FINAL REPORT
RECRUITMENT AND SELECTION OF USPHS COMMISSIONED OFFICERS IN THE CLINICAL DISCIPLINES

FOUNDATION RECRUITMENT AND SELECTION PROJECT

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Final Report
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I EXECUTIVE SUMMARY

The purpose of this project was to conduct a study of the recruitment and selection of clinically related categories (Nurse, Physician, Dentist and Pharmacist officers) for the Public Health Service Commissioned Corps.

The stimulus for the project was the fact that many senior Commissioned Officers felt that recruitment and selection process for new officers was fragmented and functioned without sufficient coordination, due in part to the underfunded and understaffed Division of Commissioned Personnel which traditional was the lead group in this activity.

The project was designed to document the current practices related to recruitment and selection of officers in the clinical categories and to identify procedures to improve upon those practices and, in particular, to evaluate similar, but perhaps more effective, practices as carried out by the other uniformed services.

The project was conducted by CAPT (Ret.) Milton Z. Nichaman and the Co-Director was RADM (Ret.) Jerrold M. Michael.

Following a series of interviews with the Chief Professional Officers of the physician, nurse, dentist and pharmacist categories, further interviews were conducted with 47 individuals in selected DHHS and non-DHHS agencies that currently have large numbers of PHS Commissioned Officers on their staffs. All interviews were recorded and summarized and provided the basis for the present report.

The major findings of the study were as follows:

- Validation of the lack of coordination in recruitment, selection and routine mentoring of Commissioned Officers
- Lack of a force management process including components of an active reserve, which can properly guide the recruitment and placement process and of a computerized information system on all officers including those being recruited and those already on duty.
- Lack of a uniform process of developing a career pathway system for all officers which can begin with the initial recruitment process.
- Lack of general knowledge of the Corps and its potential by the DHHS leadership and human resource unit personnel as well as the general public.
- Lack of information given to civil service and appointed employees about the value and potential of conversion of their employment status to that of a PHS Commissioned Officer
- Presence of antipathy toward the Corps

- Lack of useful Corps-specific recruitment material including special programs such as the Commissioned Officer Student Program (COSTEP)

These findings led to a series of recommendations which are summarized below:

- Develop a force management process, including an active reserve component,, similar to that in the other uniformed services, which among other values sets out the short and long term needs for officers
- Develop a recruitment and retention system that is under the leadership of the Surgeon General
- Ensure that all activities related to recruitment, selection and mentoring of Commissioned Officers are coordinated by the Division of Commissioned Personnel or its replacement organization
- Develop and put into place a billet system that serves the needs of the force management process
- Ensure that a PHS Commissioned Officer in included on the staff of each Agency-level Human Resources Unit.
- Ensure that each officer has a defined career pathway, beginning in the initial recruitment and placement process, that it is reviewed and amended periodically
- Conduct recruitment by discipline-specific “age appropriate” officers and with a priority focus on the use of the mechanism of COSTEP
- Provide continuing leadership, public health practice and scientific educational opportunities for officers in order to increase their value to the nation
- Provide adequate monetary and personnel support for a fully functioning DCP, or its replacement organization, under the leadership of the Surgeon General

II INTRODUCTION

On October 1, 2002 the Office of the Surgeon General awarded a contract (Contract #233-02-0079) to the PHS Commissioned Officers Foundation for the Advancement of Public Health to conduct a study of the recruitment and selection of clinically related categories (Nurse, Physician, Dentist and Pharmacist officers) in the Public Health Service (PHS) Commissioned Corps.

The contract was initiated as a follow-up of an earlier contract given to the Foundation to examine the potential of using former PHS Commissioned Officers on

the faculties of schools of the health professions as auxiliary recruiters. The project was designed to document the current practices related to recruitment and selection of officers in clinical categories and to identify procedures to improve upon those practices and, in particular, to evaluate similar, but perhaps more effective, practices as carried out by the other uniformed services

The Contract required the Investigators to present a Work Plan to the Contract officer; carry out interviews with the staff of DCP, the Chief Professional Officers(CPO) and representatives of the Agencies having a large number of Commissioned Corps personnel; determine recruitment and placement outcomes and provide recommendations to improve recruitment and placement of officers.

The Director of the project was CAPT (Ret.) Milton Z. Nichaman and the Co-Director was RADM (Ret.) Jerrold M. Michael. The project was carried between October, 2002 and June 30, 2003

III BACKGROUND

The Commissioned Corps of the US Public Health Service

Recognition of the need for a national public health focus dates back to 1798 when Congress established the Marine Hospital Service to provide medical services to merchant seaman. The need for a specialized cadre of professionals dedicated to public heath was recognized in 1871, when Dr. John Woodworth set up the Commissioned Corps as a new personnel system along military lines, a characteristic that today gives the Corps its unique uniformed service readiness. The PHS Commissioned Corps was formally authorized by Congress on January 4, 1889. Initially restricted to physicians, the Commissioned Corps has evolved into a uniformed service representing all of the major health disciplines

In its formative years, the Corps devoted its resources to health issues of the day, including care of merchant seamen, prevention of communicable diseases, and improvements in sanitation and environmental conditions. As the Corp responsibilities broadened, officers have been instrumental in pioneering research and applications in bacteriology, virology, parasitology, epidemiology and nutritional diseases.

Corps offices played vital roles in both World Wars and the Korean Conflict, during which the President placed the Corps into military status. Many officers also served in the Vietnam War. PHS officers were detailed to the armed forces to provide public health and medical expertise. Recently, hundreds of Corps officers provided emergency services at all three sites resulting from the terrorist acts of September 11th, 2001 as well as during the anthrax crisis. Officers also served in both of the Gulf Wars and are currently serving in trouble spots such as Kosovo, Afghanistan and Iraq.

Current size and dimensions of the Corps

As of June 2003 the Corps had 6033 officers as compared to 5848 in June 2002. The number of applications for Corps admission more than tripled in the past year.

Nurse and Physician officers are the largest groups at 1198 and 1224 respectively. Other relatively large groups are the pharmacists with 846 and the health services officers with 920 officers.

Among current Corps officers 43% were female and 24% were non Caucasian, although 635 (11%) did not report their ethnicity.

The largest numbers of officers, 36%, serve with the Indian Health Service (IHS). Approximately 14% are at the Centers for Disease Control and Prevention (CDC); 11% at the Bureau of Prisons (BOP); 12% at the Food and Drug Administration (FDA) and 8% each at the National Institutes of Health (NIH) and the Health Resources and Services Administration (HRSA) as of June 2003.

The Public Image of the Commissioned Corps

On October 17, 2001, the Health Care News reported that two agencies of the Department of Health and Human Services, the Centers for Disease Control and Prevention and the National Institutes of Health have the best ratings among the ten well-recognized Federal government agencies. The report noted, “The Centers for Disease Control and the National Institutes of Health are more favorably rated by the public than eight other major agencies, including the Securities and Exchange Commission (SEC), Food and Drug Administration, Environmental Protection Agency (EPA), Central Intelligence Agency (CIA), and the Federal Bureau of Investigation (FBI). Among those who say they understand what these Agencies are and what they do, the CDC received a 79% positive rating and a 17% negative rating and, similarly, the NIH had a 77% positive rating and a 21% negative rating.”

When it comes to the recognition of the role that the Commissioned Corps plays in these well regarded agencies, the results are not as favorable. Only during the period of time that the Surgeon General was Dr. C. Everett Koop did the public have a reasonable level of understanding of the Commissioned Corps and its leadership role in the health programs of the Federal government. The wearing of the uniform by all officers, particularly when they are interviewed on the visual media, is regarded by many as an important way to provide the public, with a greater understanding of the Corps and its function in advancing the public’s health.

IV PROBLEM STATEMENT

The recruitment of commissioned officers is carried out by the Recruitment and Assignment Branch of the Division of Commissioned Officer Personnel (DCP); the Human Resources units of the various Agencies of DHHS and Departments who employ Commissioned Officers outside of DHHS. Recruitment is also carried out by specific programs with large Commissioned Officer components such as the Epidemic Intelligence Service at CDC; the Chief Professional Officers and their Professional Advisory Committees (PAC); volunteer Associate Recruiters; Auxiliary Recruiters at Universities and individual officers with employment authority. Among all of these

groups, the Recruitment and Assignment Branch of DCP has been traditionally vested with the overall responsibility for managing the process of recruitment and placement.

Two and one half years ago the DCP had 115 employees. It now has 95. There are only 26 people in the Recruitment and Assignment Branch of DCP, which carries out a wide variety of functions in addition to recruitment. Only three people are free to do recruiting. As a consequence, it is difficult for that unit to follow through on broad recruitment assignments. In addition, once DCP recruits an individual, placement is under the control of the Agencies. This produces a situation in which an applicant, having gone through the recruitment process and told that she/he is eligible to join the Commissioned Corps, is then informed that she/he must find their own job unless they have already been "pre-selected" by someone in an agency.

Many individuals interview for the project have commented that from a service-wide standpoint there is insufficient priority placed on recruitment and assignment. This is further aggravated by the remote placement of the DCP away from the Surgeon General's office which further impairs the ability of DCP to meet any assumed "target" for overall recruitment.

An overarching problem in the recruitment and retention of officers is that the operation does not now follow a force management process. Such a process is one in which recruitment is driven by long term service needs. The Corps needs to know what its personnel needs are in the next five years, not only for next month, and it needs to know how many in each category are needed and where. It also needs to know if an officer is committed for a long term career.

The Surgeon General should, in consultation with Agency leadership, be able to set the targets for the size of the Corps. As noted below, such a process of force management is practiced in all of the other uniformed services.

V STUDY PROCEDURES

Following a series of interviews with the Chief Professional Officers, individuals at the Agencies with large numbers of Commissioned Corps officers were identified by CAPT Nichaman and RADM Michael as potential interviewees. Based on the recommendations from these initial interviewees, other Agency staff members were contacted and scheduled for interview. In total 52 individuals were interviewed. The names and Agency affiliations of these interviewees are provided in Appendix A.

All interviews were recorded and were then summarized by either CAPT Nichaman or RADM Michael. In order to include individuals from a variety of settings, site visits were made to Indian Health Service programs in Phoenix, Arizona, the Centers for Disease Control and Prevention in Atlanta, Georgia, as well as at the National Institutes of Health ,the Food & Drug Administration, the Division of Commissioned Personnel and the Bureau of Prisons Headquarters in Washington, DC.

In carrying out the interviews the following questions were used as guidelines:

1. What are the positive things about the current system of recruitment of PHS Commissioned Officers given the project focus of recruitment of clinical specialties (Physicians, Dentists, Pharmacists, and Nurses)? What are the negative things?
2. Is there a difference in recruitment practices when you are seeking people from the clinical specialties?
3. Are there principles involved in a successful recruitment program that can be extrapolated for application in other programs?
4. How is retention related to recruitment and recruitment related to retention?

VI CURRENT RECRUITMENT PRACTICES

Overall recruitment and Placement

It is clear from of the comments of many of the interviewees that the Division of Commissioned Personnel is seriously underfunded and understaffed, which makes it virtually impossible for it to function adequately and meet assigned targets. The DCP does not have the resources to develop and carry out timely updates to a personnel data base from which it could, if mandated, carry out a force management process such as is standard practice in the other uniformed services. Interviewees have noted that for many categories recruitment is relatively successful, but when the applicant is cleared for commissioning and must in essence seek his or her own first placement in an Agency, the process is less effective.

Agencies should be able to turn to the DCP to find eligible candidates who meet their specific needs. What is clearly needed is a functioning data system with information on current and potential officers including experience, education and credentials. Such a data system could serve as a mechanism to provide the Surgeon General with the knowledge as to who is available and where for routine rotation as well as for emergency deployment.

The ability to offer positions to applicants to the Corps rests in the Agencies. The link between DCP recruitment and these job opportunities is not always seamless or timely. There is no centralized mechanism to offer applicants a specific job. As a consequence, Agencies conduct much of the recruitment.

It was made clear in a number of the interviews that Agencies would resist a return to recruitment at a centralized level, as they would regard such a system as “interference from the outside.” At several Agencies the comment was made that the major problem with an organized recruitment process is that there is no overall centralized recruitment plan with resources to implement it. DCP has the general charge to conduct recruitment, but is given inadequate resources to develop such a plan and manage a centralized recruitment system.

In keeping with their professional mandate, the Chief Professional Officers have taken an active role in the recruitment process and in many cases are responsible for preparing discipline-related recruitment materials. However each Chief Professional Officer and their Professional Advisory Committees (PAC) are “volunteers” in regard to recruitment-related activities because they have regular full time jobs as well. To make their category's recruitment effective they have to “borrow” resources from the Agency in which they reside. There is also the matter of convincing supervisors, particularly those who are not PHS Commissioned Officers, that service on a PAC provides useful experience not only for the individual, and of course the Corps, but also for the program in which they reside and thus to the benefit of the officer’s supervisor.

DCP does maintain good relationship with most Agencies and places applicants in the vacancies that they have listed in a newly developed summary vacancy register which is posted on the DCP web site. However, this vacancy register requires that the Agencies provided information regarding their vacancies to the DCP in a timely and complete manner. Some units within an Agency are not always cooperative, and some civil service personnel do not want to deal with or hire PHS Commissioned Officers. As a consequence there are many vacancies that could potentially be filled by PHS Commissioned Officers that are never listed or known by DCP to be available.

Approximately 30% of those people who apply for the Corps get placed. Interviewees have commented that the Corps is loosing good people to other employment systems. People, they note, don’t generally apply to just one organization. Most heath professionals apply to multiple organizations and the one that is most responsive is usually the one who ends up with the new employee.

Interviewees also stated that the overall application and placement process needs to be dramatically improved and made more user friendly. Examples were given that showed that PHS Commissioned Officer applications can be “fast tracked” in as little as 15 days if the resources to permit doing that are routinely provided. There are “system enhancers” that can be used to facilitate the recruitment to placement process. These include issuing the call to duty form in advance of all of the paper work being completed when position vacancies are known and when a qualified commissioned officer is ready to accept the duty assignment and by selecting a medical facility tht can do the required physical examination in an expedited manner that does not slow up the process.

Individuals of all disciplines who were interviewed noted the common theme that for PHS Commissioned Officer recruitment and placement to be strong and timely there there must be a strong linkage between the work of the Chief Professional Officer; the Professional Advisory Committee (made up of committed people from each discipline); and the DCP.

Nurse Recruitment

In order to facilitate nurse recruitment, the Chief Nurse Officer has addressed the lack of a broad officer data system for all officers by developing a computer listing of all nurse applicants. This system is maintained by a nurse applicant committee under her direction. The system contains information on all of the education, experience, skills and interests of each applicant.

This committee includes the Chief Nurse from each DHHS Agency and other Department units staffed with PHS Commissioned Officer nurses, as well as the nurse staffing officer at DCP. They meet once a month and track all nurse applicants personally. They monitor where they are in the process, what their strengths are, where applicants want to work and then try to match them with an Agency position. Each applicant is personally contacted by one of the committee members. The information on the applicants comes partly from the nurse staffing officer in DCP and partly from the work of the committee members and other nurse associate recruiters.

With efforts such as those described above, the number of PHS Commissioned Officer nurses in FDA has doubled in the past year. A number of interviewees noted that this kind of process is needed system-wide, but should be under the direction of a revitalized DCP with adequate resources and personnel.

It has also been suggested that if CDC were to place nurses into some of their Public Health Advisor and Public Health Analyst positions, which are charged with public health consultation and advising, both things that nurses do very well given their clinical background, the result would be an increase in the number of effectively placed PHS Commissioned Officers. It would also result in the positioning of a great many more officers in States and local communities who could serve a dual purpose by being available in the event of national or local emergencies. It has also been pointed out that the addition of nurse officers in State and local health Agencies would boost the effectiveness of many public health program at these levels.

It has also been suggested that nurses join the Commissioned Corps because they are interested in careers that include both clinical service and leadership roles. About 45% of the Corps nurses have had prior military experience and they are accustomed to the issue of change and are regarded by many as “ready” for promotion that includes taking on greater responsibility. According to several interviewees they have accommodated to being mobile; a significant departure from the typical attitude of civil service nurses.

Physician recruitment

The issue of physician recruitment was noted by many interviewees to be different in a number of respects from recruitment of other disciplines. The National Health Service Corps (NHSC) has downsized and deemphasized the recruitment of PHS Commissioned Officers where in the past one in three of those selected for that program would remain in careers in the Corps. The loss of the “draft deferment”, in

force until the late 60s, also reduced the opportunity for people to experience service in the PHS. Many who did so found it very much to their liking.

When asked for the reason that there is a diminished focus on Commissioning National Health Service Corps assignees, interviewees suggested that it was probably in response to the "political environment" that presumes that private is better than government and that if people go to a National Health Service Corps site that is a shortage area and are employed by the community, or even are civil servants instead of Corps officers, they are more likely to stay there after their obligation has been fulfilled. What is overlooked in that judgment, one interviewee noted, is that Corps officers in positions like those in the NHSC are a unique force that can be called to emergency duty there or elsewhere in the event of a national emergency."

It was also pointed out that the closure of the PHS hospitals in the early 80s also put a crimp on opportunities for clinical service by physicians as an attractive starting career in the PHS. During those earlier times individuals from the Division of Hospitals would flow freely to other units in clinical, but also in research and administrative roles, providing the Service with a useful cadre of experienced physicians. What remains for entry physician positions now is service with the IHS, Epidemic Intelligence Service (EIS), Coast Guard, Immigration and Naturalization Service (INS) and Bureau of Prisons (BOP)

The EIS is the one remaining growth area for physician PHS Commissioned Officers because there is a strong preference that all EIS officers be PHS Commissioned Officers so that they will be fully and rapidly mobile. This program has been training field epidemiologist since 1951. The Epidemic Intelligence Officer program has about 70 to 75 new individuals in their training program each year. In 2002 they had 90 individuals with 65 of them being PHS Commissioned Officers. Others are internationalists and some are designated through a competitive process from DOD units. Most of the EIS officers are physicians.

From the 2001 EIS class, one person went into private practice, about 80% went into public health, (half at CDC) and 20% went to academia as a teacher or for further education. As noted above, in order to join EIS, all physicians are required to be PHS Commissioned Officers, and many of the other categories choose to be an officer because of salary, although CDC does not require them to do so. Some EIS officers are transfers from other Agencies like NIH or FDA and even a few come from IHS.

In terms of filling CDC posts, a large proportion of the PHS Commissioned Officers at CDC are from the EIS program (70 to 80%) and of these, 90 to 95 % are physicians. The pride felt by these former EIS officers devolves almost entirely from identification with CDC and not from the Commissioned Corps

Some interviewees noted that in the last ten years or so the motivation for physicians to join the Corps has been more about compensation and less about a career per se. For that reason many physicians, given the opportunity to make a choice, select Title

38 employment, which is much like Title 42 at NIH for scientists. This option is particularly rewarding in regard to initial pay for physicians who are in the difficult to recruit specialty areas.

A person coming out of medical school can make between $100,000 and $125,000 in an HMO where as the Corps can only offer them around $80,000 which includes some incentives and the prospects of going up to $180,000 in a reasonable period of time. The "real income" is much higher but it is difficult to sell this fact at the time of first employment.

It should be noted that in the Bureau of Prison, a non DHHS Agency, the vast majority of physicians are Civil Service employees because of compensation concerns and also due to the fact that many applicants do not intend to remain in the BOP, or even in government, for a career.

One problem noted in connection with the hiring of physicians in the Corps is that a "culture" exists in some Agencies to avoid recruiting PHS Commissioned Officers for the long term. It is noted by some of those who oppose Commissioned Corps appointees that they can recruit lower paid people and thus cut their immediate costs. The "short term" supervisor is often satisfied with that short term saving.

Pharmacist recruitment

Pharmacists interviewees noted that there were distinct differences among the Agencies as regards the ease of recruitment and placement. In the case of IHS and the INS, the process is often driven by PHS Commissioned Officers in the systems who are in the habit of asking for a specific number of Commissioned Officer pharmacists for open positions. This initiates the recruitment process among PHS pharmacists to deliver the required number of qualified people who can be placed into those open positions. This is also true to some extent in the FDA, particularly in recent times when national security issues resulted in a demand for a number of pharmacists in a variety of FDA programs.

The pharmacists are also clear as to the role of their Chief Professional Officer and the PAC on the issue of recruitment. They conclude that the role of their Chief Professional Officer is to develop recruitment, placement and mentoring policies; develop a pattern of sustainability of the recruitment and placement process; and support "capacity building" for the future. The latter implies working within the system to be sure that the organizational structure supports the overall process.

In reflecting on the focal point for recruitment, pharmacists are particularly enthusiastic about the value of the Associate Recruiters program (active duty officers) combined with the Auxiliary Recruiters (former PHS officers) in making university level recruitment work well. The Associate Recruiters visit the University at least twice a year and the school gets the experience of knowing that the PHS officer pharmacists are dong more than "classical" service. The contact people at the university often ask

for active duty officers to visit and participate in classes that deal with a variety of subjects ranging from regulation, research, and administration to classic pharmacy services in a clinical setting.

Pharmacists, as well as dentists and physicians, are interested in expanding the COSTEP program into a two year stint. Pharmacists, in particular, credit the COSTEP program with attracting large number of their new officers into the Corps. A former Chief Pharmacy Officer was responsible for developing affiliation agreements with 14 colleges of pharmacy for their students to spend their required internship at CDC as a COSTEP student. This activity has been extremely effective in recruiting people who then go on to Commissioned Corps service in a variety of Agencies, not only CDC. The DCP acted as an adjunct in this process, with the local pharmacy officers or colleagues at the school doing most of the actual recruitment. At one time DCP had a pharmacy recruiter on staff who was very helpful in placing former COSTEP students after graduation.

Dentist Recruitment

The leadership of the dental discipline feels that every officer should be recruiting for the Service as a whole and therefore needs to be somewhat knowledgeable regarding the other disciplines and recognizes that in many positions officers from all disciplines are interchangeable, particularly at the leadership level.

Dental vacancies and turnover rates are quite different in the various Agencies. IHS, as noted below, employs several dentists with a major job responsibility for recruitment since that Agency has high vacancy and turnover rates. (a 23% dental vacancy rate and a 30% turnover rate at the time of this assessment). In contrast, the BOP has a 4% vacancy rate in part due to the fact that incentives for dentists are substantial. As a result of repayment of student loans for service in remote stations as well as recruitment bonuses, 85 dental officers in the BOP are now receiving loan repayment stipends.

The dental category effectively uses the recruitment materials made available by the DCP and has also developed additional materials for their specific recruitment efforts (i.e. IHS specific material)

Officers in the dental category feel that to enhance recruitment they need a process wherein every officer has broad career options and where mentoring is provided as a routine matter with all officers being permitted to obtain further education, particularly in public health, in order to serve the Corps more broadly and to sastify overall national needs.

A very interesting dilemma presents itself for the dental officer. They are recruited in the main for a clinical position and most begin their careers with IHS, BOP and the Coast Guard. The leadership of the disciplineas noted above is concerned that the service should be providing continuing and long-term education for these people so

that they can also be subsequently placed in research, administrative or policy positions and thus better serve the Corps and the nation.

The discipline also recognizes that recruitment may take place at different levels. One level is the recruitment of the beginning clinician. Another is the recruitment of an experienced dentist who may also have had training in public health, management or in research methodology. Related to that is the matter of recognizing that not all dentists want to or should stay for a full 20 to 30 year career. Change is recognized as good for the individual and good for the Corps which is invigorated by a change in its makeup. The discipline leadership therefore recognizes that recruitment should consider the person who wants to stay 4 or 5 years as well as 25 years.

The IHS has dental officers specifically assigned to recruit for their Agency. In 2002 they hired 17 PHS Commissioned Officer dentists and 21 civil service dentists. The principal dental recruitment officer at IHS noted that there is a significant financial advantage to a dentist being hired through civil service because they can be hired through Title 38 which sets a new dentist's salary at $85,000 and they can also offer that civil service dentist around $24,000 to repay their dental school loans. This IHS officer noted that if he does not hire civil service people then he does not meet the quota for vacancies in IHS. On the other hand, he does counsel civil service dentists regarding switching to the Commissioned Corps within 5 years of their original hire so that they can get their civil service time credited to the Corps retirement system and help in their final retirement "package."

Recruitment and placement differs for each discipline. The recruitment of Health Services Officers is due in large part to the work of the associate recruiters, active duty officers who take on recruitment as a volunteer extra task. The value of the associate recruiters has been underscored by almost all of the disciplines.

Agency-Related Recruitment Issues

Many interviewees noted that it would be most practical to work within the existing "organizational culture" in order to affect the kind of changes in recruitment and retention that are targeted as important. They noted that culture changes slowly and we should not look for miracles that only occur in fantasies. Thus, while in theory it would be productive to have all positions "owned" by the Surgeon General, it is not likely that such a change will be forthcoming in the near future.

One interviewee noted that there is no way that you can tell an Agency head that you are going to remove the process of selection of their personnel from them and centralize it entirely. That fact makes it literally impossible to put the recruitment process totally back with the Surgeon General and expect it to thrive.

There is a distinct disconnect and clearly not a "seamless" transition between recruitment and placement. As noted previously, recruitment is usually relatively successful but when the applicant is cleared for commissioning and must in essence

seek his or her own first placement in an Agency the process looses inertia. This is at least in part due to several Agency level problems as noted above and also detailed by Agency below.

Immigration and Naturalization Service

The Division of Immigration Health Services at the Immigration and Naturalization Service (INS) does 60% of its own recruitment with DCP providing them with the applicants for the remaining 40%. Of that 40%, about one half are by transfers of commissioned officers from other programs.. With only five technicians at DCP to process new applicants for a Corps of almost 6,000 officers, the unit is hard pressed to keep things moving smartly. In order to get people processed in a more timely fashion, staff officers at INS have to do a lot of the paper work. If they did not do this the sheer volume of the load on DCP makes it difficult to get people on board in a short period of time.

Centers for Disease Control and Prevention

As noted above, CDC does its own recruiting for its very effective EIS program. They generally receive about 300 applications and select between 75 and 90 individuals for the program. CDC is not comfortable with the use of DCP in their recruitment of these mainly physician officers. "If DCP were to do the central recruiting it would be a matter of concern for CDC" said one highly placed officer. They feel that there is no need to change the way people are recruited because "you don't fix something that is not broken." CDC officials indicated that they are clearly not 100% comfortable with the track record of DCP.

Bureau of Prisons

The BOP employs almost all of their dentists and pharmacist as PHS Commissioned Officers but only a small number of their physicians are in that category because they can offer them a Title 38 employment with a higher salary. For a new physician graduate the equivalent of a GS 15 at step 10 is around $120,000 as compared to $45,000 to $55,000 for a starting PHS Commissioned Officer.

The BOP has a very positive record with use of the COSTEP process. For example, with pharmacists, they have been able to retain a large number who formerly served in a COSTEP position. Unfortunately, the BOP central office has chosen to cut funds for the COSTEP program.

National Institutes of Health

At the NIH a system of "tenured track like positions" has been developed for "Research Officers" that manages to provide an incentive type pay for physicians who are not in clinical, but are rather in research posts. This process provides equity for these hard to recruit and retain specialists who are critical to the mission of NIH.

VII MILITARY EXPERIENCE IN RECRUITMENT

The process of centralized recruitment follows a pattern in all of the other uniformed services where at least the first assignment is handled by a centralized system which is backed up by a full skills record and tied to a data system called *resumex services* that makes it possible to access the skills, background and specialties of all active duty officers.

Mentoring also takes place out of a central command where all disciplines and sub-disciplines (i.e. Nurse Anesthesiologist, Infectious disease physician) have a mentor that keeps in touch with the individual and assists in career counseling and mobility.

The recruiting process for health professions officers in the U.S. Navy is controlled through a central recruitment command and carried out exclusively by uniformed Navy personnel. In many cases this is done at recruitment centers but much of it is done at professional meetings and at universities.

Recruitment officers are given quotas for their recruitment targets and are evaluated on the number of recruits entering the Navy and not by numbers of people contacted or seminars attended. If a military recruiter fills billets he or she does well. If not, they get transferred to another job. The quotas are provided on the basis of a force management process where the total numbers of health professionals needed for each discipline is calculated on a long-term basis. The Navy also evaluates and awards scholarships for health professional schools at a central facility with centralized resources. This year (2003) they gave out 300 medial school scholarships

A key point made was related to the use of retired or former Navy Officers at the schools of the health professions as auxiliary recruiters. In those locations the former officer is commissioned as a member of the active Navy reserve and wears the uniform periodically and is paid as a reserve officer (without attending weekend or summer drills). Their obligation is to expose their students to a potential career in the Navy and to be able to steer them to the proper channels. They bring these University reservists from medicine, dentistry, nursing, etc together from time to time and update them on the issue related to recruitment.

The Naval Dental Corps relies on a scholarship program to assist in their recruitment. They have 30 three year, 30 four year and 10 two year scholarships. They also have authority to institute a program similar to the IHS program to pay back matriculation costs on a year to year basis.

Dental recruiters have found that though applicants frequently talk about “flag, uniform and country” often it is the financial support alone that attracts the individual and that comes through after they have been on duty for a while. Their retention is not as good as they need it to be and they are considering instituting a post-entry program of debt repayment to offset academic debt by officers who have been in the Corps for a period of time.

When a dentist comes into the Navy they can take advantage of a one year program that gives them additional clinical experience. In some cases it is the equivalent of what they need to pass a state dental exam. If they take the additional year, they do not have that year credited toward their payback obligation time. The Navy also sends their dentists for extended or specialty training to meet the needs of the service. When they do so, the officer accrues additional years of obligation to the service.

The Navy is considering sending young officers out to the Universities to chat with the students and serve as a recruiter for young graduates. This is similar to the Associate Recruiters Program of the PHS.

Like the other military services, the Navy carries out a “sponsor program” where a new officer and the family are helped to get settled in the community. In addition in many locations they are given an extended orientation in order to help them in the transition to military life.

A former military officer now serving in the PHS provided insights into recruitment and retention issues in the PHS as contrasted to that in the military. He noted that, in contrast to the PHS, in the military there is a consistent infrastructure to support the recruiting function. This structure begins with a clear recruitment target for each discipline that is driven by the needs of the service and is determined by a force management process**.**

A key factor in the strength of the military (and the PHS) is the development of an active or ready reserve because the service must have a universe of people to draw from to meet unexpected national needs . No uniformed service can maintain everyone who may be needed at any one time on active duty status. It is too costly and wasteful of human resources.

VIII OTHER ISSUES RELATED TO RECRUITMENT AND SELECTION OF PHS OFFICERS

Civil Service and DCP: Two Competing Personnel Systems?

Agency human resource people are almost exclusively Civil Service personnel. Some of these people have negative feelings about the Corps, but in general terms the major problem is that they lack a full knowledge of the Corps and the benefits to their Agency Secondly, even if they are knowledgeable about the Corps, they suffer from the disconnect between the recruitment efforts of the DCP, the CPOs and the PACs and their own Agency level human resource needs.

In some cases Agencies may also hesitate to select a PHS Commissioned Officer based on the misconception that the overall costs of placement of the officer vs. the civil service employee is more expensive. This was noted above in the recruitment of physicians in the BOP. They also have a concern that the officer may one day be transferred out of their control and that if their employees are moved to temporary emergency duty they may be gone for an extended period of time.

In connection with certain disciplines there is a resistance to paying for “accession bonuses” (one time incentives paid to officers such as pharmacists and dentists) when they are not sure that the person will stay in the Agency for a reasonable number of years. Given that the administrative and human resources people are also predominantly civil service personnel, they are interested in having the close allegiance of each and every employee. They look at each new employee as someone who will remain with them for their federal entire careers. They are oriented to “owning the employee”.

While there is a need to recognize that most officers should be available for transfer in order to maintain the mobility of the Corps and to permit people to have opportunities for other more challenging and rewarding assignments, it should also be recognized that some officers are so specialized in their current expertise and job that they will remain in one or two positions for their entire careers.

In addition, Agency heads and many of their associates are appointed by the political administration running the government. It is a practical issue to recognize that they have a “short-term view of life” as compared to a long-term view that would predominate in employees such as those in the Corps. Priority effort needs to be exerted with those “appointees” to demonstrate values that coincide with the views of the PHS such as flexibility, mobility and 24/7 duty status.

What could follow from such an understanding is an agreement by the Surgeon General with each Agency head as to how many of the open positions in that Agency should be filled by PHS Commissioned Officers. Also, a number of interviewees said that we should be seeking to develop agreements with other Agencies such as The Department of Agriculture and the Department of Veteran’s Affairs.

A number of interviewees noted that it would be prudent to alter the recruitment practice at the Agency level in order to more fully integrate civilian and Corps officer recruitment. The civilian human resources staffers need to be charged to include both civilian and Corps opportunities in their hiring of health professionals. They will need to be made fully competent in the procedures that are involved in hiring under both systems. The recruitment process also needs to highlight to the prospective applicant the fundamental differences between the two personnel systems. All other things being equal, the prospective PHS Commissioned Officer needs to be presented with the range of global opportunities that will be available to him or her as differing from that of a civil servant. While both may change Agencies and positions, change will be inevitable for the officer.

The integration of civil servant and PHS Commissioned Officer recruitment has been initiated with some marked success at FDA. In order for that to happen it required that a high level PHS Commissioned Officer in the Agency serve as an advocate in the strongest possible terms for that kind of change and follow through on a long-term basis to be sure that it is works in practice.

The notion of "integrating" the hiring of both systems has been introduced as a standard practice at the FDA. In the FDA the assignment of a PHS Commissioned Officer at the Agency-level Human Resources unit (introduced by Surgeon General Koop) has remained viable. In that Agency, a PHS Commissioned Officer Representative has also been assigned to almost every major human resources unit (Centers).

The head of the Human Resources office at FDA has done a number of things to enhance the use of PHS Commissioned Officers including (1) conduct of training programs to demonstrate to human resource people in the various Centers and other units the comparative financial and performance value of having officers on their staffs as well as the advantages to the employee of being a Corps officer; (2) maintaining close contact and participation with the head and members of the DCP by assigning PHS Commissioned Officers to the various human resources staffs and (3) the conduct of educational seminars to advise civil service personnel about the process for selecting PHS Commissioned Officers.

It is clear that the institutional attitude of the FDA is that Corps officers are valuable assets and the Corps is much more than a personnel system In the FDA, the senior PHS Commissioned Officer "monitors" the process to assure that equity is the standard in the offering of PHS Commissioned Officer opportunities. This senior officer takes on this role as part of her responsibility as the designated Agency member to the Surgeon General's Professional Advisory Committee**.** It may be, she noted, that such assignments should take place in every Agency if equity in recruitment is to be achieved.

The Corps as a Career Option and not a Personnel System

It is a well established, if not a documented fact, that in some Agencies of the Department the Commissioned Corps has been used only as an alternative personnel system without exacting the individual's full commitment to the Corps. That and the practice of granting instant Flag Officer positions are demoralizing to committed officers. On the contrary, the practice of promotion to leadership positions by promotion from within is one that strengthens morale and contributes to committed leadership.

It is equally important that top level positions in Agencies be filled by PHS Commissioned Officers. The determinants which make that practice appropriate are found in the positive qualities which derive from having an officer in leadership positions including mobility, flexibility and a long-term outlook for the entire enterprise.

A head of the FDA Human Resources unit noted the following six factors as the guiding principles of marketing the Corps as a career within the Agencies:

1) Ensure that strong Corps Officers who are willing to be involved in the recruitment process are in key leadership positions within the Agency.

2) Educate civil service supervisors as to the advantages of selecting PHS Commissioned Officers and inform them of how to provide incentives for their work.(i.e. awards, recognition, parity in benefits)

3) Educate human resources staffs as to the merit of advertising vacancies for application by PHS Commissioned Officers as well as civil servants and provide the opportunity for civil servants to convert to Corps status.

4) Work closely with the various staff officers in DCP

5) Enhance communications in the broadest sense using all of the tools available including seminars, group teaching, web sites and personal mentoring.

Creating a system where the Surgeon General is fully in command of all Corps officers would make the Corps a clear cut career option rather than merely a personnel system. However, as noted above, the reality is that the heads of Agencies are not likely to want to give up the control of budget, personnel and policy. Interviewees noted that "anyone who even thinks that the head of NIH or CDC report even to the Secretary are ill informed." They serve, it was concluded, at the pleasure of their constituency groups and key member of the Congress. Changing the current process to a billet system controlled by the Surgeon General is going to be very difficult even if needed.

Increasing the number of PHS Commissioned Officers would alter the relative influence of Corps officers. It has been suggested that the 900 or so officers who are in administrative positions might concentrate on hiring PHS Commissioned Officers for vacancies that they control. If that were done by having each of the 900 hire only one new officer per year; in two years it would result in 1800 new officers.

Many interviewees commented on the fact that every recruitment officer, including senior officers, must be able to make the case when asked "Why the Commissioned Corps?" All such people they said should understand that the health of the nation is tied to the security of the nation, including the health security, and thus the defense of the nation. Whether by natural or national impact, all PHS Commissioned Officers are involved in the health of our nation and that is why national preparedness is so critical.

Retention and Mentoring

The comment was frequently made that retention is often determined by future opportunity, recognition of accomplishment and appropriate promotion within the system. When this is well known, recruitment is enhanced. When it is practiced the result is that the best and the brightest remain in the service.

Many feel that career mentoring should rest, as is now the case, with the Chief Professional Officers acting as individuals with their officers and as an aggregate group. In addition there must be personnel in DCP with a specific responsibility for mentoring who can coordinate and augment the efforts of the Chief Professional Officers. Most interviewed felt that all officers of all disciplines should receive

leadership and public health training and experience to assure that senior leadership posts in the Service could be achieved by all officers .

Career changes should be guided by the CPOs acting in conformity with individual career plans, the needs of the Service and with the concurrence of the Agencies involved in such position transfers. Many interviewees noted that if the system takes care of the officer's development they will remain with the Corps.

It is of interest that at CDC, two groups of employees are closely mentored. The mentoring process is followed in two of the programs within the CDC Epidemiology program office, namely the Epidemic Intelligence Officer (EIS) and the Public Health Advisor (PHA) programs. This mentoring is carried out entirely as a function of the operations at CDC and is not done in the same manner in other units or Agencies of the Public Health Service.

When an EIS officer is assigned to a State or locality, an agreement is struck with his or her supervisor and an individual at the CDC Epidemiology Program. They guide the officer in his first assignment and that process carries through for a career related to the functioning of the Epidemiology Program office. There is a well maintained and updated "data book" on each officer who has gone through the program since its inception in 1951. This is a voluntary program of updating that has nearly 100% participation. Such a system of record does not exist for any category of officer in the Corps as such. The same type of process is followed for the first and subsequent assignments of the PHAs.

While many officers note that remuneration was not a factor in their decision to remain in the Corps, there is some evidence in places like NIH and CDC, that officers switch from a Corps position to appointment as a Title 42 employee (Scientist) or a title 38 employee (Physician) where a more attractive salary is most tempting. Title 42 employee positions, as an example, can enjoy salaries set by the Agency at as much as $250,000 without the need to advertise or to require competitive analysis. An Agency that could but does not use Title 42 and 38 opportunities is the FDA

The impact on retention of the offering long-term training to active duty Regular Corps officers was noted by a number of interviewees. Resources for such training were once lodged within the office of the Surgeon General. Such training not only imposed a requirement for the officer to remain in service for a time equivalent to the training period but also pointed up the fact that they were serving the long-term needs of the nation. Currently, training funds are now controlled by the Agencies and they are not generally inclined to provide them to anyone who would be interested in switching Agencies or even changing their job focus through education from clinical to administrative or research positions despite the value to the public health community in general.

Many regard it as important to have at least a two week orientation program, the Basic Officer Training Course (BOTC) combined with CCRF training conducted before the

person enters active duty. In addition to learning how to wear their uniform and basic military courtesies, new officers would be indoctrinated into the "culture" of the PHS Commissioned Corps and to the field of public health. This would help them to feel more conformable about wearing their uniform even if they get less than enthusiastic support from other colleagues and their supervisor. One NIH officer noted that younger officers at NIH do not have an aversion to wearing the uniform.

IX SUMMARY OF FINDINGS

- Validation of the lack of coordination in recruitment, selection and routine mentoring of all categories of Commissioned Officers
- Lack of a force management process including components of an active reserve which can properly guide the recruitment and placement process and of a detailed computerized information system on all officers including those being recruited and those already on duty.
- Lack of a uniform process of developing and monitoring of a career pathway system for all officers which can begin with the initial recruitment process
- Lack of general knowledge of the Corps and its high service potential by the DHHS leadership and human resource unit personnel as well as the general public.
- Lack of information given to civil service and appointed employees about the value and potential of conversion of their employment status to that of a PHS Commissioned Officer
- Presence of antipathy toward the Corps
- Lack of useful Corps-specific recruitment material including special programs such as the Commissioned Officer Extern Program (COSTEP)

X RECOMMENDATIONS

- Develop a force management process, including an active reserve component, similar to that in the other uniformed services which sets out the needs for officers based on the qualifications necessary for each category. These needs should be guided by the national and global health targets of the country. Such a force management system must include a comprehensive data system that records all officers and potential applicants with information that includes skills, experience and specialty certifications. This data system will also assist and support the ongoing and emergency missions of the other agencies outside of DHHS using PHS Commissioned Officers.
- Develop a recruitment and retention system that is under the leadership of the Surgeon General, is geared to a force management process and utilizes a centralized recruitment plan coordinated by DCP or its replacement organization.

- Ensure that the DCP or its replacement organization coordinates and utilizes the Chief Professional Officers and their Professional Advisory Committees, Volunteer Active duty officers serving as Associate Recruiters, and Auxiliary recruiters who are members of the PHS Reserve component and are on the faculties of health professional schools. In order to carry out this mandate, the unit must be provided with sufficient monetary and human resources for the task.
- Develop and put into place a billet system that serves the needs of the force management process and permits the flexibility of assignment that serves the ongoing and emergency needs of the Nation. This will require firm agreements between the Surgeon General and Agency Directors as to the billets to be allocated to commissioned officers and which will involve an assessment of those positions where a commissioned officer might be a preferred incumbent.
- Each Human Resources unit throughout the DHHS agencies and in Departments outside of DHHS who employ Commissioned Officers should include, at the director level, PHS Commissioned Officers to assist in the process of recruiting and placement.
- Ensure that from the point of first recruitment and placement, and throughout their careers, each officer has a defined career pathway which is reviewed and amended periodically. This process shall be monitored by the Chief Professional Officers and DCP, with a view toward ensuring that cross-over opportunities to leadership posts in all agencies are available as appropriate.
- Ensure that the process of recruitment and retention follows the findings of the Recruitment and Retention Project (PHS Foundation, March 2003) which pointed up the need for recruitment to be conducted in concert with discipline-specific "age-appropriate" officers and with a priority focus on the use of the mechanism of COSTEP.
- Examine current positions that are predominantly filled by civil service personnel and determine if it would be appropriate to place commissioned officer in these positions, particularly those that include a major placement in State and local health authorities. Such a process is supportive of emergency service capacity. Examples of such positions that may filled by both commissioned corps and service applicants are the public health advisor and public health analyst positions at CDC.
- Each officer on entrance to the Corps, and throughout their careers should be given the opportunity to be exposed to the history and standards of the Corps. Further, it is incumbent on the Service to provide leadership, emergency response and preparedness training for each officer, along with the opportunity for further graduate education in leadership, public health practice and scientific skill building for those officers who enter the regular corps. This notion is related to the recommendation above regarding career pathways for each officer.

Appendix A

List of Interviewees and Agency Affiliation

Name	Rank	Agency
Richie Taffet	CAPT (Ret)	NIH
Eugene Migliaccio	CAPT	INS/OSG
James Hughes	RADM	CDC
James Dowdy	CAPT	CDC
Austin Hayes	CAPT	CDC
Amanda Dunnick	LCDR	ATSDR
Paul White	Civil Service	CDC
Jan Lognecker	Civil Service	CDC
Steve Thacker	RADM	CDC
William Vanderwagen	RADM	IHS
Mary Couig	RADM	FDA
Dushanka Kleinman	RADM	NIH
Terry Golden	CAPT	DCP
Richard Walling	RADM	OS
John David	LCDR	INS
John Olsen	Civil Service	INS
Mary Louise Ganaway	CAPT	INS
Eric Ewers	Sr. Enlisted	US Navy
Richard Wyatt	RADM	NIH
Marlene Haffner	RADM	FDA
Mary Babcock	Civil Service	FDA
Peter Lynch	CAPT	US Navy
G. Bryan Jones	CAPT	OS
Darrel Pratt	Civil Service	IHS
Scott Murchee	Civil Service	BOP
Timothy Lozon	CAPT	IHS

Name	Rank	Agency
Linda Brown	CAPT	NIH
Jim Sayers	CAPT	OSG
Sarah Krajnik	CAPT	US Army
Rauf Hanna	Civil Service	IHS
John Freidrich	Civil Service	IHS
Betsy Bercovich	Civil Service	IHS
Claire Helminiak	CAPT	IHS
Darren Vicenti	Civil Service	IHS
Alan Croft	CAPT	IHS
Kevin Chadwick	CDR	IHS
Chris Watson	CAPT	IHS
Stephen Tetrev	CAPT	IHS
Ed Stein	CDR	IHS
Kim Smith	Civil Service	IHS
Norm Cavanaugh	CDR	IHS
Diane Montello	Civil Service	IHS
David Yost	Civil Service	IHS
Robert Hallowell	Civil Service	IHS
Kevin Buck	SGT	US Army
Penny Coppola	Civil Service	DCP
Ann Randall	Civil Service	DCP
Angela Williams	LT	BOP
Nathan Tatum	LCDR	ATSDR
Edwin Vasquez	LCDR	DCP
James Schaeffer	LCDR	NIH
Patricio Garcia	LT	INS