DEPARTMENT OF THE NAVY
BUREAU OF MEDICINE AND SURGERY
7700 ARLINGTON BOULEVARD
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BUMEDINST 6110.14A
BUMED-N3
22 Dec 2023

BUMED INSTRUCTION 6110.14A

From: Chief, Bureau of Medicine and Surgery

Subj: ASSESSING, DOCUMENTING, AND REPORTING INDIVIDUAL MEDICAL READINESS DATA

Ref: See Enclosure (1).

Encl: (1) References
(2) Department of the Navy Six Elements of Individual Medical Readiness
(3) Approved Individual Medical Readiness Electronic Data Systems
(4) Department of the Navy Individual Medical Readiness Metrics and Goals

1. Purpose. To establish Navy Medicine (NAVMED) policy and procedures for assessing, documenting, and reporting individual medical readiness (IMR), per references (a) and (b). This instruction is in support of readiness requirements for Active Component (AC) and Reserve Component (RC) Service members to maximize the IMR of units under the medical cognizance (MEDCOG) of Naval Medical Forces Atlantic, Naval Medical Forces Pacific, subordinate Navy Medicine Readiness and Training Commands (NAVMEDREADTRNCMD) and Navy Medicine Readiness and Training Units (NAVMEDREADTRNUNIT). This instruction is a complete revision and should be reviewed in its entirety.

2. Cancellation. BUMEDINST 6110.14.

3. Scope and Applicability. This instruction applies to all ships and stations with Navy Medical Department personnel.

4. Background. Readiness is both an individual and commander's responsibility, and NAVMED actively supports readiness by continually assessing AC and RC Sailors' and Marines' deployability at all provider-based encounters, performing a minimum of annual assessments of medical readiness, and entering IMR data into approved electronic data systems and the electronic health record. IMR is an integral component of force health protection that supports Sailor and Marine mission readiness. Total force medical readiness also provides an indication of a unit's ability to fulfill its mission. A joint service committee has established requirements for service level tracking and quarterly reporting of IMR data to the Assistant Secretary of Defense for Health Affairs, as outlined in reference (a).

5. Definitions and Documentation Requirements

a. Reference (a) defines the IMR elements and IMR categories across the Department of Defense (DoD) and provides guidance on the use of electronic data systems to capture, to track, and to report IMR to minimize manual data entry and facilitate data exchange.

b. Reference (a) defines excluded Service members as those who fall within specific category, code, or duty status and, therefore, are not available for the command to correct IMR deficiencies.

c. Department of the Navy (DON)-specific IMR requirements beyond DoD requirements per reference (a) are outlined in references (a) through (s) and enclosure (2).

6. MEDCOG

a. MEDCOG for medical readiness support is the framework for NAVMED Operational Forces Medical Liaison Services (OFMLS) to coordinate active engagement by NAVMED-READTRNCMDs for medical readiness support to both remote line units and co-located line units, per reference (t). This capability will create a network to which line units can reach out when experiencing difficulty with completing medical readiness requirements, regardless of rationale. OFMLS will serve as the primary points of contact for each NAVMEDREADTRNCMD, when available, and are included in the link in subparagraph 8b.

b. Reference (u) is the basis for MEDCOG assignments for medical readiness purposes.

c. NAVMEDREADTRNCMDs, per references (t) and (w), serve as single points of contact for all MEDCOG and medical readiness activities to support operational units and commands throughout their area of responsibility (AOR).

7. Roles and Responsibilities

a. Commanders, Naval Medical Forces Atlantic and Naval Medical Forces Pacific must:

(1) Provide oversight of IMR services and compliance for subordinate commands per references (t) and (w).

(2) Ensure IMR support for all commands within MEDCOG is consistently applied and serve as final authority on determining MEDCOG AORs, as per references (t) and (w).

(3) Ensure all individuals providing IMR oversight and support have access to and be knowledgeable about all information and guidance found in references (a) through (x).

b. Commanders or Commanding Officers, NAVMEDREADTRNCMDs and Officers in Charge, NAVMEDREADTRNUNITs respectively, will:

(1) Implement program actions, if not already in place, within 90 days of the date of this instruction.

(2) Ensure all IMR medical and dental data is recorded in an approved IMR tracking system, Medical Readiness Reporting System (MRRS), or its replacement, for Service members as well as new accessions in their MEDCOG. Enclosure (3) outlines the currently approved IMR Electronic Data Systems.

(3) Ensure OFMLS, or equivalent services, serve as direct liaison authority for medical readiness with all commands under their MEDCOG, per references (t) and (u).

(4) Assign an Operational Force Readiness Lead to serve as the IMR subject matter expert as part of or in collaboration with the OFMLS who will provide oversight of all medical readiness and deployment health activities, and must ensure adherence to IMR and deployment health policies and reporting of metrics.

(5) Ensure adequate clinical and administrative staffing to support compliance with access for readiness-related services, as well as documentation, tracking and reporting requirements. In addition to OFMLS and Operational Force Readiness Lead, minimum roles and responsibilities listed in subparagraphs 7b(5)(a) through 7b(5)(e) are recommended to be staffed for the purposes of IMR support:

(a) Deployability Coordinator: Per references (f) and (i).

(b) MRRS Field Manager: Assist staff and commands in obtaining MRRS access.

(c) Readiness Data Analyst: Generate and to disseminate readiness reports as directed, to serve as MRRS subject matter expert, to assist in training command representatives how to properly compile reports, and to assist in training assigned readiness coordinators and staff on how to accurately update and utilize MRRS.

(d) Medical Readiness and Dental Readiness Coordinators: Assist in coordinating medical readiness-related activities directly with individuals, units, and commands.

(e) Adequate providers and clinical support staff: Maintain access to care for readiness per reference (x).

(6) Support to line commands within MEDCOG will include, but is not limited to providing:

(a) IMR reports to those line commanders without organic medical assets at least quarterly and continue to internally monitor the monthly IMR goals of those units.

(b) Coordinate assistance to streamline accessibility of IMR services by individual Service members to achieve IMR goals and to maximize unit readiness.

(c) Resources for designated personnel to receive training and access to required readiness and deployability reporting systems, such as MRRS and the Limited Duty (LIMDU) Sailor and Marine Tracking (SMART) System for command.

(7) All personnel providing IMR services must have access to and be knowledgeable about all information and guidance found in references (a) through (x).

8. Points of Contact

a. The Active and Reserve Medical Readiness Branch is the point of contact for BUMED Force Medical Readiness (BUMED-N34) and can be contacted via e-mail at usn.ncr.bumedfchva.mbx.bumed-bumed-medical-readiness@health.mil with reference "IMR" in the subject line.

b. The up-to-date AORs for MEDCOG assignments and the NAVMEDREADTRNCMDs points of contact for Service member outreach can be found at: https://esportal.med.navy.mil/bumed/rh/m3/M34/SMMR/PHA_Regional_POCs/default.aspx.

c. The MRRS Web site can be accessed at https://mrrs.dc3n.navy.mil/mrrs/secure/welcome.m To request medical department representative, security officer, or command representative access to the MRRS Web site, users need to submit a OPNAV 5239/14 System Access Authorization Request Navy (SAAR-N) form which can be obtained from the MRRS Web site, and must submitted via e-mail to the appropriate points of contact:

(1) Active Component Navy Commands: mill_mrrs@navy.mil.

(2) Marine Corps Commands: hq_mrrs@usmc.mil.

(3) Coast Guard: d05-smb-hswlsc-opmed@uscg.mil.

(4) Navy Reserves Commands: navresfor_cnrfc_force_health_n9@navy.mil.

(5) Please Note. If points of contact are unavailable and immediate assistance is needed, contact MRRS customer support at 1-800-537-4617, option #3.

d. Personnel required to upload or transmit files to NAVMED Online may request access at https://nmo2.med.navy.mil/imr/.

9. Records Management

a. Records created as a result of this instruction, regardless of format or media, must be maintained and dispositioned per the records disposition schedules located on the DON Directorate for Administration, Logistics, and Operations, Directives and Records Management Division portal page at https://portal.secnav.navy.mil/orgs/DUSNM/DONAA/ DRM/Records-and-Information-Management/Approved%20Record%20Schedules/Forms/ AllItems.aspx.

b. For questions concerning the management of records related to this instruction or the records disposition schedules, contact the local records manager or the DON Directorate for Administration, Logistics, and Operations, Directives and Records Management Division program office.

10. Review and Effective Date. Per OPNAVINST 5215.17A, Operations (BUMED-N3) will review this instruction annually around the anniversary of the issuance date to ensure applicability, currency, and consistency with Federal, DoD, Secretary of the Navy, and Navy policy and statutory authority using OPNAV 5215/40 Review of Instruction. This instruction will be in effect for 10 years, unless revised or cancelled in the interim, and will be reissued by the 10-year anniversary date if it is still required unless it meets one of the exceptions in OPNAVINST 5215.17A, paragraph 9. Otherwise, if the instruction is no longer required, it will be processed for cancellation as soon as the need for cancellation is known following the guidance in OPNAV Manual 5215.1 of May 2016.

10. Forms and Information Management Collection

a. Forms

(1) NAVMED 6600/13 Oral Exam is available for order available for order from DSO. using stock number 0105-LF-128-1500.

(2) NAVMED 6150/5 Medical Warning Tag Order is available for order from DSO.

(3) DD Form 3024 Annual Periodic Health Assessment is available at https://eha.health.mil/eha.

(4) NAVMED 6120/4, Periodic Health Assessment, is available in electronic format at http://www.med.navy.mil/directives/Pages/NAVMEDForms.aspx

(5) NAVMED 6230/4 Adult Immunizations Record is available in electronic format at http://www.med.navy.mil/directives/Pages/NAVMEDForms.aspx;

(6) DD Form 2795 Pre-Deployment Health Assessment; DD Form 2796 Post Deployment Health Assessment; and DD Form 2900 Post Deployment Health Reassessment,

must be processed electronically through the Public Health Center's eHA Web site at https://eha.health.mil/eha, via the Deployment Health Assessment application. A common access card is required to gain access unless a one-time use password is requested and approved via the eHA Web site administrators.

(7) Centers for Disease Control (CDC)-731 International Certificate of Vaccination or Prophylaxis (formerly the Public Health Service (PHS)-07281942731, Yellow Shot Card) is available from the Government Printing Office Web site at http://bookstore.gpo.gov, using National Stock Number (NSN) 017-001-00566-5 for packages of 100 and NSN 017-001-00567-3 for packages of 25, or by calling toll free (866) 512-1800.

b. Information Management Control. The reports required in paragraphs 3, 5, and 7 are exempt from reports control per Secretary of the Navy Manual 5214.1 of December 2005, part IV, subparagraph 7k.

D. K. VIA

Releasability and distribution:
This instruction is cleared for public release and is available electronically only via the Navy Medicine Web site, https://www.med.navy.mil/Directives/

REFERENCES

(a) DoD Instruction 6025.19 of 13 July 2022
(b) SECNAV WASHINGTON DC 222101Z Feb 23 (ALNAV 015/23)
(c) SECNAV WASHINGTON DC 22240 Feb 23 (ALNAV 016/23)
(d) DoD Instruction 6490.07 of 5 February 2010
(e) BUMEDINST 1300.6
(f) OPNAVINST 1300.20D
(g) DoD Instruction 1332.45 of 30 July 2018
(h) DoD Instruction 1332.18 of 10 November 2022
(i) BUMEDINST 6000.19
(j) SECNAVINST 6120.3
(k) DHA-Procedural Instruction 6200.06, Periodic Health Assessment Program, 9 May 2017
(l) DoD Instruction 6200.06 of 8 September 2016
(m) DoD Instruction 6490.03 of 19 June 2019
(n) DHA-Procedural Instruction 6490.03 Deployment Health Procedures, 17 December 2019
(o) ASD(HA) Policy Memo 02-011 Policy on Standardization of Oral Health and Readiness Classifications (NOTAL)
(p) DoD Instruction 6025.13 of 17 February 2011
(q) BUMEDINST 6230.15B
(r) DoD Instruction 6130.03 of 4 September 2020
(s) DoD Instruction 6055.12 of 14 August 2019
(t) BUMEDINST 6440.8B
(u) BUMEDINST 6320.104
(v) BUMEDINST 5450.183A
(w) BUMEDINST 5450.184A
(x) DHA-Procedural Instruction 6015.03, Medical Readiness Services Provided to Members of the Reserve Components in Military Medical Treatment Facilities and Dental Treatment, 23 October 2021

DEPARTMENT OF THE NAVY SIX ELEMENTS OF INDIVIDUAL MEDICAL READINESS

1. Background: The DoD has six IMR elements, as defined by reference (a). Within those six elements, the DON has additional requirements that will be tracked and reported to support force medical readiness as defined by reference (b).

2. Deployment Limiting Medical Conditions. These are medical conditions that would burden deployed medical capacity and render a member unable to perform their duties in a deployed status. They are defined in references (d) and (e). This element of IMR serves as a direct measurement of deployability, while the remaining IMR elements combined with deployment-limiting medical condition administratively measure medical readiness of the individual.

a. A general deployability assessment serves as a provider's subjective assessment of the Service member's ability to perform the functions of their office, grade, rank, rating, designator, Navy enlisted classification (NEC), or military occupational specialty (MOS) code. Reference (c) defines the procedures for performing a general deployability assessment and is required per references (a) and (f). Per references (f) through (i), providers must make this determination in consideration of the factors listed in subparagraphs 2a(1) through 2a(4):

(1) Current assignment and current location.

(2) Ability to complete and to pass their Service-specific physical fitness test.

(3) Special duty qualifications of their current assignment (e.g., flight or dive status).

(4) Ability to deploy, with or without prior notification for AC members and within 30 days for RC members, as part of a unit to which they can reasonably be expected to be assigned at based on their current office, grade, rank, rating, designator, NEC, or MOS.

b. Deployability Categories (DCAT) for medical readiness define the broad concept of "deployable" and "not-deployable." Providers are required to classify the deployability assessment in alignment with the four DCATs per references (e) through (g). References (a), (e), and (f) defines what a DCAT is and includes the procedures for performing deployability assessments and the required provider actions based on the DCAT recommendations. For Active Duty, the four DCATs are:

(1) Fully Deployable, or DCAT 1. Will reflect as "fully medically ready" unless other IMR deficiencies exist.

(2) Deployable with limitations, or DCAT 2. Considered deployable, although may be limited by geographic location or platform assignment. These members require additional medical scrutiny and, in some instances, a medical waiver to be approved before they can

deploy. These members will reflect as "fully medically ready" unless other IMR deficiencies exist. Members in this category should have "deployable with limitations" checked in the deploy tab of the Medical Readiness Reporting System (MRRS) for Service and command tracking.

(3) Temporarily Non-Deployable, or DCAT 3, which will reflect as "not medically ready." See reference (a) for the medical administrative statuses that make up this DCAT.

(4) Permanently Non-Deployable, or DCAT 4, which will reflect as "not medically ready." See reference (a) for the medical administrative statuses that make up this DCAT.

3. Health Assessments. This element includes the Annual Periodic Health Assessment (PHA), DD Form 3024 or DoD PHA, and all Deployment-related Health Assessments (DRHA), including DD Form 2795, Pre-Deployment Health Assessment; DD Form 2796, Post Deployment Health Assessment (PDHA); DD Form 2900, Post-Deployment Health Re-Assessment (PDHRA); and DD Form 2978, Deployment Mental Health Assessment (DMHA) or Mental Health Assessment.

a. Submission and Certification

(1) All completed assessments, as per references (b) and (c), are submitted and certified via the electronic health assessment (eHA) Web platform noted in subparagraph 10a(3) of this instruction. This Web platform is the system for electronic submission of assessments and is not an approved electronic health record (EHR).

(2) The corresponding assessment's clinical note will be documented in the available EHR. The eHA Web platform will generate a summary of the encounter upon assessment certification for the provider to cut and paste or to attach onto an EHR encounter, or to be scanned into the Health Artifacts and Imaging Management System (HAIMS) or replacement system, to meet documentation requirements. If HAIMS is used, then it must either be appended to the clinical encounter, or the title of the HAIMS document must be referenced in the clinical encounter.

(3) In all cases, per reference (j), DD 2766, Total Force Health Readiness Flowsheet, will be maintained in the paper health record, if not using the EHR (i.e., during deployments, and situations where paper records are used for civilians and RC).

(4) Service members without adequate internet access can use their personal devices to utilize the eHA Web site when use of personal cellular devices is approved. If a CAC reader is unavailable, the Service member can use the "CAC exemption" option for a same-day only username and password verification process. The medical department representative will update MRRS with "military PHA" and the date completed, which will be overwritten when MRRS receives the data transfer from the eHA Web platform.

b. PHAs

(1) The purpose of the annual PHA is to perform a preventive health assessment on all Service members that includes the ability to assess their participation in their Service-specific physical fitness test, their general deployability, and their IMR verification status.

(a) Reference (j) is the primary DON-specific instruction for PHA requirements, and reference (k) contains the DoD-wide procedural instruction requirements for PHA completion.

(b) Per references (a), (e), and (j) through (l), DD 3024 is the only approved form for PHA completion, which includes the Mental Health Assessment, DD 2978, for its annual requirement.

(2) The PHA is "due" and will be performed annually, 365 days from last recorded PHA date in MRRS or in the current IMR tracking system. The PHA will reflect as "overdue" if not completed within 90 days following the due date.

(a) For appropriate force distribution and tracking, DON Service members will complete their PHA during their birth month per reference (b), unless operational requirements preclude its completion. Examples of operational requirements may include but are not limited to pre-deployment readiness requirements, or RC Service members who utilize group events via contracted services to complete medical readiness requirements.

(b) PHAs may not be certified if the Service member submission date is more than six months prior to the certification date. In these cases, the Service member must submit a current self-assessment.

(c) For IMR reporting, all Service members will be considered "partially medically ready" when a PHA is "overdue" 1 year plus 90 days from the last PHA completion date in MRRS.

c. DRHAs

(1) Per references (a), (j), (m), and (n), DRHAs are required to be verified at the time of the annual PHA.

(2) Reference (n) provides DRHA completion requirements. DD 2900, is required between 90 and 180 days after theater departure date and will reflect as "overdue" if not completed within 90 days of that timeline.

(3) The DRHAs are considered complete when the provider and Service member have discussed a plan for any necessary follow-up and, at a minimum, the provider has documented

any referral recommendations in the assessment and plan of the EHR. All efforts should be made to place agreed upon and recommended referrals in the EHR at the time of the assessment and to communicate the plan to the Service member's primary care team.

(4) All DRHAs will reflect their due or overdue status, as applicable, in MRRS, but only DD 2900 will make an individual "partially medically ready" when it is overdue.

4. Dental Readiness

a. Dental readiness classifications are determined as part of the initial dental examination, and again annually, at all Type 2 dental examinations.

b. Per reference (a), the Type 2 dental exam is 'due' and will be performed annually 365 days from last recorded exam. The Type 2 exam will reflect as being "overdue" if not completed within 90 days following the due date in alignment with reference (a) and other services.

c. For appropriate force distribution and tracking, it is recommended that the Type 2 dental exam be synchronized with the annual PHA to the greatest extent possible during a Service member's birth month, with the dental examination preferably preceding the PHA. This is a recommendation, not a requirement, for the PHA certification.

d. Enter dental IMR data into the Corporate Dental System, MRRS, or the currently approved electronic tracking systems and dental record.

e. Service members and dental departments are expected to complete annual Type 2 exams prior to the due date, but no later than the end of the 90-day grace period, to avoid being delinquent. Dental departments will offer Type 2 exams prior to the due date.

f. Service members who are deploying with operational units without organic dental assets are expected to have a current annual Type 2 dental exam that will allow for their due date to occur after the expected theater departure date.

g. As indicated by the dental classification system outlined in references (a) and (o), a Service member who is Dental Class 1 or 2 is fully deployable. A Service member who is Dental Class 3 or 4 is still considered deployable in accordance with reference (g) but is also considered at increased risk to experience a dental emergency, and immediate action should be taken to correct these deficits.

h. For IMR reporting, all Service members will be considered "Partially Medically Ready" one (1) year plus 90 days from the last dental exam completion date in MRRS and all Dental Class 3 will be categorized as "not medically ready"

i. RC Service members are required to see a military dental officer for the annual dental exam; however, per reference (j), a civilian dental exam using DD 2813 Department of Defense

Active Duty/Reserve/Guard/Civilian Forces Dental Examination, may be substituted for up to two exams within a 3-year period. RC Service members in any duty status, including non-paid inactive duty training, may be seen for their annual dental examination by a military dental officer.

5. Readiness Laboratory Studies. During the PHA, readiness laboratory status will be reviewed to ensure all required labs have been completed, and any labs due at the time of the PHA have been ordered. The basic laboratory studies and their "due" timeframes, which are required for a Service member to be considered "fully medically ready," are listed in reference (a).

a. For IMR reporting, all Service members will be considered "partially medically ready" when any required readiness lab is "overdue."

b. Pre- and post-deployment serum samples are required for all applicable deployments, per reference (m). The serum samples are drawn in red-top (gel without separator) tubes. The biannual human immunodeficiency virus (HIV) blood draw only meets this requirement if completed during the timeframes for the deployment, per references (m) and (n).

c. HIV-positive Service members receive a clinical evaluation and HIV disease-specific laboratory studies twice yearly at designated locations in accordance with HIV Evaluation and Treatment Unit policy, per reference (p). Routine HIV lab testing is not indicated for these personnel.

d. All readiness laboratory study results must be documented in the available EHR. Additionally, readiness laboratory study dates must be documented on DD 2766 when paper records are required (e.g., deployment records).

6. Immunizations. During the PHA, required readiness immunization status will be reviewed, and any immunizations that are due or overdue at the time of the PHA will be administered. This will apply to both booster vaccination and initial immunization series. This does not apply to a deployment or area of responsibility-specific immunization requirement when a member does not have orders to an identified deployment or area of responsibility. The basic immunizations, and their "due" timeframes, required for a Service member to be considered "fully medically ready" are listed in references (a) and (q).

a. For IMR reporting, all Service members will be considered "partially medically ready" when any required readiness immunization is "overdue."

b. Immunizations are considered overdue for IMR reporting 30 days after their due date, with the exception of the influenza vaccine, per reference (a).

c. Immunizations are documented as an encounter in the available EHR. If electronic sources are unavailable, the immunization encounter will also be documented on the NAVMED 6230/4 Adult Immunization Record. Further guidance regarding documentation of specific immunizations is found in reference (q).

d. All exemption codes must be validated and entered in an approved electronic system. Do not enter immunization exemption codes that have not been validated. All exemptions resulting from a positive titer must be properly annotated in the titer section of MRRS.

e. Per reference (q), Service members may require additional immunizations based on combatant command force health protection policy, geographic area of operation(s), occupational requirements, or immediate superior in command-specific requirements. Examples include, but are not limited to, yellow fever, typhoid, Japanese encephalitis virus, anthrax, and smallpox vaccines.

7. Individual Medical Equipment. Required medical devices are defined in reference (a) and are tracked for readiness purposes.

a. Per reference (m), Service members who require vision correction are required to have two pairs of glasses of their own, or four pairs for aviators. Service members with deployment orders who require corrective lenses will possess ballistic eye wear and gas mask inserts for the model of gas mask in use at their deployment site. Vision requirements are further outlined in reference (r).

b. Per reference (a), hearing aids and batteries are required for all deployable assets needing hearing support. Hearing requirements to include Hearing Conservation Program guidelines are outlined in reference (s).

c. NAVMED 6150/5 is used to order medical warning tags for Service members with medical conditions. Medical warning tags must be used for any condition which, if the patient was unable to give a history, would render the normally indicated course of treatment dangerous or delay proper treatment. Examples include, but are not limited to, severe allergies to drugs or insect bites, sensitivity to biologic product or immunizing agents, sickle cell trait positivity, or glucose-6-phosphate dehydrogenase deficiency and indicating “no primaquine”. The tag should indicate the condition name and drugs or treatments to be avoided.

d. Individual medical equipment is “due” for verification annually with the PHA.

e. All information regarding individual medical equipment will be entered into MRRS.

f. For Service and command level IMR reporting, all Service members will be considered “partially medically ready” when the medical warning tags have not been issued when required, the requisite number of corrective eyeglasses have not been verified in member’s

current prescription, one pair of protective mask inserts has not been issued for deploying members in need of visual correction, and hearing aids and batteries have not been issued for all deployable Service members who require hearing support.

g. For DoD-level IMR reporting, only protective mask inserts and hearing aids and batteries for those who require them will impact a member's IMR status, as per reference (a).

APPROVED INDIVIDUAL MEDICAL READINESS ELECTRONIC DATA SYSTEMS

1. The use of any electronic system not listed below for recording or tracking IMR is prohibited. Navy medical treatment facilities and Commanders, NAVMEDREADTRNCMD are prohibited from the use of "homegrown" or locally developed clinical databases for the tracking of IMR. Available enterprise electronic data systems involving IMR include:

a. MRRS is approved for use in documenting all IMR elements. Data that does not automatically transfer to MRRS must be properly entered, at a minimum, when providing any IMR support services. Ideally, updates will be made at point-of-care by the Service responsible or by identified readiness points of contact within the NAVMEDREADTRNCMD or NAVMEDREADTRNUNIT.

b. Shipboard Non-Tactical Automatic Data Processing Program Automated Medical System (SAMS), version 8.03 or later releases, and the Medical Maritime Modules of Theater Medical Information Program-Maritime (TMIP-M), which are both approved for shipboard use in documenting all IMR elements. SAMS data must be properly entered when providing any IMR support services and submitted to NAVMED Online. The information will be sent to MRRS by the NAVMED Online data broker.

c. Armed Forces Health Longitudinal Technology Application or Military Health System GENESIS, which are the electronic health records used where they are available for those units. IMR data will be entered in appropriate electronic health record modules, as discussed in subparagraph 5a(1)(a) of enclosure (2). Joint Legacy Viewer Health Information Portal may be used for the review of a Service member's medical information. Information that does not automatically update must be manually entered into MRRS as discussed in paragraph 1a.

d. Dental Common Access System (DENCAS), MRRS, Corporate Dental System, and SAMS/TMIP-M, which are all data entry tools for dental readiness data. Dental activities should ensure entries are made in DENCAS on all patients, including patients assigned to ships. Entries should reflect, at a minimum, the date of examination and the dental class at the time of care. DENCAS and SAMS/TMIP-M transmit data to MRRS via NAVMED online. Any data that do not properly transfer automatically must be manually entered into MRRS at the earliest opportunity to reflect the Corporate Dental System, DENCAS, or SAMS data appropriately.

DEPARTMENT OF NAVY INDIVIDUAL MEDICAL READINESS METRICS AND GOALS

1. Command IMR Program managers will monitor the IMR status of all Active and Selective Reserve Service members under their MEDCOG. The tracking of these metrics will not include Service members who are unavailable to deploy and are excluded per reference (a).

2. Department of Navy-specific IMR metrics and goals to be tracked by IMR Program managers, include:

a. Total force medical readiness goal is 90 percent or higher.

(1) Numerator: The sum of Service members classified as fully medically ready and partially medically ready (PMR) within the unit or aggregate of supported units.

(2) Denominator: The total number of Service members within the unit or aggregate of supported units.

b. AC PMR goal is to maintain a PMR rate of less than 15 percent. RC PMR goal is to maintain a PMR rate of less than 25 percent.

(1) Numerator: The sum of Service members classified as PMR within the unit or aggregate of supported units.

(2) Denominator: The total number of Service members within the unit or aggregate of supported units.

c. Health Assessment IMR element, including post-deployment health reassessments, which is an overdue rate of less than 5 percent of total force of unit or aggregate of supported units.

d. The sum of Dental Class 3 and 4 is less than 5 percent of total force of unit or aggregate of supported units.