



DEPARTMENT OF THE AIR FORCE
HEADQUARTERS UNITED STATES AIR FORCE
WASHINGTON, DC

DEC 28 2001

MEMORANDUM FOR SEE DISTRIBUTION

FROM: HQ USAF/SG
110 Luke Avenue, Room 400
Bolling AFB, DC 20332-7050

SUBJECT: Guidelines for the Implementation of Preventive Health Assessment and Individual Medical Readiness (PIMR) at Air Force Medical Treatment Facilities

The Preventive Health Assessment and Individual Medical Readiness (PIMR) software has been fielded at most Air Force military treatment facilities. It is one of the primary tools used by the Air Force Medical Service to help optimize the health and fitness of our active duty force. It will provide line commanders with real-time information on the medical readiness status of their forces and will give primary care managers specific information on the health of their enrolled active duty members. PIMR's ability to access Individual Medical Readiness rates is critically important in the determination of unit medical readiness capability.

The attached policy guidance will assist your facility in establishing an effective process to ensure smooth, accurate data flow within the PIMR program and enhance the overall readiness posture of the Air Force. Please review the attached guidance, ensure compliance and widest dissemination to all appropriate functionals.

My point of contact is Maj Lisa Pegues, AFMOA/SGZP, 110 Luke Avenue, Room 405, Bolling AFB, DC 20332-7050, at DSN 297-4216, e-mail: lisa.pegues@usafsg.bolling.af.mil.

A handwritten signature in black ink, appearing to read "James G. Roudebush".

JAMES G. ROUDEBUSH
Major General, USAF, MC, CFS
Deputy Surgeon General

Attachments:

1. PIMR Policy Guidance
2. AF/SG Memo, 10 Aug 01

Distribution:

HQ ACC/SG
HQ AETC/SG
HQ AFMC/SG
AFRC/SG
HQ AFSPC/SG
HQ AFSOC/SG
HQ AMC/SG
HQ PACAF/SG
HQ USAFE/SG
ANGRC/SG
NGB/SG
311 HSW/CC
HQ AFIA/SG
HQ AIA/SG
11 MDG/CC

Preventive Health Assessment and Individual Medical Readiness Guidelines

November 2001

I. OVERVIEW: The Preventive Health Assessment (PHA) and Individual Medical Readiness (PIMR) program is an upgrade to the existing PHA program instituted in November 1997. Over the last several years there have been numerous changes in the Air Force Medical Service (AFMS) and Military Healthcare Services (MHS), which are reflected in this new program. The outcome of PIMR should be a medically fit and ready force. Responsibility for ensuring a fit and healthy force is shared between commanders, primary care management teams, and the individual service members. All have a role in ensuring the success of this program.

II. PURPOSE: The PIMR process is designed to accomplish two main objectives:

A. IMR (Individual Medical Readiness): The primary purpose of PIMR is to provide a "real-time" medical readiness assessment of IMR requirements to commanders, individuals and primary care managers so they can manage and optimize the readiness status of their assigned or enrolled AF personnel.

B. PHA: The second purpose of PIMR is to provide a year-round systematic process to optimize the health and reliability of the human weapon system by providing prevention at every patient encounter, using the PHA as the "safety net" to ensure all preventive health requirements have been met and to provide feedback to all stakeholders.

III. INDIVIDUAL MEDICAL READINESS

A. Assessment of individual medical readiness must be a continuous process. It is independent of the recurring PHA cycle (or assessment). For example, if an individual completes their PHA in January and becomes due for a required immunization in March, or becomes pregnant in June, their IMR status will be immediately reflected in the PIMR program. As individual IMR services become due, members must be scheduled to accomplish them in order to maintain their full readiness status. In order for IMR status to be kept current in PIMR, these items must be updated continuously year round (as medical conditions change). The vast majority of information for the IMR portion of PIMR will be imported into the software from other computer systems or a central server. The rest will be manually entered into the PIMR system as needed.

B. IMR Factors are listed below:

1. Immunizations: Immunizations requirements (including TB skin testing) are established within the Air Force Complete Immunizations Tracking Application (AFCITA) and fed automatically to PIMR. When a required immunization/TB skin test becomes due, the IMR status changes to RED (in the PIMR software) until it is complete, or the requirement is deleted in AFCITA.

2. Dental Classification: Dental classification is managed through the Dental Classification Management System (DCMS) to PIMR automatically. A dental classification of 1 or 2 will be reflected as IMR GREEN, 3 or 4 will be reflected as RED.

3. Physical Profile: All deployment limiting profiles will be managed within the PIMR software. Providers will initiate the profile as indicated in AFI 48-123, *Physical Examinations and Standards*, Chapter 10, and utilizing the guidance in AFPAM 48-133, *Physical Exam Techniques*, Chapter 10, para 10.3.

4. Medical Readiness Lab Tests: The following lab results are required at the indicated frequency and must be recorded in PIMR:

G6PD	Once
DNA	Once
Blood Type	Once
Sicklelex	Once
HIV	Within 5 years

If these lab tests have not been accomplished and are not in the PIMR software, this area will show as RED until the requirements have been met. The data must be entered manually into the PIMR software in order to change the RED to GREEN.

5. Health Records Review (HRR) Date: This date is manually entered into the PIMR system and indicates the date the PCM review has been completed. The first day of the thirteenth month after the last assessment, this area in PIMR turns YELLOW indicating the individual is overdue for an assessment. On rare occasions, such as unannounced or rapid deployment of the individual, the PHA might be delayed up to a maximum of 6 months (or 18 months total). After 18 months, PIMR status turns RED reflecting that the person should have an assessment completed prior to any deployment.

6. Other specific Data: Special populations of active duty members may have additional requirements. Attachment 1 reflects the additional requirements for flying personnel that are programmed into the PIMR software

7. Medical Equipment data: This information (gas mask inserts, QNFT etc) will be entered into PIMR but will not affect the IMR status until October 2002 to allow the data to be entered during one normal PHA cycle.

IV. PREVENTIVE HEALTH ASSESSMENT (PHA):

A. The provision of preventive health services is an ongoing process, which must be an integral part of the routine health care for all enrollees. Every patient encounter should be used as an opportunity to address any outstanding preventive health care needs. These preventive health needs should be evaluated, scheduled and provided as needed.

B. At a minimum preventive health requirements and recommendations should be reviewed at the time of:

1. Medical In-Processing
2. Each patient visit
3. During the PHA
4. As part of any pre-deployment and post deployment processing

C. The PHA is an annual systematic process, which drives a review of all preventive health requirements for all Air Force active duty members to ensure these services have been provided. If the member has received needed preventive services as part of their routine care then little or no additional intervention may be required, and the PHA may be strictly an administrative review. As much as feasible, all reviews should be accomplished prior to or during any patient visit. All requirements should be identified in advance to minimize the time the member must spend away from their duty section. When a patient visit is required, all reasonable efforts should be made to streamline the process, combine tests, and minimize the impact on the patient; however, this should not be construed as requiring all testing to be accomplished on the same day. For example, it may not be sensitive to customer satisfaction to schedule multiple tests such as cholesterol screening, cycle ergometry, a dental exam, and a pelvic exam on the same day. This should be a local decision based on the needs of patients, commanders and staff.

D. PHA Content: There have been considerable inconsistencies in defining a "complete PHA" throughout the AFMS. A complete PHA will now be defined as having all of the following eight requirements accomplished:

- 1. Review/update of all IMR requirements:** All IMR requirements must be reviewed and accomplished as part of the PHA process. All aspects of the IMR requirements must be evaluated and those issues that can be "turned green" should be accomplished. However, the completion of a review does not necessarily affect the IMR status. For example, an individual may have a deployment limiting profile, may be deferred for an immunization, or may not be in Dental Class 1 or 2. Thus they will be complete for the review but will remain **IMR RED**

2. Health History and review of findings:

a. Health Enrollment Assessment Review (HEAR): If your facility cannot administer the HEAR, the 16 question Overprint SF 600 may be used. Local policy will determine when the HEAR or equivalent will be administered. It is strongly recommended that this be accomplished prior to the PHA, (i.e. during the dental exam, fitness exam, etc). This allows for a thorough review of this self-reporting tool for any behavioral risk or health concerns of the individual. Please keep in mind that once the HEAR is completed it must be reviewed as soon as possible (immediately for individuals on the Personal Reliability Program (PRP)) to ensure there are no indicators that require immediate intervention (such as mental health issues that could have an impact on the individual's PRP status). Only if there are indicators having immediate impact on PRP status or major health care concerns would there be a need for another patient visit. The HEAR (or equivalent) results must be reviewed as part of the PHA to ensure any further evaluation or counseling needs are identified and the patient is appropriately scheduled for any needed follow-up.

b. Interval History (since last PHA): An interval history is required for each PHA. Other sources may be used to collect the interval history such as the Dental Form 696, a web based questionnaire, telephone interview, or other modality; however, the information collected must be immediately reviewed and forwarded for inclusion in the medical record and available to review at the time of the administrative portion of the PHA.

c. Record Review: The individual's medical record must be reviewed to identify any medical conditions or behavioral risks that require further evaluation or counseling.

3. Clinical Preventive Services (CPS):

a. The Clinical Preventive Services reflected within PIMR are the minimum recommended examinations and are based on the US Preventive Services Task Force recommendations. The PIMR software uses these guidelines as the basis for determining when individuals are "due" (See attached grid, attachments 1 and 2). Providers may change the recommended frequency for individual patients based on their risk factors. This will need to be reflected in the medical record.

b. Clinical preventive service needs must be addressed as part of a member's routine health care (i.e. members who become due for a mammogram in January should not be put off until their scheduled PHA in August, but should be scheduled as they become due). At the time of the

annual PHA, all of these requirements and recommendations should be reviewed and any that have not been accomplished should be scheduled and accomplished.

NOTE: These tests should be scheduled and accomplished as part of the PHA process, but the patient's PHA may be considered "complete" for reporting purposes once the required follow-up has been ordered and member has been notified of any required/recommended services. PCM teams must ensure they have developed internal tracking mechanisms to monitor CPS and OH completion/follow up.

4. Occupational Health Exams (OHE):

a. The PHA should include exams and surveillance required for the individual's workplace or occupation. These requirements will be determined by the local MTF Occupational Health Working Group and tracked within the Aerospace Information Management System (ASIMS) or Command Core Systems (CCS). An interface for the data to be pushed from CCS to PIMR is being developed. In the meantime all required exams and frequencies should be manually entered into the PHA module of PIMR until the CCS interface is fully operational. PIMR should not be the sole tracking mechanism to ensure all personnel on the Occupational Health Examination Program for your base...you will still need to ensure you track personnel (civilians especially) using either ASIMS or CCS (depending upon which program your base is currently using). Most Occupational Health Exams are required annually, i.e. every 12 months. There are some OHEs that are required more frequently. Completion of the OHE and PHA requirements at the same time is highly encouraged (unless the OHE is required more than annually). However, in some cases it may make sense to separate them from the PHA process (i.e. when there is a large civilian workforce, when OHE's are accomplished for a particular shop during a specific period, for seasonally driven exams, or if there are special purpose exams required that do not logically fit with the normal PHA). This should be determined locally but must ensure that OHE's are accomplished at the required frequency.

b. Most OHE's are required for basic audiometric monitoring and can be easily linked with the PHA. Those bases with a significant population who require more complex special purpose exams may find it beneficial to centralize some occupational health examinations. Regardless of how OHEs are scheduled or accomplished, the PCM should ensure the currency of the occupational exam during the PHA and review the most recent findings. Prior to certifying that a PHA is complete, the PCM must ensure that all occupational health exam requirements have been accomplished either in conjunction with the PHA or prior to the PHA. Once the occupational exam is completed, the results should be reviewed

by the member's PCM and referrals should be made when appropriate. PCMs will ensure individuals are scheduled for required exams and any necessary follow-up actions, as required IAW locally established policy.

5. Fitness Assessment: The scheduling and accomplishment of fitness assessments is a complex process. These tests are monitored through a separate metric system and scheduling does not need to be linked to the PHA process unless locally advantageous. Fitness assessments are required annually and results of the most recent assessment should be reviewed as part of the PHA process as an indicator of overall health status of the individual. The PIMR software will automatically pull the most recent fitness testing data from the fitness management software.

6. PCM/PCM Team Visit If Required: If, after review of the patient's record and history, a provider visit is deemed necessary (by the PIMR guidelines, PCM request or standing orders), it should be scheduled as part of the PHA. Each PCM must work with their team to determine when a provider visit is required. For most teams, the PCM could issue standing orders to authorize technicians or nurses to order basic lab tests such as cholesterol. Technicians and nurses may also be able to provide basic behavior risk counseling, etc. However, review of results must be accomplished by the PCM.

7. PCM Review: The enrollee's PCM or designated alternate (must be a credentialed provider) will perform the final review of the PHA. The system is designed for the PCM to manage their own enrollees, as they have the best knowledge of their enrollees health needs and should be aware of any examination results. Only after this final review (ensuring that the enrollee has had any follow-up actions ordered and been notified of any follow-up actions required) should the date of completed PHA be updated in the PIMR software.

8. Member Notification of IMR Status and Any Outstanding Requirements or Recommendations: As a final step in the PHA process, all required follow-up actions should be ordered and the member should be notified of their PHA/IMR status including any remaining follow-up requirements. For those patients who did not require a visit, it is especially important to inform them of the assessment process and their PIMR status. Patients should be encouraged to make an appointment with their PCM if they have issues or concerns they would like to address that may not have been evident during the PHA process.

E. Frequency:

1. Routine Requirements: The Preventive Health Assessment becomes due 12 months after the last PHA was documented as being completed (either by PIMR software or by record review). Every effort should be made to complete the

assessment by the end of the 12th month. This is important to ensure that annual requirements like occupational health exams are accomplished IAW federal law.

2. Overdue PHA: In rare cases (deployment, unexpected TDY, emergency leave, etc) individuals may exceed 12 months since their last PHA. For those exceeding 12 months from their last PHA, the PIMR software will automatically change their PHA status to YELLOW indicating they are overdue and every effort should be made to bring them into compliance as soon as possible. YELLOW means DUE or Alert, "YELLOW" does not downgrade the overall PIMR metrics or compliance. If a PHA is not completed by the last day of the 18th month following the last PHA completion date, the PIMR software will automatically change the individual's status to "NOT MEDICALLY READY", (Note: This is similar to a Dental Classification of "4" indicating an individual is overdue for evaluation). A 4T profile will NOT be generated based solely on non-currency for some or all PIMR requirements. These individuals will be reflected as IMR RED or "NOT MEDICALLY READY", just as they would be for any other overdue IMR requirement.

3. Prior to Deployment/TDY: If a member will become due for their PHA during a **known** deployment, the PHA **MUST** be accomplished prior to deployment. It is **not** necessary to accomplish a PHA on every individual during their EAF vulnerability window. However, it is highly recommended that IMR requirements be reviewed and given increased emphasis for these individuals to ensure they are ready to deploy.

4. Flying Personnel: PHAs for flying personnel will be accomplished on or during their birth month in accordance with the timelines and procedures outlined in AFI 48-123, *Physical Examination Standards*. Flying personnel who fail to complete their flying PHA by the last day of their birth month will be DNIF and lose flight pay beginning the first day of the month following their birth month

V. PIMR RESPONSIBILITIES

A. MTF Commander: MTF Commanders must ensure that adequate resources are allotted for the PIMR program. They should monitor PIMR rates as part of the P2R2 metric system and track performance by PCM team to ensure optimal force readiness. They can view this information at https://www.afchips.brooks.af.mil/pimr/Stats_PIMR.htm.

B. Population Health Working Group: PIMR data should be reviewed/ analyzed by the Population Health Working Group on a routine basis as part of their outcomes management function. This group should work as a team to resolve issues with process completion, staff interactions, scheduling problems, etc. and to ensure line commanders are receiving adequate support.

C. PCM Teams: The primary care teams are responsible for the delivery of preventive health services on a daily basis and to ensure PHA assessments (including final review) are accomplished in a timely manner and documented appropriately. They continuously monitor IMR status for their enrollees as well as their occupational health, fitness, clinical preventive service requirements and any necessary medical follow-up actions.

D. Wing/Unit Commanders: Commanders are responsible ensuring their personnel are ready for deployment. They will ensure members get to their appropriate medical appointments to ensure a fit and healthy force.

E. Medical Support Staff: The medical support staff is responsible for providing commanders with the information (from PIMR software) regarding the medical status of their assigned personnel.

F. Individual Members: Members are responsible for the completion of tests, screenings, or immunizations as required and to maintain their health and fitness.

G. Information Systems: The MTF systems section is responsible for network management, software installation, and overall system support. The daily management of the PIMR software system is the responsibility of the application manager. The application manager should be a vested individual appointed by the SG. At least three individuals should be identified locally, a primary, secondary and alternate. These individuals must receive training on use and application of the PIMR software.

VI. PIMR: THE PROCESS

A. The PHA and PIMR is a medical group program. The process of completing PHAs must be a joint effort between many sections of the medical group. While one section may act as the central point of contact for scheduling PHAs, software upgrades, report generation, and quality control, PCM teams are expected to complete the actual assessment, including all the para-profession and professional portions. The administrative portion of Preventive Health Assessments are usually performed by a paraprofessional (PHA-trained clinical technician) and reviewed by the PCM provider (PCM provider will see the patient if required). Numerous ancillary service sections will also need to provide support in order to ensure complete assessments. Actual patient visits to their PCMs will be required only when there is a required service and /or assessment. There is no requirement for the patient to visit the PCM annually, if all Individual Medical Readiness (IMR), Occupational Health, and clinical preventive service requirements are current. However, this does not preclude the PCM team from exercising good clinical judgment and exceeding this standard when appropriate. For example, it may be reasonable for the PCM to schedule an appointment with members who have not had a medical appointment in several years, or to use as an initial interview with newly assigned enrollees.

B. When assessments/tests are required, PCM teams should schedule them so as to minimize any adverse impact on the member (i.e. accomplish as much as possible during a single patient visit but keep the customer in mind by not scheduling too many tests in one day...we do not want them overburdened). Occupational Health, fitness, and dental exams, may or may not be accomplished at the same time as the PHA as appropriate locally. PCM Teams will monitor and ensure these exams are scheduled so they are accomplished in a timely manner IAW existing requirements, but not necessarily at the time of PHA. In some cases it might be a good idea to ask the patient what scheduling times would be good for them and to try to work out a mutual schedule.

C. Some MTFs may have one section as the central point of contact for scheduling, software upgrades, report generation, PHAs and quality control. Many MTFs have the PCM teams manage the PHA program. Remember that the over-arching philosophy of PCM teams is "owning their patients' health care" and being involved in all aspects of their health care delivery. The process of how to get PHAs complete and to manage the program is a local commanders decision. However, at a minimum, Primary Care Management teams are expected to complete the actual assessment, to include the record review, scheduling any needed medical appointments, conducting patient notification and any required follow-ups.

VII. SPECIAL RULES FOR GSU'S: GSU IMR rates will be tracked separately and will not be included in the MTF baseline. Individuals assigned to a GSU should complete their PHA at least 90 days prior to their assignment and every three years thereafter (unless occupational health exams are required more frequently) if they are without intrinsic medical support or readily available medical support. All IMR and PHA requirements must be current including Clinical Preventive Services, fitness assessment, and any occupational health requirements prior to assignment to a GSU. Ongoing preventive care will be the responsibility of their assigned PCM. For GSUs with a mobility requirement, special arrangements may be necessary to ensure their readiness status is maintained and tracked. MTFs must work with these GSUs to establish local protocols and frequencies.

VIII. THE METRIC: IMR RATE

A. Individual Status: The IMR status for each individual is coded as either:

1. **GREEN** (all individual medical readiness requirements met/current) or
2. **RED** (Some IMR requirement not met or the individual has a condition which makes them not recommended for deployment)

NOTE: An individual may be "complete" for their PHA and still be IMR RED, i.e. they have completed all the fundamental requirements, but are not medically ready to deploy due to a 4T profile for an existing medical condition, etc.

3. Aggregate Status:

a. IMR Rate will be reported as the percent of assigned members medically ready for deployment. (Note: Students are not included in the denominator and GSU IMR rates are monitored separately).

b. The denominators for aggregate data should be evaluated in two ways depending on scope of responsibility. Data for both metrics must be provided through the Medical Group.

B. Wing IMR Metric: This metric should tell Wing and Unit commanders the IMR status of members under their immediate control. This should include all assigned personnel for whom the Wing is responsible. Individuals who are at GSUs, tenant units and students, should be reported separately.

C. Medical IMR Metric: This should reflect the IMR status of all members for whom the Medical Group is responsible. This should include those members enrolled to the MTF (regardless of where they may be assigned), and all members assigned to the Wing who are not enrolled in another AF MTF. This may include tenants, students, and even some GSU personnel from other installations. Those individuals who are enrolled to another AF MTF should receive their PHA from their assigned PCM. Special provisions will need to be made locally to provide PHAs for individuals assigned to the Wing but enrolled in a non-AF MTF until such time as all three services provide a similar service. Unless arrangements can be coordinated with another service MTF, it may be necessary for those individuals to have an annual appointment with an AF MTF PCM team to review their PIMR requirements and ensure the appropriate databases are updated.

NOTE: The capability to report the Medical IMR Metrics is in development. Enrollment databases are generally not yet mature enough to provide this information. Until the National Enrollment Database System (NEDS) is fully fielded and reliable, local accommodations may be necessary in order to get to the Medical Metric; however it is important for medical groups to understand that this is the population for whom they are responsible. They are also responsible to provide the Wing IMR Metric data for assigned personnel.

IX. BUSINESS RULES: The following basic business rules are required for implementation of PIMR. Additional business rules will need to be developed as this process progresses:

A. Standard procedure is that the review of an individual's PHA results will be done by their "PCM-by-name", not the "PCM of the day" This is true even if PHA's are conducted in a separate "PHA clinic".

B. All physical profiles are to be accomplished and entered into PIMR software to integrate with other IMR data. Local guidance should be established for temporary medical restrictions. (Example: PCM's may not grant medical profile restrictions over 60 days in duration without MDG Profile officer review)

- C. Results of all tests will be reported to members whether normal or abnormal.
- D. Clinical protocols should be established for PCM team technicians and nurses for common situations like reporting of normal or abnormal test results, ordering clinical exams or preventive services, counseling, referrals, etc.
- E. Data produced on computer generated PIMR reports should be reviewed for accuracy through medical record review prior to ordering tests or scheduling a patient visit.
- F. Initial implementation of PIMR should be accomplished on medical group personnel to minimize impact of any potentially inaccurate data or process problems with other Wing personnel, (i.e. practice on the medics before exporting to the line.)
- G. Initial reports should not be generated for use outside SG channels until the accuracy of the data is assured.
- H. Demand forecasting will be required to ensure sufficient open appointments for the additional needed services this will generate. (CPS, counseling, immunizations, etc)
- I. Health education opportunities should be optimized and provided by members of PCM team, Health Promoters, Health Care Integrators, and others (dietitians, mental health workers, etc) as appropriate. These opportunities include a review of behavioral risks/HEAR, counseling, and referrals as needed and include but are not limited to:
 - 1. Any health care visit
 - 2. The PHA visit/assessment (if required)
 - 3. HEAR data analysis and outreach – a proactive identification of individuals for intervention

Preventive Health Assessment Examinations (Flyers)

(Flyers- Includes All Aviation and Special Duty Personnel)



Test /Exam	Recommended Age to Start/Stop and Frequency <i>(NOTE: These are MINIMAL requirements and recommendations and good clinical judgement may drive additional requirements for individual patients)</i>								Source /Ref	Requirements / Recommendations	
	Key	Blue = Required					Gold = Recommended				
		18	20	25	30	35	40	45			50
Amsler Grid										2	
Audiogram										2	
Corneal Refractory Surgery (Question)										2	
ECG										2	
HIV Screening										2	
Health Care Provider Visit										2	
Phorias										2	
Distant Visual Acuity										2	
Near Visual Acuity										2	
Depth Perception Testing										2	
Glaucoma										2	
DNA										2	
G6PD										2	
Rubella Screen										2	Routine screening for rubella susceptibility by history of vaccination or by serology for all women of childbearing age at their first clinical encounter
Sickle Dex										2	
RECOMMENDED											
Breast Cancer Screening	Manual Breast Exam	Teach BSE during provider visit					Females: q 2 Years			1	Screen for breast cancer every 1-2 years, with mammography alone or mammography and annual clinical breast examination (CBE), for women 50-69.
	Chlamydia Screen	q 3 Years - at the time of Pap Smear								1	Screen for Chlamydia trachomatis infection in all sexually active female adolescents, high-risk pregnant women, and other asymptomatic women at high risk of infection. Screen selected high-risk male adolescents based on clinical assessment. Routine screening is not recommended for the general adult population.
Fasting Lipid Panel		Males : q 5 Years					Females: q 5 Years			1	Screening for high blood cholesterol all men ages 35-65 and women ages 45-65.
Mammogram		If High Risk, baseline at 35		Base-line at 40		Females: q 2 Years			1	Screen for breast cancer every 1-2 years, with mammography alone or mammography and annual clinical breast examination (CBE), for women 50-69.	
Pap Smear		ANNUALLY until 3 normals then q 3 Years								1	Screen for cervical cancer with Papanicolaou (Pap) testing all women who are or have been sexually active and who have a cervix. Pap smears should begin with the onset of sexual activity and should be repeated at least every three years once three normals have been documented.
Colorectal Cancer Screening	Sigmoidoscopy						q 5 Years			1	The American Cancer Society recommends annual digital rectal examination for all adults beginning at age 40, annual FOBT beginning at age 50, and sigmoidoscopy every 3-5 years beginning at age 50
	Fecal Occult Blood						ANNUAL			1	Screen for colorectal cancer all persons aged 50 and older with annual fecal occult blood testing (FOBT).
Other Clinical Preventive Services bases on increased risk											
Testicular Exam		Males: HIGH RISK ONLY q 3 Years			Males: HIGH RISK ONLY ANNUALLY						
Skin Cancer Screening											

References	
1	U.S. Preventive Services Task Force Recommendations
2	AFPAM 48-133 Physical Examination Techniques AFI 48-123 Medical Examinations and Standards

Preventive Health Assessment Examinations (Non-Flyers)

Test /Exam	Recommended Age to Start/Stop and Frequency <i>(NOTE: These are MINIMAL requirements and recommendations and good clinical judgement may drive additional requirements for individual patients)</i>										Source /Ref	Requirements / Recommendations	
	Key	Blue = Required					Gold = Recommended						
		18	20	25	30	35	40	45	50	65			
Distant Visual Acuity											2		
ECG											2		
Glaucoma											2		
HIV Screening											2		
Near Visual Acuity											2		
Rubella Screen											2	Routine screening for rubella susceptibility by history of vaccination or by serology for all women of childbearing age at their first clinical encounter	
G6PD											2		
DNA											2		
Sickle Dex											2		

RECOMMENDED

Breast Cancer Screening	Manual Breast Exam	Teach BSE during provider visit	Females: q 2 Years	1	Screen for breast cancer every 1-2 years, with mammography alone or mammography and annual clinical breast examination (CBE), for women 50-69.	
	Chlamydia Screen	q 3yrs - at the time of Pap Smear		1	Screen for Chlamydia trachomatis infection in all sexually active female adolescents, high-risk pregnant women, and other asymptomatic women at high risk of infection. Screen selected high-risk male adolescents based on clinical assessment. Routine screen	
Fasting Lipid Panel		Males : q 5 Years Females: q 5 years		1	Screening for high blood cholesterol all men ages 35-65 and women ages 45-65.	
Mammogram		If High Risk, baseline at 35	Base-line at 40	Females: q 2 Years	1	Screen for breast cancer every 1-2 years, with mammography alone or mammography and annual clinical breast examination (CBE), for women 50-69.
Pap Smear		annually until three normals then q 3 Years		1	Screen for cervical cancer with Papanicolaou (Pap) testing all women who are or have been sexually active and who have a cervix. Pap smears should begin with the onset of sexual activity and should be repeated at least every three years once three normals have been documented	
Colorectal Cancer Screening	Sigmoidoscopy			q 5 Years	1	The American Cancer Society recommends annual digital rectal examination for all adults beginning at age 40, annual FOBT beginning at age 50, and sigmoidoscopy every 3-5 years beginning at age 50
	Fecal Occult Blood			ANNUAL	1	Screen for colorectal cancer all persons aged 50 and older with annual fecal occult blood testing (FOBT).

Other Clinical Preventive Services bases on increased risk

Testicular Exam	Males: HIGH RISK ONLY q 3 Years	Males: HIGH RISK ONLY ANNUALLY	
Skin Cancer Screening			

References

1	U.S. Preventive Services Task Force Recommendations
2	AFPAM 48-133 <i>Physical Examination Techniques</i> AFI 48-123 <i>Medical Examinations and Standards</i>



DEPARTMENT OF THE AIR FORCE
HEADQUARTERS UNITED STATES AIR FORCE
WASHINGTON, DC

AUG 10 2001

MEMORANDUM FOR SEE DISTRIBUTION

FROM: HQ USAF/SG
110 Luke Avenue, Room 400
Bolling AFB, DC 20332-7050

SUBJECT: Implementation of Preventive Health Assessment and Individual Medical Readiness (PIMR) Software at Air Force Medical Treatment Facilities (MTF)

The Preventive Health Assessment (PHA) has been one of the primary tools used by the Air Force Medical Service to ensure the health and fitness of the active duty force. An upgrade to the PHA called PIMR is now being implemented across the Air Force. PIMR is a significant enhancement to PHA. It will provide line commanders with real-time information on the medical readiness status of their forces and will give primary care managers specific information on the health of their enrolled active duty members. PIMR's ability to access Individual Medical Readiness (IMR) rates is critically important in the determination of unit medical readiness capability. This metric will replace the current PHA metric reported to the CSAF.

As of July 2001, well over half of AF MTFs have upgraded to this program. In order to standardize the flow of data, optimize force readiness, and provide adequate computer support, all MTFs must convert to PIMR NLT 30 October 2001. Exceptions to this deadline for any base experiencing significant technical difficulties will be granted on a case by case basis. Requests for extensions should be coordinated through the MAJCOM SG to the POC listed below. Technical support is available from the Population Health Support Division (PHSD) help-desk at DSN 240-8190 or, if needed, through on site visits.

My point of contact is Maj Lisa Pegues, AFMOA/SGZP at DSN 297-4216, email lisa.pegues@usafsg.bolling.af.mil; 110 Luke Ave Room 405, Bolling AFB, DC 20332, if you have any questions.


PAUL K. CARLTON, JR.
Lieutenant General, USAF, MC, CFS
Surgeon General

Distribution:

HQ ACC/SG
IIQ AETC/SG
HQ AFMC/SG
AFRC/SG
HQ AFSPC/SG
HQ AFSOC/SG
HQ AMC/SG
HQ PACAF/SG
IIQ USAFE/SG
ANGRC/SG
NGB/SG
311 HSW/CC
IIQ AFIA/SG
HQ AIA/SG
11 MDG/CC