Department of Defense
INSTRUCTION

NUMBER 6025.19
January 3, 2006

USD(P&R)

SUBJECT: Individual Medical Readiness (IMR)

References: (a) Sections 136(d) and 671 of Title 10, United States Code
(b) DoD Directive 5124.2, "Under Secretary of Defense for Personnel and Readiness," October 31, 1994
(c) Section 731 of Public Law 108-375, "Ronald Reagan National Defense Authorization Act for Fiscal Year 2005," October 28, 2004
(d) DoD Directive 6200.4, "Force Health Protection (FHP)," October 9, 2004
(e) through (j), see enclosure 1

1. PURPOSE

This Instruction:

1.1. Implements policy, assigns responsibilities, and prescribes procedures to improve medical readiness through monitoring and reporting on Individual Medical Readiness (IMR), consistent with references (a) through (d). IMR provides operational commanders, Military Department leaders and primary care managers the ability to monitor the medical readiness status of their personnel, ensuring a healthy and fit fighting force medically ready to deploy.

1.2. Establishes defined, measurable medical elements for all Services. It tracks key elements of IMR across the Department of Defense, and provides operational commanders and Service headquarters the ability to continuously monitor their military personnel for medical readiness and deployability.

1.3. Requires quarterly IMR reports summarizing the IMR status of Active and Selected Reserve members of the Armed Forces, both officers and enlisted members, except those who have not completed initial active duty for training and follow-on technical skills training or others who are unavailable to deploy (e.g., recruiters, Reserve Officer Training Corps cadre, students in deferred status pursuing advanced academic degrees).

2. APPLICABILITY

This Instruction applies to the Office of the Secretary of Defense and the Military Departments, the Chairman of the Joint Chiefs of Staff, the Combatant Commands, the Office of Inspector General of the Department of Defense, the Defense Agencies, the DoD Field Activities and all other organizational entities in the Department of Defense (hereafter referred to collectively as the "DoD Components"). The term "Military Services," as used herein, refers to the Army, the Navy, the Air Force, and the Marine Corps. By agreement with the Secretary of Homeland Security, this Directive will also apply to the Coast Guard when it is not operating as a service within the Navy.

3. DEFINITIONS

Terms used in this Instruction are defined in enclosure 2.

4. POLICY

It is DoD Policy:

4.1. That a comprehensive plan be adopted to improve medical readiness and tracking of active duty and selected reserve members of the armed forces as prescribed in reference (c).

4.2. That policies and procedures be initiated to implement reporting on key IMR performance metrics to ensure a healthy and fit fighting force that is fully medically ready to deploy and provide Department of Defense the maximal ability to accomplish its mission.

4.3. That IMR will be made available to line commanders through the Status of Resources and Training System (SORTS), and migrate to the Defense Readiness Reporting System (DRRS) when it becomes available. This information will also be useful for identifying individual and cohort availability for contingency sourcing.

5. RESPONSIBILITIES

5.1. The Assistant Secretary of Defense for Health Affairs (ASD(HA)), under the Under Secretary of Defense for Personnel and Readiness (USD(P&R)), shall:

5.1.1. Evaluate the effectiveness/implementation of the IMR Program and oversee the program.

5.1.2. Recommend changes and/or revisions to policy and issue guidance as necessary to implement this Instruction.

5.1.3. Monitor implementation of this instruction and ensure that Quality Assurance/Quality Control programs are in place.

5.1.4. Consolidate IMR data and issue DoD IMR reports.

5.1.5. Establish a DoD IMR Working Group, chartered under the Force Health Protection Council to monitor, revise, evolve and otherwise improve IMR elements and supporting processes.

5.1.6. Ensure that information is shared as broadly as possible (except where limited by law, policy, or security classification) and that data assets produced as a result of the assigned responsibilities are visible, accessible, and understandable to the rest of the Department as appropriate, according to DoD Directive 8320.2 (reference (e)).

5.2. The Assistant Secretary of Defense for Reserve Affairs, under the USD(P&R)), shall monitor IMR policies for the Selected Reserve and ensure they are consistent with IMR policies established for the active component according to DoD Directive 5125.1, 32 CFR part 44, and 10 U.S.C. 10149, 1074a, and 10206 (references (f) through (h)).

5.3. The Assistant Secretary of Defense for Networks and Information Integration/DoD Chief Information Officer shall ensure that the military health system has a robust and effective strategic and tactical communications backbone to support IMR activities.

5.4. The Secretaries of the Military Departments shall:

5.4.1. Implement this Instruction and report IMR metrics according to requirements established by the ASD(HA).

5.4.2. Ensure that supporting medical units provide non-medical unit commanders with health services to support command efforts to ensure personnel remain fit and ready to deploy.

5.4.3. Ensure that IMR information is reported into SORTS (or DRRS, when available) in a format that facilitates readiness and deployability assessments.

5.4.4. Implement quality assurance and quality control systems to ensure compliance with this Instruction.

5.4.5. Provide appropriate guidance, training and support to implement the requirements of this Instruction.

5.4.6. Evaluate and recommend changes or improvements to the IMR program.

5.4.7. Establish aggressive quarterly and annual metric goals for the separate IMR elements and for the overall IMR category of Fully Medically Ready (FMR). The ultimate goals is to produce real-time reports based on complete, accurate data. The minimum goal for overall medical readiness is more than 75% of Service members FMR, with the ideal goal being 100%.

6. PROCEDURES

6.1. Assessing IMR must be a continuous process. IMR shall be monitored and reported on a regular basis in order to provide operational commanders and Service leaders with indications of a comprehensive summary picture of the IMR status of Active and Selected Reserve members of the Armed Forces, except those members who have not completed their initial active duty training as detailed in enclosure 2 or who are otherwise unavailable to deploy (e.g., students in degree-granting programs). Below are the six key elements identified for monitoring to achieve this goal. The standards for each element are detailed in enclosure 3

6.1.1. Periodic Health Assessment (PHA).

6.1.2. No Deployment-limiting Conditions.

6.1.3. Dental Readiness.

6.1.4. Immunization Status.

6.1.5. Medical Readiness Laboratory Tests.

6.1.6. Individual Medical Equipment.

6.2. Each Service will assess the overall IMR of each Service member according to the following criteria:

6.2.1. Fully medically ready. Current in all categories including dental class 1 or 2.

6.2.2. Partially medically ready. Lacking one or more immunizations, readiness laboratory studies, or medical equipment.

6.2.3. Not medically ready. Existence of a chronic or prolonged deployment limiting condition (per Service-specific physical standards guidelines), including Service members who are hospitalized or convalescing from serious illness or injury, or individuals in dental class 3.

6.2.4. Medical readiness indeterminate. Inability to determine the Service member's current health status because of missing health information such as a lost medical record, an overdue PHA or being in dental class 4.

6.3. Summary IMR reports from the Surgeon Generals of the Military Departments will be incorporated into the MHS enterprise performance measures and submitted to the Force Health Protection Council quarterly (January, April, July, and October).

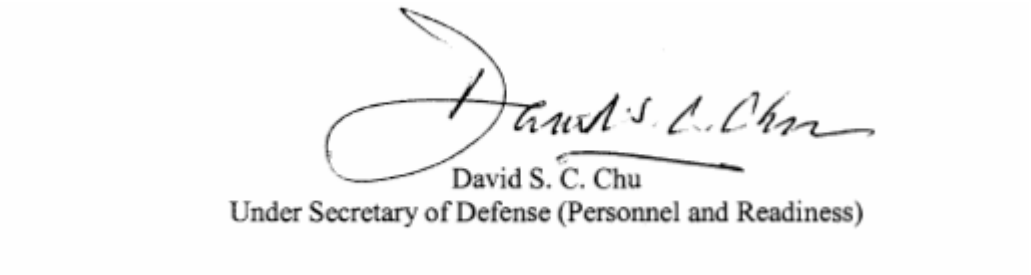
6.4. Electronic data collection systems will capture, track and report each member's IMR currency. Military Department-specific systems must interact with key enterprise IM/IT systems, such as the Defense Enrollment Eligibility Reporting System and the MHS Central Data Repository/Warehouse, to facilitate data exchange between Military Departments. Additionally, such systems must interface with other line readiness-related reporting systems, such as the DRRS.

7. INFORMATION REQUIREMENTS

The reporting requirements in this Instruction have been assigned Report Control Symbol (RCS) DD-HA(Q) 2224 in accordance with DoD 8910.1-M (reference (i)).

8. EFFECTIVE DATE

This Instruction is effective immediately.



David S. C. Chu
Under Secretary of Defense (Personnel and Readiness)

Enclosures - 1

- E1. References, continued
- E2. Definitions
- E3. IMR Key Elements Standards
- E4. Oral Health and Readiness Classification System

E1. ENCLOSURE 1

REFERENCES, continued

(e) DoD Directive 8320.2, "Data Sharing in a Net-Centric Department of Defense," December 2, 2004
(f) DoD Directive 5125.1, "Assistant Secretary of Defense for Reserve Affairs," March 2, 1994
(g) Title 32, Code of Federal Regulations, Part 44, "Screening the Ready Reserve," current edition
(h) Sections 10149, 1074a, 10206 of Title 10, United States Code
(i) DoD 8910.1-M, "DoD Procedures for Management of Information Requirements," June 30, 1998
(j) Joint Publication 1-02, "DoD Dictionary of Military and Associated Terms"

E2. ENCLOSURE 2

DEFINITIONS

E2.1.1. Individual Medical Readiness (IMR). A means to assess an individual servicemember's, or larger cohort's, readiness level against established metrics applied to key elements of health and fitness to determine medical deployability in support of contingency operations.

E2.1.2. Initial Active Duty for Training. Basic military training and technical skill training is required for all accessions. The functional relevance to individual medical readiness (IMR) is that individuals who have not successfully completed initial active duty training and follow-on specialty skill training are not qualified to deploy and IMR monitoring of these individuals is unnecessary. See also "trained strength in units" in Joint Publication 1-02 (reference (j)).

E2.1.3. Periodic Health Assessment (PHA). An annual assessment for changes in health status, especially those that could impact a member's ability to perform military duties.

E2.1.4. Selected Reserve. See reference (j). Note: persons performing initial active duty for training are excluded from IMR reporting.

E3. ENCLOSURE 3

INDIVIDUAL MEDICAL READINESS KEY ELEMENT STANDARDS

E3.1.1. Dental Readiness. All Services use the same classification system to assess and monitor dental readiness. **Pass**: Class 1 or 2 per current annual dental exam. **Fail**: Dental Class 3 or 4. The class is 4 when the annual exam is overdue. For this purpose, an exam is overdue if it is not accomplished within three months following the due month. Example: a dental exam due last accomplished in October 2005 will be counted as overdue if it has not been accomplished by the last day of January 2006.

E3.1.2. Immunization Status. Immunizations effectively prevent infectious diseases in the deployed as well as non-deployed environments. Immunizations will be monitored and kept current. **Pass**: Current for Total Force/All Services vaccines including hepatitis A, tetanus-diptheria (Td), MMR, IPV, hepatitis B (if series began) and influenza (once per season). **Fail**: overdue for one or more vaccines. Vaccinations are overdue 30 days after their scheduled due date. There is a special rule for influenza, which usually becomes available in October of each calendar year. An influenza vaccination is overdue if not administered by January 1of the current flu season. There are exceptions to vaccination requirements per Military Department or Service policy and occupational or deployment considerations (including medical and administrative reasons). Special immunizations, sometimes referred to as "flagged" vaccines are those required for one's occupation (e.g., rabies, typhoid, hepatitis B, etc.) or specific for a planned operation due to location or threat (e.g., anthrax, smallpox, Japanese encephalitis, yellow fever, etc). While important, these will not be assessed as part of the DoD IMR report until such time as all Services have the ability to consistently track and report these type of immunizations. Services with such capability are strongly encouraged to monitor "flagged" immunizations internally.

E3.1.3. Individual Medical Equipment. Medical equipment will be monitored as appropriate for personnel subject to deployment. The core requirement is one pair of gas mask inserts (GMI) for all deployable assets needing visual correction. Service-specific policies may identify additional items of medical equipment, such as two pair of prescription spectacles, hearing aid batteries, etc., but they are not part of the DoD core-reporting element. **Pass**: one pair of GMI for all deployable personnel needing visual correction. **Fail**: no GMI for all deployable personnel needing visual correction.

E3.1.4. Medical Readiness Laboratory Studies. Core studies for the Department of Defense are current HIV testing and a DNA sample on file in the Armed Forces Repository of Specimen Samples for the Identification of Remains (AFRSSIR). Military Department or Service-specific policies may identify additional readiness lab tests such as Glucose-6-phosphate dehydrogenase or hemoglobin S (sickle) testing, but they are not part of the DoD core-reporting element. For core reporting elements: **Pass**: HIV testing, with result on file, within past 24 months, and DNA sample on file with the AFRSSIR. **Fail**: one or more deficiencies.

E3.1.5. No Deployment Limiting Conditions. There are many examples of deployment-limiting conditions such as pregnancy, asthma, severe traumatic injury with incomplete rehabilitation, etc. Deployment limiting conditions are defined by Military Department-specific policies. Pass: there are no deployment limiting conditions. Fail: there is a deployment limiting condition.

E3.1.6. Periodic Health Assessments (PHA). An Annual assessment for changes in health status, especially changes that could impact a member's ability to perform military duties. Military Department-specific requirements for currency and methodology of periodic health assessment have been defined. **Pass**: annual PHA is current. **Fail**: annual PHA is overdue. For this purpose the PHA is overdue if not accomplished within three months following the due month. Example: a PHA due in October 2005 will be counted as overdue if it has not been accomplished by the last day of January 2006.

E4. ENCLOSURE 4

ORAL HEALTH AND READINESS CLASSIFICATION SYSTEM

E4.1. CLASS 1

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

E4.2. CLASS 2

E4.2.1. Patients with a current dental examination, who require non-urgent dental treatment or reevaluation for oral conditions, which are unlikely to result in dental emergencies within 12 months. Class 2 patients are worldwide deployable. Patients in dental class 2 may exhibit the following:

E4.2.1.1. Treatment or follow-up indicated for dental caries or minor defective restorations that can be maintained by the patient.

E4.2.1.2. 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 cuspal coverage is indicated.

E4.2.1.3. Edentulous areas requiring prostheses, but not on an immediate basis.

E4.2.1.4. Periodontium that requires oral prophylaxis, maintenance therapy, treatment for slight to moderate periodontitus and stable cases of more advanced periodontitis, and/or removal of supragingival or mild to moderate subgingival calculus.

E4.2.1.5. 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.

E4.2.1.6. Active orthodontic treatment. The provider should consider placing the patient in passive appliances for deployments up to six months. For longer periods of deployment, the provider should consider removing active appliances and placing the patient in passive retention.

E4.2.1.7. Temporomandibular disorder patients 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.

E4.3. CLASS 3

E4.3.1. Patients who require urgent or emergent dental treatment. Class 3 patients normally are not considered to be worldwide deployable.

E4.3.1.1. Treatment or follow-up indicated for dental caries, symptomatic tooth fracture or defective restorations that cannot be maintained by the patient.

E4.3.1.2. Interim restorations or prostheses that cannot be maintained for a 12-month period.

E4.3.1.3. Patients requiring treatment for periodontal conditions that may result in dental emergencies within the next 12 months. Such conditions include acute gingivitis or pericoronitis, active progressive moderate or advanced periodontitis, periodontal abscess, progressive mucogingival condition, periodontal manifestations of systemic disease or hormonal disturbances, and heavy subgingival calculus.

E4.3.1.4. Edentulous areas or teeth requiring immediate prosthodontic treatment for adequate mastication or communication, or acceptableesthetics.

E4.3.1.5. Unerupted, partially erupted, or malposed teeth with historical, clinical, or radiographic signs or symptoms of pathosis, that are recommended for removal.

E4.3.1.6. Chronic oral infections or other pathologic lesions including pulpal, periapical, or resorptive pathology requiring treatment and lesions requiring biopsy or awaiting biopsy report.

E4.3.1.7. Emergency situations requiring therapy to relieve pain, treat trauma, treat acute oral infections, or provide timely follow-up care (e.g., drain or suture removal) until resolved.

E4.3.1.8. Acute temporomandibular disorders requiring active treatment that may interfere with duties.

E4.4. CLASS 4

Patients who require periodic dental examinations or patients with unknown dental classifications. Class 4 patients are not considered to be worldwide deployable.