* ATP 4-02.19

DENTAL SERVICES

AUGUST 2020

* This publication supersedes chapter 5 of ATP 4-02.5, dated 10 May 2013, and chapter 5 of ATP 4-02.8, dated 9 March 2016.

Headquarters, Department of the Army

* ATP 4-02.19

Army Techniques Publication
No. 4-02.19

Headquarters
Department of the Army
Washington, DC, 14 August 2020

Dental Services

Contents

*This publication supersedes chapter 5 of ATP 4-02.5, dated 10 May 2013, and chapter 5 of ATP 4-02.8, dated 9 March 2016.

Figures

Tables

Preface

Army Techniques Publication (ATP) 4-02.19 provides discussion about the dental services function and the tactics, techniques, and procedures to plan and employ a dental company (area support) (DCAS) within an area of operation.

The principal audience for ATP 4-02.19 is commanders, staffs, command surgeons, Army Health System planners, and Army Medicine personnel and units.

Commanders, staffs, and subordinates ensure that their decisions and actions comply with applicable United States, international, and in some cases host-nation laws and regulations. Commanders at all levels ensure that their Soldiers operate in accordance with the law of war and the rules of engagement. (See FM 6-27/MCTP 11-10C.)

Due to the nature of the medical profession, which is highly regulated throughout both the civilian and military communities, Army medicine doctrine is influenced by—

- United States and international law.
- Policy guidance in the form of Army Regulations and Department of Defense policy promulgated in the form of directives and instructions and other documents.
- Medical standards established by civilian organizations (such as the Joint Commission).
- Technical guidance from both military and civilian organizations charged with medical/scientific oversight responsibilities.

Throughout this publication, as appropriate, reference is made to the major policy guidance influencing the specific topic. These references should not be considered as the only policy guidance available. When issues arise that require consideration of policy guidance, the issue should be thoroughly researched and, as appropriate, coordinated with the supporting staff judge advocate or governmental/nongovernmental agency involved.

The proponent and preparing agency of ATP 4-02.19 is the United States Army Medical Center of Excellence. Send comments and recommendations on Department of Army (DA) Form 2028 *(Recommended Changes to Publications and Blank Forms)* to **Commander, United States Army Medical Center of Excellence, ATTN: MCCS-FD (ATP 4-02.19), 2377 Greeley Road, Suite D, JBSA Fort Sam Houston, TX 78234-7731**; by e-mail to usarmy.jbsa.medical-coe.mbx.ameddcs-medical-doctrine@mail.mil or submit an electronic DA Form 2028. A rational for each proposed change is required to aid in the evaluation and adjudication of each comment.

This publication uses joint terms where applicable. Terms for which this publication is the proponent publication are marked with an asterisk (*) in the glossary.

This publication applies to the Regular Army, the Army National Guard, the United States Army Reserve, Army Civilian Corps, and Army contracted medical providers, unless otherwise stated.

This publication implements or is in consonance with the following North Atlantic Treaty Organization (NATO) Standardization Agreements (STANAGs).

TITLE	NATO STANAG
Requirement for Training in Casualty Care and Basic Hygiene for All Military Personnel, Edition 4 (Edition A Version 1) – AmedP-8.15	2122
Medical and Dental Supply Procedures (Edition A Version 1) – AmedP-1.12	2128
The Extent of Dental and Maxillo-Facial Treatment at Roles 1-3 Medical Support (Edition A Version 1) – AmedP-8.13	2453
Dental Fitness Standards for Military Personnel and the NATO Dental Fitness Classification System, Edition 3 (Edition A Version 2) AMedP-4.4	2466
Allied Joint Civil-Military Medical Interface Doctrine (Edition 2) AJMedP-6	2563
The Civil-Military Planning Process on Oral Health Care and Deployment of Dental Capabilities in All Operations with a Humanitarian Component, Edition 1 (Edition A Version 2) AMedP-6.1	2584
Allied Joint Medical Doctrine for Military Health Care (MHC), Edition 2 (Edition A Version 1) AJMedP-8	2598
Orders for the Camouflage of the Red Cross and the Red Crescent on Land in Tactical Operations, Edition 4 (Edition B Version 1) ATP-79	2931

Introduction

The content of this publication remains generally consistent on key topics while adopting updated terminology and concepts as necessary. Although the primary focus of this publication is the dental services provided in theater, it is important to understand that the emphasis on a Soldier's oral health begins at the time that they enter the Army and continues throughout their service commitment.

The material presented in this publication reflects enduring practices in providing timely dental services to the tactical commander. This publication depicts the employment of dental services from the close area through the strategic support area of operations.

ATP 4-02.19 contains five chapters and four appendixes.

Chapter 1 provides an overview of the dental services to include an introduction of the Army dental readiness program, levels of dental care, categories of dental care, dental classification, additional wartime roles, and dental care eligibility determination.

Chapter 2 provides an overview of the dental staff positions and responsibilities of officers and noncommissioned officers, the medical command (deployment support), and the medical brigade (support).

Chapter 3 discusses the organization and employment of dental capabilities from the close area through the strategic support area of operations.

Chapter 4 discusses the basic principles of dental operations.

Chapter 5 describes dental service support to unique missions to include stability tasks, Army special operations forces, detainee operations, and chemical, biological, radiological and nuclear operations.

Appendix A provides an overview on the dental readiness program.

Appendix B provides basic details on the different dental equipment sets that are used for providing dental services for operational organizations.

Appendix C provides an overview and importance of having a thorough quality assurance plan.

Appendix D provides an example of a clinical standard operating procedure.

The Medical Center of Excellence Doctrine Literature Division is reorganizing the placement of terms and definitions found in proponent publications within the Medical Center of Excellence doctrine publication library. Based on doctrinal changes, the terms identified in Introductory Table-1 will remain the same except that the proponent publication of the term will change. The glossary contains acronyms and terms.

Introductory Table-1. Army terms

Term	*Remark*
comprehensive dental care	ATP 4-02.19 is now the proponent
dental care	ATP 4-02.19 is now the proponent and modifies term definition
emergency dental care	ATP 4-02.19 is now the proponent
essential dental care	ATP 4-02.19 is now the proponent
operational dental care	ATP 4-02.19 is now the proponent

This page intentionally left blank.

Chapter 1
Dental Services Overview

Soldiers are the centerpiece of the United States (U.S.) Army; they are the basic guarantor of mission success. As such, their health and physical fitness are vitally important. Equally important is the Soldier's oral health. If oral health is not properly maintained, it can result in the Soldier becoming nondeployable and if already deployed, can render them non-mission-capable.

DENTAL SERVICES AS A MEDICAL FUNCTION

1-1. The mission of the dental services is to promote dental health; prevent and treat oral and dental disease; provide far forward dental treatment; and provide early treatment of severe oral and maxillofacial injuries.

1-2. As a medical function of the Army Health System (AHS), dental services plays a significant role in force health protection, also known as FHP, which is part of the protection warfighting function. For more information on force health protection and the other medical functions, see Field Manual (FM) 4-02. Dental services must be included in the early stages of planning and include the treatment, restoration, and maintenance of oral health. *Army Health System (AHS)* is a component of the Military Health System that is responsible for operational management of the health service support and force health protection missions for training, predeployment, deployment, and postdeployment operations. Army Health System includes all mission support services performed, provided, or arranged by the Army Medicine to support health service support and force health protection mission requirements for the Army and as directed, for joint, intergovernmental agencies, coalition, and multinational forces. (FM 4-02). *Health service support* is support and services performed, provided, and arranged by the Army Medicine to promote, improve, conserve, or restore the behavioral and physical well-being of personnel by providing direct patient care that include medical treatment (organic and area support) and hospitalization, medical evacuation to include medical regulating, and medical logistics to include blood management. (FM 4-02). *Force health protection* are measures that promote, improve, or conserve the behavioral and physical well-being of Soldiers comprised of preventive and treatment aspects of medical functions that include: combat and operational stress control, dental services, veterinary services, preventive medicine, and laboratory services. Enabling a healthy and fit force, prevent injury and illness, and protect the force from health hazards. (FM 4-02).

IMPORTANCE OF ARMY DENTISTRY

1-3. Review of past U.S. military deployments has shown that the longer a deployment lasts the more likely a Soldier is to experience a dental emergency. The same review also indicates that in the deployed setting there are fewer opportunities and resources available to enhance, maintain, and improve a Soldier's dental health. It is for these reasons that dental service assets are organic to maneuver units of the Army.

IMPACT OF DENTAL EMERGENCIES ON UNIT READINESS

1-4. Historically, 20 to 25 percent of all deployed Soldiers have experienced a dental emergency during a one-year deployment. The significance of this is the potential impact on a unit's ability to execute its mission. The following examples are provided:

- During World War II, specifically 1943, the greatest numbers of Soldier complaints were about the lack of adequate dental support.
- During the Korean War, 133,720 dental visits resulted in 493,441 dental procedures being performed. This is an average of four procedures per dental visit.

- During the Vietnam War, dental emergencies for deployed United States Navy and United States Marine Corps personnel averaged 200 dental emergencies per one thousand Sailors and Marines deployed per year.
- During deployment processing for Operation Desert Shield over 150,000 Army National Guard and Reserve Component Soldiers were processed through dental treatment facilities in the continental U.S. Over 40,500 of these Soldiers required panographic x-rays and 33,000 required dental treatments to be classified as deployable. The result was a severely stressed mobilization system that degraded its ability to process Soldiers for deployment.
- Mobilization and deployment dental processing during Operation Desert Shield and Operation Desert Storm was provided to 243,829 Department of Defense (DOD) personnel between 2 August 1990 and the end of the war. Five reserve dental units and a number of individual mobilization augmentees were activated to help with the massive dental workload brought on by reserve force mobilization. This period also saw the stateside dental capability depleted by deployment of Regular Army dental personnel.
- A review of the 12th Evacuation Hospital patient treatment records during Operation Desert Shield and Operation Desert Storm indicated that approximately 14 percent of Soldiers reporting for sick call were seen for dental emergencies. Once a detailed analysis of the information was completed the percentage of dental emergencies was actually found to be higher than 14 percent.
- During the period of FY16-18, Central Command reported 14,000 patients were treated for dental emergencies with 37,000 procedures accomplished at a cost of $2 million.

1-5. The examples in paragraph 1-4 provide us with valuable insight regarding the number of Soldiers that may require dental treatment during a lengthy deployment. They also illustrate that when dental care is not readily available and Soldiers are evacuated for treatment of dental emergencies, those Soldiers may be separated from their units for extended periods. See United States Army Dental Corps history website for additional information on Army dentistry from the Revolutionary War to present.

1-6. Based on the information provided above, good oral health is a force multiplier. Ready access to dental care can contribute significantly to unit readiness and morale.

1-7. Lessons learned from previous mobilizations indicate that—

- Little time is available for treatment of dental emergencies during mobilization and deployment operations.
- High levels of dental readiness and dental preparedness reduce mobilization dental processing and treatment time.
- Three to five days is the average length of time a Soldier is lost to their unit when they are evacuated for dental emergencies.

ORAL HEALTH THREATS

1-8. Threats to a Soldier's oral health consist of facial injuries and a variety of oral conditions. Examples of oral conditions include dental caries, endodontic complications, ulcerative gingivitis, acute pericoronitis, and periodontal abscesses, all of which are exacerbated during periods of fatigue, nutritional deficiencies, poor oral hygiene, and physical and psychological stress. Milder gingival and periodontal disease may also increase in incidence and severity. Oral and maxillofacial injuries may result from both battle injury and nonbattle injury in operational settings.

1-9. Oral and maxillofacial infections can lead to severe, life-threatening conditions if not properly managed.

This section implements STANAG 2466

DENTAL READINESS CLASSIFICATION

1-10. The Army will be ready to deploy, fight, and win decisively against any adversary, anytime, and anywhere, in a joint, large scale combat operation, high-intensity conflict while simultaneously deterring

others and maintaining its ability to conduct irregular warfare. Individual Soldier readiness directly affects unit readiness and the ability to meet combatant commander requirements. Dental disease is one of the most common causes of disease and nonbattle injury, and Soldiers with uncorrected, severe dental deficiencies have a more likely chance of experiencing a dental emergency within one year. Although the Army has experienced a considerable reduction in the number of nondeployable Soldiers since June 2016, this may increase with the change in the deployability status of class 3 and class 4 patients (see paragraph 1-12 for further discussion on this policy).

1-11. Army Directive 2019-07 (Army Dental Readiness and Deployability) and Department of Defense Instruction (DODI) 1332.45 have made changes to the dental readiness policy to enhance the readiness of all units. These changes are in concert with the Secretary of Defense's Administrative and Personnel Policies Working Group to Enhance Readiness and Lethality.

1-12. Soldiers are deployable unless they have a Service-determined reason that prevents them from deployment in accordance with DODI 1332.45. To be deployable, Soldiers must meet the criteria established in Army Directive 2018-22 (Retention Policy for Nondeployable Soldiers).

1-13. A dental readiness classification are assigned to every Soldier based on the results of a thorough dental examination. The classification is a dentist's best judgment of the state of a Soldier's oral health and are used to determine the likelihood that a patient will experience a dental emergency during a deployment. For a detailed discussion regarding dental classification criteria refer to Army Regulation (AR) 40-3. See AR 220-1 for additional information on the impact of dental categories on unit readiness.

CLASS 1 (ORAL HEALTH)

1-14. Class 1 are patients with a current dental examination, who do not require dental treatment or reevaluation. Class 1 patients are worldwide deployable.

CLASS 2 (ORAL HEALTH)

1-15. Class 2 are patients with a current dental examination, who require nonurgent dental treatment or reevaluation for oral conditions which are unlikely to result in dental emergencies within 12 months. Class 2 patients are worldwide deployable.

1-16. Patients in class 2 may exhibit the following:

- Treatment or follow-up indicated for dental caries or minor defective restorations that can be maintained by the patient. Dental caries, also known as tooth decay or cavities, is a breakdown of teeth due to acids made by bacteria.
- Interim restorations or prostheses that can be maintained for a 12-month period. This includes teeth that have been restored with permanent restorative materials for which protective cuspal coverage is indicated.
- Edentulous areas requiring prostheses but not on an immediate basis.
- Periodontium that requires oral prophylaxis.
- Periodontium that requires maintenance therapy.
- Treatment for slight-to-moderate periodontitis and stable cases of more advanced periodontitis.
- Removal of supragingival or mild-to-moderate subgingival calculus.
- Unerupted, partially erupted, or malposed teeth that are without historical, clinical, or radiographic signs or symptoms of pathosis, but which are recommended for prophylactic removal.
- Active orthodontic treatment. The provider should consider placing the patient in passive appliances for deployments up to six months. For longer periods of deployment, the provider should consider removing active appliances and placing the patient in passive retention.
- Temporomandibular disorder in remission. The provider anticipates the patient can perform duties while deployed without ongoing care and any medications or appliances required for maintenance will not interfere with duties.

CLASS 3 (ORAL HEALTH)

1-17. Class 3 are patients that require urgent or emergent dental treatment. Service members designated as Class 3 have a more likely chance of experiencing a dental emergency within one year.

1-18. Patients in Class 3 may require the following—

- Treatment or follow-up indicated for dental caries, symptomatic tooth fracture, or defective restorations that cannot be maintained by the patient.
- Interim restorations or prostheses that cannot be maintained for a 12-month period.
- Patients requiring treatment for the following periodontal conditions that may result in dental emergencies within the next 12 months:
  - Acute gingivitis or pericoronitis.
  - Active progressive, moderate, or advanced periodontitis.
  - Periodontal abscess.
  - Progressive mucogingival condition.
  - Periodontal manifestations of systemic disease or hormonal disturbances.
  - Heavy subgingival calculus.
- Edentulous areas or teeth requiring immediate prosthodontic treatment for adequate mastication or communication or acceptable esthetics.
- Unerupted, partially erupted, or malposed teeth with historical, clinical, or radiographic signs or symptoms of pathosis that are recommended for removal.
- Chronic oral infections or other pathologic lesions including:
  - Pulpal, periapical, or resorptive pathology requiring treatment.
  - Lesions requiring biopsy or awaiting biopsy report.
  - Emergency situations requiring therapy to relieve pain, treat trauma, treat acute oral infections, or to provide timely follow-up care (for example, drain or suture removal) until resolved.
  - Acute temporomandibular disorders requiring active treatment that may interfere with duties.
- Teeth that have had root canal therapy initiated, and temporarily restored with calcium hydroxide paste and a restoration.

1-19. Soldiers with a Class 3 classification are in medical readiness classification three category as deployment-limiting code two and will be considered deployable. Until the medical readiness system can be updated to automatically show these Soldiers as not medically ready and deployable, commanders will routinely make Class 3 Soldiers deployable in the commander's portal of the Medical Operational Data System. Commanders retain the ability to determine the Soldier is unable to deploy based on the dental treatment required. Commanders will ensure that Soldiers receive all appropriate dental care to correct deficiencies to their individual medical readiness.

1-20. Dental conditions that cannot be corrected within 30 days will be profiled and categorized as medical readiness classification three, deployment-limiting code one similar to other duty limiting medical conditions requiring a recovery period of 30 days or more. Commanders will minimize administrative delays and barriers to care to optimize readiness for resolution upon identification.

CLASS 4 (ORAL HEALTH)

1-21. Class 4 are patients who require dental examinations. This includes patients who require annual or other required dental examinations and patients whose dental classifications are unknown.

1-22. Soldiers who are class 4 remain deployable, however their command should make every effort to get them a dental examination prior to deployment.

ORAL HYGIENE AND PREVENTIVE DENTISTRY

1-23. Preventive dentistry, for example professional dental cleanings, is an extremely important component of the dental program. See AR 40-35 for additional information on Army Preventive Dentistry

1-24. The results of good preventive dental care practices are healthy teeth and gums and the absence of oral disease. Soldiers who incorporate good preventive dental hygiene practices prior to deployment are far less likely to become dental casualties secondary to disease.

1-25. Preventive dentistry incorporates primary, secondary, and tertiary preventive measures taken to reduce or eliminate conditions that may decrease a Soldier's fitness to perform their mission and which could result in the Soldier being removed from their unit for treatment.

1-26. Individual preventive dental care practices include—

- Eating a balanced diet.
- Brushing and flossing of the teeth and gums on a regular basis.
- Abstaining from using tobacco products.

1-27. These measures can effectively prevent the development of tooth decay and oral disease. The application of fluoride and sealants combined with regular dental checkups and oral screenings can prevent tooth decay and identify oral disease at its most treatable stages.

1-28. Due to the potential impact that dental emergencies can have on unit readiness, preventive dentistry programs must be actively supported by leaders. AR 600-63 provides additional resources and supports the need for leadership endorsement of tobacco cessation efforts. Referrals to tobacco reduction or cessation programs will be encouraged. See ATP 6-22.5 for additional information on Soldier health and fitness.

CATEGORIES OF DENTAL CARE

1-29. ***Dental care*** **is the preventive, restorative, and surgical treatment of the hard and soft oral tissues, which is comprised of operational dental care and comprehensive dental care.** Dental service planning must include the consideration of two categories of dental services in joint and multinational operations. Operational dental care is provided within the area of operations (AO), and comprehensive dental care is provided in the support base, normally found only in fixed facilities, out of theater such as in the joint security area or the strategic support area.

1-30. The planning process includes an evaluation of the size and anticipated duration of the operation, along with categories of dental care required to support the operation.

1-31. These categories are not absolute in their limits; they are the general basis for defining the dental service capabilities available at the different AHS roles of medical care.

OPERATIONAL DENTAL CARE

1-32. ***Operational dental care*** **is the dental care provided for deployed Soldiers in theater consisting of emergency dental care and essential dental care.**

Emergency Dental Care

1-33. ***Emergency dental care*** **is the care given for the relief of oral pain; diagnosis and treatment of infections; control of life-threatening oral conditions (hemorrhage, cellulitis, or respiratory difficulties); and treatment of trauma to teeth, jaws (maxilla/mandible), and associated facial structures is considered emergency care.** It is the most austere form of dental care provided to deployed Soldiers who are engaged in tactical operations.

1-34. Common examples of emergency dental treatments include:

- Airway management.
- Hemorrhage control.
- Stabilization of maxillofacial injuries (fracture stabilization, soft tissue injury/lacerations repair).

- Simple extractions.
- Management of maxillofacial infection (antibiotics, incision, and drainage).
- Interim pulp therapy (pulpectomy).
- Pain medication.
- Temporary restorations.

Essential Dental Care

1-35. ***Essential dental care*** **is the dental care necessary to intercept potential emergencies to prevent lost duty time and preserve fighting strength**. Essential dental care is the highest category of operational dental care available in theater. It enhances the individual Soldier's combat readiness and can prevent lost duty time. It is for these reasons that essential dental care is made readily available. Soldiers who are categorized as Class 2 (untreated oral disease) or Class 3 (potential dental emergencies) should receive essential care as soon as the tactical situation and availability of dental assets permit. *Essential care* is defined as the absolutely necessary initial, en route, resuscitative, and surgical care provided to save, stabilize, and return as many Soldiers to duty as quickly as possible. (FM 4-02).

1-36. Essential treatments performed by dental officers may include:

- Basic restorations.
- Extractions.
- Definitive pulp therapy (pulpectomy, obturation).
- Treatment of periodontal conditions.
- Simple prosthetic repairs.

COMPREHENSIVE DENTAL CARE

1-37. ***Comprehensive dental care*** **is the dental treatment to restore and/or maintain a Soldier's optimal oral health, function, and aesthetics.**

1-38. This category of care is usually reserved for medical support plans that anticipate an extended period of reception and training in theater and is also included as a component of the theater hospitalization capability. The scope of facilities needed to provide this level of dental support should equal that of theater hospitalization medical treatment facility (MTF) capability. *Medical treatment facility* refers to any facility established for the purpose of providing medical treatment. This includes battalion aid stations, Role 2 facilities, dispensaries, clinics, and hospitals. Due to the complexity of the procedures and the length of time generally required to perform them, comprehensive dental care is normally provided only in the strategic support area.

LEVELS OF DENTAL SUPPORT

1-39. There are three levels of dental support, previously known as levels of dental care, within the AO. These levels are defined primarily by the relationship of the dental assets supporting the patient population within each level. These levels of dental support are exclusive and not synonymous with the medical roles of care. Reference FM 4-02 for more discussion on the medical roles of care.

LEVEL 1 DENTAL SUPPORT

1-40. The first dental care a Soldier receives is provided by Level 1 dental support (previously known as unit-level dental care). This level of support consists of those services provided by dental personnel organic to the supporting medical companies and special forces groups (SFGs).

1-41. This level of support provides operational dental care to Soldiers during a range of military operations from dental assets in a direct support relationship to an area support task. Major emphasis is placed on those measures necessary for the patient to return to duty or to stabilize them and allow for their evacuation to the next role of medical care.

LEVEL 2 DENTAL SUPPORT

1-42. Level 2 dental support (previously known as hospital-level dental care) consists of those services provided by the hospital dental staff to minimize loss of life and disability resulting from oral and maxillofacial injuries and wounds. The hospital dental staff provides operational dental care and preventive dental care to all injured or wounded Soldiers, as well as the hospital staff. The hospital dental staff will not normally provide Level 1 dental support to organizations outside of the hospital, however they will direct patients to the Level 3 dental support activity.

1-43. Emphasis is placed on those measures necessary for the patient to return to duty or to stabilize them and allow for their evacuation to the next role of medical care. If needed the hospital dental staff can coordinate with the dental company (area support) (DCAS) for patient consultation and treatment.

LEVEL 3 DENTAL SUPPORT

1-44. Level 3 dental support (previously known as area dental support) is provided for units that do not have organic dental assets or those patients being referred by the Level 2 dental support. This level of support is provided by the DCAS.

1-45. The DCAS provides operational dental care and has dental assets which can deploy, when and where necessary, to provide augmentation and/or reinforcement to the area support squads.

ARMY DENTAL READINESS

1-46. Dental readiness refers to a Soldier's dental health as it relates to their worldwide deployment status. Dental readiness is fundamental to maintaining unit readiness and reducing noncombat dental casualties during deployments. The importance of dental readiness cannot be overstated. Failure to maintain high levels of dental readiness adversely impacts the unit's ability to quickly mobilize and deploy.

1-47. Community oral health protection emphasizes not only oral health, but also general wellness and overall fitness of our Soldiers and all authorized beneficiaries. AR 40-35 provides guidance for the development and conduct of dental readiness and community oral health protection programs for all authorized beneficiaries of the dental care system. It describes the dental readiness program for Regular Army Soldiers and other programs that benefit all members of the Army community.

1-48. In accordance with AR 40-35 unit commanders, the dental care system, and the Soldier share responsibility for the dental readiness. The Dental Readiness Program provides the methods to reduce the risk of Soldiers becoming noncombat dental casualties when such an event would jeopardize mission accomplishment.

1-49. High levels of premobilization dental readiness significantly reduce the number of dental emergencies experienced by deployed Soldiers. See Appendix A for dental readiness program procedures.

This paragraph implements STANAGs 2122 and 2598

ADDITIONAL ROLES

1-50. The training of first-aid and emergency care in combat situations and basic hygiene to all military personnel is essential. The basic ability to stabilize an injured person greatly improves the likelihood of survival and allows time for medical personnel and other professionals to respond. To stop serious bleeding, securing the airway and providing the casualty the ability to breathe are the first steps towards successful resuscitation and stabilization. Additionally, all military personnel need some understanding and training in simple hygiene and force health protection measures to prevent and limit the development and transmission of infectious diseases in a deployed environment. The knowledge and skills necessary to conduct casualty care and basic hygiene are required by all Service Members. These skills should be acquired and reassessed before personnel are deployed abroad. See Training Circular (TC) 4-02.1 for additional information on first aid and TC 4-02.3 for additional information on field sanitation.

1-51. Dental personnel have the additional wartime role of augmenting medical personnel during mass casualty situations and conducting veterinary dental support. Under these circumstances, dental personnel may be called upon to augment and assist the medical staff of these facilities during mass casualty situations. Proper planning and training are essential to successful mass casualty situation support.

MASS CASUALTY SITUATIONS

1-52. Dental personnel may have the additional role of augmenting medical personnel during mass casualty situations. *Mass Casualty* is defined as any number of human casualties produced across a period of time that exceeds available medical support capabilities (JP 4-02). Dental officers and personnel may be called upon to render assistance in the following areas:

- Triage of combat casualties.
- Emergency medical treatment.
- Chemical, biological, radiological, and nuclear (CBRN) casualty management.
- Surgical procedures.
- Forensic dental identification.
- Maxillofacial injury treatment.
- Soft tissue wound management.
- Orthopedic injury treatment.
- Initial burn treatment.
- Intravenous infusion techniques.
- Intubation of surgical patients and patients with compromised airways.
- Infection control and sterile techniques.

1-53. While the focus on additional roles has generally been on the individual provider, collective use of the dental unit or its subordinate elements may also be appropriate when the situation requires a consolidated medical response. Dental services must be included in the planning and rehearsal of mass casualty situations.

1-54. The medical unit should not assume that dental personnel are familiar with all/most of the roles identified in paragraph 1-52. For these situations, the role of the dentist and supporting personnel should be established by the medical unit ahead of time, based on the comfort level and training of the assigned dentist. This role should be included in an established standard operating procedure (SOP) and thoroughly rehearsed with the medical unit. If the dentist is chosen to triage casualties, the medical unit must ensure the dentist rehearses with and understands the surgical team's guidance and priorities.

VETERINARY DENTAL SUPPORT

1-55. An additional role for dental personnel involves providing dental treatment for military working dogs. On those occasions when military working dogs require emergency or essential dental care, Veterinary Corps officers may request the assistance or services of dental assets to treat these animals. Veterinary Corps officers should oversee all military working dogs' dental treatment, as the military working dogs requires general anesthesia for dental procedures. See Technical Bulletin, Medical (TB MED) 298 for dental care of the military working dog.

ELIGIBILITY DETERMINATION FOR DENTAL CARE

1-56. During interagency and multinational operations, common questions are: "who is eligible for care in an Army-established MTF?" and "What is the extent of care authorized?" For a detailed discussion regarding eligibility determination for care refer to FM 4-02.

1-57. Numerous categories of personnel seek care in facilities that are located in austere areas where host-nation civilian medical infrastructure is nonexistent or is not capable of providing adequate care. A determination of eligibility and whether reimbursement for services is required is made at the highest level possible and in conjunction with the supporting staff judge advocate. Additionally, the Department of State and/or military staff sections (such as the Assistant Chief of Staff, Civil Affairs, G-9) may also be involved in the determination process. Each operation is unique and the authorization for care is based on appropriate

U.S. and international laws, Department of Defense Directive (DODD), DODIs, ARs, doctrine, and SOPs. Other factors impacting the determination of eligibility are command guidance, practical humanitarian and medical ethics considerations, availability of AHS assets (in relationship to the threat faced by the force), and the potential training opportunities for AHS forces.

1-58. Basic documents required for determining eligibility of beneficiaries include– AR 40-400; FM 6-27/MCTP 11-10C; relevant sections of Title 10, U.S. Code; relevant DOD directives and DODIs; acquisition and cross-servicing agreements; orders from higher headquarters; interagency agreements such as memorandum of understanding and memorandum of agreement; and appropriate multinational agency guidance for the specific operation. If contractor personnel are present, under the terms and conditions of their contracts, contractors are responsible for providing employees who are medically and psychologically fit to perform duties as specified in their contracts. All contractors authorized to accompany the force must undergo a medical and dental assessment within 12 months prior to arrival at the designated deployment center. The medical preparation of contractors authorized to accompany the force per theater or location reporting instructions includes deployment health briefings, medical surveillance screening, medical and dental evaluations, DNA [deoxyribonucleic acid] specimen collection, determining prescription and eyewear needs, and immunizations. Per DOD policy, contracting officers incorporate these requirements into all contracts for performance in the AOR via standard contract clauses or mission specific contract language as applicable. Additional medical screening and evaluation guidance can be found in DODI 3020.41 and Joint Publication (JP) 4-10.

1-59. Finally, the political-military environment of the AO must be taken into account as the command and control headquarters and its higher headquarters develop the eligibility matrix. The eligibility matrix should be as comprehensive as possible. If necessary, it should include eligibility determination by name. Refer to FM 4-02 for an example of an eligibility matrix. If individuals arrive at the emergency medical service section of the MTF who are not included in the medical/dental support matrix, the MTF must always stabilize the individual first and then determine the patient's eligibility for care. The command point of contact for eligibility determinations should be contacted immediately. Further, care will be provided in accordance with the SOP pending eligibility determination. For example, a host nation civilian presents himself at the gate and requests medical treatment. Although on the surface it may appear that they are not eligible for care, this determination can only be made after a medical assessment is completed by competent medical personnel. In some cases, the individual may have to be brought into the MTF to accomplish an adequate medical assessment. Conducting a medical assessment does not obligate the military to provide the full spectrum of medical care. Although it does obligate the MTF to provide immediate stabilization for life-, limb-, and eyesight-threatening medical conditions and to prepare the patient for evacuation to the appropriate civilian or national contingent MTF when the patient's medical condition permits.

Note. Individuals requesting medical care should receive a timely medical assessment of their condition. Even though the individual is not eligible for treatment, life-, limb-, or eyesight-saving procedures warranted by the individual's medical condition are provided to stabilize the individual for transfer to the appropriate civilian or other nation MTF.

1-60. The MTF staff must be familiar with the medical care available in the AO from other sources. These could include our unified action partners which include multinational or host nation military (tactical and strategic) forces, nongovernmental organizations or international organizations such as the United Nations, and local civilian resources. When appropriate and by knowing the level and types of care available, the MTF staff can plan for the continued care of the patient after initial stabilization is provided in the U.S. MTF and the patient can be transferred to another facility for continued care.

1-61. It is essential that eligibility for medical care guidance is disseminated and understood by the chain of command and all civilians and military members of the deployed force. The AHS commander must be able to articulate the basic concepts for medical eligibility determinations. This means that they will need to condense them into simple, easily understood instructions and widely disseminate them through electronic means or other media (such as pocket-sized cards). As the chief planner for medical operations, the AHS commander must ensure that this information is contained in the appropriate operation plan and operation order and briefed to the appropriate senior leadership of the command.

1-62. Most Geographic Combatant Commands, also known as GCC/COCOM, had established rules of eligibility for medical care. The details are normally contained in standard operational plans and contingency plans in the appropriate medical annex.

Chapter 2

Dental Staff Positions and Responsibilities

The modular force is based on brigade-size elements with specialized capabilities. Because of their size and mobility, they are capable of conducting expeditionary and joint operations and once deployed are better able to quickly respond to ever-changing mission requirements. Modular units allow Army planners to tailor the force to be flexible and agile. Specifically tailoring the force, reduces strategic lift requirements and enables the U.S. to put combat power where it is needed in considerably less time than previously possible. To better support the modular force, the AHS command and control organizations have also been redesigned to be more modular.

DENTAL STAFF POSITIONS AND RESPONSIBILITIES OVERVIEW

2-1. To ensure that Soldiers have ready access to dental treatment, dental assets are organic to the supporting medical companies of the brigade combat team (BCT), and SFGs. The active component Civil Affairs brigade has a Chief Dental Officer. This is a staff position, without assigned clinical duties. However, the Dental Officer provides operational dentistry in a direct support of civil affairs operations when theater assets are not well suited to the mission. Refer to ATP 4-02.3 for additional information on dental support to the maneuver forces and ATP 4-02.43 for additional information on dental support to special operations forces.

2-2. Dental staff officers and noncommissioned officers (NCO) at all levels of command and within each role of care are responsible for developing and implementing dental policies and procedures and providing running estimates and plans for how they will provide dental support for their respective commands. See TC 8-20-1 for additional information on the roles of dental NCOs and specialists. STP 8-68E14-SM-TG provides critical task summaries that support unit missions during wartime for Soldiers holding MOS/SL 68E 1,2,3, and 4. STP 8-68EN5-SM-TG provides similar information for dental laboratory specialists.

2-3. The dental staff officers and NCOs determine what resources are required to adequately support the troop population in their AO. They develop running estimates for inclusion in AHS annexes to the operation plan. Refer to Army Doctrine Publication (ADP) 5-0, ATP 4-02.42, and ATP 4-02.55 for information concerning the preparation of AHS estimates and plans. They provide technical guidance on dental matters to subordinate dental units. They monitor the oral health of the supported troops and the readiness of all assigned dental assets (personnel and equipment). They continually evaluate AHS dental service support plans to determine dental resource requirements and adequacy of available assets. Specific duties may include surveillance of the—

- Operational readiness status of dental resources in the AO.
- Operational requirements of supported troops (for example, number and types of units supported or in the area of operations; number of troops being supported; the anticipated duration of the operation; the tactical situation; the location and distribution of supported units; and the expressed needs of commanders).
- Provision of dental services to detainees.
- Provision of dental services to other supported populations when authorized and directed to provide care.

ARMY DENTAL STAFF OFFICER AND NONCOMMISSIONED OFFICER POSITIONS

2-4. There is no dental officer located within the Army Service component command surgeon's cell.

MEDICAL COMMAND (DEPLOYMENT SUPPORT)

2-5. The medical command deployment support (MEDCOM[DS]) headquarters company has a dental surgeon, one public health dentist, and one chief medical NCO position reflected on its table of organization and equipment (TOE).

2-6. The MEDCOM(DS) dental surgeon is the senior dentist in the MEDCOM(DS) and is responsible for —

- Establishing an effective and consistent program for dental services and dental operations on a theater wide basis.
- Collecting and consolidating of dental treatment data and forwarding the data to the central data repository in theater.
- Developing theater-level policies and procedures to be executed by subordinate dental service support assets.
- Exercising technical supervision over all the dental units in the theater if the medical brigade (support) (MEDBDE[SPT]) is not deployed.
- Directing the dental service element of the headquarters.
- Providing dental staff support to the MEDCOM(DS) commander.

2-7. The MEDCOM(DS) public health dentist that supports the MEDCOM(DS) dental surgeon in all staff actions. Specific duties include—

- Providing oral health surveillance information in support of policy and procedure development.
- Developing plans and orders concerning oral fitness and preventive dentistry programs.
- Recommending dental treatment policies.
- Developing programs for dental support of foreign humanitarian assistance operations.
- Ensuring theater wide collection of dental workload information.

2-8. The MEDCOM(DS) chief medical NCO is a sergeant major who supports the MEDCOM(DS) dental surgeon in all staff actions. Specific duties include—

- Supervising the general administrative functions and coordination of personnel assignments.
- Evaluating the training programs and requirements.
- Assisting dental staff officers in the administrative and technical supervision of subordinate dental facilities.
- Assisting in the development of running estimates for operation plans.
- Providing technical assistance in planning and staffing of subordinate dental facilities.

2-9. The modular design of medical units gives the MEDCOM(DS) the ability to—

- Assist in deploying the optimal mix of medical capabilities.
- Ensure seamless, state-of-the-art medical and dental care, regardless of location.
- Provide tested and proven systems to the battlefield and ensure the provision of the right care at the right place and time.
- Promote scalability through easily tailored, capabilities-based packages that result in improved tactical mobility, reduced footprint, and increased modularity for flexible task organization.
- Provide and enable the joint force commander the ability of choosing augmentation packages which enable rapid synchronization and deployment of desired medical capabilities.
- Maintain a regional focus in support of the combatant commander's theater engagement strategy.

MEDICAL BRIGADE (SUPPORT)

2-10. The MEDBDE(SPT) headquarters staff has one chief dental officer assigned to serve as a dental surgeon and one chief medical NCO.

2-11. The chief dental officer serves as the MEDBDE(SPT) dental surgeon whose principle responsibility is to advise the chief, clinical operations section, on the dental health of the command and the supported troop population. Their duties and responsibilities include—

- Exercising technical supervision over dental assets in assigned hospitals and dental units subordinate to the MEDBDE(SPT).
- Monitoring preventive dentistry programs within the command and determining dental readiness rates.
- Developing policy, procedures, and protocols for dental treatment within the MEDBDE(SPT) dental treatment facility.
- Advising the chief, professional services when augmentation of oral and maxillofacial surgical resources is required.
- Providing consultation to MEDBDE(SPT) MTFs on medical evacuation requirements for dental surgical patients entering the United States Air Force evacuation system.

2-12. The MEDBDE(SPT) dental surgeon may also be called upon to serve as the division dental surgeon. Their responsibilities in this capacity include providing technical supervision for subordinate dental officers that are assigned to medical companies in support of BCTs, armored cavalry regiment, and SFGs, as well as for dental assets assigned within the MEDBDE(SPT).

2-13. The duties and responsibilities of the chief medical NCO tasked with the providing the MEDBDE(SPT) with advice and assistance, in concert with the command dental surgeon, include—

- Monitoring dental activities for the command.
- Receiving reports from subordinate units, consolidating the data, and forwarding it to their higher headquarters.
- Coordinating policies, procedures, and protocols for the treatment of dental conditions and preventive dentistry programs.
- Recommending priority of fill and assignment of dental personnel to subordinate dental elements.
- Serving as the principal NCO providing technical assistance to subordinate unit enlisted dental personnel.

UNIT LEVEL

2-14. Dental officers assigned to medical companies in support of BCTs, armored cavalry regiment, SFGs, and the active component Civil Affairs Brigade serve as the dental surgeons for the parent unit. Dental officers assigned to these formations serve as advisors to the brigade commanders on matters involving unit dental readiness. They use dental classification information provided by the supporting dental treatment facility to accurately determine the dental readiness of the organization and make recommendations on how to improve the unit's dental readiness posture. Additional responsibilities involve providing running estimates and recommendations concerning the delivery of dental support for operations.

This page intentionally left blank.

Chapter 3

Organization and Employment of Dental Capabilities

The principles of the AHS are the foundation—enduring fundamentals—upon which the delivery of health care in a field environment is founded. The principles guide medical planners in developing operation plans which are effective, efficient, flexible, and executable. The AHS support plans are designed to support the operational commander's scheme of maneuver while still retaining a focus on the delivery of health care.

The AHS principles of conformity, proximity, flexibility, mobility, continuity and control apply across all medical functions. The AHS principles are synchronized through command, control, close coordination, and synchronization of all deployed medical assets through medical technical channels. Refer to FM 4-02 for a more definitive explanation of the AHS principles.

This chapter implements STANAGs 2453 and 2598

CONCEPT OF OPERATIONS

3-1. To ensure that Soldiers have ready access to dental treatment, dental assets are organic to the supporting medical companies/troops of the BCTs, armored cavalry regiment, and SFGs. Dental treatment of Civil Affairs units is provided by theater assets, but can be provided by the Civil Affairs Dental Officer in isolated or austere locations.

3-2. Based on the current force structure, dental service assets are located in four specific operational areas, which are: close area, consolidation area, joint security area and the strategic support area. See Figure 3-1. on page 3-2 for an operational area overview.

3-3. The placement of dental assets in these areas ensures that Soldiers have ready access to dental treatment when they need it and provides two key benefits. These are—

- Soldiers are able to be seen, evaluated, treated, and quickly returned to duty with less time away from their unit.
- Soldiers are less likely to be evacuated to a higher level of dental support for routine dental treatment which results in fewer Soldiers being lost to the unit.

EXTENDED BATTLEFIELD ENVIRONMENT

3-4. The interrelationship of air, land, maritime, space and cyberspace requires a cross-domain understanding of an operational environment. Commanders and staff must understand friendly and enemy capabilities that reside in each domain and potential operational impacts.

3-5. During large-scale ground combat against peer threats, friendly forces should assume they are in contact and under observation in the space and cyberspace domains, as well as the information environment. In light of potential adversary capabilities, all personnel must be prepared to operate in denied, degraded, and disrupted communication environments. FM 6-99, *U.S. Army Reports and Message Formats* includes standardized report and message formats, including the medical status report, medical spot report, medical situation report, medical location report, logistics resupply request, and the U.S. medical status report.

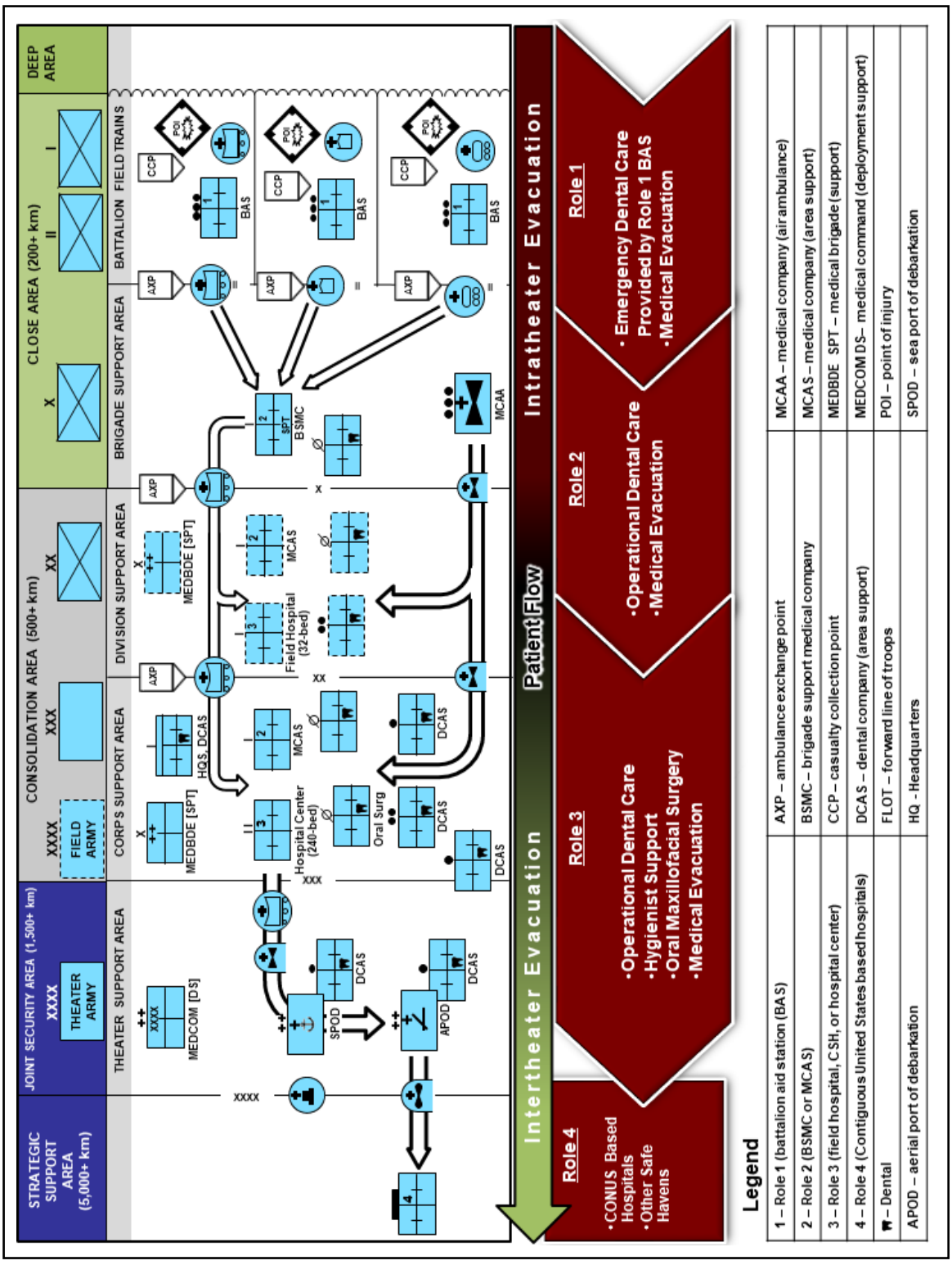

Figure 3-1. Operational area overview

DENTAL SERVICE SUPPORT PLANNING

3-6. As with all Army operations, dental service support planning is mission, enemy, terrain and weather, troops and support available, time available, civil considerations (METT-TC) driven. Dental unit commanders must be actively involved in the planning process. This assures that the plans they develop effectively implement guidance given by their higher headquarters. It also helps to ensure that the plan is coordinated with, and integrated into the overall operation planning process. For specific guidance on the military decision making process, refer to ADP 5-0. For dental planning considerations for AHS support operations, refer to ATP 4-02.42 and ATP 4-02.55. This process leads to rehearsal and the execution and assessment of the mission.

MEDICAL EVACUATION OF DENTAL PATIENTS

3-7. When dental patients require care that exceeds the capability of their supporting dental assets, they may require medical evacuation. Medical evacuation of these patients is no different than that which is provided for combat casualties or severe illnesses. The medical evacuation assets that routinely provide evacuation support for a unit will transport dental casualties based on their medical condition and the evacuation precedent assigned to that patient. See ATP 4-02.2 for additional information on medical evacuation.

DENTAL CAPABILITIES LOCATED IN THE CLOSE AREA

3-8. In the close AO, dental capabilities are normally located with the:

- Command Surgeons section for special operations forces including SFG and Civil Affairs brigade.
- Battalion aid station which is located with the maneuver battalions.
- Brigade support medical company (BSMC) which is located in the brigade support area.

SPECIAL OPERATIONS FORCES AND CIVIL AFFAIRS BRIGADE

3-9. Command Surgeons section of special operations forces including SFG and Civil Affair Brigade usually operate in the close area. See ATP 3-05.40 and ATP 4-02.43 for more information of dental capabilities of SOF formations.

BATTALION AID STATION

3-10. Dentists are not assigned to a battalion aid station. The battalion surgeon or physician assistant, if trained and equipped, may be able to provide emergency dental care until the patient can be seen by a dentist.

3-11. Although collocated within the AO of the Soldiers that they support, the battalion surgeon or physician assistant may be overwhelmed by the number of patients and unable to fully support the patient population without assistance. When necessary, the BAS may request support from the BSMC to treat the increased number of patients being seen.

3-12. The DCAS forward dental treatment section has the capability to forward deploy, when requested, to support BAS operations.

BRIGADE SUPPORT MEDICAL COMPANY

3-13. Dental assets are a component of the area support squad assigned to BSMC of the brigade support battalion and provide Level 1 dental support consisting of operational dental care within BCT AO. Although collocated within the AO of the Soldiers that they support, dental assets may be overwhelmed by the number of patients and unable to fully support the patient population without assistance. When necessary, the BSMC may request support from the DCAS to treat the increased number of patients being seen.

3-14. The DCAS forward dental treatment section has the capability to forward deploy, when requested, to support BSMC operations.

Personnel

3-15. Dental personnel assigned to the area support squad of a medical company are depicted in Table 3-1.

Table 3-1. Dental personnel organic to a brigade support medical company

Paragraph	*Paragraph description*	*Title*	*Grade*	*AOC/MOS*
06	area support squad	general dentist	O3	63A
		dental specialist	E4	68E10
Legend: AOC area of concentration MOS military occupational specialty				

Equipment

3-16. Dental equipment assigned to the area support squad of a medical company are depicted in Table 3-2.

Table 3-2. Dental equipment organic to a brigade support medical company

Paragraph	*Paragraph Description*	*TITLE*	*Line Item Number*
06	area support squad	dental equipment set: dental x-ray field:	D39478
		dental equipment set: comprehensive dentistry field:	D43802
		dental equipment set: dental support:	D95343
		dental instrument and supply set: emergency treatment field:	F95504
		dental supply set: emergency denture repair:	F95778

DENTAL CAPABILITIES LOCATED IN THE CONSOLIDATION AREA

3-17. In the Consolidation AO, dental capabilities are normally located in the Role 3 hospitals, the medical company (area support) (MCAS), and the DCAS. These organizations are normally employed in the corps support area, however the DCAS is modularly designed to further deploy forward to the division support area or to the close area in support of the BSMC or BAS if requested.

HOSPITAL AUGMENTATION DETACHMENT (MEDICAL 32 BED)

3-18. The dental services capability is normally located in the dental section of the hospital augmentation detachment (medical 32 bed) and provide Level 2 dental support consisting of operational dental care and limited preventive dentistry for patients and staff of the hospital center. For further information on the employment of this capability or hospital center, refer to ATP 4-02.10, *Hospitalization*. Although collocated within the AO of the Soldiers that they support, the dental section may be overwhelmed by the number of patients and unable to fully support the patient population without assistance. In those situations, the DCAS can augment the dental section to treat the increased number of patients being seen.

3-19. Along with providing dental care for patients and staff of the hospital center, dental personnel will augment the hospital with additional combat casualty care capabilities during mass casualty situations.

3-20. The dental capability in the dental section is very similar to that of the dental team that is located in the medical companies, however the dental section has the added capability of a preventive dentistry sergeant.

Personnel

3-21. Dental personnel assigned to the dental section of the hospital augmentation detachment (medical 32 bed) are depicted in Table 3-3.

Table 3-3. Dental personnel organic to the dental section, hospital augmentation detachment (medical 32 Bed)

Paragraph	*Paragraph description*	*Title*	*Grade*	*AOC/MOS*
08	dental section	comprehensive dental officer	O4	63B
		preventive dentistry sergeant	E5	68E20 ASI X2
		dental specialist	E4	68E
Legend: AOC area of concentration MOS military occupational specialty				

Equipment

3-22. Dental equipment assigned to the dental section of the hospital augmentation detachment (medical, 32 bed) are depicted in Table 3-4.

Table 3-4. Dental equipment organic to the dental section, hospital augmentation detachment (medical 32 bed)

Paragraph	*Paragraph Description*	*TITLE*	*Line Item Number*
08	dental section	dental equipment set: dental hygienist field:	D39228
		dental equipment set: dental x-ray field:	D39478
		dental equipment set: comprehensive dentistry field:	D43802
		dental equipment set: dental support:	D95343
		dental instrument and supply set: emergency treatment field:	F95504
		dental supply set: emergency denture repair:	F95778

HOSPITAL AUGMENTATION DETACHMENT (SURGICAL 24 BED)

3-23. The oral maxillofacial surgical capability is normally located in the operating room (OR)/centralized material service (CMS) section of the hospital augmentation detachment (surgical, 24 bed). The operating room/centralized material service section, incrementally expands the operative capabilities of the hospital with two OR tables and staff for 36 operating table hours per day and provides sterilization and operator maintenance of equipment. The section augments the field hospital (32-Bed) OR/CMS as one surgical service.

Personnel

3-24. Dental personnel assigned to the OR/CMS section of the hospital augmentation detachment (surgical, 24 bed) are depicted in Table 3-5. These personnel do not provide operational dental care or comprehensive dental care, as their mission is to provide the oral and maxillofacial surgical capability.

Table 3-5. Dental personnel organic to the operating room/centralized material service (OR/CMS) section, hospital augmentation detachment (surgical 24 bed)

Paragraph	*Paragraph description*	*Title*	*Grade*	*AOC/MOS*
03	OR/CMS section	oral & maxillofacial surgeon	O4	63N
		dental specialist	E4	68E
Legend: AOC area of concentration MOS military occupational specialty				

Equipment

3-25. Dental equipment assigned to the OR/CMS section of the hospital augmentation detachment (surgical, 24 bed) are depicted in Table 3-6. The dental surgical capability is dependent on the other nondental equipment located in the OR/CMS section for full surgical capability.

Table 3-6. Dental equipment organic to the operating room/centralized material service (OR/CMS) section, hospital augmentation detachment (surgical 24 bed)

Paragraph	*Paragraph Description*	*TITLE*	*Line Item Number*
03	OR/CMS section	dental materiel set: oral maxillofacial surgery:	D65925

MEDICAL COMPANY (AREA SUPPORT)

3-26. The MCAS is normally employed in the corps support area of the consolidation area. The MCAS' mission is to provide Role 1 and Role 2 health service support to units located in the area of responsibility. Depending on METT-TC, the MCAS can be forward deployed to the division support area within the consolidation area as needed.

3-27. The dental capability in this organization is identical to that of the BSMC, to provide Level 1 dental support consisting of operational dental care however, this section provides this care on an area basis. Although collocated within the AO of the Soldiers that they support, dental assets may be overwhelmed by the number of patients and unable to fully support the patient population without assistance. When necessary, the MCAS may request support from the DCAS to treat the increased number of patients being seen.

3-28. The DCAS forward dental treatment section has the capability to forward deploy, when requested, to support MCAS operations.

Personnel

3-29. Dental personnel assigned to the area support squad of a medical company are depicted in Table 3-7 on page 3-7.

Table 3-7. Dental personnel organic to a medical company (area support)

Paragraph	*Paragraph description*	*Title*	*Grade*	*AOC/MOS*
05	area support squad	general dentist	O3	63A
		dental specialist	E4	68E10
Legend: AOC area of concentration MOS military occupational specialty				

Equipment

3-30. Dental equipment assigned to the area support squad of a medical company are depicted in Table 3-8.

Table 3-8. Dental equipment organic to a medical company (area support)

Paragraph	*Paragraph Description*	*TITLE*	*Line Item Number*
05	area support squad	dental equipment set: dental x-ray field:	D39478
		dental equipment set: comprehensive dentistry field:	D43802
		dental equipment set: dental support:	D95343
		dental instrument and supply set: emergency treatment field:	F95504
		dental supply set: emergency denture repair:	F95778

DENTAL COMPANY AREA SUPPORT

3-31. The DCAS is normally employed in the corps support area of the consolidation area but may be forward deployed depending on METT-TC.

Operational Information

3-32. The following information was extracted from section one of the DCAS and was current at the time this publication was written. The information provided should be used as a knowledge base, however units should reference specific modified table of organization and equipment operational information. See Figure 3-2 on page 3-8 for an organization overview.

Mission

3-33. The mission of the DCAS is to provide, on an area basis, operational dental care consisting of emergency and essential dental care, designed to eliminate potential dental emergencies.

Assignment and Dependencies

3-34. The DCAS is assigned to the MEDCOM(DS) or the MEDBDE(SPT).

3-35. The DCAS is dependent upon the following:

- Appropriate elements with the theater for religious, legal, force health protection, finance, personnel and administrative services.
- The support maintenance company for all field level maintenance.
- Field Feeding Company for field feeding support.

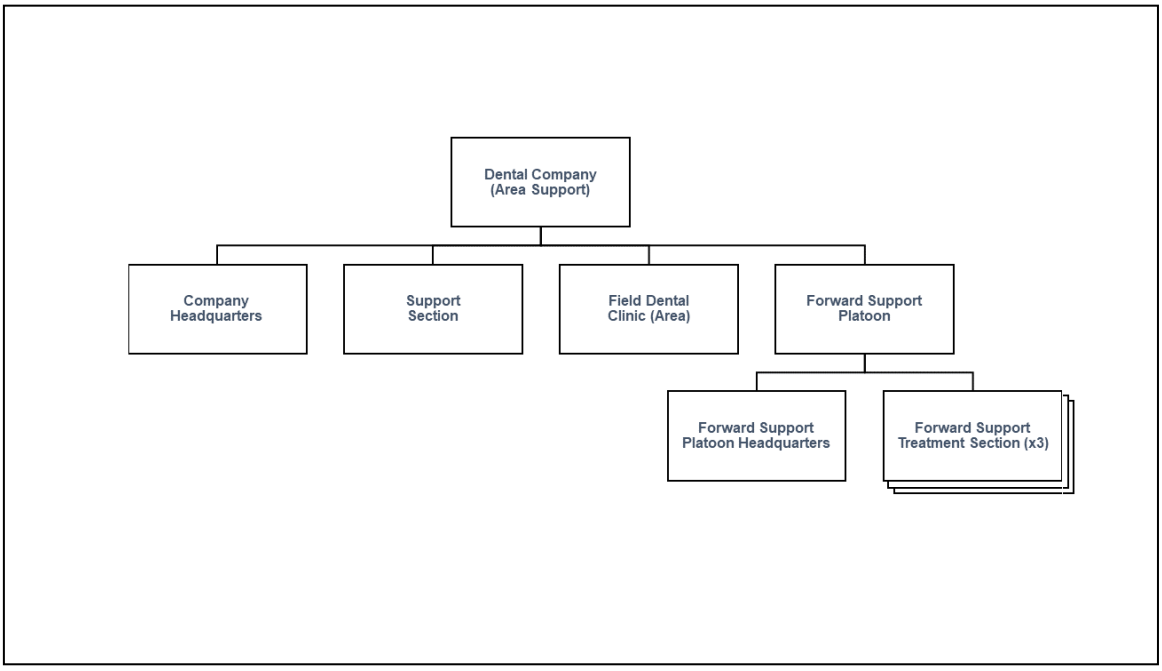

Figure 3-2. Dental company (area support)

Employment

3-36. The DCAS is employed with the MEDCOM(DS) or the MEDBDE(SPT) within a theater of operations. Dental teams may be employed in the BCT area to provide forward operational dental care.

Basis of Allocation

3-37. The DCAS is allocated on one per 43,000 personnel supported in the theater. This is based upon the ratio of one dentist in support of 1,175 Soldiers.

Capabilities

3-38. The DCAS provides:

- Command and control of subordinate dental elements.
- Operational dental care, consisting of emergency dental care and essential dental care.
- Reinforcement and reconstitution of BCT and armored cavalry regiment dental assets.
- Far forward operational dental care to small and forward deployed troop concentrations. This section is composed of three forward support treatment sections. Each section is composed of six treatment teams for a total of 18 forward treatment teams for area support.
- Augmentation of medical assets during mass casualty situations.

3-39. Individuals of this organization can assist in the coordinated defense of the unit's area or installation.

3-40. This unit does not perform field maintenance on organic equipment (including communications-security equipment) except for medical equipment. The medical maintenance personnel will perform limited maintenance on the unit's organic medical equipment. The remaining maintenance personnel will augment the maintenance capability of the unit that performs field maintenance on the unit's organic vehicles and power equipment.

Functions

3-41. Paragraph 01, company headquarters provides command and control, and daily unit level administration and logistical support for the organization and assigned and attached elements.

3-42. Paragraph 02, support section provides nonclinical support activities to include wheel vehicle, power generation and medical equipment maintenance for the organization.

3-43. Paragraph 03, field dental clinic (area) provides operational dental care consisting of emergency dental care and essential dental care. The clinic is broken down into a specialty section and general dentistry section. The specialty section provides emergency and essential dental care that includes endodontics, periodontics, and prosthodontics specialty care.

3-44. Paragraph 04, forward support platoon headquarters provides command and control, and administrative support to the treatment sections.

3-45. Paragraph 05, forward support treatment section (x3) provides operational dental care consisting of emergency dental care and essential dental care throughout the combat zone and isolated troop concentrations. Each forward support treatment section consists of six (6) semi-mobile teams made up of a dental officer, dental technician, dental equipment/supplies and mobile electric power.

Mobility

3-46. This unit requires 50% mobility of its TOE equipment to be transported in a single lift using its organic vehicles.

PERSONNEL

3-47. The field medical assistant in the forward support platoon headquarters, Para 04, plans, coordinates, monitors, evaluates, and assist the platoon leader and staff in medical and non-medical areas of patient care and management.

3-48. Table 3-9 lists all personnel assigned to the current TOE of the DCAS.

Table 3-9. Personal organic to a dental company (area support)

Paragraph Number and title	*Grade*	*AOC/MOS*	*Additional Skill Identifier*	*Title*	*Staffing Level*
01 company headquarters	O6	63R00		commander	1
	O5	67A00		executive officer	1
	E8	68E5M		first sergeant	1
	E5	92Y2O		supply noncommissioned officer	1
	E4	74D1O		Chemical biological radiation nuclear specialist	1
	E4	92Y1O		supply specialist	1
02 support section	E7	68E4O		operations sergeant	1
	E6	91B3O		motor sergeant	1
	E5	91B2O		wheeled vehicle mechanic	1
	E5	91D2O		tactical power generator specialist	1
	E5	92A2O		equipment records/parts sergeant	1
	E4	68A1O		biomedical equipment specialist	1
	E4	68A1O		biomedical equipment specialist	1

Table 3-9. Personal organic to a dental company (area support) (continued)

Paragraph Number and title	*Grade*	*AOC/MOS*	*Additional Skill Identifier*	*Title*	*Staffing Level*
02 support section	E4	91B1O		wheeled vehicle mechanic	1
	E3	91B1O		wheeled vehicle mechanic	1
	E3	91D1O		tactical power generator specialist	1
03 field dental clinic (area)	O5	63B00		comprehensive dent off	1
	O5	63D00		periodontist	1
	O5	63E00		endodontist	1
	O5	63F00		prosthodontist	1
	O3	63A00		general dental officer	5
	E7	68E4O		dental noncommissioned officer	1
	E6	68E3O		senior dental sergeant	1
	E6	68E3O	N5	senior dental laboratory sergeant	1
	E5	68E2O	X2	preventive dentistry sergeant	1
03 field dental clinic (area)	E5	68E2O	X2	preventive dentistry sergeant	1
	E5	68E2O		dental sergeant	1
	E5	68E2O	N5	dental laboratory sergeant	1
	E5	68E2O	N5	dental laboratory sergeant	1
	E4	68E1O	N5	dental lab specialist	2
	E4	68E1O	N5	dental lab specialist	1
	E4	68E1O		dental specialist	1
	E4	68E1O		dental specialist	1
	E4	68E1O		dental specialist	1
	E4	68E1O		dental specialist	1
	E4	68E1O	X2	preventive dentistry specialist	2
	E4	68E1O	X2	preventive dentistry specialist	2
	E3	68E1O		dental specialist	3
	E3	68E1O		dental specialist	2
04 forward support platoon headquarters	O4	63B00		comprehensive dent off	* 0
	O3	70B67		field medical assistant	1
	E7	68E4O		platoon sergeant	1
Note. * This position is captured in paragraph 05, Forward Dental Treatment Section					

Table 3-9. Personal organic to a dental company (area support) (continued)

Paragraph Number and title	*Grade*	*AOC/MOS*	*Additional Skill Identifier*	*Title*	*Staffing Level*
05 forward dental treatment section	O4	63B00		chief dental officer	3
	O3	63A00		general dental officer	15
	E6	68E3O		senior dental sergeant	3
	E5	68E2O		dental noncommissioned officer	3
	E5	68E2O		dental sergeant	3
	E4	68E1O		dental specialist	3
	E4	68E1O		dental specialist	3
	E3	68E1O		dental specialist	3
	E3	68E1O		dental specialist	3
Legend: AOC area of concentration MOS military occupational specialty					

Equipment

3-49. Table 3-10 lists the dental equipment that is assigned to the current TOE of the DCAS. For a comprehensive list of all the equipment that is assigned to the DCAS reference the specific units modified table of organization and equipment.

Table 3-10. Equipment organic to a dental company (area support)

Paragraph Number and title	*LIN*	*TITLE*	*Required Level*
03 field dental clinic (area)	D39228	dental equipment set: dental hygienist field:	6
	D39478	dental equipment set: dental x-ray field:	2
03 field dental clinic (area)	D43802	dental equipment set: comprehensive dentistry field:	9
	D95343	dental equipment set dental support:	9
	D95617	dental equipment set: prosthodontics:	1
	F95504	dental instrument and supply set emergency treatment field:	9
	F95778	dental supply set emergency denture repair:	1
05 forward dental treatment section	D39478	dental equipment set: dental x-ray field:	18
	D43802	dental equipment set: comprehensive dentistry field:	18
	D95343	dental equipment set dental support:	18
	F95504	dental instrument and supply set emergency treatment field:	18
	F95778	dental supply set emergency denture repair:	3
Legend: LIN line item number			

DENTAL CAPABILITIES LOCATED IN THE JOINT SECURITY AREA

3-50. Depending on METT-TC, the DCAS may employ the forward support treatment section to provide Level 3 dental support throughout this area and isolated troop concentrations.

DENTAL CAPABILITIES LOCATED IN THE STRATEGIC SUPPORT AREA

3-51. Dental services in the strategic support area are normally provided by the fixed dental treatment facilities located in a garrison environment.

Chapter 4
Dental Service Operations

This chapter discusses the basic principles of dental service operations and considerations in the employment of dental capabilities. As with all operations, leaders must understand the commander's intent and key tasks to successfully accomplish their mission and employ their organizations effectively.

ESTABLISHING THE DENTAL TREATMENT FACILITY

4-1. The following are broad-based topics of discussion and factors to consider when establishing the dental treatment area. It is not intended to be an all-encompassing list but rather a starting point for other considerations that are affected by METT-TC.

4-2. As discussed in chapter 3 the AHS principles of conformity, proximity, flexibility, mobility, continuity and control apply across all medical functions and also when establishing the dental treatment facility.

SITE SELECTION CONSIDERATIONS

4-3. When establishing a dental treatment facility in the field, careful consideration should be given to the location and choice of terrain on which the dental treatment facility will be operating. Some of the advantages that a carefully selected site offers include: easy access to the facility; a smooth flow of vehicle traffic into and out of the area; concealment; defensibility; and adequate drainage during inclement weather. The use of current multispectral imagery and terrain data in the planning phase of site selection greatly enhances the suitability of proposed locations.

4-4. There are many factors that influence where the dental treatment facility should be located, all of which are METT-TC driven. Considerations which influence the location of the dental treatment facility include the—

- Mission.
- Commander's intent.
- Specifics of the operation plan.

4-5. Additional considerations which should be taken into account when establishing the location of the dental treatment facility include—

- Placing the dental treatment facility on terrain that—
  - Provides easy access to routes of evacuation and which is accessible to the supported troops.
  - Provides good drainage, is free of obstacles, and provides adequate space to operate.
  - Provides an area cleared of mines, improvised explosive devices, booby traps, and CBRN hazards.
  - Enables or enhances communications capabilities.
  - Provides natural cover and concealment.
  - Defends easily in the event of attack.
  - Provides an area free of garbage dumps, landfills, toxic industrial materials or other waste disposal sites.
  - Provides sufficient space for incoming and outgoing air ambulances and ground ambulance turnaround.
- Placing the dental treatment facility as far as possible/practical from—

- Terrain that is a likely breeding site for flies, mosquitoes, and other pests.
- Structures, facilities, or equipment that may be considered likely targets for the enemy.

4-6. If the unit's mission requires that it relocate frequently, establishing a complete treatment area may not be practical. Under these circumstances, the dental treatment facility may choose to set up an expedient shelter under which to conduct treatment operations. Time may allow only essential services, shelters, and equipment to be used. If however, it is anticipated that the unit will be located at one site for an extended period of time, existing shelters or buildings when available, may be used.

SHELTERING THE DENTAL TREATMENT FACILITY

4-7. When providing dental care in a field environment, the dental treatment facility should be established so that the patients and staff are sheltered from the elements. It is also desirable to have some degree of environmental control.

Expedient Shelters

4-8. Expedient shelters are generally more convenient and easier to establish and use when a unit is conducting a movement and must provide emergency dental care. Expedient shelters may be as simple as a tarp being erected to shield the patient and dental staff from the sun or rain. In situations where weather and terrain permit, a shaded area adjacent to the route of march will suffice. It may be as simple as setting up on the tailgate of a vehicle which may be adequate for the immediate situation.

Tents

4-9. United States Army field dental units are not organically equipped with tents in accordance with their table of organization equipment. Tents are available to a unit based on the common tables of allowance and the unit's modified table of organization and equipment.

Note. When a unit replaces existing tents, selection criteria for new tents must include compatibility with the unit's existing heating, cooling, and electrical requirements and capabilities.

4-10. Tents provide dental personnel with a shelter system that is quick to set up and break down. Their portability and convenience are especially useful for forward deployed dental treatment teams. Tents are easy to camouflage and conceal and allow flexibility in site selection.

Semi-permanent Buildings

4-11. Semi-permanent buildings are generally constructed and used in base clusters or forward operating bases particularly in long-term stability operations. Semi-permanent buildings offer a number of features that make them very desirable. The structures can be built to specific dimensions which are required to establish and operate a dental treatment facility.

Buildings of Opportunity

4-12. Buildings of opportunity present a number of distinct advantages and should be used whenever possible. These may include electrical lighting, air conditioning and central heat, telephones, running water, and toilets. Prior to establishing a dental treatment facility in an existing structure, the building must first be inspected and approved for occupancy by the supporting engineers. The building's existing layout may pose a significant challenge to dental personnel when trying to establish an efficient layout.

SECURITY AND PROTECTION

4-13. Field dental units that reside on bases assist the camp commander with security and defense. The camp commander may assign specific tasks such as security responsibilities within and around the dental facility and providing personnel to augment base camp defense.

4-14. Efficient and effective dental support increasingly depends upon the DOD information network-Army, also known as DODIN-A, to fulfill its role. Threats to the DOD information network-Army include state and non-state actors, criminals, insider threats, and the unwitting individuals who intend no malice. A single vulnerability within this network can place units and operations at risk, potentially resulting in mission failure. Every individual is responsible for compliance with the proper practices and procedures for safeguarding information and information technology. See FM 3-12 for more information on cyberspace operations and AR 25-2 for additional information on Army cybersecurity.

4-15. Protective construction implements specific measures to strengthen structures and mitigate threats. These measures include barriers, sidewall protection, overhead protection, bunkers, and fighting positions. See ATP 3-37.10/MCRP 3-40D.13 for additional protection and security considerations in base camps.

This paragraph implements STANAG 2931

CAMOUFLAGE OF MEDICAL UNITS

4-16. The aim of STANAG 2931, is to detail the authority for the camouflage of medical personnel and facilities on land where the lack of camouflage may compromise military operations in armed conflict.

GENERAL

4-17. The Geneva Convention for the "Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field, August 12, 1949" and the additional Protocols 1 and 2 to the Geneva Convention govern the display of the protective medical emblems on medical personnel and facilities, although the U.S. has not ratified these additional protocols.

4-18. The Geneva Conventions invoke the protection and respect of medical units and facilities, military medical personnel, chaplains, and medical transports, by the parties to the conflict, so that they may be free to pursue their duties and must not be made the object of attack.

4-19. The competent military or civilian authority shall ensure that medical units and establishments are, as far as military considerations permit, situated in a manner that attacks against military objectives cannot imperil their safety, and their distinctive medical emblems are properly displayed.

CAMOUFLAGE OF THE PROTECTIVE MEDICAL EMBLEMS

4-20. Although the Conventions require medical emblems be highly visible and prominently displayed, in so far as military considerations permit, circumstances may occur where, the normal color scheme of these emblems could be detrimental to tactical operations, and/or medical personnel or facilities displaying these emblems could be subject to direct targeting. The risk of camouflaging medical personnel and facilities is that they cannot be identified as persons or facilities which are to be respected and protected; therefore, there is an increased risk that enemy forces will not recognize their protected status and attack them in error. Medical facilities and personnel on land will display or camouflage the protective medical emblems in accordance with national regulations and procedures.

4-21. When the use of highly visible and prominently displayed medical emblems could compromise military operations, camouflage of medical personnel and/or facilities may be ordered by a competent military or civilian authority with the necessary insight to balance operational concerns with the protection of medical facilities and personnel. In the practice, removal or obscuration of the distinctive emblem is generally controlled by the responsible major tactical commander, such as a brigade commander or higher. The competent military or civilian authority may authorize the removal or obscuring of the distinctive emblem for tactical purposes, such as camouflage. Medical personnel must operate in the same manner regardless of whether or not their protective emblem is camouflaged (i.e. their intended use must be humanitarian or noncombatant).

4-22. Dispersion of tents and equipment is accomplished to the maximum extent possible. A controlled entry into the medical unit's area is established. STANAG 2931 provides for camouflage of the Geneva emblem

and Red Crescent on medical facilities where the lack of camouflage might compromise tactical operations. The STANAG defines medical facilities as medical units, medical vehicles, and medical aircraft on the ground. Camouflage of the Red Cross means covering it up or taking it down.

Note. The black cross on an olive background is not a recognized emblem of the Geneva Conventions.

4-23. It is not envisioned that fixed, large, medical facilities would be camouflaged. For an in-depth discussion of the Geneva Conventions refer to FM 4-02 and FM 6-27/MCTP 11-10C. See ATP 3-37.34/MCTP 3-34C for additional information on camouflage.

ADMINISTRATIVE TOOLS AND REQUIREMENTS

4-24. As with any treatment facility, there are administrative tools and requirements that must be used and completed to properly treat and document the care given to the patient.

STANDARD OPERATING PROCEDURE

4-25. A SOP is a set of instructions or steps which enables Soldiers following it to complete a job safely, with no adverse impact on the environment, meets regulatory guidance and compliance standards, and in such a manner that maximizes operational and production requirements.

4-26. A SOP may take one of two forms within the medical community; the clinical standard operating procedure (CSOP) and tactical standard operating procedure.

- The tactical standard operating procedure outlines how the unit conducts operations in a tactical environment. An example might cover CBRN detection and response issues, perimeter defense, and road marches.
- The CSOP (see Appendix D) addresses how the unit establishes and operates the clinical areas of the dental treatment facility; how it performs the patient care mission; and how the unit establishes patient flow into, through, and out of the dental treatment facility. The CSOP also addresses issues regarding equipment operation, maintenance, and safety.

4-27. Every dental unit must develop, publish, update, and train assigned personnel to established standards outlined in the unit's SOPs. Army guidance for development of SOPs is contained in ATP 3-90.90.

Developing the Standard Operating Procedure

4-28. After writing the SOPs for each job, they should be tested before putting them into effect. Revise SOPs after an on-the-job trial. Also revise the SOP when changes or modifications are made to equipment, machinery, buildings or other structures, or procedures within the immediate work area that might affect performance of a job, or the environment in which it is performed.

4-29. It is not practical to write SOPs for each job that requires this level of detail overnight. To effectively meet this challenge, priorities must be established. New SOPs should be written when new equipment or processes create new work situations. It may be necessary to write or rewrite SOPs when new information suggests benefits from modifying work practices to improve performance. Accident investigations might show that procedural, safety and environmental guidelines are insufficient, incomplete, or even missing for certain jobs or parts of jobs. Systematically update all safety and environmental guidelines by asking Soldiers to evaluate existing SOPs and other documents that contain work safety and environment guidelines. Then rank these jobs as to which should be revised first through last. These procedures could be revised, perhaps by the groups that ranked them.

4-30. The SOPs are used for a variety of reasons and audiences; they must be comprehensive, which means they are as long as necessary to cover a job. For long SOPs or for jobs performed infrequently, it pays to keep the long form SOP handy. Once a Soldier is familiar with a process, they will most likely be able to perform a series of short SOP steps from memory. These steps can be written as a short form SOP. If someone

is going to use a short-form SOP, it should be prepared after a full long-form SOP has been tested and approved and should be handed out after a Soldier has passed the appropriate training.

4-31. Unit SOPs should always reflect the guidance contained in the parent organization's SOPs.

References

4-32. List all publications that guide or govern the reader in this subject area (for example, ARs, FMs, other SOPs, and policy memorandums). Use a separate subparagraph for each. Give the full title of each, to cite—

- Publications give the type of publication (AR, FM, or similar designation), its number, date of publication, and title. If there is no publication number, cite the title, date of publication, and source of where the publication can be obtained.
- Correspondence give the type of correspondence, office symbol, date, and subject.
- Meetings and telephone calls, list the type, the parties involved and their units, the date, and the subject.
- Electronic mail messages give the type, name of the sender, the sender's organization, the subject, and the date.

Purpose

4-33. Write a precise purpose statement that indicates what specific goal the publication serves. For example: To specify the procedures required to perform operator maintenance on the field dental chair.

Summary

4-34. In a paragraph less than one inch deep, recap the main points of your document. Write it after the Responsibilities and Procedures paragraphs have been written. Summarize (do not introduce) the key points, but be precise. Write complete sentences in the present tense.

Scope

4-35. State to whom the SOP applies and under what specific conditions it applies.

Definitions

4-36. Define all terms the readers might not fully understand. If not needed, omit this paragraph.

Responsibilities

4-37. Focus here on WHO does WHAT. List precise duties for key persons or groups.

- Specify WHOM is being addressed. Write a short title. For example: Commander, 123rd Dental Company (Area Support).
- Write imperative sentences as if addressing the person directly. Use the present tense and active voice. Start with an action verb. Avoid unneeded helping verbs such as must, will, or will be.
- Maintain parallelism in your lists. If there is subparagraph "a" or an "a (1)", have a subparagraph "b" or a "b (1)".

Procedures

4-38. Focus here on the sequence of events to be followed. In chronological or topical order, describe exactly what happens. Indicate WHO does WHAT, WHEN, HOW, to WHOM, and in WHAT order.

4-39. Write declarative sentences with a subject and a verb in the present tense and active voice. Describe what happens. For example: On the day of firing, the supply sergeant provides a warming tent at the range. They also issue individual field rations and collect money from Soldiers on separate rations.

4-40. Create new paragraphs or use enclosures to discuss miscellaneous administrative and logistical topics.

Files

4-41. If applicable state what files or records must be kept, otherwise omit this paragraph.

DENTAL RECORDS

4-42. Maintenance and disposition of dental treatment records are governed by AR 40-66. See TB MED 250 for additional information on dental records.

Outpatient Treatment Records

4-43. Outpatient treatment records are prepared for each patient treated by a United States Army dental treatment facility. An outpatient treatment record will be prepared by the first dental treatment facility to which a person reports for outpatient treatment. After being initiated, the outpatient treatment record will be kept at the dental treatment facility.

Dental Treatment Facility Logbooks

4-44. The dental treatment facility's daily dental treatment logs are maintained by the dental officer at each dental treatment facility. The dental treatment facility logbook is maintained by each dental treatment facility to record the names, rank, and unit of the patients treated at that dental treatment facility, and the patient's disposition. Other useful information includes the date, time, and the reason for the visit and whether the treatment provided was for disease and nonbattle injury or battle injury-related conditions. This log is retained for the clinics record and the information provides a valuable source of data for statistical reporting.

DENTAL REPORTS

4-45. The following are possible reports that the dental treatment facility may have to complete during combat operations. For a complete list of what reports are required in the assigned area operation, further guidance must be sought by the command surgeon.

Daily Dental Unit Status Report

4-46. The daily dental unit status report provides a brief summary of supported units' current dental condition. The frequency with which the report is submitted is situationally dependent. The report is submitted to the dental company's higher headquarters.

Quarterly Dental Activity Report

4-47. The quarterly dental activity report is a summary of the dental treatment facility's activities during the quarter. This report is required to be submitted to the dental treatment facility's higher headquarters by the 15th of the month following each fiscal quarter of the year by the division/corps surgeon. For example, each dental treatment facility will submit a report covering the period 1 July through 30 September not later than the 15th of October of that year. If participation in an operation or exercise ends before the end of a quarter, the final dental activity report will be due 15 days after return to the home station.

4-48. The dental activity report will include—

- Name and location of unit or dental treatment facility.
- Dates of the report period.
- Description of facilities.
- Dental unit or dental treatment facility movement during report period.

4-49. Personnel information includes—

- Name, rank, and area of concentration (AOC) for officers and the name, rank, and military occupational specialty (MOS) and additional skill identifier for all enlisted personnel.
- Identity of the officer in charge, executive officer, and noncommissioned officer in charge.
- Date of arrival and departure of all personnel.
- Personnel awards, honors, and achievements.

- Units supported, to include date support began and date support terminated.
- Dental and organizational equipment to include deficiencies, excesses, problems, and recommendations.
- Supply and maintenance, to include deficiencies, excesses, problems, and recommendations.
- Activities and programs (for example, foreign humanitarian assistance, preventive programs, professional and unit training, and distinguished visitors).
- Suggestions for improvement.

4-50. The dental activity report is intended to keep command channels informed of the status of dental resources and activities in the field. The report provides commanders with a tool that may be used to address specific issues and concerns.

4-51. After a complete initial report is submitted, subsequent reports need not repeat information which has not changed. Unless changes are made on subsequent reports, it may be assumed that the data furnished in the previous reports are still valid and serve as a cumulative record of dental service for that unit.

4-52. Daily dental unit status reports and quarterly dental activity reports are submitted through command channels to the MEDCOM(DS) dental surgeon. The dental treatment facility dental reports are retained at the dental facility and are available for audit if needed. Medical command and dental command surgeons extract data which is used to assess resource management and professional policy needs before forwarding reports to the next higher level. A summary of the dental treatment facility's daily dental activities report is the only numerical manipulation required at the dental treatment facility level. Dental surgeons and dental commanders may extract additional information required to prepare their quarterly dental activities report.

Annual Historical Report

4-53. AR 870-5, *Military History: Responsibilities, Policies, and Procedures,* prescribes procedures for providing the Department of the Army with annual reports of administrative, professional, and operational activities of Army Medicine. They are essential as reference and source material for the historical programs and missions of Army Medicine. They are frequently referred to when data are required by or requested of Army Medicine in its current operations. The reports are also used as teaching reference material.

4-54. Reports will be written in narrative form and prepared on one side of 8 1/2 X 11-inch paper. Each page will be identified at the top by the preparing agency designation and calendar year and numbered consecutively in the center of lower margin.

4-55. A margin of 1 1⁄2 inches will be left at the top and left of each page.

4-56. Each report will be stapled by not more than two staples along the left margin. No other form of fasteners will be used.

- The following topics are suggestions. It is not intended that each should be reported on solely because it is mentioned. The report should include any subjects which are appropriate to adequately reflect all important activities of the reporting unit.
- Mission. Identify unusual mission assignments; include changes in mission and/or unit relocation and reasons therefore.
- Organization. Important changes in organization and reasons therefore; include an organizational chart for clarity.
- Personnel. Unusual factors which significantly influence staffing of major professional and administrative elements or other considerations which have significance for development of personnel staffing guides.
- Training. Significant and unusual training activities, objectives, and programs.
- Materiel. Significant and unusual supply and maintenance programs.
- Construction. Major construction, alteration, or repair programs.
- Patient care and evaluation. Major professional policies or procedures for inpatient or outpatient care; unusual cases of historic importance; special problems and their solutions; comments on significant patient evacuation experience; significant accomplishments and trends.

- Dental service. Significant factors relating to operation of dental services, progress, and accomplishments in preventive dentistry and continuing educational programs.
- Health and environment. Significant factors affecting the health of the command such as incidence, epidemiology, and control of infectious diseases; environmental hygiene; occupational health service and nutrition; Army Public Health Nursing programs and activities and where indicated, medical and health problems of the civilian or multinational military population in the area.

Dental Readiness and Community Oral Health Protection Report

4-57. Dental readiness is fundamental to maintaining unit readiness and reducing noncombat dental casualties during deployments. Community oral health protection emphasizes not only oral health, but also general wellness and overall fitness of our Soldiers and all authorized beneficiaries. AR 40-35 provides guidance for the development and conduct of the dental readiness and the community oral health protection programs for all authorized beneficiaries of the dental care system. It describes the dental readiness program for active duty Soldiers and other programs that benefit all members of the Army community.

4-58. The dental readiness and community oral health protection programs include the following components:

- Dental readiness program.
- Clinical oral health and health promotion program.
- Community health promotion and disease prevention program.

TREATMENT FACILITY OPERATIONS

4-59. During clinical operations, patient care utilizing standard operating procedures are key to a successfully operation.

DENTAL CARE IN AN OPERATIONAL ENVIRONMENT

4-60. Providing dental care in an operational environment requires rugged, lighter, agile, and modular equipment, austere clinical skills, and standards of practice, similar to those provided in garrison dental treatment facilities. There are, however, unique challenges to dental personnel working in a field environment presented by the varying terrain features, environmental conditions, availability or lack of facilities, and the tactical situation.

4-61. To effectively support and quickly return Soldiers to duty, dental personnel must be capable of working quickly and accurately in a field environment.

4-62. Dental treatment can be provided as soon as a suitable working area and power are established. The objective, as previously stated is to provide the necessary care and return Soldiers to duty as quickly as possible. See ATP 4-02.82 for additional information on occupational and environmental health risk assessments.

PATIENT SAFETY

4-63. Patient safety in the health care setting involves a variety of clinical and administrative activities that organizations undertake to identify, evaluate, and reduce the potential for harm to beneficiaries and to improve health care quality. Effective patient safety initiatives seek to control untoward events before they occur and, as such, elements of risk assessment, risk identification, and risk reduction or containment are involved.

4-64. Leaders in MTFs play a critical role in the facility-based patient safety program given the influence that leaders exert on activities directly associated with this program (such as performance improvement, environmental safety, and risk management). Although the beneficiary is the central focus of patient safety, it is difficult to create an organization-wide patient safety initiative that excludes staff, Family members, and others.

4-65. Many of the activities implemented to improve patient safety (for example, security, fire safety, equipment safety, infection control, and falls prevention) encompass staff and others, as well as patients. Patient safety is a critical component of both a table of distribution and allowances and/or TOE organization's comprehensive safety efforts. As such, patient safety activities and processes must be effectively integrated with those of the existing Safety Program.

4-66. Patient safety and the reporting of adverse events, especially sentinel events, are likewise important in the field environment. Wherever practical, efforts must be made by leadership to emphasize patient safety and to minimize patient harm associated with the provision of health care to Soldiers.

4-67. Universal precautions will be implemented by all dental personnel. To prevent cross-contamination, barrier protection materials are included in the dental equipment set (DES). Dental equipment sets are discussed in Appendix B. See TB MED 510 on safety precautions related to waste anesthetic gas exposure.

INFECTION CONTROL AND EXPOSURE CONTROL

4-68. All United States Army dental treatment facilities and all United States Army medical providers are governed by infection control policies and regulatory guidance provided by the—

- Assistant Secretary of Defense for Health Affairs.
- Office of The Surgeon General.
- Dental Directorate.
- Occupational Safety and Health Administration.
- Centers for Disease Control and Prevention.

4-69. All Army dental units must adhere to infection control/exposure programs based on existing regulatory guidance. These programs provide site specific guidance in all aspects of infection and exposure control for medical providers.

QUALITY ASSURANCE PLAN

4-70. The quality assurance plan is a tool which dental commanders can use to ensure that deployed Soldiers have access to the same quality of care that they would at their home station dental treatment facility. The plan allows the dental commander to make a standardized assessment of Soldier's access to care, quality of care provided, effectiveness and utilization of dental assets and resources, and risk management considerations and solutions. Quality assurance plans are discussed in detail in Appendix C.

WASTE MANAGEMENT

4-71. Dental units generate three types of waste materials, they are—

- General waste.
- Hazardous waste.
- Medical waste (to include regulated medical waste).

5-72. For a detailed discussion regarding the collection, handling, and disposal of waste materials refer to Technical Manual (TM) 3-34.56. Proper handling and disposal of medical waste is required to protect the force and avoid environmental contamination. Assistance with the removal and disposal of medical waste is normally available through supporting engineer units, preventive medicine teams, and local MTFs.

RADIOLOGY OPERATIONS

4-73. The ability to produce x-ray images is an important diagnostic tool in modern dentistry. It is for this reason that handheld digital x-ray equipment is an integral part of each DES. As with all radiology operations, applicable safety precautions must be put in place and observed to reduce the threat of injury associated with this type of equipment. See TB MED 521 for additional information on x-ray system safety.

4-74. Dental radiology equipment is found in the DCAS, hospital augmentation detachment (medical 32 bed), BSMC, and MCAS. The handheld digital x-ray equipment is capable of producing a full range of intraoral x-rays and, when necessary, may be used for other medical procedures.

4-75. Operation of handheld digital x-ray equipment is an additional responsibility of the dental specialists assigned to the unit. As with all radiology operations, the use of patient protective aprons is mandatory when x-ray images are being made.

4-76. The manufacturer's instructions and guidelines for the care and use of x-ray equipment and associated materials must be followed. These procedures and precautions should be addressed in the unit's CSOP.

PROSTHODONTIC CARE OPERATIONS

4-77. Soldiers who wear dentures that begin to cause discomfort and pain, are damaged, or are lost are classified as dental casualties. These casualties can be treated by the dental company prosthodontic section which is capable of repairing or replacing dentures in the field.

4-78. Dental company DES contain the tools and materials necessary to provide temporary fixed prosthodontic coverage and cementation. Additionally, each treatment section of the DCAS are equipped with emergency denture repair kits to effect prosthodontic repairs.

4-79. Theater prosthodontic laboratory capabilities include—

- Wax records and bases.
- Impression procedures and cast fabrication.
- Stain and glazing.
- Immediate transitional resin dentures.
- Die fabrication and trimming.
- Relining/rebasing.
- Repairs.

4-80. Patient requirements that exceed the capability of the theater laboratory can be mailed through the Army post office system back to Continental U.S. area dental laboratories for fabrication. The benefit of this capability is that the unit is not required to keep the additional personnel and equipment on hand. The savings in weight and cube contributes significantly to the mobility of the unit. See TB MED 148 for additional information on prosthodontic services provided by the United State Army Dental Laboratory.

MEDICAL LOGISTICS

4-81. Medical products and services are critical to the success of the mission and subject to the strict standards and practices that govern the U.S. health care industry including regulatory guidelines as published by the United States Food and Drug Administration and Drug Enforcement Administration. Medical logistics focuses on the specialized requirements of a multifunctional Military Health System in order to reduce morbidity and mortality among Soldiers.

4-82. Specific peculiarities of Class VIII materiel include—

- Items subject to deterioration (short shelf life and dated items).
- Subject to damage by freezing or high heat.
- Subject to damage if not properly refrigerated or frozen for preservation.
- Flammable and corrosive items.
- Controlled medical items or controlled substances to include alcohol, narcotics, and precious metals.
- Radioactive materials.
- Fragile items requiring special storage, handling, and packaging.
- Medical gases.

4-83. Disposal of Class VIII items and other medical waste must be carefully monitored and coordinated by MEDLOG personnel. This is especially important because of the sensitivity and health risks associated with the materiel. See ATP 4-02.1 for additional information on medical logistics.

Chapter 5

Dental Service Support to Unique Missions

This chapter describes dental service support to unique missions to include stability tasks, Army special operations forces, detainee operations, and chemical, biological, radiological and nuclear operations.

DENTAL SERVICE SUPPORT TO STABILITY OPERATIONS

5-1. Stability operations, a part of military operations, are recognized in DODD 3000.05 and FM 3-0. As a result, the expanding mission of the dental corps includes supporting the main tenets of stability operations.

5-2. Dental support to stability operations ranges from traditional support for deployed U.S. forces to establishing and/or augmenting dental programs in security assistance and foreign humanitarian assistance operations. These types of operations encompass a wide variety of activities that require flexibility and innovation on the part of those involved. For more detailed discussions refer to FM 3-0 and ATP 4-02.42.

DENTAL SERVICE SUPPORT TO ARMY SPECIAL OPERATIONS FORCES

5-3. Dental support is designed to provide operational care to avoid the loss of trained manpower due to dental disease or injury. The Army special operations forces and conventional applications are similar. For Army special operations forces, the scope of treatment may also include indigenous personnel. For more detailed discussions refer to ATP 4-02.43.

DENTAL SERVICE SUPPORT TO DETAINEE OPERATIONS

5-4. The primary unique concern in detainee medical operations is security. Designing the placement and location of chairs and the clinic floor plan should be to increase emphasis on security within the theater detention facility rather than patient privacy. Equipment and supplies should be accounted for at all times. All instruments should be inaccessible to detainees. Detainees should be visible to guards at all times. Detainees should not have ready access to exits. When detainees are being treated, weapons assigned to the dental staff must be secured. Keep in mind that any treatment offered to coalition forces must be extended to detainees pending all status of forces agreement. For more detailed discussion refer to ATP 4-02.46.

5-5. The scope of dental services available to detainees is determined by the detainee operations medical director according to established theater policy. Operational dental support (emergency and essential) is normally available within a joint operations area. Comprehensive dental care is normally provided in a support base, but not in a deployed setting. Detention facilities do not have organic dental personnel or equipment. Depending on the anticipated dental workload, dental assets may be collocated with the detention facility. If dental assets are not collocated with the detention facility, coordination with the supporting dental facility is required. The detention facility must provide the required guard support for detainees who are being transported to the supporting dental facility. For additional information on detainee operations see FM 3-63.

EXAMINATIONS

5-6. The initial screening examination of detainees is used to identify obvious swelling, trauma, abscess, excessive bleeding, and lesions.

- Screening is done as a look-see, which is completed by using a flashlight and tongue depressor.

- When one or more of the above are noted, the detainee should be brought to the dental clinic immediately for a more involved examination with x-rays and treatment, if necessary.
- Prescriptions are written as deemed necessary for the treatment of the detainee's dental condition.

5-7. Screening examination findings are recorded on Standard Form (SF) 603 *(Medical Record—Dental)* and SF 603A *(Medical Record—Dental-Continuation)* and placed in the detainee's medical record which was initiated during the medical screening conducted when the detainee was inprocessed to the theater detention facility.

- Obvious findings recorded include extractions (such as root tips or nonrestorable caries), restorable caries, and partially impacted wisdom teeth.
- Detainees are asked if pain is involved and the response is noted.

TREATMENT SCREENING PROCEDURES

5-8. After detainees have been medically inprocessed to the theater detention facility, periodic screens may be required to intercept dental emergencies.

5-9. A specific detainee may be referred for dental evaluation and treatment from a number of areas. The procedure for requesting a specific detainee to report for dental evaluation and treatment is to provide a memorandum to the military police the night before, requesting the detainee report in the morning. The detainee can be referred by—

- Consults turned in from doctors.
- Medical inprocessing screens.
- Sick call.
- Follow-ups from the previous day.

5-10. When detainees come for treatment, the treatment is documented on a new SF 603 and SF 603A.

- The detainee's name and internment serial number is written in pen and their domicile location is entered in pencil as this may change.
- The SF 603 and SF 603A are maintained in the detainee's individual medical record. The medical record is requested from the supporting patient administration division, as required.

5-11. Evaluation and determination of required treatment consists of the following—

- The dentist and translator screen the detainee's medical history for any adverse reaction to previous dental treatment.
- The detainee is asked where and what kind of pain they are experiencing. This is documented on the SF 603 and SF 603A.
- Radiographs are taken of the teeth that the detainee has complained about. The dental officer determines whether other teeth need to be x-rayed that may require dental treatment.
- Once taken, the dentist is notified and interprets the x-ray. The assistant is then told what type of treatment to setup for.
  - Detainees are informed through a translator of treatment required.
  - They have the opportunity to either accept or refuse treatment.
  - If treatment is refused, they are informed of the complications that may result from not having treatment and the refusal is noted in their dental records.

5-12. Detainees often do not get to eat breakfast before they come in the morning; therefore, the dental clinic maintains nutritional support drinks in the clinic, for those detainees who—

- Need to take pain medication immediately.
- Will have extensive oral surgery (several teeth taken out in one day).
- Are diabetic (given before receiving treatment).

5-13. Once the dental procedure is completed, if a—

- Prescription is required and subsequently written, it will include the detainee's name, internment serial number, and domicile location.

- Prescription for an immediate dose is written, the assistant will take it down to the pharmacy to have it filled.
- Prescription is written for the detainee to take later, this is indicated across the top and turned in to the pharmacy.

5-14. Once the detainee is finished with the dental procedure, —

- Postoperative instructions are given through a translator.
- If required, an immediate dose of medication is given.

Note. Detainees will not keep medications on their person. All doses of the medication will be provided per established procedures in the theater detention facility SOP.

- The guard is asked to return the detainee to the compound, hospital ward, or holding cell as appropriate.
- The guard is asked to bring in the next detainee. For security reasons, a maximum number of detainees permitted in the clinic is one at a time. This is dependent upon the size of the area and the number of providers.
- Follow-up examinations will be requested as needed.

Weapons

5-15. Weapons belonging to staff members should not be allowed into the clinic area when detainees are being examined or treated. Weapons should be secured in predesignated areas in accordance with established policies and procedures. This will ensure that they are inaccessible to detainees.

Translators

5-16. A translator is required during all dental treatment of detainees. The translator is required to assist the dental officer in ensuring the medical history is accurately reviewed, to inform the detainee of the procedures to be performed, and to translate the concerns of the detainee to the dental officer and of the dental officer to the detainee during treatment.

Photographs

5-17. There are stringent regulations pertaining to the photographing of detainees. Medical photographs will only be used to document preexisting conditions and traumatic injuries and to provide a basis for justification of why treatment was performed. Any medical photographs taken become a part of the detainee's medical record.

Dental Emergencies

5-18. Dental emergencies (such as bleeding, externally expanding abscesses, pain, and trauma) are treated immediately after emergency room notification, dental evaluation, and confirmation of urgency.

HOSPITAL PATIENTS

5-19. Inpatients are treated on a per consult basis either at the bedside or in the clinic based on ambulatory capacity. All detainee inpatients must be under guard when leaving the ward and continuously while they are off the ward. Detainee inpatients cannot move within the facility or to the clinic unless under guard.

5-20. Detainees admitted for reasons related to dental emergencies may be admitted by the emergency room physician per dental consult and emergency care required. Discharge is per mutual agreement between medical and dental staff.

DENTAL SERVICE SUPPORT TO CHEMICAL, BIOLOGICAL, RADIOLOGICAL, AND NUCLEAR OPERATIONS

5-21. Health service support operations conducted in a CBRN environment are described in detail in ATP 4-02.7/MCRP 4-11.1F/NTTP 4-02.7/AFTTP 3-42.3. Medical units must be prepared to establish a patient decontamination station in proximity to the MTF.

5-22. Medical units are not staffed to conduct patient decontamination operations and require augmentation from the supported units. The treatment of contaminated patients, to include treatment protocols are defined in ATP 4-02.7/MCRP 4-11.1F/NTTP 4-02.7/AFTTP 3-42.3, ATP 4-02.83/MCRP 4-11.1B/NTRP 4-02.21/AFMAN 44-161, ATP 4-02.84/MCRP 3-40A.3/NTRP 4-02.23/AFMAN 44-156_IP, ATP 4-02.85/MCRP 3-40A.1/NTRP 4-02.22/AFTTP(I) 3-2.69, and other Army medical doctrine.

FUNDAMENTALS

5-23. Upon notification and or verification of a CBRN attack, dental units immediately cease dental treatment operations and assume the appropriate levels of mission-oriented protective posture. Due to their proximity to the combat forces which they support, dental units must be able to operate successfully in CBRN environments. Successful operations hinge on their ability to recognize and respond to the CBRN threat. Their ability to respond appropriately prevents injury, damage, or loss of both personnel and materiel.

5-24. All units have inherent capabilities to perform the basic CBRN functions of assessed threats and hazards, provide protection in and against CBRN environments, and mitigate CBRN incidents. While CBRN enablers may be within the support area, their primary focus will be in support of the missions of movement and maneuver forces. Staffs plan for CBRN defense as part of the protection plan and plan support as needed from CBRN enablers. The integrating activity of hazard awareness and understanding integrates the activities of all the functions to gain situational understanding of how CBRN hazards in the area of operations affect mission accomplishment.

ASSESS

5-25. Through information collection and dissemination, effective warning and reporting, modeling, and hazard awareness and understanding units possess the ability to estimate the potential for (or the existence of) CBRN threats and hazards. Assessing hazards allows proactive decision making and encompasses all of the capabilities to evaluate the potential for CBRN threats and hazards in the operational environment, detect and model CBRN hazards, and determine the characteristics and parameters of hazards throughout the operational environment that bear on operational and tactical decisions. Detection in CBRN environments refers to the presumptive confirmation/denial of a CBRN hazard. Detection may be conducted by visual observation of a CBRN release/strike, potential CBRN casualty, or by CBRN detectors. Any personnel or unit that detects a CBRN agent must immediately execute battle drill 10 (React to a chemical attack) and transmit a CBRN 1 Report.

PROTECT

5-26. All units have capabilities for protection against CBRN incidents. *Protection* is the preservation of the effectiveness and survivability of mission-related military and nonmilitary personnel, equipment, facilities, information, and infrastructure deployed or located within or outside the boundaries of a given operational area (JP 3-0). It encompasses the execution of physical defenses to negate the effects of CBRN hazards on personnel and material. Protection conserves the force by providing individual and collective protection postures and capabilities.

5-27. Protecting the force from CBRN incidents includes hardening systems and facilities, preventing or reducing individual and collective exposures, or applying medical prophylaxes. Successful protection efforts prevents disruption to operations and organizations by minimizing unnecessary time in cumbersome protective postures and by minimizing decontamination requirements. Protection may be achieved by bypassing contamination or avoiding contaminated areas. Avoiding contamination requires the ability to recognize the presence or absence of CBRN hazards in the air; on water, land, personnel, equipment, and facilities; and at short and long ranges.

MITIGATE

5-28. Contamination mitigation is described as the planning and actions taken to prepare for, respond to, and recover from contamination associated with all CBRN threats and hazards in order to continue military operations (JP 3-11). The mitigate function includes capabilities to negate hazards, such as the decontamination task. Following a CBRN attack, decontamination should be conducted as soon as possible in order to reduce the possibility of CBRN casualties. The decision to conduct decontamination should be made only after considering the options that are available based on the type of contamination (persistent, nonpersistent), time available, tactical situation, weather, and readiness of the forces in protective equipment.

5-29. The levels of decontamination are immediate, operational, thorough, and clearance—

- **Immediate**. Immediate decontamination is a lifesaving measure that should be conducted as soon as possible by the individual, buddy, or crew. It includes skin decontamination, personal wipe down, operator wipe down, and spot decontamination. Immediate decontamination should be trained as a battle drill following a CBRN attack and is conducted at the point of contamination.
- **Operational**. Operational decontamination limits the spread of contamination, allows the force to continue operations within the contaminated area, and enables the freedom of maneuver. The tasks include mission-oriented protective posture gear exchange and vehicle wash down. In a CBRN hazard area, the operational decontamination is conducted in a clean area, close to the objective. It is conducted with organic capabilities and the unit trained team.
- **Thorough**. Thorough decontamination provides a reduction of risk that allows long-term mission-oriented protective posture reduction. The tasks include detailed equipment decontamination and detailed troop decontamination. Outside support from the CBRN unit may be requested, and augmentation is provided to support. Thorough decontamination is resource- and time-intensive, and it is recommended to take place after a unit has completed operations. Detailed troop decontamination is conducted by the unit.
- **Clearance**. Clearance decontamination allows unrestricted transportation, maintenance, and the employment or disposal of equipment. CBRN forces may be called on to advise a commander on support to clearance decontamination. Current United States Army CBRN structures are unable to conduct clearance decontamination to DOD policy standards. Outside agencies are needed to support clearance decontamination.

This paragraph implements STANAG 2584

DENTAL SUPPORT TO GLOBAL HEALTH ENGAGEMENT OPERATIONS

5-30. Dental problems and oral pain are very common in most countries. Oral conditions affected 3.9 billion people and the the burden of oral disease accounted for 15 million disability-adjusted life-years in the Global Burden of Disease Study 2010. Untreated caries in permanent teeth was the most prevalent condition (global prevalence 35% for all ages combined) evaluated for the entire study. Oral health is a determining factor for quality of life (work and school absenteeism) and has a proven strong correlation with general health.

5-31. Caries, periodontitis, oral pathology are the most common causes of oral problems. These diseases are mostly preventable diseases.

5-32. A medical component can be tasked to provide for humanitarian care for local people. Due to the morbidity rate of oral health disease the demanded care will be for the dental services. The following paragraphs provide guidelines and considerations for planning and delivering oral health care. They provide guidelines for the dental (oral health) involvement in missions with a humanitarian character as described in AJMedP-6. (STANAG 2563, Edition 2, 5 November 2015).

PRINCIPLES

5-33. The main principle for humanitarian aid is to provide necessary care for local people or refugees. Military forces should tailor the care provided to meet the needs of local people without undermining the local oral health care system availability, and level of care. They should allow oral health care sustainment by local care providers, international organizations or non-governmental organizations after withdrawal of operational military forces. See ATP 3-57.20/MCRP 3-33.1C for additional information on foreign humanitarian assistance.

5-34. Chronic diseases require continuing care and prevention. Long term sustainability of care should be considered in the planning process. Prevention of most diseases, general and oral, can be done by improving personal hygiene.

5-35. The three phases in humanitarian oral health care are:

- Pain relief.
- Prevention.
- Education and support of patients and local care providers.

General Guidelines

5-36. Adjust deployed dental team activities in accordance with existing local resources and level of care.

5-37. Focus on activities that can be sustained.

5-38. Work together with local care providers.

5-39. Support the improvement of local deliverance of care services (infection prevention control).

5-40. Be aware of creating tension between local care providers and the local population through intervention.

5-41. The final goal is to empower local people and not to leave them more dependent.

MILITARY ORAL HEALTH CARE

5-42. In most military operations oral health care capabilities are present. The involved dental personnel can provide humanitarian care using the guidelines described in this document. The skill sets needed are available in every Role 2 and 3 scenario. Extra resources such as supplies and additional equipment might be needed when operating on a larger scale or in an off-base location.

5-43. Military care providers will be present for a relatively short period, therefore in all operations with a humanitarian component the continuity of care should be considered. The program should be simple on every level so local care providers or nongovernmental organization can take over easily after deployment.

CONSIDERATIONS FOR PLANNING

5-44. Decisions on planning are made in consultation with the deployed dental team. The humanitarian aid should never be provided to the detriment of the military units' integral oral health care support. Thus, deployment of extra personnel and resources may be required in support of a humanitarian operation.

5-45. The first consideration is applicable to every mission type. Is local oral health care available? If no: military care providers could provide care on limited levels as described in the table 5-1 on page 5-7. If yes: first investigate local needs through communication with local care providers.

5-46. Is medical civil-military operations or interorganizational cooperation feasible? If no: help to improve local facilities with materials, supplies and/or personnel. Education of local care providers can be added to the program. If yes: good communication with civilian, local care providers and authorities is needed. Patients should also know what they can expect and what is available.

5-47. Next, focus on improvement through provision of materials, supplies and personnel, starting a prevention program like 'fit for school' is possible. Education of local care providers can be added to the program.

POSSIBILITIES FOR ORAL HEALTH CARE ACROSS DIVERSE MISSION TYPES

5-48. The four diverse mission types are divided into Collective defence-Article 5 operations and three Non-article 5 crisis response operations. The NATO Web site contains information about Article 5 of the North Atlantic Treaty (also known as the Washington Treaty of 1949).

5-49. The Non-article 5 crisis response operations are:

- Peace Support Operations.
- Non Combatant Evacuation Operations.
- Humanitarian Assistance Operations.

5-50. Table 5-1 describes the possible dental care needed for the diverse mission types.

Table 5-1. Types of dental care needed for diverse mission types

Type of mission	*Article 5*	*PSO*	*NEO*	*HA*
Types of dental care	Pain relief	Pain relief Prevention Education and support of patients and local care providers	Pain relief	Pain relief Prevention Education and support of patients and local care providers

HA	Humanitarian Assistance Operations	MHA	Medical Humanitarian Assistance
PSO	Peace Support Operations	NEO	Non Combatant Evacuation Operations

5-51. DODI 2000.30 instructs the DOD to conduct Global Health Engagement activities in support of U.S. national security policy and defense cooperation strategy. For detailed discussion regarding dental support to global health engagement operations, refer to FM 4-02 and DODD 6200.04.

This page intentionally left blank.

Appendix A

Dental Readiness Program

The intent of the dental readiness program is to reduce the risk of noncombat related dental casualties. Dental readiness program methods include—

- Annual dental examinations in order to determine the oral fitness and classification of each Soldier in the command.
- Priority examinations and treatment appointments for Soldiers who are at high risk or who have not had recent dental examinations (dental class 3 and dental class 4).
- Monthly dental readiness reports to unit commanders that identify the dental risk profile of the unit.

PROCEDURES

A-1. The dental records of every Regular Army Soldier will be screened on arrival at a new permanent duty station.

- Regular Army Soldiers in-processing at their permanent duty stations whose dental records indicate that no examination has been performed within the previous six months or who are dental class 3 or dental class 4 must have a dental examination at the local dental treatment facility prior to completing their in-processing procedures. Every effort will be made to achieve dental class 1 or dental class 2 for all in-processing Soldiers prior to reporting to their unit.
- Soldiers whose records indicate they are in dental class 1 or dental class 2 will have their next annual dental examination scheduled no later than 13 months from the date of completion of their last dental examination and readiness classification.
- Every Soldier's record will also be screened to ensure a panographic x-ray is present and that it is of adequate quality for diagnostic/identification purposes. If no panographic x-ray is present, one will be taken and placed in the dental record. There is no time requirement on updating panographic x-rays; however, the existing images must accurately represent the current oral condition of the Soldier.

A-2. Soldiers will have their dental readiness classification updated annually by a clinical examination. Soldiers who fail to receive a dental examination by the last day of the 15th month from the date of their last examination or dental readiness update are automatically classified as dental class 4. This Soldier is then in a non-ready but deployable status in accordance with Army Directive 2019-07 (Army Dental Readiness and Deployability) and DODI 1332.45 (Retention Determinations for Non-Deployable Service Members).

A-3. Appointments for dental treatment required to achieve a satisfactory dental readiness status are scheduled according to the Soldier's current dental classification.

- Soldiers in dental class 1 require no treatment.
- Soldiers in dental class 2 are counseled on their dental needs and every effort must be made to move that patient to dental class 1.
- Soldiers in dental class 3 will have the condition causing the potential dental emergency described in the narrative portion of their dental health record so they may be reclassified to dental class 1 or dental class 2 as soon as the condition is corrected. Personnel in dental class 3 will receive expedited treatment to remove them from this unsatisfactory dental classification. The immediate goal of expedited treatment is to take care of the patients most urgent dental needs and to avoid a potential dental emergency.
- Soldiers in class 4 will have their annual or other required dental examinations scheduled. The Soldier's dental readiness category will be updated and an appointment will be scheduled as above.

ORGANIZATIONAL RESPONSIBILITIES

A-4. Commanders are responsible for the dental readiness of the Soldiers assigned to their command. Commanders must establish and implement procedures that will ensure that their command meets dental readiness standards as required by the dental readiness program. Commanders will make their personnel available for appointments and maintain surveillance over the program to ensure the following:

- The supporting unit's dental clinic is the sole custodian of all unit personnel dental records. Newly arriving Soldiers will turn in their dental records to dental personnel for initial screening.
- When out-processing a duty station, Soldiers whose records indicate no examination in the previous six months or who are a dental class 3 or dental class 4 will have dental examinations prior to completing their out-processing procedures. If a Soldier out-processes without achieving dental class 1 or dental class 2, they must receive priority care at their next duty location for a dental examination and/or to eliminate the emergent dental care problem. The unit's executive officer and senior noncommissioned officer (NCO) will be notified to assure follow-up care through the supporting dental clinic.
- All Soldiers in the unit will report for annual dental examinations. The unit is responsible for providing current personnel rosters to the supporting dental facility. The dental treatment facility uses these rosters to verify that each Soldier's dental treatment record is on file.
- The supporting dental clinic provides rosters to the unit through both the Medical Protection System and Corporate Dental Application at 60 days and again at 30 days prior to their Soldiers being listed as dental class 4.
- The unit ensures that Soldiers listed as dental class 3 or dental class 4 or who require an annual dental examination are available for examination. The units also establish policies and procedures for dealing with Soldiers who are in repeated noncompliance.
- Emphasis should be placed on ensuring that Soldiers being assigned to recruiting duty, full-time manning programs for the United States Army Reserve, Reserve Officers' Training Corps duty, and military assistance group or embassy duty are in dental class 1 before departing for their new assignments.
- Emphasis must be placed on ensuring that Soldiers in early deployment forces are maintained in a dental class 1 or dental class 2 status.

A-5. Commanders of dental activities, dental clinic commands, and separate Regular Army dental units are responsible for assisting supported units in maintaining the readiness of Soldiers.

A-6. Dental activity/dental clinic commands/dental unit commanders are responsible for the following functions:

- Serve as dental readiness advisors to unit commanders to assure compliance with the goal of 95 percent dental readiness (dental class 1 and dental class 2 combined).
- Screen dental records of newly arrived Soldiers to establish their dental readiness classification.
- Assist unit commanders in the elimination of dental class 3 and dental class 4 ratings by timely unit notification and coordination of appointments. Rosters are delivered in person or made available electronically at 60 days and then again at 30 days prior to the Soldier's required annual examination date.
- Provide monthly updates to the unit or its supporting personnel activity on changes in each Soldier's dental classification and date of last dental examination.
- Conduct audits of dental records annually against the unit's dental readiness program roster located in Corporate Dental Application.

Appendix B

Dental Equipment Sets

Organizational equipment authorizations are identified on a respective unit's modified table of organization and equipment. This appendix will provide basic details on the different dental equipment sets that are used for providing dental services for operational organizations.

This appendix implements STANAG 2128

FIELD DENTAL SETS

B-1. Field dental sets provide the equipment necessary for dental corps personnel to deliver and provide forward dental service support in austere environments. The equipment is designed to be portable for easy transport and set up. The equipment is robust and requires very little electrical power to operate.

B-2. All medical materiel, where specific conditions for storage or transportation such as humidity or temperature limitations apply, must be clearly marked with all relevant information.

B-3. All pharmaceuticals must be clearly marked with specific information on contents with the addition of generic name and the amount of contents in metric. All requirements for storage and conditions for transportation must be clearly indicated, if the requirements go beyond the "normal" conditions for storage and transportation of pharmaceuticals (for example drugs which are to be transported free from frost or preparations which must be protected from excessive heat, such as ointments or suppositories).

B-4. Ideally date of production, lot number, and date of expiration should appear. As a minimum date and time (if applicable) of expiration must be stated.

B-5. Each general and comprehensive dental officer in a field clinical position has the following DES assigned:

- Dental instrument and supply set, emergency care.
- Dental equipment set, comprehensive dentistry.
- Dental equipment set, dental support.
- Dental equipment set, emergency denture repair.
- Dental equipment set, dental x-ray, field.

B-6. The descriptions provided below are intended only to provide a brief description of the set and its intended purpose. For a list of the equipment contained in each of these sets go to the United State Army Medical Materiel Agency website or contact the following:

- United States Army Medical Materiel Agency, Customer Relations Management Office: Telephone: Defense Switched Network 343-2956 or commercial (301) 619-2956. The e-mail address is: usarmy.detrick.medcom-usamma.mbx.customer-relations-mgt@mail.mil.
- United States Army Medical Materiel Agency, Operations Center and Support Office: Telephone: Defense Switched Network 343-4408 or commercial (301) 619-4408. The e-mail address is: usarmy.detrick.medcom-usamma.mbx.ops-center@mail.mil.

DENTAL INSTRUMENT AND SUPPLY SET, EMERGENCY CARE

B-7. The dental instrument and supply set is a small dental emergency kit that is contained in a hand carried medical aid bag. It contains the instruments and materiels required for simple extractions and expedient

temporary restorations. Essential in this kit is the battery-operated hand piece, which allows the dental officer to open an infected tooth, prepare a cavity for temporary restoration, or section a tooth for extraction.

B-8. The dental instrument and supply set, emergency care, is intended for use when the situation does not permit the setup of the dental officer's standard equipment.

DENTAL EQUIPMENT SET, COMPREHENSIVE DENTISTRY

B-9. The DES, comprehensive dentistry is considered the primary dental equipment set for providing operational care. The field dental equipment contained in the DES is compact, rugged, and requires a limited power demand. This set provides the dental armamentarium used in the procedures to diagnosis and treat:

- Caries.
- Defective restorations.
- Occlusal trauma.
- Tooth luxation/evulsion.
- Gingivitis and early/moderate periodontitis.
- Periodontal abscess.
- Oral lesions that are traumatic or inflammatory.
- Routine endodontics.
- Postmortem examination.
- Extractions.

B-10. Major items of equipment include one each, portable, field-type: dental chair and stool unit; dental operating and treatment unit; dental light set; and compressor.

DENTAL EQUIPMENT SET, DENTAL SUPPORT

B-11. The DES, dental support, is found in both the area support squad of medical companies, hospital augmentation detachment (medical 32 bed), and the DCAS. It contains items which can be shared in a clinical environment and is issued to each forward treatment team.

B-12. It provides necessary support items that include a curing light, composite resin, electric pulp tester, sterilizer, sink, and laboratory table.

DENTAL EQUIPMENT SET, EMERGENCY DENTURE REPAIR

B-13. The DES, emergency denture repair, provides basic materials for expedient denture repairs.

DENTAL EQUIPMENT SET, DENTAL X-RAY, FIELD

B-14. The DES, dental x-ray, field, provides a standard dental x-ray capability for the dental team.

SPECIALTY DENTAL SETS

B-15. General and comprehensive dental officers and dental specialists assigned to field clinical positions may have the following DES and specialty dental sets at their disposal:

- Dental equipment set, prosthodontic.
- Oral and maxillofacial surgery set.
- Dental hygiene, field, DES.

DENTAL EQUIPMENT SET, PROSTHODONTIC

B-16. This set provides clinical and laboratory items necessary to support fixed and removable prosthodontic procedures. The prosthodontic DES must be used in conjunction with the DES, dental support.

ORAL AND MAXILLOFACIAL SURGERY SET

B-17. This set is also a new addition intended to support the oral and maxillofacial surgeon in the combat support hospital and the field hospital. This set contains modern bone drill and plating systems.

DENTAL HYGIENE, FIELD, DENTAL EQUIPMENT SET

B-18. This set includes those instruments and materials necessary for providing preventive dentistry services by the preventive dentistry specialist/sergeant.

MANAGEMENT OF CLASS VIII SUPPLIES

B-19. The Class VIII supply functions for medical units/elements is primarily accomplished through the management of assigned medical/dental equipment sets and through basic ordering for replenishment procedures. For a detailed discussion on medical logistics refer to ATP 4-02.1.

This page intentionally left blank.

Appendix C

Quality Assurance Plans

Quality assurance plans provide a system of checks and balances that enable dental commanders and their staffs to objectively assess the quality of care being provided and the efficiency of the dental units. The objectives of the plan are to—

- Provide dental care consistent with the capabilities of the dental treatment facility and staff qualifications.
- Reduce risk creating incidents for the patients treated.
- Improve provider patient communication and patient satisfaction.
- Evaluate practitioner performance.

QUALITY ASSURANCE IN THE THEATER

C-1. The dental unit commander is responsible for the management of the unit's quality assurance plan. Policy and guidance on quality assurance matters comes through the technical/staff dental surgeon channels. As with other matters for which policy is stated in references directed at peacetime care and organizations, quality assurance policy in AR 40-68 must be modified to fit the tactical situation.

C-2. In any case, the spirit of quality assurance must be addressed. The Soldier in the theater should have access to the highest possible quality of dental care, consistent with the tactical scenario, as they would receive in a garrison dental facility. Establishment of a sound quality assurance plan by dental commanders and staff dental surgeons at all levels helps to ensure the individual Soldier's accessibility.

PATIENT CARE EVALUATION

C-3. Patient care evaluations provide a tool to evaluate the quality and appropriateness of dental care being provided. These evaluations also provide a means to ensure that dental treatment records are established and maintained in accordance with regulatory guidance and established policies.

C-4. Periodic audits also aid dental commanders and their staff in evaluating distribution of care and compliance with theater treatment policies regarding the type of care to be provided. Dental radiology, infection control, and barrier protection are areas of special command interest in field environments.

UTILIZATION MANAGEMENT

C-5. Access to and the effective utilization of dental services in theater is METT-TC driven. The goal of utilization management is to provide the highest quality dental care possible in the most efficient manner.

C-6. Utilization management is part of performance improvement data collected for the purpose of organizational improvement. For more information on this subject, see AR 40-68. Specific areas of interest include but are not limited to:

- Time management in patient care.
- Patient waiting time.
- Number of patients treated per unit of practitioner's time.
- Equipment and facility management.
- Logistics management.

C-7. Emergency and preventive care should be provided as close to supported troop populations as possible. The result is faster return to duty of Soldiers and fewer dental emergency evacuations. Preventive and operational dental care are provided at the convenience (location and time) of supported units.

RISK MANAGEMENT

C-8. The risk management program is concerned with the prevention of accident and injuries. For dental support in the theater, it encompasses the reduction of risk to patients, visitors, and unit personnel. For more information concerning risk management, see ATP 5-19.

DENTAL RADIOLOGY

C-9. Quality assurance measures regarding dental radiology procedures include training personnel who operate dental x-ray equipment to recognize the risks associated with the use of this equipment. This training should include risk management and risk avoidance techniques which must be implemented. The following represent some of the techniques:

- X-ray equipment is set up and operated in accordance with the manufacturer's operational guidelines.
- Patient shielding and protection measures are implemented.
- Techniques of substituting distance for protective shielding during x-ray operations are used.
- Exclusion areas are clear of all personnel prior to putting x-ray equipment into operation.
- Dental personnel operating x-ray equipment are issued dosimeters and the dosimeters are handled and processed correctly.
- All radiographic information is entered in the patients' records.

Appendix D

Sample Clinical Standard Operating Procedure

The CSOP addresses only those issues relating to clinical policies, procedures, and operations. Procedures selected for inclusion in the CSOP are those which meet the unit's clinical mission.

PUBLICATION FORMAT

D-1. The most often used format for the CSOP is a loose-leaf binder arrangement. Clinical policies and procedures are subject to frequent change and a loose-leaf arrangement can be easily updated. It is also relatively inexpensive and easily produced in multiple copies at the unit level.

ORGANIZATION

D-2. Annexes with supporting appendixes and tabs are easy to change and update; therefore, maximum use of annexes in a CSOP is advisable. The CSOP should be organized as follows:

- Directive.
- Table of contents.
- Record of changes and corrections.
- Annexes, appendixes, and tabs.

DIRECTIVE

D-3. The commander's directive should be the first page of the CSOP. This directive is a letter order signed by the commander that directs implementation of the CSOP. The directive should be on unit letterhead and in memorandum format.

TABLE OF CONTENTS

D-4. The information contained in CSOP is variable and will depend on the type of unit and, of course, guidance and policy from the unit commander and their higher headquarters. The table of contents should have an outline of annexes, appendixes, and tabs.

RECORD OF CHANGES AND CORRECTIONS

D-5. Since information in the CSOP is subject to frequent change, include a page in the front of the binder to record changes and corrections. This allows the user and the dental treatment facility officer in charge to easily audit that particular copy of the CSOP. A single page formatted as shown in Figure D-1 on page D-2 will serve this purpose.

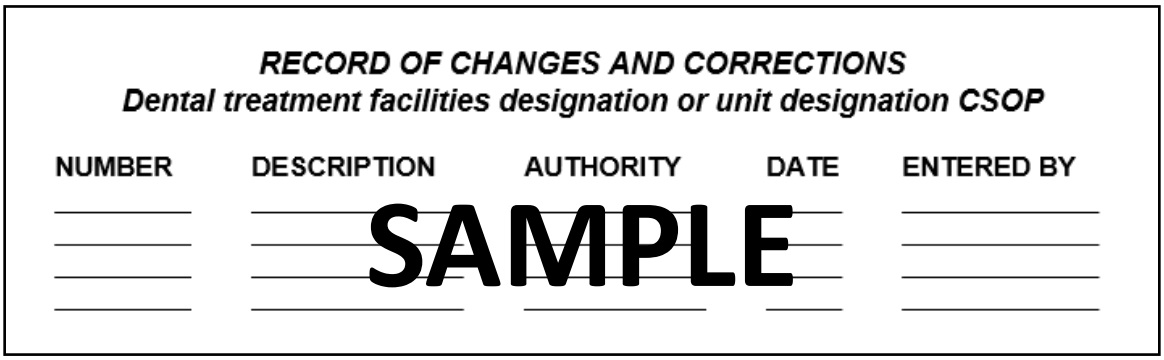

Figure D-1. Format for changes and corrections

ANNEXES

D-6. Information in the CSOP is incorporated into annexes dealing with general areas. Annexes are supported by appendixes and tabs that deal with more specific issues. Information in annexes and supporting appendixes and tabs should not be redundant, nor voluminous.

D-7. There should be sufficient detail to ensure proper performance of the task addressed or compliance with the policy prescribed. As with the tactical standard operating procedure, annexes to the CSOP are directive and address who, what, where, when, and how.

D-8. Annexes are attached in alphabetical order after the body of the table of contents, with appendixes (numerical) and tabs (alphabetical) following their supported annexes. Annexes are generally formatted in the same manner prescribed for the tactical standard operating procedure; however, as a matter of expediency and economy, some material may be incorporated as an appendix or tab in its original form simply by adding a tab or appendix designator. Some examples of this method are manufacturer's instruction manuals, military technical manuals, or written policy directives from higher headquarters.

D-9. The information contained in annexes is variable and will depend on the type of unit and, of course, guidance and policy from the unit commander and their higher headquarters. The following is an outline of annexes, appendixes, and tabs recommended for inclusion in a generic CSOP.

D-10. Annex A—Organization. A general statement of the mission and organization of the unit.

- Appendix 1—Dental treatment facility layout and load plans.
  - Tab A—Dental treatment facility layout. Line diagram of the suggested dental treatment facility layout.
  - Tab B—Vehicle load plans. Load plans for the dental treatment facility personnel and equipment.
- Appendix 2—Personnel and duty descriptions
  - Tab A— Organization of personnel assigned to the dental treatment facility and delineation of duties.
  - Tab B—Duty description. Detailed description of individual and special duties as necessary.

D-11. Annex B—Equipment. Listing of equipment assigned to the dental treatment facility.

- Appendix 1—Operation and maintenance. Statement of dental treatment facility policy for equipment operation and operator maintenance.
  - Tab A—Major End Items. Manufacturer's operator manual or service technical manual, if available, for each major item of equipment, to include vehicles and generators.
  - Tab B—Subcomponent Items. Manufacturer's operator manual or service technical manual, if available, for each component item of equipment, to include medical devices.
- Appendix 2—Maintenance support procedures. Prescribe procedure for obtaining maintenance support.

D-12. Annex C—Supply.

- Appendix 1—class VIII medical supply. Statement of procedure for ordering, receiving, storing, and issuing class VIII medical supplies.
- Appendix 2—Property control. Hand receipt procedure for maintaining accountability of the dental treatment facility's TOE and common tables of allowance property.
- Appendix 3—Precious metals control. Procedure for control of precious metals and finished fixed prosthodontic cases, if appropriate.
- Appendix 4—Medication control measures. Procedure for prescribing, issuing, storing, and disposing of schedule substances.

D-13. Annex D—Patient care operations.

- Appendix 1—Patient treatment policy. Statement of treatment policy to include priority of care, if appropriate.
  - Tab A—Policy letters from higher headquarters.
  - Tab B—Eligibility for care matrix.
  - Tab C—Patient flow. Prescribe patient flow.
  - Tab D—Detainee dental operations. Provide information on security procedures.
- Appendix 2—Patient records. Prescribe procedure for preparation and maintenance of patient records.
- Appendix 3—Workload reporting. Prescribe procedure for workload data accountability and reporting.
- Appendix 4—Preventive dentistry. Describe and define responsibilities for the dental treatment facility's preventive dentistry program.
- Appendix 5—Referrals. Prescribe procedure for referral and evacuation of patients for treatment available at other dental treatment facilities.
- Appendix 6—Nutritional supplements. Provide guidance on providing patients undergoing lengthy treatment nutritional supplements prior to undergoing a dental procedure.

D-14. Annex E—Immediate response situations.

- Appendix 1—Mass casualty scenarios.
- Appendix 2—Reaction to enemy action. Prescribe the dental treatment facility's response in the event of enemy action, to include handling of patients within the dental treatment facility.
  - Tab A—CBRN response.
  - Tab B—Ground attack.
  - Tab C—Air attack.
- Appendix 3—Mass casualty response. Prescribe the dental treatment facilities responsibilities in the event of mass casualties (alternate wartime role).

D-15. Annex F—Infection control. Statement of required infection control procedures.

- Appendix 1—Personal and patient protection. Prescribe procedure for protection of medical provider and patient.
- Appendix 2—Sterilization of instruments.
- Appendix 3—Disposal of medical waste.

D-16. Annex G—Relocation. Procedures for emplacement and displacement of the dental treatment facility.

- Appendix 1—Dental treatment facility setup.
- Appendix 2—Dental treatment facility takedown.
- Appendix 3—Provision of dental treatment during relocation. Prescribe procedure for provision of emergency dental treatment during relocation.

D-17. Annex H—Safety. Statement of safety policies and procedures.

- Appendix 1—X-ray operations.
- Appendix 2—Fire safety.

- Appendix 3—Hearing conservation.
- Appendix 4—Hazardous material handling.

D-18. Annex I—Physical security. Statement of physical security plan for the dental treatment facility.

Glossary

This glossary lists acronyms and terms with Army or joint definitions. Where Army and joint definitions differ, (Army) precedes the definition. Terms for which ATP 4-02.19 is the proponent are marked with an asterisk (*). The proponent publication for other terms is listed in parentheses after the definition.

SECTION I – ACRONYMS AND ABBREVIATIONS

ADP	Army Doctrine Publication
AFMAN	Air Force Manual
AFTTP	Air Force Tactics, Techniques, and Procedures
AHS	Army Health System
AO	area of operations
AR	Army Regulation
BCT	brigade combat team
ATP	Army Technique Publication
BSMC	brigade support medical company
CBRN	chemical, biological, radiological, and nuclear
CMS	centralized material service
CSOP	clinical standard operating procedure
DA	Department of Army
DCAS	dental company (area support)
DES	dental equipment set
DOD	Department of Defense
DODI	department of defense instruction
FM	Field Manual
JP	Joint Publication
MCAS	medical company (area support)
MCRP	Marine Corps Reference Publication
MCTP	Marine Corps Tactical Publication
MEDBDE(SPT)	medical brigade (support)
MEDCOM(DS)	medical command (deployment support)
METT-TC	mission, enemy, terrain and weather, troops and support available, time available, civil considerations
MTF	medical treatment facility
NATO	North Atlantic Treaty Organization
NCO	noncommissioned officer
NTRP	Navy Tactical Reference Publication
NTTP	Navy Tactics, Techniques, and Procedures

OR	operating room
SF	standard form
SFG	special forces group
SOP	standard operating procedure
STANAG	standardization agreement
TB MED	technical bulletin, medical
TC	training circular
TM	technical manual
TOE	table of organization and equipment
U.S.	United States

SECTION II – TERMS

Army Health System

A component of the Military Health System that is responsible for operational management of the health service support and force health protection missions for training, predeployment, deployment, and postdeployment operations. Army Health System includes all mission support services performed, provided, or arranged by the Army Medicine to support health service support and force health protection mission requirements for the Army and as directed, for joint, intergovernmental agencies, coalition, and multinational forces. (FM 4-02)

***comprehensive dental care**

Dental treatment to restore and/or maintain a Soldier's optimal oral health, function, and aesthetics.

contamination mitigation

The planning and actions taken to prepare for, respond to, and recover from contamination associated with all chemical, biological, radiological, and nuclear threats and hazards to continue military operations. (JP 3-11)

***dental care**

The preventive, restorative, and surgical treatment of the hard and soft oral tissues, which is comprised of operational dental care and comprehensive dental care.

***emergency dental care**

Care given for the relief of oral pain; diagnosis and treatment of infections; control of life-threatening oral conditions (hemorrhage, cellulitis, or respiratory difficulties); and treatment of trauma to teeth, jaws (maxilla/mandible), and associated facial structures is considered emergency care.

essential care

The absolutely necessary initial, en route, resuscitative, and surgical care provided to save, stabilize, and return as many Soldiers to duty as quickly as possible. (FM 4-02)

***essential dental care**

Dental care necessary to intercept potential emergencies to prevent lost duty time and preserve fighting strength.

force health protection

(Joint) Measures to promote, improve, or conserve the behavioral and physical well-being of Service members to enable a healthy and fit force, prevent injury and illness, and protect the force from health hazards. Also called FHP. (JP 4-02) (Army) Force health protection are measures that promote, improve, or conserve the behavioral and physical well-being of Soldiers comprised of preventive and treatment aspects of medical functions that include: combat and operational stress control, dental services, veterinary services, preventive medicine, and laboratory services. Enabling a healthy and fit force, prevent injury and illness, and protect the force from health hazards. (FM 4-02)

health service support

(Joint) All services performed, provided, or arranged to promote, improve, conserve, or restore the mental or physical well-being of personnel. Also called HSS. (JP 4-02) (Army) Health service support is support and services performed, provided, and arranged by the Army Medicine to promote, improve, conserve, or restore the behavioral and physical well-being of personnel by providing direct patient care that include medical treatment (organic and area support) and hospitalization, medical evacuation to include medical regulating, and medical logistics to include blood management. (FM 4-02)

mass casualty

Any number of human casualties produced across a period of time that exceeds available medical support capabilities. (JP 4-02)

medical treatment facility

(Joint) A facility established for the purpose of furnishing medical and/or dental care to eligible individuals. (JP 4-02) (Army) Medical treatment facility refers to any facility established for the purpose of providing medical treatment. This includes battalion aid stations, Role 2 facilities, dispensaries, clinics, and hospitals. (FM 4-02)

***operational dental care**

The dental care provided for deployed Soldiers in theater consisting of emergency dental care and essential dental care.

protection

The preservation of the effectiveness and survivability of mission-related military and nonmilitary personnel, equipment, facilities, information, and infrastructure deployed or located within or outside the boundaries of a given operational area. (JP 3-0)

This page intentionally left blank.

References

All URLs were accessed on 12 February 2020.

REQUIRED PUBLICATIONS

These documents must be available to the intended users of this publication.

ADP 1-02, *Terms and Military Symbols*, Change 1, 14 August 2018.

FM 1-02.1, *Operational Terms*, 21 November 2019.

FM 4-02, *Army Health System*, 26 August 2013.

DOD Dictionary of Military and Associated Terms, June 2020.

RELATED PUBLICATIONS

These documents contain relevant supplemental information.

GENEVA CONVENTIONS

These documents are available online at: http://www.loc.gov/rr/frd/Military_Law/Geneva_conventions-1949.html.

Convention (I) for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field, 12 August 1949.

Convention (II) for the Amelioration of the Condition of Wounded, Sick and Shipwrecked Members of Armed Forces at Sea, 12 August 1949.

UNITED STATES CODE

This document is available online at: https://uscode.house.gov/browse.xhtml.

Title 10, Armed Forces, 3 January 2007.

NORTH ATLANTIC TREATY ORGANIZATION STANDARDIZATION AGREEMENTS

These documents are available online at: http://nso.nato.int (password required).

STANAG 2122, *Requirement for Training In Casualty Care And Basic Hygiene For All Military Personnel*, Edition 4, 10 July 2017 (AMedP-8.15, Edition A, Version 1, 10 July 2017).

STANAG 2128, M*edical and Dental Supply Procedures*, Edition 6, 21 January 2014 (AMedP-1.12, Edition A, Version 1, 21 January 2014).

STANAG 2453, *The Extent Of Dental And Maxillo-Facial Treatment At Role 1-3 Medical Support*, Edition 3, 6 February 2017 (AMedP-8.13, Edition A, Version 1, 6 February 2017).

STANAG 2466, *Dental Fitness Standards for Military Personnel and the NATO Dental Fitness Classification System*, Edition 3, 10 October 2014 (AMedP-4.4, Edition A, Version 2, 18 December 2017).

STANAG 2563, *Allied Joint Civil-Military Medical Interface Doctrine*, Edition 2, 5 November 2015 (AJMedP-6, Edition A, Version 1, 5 November 2015).

STANAG 2584, T*he Civil-Military Planning Process On Oral Health Care And Deployment Of Dental Capabilities In All Operations With A Humanitarian Component*, Edition 1, 19 June 2014 (AMedP-6.1, Edition A, Version 2, 20 December 2017).

STANAG 2598, *Allied Joint Medical Doctrine for Military Health Care (MHC)*, Edition 1, 8 February 2018 (AJMedP-8, Edition A, Version 1, 8 February 2018).

STANAG 2931, *Orders for the Camouflage of Protective Medical Emblems on Land in Tactical Operations*, Edition 4, 19 January 2018 (ATP-79, Edition B, Version 1, 19 January 2018).

DEPARTMENT OF DEFENSE DIRECTIVE/INSTRUCTION

This document is available online at: https://www.esd.whs.mil/dd.

DODD 3000.05, *Stabilization*, 13 December 2018.

DODD 6200.04, *Force Health Protection (FHP)*, 9 October 2004.

DODI 1332.45, *Retention Determinations for Non-Deployable Service Members*, 30 July 2018.

DODI 2000.30, *Global Health Engagement (GHE) Activities*, 12 July 2017.

DODI 3020.41, *Operational Contract Support (OCS)*, 20 December 2011.

JOINT PUBLICATIONS

These documents are available online at: https://www.jcs.mil/Doctrine.

JP 3-0, *Joint Operations*, 17 January 2017, *Incorporating Change 1*, 22 October 2018.

JP 3-11, *Operations in Chemical, Biological, Radiological, and Nuclear Environments*, 29 October 2018.

JP 4-02, *Joint Health Services*, 11 December 2017, *Incorporating Change 1*, 28 September 2018.

JP 4-10, *Operational Contract Support*, 4 March 2019.

MULTI-SERVICE PUBLICATIONS

These documents are available online at: https://armypubs.army.mil/.

FM 6-27/MCTP 11-10C, *The Commander's Handbook On The Law Of Land Warfare*, 7 August 2019.

ATP 3-37.10/MCRP 3-40D.13, *Base Camps*, 27 January 2017.

ATP 3-37.34/MCTP 3-34C, *Survivability Operations*, 16 April 2018.

ATP 3-57.20/MCRP 3-33.1C, *Multi-Service Techniques for Civil Affairs Support to Foreign Humanitarian Assistance*, 15 February 2013.

ATP 4-02.7/MCRP 4-11.1F/NTTP 4-02.7/AFTTP 3-42.3, M*ulti-Service Tactics, Techniques, and Procedures for Health Service Support In A Chemical, Biological, Radiological, and Nuclear Environment*, 15 March 2016.

ATP 4-02.83/MCRP 4-11.1B/NTRP 4-02.21/AFMAN 44-161, *Multi-Service Tactics, Techniques, and Procedures for Treatment of Nuclear and Radiological Casualties*, 5 May 2014.

ATP 4-02.84/MCRP 3-40A.3/NTRP 4-02.23/AFMAN 44-156_IP, *Multi-Service Tactics, Techniques, and Procedures for Treatment of Biological Warfare Agent Casualties*, 21 November 2019.

ATP 4-02.85/MCRP 3-40A.1/NTRP 4-02.22/AFTTP(I) 3-2.69, *Multi-Service Tactics, Techniques And Procedures For Treatment Of Chemical Warfare Agent Casualties And Conventional Military Chemical Injuries (this item is published w/ basic incl c1)*, 2 August 2016.

ARMY DIRECTIVES

These documents are available online at: https://armypubs.army.mil/.

Army Directive 2018-22, *Retention Policy for Nondeployable Soldiers*, 08 November 2018.

Army Directive 2019-07, *Army Dental Readiness and Deployability*, 25 February 2019.

ARMY PUBLICATIONS

These documents are available online at: https://armypubs.army.mil/.

ADP 5-0, *The Operations Process*, 31 July 2019.

AR 25-2, *Army Cybersecurity*, 4 April 2019.

AR 40-3, *Medical, Dental, and Veterinary Care*, 23 April 2013.

AR 40-35, *Preventive Dentistry and Dental Readiness*, 21 July 2016.

AR 40-66, *Medical Record Administration and Healthcare Documentation*, 17 June 2008.

AR 40-68, *Clinical Quality Management*, 26 February 2004.

AR 40-400, *Patient Administration*, 8 July 2014.

AR 220-1, *Army Unit Status Reporting and Force Registration – Consolidated Policies*, 15 April 2010.

AR 600-63, *Army Health Promotion*, 14 April 2015.

AR 870-5, *Military History: Responsibilities, Policies, and Procedures*, 21 September 2007.

ATP 3-05.40, *Special Operations Sustainment*, 3 May 2013.

ATP 3-90.90, *Army Tactical Standard Operating Procedures*, 1 November 2011.

ATP 4-02.1, *Army Medical Logistics*, 29 October 2015.

ATP 4-02.2, *Medical Evacuation*, 12 July 2019.

ATP 4-02.3, *Army Health System Support To Maneuver Forces*, 9 June 2014.

ATP 4-02.10, *Hospitalization*, 1 August 2020.

ATP 4-02.42, *Army Health System Support To Stability And Defense Support Of Civil Authorities Tasks*, 9 June 2014.

ATP 4-02.43, *Army Health System Support To Army Special Operations Forces*, 17 December 2015.

ATP 4-02.46, *Army Health System Support To Detainee Operations*, 12 April 2013.

ATP 4-02.55, *Army Health System Support Planning*, 16 September 2015.

ATP 4-02.82, *Occupational and Environmental Health Site Assessment*, 1 April 2012.

ATP 5-19, *Risk Management*, 14 April 2014.

ATP 6-22.5, *A Leaders Guide To Soldier Health and Fitness*, 10 February 2016.

FM 3-0, *Operations*, 6 October 2017.

FM 3-12, *Cyberspace and Electronic Warfare Operations*, 11 April 2017.

FM 3-63, *Detainee Operations*, 02 January 2020.

FM 6-99, *U.S. Army Report And Message Formats*, 19 August 2013.

STP 8-68E14-SM-TG, *Soldier`s Manual and Trainer`s Guide, MOS 68E, Dental Specialist, Skill Levels 1/2/3/4*, 20 October 2015.

STP 8-68EN5-SM-TG, *Soldier`s Manual and Trainer`s Guide, MOS 68E, ASI N5, Dental Laboratory Specialist, Skill Levels 1/2/3*, 26 June 2009.

TB MED 148, *U.S. Army Dental Laboratory Prosthodontic Service*, 5 July 2011.

TB MED 250, *Dental Record Administration, Recording and Appointment Control*, 28 April 2006.

TB MED 298, *Veterinary Care and Management of the Military Working Dog*, 9 May 2019.

TB MED 510, *Guidelines for the Recognition, Evaluation, and Control of Occupational Exposure to Waste Anesthetic Gases*, 1 August 2004.

TB MED 521, *Occupational and Environmental Health: Management and Control of Diagnostic, Therapeutic, and Medical Research X-Ray Systems and Facilities*, 26 February 2002.

TC 4-02.1, *First Aid*, 21 January 2016.

TC 4-02.3, *Field Hygiene and Sanitation*, 6 May 2015.

TC 8-20-1, *Dental Specialist*, 22 May 2017.

TM 3-34.56, *Waste Management for Deployed Forces*, 29 March 2019.

WEB SITES

Centers for Disease Control and Prevention. http://www.cdc.gov/.

North Atlantic Treaty Organization. https://www.nato.int/cps/en/natohq/official_texts_17120.htm.

US Army Dental Corps History. https://history.amedd.army.mil/corps/dental/dental.html.

US Army Medical Materiel Agency. https://www.usamma.amedd.army.mil/Pages/main01.aspx.

REFERENCED FORMS

Unless otherwise indicated, DA forms are available on the Army Publishing Directorate website at https://armypubs.army.mil. SFs are available on the U.S. General Services Administration website at https://www.gsa.gov/reference/forms.

DA Form 2028, *Recommended Changes to Publications and Blank Forms*.

SF 603, *Medical Record—Dental.*

SF 603A, *Medical Record—Dental–Continuation.*

Index

Entries are by paragraph number unless indicated otherwise.

This page intentionally left blank.

ATP 4-02.19
14 August 2020

By Order of the Secretary of the Army:

JAMES C. MCCONVILLE
General, United States Army
Chief of Staff

Official:

KATHLEEN S. MILLER
Administrative Assistant
to the Secretary of the Army
2021215

DISTRIBUTION:

Active Army, Army National Guard, United States Army Reserve: Distributed in electronic media only(EMO).

This page intentionally left blank.

PIN: 206927-000