REFORGER 92: Operation Desert Shield/Storm Lessons Learned Applied

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This article describes lessons learned from Operation Desert Storm, about dental workload reporting and how it was applied during Return of Forces to Germany (REFORGER) '92, by the Army Dental Care System in Europe.

This article describes lessons learned from Operation Desert Storm about dental workload reporting and how it was applied during REFORGER '92 by the Army Dental Care System in Europe. After providing a brief historical perspective on dental workload reporting during Operation Desert Storm and in United States Army, Europe (USAREUR), before Operation Desert Storm, corrective actions taken and utilized during REFORGER '92 are discussed. The results of their implementation and conclusions are presented.

Historical Perspective

Reporting of accurate dental patient workload, disease, and injury statistics has been difficult in a theater of operations.[1] Operations Desert Shield/Storm were no different in this aspect.

Dental units were staffed and task organized within weeks of deployment with a new dental command structure.[2] The length of Operation Desert Shield/Desert Storm and the build-up of the dental support assets deployed was in flux. Dental support was austere despite the number of deployed units and massive build-up of soldiers.[1,2]

Hospital beds occupied, admissions, discharges, and transfers are just some of the medical statistics which have been tracked daily for decades within the US Army Medical Department in the management of medical assets. The US Army Dental Care System does not have a management tool established that provides information to the dental commander on the patients deployed in a theater of operation who are using the Army Dental Care System.

No institutionalized workload reporting mechanism was utilized by the dental units deployed from 7th Medical Command (MEDCOM) to ensure that the 2d Medical Detachment (the dental command and control element) could obtain this information. A dental workload reporting system was established late in Operation Desert Shield, which illustrated that there was no central workload reporting mechanism. Two-thirds of the dentists deployed were not under dental command and control but were attached to medical units and divisional organizations.[2] Data on the diseases and injuries would have provided valuable information in determining the priorities for dental resources, staffing levels, and epidemiological purposes. Workload documentation would have provided data for historical uses and references for future deployment.[1,4].

USAREUR—Before Desert Storm

Before Operation Desert Storm, there was no routine dental care workload report included in the Field Standard Operating Procedure (FSOP) of 7th MEDCOM nor the Army Dental Care System, Europe.[6,7] Dental workload reporting was not a routine part of exercise simulation within the REFORGER deployment exercises and other field training/command post exercises in USAREUR and 7th Army. Disease and injuries seen by the supporting dental units during exercises were of no concern to officials as part of the exercise scenario. Concerns were for actual care to participants.[9,10]

Actual dental workload procedures performed on REFORGER participants were reported as part of the 7th MEDCOM'S Dental Workload Reporting System (DWRS), which is the basis for supply cost reimbursement in a garrison environment. The DWRS told reviewing leadership what procedures the dental team performed. It did not tell what diseases and injuries were presenting for care. The DWRS report is long and detailed, and it is compiled both manually and in an automated manner. The communications equipment as well as the labor intensive handling of the DWRS reporting data was not practical in the field environment.[9,10]

The questions raised in the Post Desert Storm/Post Cold War era were as follows: (1) Could we report the disease and injuries seen in a meaningful manner? (2) Could we improve the distribution of assets with this information? We attempted to answer these questions during REFORGER '92.

Corrective Actions

To update the dental field Standard Operating Procedure (SOP) as well as answer these questions, we looked to the 18th Medical Command, Korea.[6] The "10th Medical Detachment (DS) Field Standing Operating Procedures (FSOP)" was reviewed.[7] Their reporting mechanism, with minor changes, was included in the REFORGER '92 operations order. REFORGER '92 was the first time workload was captured from a field exercise and reported to the wartime dental headquarters in the post Cold War/post Desert Storm period.

Figure 1 depicts the reporting mechanism applied during REFORGER '92.

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Interviews with MSG Tom Rodgers, 1980-1984, 2d Medical Detachment, Senior Dental Noncommissioned Officer, Heidelberg, Germany. Dental NCO, Office of the Inspector General, 7th MEDCOM, 1986-1992.

Interviews with SGM Philip R. Menard, 1984-1987, 2d Medical Detachment, Senior Dental Noncommissioned Officer, Heidelberg, Germany.

A quick review shows the line items A-V. These items were explained in detail in the reports annex of the 7th MEDCOM operation order. These line items include the reporting unit, the report date, the unit's location, 15 dental disease/injury categories presenting, and the sources of the patients. A patient reporting with several conditions would generate a count on more than one line of the report as they would require more than one type of care.

During REFORGER '92, the data was tabulated by personnel from 7th MEDCOM's 86th Medical Detachment (DS) and the Reserve Component's 333d Medical Detachment (DS), on a daily basis. Both units provided dental service support to the REFORGER soldiers. These reports were sent via phone or facsimile to the Headquarters, 93d Medical Battalion (DS), the command and control element for all the dental Modified Table of Organization and Equipment (MTOE) assets within 7th MEDCOM. The workload was reviewed by the supporting unit commander and the 7th MEDCOM Assistant Chief of Staff, Dental Service. The information was presented during the 7th MEDCOM Commanding General's morning update.

Report Line		Patient Totals
A	Unit — 86th/333d	
B	Date	
C	Location – Rivers Barracks	
D	Caries, Mild/Moderate	61
E	Caries, Advanced	20
F	Defective Restoration	40
G	Defective Removable Pros	0
H	Trauma/Occlusal/Incisal	5
I	Gingivitis	88
J	Periodontitis, Mod/Severe	5
K	Periodontal Abscess	13
L	Oral Lesions	6
M	TMJ Disorder	1
N	Pericoronitis	9
O	Post OP Complications	5
P	Self Referral/Annual Exam	203
Q	Endodontic Treatment	0
R	Post Mortem Examination	0
S	Active Army Personnel	271
T	Reserve Personnel	55
U	Allied Service Personnel	1
V	US Armed Forces – non-Army	0

Figure 1. *REFORGER '92 disease and injury reporting format and summary data.*

Other senior Dental Corps staff officers reviewed the data and all concurred that the cases tracked through this methodology would be of definite benefit for resource allocation decisions as well as for epidemiological and historical value if used routinely. It was evident to them that gingivitis exacerbated among REFORGER soldiers because of stress and the change in diet and sleep patterns.

Results

The questions raised in the Post Desert Storm/Post Cold War era were answered YES during REFORGER'92! We captured meaningful information on the dental diseases and injuries treated. We can improve the distribution of assets with this information.

This extension of meaningful workload reporting gave the Army Dental Care System, Europe these additional training benefits: (1) utilization of the Patient Administration Specialist (71G) assigned to the headquarters in a role expected of this military occupational specialty; (2) exercise of the newly established battalion headquarters element under the Medical Force 2000 MTOE; (3) and provision of meaningful exercises participation in REFORGER '92 for Corps level dental units, enabling the active and reserve component dental units actual experience at workload reporting to their "wartime" headquarters. All these benefits had not been accomplished in previous exercises. The Army Dental Care System, Europe was executing the "train like you are going to fight" philosophy of the "Line."

CONCLUSION

Under the Medical Force 2000 concept, the Medical Battalion (DS) commander must allocate limited dental care providers and scarce supplies. Mission, population supported, and epidemiological disease and injuries experienced within the area supported that all play key roles in resource allocation decisions. A standardized reporting method for dental disease and injuries treated needs to be established for all Medical Battalions (DS) in the Army Medical Department. Until the Army Dental Care System implements one, the 93d Medical Battalion (DS) will incorporate this workload reporting mechanism into their FSOP as a result of this effort.

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