of the Academy. Present to the Board of Trustees at the 2012 Ad Interim meeting a report on the May 2013 reception, including attendance figures and other pertinent information.

*Background and Intent:* This is a standing charge to the Committee. It is the intent of the Board to encourage membership in the Academy beyond the years of graduate education and to build a sense of "community" with the Academy and with pediatric dental colleagues. A social occasion for post-doctoral students at the annual session can provide recognition of the importance we place on our future colleagues and leaders. It is important to provide a structure to the occasion, which emphasizes the elements of active Academy membership, attendance at our annual meetings, and the inclusiveness of our organization.

### Progress Report for Charge 2

2012 New Pediatric Dentist Happy Hour, San Diego

Many new dentists and student members from across the country took advantage of this networking event. This year's event was sponsored by Treloar & Heisel and was held in a great location in the Gaslamp District. The location made it easy for members to walk to. Those in attendance were happy with the food, drinks, and entertainment provided in this fun venue. 380 tickets were sold in advance and at the door.

The representatives of Treloar and Heisel were happy with event. They would like to continue to sponsor this event in the future.

2012 Welcome Reception, "Family Friendly" Section at the Block Party Gaslamp District, San Diego

The family friendly section at the 2012 AAPD Annual Session Welcome Reception was a success with many members and their families enjoying the children's area. 245 children's tickets were sold. The Kid Zone area included professional babysitters as well as entertainment and games for children of all ages. Ping-pong, air hockey, Wii games and Guitar Hero were some crowd favorites. As part of the Welcome Reception, Sun stars America, Inc sponsored the family friendly section.

Negative feedback of the event included complaints that parents were not aware until they got there that children had to be in the kid zone due to new San Diego city statutes. It was also suggested that a separate entrance for families with children would be appreciated. Many children lost their patience due to long wait times to get into the event. There was also mention of cigars being inappropriate at an AAPD event.

### Charge 3. Status of Charge 3: Completed

Evaluate other dental and medical associations' annual session registration policies. Consider an experiment to see if reducing fees for annual session registration will increase attendance of the younger members.

*Background and Intent:* Residents attend the annual session because the program pays the fees. After graduation, new dentists may face financial issues such as loan repayment,

board fees, review courses, travel expenses, etc. The intent of this charge is to determine if there is a need to adjust fees to increase new graduate attendance, to support the personal issues of new pediatric dentists, and to encourage them to attend the annual session and become involved in the Academy.

## Progress Report for Charge 3

Evaluation of the attendance trends, at our meeting, shows that the percentage of recently graduated pediatric dentists that attend the annual session mirrors that of our general membership. Our goal is to increase the attendance of these new grads and consequently see an increase in overall attendance over time. Understanding that new graduates have a great deal of financial burden our hope is to increase attendance by reducing their fees. Other specialties including, Endodontics (AAE) and Periodontics (AAP), have also adopted a reduced rate for new graduates in hopes to increase attendance. Endo has a one year reduction from the meeting fee of $945 to $473. Perio reduces fees for two years from $635 to $300. We want to have a 50% reduction for 2 years to see if our attendance numbers will increase over the long term. Our charge is to re-evaluate our attendance trends in 5 years to monitor change. If no improvements are seen we will eliminate the meeting fee reduction.

With the approval of this charge, the new pediatric dentist committee realizes the importance of monitoring attendance of the annual session over the next two years. Our committee will continue to monitor the attendance as well as monitoring the marketing of the newly added fee reduction.

## Council on Membership and Membership Services, New Pediatric Dentist Committee, 2012-2013

Appendix 1. Survey results

### New Pediatric Dentists Program Topics at AAPD Annual Session

**Q1. What topics would you be interested in learning about at our annual meeting?**

| Answer Options | Response Percent | Response Count |
|---|---|---|
| Corporate Dentistry- Evaluate different models of practices | 30.1% | 69 |
| Insurance- How to code and maximize insurance | 59.4% | 136 |
| How to communicate with your medical colleagues- Strategies for educating our colleagues and marketing our practices to them. | 44.5% | 102 |
| Malpractice | 29.3% | 67 |
| Customer Service/ Team Building | 41.9% | 96 |
| “Master Pediatric Dentist” panel- Pearls of wisdom | 69.9% | 160 |
| Comments | | 13 |
| | answered question | 229 |
| | skipped question | 2 |

**Q2. Did you attend the 65th AAPD Annual Meeting in San Diego this year?**

| Answer Options | Response Percent | Response Count |
|---|---|---|
| Yes | 44.7% | 102 |
| No | 55.3% | 126 |
| | answered question | 228 |
| | skipped question | 3 |

**Q3. How long have you been out of residency?**

| Answer Options | Response Percent | Response Count |
|---|---|---|
| 1 - 2 Years | 62.1% | 131 |
| 3 - 4 Years | 26.1% | 55 |
| 5 - 6 Years | 11.8% | 25 |
| Greater than 7 Years | 0.0% | 0 |
| | answered question | 211 |
| | skipped question | 20 |

## Council on Membership and Membership Services, New Pediatric Dentist Committee, 2012-2013

**Q4. What type of practice are you in?**

| Answer Options | Response Percent | Response Count |
|---|---|---|
| Private Group Practice | 56.0% | 121 |
| Private Solo Practice | 20.8% | 45 |
| Hospital | 13.0% | 28 |
| Corporate | 4.2% | 9 |
| Health Center | 8.3% | 18 |
| Academics | 20.8% | 45 |
| Comments | | 12 |
| | answered question | 216 |
| | skipped question | 15 |

**Q5. If you would like to be entered into a drawing to win a free 66th Annual Session registration in Orlando, Florida please enter your name.**

| Answer Options | Response Count |
|---|---|
| | 197 |
| answered question | 197 |
| skipped question | 34 |

# 2012-2013 Report of the Council on Membership and Membership Services, Pediatric Dental Resident Committee

**Anna R. Forsyth, Chair, October 2010-October 2012**
**Maria Cordero, Chair, October 2012-October 2013**
**Man Wai Ng, Board Liaison**
Suzanne Wester, Staff Liaison

*Members(Graduation date in parentheses)*
Claudia E. Maiolo, District 1 (2010)
Leslie Blackburn, District 2 (2014)
Derek Blank, District 2 (2013)
Flynne Weingarten, District 2 (2014)
D. Kennon Curtis, Jr., District 3 (2013)
Lauren A. Sanzone, District 3 (2013)
Ashla Martin, District 5 (2013)
Christen M. Massey, District 5 (2012)
Ashley Orynich, District 5 (2014)
David Avenetti, District 6 (2013)

*Consultants*
Erin Hinze
Anna R. Forsyth (after October 2012)
Amir Rabiee
Lauren Levine

## VISION AND DUTIES

The vision of the Council on Membership and Membership Services, Pediatric Dental Resident Committee is to evaluate, address, and support the needs and desires of residents in order to establish a lifelong relationship with the AAPD.

The duties of the Council on Membership and Membership Services, Pediatric Dental Resident Committee, as listed in the AAPD *Administrative Policy and Procedure Manual*, are to: 1) Provide a forum for residents issues and a communications mechanism to link residents across the country; 2) Facilitate opportunities for residents to contribute to AAPD activities and initiatives; 3) Assist residents education about the AAPD as well as current issues facing pediatric dentistry on a local, national, and global level; 4) Cultivate future pediatric dentistry leaders.

## REPORT

### Charge 1. Status of Charge 1: Completed

In conjunction with the Council on Annual Session, review annually the Career Opportunities Fair as part of the Annual Session and report to the Council on Membership to be included with Charge 4 with the Council on Membership and Membership Services report at each Ad Interim meeting on the previous Annual Session.
*Background and Intent:* The intent of this charge is to attract residents and young pediatric dentists to Annual Session and to provide a benefit to both residents and established pediatric dentists by providing information regarding practice and career transition opportunities in an informal setting.

## Council on Membership and Membership Services, Pediatric Dental Resident Committee, 2011-2012

### Progress Report for Charge 1

The Career Opportunity Fair survey was implemented using Survey Monkey in October. Of 20 vendors, we had a 20% response rate. Of those who responded, 75% were recruiting for private practice positions and 75% of respondents were unsuccessful. All were satisfied with registration process and no dissatisfaction with facilities or booths. Intention to participate in 2013 COF is 50% No and 50% undecided. See attachment for full report.

**Recommendations/Future Initiatives**: Although there is room for improvement in this evaluation process, there is not a great deal gained from its collection. At our last meeting it was recommended to discontinue this charge.

### Charge 2. Status of Charge 2: Postponed until 2013

Evaluate every three (3) years the results of the two surveys distributed to new residents in the first year and to graduating residents, that would address what residents are looking for that would promote continued membership. Present to the Board at the January 2014 Winter Board meeting.

*Background and Intent:* The intent of this charge is to gain information from incoming and outgoing residents about needs specific to the pediatric dental resident.

### Progress Report for Charge 2

The last surveys were completed in 2010 and have been submitted to the AAPD in the last winter report. A new survey will be planned for 2013.

### Charge 3. Status of Charge 3: Postponed until Summer 2012

Evaluate the effectiveness of email communications and online presence for residents and report to the Board by May 2013.

*Background and Intent:* The intent of this charge is to meet the needs and desires of the residents based on the results of the most recent survey – increasing communication to indicate benefits of AAPD membership.

### Progress Report for Charge 3

The Resident webpage went "live" in January. It is available for review at: http://www.aapd.org/resources/residents/. Concurrently, we have begun the monthly e-blasts to current residents and program directors. A bank of e-blasts has been created in order to create continuity. They are sent monthly by Suzanne Wester. The list was presented during the Winter Board meeting and is available from Suzanne upon request.

**Recommendations/Future Initiatives:** With the help of Tom McHenry, track and evaluate the traffic to the resident website to evaluate which parts are most interesting and used. We will also add a question to the resident survey of Charge 2 to evaluate the effectiveness of the website in raising awareness, membership value, and quality of information.

## Council on Membership and Membership Services, Pediatric Dental Resident Committee, 2011-2012

### Charge 4. Status of Charge 4: In Progress

Develop methods to increase continuity and improve participation in the Residents Committee and present to the board by May 2013.

*Background and Intent:* The intent of this charge is to maintain higher levels of productivity within the constantly changing Residents Committee make-up so that residents are adequately represented within the AAPD.

### Progress Report for Charge 4

Upon discussion during Winter Board meeting, this topic will be refocused at the next annual session. Internally, the committee has emphasized early participation to improve continuity, allowed graduated residents to remain as consultants, and offset the transition of Chair leadership to reflect the educational calendar.

### Charge 5. Status of Charge 5: In Progress

Implement and evaluate solicitation by residents of brief articles featuring residents doing innovative and interesting activities in their training programs, to be published on the AAPD website and in PDT on a quarterly basis. Present guidelines for article submission and scoring criteria to the Board of Trustees at the Ad Interim 2012 meeting.

*Background and Intent:* The intent of this charge is to promote greater awareness of and interest in using the AAPD website and residents' community page.

### Progress Report for Charge 5

The announcement for the Resident Award was released in February. We received 20 applications. They are currently being reviewed by Man Wai Ng, Paula Coates, Matt Schieber, and Maria Cordero as representatives of the Membership Committee. The recipient will be announced at the Annual Session Award Ceremony, receive a $100 award and certificate, and have a brief in PDT as recognition. The award will be selected quarterly.

# 2012-2013 Report of the Council on Membership and Membership Services, Committee on Communications

**Ryan J. Hughes, Chair**
**K. Jean Beauchamp, Board Liaison**
Cindy Hansen and Erika Skorupskas, Staff Liaisons

*District Representative members:*
David M. Petrarca (I)
Elisa J. Velazquez (II)
James P. (Jay) Crews, II (III)
Daniel J. DeJarlais (IV)
George A. Gutierrez (V)

*Consultants*
Candace T. Wakefield

## VISION AND DUTIES

The vision of the Committee of Communications is to interact as an advisory body to the AAPD staff and serve as consultants when required.

The duties of the Council on Membership and Membership Services, Committee on Communications, as listed in the AAPD *Administrative Policy and Procedure Manual*, are to: 1) periodically review communications concerning AAPD member services and make recommendations for enhancement of such communications; 2) periodically review PDT (Pediatric Dentistry Today) and assist with the development of reader surveys and other feedback mechanisms to enhance the magazine's quality — with an ultimate goal of making PDT the premier magazine for children's oral health care issues; 3) make recommendations and justifications regarding the need for the development of new AAPD publications, including books; 4) perform such other duties as assigned by the President or the Board of Trustees.

## REPORT

### Charge 1. Status of Charge 1: In Progress

Interact as an advisory body to the staff in charge of all publications (including online presence) and serve as consultants when required or at the request of the staff.

### Progress Report for Charge 1

This is an ongoing charge that committee continues to perform at each meeting and with online communications. Recently, the Committee has assisted the staff on updating text and pictures on the brochures related to fluoride, sealants, regular dental visits and dental care for your baby.

## Council on Membership and Membership Services, Committee on Communications, 2012-2013

### Charge 2. Status of Charge 2: In Progress

Prepare annually for publication in PDT a summary of issues and activities relevant clinical topics to be published in PDT.

*Background and Intent:* This is a standing charge to the committee. The Board desires that relevant oral clinical topics including adolescent oral health and well-being receive a greater awareness and appreciation in the pediatric dental community.

### Progress Report for Charge 2

The committee is currently discussing topics and the direction they want to take with this charge. Goal is to have an article ready for the May 2013 PDT issue.

### Charge 3. Status of Charge 3: In Progress

Research Vendors and get quotes for development of Dental Dictionary and accompanying electronic format.

*Background and Intent:* This charge is an outcome of the Focus Group convened in 2009. Member offices expressed a need for educational material to assist in explaining anticipatory guidelines to patients and caregivers.

### Progress Report for Charge 3

Staff is currently exploring options in regard to vendors and formatting. No change since last report.

### Charge 4. Status of Charge 4: Completed

Review all topic sheets every 3 years; update and combine as needed.

*Background and Intent:* Topic cards need to be modernized and streamlined.

### Progress Report for Charge 4

This was completed in Spring of 2011.

### Charge 5. Status of Charge 4: In Progress

Evaluate social media strategies as they pertain to the AAPD membership. Give recommendations to the Board by Winter 2013.

*Background and Intent:* Social media will play a bigger role in the way members will communicate with other members and with patients. The intent is to make recommendations on which form of social media will give the best benefit.

### Progress Report for Charge 5

The committee is discussing ways to evaluate how social media affects our members and organization. This is such a fast moving issue that we are still trying to establish a roadmap to evaluate all those things. This may be the most important thing that this committee does going forward. No change since last report. Looking toward Annual Session 2013 to discuss with the committee.

# 2012-2013 Report of the Council on Post-Doctoral Education

**Erwin G, Turner, Chair**
**Catherine M. Flaitz, Board Liaison**
Scott Dalhouse, Staff Liaison

*District Representative* members:
Linda Nelson (I)
Vineet Dhar (II)
Janice G. Jackson (III)
Brian J. Sanders (IV)
Alton G. McWhorter (V)
Richard D. Udin (VI)

*Consultants and Ex-Officio members:*
Stephen K. Brandt, Consultant
Paul S. Casamassimo, Consultant
Jessica Y. Lee, Consultant
Farhad Yeroshalmi, Ex-Officio (Chair, Society of Post-Doctoral Program Directors)

## VISION AND DUTIES

The vision of the Council on Post-Doctoral Education is to assist, support, and provide resources for post-doctoral pediatric dentistry programs to help assure that all advanced education students in pediatric dentistry receive optimal didactic and clinical education.

The duties of the Council on Post-Doctoral Education, as listed in the AAPD *Administrative Policy and Procedure Manual*, are to: 1) recommend criteria for establishment of acceptable training for the current practice of pediatric dentistry; 2) monitor and recommend to the Board of Trustees activities concerning workforce issues; 3) perform such other duties as assigned by the President or the Board of Trustees.

## REPORT

### Charge 1. Status of Charge 1: Completed

Develop a plan to educate membership on the critical level and vital nature of the academic workforce crisis and present the plan to the Board of Trustees no later than the 2012 Ad Interim meeting. Implement the plan as directed by the Board of Trustees.

*Background and Intent:* It is important the membership gain understanding of the nature and potential impact of the academic workforce shortage and the potential impact of this crisis on the existence of our specialty, using the specific data developed in 2002 by the Task Force. Information should be gathered at the state level on faculty shortages of specific programs. Communication should flow from Academy leadership and commence through the journals and newsletter, through an annual editorial from the AAPD president on workforce shortage. This communication campaign should be expanded to engage the creative ideas and the resources of our membership in identifying solutions to the crisis.

## Council on Post-Doctoral Education, 2012-2013

### Progress Report for Charge 1

AAPD president Dr. Joel Berg has included a discussion of this topic in his final article for the May issue of *Pediatric Dentistry Today*. He has also addressed the issue of faculty workforce shortage at various meetings and venues throughout the year and how the Academy is continuing to lobby policy makers for federal loan repayment programs and Title VII funding. AAPD leadership has been supportive of and responsive to the Council's charges to monitor the workforce shortage and develop methods to ameliorate the situation.

### Charge 2. Status of Charge 2: Completed for 2013

Working with the Society of Post-Doctoral Program Directors (SPPD), plan and implement the Program Directors' Symposium (Academic Day) at the 2013 Annual Session.

*Background and Intent:* This is a standing charge to the Council to facilitate the meeting of the program directors in conjunction with the Annual Session. As the SPPD is an independent body, the charge from the Board of Trustees must be made to the Council on Post-Doctoral Education.

### Progress Report for Charge 2

The Society of Postdoctoral Program Directors will meet during the Joint Academic Day in Orlando. The program will consist of topics of interest to those members involved in advanced education programs in pediatric dentistry that include discussion of a survey pertaining to pre-application experiences and available research opportunities for residents. Rounding out the afternoon is a presentation from the American Board of Pediatric Dentistry and discussion on the computerized In-Service Examination.

### Charge 3. Status of Charge 3: In Progress

Continue in efforts to assist the Society of Post-Doctoral Program Directors (SPPD) in developing a mentoring program for new Program Directors. Report annually to the Board on progress in this endeavor.

*Background and Intent:* This charge grows out of an earlier charge to the council to develop an academic resource panel to assist the academic community in efforts to initiate new training programs and expand the capacity of existing ones. The SPPD has established four workgroups to develop substantial resources (e.g., handbooks, manuals, mentoring programs) that will provide substantial support to new and expanded programs. The Council has requested that this charge be an annual charge.

### Progress Report for Charge 3

This is a standing charge to the Council on Postdoctoral Education. The Council continues its support of the Society of Postdoctoral Program Directors and their efforts in mentoring new program directors. As resources become available they are disseminated electronically and added to the AAPD website under the postdoctoral directors' on-line community.

## Council on Post-Doctoral Education, 2012-2013

### Charge 4. Status of Charge 4: In Progress

Assist the Council on Government Affairs with advocating for sufficient federal funding of Title VII grant funds for faculty loan repayment, publicizing the availability of such grants, encouraging applications, and documenting faculty beneficiaries and the long-term impact of such funding on recruitment and retention of pediatric dental faculty.

*Background and Intent:* Resources are needed to address the earning discrepancy between contemporary private practice and academics. It is vital to develop ways to ease the financial burden of those entering academic careers. One critical method is to advocate for sufficient federal funding of this program and help document its successful impact.

### Progress Report for Charge 4

The Council helped publicize availability of funding and will profile award recipients of FY 2012 Faculty Development Grants. For more details, please see the Council on Government Affairs report.

### Charge 5. Status of Charge 5: In Progress

Prepare and present to the Board of Trustees an annually updated "core bibliography" of historical and contemporary literature citations appropriate for distribution to post-doctoral pediatric dental education programs and general membership.

*Background and Intent:* This list is updated annually. It is the intent of the Council to disseminate this information via the AAPD website and post-doctoral director's list serve.

### Progress Report for Charge 5

Leading this project with council members are Drs. Richard Udin and Linda Nelson. The bibliography has been reviewed and revised by the Council. The Council has sought out subject experts from the Committee on Sedation and Anesthesia and the Committee on Special Health Care needs for input relating to those sections of the bibliography. The resulting product will be the 2013 AAPD Core Curriculum Reading List which will be available for purchase during the Annual Session in Orlando.

### Charge 6. Status of Charge 6: Completed

Investigate changes in patient availability and types of patient availability in postdoctoral pediatric dentistry programs.

*Background and Intent:* Given the current economic downturn and emergence of alternative patient care facilities in the community, such as Medicaid clinics that have extended weekend hours to serve children, it is important to explore the impact to the training programs.

### Progress Report for Charge 6

This is a tandem charge with the Council on Pre-doctoral Education. Program directors were initially surveyed in March 2011 and the response rate was poor. At the 2012 Joint Academic Day, attendees were resurveyed. The survey is being analyzed by Dr. Udin. This topic will be the subject of the 2013 Joint Academic Day in Orlando as how it relates to strengthening pediatric dentistry education at the undergraduate and graduate levels.

## Council on Post-Doctoral Education, 2012-2013

### Charge 7. Status of Charge 7: Completed

Create and provide an opportunity, along with the Council on Pre-Doctoral Education, for pre- and postdoctoral programs in search of filling faculty vacancies to participate and recruit at the Career Fair held during the Annual Session. Progress on this activity will be reported during the Winter Planning Meeting.

*Background and Intent:* It is important the membership understands the nature and potential impact of the academic workforce shortage. The shortage exists not only in the postdoctoral or graduate programs but within the undergraduate dental school education.

### Progress Report for Charge 7

This is a shared charge with the Council on Pre-doctoral Education. Dental school and graduate program directors and chairs were surveyed to gauge their interest in being able to meet with prospective faculty during the Annual Session. Due to the limited interest in this activity, the Council has decided not to pursue this charge.

### Charge 8. Status of Charge 8: Completed

Work with the Council on Clinical Affairs, Committee on Sedation and Anesthesia, to review the AAPD Core Curriculum Reading List for the topic "sedation" and make recommendations for additions and/or deletions to the list. The Committee will provide this information to the Council in time for the Council to report to the Board of Trustees at the Winter Planning Meeting.

*Background and Intent:* The Committee on Sedation and Anesthesia has the knowledge and resources to make the best recommendations for modifications and updates in the Core Curriculum Reading List.

### Progress Report for Charge 8

The Core Curriculum Reading List has been updated as described in Charge 5.

### Charge 9. Status of Charge 9: Completed

Work with the Council on Clinical Affairs, Committee on Special Health Care Needs, to review the AAPD Core Curriculum Reading List for the topic "care for special needs patients" and make recommendations for additions and/or deletions to the list. The Committee will provide this information to the Council in time for the Council to report to the Board of Trustees at the Winter Planning Meeting.

*Background and Intent:* The Committee on Special Health Care Needs has the knowledge and resources to make the best recommendations for modifications and updates in the Core Curriculum Reading List.

### Progress Report for Charge 8

The Core Curriculum Reading List has been updated as described in Charge 5.

# 2012-2013 Report of the Council on Post-Doctoral Education, Post-Doctoral InService Examination Committee

**Elliot R. Shulman, Chair (Deceased)**
**Eileen M. Studders, Interim Chair**
**Catherine M. Flaitz, Board Liaison**
Scott Dalhouse, Staff Liaison

Homa Amini
Lori R. Barbeau
Lina M. Cardenas
Ann L. Greenwell
Clarice S. Law
Linda P. Nelson
Eileen M. Studders

## VISION AND DUTIES

The vision of the Council on Post-Doctoral Education, Post-Doctoral In-Service Examination Committee is to support advanced education programs in Pediatric Dentistry by providing outcome measures for post-doctoral students which enable graduates to meet the oral health needs of infants, children, adolescents and those with special health care needs.

The duties of the Council on Post-Doctoral Education, Post-Doctoral In-Service Examination Committee, as listed in the AAPD *Administrative Policy and Procedure Manual*, are to: 1) develop, monitor, implement and evaluate the Post-doctoral In-service Examination; 2) promote participation in the Post-doctoral In-service Examination among program directors; 3) perform such other duties as assigned by the President or the Board of Trustees.

## REPORT

### Charge 1. Status of Charge 1: In Progress

In conjunction with the AAPD Headquarters Office Staff, continue management and oversight of the standardized written examination for students in pediatric dentistry post-doctoral training.

*Background and Intent:* A survey of program directors indicated strong support for the development of a standardized written examination to be administered to entering and exiting post-doctoral students. Such a tool is necessary for outcomes measurements required by CODA and is beneficial for program self-evaluation relative to a national standard. An examination was developed by the Inservice Examination Subcommittee of the Council on Education and administered for the first time in 1999. The intent of this charge is to direct the subcommittee to continue to oversee the administration and grading of the exam, the assessment of exam validity, the communication with program directors, and the continual updating of the examination.

## Council on Post-Doctoral Education, Post-Doctoral InService Examination Committee, 2012-2013

### Progress Report for Charge 1

This is an ongoing charge to the In-Service Exam Committee. The Committee usually meets twice per year, once for a test construction meeting where the exam is formulated and results from the prior year are evaluated and reviewed and again during the Annual Session for item writing and review. The last test construction meeting was held during October 2012 at our test development vendor (the National Board of Osteopathic Medical Examiners [NBOME]) offices in Chicago.

### Charge 2. Status of Charge 2: In Progress

Review the results of the examination, in conjunction with the National Board of Osteopathic Medical Examiners (NBOME), the AAPD Headquarters Office Staff, and make recommendations for improvement. Report annually to the Board.

### Progress Report for Charge 2

This is an ongoing charge to the Committee. The Committee will review the results and statistics of the 2013 examination during their test construction meeting in October 2013. The Committee will also discuss how the process worked for the first year of the computerized examination.

### Charge 3. Status of Charge 3: In Progress

Maintain, update and expand a question bank to be used for future examinations.

### Progress Report for Charge 3

Committee members write items throughout the year that are initially reviewed by the Chair. New items are then reviewed by the entire committee at their meetings and then with NBOME to ensure they are psychometrically sound. These items are then deposited into the item bank to provide a robust pool of questions and cases About 100 questions were added to the bank from May 2012 with nearly an additional 100 done in October 2012. We plan to continue to increase the data question bank at this rate for the next year as well.

### Charge 4. Status of Charge 4: Completed

Prepare a proposal for the inservice examination to be given at the end of the first year of an advanced education program in pediatric dentistry.

*Background and Intent:* Some program directors have been asking for an examination to be administered midway through a residency to allow for the programs to uncover deficiencies early in the residency. This is done for many medical residencies. The intent of this charge is to develop a statistically valid method and a cost of implementation.

### Progress Report for Charge 4

This charge has been reviewed several times by the committee. The feasibility of administering an end-of-year exam to first year residents requires a participation of the majority of the programs in order to have statistically valid results and would

## Council on Post-Doctoral Education, Post-Doctoral InService Examination Committee, 2012-2013

significantly increase costs. The committee has decided to no longer pursue an end-of-year exam for first year residents.

### Charge 5. Status of Charge 5: Completed

Engage in discussions with the American Board of Pediatric Dentistry (ABPD) to determine the feasibility of integrating examination development and creating efficiency savings for both test-writing groups. Present a report to the Board of Trustees by the Winter 2013 meeting.

*Background and Intent:* Currently both the AAPD and the ABPD develop examination questions on similar topics independently. The ABPD is interested in collaborating on these examinations. Question development and potentially even examination analysis could be done by both groups working together and significantly reduce the work load of the volunteers. The intent is that there will still be an examination given and the start and end of a resident's education, and an ABPD Qualifying Examination near the end of their program.

### Progress Report for Charge 5

Initial discussions occurred with the ABPD and exam blueprints were exchanged and reviewed. Following these discussions the committee and the ABPD reached consensus to keep the exam development individually by both organizations.

# 2012-2013 Report of the Council on Pre-Doctoral Education

**Homa Amini, Chair**
**Catherine M. Flaitz, Board Liaison**
Scott Dalhouse, Staff Liaison

*District Representative members:*
Charles D. Larsen (I)
Diana M. Capobianco (II)
Neva Penton Eklund (III)
Steven P. Hackmyer (V)
Jenn-Yih (Simon) Lin (VI)

*Consultants and Ex-Officio members:*
Margaret A. Elliott, Consultant
Alton G. McWhorter, Consultant
Adriana Modesto Vieira, Consultant
Randall Niederkohr, Consultant
John B. Thornton, Jr., Consultant
Brenda S. Bohaty, Expert Consultant

## VISION AND DUTIES

The vision of the Council on Pre-Doctoral Education is to promote the oral health of children by supporting pre-doctoral pediatric dental education to assure that graduating general dentists can provide the highest level of pediatric dental care

The duties of the Council on Pre-Doctoral Education, as listed in the AAPD *Administrative Policy and Procedure Manual*, are to: 1) monitor and recommend to the Board of Trustees activities concerning pre-doctoral pediatric dentistry education; 2) perform such other duties as assigned by the President or the Board of Trustees.

## REPORT

### Charge 1. Status of Charge 1: Ongoing/Completed for 2013

Facilitate the meeting of pediatric pre-doctoral program directors at the AAPD Annual Session. Report on the agenda and other particulars of the previous meeting to the Board of Trustees at the 2012 Ad Interim meeting and on plans for the following meeting as developed.

*Background and Intent:* The pediatric pre-doctoral program directors will serve as an intellectual resource for the Council on Pre-Doctoral Education. This meeting will serve as a vehicle for collaborative information exchange.

### Progress Report for Charge 1

Drs. Kowolik and Mruz, co-chairs of the Society of Predoctoral Program Directors have developed the program for 2013 meeting in Orlando. The program will feature a presentation by Drs. Kowolik and Mruz titled *Integrating Children's Oral Health and Access to Care into Multiple Educational Settings*. There will be discussion about further developing AAPD student chapters at the dental schools and how to effectively

disseminate information on pediatric dentistry to dental students. The Society's business meeting will also occur that afternoon.

**Charge 2.** **Status of Charge 2: Ongoing/Completed for 2013**

Distribute to pre-doctoral directors in the Departments of Pediatric Dentistry or their academic counterparts the advisory list of integral experiences that constitute a pre-doctoral pediatric dental education meeting or exceeding the basic requirements for clinical competency. Review and make modifications as necessary to the list at least bi-annually. Prepare a report for the Board at least annually.

*Background and Intent:* Competent and qualified general dental practitioners are integral to the AAPD's vision to provide the highest level of care to all children. The development of an advisory list of competency experiences for the pre-doctoral dental student is instrumental in our workforce goals.

**Progress Report for Charge 2**

The *Predoctoral List of Integral Experiences* was last reviewed by the Council during their 2012 meeting. Several suggestions were made for new experiences to include. The revised list was again vetted by the Council members and in January 2013 was disseminated to all predoctoral pediatric dentistry program directors and chairs.

**Charge 3.** **Status of Charge 3: Ongoing/Completed for 2013**

Facilitate ongoing development and dissemination of the AAPD Pre-Doctoral Literature Review List. Review and make modifications as necessary to the list at least bi-annually. Prepare a report for the Board at least annually.

*Background and Intent:* It is the intent of this charge to develop a dynamic literature review list in pediatric dentistry to which pre-doctoral dental students should be exposed during their education. It is the intent of the Council to disseminate this information via the AAPD website and pre-doctoral directors' list serve.

**Progress Report for Charge 3**

This is an ongoing charge to the council. The literature review list was reviewed and updated at the annual council meeting in May. The list received a complete update with many revisions included reordering and renaming the various literature domains, adding new articles and deleting articles deemed outdated. The revised list was vetted through the Council for final approval and was renamed to the *Predoctoral Education Literature Resource List* to better reflect its content. In January 2013 the list was disseminated to all predoctoral pediatric dentistry program directors and chairs.

**Charge 4.** **Status of Charge 4: Completed**

Collect financial best practices/creative endeavors from pre-doctoral directors designed to attract and retain qualified faculty for positions in pre-doctoral pediatric dental education. Report to the Board at the May 2013 meeting.

*Background and Intent:* This charge is developed to promote sharing and dissemination of information to pre-doctoral program directors in regard to enhancing salary and benefits for pre-doctoral faculty positions.

## Council on Pre-Doctoral Education, 2012-2013

### Progress Report for Charge 4

This charge was completed. The results of the survey were presented by Dr. Amini at the meeting of the pre and post-doctoral Program Directors during the 2011 Annual session (attached). The results were also shared with the Predoc Council at the annual meeting. This charge has been completed and was marked for deletion during the 2013 Winter Planning Meeting.

### Charge 5. Status of Charge 5: Completed

Investigate changes in pediatric patient availability in predoctoral pediatric dentistry programs.

*Background and Intent:* Given the current economic downturn and emergence of alternative patient care facilities in the community, such as Medicaid clinics that have extended weekend hours to serve children, it is important to explore this impact to pre-doctoral education programs.

### Progress Report for Charge 5

This is a tandem charge with the Council on Pre-doctoral Education. Program directors were initially surveyed in March 2011 and the response rate was poor. At the 2012 Joint Academic Day, attendees were resurveyed. The survey is being analyzed by Dr. Udin. This topic will be the subject of the 2013 Joint Academic Day in Orlando as how it relates to strengthening pediatric dentistry education at the undergraduate and graduate levels.

### Charge 6. Status of Charge 6: Completed

Create and provide an opportunity, along with the Council on Post-doctoral Education, for pre- and postdoctoral programs in search of filling faculty vacancies to participate and recruit at the Career Fair held during the Annual Session. Progress on this activity will be reported during the Winter Planning Meeting.

*Background and Intent:* It is important the membership understands the nature and potential impact of the academic workforce shortage. The shortage exists not only in the postdoctoral or graduate programs but within the undergraduate dental school education.

### Progress Report for Charge 6

This is a shared charge with the Council on Postdoctoral Education. Dental school and graduate program directors and chairs were surveyed to gauge their interest in being able to meet with prospective faculty during the Annual Session. Due to the limited interest in this activity, the Council has decided not to pursue this charge.

# 2012-2013 Report of the Council on Scientific Affairs

**Indru C. Punwani, Chair**
**Jane Gillette, Board Liaison**
Scott Dalhouse and Janice Silverman, Staff Liaisons

*District Representative members:*
Isabelle I. Chase (I)
R. Glenn Rosivack (II)
Jan Ching Chun Hu (IV)
Adriana Segura (V)
Francisco J. Ramos-Gomez (VI)

*Consultants and Ex-Officio members:*
Anne C. O'Connell, International Consultant
Soraya M. Beiraghi, Consultant
Tegwyn H. Brickhouse, Consultant
Donald L. Chi, Consultant
Kimon Divaris, Consultant
Gajanan V. Kulkarni, Consultant
Indru C. Punwani, Consultant
Rocio B. Quiñonez, Consultant
Rebecca L. Slayton, Consultant
John B. Thornton, Jr., Consultant
Anne R. Wilson, Consultant
J. Timothy Wright, Consultant
Joseph S. Young, Ex-Officio (Chair, Scientific Program Committee)

## VISION AND DUTIES

he mission of the AAPD's Council on Scientific Affairs (CSA) is to ensure that the organization's policies, guidelines and programs are evidenced based and supported by the most recent and up to date science. The CSA also sets AAPD Research Agenda, which is used for allocation of research funding support.

The duties of the Council on Scientific Affairs, as listed in the *AAPD Administrative Policy and Procedure Manual*, are to: 1) investigate research activities appropriate for AAPD involvement and make recommendations to the Board of Trustees; 2) administer the Graduate Student Research Competition; 3) administer the AAPD Foundation Research Award Competition; 4) administer the research oral and poster presentations at the AAPD annual session; 5) plan and conduct the Contemporary Clinical Issues Workshop at the AAPD annual session in collaboration with the Scientific Program Committee; 6) perform such other duties as assigned by the President or the Board of Trustees.

## REPORT

### Charge 1. Status of Charge 1: Ongoing

Annually update and affirm the AAPD research agenda. Select the two or three highest ranked topic areas for concentrated investigation and report annually to the Board.
*Background and Intent:* This is a standing charge to the Council. The Council on Scientific Affairs' list of research topics of relevance reflects areas of clinical inquiry of significance across the broad spectrum of the specialty of pediatric dentistry. The research agenda is

to be shared annually with interested parties and HSHC as it develops its priorities for funding.

**Progress Report for Charge 1**

The agenda for the all day program "Interproximal caries, Challenges, Current Clinical Recommendations, Innovative approaches and Future Directions" to be presented at the Annual meeting in Orlando, is now finalized. The speakers are: Drs. Ganganan Kiran Kulkarni, Peter Milgrom, Timothy Wright, Sebastian Paris and Joel Berg.

## Charge 2. Status of Charge 2: Ongoing

Annually submit to the Scientific Program Committee a list of potential topics for a contemporary clinical issues program to be presented at the Annual Session.

*Background and Intent:* This is a standing charge to the Council, updated yearly, that uses the Council's expertise in planning a portion of the Annual Session. It was the feeling of the both the Council on Scientific Affairs and the Scientific Program Committee that the potential topics for this kind of course should come from the Council on Scientific Affairs but planning and execution of this course should come from the Scientific Program Committee.

**Progress Report for Charge 2**

Discussion on this charge is in progress.

## Charge 3. Status of Charge 3: Ongoing

Review studies and/or scientific protocols being considered for funding by AAPD and/or HSHC and make recommendations for approval, disapproval, or revision.

*Background and Intent:* This is a standing charge to the Council. This charge calls upon the Council's scientific expertise in assisting HSHC. When the HSHC Grants and Programs Committee receives requests for funding, they may ask for assistance in determining whether or not to grant funding. The Council on Scientific Affairs also assists HSHC in recommending research topics or projects for funding.

**Progress Report for Charge 3**

In progress

## Charge 4. Status of Charge 4: Ongoing

Review research fellowship and awards to include, but not be limited to, the GSRA and 3M ESPE competitions. Additionally the Chair will review each application for appropriate and relevant content prior to release for Council review.

*Background and Intent:* This is a standing charge to the Council. This charge calls upon the Council's scientific expertise reviewing the AAPD's research awards and fellowships.

**Progress Report for Charge 4**

In progress.

## Charge 5. Status of Charge 5: Ongoing

Assist the Council on Clinical Affairs in identifying scientific support for the policies and guidelines developed for the AAPD Reference Manual.

*Background and Intent:* This is a standing charge to the Council. The Council on Scientific Affairs will be asked to provide input to the Council on Clinical Affairs as the council revises the policies and guidelines each year. Ad hoc advisors to the Council on Scientific Affairs, with specific expertise on particular areas under development, will be asked to work early on with the Council on Clinical Affairs as these policies and guidelines are developed or revised. This input will help to ensure that the guidelines and policies in the Reference Manual are supported by current science. Council on Scientific Affairs as a body will be asked to review the final drafts of policy and guidelines for comment before submission to the Board of Trustees.

### Progress Report for Charge 5

The chair attended the November meeting of the CCA and exchanged ideas with the CCA chair, their Board Liaison member and the CCA members to consider ways to further enhance collaboration between the two councils in the document review process. The CCA members expressed their opinion that the communication between the reviewers from both the councils was increasing and was quite productive. One suggestion presented by Punwani was to include CSA member input in the reviews process at an earlier stage and invite CSA members (by rotation) to participate in the discussion of the draft documents at the November meeting of the CCA. Sara Filstrup and Joe Castellano were favorably inclined to look into the budgetary implications of the suggestion.

## Charge 6. Status of Charge 6: Completed

Identify topics for clinical guideline development using evidence-based approaches.

*Background and Intent:* This is a standing charge to the Council. The Council on Scientific Affairs will be asked to solicit input clinical relevant topics from other councils and general membership for consideration. The Council will then rank topics to be considered for EBD guideline development based on evidence available.

### Progress Report for Charge 6

The council has identified 2 topics:

1. Pulp therapy in the primary dentition.
2. Dental Sealants.

These two guidelines will be first ones using EBD methodology.

## Charge 7. Status of Charge 7: Ongoing

Using evidence based dentistry approaches; the Council on Scientific Affairs will develop EBD clinical guidelines.

*Background and Intent:* This is a standing charge to the Council. The Council on Scientific Affairs will be asked to convene an expert panel on a topic selected for EDB guideline development. Working with the panel, the CSA will develop the guideline using rigorous EBD approaches.

## Progress Report for Charge 7

The team headed by Dr. Timothy Wright (Indru Punwani, Jessica Lee and Jan Silverman) has developed a recommended job description for the EBD staff person recommended by the previous report to the board from the EBD committee (Appendix 1). This description is to be presented to the Board during the January meeting at the request of the board.

The Manager of EBD has been recruited and will be On-Board before the Annual meeting.

## Charge 8. Status of Charge 8: Ongoing

Provide recommendations to the Board of Trustees concerning the scientific validity of all communications, endorsements and publications sponsored by the Academy.

*Background and Intent:* Requests from outside organizations for endorsement or support of products, services or communications will go to the Council on Scientific Affairs for review and recommendation as to scientific validity prior to presentation for consideration of the Board of Trustees.

This is a standing charge to ensure that the publications and promotional and educational materials offered to our members, other professionals, and the public are supported by scientific basis and accuracy.

## Progress Report for Charge 8

In progress.

## Charge 9. Status of Charge 9: In Progress

Review the medical and dental literature to identify emerging products, practices, therapeutics, interventions, treatments, strategies, philosophies and trends applicable to pediatric oral health care. Based on this review, recommend to the Board of Trustees no later than May of each year any policy or guideline that needs to be developed or updated.

*Background and Intent:* This is a standing charge to the Council. This charge results from a recommendation of the January 2004 Planning Session that the Academy take the initiative in anticipating changes in clinical practice, including "off-label" use of pharmaceuticals and advances in diagnostic technology. With the development of new products and procedures in pediatric dentistry, it is imperative that the Academy take the initiative to anticipate changes in clinical practice and develop appropriate clinical guidelines.

## Progress Report for Charge 9

In progress.

## Charge 10. Status of Charge 10: In Progress

Maintain and update as necessary a list of organizations, agencies and individuals actively engaged in research activity which closely parallels our highest-ranked research priorities. Specify how the work being done by these groups and individuals parallels the

AAPD research priorities. Recommend ways by which the AAPD and HSHC can collaborate and establish partnerships with these groups and individuals.
*Background and Intent:* This is a standing charge to the Council. Forming partnerships with other organizations would afford AAPD greater visibility in these efforts and would help leverage limited resources. The NIH/NIDCR Strategic Plan has provided funding for many good research areas of interest to pediatric dentistry.

**Progress Report for Charge 10**

In progress

## Charge 11. Status of Charge 11: In Progress

Develop a methodology for which proposed pediatric research projects using the National Practice Based Network would receive AAPD support.
*Background and Intent:* NIDCR has announced the funding of a National Practice Based Research Network. The clinical pediatric dentist offers an untapped opportunity to address and capture the wealth of information and patients advance research. The AAPD would like to encourage principle investigators to engage the National PBRN and to assist with this effort will support scientifically sound clinical research endeavors.

**Progress Report for Charge 11**

In progress

## Charge 12. Status of Charge 12: In Progress

Collaborate with international pediatric dental organizations to develop mechanisms for scientific partnerships. Report to the Board on an annual basis.
*Background and Intent:* This is a standing charge to the Council. The Academy seeks to enhance its membership through, among other approaches, the international research and knowledge base. Outreach to international dental societies can be the starting point. For example, the European Dental Society is known for its research. Welcoming these members would enhance AAPD members' research and practice, and recognize them as part of the global dental community.

**Progress Report for Charge 12**

In progress

## Charge 13. Status of Charge 13: In Progress

Develop a mechanism to maintain a national Pediatric Dental Residents Research Database to be posted on the AAPD website.
*Background and Intent:* The council is already maintaining an updating as necessary a list of organizations, agencies and individuals actively engaged in research activity which closely parallels the AAPD's highest ranking research priorities. Development of this database would assist AAPD in tracking areas of residents' research, and in promotion national and international research collaborations.

**Progress Report for Charge 13**

In progress

## Charge 14. Status of Charge 14: In Progress

Monitor the NIDCR program grants for practice based clinical research and encourage investigations related to pediatric oral health and report annually to the Board on this activity.

*Background and Intent:* The Board desires information on the RFPs and any potential opportunities this project might suggest to our organization or our membership.

### Progress Report for Charge 14

In progress

## Charge 15. Status of Charge 15: In Progress

Investigate the opportunities for the development of a National Early Childhood Caries Registry.

*Background and Intent:* It is well established that ECC is the most common chronic disease of childhood, but very little is documented of national trends in treatment, adverse event and costs. The AAPD would like to investigate possible opportunities to develop a national ECC registry.

### Progress Report for Charge 15

This request was communicated to the President of the NIDCR via a letter from President Joel Berg.

## Charge 16. Status of Charge 16: In Progress

Assist with the further development of a Pediatric Oral Health Research (POHR) group within the International Association of Dental Research (IADR).

*Background and Intent:* This is an ongoing charge to the Council. The Academy seeks to enhance its research presence with other groups in organized dentistry on a national and international basis. Earlier in 2012, the Academy solicited its members in academics and research to gauge their interest in being part of the founding members of this new group in IADR. A draft constitution for the group as well as a roster of AAPD members interested in joining the POHR was submitted to IADR.

### Progress Report for Charge 16

The Pediatric Oral Health Research (POHR) group met for their first IADR meeting in Seattle on March 21, 2013. The meeting was chaired by Dr. Punwani and was well attended by AAPD/IADR members; including the POHR group Executive Committee members and other international PHHR/IADR members from other countries. Mary MacDougall , the IADR President addressed our meeting to commend the group and wish the new group the very best. After a preliminary discussion on the purpose of the new group, the group members reviewed and approved the draft constitution. Following that the members elected the slate of officers, program director, coordinators and International Counselors from North America, Latin America the Middle East/Africa, Pacific; Asia and Europe were elected, as per the constitution.

## Council on Scientific Affairs, 2012-2013

The Slate of officers elected unanimously were: Indru Punwani-President, Tegwyn Brickhouse-President Elect, Francisco Ramos-Gomez-Secretary Treasurer. The rest of the members of the Executive Committee were also elected in other positions. In the following discussion it was agreed that we need to share the existence of this group with the AAPD, IAPD and the IADR members ASAP. Dr. Punwani will be sharing this information at the Academic Day during the AAPD Annual meeting in Orlando.

The Executive Committee of the POHR group will be meeting at the Annual meeting of the IADR in Seattle, Washington to discuss future plans for the development of the group. An Announcement on the official recognition of the POHR group has been sent to the Graduate Program Directors by AAPD staff.

Appendix 1.

# American Academy of Pediatric Dentistry

## Job Description

**Position:** **Evidence-Based Dentistry (EBD)**

**Manager Reports to:** **Jan Silverman, POHRPC, Assistant Director**

**Incumbent:** **TBD**

**Status:** **Exempt**

**SUMMARY:** The EBD Manager will oversee AAPD's Evidence Based Guideline development Process. This individual will lead each workgroup through development of a Clinical Practice Guideline, moving the AAPD forward in an efficient and effective manner providing oversight from the initial literature review through each document's publication and posting on AAPD and NGC's websites.

**Duties**

1. Compiling, reviewing, and disseminating scientific literature as directed by the AAPD EBD Committee[1], the AAPD Council on Scientific Affairs, and the POHRPC Assistant Director.
2. Guiding the scientific review and statistical analysis during the clinical guideline development process.
3. Working with the councils, committees, workgroups, and individual members to prepare drafts, format and edit reports, etc
4. Performing ongoing literature searches to confirm currency of evidentiary base.
5. Ensuring process & product are consistent with the inclusion criteria of National Guideline Clearinghouse (NGC) of the Department of Health and Human Services Agency for Healthcare Research and Quality (AHRQ).
6. Facilitating the guideline development process by circulating to reviewers and stakeholders all drafts and compiling comments to allow for review/revisions.
7. Preparing final report for publication.
8. Coordinating process for guideline submission to/acceptance by NGC as well as completing NGC's required annual reviews for all guidelines.
9. Coordinating telephone conferences, meetings, etc. to facilitate EBD clinical guideline development.

[1] The EBD Committee would be formed under the Council on Clinical Affairs (this would require a P&P update).

10. Performing other duties as directed

**Supervision and Guidance**

Works under the direct supervision of the POHRPC Assistant Director. Obtains direction and guidance on all employment policies and Academy policy matters from the Chief Executive Officer and Chief Operating Officer & General Counsel. The employee is expected to perform all activities, duties, and functions in accordance with AAPD policy. The employee's work will be evaluated on initiative, productivity, ability to work well with others, and overall accomplishments.

**Qualifications**

Evidence-Based Dentistry Manager must possess excellent verbal and written communication skills, excellent organizational skills, strong attention to detail, multi- tasking abilities, willingness and aptitude to learn. A strong science background and a functional understanding of basic statistical principles is a must. Educational requirement: Master's degree in public health, informatics, epidemiology or a related field. At least five years' experience in an association, non-profit organization, university, or government setting utilizing comparable skills. Individual must have proficiency in **excellent computer literacy** in MS Office programs (Word, Excel, PowerPoint, etc.).

*Created 12/12*

# 2012-2013 Report of the Council on Scientific Affairs, Consumer Review Committee

**Richard S. Chaet, Chair**
**Jane Gillette, Board Liaison**
Janice Silverman, Staff Liaison

Indru C. Punwani
Anupama Tate
John B. Thornton, Jr.

## VISION AND DUTIES

The duties of the Council on Scientific Affairs, Consumer Review Committee, as listed in the *AAPD Administrative Policy and Procedure Manual*, are to: 1) develop a protocol, consistent with the Principles for Interaction with Industry and Other Organizations described in Section 13.K, for determining whether the AAPD should review or develop scientifically accurate consumer messaging that is adjunct to the marketing of a consumer product and or included in a commercial print or electronic publication intended for consumers; 2) based on the developed protocol, determine when the AAPD logo should accompany such messaging, and ensure that in all cases the following phrase should be included in a prominent location immediately adjacent to the AAPD logo: "The information presented in this _____ has been reviewed [or provided] by the American Academy of Pediatric Dentistry and is consistent with the current science related to oral health care for children. This does not represent any endorsement by the AAPD of the product [or service or publication]."; 3) implement licensing agreements with such organizations permitting use of the AAPD logo as indicated in paragraph 2, in exchange for an appropriate organization commitment to Healthy Smiles, Healthy Children. Such commitments may be via a direct charitable contribution, or via a percentage of proceeds from sales being donated to Healthy Smiles, Healthy Children; 4) regularly report to the Board of Trustees concerning such reviews; and 5) perform such other duties as assigned by the President or the Board of Trustees.

## REPORT

The Consumer Review Committee reviewed the following books since May, 2012:

1. United Concordia: **Baby Book of Oral Health Second Edition**
2. Prenatal Oral Health Program (POHP) materials developed as a collaboration between the Schools of Dentistry and Medicine at the University of North Carolina at Chapel Hill; specifically Dr. Kim Boggess (OBGYN) and Rocio Quinonez (Pediatric Dentist).

The Consumer Review Committee reviewed the materials and provided feedback to increase the correspondence between the materials and the AAPD guidelines. In both

instances, AAPD feedback was incorporated into the resource and the committee approved the resources for using the statement, "The information presented in this book has been reviewed by AAPD and found to be consistent with the current science related to oral care for children".

# 2012-2013 Report of the Task Force on Strengthening the Science in AAPD's Guidelines and Journals

**Jenny Ison Stigers, Chair**
N. Sue Seale, Board Liaison

*Members*
Sara Filstrup
Indru Punwani

## Charge — Status of Charge: Completed

To determine the processes necessary to strengthen the scientific basis of AAPD's clinical practice guidelines and journals.

## Progress Report

AAPD began a concerted effort to strengthen the scientific basis for its policies and guidelines more than a decade ago. The Councils on Clinical Affairs and Scientific Affairs joined forces to develop and revise documents supported by current scientific literature. Shortly thereafter, AAPD began submitting its guidelines to the National Guideline Clearinghouse of the Department of Health and Human Services Agency for Healthcare Research and Quality.

An increasing emphasis on systematic processes and strength of evidence in clinical practice guidelines dictated changes in AAPD's protocol for guideline development. Last year, this taskforce proposed a new process for development of evidence-based clinical practice guidelines. Critical to this process – to ensure a transparent, rigorous, and systematic process as well as continuity and consistency of efforts – is skilled support staff. We are very excited that AAPD leadership agreed to hire – and recently has successfully recruited – an individual experienced in evidence-based healthcare. This is a huge step forward for our organization and will help ensure that AAPD remains a leader in clinical practice guidelines. Members of this task force stand ready to support and work with our new evidence-based dentistry manager.

# 2012-2013 Report of the Task Force on Governance

**Scott W. Cashion, Chair**
Rhea M. Haugseth, Board Liaison

*Members*
Monica Cipes, District I
Ed Ginsberg, District II
Mark Meyer, District III
Eric TeDuits, District IV
Bruce Weiner, District V
Jade Miller, District VI

The Task Force on Governance was approved at the January 2012 Board of Trustees meeting. The Task Force membership included a member from each AAPD district and the chair. The members of the Task Force are as follows:

Chair- Scott Cashion, scashion@me.com
District I- Monica Cipes, monicacipes@snet.net
District II- Ed Ginsberg, edginsberg@gmail.com
District III- Mark Meyer, mmeyer@triad.rr.com
District IV- Eric TeDuits, eteduits@wisc.edu
District V- Bruce Weiner, bruce2th@gmail.com
District VI- Jade Miller, jmkiddds@aol.com

In February 2012, the Task Force had its initial conference call. During the call we reviewed the Background and Intent (Appendix A) and the current governance structure.

From the beginning, the Task Force tried to be transparent and to get as much input as possible from the leadership of the districts and states as well as from individual members. The Task Force members were charged with attending district and state meetings and talking with members and leadership within their districts and states in order to learn their opinions.

We began our review of the AAPD's governance structure, providing each Task Force member a list of names of AAPD members in each state within their district. Each Task Force member then obtained a district membership list if available. However, some districts do not maintain membership rosters. Next we obtained a membership list from each state in the district if possible. Unfortunately many states are not organized and do

not keep membership rosters. The Task Force members then cross referenced each list to determine how many members were on all three lists (i.e. tripartite members), AAPD and district members, AAPD and state members, district and state members, and AAPD members only, district members only and state members only.

The chair collected the information and placed the information in a grid. Although the data were not scientific or complete we noticed some trends. We examined the number of tripartite members and the number of members in each district and each state. (See Appendix B). Where information is missing it is because the information was not available or a state did not respond to the Task Force member.

The Task Force members felt it was important to see where the AAPD stood as a tripartite organization.

In addition to membership figures, we also collected the amount each district and state charged for dues and how they collected the information.

In May, the Task Force met at the annual session in San Diego and reviewed the information collected. We determined several trends:

1. Tripartite membership seems to be working in some regions and not in others.
2. Larger districts and states tended to be more organized and to have more tripartite members.
3. The amount of dues for each state varied widely from $0 (no dues collected) to $350 dollars (See Appendix B for specific amounts).
4. The dues for each district varied from $0 (no dues collected) to $100. (See Appendix B for specific amounts)
5. The level of organization of districts varied from no organization or district meeting to very organized with regular meetings.
6. The level of organization of states ranged from no state meeting or membership to very organized with regular meetings.

The Task Force members also attended their district caucuses at the annual meeting and received input from those present.

The Task Force's next step was to seek input from the leadership of each district (for those that were organized) and from the leadership of each state (for those that were organized). Each member developed a short survey that could be answered by the leadership in the each district and state either in person, by phone or by email. The surveys included the following information:

1. Whether the Tripartite structure was working and whether it should be enforced?
2. Were the district lines fair or should the lines be redrawn? (See Appendix C for AAPD membership by District)
3. Were the districts working organizationally?

4. Should the AAPD enforce the ADA membership requirement? (See Appendix D for a list of specialty organizations that require ADA membership to be a member and those that do not)
5. Should the AAPD collect district and state dues?
6. Were there other concerns about the AAPD's Governance?

The Task Force had a conference call in August to review the information collected from the leadership in the states and districts. The Task Force members noted the difficulty of collecting this information due to variability in organization and lack of membership data in some of the districts and states.

Among those who did respond, there was a general feeling that the tripartite was not working. Opinions of whether to enforce the tripartite varied among districts and states. Most felt the district lines did not distribute the number of members evenly but did not feel redrawing district lines was a solution. Overall it was felt that ADA membership was important for AAPD members. However, some felt that ADA membership should be required only to join AAPD with continued membership optional. Most states whose dues were being collected by the AAPD were satisfied with the arrangement. Some states preferred collecting their own dues. Several expressed the opinion that this should be an AAPD member benefit and there be no fee for dues collection.

As a result of the August conference call the Task Force determined the next step was to survey the entire membership of the AAPD. The Task Force developed a membership survey, which was sent out in an e-blast from the AAPD with a link to Survey Monkey. The e-blast was repeated several times giving the membership ample opportunity to respond. Four Hundred twenty nine (429) people responded to the survey. (See Survey Appendix E and Survey results Appendix F and Appendix G).

The Task Force met in Chicago on Saturday, November 3. The membership survey was reviewed. We discussed the data we collected both formally and informally and formulated our recommendations for the Board of Trustees.

Our recommendations are the result of all of the data and input we received from over the past 10 months from the leadership of the districts and states, individual members and the membership survey we conducted.

The Task Force's recommendations are as follows:

1. The AAPD should no longer require tripartite membership. District and state membership should be optional.
    a. The Task Force determined that overall, the tripartite was not working and would not work unless it was enforced. Taking into consideration what was best for the AAPD, its very high membership retention and successful recruitment rate, the task force felt requiring tripartite membership was not in the AAPD's best interest.
    b. The task force recognizes that some of the districts and states (in particular those that are highly organized) would prefer the tripartite be

enforced. We do not recommend that the district and state components be dissolved. The Task Force suggests the AAPD take a more active role in helping the districts and the states. An example follows in the next recommendation.

2. The AAPD should offer collection of district and state dues at no cost.
    a. This should be offered as a membership benefit
    b. This can be presented to the districts and states as a way of increasing membership at both levels.
    c. The AAPD has offered to collect dues for a fee for states choosing this service. States that have chosen this option have seen an increase in membership. The likely reason for this is that members find it more convenient to write their check for both the AAPD dues and their state dues at the same time.
    d. We suggest that the districts and states be given the option to have the AAPD collect their dues but should not be required. This would allow a state to participate even if their district preferred to bill separately or did not have dues. Conversely, the district could opt to have the AAPD to collect their dues while states within the district could choose to collect dues on their own.
    e. Language on the dues statement could suggest that members pay dues for those organizations they would like to belong to. For example, "Please submit payment to maintain benefits of active membership in these organizations…". The district and/or state would be listed and the person could pay all three or just pay dues for the organizations they choose in order to receive member benefits. It has been shown; organizations that use this type of statement see an increase in membership.

3. The AAPD should require membership in the ADA at the time of applying for membership to the AAPD
    a. The AAPD Constitution and Bylaws (Chapter 1. Membership, Section 2. Eligibility, A. Active: #1) would require striking …and maintains membership in… and add at the end of the statement "at the time of application".
    b. It is important for the AAPD to keep this requirement at time of application to maintain our good working relationship with the ADA and to ensure this continues.
    c. We recognize that we are a smaller organization and that our relationship with the ADA enables us to work together on a federal and state level on legislative issues of importance to dentistry.
    d. The AAPD is one of four specialty organizations that require ADA membership. (See appendix D)
    e. Currently 4930 pediatric dentists are members of the ADA.

4. The AAPD should combine Districts I and II to more evenly distribute the number of members in each district.

a. The district numbers:
   District I- 719
   District II- 530
   District III- 1135
   District IV- 835
   District V- 847
   District VI- 1299
b. The district numbers if Districts I and II are combined:
   District I/II- 1249
   District III- 1135
   District IV- 835
   District V- 847
   District VI- 1299

c. The Task Force heard concern that some districts were twice the size of other districts. It became clear that the districts that were larger did not want to see the states in their districts change. Some felt that the larger districts should have more representation on the Board of Trustees, councils and committees. However, this was not the majority opinion. Considering these concerns, the Task Force determined that if the district lines were redrawn, the best solution was to combine Districts I and II. This would more evenly distribute the membership of each district. Districts I and II are not highly organized and this may allow for better organization of the district making it stronger.
d. This would decrease the size of the Board of Trustees by one member.

5. The AAPD should add past district presidents to those eligible to be members of the nominations committee.
   a. This will give the districts a larger pool to choose from when nominating a member for the nominations committee.

The Task Force would also like the Board of Trustees to strongly consider the following:

Strong feelings were expressed by the district and state leaders and in the member survey that the communication with the grass roots members should be improved. There was a desire to know more about what is going on in the AAPD's Councils and committees. The academic community would also like more communication. The Task Force recognizes that some of this information is already available but some members are unaware of it for a variety of reasons. We feel however this perception should be addressed.

1. In Pediatric Dentistry Today (PDT) and in e-blasts include a column discussing current issues of AAPD business. For example, a summary of the action items of the Board Of Trustees after each of their meetings could be included in PDT. This would be in addition to information that is posted on

the website which may not be seen by all members. In addition, a summary of key work/initiatives that councils and committees are doing should also be included.

2. The Academic Trustee should have a column in the PDT and e-blasts on a regular basis, discussing issues facing academics and other AAPD issues of interest. The leadership and the academic trustee should have a strong presence at academic day prior to the annual session. Dialogue should be fostered between the two groups to keep the academic community informed of AAPD issues and vice versa.
3. District Trustees should be required to communicate on a regular basis with their district and states. They need to create an email list of the leadership in their district and report to them Board Of Trustees actions and information on at least a quarterly basis or after each Board Of Trustee meeting. This will require some work, as we found some districts and states are better organized than others. The trustees should be held accountable for this.
4. In order to grow the AAPD's leadership pool and to help the district trustees find qualified individuals for positions on councils and committees we suggest a leadership application be available to all members. This could be submitted to the AAPD headquarters office that could keep a database and forward the information to the appropriate district trustee. By having this database maintained by the AAPD headquarters office the list would be available to the leadership when leadership positions needed to be filled.

In addition to the above recommendations, the Task Force considered other areas of the AAPD governance structure. We discussed the Board of Trustees, a general assembly vs. a house of delegates, the size of the board, the committee and council structure and representation on them. We thoroughly vetted each area of governance. The overall feeling of the AAPD membership, leadership and this Task Force is that the AAPD is a strong and effective organization. We hope our recommendations can make the AAPD, its districts and states even stronger. We recognize that not all will agree with the recommendations but feel we have made suggestions that will continue to make the AAPD the voice of children's oral health.

This Task Force appreciates the opportunity to work on such an important issue for the AAPD.

Respectfully Submitted,

Scott W. Cashion-Chair
Monica Cipes- District I
Ed Ginsberg- District II
Mark Meyer- District III
Eric Teduits- District IV
Bruce Weiner-District V
Jade Miller- District VI

## Appendix A

Task Force on Governance Background and Intent

The governance structure of the AAPD has served us well over the past decade or so. The tripartite reorganization years ago allowed the AAPD to organize the councils such that geographic distribution was possible with equal representation for all the districts. The requirement of state and district membership in order to be a member of AAPD gave the AAPD varied opinions in our governance that represented all the states and districts. Currently all states and districts are organized and have representation. The ADA membership requirement also made sure our membership recognized how important organized dentistry is to both the individual private practice and academic career. In addition, the recognition that dentistry needs to present a united voice to legislatures and those who wish to represent dentistry on many levels.

The intent of the Task Force on Governance is to evaluate the current governance structure of the AAPD and make recommendations as to which organizational structure may best serve the AAPD going forward. They are to look at both the private practitioners as well as the academic practitioner in our membership ranks. They are then to present those structures that will in the future best serve the AAPD and its members. These recommendations are to be presented no later than the January 2013 Winter Planning Session.

Task Force on Governance, 2012-2013

## Appendix B

Membership Grid with dues

| | Dues | AAPD Membership | District | State |
|---|---|---|---|---|
| **District I** | No | | | |
| Connecticut* | $75 | 100 | 0 | 99 |
| Massachusetts* | $125 | 175 | 0 | 154 |
| Maine | $100 | 13 | 0 | 14 |
| New Hampshire | $60 | 26 | 0 | 24 |
| New York | $75 | 355 | 0 | 401 |
| Rhode Island | $0 | 17 | 0 | 17 |
| Vermont | $0 | 8 | 0 | 8 |
| Canada | | 25 | 0 | 45 |
| **Total** | | **719** | **0** | **762** |

| | Dues | AAPD/ District/ State | AAPD/ District | AAPD/ State | District/ State | District only | AAPD only | State only |
|---|---|---|---|---|---|---|---|---|
| **District I** | No | | | | | | | |
| Connecticut* | $75 | 0 | 0 | 91 | 0 | 0 | 9 | 8 |
| Massachusetts* | $125 | 0 | 0 | 150 | 0 | 0 | 25 | 4 |
| Maine | $100 | 0 | | 11 | 0 | 0 | 2 | 3 |
| New Hampshire | $60 | 0 | 0 | 19 | 0 | 0 | 7 | 5 |
| New York | $75 | 0 | 0 | 316 | 0 | 0 | 39 | 85 |
| Rhode Island | $0 | 0 | 0 | 17 | 0 | 0 | 0 | 0 |
| Vermont | $0 | 0 | 0 | 8 | 0 | 0 | 0 | 0 |
| Canada | | 0 | 0 | 23 | 0 | 0 | 2 | 20 |
| **Total** | | **0** | **0** | **635** | **0** | **0** | **84** | **125** |

District not organized and no dues.
*AAPD Collects dues

## Task Force on Governance, 2012-2013

| | Dues | AAPD Membership | District | State |
|---|---|---|---|---|
| **District II** | No | | | |
| Maryland | $50 | 120 | 0 | 61 |
| New Jersey | $50 | 199 | 0 | 92 |
| Pennsylvania* | $90 | 164 | 0 | 143 |
| Delaware | No | 12 | 0 | No |
| Wash. DC | No | 14 | 0 | No |
| Federal | No | 21 | 0 | No |
| **Total** | | **530** | **0** | **296** |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

| | Dues | AAPD District State | AAPD/ District | AAPD/ State | District/ State | District only | AAPD only | State only |
|---|---|---|---|---|---|---|---|---|
| **District II** | No | | | | | | | |
| Maryland | $50 | 0 | 0 | 51 | 0 | 0 | 69 | 10 |
| New Jersey | $50 | 0 | 0 | 75 | 0 | 0 | 124 | 17 |
| Pennsylvania* | $90 | 0 | 0 | | 0 | 0 | | |
| Delaware | no | 0 | 0 | 12 | 0 | 0 | | 0 |
| Wash. DC | no | 0 | 0 | 14 | 0 | 0 | | 0 |
| Federal | no | 0 | 0 | 21 | 0 | 0 | | 0 |
| **Total** | | **0** | **0** | **173** | **0** | **0** | **193** | **27** |

District not organized and no dues.
*AAPD Collects dues

## Task Force on Governance, 2012-2013

| | Dues | AAPD Membership | District | State |
|---|---|---|---|---|
| **District III** | $100 | | | |
| Alabama* | $200 | 78 | | |
| Florida* | $300 | 269 | | |
| Georgia | $45 | 173 | 61 | 176 |
| Kentucky | $100 | 71 | 24 | 70 |
| Mississippi | No | 46 | 0 | 0 |
| North Carolina | $150 | 140 | 45 | 124 |
| South Carolina | $100 | 70 | 38 | 68 |
| Tennessee | $100 | 103 | 26 | 62 |
| Virginia | $75 | 150 | 32 | 106 |
| West Virginia | $150 | 16 | 5 | 17 |
| Puerto Rico | | 19 | | |
| **Total** | | 1135 | 327** | 623 |

| | Dues | AAPD/ District/ State | AAPD District | AAPD/ State | District/ State | District only | AAPD only | State only |
|---|---|---|---|---|---|---|---|---|
| **District III** | $100 | | | | | | | |
| Alabama* | $200 | | | | | | | |
| Florida* | $300 | | | | | | | |
| Georgia | $45 | 51 | | 98 | 5 | 4 | 21 | 28 |
| Kentucky | $100 | 19 | | 37 | 1 | 3 | 19 | 13 |
| Mississippi | $0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| North Carolina | $150 | 38 | | 72 | 6 | 0 | 33 | 8 |
| South Carolina | $100 | 28 | | 24 | 4 | 5 | 13 | 12 |
| Tennessee | $100 | 23 | | 29 | 1 | 1 | 46 | 9 |
| Virginia | $75 | 27 | | 46 | 0 | 1 | 84 | 19 |
| West Virginia | $150 | 5 | | 11 | 0 | 0 | 0 | 1 |
| Puerto Rico | | | | | | | | |
| **Total** | | 191 | | 317 | | 14 | 216 | 90 |

District organized with dues.

* AAPD Collects Dues (This will be first year for both)

** Includes Florida, Alabama and Puerto Rico (do not have specific numbers)

## Task Force on Governance, 2012-2013

| | **Dues** | **AAPD Membership** | **District** | **State** |
|---|---|---|---|---|
| **District IV** | | | | |
| Wisconsin* | $100 | 75 | | 82 |
| | | | | |
| Minnesota | $100 | 65 | | 65 |
| Michigan | $200 | 100 | | |
| Indiana* | $125 | 96 | | |
| Nebraska* | $50 | 34 | | |
| Iowa | $50 | 46 | | |
| South Dakota | $0 | 13 | | |
| North Dakota | $0 | 8 | | |
| Illinois | $100 | 164 | | |
| Ohio | $75 | 150 | | |
| Canada | | 84 | | |
| Ontario | $105 | | | |
| Manitoba | $350 | | | |
| **Total** | | **835** | | |

| | **Dues** | **AAPD/ District/ State** | **District/ AAPD** | **AAPD/ State** | **District State** | **District only** | **AAPD only** | **State only** |
|---|---|---|---|---|---|---|---|---|
| **District IV** | | | | | | | | |
| Wisconsin* | $100 | | | 82 | | | 10 | 0 |
| Minnesota | $100 | | | 65 | | | | |
| Michigan | $200 | | | 107 | | | | |
| Indiana* | $125 | | | 99 | | | 12 | 8 |
| Nebraska* | $50 | | | | | | | |
| Iowa | $50 | | | 46 | | | 3 | 2 |
| South Dakota | $0 | | | 14 | | | 0 | 0 |
| North Dakota | $0 | | | 11 | | | 0 | 0 |
| Illinois | $100 | | | 163 | | | 19 | 2 |
| Ohio | $75 | | | 114 | | | | |
| Canada | | | | 83 | | | | |
| Ontario | $105 | | | | | | | |
| Manitoba | $350 | | | | | | | |
| **Total** | | | | **784** | | | **44** | **12** |

## Task Force on Governance, 2012-2013

| | Dues | AAPD Membership | District | State |
|---|---|---|---|---|
| **District V** | $100 | | | |
| Arkansas | $0 | 29 | 29 | 47 |
| Colorado* | $125 | 119 | | |
| Kansas | $0 | 26 | 28 | 42 |
| Louisiana | $50 | 63 | 54 | 87 |
| Missouri | $35 | 57 | 35 | 79 |
| New Mexico | $0 | 26 | 15 | 11 |
| Oklahoma | $150 | 43 | 26 | 57 |
| Texas | $300 | 484 | 306 | 198 |
| Mexico | | | | |
| **Total** | | **847** | **493** | **521** |

| | Dues | AAPD/ District/ State | AAPD/ District | AAPD/ State | District/ State | District only | AAPD only | State only |
|---|---|---|---|---|---|---|---|---|
| **District V** | $100 | | | | | | | |
| Arkansas | $0 | 22 | 5 | 11 | 1 | 1 | 3 | 13 |
| Colorado* | $125 | | | | | | | |
| Kansas | $0 | 18 | 2 | 4 | 5 | 3 | 1 | 15 |
| Louisiana | $50 | 33 | 7 | 13 | 10 | 4 | 6 | 11 |
| Missouri | $35 | 18 | 0 | 16 | 16 | 1 | 2 | 29 |
| New Mexico | $0 | 5 | 8 | 4 | 0 | 2 | 9 | 2 |
| Oklahoma | $150 | 29 | 2 | 11 | 8 | 7 | 0 | 9 |
| Texas | $300 | 128 | 115 | 41 | 18 | 45 | 173 | 11 |
| Mexico | | | | | | | | |
| **Total** | | **253** | **139** | **100** | **58** | **63** | **194** | **81** |

District is organized with dues.
*AAPD Collects dues (this is first year)

## Task Force on Governance, 2012-2013

| | Dues | AAPD Membership | District | State |
|---|---|---|---|---|
| **District VI** | $40 | | | |
| Alaska* | $160 | 19 | 22 | 22 |
| Arizona | | 128 | | 72 |
| California | $350 | 651 | 500 | 553 |
| Hawaii | $100 | 36 | 37 | 37 |
| Idaho | $40 | 26 | | 29 |
| Montana | $0 | 14 | 0 | 11 |
| Nevada | $100 | 46 | | 47 |
| Oregon* | $75 | 74 | 67 | 75 |
| Utah | $0 | 71 | 0 | 0 |
| Washington | $160 | 159 | 140 | 140 |
| Wyoming | $0 | 16 | 0 | 0 |
| Canada | $105 | 59 | 25 | 25 |
| **Total** | | **1299** | **791** | **1011** |

| | Dues | AAPD/ District/ State | AAPD/ District | AAPD/ State | District/ State | District only | AAPD only | State only |
|---|---|---|---|---|---|---|---|---|
| **District VI** | | | | | | | | |
| Alaska* | $160 | | | | | | | |
| Arizona | | | | | | | | |
| California | $350 | | | 50? | | | 135? | |
| Hawaii | $100 | 36 | 0 | 0 | 1 | 0 | 0 | 0 |
| Idaho | $40 | | | | | | | 3 |
| Montana | $0 | 0 | 0 | 11 | 0 | 0 | 3 | 0 |
| Nevada | $100 | | | | | | | 1 |
| Oregon* | $75 | | | | | | 18 | 8 |
| Utah | $0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Washington | $160 | | | | | | | |
| Wyoming | $0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Canada | $105 | | | | | | | |
| **Total** | | | | | | | | |

District is organized and with dues.
*AAPD collects dues

## Task Force on Governance, 2012-2013

**Appendix C**

AAPD Members by District

District I- 719
District II- 530
District III- 1135
District IV- 835
District V- 847
District VI- 1299

Overall Active members- 5365

**Appendix D**

Specialty organizations and ADA membership

| Organization | ADA Membership Required? | |
|---|---|---|
| AAPHD | No | |
| AAE | Yes | Active, Associate, Educator |
| AAOMP | No | |
| AAOMR | No | |
| AAOMS | No | |
| AAO | Yes | |
| AAPD | Yes | |
| AAP | Yes | Active, Associate, Educator |
| ACP | No | |

**Appendix E**

Membership Survey

Earlier this year, the Board of Trustees of the AAPD appointed a task force to look at the current governance structure of the AAPD. A representative from each district was asked to serve on this committee. Our task force has polled and spoken to the leadership of each of the districts and states in order to explore their opinions and the opinions of their constituents on this matter. Now we want to hear from you.

Below you will find a short survey about the AAPD's Governance. Please respond to the survey by September 30, 2012. It will only require 5 minutes of your time. We want to be sure your opinions are considered in our recommendations to the Board of Trustees.

This is a chance for your voice to be heard so please take some time and respond to the survey.

# AAPD Governance Survey

## Tripartite Membership

The AAPD currently requires members (those who have joined since 1999) to belong to their state units and district organizations and the AAPD. Currently this is not strictly enforced.

When answering the following question consider the potential impact:
• Increase or loss of membership at all levels
• Increased effectiveness in representing pediatric dentistry to members and to a broader community
• Member perceived value in state and district dues

### 1. Should the AAPD keep the requirement of Tripartite Membership?

- ◯ Yes, tripartite membership should be enforced.
- ◯ No, membership in our state units and district organizations should be voluntary .
- ◯ No, require membership in the AAPD and the state unit only.
- ◯ No, require membership in the AAPD and the district organization only.
- ◯ Other (please specify)

## ADA Membership

Currently the AAPD requires membership in the ADA to be a member. At present, ADA membership is only verified when you first join. Of the 9 specialty organizations 4 require membership while 5 do not.

When answering the following question consider:
• Effectiveness working with the ADA; we can reach a much broader group, which benefits pediatric dentistry
• The public looks at the ADA as the authority on Oral Health; will our relationship with them influence pediatric dentistry?
• Within the ADA can we be more effective in pediatric oral health issues?
• Risk of loss or gain in membership if enforced
• Value in ADA membership

### 2. Should the AAPD continue to require membership in the ADA?

- ◯ Yes
- ◯ No

## District Structure

The next three questions consider the district structure. Please consider the following in your response:

• Is proportional representation critical to achieve?
• Should a more proportional representation at the trustee/council/committee level be addressed?
• Should the number of trustees be maintained but re-proportioned or should it be increased?
• Will increasing size raise costs and result in bigger and less effective governance structure?

# AAPD Governance Survey

BACKGROUND: Currently the AAPD has six districts. Below are the current states/provinces within each district and the number of AAPD members in each district (note number in parentheses is number of AAPD members in that state).

DISTRICT I: NORTHEASTERN SOCIETY OF PEDIATRIC DENTISTRY
721 AAPD members

Canadian provinces (25)
Newfoundland
New Brunswick
Nova Scotia
Prince Edward Island
Quebec
Connecticut (102)
Maine (13)
Massachusetts (175)
New Hampshire (26)
New York (355)
Rhode Island (17)
Vermont (8)

DISTRICT II: EASTERN SOCIETY OF PEDIATRIC DENTISTRY
562 AAPD Members

Delaware (12)
District of Columbia (14)
Maryland (120)
New Jersey (198)
Pennsylvania (164)
Members of the Federal Services (21)
Foreign Countries not specifically cited (33)

DISTRICT III: SOUTHEASTERN SOCIETY OF PEDIATRIC DENTISTRY
1135 AAPD members

Alabama (78)
Commonwealth of Puerto Rico (19)
Florida (269)
Georgia (173)
Kentucky (71)
Mississippi (46)
North Carolina (140)
South Carolina (70)
Tennessee (103)
Virginia (150)
West Virginia (16)

DISTRICT IV: NORTH CENTRAL SOCIETY OF PEDIATRIC DENTISTRY
835 AAPD members

Canadian Provinces (84)
Manitoba and Ontario
Illinois (164)
Indiana (96)
Iowa (46)
Michigan (100)

# AAPD Governance Survey

Minnesota (65)
Nebraska (34)
North Dakota (8)
Ohio (150)
South Dakota (13)
Wisconsin (75)

DISTRICT V: SOUTHWESTERN SOCIETY OF PEDIATRIC DENTISTRY
847 AAPD members

Arkansas (29)
Colorado (119)
Kansas (26)
Louisiana (63)
Missouri (57)
New Mexico (26)
Oklahoma (43)
Texas (484)

DISTRICT VI: WESTERN SOCIETY OF PEDIATRIC DENTISTRY
1299 AAPD members

Alaska (19)
Arizona (128)
California (651)
Canadian provinces:(59)
Alberta
British Columbia
Northwest Territories
Nunavut
Saskatchewan
Yukon Territory
Hawaii (36)
Idaho (26)
Montana (14)
Nevada (46)
Oregon (74)
Utah (71)
Washington (159)
Wyoming (16)

**3. Should the AAPD change the AAPD district lines to even out the distribution of members?**

- ◯ No, leave the districts as they are currently.
- ◯ Yes, redraw the district lines but keep it at 6 districts.
- ◯ Yes, redraw the lines and add more districts.
- ◯ Yes, redraw the lines and merge some of the districts.
- ◯ Other (please specify)

# AAPD Governance Survey

**4. Should the AAPD keep the six districts as they are but change the number of trustees based on the number of members in the district. (i.e., larger districts would have two trustees and smaller districts would have only one trustee)?**

- ◯ Yes
- ◯ No

**5. Should the AAPD keep the six districts with six district trustees but increase the number of members from the larger districts on AAPD Councils/ Committees to proportional representation (currently there is one person from each district represented on a council)?**

- ◯ Yes
- ◯ No

## Dues Collection

The AAPD currently offers to collect dues for a state or a district at a cost. Some states have opted to have them do this.

**6. Should the AAPD bill and collect state and/or district dues?**

- ◯ Yes
- ◯ No

## Additional Comments

**7. Do you have any other ideas or comments about the AAPD's Governance?**

## Demographic Information

**8. What is your age range?**

- ◯ Under 30
- ◯ 30-39
- ◯ 40-49
- ◯ 50-65
- ◯ 65 and over

# AAPD Governance Survey

### 9. What is you AAPD District?

- ◯ District I - Northeastern Society of Pediatric Dentistry
- ◯ District II - Eastern Society of Pediatric Dentistry
- ◯ District III - Southeastern Society of Pediatric Dentistry
- ◯ District IV - North Central Society of Pediatric Dentistry
- ◯ District V - Southwestern Society of Pediatric Dentistry
- ◯ District VI -Western Society of Pediatric Dentistry

### 10. What is your state?

### 11. What is your gender?

- ◯ Male
- ◯ Female

### 12. What year did you graduate from residency?

## Thank you for taking our survey! We appreciate your input.

If you have questions or would like to discuss this in more depth, please feel free to contact any of us.

Members of the AAPD's Governance Task Force

Chair: Scott Cashion, scashion@me.com
District I: Monica Cipes, monicacipes@snet.net
District II: Ed Ginsberg, edginsberg@gmail.com
District III: Mark Meyer, mmeyer@triad.rr.com
District IV: Eric teDuits, eteduits@wisc.edu
District V: Bruce Weiner, bruce2th@gmail.com
District VI: Jade Miller, jmkiddds@aol.com

## Appendix F - Membership Survey Results

# AAPD Governance Survey

SurveyMonkey

### 1. Should the AAPD keep the requirement of Tripartite Membership?

| | Response Percent | Response Count |
|---|---|---|
| **Yes, tripartite membership should be enforced.** | **44.6%** | **190** |
| No, membership in our state units and district organizations should be voluntary . | 37.8% | 161 |
| No, require membership in the AAPD and the state unit only. | 12.7% | 54 |
| No, require membership in the AAPD and the district organization only. | 1.2% | 5 |
| Other (please specify) | 3.8% | 16 |
| | **answered question** | **426** |
| | **skipped question** | **3** |

### 2. Should the AAPD continue to require membership in the ADA?

| | Response Percent | Response Count |
|---|---|---|
| **Yes** | **60.0%** | **254** |
| No | 40.0% | 169 |
| | **answered question** | **423** |
| | **skipped question** | **6** |

## 3. Should the AAPD change the AAPD district lines to even out the distribution of members?

| | Response Percent | Response Count |
|---|---|---|
| **No, leave the districts as they are currently.** | **50.0%** | **202** |
| Yes, redraw the district lines but keep it at 6 districts. | 21.0% | 85 |
| Yes, redraw the lines and add more districts. | 17.3% | 70 |
| Yes, redraw the lines and merge some of the districts. | 3.2% | 13 |
| Other (please specify) | 8.4% | 34 |
| | **answered question** | **404** |
| | **skipped question** | **25** |

## 4. Should the AAPD keep the six districts as they are but change the number of trustees based on the number of members in the district. (i.e., larger districts would have two trustees and smaller districts would have only one trustee)?

| | Response Percent | Response Count |
|---|---|---|
| Yes | 40.7% | 164 |
| **No** | **59.3%** | **239** |
| | **answered question** | **403** |
| | **skipped question** | **26** |

## 5. Should the AAPD keep the six districts with six district trustees but increase the number of members from the larger districts on AAPD Councils/ Committees to proportional representation (currently there is one person from each district represented on a council)?

| | Response Percent | Response Count |
|---|---|---|
| Yes | 38.0% | 154 |
| **No** | **62.0%** | **251** |
| **answered question** | | **405** |
| **skipped question** | | **24** |

## 6. Should the AAPD bill and collect state and/or district dues?

| | Response Percent | Response Count |
|---|---|---|
| **Yes** | **51.9%** | **215** |
| No | 48.1% | 199 |
| **answered question** | | **414** |
| **skipped question** | | **15** |

## 7. Do you have any other ideas or comments about the AAPD's Governance?

| | Response Count |
|---|---|
| | 102 |
| **answered question** | **102** |
| **skipped question** | **327** |

## 8. What is your age range?

| | Response Percent | Response Count |
|---|---|---|
| Under 30 | 1.5% | 6 |
| 30-39 | 23.5% | 97 |
| 40-49 | 21.5% | 89 |
| **50-65** | **37.5%** | **155** |
| 65 and over | 16.0% | 66 |
| | **answered question** | **413** |
| | **skipped question** | **16** |

## 9. What is you AAPD District?

| | Response Percent | Response Count |
|---|---|---|
| District I - Northeastern Society of Pediatric Dentistry | 15.5% | 63 |
| District II - Eastern Society of Pediatric Dentistry | 10.3% | 42 |
| **District III - Southeastern Society of Pediatric Dentistry** | **21.4%** | **87** |
| District IV - North Central Society of Pediatric Dentistry | 16.0% | 65 |
| District V - Southwestern Society of Pediatric Dentistry | 17.7% | 72 |
| District VI -Western Society of Pediatric Dentistry | 19.2% | 78 |
| | **answered question** | **407** |
| | **skipped question** | **22** |

## 10. What is your state?

| | Response Count |
|---|---|
| | 393 |
| **answered question** | **393** |
| **skipped question** | **36** |

## 11. What is your gender?

| | Response Percent | Response Count |
|---|---|---|
| **Male** | **61.2%** | **249** |
| Female | 38.8% | 158 |
| **answered question** | | **407** |
| **skipped question** | | **22** |

## 12. What year did you graduate from residency?

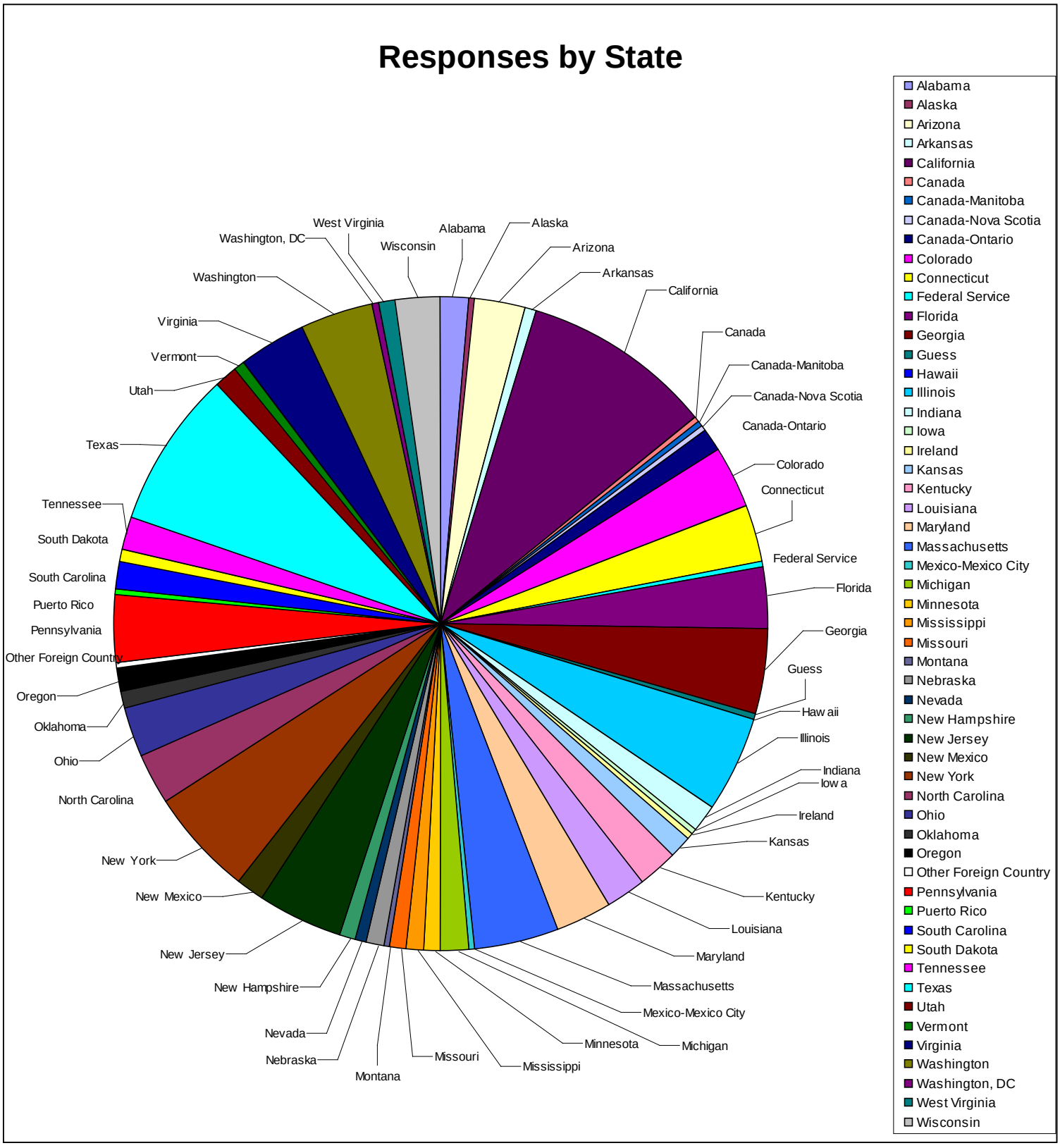
| | Response Count |
|---|---|
| | 388 |
| **answered question** | **388** |
| **skipped question** | **41** |

## Appendix G

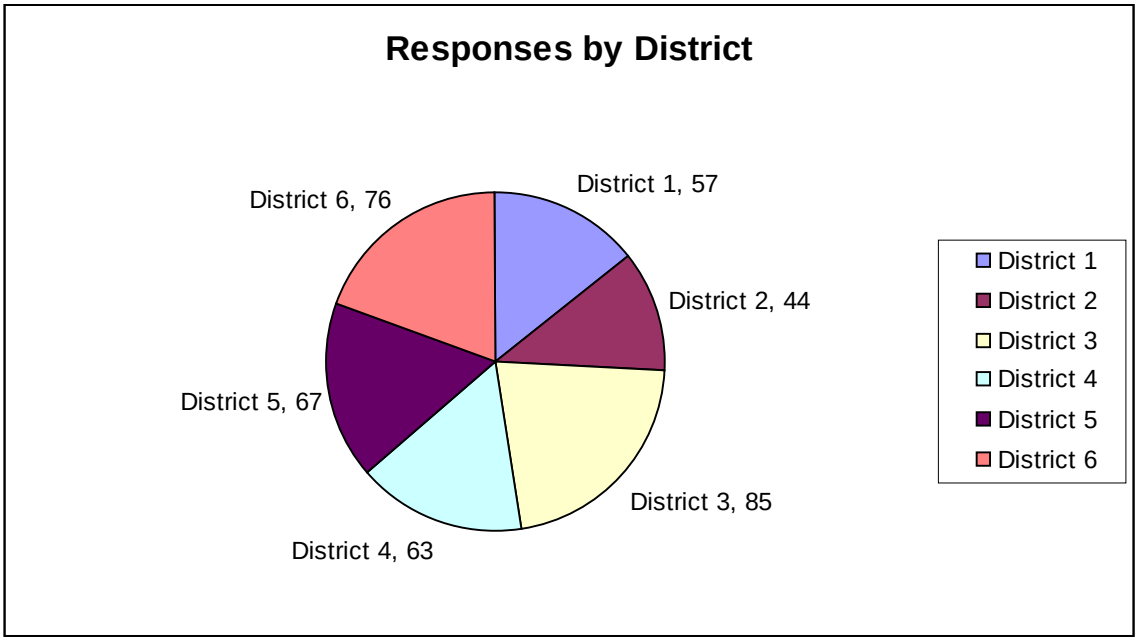
### Responses by State

| State | Responses |
|---|---|
| Alabama | 5 |
| Alaska | 1 |
| Arizona | 10 |
| Arkansas | 2 |
| California | 38 |
| Canada | 1 |
| Canada-Manitoba | 1 |
| Canada-Nova Scotia | 1 |
| Canada-Ontario | 4 |
| Colorado | 12 |
| Connecticut | 11 |
| Federal Service | 1 |
| Florida | 12 |
| Georgia | 16 |
| Guess | 1 |
| Hawaii | 1 |
| Illinois | 18 |
| Indiana | 6 |
| Iowa | 1 |
| Ireland | 1 |
| Kansas | 4 |
| Kentucky | 8 |
| Louisiana | 7 |
| Maryland | 11 |
| Massachusetts | 17 |
| Mexico-Mexico City | 1 |
| Michigan | 5 |
| Minnesota | 3 |
| Mississippi | 4 |
| Missouri | 3 |
| Montana | 1 |
| Nebraska | 3 |
| Nevada | 2 |
| New Hampshire | 4 |
| New Jersey | 16 |
| New Mexico | 5 |
| New York | 21 |
| North Carolina | 10 |
| Ohio | 10 |
| Oklahoma | 3 |
| Oregon | 4 |
| Other Foreign Country | 1 |
| Pennsylvania | 13 |
| Puerto Rico | 1 |
| South Carolina | 6 |
| South Dakota | 2 |
| Tennessee | 7 |
| Texas | 30 |
| Utah | 4 |
| Vermont | 3 |
| Virginia | 13 |
| Washington | 14 |
| Washington, DC | 1 |
| West Virginia | 3 |
| Wisconsin | 9 |

## Task Force on Governance, 2012-2013



## Task Force on Governance, 2012-2013



Task Force on Governance, 2012-2013

**Responses by Graduation Date**

| | | |
|---|---|---|
| 1960- 3 | 1965-1 | |
| 1961-0 | 1966-0 | |
| 1962-2 | 1967-2 | |
| 1963-2 | 1968-2 | |
| 1964-4 | 1969-4 | |
| **Total** | | **20** |

| | | |
|---|---|---|
| 1970- 5 | 1975-7 | |
| 1971-0 | 1976-12 | |
| 1972-6 | 1977-11 | |
| 1973-6 | 1978-8 | |
| 1974-8 | 1979-13 | |
| **Total** | | **76** |

| | | |
|---|---|---|
| 1985-10 | | |
| 1986-7 | | |
| 1982-7 | 1987-2 | |
| 1983-5 | 1988-11 | |
| 1989-9 | | |
| **Total** | | **84** |

| | | |
|---|---|---|
| 1990-9 | 1995-9 | |
| 1991-6 | 1996-5 | |
| 1992-8 | 1997-5 | |
| 1993-2 | 1998-8 | |
| 1994-5 | 1999-10 | |
| **Total** | | **67** |

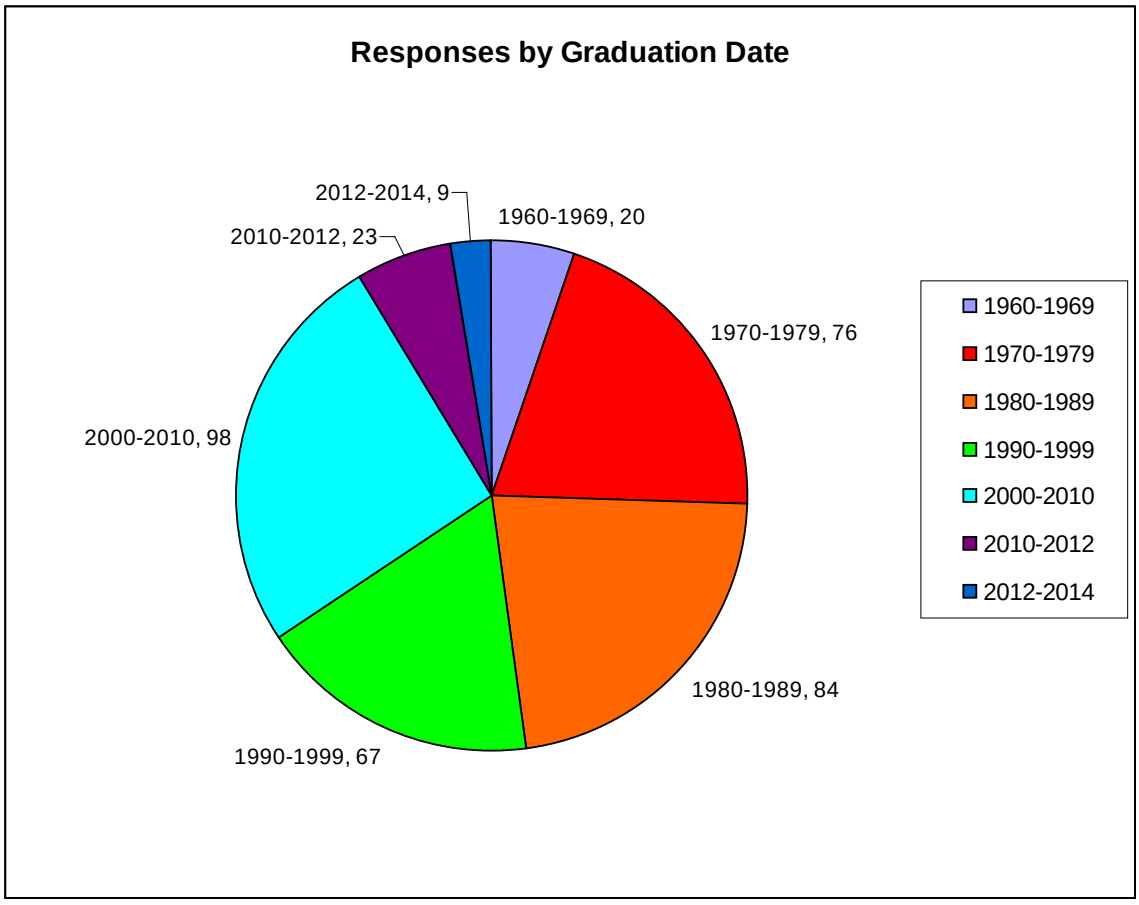
| | | |
|---|---|---|
| 2000-9 | 2005-15 | |
| 2006-6 | | |
| 2002-8 | 2007-14 | |
| 2003-6 | 2008-6 | |
| 2004-8 | 2009-11 | |
| **Total** | | **98** |

| | | |
|---|---|---|
| 2010-12 | | |
| 2011-11 | | |
| **Total** | | **23** |

**These folks answered the survey but are still in residency**
2012-6
2013-2
2014-1

Please note there were two other residents who filled out the survey but did not put a graduation year. There were 9 who were either general dentist or made a comment but did not specify a graduation year. There were 41 who did not answer the question at all.

## Task Force on Governance, 2012-2013



# 2012-2013 Report of the Task Force on Talent Pool Development

**Charles Czerepak, Co-chair**
**Rebecca Slayton, Co-chair**
**Joel H. Berg, Board Liaison**
John S. Rutkauskas, Staff Liaison

*Members*
Dennis McTigue, ABPD Representative
Ryan Hughes
Lois Jackson

## Charge — Status of Charge: In Progress

To identify, recruit, and develop AAPD members to serve the specialty.

## Progress Report

To begin, the Task force looked at the type of assignments the members filled within the organization. Once classified, the tasks were placed in general categories. Looking at the categories, an operational flow chart was developed to outline the entire process of talent identification and mentoring. From the Flow chart assignments were made to examine and define each step of the process. Currently, the task force is examining the entry points to the process and how the candidates will be evaluated. The last piece will be the development of criteria to identify participants, mentors and management of the process.

**Tasks identified within the AAPD are:**

1. Councils
2. Committees
3. BOT members
4. Foundation members
5. Experts (content)
6. Spokespersons
7. Master Clinicians
8. Boundary Spanners to other professional organizations
    a. ADA
    b. ADEA
    c. AAP/AMA/AAPF
    d. College of Diplomates
    e. ACD
    f. ICD
    g. Pierre Fauchard
    h. State Dental Associations

        i. American Association of Public Health Dentistry
    9. Executive Committee Members
    10. Local Officers
    11. Regulatory members (state boards)
    12. CODA / Consultants
    13. Public Policy Advocates
    14. Child Health Advocates.
    15. Speakers Bureau
    16. American Board
        a. Examiners
        b. Committee members
        c. BOD
    17. Community Involvement
    18. Part Time Faculty
    19. Full Time Academics
    20. Public Service
    21. Public Health Dentistry
    22. Research

**Tasks Categories**

1. Research / Academics
2. Leadership / Advocacy
3. Community Relations
4. Clinical Practice

**Critical to success of the Talent Development Task Force is Partnering with these groups of members within the Academy.**

1. Program Directors (pre-doc and post-doc)
2. ABPD leaders
3. Current and Past AAPD Leadership
4. Kellogg and Wharton Participants
5. AAPD Staff
6. Council and Committee Chairs
7. Under 40 Leaders
8. AAPD Membership

**Flow Chart for Talent Acquisition and Mentoring Process**

See Figure 1.

## Task Force on Talent Pool Development, 2012-2013

**Task Force Time Line**

| | |
|---|---|
| January 19, 2013 | Project start date |
| May 19, 2013 | Final Definitions, Develop Plan, Assign tasks |
| September 1, 2013 | Preliminary Report |
| October 1, 2013 | Develop test groups |
| December 1, 2013 | Final report |
| January 10, 2014 | Presentation to Board of Trustees |
| March 1, 2014 | Refine Report, Plan Kick-off |
| May 20, 2014 | Kickoff event, Start Process |

**Current Assignments**

| Action Item | Assigned to | Start Date | Completed |
|---|---|---|---|
| Letter from Dr. Berg/ Brill to alert membership to process | Slayton Czerepak | 1/19/2013 | |
| Leadership Inventory | Czerepak McTigue | 1/19/2013 | |
| Develop a talent form Instrument | Slayton McTigue | 1/19/2013 | 2/1/2013 |
| Communication plan for target groups of AAPD | Czerepak | 1/19/2013 | |
| Outline used by Dr. Jackson in NY | Jackson | 1/19/2013 | 2/1/2013 |
| Contact CSPD (Dr. Santos) to inquire as to progress of parallel task force in California | Hughes Jackson | 1/19/2013 | |
| Develop a survey to be administer to New Dentist Members | Hughes | 1/19/2013 | |
| Define and Develop a Steering Committee | All | 1/19/2013 | |
| Break Process into component parts an make individual assignments | All | 1/19/2013 | |

Task Force on Talent Pool Development, 2012-2013

## Figure 1

## Flow Chart for Talent Search Process

# 2012-2013 Report of the Task Force on Global Interactions

**Amr Moursi, Chair**
**Joel H. Berg, Board Liaison**
Suzanne A. Wester, Staff Liaison

*Members*
Kaaren Vargas, ABPD Representative
Donald Chi
Kerry Maguire
Ana Lucia Seminario

## Charge — Status of Charge: In Progress

To determine strategies to enhance AAPD interactions with global pediatric oral health organizations and communities in order to increase synergy and global impact.

## Progress Report

The task force has met three times in person or by conference call since our inception in the Fall of 2012. We began our work by identifying global issues of importance to the AAPD and then correlated these with anticipated topics of interest for the international organizations. We then prioritized these potential areas of interaction, see below:

**Potential Areas of Interaction:**

High Priority
- Increase Membership
- Enhance Meetings
- Enhance Research and Publications
- Enhance Governance Opportunities

Moderate Priority
- Improve Education Opportunities and Resources
- Explore Cooperation on Guidelines and Policies
- Enhance Global Service and Advocacy Activities

Related Issues
- CODA Accreditation
- ABPD Board Certification

## Task Force on Global Interactions, 2012-2013

Although the members of the task force represent a wealth of experience and knowledge from various international regions, we were careful not to presume to completely comprehend all the issues that may interest the many diverse international pediatric dental organizations. Therefore, we developed a plan to collect information from international organization leaders related to topics of interest, and particularly our identified high priority areas. We will collect input through conference calls and face-to-face meetings with international leaders and focus groups of AAPD international members. This plan is detailed further in the attached time line. Also attached are the results of our Task Force brainstorming session.

Some of the issues we will address as we get input from international leaders include:

- What would international leaders like to see in interactions between their organization and AAPD
- Values and perceptions of AAPD
- Thoughts on our high priority Areas of Interaction

We have currently had discussions with the following international leaders:

Dr. Paddy Fleming
President-Elect, EAPD

Dr. Eduardo Alcaino
President, IAPD

Dr. Raman Bedi
Chairman, Global Child Dental Fund

The consensus from these discussions has been an overwhelming support and enthusiasm for the effort the AAPD is making in addressing global interactions. In particular there was strong support for the following areas of interactions:

- Increased promotion of the benefits of AAPD international membership
- Additional benefits for international members and possible reciprocity
- AAPD-sponsored presentations or symposia embedded within international meetings
- Joint meetings, in particular with IAPD and at the regional level
- Internationally focused sessions, perhaps with foreign language presentations or translation services at AAPD Annual Sessions and CE courses
- Sending AAPD representatives to international meetings, invitation of international leadership to AAPD meetings
- Exchange of exhibit space between AAPD and international organizations at major meetings
- Interaction with international organizations on advocacy issues (UN, WHO, FDI, Global Child Dental Fund, etc.)
- Cooperation in promoting AAPD guidelines

- Exploring the possibility of endorsement of selected international organization guidelines
- Cooperation with international organizations when modifying or creating clinical guidelines

We will discuss these, and other topics, in more detail during additional calls to international leaders (see attached list) and when we meet face to face at the IAPD meeting in June.

Some of the issues we will address when we organize a focus group of AAPD international members include:

- What the value is in AAPD international membership?
- Why they joined?
- What benefits do they find most important?
- What additional benefits would they like?
- What would attract more international members?

We will use the information we gather to create talking points to speak to potential international members and with international leaders. These talking points will also be distributed to AAPD leadership so they can be used when discussing issues at the International Reception at the Annual Session.

I would like to thank all the members of the Task Force and Suzanne Wester for their efforts and look forward to presenting our work to the Board of Trustees in greater detail.

Respectfully Submitted,

Amr Moursi

**Task Force on Global Interactions**
Time Line

**December, 17, 2012 –** Task force conference call to discuss goals and strategies

**January 19, 2013 –** Task Force meeting, Chicago IL, to identify and prioritize areas of interaction, create action plan and time line

**January 21, 2013** – Write proposed bylaws change to include non-CODA trained pediatric dentists who are board certified to be eligible for Active Membership in AAPD – A. Moursi (COMPLETED)

**January 25, 2013** – Draft Letter due for call with international leaders and prospective list to invite – AL Seminario (COMPLETED)

**February 8, 2013** – Send letter to invite international leaders to conference calls-A. Moursi (COMPLETED)

**February-April, 2013 –** Conference calls with leaders of international organizations-A. Moursi and other task force members as available (ONGOING)

**March 19, 2013** – Task Force face to face Meeting – Seattle – ADEA Meeting

**March 29, 2013** – Submit interim progress report to Board – A. Moursi (COMPLETED)

**April 2013** – Invite international members and attendees to Focus Group at Annual Session – K. McGuire and S. Wester

**April 1, 2013** – Invite international organization leaders to meeting at IAPD meeting in Seoul, June, 2013 – A. Moursi and J. Berg

**May 25, 2013 –** Orlando, 4-5 pm – AAPD International Attendee Focus Group – led by K. Maguire

**May 26, 2013 –** AAPD Annual Session, Orlando, Task Force meeting, 8:00 am Eastern

**June 12-15, 2013 –** Face to face meeting at IAPD meeting in Seoul with international leaders, separate meeting requested with IAPD leadership

**September 5, 2013** – Task Force Conference call, 11:00 am central

**November 15, 2013** – Task Force Conference Call, time to be determined

**January 2014** – Task Force face to face meeting at AAPD Winter Planning Meeting

**April 1, 2014** – Final Report and recommendations to BOT for review at 2014 Annual Session

## Task Force on Global Interactions, 2012-2013

**Task Force on Global Interactions**
International Pediatric Dental Organization Leaders

**Asia**

- President JSPD: Prof. Youichi YAMASAKI
- Comm. on Foreign Affairs Relations JSPD: Prof. Yasuo TAMURA
- President KSPD: Soon Hyeun NAM
- Vice President KSPD: Ki Tae PARK

**Latin America**

- IADR Latin-America: Dr. Rita Villena
- ALOP (Latino America Society of Pediatric Dentistry): Dr. Francisco Hernandez
- President elect IAPD: Dr. Jorge Luis Castillo

**Australia and IAPD**

- President IAPD: Dr. Eduardo Alcaino

**Middle East**

- Egyptian Society for Pediatric Dentistry and Children with special needs: Dr. Mervat Rashed, President
- Saudi Board in Pediatric Dentistry: Dr. Ali Al Ehaideb, Chairman

**Europe**

- President elect EAPD: Dr. Paddy Fleming
- President EADPH: Dr. Kenneth Eaton
- Chief, Oral Health Program World Health Organization: Dr. Paul Erik Petersen
- Chairman, Global Child Dental Fund: Dr. Raman Bedi

**Africa**

- President Paedodontic Society of South Africa: Dr Janet Gritzman

**Task Force on Global Interactions**

Brainstorming Session
Task Force meeting, January 19, 2013, Chicago IL

The Task Force conducted a preliminary brainstorming session to identify possible strategies and activities within each Area of Interaction that would help achieve our charge. These are intended simply as examples for discussion with various groups. A full set of well-supported recommendations will be provided to the Board of Trustees in our Final Report.

**Potential Areas Of Interaction**

**High Priority**

**Increase Membership**

- Increase AAPD international membership, regular and student categories
- Address discrepancy in membership rules which prevent non-CODA trained pediatric dentists who are board certified (full-time educators) to be eligible for Active Membership in AAPD
- Explore additional benefits for international members, International Fellowship Status?
- Explore reciprocity (discounts, additional benefits, etc.) with members of international organizations

**Enhance Meetings**

- Review past annual session international attendees
- Determine to what extent international societies and licensing boards accept AAPD CE.
- Explore the possibility of AAPD-sponsored presentations or symposia embedded within international meetings
- Host meeting of international pediatric dental educators with focus on innovations in education
- Initiate annual meeting of Pediatric Dental Organization Leaders alternating between the AAPD annual session and an International meetings
- Create an international focused session within the Annual Session
- Translation Services at AAPD Annual Session and CE courses
- Foreign language presentations at Annual Session
- Joint meetings with focused topic. US and international speakers on the same topic for different perspectives
- Send official representatives to international meetings, invite international leadership to our meetings
- Exhibit booth at major international meetings
- Presence at US meetings of international dental groups (Hispanic dental society, Indian Dental Society, etc.)

## Task Force on Global Interactions, 2012-2013

**Enhance Research and Publications**

- Encourage AAPD membership on editorial boards of international publications, submit editorials to international publications
- Invite international members to join AAPD editorial boards, invite international editorials
- Research awards and grants for International Members – help make connections, expand eligibility for awards
- Offer travel awards for international members and students with top submissions to Annual Session

**Enhance Governance Opportunities**

- Trustee at Large for International Membership
- New International Student Membership
- Board Certified Dentists to be Active Members
- Explore additional ways to enhance international membership input into governance

**Moderate Priority**

**Education**

- Exchange of curriculum, reading lists, etc.
- Host clearinghouse of educational material

**Service**

- Form relationships with key international service programs
- Create guidelines or policy statement regarding international community outreach programs
- Host volunteering clearinghouse on the AAPD website

**Advocacy**

- Interact with international organization on advocacy issues (UN, WHO, FDI, GCDF etc.)

**Guidelines**

- Guidelines – Market AAPD guidelines to other organizations for endorsements, i.e. how the Australians did.
- Consider endorsement of selected international organization guidelines
- Enhance awareness of AAPD guidelines
- Interact with international organizations when modifying or creating guidelines

**Related Issues**

**CODA Accreditation**

- Interact with CODA as they initiate International Accreditation

## Task Force on Global Interactions, 2012-2013

**ABPD Board Certification**

- Change in bylaws to allow eligibility for Active Membership in AAPD for non-US trained pediatric dentists who are board certified by the ABPD
- Interact with ABPD as they consider any new international categories

# 2012-2013 Report of the Task Force on Project Management

**Joel H. Berg, Chair and Board Liaison**

*Members – AAPD Staff*
John S. Rutkauskas, Chief Executive Officer
C. Scott Litch, Chief Operating Officer and General Counsel
Tonya Almond, Meeting Services Senior Director
Paul W. Amundsen, Development Director
Margaret A. Bjerklie, Executive Assistant and Office Manager
Philip S. Bloch, HSHC Database Coordinator
Janice Silverman, Health Policy Center Assistant Director

The task force met at the AAPD Headquarters in Chicago on Friday, January 18, 2013.

- Objectives for meeting:
  - Introduce the concept
    - How the Academy manages projects
      - Current state vs. ideal state
    - How to keep track of projects
  - Lay out the process – roles, responsibilities, timeline
- The concept
  - Project Management System
    - Should allow one to view status from many perspectives
    - Allow cross-functional knowledge; not just "my council is doing x", but how it relates to other departments
  - Strategic planning will become a visionary exercise
  - Train council/committee chairs in project management so they know what is expected
- The Strategic Plan is our "road map"
  - Charges are activities based on the SP
    - Many are clearly doable and can be done in one year
    - Others will be better done on a longer cycle
  - For the purpose of tracking: staff (internal), volunteer, and external organization activities
- How to begin?
  - Look at the basics – governance, research, etc.
    - Look at the processes involved in these

    - Look at the councils/committees/task forces. Their charges are operating plans
        - How to measure the success of standing charges?
        - Is it critical to do so?
- Current state of activities and projects
    - Strategic plan/operations
        - Trends, uncertainties, topics
    - Annual council and committee activities/charges
    - Task forces
        - Task orientation and actions needed at that time
    - Future annual sessions
    - Internal and external meeting calendar
        - CE
        - Governance
        - Other organizations
    - Appointment tracking
    - Grant funding cycles (incoming funds)
    - Grant funding cycles (outgoing funds)
    - Evaluation metrics
- Issues
    - What to do with "sacred cows" – develop an evaluation method
    - Resource allocation
    - How to use this in terms of prioritization and culling of waste
    - Communications/Timing
- Challenge is to change our modus operandi and decide what needs to be a project and what doesn't
- Next steps
    - Conference call on April 4, 2013, 9:30 – 11 am (Central)
        - Agenda: Timeline and proposal to board
    - Roles and responsibilities (see below)

| Activity | Date Due | Product | Responsibility |
|---|---|---|---|
| Outline major categories using strategic plan | March 2013 | Outline | Scott |
| Investigate software | February 2013 for March BFC meeting | Product comparisons<br>Cost estimates | Phil – lead<br>Margaret- communicate with DG and any of their clients they may be able to connect us with |

## Task Force on Project Management, 2012-2013

| Activity | Date Due | Product | Responsibility |
|---|---|---|---|
| List all projects and sub-projects | December 2013 | | Scott-lead<br>All task force members |
| Data population of test projects (task force, council charge); test | December 2013 | | Tonya |
| Prioritize projects | December 2013 | | All task force members |
| Launch announcement | January 2014 | | Dr Berg |
| Software installation and staff training | January 2014 | | Vendor<br>(“Train the Trainer”?) |
| Data Population | January-June 2014 | | All Task Force members |
| Volunteer training | January-June 2014 | | Vendor /Task Force trainers |
| Project Management Orientation | May 2014 | Demonstration | Dr. Berg, Tonya |
| Go Live | July 1, 2014 | | |

# 2012-2013 Report of the AAPD Political Action Committee Steering Committee

**Lewis A. Kay, Chair**
John A. Hendry, Board Liaison
Richard P. Mungo, Vice Chair
John S. Rutkauskas, Treasurer
K. Jean Beauchamp, Assistant Treasurer
C. Scott Litch, Secretary

*District Representatives:*
Reneida E. Reyes (I)
Cavan M. Brunsden (II)
David K. Curtis (III)
Neophytos "Ned" Savide (IV)
Philip H. Hunke (V)
Jade Miller (VI)

**March 2013 Meeting**
The AAPD PAC Steering Committee met on March 10, 2013 in Washington, D.C. in conjunction with the AAPD Public Policy Advocacy conference. In addition to the Steering Committee members, C. Michael Gilliland, Esq., of Hogan Lovells and members of the Council on Governmental Affairs (CGA) also participated in the meeting. The meeting allowed an opportunity to discuss and evaluate past activities and begin planning for the 2014 Congressional election cycles. A number of key supporters of AAPD issues are up for re-election in the U.S. Senate. In conjunction with the conference, for the first time in PAC history we organized a fund raiser in Washington, D.C. (rather than participating in events organized by others). This fund raiser, organized in conjunction with the Hogan Lovells PAC, was held for **Congressman Jack Kingston (R-Georgia 1st)**, who is the new chair of the House Appropriations Subcommittee on Labor-HHS-Education. It was a great success and well worth the effort. Also, later in the conference the PAC sponsored a presentation by CNN's chief political analyst **Gloria Borger,** who gave a well-received overview of "The Insider's View from Washington."

**Candidates Supported by the AAPD PAC for the 2012 Congressional Elections**
The AAPD PAC did well in support of successful Republican and Democratic candidates in the 2012 Congressional election cycle. **I am pleased to report that our overall success rate was 91% (62/68).** We had a number of AAPD members deliver checks and in some cases organize local fund-raising events. The total amount of support provided in this cycle was over $200,000. Our PAC continues to grow more sophisticated and will continue to engage AAPD members in this important activity.

## AAPD Political Action Committee
## Steering Committee, 2012-2013

**Senate Races (4 DEMOCRATS, 4 REPUBLICANS)**
**Senate Success Rate = 75% (6/8)**

| Candidate/Party/State | Election Result |
|---|---|
| Ben Cardin (D-Md.) | Won 55-27% (an independent received 17%) |
| Josh Mandel (R-Ohio) | Lost to incumbent Sherrod Brown (D) 50-45% |
| Robert Menendez (D-N.J.) | Won 58-40% |
| Denny Rehberg (R-Mont.) | Lost to incumbent Jon Tester (D) 49-45% |
| Debbie Stabenow (D-Mich.) | Won 59-38% |
| Roger Wicker (R- Miss.) | Won 57-40% |
| Dean Heller (R-Nev.) | Won 46-45% |
| Chris Murphy (D-Conn.) | Won 55-43% |

**House Races (29 DEMOCRATS, 31 REPUBLICANS)**
**House Success Rate = 93% (56/60)**

| Candidate | Party-State-District | Election Result |
|---|---|---|
| **Paul Gosar1** | R-Arizona (4th) | Won 67-28% |
| Michael C. Burgess2 | R-Texas (26th) | Won 68-29% |
| GK Butterfield | D-North Carolina (1st) | Won 75-25% |
| Rosa DeLauro | D-Connecticut (3rd) | Won 75-25% |
| Sam Farr | D-California (20th) | Won 73-27% |
| Walter Jones | R- North Carolina (3rd) | Won 63-37% |
| Rick Larsen | D-Washington State (2nd) | Won 61-39% |
| Nita Lowey | D-New York (17th) | Won 64-35% |
| Alan Nunnelee | R-Mississippi (1st) | Won 60-37% |
| Tom Price3 | R- Georgia (6th) | Won 65-35% |
| **Mike Simpson4** | R-Idaho (2nd) | Won 65-35% |
| Ed Whitfield | R-Kentucky (1st) | Won 70-30% |
| Steny Hoyer<br>House Minority Whip | D-Maryland (5th) | Won 62-35% |
| Diana DeGette | D-Colorado (1st) | Won 68-27% |
| Gregg Harper | R-Mississippi (3rd) | Won without opposition |
| Eric Cantor<br>House Majority Leader | R-Virginia (7th) | Won 59-41% |
| Marsha Blackburn | R-Tennessee (7th) | Won 71-24% |
| Mo Brooks | R-Alabama (5th) | Won 65-35% |
| Lois Capps | D-California (24th) | Won 55-45% |
| Elijah Cummings | D-Maryland (7th) | Won 76-21% |
| Phil Gingrey | R-Georgia (11th) | Won 69-31% |

[1] Dentist
[2] Practicing obstetrician from 1981-2003
[3] Orthopedic surgeon.
[4] Dentist

## AAPD Political Action Committee
## Steering Committee, 2012-2013

| Candidate | Party-State-District | Election Result |
|---|---|---|
| Billy Long | R-Missouri (7th) | Won 64-31% |
| Betty McCollum | D-Minnesota (4th) | Won 62-32% |
| Dutch Ruppersberger | D-Maryland (2nd) | Won 65-31% |
| John Shimkus | R-Illinois (15th) | Won 69-31% |
| Henry Waxman | D-California (33rd) | Won with no opposition |
| Mike Honda | D-California (17th) | Won 73-27% |
| Frank Pallone | D-New Jersey (6th) | Won 63-45% |
| Joe Pitts | R- Pennsylvania (16th) | Won 55-39% |
| Yvette Clark | D-New York (9th) | Won 87-12% |
| Bill Cassidy5 | R-Louisiana (6th) | Won with no opposition |
| Danny Davis | D-Illinois (7th) | Won 85-11% |
| Rodney Alexander | R-Louisiana ( 5th) | Won with no opposition |
| Fred Upton | R-Michigan (6th) | Won 54-43% |
| Eliot Engel | D-New York (16th) | Won 77-21% |
| John Runyan | R-New Jersey (3rd) | Won 54-45% |
| Charlie Boustany, Jr.6 | R-Louisiana (7th) | Won run-off early December |
| Hayden Rogers | D-North Carolina (11th)- open seat formerly held by Heath Shuler | Lost 57-43% |
| Gus Bilirakis | R-Florida (12th) | Won 63-33% |
| Howard Coble | R-North Carolina (6th) | Won 61-39% |
| Joe Courtney | D-Connecticut (2nd) | Won 68-29% |
| Mike Fitzpatrick | R-Pennsylvania (8th) | Won 57-43% |
| Kay Granger | R-Texas (12th) | Won 71-27% |
| Barbara Lee | D- California (13th) | Won with no opposition |
| Dana Rohrabacher | R-California (48th) | Won 61-39% |
| Lucille Roybal-Allard | D-California (40th) | Won 60-40% |
| Lorretta Sanchez | D-California (46th) | Won 62-38% |
| Allyson Y. Schwartz | D-Pennsylvania (13th) | Won 69-31% |
| Pete Stark | D- California (15th) | Lost 52-48% |
| Peter Welch | D-Vermont (at large) | Won 72-23% |
| Kevin McCarthy | R-California (23rd) | Won with no opposition |
| Jackie Speier | D-California (14th) | Won 74-26% |
| Robert Dold | R-Illinois (10th) | Lost 50-50% (by about 2500 votes) |
| Adam Kinzinger | R-Illinois (16th) | Won 62-38% |
| Julia Brownley | D-California (26th)- open seat | Won 52-48% |
| J. Scott Keadle7 | R-North Carolina (running | Lost in primary (note that |

[5] Physician, founded Greater Baton Rouge Community Clinic
[6] Cardio-thoracic surgeon
[7] General dentist

| Candidate | Party-State-District | Election Result |
|---|---|---|
| | in 8th district) | Democratic incumbent Larry Kissell lost in the general election) |
| John Larson | D-Connecticut (1st) | Won 69-28% |
| Jackie Walorski | R- Indiana (2nd)- open seat | Won 49-48% |
| Steve Daines | R-Montana (at large)- open seat | Won 53-43% |
| Rodney Davis (R) | R-Illinois (13th)- open seat | Won 47-46% |

**AAPD PAC Legislator of the Year Award**

The PAC Steering Committee presented the 2013 PAC Legislator of the Year Award to Senator **Ben Cardin** (D-Maryland), who has been a strong champion for children's oral health. The award was presented at a reception and dinner on March 12, 2013 as part of the AAPD Public Policy Advocacy Conference in Washington, D.C. Senator Cardin helped make oral health required coverage for children under both the Children's Health Insurance Program (CHIP) and the Affordable Care (ACA). I wish to reprint here the wonderful introductory remarks by AAPD President-elect Warren A. Brill (Baltimore, Md.):

**Introduction for Senator Ben Cardin**

It is my pleasure to introduce U.S. Senator Ben Cardin, whom I've known for many years. Our district II trustee, Shari Kohn and her family also have a long personal relationship with Ben. Ben is a very visible legislator in Maryland and the Baltimore area, befriending many people, which has enabled him to be one of the most effective elected officials at both the state and federal level.

Senator Cardin was first elected to the U.S. Senate in 2006 and re-elected in 2012. Prior to being elected to the Senate, Ben was a member of the House of Representatives for 20 years. And yes the AAPD PAC supported him!

In both houses, Ben has been a national leader on health care, retirement security, the environment and fiscal issues. He also has an international presence as chair of the Commission on Security & Cooperation in Europe, also known as the Helsinki Commission.

Let me quote some local media regarding Senator Cardin. The *Washington Post* has said he has a "command of issues, proven integrity, formidable intellect and an unstinting work ethic," and that he "is sensible, tough-minded and independent." The *Baltimore Sun* has said: "He has been able to work both sides of the aisle" to help workers save for retirement and to champion the expansion of Medicare benefits. In 2001, Ben was named by Worth Magazine as among the top "100 people who have influenced the way Americans think about money." In 2004, he was named to **Treasury** and Risk Management's list of "100 Most Influential People in Finance." Support for the Chesapeake Bay has also been one of Senator Cardin's signature issues.

I would like to mention a little more about the Senator's background. He was born in Baltimore, the grandson of Russian Jewish immigrants. His father served in the Maryland legislature and later as a well-known and respected judge. Ben received his BA cum laude from the University of Pittsburgh and his law degree from the University of Maryland. He served in the Maryland House of Delegates from 1967 to 1986, first elected while still attending law school. At age 35 he became the youngest Speaker of the House in Maryland history, a post he held until successfully running for Congress in 1986.

**Now, let me highlight a critical children's oral health issue championed by Senator Cardin.** We all know about the tragic death of Maryland child Deamonte Driver from a tooth infection. Senator Cardin was moved and motivated to take action to fix things, and in the 111th Congress, he was successful in getting a guaranteed dental benefit included in the reauthorization of the Children's Health Insurance Program- CHIP. He also understands we have to make programs like Medicaid and CHIP work better, because even though Deamonte Driver had coverage that did not necessarily mean access. Ben has been hugely supportive of dental coalition efforts in Maryland that have taken a multi-pronged approach at improving things.

Senator Cardin felt so strongly about this achievement that he featured it in a campaign ad last year. From AAPD's perspective, it is quite noteworthy—and greatly appreciated-- for a U.S. Senator to feature children's oral health so prominently. Let's take a look.

> [at this point we viewed the 30 second ad *My Friend Ben*, which is available on YouTube at:
> http://www.youtube.com/watch?v=chYN8fC-RCk]

Lastly, when Ben is not personally available to talk with us, he directs his Policy Director, Priscilla Ross to handle that duty. Heber has told you about how wonderful it is to work with her and I want to publicly second that. Ben, thank you for making such an able and enthusiastic executive staff member available to give us advice on not only the status of legislation, but also introductions to other Senate offices.

**Senator Cardin, on behalf of AAPD Dr. Joel Berg and the entire Academy membership, it is my pleasure to present you with the AAPD PAC Legislator of the Year Award for 2013.**

### Hosting a Fund Raiser

The AAPD PAC will continue to focus on making contributions to key supporters earlier in the campaign cycle, and also assisting our members in setting up local fund-raisers in their homes or offices. This allows for an excellent opportunity to further educate politicians concerning pediatric oral health care.

### Raising Money for the AAPD PAC

The Steering Committee district representatives make PAC contribution appeals at various state and district meetings throughout the year. The AAPD has a PAC table top display and a standardized power point presentation to help promote the AAPD PAC to

our members around the country. *PDT* (Pediatric Dentistry Today) magazine includes regular "PAC Corner" articles citing numerous benefits and importance of member PAC contributions, and the ongoing PAC Steering Committee's goal to increase membership contributions to 50% of our eligible members.

As in previous years, the six district representatives on the PAC Steering Committee will be communicating this coming June, by letter, to the members in their respective districts in advance of the AAPD annual dues billing notices. These letters will call attention to the need to increase our fund-raising efforts in order to continue to have appropriate funds to support deserving congressional members and candidates. Thanks to your generous past support, as of March 2013 we already have on hand approximately $240,000 in "hard" dollars to donate to candidates in the 2014 election cycle. We also have approximately $326,000 in "soft" dollars, which goes toward PAC administrative expenses as well as related advocacy activities such as lodging for Public Policy Advocacy Conference attendees, travel and lodging for the state Public Policy Advocates orientation program, grass roots software, and travel to attend political fund-raisers.

**Hard Dollars vs Soft Dollars**

In the jargon of Political Action Committees, "hard" money donations are those that can be used to support candidates. These donations come from contributors' personal funds. "Soft" money is a donation from a corporate source. In the AAPD, that would be a check written on your practice account. Soft money, as noted above, supports administrative functions of the PAC which would otherwise come from the AAPD operating budget (supported by your dues). The PAC Steering Committee would like to increase the ratio of hard money to soft money donations to our PAC, and we encourage AAPD members to donate to the AAPD PAC from their personal funds.

**Concluding Thoughts**

It has been a pleasure to Chair the PAC Steering Committee for the past four years, from 2009 to 2013. As I now reach the end of my two terms, I pass the PAC chair baton to **Dr. Reneida Reyes**, who has served the past six years as District I representative to the PAC**. I ask the membership to give her the same wonderful support that they gave to me over the years.** I will continue to be active in the PAC by serving on its advisory board. I sincerely appreciate the excellent support of the Committee members, the Board of Trustees, and the Headquarters staff, particularly Scott Litch and Margaret Bjerklie who have been invaluable to me throughout the year. Our success in advocacy would not be possible without the dedicated efforts of Congressional Liaison Heber Simmons Jr., Child Advocate Jim Crall, and Mike Gilliland of Hogan Lovells in Washington, D.C. I would be remiss if I did not thank John Rutkauskas our Chief Executive Officer (and PAC Treasurer) for his ever present guidance. I am confident that the AAPD PAC will continue to make a difference in Washington, D.C. on behalf of the children of the United States.

# 2012-13 Report of the American Board of Pediatric Dentistry to American Academy of Pediatric Dentistry Members

**2012-2013 ABPD Board of Directors**

Jenny Ison Stigers, President
**Dennis J. McTigue**, Immediate Past President
Jeffrey A. Dean, Executive Director
Arthur J. Nowak, Executive Director Emeritus

*Directors:*
Joseph C. Creech, Jr.
J. C. Shirley
Cynthia L. Hipp
William A. Greenhill

**VISION STATEMENT:**
The Vision of the American Board of Pediatric Dentistry is to achieve excellence in pediatric dentistry through certification of all pediatric dentists.

**MISSION STATEMENT:**
The ABPD certifies pediatric dentists based on standards of excellence that lead to high quality oral health care for infants, children, adolescents, and patients with special health care needs. Certification by the ABPD provides assurance to the public that a pediatric dentist has successfully completed accredited training and a voluntary examination process designed to continually validate the knowledge, skills, and experience requisite to the delivery of quality patient care.

## 2012-13 Diplomate, Candidate, and Applicant Statistics as of March, 2013

| | |
|---|---|
| Active Time-Limited Diplomates | 2,963 |
| Active Unlimited Diplomates | 577 |
| Active Unlimited P-Diplomates | 16 |
| Active Life Diplomates | 191 |
| Total Number of Active **Diplomates** | **3,747** |
| Active Candidates | 914 |
| Active Applicants | 558 |

From the AAPD website, accessed March 2013, there are:

| | |
|---|---|
| Active Pediatric Dentist Members | 5,621 |
| Active Pediatric Dentist Life Members | 444 |
| Total Active **Pediatric Dentist Members** | **6,165** |

Therefore, 60.8% of eligible AAPD members are Diplomates.

## American Board of Pediatric Dentistry, 2012-2013

### Examinations Update

Each year, in order to produce valid and relevant certification/recertification processes, ABPD consults experts within and beyond our specialty, confers with other dental and medical specialty boards, surveys stakeholders, and revises our examinations. Fifty diplomates currently serve as members of our examination subcommittees, developing test questions, clinical vignettes, and continuous quality improvement modules used in our examination and recertification processes. They are invited to attend a workshop on examination development and to participate in the administration of the Oral Clinical Examination. Serving on the ABPD examination subcommittees for 2013 are:

Homa Amini
Kyoko Awamura
Charles Bookwalter
Mark Boone
Mary Burke
Richard Burke, Jr.
Richard Chaet
Wendy Cheney
Richard Cohen
Yasmi Crystal
Larry Dormois
Joanna Douglass
Shahrbanoo Fadavi
Timothy Fagan
John Gawlik
Andrea Gonzalez
Marcio Guelmann
Jennifer Hill
Craig Hollander
Catherine Hong
Donald Huebener
E. LaRee Johnson
Martha Ann Keels
Carolyn Kerins
Reena Kuba
Rochelle Lindemeyer
Jeffrey Mabry
Tad Mabry
Alton McWhorter
Linda Nelson
Man Wai Ng
Gregory Olson
Dorothy Pang
Harold Pincus
Nancy Rajchel
Steven Rayes
Priya Ritwik
N. Sue Seale
Maria Simon
Thomas Stark
David Sullivan
Leslie Tanimura
Anupama Tate
Sarat Thikkurissy
Janice Townsend
Kaaren Vargas
Kavitha Viswanathan
Martha Wells
Anne Wilson
Leila Younger

The Qualifying Examination (**QE**), the first of two examinations required for ABPD certification, is based on the educational standards for pediatric dentistry residency programs. The 2012 QE was administered to 486 individuals and had a pass rate of 85 percent with a reliability of 0.85. As of this writing, 522 individuals (441 residents and 81 board candidates) have registered for the 2013 QE. The ABPD is working to provide more meaningful feedback on examination performance to both successful and unsuccessful candidates, as well as to their residency programs.

The Oral Clinical Examination (**OCE**) was administered in October, 2012 to 495 candidates. The pass rate was 86 percent, with a reliability score of 0.93. Nearly 100 diplomates from 35 states, as well as Canada and Ireland, participated in the administration of this examination. These volunteer examiners come from private practice and academia, as well as hospital, military, and public health practice settings. Orientation and calibration sessions are required of all examiners prior to test administration.

## American Board of Pediatric Dentistry, 2012-2013

### Renewal of Certification Process (ROC-P)

In 2012, a total of 2,958 diplomates (98.6 percent of diplomates with time-limited certificates) completed the ROC-P by the December 31st deadline. Due to various constraints around the holidays and because of increasing numbers of requests for verification of board status by other agencies (eg, hospital credentialing staffs) before the end of the year, the Board has changed the annual deadline for completion of all ROC-P requirements to **November 30th**. Although this date is a month earlier than the previous two years, we are convinced the adjusted timeline will allow us to better support diplomates as they negotiate the renewal process and renew hospital privileges. Diplomates are encouraged to complete their continuous quality improvement modules and register their CE hours at their earliest convenience. Renewal for 2014 will begin on October 1.

### Finances

We are pleased to report our financial status remains stable. A healthy number of applicants and candidates continue to challenge the certification process, and nearly all diplomates continue to renew their certification each year. Although the expansion of our Renewal of Certification Process required a slight increase in annual renewal fees a few years ago, fees for the QE, board candidacy, and the OCE have remained the same for many years. ABPD examination fees are comparable to our sister specialty boards, both in dentistry and in medicine.

### ABPD Headquarters

We have completed our first year with an offsite executive leadership model. A review of the new model's effectiveness and impact, as well as Board and staff satisfaction with the change, was overwhelmingly positive. In addition to continued efficiency of and satisfaction with headquarters' operations, we have realized some cost savings. Of course, there is always room for improvement, and the Board and staff continue to work towards enhancements.

### Technology Update

Because of our increasing reliance on technology services, the ABPD completed a comprehensive technology enhancement last year, including major items such as communications (new phone system, videoconferencing capabilities, etc), new server and backup, both hardware and software upgrades and coordination, and digitized file storage. Improving the experience and efficiency for candidates, diplomates, and other affiliates of the ABPD continues to be an important goal.

### AAPD

ABPD is thankful to have such a strong relationship with AAPD, our sponsoring organization, We were delighted to host President-Elect Warren Brill at our ad interim meeting in December and look forward to having his successor, Dr. Ed Moody, attend a meeting in the coming year. We also are pleased that AAPD Immediate Past President Rhea Haugseth and several trustees were able to serve as examiners for the 2012 OCE.

## American Board of Pediatric Dentistry, 2012-2013

ABPD appreciates the opportunity to continue to participate in the meetings of the Board of Trustees of AAPD. We thank President Berg for graciously including a representative of ABPD on the Task Force on Talent Pool Development and the Task Force on Global Oral Health. We also are pleased with the invitation extended to our executive director and our incoming director to take part in the AAPD orientation program in June. These activities not only enrich personal relationships with each other, but will strengthen our knowledge of each other's commitment and operations to further enhance collaborative efforts.

AAPD staff continues to be responsive to and supportive of ABPD's requests. This past year, we were provided opportunities to include information in AAPD's blast e-mails to the membership and *Pediatric Dentistry Today*. We appreciate the continued support of AAPD staff in assisting us in preparations for ABPD functions at the AAPD Annual Session, and especially for help with Dr. Nowak's retirement celebration in San Diego.

And, if I might end on a personal note, I will be forever grateful to the membership of AAPD for the honor and privilege to serve as a director and president of ABPD. The rewards of this experience are beyond words.

Respectfully Submitted,

Jenny Ison Stigers
President, American Board of Pediatric Dentistry

# 2012-13 Report of the American Academy of Pediatrics Section on Oral Health to American Academy of Pediatric Dentistry Members

## Update on Risk Assessment Validation

Martha Ann Keels, DDS, PhD, Immediate Past Chairperson, and other collaborators have received funding from the President's Award (Marguerita Fontana) and the National Institute of Health. The main objective is to identify those risk factors that predict the presence of caries or no caries. This project will continue over the next 5 years. AAP, AAPD, and other key stakeholders are in the process of discussing a potential collaboration on risk assessment in primary care and dental settings.

## New SOOH Structure

At the Spring meeting the group voted to move forward with a request to the Board to change the structure of the SOOH Executive Committee from a 6 person to a 7 person Committee, with 3 pediatric dentists, 3 pediatricians, and 1 chairperson whom can be either a pediatrician or a dentist. The group reaffirmed this desire and discussed procedures for the election in 2013. If the new structure is approved, the Section will need to elect 2 pediatricians and 1 pediatric dentist to the EC in the Spring. If the new structure is not approved, the Section will need to elect 2 pediatricians.

## Increased Dues Sharing for SOOH

Currently, the SOOH receives only $50.00 of the $323.00 that is charged to pediatric dentist members. The EC would like to request that a larger share of these dues be returned to the SOOH for programming and other operating costs.

## Friends of Children Donations

David Krol, MD, FAAP, EC Member, asked how to earmark funds donated to the AAP Friends of Children Fund to the Section. On the form that is submitted with the donation the member can write "Donate to Section on Oral Health" and it will be credited to the Section. The same can be done by a company on a matching form.

## Oral Health Webinar

The Health Resources and Services Administration, the American Dental Association, and the American College of Obstetricians and Gynecologists, have recently published a consensus statement on oral health during pregnancy. Through the AAP Strategic Partnerships to Advance Maternal and Child Health grant, the Section has the opportunity to host another Webinar on oral health. The group agreed that a Webinar on Oral Health during pregnancy would be a good topic to use for this event. Potential speakers include Renee Samelson, MD, FACOG, and Jay Kumar, DDS. The Webinar could be produced in collaboration with Georgetown University, who hosted the expert

meeting to develop the consensus statement, and the National Interprofessional Initiative on Oral Health.

### Healthychildren.org Review

The section will be to reviewing the topics listed on the website and will identify gaps in the information and ensure consistent messaging.

### Strategic Planning

Ken Slaw, PhD, Director, Department of Membership and Customer Service has led the group through the second phase of strategic planning.

### CATCH Grants

Charles Czerepak, DDS, Community Access to Child Health (CATCH) Liaison, gave a report on the CATCH program. The CATCH program is seeing a reduction in funding sources and is actively seeking new funding streams. In 2012, eight oral health grants were submitted. Approximately 4 resident grants and 4 full grants for practicing pediatricians.

### Policy Statements

David Krol, MD, and the section have reviewed several Chapters of the Pediatric Textbook Online and the ADA Evidence Based Dentistry Guideline on the Use of Topical Fluoride Agents for Caries Prevention.

The clinical report on Oral Health and Children with Disabilities has been finalized and submitted to Pediatrics for publication. Drs. Clark and Slayton are close to completing the clinical report on Fluoride Use in Pediatrics. The next step will be to send it out for internal and external review.

Policies still in progress are the Dental Trauma Clinical Report, authored by Dr Keels and the revisions to the Preventive Oral health in Pediatrics Statement, authored by Dr Krol.

### Nominations

There will be 2 vacancies on the Section EC to fill during the 2013 election. Although one dentist and one pediatrician will be transitioning off the group, 2 pediatricians will need to be elected to keep the balance of the group. Dr Keels will be the nominations committee chairperson and Drs Czerepak and Marquez will serve on the committee. The group will seek nominations for the Spring election.

### Chapter Oral Health Advocates (COHAS)

Melinda Clark, MD, COHA Chairperson, reported on the activities of the COHAS. She noted that the COHA Advisory Group is completing their 1 year transition period. The COHAs continue to be active and are finishing up their Dental Trade Alliance grants for 2012.

## AAP Section on Oral Health, 2012-2013

### Education Report

*National Conference and Exhibition*

Individual presentations at the 2012 NCE included, "Addressing Controversial Dental Questions in the Pediatrician's Office," presented by Rocio Quinonez, DMD, MPH, MS; "Addressing Oral Health Disparities Through the Medical Home," presented by Rani Gereige, MD, FAAP; and "What the Skin and Teeth Can Tell You About Genetic Disorders," presented by Barbara Sheller, MD and Virginia Sybert, DDS. The Section also hosted an H Program entitled the Pediatrician's Oral Health Toolbox and has received partial funding for the Section awards luncheon from DR Products, LLC.

The Section submitted 4 proposals for the general session and one Section program for the 2013 NCE. "When Your Patient is Hospitalized with Dental Issues" and "Oral Health 101 for Pediatricians" were accepted, and "Using the AAP/Bright Futures Oral Health Risk Assessment Tool and How to Apply Fluoride Varnish" and "Identifying the Head and Dental Signs of Abuse in Children" were rejected. The Section plans to also conduct its H program, "What's Next for Oral Health in Primary Care" and solicit abstracts for a poster session.

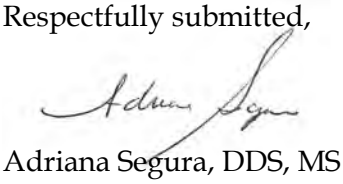
*EQIPP*

The Oral Health in Primary Care EQIPP module is complete and undergoing HRSA/HHS/CDC/NIH clearance. It is anticipated that it will be available in early 2013. 50 free subscriptions will be available. The group suggested having a raffle for the EQIPP subscriptions with a member being entered in to the raffle when they refer a friend to the Section or to offer the subscriptions to Chapter Presidents and then have them promote the availability of the module to their membership.

### 2012 Oral Health Service Award

Charles Czerepak, DDS, was awarded the 2012 AAP Oral Health Service Award for his work on the Community Access to Child Health Grants and other children's oral health related efforts.

Respectfully submitted,



Adriana Segura, DDS, MS
Chair, AAP Section on Oral Health

# 2012-2013 Report of the Pediatric Dentistry Review Committee (PRC), Commission on Dental Accreditation (CODA)

**Kevin J. Donly, Chair**
Sherin Tooks, Commission Staff

*Members*
Brenda Bohaty
Richard Udin
Rosie Roldan
Jeffrey Hochstein
Renee DeVries

The January, 2013 Pediatric Dentistry Review Committee (PRC) was composed of Drs. Kevin Donly (Chair), Brenda Bohaty, Rosie Roldan, and Richard Udin as pediatric dentistry members and Dr. Jeffrey Hochstein, as the non-specialist member and Dr. Renee DeVries as the member-at-large. The PRC is assisted by Ms. Sherin Tooks of CODA staff. As Chair, I would like to recognize the time, effort and expertise of all members of the PRC, as well as Janice Jackson and Amr Moursi who ended their service over this past year. Ms. Sherin Tooks has been promoted to Director of CODA. She has been a fabulous asset to Pediatric Dentistry as our Advanced Specialty manager. Ms. Catherine Baumann will now be the Pediatric Dentistry Advanced Specialty manager.

The PRC thoroughly discussed the comments submitted about the proposed modifications in standards during the January, 2013 meeting and reviewed new consultants. Please remember, the new standards will be implemented in July, 2013.

Topics of interest for pediatric dentistry are:

1. Accreditation of dental schools/programs outside of the United States,
2. Alternative site visit models for program accreditation,
3. Accreditation standards for mid-level providers, including potential accrediting agencies.

# 2012-2013 Report from the Academy for Sports Dentistry

First, ASD would like to thank AAPD for helping promote our last annual meeting focused on "Women in Sports" in its various publications. We would gratefully request your help in notifying AAPD members of future ASD meetings relevant to pediatric dentists.

ASD would again re-iterate its stance regarding mouthguards and concussions. Current thinking is mouthguards can greatly reduce dental injuries but there is no scientific evidence to support claims mouthguards reduce concussions. Recently, the FTC successfully reached a settlement with Brain-Pad prohibiting them "from misrepresenting the health benefits of any mouthguard or other athletic equipment designed to protect the brain from injury."

ASD partnered with AAPD, AAOMS and AAO to successfully promote Facial Protection Month in April 2012. Hopefully, this collaboration can continue for this and other ventures in the future.

Our next annual symposium, August 1-3, 2013 in Philadelphia, PA has some interesting topics for pediatric dentists. From "Team Dentist Certification", to custom mouthguard fabrication, "Restoring the Pieces After a Sports Accident, to a discussion on concussions, the meeting has much to offer members of AAPD.

Again, we look forward to working with AAPD on any future projects where we can be of assistance to your members.

Respectfully submitted

Andrew Spadinger, DDS