

Department of the Army  
Pamphlet 40-507

Medical Services

# Preventive Dentistry

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**UNCLASSIFIED**

# ***SUMMARY***

DA PAM 40-507  
Preventive Dentistry

This new publication, dated 29 May 2015--

- o Provides implementation guidance for the Clinical Oral Health and Health Promotion Program (chap 3).
- o Provides implementation guidance for the Community Health Promotion and Disease Prevention Program (chap 4).
- o Serves as a companion publication to AR 40-35 (throughout).



## FOREWORD

Preventive dentistry efforts maintain dental readiness by promoting oral health, general wellness, and overall fitness of Soldiers and all authorized beneficiaries. The goal of the Dental Readiness Program is to minimize oral disease and injury of Soldiers, thereby maximizing unit readiness for their assigned missions and reducing noncombat dental casualties during deployments by using evidence-based preventive dentistry techniques. The goal of community oral health protection is to improve the general wellness and overall fitness of all authorized beneficiaries by optimizing their oral health.

Dental readiness is fundamental to maintaining unit readiness for deployment and reducing noncombat dental casualties during deployments. Soldiers who deploy with untreated dental disease are at increased risk of becoming a dental casualty and depriving commanders and units of needed manpower at potentially critical times during mission execution. Oral diseases can suddenly develop into dental emergencies that are painful, debilitating, and sometimes even life-threatening. Soldiers often require medical evacuation to a location where dental treatment is available, endangering themselves and others due to the hazardous nature of travel in theater.

Oral diseases are widespread in the Army population, and impair daily functioning and quality of life. Orofacial pain can interfere with eating, swallowing, and speaking. Problems or pain from teeth, gums, and jaw joints affect job performance by interfering with sleep, disrupting concentration, or requiring time off from work for treatment and recuperation. Poor eating ability affects overall health through reduced enjoyment of food and a less nutritious diet. Orofacial (mouth) injuries often result in pain, lost time from work for treatment, and facial disfigurement. Tooth loss due to injuries is more common among Army Soldiers than among members of the other branches of service. Unsightly oral disease and missing teeth reduces quality of life through negative self-esteem, reduced confidence, and impaired social functioning.

## Medical Services

### Preventive Dentistry

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By Order of the Secretary of the Army:

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Official:



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**History.** This publication is a new Department of the Army pamphlet.

**Summary.** This pamphlet provides guidance on establishing, maintaining, and enhancing the Clinical Oral Health Promotion Program and Community Oral Health Protection Programs. The procedures regarding oral health and dental readiness are in accordance with provisions in AR 40-3, AR 40-5, Department of Defense Instruction 6025.19, Health

Affairs Policy 98-021, Health Affairs Policy 02-011, Health Affairs Policy 06-001, and current professional standards.

**Applicability.** This pamphlet applies to the Active Army, the Army National Guard/Army National Guard of the United States, and the U.S. Army Reserve, unless otherwise stated. This publication is applicable during mobilization.

**Proponent and exception authority.**

The proponent of this pamphlet is The Surgeon General. The proponent has the authority to approve exceptions or waivers to this pamphlet that are consistent with controlling law and regulations. The proponent may delegate this approval authority, in writing, to a division chief within the proponent agency or its direct reporting unit or field operating agency, in the grade of colonel or the civilian equivalent. Activities may request a waiver to this pamphlet by providing justification that includes a full analysis of the expected benefits and must include formal review by the activity's senior legal officer. All waiver requests will be endorsed by the commander or senior leader of the requesting activity and forwarded through their higher headquarters to the policy

proponent. Refer to AR 25-30 for specific guidance.

**Suggested improvements.** Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) directly to The Surgeon General (DASG-DC), 7700 Arlington Blvd, Suite 5140, Falls Church, VA 22042-5140.

**Distribution.** This publication is available in electronic media only and is intended for command levels A, B, C, D, and E for the Active Army and the Army National Guard/Army National Guard of the United States, and D and E for the U.S. Army Reserve medical activities only; and for command levels B, C, D, and E for the Active Army and the Army National Guard/Army National Guard of the United States, and D and E for the U.S. Army Reserve (all other activities).

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## **Chapter 1 Introduction**

### **1–1. Purpose**

This Department of the Army (DA) pamphlet provides guidance on developing and conducting a preventive dentistry program for all authorized beneficiaries of the U.S. Army Dental Care System, in accordance with Army Regulation (AR) 40–3, AR 40–5, and AR 600–63 by implementing the Clinical Oral Health Promotion Program and the Community Oral Health Protection Programs. It describes the Dental Readiness Program for active-duty status Soldiers, Reserve Component Soldiers, and other community-based preventive dentistry programs that benefit all members of the Army community. This pamphlet describes the processes and procedures necessary to carry out the policies established in AR 40–35.

### **1–2. References**

See appendix A.

### **1–3. Explanation of abbreviations and terms**

See the glossary.

### **1–4. Objectives and scope of dental readiness and oral health protection**

*a.* The goal of the Dental Readiness Program is to minimize oral disease and or injury of Soldiers, to reduce noncombat dental casualties during deployments, and to enhance unit readiness (see chap 2).

*b.* The objective of the Army’s Oral Health Protection Program is to ensure that all Department of Defense (DOD) beneficiaries have access to the information and resources that they need to use on a daily basis in order to prevent oral disease and optimize oral health.

*c.* The scope of the Oral Health Protection Program includes the following components:

- (1) Clinical Oral Health Promotion and Disease Prevention Program (see chap 3).
- (2) Community Oral Health Promotion and Disease Prevention Program (see chap 4).

## Chapter 2 Dental Readiness Program

### 2-1. General

Dental readiness is a commanders program. Unit commanders, the dental care system, and the Soldier share responsibility for 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.

### 2-2. Implementation guidance

Refer to AR 40-35 to implement the Dental Readiness Program.

### 2-3. Dental readiness classification guidance—based on Health Affairs Policy 02-011

*a. Class 1.* These Soldiers have a current dental examination and do not require dental treatment or reevaluation for disease or restoration of oral structure or function. Class 1 Soldiers are worldwide deployable.

*b. Class 2.* These Soldiers have a current dental examination and require non-urgent dental treatment or reevaluation for oral conditions which are unlikely to result in dental emergencies within 12 months. Dental readiness classification (DRC) 2 Soldiers are worldwide deployable. Soldiers in DRC 2 may exhibit the following:

(1) Treatment or follow-up indicated for dental caries or minor defective restorations that can be maintained by the patient. This includes Soldiers who are classified as a moderate or high caries risk and require recall for fluoride varnish application or dental sealants. Once varnish applications are completed, these Soldiers can be reclassified as DRC 1.

(2) 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 coverage is indicated.

(3) Edentulous areas requiring a prostheses but not on an immediate basis.

(4) Periodontium that—

(a) Requires oral prophylaxis (at least one sextant with a score of two or more upon periodontal screening and recording (PSR) examination).

(b) Requires recall for periodontal maintenance therapy when there is evidence of active periodontal disease.

(c) Requires treatment for slight to moderate periodontitis and stable cases of more advanced periodontitis.

(d) Requires removal of supragingival or mild to moderate subgingival calculus.

(5) 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.

(6) Active orthodontic treatment. The provider should consider placing the patient in passive appliances for deployments up to 6 months. For longer periods of deployment, the provider should consider removing active appliances and placing the patient in passive retention.

(7) Temporomandibular disorder Soldiers 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.

*c. Class 3.* These Soldiers require urgent or emergent dental treatment. DRC 3 Soldiers normally are not considered to be worldwide deployable.

(1) Treatment or follow-up indicated for dental caries, symptomatic tooth fracture, or defective restorations that cannot be maintained by the patient.

(2) Interim restorations or prosthesis that cannot be maintained for a 12-month period.

(3) Soldiers requiring treatment for the following periodontal conditions that may result in dental emergencies within the next 12 months—

(a) Acute gingivitis or pericoronitis.

(b) Active progressive moderate or advanced periodontitis.

(c) Periodontal abscess.

(d) Progressive mucogingival condition.

(e) Periodontal manifestations of systemic disease or hormonal disturbances.

(f) Heavy subgingival calculus.

(4) Edentulous areas or teeth requiring immediate prosthodontic treatment for adequate chewing or talking, or acceptable esthetics.

(5) Unerupted, partially erupted, or malposed teeth with historical, clinical, or radiographic (X-ray) signs or symptoms of pathosis that are recommended for removal.

(6) Chronic oral infections or other pathologic lesions including—

(a) Pulpal, periapical, or resorptive pathology requiring treatment.

(b) Lesions requiring biopsy or awaiting biopsy reports.

(7) Emergency situations requiring therapy to relieve pain, treat trauma, treat acute oral infections, or provide timely follow-up care (for example, drain or suture removal) until resolved.

(8) Acute temporomandibular disorders requiring active treatment that may interfere with duties.

*d. Class 4.* These Soldiers require dental examinations. This class includes Soldiers who require annual or other required dental examinations, Soldiers who do not have a digital panoramic image in the Corporate Dental System or the Army Dental Digital Repository, and Soldiers whose dental classifications are unknown (see AR 40-3, AR 40-501, Health Affairs (HA) Policy 98-021, and HA Policy 07-017). DRC 4 Soldiers normally are not considered to be worldwide deployable.

## Chapter 3 Clinical Oral Health Promotion and Disease Prevention Program

### 3-1. General

This program consists of measures provided in Army dental clinics to prevent orofacial injuries and oral diseases as well as promote health. Dental readiness officers (DROs), preventive dentistry officers (PDOs) and health promotion directors (HPDs) will encourage use of these measures to the greatest extent possible by all dental health care providers.

### 3-2. Implementation guidance—examination and risk assessment

*a. Examination.* Oral evaluations should assess the current state of oral health, risk for future oral disease, as well as assessing general health factors that relate to the treatment of patients.

(1) Initial, periodic (annual), and comprehensive oral evaluations of Soldiers will include hypertension screening as well as caries, tobacco, periodontal, and oral cancer risk assessments.

(2) Blood pressure readings that indicate hypertension should be referred to appropriate medical facilities and followed-up at subsequent appointments to prevent potential adverse events during dental treatment.

(3) The need for mouthguards will be assessed during the annual examination by asking whether the Soldier is at risk for maxillofacial injuries from sport, recreation, or occupational activities that may result in head-to-head contact, falls, tooth clenching, or blows to the mouth. Examples include activities such as boxing, football, basketball, soccer, pugil stick combat, individual weapon bayonet training, obstacle or confidence course, combatives, parachute operations, and riding in a vehicle while occupying the weapon station cupola or turret.

(4) Providers should gather information from patients on oral health behaviors and oral disease risk factors. Such information should be annotated in the dental record and include daily oral hygiene habits (brushing and flossing), dietary habits (sugar consumption and frequency), tobacco use (type, frequency), occupational or recreational activities predisposed to oral injury, and so forth.

(5) At the annual examination and all other dental encounters, dental providers should be alert to the signs of family abuse and neglect as provided by the Prevent Abuse and Neglect through Dental Awareness Coalition protocols (<http://www.healthy.arkansas.gov/programsServices/oralhealth/Pages/PANDA.aspx/>). When there are signs consistent with abuse and neglect, providers are required to report these findings in accordance with AR 608-18.

*b. Caries risk assessment.* Using caries risk assessment criteria to categorize patients into treatment groups enables targeting of resources to those with greatest need. It also facilitates treatment planning by distinguishing patients who will only benefit from traditional operative procedures from those who can benefit from a remineralization program. Information on the caries risk assessment can be found on the U.S. Army Dental Command (DENCOM) SharePoint Web site at <https://info.dencom.army.mil/STF/DHW/default.aspx/>. Classify Soldiers as low, moderate, or high risk for caries as described below:

(1) Low caries risk.

(a) No incipient, or cavitated, primary or secondary carious lesions at the current exam. Incipient lesions include white spot lesions, which can be the first visual signs of caries and indicate areas where infected plaque has accumulated and caused the tooth surface to undergo demineralization and remineralization.

(b) No factors that may increase caries risk (see para 3-2b(4)).

(2) *Moderate caries risk.* Includes any of the following:

(a) One or two new incipient, or cavitated, primary or secondary carious lesions at the current exam.

(b) No incipient, or cavitated, primary or secondary carious lesions, but presence of at least one factor that may increase caries risk (see para 3-2b(4)).

(3) *High caries risk.* Includes any of the following:

(a) Three or more new incipient or cavitated primary or secondary carious lesions at the current examination.

(b) Presence of multiple factors that may increase caries risk (see para 3-2b(4)).

(c) Xerostomia or decreased salivary flow as determined from past medical history or unstimulated salivary flow testing (< 0.2 milliliters (ml)/min). Normal unstimulated saliva flow rate varies between 0.3 and 0.4 ml/min. Xerostomia can be induced by dehydration, medications, radiation, or disease. (Refer to para 3-2b(4)(m) and table 3-2 for additional information.)

(4) *Modifying factors.* The following modifying factors should be taken into account prior to a caries risk classification, as some of the factors may predispose an individual for dental decay.

(a) *Poor oral hygiene.* Poor oral hygiene permits the colonization of overwhelmingly high numbers of cariogenic bacteria on tooth surfaces. Poor oral hygiene may also be an indication that the individual is not receiving an adequate amount of topical fluoride through tooth brushing. Poor oral hygiene practices may place the individual in the next higher risk classification

(b) *Cariogenic diet.* There is strong evidence to support the relationship of dental caries and the intake of refined carbohydrates, especially sugar. Consuming foods containing simple carbohydrates such as sugar or starch frequently or between meals can cause dental caries. Between-meal consumption of beverages that are sweetened with sugar or

high-fructose corn syrup, such as sports drink, energy drink, or soda, also promotes dental caries. These drinks may also contain polybasic organic acids that hasten the demineralization process, causing dental erosion and exacerbating dental caries.

(c) *Suboptimal fluoride exposure.* Fluoride exposure for caries prevention should include, at a minimum, daily use of optimally fluoridated water and twice daily use of dentifrice containing at least 1100 parts per million (ppm) fluoride. More information may be obtained from the Centers for Disease Control and Prevention (CDC) Morbidity and Mortality Weekly Report (MMWR) entitled, "Recommendations for Using Fluoride to Prevent and Control Dental Caries in the United States" at [http://www.cdc.gov/mmwr/indrr\\_2001.html](http://www.cdc.gov/mmwr/indrr_2001.html).

(d) *Exposed root surfaces.* Patients who suffer from coronal caries are also at an increased risk of developing root caries when gingival recession occurs.

(e) *Tooth morphology.* The presence of deep uncoalesced pits and fissures place individual teeth at an increased risk for caries. These surfaces are easily infected with colonies of bacteria and are nearly impossible to be cleaned with routine home care. Inherited disorders of tooth development with altered enamel structure increase the incidence of dental caries.

(f) *Multisurface restorations.* The presence of many multisurface restorations is a good indicator of past dental experience and susceptibility to future dental disease.

(g) *Defective restorations.* Restoration overhangs or open margins promote plaque accumulation and increase susceptibility to dental caries.

(h) *Orthodontics.* Soldiers undergoing orthodontic treatment have more difficulty with plaque control due to the orthodontic appliances in their mouths. White spot lesions can develop in areas of poor oral hygiene.

(i) *High titers of cariogenic bacteria.* Levels of mutans streptococci of  $10^5$  colony forming unit, per unit of measure (cfu/ml) and lactobacilli levels of  $10^3$  cfu/ml and above in stimulated saliva are considered high risk. Chair side tests for cariogenic bacterial challenge are sufficiently sensitive to provide a level of low, medium, or high cariogenic bacterial challenge. Bear in mind that numerous other strains of bacteria are also cariogenic, so a low titer for mutans strep or lactobacilli does not preclude a diagnosis of high caries risk.

(j) *Chemotherapy, radiation therapy, or medication.* Any treatment that causes changes to salivary flow or quality places a Soldier at increased risk for dental caries. Medications that may reduce salivary flow include anti-allergy medications (antihistamines and decongestants), central analgesics, sedatives, diuretics, cardiovascular medications (angiotensin-converting enzyme inhibitors and calcium channel blockers), muscle relaxants, antidepressants, antacids, and many others.

(k) *Eating disorders.* Both anorexia and bulimia can lead to an increase in dental erosion due to acid exposure as well as dental caries due to changes in salivary function.

(l) *Medical conditions.* Patients with physical or mental disability may be unable to properly perform oral hygiene procedures, putting them at a higher risk for dental caries. Patients with systemic conditions such as diabetes, rheumatoid arthritis, acquired immune deficiency syndrome, cystic fibrosis, and hypertension may also be at an increased risk for caries.

(m) *Xerostomia.* Patients' perceptions of xerostomia often do not correlate with objective findings of reduced salivary flow rate. Before developing a preventive and restorative treatment plan, assess the true extent of salivary gland function. Determine if the reduced salivary flow is related to dehydration, as this will affect the management strategy.

c. *Tobacco risk assessment.* Tobacco has been identified as a risk factor for many diseases, including oral cancer, periodontal disease, heart disease, lung cancer, emphysema, and other respiratory diseases. There are no safe forms of tobacco. The oral cavity is the usual site for the inhalation or ingestion of tobacco and creates a prime opportunity for dentists to diagnose pathology and educate patients.

(1) At each periodic oral examination, Soldiers should be classified in one of four tobacco risk classification categories—

(a) No—Soldier uses no forms of tobacco.

(b) Smoke—Soldier smokes one or more forms of tobacco. This refers to use of any type of smoked tobacco product, including but not limited to: cigarettes, pipes, cigars, mini cigars, cigarillos, or water pipes.

(c) Smokeless—Soldier uses one or more forms of smokeless tobacco products, including but not limited to: moist snuff, dried snuff, chewing tobacco, pouches, and so on.

(d) Both—Soldier uses one or more forms of tobacco products.

(2) Soldiers who use any form of tobacco must be informed of the health risks. Patients who are interested in quitting should be referred to a tobacco cessation program, either at the local medical treatment facility (MTF) or another program such as the Quit Tobacco – Make Everyone Proud Web site at <http://www.ucanquit2.com>, which contains 24 hours a day/7 days a week access to interactive tobacco cessation tools, personalized quit plans, live chat support, and other resources. The U.S. Army Public Health Command (USAPHC) Tobacco Free Living Web site at <http://phc.amedd.army.mil/topics/healthyliving/tfl/Pages/default.aspx> contains other resources.

d. *Periodontal risk assessment.* Periodontal disease is a major cause of tooth loss among adults, and has been shown

to be associated with increased risk of adverse cerebrovascular and cardiovascular incidents, respiratory disease, and poor glycemic control in patients with diabetes.

(1) The PSR examination is a quick, efficient way to screen patients for periodontal diseases and summarizes necessary information with minimum documentation. The American Dental Association (ADA) and the American Academy of Periodontology recommend that PSR be conducted by dentists for all patients as an integral part of oral examinations. Refer to Technical Bulletin Medical (TB MED) 250 for guidance on how to properly perform and record the PSR. A free online training session with a downloadable training booklet is available at [www.dentalcare.com/en-US/dental-education/continuing-education/ce53/ce53.aspx](http://www.dentalcare.com/en-US/dental-education/continuing-education/ce53/ce53.aspx).

(2) The PSR is not intended to replace a full-mouth periodontal examination. Patients who have been treated for periodontal diseases and are in a maintenance phase of therapy require periodic comprehensive periodontal examinations. In addition, PSR is designed primarily for use with adult patients, age 18 and older, and has limited utility in screening children and adolescents.

(3) Use a periodontal probe that has a 0.5 millimeter (mm) ball tip and is marked with a colored band from 3.5 mm to 5.5 mm from the probe tip.

(4) The objective of this screening system is to examine every tooth individually. Implants are examined in the same manner as naturally occurring teeth. The probe tip is gently inserted into the gingival crevice until resistance is met. The total extent of the crevice should be explored by "walking" the probe around the crevice. At least six areas in each tooth should be examined: mesiofacial, midfacial, distofacial, and the corresponding lingual/palatal areas. The deepest probing depth obtained determines the code for that sextant. Codes are based on the following system:

(a) *Code 0*: The colored area of the probe remains completely visible in the deepest crevice of the sextant (indicating a probing depth of less than 3.5 mm). There is no calculus or defective margin detected. The gingival tissues are healthy with no bleeding after gentle probing.

(b) *Code 1*: The colored area of the probe remains completely visible in the deepest probing depth in the sextant. There is no calculus or defective margin detected. There is bleeding after gentle probing.

(c) *Code 2*: The colored area of the probe remains completely visible in the deepest probing depth in the sextant (indicating a probing depth of less than 3.5 mm). Supra- or subgingival calculus and/or defective margins are detected.

(d) *Code 3*: The colored area of the probe remains partly visible in the deepest probing depth in the sextant (indicating a probing depth of less than 5.5 mm).

(e) *Code 4*: The colored area of the probe completely disappears, indicating probing depth of greater than 5.5 mm.

(f) *Code \**: Is added to the score for a sextant to denote clinical abnormalities, including but not limited to: furcation invasion, mobility, mucogingival problems, or recession extending to the colored area of the probe (3.5 mm or greater).

(g) *Code X*: Denotes edentulous sextant.

(5) Following the examination, each patient should be told his or her PSR score (along with an explanation of its significance). Patients with a PSR score of 3 or more in any sextant must be referred for a comprehensive periodontal examination and treatment plan.

*e. Oral cancer screening and soft tissue examination.* Oral cancer kills about one American per hour. It is the eighth most common cancer among men.

(1) Inquire about risk factors for oral cancer, which include the following: tobacco use; alcohol use; marijuana use; sunlight or radiation exposure; increased age; male gender; black race; viral sexually transmitted diseases (such as human papilloma virus (HPV) and human immunodeficiency virus (HIV)); inadequate intake of vitamins A, C, E, carotene, iron, fruits, and vegetables; and poor oral hygiene.

(2) Perform an oral cancer examination that includes visual examination and palpation. Guidelines for performing an oral cancer examination can be found on the National Oral Health Information Clearinghouse Web site at [www.nidcr.nih.gov/OralHealth/Topics/OralCancer/DetectingOralCancer.htm](http://www.nidcr.nih.gov/OralHealth/Topics/OralCancer/DetectingOralCancer.htm).

(3) A soft tissue examination should be performed to detect any other oral pathology as well, including viral, fungal or bacterial infections and micronutrient deficiency. Some of the first signs of micronutrient deficiency appear in the mouth, and include glossitis, cheilitis, angular stomatitis, and gingivitis. Patients with any positive findings should be referred to an oral and maxillofacial surgeon, oral pathologist, or the patient's primary care provider.

### **3-3. Implementation guidance—preventive interventions**

In accordance with AR 40-3, all dental treatment plans will include measures to promote oral health and prevent dental disease and injury. Choose preventive interventions that address the level of risk assessed for each of the above areas. Guidance on current dental terminology (CDT) code use for preventive procedures is in table 3-1. Table 3-1 lists the minimal performance requirements for taking each code as workload. Table 3-1 is not all inclusive of preventive services that may be employed.

**Table 3-1.**  
**Guidance on current dental terminology code use for preventive procedures**

Name of procedure	CDT code	CDT definition	Further guidance
Nutritional counseling for control of dental disease	D1310	Counseling on food selection and dietary habits as part of treatment and control of periodontal disease and caries	Requires a minimum of 10 minutes identifying a patient's current food and beverage consumption and giving customized advice on limiting or eliminating harmful items and adding foods that increase nutrients for oral health. Patient may be referred to military treatment facility dietician if service is available.
Nutrition counseling referral	A1312	Use this code when the practitioner refers a patient to a dietitian or nutritionist for dietary counseling.	The referral can be written or a verbal referral discussion with the dietitian or nutritionist. Informing the patient that he/she should change their diet or seek dietary counseling does not qualify. Credit one for each patient.
Tobacco counseling for the control and prevention of oral disease	D1320	Reduce patient risks of developing tobacco-related oral diseases and conditions and improves the prognosis for certain dental therapies	Requires a minimum of 10 minutes identifying and assessing patient's current use of tobacco and giving customized advice. Referral to a tobacco cessation program may be appropriate if available or information can be obtained by the patient at <a href="http://www.ucanquit2.com">http://www.ucanquit2.com</a> .
Tobacco cessation referral	A1322	Use this code when the practitioner refers a patient to a tobacco cessation program.	The referral can be written or a verbal referral with the tobacco cessation administrator. Informing the patient that he/she should quit smoking or to seek the tobacco cessation class does not qualify. Credit one for each patient.
Oral hygiene instructions	D1330	May include instructions for home care to include brushing technique, flossing, and use of special oral hygiene aids	Requires a minimum of 5 minutes defining the problem and its etiology for the patient, addressing the reason for lack of proper oral hygiene and/or compliance, setting realistic objectives, discussing possible and desired outcomes, outlining specific instructions, and having the patient demonstrate proper technique. Hygiene appointments are the ideal time to perform.
Group oral health counseling	A1331	Counseling of groups of individuals concerning the attaining and maintaining of oral health.	Credit one per group regardless of size.
Sealant (per tooth)	D1351	Mechanically and/or chemically prepared enamel surface sealed to prevent decay	No cavitation present.
Preventive resin restoration in a moderate to high caries risk patient-permanent tooth	D1352	Conservative restoration of an active cavitated lesion in a pit or fissure that does not extend into dentin; includes placement of a sealant in any radiating non-carious pits or fissures.	If the lesion is cavitated and into the dentin, do not claim sealant or preventive resin restoration. Use D2391 or D2140.
Occlusal guard	D9940	Removable dental appliance which is designed to minimize the effects of bruxism and other occlusal factors.	
Fabrication of athletic mouthguard	D9941	Lab-created, diagnostic impressions are integral to the procedure and should not be coded separately. Not to be confused with occlusal guard or boil-and-bite mouthguard.	
Boil and bite mouth protector	A9100	Not to be confused with lab-created athletic mouthguard.	

*a. Antimicrobial agents.* Unless contraindicated, antimicrobial therapy should be initiated for all patients at risk for dental caries. The method, dose, and frequency of therapy should be based upon risk assessment.

(1) *Chlorhexidine gluconate.* Chlorhexidine is a broad-spectrum antibacterial that is effective against mutans streptococci. In the United States, only 0.12 percent chlorhexidine gluconate is available as a mouth rinse. It can be used as a rinse or brushed on with a toothbrush. Patients should use 10 to 15 ml for one minute twice a day for 2 weeks after caries control and removal of all foci of infection. High caries risk individuals may need to repeat this therapy every 2 to 3 months for approximately 1 year. Recent data indicates that 1 week every month is similarly effective.

(2) *Xylitol.* Xylitol is a natural sweetener that tastes like sucrose but is not fermented by cariogenic bacteria. Xylitol also inhibits attachment and transmission of cariogenic bacteria and has been shown to have antimicrobial actions. Xylitol has been extensively tested as both chewing gum and lozenges and may be recommended for moderate and high risk patients. Patients with frequent exposures to sugary foods or drinks should consume 1.5 to 2 grams of xylitol 3 to 5 times a day, for a total of 6 to 10 grams per day. For example, 2 pieces of Xylitol gum can be chewed

immediately after meals or snacks for 10 minutes. Xylitol is currently available in meals, ready to eat (MREs) and in theater dining facilities.

(3) *Fluoride*. Topical fluoride can inhibit bacterial activity; however, its primary benefit is remineralization, so its use will be discussed under remineralization agents.

*b. Remineralization agents*. Carious lesions that do not extend past the outer one-third of dentin should be considered for remineralization if cavitation of the outer enamel surface has not occurred. Caries remineralization therapy can be used to arrest or reverse the caries process in compliant patients once caries risk factors have been reduced or eliminated.

(1) *Professionally applied topical fluoride*. Set up an appropriate recall schedule to apply topical fluoride: gel, foam, or varnish. Soldiers with moderate caries risk should receive fluoride varnish or gel applications at 6-month intervals or, for deploying Soldiers, three varnish applications in a 1 to 2 week period. Soldiers with high caries risk should receive four fluoride varnish applications in a 1 to 3 month period. Every high caries risk patient should have a fluoride varnish at every operative or hygiene visit. Providers use products that contain a high with concentration of fluoride, such as 1.23 acidulated phosphate fluoride (APF) products (which contain 12,300 ppm fluoride), 8 percent stannous fluoride gel (19,363 ppm fluoride), or 5 percent sodium fluoride varnish (sodium fluoride (NaF) 22,600 ppm). APF products should be avoided if the patient has composite resin or glass ionomer restorations, since the acidity of the APF can dissolve the resin component of the restorations. These patients should receive 5 percent NaF. Two percent NaF products are less than ideal, because they do not contain as much fluoride (9,050 ppm). Over the counter fluoride rinse (.05 percent NaF or 226 ppm) or school fluoride rinse (0.2 percent NaF, 905 ppm) are inadequate and are not indicated for use as a professional topical fluoride treatment.

(2) Prescribe home topical fluorides to promote caries prevention and/or remineralization based on caries risk assessment, taking into account patient compliance.

(a) Toothpaste that contains at least 1,100 ppm fluoride should be used for at least 2 minutes, twice each day.

(b) Moderate caries risk. Toothpaste that contains at least 1,100 ppm fluoride should be used for at least 2 minutes, twice each day. Practitioners may want to consider the application of an additional home fluoride such as 5,000 ppm fluoride gel.

(c) High caries risk. Toothpaste that contains at least 1,100 ppm fluoride should be used for at least 2 minutes, twice each day. Patients may also be prescribed higher fluoride toothpaste such as one of the 1.1 percent 5,000 ppm sodium fluoride toothpastes. In addition, the patient should use multiple applications of fluoride using a custom-made tray. Deployed patients may prefer to use one 2.2 milligram (mg) sodium fluoride tablet once per day as an alternative to custom trays or gels. However, it must be emphasized that maximum benefit from fluoride is obtained via a topical effect, which is accomplished best by holding the fluoride tablet in the mouth and allowing it to dissolve slowly, rather than chewing it.

*c. Counseling*. All health care providers should make sure that their patients understand the importance of maintaining good oral health. For information on how you can make your counseling more effective, refer to USAPHC's changing health behaviors resources on the Health Care Providers Oral Fitness Web page at <http://phc.amedd.army.mil/topics/healthyliving/of/Pages/OralHealthforHealthcareProviders.aspx>. Refer to table 3-1 for additional CDT coding information.

(1) *Individual oral hygiene instruction*. Identify plaque as a cause of caries and periodontal disease. Advise patients on plaque control. Information on maintaining oral health in a field environment should be included for all Soldiers.

(2) *Nutrition counseling*. Under nutrition exacerbates oral infections and has been associated with increased progression of periodontal disease. Nutrients such as vitamins A, C, D, E, B2, niacin, B6, B12, and folic acid, as well as minerals such as zinc, iron, magnesium, and calcium are essential for repairing oral epithelium, maintaining periodontal attachment, preventing demineralization of bones and teeth, and ensuring an adequate amount of saliva of sufficient quality to protect the oral cavity. Basic nutrition counseling resources can be found on the USAPHC Web site at <http://phc.amedd.army.mil/topics/healthyliving/n/Pages/default.aspx>. Patients with more complex nutrition issues should be referred to an MTF nutrition care division for evaluation and counseling by a dietician.

(a) Deployed Soldiers can suffer from dehydration and micronutrient deficiencies that lead to skin conditions, stress fractures, anemia, and other conditions. These same micronutrient deficiencies can prevent the oral epithelium from renewing or repairing itself, and may compromise saliva flow and function. In addition to enabling taste, mastication, and digestion, saliva is critical for defense against oral diseases. Weak saliva production, and/or flow, hinders or eliminates its anti-fungal, anti-viral, and anti-bacterial activities. Then teeth are exposed to demineralization by acids, from oral bacteria or foods and beverages.

(b) Provide nutrition counseling to individuals when indicated by the results of examination and risk assessment, and current assignment situation. Examples of dietary screening questions to ask are included in table 3-2. There should be an emphasis on the relationship of caries and periodontal disease risk to the type of food, nutritional content, acidity (erosive potential), carbohydrate content, as well as frequency and timing of intake of carbohydrates and erosive items. Additional information is available from the Bulletin of the World Health Organization article entitled, "The

Role of Diet and Nutrition in the Etiology and Prevention of Oral Diseases,” which is available at <http://www.who.int/bulletin/volumes/83/9/694.pdf>.

(c) Patients with high caries risk or eating disorders should be referred to a nutritionist or dietician for counseling.

**Table 3–2.**  
**Dietary screening**

Do you eat snacks between meals or instead of meals?
Do you eat fruits and brightly colored vegetables at least 5 times per day?
Do you eat mints, hard or chewy candies, candy bars, donuts, pastries, chips, crackers, or other similar snack foods between meals?
Do you eat proteins like meats, eggs, fish, nuts, or dried beans at least twice daily?
Do you chew regular (not sugar-free) chewing gum most days of the week?
Do you drink or eat dairy foods at least twice daily?
Do you eat whole grain breads or cereals at least 4 times per day?
Do you eat or drink any food or beverage 5 or more times per day?
Do you drink 6 to 8 cups of water daily?
Do you eat green leafy vegetables daily?
Do you drink nondiet soda, sport drinks, energy drinks, lemonade, fruit drinks, or sugar-sweetened tea or coffee between or after meals?

(3) *Oral cancer risk counseling.* When indicated, the patient should be informed of risk of oral cancer from any of the risk factors described in paragraph 3–2e, as well as their risk of skin and lip cancer from sun exposure.

(4) *Tobacco cessation counseling.* Providers should use the tobacco risk information to properly educate patients about tobacco use and the risks involved, and assist in the development of strategies to quit.

(a) Dental clinics may prefer to develop their own tobacco cessation classes. Tobacco education can be in any format and should be participatory in nature. Providers need to identify or recognize the “teachable moments” in many dental encounters and to use those moments to impart the tobacco cessation message. Individuals who use tobacco and are willing to quit should be treated using the “5 A’s”: Ask all patients about the type and frequency of use; Advise on the adverse effects, especially as it relates to oral cancer and periodontal health; Assess their willingness for cessation; Assist in setting a quit date; and Arrange for organized tobacco intervention services by referral as necessary.

(b) Dental providers may refer patients to other on-post cessation efforts when deemed appropriate. Dental providers can be involved as instructors with those cessation efforts. The DOD Quit Tobacco – Make Everyone Proud Web site (<http://www.ucanquit2.org/>) is another resource to assist patients and providers with quit tips, tobacco information, and training material.

d. *Dental prophylaxis.* Active duty Soldiers and other eligible beneficiaries should be provided with a thorough dental prophylaxis as needed, based on the periodontal risk assessment, for the prevention of periodontal disease. Frequency of dental prophylaxis should be based upon periodontal risk assessment results or findings of a complete periodontal examination.

e. *Sealants.* Approximately 90 percent of carious lesions are found in pits and fissures. Sealants are excellent for the prevention of initiation of decay as well as arresting the progression of incipient lesions or noncavitated caries. Sealants should be placed on pits and fissures of adults’ permanent teeth when it is determined that the tooth, or the patient, is at risk of experiencing caries. Sealants provide a physical barrier that prevents food particles from collecting in pits and fissures, inhibiting bacteria. When sealants are placed over incipient lesions the demineralization process is arrested, and remineralization may sometimes occur. Resin-based sealants are preferable to glass ionomer because of increased retention rates, but glass ionomer may be used when moisture control is a problem and may compromise placement of resin-based sealants.

f. *Mouthguards.* Advise Soldiers who are at risk for maxillofacial injuries from sport, recreation, or occupational activities to wear a mouthguard. Boil-and-bite mouthguards are effective at preventing orofacial injuries. Use procedure code A9100, Boil and Bite Mouth Protector, for these types of mouthguard. Dental providers should fabricate a custom mouthguard for Soldiers who need to wear a mouthguard frequently or for extended time periods. The superior fit, comfort, and retention that can be provided by a custom mouthguard improves compliance with wear. Use code D9941, Fabrication of Athletic Mouthguard (impressions are integral to the procedure and should not be coded separately). A USAPHC review found that:

(1) The use of mouthguards can reduce dental and orofacial injuries by almost two thirds (60 percent fewer injuries).

(2) Any type of mouthguard prevents injuries, as long as the material does not become thinned when it is being fitted.

(3) Mouthguards only need to cover the teeth and the gums around the teeth—large, bulky rims covering the entire gum area or roof of the mouth are not necessary.

*g. Clinical oral health promotion activities.* These include but are not limited to the following:

(1) Have health promotion materials (that is, posters, videos, fact sheets, and so on) displayed at your clinic, in-processing, or mobilization/Soldier readiness processing station. Consider using social media to disseminate health promotion and wellness information.

(2) Use motivational interviewing techniques to improve patient adoption of oral disease prevention health habits.

(3) Use the oral health provided by DENCOM.

(4) Play the Dental Readiness Training Video in the clinic waiting room. This video is intended for clinic Soldier education about the causes of dental diseases and how to combat them. Order a copy of the Public Health Service Dental Readiness Training Video from the Defense Imagery Web site at <http://defenseimagery.mil/imagery.html#apid=999133131>.

(5) Conduct health promotion refresher training annually for all dental activity (DENTAC) personnel who interact with patients.

(6) Have a standardized referral process for patients interested in tobacco cessation classes.

(7) Encourage providers who have received training to offer tobacco cessation counseling and prescribe Nicotine Replacement Therapy/Bupropion for patients if these services are not available through the local military health system.

(8) Include the DENCOM health promotion initiatives in graduate education programs that are hosted at your DENTAC.

## Chapter 4 Community Oral Health Promotion and Disease Prevention Program

### 4-1. General

The Community Oral Health Promotion and Disease Prevention Program will help ensure that both Soldiers and Family members have ready access to information and resources that they need to prevent oral diseases at home. The operation of the Community Oral Health Promotion and Disease Prevention Program will not interfere with necessary dental services for active duty Soldiers or with the provision of emergency care.

### 4-2. Implementation guidance

*a. Command representation.* The commanders of DENTACs, dental clinic commands (DCCs), or separate dental units (Active Army) or their appointed representative (the PDO or HPD) will serve on the Community Health Promotion Council, in accordance with AR 600-63, and will facilitate the integration of oral health promotion and disease prevention information into all related Army Medical Department and community programs (for example, nutrition, neonatal education, community health visits, school programs, physical examinations, safety and injury prevention, and outpatient and troop medical clinic visits).

*b. Space available care.* Commanders and unit dental readiness liaisons of supported units will ensure that all Family readiness groups, Soldiers, and their Family members are aware of the lack of availability of dental care at post facilities and have information on how to obtain and utilize dental insurance in accordance with AR 40-35.

*c. Fluoridation of community water supply.* The CDC recommends community water fluoridation as a safe, effective, inexpensive way to prevent dental caries. The addition of fluoride to drinking water is a community health measure that enhances and supports the oral health and readiness of all Soldiers and Family members of all ages, regardless of income level. More than 60 years of research has shown that water containing fluoride in the amount of 0.7 ppm is safe and effective in reducing dental decay by an additional 25 percent, even after accounting for the use of fluoride toothpaste or other fluoride products.

(1) Installation water engineers should refer to the recommendations of the CDC for proper water fluoridation levels. This will include efforts to reduce fluoride levels in areas where the natural fluoride concentration exceeds 4 ppm.

(2) Water fluoridation training is available through the CDC at <http://www.cdc.gov/fluoridation/engineering/training.htm>. Additional information can be found in TB MED 576 or in the CDC MMWR Recommendations and Reports entitled, "Report Engineering and Administrative Recommendations for Water Fluoridation, 1995" at [http://www.cdc.gov/mmwr/preview/ind1995\\_rr.html/](http://www.cdc.gov/mmwr/preview/ind1995_rr.html/).

(3) The best source of information on water fluoride levels for installations that receive their water from a U.S. State or territorial water system is the local water utility. All water utilities must provide their consumers with a consumer confidence report that provides information on a system's water quality, including its fluoridation level. The State drinking water administrator or State oral health program also should be able to help identify the fluoride level of public drinking water.

(4) The current optimum level is 0.7 mg per liter or 0.7 ppm. The Environmental Protection Agency secondary maximum contaminant level is currently 2.0 mg per liter or 2.0 ppm, to prevent the development of dental fluorosis in young children. In accordance with CDC water fluoridation engineering guidance, water systems with fluoridation levels in excess of 2 ppm will take action to correct fluoridation overfeed. If levels are less than 4.0 ppm, and the problem is resolved within 24 hours, no community notification would be required. If the repairs cannot be completed quickly, then the incident should be reported to the proper authorities and the local community informed of what actions they should take while the fluoridation pump is being repaired or adjusted. While toxicity is not a concern for healthy adults, water consumers should take certain steps in order to reduce the risk of dental fluorosis in children:

(a) Children under the age of 8 years should not drink the water until the fluoride level is adjusted.

(b) Parents who give their infants or toddlers concentrated formula that requires water for preparation should be reminded not to use fluoridated tap water to prepare the formula, especially if it is soy-based formula.

(5) Resources to assist with communication of the benefits and safety of water fluoridation are available from the CDC at [www.cdc.gov/fluoridation/index.htm](http://www.cdc.gov/fluoridation/index.htm) and [http://www.cdc.gov/mmwr/indrr\\_2001.html](http://www.cdc.gov/mmwr/indrr_2001.html) and from the ADA at [www.ada.org/goto/fluoride](http://www.ada.org/goto/fluoride).

*d. Alternative fluoride administration.* The PDO will advise physicians and dentists on professional guidelines for prescribing fluorides in concurrence with the ADA Fluoride Supplement Dosage Schedule (see <http://www.ada.org/en/member-center/oral-health-topics/fluoride-supplements>). Important considerations when using the ADA Fluoride Supplement Dosage Schedule include:

(1) If the fluoride level is unknown, drinking water should be tested for fluoride content before supplements are prescribed. For testing of fluoride content, contact the local or State health department.

(2) All sources of fluoride should be evaluated with a thorough fluoride history.

(3) Patient exposure to multiple water sources can make proper prescribing complex.

(4) Ingestion of higher than recommended levels of fluoride by children has been associated with an increase in mild dental fluorosis in developing, unerupted teeth.

(5) Fluoride supplements require long-term compliance on a daily basis.

*e. Family violence.* A system for reporting suspected cases of family violence that involve abuse or neglect will be coordinated with the local Family Advocacy Program per AR 608–18. An example of abuse would be head or facial injuries inconsistent with the stated cause. If parents have been informed of dental abscesses, large carious lesions, or extensive periodontal disease but have not taken corrective action, referral for child neglect may be indicated.

*f. Community education.* In accordance with AR 600–63, the PDO and HPD will partner with the medical and installation communities to promote oral health to the broadest audience possible. Oral health promotion activities should be included with other installation health and safety events, including but not limited to the Great American Smokeout, retiree health fairs, community safety programs, and other National health observances that can be linked to oral health. Stakeholders include but are not limited to the following:

(1) *Family practice and obstetrics providers.* Many women are not aware that dental treatment during pregnancy is not only safe, but it can be necessary in order to prevent oral diseases from causing a serious emergency. Prenatal care providers have a significant role in educating women concerning the importance of good oral health during pregnancy. The prenatal care team can encourage women to maintain a high level of oral hygiene, recommend that they visit an oral health professional, and promote the completion of all needed treatment during pregnancy. The following recommendations are from the new DOD and Department of Veterans Affairs Clinical Practice Guidelines for Uncomplicated Pregnancy, and the American Academy of Pediatrics, and are available at <http://www.healthquality.va.gov/guidelines/WH/up/>.

(a) Prenatal care providers should provide instruction on maintaining a high level of oral health to all pregnant women during their initial prenatal visit. Instruction on oral health for pregnant women should include expected physiologic changes in the mouth and interventions to prevent threats to their oral health.

(b) Prenatal care providers should recommend that all pregnant women receive an oral exam and routine dental care, including preventive treatment, x-rays and periodontal therapy, as early in pregnancy as possible. These treatments are effective and safe during pregnancy. Additional information can be found in the Department of Veterans Affairs and DOD Clinical Practice Guideline for Pregnancy Management, which can be accessed at <http://www.healthquality.va.gov/guidelines/WH/up/>.

(c) Eliminating oral disease in mothers promotes infant oral health as well, since mothers with high levels of cariogenic bacteria are more likely to infect their children and initiate the development of early childhood caries. In addition to completing any necessary dental treatment, expectant mothers who are at moderate or high caries risk should consume 1.5 to 2 grams of xylitol 3 to 5 times a day, for a total of 6 to 10 grams per day. Regular use of xylitol products by mothers has been shown to inhibit transmission of cariogenic bacteria from mothers to infants, thereby preventing or delaying the development of early childhood caries. Xylitol gum should be chewed immediately after meals or snacks for at least 5 but no more than 10 minutes.

(d) Infant oral health care should be included as part of other prenatal education counseling or classes on infant care. Ideally, pregnant women should receive instruction on infant oral health care during the second trimester of pregnancy when they are the most receptive to new information. Training and education materials for patients are available on the USAPHC Web site at <http://phc.amedd.army.mil/topics/healthyliving/Pages/default.aspx>. Additional information is available from the National Maternal and Child Oral Health Resource Center at <http://www.mchoralhealth.org/Toolbox/professionals.html>.

(2) *Pediatric primary care providers.* Oral health is an integral part of the overall health and well-being of children. Both the American Academy of Pediatrics and the American Academy of Pediatric Dentistry recommend that primary care pediatric practitioners incorporate oral disease prevention into their pediatric preventive visits, particularly for children aged 0 to 3 years.

(a) An oral health risk assessment should be administered periodically to all children as part of the well child visit. Oral health resources for pediatric primary care providers are available on the American Academy of Pediatrics Web site at <http://www.aap.org/healthtopics/oralhealth.cfm> and from the National Maternal and Child Oral Health Resource Center at <http://www.mchoralhealth.org/Toolbox/>.

(b) Oral health risk-assessment training should be completed by medical practitioners who are in training programs and those who currently administer care to children. Online training in oral health screening and disease prevention for providers that provides CME credit is available on the American Academy of Pediatrics Web site at [http://pedialink.aap.org/visitor/cme/cme\\_finder/cme-detail?guid=ec533459-1d01-4e6a-a6a2-4193271327ea/](http://pedialink.aap.org/visitor/cme/cme_finder/cme-detail?guid=ec533459-1d01-4e6a-a6a2-4193271327ea/).

(c) Dietary counseling for optimal oral health should be an intrinsic component of general health counseling.

(d) Anticipatory guidance for oral health should be an integral part of comprehensive patient counseling.

(e) Administration of all fluoride modalities should be based on an individual's caries risk. Patients who have a high risk of caries are candidates for consideration of more intensive fluoride exposure after dietary counseling and oral hygiene instruction as compared with patients with a lower risk of caries. Also review dietary intake of sugar sources (juice, soft drink, chocolate milk, and so forth) and assess oral hygiene (plaque, inflammation) at each appointment.

(f) Supervised use of fluoride toothpaste is recommended for all children with teeth.

(g) The application of fluoride varnish by the medical practitioner is appropriate for patients with significant risk of dental caries who are unable to establish a dental home.

(h) Every child should have a dental home established by 1 year of age. According to the American Academy of Pediatric Dentistry, “The dental home is the ongoing relationship between the dentist and the patient, inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way. Establishment of a dental home begins no later than 12 months of age and includes referral to dental specialists when appropriate.”

(i) Collaborative relationships with local dentists should be established to optimize the availability of a dental home.

(3) *Dieticians.* Poor oral health affects eating ability, and can result in reduced enjoyment of food and a less nutritious, low fiber diet. As mentioned in paragraphs 3–2b and 3–3d, proper diet and nutrition are essential for good oral health. All dietary counseling should incorporate appropriate oral disease prevention principles in order to minimize or eliminate nutrition-related oral disease. Dieticians will coordinate with dentists to provide oral health and nutrition counseling for Soldiers and Family members who have multiple dietary risk factors for oral disease, including but not limited to high amount and frequency of refined carbohydrate intake, low fruit and vegetable intake, poor nutrition, and inadequate dietary fiber intake.

(4) *Army Substance Abuse Program.* The Army Substance Abuse Program annual training should include information on harm to the oral cavity that is caused by substance use or abuse, and include tobacco as one of the addictive drugs whose use is discouraged. Information and training materials are available from USAPHC or the Army Substance Abuse Program office at Aberdeen Proving Ground. Information is also available from the DOD Quit Tobacco – Make Everyone Proud Web site at <http://www.ucanquit2.org>.

(5) *Child, youth, and school services.* The local child, youth, and school services (CYSS) personnel (such as the director, nurse, and other staff) and the Army public health nurse who provides oversight, will work with the DENTAC, DCC, or dental unit PDO or HPD to ensure that proper procedures are followed for establishing and maintaining tooth brushing stations for the children in child care centers.

(a) The National Academy of Early Childhood Programs (see <http://www.naeyc.org/academy/>) is the accrediting arm of the National Association for the Education of Young Children (NAEYC) (see <http://www.necpa.net/index.php>). NAEYC accredits CYSS facilities and requires that programs serving two or more meals must provide tooth and gum cleaning for children older than 1 year. Guidance on toothbrush care in schools and group settings is available from the NAEYC and on the CDC Web site at <http://www.cdc.gov/oralhealth/infectioncontrol/factsheets/toothbrushes.htm>.

(b) CYSS and the Army public health nurse who provides oversight to ensure that child development center staff has up to date information on oral disease prevention techniques and reinforcement of positive oral hygiene behaviors should work with PDO or the HPD, and ensure that this information is shared with the parents and/or caregivers.

(c) The CYSS dietician or nurse and the Army public health nurse who provides oversight should coordinate with the PDO or HPD to ensure that snacks served by child development center facilities and Family child care providers are nutritious and have as low caries-promoting potential as possible. Information on healthy snack alternatives is available from the National Institute of Dental and Craniofacial Research Web site, at <http://www.nidcr.nih.gov/OralHealth/Topics/ToothDecay/AHealthyMouthforYourBaby.htm> and from the U.S. Department of Agriculture Web site, at <http://www.nutrition.gov>.

(6) *Army Community Service.* Army Community Service (ACS) can promote oral health by keeping the PDO and the HPD informed about community events for families where oral health and TRICARE Dental Program information can be distributed. ACS also coordinates several programs that can assist with oral disease prevention in the pediatric population. These programs include but are not limited to—

(a) *Women, Infants, and Children Program.* Since this program serves the population at highest risk for oral disease overseas, this is the ideal agency to promote early childhood caries prevention. This program should require that formula recipients receive oral disease prevention education as one of the infant health classes that they must attend when they receive their allotment of formula. Studies have shown that program workers can also be effectively trained to screen young children for oral disease and refer them for treatment.

(b) *Family Advocacy Program.* The role of the Family Advocacy Program in preventing family violence or child dental neglect is discussed in paragraph 4–2d.

(c) *New Parent Support Program.* This program can provide information to Soldiers about healthy feeding practices and appropriate oral hygiene procedures. The New Parent Support Program home visits are an ideal time to emphasize preventive feeding and hygiene practices. The New Parent Support Program staff should obtain educational information from the PDO or HPD.

(d) *Relocation Assistance Program.* The Relocation Assistance Program can inform Soldiers how to find a participating dental provider in the area.

(7) *Retail outlets on post.* The commissary system and the Army and Air Force Exchange Service are important allies in ensuring the availability of home-use fluoride and oral hygiene implements. Commissaries and post exchanges can ensure that they carry at least one variety of bottled water that contains fluoride and is competitively priced. Both commissaries and post exchanges can ensure that they carry fluoridated toothpaste in child-friendly flavors such as bubble gum or berry. Most small children cannot tolerate the strong mint flavors in adult toothpaste, and they may resist tooth brushing sessions to avoid the taste. In addition, the flavoring agents in adult toothpastes can be irritating to the tissues of young children’s mouths. Commissaries and post exchanges should offer an assortment of xylitol gums

and mints, appropriate oral hygiene items (infant- and toddler-sized through adult), and healthy food and snack choices at affordable prices. The local dietitian and PDO or HPD can work with the commissary managers to ensure that they have many options in stock, and create displays with information on “tooth-friendly” foods that can be displayed periodically at the entrance to or specific locations within facilities.

*g. School-based programs.*

(1) Each DENTAC and/or DCC, or dental unit PDO or HPD, may establish a cooperative relationship with any DOD dependent school in its area of responsibility. The DENTAC and/or DCC PDO or HPD will encourage oral health education and support teacher training, classroom activities, and school health officials in their dental health education efforts.

(2) DENTAC and/or DCC PDO activities recommended include, but are not limited to—

(a) Oral screening, with parental consent; results should be reported to parents and school health officials.

(b) Comprehensive age appropriate oral health instruction. It should include brushing, flossing, diet counseling, and the appropriate use of fluorides. Sports safety (mouth guards), tobacco interdiction, sealants, and sun safety are also recommended as part of the health promotion message when suitable.

*h. Nutrition environment assessment.* Availability of healthy food and snack choices is essential to maintaining Soldier fitness and oral health. Soldiers should have an adequate intake of fruits and vegetables rich in calcium, magnesium, B vitamins and zinc, and reduced frequency and amount of exposure to foods, beverages, or snacks that contain simple carbohydrates and polybasic organic acids. Soldiers should also have opportunities to consume anticariogenic foods (such as tea, cheese, and xylitol gum). PDOs may—

(1) Collaborate with the installation Community Health Promotion Council and/or MTF dietitian to improve the accessibility of healthier food options that are sold or served on the installation.

(2) When a Community Health Promotion Council or registered dietitian does not exist, contact and consult with the dietitian at the closest MTF. Create a coalition team to address nutrition issues on an ongoing basis. Use a standardized tool to assess and improve the eating environment.

(3) The Military Nutrition Environment Assessment Tool (m-NEAT) is a Joint Service standardized tool used to promote healthy eating and increased consumption of healthy foods. It enables health promotion professionals, commanders, and other stakeholders to assess how well the base or installation is doing at making healthier options accessible. The m-NEAT provides a baseline assessment of the nutrition environment and identifies strengths and potential target improvement areas. The tool is used to—

(a) Assess vending machines, convenience stores, DOD dependents schools, commissaries, permanent parties, and initial military training dining facilities, fitness centers, worksites, and sit-down food service establishments.

(b) Gather information about the community in relation to the nutrition environment in a standardized, systematic fashion using national and DOD standards.

(c) Form a local strategic plan by identifying strengths and potential target improvement areas.

(d) Engage leaders, community members, and stakeholders.

(4) Find the m-NEAT on the Navy and Marine Corps Public Health Center’s Web site at <http://www.med.navy.mil/sites/nmcphc/health-promotion/healthy-eating/Pages/m-neat.aspx>.

*i. Local media outlets.* PDOs, HPDs, or deployed dentists can—

(1) Coordinate with all local media outlets, including social media, to distribute information related to oral health promotion or oral health events via posters, articles, announcements, or event highlights placed in local newspapers, radio, or television.

(2) Publish their own dental newsletter and distribute it at MTF, ACS, CYSS, and morale, welfare, and recreation locations.

## **Appendix A References**

### **Section I Required Publications**

Unless otherwise indicated, all publications are available on the Army Publishing Directorate Web site (<http://www.apd.army.mil/>).

#### **AR 40-35**

Dental Readiness and Community Oral Health Protection (Cited in paras 1-1, 2-2, 4-2b.)

#### **AR 600-63**

Army Health Promotion (Cited in paras 1-1, 4-2f, 4-2a.)

#### **AR 608-18**

The Army Family Advocacy Program (Cited in paras 3-2a(5), 4-2e.)

#### **TB MED 250**

Dental Record Administration, Recording, and Appointment Control (Cited in para 3-2d(1).)

#### **TB MED 576**

Occupational and Environmental Health Sanitary Control and Surveillance of Water Supplies at Fixed Installations (Cited in para 4-2c(2).)

### **Section II Related Publications**

A related publication is a source of additional information. The user does not have to read it to understand this publication. DOD issuances are available at <http://www.dtic.mil/whs/directives/index.html>. Health Affairs policy memorandums are available at <http://www.health.mil/policies/>.

#### **AR 25-30**

The Army Publishing Program

#### **AR 40-3**

Medical, Dental, and Veterinary Care

#### **AR 40-5**

Preventive Medicine

#### **AR 40-66**

Medical Record Administration and Healthcare Documentation

#### **AR 40-501**

Standards of Medical Fitness

#### **AR 600-8-101**

Personnel Processing (In-, Out-, Soldier Readiness, Mobilization, and Deployment Cycle)

#### **DA Pam 600-81**

Information Handbook for Operating Continental United States (CONUS) Replacement Centers and Individual Deployment Sites

#### **Department of Veterans Affairs/DOD Clinical Practice Guideline for Pregnancy Management**

Available at <http://www.healthquality.va.gov/guidelines/WH/up/>.

#### **Department of Veterans Affairs/DOD Clinical Practice Guidelines for Uncomplicated Pregnancy**

Available at <http://www.healthquality.va.gov/guidelines/WH/up/>.

#### **DODI 6025.19**

Individual Medical Readiness (IMR)

## **Engineering and Administrative Recommendations for Water Fluoridation, 1995**

CDC MMWR Recommendations and Reports (September 29, 1995/Vol. 44 /No. RR-13) (Available at [http://www.cdc.gov/mmwr/preview/ind1995\\_rr.html/](http://www.cdc.gov/mmwr/preview/ind1995_rr.html/).)

### **HA Policy 02-011**

Policy on Standardization of Oral Health and Readiness Classifications

### **HA Policy 06-001**

Policy on Oral Health and Readiness

### **HA Policy 07-011**

Policy on Space Available Dental Care

### **HA Policy 07-017**

Updated Changes to Health Affairs' Policy on Dental Readiness within the Services

### **HA Policy 96-023**

Dental Readiness Within the Services

### **HA Policy 96-024**

Inclusion of Dentistry in TRICARE Regions

### **HA Policy 98-021**

Policies on Uniformity of Dental Classification System, Frequency of Periodic Dental Examinations, Active Duty Overseas Screening, and Dental Deployment Standards

## **Quit Tobacco – Make Everyone Proud**

(Available at: <http://www.ucanquit2.org>)

## **Recommendations for Using Fluoride to Prevent and Control Dental Caries in the United States**

CDC MMWR Recommendations and Reports (August 17, 2001/Vol. 50/No. RR-14) (Available at [http://www.cdc.gov/mmwr/indrr\\_2001.html](http://www.cdc.gov/mmwr/indrr_2001.html).)

## **The Role of Diet and Nutrition in the Etiology and Prevention of Oral Diseases**

Bulletin of the World Health Organization (Volume 83, Number 9, September 2005) (Available at <http://www.who.int/bulletin/volumes/83/9/694.pdf>.)

## **Treating Tobacco Use and Dependence: Clinical Practice Guidelines**

U.S. Department of Health and Human Services, Public Health Service, May 2008 Update (Available at <http://www.ncbi.nlm.nih.gov/books/NBK63952/>.)

## **Section III**

### **Prescribed Forms**

This section contains no entries.

## **Section IV**

### **Referenced Forms**

Unless otherwise indicated, DA forms are available on the Army Publishing Directorate Web site (<http://www.apd.army.mil>).

### **DA Form 2028**

Recommended Changes to Publications and Blank Forms

## **Glossary**

### **Section I Abbreviations**

**ADA**

American Dental Association

**ACS**

Army Community Service

**AR**

Army regulation

**CDC**

Centers for Disease Control and Prevention

**CYSS**

child, youth, and school services

**DA**

Department of the Army

**DCC**

dental clinic command

**DENCOM**

U.S. Army Dental Command

**DENTAC**

dental activity

**DOD**

Department of Defense

**DRC**

dental readiness classification

**DRO**

dental readiness officer

**HIV**

human immunodeficiency virus

**HPV**

human papiloma virus

**mg**

milligram

**ml**

milliliters

**mm**

millimeter

**MMWR**

Morbidity and Mortality Weekly Report

**MRE**

meal, ready to eat

**MTF**

medical treatment facility

**ppm**

parts per million

**TB MED**

technical bulletin medical

**USAPHC**

U.S. Army Public Health Command

**Section II****Terms****angular stomatitis**

Inflammation of the corners of the mouth. (See chelitis.)

**caries**

Refers to dental caries—a bacterial infection of the hard tissue (enamel and dentin) of the teeth, which can lead to decay and cavitation.

**cariogenic bacterial challenge**

An overgrowth of bacteria that can lead to tooth decay.

**cerebrovascular**

Associated with the blood vessels in or around the brain.

**chelitis**

Inflammation of the lips often isolated to the corners of the mouth. (See angular stomatitis.)

**edentulous**

Lacking teeth, either one part of the mouth or the entire mouth.

**furcation invasion**

Pathological involvement of the crotch of a multi-rooted tooth, usually by periodontal disease-associated bone loss.

**glossitis**

Soreness or inflammation of the tongue.

**lactobacilli**

Acid-producing bacteria in the mouth also associated with tooth decay.

**mucogingival condition**

Any disease or traumatic condition of the gums, or soft tissue of the mouth. It may be isolated to one or a few teeth, or generalized throughout the mouth.

**mutans streptococci**

The group of bacteria most often associated with tooth decay.

**periapical pathology**

A disease condition affecting the area of the gum, around the tip of the root of a tooth, usually secondary to either pulpal pathology or localized periodontitis.

**pericoronitis**

Inflammation of the gum around an erupting tooth, usually associated with a third molar (wisdom tooth).

**periodontitis**

Gum disease.

### **Prevent Abuse and Neglect through Dental Awareness Coalition**

An educational coalition, organized at the State-government level, which provides programs aimed at increasing awareness of child abuse and neglect and helping dental personnel recognize and report suspected cases.

### **pulpal pathology**

A disease condition affecting the tooth pulp. It may be reversible or irreversible.

### **subgingival calculus**

Tartar that develops below the gum line.

### **temporomandibular disorder**

A disorder of the jaw joint that can result in pain; limited motion of the jaw; popping of the joint; or inability to close, bite, or chew.

### **Xerostomia**

Dry mouth caused by inadequate or total loss of saliva production.

## **Section III**

### **Special Abbreviations and Terms**

#### **APF**

acidulated phosphate fluoride

#### **CDT**

current dental terminology

#### **cfu/ml**

colony forming unit, per unit of measure

#### **HA**

Health Affairs

#### **HPD**

health promotion director

#### **m-NEAT**

Military Nutrition Environment Assessment Tool

#### **NAEYC**

National Association for the Education of Young Children

#### **NaF**

sodium fluoride

#### **PDO**

preventive dentistry officer

#### **PSR**

periodontal screening and recording

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