FINAL VERSION

STATEMENT BY

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COMMITTEE ON ARMED SERVICES
SUBCOMMITTEE ON OVERSIGHT & INVESTIGATIONS
UNITED STATES HOUSE OF REPRESENTATIVES

23 APRIL 2008

NOT FOR PUBLICATION
UNTIL RELEASED BY THE
COMMITTEE ON ARMED SERVICES

I am Colonel Mark Bodenheim and I want to thank the Committee Members for allowing me to speak to you concerning the present state and future initiatives concerning Army Reserve Component dental readiness. I am a U.S. Army Reserve Dental Officer of 35 years and I have been voluntarily mobilized for more than five years to serve as the Chief of Reserve Component Mobilization Operations for the U.S. Army Dental Command. In my civilian employment, I am the Dental Director for a 13 county, clinical dental public health program in North East Georgia.

Army Active Component Dental Readiness - Historical Perspective

A short historical perspective is appropriate in order to understand the challenges in achieving full dental readiness in the Army Reserve Components (RC). In response to dental non- battle injury emergency rates averaging sixteen percent during Vietnam, in 1968 the Army implemented the Oral Health Maintenance Program to target Army Active Component (AC) Soldiers through an annual dental exam and treatment program. During the 1980s, the Army Dental Care System initiated the Oral Health Fitness Program which identified potential high risk dental casualty Army AC Soldiers through the use of a Dental Fitness Classification (DFC) system, DFC 1 thru DFC 4, which continues in use today. Army AC commanders began receiving monthly reports on the dental readiness of their AC Soldiers and only those with a GO (DFC 1 or DFC 2) rating were recommended for worldwide deployment. During this period, the Health Services Command dental directorate (now U.S. Army Dental Command or DENCOM), set goals to maintain the Army AC at a 95% DFC 1 or DFC 2 dental deployment status. Subsequent studies continued to show that DFC 3 deployed Soldiers experienced

significantly higher dental emergency rates than DFC 1 or DFC 2 Soldiers. A DFC 3 Soldier is 8 times more likely to have a dental emergency than a DFC 1 Soldier and 4 times more likely than a DFC 2 Soldier. For the Army AC, dental readiness coordinators located at DENCOM dental treatment facilities (DTFs) review monthly unit dental readiness status reports, creating lists of AC Soldiers who are due for their annual exam, and if found to be DFC 3, prioritize subsequent treatment. The unit command structure has high visibility of unit dental readiness status reports and has command directive capability to order AC Soldiers to attain deployment DFC status.

Army Reserve Components Dental Readiness - Historical Perspective

In contrast, the Army RC, which now consists of over 550,000 Army National Guard (ARNG) and U.S. Army Reserve (USAR) Soldiers, did not share the same command-directed dental readiness history. The lack of a dental readiness program was evident during the First Gulf War as reported in a March 2001 American Forces Information Services News Article which quoted an Army Reserve source stating "roughly 35-45 percent of Army Reservists activated during the Gulf War needed dental work before they could deploy." A February 2004 testimony to the House Armed Services Committee, Total Force Subcommittee, by The Military Coalition, a consortium of nationally prominent uniformed services and veterans' organizations stated, "the number one deployment problem in the First Gulf War was dental 'un-readiness' and the same is true today." In 1998, the Department of Defense issued a policy directing that Active Duty (i.e. Active Component) and Selected Reserve personnel (excluding members of the Individual Ready Reserve or IRR) complete a periodic dental examination on an annual basis. In 2000, the TRICARE Dental Program (TDP)

provided the first Army RC dental readiness system. This was an optional program requiring the Soldier to pay monthly premiums and treatment co-payments. The financial burden on Soldiers is considered a contributing factor to the poor enrollment rates that continue today (7.0% ARNG, 5.1% USAR). Army RC units mobilized between 1997 and 2001 presented to mobilization platforms with DFC 3 rates between 14-36%. In 2002, the contracted Federal Strategic Health Alliance (FEDS_HEAL) dental network provided pre-mobilization dental "screenings" at no cost to Army RC Soldiers in an attempt to improve dental readiness. NO GO (DFC 3 or 4) rates showed little improvement with Army RC Soldiers presenting to mobilization platforms from January-August 2002 with DFC 3 rates of 25%. By November 2002, a series of incremental statutory and policy changes were implemented which authorized examinations and DFC 3 treatment at no cost to the Soldier upon receipt of mobilization orders. Because mobilization orders were frequently issued less than 60 days ahead of the mobilization station arrival date (MOBSAD), the Army realized little improvement in dental readiness. Army RC Soldiers were then authorized to receive DFC3 treatment upon an alert order in an attempt to improve available time for dental readiness examination and care prior to MOBSAD. Again, improvements in MOBSAD dental readiness GO rates were not realized because the alert orders and the mobilization orders were being issued almost simultaneously shortly before MOBSAD. These fractured and incremental approaches to Army RC dental readiness, and the prolonged training periods at the mobilization platforms prior to deployment, were the major reasons for a "fix it at the mobilization station" attitude by Army RC unit commanders. Over 87% of Army RC Soldiers were reporting as a "NO GO", with a DFC 3 rate of 19%, according to mobilization platform report rate statistics in February 2004.

Standardizing Army RC Dental Readiness and Army AC Mobilization Processing

In June 2003, the DENCOM commander directed the evaluation of Army RC pre-mobilization dental readiness exam standards. At that time, Army Regulations permitted Army RC Soldiers to receive cursory dental screenings without the use of a mirror, probe, or supporting radiographs to establish a DFC. In addition, exams were being documented inconsistently by the pre-mobilization contracted providers. This led to massive re-examinations at the mobilization platform in order to meet Army AC exam standards. Working with the dental surgeons of the National Guard Bureau (NGB) and the U. S. Army Reserve Command (USARC), the “One Army” dental exam standard for the Army RC was initiated in April 2004. It was published in Army Regulation 40-501 in February 2005. By September 2005, the “GO” validation rate of Army RC Soldiers presenting to mobilization stations improved to 51% mainly due to the exam standard implementation. DFC 3 rates remained at a high level of 22%, mainly due to the new Army RC exam standard identifying more DFC 3 Soldiers. The DENCOM Commander further directed standardization of dental Soldier Readiness Processing (SRP) at the mobilization platforms to ensure consistent validation processing throughout DENCOM SRP dental stations. A comprehensive, operational processing standard was issued by DENCOM in July 2005 which improved processing efficiency, permitted detailed data reporting, and reduced the duplication of pre-mobilization dental readiness processes. A DVD training video, power point presentation updates to the DVD, and an extensive, detailed mobilization dental requirements section located on the DENCOM web page are used for training Army RC unit commanders, DENCOM, ARNG and USAR dental personnel on these changes. Additionally, over the past two years, the Office of the

Surgeon General dental consultant has chaired the Dental All Army Working Group which consists of dental representatives from the NGB, USARC, the Reserve Health Readiness Program (RHRP which replaced FEDS_HEAL), and DENCOM to continue standardization improvements of the Army RC dental readiness system. The major achievement of this group was the improvement of the existing ARNG electronic dental exam record/tracking system, DENCLASS; its implementation for the USAR and RHRP by May 2008; and the creation of the Army Dental Digital Repository (ADDR), hosted by the Army AC, which integrates dental data collected from Army AC dental treatment facilities, Army RC dental readiness programs using DENCLASS, and Army AC mobilization platforms.

Present State of Army RC Dental Readiness

Army RC dental readiness can interfere with deployed theater operations and with mobilization platform pre-deployment training. An internal DENCOM study estimated that an average of 11 hours of duty is lost for each DFC 3 RC Soldier performing pre-deployment training at the mobilization platform due to appointment time, transit time, oral surgery healing time and escorts for Soldiers sedated for oral surgery. In Fiscal Year (FY) 2006, an estimated 9500 ten-hour training days were lost at mobilization platforms due to DFC 3 treatment and in FY07 an estimated 6600 ten-hour training days were lost. Thus far in FY08 through the end of the 2nd quarter, we estimate over 3500 training duty days have been lost. Another internal DENCOM study at Camp Shelby from Feb-May 2007, determined that over 23% of the DFC 3 Soldiers required more than 30 days to attain a minimum DFC 2 deployment status due to the difficulty of appointing intensive care DFC 3 Soldiers without conflicting with their

training time and the recovery periods required after oral surgery. Clearly, DFC 3 treatment and the state of Army RC dental readiness must move to the left of the MOBSAD.

Table 1 shows the dental readiness state of Army RC Soldiers presenting to mobilization platforms over the past two and one-half years.

TABLE 1	**Army RC Mobilization Station Dental Readiness Validation Rate**					
Date Range	**FY06**		**FY07**		**FY08 (Q1+Q2)**	
Component	**ARNG**	**USAR**	**ARNG**	**USAR**	**ARNG**	**USAR**
GO	**56%**	**36%**	**61%**	**40%**	**80%**	**52%**
NO GO	**44%**	**64%**	**39%**	**60%**	**20%**	**48%**
DFC 3	**17%**	**23%**	**15%**	**17%**	**9%**	**14%**
Source:	**DENCOM Corporate Dental Application (CDA) RC Mobilization Module**					
Legend:	**DFC 1 + DFC 2 = GO DFC 3 + DFC 4 = NO GO**					

I use FY06 as the initial baseline for comparison because by October 2005, the Army RC and their contracted dental readiness entities, as well as DENCOM mobilization platform dental stations, had standardized exam documentation and mobilization validation processing requirements. We saw steady but slow improvement through FY07. During the first half of FY08, more dramatic improvements occurred, especially by the ARNG Brigade Combat Teams (BCTs). I attribute these improvements in dental readiness to a combination of 1st Army command emphasis directed at the BCT commanders, dental readiness systems initiated earlier in the alert phase compared to previous history, and diligent work done by the state dental surgeons. The 39th BCT from Arkansas exemplified this improvement. The 39th began its exam process in the summer of 2007 for a January 2008 MOBSAD at Camp Shelby. The unit used both RHRP and a direct contractor (Onsite Dental). The 39th conducted multiple SRPs through the months leading up to the MOBSAD. In addition, Camp Shelby dental

personnel instructed ARNG personnel on the ground in Arkansas on dental readiness standards.

In Table 2, the recent ARNG BCT mobilization platform validation rates are compared to the smaller unit validation rates at different mobilization platforms and demonstrate that the dental readiness of smaller units is less predictable. Small units may have less command influence and they are more directly affected by cross-leveled Soldiers from non-alerted units. Cross-leveling occurs in both Reserve Components, but is more prevalent in USAR units. It occurs prior to the unit MOBSAD and continues after the MOBSAD. As an example, the 39th BCT had nearly 190 Soldiers (6% of total BCT) cross-leveled into the unit after the MOBSAD with 54% presenting in a NO GO status and after examination 26% were classified as DFC 3. One Soldier was Released From Active Duty (REFRAD) for dental issues. By contrast, the main body of the 39th BCT had no REFRADs. These statistics highlight the crux of Army RC dental readiness – in order to operationalize the Army RC, all Army RC Soldiers, even those from non-alerted units, must continually maintain a GO state of dental readiness.

TABLE 2	Army RC Mobilization Station Dental Readiness Validation Rate					
UIC/Unit Name	Compo	SRP Date	Mob Site	GO	NO GO	DFC 3
27th BCT	ARNG	Jan 08	Bragg	97%	3%	3%
39th BCT	ARNG	Jan 08	Shelby	88%	12%	8%
76th BCT	ARNG	Dec 07	Atterbury	87%	13%	8%
45th BCT	ARNG	Oct 07	Bliss	80%	20%	12%
37th BCT	ARNG	Jan 08	Hood	78%	22%	7%
WP8TAA - 1175 MP CO	ARNG	3-Mar-08	Dix	74%	26%	14%
WSTLAA - 894 QM CO	USAR	27-Feb-08	Dix	26%	74%	27%
WP1LT0 - 201 EN BN- HHC	ARNG	6-Mar-08	McCoy	67%	33%	19%
WRZUAA - 955TH EN BN	USAR	2-Apr-08	McCoy	61%	39%	29%
WTHFAA - 1710 TC	ARNG	13-Mar-08	Atterbury	69%	31%	14%
WS0VAA - 846th TC	USAR	2-Apr-08	Atterbury	46%	54%	33%
WP6ZAA - 2228 MP	ARNG	26-Mar-08	Shelby	94%	6%	3%
W8JCAA - 1186th TRAN	USAR	12-Mar-08	Shelby	63%	37%	14%
Source:	DENCOM Corporate Dental Application (CDA) RC Mobilization Module					
Legend:	DFC 1 + DFC 2 = GO DFC 3 + DFC 4 = NO GO					

Army RC Mobilization Processing

I would like to provide a synopsis of mobilization processing. Using the 39th BCT as an example, the unit provided dental records to the Camp Shelby SRP dental station prior to their MOBSAD validation processing. Pre-screening validation of each record occurs with an initial record audit by dental assistant personnel to confirm the presence of all required documents to include: a current (within 365 days) exam documented to the standard; supporting radiographs for diagnostic purposes; a panoramic radiograph that reflects the Soldier's current oral condition for diagnostic and forensic purposes; and a DFC of 1 or 2. If documents are missing, the audit personnel are required to look in the ADDR for those documents and print them for inclusion in the record. Then each record is reviewed by a dentist who validates the GO or NO GO status of the record to include quality assurance reviews of radiographs or written documentation. After the unit arrives at the mobilization station, Soldiers are processed through a "live" validation SRP process. This is set up the same way as the pre-SRP record screen process with

the addition of a data entry desk that populates the RC mobilization module in the DENCOM Corporate Dental Application (CDA). Those Soldiers with pre-screened GO records will go directly to the validation dentist who will ask the Soldier if they have any dental problems since their last exam (~3% do). If they do have a new dental problem, they receive an exam and are appointed for DFC 3 treatment if required. Validated GO Soldiers proceed to the CDA data entry desk for entry into the mobilization module which populates MEDPROS and the CDA unit tracking system. The process takes less than two minutes. A Soldier with a pre-screened NO GO record proceeds to the record audit desk to determine if any new dental documentation is presented by the Soldier. The record is then reviewed by the validation dentist. All NO GO Soldiers receive an examination and their DFC entered into CDA. DFC 3 Soldiers receive appointments within the facility and through a contracted network of providers at certain locations. Any DFC 3 Soldier with treatment requirements that cannot be completed before their deployment date is recommended for a dental REFRAD. In FY07, over 39,000 Army RC Soldiers processed through mobilization platforms and over 5,900 (15%) were determined to be DFC 3. Only 25 Army RC Soldiers were specifically REFRAD for dental reasons in FY07. All others were deployed as a DFC 1 or 2 - a testament to the Herculean efforts at mobilization platforms to deploy dentally fit RC Soldiers.

Army RC De-Mobilization Processing

Current demobilization processing is outlined in Annex B (Dental Processing) to the MEDCOM Demobilization Plan. Details of the plan can be found on the DENCOM web page under the demobilization processing requirements section which is accessible to the public. Demobilization occurs within a 4-6 day period and a Soldier's unit is made

available to the SRP dental station for a 1-2 hour period during the demobilization process. Soldiers present to the record audit desk of the SRP dental station where specific forms are reviewed. If available, the dental record is reviewed and the Soldier is given a one-page handout describing their three post mobilization options: Department of Veterans Affairs (DVA) dental benefit; Transitional Health Benefits; and enrollment in the TRICARE Dental Program (TDP). Each Soldier is given a DVA form 10-10-EZ and has 180 days to contact the DVA to coordinate dental treatment. Then each Soldier is given a dental treatment record form with the pre-stamped statement: "Member was provided a complete dental exam and all appropriate dental services and treatment within 90 days prior to separation." The "NO" block is checked, which permits the DD214, statement 17 (same as record statement) block to be checked "NO" and allows the demobilizing soldier to gain access to VA provided dental care. Army RC Soldiers who present with emergency conditions are scheduled for examination and treatment at the demobilization DTF.

Current Challenges to Army RC Dental Readiness

The most immediate way to improve the Army RC IMR-Dental statistics (see Table 1), would be to enforce current policy that directs all SELRES personnel to undergo an annual dental examination. The first and foremost way to improve dental readiness is command emphasis and support at all levels. The Army Reserve leadership must hold unit commanders and individual service members responsible for the member's readiness to deploy. The individual has personal responsibilities and the unit must provide monitoring and processes to ensure readiness.

However, the challenges are considerable. Consider these contrasts: the AC Soldier is assigned to a limited number of installations (except for a small percentage of detached duty Soldiers, i.e., recruiters, ROTC instructors) with supporting DTFs located where the Soldier either lives on post or in the nearby community. The AC Soldier does not lose pay for attending dental readiness appointments, as it is considered part of the job description. The AC Soldier receives dental care at no cost regardless of their alert status; and their dental readiness is managed by DTF dental readiness coordinators and unit command staff. By contrast, the RC Soldier is assigned to one of hundreds of ARNG armories or USAR centers and can live some distance from those sites, and must take time from work (many from hourly paid jobs without sick leave benefits) to attain dental readiness. The RC Soldier may receive an annual dental exam at no cost regardless of alert status, but can only receive DFC 3 treatment at no cost upon alert or mobilization status, thereby reducing the incentive to improve their dental health. The RC Soldier's dental readiness is managed by unit administrators overwhelmed with other administrative priorities, forcing them to relegate the importance of dental readiness to an impending unit mobilization.

Since 2004, DENCOM has operated the First Term Dental Readiness (FTDR) program, which was designed to evaluate and treat Army AC and RC Soldiers during initial entry training (IET) and subsequent Advanced Individual Training (AIT). Full training schedules and rigorous timelines to complete IET and AIT make it difficult for Soldiers to receive comprehensive dental treatment. The program is presently focused on examining and treating DFC 3 Soldiers who are identified through a Panoramic radiograph screening. Additional challenges include the fact that there is over a 40% surge of Army RC Soldiers in IET during the three summer months. At the same time

the Army AC direct care system experiences the summer underlap (PCS moves, REFRAD, etc). Contracted solutions are not readily available in the dental contracting community due to the summer surge's episodic, short term nature, and the difficulty of hiring at several IET sites. The challenges to expanding the FTDR program to include examination of all Army RC Soldiers at IET are: access to Soldiers to address all dental requirements during training (TRADOC limitation); facility constraints in the number of dental treatment rooms (DTRs) available; and adequate staffing (core mission staff, AC Dental officers and Civilians, perform 45% of present FTDR workload).

Resetting Army RC dental readiness during demobilization has the potential to improve baseline readiness of the entire population by approximately 10%, but is not without significant challenges. Since January 2004, mobilization SRP dental stations were authorized staffing based upon a 90% MOBSAD GO report rate and an administrative, not clinical, demobilization protocol. The statistics in table one indicate that the 90% GO rate has not been achieved on a consistent basis resulting in DENCOM core mission staff augmenting mobilization processing. Four of the mobilization platforms that process over 50% of Army RC Soldiers are located at ARNG and USAR installations that have minimal dental facilities and constraints to expand those facilities; these would need to be augmented substantially, or demobilization would need to take place elsewhere. An improvement in Army RC dental readiness GO rates at mobilization platforms would permit a limited redirection of mobilization platform staff to the demobilization mission. Expanding dental readiness access during Army RC annual training through expanded clinic hours or weekends also requires major enhancements in existing provider contracts.

Current and Future Initiatives

Within his first 100-days as Army Surgeon General, LTG Eric Schoomaker directed a complete review of RC dental readiness. The Assistant Surgeon General for Force Projection assembled a multi-component work group in March 2008 to conduct a capabilities-based assessment and develop a prioritized list of courses of action. These courses of action are currently being worked through the Army staff and will seek to address every aspect of RC dental readiness. These initiatives cover a full range of options that will enhance readiness. The solution sets require further refinements and senior leadership approval, but we are moving forward with urgency.

In order for the RC to become a truly operational force and meet its current demands, RC dental readiness must be transformed, and we have already made recommendations to achieve that transformation. I am proud to note the steady improvement in RC dental readiness over the last few years. I am confident that the Army will continue to address shortfalls in RC dental readiness with thoughtful solutions that will lead to continued improvement. Thank you for holding this hearing and inviting me to share my thoughts. Thank you for your continuing efforts in support of dental readiness, I look forward to your questions.